The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Board of Directors | Public Meeting 07.10.2026

MEETING
7 October 2026 09:30 BST

PUBLISHED
6 October 2026

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Agenda

Location
Meeting Room 1, Main Entrance

Date
7 Oct 2026

Time
09:30 BST

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1	Welcome			09:30	-
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3	Rheumatology Service Presentation	Information	Chief Operating Officer / Deputy CEO	09:45	-
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12.1	Next Meeting: 02 December 2026				-

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

BOARD OF DIRECTORS | PUBLIC MEETING

WEDNESDAY 29 JULY 2026 AT 9:30AM AT RJAH ORTHOPAEDIC HOSPITAL

MINUTES OF MEETING

Voting Members in Attendance

Name (and identifying Initials)	Role	Attending
Harry Turner (HT)	Chair	✓
Sarfraz Nawaz (SN)	Non-Executive Director	×
Martin Newsholme (MN)	Non-Executive Director	✓
Penny Venables (PV)	Non-Executive Director	✓
Lindsey Webb (LW)	Non-Executive Director	✓
Martin Evans (ME)	Non-Executive Director	✓
Mike Hallissey (MH)	Non-Executive Director	×
Stacey Keegan (SK)	Chief Executive Officer	✓
Angela Mulholland-Wells (AMW)	Chief Finance and Commercial Officer	✓
Clair Hobbs	Interim Chief Nurse and Patient Safety Officer	✓
Ruth Longfellow (RL)	Chief Medical Officer	×
Mike Carr (MC)	Deputy CEO and Chief Operating Officer	×

Others in Attendance

Name (Initial)	Role	Attending
Paul Maubach (PM)	Associate Non-Executive Director	✓
John Pepper (JP)	Associate Non-Executive Director	×
Denise Harnin (DH)	Chief People and Culture Officer	✓
Dylan Murphy (DM)	Trust Secretary	✓
Mary Bardsley (MB)	Assistant Trust Secretary (minutes)	✓
Chris Hudson (CH)	Head of Communications	✓
Maureen Wain (MW)	Director of Delivery and Performance	✓
Richard Potter (RP)	Deputy Chief Medical Officer	✓
Colin Chapman (CC)	Governor – observing	✓
Jan Greasley (JG)	Governor – observing	✓
Victoria Sugden (VS)	Governor – observing	✓
Kate Betts (KB)	Governor – observing	✓
Sheila Hughes (SH)	Governor – observing	✓
Neil Turner (NT)	Governor – observing	✓

Ref	Discussion and Action Points
1.0	**Welcome and introductions**
	HT opened the meeting and welcomed all attendees, with particular thanks to MW and RP for joining the meeting to represent of MC and RL.
1.1	**Apologies**
	Apologies were received from Sarfraz Nawaz, Mike Hallissey, John Pepper, Mike Carr and Ruth Longfellow It was formally confirmed that the Board was quorate, enabling the meeting to proceed with full decision-making authority.
1.2	**Declarations of Interest**
	The Chair reminded attendees of their obligation to declare any interest which may be perceived as a potential conflict of interest with their Trust role and their role on this Board. There were no conflicts of interest identified in relation to the items for discussion which required members to withdraw from discussion or decision-making.
1.3	**Minutes of the previous meeting**

Ref	Discussion and Action Points
	The minutes of the Board of Directors (Public) meeting held on 1 July 2026 were approved as an accurate record, subject to the following amendments: • **Attendance table:** DM to be recorded as having submitted apologies. • **Page 5 – Maternity Services:** The section to be amended to reflect that, although the Trust does not provide maternity services, elements of the national improvement plan are relevant to its wider patient engagement responsibilities. The importance of considering and applying the learning within Trust services should also be reflected. • **Page 6 – Learning from Deaths:** The section to be amended to reflect the encouraging evidence of organisational learning from complaints and the patient engagement work implemented to support improvements in the complaints process.
1.4	**Matters Arising and Action Log**
	The Board discussed the following actions: • **Action 1 – CEO Report, Heatwave:** The Executive Team confirmed that the action was on track. An after-action review has been scheduled to identify learning from the recent heatwave, and this work has been added to the Quality and Safety Committee workplan. The findings will be reported to the Board through the Committee Chair's Assurance Report. The Board agreed that the action could be closed. There were no matters arising shared.
2.0	**Chair and CEO Update**
	Chair Update HT provided the following updates: • **Regional Chair Event and Enhanced Recovery** - Positive feedback was received following the recent regional chairs' event, where RJAH was recognised for its work on productivity and enhanced recovery. The workshop brought together organisations to share best practice, and the Trust delivered a presentation on its enhanced recovery programme. MC, Professor Geraint Thomas and Becky Warren presented and responded to questions from attendees. Feedback was overwhelmingly positive and reflected the strength of the Trust's clinical leadership, Board ownership of the programme, and commitment to continuous improvement. HT expressed thanks to MC, Professor Geraint Thomas and Becky Warren for their excellent contribution and for showcasing the Trust's work so effectively. • **NHSE Board Appraisal Process (FPPT)** - The annual Fit and Proper Persons Test (FPPT) process for all Board members has been completed, with support provided by MB and DM. Individual reviews have been undertaken and the submission was made within the required timescales. No queries have been raised by NHSE following submission. • **NHSE Winter Planning** - The winter planning process will commence in September. Progress and plans will be reported to the Board through the September Board Assurance Statement. • **Committee Membership Review** - A review of Non-Executive Director committee memberships is required to ensure workloads remain manageable and balanced. It had previously been anticipated that the Activity Recovery Committee and Electronic Patient Record (EPR) Implementation meeting would be stood down; however, the EPR meeting may need to remain in place for longer than originally envisaged and this will be reconsidered. • **Board-to-Board Session with ROH** - RJAH will host the Board-to-Board session with the Royal Orthopaedic Hospital (ROH) in October which will give the organisations opportunities to showcase the Trust's work and share learning with colleagues from ROH. Further consideration will be given to the programme and arrangements for the day. **Chief Executive Officer Update** SK provided the following updates: • **Heatwave Response and Estates Planning** - Thanks were extended to all staff for their commitment, flexibility and resilience during the recent heatwave conditions. Despite challenging temperatures, staff continued to deliver high-quality care and support to patients. June and July saw record-breaking temperatures, highlighting the need for the Trust to adapt to more frequent periods of extreme weather. The Trust is reviewing its Estates Strategy and cooling plans to ensure facilities remain fit for the future and support the wellbeing of patients, visitors and staff.

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Ref	Discussion and Action Points
	• **National Publications** - Several key national publications have been released which will influence the Trust's strategic and operational priorities. The National Patient Standards focus on improving the experience of elective care patients through enhanced communication, information sharing and personalised support. A multidisciplinary working group has been established to oversee implementation of the National Patient Standards. The National Quality Strategy aligns with the Government's 10-Year Health Plan and focuses on quality improvement, reducing variation, tackling inequalities and increasing transparency. The Trust has commenced a review of its quality and improvement strategies to ensure alignment. New National Staff Standards have been published, setting expectations regarding wellbeing, inclusion, leadership, development and support. The NHS Management and Leadership Framework has been introduced to strengthen leadership capability, accountability and continuous improvement. Work is underway to assess the implications of these publications and refresh relevant Trust strategies, policies and programmes. • **Neighbourhood Health Visit** - attended the NHS England/ICB Cluster Neighbourhood Health visit led by Dr Claire Fuller. The visit provided an opportunity to showcase progress across the Cluster, including RJAH's leadership of musculoskeletal (MSK) transformation. Feedback was highly positive, recognising the strong foundations established and progress made to date. Constructive challenge was provided to encourage partners to accelerate delivery and strengthen collaborative working across the system. The visit was viewed as a positive step forward in supporting neighbourhood health and wider system transformation. • **Care Quality Commission (CQC)** Engagement - The Trust welcomed the CQC Engagement Team during July. The visit included presentations and visits to a range of clinical and corporate departments. The engagement provided an opportunity to showcase Trust services, culture and approach to patient care. Discussions were constructive and focused on learning, improvement and identifying opportunities for further development. • **Patient Records and Information** Governance - Recent national communications have highlighted instances of inappropriate access to patient records across the NHS. Unauthorised access to patient information constitutes a breach of confidentiality and can result in disciplinary action, including dismissal. The Trust will launch a staff awareness campaign to reinforce responsibilities relating to the appropriate access and handling of patient information. The campaign will highlight both legal and ethical obligations, together with the potential consequences of non-compliance. • **RJAH Stars Awards** - Since the last public Board meeting, two RJAH Stars Awards have been presented. Ellie Moore, Nursing Associate on Ludlow Ward, received the July award after being nominated by a patient for demonstrating exceptional compassion, kindness and reassurance. Dan Booth, Clinical Audit Quality Lead, received the June award in recognition of his significant contribution to the implementation of Radar Healthcare and support provided to teams across the Trust. Congratulations were extended to both recipients for their outstanding contribution and commitment to Trust values. Following the updates provided by HT and SK, the Board discussed the following matters: • **Neighbourhood Health:** In relation to the recent Neighbourhood Health visit, there was a query whether a detailed update could be provided to the Board and Non-Executive Directors on the progress being made across the system in delivering the Neighbourhood Health plan. It was agreed that a more comprehensive update would support Board understanding and oversight. The Board noted ongoing challenges within the Outpatient Transformation Programme. ME advised that they are supporting this workstream and recognised the potential alignment and opportunities for collaboration with the MSK Working Group. • **Strategy Delivery Group**: Members welcomed the establishment of the Strategy Delivery Group (SDG) and reflected positively on the associated discussions that had taken place at the committee meetings throughout the month. • STAR Award: The Board expressed its appreciation to DM in relation to the STAR Award initiative and requested that its thanks be formally recorded within the minutes. • **Veterans Strategy:** An update was provided on the Veterans Strategy. It was noted that reporting on progress and outcomes would be submitted through the Finance and Performance Committee; however, members felt that the significance of the strategy

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Ref	Discussion and Action Points
	extended beyond a single committee and should be reflected appropriately through wider Board and committee reporting arrangements. The Board noted the updates from HT and SK.
3.0	**Risk Management**
3.1	**Board Assurance Framework**
	DM presented the Board Assurance Framework, highlighting the following: • The Board received the first full iteration of the Board Assurance Framework (BAF) for 2026/27. • It was noted that the revised framework comprises nine strategic risks, including three new areas of focus relating to health inequalities, innovation and growth, and digital, data and AI security. • Members noted that the BAF had been reviewed through the July cycle of Committee meetings, with further commentary and recommendations reflected within the Chairs' Assurance Reports. The Board discussed the following: • BAF 2 and BAF 7: During discussion, members highlighted the interdependencies between BAF 2 (equity of service and addressing health inequalities) and BAF 7 (the challenges of operating across the Welsh and English health systems), noting that further consideration should be given to how these risks interact and influence risk scoring and controls. • BAF 6: It was also noted that the narrative supporting BAF 6 (delivering innovation, improvement and growth) should more clearly reflect the role and contribution of the Chief Digital and Information Officer and the importance of digital transformation in supporting delivery of the objective. • The Board agreed that greater alignment was required between the metrics reported through the Integrated Performance Report (IPR) and the BAF, with clearer links and traceability between performance indicators, sources of assurance and strategic risks. Members also noted that some areas of the framework would benefit from further updates to reflect recent progress and developments. • The Board welcomed the assurance that ownership and monitoring of the BAF is embedded within the work of the relevant Committees and reporting structures. Specific discussion took place regarding BAF 2 and health inequalities, with members noting that relevant data is routinely reviewed through the Quality and Safety and Finance and Performance Committees. It was agreed that assurance on this area would continue to be provided to the Board through the Chairs' Assurance Reports. The Board: • Noted the first full iteration of the Board Assurance Framework for 2026/27. • Considered feedback and recommended revisions arising from Committee review. • Received assurance regarding the ongoing oversight and monitoring arrangements in place through Board Committees and associated reporting mechanisms.
3.2	**Corporate Risk Register**
	The Board received a report outlining the 26 risks currently rated at 15 or above on the Trust Risk Register that had been considered through the July Committee cycle. It was noted that each risk had been allocated to at least one Board Committee for oversight and scrutiny. The Board heard that Committees had received detailed risk summaries, including risk scores, current position, controls, assurance ratings and anticipated timescales for risk reduction or closure. Following Committee feedback, future reports would be further refined to focus on key assurance messages and areas requiring escalation. It was noted that the Trust continues to embed two significant changes to its risk management arrangements: the transfer of risks from the Apollo Programme into the corporate risk framework, and the implementation of Radar Healthcare as the Trust's new risk management system. Members acknowledged that both developments had presented practical challenges and that work remains ongoing to refine transferred risks and optimise the use of Radar Healthcare. The Board discussed the following:

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	• the reporting arrangements and noted that the organisation is still becoming familiar with the functionality and reporting capabilities available through Radar Healthcare. It was recognised that further development of reporting will continue as the system becomes embedded. • Discussion took place regarding Risk 202, relating to Occupational Health. Members were advised that further improvements are being pursued in relation to procurement arrangements. Concerns remain regarding the compliance of the current provider and the potential transfer of information during any future handover process. It was noted that similar discussion had taken place at the Quality and Safety Committee. The Trust has formally written to the supplier and a response has been received, which is currently being reviewed. • Members noted that further detail on individual risks and discussions held at Committee level are reflected within the respective Chairs' Assurance Reports. The Board was assured that the revised reporting process was providing greater visibility of the Trust's highest-rated risks. Members welcomed the opportunity to challenge and discuss the most significant risks and agreed that recent discussions demonstrated a positive and transparent approach to risk reporting and oversight.
4.0	**Quality and Safety**
4.1	**Performance Report – Quality and Safety Committee**
	The Board received the Quality and Safety Performance Report (by exception) and noted the following key points: • The Integrated Performance Report was reviewed by the Quality and Safety Committee. One death was recorded in June; this had been anticipated and was not unexpected. • Positive assurance relating to complaints reduced during June. It was noted that it is too early to determine whether this reflects any impact from the recent complaints review. • Patient care, nutrition and hydration continue to be common themes within complaints. Whilst current reporting does not indicate a direct link to the recent review findings, the Committee noted the importance of ongoing monitoring and analysis of complaint themes. The Board noted the report and the assurance provided.
4.2	**Chair's Assurance Report – Quality and Safety Committee**
	LW presented the key points from the Quality and Safety Committee Chair's Assurance Report and highlighted the following matters: • A deep-dive review of complaints was received. Early indications demonstrate improvements in both the number of complaints and response times. The Committee will continue to monitor progress and seek further assurance that improvements are sustained. • The Committee reviewed the Board Assurance Framework and discussed the associated risk scores. No matters were identified that required escalation to the Board; however, the discussion and rationale for the current scores were noted. • The Corporate Risk Register was also reviewed and issues or risks requiring escalation were identified. • An update was received on the Radiology Apollo implementation. The Committee emphasised the importance of ensuring that all patient harm reviews are completed and appropriately monitored as part of the implementation process. • The Committee considered the Fuller Board Assurance Statement, which is reported separately on the agenda. • The Committee was content with the performance presented and the level of assurance provided. The Board noted the Chair's Assurance Report, confirmed that it was satisfied with the level of assurance provided, and acknowledged the Committee's continued focus on key quality and safety risks.
4.3	**Learning From Deaths Report**
	RL presented the learning form deaths paper highlighted the following: • Three patient deaths were reported during Quarter 1. • One death occurred in June, with positive feedback received from the patient's family.

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	• One death related to a cancer patient, with positive feedback also received from the family regarding the care provided. • One post-operative death occurred in August. The case has been referred to the Coroner, and the inquest process is underway. Learning identified through these cases continues to be disseminated via the Learning from Deaths Group and relevant multidisciplinary team (MDT) meetings to support organisational learning and service improvement. The Board noted the report.
4.4	**Fuller Board Assurance Statement**
	The Board received the Fuller Board Assurance Statement, prepared in response to the recommendations arising from the Fuller Inquiry and NHS England's subsequent requirements for NHS organisations. The statement outlines the Trust's assurance arrangements relating to the care of people after death, including safeguarding oversight, governance arrangements, estates assurance, and consideration of the recommendations relevant to NHS providers. It was noted that the requirement follows correspondence received from NHS England in June regarding concerns relating to mortuary services and the associated review. Due to the submission timescales, the assurance statement had been reviewed by the Executive Team and considered by the Quality and Safety Committee outside of the normal meeting cycle. The Board thanked LW for undertaking the committee review and providing assurance on behalf of the Committee. LW confirmed that the Quality and Safety Committee supported the assurance statement and recommended its approval by the Board. It was noted that the additional actions identified within the statement are intended to provide further assurance and strengthen existing arrangements, rather than address any immediate concerns. The Board noted the requirement to undertake an audit with the Trust's off-site mortuary provider and to continue reviewing associated contractual arrangements and key performance indicators as part of the ongoing assurance process. Following discussion, the Board was assured regarding the contents of the statement and approved its submission to NHS England ahead of the required deadline.
5.0	**People and Workforce**
5.1	**Performance Report**
	The Board received the People and Workforce Performance Report (by exception) and noted the following key points: • Sickness absence, vacancy rates and staff turnover remained within target, with sustained positive performance across all three indicators. • Agency expenditure had reduced slightly during the reporting period. Temporary staffing expenditure remained marginally above plan and continues to be closely monitored. • It was noted that attendance at the Health and Wellbeing best practice event had been beneficial, particularly in relation to sickness absence management. PM, DH and ME attended on behalf of the Trust and identified several examples of good practice. The Trust has agreed to engage further with Leicester to explore opportunities for additional support and to consider initiatives that could enhance staff health and wellbeing. The Board noted the report and was assured by the overall workforce performance position. No significant workforce issues or concerns were identified that required further Board action.
5.2	**Chair's Assurance Report – People and Culture Committee**
	PM provided an overview of the key matters discussed at the People and Culture Committee for Board assurance. The Committee noted the Trust's strong workforce performance and discussed opportunities to benchmark against higher-performing organisations, with learning opportunities to be explored with Leicester.

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	An update was provided on Corporate Risk Register Risk 202 and mandatory training compliance. Whilst the introduction of a three-month grace period had improved the position, levels of non-compliance remained above the target. The Board discussed the need to ensure staff were aware of the revised policy and requested reporting on compliance both within and outside the grace period. The Board emphasised the importance of understanding whether any mandatory training requirements should not be permitted to lapse due to potential health and safety implications. Members sought assurance that staff providing care remained appropriately trained and competent. High DNA rates for training sessions were noted. The Board requested consideration of training provision, including the timing and availability of sessions, to ensure staff were able to attend. Challenges associated with releasing staff from 12-hour shifts and ensuring bank staff remained compliant were acknowledged. DH advised that mandatory training topics were being risk assessed to identify the areas of greatest organisational risk and that training provision was also being reviewed. PM emphasised that the Trust continued to perform strongly in relation to mandatory training compliance, noting that the three-month grace period accounted for approximately 8% of the workforce. The aspiration remained to achieve 100% compliance. ACTION: A further report on mandatory training compliance and associated risks to be presented to the People and Culture Committee in September, with the August report to be shared with the Chair outside the normal meeting cycle. The Board discussed temporary staffing pressures and noted that maintaining activity levels had contributed to increased bank expenditure. Concerns regarding pressures within anaesthetic services and the potential impact on Finance and Performance and Quality and Safety were also considered. It was reported that sickness absence within the anaesthetic team was being managed, recruitment activity was underway with significant interest shown, and that middle-grade anaesthetists nearing completion of their qualifications would help mitigate current workforce pressures. The Board welcomed the planned deep dive into mandatory training compliance, acknowledged the positive workforce performance reported and was content with the assurance provided. The Board acknowledged the strong workforce metrics and positive performance reported and expressed its thanks for the continued efforts of staff across the Trust.
5.3	**Freedom to Speak Up Q1 Report**
	DM presented the report confirming the People and Culture Committee received the first Freedom to Speak Up report presented by Kate Hannah since taking up the Guardian role. The report included the routine Quarter 1 update, together with a proposed work plan outlining key priorities for the year ahead. Members welcomed the report and noted the positive impact of the new Guardian's appointment. It was recognised that there is a clear vision for the role, with a focus on further developing the service and strengthening support for staff across the Trust. The Board noted that the number of cases reported remained relatively low. It was acknowledged that this may, in part, reflect the period during which the Trust did not have an on-site Freedom to Speak Up Guardian, with interim support being provided by the Royal Orthopaedic Hospital. The Board was assured that the Trust is in a positive position and had no matters requiring escalation to the Board at this time. Members placed on record their thanks to Claudette Jones for the support provided to the Trust during the interim period prior to the appointment of the substantive Freedom to Speak Up Guardian.
5.4	**Guardian of Safe Working Hours Q1 Report**

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Ref	Discussion and Action Points
	The Committee received the Guardian of Safe Working Hours (GSWH) Quarter 1 Report and noted the positive assurance provided. It was reported that no exception reports had been submitted during the reporting period. Members noted that resident doctors had been encouraged and empowered to raise concerns regarding safe working practices following publication of the report. The Board acknowledged that a number of vacancies continued to be covered through premium rate shifts to maintain service delivery and staffing resilience. In relation to section 3.3.2, concerning weekend working and night cover, it was noted that a dedicated working group had been established to review arrangements and support improvements. This work was also linked to the wider programme of insourcing activity being undertaken at weekends. A query was raised regarding progress against the Medical Workforce 10-Point Plan. Members were advised that oversight is being provided through the People Committee, with involvement from the Lead Non-Executive Director, Executive leads, and the Chief Medical Officer. Further updates will continue to be reported through that forum. The Committee noted the contents of the Quarter 1 Guardian of Safe Working Hours Report and the assurances provided.
6.0	**Performance and Finance**
6.1	**IPR Exception Report (inc. Long Waiting Patients)**
	MW presented the Integrated Performance Report (IPR), highlighting current performance against key operational metric noted the positive position across a number of key performance indicators, The Board acknowledged the progress made against key performance standards and reaffirmed the importance of maintaining momentum to ensure delivery of the operational plan, further reduction in long waits, and timely treatment for patients. MW presented the Integrated Performance Report (IPR), highlighting current performance against key operational metrics. The Board noted the positive position across a number of key performance indicators, particularly in relation to cancer access standards and elective recovery. The Board heard that performance against the 18-week Referral to Treatment (RTT) standard continued on a positive trajectory and remained ahead of plan. Whilst annual leave periods had presented some operational challenges and resulted in lower activity levels, overall performance remained significantly ahead of trajectory, both in terms of RTT performance and reduction in the size of the waiting list. An update was also provided on Welsh RTT performance, which had improved by 1.82 percentage points during the month. The Board noted a number of ongoing challenges, including an increase in English 52-week waits. An escalation process has been established for specialist services to address these concerns. In addition, MRI performance has been impacted by scanner issues during periods of hot weather, affecting capacity and delivery. Whilst elective activity remains above plan, the Board noted that current performance is being supplemented through insourcing arrangements. Concern was raised that this does not fully reflect underlying performance levels, and members were advised that a dedicated review meeting has been established to consider longer-term solutions and sustainability. ACTION: A six-month performance review and assessment of performance trajectories for the remainder of the financial year to be presented to a future Finance and Performance Committee. The Board acknowledged the progress made against key performance standards and reaffirmed the importance of maintaining momentum to ensure delivery of the operational plan, continued reduction in long waits, and timely access to treatment for patients.
6.2	**Finance Performance Report**

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Ref	Discussion and Action Points
	AMW presented the Finance Performance Report and highlighted the following key points: • The Trust is reporting a break-even position at the end of Quarter 1. • Elective activity and overall activity levels remain below plan, resulting in income pressures. This has also contributed to increased variable pay costs due to insourcing and outsourcing arrangements. • The adverse income variance against plan is currently being offset through cost mitigation measures and non-recurrent actions, including the release of prior-year accruals and contractual provisions within Quarter 1. • Delivery of planned activity remains a key dependency for achieving the forecast income position during the remainder of the financial year. • A Productivity Improvement Group has been established and will review productivity opportunities and consider the need to reforecast activity plans for the second half of the year. • The Trust's cash position remains strong, with no issues to report. Cash balances are forecast to be approximately £0.5m ahead of plan. • Capital expenditure is progressing positively. Although some schemes have experienced minor slippage, the capital programme will be rephased accordingly. The Board noted that, despite ongoing activity and income pressures, the Trust remains financially well controlled and is performing slightly ahead of plan. Mitigating actions continue to be implemented to address productivity and contractual challenges, while maintaining a stable cash position and robust financial oversight.
6.4	**Chair Report from Finance and Performance Committee**
	The Chair's Assurance Report was presented and highlighted the following key points: • Discussion took place regarding theatre activity and performance. A reforecast for the second half of the year has been requested to provide greater clarity on expected activity levels and delivery against plan. • The Committee discussed risks relating to the Orthotics service, noting that several risks remain on the Corporate Risk Register. Concerns were raised regarding the potential impact on patients arising from the inactive service. Assurance on this matter has been requested through the Quality and Safety Committee. It was noted that the issue has been escalated within the wider system and reflects a national challenge. • Concerns regarding theatre productivity and activity were discussed. The Board noted the proactive management approach being taken, including the establishment of dedicated working groups to support improvement and recovery. • Clinically ready for Discharge patients were discussed, with members noting that this remains a challenge across a number of organisations. The Board requested a future update outlining the current impact and progress being made. Particular concern was raised regarding spinal injury patients, where ongoing discussions are taking place to identify additional support arrangements. Patient transport was also highlighted as a contributing factor to discharge delays. The Board discussed the following: • CH advised that the issue of patient transport would be raised at the ICB Chief Nursing Officer meeting. Members discussed what further actions could be taken to support timely discharge. It was noted that the team is being kept informed of delayed discharges and that MC is raising the matter through commissioning discussions relating to both English and Welsh patients. The Board noted that the issue is also being monitored through the Quality and Safety Committee. • ME commented that it would be helpful for future reports to provide a clearer indication of progress and the areas where the greatest impact is being achieved. • PM highlighted a typographical error within the Performance Report, noting that the numerator should refer to patients waiting less than 26 weeks rather than less than two weeks. • PM also noted a marginal increase in Patient Initiated Follow-Up (PIFU) activity and sought clarification as to whether this represented a positive trend. Assurance was provided that the increase is aligned with the Trust's transformation programme and that performance currently exceeds plan.

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Ref	Discussion and Action Points
	The Board received and noted the Chair's Report from the Finance and Performance Committee and confirmed that it was satisfied with the level of assurance provided.
7.0	**Digital, Education, Research, Innovation and Commercialisation**
7.1	**Chair Report from Digital, Education, Research, Innovation and Commercialisation Committee**
	ME presented the Chair's Assurance Report and highlighted the following key areas: • Progress continues in delivering the strategic priorities for improvement and innovation across the portfolio. • The Commercialisation Strategy was presented for Board approval. Given the commercially sensitive nature of the content, the strategy was considered in private session. It was noted that the strategy will continue to evolve as work progresses. • Significant work is underway in relation to the Electronic Patient Record (EPR) programme. The Committee noted anticipated delivery of key milestones during September, which are expected to positively impact the associated risk profile, leading to a reduction in risk rating and increased assurance. The next Committee meeting will focus on assessing the effectiveness of these developments and the benefits realised for staff. • The Integrated Performance Report (IPR) remains under development. Executive leads are progressing work across the five key strands to establish meaningful performance reporting and provide greater organisational insight. • Good assurance was received regarding cyber security. The Committee noted the successful completion of a phishing exercise, with key learning points to be shared across the organisation. • It was noted that elements of performance reporting currently presented through the IPR may need to transition to other committees as reporting arrangements mature and development work is completed. • The Committee welcomed attendance from the Communications Team, noting the value this brings in supporting effective communication and sharing of Committee activity and achievements. The Board noted the Chair's Assurance Report and was satisfied with the level of assurance provided, recognising the progress being made across the Committee's portfolio of work.
8.0	**Questions from the Governors and Public**
	The Chair welcomed comments and questions from Governors and members of the public. • **Theatre Activity and Staffing of the New Theatre Facility -** queried the reduction in theatre activity and sought assurance regarding the staffing of the new theatre development, noting ongoing recruitment activity within the service. In response, it was explained that the reduction in activity was attributable to a number of factors, including significant changes to consultant job plans, which have been supported through the use of fellows, and unplanned maternity leave. Theatre productivity and case volumes continue to be monitored through the Theatre Improvement Group. The Board was advised that recruitment for the new theatre development has been completed, with plans progressing as expected. The opening of the new theatre is aligned to the onboarding of newly appointed consultants. Preparation work remains on track and progressing well. It was noted that there are no current concerns regarding theatre staffing. The Trust has appointed six new surgeons, with approved job plans aligned to the additional theatre capacity. Flexibility sessions have also been incorporated into workforce planning to support future service requirements. The position continues to be monitored through both Operational and People Services, with regular reporting provided to the People Committee. • **Bank Pay Overpayment Issue** - sought clarification regarding bank pay and whether this related to the recent staff overpayment issue. The Board was advised that the matter had largely been resolved. Pay adjustments had been completed and additional support had been provided through manager briefing notes, frequently asked questions and targeted troubleshooting support. It was reported that the issue had arisen as a result of an error within a system algorithm. The Trust will continue to monitor the position to ensure no further issues arise. The Board noted that a report had been requested for a future meeting of the Audit and Risk Committee, setting out the cause of the issue, lessons learned, actions taken and assurance that appropriate controls are now in place.

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Ref	Discussion and Action Points
	• **Welsh Waiting List Reductions** - welcomed the positive progress made in reducing the Welsh waiting list and expressed appreciation for the improvement achieved.
9.0	**Risk and Value Reflection**
	Reflecting on the meeting there were no specific risks to raise which were not already recorded on either the corporate risk register or the Board Assurance Framework.
10.0	**Any Other Business**
	There were no further items of business shared. HT thanked the attendees for their contribution to the meeting before brining it to a close.
10.1	**Date and time of next meeting:** Wednesday 07 October 2026 at 9:30am

DRAFT

Board of Directors Meeting

Updated: 30 Sept 2026

Action Log No.	Original Meeting Date	Minute reference	Action	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
2	29-Jul-2026	**Chair Report - People and Culture Committee**	A further report on mandatory training compliance and associated risks to be presented to the People and Culture Committee in September, with the August report to be shared with the Chair outside the normal meeting cycle.	DH	**30-Sep-2026**	Complete - Mandatory training was discussed at the informal People and Culture Committee meeting in August, with a further report presented to the Committee in September. Upward reporting has been included within the Chair's Report from the People and Culture Committee, which is contained within the meeting pack.	**COMPLETE**
3	29-Jul-2026	**Perofmrnacne Report**	A six-month performance review and assessment of performance trajectories for the remainder of the financial year to be presented to a future Finance and Performance Committee.	MC	**30-Sep-2026**	Complete - reforecast presented to the Finance and Performance Committee in September	**COMPLETE**

Member	First Name	Surname	Email	Position	Type of Interest	Description of Interest (including for indirect interests, details of the relationship with the person who has the interest)	Date interest relates From	Date interest relates To
Board	Harry	Turner		Chairman	Non-Financial Personal Interests	Presiding Justice West Mercia judiciary	01/10/2026	Ongoing
Board	Sarfraz	Nawaz		Non Executive Director	Financial Interests	Wakefield Council – Corporate Director of Resources	01/02/2026	Ongoing
Board	Sarfraz	Nawaz		Non Executive Director	Non-Financial Professional Interests	Member of CIPFA	01/01/2021	Ongoing
Board	Sarfraz	Nawaz		Non Executive Director	Non-Financial Professional Interests	S151 Officer for West Yorkshire Joint Services, and YPO	01/09/2025	Ongoing
Board	Martin	Evans		Non Executive Director	Financial Interests	Non-Executive Director at North Staffordshire Combined Healthcare NHS Trust	28/08/2024	Ongoing
Board	Martin	Evans		Non Executive Director	Financial Interests	Director at MJE Associates Ltd.	01/04/2020	Ongoing
Board	Martin	Evans		Non Executive Director	Financial Interests	Coach for the National Neighbourhood Health Implementation Programme	01/09/2025	Ongoing
Board	Penny	Venables		Non Executive Director	Financial Interests	Consultant – In-Form Solutions Ltd, Lichfield Business Hub, Lichfield Council House, 20 Frog Lane, Lichfield, Staffordshire, WS13 6YY. Work as a management consultant via this business.	01/01/2021	Ongoing
Board	Penny	Venables		Non Executive Director	Financial Interests	Trustee Board of Birmingham University Guild of Students	01/01/2025	Ongoing
Board	Penny	Venables		Non Executive Director	Financial Interests	Member of the Members Council of the West Bromwich Building Society	01/10/2024	Ongoing
Board	Penny	Venables		Non Executive Director	Non-Financial Professional Interests	Husband has also just been appointed as Interim CEO to the Devon, Cornwall and Scilly Isles	19/03/2026	Ongoing
Board	Penny	Venables		Non Executive Director	Non-Financial Personal Interests	Husband is NED at Birmingham and Black Country ICB	01/02/2026	Ongoing
Board	Penny	Venables		Non Executive Director	Non-Financial Personal Interests	Chair Kore Wellness, Tipton Sports Acadamy, Wednesbury Oak Road, Tipton, West Midlands DY4 0BS.	01/11/2023	Ongoing
Board	Martin	Newsholme		Non Executive Director	Financial Interests	Non executive Chairman of Shropshire Doctors Co-operative Limited	01/08/2019	Ongoing
Board	Martin	Newsholme		Non Executive Director	Financial Interests	Non executive director at Warrington Housing Association	01/09/2018	Ongoing
Board	Lindsey	Webb		Non Executive Director	Indirect Interests	Husband is a Deputy Chair at Birmingham, Black Country and Solihull ICB	17/11/2025	Ongoing
Board	Mike	Hallissey		Non Executive Director	Non-Financial Professional Interests	Non-Executive Director of Sandwell and West Birmingham NHS Trust	01/01/2022	Ongoing
Board	Mike	Hallissey		Non Executive Director	Non-Financial Professional Interests	Consultant Surgeon, University Hospitals Birmingham NHS Foundation Trust	01/05/1995	Ongoing
Board	Mike	Hallissey		Non Executive Director	Indirect Interests	Director, Pegasus Classic Car Parts Ltd	01/11/2025	Ongoing
Board	John	Pepper		Associate Non Executive Director	Financial Interests	GP appraiser for NHSE	2012	31/03/2026
Board	Paul	Maubach		Associate Non Executive Director	Non-Financial Professional Interests	Member of CIPFA	01/03/2023	Ongoing
Board	Paul	Maubach		Associate Non Executive Director	Financial Interests	Director for Neighbourhood Health (Department of Health)	01/08/2024	Ongoing
Board	Paul	Maubach		Associate Non Executive Director	Financial Interests	Director and Owner of Maubach Consulting Ltd	01/04/2023	Ongoing
Board	Stacey	Keegan		Chief Executive Officer	Non-Financial Professional Interests	Lead CEO for the NOA	01/12/2025	Ongoing
Board	Stacey	Keegan		Chief Executive Officer	Non-Financial Professional Interests	A member of the National Orthopaedic Alliance Board	03/05/2024	Ongoing
Board	Stacey	Keegan		Chief Executive Officer	Non-Financial Professional Interests	STW ICB Non Board Member	10/09/2026	Ongoing
Board	Ruth	Longfellow		Chief Medical Officer	Financial Interests	Private Practice work for RJAH	01/01/2011	Ongoing
Board	Ruth	Longfellow		Chief Medical Officer	Non-Financial Professional Interests	Member and chair of the Jenner Society at Morton Hall and organiser of the annual MMI evening at RJAH	01/01/2016	Ongoing
Board	Ruth	Longfellow		Chief Medical Officer	Non-Financial Professional Interests	Member of Orthopaedic Institute	01/01/2016	Ongoing
Board	Mike	Carr		Chief Operating Officer	Indirect Interests	Parent is Chief Executive of Midlands Partnership NHS Trust.	01/05/2022	Ongoing
Board	Mike	Carr		Chief Operating Officer	Non-Financial Personal Interests	Trustee at Stay Charity	01/02/2025	Ongoing
Board	Denise	Harnin		Chief People and Culture Officer	Non-Financial Personal Interests	Spouse is completing consultant work at Johnson Fellows Charter House, Birmingham, Ad hoc HR consultancy Johnson Fellows (previously a senior partner)		Ongoing
Board	Angela	Mulholland-Wells		Chief Finance and Commerical Officer	Non-Financial Professional Interests	Board Trustee and chair of the Audit, Finance and Risk Committee for Mines Advisory Group.	01/10/2023	Ongoing
Board	Clair	Hobbs		Chief Nurse and Patient Safety Officer	No interest to declare	N/A	N/A	N/A
Board	Kevin	Upshaw		Chief Digital and Information Officer	No interest to declare	N/A	N/A	N/A

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chief Executive Officer Update

Committee / Group / Meeting, Date

Board of Director - Public Meeting, 07 October 2026

Author:		Contributors:
Name:	Stacey Keegan	Chris Hudson,
Role/Title:	Chief Executive Officer	Head of Communications

Report sign-off:

Stacey Keegan, Chief Executive Officer

Is the report suitable for publication:

Yes

Key issues and considerations:

This paper provides an update regarding key activities and updates not covered within the main agenda since the last Board from the Chief Executive Officer.

Recommendations:

The Board is asked to note and discuss the contents of the report.

Acronyms	
AHP	Allied Health Professional
CEO	Chief Executive Officer
CQC	Care Quality Commissioner
GTPS	Greater Trochanteric Pain Syndrome
HSJ	Health Service Journal
NHS	National Health Service
NOF	National Oversight Framework
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust
ICS	Integrated Care System
AGM	Annual General Meeting
VCHA	Veterans Covenant Healthcare Alliance

Chief Executive Officer Update

Thirlwall Inquiry

The publication of the Thirlwall Inquiry report represents a significant moment for the NHS and reinforces the importance of maintaining a culture where concerns are heard, escalated and acted upon. The findings highlight the critical role of leadership, effective governance, professional curiosity and organisational transparency in ensuring patient safety remains at the centre of decision-making.

The Board and Executive Team have begun reviewing the Inquiry's findings and recommendations to understand their relevance to RJAH and to identify any opportunities to strengthen our existing arrangements. While the Trust has a strong culture of quality, safety and openness, we will use the Inquiry as an opportunity to reflect, learn and ensure that our governance, assurance and speaking-up arrangements continue to support the highest standards of patient care and safety.

National Oversight Framework

Since the last public Board meeting, NHS England has published its Quarter 1 2026/27 National Oversight Framework results. RJAH remains in segment 1 and has risen one place to 16th out of 134 trusts, continuing its record of improving its national league table position with every iteration since the framework was launched in September 2025.

The Quarter 1 results are the first produced under the revised 2026/27 framework, which includes updated metrics and a new threshold-based approach to segmentation. Direct comparisons with previous quarters should therefore be treated with appropriate caution. Further information on the Trust's progress and position is provided at Appendix 1.

Provider Capability Self-Assessment Submissions

In line with the *Assessing Provider Capability* guidance, the Trust completed and submitted its annual capability self-assessment to NHS England. As part of this process, NHS boards are required to assess their performance across the six domains of *The Insightful Provider Board*:

- Strategy, leadership and planning
- Quality of care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

The Trust's self-assessment will be triangulated against NHS England's view of the organisation, taking account of its recent performance, management capability, track record, and other available intelligence, including information from third-party sources. The process provided a valuable opportunity for the Trust to reflect on its achievements over the past year and recognise the progress the organisation continues to make. The Trust expects to receive the outcome of the assessment in December.

NHSE Leadership Event

I attended the national NHS Chief Executive meeting during the reporting period, which focused on delivery of the NHS 10-Year Health Plan, operational performance, productivity and financial sustainability across the NHS. A significant element of the discussion centred on the findings of the Thirlwall Inquiry and the actions expected of NHS organisations to strengthen patient safety, organisational culture, leadership accountability and processes for listening and responding to concerns raised by patients, families and staff.

NHSE Provider Review Meeting

The Trust's latest Provider Review Meeting with NHS England was positive, with recognition of our continued strong organisational performance, Segment 1 NHS Oversight Framework rating, leadership stability and strategic progress. Discussions focused on delivery of the 2026/27 plan, our developing partnership with the Royal Orthopaedic Hospital, digital transformation, and our wider ambitions to further strengthen RJAH's leadership role across the system for MSK.

NHS England were supportive of the Trust's direction of travel and recognised the progress being made across a number of key areas.

Integrated Care Board

During this reporting period, I have been appointed as a non-voting partner member of the NHS Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent ICB. This role will further

strengthen RJAH's contribution to system leadership and provide an additional opportunity to influence strategic decision-making and partnership working across the wider NHS.

Executive to Executive Meeting – ICS

In September, RJAH and the Integrated Care System (ICS) came together for a joint Executive Team meeting, providing dedicated time to review progress against the Trust's operational and financial plans. The session also explored the current challenges facing both organisations, while offering an opportunity to discuss future strategic priorities and areas of shared focus.
The meeting enabled colleagues to strengthen relationships, welcome and engage with new members of both executive teams, and further enhance collaborative working across the system. The discussions reinforced a shared commitment to partnership working and delivering high-quality, sustainable services for the population we serve.

Annual General Meeting

On 30 September, the Trust held its Annual General Meeting (AGM), bringing together staff, patients and members of the public to reflect on the achievements and challenges of 2025/26 and to look ahead to our ambitions for 2026/27. The meeting provided an opportunity to celebrate progress, share key updates, and discuss future priorities. The full Annual Report and Accounts is available on the RJAH website.

Adult Inpatient Survey

I am delighted to report that RJAH was ranked number one nationally for overall patient experience in the latest Care Quality Commission (CQC) Adult Inpatient Survey. The survey, based on feedback from patients who received inpatient care during November 2025, awarded RJAH an overall score of 9.35 out of 10, representing the first time in three years that the Trust has achieved the top national position. The result is a significant achievement and reflects the consistent commitment of our staff to delivering compassionate, high-quality, patient-centred care. More than 1,200 RJAH patients were invited to participate, with 827 responding, giving a response rate of 66%, substantially above the national average. RJAH was also one of only eight trusts nationally to be rated as delivering patient experience that was "much better than expected", further reinforcing our reputation as a leading specialist hospital and highlighting the outstanding care provided across our services.

NHS Veterans Covenant Alliance Annual National Conference 2026

During the reporting period, I attended the national Veterans Covenant Healthcare Alliance (VCHA) Conference, which brought together healthcare organisations from across the country to share learning and best practice in delivering high-quality care for veterans and the Armed Forces community. The conference highlighted the importance of recognising the unique needs of veterans within healthcare services and showcased innovative approaches to improving access, experience and outcomes for this patient group.
The event provided a valuable opportunity to reflect on the continued development of RJAH's Veterans' Orthopaedic Service and our wider commitment to supporting veterans through the principles of the Armed Forces Covenant. The learning gained will help inform our ongoing work to ensure veterans receive timely, personalised and high-quality care.

Working towards University Hospital status

A key ambition of our Trust is the achievement of University Hospital status. It is something we have been working towards for some time, and I am pleased to say that we are now planning to begin the application process in October, with the support of Keele University. The aim is to have process completed during the current financial year, and I commend Ruth Longfellow for the leadership she is showing on this ambition. The benefits of this initiative are many: it would strengthen our ability to attract talent, it would aid us in growing research and innovation, it would help in developing our workforce, and it would ultimately be a strong contributory factor in improving care for patients.

Commercial Strategy

Another key strategy development was the approval last month of the Trust's first ever Commercial Strategy. This sets out how RJAH will use its specialist strengths to create additional value for patients, staff and the wider NHS. It is not about moving away from our NHS purpose. It is about building on what makes us distinctive – our orthopaedic expertise, specialist knowledge & assets, research, education,

estate and partnerships, to generate income and value that can be reinvested back into the Trust. The strategy is grounded in our mission of Improving lives through excellent and innovative care, and in our commitment to caring for our patients, our staff and our finances. It sets out a responsible, values-led way to strengthen RJAH's financial resilience while protecting NHS services, patient access, quality and safety.

Launching our flu vaccination campaign

We're into October now, and that means our flu vaccination campaign for 2026/27 is underway. As healthcare workers, we know how easily flu can spread. We may be more likely to be exposed to flu through contact with patients and colleagues, and anyone can carry and spread without having any symptoms themselves. Having a flu vaccination is the best way to protect ourselves against flu, while also helping to protect the patients we care for, as well as our families, friends and loved ones. Last winter, the NHS flu vaccination programme was estimated to have prevented approximately 104,000 hospital admissions and around 7,100 deaths, highlighting the important role vaccination plays in protecting people from serious illness. We are keen to ensure that the progress we made last year is continued, and the team has a strong programme to give staff in all areas a chance to get their vaccination.

National Staff Survey

The 2026 NHS Staff Survey launched this week and provides an important opportunity for colleagues to share their experiences and tell us whether they feel we are making progress in the areas that matter most to them. Following last year's survey, managers across the Trust have reviewed their local results and developed improvement plans, with 28 of our 32 areas now having actions in place that are monitored regularly to ensure progress is maintained.

While there is much to be proud of, we recognise there is more to do. The survey is one of the most important ways in which we listen to our workforce, and I would encourage all colleagues to take part so that we can better understand where improvements are being seen and where further focus is required to make RJAH an even better place to work.

Innovation Kickstart Fund

The voice of our staff is so important – and so often the best ideas come from those on the frontline who can see where we need to act and where we can do better. It's why I am so pleased the Innovation Kickstart Fund has now launched. This fund is designed for new ideas or approaches that wouldn't be covered through existing funding routes. Staff have the opportunity to apply for one-off funding for up to £5,000 to help turn innovative ideas into reality. I look forward to seeing the outcomes.

Visit from CEO of NHS Charities Together

I was delighted to welcome Ellie Orton OBE, Chief Executive of NHS Charities Together, to RJAH in August to see first-hand the impact that charitable funding is having on our patients, staff and volunteers. The visit provided an opportunity to showcase a number of projects supported through NHS Charities Together, including the Path of Positivity, the Future Friends volunteering programme and a workforce wellbeing initiative within our Theatre department.

Ellie also met members of our Future Friends volunteering team and heard how the programme is helping young people develop confidence, skills and experience while making a meaningful contribution to the care and support we provide. The visit highlighted the significant difference charitable funding makes in enhancing the experience of patients, staff and volunteers across RJAH and reinforced the strength of our partnership with NHS Charities Together and the League of Friends.

Pioneering robotic rehabilitation project launching

I am always keen to see RJAH at the forefront of innovation and to ensure our patients have access to emerging technologies that have the potential to improve outcomes and experience. During the reporting period, I was delighted to see the launch of a pioneering upper limb rehabilitation project focused on the continued development of ExoARM, a lightweight robotic rehabilitation device designed to support patients recovering from neurological and musculoskeletal injury.

Supported through charitable funding, the project will enable the development of a clinically usable prototype, the production of two fully functional devices and an initial evaluation with a small cohort of RJAH patients. Clinically led by Mr Simon Pickard, Consultant Orthopaedic Hand and Upper Limb Surgeon, the project demonstrates our commitment to research, innovation and the development of new technologies that have the potential to transform rehabilitation and improve patient outcomes in the future.

Chief Executive Officer Update

National award recognition for pioneering hip service

I was delighted to learn that RJAH has been shortlisted as a finalist in the HSJ Awards 2026 in the Acute Sector Innovation of the Year category for our focused shockwave therapy service for patients with Greater Trochanteric Pain Syndrome (GTPS). This national recognition reflects the Trust's continued commitment to innovation, research and the development of evidence-based treatments that improve patient outcomes and experience.

The service was developed following pioneering research led by Mr Robin Banerjee, Consultant Orthopaedic Surgeon, which demonstrated significantly improved outcomes for patients treated with focused shockwave therapy compared with ultrasound-guided steroid injections. To be recognised at a national level by the HSJ Awards is a tremendous achievement and a testament to the dedication, expertise and innovation of our clinical and research teams, as well as RJAH's position as a leader in specialist musculoskeletal care.

Tricia Moate Award for Sarcoma Nurse Specialist

On the theme of awards and recognition, it was also great to see Elaine Richardson, a Macmillan Sarcoma Clinical Nurse Specialist, winning the Tricia Moate Award. The award was established by the charity Sarcoma UK in memory of Tricia – a former clinical nurse specialist – who was diagnosed with Sarcoma and sadly passed away in 2018. Tricia drew on her experience as a patient and her professional knowledge to become an advocate for the sarcoma community. The award was created to support the personal and professional development of AHPs and nurses, ultimately benefiting sarcoma patients. Through the award, Elaine will receive sponsorship to attend the British Sarcoma Group annual conference, where she will also have the opportunity to produce information to present to the international delegates.

Bone and soft tissue team celebrate 10th anniversary

Elaine is a valued member of the Montgomery Unit and Oswald Ward team here at RJAH. The team came together recently to celebrate its 10th anniversary. Over the past decade, the team has grown considerably while maintaining its commitment to providing dignified and compassionate care to patients and their families. The anniversary celebration recognised everyone who has contributed to the service over the past 10 years, including current and former staff, patients and families, as well as the community and charitable supporters who helped bring the facility to life.

RJAH Stars Award

Each month, I have the pleasure of presenting the RJAH Stars Award to an individual or team in recognition of exceptional achievement or performance. Since the Board last met in public, I have presented two of these awards.

- Our September winner was **Holly Owens**, a Catering Compliance Supervisor, who was recognised for her contribution to the Catering Team through supporting food safety and compliance, while finding new ways to improve services and communicate important information to colleagues. She was nominated by Sian Langford, Facilities Compliance and Sustainability Manager, who praised her work ethnic and the positive impact she has made.

- Our August winner was **Sarah Timney**, an Outreach Nurse, who was recognised for her outstanding professionalism, calm leadership and unwavering commitment to patient care during high-pressure clinical situations. Sarah was nominated by her colleagues for consistently demonstrating confidence, compassion and clinical expertise while supporting patients, relatives and staff through complex and challenging circumstances.

Congratulations to both, their dedication and care truly embody the spirit of the RJAH Stars Award.

Conclusion

The Board is asked to note and discuss the contents of the report.

National Oversight Framework

(Part 1) Covering paper

Committee / Group / Meeting, Date	
Board of Directors – Public Meeting. 07 October 2026	
Author:	**Contributors:**
Name: Steph Wilson Role/Title: Head of Improvement and Business Insight	
Report sign-off:	
Name: Stacey Keegan Role/Title: Chief Executive Officer	
Is the report suitable for publication?:	
Yes	

Executive Summary:

The revised and evolved NHS England Oversight Framework (NOF) went live and became public facing during the 2025/26 financial year. 2026/27 has seen this further evolve with some metrics being removed and additional metrics forming part of this.

A further change implemented for 2026/27 is the refinement of the overall delivery segmentation methodology. This has moved from a quartile-based approach to statistical thresholds. This now means that the Trust must achieve an overall score below 1.94 to be allocated segment 1 (high performing).

As in 2025/26, the revised NHS Oversight Framework continues to apply a financial override that stipulates that no organisation in financial deficit can be segmented higher than segment 3.

The Trust achieved segment 1 (High Performing) for Q4 2025/26. Quarter 1 (Q1) for 2026/27 has now been published. This paper provides the Q1 positions and movements seen for 2026/27.

- The Trust has remained in segment 1 (High Performing) under the revised 2026/27 metrics and methodology. The Trust achieved a score of 1.89 overall.

Oversight continues across NOF metrics. Example reflections from the latest publication include;

- The Trust has continued to improve its 'Access to Services'
- Financial plans have continued to be met.
- Infection rates remain low.
- 'National Education and Training Survey overall experience' is number 1 in the country.

Committee/board reports will be updated accordingly to align with the 2026/27 evolvements.
It is to note that due to the changes to the metrics and methodology, it is not possible to identify each individual segments overall improvement and deterioration from Q4 2025/26 accurately. However, we can observe progress and movements for individual metrics that have continued from 2025/26 over to 2026/27.

RJAH board is requested to review the latest published performance for Q1; noting the performance and movements from 2025/26 where metrics have remained and note the new metrics included.

Recommendations:

RJAH will continue:

• To review evolvements to NOF metrics and to ensure our board reports align.
• To ensure the Trust has oversight and actions in place to mitigate as far as possible current risks and/or is taking actions to support improvements. The Trust recognises the opportunities that could further support improvements to the Trust NOF scores.

National Oversight Framework

(Part 2) Strategic alignment and supporting detail

Strategic objectives and associated risks:

The following strategic objectives, developed in light of national and system priorities, are relevant to the content of this report:

Trust Objectives		
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	✓
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	✓
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	✓

The NOF contains metrics that relate and support delivery to Trust Objectives:

- Caring for Staff
- Caring for Patients
- Caring for Finances

This report relates to the following Board Assurance Framework (BAF) themes and associated strategic risks:

Board Assurance Framework Themes		
1	Continued focus on excellence in quality, safety and patient experience.	✓
2	Focus on equity of service and addressing health inequalities	✓
3	Effective engagement with the workforce to support a positive staff experience and a culture of continuous improvement	✓
4	Delivering financial sustainability	✓
5	Delivering the required levels of productivity, performance and activity	✓
6	Delivering innovation, improvement and growth	✓
7	The challenges of operating in both the Welsh and English health systems	✓
8	Responding to a significant disruptive event	✓
9	Security of digital, data and AI systems and ability to respond to cyber threats	✓

The segments for the NOF relate across themes.

Trust values:

The content of this report reflects / supports the following Trust values:

Trust Values		
1	Professional	✓
2	Excellence	✓
3	Respect	✓
4	Friendly	✓
5	Inclusive	✓
6	Caring	✓

Report development and engagement:

The Q1 2026/27 NOF ratings have been presented as part of performance reporting through our sub-committees of the Trust board during September 2026. The latest results are also available to the public via the public facing NHS England dashboard.

Next steps:

The Trust will continue to monitor NOF ratings internally through its Integrated Performance Reports. Internal reports will evolve appropriately where required.

Supporting detail (if required):

Trusts have been made aware of the Q1 2026/27 National Oversight Framework (NOF) scores, and these are shown in Attachment A.

National Oversight Framework

A high-level summary of the Trust overall NOF movement seen for each quarter is shown in the table below. To note that the 'Average metric score' has been derived from an evolved set of metrics for Q1 2026/27 and therefore not directly comparable to 2025/26.

	Segment	Average Metric Score *(and improvement since previous quarter)*	Metric score improvement since Q1 (25/26)	League table position *out of 134 (and change since previous quarter)*	League position improvement since Q1 (25/26)
2026/7, Q1	**1**	**1.89 (0.04)**	**0.42**	**16 (+1)**	**+11**
2025/6, Q4	1	1.93 (0.26)	0.38	17 (+5)	+ 10
2025/6, Q3	2	2.19 (0.03)	0.12	22 (+3)	+ 5
2025/6, Q2	2	2.22 (0.09)	0.9	25 (+2)	+ 2
2025/6, Q1	2	2.31	-	27	-

Acronyms

NOF	**National Oversight Framework**
Q4	**Quarter 4**
Q1	**Quarter 1**
RJAH	**Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust**
RTT	**Referral to Treatment**

Attachments

Attachment A	**National Oversight Framework**

National Oversight Framework

Background: - National Oversight Framework

The published National Oversight Framework from NHS England is with an aim to ensure consistency and transparency in assessing integrated care boards (ICBs) and NHS trusts and foundation trusts. It provides a foundation for how NHS England works with systems and providers to support improvement.

The framework is supported by a focused set of national priorities, including those that are set out within NHS England planning guidance.

2026/27 focused metrics are categorised into six segments: - 'Access to Services', 'Experience of Care', 'Effectiveness of Care and Population Health', 'Patient safety', 'People', 'Finance, Productivity and Innovation'. Trust performance is published via an NHS England dashboard available to the public.

The NHS England published dashboard provides a view of how NHS trusts are performing in key services including urgent and emergency care, elective services, mental health and more.

The league tables show how local trusts compare with others across England on both these individual services and at an overall level. The league tables also include a 'Trust Rank' as part of benchmarking this position.

Based on their performance each trust is placed into one of four core segments - segment 1 represents the organisations with the narrowest range of challenges while segment 4 contains those with the broadest.

2026/27 has seen refinement of the overall segmentation methodology, moving from a quartile-based approach to statistical thresholds, to make tracking of improvement easier. Each organisation's average metric score assigns them to a segment based on the following thresholds:

- Segment one: Any overall score below 1.94
- Segment two: Any overall score between 1.94 and 2.33
- Segment three: Any overall score between 2.33 and 2.77
- Segment four: Any overall score greater than 2.77

RJAH has achieved segment 1 (High Performing) under this revised 2026/27 methodology. RJAH also achieved segment 1 under the previous methodology for Q4 2025/26.

Only 18 Trusts are in segment 1 in this latest iteration of the 2026/27 league tables.

Positive Movement for 2026/27: - National Oversight Framework

RJAH for Q1 2026/27 has been ranked 16th among all 134 NHS Acute Trusts in the latest league tables published as part of the NHS National Oversight Framework (NOF). The Trust continues to see positive movements.

The published results for RJAH quarter 1 (Attachment A) are reflective of the continuous improvement efforts within our hospital.

For example, 'Access to Services' metrics that have remained from 2025/26 continue to improve. For Q1 2025/26 RJAH had 45.39% of people waiting less than 18 weeks. For Q1 2026/27 this has improved to 65.05%. This metric has moved from a Trust rank from 131/131 to 73/129. The Trust continuous improvement focus is ongoing.

All NOF metrics are reviewed across segments, and organisation actions are taken accordingly for any opportunities to improve. Engagement with NHS England has also taken place as part of assessments on the evolved 2026/27 metrics. For example; other specialist Trusts are also impacted by the inclusion of the 'Relative cost difference (National Cost Collection Index) score'.

Attachment A – National Oversight Framework

SUB-CATEGORY	METRIC	Score					Performance					Rank					Time period utilised for latest quarter
		2025/26				2026/27	2025/26				2026/27	2025/26				2026/27	
		Q1	Q2	Q3	Q4	Q1	Q1	Q2	Q3	Q4	Q1	Q1	Q2	Q3	Q4	Q1	
Elective Care	Percentage of people waiting less than 18 weeks score	4	3.82	3.45	3.19	2.69	45.39%	52.72%	55.8%	62.2%	65.1%	131/131	123/131	107/131	95/130	73/129	June 2026
	Percentage of patients waiting over 52 weeks score	3.98	3.94	3.85	3.13	3.26	7.75%	6.95%	4.09%	1.80%	1.46%	130/131	128/131	124/131	104/130	83/129	June 2026
Diagnostics	Percentage of referrals where the patient is waiting six weeks or longer for a test or procedure score					1.62					7.47%					28/131	June 2026
Access to Services Overall Segment		4	4	3	3	2	**3.66**	**2.92**	**2.77**	**2.44**	**2.52**	*131/131*	*109/131*	*95/131*	*85/131*	**63/131**	
Experience	CQC inpatient survey satisfaction rate score	1	1	1	1	1											Inpatient survey
	NHS staff survey advocacy sub-score score					1.2					7.63 out of 10					10 / 134	Staff survey 2025
Patient flow	Percentage of intermediate care beds occupied by patients without criteria to reside					3.61					39.22%					41/50	Q1 2026/27 average
Experience of care Overall Segment		1	1	2	1	1	**1.46**	**1.35**	**2.18**	**1.26**	**1.94**	*15/134*	*12/134*	*62/134*	*12/134*	**35/134**	
	Percentage of patients readmitted within 30 days of discharge score					1											2024/25
Effectiveness of Care and Population Health Overall Segment		1	1	1	1	1	**1.95**	**1.93**	**1.7**	**1.72**	**1**	*36/134*	*35/134*	*27/134*	*29/134*	**1/134**	
Safe Culture	NHS Staff Survey - raising concerns sub-score score	2.17	2.17	2.17	2.35	2.35	6.51	6.51	6.51	6.36	6.36 out of 10	53/134	53/134	53/134	61/134	61/134	Staff survey 2025
High Quality Care	Clinical audit outlier score					1											Various Audits
Safe Outcomes	12 month rolling count of MRSA cases score	1	1	1	1	1	0.00	0.00	0.00	0.00	0.00						To June 2026
	12 month rolling count of C. difficile cases as a proportion of trust threshold score	1	3.7	1	1	2	1.00	1.50	0.50	0.50	1.00						To June 2026
	12 month rolling count of E. coli cases as a proportion of trust threshold score	1	1	1	1	2	0.67	0.22	0.11	0.22	0.43						To June 2026
Patient Safety Overall Segment		1	1	1	1	1	**1.59**	**2.04**	**1.59**	**1.68**	**1.67**	*3/134*	*21/134*	*3/134*	*9/134*	**17/134**	
People and Culture	Sickness absence rate score (quarter)	2.69	2.66	2.19	1.88	2.1	5.49%	4.97%	5.01%	5.29%	5.18%	87/134	86/134	67/134	50/134	61/134	To March 2026
	NHS staff survey engagement theme score	1.2	1.2	1.2	1.56	1.56	7.34	7.34	7.34	7.04	7.04 out of 10	10/134	10/134	10/134	26/134	26/134	Staff survey 2025
	National Education and Training Survey overall experience sub-score score					1.01					91.25%					1/134	2025 Survey
	NHS staff standards sub-score score					1.34					7.76 out of 10					16/134	Staff survey 2025
	Percentage of frontline healthcare workers to receive a flu vaccination score					1.93					52.80%					47/134	Q1 2025/26
Workforce	Temporary staffing cost relative band score					3.00					Bank score: - 4 Agency score: - 1						Q1 2026/27
People Overall Segment		1	1	1	1	1	**1.95**	**1.93**	**1.7**	**1.72**	**1.82**	*36/134*	*35/134*	*27/134*	*29/134*	**24/134**	
Finance	Combined finance score	1	1	1	1	1											
	Planned surplus/deficit score	1	1	1	1	1	0	0	0	0	0	12/134	12/134	12/134	12/134	8/134	2026/27 Plan
	Variance year-to-date to financial plan score	1	1	1	1	1	0.03	0.01	0.00	0.96	0.07%	25/134	30/134	33/134	7/134	8/134	June 2026
Productivity	Relative cost difference (National Cost Collection Index) score					3.61					115.05%					123/134	December 2025
Innovation	Overall Data Quality Maturity Index score					1.03					99.20					3/134	April 2026
Finance, Productivity and Innovation Overall Segment		3	3	3	3	1	**2.22**	**2.49**	**2.45**	**2.29**	**1.88**	*59/134*	*72/134*	*56/134*	*69/134*	**19/134**	
OVERALL SEGMENT, AVERAGE METRIC AND LEAGUE TABLE POSITION		**2**	**2**	**2**	**1**	**1**	**2.31**	**2.22**	**2.19**	**1.93**	**1.89**	**27/134**	**25/134**	**22/134**	**17/134**	**16/134**	

2025/26 segment scoring not comparable due to different metrics monitored.

Key:

Low performing
Below average
Above average
High performing

Corporate Risk Summary

(Part 1) Covering paper

Committee / Group / Meeting, Date	
Board of Directors, October 2026	
Author:	**Contributors:**
Name: Dylan Murphy Role/Title: Trust Secretary	Clinical Governance team / risk owners / executive team / Risk Management Group
Report sign-off:	
N/A	
Is the report suitable for publication:	
Yes	

Exec Summary:

This corporate risk report presents information on high-rated risks captured within the Trust's risk management system.

The risks on the system currently rated at 15 or above which have been agreed by the Risk Management Group have each been assigned to:

- An Executive Director, for executive oversight; and
- A committee of the Board, for Board oversight.

34 risks rated 15 or above were presented to the Risk Management Group meeting on 10 September 2026. Following consideration at the meeting:

- 24 were accepted as high-level risks for inclusion in the CRR report but 2 have subsequently been reduced.
- 1 was retained for potential inclusion on the CRR report, pending further review by the risk / executive owner.
- 7 were referred back to the Units for further consideration.
- 1 was closed (as it was amalgamated with a similar risk).
- 1 was referred back to the risk owner to reduce the score to appropriately reflect the level of risk / effectiveness of the mitigations.

As such, 22 risk summaries were referred to the Committees for consideration.

There were 5 risks reported to RMG that scored 20 or above. These were:

RSK-071 Orthotics Service Risk – subsequently reduce to a 16 on Accountable Executive's review.
RSK-162 Homecare Prescription Backlog
RSK-185 Compromise to patient data due to cyber-attack (Malware)
RSK-347 Non delivery of planned elective activity growth leading to income loss 26/27
RSK-350 Efficiency Programme Slippage leading to increased costs

It was identified at the RMG meeting that a number of target dates need review. This was / will be fed back to risk owners.

Risks with a digital component are to be reviewed by the Chief Digital and Information Officer (CDIO). That will involve consideration of the relative roles of digital and operational teams in assessing and addressing certain risks.

Since the last CRR report to the Board:

- One risk is undergoing further review by the risk / executive owner:
  - RSK-202, Occupational Health Surveillance. Previous score: 16. Status to be reviewed
- Four risks have been removed from the CRR:
  - RSK-140, Radiology Safety and Inefficiencies Due to Underutilisation of Digital Order Communication. Score reduced to 10 due to mitigations.
  - RSK-152, Missing Outpatient Follow-Up Waiting List Review Dates. Risk as described closed and the risk relating to "inappropriate" follow-up dates and implications is picked up in other risks, including RSK-182
  - RSK-327, Orthotics accommodation on SATH sites. Score reduced to 12 due to mitigations.

Corporate Risk Summary

- RSK-353, Welsh commissioning - overperformance against contract 26/27 leading to non payment of activity. Score reduced as Powys has been successful in securing Welsh Government funding for the 104-week backlog and a contract is being developed.

Each Committee was asked to:
1. NOTE the extracts from the high-rated risks relevant to the remit of the Committee;
2. COMMENT on the revised format, to inform future reports; and
3. IDENTIFY any risk-related issues it wishes to raise with the Board via the Chair's assurance report.

Recommendations:

That the Board:
1. NOTE the risks rated at 15 or above, as considered by the Board Committees during September 2026;
2. CONSIDER any escalations from the September round of Committee meetings; and
3. CONSIDER the level of assurance provided by the risk management arrangements, as reflected in this paper, the corporate risk register, and the Chairs' assurance reports.

(Part 2) Strategic alignment and supporting detail

Strategic objectives and associated risks:

The following strategic objectives, developed in light of national and system priorities, are relevant to the content of this report:

Trust Objectives		
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	✓
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	✓
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	✓
Corporate risks could relate to delivery of any of the Trust's strategic objectives.		

This report relates to the following Board Assurance Framework (BAF) themes and associated strategic risks:

Board Assurance Framework Themes		
1	Continued focus on excellence in quality and safety	✓
2	Creating a sustainable workforce	✓
3	Delivering the financial plan	✓
4	Delivering the required levels of productivity, performance and activity	✓
5	Delivering innovation, growth and achieving systemic improvements	✓
6	Responding to opportunities and challenges in the wider health and care system	✓
7	Responding to a significant disruptive event	✓
Strategic risks are outlined in the Board Assurance Framework. The risks included on the Trust's corporate risk register may contribute to those wider strategic risks.		

Trust values:

The content of this report reflects / supports the following Trust values:

Trust Values		
1	Professional	
2	Excellence	✓
3	Respect	
4	Friendly	
5	Inclusive	
6	Caring	
The effective management of risk contributes to the continued drive for excellence (though individual risks could have elements that relate to multiple other Trust values).		

Report development and engagement:

The May round of committee reports were direct reports from the Trust's risk management system (Radar Healthcare). Previous reports were based on extracts from the previous risk management system (Datix) that were subsequently transferred into an alternative format via a manual review process.

While more work is being done to refine use of the system to support effective assurance reporting, the July reports were generated via a combination of direct reporting from the system and manual review and revision to provide a more succinct, consistent reporting format. That approach has been refined for the September reports, following feedback at the July round of meetings.

The risks covered in the report were discussed at the Risk Management Group (RMG) meeting on 10 September 2026. They were also considered at the Executive Team meeting on 15 September.

Next steps:

The Chief Nurse and Patient Safety Officer, supported by the Interim Assistant Chief Nurse and Patient Safety Officer, are leading a number of strands of work relating to the Trust's risk management arrangements. This includes:

- Meeting high-level risks owners individually to work through the risks, consider the mitigations in place, and the appropriate scoring of the risks.
- Reviewing the risk review process prior to consideration at the RMG to strengthen the operational ownership and challenge of risks and associated mitigations at the most appropriate level within the organization. That would enable the RMG to focus on assurance (rather than operational detail) and, in turn, will support assurance reporting to the Board committees.
- Reviewing the current training material and the risk training coverage to ensure all staff are receiving the appropriate level of training in a timely manner.
- Reviewing the operation of the risk management system.

Thought will also be given to a mechanism for identifying dependencies and the wider implications of risk and associated mitigating action e.g. how would certain workforce risks / mitigations affect operational delivery and therefore delivery of the financial plan.

Supporting detail:

Strategic versus operational risk

Strategic Risks relate to delivery of the strategic objectives of the Trust. They can be affected by factors such as capital availability; political, legal and regulatory changes; reputational issues etc. These will usually be identified at Board, or Executive level, and are generated "from the top down'. These strategic risks are captured in the Board Assurance Framework.

Operational risks concern the day-to-day running of the Trust. These are usually identified by departments or business units and are captured on local risk registers. As such, these are usually generated "from the bottom up". Where these risks become sufficiently serious they are escalated to the corporate risk register. Each entry on the corporate risk register is reviewed on a monthly basis, has an identified executive lead, and is overseen by a committee of the Board. The benchmark for consideration for inclusion on the corporate risk register has been set at 15 or above.

Risk Management Group and risk review process

In accordance with the Risk Management Policy, a Risk Management Group has been established. This Group meets monthly and is chaired by the Chief Nurse and Patient Safety Officer, and reports into the Audit and Risk Committee.

As part of the Trust's wider risk management process:

- staff across the organisation continue to manage operational risk;
- the risk management training programme continues – the next steps include targeted support to individuals who are responsible for managing a large number of risks (particularly high scoring risks) that have not yet attended a session;
- the Trust Performance and Operational Improvement Group, chaired by the Chief Operating Officer, continues to monitor high-level risks and associated mitigating actions;
- the Risk Management Group and clinical governance team continue to review and develop the processes and procedures necessary to implement risk management arrangements.

Attachment: "Corporate risks" considered by Board committees in September 2026:

Attachment: “Corporate risks” considered by Board committees in September 2026:

Risk ref.	Headline risk	Ctte	Sept 26 Score	Notes
RSK-044	Document Scanning solution post Apollo go-live	DERIC	**C4 X L4 = 16**	There is a risk that the absence of a like-for-like document scanning solution following Apollo go-live will increase reliance on manual document uploads, creating additional workload, reducing efficiency benefits and impacting downstream operational processes. Current controls include reducing paper-based documentation and developing barcode/QR code and robotic automation solutions; however, the Risk Management Group has highlighted that the target date and ownership require review, and that delivering the necessary automated processes will incur additional costs and operational considerations
RSK-057	Fragmented and Non-Sequential Clinical Documentation in CareFlow	DERIC	**C4 X L4 = 16**	There is a risk that fragmented and poorly linked clinical documentation within CareFlow could delay clinical decision-making, increase the potential for errors or omissions, and adversely affect patient safety, care quality and clinician efficiency. Current controls include system configuration improvements, clinical-view filters and engagement with System C, but key enhancements remain planned or overdue; the Risk Management Group has noted that resolution is dependent on a system upgrade now expected in **December 2026/January 2027**, and that both the target date and target risk score should be reviewed to reflect the current implementation plan
RSK-071	Orthotics Service Risk	F&P / P&C / Q&S	**C4 X L4 = 16**	There is a risk that ongoing workforce shortages and increasing demand for orthotics services will result in patients not being seen within recommended timeframes, leading to deterioration in clinical outcomes, increased patient harm and further pressure on the service. Current controls include clinical prioritisation, overtime clinics, workforce recruitment initiatives and demand management measures; however, the Risk Management Group has recognised that sustainable solutions require wider system support, the issue has been escalated to the ICB risk register, and escalation will continue while workforce and demand challenges persist. The Accountable Executive has reduced the current risk score from **20 to 16**, recognising it as a very high service risk but not one of the Trust’s highest overall risk
RSK-098	Traceability of orthoses to patients	DERIC / Q&S	**C4 X L4 = 16**	There is a risk that the absence of a system to trace orthoses and orthotic components to individual patients could compromise patient safety, increase litigation risk, create additional clinical workload and result in significant commissioner costs if components require recall or replacement. Current controls include governance oversight, clinical management and replacement programmes, alongside development of a digital traceability system; however, the Risk Management Group has noted that delivery is dependent on a new system now expected to go live in **December 2026/January 2027**, that the target date should be reviewed, and that consideration should be given to any operational mitigations in addition to the digital solution.
RSK-149	Noncompliance with AHP and pharmacy standards for Critical Care Patients	P&C / Q&S	**C4 X L4 = 16**	There is a risk that the absence of a system to trace orthoses and orthotic components to individual patients could compromise patient safety, increase litigation risk, create additional clinical workload and result in significant commissioner costs if components require recall or replacement. Current controls include governance oversight, clinical management and replacement programmes, alongside development of a digital traceability system; however, the Risk Management Group has noted that delivery is dependent on a new system now expected to go live in **December 2026/January 2027**, that the target date should be reviewed, and that consideration should be given to any operational mitigations in addition to the digital solution.
RSK-161	Insufficient blood monitoring system relating to Rheumatology DAWN system	Q&S	**C4 X L4 = 16**	There is a risk that the absence of a sufficient digital blood-monitoring system for rheumatology patients could result in abnormal results or overdue monitoring not being identified promptly, leading to inappropriate continuation of medication, potential patient harm and significant additional workload for clinical and pharmacy teams. Current controls rely on manual monitoring and joint working between Rheumatology and Pharmacy;

Risk ref.	Headline risk	Ctte	Sept 26 Score	Notes
				however, the Risk Management Group has noted that a new technician is now in post to help develop solutions, discussions are required between Digital and Pharmacy teams to determine the best option, and the Chief Pharmacist will review whether related rheumatology risks (RSK-161, RSK-162 and RSK-268) should be redefined or amalgamated.
RSK-162	Homecare Prescription Backlog	P&C / Q&S	**C4 x L5 = 20**	There is a risk that a significant backlog of rheumatology homecare prescriptions awaiting clinical authorisation could result in patients missing medication doses, poorer disease control, increased anxiety and potential disease progression. Current controls include urgent prescription prioritisation, additional prescribing support, recruitment of a pharmacy technician and governance escalation processes; however, the Risk Management Group has highlighted that around **600 prescriptions remain overdue**, that rheumatology risks are interdependent and likely to reduce together, and that the Chief Pharmacist will review whether related rheumatology risks (**RSK-161, RSK-162 and RSK-268**) should be redefined or amalgamated
RSK-176	Electrical Infrastructure Capacity	Q&S	**C5 x L3 = 15**	There is a risk that increasing electricity demand from site expansion and planned renewable-energy projects could exceed the hospital's existing electrical infrastructure capacity, potentially disrupting critical services and affecting patient safety. Current controls include solar photovoltaic generation and plans to upgrade capacity and provide a new site supply; however, the Risk Management Group has noted that interim plans are expected to achieve a partial improvement in the short term, which should reduce the risk score in the coming month, while the longer-term solution remains in development and the target score and completion date will be reviewed accordingly
RSK-182	Risk to not delivering against the Harms Review Policy	Q&S	**C4 X L4 = 16**	There is a risk that harms-review cohorts will not be completed within the required timescales because the introduction of Apollo and increasing overdue follow-up lists have made patient identification and review processes more complex, potentially delaying reviews for patients at risk of harm. Current controls include operational monitoring, trajectory management and a helpline model for higher-risk services; however, the Risk Management Group has noted that the risk will remain until the position can be reviewed against a new dataset expected the following week, with the current risk score remaining at **16**.
RSK-185	Compromise to patient data due to cyber attack (Malware)	DERIC	**C5 x L4 = 20**	There is a risk that a cyber attack, including exploitation of unpatched or vulnerable systems and medical devices, could compromise patient data, disrupt services and adversely affect patient care. A comprehensive range of cyber security controls is in place, including monitoring, patching, backups, penetration testing, MFA and incident response arrangements; however, the Risk Management Group has advised that the new Executive owner will review the current cyber risks to develop a single overarching cyber risk, supported by more specific digital risks for individual departments.
RSK-194	Data loss due to use of deprecated encryption protocols	DERIC	**C5 x L3 = 15**	There is a risk that the continued use of deprecated encryption protocols within the legacy Graphnet EPR system could compromise the confidentiality and integrity of patient data, potentially resulting in unauthorised disclosure of information. Current controls include restricting Graphnet access and progressing migration to CareFlow/BridgeHead; however, the Risk Management Group has advised that the risk should be reviewed as it is linked to Graphnet, which is expected to be switched off during September, with the risk anticipated to reduce significantly or close entirely by the end of the month
RSK-221	Absence of investigation tracking	DERIC / Q&S	**C4 x L4 = 16**	There is a risk that the absence of a robust investigation-tracking system following the move to RIO could result in delayed or missed test results, failure to meet radiology failsafe standards, patient harm, increased staff workload and reputational damage. Current controls rely on manual tracking processes and planned reporting

Risk ref.	Headline risk	Ctte	Sept 26 Score	Notes
				functionality within RIO; however, the Risk Management Group has noted that this risk has now been amalgamated with the previous risk relating to poor system integration across MSST (RSK-197), reflecting the interconnected nature of the underlying system issues.
RSK-234	Consultant Anaesthetist vacancies and recruitment impacting on operational plan	F&P / P&C	**C4 x L4 = 16**	There is a risk that consultant anaesthetist vacancies and ongoing recruitment challenges could affect delivery of the Operational Plan, reduce planned operating capacity and increase reliance on locum staffing, with associated operational and reputational impacts. Current controls include substantive recruitment, fellowship programmes and locum cover; however, the Risk Management Group has noted that the target date requires review, while the Accountable Executive has confirmed the risk should remain at **16** currently and reduce to **12 by April 2027**, reflecting expected increases in independent SAS-grade clinicians, further recruitment and insourcing, although the ageing workforce means the risk is unlikely to reduce below 12.
RSK-238	Lack of Radiology System's Management resource	DERIC / P&C	**C4 x L4 = 16**	There is a risk that insufficient dedicated radiology systems management resource could lead to delays in imaging services, system outages, reporting backlogs and reduced support for clinical services, potentially affecting patient safety, regulatory compliance and Trust performance. Current controls rely on interim staffing arrangements, overtime and consultancy support while recruitment is underway; however, the Risk Management Group has noted that good progress is being made with recruitment adverts issued, although the risk reduction will not be immediate once staff are appointed and the target date will need to be revised to reflect the time required for capability and resource to become established. The Accountable Executive has further advised that the target date should be brought forward to **1 January 2027** to reflect active recruitment.
RSK-240	Loss of previous Bluespier function - no stock management for waiting list	DERIC / Q&S	**C4 x L4 = 16**	There is a risk that the loss of stock-management functionality following Apollo go-live could result in insufficient notice to obtain required implants or resources for patients, leading to procedure cancellations and potential patient harm. Current controls include prioritising bespoke stock requirements and monitoring implant events, while a Bluespier system upgrade is intended to restore the missing functionality; however, the Risk Management Group has advised that the risk is expected to close once the PAS/Bluespier upgrade is completed, subject to a review confirming that no other operational implications remain.
RSK-268	3308 | Increased demand to Rheumatology due to primary care not adopting shared care agreements	F&P / P&C / Q&S	**C4 x L4 = 16**	There is a risk that continued non-adoption of shared care agreements by primary care will increase demand on Rheumatology services, resulting in delays to prescribing and monitoring, increased waiting times, unsustainable workload pressures and potential impacts on patient care. Current controls include pharmacy and prescription-backlog support, escalation to the Executive Team and ICB, and development of a business case for additional nursing resource; however, the Risk Management Group has noted that a case of need is being developed and that further assurance is required regarding whether the current risk score appropriately reflects evidence of patient harm, as there are currently no reported harm signals to support the high rating. The Chief Pharmacist will also review whether related rheumatology risks (**RSK-161, RSK-162 and RSK-268**) should be redefined or amalgamated.
RSK-298	Orthotic IT System	DERIC / Q&S	**C4 x L4 = 16**	There is a risk that failure of the ageing and unsupported Orthotics IT system could result in the loss of prescription and order-tracking data, delays to patient care, increased administrative burden and reduced ability to reproduce historical orders. Current controls include paper records, Oracle order records and plans to implement a new digital Orthotics system; however, the Risk Management Group has noted that delivery of the solution is dependent on the same system implementation underpinning RSK-098, and consideration will be given to amalgamating the two risks given their close relationship.

Risk ref.	Headline risk	Ctte	Sept 26 Score	Notes
RSK-343	Clinical Adoption of Apollo EPR due to limitations in ease access to modules from key screens	DERIC	**C4 x L4 = 16**	There is a risk that limitations in Apollo EPR functionality, including the inability to launch key workflows directly from Workspace and Bluespier, will reduce clinical adoption, increase administrative workload, create inefficiencies and increase the risk of errors, cancellations and reduced data quality. Current controls focus on system development and planned Workspace enhancements; however, the Risk Management Group has noted that ownership of the risk requires review and that the Workspace go-live date has been revised from September to **November/December 2026**, meaning the risk will remain until those developments are delivered. The Accountable Executive has confirmed the score should remain at **16**, with the target date revised to **31 December 2026** to align with planned system upgrades and developments.
RSK-347	Non delivery of planned elective activity growth leading to income loss 26/27	F&P	**C5 x L4 = 20**	There is a risk that failure to deliver the planned 10% growth in elective activity will result in a loss of income assumed within the Trust's 2026/27 financial plan, potentially leading to a deterioration in the overall financial position. Current controls include performance monitoring, forecasting, oversight through established improvement groups and insourcing activity; however, the Risk Management Group has noted that the PFIG is being reconvened and dedicated theatre forecasting and productivity improvement arrangements have been established, which should help improve delivery trajectories and reduce the risk over time. The Accountable Executive has also requested that the target date be brought forward to **30 November 2026** to align with planned insourcing, recruitment and additional theatre capacity coming online in October.
RSK-350	Efficiency Programme Slippage leading to increased cost 26/27	F&P	**C5 x L4 = 20**	There is a risk that failure to deliver the Trust's efficiency programme will result in higher costs or lower productivity than planned, leading to a deterioration in the Trust's financial position. Current controls focus on monthly performance monitoring and assurance through Trust governance and finance reporting; however, the Risk Management Group has noted that the programme is currently reported as off plan, a supporting business case has been declined by the region, and further work is underway to identify gaps by **November/December 2026**, with time required to develop and implement mitigating actions.
RSK-352	English commissioning - overperformance against contract 26/27 leading to non payment of activity	F&P	**C5 x L3 = 15**	There is a risk that delivery of elective activity above commissioner affordability levels will result in the Trust incurring the cost of treatment without receiving the associated income, adversely affecting the Trust's financial position. Current controls include contractual payment arrangements, close monitoring and forecasting with commissioners, and assurance over activity reporting and data quality; however, the Risk Management Group has noted that this risk is closely linked to RSK-347 (Non-Delivery of Planned Elective Activity Growth), reflecting the interdependency between activity delivery and the associated financial consequences.
RSK-356	Workforce Review of Pharmacy sustainability	P&C / Q&S	**C4 x L4 = 16**	There is a risk that the current Pharmacy workforce model will be unable to sustain increasing service demand, potentially affecting medicines management, discharge processes, surgical pathways and patient safety, while increasing workload and recruitment challenges. Current controls focus on operational prioritisation, process improvements and business continuity arrangements; however, the Risk Management Group has noted that a workforce plan is due to be considered by TPOIG in October, and that both the risk score and target date should be reviewed to ensure they accurately reflect the emerging workforce plan and the effectiveness of existing mitigations.

Executive Summary - Quality & Safety Committee

Assurance

Variation	P: Will consistently pass the target if nothing changes	?: Will not consistently pass or fail the target if nothing changes	F: Will consistently fail the target if nothing changes	No Target or Moving Target
H / L: Improving variation (high or low) or 3 months better than target				Number of Compliments Medication Errors
No significant change or N/A to SPC	RJAH Acquired C.Difficile RJAH Acquired E. Coli Bacteraemia RJAH Acquired MRSA Bacteraemia	RJAH Acquired MSSA Bacteraemia 30 days Emergency Readmissions 62 Day General Standard		Number of Patient Safety Reviews Number of Complaints Discharge Ready Date to Actual Discharge Date Theatre Cancellations On The Day of Surgery
H / L: Concerning variation (high or low) or 3 months off target		No of Spinal Injury Patients Fit for Admission Surgical Site Infections Medication Errors with Harm	Patients Returning to Theatre within 28 Days	Standard Complaints Response Rate - 30 Days

Please note - this is defined by the associated SPC graph within the IPR. Many KPIs show as a moving target due to the change of targets/plans as we moved into new financial year and monthly phasing.
Metric placed in boxes above based on the variation icon for latest data point, but over-ridden by whether meeting/failing target for last three months.
If metric placed in a box based on meeting/failing plan, but does show improvement or deterioration - text colour will indicate that.

Trust Board - Quality & Safety

August 2026 – Month 5

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust



Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

SPC charts are line graphs that employ statistical methods to aid in monitoring and controlling processes. An area is calculated based on the difference between points, called the control range. 99% of points are expected to fall within this area, and in doing so are classed as 'normal variation'. There are a number of rules that apply to SPC charts designed to highlight points that class as 'special cause variation' - abnormal trends or outliers that may require attention.

There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

The rules that are currently being highlighted as 'special cause' are:

- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of the control range (with the mean considered the centre)

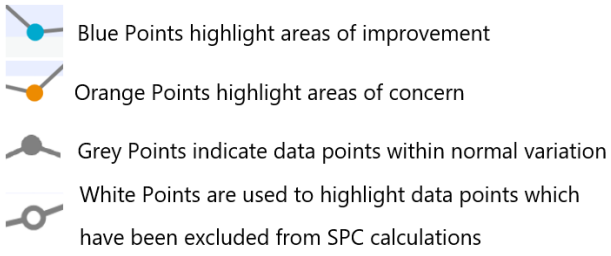
Different colours have been used to separate these trends of special cause variation:

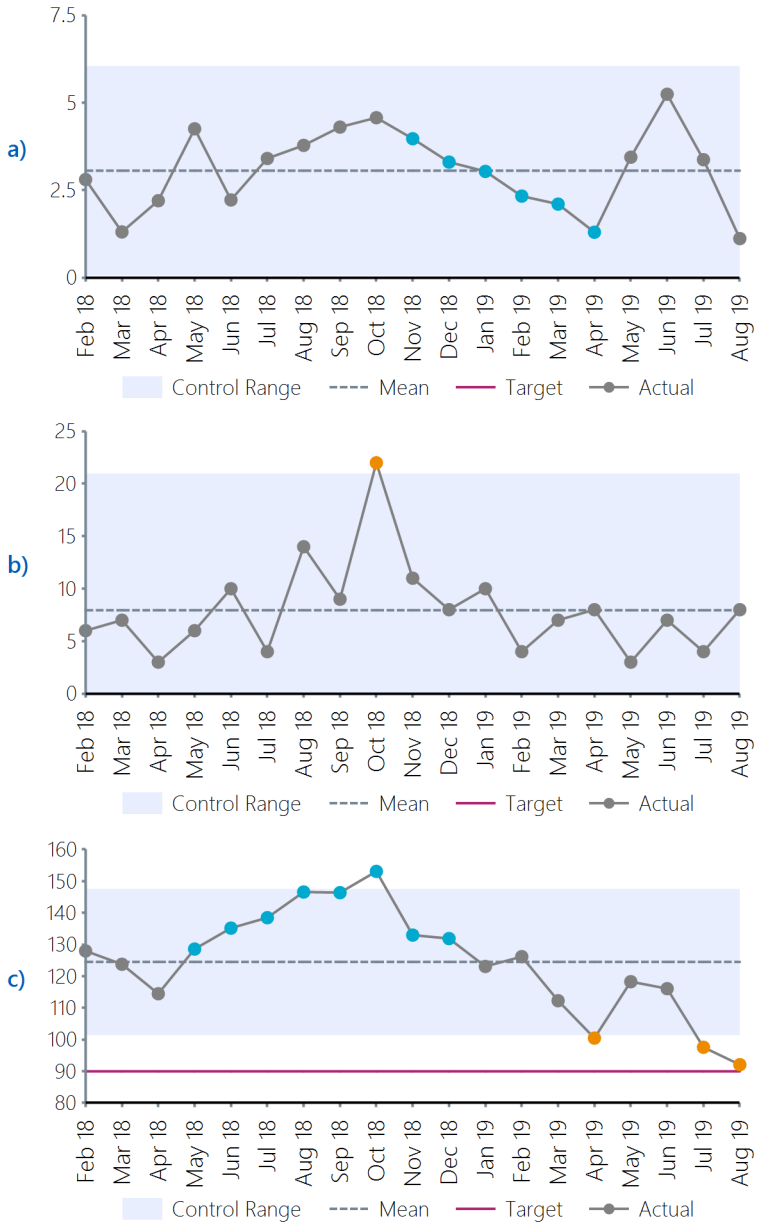
Some examples of these are shown in the images to the right:

a) shows a run of improvement with 6 consecutive descending months.

b) shows a point of concern sitting above the control range.

c) shows a positive run of points consistently above the mean, with a few outlying points that are outside the control limits. Although this has highlighted them in red, they remain above the target and so should be treated as a warning.





Summary Icons Reading Guide

With the redesign of the IPR you will now see 2 summary icons against each KPI, which have been designed by NHSI to give an overview of how each measure is performing at a glance. The first icon is used to show whether the latest month is of concerning or improving nature by using SPC rules, and the second icon shows whether or not we can reliably hit the target.

Exception Reporting

Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually set as an execption if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

For KPIs that are not applicable to SPC; to identify exceptions we look at performance against target over the last 3 months - automatically assigning measures as an exception if the last 3 months have been falling short of the target in line with how we're calculating the assurance icon for non-SPC measures.

Variation Icons

Are we showing improvement, a cause for concern, or staying within expected variation?



Orange variation icons indicate special cause of **concerning nature** or high pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.



Blue variation icons indicate special cause of improving nature or lower pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.



A grey graph icon tells us the variation is common cause, and there has been no significant change.

For measures that are not appropriate to monitor using SPC you will see the "N/A to SPC" icon instead.

The special cause mentioned above is directly linked to the rules of SPC; for variation icons this is if the latest point is outside of the control range, or part of a run of consecutively improving or declining points.

Assurance Icons

Can we expect to reliably hit the target?



An orange assurance icon indicates consistently (F)alling short of the target.



A blue assurance icon indicates consistently (P)assing the target.



A grey assurance icon indicates inconsistently passing and falling short of the target.



For measures without a target you will instead see the "No Target" icon.



Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months in comparison to the target, showing F or P icons if consistently passing of falling short.

Data Quality Rating Reading Guide

The Data Quality (DQ) rating for each KPI is included within the 'heatmap' section of this report. The indicator score is based on audits undertaken by the Data Quality Team and will be further validated as part of the audit assurance programme.

Colours

When rated, each KPI will display colour indicating the overall rating of the KPI

Blue	Green	Amber	Red
No improvement required to comply with the dimensions of data quality	Satisfactory - minor issues only	Requires improvement	Siginficant improvement required

Dates

The date displayed within the rating is the date that the audit was last completed.

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
Patient Safety Incident Investigations		0		N/A to SPC	No Target			
Number of Complaints	14	19			Moving Target	+		
Discharge Ready Date to Actual Discharge Date	0.61	0.47		N/A to SPC	?	+		
RJAH Acquired C.Difficile	0	0		N/A to SPC	P	+		+
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	P	+		+
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P	+		+
RJAH Acquired MSSA Bacteraemia	0	1		N/A to SPC	?	+		
RJAH Acquired Klebsiella spp	0	0		N/A to SPC	P			
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P			
Surgical Site Infections	0	1			?	+		

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
Outbreaks	0	0		N/A to SPC	P			
Number of Deteriorating Patients	5	4			?			
Total Deaths	0	0		N/A to SPC	?			
WHO Quality Audit - % Compliance against NatSSIPs 2	95%	99%		N/A to SPC	P			

Number of Complaints

Number of complaints received in month 211105

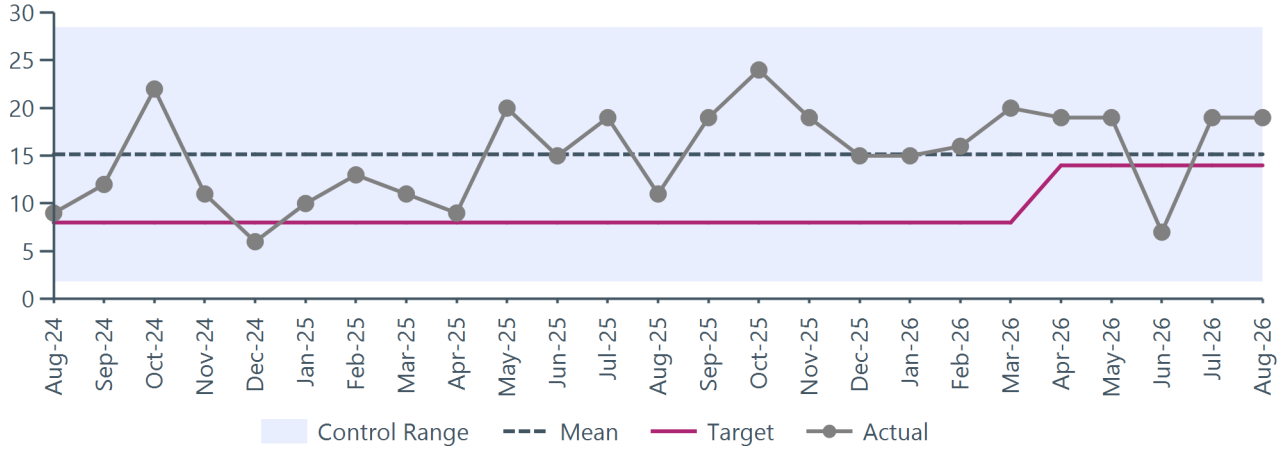
Exec Lead
Chief Nurse and Patient Safety Office

Target/Plan	Latest Value	Variation	Assurance	NOF
14	19		Moving Target	

Trajectory



Actual
Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. Following the target change, the assurance icon indicates a moving target.

Narrative

There were nineteen complaints received in August. The following provides a breakdown of the reasons for complaints:
* Appointments including delays and cancellations (6)
* Communications (4)
* Values and Behaviours - Staff (3)
* Waiting Times (2)
* Patient Care (2)
* Trust Administration (1)
* Admission Arrangements (1)

Actions

Complaints are reviewed, with learning shared through Unit governance and the Patient Experience Committee.

Complaint themes and learning will be discussed collectively through regional and national Chief Nurse networks to share learning and consider improvement actions.

There were recent process changes to the handling of complaints with focus on early resolution. This is still embedding across the Trust and was impacted by annual leave throughout August where key stakeholders were unavailable. Follow up meetings have been held and the key focus still remains on progressing the changes to complaints management across the Trust but will take time for the changes to reflect in our reporting.

Trust is working on implementation of Dr Dr Waiting Well module that will significantly improve patient communication with automated updates. It is anticipated this will have a positive impact on the number of complaints received. It is planned to go live before the end of the financial year.

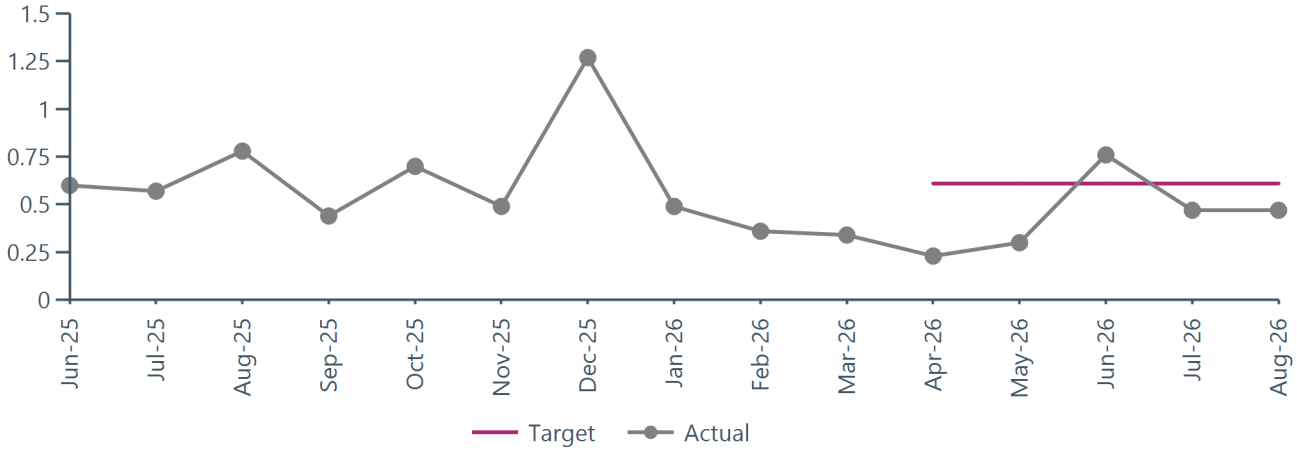
Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
11	19	24	19	15	15	16	20	19	19	7	19	19

Discharge Ready Date to Actual Discharge Date

Average Number of Days from Discharge Ready Date to Actual Discharge Date - including zero days 217888

Exec Lead
Chief Nurse and Patient Safety Office

Target/Plan	Latest Value	Variation	Assurance	NOF
0.61	0.47	N/A to SPC	?	



Trajectory



What these graphs are telling us

This measure is not appropriate to display as SPC. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

This metric forms part of the IPR to ensure it encompasses all metrics that form part of the National Oversight Framework (NOF). The latest publication received in September no longer includes this metric as part of the framework therefore it is proposed it is removed next month.

This metric reports on the 'Average Days from Discharge Ready Date to Actual Discharge Date'; it includes zero days - as per NHSE methodology. It measures the extent of delays experienced by patients who are medically ready for discharge but are unable to be discharged from hospital.

For those patients discharged in August the average days was 0.47 days so sits within the target.

Actions

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
0.78	0.44	0.70	0.49	1.27	0.49	0.36	0.34	0.23	0.30	0.76	0.47	0.47

RJAH Acquired C.Difficile

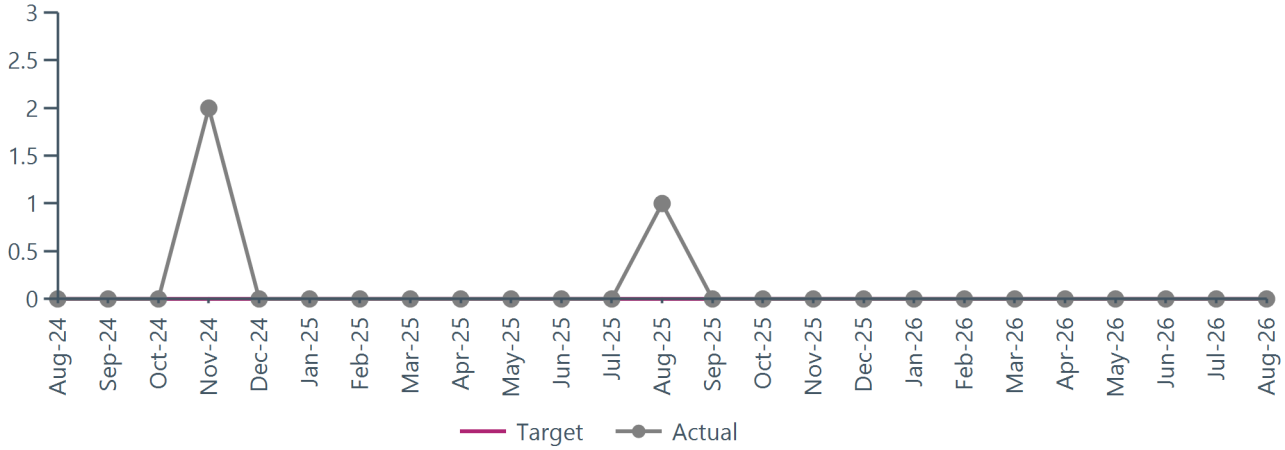
Number of cases of C.Difficile in Month 211149

Exec Lead
Chief Nurse and Patient Safety Office

Target/Plan	Latest Value	Variation	Assurance	NOF
0	0	N/A to SPC	P	+

Trajectory





What these graphs are telling us

This measure is not appropriate to display as SPC. Metric is consistently meeting the target.

Narrative

There were no RJAH Acquired C.Difficile reported in August. This metric has been included as an exception to reference the latest NOF publication.

The latest NOF Publication relates to Quarter 1 where the NOF score for this metric is 2. This position relates to the rolling twelve months period of July-25 to June-26 where in that period the Trust reported one infection in August-25.

Actions

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
1	0	0	0	0	0	0	0	0	0	0	0	0

- Staff - Patients - Finances -

RJAH Acquired E. Coli Bacteraemia

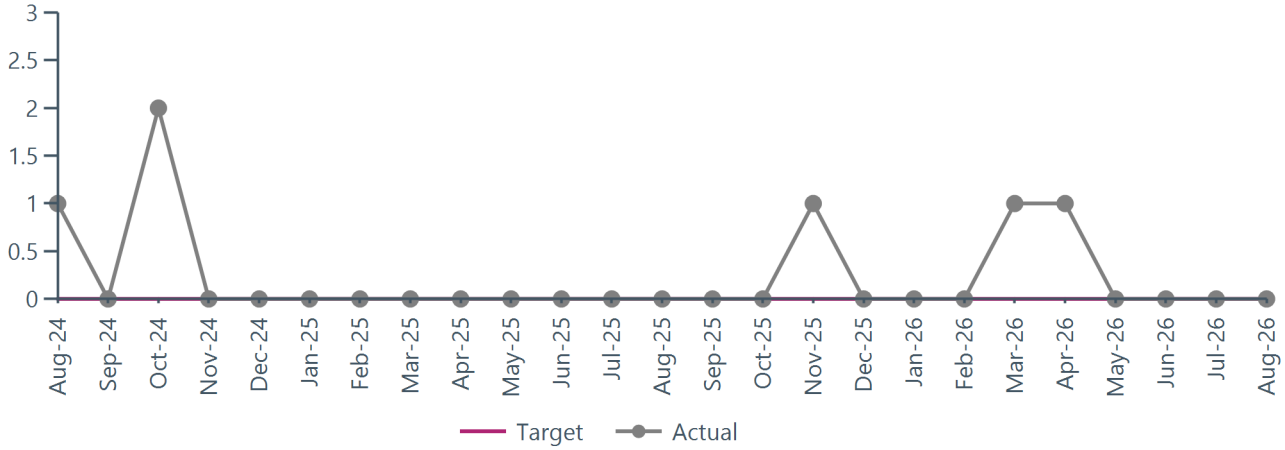
Number of cases of E. Coli Bacteraemia in Month. 211150

Exec Lead
Chief Nurse and Patient Safety Office

Target/Plan	Latest Value	Variation	Assurance	NOF
0	0	N/A to SPC	P	+

Trajectory





What these graphs are telling us

This measure is not appropriate to display as SPC. Metric is consistently meeting the target.

Narrative

There were no RJAH Acquired E. Coli Bacteraemia reported in August. This metric has been included as an exception to reference the latest NOF publication.

The latest NOF Publication relates to Quarter 1 where the NOF score for this metric is 2. This position relates to the rolling twelve months period of July-25 to June-26 where in that period the Trust reported three infections; November-25 (1), March-26 (1) and April-26 (1).

Actions

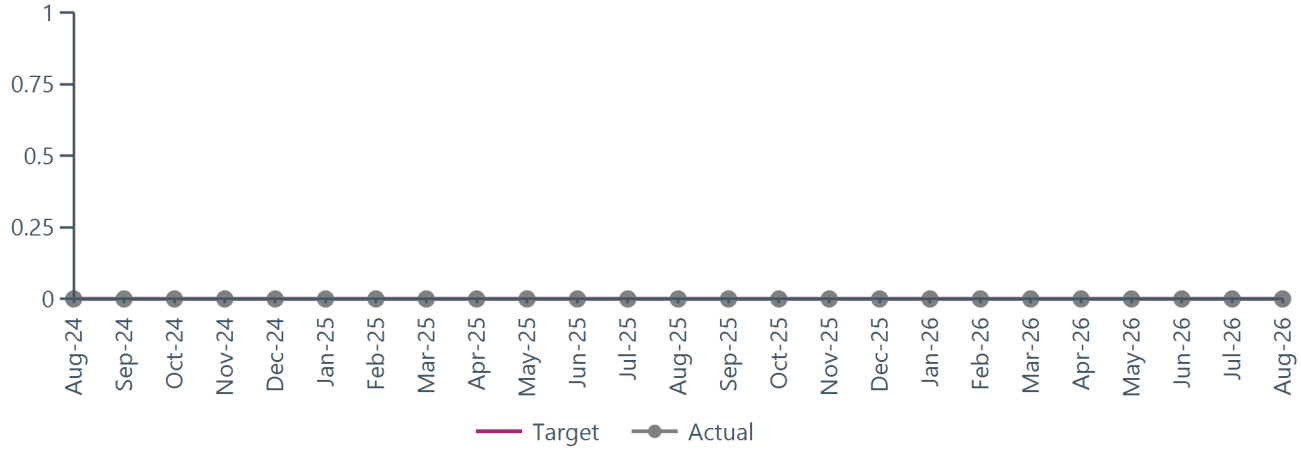
Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
0	0	0	1	0	0	0	1	1	0	0	0	0

RJAH Acquired MRSA Bacteraemia

Number of cases of MRSA bacteraemia in month 211151

Exec Lead
Chief Nurse and Patient Safety Office

Target/Plan	Latest Value	Variation	Assurance	NOF
0	0	N/A to SPC	P	+



Trajectory



What these graphs are telling us

This measure is not appropriate to display as SPC. Metric is consistently meeting the target.

Narrative

There were no RJAH Acquired MRSA Bacteraemia reported in August. This metric has been included as an exception to reference the latest NOF publication.

The latest NOF Publication relates to Quarter 1 where the NOF score for this metric is 1. This position relates to the rolling twelve months period of July-25 to June-26 where in that period there have been none reported.

Actions

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
0	0	0	0	0	0	0	0	0	0	0	0	0

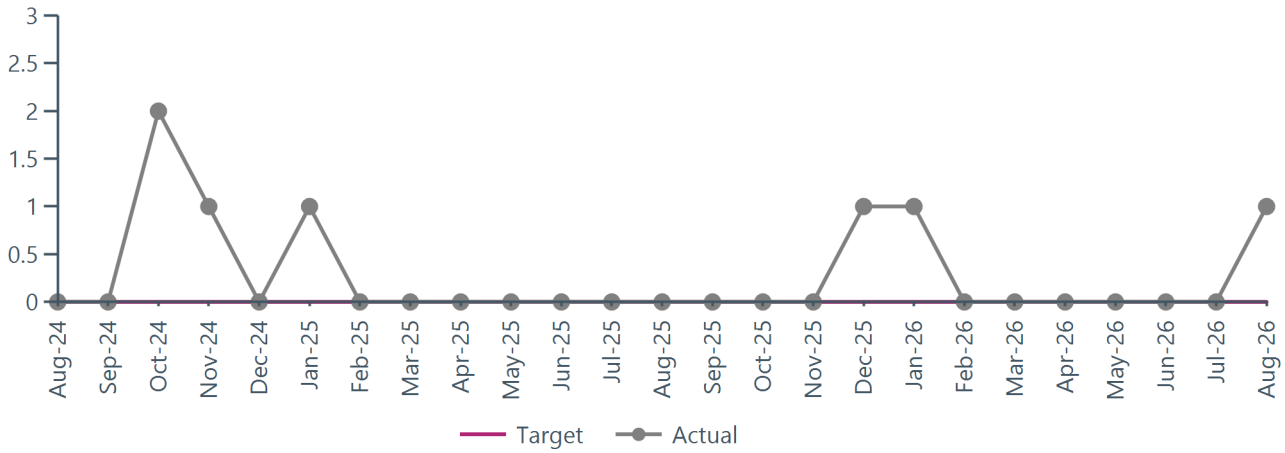
- Staff - Patients - Finances -

RJAH Acquired MSSA Bacteraemia

Number of cases of MSSA bacteraemia in month 211152

Exec Lead
Chief Nurse and Patient Safety Office

Target/Plan	Latest Value	Variation	Assurance	NOF
0	1	N/A to SPC	?	



Trajectory



What these graphs are telling us

This measure is not appropriate to display as SPC. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

There was one RJAH Acquired MSSA Bacteraemia reported on Powys Ward in August.

Actions

At the time of IPR production, the Post Infection Review is scheduled.

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
0	0	0	0	1	1	0	0	0	0	0	0	1

Surgical Site Infections

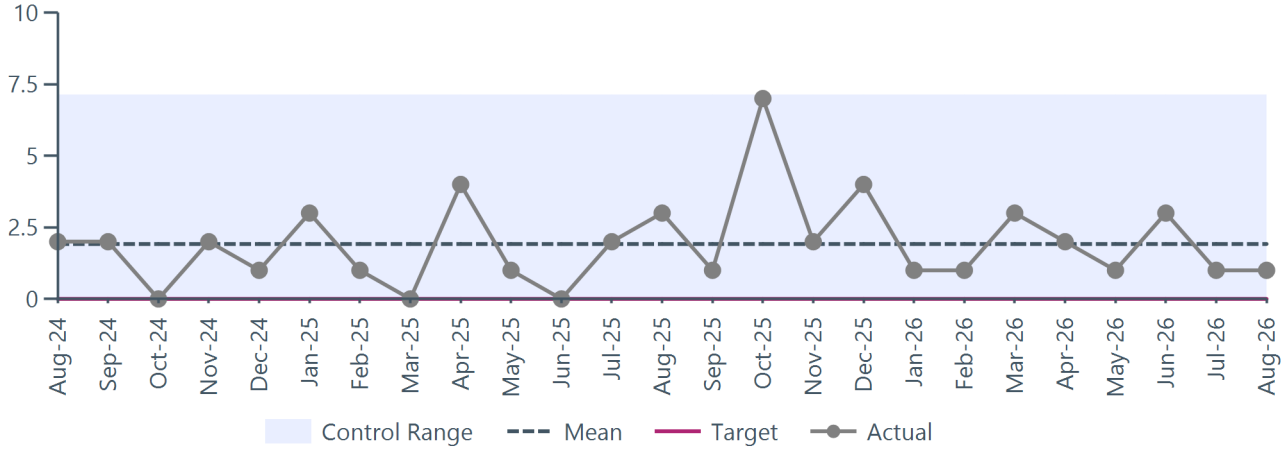
Surgical Site Infections reported for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement in previous twelve months.
217727

Exec Lead
Chief Nurse and Patient Safety Office

Target/Plan	Latest Value	Variation	Assurance	NOF
0	1			

Trajectory





What these graphs are telling us

Metric is experiencing common cause variation. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

Surgical Site infections are monitored for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement. They are monitored through each quarter for a period of 365 days following the procedure. The data represented in the SPC above shows any surgical site infections that have been confirmed. SSI rates are benchmarked by the UKHSA against all providers, and Trusts are notified if the data identifies them as an outlier.

There were three infections confirmed in August, as outlined below:
* 1 x Clywd Ward - procedure took place in June-26
* 1 x Ludlow Ward - procedure took place in July-26
* 1 x Clywd Ward - procedure took place in August-26

Actions

For the SSI in relation to procedure in June, the One Together audit has been completed.

At time of IPR production, the One Together audits are scheduled for the other two SSIs.

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
3	1	7	2	4	1	1	3	2	1	3	1	1

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Quality and Safety Committee

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 7 October 2026

Author: **Contributors:**

Name: Sophie Donnelly
Role/Title: Executive Assistant

Report sign-off:

Penny Venables, Non-Executive Director – Chair of the Quality and Safety Committee

Is the report suitable for publication?:

Yes

1. Key issues and considerations:

The Trust Board has established a Quality and Safety Committee. According to its terms of reference: "The purpose of the Quality and Safety Committee is to assist the Board obtaining assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. The Committee will work with the Audit and Risk Management Committee to ensure that there are adequate and appropriate quality governance structures, processes, and controls in place throughout the Trust to:

- Promote safety and excellence in patient care.
- Identify, prioritise, and manage risk arising from clinical care.
- Ensure efficient and effective use of resources through evidence based clinical practice."

To fulfil its responsibilities, the Committee has established a number of sub-committees (known as "Meetings") which focus on particular areas of the Committee's remit. The Quality and Safety Committee receives regular assurance reports from each of these "Meetings" and escalates issues to the Board as necessary via this report.

This report provides a summary of the items considered at the Quality and Safety Committee on 24 September 2026. It highlights the key areas the Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

The following strategic objectives, developed in light of national and system priorities, are relevant to the content of this report:

	Trust Objectives	
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	✓
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	✓
4	Grow our services and workforce sustainably	
5	Innovation, education and research at the heart of what we do	

This report relates to the following Board Assurance Framework (BAF) themes and associated strategic risks:

	Board Assurance Framework Themes	
1	Continued focus on excellence in quality, safety and patient experience.	✓
2	Focus on equity of service and addressing health inequalities	✓
3	Effective engagement with the workforce to support a positive staff experience and a culture of continuous improvement	
4	Delivering financial sustainability	
5	Delivering the required levels of productivity, performance and activity	
6	Delivering innovation, improvement and growth	✓
7	The challenges of operating in both the Welsh and English health systems	✓
8	Responding to a significant disruptive event	✓
9	Security of digital, data and AI systems and ability to respond to cyber threats	

Chair's Assurance Report
Quality and Safety Committee

Trust values:

The content of this report reflects / supports the following Trust values:

Trust Values		
1	Professional	✓
2	Excellence	✓
3	Respect	✓
4	Friendly	✓
5	Inclusive	✓
6	Caring	✓

3. Assurance Report from Quality and Safety Committee

3.1 Areas of non-compliance/risk, matters to be addressed urgently, or other significant developments

ALERT - The Quality and Safety Committee wishes to bring the following issues to the Board's attention as they:
Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address;
Represent significant developments / improvements that will help the Trust deliver its objectives; AND / OR
Require the approval of the Board for work to progress.

Patient Harms Report: noted that the overdue follow-up cohort had reduced to 11,987 and that RTT recovery work was substantially complete. Residual patient safety and operational risk remains while the non-RTT cohort is validated, consistent processes are embedded and system-related reporting issues are resolved. The Chief Nurse is Senior Responsible Owner, and a phased recovery plan, trajectory and quarterly reporting will support continued oversight.

Safe Staffing Review: received assurance that adult inpatient services were safely staffed at the time of review, based on triangulation of staffing data, professional judgement and quality and safety outcomes. Fill rates were within the national range and no patient harm was attributed to staffing levels. Submission to Board was approved subject to agreed amendments.

IPC Board Assurance Framework & HCSA Compliance Report: noted 95% compliance with action plans in place for areas not fully compliant. The report was approved for onward submission subject to refinement of the narrative to better reflect work already underway.

Safeguarding Annual Report: received assurance on statutory compliance, governance and multi-agency working and approved the Annual Report and priorities for 2026/27, subject to clarification of training assurance.

Controlled Drugs Accountable Officer Annual Report: received assurance that controlled drugs were being managed safely and statutory requirements were met. Governance had strengthened across receipt, transport and supply, and opioid stewardship had reduced discharge quantities without an associated increase in reported postoperative pain. The report was approved.

Well-Led Action Plan: noted that 7 of the 8 actions relevant to the Committee were complete and supported realignment of the remaining action on clinical engagement to the Organisational Development and Engagement Working Group.

Provider Capability Self-Assessment: supported the proposed approach and the working assessment of green across all 6 domains, subject to final consistency review, executive consideration and Chair and Chief Executive approval before submission.

3.2 Areas of on-going monitoring with new developments

ADVISE - The Quality and Safety Committee wishes to bring the following issues to the Board's attention as they represent areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives:

Corporate Risk Register: reviewed 12 high-rated risks allocated wholly or jointly to the Committee. Members requested clearer distinction between controls that maintain the current position and actions that address underlying causes, together with clearer target dates, progress and evidence of effectiveness. Particular focus remains on digital dependencies, the homecare prescription backlog, shared-care arrangements and Pharmacy workforce sustainability.

Integrated Performance Report: noted 19 complaints in August, with response performance below target, 1 RJAH-acquired MSSA bacteraemia, 3 surgical-site infections, 5 medication incidents resulting in low-level harm, 7 unplanned returns to theatre and 33 on-the-day cancellations. Earlier patient contact, stronger unit-level scrutiny and continued monitoring of quality indicators remain areas of focus.

Premises Assurance Model Report: noted overall compliance of 82.1% against the revised national model. The low helipad score reflected changed guidance rather than deterioration in the site, and routine access remains paused while documentation and improvement requirements are addressed. Assurance on notable deficiencies and the associated costed action plan will continue through the relevant governance routes.

Chair Reports from Patient Safety and Health and Safety Meetings: noted an outstanding governance gap relating to historic and current non-clinical risk assessments, including the absence of a Trust-approved template, central recording and audit arrangements, and incomplete transfer of historic information from Datix to Radar. An update will be provided to the next meeting on the extent of the issue, immediate mitigations, migration arrangements, timescales and whether escalation to the Corporate Risk Register is required.

Chair Report from Clinical Effectiveness Meeting: noted that investigation tracking within MSST remains reliant on manual processes and does not provide a fully auditable electronic referral and reporting system. The issue is recorded on the Trust Risk Register and has been escalated to system partners, including the ICB and provider executives.

Chair Report from EPR Assurance Meeting: noted that Workspace V2 deployment has been delayed while clinical, operational and digital defects are addressed. System reliability also remains a concern, with P1 incidents occurring more frequently than expected and continuing to affect user confidence and operational resilience. Supplier performance and delivery of the revised digital roadmap remain under close review.

Chair Report from Health Inequalities Working Group: noted that Welsh patients from more deprived communities remain disproportionately represented within longer waiting-time cohorts. Further analysis, improved demographic data, targeted intervention and a consistent Trust-wide offer for patients experiencing digital exclusion remain in development.

Chair Report from Trust Performance and Operational Improvement Group: noted continued pressure from below-plan MSK theatre activity and on-the-day cancellations, together with ongoing monitoring of HDU compliance, Theatre 11 capacity, spinal waiting lists, the long-term governance of the Biobank, off-site records and Pharmacy workforce sustainability.

Chair Report from Strategy Delivery Group: noted that the Trust's electrical infrastructure is approaching capacity, presenting a strategic constraint on future estates development, digital infrastructure, clinical services and decarbonisation plans. Options, costs, funding and sequencing will be considered alongside the Trust's wider strategies.

Policy Tracker: noted 12 overdue policies within the Committee's remit. Policies continue to progress through the relevant governance routes, with the Patient Access Policy to be completed without further delay and updated later if a system-wide policy is agreed.

3.3 Areas of assurance

ASSURE - The Quality and Safety Committee considered the following items and did not identify any issues that required escalation to the Board.

PSIRF Report: noted that no Patient Safety Incident Investigations were commissioned during August. Two multidisciplinary patient safety reviews were initiated, and work continues to strengthen actions, revised completion dates and monitoring through Radar and Unit Governance Meetings.

2025 Adult Inpatient Survey: received strong assurance from the results, with RJAH ranked 2nd overall and 1st nationally for patient experience, care and treatment, cleanliness and shared decision-making. No areas were rated worse than expected. Waiting for admission and communication while waiting remain the principal opportunities for improvement.

Chair Reports: received assurance from the Patient Experience, Adult and Children's Safeguarding, Patient Safety, Health and Safety, IPC&C, Health Inequalities, Regulatory Oversight, Clinical Effectiveness, EPR Assurance, Trust Performance and Operational Improvement and Strategy Delivery reports. Positive assurance included improved DBS compliance, the signed Microbiology SLA, progress with accessibility and patient transport work, stronger antimicrobial stewardship, and development of strategic and digital governance arrangements.

Business Continuity and Emergency Preparedness: noted that the response to the significant water-supply incident on 11 August 2026 had been positive and the post-incident review had been signed off. The Trust had also submitted its annual EPRR self-assessment as fully compliant, with the confirm-and-challenge outcome to return to the Committee.

Recommendation

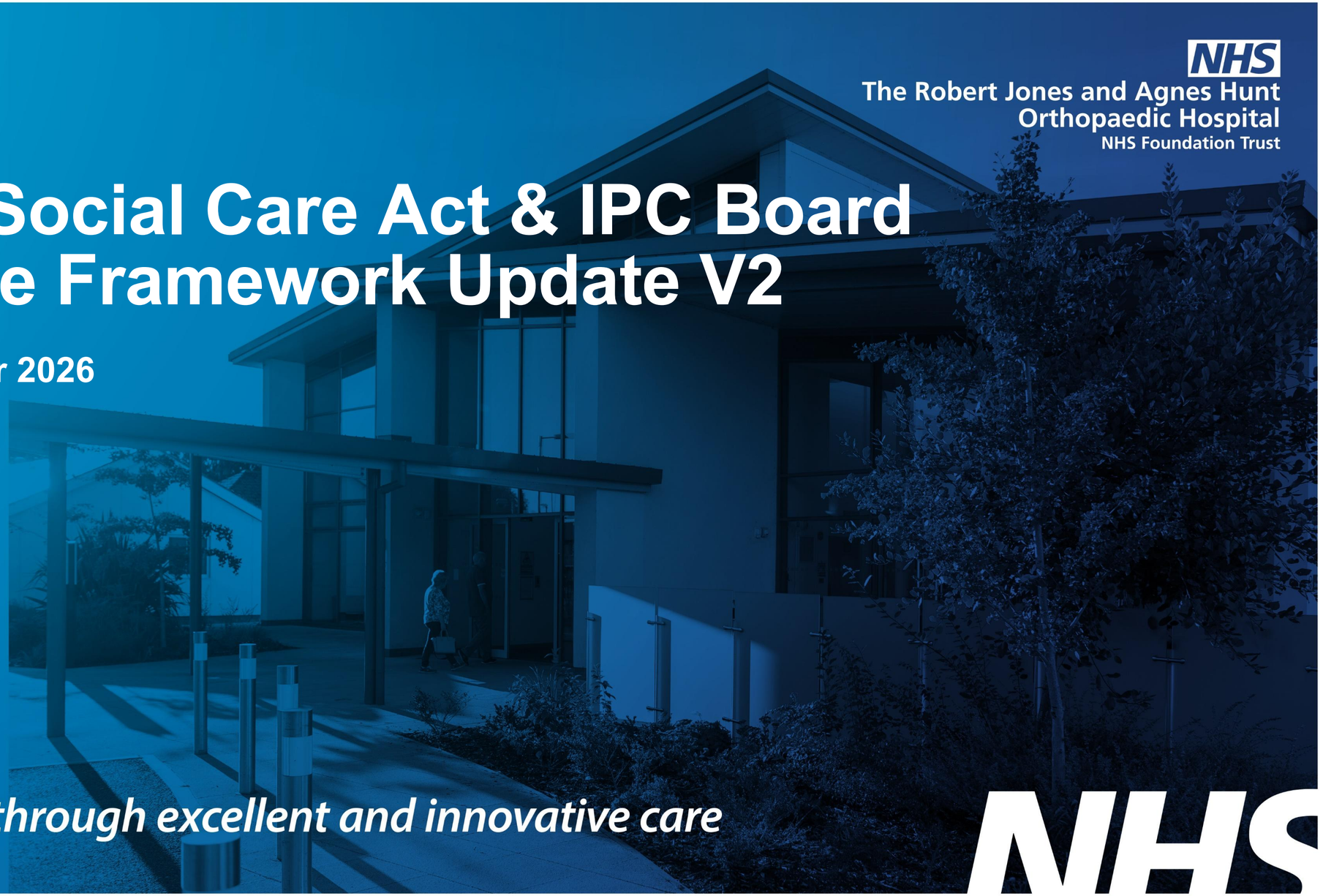
The Board is asked to:

1. CONSIDER the overall assurance level listed at section 2,
2. CONSIDER the content of section 3.1 and agree any action required;
3. NOTE the content of section 3.2 and CONSIDER whether any further action is required; and
4. NOTE the content of section 3.3.

NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Health & Social Care Act & IPC Board Assurance Framework Update V2

Revised September 2026



Improving lives through excellent and innovative care

NHS

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Overview

What is HSCA/BAF compliance?

The Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance provides the statutory framework that health and adult social care organisations in England must consider when establishing effective infection prevention and control (IPC) arrangements. The Code sets out 10 compliance criteria against which the Care Quality Commission (CQC) assesses organisations, covering areas such as governance and risk management, a clean and safe environment, antimicrobial stewardship, information sharing, prompt identification and management of infection risks, staff education and responsibilities, isolation facilities, laboratory support, safe care practices, and appropriate management of medical devices.

Within RJAH, the Code is reflected in IPC governance arrangements and assurance processes, with compliance monitored through IPCCM, and reported to Quality & Safety Committee, working groups, audit programmes and Board assurance frameworks to demonstrate adherence to the Code's requirements.

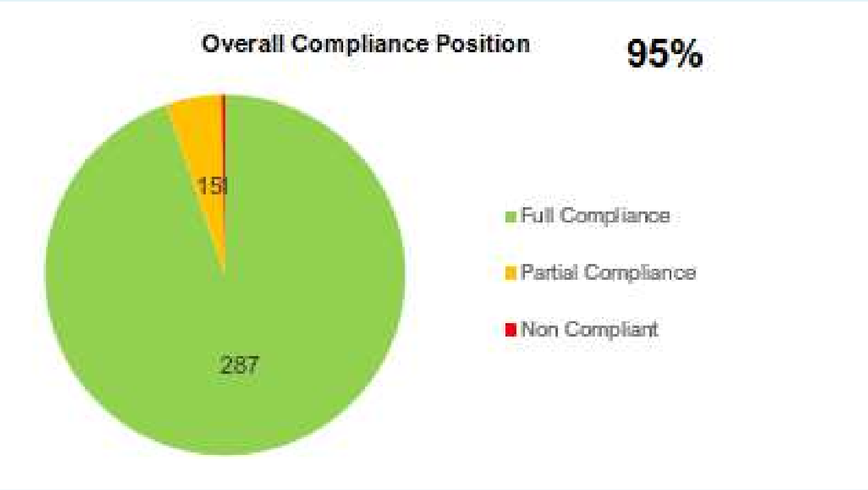
A HCSA/BAF toolkit was set up in 2023 and previously managed by the Deputy DIPC, and since 2025 is managed by the IPC Clinical Lead Nurse, with oversight from the Interim DIPC.

The next slides show the overall compliance to the HSCA/BAF and exceptions with associated actions.

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Current Position

Review undertaken in June 2026

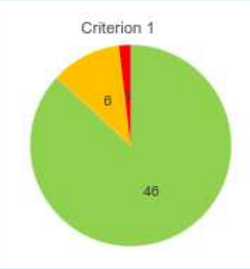


Overall compliance position is 95% with the breakdown shown below:

Criterion	Full Compliance	Partial Compliance	Non Compliant	Percentage%
1	46	6	1	87%
2	41	0	0	100%
3	9	2	0	82%
4	16	2	0	89%
5	7	0	0	100%
6	8	3	0	73%
7	9	0	0	100%
8	12	0	0	100%
9	120	1	0	99%
10	19	1	0	95%
Totals	287	15	1	303

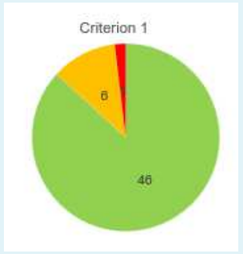
The next slides show the partial/noncompliance for each criterion.

Criterion 1:



Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	Compliance rating	Gaps in Assurance	Progress/Update
There are mechanisms in place by which the registered provider can ensure that sufficient resources are available to secure effective IPC		**June 26:** SLA with SaTH is out of date No DDIPC in post since Feb 2025 No admin support for IPC Team	**Jul 23:** Completion of Microbiology SLA with SaTH remains stalled. Microbiological support for RJAH in the interim continues as business as usual **Mar 23:** SLA remains under review HSCA does not stipulate microbiology services need to be on site. **May 24:** SLA review in progress with DF (Ops) and to include CPE screening monthly. **June 24**: SLA with Sheffield for microbiology services in place. Reviewing SaTH SLA for potential changes and rotational posts. Presenting to execs 18.6.24. Update in two weeks; current SLA still stands. (New updated action created 181) **July 24**: Rotational Posts agreed. Trust will formalise process **June 26:** Changed to Partial given no DDIPC. SaTH SLA out of date. Changes to Link Staff programme do not work for IPC **Sept 26:** Pathology SLA signed off and in place. No admin staff in post since Oct 24. Clinical team performing all admin duties since this time. IPC team went out to recruit in 2025 - both shortlisted candidates not suitable so did not recruit. IPC budget used to support TVN secondment role which depleted IPC admin budget. Current Band 2 admin post (12 hours per week/internal post) advertised on Trac with one applicant upon closing date 25/9/26.
Assurance framework in NHS provider organisations Activities to demonstrate that IPC (including cleanliness) and antimicrobial stewardship are an integral part of quality assurance should include regular presentations from the DIPC and/or the IPC and antimicrobial stewardship teams to the NHS board or registered provider. These should feature a trend analysis for infections, antimicrobial resistance, antimicrobial prescribing and compliance, with quarterly reporting to the NHS board or registered provider by clinical directors and matrons (including nurses who do not hold the specific title of 'matron' but who operate at a similar level of seniority and who have control over similar aspects of the service user or the service user's environment). What is reported on will vary according to the local arrangements.		**June 26**: changed this to Partial unitl more assurance around AMS	**Aug 26:** Antimicrobial Pharmacist now delivers AMR report to the IPCCM for DIPC oversight. **Sept 26:** AMR reports also delivered to Drugs & Therapeutics Committee with Quality & Safety Committee oversight and assurance via Chair Reports. AM to liaise with DIPC - is this sufficient to be considered 'green'.
Regular review of antimicrobial prescribing decisions		**June 26**: AMP in place however No antibiotic ward round in place. This ceased upon retirement of the RJAH Infection Control Doctor in 2022	**Sept 26:** Antimicrobial pharmacist reviews antibiotics prescribed and provides advice on alterations if required. IPC Team receive a daily list of positive samples via the SaTH lab - procvess involves checking antibiotics against senstivities and contacted the medicla team if differences would require review of treatment. Aspiration is for the AMP/IPC team to carry out a regular ward round together with a designated doctor. AMP is reviewing the options for this and awaiting feedback from medical team.

Criterion 1 cont.…:

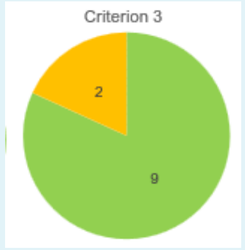


Framework	Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	Compliance rating	Gaps in Assurance	Progress/Update
HSCA	**IPC (including cleanliness) infrastructure** An infection prevention infrastructure should encompass: In acute healthcare settings, for example, an infection prevention team consisting of an appropriate mix of both nursing and consultant medical expertise (with specialist training in infection prevention and cleanliness), other healthcare workers and appropriate administrative and analytical support, estates and facilities management and adequate information technology – the DIPC is a key member of the Infection prevention team		**June 26**: No DDIPC in post since Feb 2025. No data analyst in post. Consultant support from SaTH for patient specific queries however no ICD to attend IPCCM or E&F Groups	**Jun 24:** Policy tracker in place and insight added to IPC QMS dashboard monitoring progress to works. Dashboard presented at IPC&C Meeting monthly. **Apr 25:** Policies aligned to NIPCM IPC QMS will now monitor Policy review. **Sept 26:** Substantive DIPC role in post since April 2026, fully supporting IPC Team. Microbiologist available for patient specific support queries. IPC Lead in discussions with DIPC around how the Trust and Team would beneift from having an IPC doctor within the Trust to support IPC in the built environement and the implemtation of national guidance/policies.
HSCA	other healthcare workers and appropriate administrative and analytical support		**June 26:** No admin support since Oct 2024	**Sept 26:** Clinical team performing all admin duties since Oct 2024. IPC team went out to recruit in 2025 - both shortlisted candidates not suitable so did not recruit. IPC budget used to support TVN secondment role which depleted IPC admin budget. Current Band 2 admin post (12 hours per week/internal post) advertised on Trac with one applicant upon closing date 25/9/26.

Actions in progress:

- Review of Microbiology SLA by DIPC
- AMP to provide AMS reports through IPCCM for DIPC oversight
- DTC to support the implementation of an antimicrobial ward round
- Once substantive DIPC appointed – future plans for Deputy DIPC will be in place
- IPC Admin post currently going through post approval process

Criterion 3:

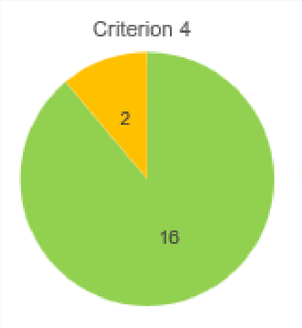


Framewor	Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	Compliance rating	Gaps in Assurance	Progress
HSCA	Providers should develop a local antimicrobial stewardship policy and local infection management guidelines drawing on national guidance (including from NICE), the British National Formulary and UK Health Security Agency (UKHSA) that takes account of local antimicrobial resistance patterns. The policy should cover the principles of diagnosis, treatment and prophylaxis of common infections, and prescribers should document allergy status, reason for antimicrobial prescription, dose, route and duration of treatment. Adherence to antimicrobial prescribing guidance and compliance with hospital post-prescribing review at 48 to 72 hours should be monitored and audited on a regular basis, with data fed back to prescribers and incorporated into service user safety reporting systems to boards and commissioners. Peer comparison and trend data, and prescribing audits should be used to demonstrate progress in antimicrobial stewardship in all settings. There should be evidence of appropriate action taken to deal with occurrences of inappropriate prescribing of antimicrobials including, where applicable, root cause analysis, emphasis on lessons learnt and/or post-		**June 26:** No Antimicrobial Stewardship Policy in place.	**Jan 24:** Chief Pharmacist in post. EPMA priority works continue. AMS to be further developed following Go Live. Infection guideline SaTH/STW and specialist input from Sheffield for complex infections. **Jan 25:** AMR Report to DT&C will include activities relating to 5 year plan. Template included as evidence. Completed report will be recieved once completed. **Feb 25:** AMR tool implemented. Pharmacy is conducting a six-week trial on Sheldon Ward using the tool. Report will be compiled upon completion and will be presented to IPC&C Meeting **Apr 25:** The 6-week trial has concluded, and the data is currently being analysed. A report with recommendations will be prepared and presented at IPC&CM. Action paused due to pharmacy capacity constraints for Apollo go-live **July 26:** EOLAS has been implemented and now contains the Trust's antimicrobial prescribing guidance, providing clinicians with access to approved antibiotic recommendations. Antimicrobial Pharmacist is gathering supporting evidence and benchmarking AMS policies from neighbouring organisations to support development of a formal Trust Antimicrobial Stewardship Policy for RJAH.
HSCA	In acute care settings, providers should report local antimicrobial susceptibility data (drug-bug combinations) and information on antimicrobial consumption to the national surveillance body. Surveillance information should be used by the local and regional stewardship committees or equivalent to monitor local resistance patterns and guide local antimicrobial prescribing guidelines and antimicrobial stewardship activities. This information should be communicated back to prescribers across the health and social care system to improve prescribing quality.		**June 26:** Surveillance information is not reviewed at DT&C	**June 23:** IPC Assurance Lead supporting Pharmacy leads to configure Audits onto Tendable **Jul 23:** Audit currently in design stages. IPC Assurance Lead continues to work with Tendable and Pharmacy to ensure its set up **Aug 23:** Audits configured on Tendable Pharmacy lead awaiting sign up to system to undertake audits. **Sept 23:** Audits being undertaken Dashboard created to collect, display and analyse results. **July 26**: A programme of antimicrobial stewardship audit is being established, including 48–72-hour antimicrobial review audits. Caroline will look to commence Point Prevalence Surveys (PPS) and explore how EPMA can support data collection, reporting and audit requirements. Caroline has contacted Rebecca Hawkins (SaTH) to obtain guidance on PPS methodology and antimicrobial stewardship audit arrangements used locally.

Actions in progress:

- AMP under new line management and given protected time to support AMS duties, including development of AMS policy
- A programme of antimicrobial stewardship audit is being established, including 48–72-hour antimicrobial review audits. AMP to commence Point Prevalence Surveys (PPS) and explore how EPMA can support data collection, reporting and audit requirements.

Criterion 4:

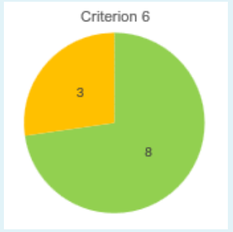


Framework	Criterion 4: Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion	Compliance rating	Gaps in Assurance	Progress
NIPCBAF	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.		**June 26:** Need assurance that all leaflets are accessible to whole demograpic	**Sept 26:** IPC Team in liason with the Comms Team for advice on how patient information is made accessible in a multitude of formats.
HSCA	The importance of compliance by visitors with hand hygiene		**June 26:** Minimal visible reminders for visitors to perform hand hygiene	**Sept 26:** IPC guidance is sited on Trust website. IPC Team working on developing graphocs for entrances and high traffic areas to encourage all visitors to the Trust to perform hand hygiene.

Actions in progress:

- IPC Team to liaise with Communications Team around ensuring all patient leaflets are in an accessible format
- IPC Team designing hand hygiene graphics for hospital entrances promoting hand hygiene to visitors

Criterion 6:

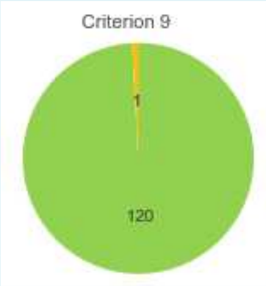


Framework	Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Compliance rating	Gaps in Assurance	Progress
NIPCBAF	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.		**June 26:** staff are trained in donning and doffing of PPE excluding HCID PPE ensemble.	Sept 26: All staff undertake IPC induction as a new starter. IPC Level 2 training completed by all clinical staff as part of mandatory training. Donning and doffing videos available for staff. Ipc Team promote NIPCM which outlines PPE requirments. Regaular audits and spot checks identify gaps in practice, and opportunities to carry out on the job teaching sessions to support in correct PPE selection. The Health & Safety Team have developed a SOP for the Perso respirator hoods in the event of requiring RPE if no FFP3 masks were available. SOP awaiting endorsement through the IPCCWG before approval at IPCCM.
NIPCBAF	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.		**June 26:** Not all identified have an up to date FIT test. No FFP3 masks held on site mitgated with respirator hoods (not be to used for HCID)	**May 23:** Trust looking into appointing a full time fit tester to undertake fit testing for staff. Risk sited on the Risk register escalated to IPC&C Meeting April & May sighted at exec level. **Jun 23:** Proposal to out source fit testing to external contractor will be taken to IPC&C Meeting 27.6.23 by H&S Manager **Jul 23**: Costs for external provision obtained. **Aug 23:** Options appraisal paper to be presented to execs for consideration. **Sept 23:** External service costings are excessive. H&S Manager will revise options appraisal with DDIPC approval to align fit testing with NIPCM through a risk-based approach. **Oct 23:** SOP shared at IPC&CWG outlining revised plan for fit testing staff approved at IPC&C Meeting. **Dec 23:** Finance approval for external contract. **Jan 24:** H&S published dates for FFP3 Fit Testing March 24. **Mar 24**: Fit testing commenced for clinical staff. Managers are uploading to ESR. **Aug 26**: Meeting between DIPC/H&S Team /IPC Team have identified a FIT mask testing programme which will be undertaken by Fire Safe International. A list of all staff tested is held within ESR as per NHSE requirements. **Sept 26:** IPC Team to develop up to date list of staff groups required to be FIT tested, with accompanying comms delivered to teams. Currently in progress.

Actions in progress:

- IPC Clinical Lead working with PDN team to establish assurance around ANTT training and audit
- HCID training booked for August, facilitated by NHSE
- IPC Team and H&S Teams working together to establish who should be FIT tested to current requirements and how this will be recorded on ESR by November 2026

Criterion 9:

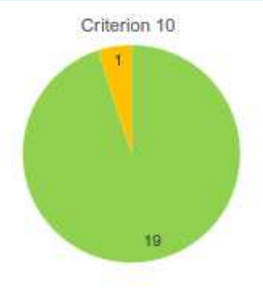


Framework	Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	Compliance rating	Progress
HSCA	An audit should be undertaken to monitor compliance with the technique		**Sept 26:** Agreed with PDN Team and DIPC that ANTT compliance will be uploaded to ESR to audit compliance. Awaiting ETOM approval.

Actions in progress:

IPC Clinical Lead has requested this information from PDN Team for assurance

Criterion 10:



Framewo	Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection	Compliance rating	Gaps in Assurance	Progress
HSCA	Having arrangements in place for regularly reviewing the immunisation status of care workers and providing vaccinations to staff as necessary in line with Immunisation against infectious disease ('The Green Book') and other guidance from Public Health England		**June 26:** A central HR-led system to record and monitor Bloodborne Virus (BBV) vaccination status for all staff performing invasive procedures is currently not in place. Such a system is needed to track boosters, maintain up-to-date records, and include vaccination checks during induction to ensure staff immunity is effectively monitored.	**Jan 26**: Human Resources will lead the establishment of a central system to record and monitor Bloodborne Virus (BBV) vaccination status for all staff performing invasive procedures. This will include tracking required boosters, maintaining up-to-date records, and incorporating vaccination checks during induction for new starters. Progress on this action will be monitored and supported through the Regulatory Oversight Meeting to ensure ongoing oversight and compliance. **Sept 26:** Immunisation records held by current provider. Change of OH provider imminent.

Actions in progress:

- Following a tender process for OH services, the new provider will be expected to hold this information and will be required to attend all IPCCMs to provide assurance to DIPC

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Monitoring

- Detailed HSCA/BAF review bi-annually
- Actions monitored through IPC Quarterly reports to IPCCM
- IPCCM Chair Report to Quality & Safety Committee for oversight

IPC Health & Social Care Act (HSCA) and Board Assurance Framework (BAF) Compliance Position June 2026

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Committee / Group / Meeting, Date	
Quality and Safety Committee, 24 September 2026 Board of Directors – Public meeting, 07 October 2026	
Author:	**Contributors:**
Name: Anna Morris Role/Title: IPC Clinical Lead Nurse	
Report sign-off:	
Name: Clair Hobbs Role/Title: Chief Nurse and Director for IPC (DIPC)	
Is the report suitable for publication?:	
YES	

Executive Summary:

The Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance provides the statutory framework that health and adult social care organisations in England must consider when establishing effective infection prevention and control (IPC) arrangements.

The Code sets out 10 compliance criteria against which the Care Quality Commission (CQC) assesses organisations, covering areas such as governance and risk management, a clean and safe environment, antimicrobial stewardship, information sharing, prompt identification and management of infection risks, staff education and responsibilities, isolation facilities, laboratory support, safe care practices, and appropriate management of medical devices.

Within RJAH, the Code is reflected in IPC governance arrangements and assurance processes, with compliance monitored through IPCCM, and reported to Quality & Safety Committee, working groups, audit programmes and Board assurance frameworks to demonstrate adherence to the Code's requirements.

A HCSA/BAF toolkit was set up in 2023 and previously managed by the Deputy DIPC, and since 2025 is managed by the IPC Clinical Lead Nurse, with oversight from the Interim DIPC.

This presentation shows the June 2026 position to the Health and Social Care Act (2008) Code of practice for the prevention and control of infection, and the IPC Board Assurance Framework.

The current position is 95% compliance across 10 Criterion, with 15 partial compliance, and 1 non-compliant. Action plans are in place for all areas without full compliance.

Recommendations:

The Board is requested to:

- Note the report.
- Confirm the report's assurance level, as recommended by the Quality and Safety Committee.

Safeguarding Annual Report 2025/26

(Part 1) Covering paper

Committee / Group / Meeting, Date	
Quality and Safety Committee, 24 September 2026 Boardof Directors, 06 October 2026	
Author:	**Contributors:**
Helen Harris & Edyta Szpila Named Nurse Safeguarding Adults & Named Nurse Safeguarding Children and Young People and DASV Trust Lead	
Report sign-off:	
Clair Hobbs Executive Lead for Safeguarding and Chief Nurse and Patient Safety Officer	
Is the report suitable for publication?:	
YES	

Executive Summary:

The Safeguarding Annual Report provides assurance on the Trust's safeguarding arrangements and activity from 1 April 2025 to 31 March 2026. It demonstrates continued compliance with statutory duties and national and local safeguarding frameworks, supported by established leadership, governance and multi-agency working.

- Key achievements include improved mandatory training compliance, launch of the Safeguarding Champions Programme, progression of CP-IS implementation, policy development, strengthened domestic abuse and sexual safety arrangements, and completion of 3 safeguarding assurance audits.
- Activity during the year included 16 adult safeguarding referrals, 35 DoLS applications, 17 children and Early Help referrals, 44 Prevent information-sharing requests, 94 safeguarding children advice or supervision contacts, and 28 domestic abuse disclosures.
- Assurance is provided by the Section 11/Care Act audit, which reported 96% overall compliance, positive learning disability and autism feedback, and sustained compliance above target in several mandatory training areas.
- Adult Level 3 safeguarding training remained below the 90% target at 85%, although this was the highest level achieved to date. Actions arising from audits and areas requiring improvement remain subject to monitoring.
- 11 priorities have been identified for 2026/27, including policy reviews, improved dementia support, organisational learning, simulation training, the Reasonable Adjustments Digital Flag, CP-IS, a Was Not Brought audit and a Domestic Abuse and Sexual Violence audit.

Recommendations:

The Committee is asked to:

- Approve the Safeguarding Annual Report 2025/26 and take assurance from the safeguarding activity, governance and statutory compliance described.
- Approve the safeguarding priorities for 2026/27.
- Approve for submission to Public Board and Trust Internet site.

(Part 2) Strategic alignment and supporting detail

Strategic objectives and associated risks:

The following strategic objectives are relevant to this report:

Trust Objectives		
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	✓
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	✓

The report supports high-quality clinical services through robust safeguarding governance, training, audit and specialist advice. It also supports integrated pathways and sustainable workforce development through partnership working, safeguarding champions, targeted education and digital initiatives including CP-IS and the Reasonable Adjustments Digital Flag.

This report relates to the following Board Assurance Framework (BAF) themes and associated strategic risks:

Board Assurance Framework Themes		
1	Continued focus on excellence in quality, safety and patient experience.	✓
2	Focus on equity of service and addressing health inequalities	✓
3	Effective engagement with the workforce to support a positive staff experience and a culture of continuous improvement	✓
4	Delivering financial sustainability	
5	Delivering the required levels of productivity, performance and activity	
6	Delivering innovation, improvement and growth	✓
7	The challenges of operating in both the Welsh and English health systems	✓
8	Responding to a significant disruptive event	
9	Security of digital, data and AI systems and ability to respond to cyber threats	✓
The report provides assurance on quality, safety and patient experience by demonstrating compliance with safeguarding duties and oversight of risk. Reasonable adjustments, learning disability and autism initiatives and partnership working support equitable access and reduce health inequalities. Training, champions and learning activity strengthen staff capability and continuous improvement, while CP-IS and digital flag developments support safe information sharing across English and Welsh pathways.		

Trust values:

The content of this report reflects / supports the following Trust values:

Trust Values		
1	Professional	✓
2	Excellence	✓
3	Respect	✓
4	Friendly	✓
5	Inclusive	✓
6	Caring	✓
The report reflects all Trust values through professional, evidence-based safeguarding practice; a focus on excellence and continuous improvement; respect for rights, dignity and autonomy; approachable advice and support; inclusive reasonable adjustments; and compassionate care for children, young people and adults at risk.		

Report development and engagement:

Safeguarding activity and assurance have been considered through relevant Trust governance forums and multi-agency safeguarding partnerships throughout 2025/26. The Safeguarding Team has contributed to local and regional oversight groups, statutory review processes, audit activity and implementation workstreams. The Annual Report brings this evidence together for Committee assurance.

Next steps:

- Deliver and monitor the 11 safeguarding priorities for 2026/27.
- Continue action-plan monitoring from safeguarding audits and target improvement in Adult Level 3 training compliance.
- Progress CP-IS phase 2 and implementation of the Reasonable Adjustments Digital Flag.
- Complete planned WNB and DASV audits and progress relevant policy reviews.
- Provide the next annual safeguarding assurance report following the end of the 2026/27 reporting period, with interim assurance through established governance arrangements.

Supporting detail (if required):

Safeguarding Annual Report 2025/26

The attached Annual Report contains detailed evidence on statutory frameworks, safeguarding governance, mandatory training, adult and children's safeguarding activity, domestic abuse and sexual safety, learning reviews, audit findings and priorities for 2026/27. It reports sustained investment in specialist safeguarding leadership and demonstrates established processes for advice, supervision, referral, information sharing, incident response and multi-agency engagement.

Specific areas requiring continued oversight are Adult Level 3 training compliance, completion of audit actions, policy review, consistency in the use of hospital passports and reasonable adjustments, and delivery of the digital safeguarding priorities. The report concludes that the Trust's safeguarding arrangements remain robust and effective while recognising clear opportunities for further improvement.

Acronyms

CP-IS	Child Protection Information Sharing
DASV	Domestic Abuse and Sexual Violence
DoLS	Deprivation of Liberty Safeguards
RADF	Reasonable Adjustments Digital Flag
WNB	Was Not Brought

Attachments

Attachment A **Safeguarding Annual Report 2025/26**

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Safeguarding Annual Report 2025/2026

Authors:

Helen Harris - Named Nurse Safeguarding Adults

Edyta Szpila - Named Nurse Safeguarding Children and Young People

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Introduction

The Safeguarding Annual Report provides assurance to the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) Board regarding safeguarding activity for the reporting period 1st April 2025 – 31st March 2026.

RJAH is committed to ensuring that all staff are aware of their safeguarding responsibilities in relation to children, young people and adults at risk. The report demonstrates continued organisational compliance with statutory requirements and national and local safeguarding frameworks.

In 2024/2025, the Trust strengthened its safeguarding arrangements with significant investment in the Safeguarding Team with the recruitment of dedicated Named Nurses for Adults and Children, together with a Domestic Abuse and Sexual Violence Lead. Throughout 2025/2026, the Trust maintained investment in the team ensuring safeguarding continues to be prioritised as a core component and seen as '*business as usual*'.

The team are committed to the promotion of safeguarding best practice and ensures that all statutory functions are fulfilled, responding proactively to the needs of staff members, patients and their support mechanisms. The vision of the team is to truly embed safeguarding practices within the Trust, making it visible within everyday core business.

Safeguarding governance contributes to a wide range of performance and quality measures both internally and externally, in accordance with the Care Quality Commission (CQC), Shropshire Safeguarding Community Partnership (SSCP), Telford & Wrekin Safeguarding Partnership and our local Integrated Care Board (ICB). This includes:

- Mandatory safeguarding training compliance
- Deprivation of Liberty Safeguards (DoLS) applications
- Referrals to Adult and Children's Social Care
- Section 42 enquiries
- Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHRs), Child Safeguarding Performance Reviews (CSPRs) and LeDeR Reviews
- Prevent and Channel Pannel requests
- Domestic Abuse Stalking and Harassment (DASH) risk assessments
- Safeguarding supervision and advice provided given to staff
- Allegations against staff, including LADO & PiPoT processes
- Was Not Brough (WNB) rates for children and young people
- National Referral Mechanism

Safeguarding Structure

NHS organisations are required to appoint designated safeguarding professionals who provide expert advice, leadership and support to staff while promoting best practice across the organisation. These roles include the Named Doctor and Named Nurse for Safeguarding Children and Young People and the Named Nurse for Safeguarding Adults. Together, they support the Trust to meet its statutory safeguarding responsibilities and ensure that relevant legislation, national guidance and local procedures are embedded throughout clinical practice and service delivery.

The Executive Lead for Safeguarding provides strategic leadership and ensures that safeguarding remains a core organisational priority, embedded across all areas of Trust business and service provision. The designated Non-Executive Lead provides independent scrutiny and challenge at Board level, supporting effective oversight, assurance and accountability for the Trust's safeguarding arrangements.



Executive Lead for Safeguarding	Claire Hobbs Executive Lead and Patient Chief Safety Offi
Non-Executive Lead for Safeguarding	Lindsey Webb
Named Doctor for Safeguarding Children & Young People	Dr Richa Kulshrestha Consultant Paediatric Neurodisability
Named Nurse Safeguarding Children & Young People and DASV Trust Lead	Edyta Szpila
Named Doctor for Safeguarding Adults and MCA Lead	Dr Paul Hughes Consultant Anaesthetist
Named Nurse Safeguarding Adults and Prevent Le	Helen Harris
Adult Safeguarding Practitioners	Rebecca Wright-Powell Bethan Mallen

Key Achievements

- Safeguarding priorities for 2025/2026 progressed across the organisation, supported by a steady increase in mandatory safeguarding training compliance throughout the year.
- The Safeguarding Champions Programme was launched and has been well received.
- Phase two of the CP-IS implementation commenced in December 2025 and will continue into

2026/2027

- Collaborative work was undertaken with the SATH Safeguarding Team to review and develop the Chaperone Policy in response to NHS England's *Improving chaperoning practice in the NHS: key principles and guidance*, published on 5 December 2025 as part of the national update on actions to prevent sexual misconduct in the NHS.

- Safety Intervention training was commissioned and delivered to the theatre staff to strengthen their knowledge, skills and confidence when caring for children attending dental theatre lists who have learning disabilities, additional communication needs and behaviours that may challenge.

- Family First Partnership and Children's Social Care Reform meetings were attended to support local preparation for and implementation of the national children's social care reforms.

- Support and facilitation / chairing of best interest meetings.

- Creation, implementation and embedding of the Adult Safeguarding and Complex Care checklist within Apollo for in-patients and those patients coming through Pre-Operative Assessment Clinics.

Additional Training:

- ✓ Practical Application of Mental Capacity Act (MCA), Best Interests (BI) and Deprivation of Liberty Safeguards (DoLS)
- ✓ Non-Clinical Staff Sessions – MCA & BI.
- ✓ Non-Clinical Staff Session – Challenging Patient Conversations.
- ✓ Non-Clinical Staff Session – Safeguarding and Complex Care.
- ✓ The Family A learning session**-** a learning presentation based on the Joint Adult and Child Review of Family was delivered across key governance forums, including the Specialist Governance Meeting, Specialist Delivery Unit Governance Meeting, and MSK Governance Unit.

The White Ribbon Event

The campaign ran for 16 days, featuring the White Ribbon logo on Trust computer screensavers and two information boards for staff and patients. These boards shared information, promoted the new Women's Aid phone number, and offered SDAS and Women's Aid leaflets, which were widely taken. The team also held three Lunch and Learn training sessions on completing a Caada Dash Risk assessment.

Staff Allegation Taster Training Session

28 staff participated in scenario-based safeguarding questions (Managing Allegations Quiz). This session covered:

- 3 safeguarding scenarios
- Knowledge-check questions
- Immediate feedback

Updated Policies, SOPS and Procedures:

- ✓ Domestic Abuse Policy (supersedes Domestic Abuse Procedure).
- ✓ Pediatric Consent SOP.
- ✓ Restrictive Practices Policy.
- ✓ Managing Allegations Against Staff / PiPoT Policy.

In Review at Time of Report:

- ✓ Management of a Child Who Was Not Brought (WNB).
- ✓ Chaperoning Policy.

Assurance Audits:

- ✓ Section 11 / Care Act Audit.
- ✓ MCA Audit.
- ✓ Learning Disability Service Evaluation Audit.

Section 1: Statutory Frameworks and National Policy Drivers

Whilst there are significant differences in the laws and policies that shape how we safeguard children, young people and adults at risk, the objective of all legislation is to ensure that all individuals are protected to life free from harm, abuse and neglect.

This report provides a summary of RJAH discharges its statutory duties in relation to:

- Mental Capacity Act (2005) / Deprivation of Liberty Safeguards Amendments (2009)
- Care Act (2014)
- Counter Terrorism and Security Act (2015)
- Learning from Lives and Deaths (LeDeR) (2021)
- Children Act (1984, 2023)
- Working Together to Safeguard Children (2018, 2023, 2026)
- Domestic Abuse Act (2021)
- NHS Sexual Safety Charter (2023)
- SSCP / Telford & Wrekin Safeguarding Partnership
- National Referral Mechanism (NRM
- Human Rights Act 1998
- Safeguarding Vulnerable Groups Act 2006

In additions the national statutory guidance and children's social care reform implementation requirements

- The Families First Partnership (FFP) Programme Guide Delivery expectations for statutory safeguarding partners in England: Year 2 (2026 to 2027)
- Children's Social Care National Framework Statutory Guidance on the purpose, principles for practice and expected outcomes of children's social care March 2026

The Mental Capacity Act (2005) / Deprivation of Liberty Safeguards (DoLS) Amendments (2009)

The Mental Capacity Act 2005 protects and empowers individuals who are, or may be, unable to make decisions for themselves. It applies to everyone working in health and social care providing support, care and treatment to people aged 16 and over who live in England and Wales.

The five fundamental principles of the MCA ensure that all individuals are provided with an opportunity to engage in the decision-making process, even where it is identified that they lack the mental capacity to make their own decisions.

The act allows restraint and restrictions to be used, but only where it is identified that they are in the best interests of the individual and utilising extra safeguards, which are Deprivation of Liberty Safeguards (DoLS). DoLS was due to be replaced by Liberty Protection Safeguards (LPS) however HM Government announced in 2023 that implementation is delayed, with no further update.

The Care Act (2014)

Adult safeguarding is established as a core function of every local authority's care and support system. The Care Act sets out the statutory framework for safeguarding adults. The Act requires local authorities to have a Safeguarding Adult Board (SAB); one key function of which is to ensure that policies and procedures governing adult safeguarding are fit for purpose and can be translated into effective adult safeguarding practice.

The Counterterrorism and Security Act (2015)

The overall aim of HM Government's counter-terrorism strategy, CONTEST, is to reduce the risk from terrorism to the UK population, ensuring that citizens can go about their lives freely and with confidence. PREVENT remains one of the four key pillars of the CONTEST framework; Prevent, Pursue, Protect and Prepare.

Whilst RJAH remains a non-priority site, all healthcare and other regulated bodies have a statutory duty to engage with the framework to ensure early identification and intervention of individuals who are susceptible to radicalisation.

Prevent Duty Guidance - Requires specific public bodies, including NHS organisations, to have due regard to preventing people from being drawn into terrorism.

Learning from Lives and Deaths (LeDeR) 2021

LeDeR was introduced in 2017, developed and designed to improve the care of individuals with a learning disability and/or autism. Individuals within these groups are likely to die 25 years earlier than others. The aim of LeDeR is to reduce health inequalities and prevent individuals from dying sooner than they should. In 2021, the NHS Long Term Plan made a commitment to continue LeDeR and a new LeDeR policy was produced, providing for the first time core aims and values of the programme and the expectations placed on the health and social care system.

The RJAH Safeguarding Team attended local LeDeR governance and steering groups reviewing deaths and taking actions to improve services within the local areas, ensuring compliance with the LeDeR policy. The Learning Disability Improvement Standards (LDIS) were developed in conjunction with experts with experience with the Listen, Act, Do framework being fundamental.

The Reasonable Adjustments Digital Flag (RADF) has been discussed within the ICS, ensuring that moving forward there will be interface with the GP Spine; this is an ongoing conversation with the Apollo Team. Until full implementation, local reasonable adjustment flags are active within the Apollo system to ensure Phase I of the RADF is underway and compliant.

The team has been instrumental in the creation and launch of the patient facing RJAH Learning Disabilities and Autism website. Once the ICB LD&A website is developed and live, the plan is for both to link to support patients across the system. The website has been promoted within the Trust via the Patient Engagement Group, Healthcare Professionals Network (previously SNAHP) and the Quality and Safety Group.

The Learning Disability Service Evaluation questionnaire has been approved identifying patient and carer feedback; however, this has been deferred to Q1 2025 / 2026.

The Children Act (1984, 2004) / Working Together to Safeguard Children (2018, 2023, 2026)

The Children Act (1989) and Section 11 of the Children Act (2004) placed a statutory duty on all NHS Trusts to plan to ensure that it has regard for the need to safeguard and promote the welfare of children when exercising its functions. The new arrangements are led by three statutory partners, The Shropshire Safeguarding Community Partnership, the Local Authority, West Mecia Police and ICB.

Domestic Abuse Act (2021)

Domestic abuse is a public health epidemic, and health services have to be part of the solution. The government's strategy for tackling domestic abuse is based on prevention, protection, justice, and support. Evidence has shown many survivors of domestic abuse desperately wanted someone to ask them what was happening at home when in contact with a health professional and thus the government believes that the NHS has a particular contribution to make. The Domestic Abuse Act 2021 provides a more comprehensive definition of domestic abuse, recognizing not only physical violence but also emotional, coercive, and controlling behavior. This expanded definition ensures that various forms of abuse are addressed.

Training on domestic abuse is part of the Safeguarding Adults L3 training package. The topic of children as standalone victims of domestic abuse, as well as emotional abuse resulting from domestic abuse, is also addressed in the L3 Safeguarding Children Training as well as content of the Safeguarding

Champion's Programme. Additional training was lunched during the White Ribbon Campaign about asking the DA questions and completing Caada Dash risk assessment.

NHS Sexual Safety Charter (2023)

During 2025/26, the Trust continued to strengthen its arrangements for the prevention, identification and management of sexual misconduct, in line with the NHS Sexual Safety Charter and the additional actions required by NHS England.

The Trust completed a comprehensive review of its Chaperoning Policy. The revised policy strengthens requirements relating to consent, patient choice, documentation, formal chaperones, children and young people, reasonable adjustments and the escalation of concerns. The updated policy is ready to be presented for approval at the Quarter 1 Safeguarding Committee meeting.

A new Sexual Safety Policy was also developed by the People Service with input from the Trust's Domestic Abuse and Sexual Violence Lead. The draft policy is scheduled to be presented to the Joint Consultative Committee during Quarter 2 as part of the formal approval process.

Human Rights Act 1998

It underpins safeguarding by affirming the right to life, protection from inhuman or degrading treatment, and respect for private and family life.

In safeguarding practice, it ensures:

- That interventions are lawful, proportionate, and necessary.
- That individuals' dignity and autonomy are respected.
- That safeguarding decisions balance protection with rights-based approaches.

Safeguarding Vulnerable Groups Act 2006.- Establishes DBS checks and barred lists to prevent unsuitable individuals from working with vulnerable adults

Safeguarding Partnerships

SSCP and Telford & Wrekin Safeguarding Partnership are they statutory bodies for coordinating and ensuring effectiveness of arrangements to safeguard and promote the welfare of children, young people and adults at risk within Shropshire, Telford & Wrekin. All Trust Safeguarding policies, procedures and training are aligned with ICB Safeguarding policies and guidance.

RJAH attended:

- Children Quality Assurance and Performance Group
- JTAI Preparation meetings
- Adult Safeguarding & Protection Practice Oversight Group
- Children's Safeguarding & Protection Practice Oversight Group
- Children's Oversight Group
- Statutory Case Review Group
- Training Pool
- Adult Statutory Case Review Group
- Child Sexual Abuse Task and Finish Group
- Domestic Abuse Forum
- Neglect Sub-Group
- MCA Midlands Forum
- Telford Safeguarding Partnership Panel Meetings
- Telford Child Sexual Exploitation (CSE) Sub-Group
- Participated in MACFA in Shropshire as well as in Telford and Wrekin
- Multiagency MCA and DOLS Operational Group
- CPIS Phase Two Implementation meetings
- The Family First Programme Meetings.
- The Domestic Abuse Subgroup meeting
- The Reginal Named Professionals Meeting

- Family Group Decision making workstreams
- Family Group Decision making
- SSCP Children Statutory Case Review Group
- Circle of Support meeting
- CP-IS system and National meetings
- The Family Help Working Group
- National Safeguarding Childrens Network
- Regional Named Professionals Meeting
- DALP strategy workshop

Safeguarding Assurance Audits

Audits provide an opportunity to assess and evaluate safeguarding knowledge, skills and confidence, in conjunction with evaluating processes and procedures throughout the organisation. The audit process provides fundamentally provides assurance against regulatory standards and systemically enables benchmarking within the Trust, locally and nationally, ensuring that NHS providers are compliant with robust regulatory standards are in place.

There were 3 assurance audits completed within the reporting period:

- **Section 11 / Care Act Audit**
  A joint adult and children self-assessment audit was undertaken from West Midlands / Black Country and Integrated Care Board (ICB). Of the 69 identified standards, 9 were 'outstanding' elements, 57 were 'good' and 3 'required improvement'. Therefore overall compliance was deemed substantial with an overall compliance of 96%. An action plan was established to track the progress of the latter elements.

- **MCA Audit**
  The team completed a deep dive audit in relation to assessments of mental capacity undertaken within the Trust. A total of 6 records were chosen at random, with 5 of the forms capturing the correct decision information in the capacity assessment. The small sample did not provide an overall picture of the Trust position, therefore an additional audit was complete in Q3 for assurance purposes. The sample size was increased to 13; the stage one diagnostic criteria was 77% compliant and stage two functional criteria being 92% compliant.

  Ongoing advice and support continues to be provided by the team throughout the Trust, with ad hoc and bespoke training, as well as MCA / DoLS being incorporated into L3 Safeguarding Adult training. Additional, lunch and learn sessions have been provided inline with the implmentation of the MCA / BI toolkit and amended forms. Feedback is also given directly to staff on completion of MCA forms identified.

- **Learning Disability Service Evaluation**
  A Learning Disability and Autism Patient Feedback Service Evaluation was undertaken by the Safeguarding Team to assess the experiences of patients with learning disabilities, autism and neurodivergence accessing services at RJAH. Feedback from patients and carers was highly positive, with respondents reporting that staff understood their needs, involved them in decisions about their care, communicated effectively and provided appropriate reasonable adjustments. Most patients were asked about hospital passports, althought this was identified as an area for improvement to ensure consistent use throughout the patient journey. Actions include promoting awareness and use of hospital passports across the Trust and continuinging to support staff education through Oliver McGowan training. Overall, the evaluation demonstrated that RJAH provides accessible, person-centred care and supports positive patient and carer experiences.

Section 2: Mandatory Training

Safeguarding Children L3 consistently exceeded the 90% compliance target in Q4. Whilst Adult L3 compliance remains below KPI, performance has reached its highest level to date at 85%. Whilst good progress has been made with Adult safeguarding training work continues to review roles that require the full day level 3 training or where this may not be necessary. Mitigation continues with the Safeguarding

Team supporting staff within the wider organisation whilst we continue to support completion of training. Trustwide implementation of Child Sexual Exploitation (CSE) training was not endorsed at Board level, therefore, compliance remains targeted.

Training	Yearly Compliance for 25/26
Level 3 Safeguarding Adults	85%
Level 3 Safeguarding Children	92%
Child Sexual Exploitation	92%
Oliver McGowan Training Part 1	94%
Oliver McGowan Training Part 2 (Tier 1)	50%
Oliver McGowan Training Part 2 (Tier 2)	55%
PREVENT Training	94%

Additional Training Provided - 2025-2026

- ✓ Practical Application of Mental Capacity Act (MCA), Best Interests (BI) and Deprivation of Liberty Safeguards (DoLS).
- ✓ Non-Clinical Staff Sessions – MCA & BI.
- ✓ Non-Clinical Staff Sessions – Challenging Patient Conversations.
- ✓ Non-Clinical Staff Sessions – Safeguarding and Complex Care.

Learning Disability and Autism

The Trust continues to support staff compliance with the Oliver McGowan Mandatory Training on Learning Disability and Autism, which is delivered by an externally commissioned provider. All staff members are required to undertake Part 1 and then Part 2, which comprises of either Tier 1 or Tier 2. Compliance remains strong with 94% of staff completing Part 1, and Part 2 compliance reaching 50% for Tier 1 and 55% for Tier 2. Both Tier 1 and Tier 2 compliance rates significantly exceed the ICB KPI of 30%, demonstrating the Trust's commitment to ensuring staff have the knowledge and skills required to support people with learning disabilities and autistic people effectively.

Mental Health

Mental health training continues to form part of the Trust's mandatory training programme, with relevant staff completing the ESR eLearning module; with current compliance or 95% consistently exceeding the Trust target of 90%. Mental health conditions remain common, with approximately one in four adults experiencing a diagnosable mental health problem each year, highlighting the importance of ensuring staff have the knowledge and skills to recognise and respond appropriately to patient's needs. The Trust has committed to Mental health first aider programme to support staff's understanding, knowledge and peer support. MCSI commissioned MPFT De-escalation and Breakaway Training as a pilot due to increased incidents.

Dementia

People living with dementia, as well as those experiencing other forms of cognitive impairment represent a significant proportion of those accessing hospital services, with evidence suggesting that up to one in four acute hospital beds are occupied by a person with dementia, and up to half of older patients admitted, have some form of cognitive impairment. Dementia training continues to form part of the Trust's mandatory training programme and is completed through an ESR eLearning module. Compliance is currently 98%, consistently exceeding the Trust target of 90% and supporting staff to provide safe, effective, and person-centred care for patients living with dementia and cognitive impairment.

Section 3: Safeguarding Adult Activity

Safeguarding Activity

Referrals to Adult Social Care / Local Authority
A total of 16 safeguarding referrals were made by RJAH staff to Adult Social Care or the relevant local authority, with the majority directed to Shropshire. Additional referrals were made to Staffordshire, Flintshire, Wrexham, Cheshire East and London Kingston, demonstrating our role as a national provider, with patients accessing our services from well beyond the local region.

In line with Section 42 of the Care Act 2014, the organisation continues to meet its statutory duty to engage with social care in response to concerns relating to adults at risk. At the time of reporting, the Safeguarding Team is not aware of any ongoing Section 42 (S42) enquiries.

Deprivation of Liberty Safeguards (DoLS) Applications
Throughout 2025/2026, staff completed 35 DoLS applications in line with statutory requirements. Of these, 24 were submitted to Shropshire as the supervisory body, with further applications made to the following authorities:

- Telford & Wrekin (3)
- Cheshire West (3)
- Cheshire East (1)
- Warwickshire (1)
- Staffordshire (1)
- Stoke on Trent (1)
- BCUHB (1)

The above distribution again reflects the wide geographical reach of our patient population. In one Shropshire case, the patient's family raised objections to the application, which was appropriately escalated to the Local Authority DoLS Team. A Best Interest Accessor (BIA) attended RJAH; however, no outcome was reached as the patient was discharged before the assessment could be completed. All applications were completed in accordance with DoLS guidance to ensure patients who lack, or may lack, capacity to the arrangements, are lawfully safeguarded, and that any restrictions on their liberty remain necessary, proportionate and in their best interests.

Pressure Ulcers / SG Protocol
Across the organisation, pressure ulcers continue to be reported, with those with multiple category 2, or any category 3 or category 4 then requiring completion of the national decision-making document; Safeguarding Adults Protocol: Pressure Ulcers and the Interface with a Safeguarding Enquiry Process (PUSG). This assessment tool subsequently determines the requirement for a safeguarding referral to be made to the local authority; this being those scoring 15 and above.

Across the year, the majority of pressure ulcers reported occurred prior to admission, with a proportion meeting the PUSG threshold, and one case progressing to a safeguarding referral.

Quarter	Total PU Reported	Occured P to Admiss	MET PUSG Threshold	SG Referral Made	LA
Q1	17	16	10	0	-
Q2	14	13	8	0	-
Q3	30	27	16	1	Shropshire
Q4	22	19	12	0	-
Total	83	75	46	1	Shropshire

As previously noted, the Safeguarding Team is not aware of any ongoing Section 42 enquiries, indicating

that cases were either not progressed following initial review or subsequently being closed by the Local Authority.

Prevent / Channel Requests

In accordance with Section 38 of the Counter Terrorism and Security Act 2015, the organisation continues to meet its statutory duty to share information that supports the prevention of radicalisation and potential exploitation of children, young people and adults at risk. Prevent / Channel information-sharing requests increased significantly during 2025/2026, rising from 17 in the previous year to 44; an increase of 159%. Requests were in relation to both adults and children, with only a small number of individuals known to RJAH services. There were no requests for the Safeguarding Team to attend any Channel Panels during the reporting period. All requests were reviewed and responded to appropriately, ensuring timely engagement with multi-agency partners and adherence to national Prevent guidance.

Quarter	Total Requests	Adults	Children	Known to RJAH	
				Adults	Children
Q1	15	7	8	1	3
Q2	11	3	8	0	1
Q3	8	5	3	1	1
Q4	10	4	3	2	0
Total	44	19	25	4	5

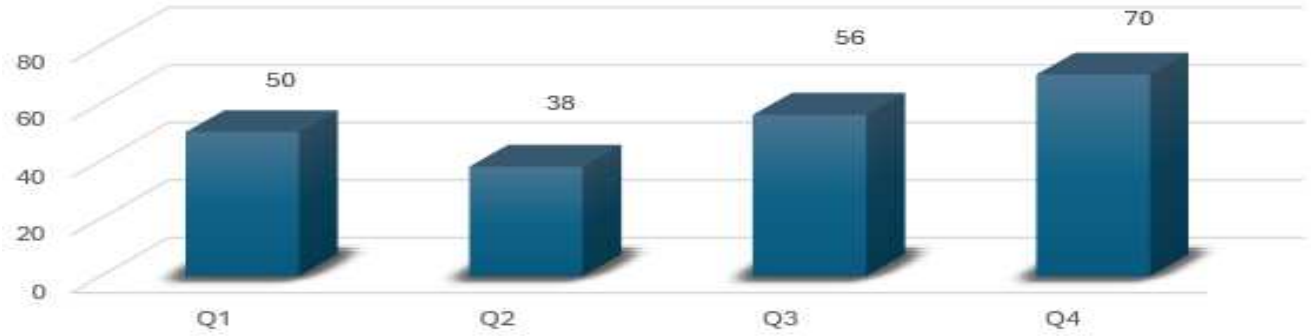
Mental Health Liaison

Colleagues at Midlands Partnership Foundation Trust (MPFT) continue to provide a mental health service for inpatients at RJAH. During the reporting period, the Liaison Mental Health Team have received a total of 75 referrals and undertaken a total of 175 contacts with patients.

Quarter	Referrals	Contact Visits
Q1	15	33
Q2	20	59
Q3	19	38
Q4	21	45
Total	75	175

Safeguarding Adults Advice & Support Contacts

Across the reporting period the Safeguarding Adult team provided support, advice and guidance to staff on more than 214 occasions; an increase of 20% from the previous year.



Staff Allegations
In accordance with statutory requirements for managing allegations under the Local Authority Designated Officer (LADO) framework and the People in Positions of Trust (PiPoT) guidance, the Trust's *Managing Allegations Against Staff Working with Children, Young People and Adults at Risk (PiPoT)* policy was applied to seven staff-related allegations during 2025/2026.
Three cases met the threshold for referral to the LADO, one of which was subsequently referred to the relevant Professional Body. Of the remaining cases, one did not meet the statutory threshold, and one was closed following initial review. The Trust continues to ensure that all allegations are managed robustly, transparently and in line with national safeguarding legislation and local partnership procedures.

Complex Care
Patients attending Pre-Operative Assessment have a Safeguarding and Complex Care checklist completed. This identifies any safeguarding concerns, but also those individuals requiring additional support, and any reasonable adjustments. A ward alert is subsequently completed by the Trust Co-ordination Centre for those patients, ensuring effective, clear and comprehensive awareness by the relevant teams. The Safeguarding Team liaises closely with Clinical Site Management Team and Co-ordination Centre to monitor alerts, reviewing patients as required and providing specialist support where appropriate.

Reasonable Adjustment Digital Flag is identified as a key SG priority for 2026/2027. The team continue to attend LeDeR Governance Panel, sharing good practice and innovations Trust Wide. The patient facing RJAH Learning Disabilities and Autism website is maintained and updated regularly as requirements emerge. In the future the website will link in with the ICB LD&A webpage once that is developed. The awareness of this resource has been raised through the Patient Engagement Group and HCPN.

Section 4: Safeguarding Children and Young People

Children Social Care Referrals
Across all four quarters, a total of 17 safeguarding referrals were completed. This included 15 referrals to children's social care and 2 referrals to Early Help.

Quarter	Children's Social Care	Early Help	Total
Q1	3	1	4
Q2	2	0	2
Q3	4	1	5
Q4	6	0	6
Total	15	2	17

To compare to the last year, the Trust made only five referrals to Children's Social Care and three referrals to the Early Help service. Which is an increase of seven referrals.

Safeguarding Children Advice and Supervision

Safeguarding children advice was sought by staff across all four quarters, alongside the delivery of safeguarding supervision sessions.

Quarter	Advice Sessions	Supervision Sessions	Total
Q1	15	0	15
Q2	14	12	26
Q3	23	0	23
Q4	12	18	30
Total	**64**	**30**	**94**

A total of 64 advice was given to staff and 30 staff received supervision. Advice activity peaked in Quarter 3, whereas supervision was primarily delivered in Quarters 2 and 4.

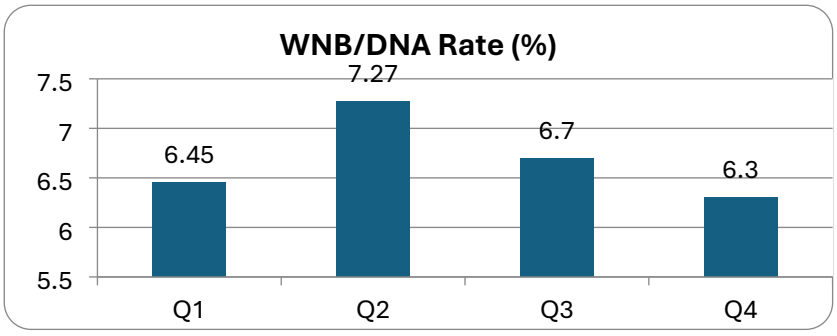
NRM Requests

Telford and Wrekin, along with Shropshire, successfully secured participation in the National Referral Mechanism (NRM) decision-making panel pilot. As part of this initiative, there is now a requirement for health information to be collected and shared within five working days of a request, with Integrated Care Board (ICB) leads providing representation at the panels. An information-sharing agreement is currently under development, and providers have been reminded to classify all related records as sensitive. Telford and Wrekin began accepting referrals in October 2025.

Since the pilot commenced in October 2025, 35 referrals have been received; among these, two children were previously seen at RJAH but are not under our active care.

Children Not Brought to Appointments (WNB)

WNB/DNA rates stayed mostly steady over the reporting year. Quarter 1 saw a mild rise, reaching 6.8% in May. Rates peaked in Quarter 2 at 8.3% in July, then averaged 7.27%. Quarter 3 was relatively stable, while Quarter 4 showed a gradual decline from 7.4% in January to 5.6% in March.



Safeguarding Children 0-19 Liaison Forms

Quarter	Number of 0-19 Liaison Forms
Q1	5

Q2	3
Q3	5
Q4	2
Total	**15**

The 0-19 children liaison was established in June 2025, and a total of 15 liaisons with health visiting and school nursing services occurred in 2025-2026.

Overall, liaison activity remained steady across the reporting period, demonstrating continued engagement with partner agencies and supporting coordinated safeguarding practice

Section 5: Domestic Abuse and Sexual Safety Activity

Domestic Abuse

There were 28 disclosures of domestic abuse made by service users and staff and 4 Cadda Dash risk assessments were completed. These disclosures resulted in four referrals to the Local Authority, one to Children Social Care, one to the Police and one to IDVA services. Additionally, five liaisons were established: two with allocated social workers, two with DA services, and one with a GP.

MARAC referrals

There were no MARAC referrals completed for service users.

Harmful Practices / Gender Based Abuse (FGM / Forced Marriage / Honour Based Abuse)

During the reporting period there were no identified cases of FGM, Forced Marriage or Honour Based Abuse.

Learning Reviews

Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHRs), Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR) and Child Safeguarding Practice Reviews (CSPRs) are statutory processes through which the Trust contributes to multi-agency learning and assurance. These reviews provide independent scrutiny where serious harm or death has occurred, enabling the identification of improvements in safeguarding practice, clinical pathways and inter-agency coordination.

Within 2025/2026, the Safeguarding Team responded to 16 statutory scoping requests for information. Of these, one individual was known to RJAH services, and a decision regarding progression to a DHR remains pending. The team continues to contribute to local multi-agency review processes, ensuring that any system-wide learning is identified, shared and embedded to strengthen safeguarding practice across the wider health and care system.

Quarter	Scoping Requests	DHR	SAR	CSPR	Review to Proceed
Q1	**1**	**1**	**0**	**0**	**1**
Q2	**6**	**0**	**4**	**2**	**3**
Q3	**3**	**0**	**1**	**2**	**1**

Q4	**6**	**5**	**1**	**0**	**TBC**
Total	**16**	**6**	**6**	**4**	**5**

Section 6: Priorities 2026 / 2027

The Safeguarding Team has identified eleven key priorities for 2026/27 to improve safeguarding standards across the Trust for both adults and children. These priorities focus on policy updates, training compliance, digital improvements, and strengthening internal frameworks:

- Access Policy Review
- PREVENT Policy Review
- Improve Dementia Awareness and Support
- Safeguarding Adult Policy Review
- Learning from Reviews / Organisational Learning
- Develop Simulation Training Package
- NHSE Reasonable Adjustments Digital Flag (RADF)
- Was Not Brought (WNB) Audit (Children)
- Child Protection Information Sharing (CP-IS) System
- Domestic Abuse and Sexual Violence (DASV) Audit
- Safeguarding Response to Self-Harm, Suicide Risk and Domestic Abuse

Conclusion

During 2025 / 2026, RJAH has continued to strengthen safeguarding practice across the organisation, ensuring the protection of children, young people and adults at risk remains a key priority. Effective governance, strong partnership working, robust assurance activity and ongoing investment in safeguarding leadership have supported the Trust in meeting its statutory responsibilities.

Progress has been demonstrated across several key areas, including increased staff awareness, improved training compliance, learning disability and autism initiatives, Mental Capacity Act compliance, domestic abuse awareness, and the development of the Safeguarding Champions Programme. Service evaluations and safeguarding activity continue to provide assurance that safeguarding arrangements are effective while identifying opportunities for further improvement.

Within 2026 / 2027, the Trust will focus on delivering its identified priorities, strengthen organisational learning, enhanced digital systems, and further embedding safeguarding within everyday practice. Overall, this report provides assurance that safeguarding arrangements within RJAH remain robust and effective, supporting the delivery of safe, high-quality and person-centre care.

Abbreviations

CAADA	Coordinated Action Against Domestic Abuse
CQC	Care Quality Commission
CIN	Child in Need
CP	Child Protection
CPIS	Child Protection Information System
CSE	Child Sexual Exploitation
CSPR	Child Safeguarding Practice Review
DASH	Domestic Abuse Stalking & Harassment
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
EPR	Electronic Patient Record

ESR	Electronic Staff Record
FGM	Female Genital Mutilation
ICB	Integrated Care Board
ICS	Integrated Care System
LADO	Local Area Designated Officer
LD&A	Learning Disability and/or Autism
LeDeR	Learning Disability Mortality Review
LPS	Liberty Protection Safeguards
MARAC	Multi-Agency Risk Assessment Conference
MCA	Mental Capacity Act
MCSI	Midlands Centre for Spinal Cord Injury
MPFT	Midlands Partnership Foundation Trust
NHSE	NHS England
PiPoT	People in Positions of Trust
RADF	Reasonable Adjustment Digital Flag
RJAH	Robert Jones & Agnes Hunt Orthopaedic Hospital
SAB	Safeguarding Adult Board
SAR	Safeguarding Adult Review
SCPR	Safeguarding Children Practice Review
SSCP	Shropshire Safeguarding Community Partnership
WNB	Was Not Brought

Bi- Annual Safe Staffing Paper

Committee/Meeting, Date

Quality and Safety Committee, 25 September 2026
Board of Directors, 07 October 2026

Author: **Contributors:**

Name: Jayne Johnson
Role/Title: Nursing & AHP Lead- Workforce

Report sign-off:

Name: Clair Hobbs
Role/Title: Interim Chief Nurse & Patient Safety Officer

Is the report suitable for publication?:

YES

Key issues and considerations:

The purpose of this paper is to provide advice and assurance to the Trust's Quality and Safety Committee and Trust Board regarding the provision of Safer Nurse Staffing and adherence to national policy. The paper provides the committee with an overview of the bi- annual nursing workforce establishment review for February 2026 and is set out in line with the National Quality Board Standards and Expectations for Safe Staffing published in 2016. The National Quality Board guidance and Developing Workforce Safeguards Standards sets out expectations for Nursing and Midwifery staffing levels to assist local trust board decisions in ensuring the right staff, with the right skills are in the right place at the right time.

Strategic objectives and associated risks:

The following strategic objectives are relevant to the content of this report:

Trust Objectives		
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	

This report relates to the following Board Assurance Framework (BAF) themes and associated strategic risks:

Board Assurance Framework Themes		
1	Continued focus on excellence in quality and safety	✓
2	Creating a sustainable workforce	✓
3	Delivering the financial plan	✓
4	Delivering the required levels of productivity, performance and activity	✓
5	Delivering innovation, growth and achieving systemic improvements	
6	Responding to opportunities and challenges in the wider health and care system	
7	Responding to a significant disruptive event	✓

System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system. The following objectives are relevant to the content of this report:

System Objectives		
1	Improve outcomes in population health and healthcare	✓
2	Tackle inequalities in outcomes, experience and access	✓
3	Support broader social and economic development	✓
4	Enhance productivity and value for money	✓

Bi- Annual Safe Staffing Paper

Recommendations:

- For the Quality and Safety Committee and Trust Board to take assurance that the Trust has safe staffing for it's adult inpatient facilities and agree the next steps.
- Following consideration of this paper the Chief Nursing & Patient Safety Officer and Medical Director confirm that they are satisfied with the outcome of the assessment, and that staffing is deemed safe, effective and sustainable.

Report development and engagement history:

- This report has been compiled using a 30-day data collection that took place in February.
- The evidenced based and NICE approved Safe Nursing Care Tool (SNCT) for Adult inpatient wards was used as part of a triangulated approach to support the bi- annual establishment setting process along with professional judgement and outcomes.
- The information presented within this paper was considered as part of the bi-annual Nursing workforce establishment review in partnership with the Ward Managers, the Matrons, the Nursing & AHP Lead- Workforce, the Assistant Chief Nurse and Chief Nurse in May 2026.

Next steps:

- Work towards ensuring two clean SNCT data sets to inform and direct future staffing requirements.
- Benchmark safe staffing metrics with other specialist Orthopaedic hospitals to provide additional assurance.
- Repeat the data collection in September and then bi-annually thereafter until two clean datasets are obtained.
- Progress the actions outlined in the attached Developing Workforce Safeguards gap analysis, reporting monthly via the Non- Medical Safe Staffing Group (NSSG).
- Aim to capture Children & Young People's Inpatient Ward safe staffing data in 2027 data collections.
- Explore the data functionality and monthly reporting capabilities relating to Safe Care to provide robust assurance against the National Quality Board guidance (2016).
- Appoint substantively to posts reduce Bank and Agency spend.
- Conduct a wider review relating to ward requirements and bed numbers.
- Targeted actions required in relation to night-time Registered Nurse resilience and increasing pressure from rising patient acuity.

Acronyms and abbreviations

See Appendix:2

Bi- Annual Safe Staffing Paper

1. Background / context

1.1 NHS Provider Boards are accountable for ensuring their organisation has the right culture, leadership, and skills in place for safe, sustainable, and productive staffing that will support safe, effective, caring, responsive and well-led care.

Demonstrating safe staffing is one of the essential standards that all health care providers must comply with to meet Care Quality Commission (CQC) regulation, Nursing and Midwifery Council (NMC) recommendations and national policy on safe staffing. The National Quality Board (2016) guidance and Developing Workforce Safeguards (2018) sets out expectations for Nursing and Midwifery staffing levels to assist local Trust Board decisions in ensuring the right staff, with the right skills are in the right place at the right time.

It is well documented that ensuring adequate Registered Nurse (RN) staffing levels in line with national recommendations has many benefits including improved recruitment and retention, reduction in staff stress, reduction in patient mortality and improved quality and safety metrics.

The Developing Workforce Safeguards national policy (2018) was established from safe staffing work when system leaders identified a gap in support around workforce and builds on the National Quality Board (2016) guidance. It identifies that NHS Trusts must ensure the below three components are used in their safe staffing processes:

- Evidence based tools and data.
- Professional judgement
- Outcomes

The Trust uses the NICE endorsed Safer Nursing Care Tool (SNCT) for adult inpatient wards in acute hospitals and has the required licencing in place to do so. Twice-yearly safe staffing assessments combine SNCT findings, triangulated with Safe-Care data, professional judgement and patient outcomes.

A 30-day SNCT data collection took place in February as part of the bi- annual establishment setting process. The audit sample consisted of adult inpatients admitted to inpatient wards at The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, excluding Oswald and the High Dependency Unit (HDU). These wards were excluded as they operate under different staffing models and acuity profiles that are not directly comparable to standard inpatient ward settings. Our Paediatric in-patient ward, Alice Ward was also excluded from this review as they operate under different staffing models and acuity profiles that are not directly comparable to the Children & Young People's Inpatient Wards Safer Care Tool.

Results were reviewed in May to align with the appointment of the Interim Chief Nurse. It was evident that there was a need to repeat the data collection due to an incomplete SNCT data capture and it was evident that there was a need to explore the data functionality and monthly reporting capabilities relating to Safe Care to provide robust assurance against the National Quality Board guidance (2016), which emphasises having the right staff, with the right skills, in the right place at the right time. Another 30-day SNCT data collection is planned for September and the bi-annual establishment setting process will be repeated.

A Developing Workforce Safeguards gap analysis has been undertaken since appointment of the new Chief Nurse that has identified recommendations requiring action to achieve full compliance. This gap analysis is included in appendix: 1 of this report.

This report outlines the findings of the second set of data, collected in February 2026 for the bi- annual safe staffing review, but as previously mentioned will need to be repeated in order to provide a meaningful, triangulated approach. This has been scheduled for September.

2.0 Nurse to Patient Ratio- Adult In-Patient Wards

2.1 Nurse to patient ratios are a useful benchmark for assessing the average amount of patients each Nurse is caring for.

2.2 It should be noted that this method may not always accurately reflect the needs of the individual patient as their dependency on Nursing input may differ at various points. NICE 'Safe Staffing guidance for adult Inpatient Wards in Acute Hospitals' (2014) states that there is no single nurse- to- patient ratio but highlights that a Registered Nurse caring for more than 8 patients carries an increased risk of harm. We acknowledge these recommendations and that staffing must match patient acuity, dependency needs, and that professional judgement and the use of evidence -based tools supports decision making on optimal Nurse staffing establishments. The SNCT is a NICE endorsed evidence- based workforce planning tool that is used to support this decision making on optimal Nurse staffing establishments within adult inpatient areas. It should be acknowledged that for adult High Dependency Critical Care Units and children and young people's inpatient wards in acute hospitals these nurse-to-patient ratio does not apply.

2.3 At present there is no national guidance of Nurse-to-patient ratios for night duty per ward however professional judgement of the Chief Nurse who is also a National CNO Safer Staffing Fellow is recommending 1:13.

2.4 Table 1 shows the average Registered Nurse (RN): Patient ratio at Robert Jones & Agnes Hunt Orthopaedic Hospital NHS FT during February 2026 for our adult inpatient areas. This aligns to the 30-day data collection that took place took as part of the bi- annual establishment setting that was deferred to May 26' to align with the appointment of the new Interim Chief Nurse. It demonstrates that during February 2026 all inpatient wards more than met the recommended staffing ratio.

2.5 It also identifies that RN to patient ratios are rich and higher than would be expected but this is due to the small number of beds on each ward and occupancy being low.

2.6 The RN-to-patient ratio data presented in this paper is based on a 24-hour reporting period. To provide robust assurance, the functionality and reporting capabilities within Safe Care should be explored to enable the data to be analysed separately for day and night shifts.

Table 1: Actual Average RN: Patient ratio February 2026 (days and nights combined)

In- patient Ward	Number of beds	RN: Patient Ratio- Actual
Ludlow Ward	16	1:4
Clwyd Ward	16-28	1:5
Powys Ward	16-26	1:4

Kenyon Ward	12-22	1:4
Sheldon Ward	19	1:6
MCSI- In-patient Ward	46	1:5

2.7 Nursing Associates (NA's) are used in the Trust and the updated SNCT tool includes NA's in the Registered Nurse (RN) count. The use of NA's to the Trust is now embedded to many of our areas but to ensure safety, professional judgement is applied with triangulation of quality and safety data as a standard daily expectation of leaders and managers. It is to be noted that within the Trust the qualified NA's are included in the RN ratios.

2.8 Actual versus planned staffing numbers for Feb 2026 showed that:

Ward	% of shifts (both RN and HCSW) covered by substantive staff	% of shifts (both RN and HCSW) covered by bank/ agency staff	July 2025 data % of shifts (both RN and HCSW) covered by bank/ agency staff
Ludlow Ward	86%	↑ 14%	13%
Clwyd Ward	80%	↑ 20%	10%
Powys Ward	69%	↑ 31%	19%
Kenyon Ward	80%	↑ 20%	28%
Sheldon Ward	87%	↑ 13%	17%
MCSI	76%	↑ 24%	26%

2.9 For context - during February for Powys and Kenyon ward, each booked only 1 agency shift.

2.10 All wards saw an increase in shifts covered by bank/agency in comparison to the previous data collection in July 25.

2.11 The HCA day and night fill rate for Powys Ward the HCA fill rate for Kenyon were higher than planned to maintain ongoing management and safety for patients requiring increased complexity of care.

3.0 Safer Nursing Care Tool (SNCT)

3.1 The SNCT is an evidence-based tool that is endorsed by NICE to measure individual patient acuity and dependency. It is proposed that using SNCT offers greater understanding regarding if actual hours match required hours.

3.2 SNCT (Adult inpatient wards) data collection took place in February, utilising the SNCT 'Adult Inpatient Wards in Acute Hospitals' - the toll works out required staffing based on a 65 RN to 35 HCSW split. The bi- annual establishment setting process took place in May 26' to align with the appointment of the Interim Chief Nurse.

3.3 The SNCT allows clinical staff to assess the needs of every individual patient. It is worth noting that as a generic tool, subjective application of SNCT has an expected 10% variation from ward to ward and is not designed to indicate required skill mix. It should be used as part of professional judgement and patient outcomes as is the case with this review.

3.4 The Trust gained its updated licences for Adult Inpatient Wards in Acute Hospitals in January 2025. We will continue to collect 2 sets per year, as this allows us to understand our adherence to the national standards and offer the Board greater assurance.

MSK

3.5 **Ludlow Ward** has 16 beds with the daily average at 10.3 patients at the time of the data collection. It should be noted that the ward was closed to admissions for two days during this data collection due to a D & V outbreak. The staffing split is 59:41 RN to HCA. The data suggests that there is a deficit of -1.2 RN WTE compared with SNCT recommendation and that Support staff (Bands 2-4) are close to the recommended establishment.

Beds	Level 0	Level 1a	Level 1b	Level 1c	Level 1d	Actual Establishment	Suggested Establishment
16	7.17	0.3	2.83	0.00	0.00	RN (Band 5 & 6) **14.35** Other (Band 2,3 & 4) **8.27**	RN (Band 5 & 6) **15.55** Other (Band 2,3 & 4) **8.37**

3.6 **Clwyd Ward** has 16 beds but has the capacity to increase to 28 for escalation. For 15 days of the reporting period, the ward flexed to 22 beds. The daily average for this data collection was 14.15 patients. There was insufficient data collected for this period as only 19 days were recorded. The staffing split for July 2025 was 50:50 RN to HCA.

Beds	Level 0	Level 1a	Level 1b	Level 1c	Level 1d	Actual Establishment	Suggested Establishment
16	11.10	0.00	0.27	0.03	0.00	RN (Band 5 & 6) **13.71** Other (Band 2,3 & 4) **12.35**	RN (Band 5 & 6) **14.87** Other (Band 2,3 & 4) **8.01**

3.7 **Kenyon Ward** is a 22 bedded Unit, currently budgeted to staff 12, with an additional 4 beds for physiotherapy patients with a daily average at 17.27 patients at the time of the data collection. The staffing split is 55:45 RN to HCA. The data suggests that there is a deficit -1.52 RN WTE compared with SNCT recommendations and that surplus support staff (Bands 2–4) are being used to offset the RN gap (+1.09 in July 2025; +1.03 in Feb 2026), indicating substitution within the overall establishment.

Beds	Level 0	Level 1a	Level 1b	Level 1c	Level 1d	Actual Establishment	Suggested Establishment

22	4.20	0.20	5.33	0.13	0.00	RN (Band 5 & 6) **12.20** Other (Band 2,3 & 4) **8.27**	RN (Band 5 & 6) **13.72** Other (Band 2,3 & 4) **7.39**

Specialist Unit

3.8 **Powys Ward** has 16 beds but has capacity to increase to 26 for escalation, with the daily average at 9.73 patients at the time of the data collection. The staffing split is 52:48 RN to HCA. The data suggests that there is a deficit of 4 RN WTE compared with SNCT recommendations. A surplus of support staff (Bands 2–4) used to maintain activity potentially masks the RN gap.

Beds	Level 0	Level 1a	Level 1b	Level 1c	Level 1d	Actual Establishment	Suggested Establishment
16	2.77	3.17	3.80	0.00	0.00	RN (Band 5 & 6) **13.32** Other (Band 2,3 & 4) **12.0**	RN (Band 5 & 6) **17.36** Other (Band 2,3 & 4) **9.35**

3.9 **Sheldon Ward** has 19 beds with the daily average at 17.27 patients at the time of the data collection. The staffing split is 45:55 RN to HCA. The data suggests that there is a deficit of 11.86 RN WTE compared with SNCT recommendations and that surplus support staff (Bands 2–4) are being used to offset the RN gap.

Beds	Level 0	Level 1a	Level 1b	Level 1c	Level 1d	Actual Establishment	Suggested Establishment
19	0.93	0.00	12.17	4.17	0.00	RN (Band 5 & 6) **16.52** Other (Band 2,3 & 4) **19.81**	RN (Band 5 & 6) **28.38** Other (Band 2,3 & 4) **15.28**

3.10 **MCSI** has 46 beds with the daily average at 42.30 patients at the time of the data collection. The staffing split is 45:55 RN to HCA. The data suggests that there is a significant deficit of 17.51 RN WTE compared with SNCT recommendations and that and that surplus support staff (Bands 2–4) are being used to maintain activity, masking the RN gap (+17.6 in July 2025; +18.67 in Feb 2026).

Beds	Level 0	Level 1a	Level 1b	Level 1c	Level 1d	Actual Establishment	Suggested Establishment
46	2.00	0.20	40.30	0.00	0.00	RN (Band 5 & 6) **36.8 (+2** PDN & GPEN))	RN (Band 5 & 6) **54.31**

						Other (Band 2,3 & 4) **47.91**	Other (Band 2,3 & 4) **29.24**

3.11 The gold standard for skill mix of staff would be 70% RN to 30% HCSW (Royal College of Nursing 2012) linking to evidence suggestive that increasing RNs within a ward skill mix reduces mortality and increases patient safety and quality of Care. (Aiken et al 2010, 2013, 2016, 2018, Ball et al 2018, Blegan et al 2011, Estabrook et al 2005, Griffiths et al 2016, RCN 2021).

3.12 Although the SNCT data based on 65:35 split recommends an increase in the RN establishment across all areas, the Chief Nursing Officer (CNO) does not recommend implementing these increases at this time. This is due to data inconsistencies, including variations in bed occupancy, multiple bed closures and the SNCT recommended 65:35 RN-to-HCSW skill mix. A decision should be deferred until two complete, reliable datasets are available to support the CNO's assessment.

3.13 Whilst the CNO recognises that RJAH do not currently meet the recommended or SNCT RN to HCSW spilt, it is worth noting that these recommendations are based on acute hospital sites whereas RJAH is overall an elective site with a high proportion of rehabilitation rather than nursing for acutely unwell patients. This alongside the quality and safety metrics and other staffing metrics indicate that it is safe to wait for 2 clean consecutive SCNT data sets prior to making recommendations to budgeted establishments.

3.14 The cost to the Trust in February 2026 for substantive RN/HCA staff was **813,180K** with an additional bank cost of **182,275K** and an agency cost of **£1,089K,** which is a total additional cost of **996,544k** for staffing in February 2026. (see Table below)

Table 2 staffing costs for February 2026

	Substantive RN	Substantive HCA	Bank RN	Bank HCA	Agency RN	Agency HCA
	£	£	£	£	£	£
Ludlow	62,901	23,969	10,934	-9,965	462	0
Clwyd	54,530	35,713	13,141	4,471	0	0
Oswald	52,148	12,836	9,799	1,852	0	0
Powys	43,037	34,337	15,712	15,340	156	0
Kenyon	51,590	27,483	14,924	3,105	471	0
Sheldon	68,110	63,199	9,975	10,468	0	0
MCSI	174,502	108,825	33,832	48,687	0	0
Totals	506,818	306,362	108,317	73,958	1089	0

* *note credit balance for Ludlow bank HCA –payroll corrections posted in-month*

4.0 Children & Young People's Inpatient Wards Safer Care Tool

4.1 Update and changes were made 2026 to the SNCT (Children & Young People's Inpatient Wards (CYP).

4.2 The tool has been updated and launched, and training and the Inter-Rater Reliability Assessments were provided in July 26' by NHS England.

4.3 Data from Alice Ward were not included in this bi-annual review because the ward does not meet the minimum bed-number requirements of the Children and Young People's Safer Nursing Care Tool (CYP SNCT).

4.4 The Trust aims to capture safe staffing data for the Children and Young People's Inpatient Ward during the 2027 data collection. However, the findings should be interpreted with caution, as the tool's functionality and embedded minimum bed-number assumptions may affect the reliability of the data.

5.0 Fill rates for inpatient wards

5.1 Trusts are required to collate and report staffing fill rates for external data submission to NHSE monthly. Fill rates are calculated by comparing planned (rostered) hours against actual hours worked for both RN and HCA.

5.2 The position for February 2026 (Feb 1st – 28th 2026) is shown in table 3.

Table 3 – Fill rates (February 2026)

	Day		Night	
Ward	**Average fill rate – Registered nurses (%)**	**Average fill rate – care staff (%)**	**Average fill rate – Registered nurses (%)**	**Average fill rate – care staff (%)**
Ludlow	98.0%	95.6%	102.7%	107.41%
Clwyd	104.7%	99.4%	101.7%	98.02%
Oswald	98.6%	103.7%	101.3%	100.0%
Powys	98.9%	117.7%	100.0%	117.81%
Kenyon	101.4%	89.3%	100.9%	114.81%
Sheldon	95.9%	102.3%	100.0%	100.0%
MCSI	94.8%	95.6%	98.8%	97.32%

5.3 We can see from the table that the fill rates for both RN and HCA are within the National Quality Board (NQB) Target range, 80- 120%. The HCA day and night fill rate for Powys Ward the HCA fill rate for Kenyon were higher than planned to maintain ongoing management and safety for patients requiring complexity of care.

5.4 Fill rates do not consider the skill mix within an area including what percentage of this fill was temporary staff, all of which are contributing factors to quality and safety within the clinical environment.

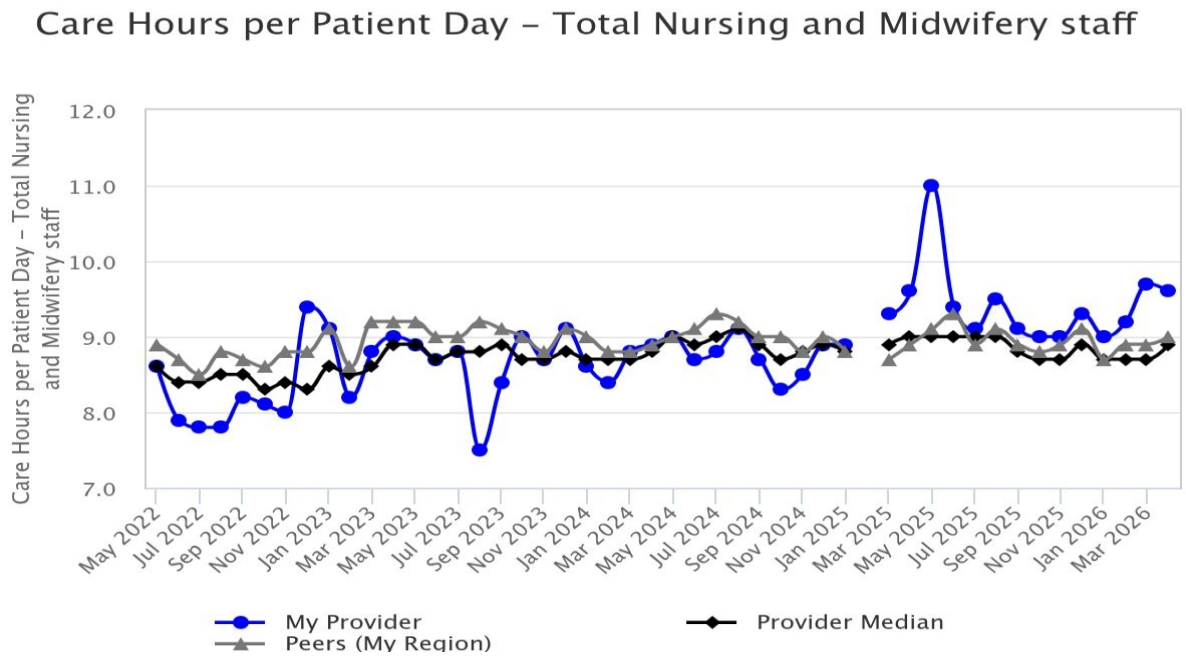
5.5 Overall bed occupancy rates reported for February 2026 were 79.45%. The breakdown for bed occupancy per ward as, Ludlow 60.6%, Clwyd 74.4%, Oswald 78.6%, Powys 70.0%, Kenyon 77.1%, Sheldon 94.5%, MCSI 91.5%

5.6 There were no area's reporting 100% RN agency or temporary staffing.

6.0 Care Hours per Patient Day (CHPPD)

6.1 Care Hours per Patient Day (CHPPD) is a useful means of benchmarking against other NHS Trusts via the Model Hospital website. Data is available on the Model Hospital site and on performing benchmark analysis, for April 2026, the average overall for our Trust is **9.6 care hours** per patient day (CHPPD), compared to peer average 9.0. These values putting RJAH into the third quartile which is above average and towards the mid to higher end of the range.

Table 4 - Model Hospital Benchmarking table



In comparison with similar specialist Orthopaedic providers (as shown in table 5) RJAH average CHPPD was consistent with two of the 5 organisations. This data cannot be viewed in isolation and when triangulating with other data and professional judgement and quality and safety indicators there is not a cause for concern. CHPPD will continue to be monitored monthly.

Table 5:

Organisation Name	CHPPD - overall	Quartile
The Robert Jones & Agnes Hunt Orthopaedic Hospital	**9.6**	**3**
The Royal National Orthopaedic Hospital	**10.4**	**4**
The Royal Orthopaedic Hospital NHS Foundation Trust	**8.6**	**2**
Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust	**9.9**	**3**

Oxford University Hospitals NHS Foundation Trust	**9.9**	**3**

6.2 Care hours per patient day are calculated by dividing the total number of Nursing hours on a ward by the number of patients in beds at midnight. The calculation provides the average number of care hours available each patient on the ward and thus there is variation each month and for each ward.

7.0 Incidents

7.1 During February 2026 there was 1 incident reported for Oswald Ward relating to staffing issues, with a shortfall of HCA hours reported. On review, this incident relates to staff redeployment with no harm to patients, however recorded as a near miss due to all patients being nursed in side rooms, high acuity, risk of patient safety incidents & delays to treatment/interventions.

7.2 During February 2026 there were 6 inpatient falls reported which occurred across 7 of our inpatient areas which equates to a rate 2.01 falls per 1000 Occupied Bed Days (OBDs)

7.3 Table 6 below shows the rolling year for falls. When we triangulate the data for Feb 2026 for our Adult In-patient Wards, staffing was not recorded or reported as being attributed.

Table 6 – Falls Data

Year		Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
2025/26	**Falls**	3	**3**	10	5	8	8	14	10	9	7	6
	Falls/ 1000 OBDs	1.00	0.86	3.70	1.63	3.21	2.91	3.78	3.38	2.40	2.19	2.01

8.0 Red Flags

8.1 There are 6 elements to the Nice Red Flags, these include:

1. Omission in providing medication

2. Delay of more than 30 minutes in providing pain relief

3. Patients vital signs not assessed in line with care plan

4. Delay or omission of regular checks on patients to ensure care needs are met as outlined in the care plan

5. A shortfall of more than 8 hours or 25% (whichever is reach first) of registered nurse time available compared to the actual requirement of the shift.

6. Less than 2 Registered Nurses present on a ward during any shift

8.2 Monthly metrics are captured that relate to red flags. These metrics are reviewed in NSSG, and actions are taken when metrics are not compliant.

8.3 Radar is used to monitor any delays in pain relief; vital signs not being assessed and delays or omissions or regular check on patients. **In February 2026 there were no incidents relating to these.**

8.4 In line with safer staffing requirement, red flags are reported where there is a shortfall of more than 8 hours or 25% (whichever is reached first) of RN time available compared with the actual requirement for the shift or where fewer than two RNs are present on a ward during any shift. During February 2026 there were 5 red flags raised within safe care, 3 of the red flags reporting a shortfall in RN time. **No patient harm related to staffing was reported as a result.**

8.5 When we review the incidents for February 2026, we can see that there were **no patient safety incident investigations reported**. There was one incident relating to workload resource, this was reviewed and relates to a shortage of HCA hours, with no harm to patient documented. There were no reported hospital acquired pressure ulcers and a total of 10 falls, when triangulated, staffing was not a contributing factor. There were 14 medication incidents in total for February. Of the 14 reported incidents, 8 were reported within MCSI, 3 relating to an administration error or omission of patient's medications, 6 relating to the prescription of medications and 3 relating to the prescription of medications. Across the other inpatient areas 2 incidents were related to the safe storage, 2 were related to the prescription of medications and 2 related to an administration error or omission of patient's medications. **None of these incidents were a result of staffing levels.**

9.0 Risks to Safer Staffing

9.1 NHSE gave all Trusts a directive to reduce costs for both agency and bank usage. For 26/27 a 15% reduction in Bank has been directed.

9.2 Work has been undertaken to increase the Bank to enable us to have sufficient temporary staffing when gaps occur and to further reduce Agency reliance. We have an ongoing recruitment campaign for substantive positions to ensure temporary staffing numbers are maintained at a level that is sufficient to support the Trust.

9.3 Targeted actions are required in relation to night-time RN resilience and increasing pressure from rising patient acuity

10.0 Recommendations available to review and accept

10.1 To continue to embed the twice-yearly data collection tool for the Adult inpatient areas.

10.2 To continue to monitor the E-roster Safe Care weekly to ensure consistent compliance.

10.3 To complete all Developing Workforce Safeguards gap analysis actions to achieve full compliance with National policy.

10.4 Work continues with the recruitment and retention plan, to support the Trust in filling the vacancy gaps and improving the overall safer staffing substantive numbers, that includes the recurrent provision of Nursing Associate and Registered Nurse top up Apprenticeship programmes.

10.5 Reporting of the Bank costs used to support staffing gaps, enhanced care and escalation beds needs further scrutiny. It may be more cost effective to add additional substantive staff to the establishment that could reduce the bank costs in the future.

10.6 Introduce professional consensus guidance and professional judgement for adult Critical Care Guidelines for the Provision of Intensive Care Services when applying the principles of safer staffing triangulation.

10.7 Await confirmation from the Chief Nurse in future staffing reviews that the Trust has acquired 2 consecutive clean data sets prior to recommending or making any adjustments to budgeted establishments. It is the professional judgement of the CNO that current budgeted establishments for the inpatient wards should remain for now and is safe to do so.

11.0 Revalidation of Registered Nurses/Pharmacy/ HCPC registered staff

11.1 Registered Nurses get notification from the NMC regarding their revalidation at the 100 and 60 days prior to revalidation and emails via ESR at 12, 6 and 4 months.

11.2 HCPC registrants receive notification from the HCPC regarding their renewal 2 months prior to renewal and emails via ESR at 3 and 1 month.

11.3 Registered Pharmacy staff receive notification from GPhC regarding their revalidation 2 months prior to revalidation and emails via ESR at 3 and 1 month

11.4 Whilst the Trust puts reminders in place for staff it is the responsibility of the registrant to ensure that their registration is valid at all times.

11.5 The Trust has 353.87 WTE which equates to 453 individual Registered Nurses and Registered Nursing Associates that need to renew their PIN by paying their annual fee and revalidate every 3 years. In the last 12 months September 2025 to August 2026 there has been zero occasions where staff have failed to revalidate.

11.6 The Trust has 201.67 WTE/272 Headcount of Allied Health Professionals registered with the HCPC. Re-registration takes place on a biannual basis for each profession, whereby the registrant both pays their annual fee and completes a self-declaration of adherence to professional standards. In the last 12 months, September 25 to August 2026, there have been zero occasion/s where a staff member who did not complete their re-registrations within the deadline for their profession.

11.7 The Trust has 25.61 WTE Pharmacy staff which equated to 17 Pharmacists and 15 Pharmacy Technicians registered with GPhC. Revalidation takes place on an annual basis, whereby the registrant both pays their annual fee and revalidates. In the last 12 months, September 2025 to August 2026, there have been zero occasions where staff failed to revalidate.

12.0 Conclusion

Staffing remains safe -CHPPD benchmarks well, fill rates are good and in excess of 100% on regular occasions, RN to patient ratios are rich and higher than would be expected but this is due to small bed numbers and difficulty to reduce. RN to HCSW ratios vary across wards – none are in line with the gold standard of 70:30 but it is the professional judgement of the CNO that this is not required when triangulated with wider safety and quality measures. The aim should be to work towards a consistent 60:40 split.

The Chief Nursing & Patient Safety Officer and Medical Director confirm that the Trust has safe staffing – this will be added to the annual governance statement in compliance with the Developing Workforce Safeguards Standards. Benchmarking safer staffing metrics against those of other specialist orthopaedic hospitals in the future would provide additional assurance.

No registration lapses were reported. Training and completion of the actions within the Developing Workforce Safeguards gap analysis should continue to support full compliance with national policy. The Trust should also continue routine data collection and maintain up-to-date SNCT licences.

The Trust should work towards obtaining two complete, reliable SNCT datasets to inform future staffing requirements. It should also be recognised that the small number of beds within individual wards may limit operational efficiency.

13.0 Proposed next steps

- Work towards ensuring two clean SNCT data sets to inform and direct future staffing requirements.
- Benchmark safe staffing metrics with other specialist Orthopaedic hospitals to provide additional assurance.
- Repeat the 30-day data collection in September and then bi-annually thereafter providing a clean dataset is obtained.
- Progress the actions outlined in the attached Developing Workforce Safeguards gap analysis, reporting monthly via the Non- Medical Safe Staffing Group and bi- annually via the safe staffing paper presented to Quality and Safety Committee and Trust Board.
- Aim to capture Children & Young People's Inpatient Ward safe staffing data in 2027 data collection.
- Explore the data functionality and monthly reporting capabilities relating to safe care to provide robust assurance against the National Quality Board guidance (2016).
- Appoint substantively to posts reduce Bank and Agency spend.
- Conduct a wider review relating to ward requirements and bed numbers.
- Targeted actions required in relation to night-time RN resilience and increasing pressure from rising patient acuity

14.0 Recommendation

- For the Quality and safety Committee and Trust Board to take assurance that the Trust has safe staffing for it's adult inpatient facilities and agree the next steps.

- Following consideration of this paper the Chief Nursing & Patient Safety Officer and Medical Director confirm that they are satisfied with the outcome of the assessment, and that staffing is deemed safe, effective and sustainable.

Supporting Literature

Aiken, LH., Sloane, D., Griffiths, P. Rafferty, A.M., Bruyneel, L., McHugh, M., Maier, C.B.,

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Appendix:1 Developing Workforce Safeguards gap analysis (see separate document)

Appendix 2: Acronyms and abbreviations

AHP	Allied Health Professional
BAF	Board Assurance Framework
CHPPD	Care Hours per Patient Day
CNO	Chief Nursing Officer
CQC	Care Quality Commission
CYP	Children and Young People
D&V	Diarrhoea and vomiting
DWS	Developing Workforce Safeguards
ESR	Electronic Staff Record
FT	Full Time
GPhC	General Pharmaceutical Council
HCA	Healthcare Assistant
HCPC	Health and Care Professions Council
HCSW	Healthcare Support Worker
HDU	High Dependency Unit
MCSI	Midlands Centre for Spinal Injuries
MSK	Musculoskeletal
NA	Nursing Associate
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
NQB	National Quality Board
OBD	Occupied Bed Day
PDN	Practice Development Nurse
PIN	Professional registration number
RCN	Royal College of Nursing
RJAH	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
RN	Registered Nurse
SNCT	Safer Nursing Care Tool
WTE	Whole-time equivalent

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Controlled Drugs Annual Report 2025/2026

Committee / Group / Meeting, Date

Quality and Safety Committee, 24 September 2026
Board of Directors – Public Meeting, 07 October 2026

Author:

Name: Caroline Jenkins
Role/Title: Chief Pharmacist, Controlled Drug Accountable Officer

Contributors:

Name: Jess Shiel/Sarah Norris
Role/Title: Trust Medication Safety Officer

Report sign-off:

Name: Dr Ruth Longfellow
Role/Title: Chief Medical Officer

Is the report suitable for publication?:

No

Key issues and considerations:

The Trust is legally required to appoint a Controlled Drugs Accountable Officer (CDAO) who is responsible for overseeing all aspects of use of Controlled Drugs at the Trust.

This report is written by the CDAO to provide assurance to the board around the governance and usage of CDs in 2025 – 2026. The report gives an oversight of the patterns of usage of CDs, the mechanisms in place to measure compliance with the governance requirements, highlights current gaps in assurance and provides progress against prior actions and a detailed improvement action plan for 2026 – 2027.

The report provides assurance that controlled drugs are being used safely at RJAH, in accordance with legislative requirements.

The gaps in assurance relate primarily to the need to update policies and procedures now that the Trust has successfully implemented EPMA. Considerable progress against this action was made in 2025 – 2026 as processes and intelligence evolved around EPMA. A completion date in 2026 has been forecast.

Improved data and insights are being developed, and it is hoped by the end of 2025/26 more accurate usage data for controlled drugs will be available however the reporting tools are still in their infancy and data assurance is still be gathered. The report shows increasing volumes of CDs being dispensed to support early discharge of patients on enhanced recovery pathways. Prescribing Audits have identified improvement actions which hope to be embedded by 2026/27.

Training achievement is high for CDs however an action for improving the relevance of training is due to be implemented. CD Audit results remain on track. Main themes from the Q4 CD audits identified some improvements pertaining to stock lists, documentation, two-practitioner checks, expired stock and safe disposal. All improvements have been escalated using appropriate governance routes.

Strategic objectives and associated risks:

The following strategic objectives are relevant to the content of this report:

Trust Objectives		
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	

This report relates to the following Board Assurance Framework (BAF) themes and associated strategic risks:

Board Assurance Framework Themes		
1	Continued focus on excellence in quality and safety	✓
2	Creating a sustainable workforce	
3	Delivering the financial plan	
4	Delivering the required levels of productivity, performance and activity	
5	Delivering innovation, growth and achieving systemic improvements	✓
6	Responding to opportunities and challenges in the wider health and care system	✓
7	Responding to a significant disruptive event	

System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system. The following objectives are relevant to the content of this report:

System Objectives		
1	Improve outcomes in population health and healthcare	✓
2	Tackle inequalities in outcomes, experience and access	
3	Support broader social and economic development	
4	Enhance productivity and value for money	✓

Recommendations:

The action plan is detailed within Table 6. The plan provides a detailed breakdown of all the recommendations completed or part of ongoing improvement work for CD assurance at RJAH.

The Board is asked to review the contents of the report and confirm the assurance level provided following a recommendation from the Quality and Safety Committee.

Report development and engagement history:

Pharmacy governance team, previous chief pharmacist, previous medicines safety officer

A&E – Accident and Emergency
AHSN – Academic Health Services Network
CBPM – Cannabis Based Products for Medicinal Use
CDAO – Controlled Drug Accountable Officer
CD – Controlled Drug
CDLIN – Controlled Drug Local Intelligence Network
CLEO – Clinical Excellence Online (digital prescription software)
CMM – Careflow Medicines Management (pharmacy system)
CQC – Care Quality Commission
D+T – Drug and Therapeutics Meeting
DDD – Defined Daily Dosage (standardised measure to represent average daily dose of a medicine)
DMS – Discharge Medicines Service
EPMA – Electronic Prescribing and Medicines Administration
GLP-1 – Glucagon-Like Peptide-1
HARMS – A system of reviewing patient incidents to assess contributing factors to causes of patient harm
ICS – Integrated Care System
LIN – Local Intelligence Network
LSD – Lysergic Acid Diethylamide
MDT – Multidisciplinary Team
MHRA – Medicines and Healthcare products Regulatory Agency
MSO – Medicines Safety Officer
NMP – Non-Medical Prescriber
RJAH – Robert Jones and Agnes Hunt Orthopaedic Hospital
SEIPS – Systems Engineering Initiative for Patient Safety
SOP – Standard Operating Procedure
TTO – To Take Out (descriptor for discharge medicines given to patients)

Controlled Drugs Annual Report 2025/2026

1. Background / context

1.1 The purpose of Report

- To provide assurance to the Board on the governance arrangements around the management of Controlled Drugs at RJAH.
- To provide assurance that use of controlled drugs at RJAH is in line with the regulatory and legislative requirements relating to controlled drugs.
- To highlight any areas of concern relating to management of controlled drugs
- To raise awareness of quality improvement and best practice relating to controlled drugs
- To update on actions from the report of 2024 – 2025 and propose a new action plan for management of controlled drugs for 2026 - 27

1.2 Background

The Trust is required to work under two main areas of legislation: The Misuse of Drugs Act 1971 and supporting regulations (Home Office legislation) (1) and The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (Department of Health legislation)(2).

The main purpose of the Misuse of Drugs Act is to prevent the misuse of Controlled Drugs by imposing restrictions on their possession, supply, manufacture, import and export. The Department of Health regulations set out strengthened governance arrangements for Controlled Drugs used as medicines. The Misuse of Drugs Act divides controlled drugs into five schedules each specifying the requirements governing activities such as supply, possession, prescribing (handwriting requirements), storage and record keeping. See below for summary of the schedules and required restrictions.

Table 1. Summary of CD schedules and applicability at RJAH

Schedule 1	includes drugs not used medicinally such as hallucinogenic drugs (e.g. LSD), ecstasy-type substances, raw opium, and cannabis. A Home Office licence is generally required for their production, possession, or supply.	Not Applicable at RJAH
Schedule 2	Includes strong opiates, cocaine, ketamine, and cannabis-based products for medicinal use in humans. Full CD requirements relating to prescriptions, safe custody and documentation.	Applicable at RJAH
Schedule 3	includes the barbiturates, buprenorphine, gabapentin, midazolam, pregabalin, temazepam, and tramadol. There is variation for each drug regarding handwriting/storage and documentation which makes it confusing for staff with the potential to miss a necessary requirement. Therefore, under RJAH Trust Policy POL002, Controlled Drug Policy, all schedule 3 drugs are treated the same as schedule 2 for assurance and best practice.	Applicable at RJAH
Schedule 4	Includes benzodiazepines, non-benzodiazepine hypnotics (zolpidem tartrate, and zopiclone). Controlled drug prescription requirements do not apply, and Schedule 4 Controlled Drugs are not subject to safe custody requirements. Records in registers do not need to be kept	Applicable at RJAH
Schedule 5	Includes low strength codeine and morphine, which due to their low strength, are exempt from virtually all Controlled Drug requirements. Note nitrous oxide is included in this schedule	Applicable at RJAH

The Controlled Drug Regulations 2013 require healthcare organisations to appoint a Controlled Drugs Accountable Officer (CDAO) who has responsibility for: -

- All aspects of Controlled Drugs management within their organisation
- Ensuring standard operating procedures are up to date and followed in practice.
- The procurement and storage arrangements of CDs
- That safe practices are in place for prescribing and administration of CDs.
- That CDs are used appropriately.
- Relevant individuals are trained.
- There are effective routes for reporting controlled drug related concerns.
- CDAOs are required to submit a quarterly occurrence report of controlled drug incidents from within their organisation so that the Area Team CDAO can identify trends of concern. Each area has a Local Intelligence Network (LIN) where trends and intelligence across the area can be shared.

The Gosport Report [3], published in 2018, highlighted patient deaths linked to inappropriate prescribing and administration of CDs. Following the publication of this report several recommendations were made for all healthcare organisations to put in place:

- Regular monitoring of prescribing patterns to ensure unusual prescribing or unusually high doses are identified.
- Ensure staff have ability and confidence to escalate concerns around usage of CDs.
- Mortality review with reference to medication/prescribing

1.3 Assurance of Governance Processes for Controlled Drugs

The CDAO for RJAH is the Chief Pharmacist who took over the role from the Chief Nurse in March 2024. The CDAO is supported in their role by the Trust Medicines Safety Officer and the Assistant Chief Nurse, Patient Safety Officer. In 2025 the current chief pharmacist moved to another trust and was replaced in August by a new chief pharmacist. The CQC were made aware of the changes and named CDAO record were contemporaneous.

Controlled Drugs Annual Report 2025/2026

The following arrangements/processes are in place within the Trust in accordance with legislation:

Table 2. Summary of governance requirements, assurance and known gaps.

Legally Required Action/Process	Assurance for RJAH	Gaps in Assurance
Ensuring standard operating procedures are up to date and followed in practice.	• The Trust has a policy for Controlled Drugs (POL022) with a suite of supporting SOPs regarding prescribing, administration, storage and all other aspects of CD management outside Pharmacy. The policy was reviewed in 2025 in line with actions from the preceding CDAO report. Several SOPs were also updated and strengthened to reflect legislation. • Pharmacy department audits training achievement across the trust quarterly • Localised induction ensures that pharmacy staff are aware of the current SOPs and policies. Protected time is given at induction to ensure staff are trained in processes.	• Although a large amount of work has been undertaken to review and strengthen Policy/SOP documents this continues to be part of a wider piece of work reflective of the significant change in patient management systems and leadership. • The programme of work to update processes remains on the risk register to raise awareness that the policies and SOPs are in a state of transition with wider familiarisation and training required among those staff reliant on the processes. • A simulation package of training is in development to address gaps in knowledge with documentation and handling. • CD Omnicell installation delayed to April 2026
The procurement and storage arrangements of CDs.	• Pharmacy ordering processes follow agreed SOPs using Pharmacy computer system. Full audit trail of ordering. • Storage of CDs in wards and Pharmacy in line with Trust policy and legal requirements – quarterly audits complete.	• External audit of CDs to be arranged. Added to action plan for 26/27 in collaboration with West Midlands Chief Pharmacists following new Omnicell implementation and update of SOPs/Policies.
Safe practices are in place for prescribing and administration of CDs.	• Policy and SOPs in place for prescribing and administering CDs. • Pre-printed prescriptions developed and approved for enhanced recovery, discharge prescriptions and end of life discharge prescriptions. This is in line with Trust prescribing guidance and is audited. • Pharmacists clinically check majority of prescriptions at admission and at least once a week if in-patient for longer. Doses and appropriateness of CDs form part of this clinical check. • New electronic prescription system introduced so only authorised staff have a password to prescribe and administer medicines. In addition, protocols have been built for certain common pathways using CDs and the discharge prescription is automatically printed to meet prescription writing regulations	• Please see above re policy review • Paperwork to support change in dosing instruction has been ordered. In the meantime, where necessary doses are amended by competent NMP pharmacists • Cross border arrangements are not as robust for informing primary care providers about medicines at discharge.

	• A CD audit review of morphine prescription for discharge has enabled collaboration with practitioners and agreement on standard dosing in line with commonly used doses to ensure excessive amounts of morphine are not supplied on discharge • DMS supports the transfer of information for new opioids to primary care partners	
That CDs are used appropriately	• Audits of CD usage quarterly. • Clinical check of prescriptions by pharmacists. • The CD audits now reported in Trust audit report template and reported through Drug and Therapeutics	Due to vacancy and sickness in Pharmacy there have been occasional delays to CD audits and MSO thematic reports, but all have been completed and reported in line with SOP/Policy
Relevant individuals are trained.	• Mandatory training package on controlled drugs – training compliance monitored and reported to D+T meeting. Achievement is 95%	Plans for 26/27 to ensure training is relevant to activities and develop simulation based on common errors reported.
There are effective routes for reporting and escalating controlled drug related concerns.	• The Trust encourages staff to report all CD related incidents on the Trust Incident reporting system. • Importance of escalation/reporting included in training. • New form developed to support managers with reports of unaccounted for losses with weekly HARMs meeting for any moderate or severe harms.	Separate meeting for panel and report to be developed in 26/27 to support process further.
CDAOs required to submit quarterly occurrence report of controlled drug incidents from within their organisation to the CDLIN.	• Quarterly reports submitted in full for 25/26	There was a gap identified regarding pulling reports for CD incidents from radar following the transition across from DATIX 16/03/2026. Governance have supported Pharmacy department and MSO to ensure reporting is correct. Ongoing concerns around tracking CD incidents and actions being taken to ensure full granularity.
Regular monitoring of prescribing patterns to ensure unusual prescribing or unusually high doses are identified.	• Usage of CDs issued from Pharmacy are reviewed regularly to detect any unusual ordering patterns. • Prescriptions clinically checked by pharmacists. • Electronic prescribing implemented in May 25	• While Trust was still using paper-based prescribing it was difficult to track and monitor prescribing at a patient/doctor level. With new EPMA system need to explore what reports are now possible.
Mortality review with reference to medication/prescribing	In the event of an expected death, RJAH governance team complete a mortality review which includes a review of medication.	

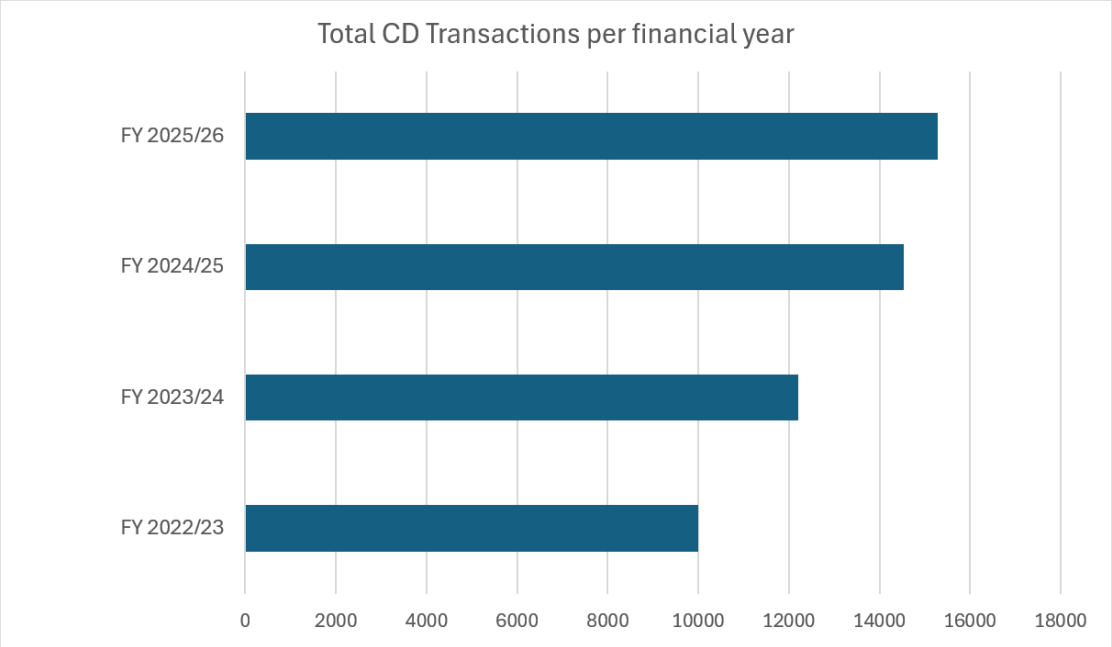
1.4 Controlled Drug Use at RJAH

1.4.1 Consumption

The number of doses of Controlled drugs issued from Pharmacy can be monitored using the Pharmacy electronic stock control system (CMM). The system was introduced to RJAH in 2016 but reporting capability has not been fully utilised to date and reports are limited. A new Pharmacy Digital team was recruited in summer 2024 and, alongside implementing EPMA, the business intelligence around reporting on medicines has improved. Together with the MSO further scrutiny of CD monitoring was developed in Q4 25/26.

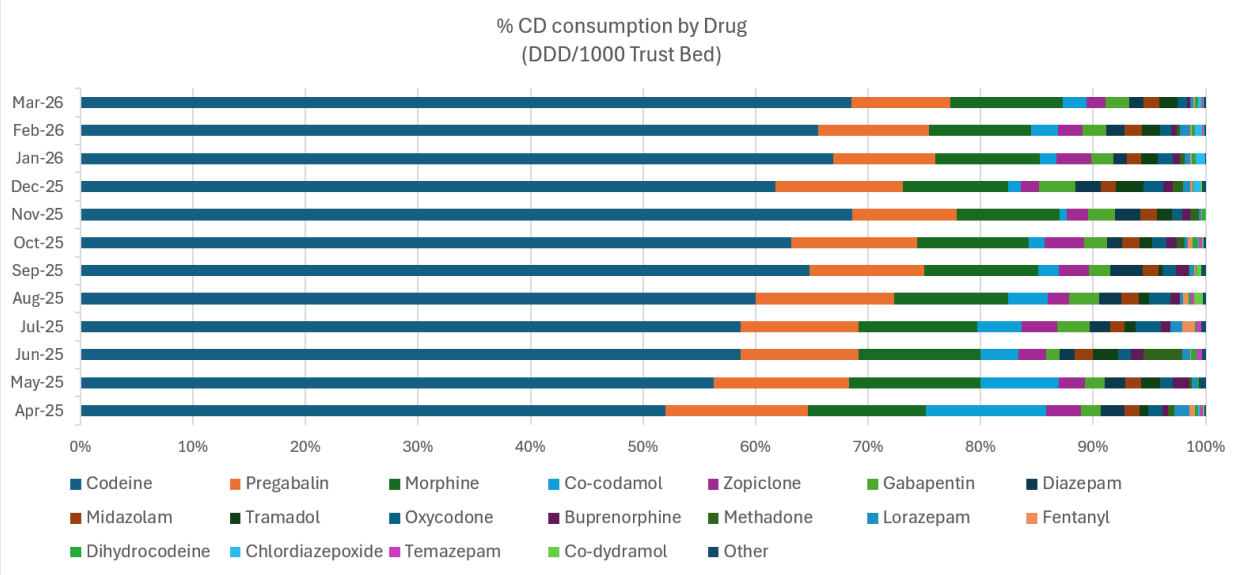
Usage of controlled drugs has continued to rise in recent years with volume dispensed in the last 3 financial years greater than 2001/2022. Controlled drugs dispensed continue to grow. (See Graph 1).

The pattern of CD consumption is illustrated in Graph 2 using DDD/1000 trust beds. Codeine, Pregabalin, Morphine and Co-codamol are responsible for over 80% of the total consumption of controlled drugs at RJAH (all uses)



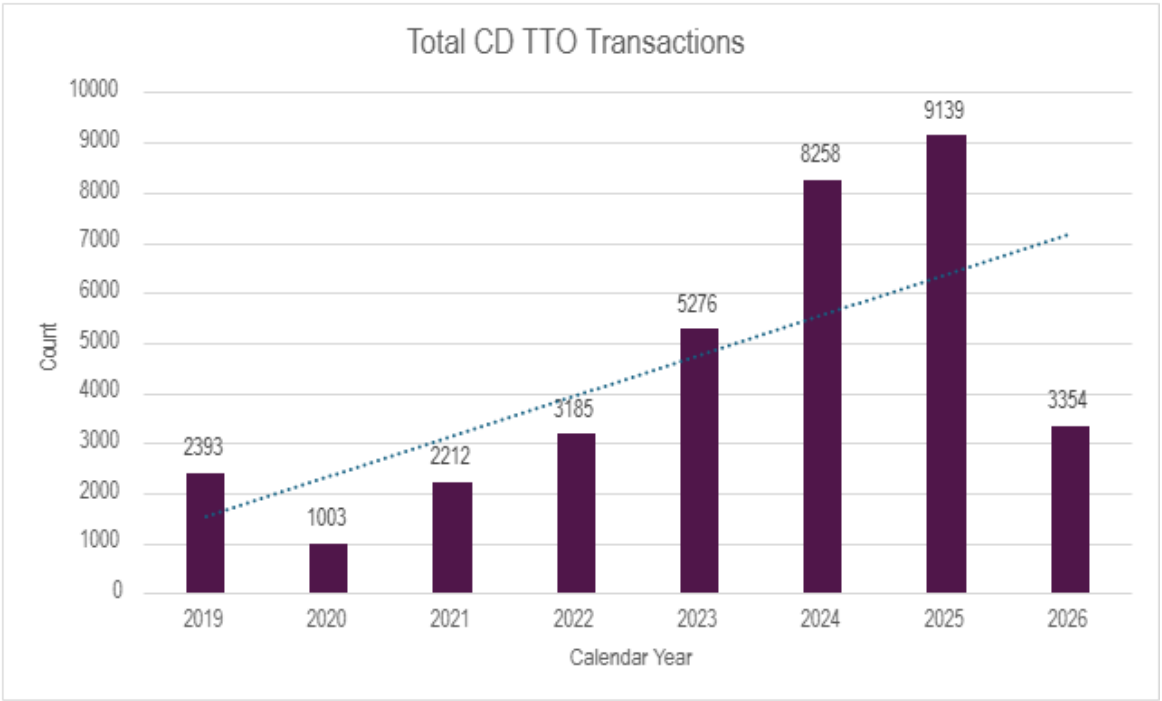
Graph 1. Total CD transactions per financial year. Transactions continue to increase

CD TTO dispensing continues to increase. See Graph 3 below. CD TTO activity has increased since the introduction of enhanced recovery processes in 2022/23. Prior to the introduction of Enhanced recovery, patients would have received post operative opiate-based analgesia on the ward on an as required basis – i.e. may not always need opiate analgesia post operatively or at discharge. As enhanced recovery patients are discharged within 24 hours of surgery there is the need to supply them with a small quantity of oral morphine to control post-op pain on an as required bases. The increase in CD dispensing activity carries a significant workload burden for pharmacy due to additional governance requirements, however this cannot be avoided



Other:	Methylphenidate	Phenobarbital sodium
Zolpidem	Lisdexamfetamine	Ketamine
Clobazam	Clonazepam	Remifentanil
Nitrazepam	Tapentadol	Diamorphine
Phenobarbital	Tramadol + Paracetamol	Alfentanil
Testosterone	Oxazepam	Bupivacaine + Fentanyl

Graph 2. The pattern of CD consumption is illustrated in the graph above using DDD/1000 trust beds. Codeine, Pregabalin, Morphine and Co-codamol are responsible for over 80% of the total consumption of controlled drugs at RJAH (all uses). The CDs contained in the "other" category are listed below



Graph 3. CD TTO transactions. Volume continues to increase in line with trust activity plans

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1.5 Improving Patient Safety with Controlled Drugs

1.5.1 Improvement and safety work within the Trust

During 23/24 the Trust moved from prescribing morphine liquid 10mg/5ml for enhanced recovery discharges to using the immediate release morphine tablet (Actimorph). This followed a safety update from the faculty of pain medicine and advice from local intelligence.

Following the growth in CD TTOs and clinician feedback across the MDT, an audit project was commenced in early 2025. This project was designed to review the appropriateness of the dosing and quantities of opiates dispensed for enhanced recovery patients. This audit involved speaking with patients after their surgery to establish if they had used the morphine provided, how much they needed and ensure they know how to dispose of it safely e.g. by taking to community pharmacy. The dosing was also correlated with patient characteristics, prescriber type and procedure.

The results of the audit flagged concerns around the higher dose option of morphine post operatively. The audit concluded that 70% of morphine prescriptions were reduced or amended by pharmacist NMPs for safety with no corresponding increase in pain symptoms by service users. Full courses of morphine were not required for the majority, but where they were needed it was highlighted that it prevented escalation to community providers and A&E attendances.

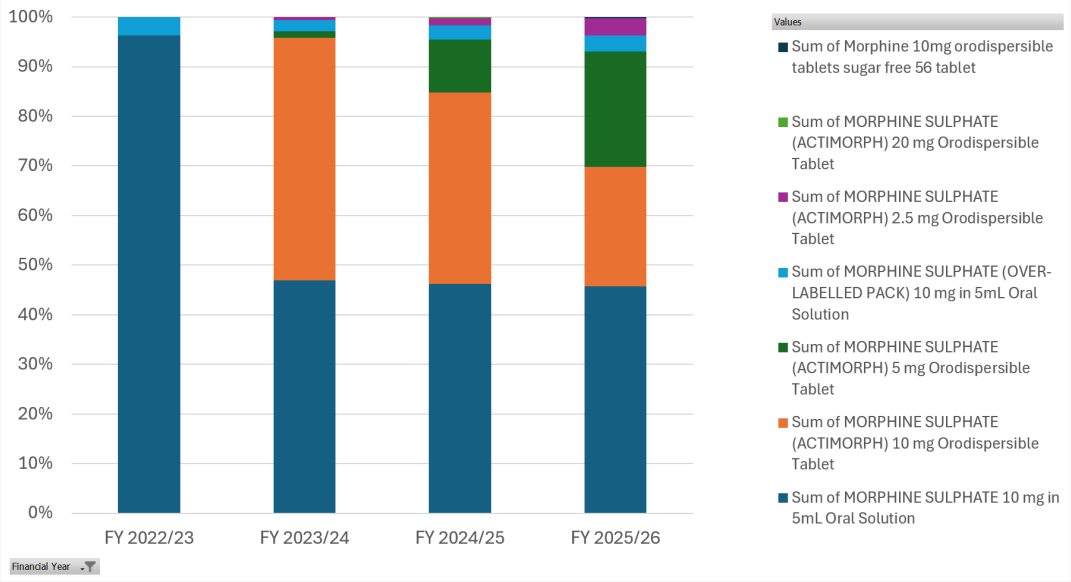
Following MDT discussion and acknowledging the mitigations in place with the enhanced recovery helpline and the improved package of information around opioid safety the quantity of morphine provided on discharge was reduced marginally and the standard dosing instruction post operatively was reduced.

The safety profile of CDs dispensed on TTOs improved in 25/26 showing a move to lower strengths of morphine tablets being dispensed and maintained reduction in morphine liquid dispensing. This demonstrates the learning and actions post audit have embedded for morphine at discharge.

The impact on Pharmacy activity has been significant, pharmacist NMP workforce has a demonstrable safety role in opioid stewardship for the Trust and provides assurance that patient safety is at the heart of activities. see graph 4 below.

Controlled drugs can cause serious harm if prescribed or administered inappropriately. Historically, many patients would continue opiates post discharge as the opiate formed part of the discharge prescription, and it was simply added to the repeat prescription in primary care.

In March 2025 the MHRA published a safety report entitled Modified Release Opioids and Treatment of Post-operative Pain, Public Assessment Report [4]. The use of Actimorph (orodispersible morphine tablet), was adopted in 2023 to allow for more accurate dosing and shorter courses of opioids on discharge. The product facilitates dosing from a patient acceptability perspective and supports strategies to prevent prescribing of long-term opioid treatments.



Graph 4. Illustrates difference in strength of morphine prescribed at discharge. Note reduction in quantity of morphine 10mg orodispersible tablet and increase in 5mg and 2.5mg orodispersible strengths reducing overall opioid intake whilst maintaining service user experience.

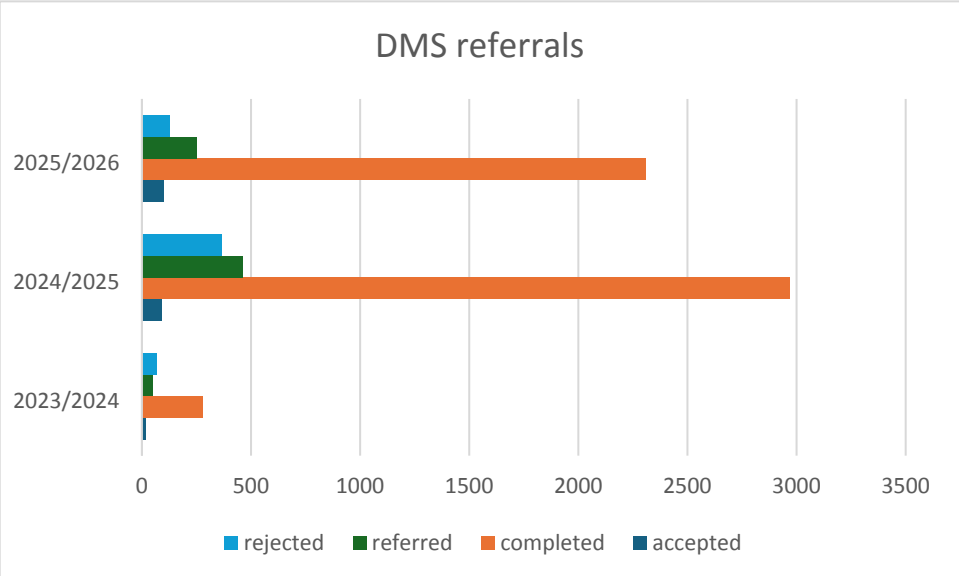
1.5.2 Improvement and safety work <u>across</u> the System

It should provide the Trust with assurance that RJAH had already moved to use immediate release morphine prior to this in line with safety recommendations. The use of modified release opiates continues to be rare at RJAH and are only prescribed for patients who have legitimate indications for long term use – e.g. cancer patients.

Reducing morphine consumption through a multi-pronged strategy became a local priority across Shropshire Telford and Wrekin ICS in 2022 due to the outlier data associated with the ICS in 2019. RJAH Pharmacy and clinicians worked with ICS colleagues and Academic Health Services Network (AHSN) – Now Health Innovation Network, to reduce the potential for patients to take long term, high dose opiates. Improvements were made to discharge information for patients, increasing referral to community pharmacy colleagues as part of the DMS service and local mechanisms due to the cross-border limitations. RJAH pharmacy service also worked to ensure clear instructions on labelling and discharge letters were adhered to in line with red tape challenge recommendations.

The Discharge Medicines Service (DMS) improves patient safety after hospital discharge by securely sharing discharge medication information with the patient's community pharmacy. Community pharmacists contact patients after discharge to provide medicines support and ensure they understand their treatment. Referring patients discharged on opioids through DMS helps promote short-term use, supports safe pain management, and reduces the risk of inappropriate long-term opioid use.

DMS referrals from RJAH to community pharmacy have increased significantly in the past year going from less than 50 per month in the year 23/24 to triple that rate in the last two years. This has been achieved by allocating dedicated Pharmacy assistant hours to the Discharge Medicines Service. Since EPMA implementation referral information has been more difficult to extract signified by the reduced numbers referred in 25/26.



Graph 5. DMS referrals undertaken by dedicated pharmacy support staff.

In 2024/25, a new initiative was launched through collaboration between the Pharmacy Team and the RJAH Pain Team to support patients taking long-term opioid medicines to reduce their opioid use before and after surgery. Although the programme is still in its early stages, Pain Team nurses have already reported success in helping some patients reduce their dependence on long-term opioids. With the recent recruitment of a Complex Pain Service at RJAH, there is significant opportunity to further develop and expand this work. Funding is being sought to enable GPs to refer patients into the service prior to surgery, allowing earlier intervention and optimisation of pain management, whilst an additional challenge is supporting the ICS with reducing long term inappropriate opioid prescriptions for patients with musculoskeletal conditions.

1.6 Improving assurance and compliance with legislation

In August 2025 a new pharmacy governance lead was recruited into a vacancy. The post holder has been tasked with updating and refreshing process and procedures to ensure compliance with legislation regarding CDs. It is also important to acknowledge that the MSO for the Trust was absent in Q4.

1.6.1 Governance and policy review

During the reporting period, the Trust reviewed its controlled-drug governance arrangements against the Controlled Drugs (Supervision of Management and Use) Regulations 2013, as amended, relevant CQC guidance and national medicines-safety intelligence.

The current statutory framework continues to provide the basis for the safe management and use of controlled drugs. The legislative framework has been updated to reflect the establishment of Integrated Care Boards as responsible bodies in England, replacing previous references to Clinical Commissioning Groups. The Trust will continue to work with the local Controlled Drugs Accountable Officer network, Integrated Care Board and other relevant partners in accordance with information-sharing and governance requirements.

Review of the Trust's arrangements identified three priority areas for improvement:

1. The relevance and implementation of the Trust controlled-drug policy and supporting standard operating procedures.
2. Assurance regarding the delivery, transport, transfer and receipt of controlled drugs across Trust sites and services.
3. Strengthening the process for the prompt, proportionate and documented investigation of controlled drug incidents associated with unaccounted-for controlled-drug losses and discrepancies.

These actions have been incorporated into the CDAO action plan and will be monitored through the Trust's Drug and therapeutics meeting and patient safety governance arrangements.

1.6.2 Controlled-drug policy and SOP review

The Trust identified that elements of the controlled-drug policy and associated SOP suite require updating and rationalisation. A structured review programme has therefore been initiated to ensure that documents are current, consistent across clinical areas, clearly assign responsibilities and reflect the Trust's current service model. Considerable work has been undertaken in 2025/26, and it is anticipated that the first full cycle will complete in 2026/27. The process will become a rolling programme of review as part of assurance.

The review includes a broad spectrum of CD management. Revised policies and SOPs will be subject to multidisciplinary review and approval through Drug and Therapeutics meeting. Implementation will be supported through controlled dissemination, staff communication, targeted training and compliance audit. A good, worked example of the activity being undertaken is the implementation of a nitrous oxide oversight policy and process due to be ratified in 2026/27.

In Quarter 4 of 2025/26, the Trust commenced work to strengthen nitrous oxide supervision. Nitrous Oxide became a Schedule 5 controlled drug on 8 November 2023, following the introduction of the Misuse of Drugs (England and Wales and Scotland) (Amendment) Regulations 2023. A legislative gap analysis was undertaken by the Pharmacy Governance Team, alongside a review of current practice across theatres, radiology and estates. This informed development of a practical Trust-wide policy and SOP covering the handling and movement of nitrous oxide, designed to meet legislative requirements while fitting existing operational models. This provides a consistent framework for roles, responsibilities, accountability and assurance across the relevant services.

1.6.3 Movement and transfer of controlled drugs

Following the introduction of a new delivery receipt form in December 2024 the pharmacy governance team have worked to undertake a Trust-wide review of arrangements for the delivery, transport, transfer and receipt of controlled drugs. This has included movement between pharmacy and clinical areas, between Trust sites, and where applicable, through external or third-party courier arrangements.

The review considered all aspects of the chain-of-custody**.** In March 2026 new red CD courier bags were purchased by the Trust to support the improved processes. The initial form has been updated to ensure the process reflects local workflows, and the Pharmacy team have engaged with ward areas to embed the new process. Revised processes will establish a clear and auditable trail from issue to receipt and define the actions required when a consignment is delayed, damaged, missing or does not reconcile. The new process went live in April 2026, and the impact will be

monitored through targeted audit and incident reporting. The impact will be reported in the annual CD report 26/27.
*Note delivery receipt forms have been identified as good practice by the Home Office and CQC during inspections at other Trusts.

1.6.4 Controlled Drug Incidents

When anomalies or errors occur at any stage in the management of controlled drugs, staff are trained and encouraged to report via the Trust's incident reporting system. Each incident is investigated by the Medicines Safety Officer and the senior nurse/manager for the relevant area (all shared with the CDAO at time of reporting) and subsequently compiled into a report for submission to the CD Local Intelligence Network (LIN).

During Q4 of 2025/2026 the MSO for the trust was absent. The governance team worked to ensure CD reporting and compliance was completed and any necessary review completed with nurse managers as part of any harms process. There were discrepancies in the reports following the introduction of a new incident management system however the data is being monitored closely with a view to developing a medicines safety dashboard in Radar.

The Trust reports controlled drug incidents, concerns and occurrences to the Controlled Drugs Accountable Officer in line with national requirements. Reporting is risk-based and includes incidents involving all schedules of controlled drugs where there are concerns regarding patient safety, diversion, misuse, theft or governance. Oversight is maintained for Schedule 2 and Schedule 3 controlled drugs due to the enhanced legal controls associated with these medicines
The quarterly report is shared at Patient Safety Meeting and Drug and Therapeutics. See Table 3 below for numbers of CD related incidents reported 2025-2026.

Table 3. Incident reported by category for each quarter.

Incident by CD Lin Category for 2025-26	Incidents Q1	Incidents Q2	Incidents Q3	Incidents Q4
Accounted for Losses	6	8	6	8
Governance	11	16	14	1
Unaccounted for Losses	3	3	0	1
Patient Involved	2	8	15	21
Patient or member of the Public of concern	0	0	0	0
Professional/Individuals of Concern	0	0	0	0

Following the implementation of electronic prescribing, business intelligence was being developed to support the ongoing governance and surveillance processes for Trust CD management. Reports were developed in Q4 and reviewed for usability. The final surveillance package was settled upon in Q1 2026/27 and will be used to inform this report in 26/27.

1.6.5 Unaccounted-for losses and discrepancies

A consistent approach to the investigation of unaccounted-for controlled-drug losses has been introduced and has shown early benefit. Review of unaccounted-for losses has been incorporated into the HARMS meeting with ward managers, and an investigation checklist was trialled in clinical areas with higher rates of medicines-

management incidents. Feedback from ward managers indicated that the documentation provides greater structure and support for investigations. However, opportunities to identify themes and optimise shared learning across the Trust have not yet been fully realised.

The Trust has therefore identified the need to further strengthen and standardise the process during 2026/27. A revised SOP and investigation process will support a clear, timely and proportionate response to unexplained controlled-drug discrepancies. This will include immediate patient-safety and stock-security actions; verification of stock and relevant records; timely incident reporting; escalation to pharmacy, senior operational management and the CDAO; documented fact finding; root-cause analysis; learning; actions and formal closure.

The process will distinguish between discrepancies that can be evidenced as recording, transcription or process errors and those that remain unexplained following initial checks. Unexplained losses, suspected diversion, repeated discrepancies, significant quantities, or concerns regarding staff conduct will be escalated promptly to the CDAO and, where appropriate, to Trust security, HR, local counter-fraud, safeguarding, police and relevant local controlled-drug intelligence arrangements.

A planned panel to review controlled-drug incidents involving missing medicines was not established during quarter 4 of 2025/26 because of the CDAO transition, implementation of a new incident-reporting system and absence of the Medicines Safety Officer. This action will be replaced in 2026/27 by standalone multidisciplinary meetings to review unaccounted-for controlled-drug losses. The meetings will include the Trust Governance Lead, Medicines Safety Officer and CDAO, with other colleagues invited where needed.

The meetings will provide assurance that incidents have been investigated appropriately and consistently, enable assessment of potential diversion or misuse of controlled drugs, identify recurrent process failures and ensure that learning is shared across clinical areas. Investigation records will include the chronology of events, stock and documentation checks, relevant prescribing and administration records, access arrangements, outcome, contributory factors, actions, named owner, completion date and residual risk.

Themes, outcomes and learning arising from these reviews will be reported through the Controlled Drugs Group and included in the quarterly Controlled Drugs Local Intelligence Network report.

1.7 Safe and Legal Prescribing of Controlled Drugs

Prescribing and dispensing of controlled drugs (CDs) is governed by the Misuse of Drugs Act and associated regulations. Pharmacists cannot legally dispense a prescription for a controlled drug unless all legal requirements have been met. Consequently, omissions or errors on discharge prescriptions can lead to delays in patients receiving their medicines.

To support safer and more efficient prescribing, the Pharmacy Team has introduced pre-populated discharge prescription templates for enhanced recovery and end-of-life care. These templates incorporate opioid choices and dosing that align with Trust guidelines, helping to reduce prescribing errors, improve compliance with legal requirements, and promote best practice in pain management.

While the introduction of the Electronic Prescribing and Medicines Administration (EPMA) system has significantly improved many prescribing processes, controlled drug prescribing remains challenging. Current UK legislation still requires a handwritten ("wet") signature on Schedule 2 and 3 controlled drug prescriptions

issued for discharge or outpatient use. This requirement limits the full benefits that can be achieved through digital prescribing.

In addition, some clinical areas have been unable to transition fully to EPMA-supported controlled drug workflows. The requirement for wet signatures, combined with the lack of a Home Office-approved electronic controlled drug management system for internally issued hospital prescriptions, means that certain prescribing and dispensing processes continue to rely on paper-based systems. This creates operational inefficiencies and introduces additional administrative burden for clinical teams.

Plans are underway to implement the CLEO Electronic Prescription Service (EPS) during Quarter 3 of 2026/27. This development will enable the secure electronic transmission of eligible prescriptions to community pharmacies and is expected to deliver significant improvements in prescribing efficiency, auditability, and governance. It will strengthen assurance around controlled drug prescribing by improving traceability, reducing transcription and processing errors, and providing enhanced oversight of prescribing activity across part of the patient pathway.

1.8 Cannabis-based medicinal products

The Trust does not routinely initiate, prescribe or hold stock of cannabis-based products for medicinal use. However, patients may be admitted while receiving a CBPM that has been prescribed by an external specialist provider.

A policy and supporting procedure have been implemented and updated in line with changes to the CBPM legislation. The procedure defines the responsibilities of the admitting clinical team, pharmacy, nursing staff and patients, and provides escalation arrangements where a product cannot be verified, is not appropriately labelled, is unsuitable for continued use, or raises a clinical or controlled-drug governance concern.

Patients using their own CBPM do so under the Trust policy which covers appropriate safe-custody, documentation, stock-accountability, discrepancy-management and destruction or return arrangements according to the product's legal classification. CQC states that organisations handling only patients' own controlled drugs do not require a Home Office controlled-drugs licence solely for that activity.

1.9 Emerging medicines risks

The Trust recognises that certain medicines which are not controlled drugs may nevertheless present heightened governance, patient-safety, financial, supply or diversion risks. In line with wider national medicines-safety intelligence, the Trust has taken action to strengthen oversight of botulinum toxin products and medicines used for weight management.

While botulinum toxin products and GLP-1 receptor agonists used for weight management, such as semaglutide, are not controlled drugs, they have been considered through the Trust's wider medicines-governance arrangements. These actions are reported in the CDAO annual report as evidence of proactive identification and management of emerging medicines risks; they do not alter the statutory controlled-drug requirements. CQC's controlled-drugs updates include wider relevant medicines-safety intelligence alongside its statutory controlled-drug oversight activity.[5]

1.9.1 Botulinum toxin governance

The Trust has introduced a defined governance process for botulinum toxin products. The process provides proportionate assurance over supply and balance processes in

clinical areas and pharmacy. This supports stock accountability, traceability, incident reporting and audit.

The Trust will continue to monitor compliance with these requirements through audit, review of incidents and wastage, unaccounted for losses and medicines-governance reporting.

1.9.2 Weight-management medicines

The Trust has considered the increasing use, public demand and supply pressures associated with medicines used for weight management, including GLP-1 receptor agonists such as semaglutide. The Trust is strengthening governance arrangements to support appropriate requests for supply and stock management scrutiny to raise assurance of any diversion.

Controlled Drugs Annual Report 2025/2026

2. Controlled Drug Audits and Training

2.1 Controlled Drug Audits

There is formal audit of all clinical areas every quarter looking at the: -

- Ordering process.
- Receipt documentation.
- Entry into the clinical area register.
- Maintenance of the clinical area register.
- Scrutiny of the administration records.
- Ensuring balance is correct and stock is suitable for use.
- Storage.
- Review of the documentation of part used CDs.
- Destruction process as documented in the register.

Audits were completed by the Pharmacy team using the Tendable® platform in Q1-Q3. In Q4 2025/2026 the Tendable® platform was replaced with a new data management system called Radar®. There have been some early learning issues around the implementation and design of these audits, so reports were completed early in Q4 of 25/26 prior to Tendable® going offline. The CD policy and SOP for drug audits specifies that they should be completed a minimum of every six months. With any areas scoring less than 90% receiving a reaudit after three months so that increased focus can be placed on addressing non-compliance and risks.

Table 4. Controlled Drug Audit Data as of April 2026. Shows compliance with standards for CD management by area.

Area	Current % Compliance	Re-audit Date
Alice	87%	June 2026
Baschurch	100%	September 2026
Clwyd	95.8	June 2026
MCSI Gladstone	95.8	June 2026
HDU	100%	June 2026
Kenyon	95.8%	June 2026
Ludlow	100%	June 2026
Main Recovery	95.7%	June 2026
Oswald	87.5%	June 2026
Powys	90.9%	June 2026
Sheldon	100%	June 2026
Theatre 1	100%	September 2026
Theatre 2	95.7%	September 2026
Theatre 3	100%	June 2026
Theatre 4	100%	September 2026
Theatre 5	95.7%	September 2026
Theatre 6	100%	June 2026
Theatre 7	100%	June 2026
Theatre 8	100%	September 2026
Theatre 9	100%	September 2026

Theatre 10	100%	June 2026
Theatres Menzies 11 (M11)	100%	June 2026
Theatres Menzies 12 (M12)	100%	June 2026
Theatre 11 New build	100%	September 2026
MCSI Wrekin	87.5%	June 2026
X-Ray	100%	September 2026

Main themes from the Q4 audit identified; absence of approved stock lists in some areas, legally and locally required documentation for part-used ampoules, spillages and destruction, compliance with two-practitioner administration checks, record correction practices, expired CD stock management, and safe disposal of part-used ampoules.

Following audit, the findings are fed back to the clinical area and any immediate actions completed. Results are also incorporated into pharmacy governance action plans so that assurance may be strengthened

2.2 Controlled Drug Training

CD training compliance across the Trust is at 95.4% an increase from the previous 2 financial years. Full training compliance can be seen in the table 2 below.

Table 5. Job Related CD Training Compliance shows Compliance with CD training per quarter. Taken from education and training records.

	Not Including Bank Staff			Including Bank Staff		
Quarter	Number of Staff Required to Complete	Number of Staff Completed	Compliance Percentage	Number of Staff Required to Complete	Number of Staff Completed	Compliance Percentage
Q1	366	344	93.99%	404	373	92.3%
Q2	370	343	92.70%	402	371	92.3%
Q3	384	364	94.79%	414	390	94.2%
Q4	383	367	95.82%	411	392	95.4%

The action plan contained within this report has been developed to reflect that of the CDAO 2024/2025 report. However, there are actions pertinent to CDs that are also part of actions associated with other groups and meetings not reflected on this. Following an exercise with the MSO a single action plan has been developed which amalgamates the controlled drug actions from the Annual CD Report 2024/25, Quarter 4 SEIPS report and Q4 CD LIN report. Duplication has been removed and actions have been reordered into a single assurance-focused plan, using the SEIPS action plan structure for clarity, ownership, monitoring and review. Please see Table 6 below.

Controlled Drugs Annual Report 2025/2026

References:

1. Learning from Gosport, The Government response to the report of the Gosport, Independent Panel. 21 November 2018
2. The Misuse of Drugs Regulations 2001. legislation.gov.uk. 2001.https://www.legislation.gov.uk/uksi/2001/3998/
3. The Human Medicines Regulations 2012. legislation.gov.uk. 2012.https://www.legislation.gov.uk/uksi/2012/1916/regulation
4. The Controlled Drugs (Supervision of Management and Use) Regulations 2013 https://www.legislation.gov.uk/uksi/2013/373/
5. The safer management of controlled drugs: annual update 2024. [Updated 2025 July 15] Care Quality Commission. 2026. https://www.cqc.org.uk/publications/controlled-drugs/2024/issues

Table 6. Action plan progress from 2024/25 and forward plan for 2026/27

No.	Action	Owner	Update	Tool / measure	Reported through	Monitoring / oversight	Review date
Completed / closed actions							
1	Improve timeliness of CD stock destruction in Pharmacy, including policy expectations for stock holding and maximum collection times from clinical areas.	Pharmacy Dispensary Manager	Complete. SOP updated in line with legislative requirements; named senior authorised staff identified and rota established.	Updated SOP; authorised staff list; destruction rota.	Pharmacy Governance	Pharmacy Governance / CDAO	Closed
2	Introduce West Midlands theatre CD audit tool to improve assurance around CD use in theatres, particularly documentation and destruction of unused part vials.	CDAO / MSO / Chief Nurse and deputies	Complete. Added to audit template; one review completed and template added to Tendable® for future audits.	Theatre CD audit template and audit report.	D&T / audit reporting	CDAO / MSO	Closed
3	Present written CD audit reports at Trust D&T Committee for appropriate oversight.	MSO	Complete. Audit report completed and presented to D&T July 2025 following delay due to long-term sickness.	CD audit report.	D&T Committee	D&T Committee	Closed
4	Provide face-to-face training sessions for prescribers.	Appollo	Implemented December 2025.	Training figures.	Quarterly reporting	Appollo	Closed
5	Provide Top Tips advice for prescribing and administration via CMM and make available on Percy.	CMM	Implemented May 2026.	Tips accessible via Percy.	Monthly	TBC	Closed
6	Review induction process for medicines management.	Matron / Ward-area Managers / Pharmacy Governance	Review completed with induction pathway available to support consistent medicines management practice for staff.	Induction pathway availability.	Monthly	Pharmacy Digital Team / PGAG	Closed

7	Couriering of controlled drugs in the Trust.	Pharmacy Governance / Matron	Action completed to support safe couriering of controlled drugs across the Trust, with monitoring through incident reporting.	Incident reporting via RADAR.	Quarterly	Pharmacy Governance review of incidents	Closed
8	Install and implement Omnicell electronic CD cabinet in Pharmacy.	Digital Pharmacy Team / Dispensary Manager / Chief Pharmacist	Capital bid approved and Omnicell purchased; installation delayed due to EPMA/EPR delays.	Installed Omnicell; implementation plan.	Pharmacy Governance	Digital Pharmacy Team / Chief Pharmacist	Closed
9	Share Q4 CD audit report through appropriate governance routes and with Matrons and Ward Managers.	Pharmacy governance	Report to be shared at D&T, Patient Safety Working Group and with Matrons/Ward Managers after CDAO approval.	Q4 CD audit report.	D&T / PSWG	CDAO / pharmacy governance	Closed
10	Review CD medicines returns SOP in line with current practice.	MSO / Pharmacy Governance	Closed	New SOP available for staff.	D&T / PGAG	Pharmacy Governance Team	Closed
11	Review feedback messaging from incident reports and provide a monthly bulletin for staff.	MSO / Matron	In progress.	Monthly bulletin available to staff - via Trust notice board	Monthly	MSO / Matron	Closed
12	Review CD policy and associated SOPs to include new registered staff roles and review audit frequency in line with risk.	CDAO / MSO / Senior Nurses	Amendments approved Sept 2024. Policy updated 2026. Associated SOPs on rolling update plan.	Updated policy now on intranet and SOPs are part of a rolling quarterly review embedded as BAU.	D&T	CDAO / MSO	Closed
Open / ongoing actions							
13	Implement a robust process for investigating and accountability following an unaccounted-for loss of a controlled drug.	CDAO / MSO / Chief Nurse / Senior Nurses	Investigation document developed and piloted by MCSI. First panel meeting July 2025; communication to wards required.	Investigation template; panel process.	Governance reporting	CDAO / MSO / Chief Nurse	Oct-26

14	Improve reporting on usage of CDs via CMM data and EPMA reporting post go-live.	Digital Lead Pharmacist / Senior Digital Technician / Pharmacy Digital Team	EPMA implementation delayed; improved reporting expected once digital team are familiar with reporting tools.	CMM / EPMA reports; CD usage dashboard.	D&T / quarterly report	Digital Pharmacy Team / CDAO / MSO	Ongoing
15	Develop plan for incremental installation of electronic medicine storage cabinets in ward areas, particularly areas of high CD use.	CDAO / MSO / Chief Nurse / Deputies / Pharmacy Governance Lead	Digital project delayed due to EPMA/EPR go-live delay; capital case required for high-use areas such as theatres and MCSI.	Capital investment case; implementation plan.	Capital planning / governance	CDAO / Chief Nurse / Pharmacy Governance	Oct-26
16	Consider external audit of CD processes by a system partner, including CDs in Pharmacy.	CDAO	Requires further exploration with partners across the West Midlands region. Self assessment in plan for Nov 2026	External audit proposal.	CDAO reporting	CDAO	Nov-26
17	Work with theatre staff and anaesthetists to improve accountability and signatures for destruction of unused remains of CDs in theatres.	Anaesthetic Lead Consultant / Theatre Manager / MSO / CDAO	Action remains required following theatre CD audit intelligence.	Audit data; theatre documentation review.	Theatre governance / D&T	MSO / CDAO / Theatre leadership	Dec-26
18	Improve accountability and assurance where ward areas are not consistently completing CD documentation correctly.	MSO / Senior Pharmacy Technician / Matrons / ACNs	Incident forms to be completed for continued non-compliance; CD register to note when an incident has been raised to avoid duplication.	Incident forms; CD register review; audit standards.	RADAR / audit reporting	Matrons / Pharmacy staff	Ongoing
19	Ensure all clinical areas have a current CD stock list.	Pharmacy Technicians	Pharmacy Technicians to review clinical areas and ensure a current CD stock list within one year is available.	Stock list check.	Audit follow-up	Pharmacy Technicians	Sep-26
20	Complete review of handling of CDs within theatres and map workflow against current legislation.	Pharmacy Governance Lead / MSO	Review required to compare current practice and expected process and map workflow within current legislation.	Workflow map; theatre CD review.	Governance review	Pharmacy Governance / MSO	Dec-26

21	Scope use of electronic CD registers for theatres and MCSI initially.	MSO	Scoping required to streamline and digitalise processes, minimising human errors and gaps in safe handling of CDs.	Scoping review; digital options appraisal.	Digital governance	MSO / Digital Pharmacy	Apr-27
22	Remove expired stock from wards.	MSO / Pharmacy Technicians	MSO to remind wards of process; technicians to remove expired stock.	Expired stock checks.	Ward audit / pharmacy review	MSO / Pharmacy Technicians	Ongoing
23	Update CD e-learning module.	MSO / Pharmacy Governance	In progress.	New module available to staff.	Training governance	Pharmacy Governance Team	Oct-26
24	Incorporate CD scenarios into simulation sessions for accurate preparation, documentation and administration.	PDN / MSO	In progress.	Simulation session available to staff.	Training governance	PDN / MSO	Sep-26
25	Review Cas Pack SOP in line with current practice.	Ward Manager / MSO	In progress.	New SOP available for staff.	Governance review	Ward Manager / MSO	Ongoing
26	Look at internal Pharmacy process for TTO clinical checking.	CMM / Pharmacy Governance	SOP being ratified at PGAG March 2026.	Incident reporting via RADAR.	Quarterly	Pharmacy Governance review of incidents	Jun/Aug 2026
29	Include learning from the CD incident investigation panel in quarterly reports.	MSO / Senior Technician	Learning from CD incident investigation panel to be incorporated into quarterly reporting for assurance and shared learning.	Quarterly CD report; incident panel learning log.	Quarterly report	MSO / Senior Technician	Nov-26
30	Review signatory approval process and records. Ensure electronic signatures are collected for new starters and kept up to date by clinical areas	MSO/Digital Technician	New account requests should prompt managers to record electronic signature and records held in pharmacy	Electronic signature recorded for all staff involved in ordering and prescribing	Quarterly review	Dispensary manager and medicines governance administrator	Nov 2026

Executive Summary - People Committee

Assurance

Variation	Will consistently pass the target if nothing changes	Will not consistently pass or fail the target if nothing changes	Will consistently fail the target if nothing changes	No Target or Moving Target
Improving variation (high or low) or 3 months better than target	Vacancy Rate % of Staff on E-Rostering System % of System-Generated E-Roster	Staff Retention		Sickness Absence Sickness Absence - Long Term
No significant change or N/A to SPC	E-Rostering Level of Attainment		E-Job Planning Level of Attainment	% Staff Availability Bank Spend against Plan
Concerning variation (high or low) or 3 months off target		Personal Development Reviews	% of E-Rosters Approved 6 Weeks Ahead % of Staff with an Active E-Job Plan	Sickness Absence - Short Term HCSW Vacancy Rate

Please note - this is defined by the associated SPC graph within the IPR. Many KPIs show as a moving target due to the change of targets/plans as we moved into new financial year and monthly phasing.
Metric placed in boxes above based on the variation icon for latest data point, but over-ridden by whether meeting/failing target for last three months.
If metric placed in a box based on meeting/failing plan, but does show improvement or deterioration - text colour will indicate that.

Trust Board - People & Workforce
August 2026 – Month 5

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust



Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

SPC charts are line graphs that employ statistical methods to aid in monitoring and controlling processes. An area is calculated based on the difference between points, called the control range. 99% of points are expected to fall within this area, and in doing so are classed as 'normal variation'. There are a number of rules that apply to SPC charts designed to highlight points that class as 'special cause variation' - abnormal trends or outliers that may require attention.

There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

The rules that are currently being highlighted as 'special cause' are:

- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of the control range (with the mean considered the centre)

Different colours have been used to separate these trends of special cause variation:



Blue Points highlight areas of improvement



Orange Points highlight areas of concern



Grey Points indicate data points within normal variation



White Points are used to highlight data points which have been excluded from SPC calculations

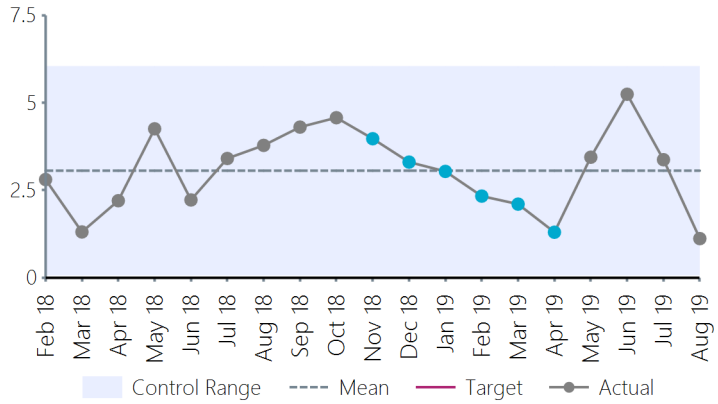
Some examples of these are shown in the images to the right:

a) shows a run of improvement with 6 consecutive descending months.

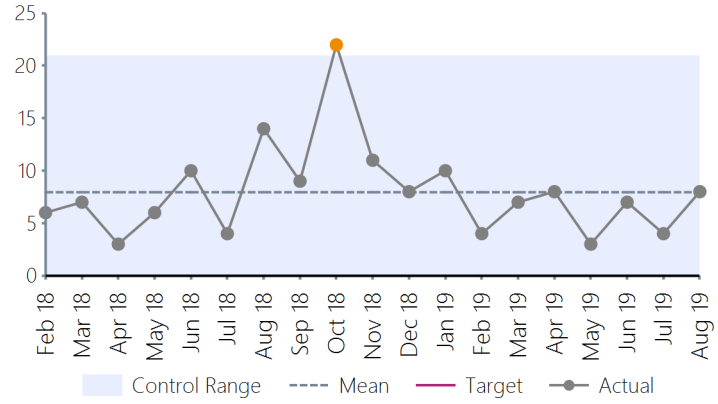
b) shows a point of concern sitting above the control range.

c) shows a positive run of points consistently above the mean, with a few outlying points that are outside the control limits. Although this has highlighted them in red, they remain above the target and so should be treated as a warning.

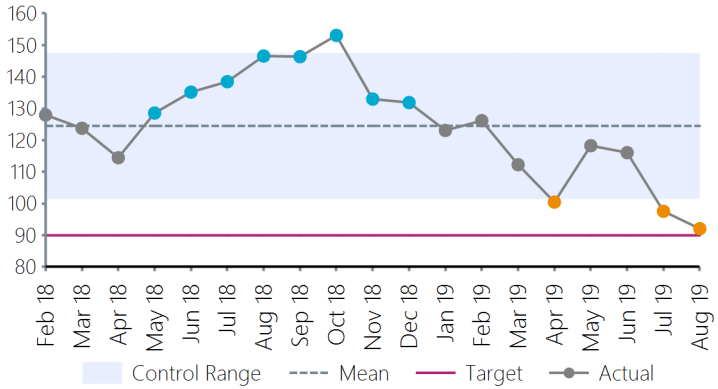
a)



b)



c)



Summary Icons Reading Guide

With the redesign of the IPR you will now see 2 summary icons against each KPI, which have been designed by NHSI to give an overview of how each measure is performing at a glance. The first icon is used to show whether the latest month is of concerning or improving nature by using SPC rules, and the second icon shows whether or not we can reliably hit the target.

Exception Reporting

Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually set as an execption if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

For KPIs that are not applicable to SPC; to identify exceptions we look at performance against target over the last 3 months - automatically assigning measures as an exception if the last 3 months have been falling short of the target in line with how we're calculating the assurance icon for non-SPC measures.

Variation Icons

Are we showing improvement, a cause for concern, or staying within expected variation?



Orange variation icons indicate special cause of **concerning nature** or high pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.



Blue variation icons indicate special cause of improving nature or lower pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.



A grey graph icon tells us the variation is common cause, and there has been no significant change.

For measures that are not appropriate to monitor using SPC you will see the "N/A to SPC" icon instead.

The special cause mentioned above is directly linked to the rules of SPC; for variation icons this is if the latest point is outside of the control range, or part of a run of consecutively improving or declining points.

Assurance Icons

Can we expect to reliably hit the target?



An orange assurance icon indicates consistently (F)alling short of the target.



A blue assurance icon indicates consistently (P)assing the target.



A grey assurance icon indicates inconsistently passing and falling short of the target.



For measures without a target you will instead see the "No Target" icon.



Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months in comparison to the target, showing F or P icons if consistently passing of falling short.

Data Quality Rating Reading Guide

The Data Quality (DQ) rating for each KPI is included within the 'heatmap' section of this report. The indicator score is based on audits undertaken by the Data Quality Team and will be further validated as part of the audit assurance programme.

Colours

When rated, each KPI will display colour indicating the overall rating of the KPI

Blue	Green	Amber	Red
No improvement required to comply with the dimensions of data quality	Satisfactory - minor issues only	Requires improvement	Siginficant improvement required

Dates

The date displayed within the rating is the date that the audit was last completed.

Summary - Caring for Staff

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
Sickness Absence	4.20%	3.72%		L	Moving Target	+		+
Staff Turnover - FTE	9.77%	9.28%			Moving Target			
Leavers per Month	12	18			?			
Vacancy Rate	8.00%	5.61%		L	P	+		

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
Agency Spend against Plan	86	49		N/A to SPC	Moving Target			
Proportion of Temporary Staffing as a % of the Trust Pay Costs	5.64%	5.55%		N/A to SPC	Moving Target			
Bank Spend against Plan	458	465		N/A to SPC	Moving Target	+		

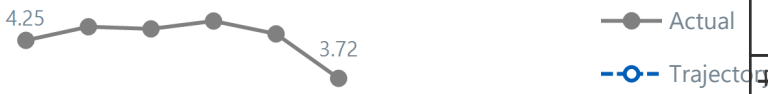
Sickness Absence

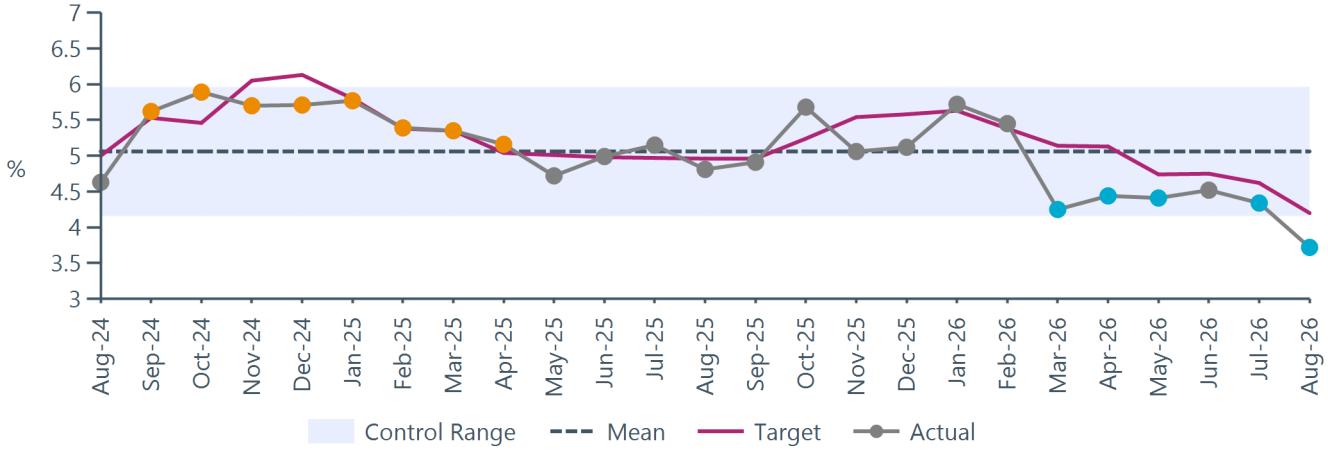
FTE days lost as a percentage of FTE days available in month. Target as per Trust's Operational Plans. 211161

Exec Lead
Chief People Office

Target/Plan	Latest Value	Variation	Assurance	NOF
4.20%	3.72%	L	Moving Target	+

Trajectory





What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric has a moving target; derived from the Trust's Operational Plan.

Narrative

The Overall Sickness Absence rate for August is reported at 3.72%. As demonstrated on the SPC above, this is indicated as special cause variation of an improving nature. The position over the last six months has consistently been below the plan. Throughout August, the top three reasons for overall sickness were:
* Anxiety/stress/depression/other psychiatric illnesses
* Other known causes - not elsewhere classified
* Other musculoskeletal problems

Hot spot areas for overall sickness were:
* Theatre Support Workers - 20.23%
* Radiology Bookings - 15.95%
* Kenyon Ward - 14.97%

The latest NOF Publication reports the NOF score at 2.1; this relates to the 5.18% sickness absence rate for the quarter ending March-26.

Actions

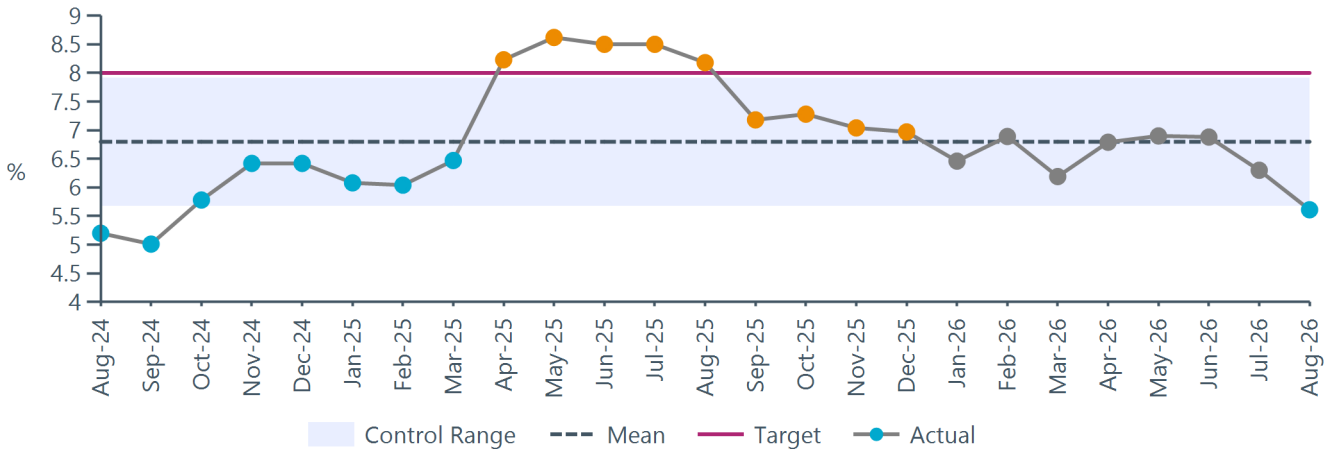
Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
4.81%	4.91%	5.68%	5.06%	5.12%	5.72%	5.45%	4.25%	4.44%	4.41%	4.52%	4.34%	3.72%

Vacancy Rate

% of Posts Vacant at Month End 211183

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
8.00%	5.61%	L	P	



Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric is consistently meeting the target.

Narrative

The Vacancy Rate at the end of August is reported at 5.61%. As demonstrated on the SPC above, this is indicated as special cause variation of an improving nature with the position below the expected control range. The position has been consistently reported below the 8% plan for the last twelve months.

Actions

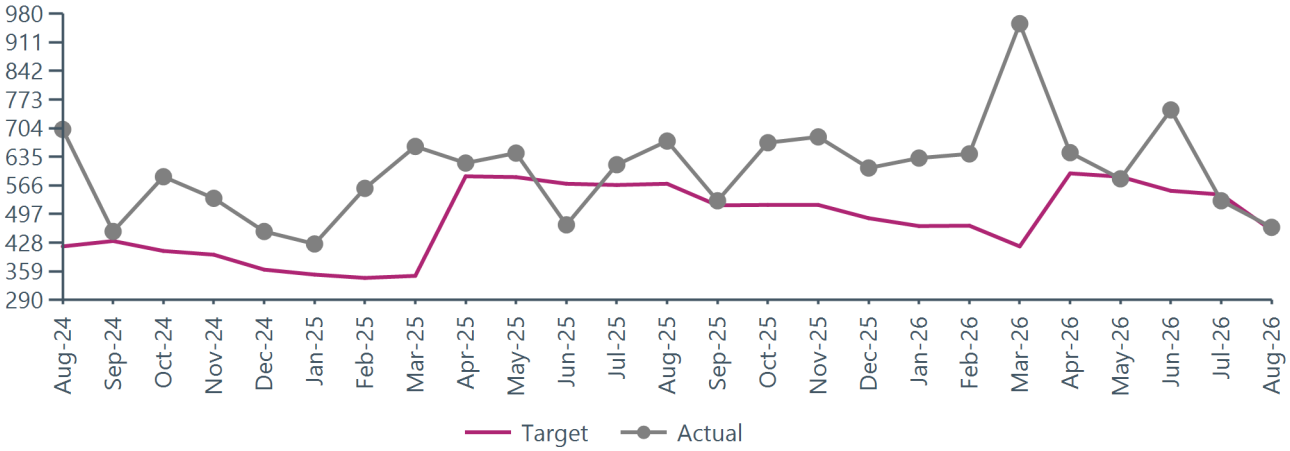
Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
8.18%	7.18%	7.28%	7.04%	6.97%	6.46%	6.89%	6.19%	6.79%	6.90%	6.88%	6.30%	5.61%

Bank Spend against Plan

National planning guidance requires a 15% reduction in bank costs in 26/27 relative to 25/26, plan calculated nationally based on M6 25/26 FOT 217872

Exec Lead:
Chief Finance & Commercial Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
458	465	N/A to SPC	Moving Target	



Trajectory



What these graphs are telling us

This measure is not appropriate to display as SPC. Metric has a moving target.

Narrative

Bank spend £7k adverse to plan in month , £232k adverse ytd. Bank activity is reviewed weekly at the Variable Pay meetings chaired by the Chief People Officer.

Actions

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
673	529	669	683	608	632	642	956	645	582	748	529	465

Chair's Assurance Report
People and Culture Committee

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Committee / Group / Meeting, Date

Board of Directors Meeting – Public Meeting, 07 October 2026

Author:	**Contributors:**
Name: Emma Jones Role/Title: Executive Assistant	

Report sign-off:

Paul Maubach, Chair of the People and Culture Committee

Is the report suitable for publication: Yes

1. Key issues and considerations:

The Trust Board has established a People and Culture Committee. According to its terms of reference: *"The purpose of the People and Culture Committee is to assist the Board obtaining assurance that the Trust's workforce strategies and policies are aligned with the Trust's strategic aims and support a patient-focused, performance culture where staff engagement, development and innovation are supported. The Committee will work with the Audit and Risk Committee to ensure that there are adequate and appropriate governance structures, processes, and controls in place throughout the Trust to:*

- *Promote excellence in staff health and wellbeing.*
- *Identify, prioritise, and manage risks relating to staff.*
- *Ensure efficient and effective use of resources."*

In order to fulfil its responsibilities, the Committee has established sub-committees (known as "Meetings") which focus on particular areas of the Committee's remit. The People and Culture Committee receive regular assurance reports from each of these "Meetings" and escalates issues to the Board as necessary via this report.

This report provides a summary of the items considered at the People and Culture Committee on 24th September 2026. It highlights the key areas the People and Culture Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

The following strategic objectives are relevant to the content of this report:

	Trust Objectives	
1	Deliver high quality clinical services	
2	Develop our veterans service as a nationally recognised centre of excellence	
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	

This report relates to the following Board Assurance Framework (BAF) themes and associated strategic risks:

	Board Assurance Framework Themes	
1	Continued focus on excellence in quality, safety and patient experience.	✓
2	Focus on equity of service and addressing health inequalities	
3	Effective engagement with the workforce to support a positive staff experience and a culture of continuous improvement	✓
4	Delivering financial sustainability	✓
5	Delivering the required levels of productivity, performance and activity	
6	Delivering innovation, improvement and growth	✓
7	The challenges of operating in both the Welsh and English health systems	✓
8	Responding to a significant disruptive event	
9	Security of digital, data and AI systems and ability to respond to cyber threats	

Trust values:

The content of this report reflects / supports the following Trust values:

Trust Values		
1	Professional	✓
2	Excellence	✓
3	Respect	✓
4	Friendly	✓
5	Inclusive	✓
6	Caring	✓

3. Assurance Report from People and Culture Committee

3.1 Areas of non-compliance/risk or matters to be addressed urgently.

ALERT - The People and Culture Committee wish to bring the following issues to the Board's attention as they:

- Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address, OR require the approval of the Board for work to progress.

Occupational Health Data:

Data supplied by Optima suggested immunisation and occupational health compliance of approximately 70–76% across six areas but could not be validated at individual level. The Trust is reconciling electronic and paper records, prioritising higher-risk groups and undertaking sample checks to establish the true compliance position, quantify gaps and agree remediation. Contract management, data governance and lessons for the new provider will be considered separately.

3.2 Areas of on-going monitoring with new developments

ADVISE - The People and Culture Committee wish to bring the following issues to the Board's attention as they represent areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives:

Statutory and Mandatory Training:

Overall compliance had improved to approximately 93.2%; however, seven subjects remained below the required threshold, and some staff had been non-compliant for prolonged periods. Role-based requirements must first be validated so staff are measured only against relevant training. A definitive list, consistent escalation process and implementation timetable will return to the November Committee, with managers held accountable alongside individual staff.

Anaesthetic Capacity:

Anaesthetic capacity continued to constrain additional private-patient activity. A coordinated workforce and finance review will separate funded vacancies, sickness and operational unavailability from any genuine need for additional establishment. It will also determine whether the approximately £1 million investment in eight middle-grade posts has released consultant capacity and supported additional activity.

E-Roster Approval:

Approval six weeks in advance improved from 60.61% in August to 88.41% in September but remained below the 90% target. Nursing performance was approximately 94–95%. Future reporting will show performance by service and staff group and distinguish genuine operational risk from areas where a shorter approval period is operationally appropriate.

Medical Job Planning:

Electronic job plans were in place, but many were historic or unsigned, limiting reliable demand, capacity and productivity planning. The Committee requested clear ownership, explicit expectations

for clinical and operational leads, and a mechanism for holding managers accountable for completion and sign-off.

Staff Standards Framework:
The integrated framework and mapping were endorsed, with leadership and line-management capability identified as the immediate priority. Organisational, manager and individual responsibilities must be clearly defined, with managers given the necessary training, tools and support. Delivery dates, a baseline assessment and a single assurance dashboard are being developed.

Employment Rights Changes:
Phased changes across 2026 and 2027 will affect family and sick leave, trade-union rights, harassment protections, tribunal time limits, unfair dismissal, dismissal and re-engagement, performance management and probation. HR is reviewing policies, documentation, record keeping, communications and manager support in preparation.

3.3 Areas of assurance

ASSURE – People and Culture Committee considered the following items and did not identify any issues that required escalation to the Board.

Workforce Performance:
Sickness absence was 3.72%, below the 4.00% plan, with the quarter-one rate improving to 4.45% from 5.13% in quarter four. The healthcare support worker vacancy rate reduced to 8.81% from 12.87% in August 2025, while staffing was forecast to reach approximately 1,660 by the end of September, 11.5 WTE above plan, supported by a recruitment pipeline of 65.77 WTE.

Medical Appraisal:
The annual report provided assurance on the medical appraisal process. A peer review with the Royal Orthopaedic Hospital confirmed overall assurance while identifying opportunities for further improvement, and the need for permanent appraisal coordination capacity was noted.

Resident Doctor 10 Point Plan:
Overall compliance was reported at 88%, with strong progress across several areas. Clear completion dates are being established for the remaining actions before they transfer into relevant business plans and established oversight arrangements.

Equality, Diversity and Inclusion:
The annual PSED report demonstrated progress in workforce turnover, data maturity, pay-gap analysis, anti-racism, sexual safety and staff networks. It was approved for publication subject to clearer presentation of undeclared and unrecorded data, additional local population comparison and an accurate update on staff-network leadership.

Well-Led Action Plan:
The Committee endorsed closure of the standalone action plan following good progress. Remaining actions will transfer into clearly owned business plans, workstreams and established governance arrangements so accountability and monitoring continue through business as usual.

Recommendation
The Board is asked to:
- CONSIDER the content of section 3.1 and agree any action required.
- NOTE the content of section 3.2 and CONSIDER whether any further action is required; and
- NOTE the content of section 3.3.

Accountable Officer Appraisal Annual Report

(Part 1) Covering paper

Committee / Group / Meeting, Date	
People & Culture Committee, 24th September 2026 Board of Directors – Public Meeting, 07 October 2026	
Author:	**Contributors:**
Name: Nilesh Makwana and Kate Emery Role/Title: Medical Appraisal Lead and Medical Appraisal Coordinator	Name: Ruth Longfellow Role/Title: Chief Medical Officer
Report sign-off:	
Name: Ruth Longfellow Role/Title: Chief Medical Officer	
Is the report suitable for publication?:	
Yes	
Executive Summary:	

The NHS Annual Organisational Audit (AOA) provides national and regional assurance that healthcare organisations have effective systems in place for medical appraisal and revalidation. It ensures that Hospitals Boards and Responsible Officers actively monitor medical governance, manage fitness-to-practice concerns and maintain quality standards. The report has been completed ready for People & Culture Committee on 24th September 2026, Trust Board on 7th October 2026 ready for final submission to NHS England by 31st October 2026.

The Trust has maintained ongoing professional development of medical staff and the maintenance of a fair and robust procedure for managing concerns which are described in the report. Medical concerns are handled sensitively and professionally, in collaboration with external bodies, in a timely manner and relevant data is reported to the P&C Committee.

The quality of appraisal outputs has been good throughout the year, and the appraiser CPD and recruitment processes are effective. Permanency of the Medical Appraisal Coordinator will enable the organisation to maintain high standards of medical performance and quality assurance.

The new CPO commencing in post in November 2026, offers the opportunity to review the processes included in this report, including the established process for responding to concerns about a medical practitioner's fitness to practise, to assess for improvements in process.

Recommendations:

The People & Culture Committee reviewed the AOA report at the September committee meeting and confirmed that it is satisfied with the level of assurance provided, and recommend approval of the AOA report to the Trust Board.

(Part 2) Strategic alignment and supporting detail

Strategic objectives and associated risks:

The following strategic objectives, developed in light of national and system priorities, are relevant to the content of this report:

Trust Objectives		
1	Deliver high-quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	

4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	✓

This report relates to the following Board Assurance Framework (BAF) themes and associated strategic risks:

Board Assurance Framework Themes		
1	Continued focus on excellence in quality, safety and patient experience.	✓
2	Focus on equity of service and addressing health inequalities	
3	Effective engagement with the workforce to support a positive staff experience and a culture of continuous improvement	✓
4	Delivering financial sustainability	
5	Delivering the required levels of productivity, performance and activity	
6	Delivering innovation, improvement and growth	✓
7	The challenges of operating in both the Welsh and English health systems	
8	Responding to a significant disruptive event	
9	Security of digital, data and AI systems and ability to respond to cyber threats	

Trust values:

The content of this report reflects / supports the following Trust values:

Trust Values		
1	Professional	✓
2	Excellence	✓
3	Respect	✓
4	Friendly	✓
5	Inclusive	✓
6	Caring	✓

Report development and engagement:

The Medical Appraisal Lead and Medical Appraisal Coordinator have prepared the report with oversight and support from the Chief Medical Officer.

Next steps:

The report will be submitted to the Trust Board for consideration on 7th October 2026 ahead of the NHS England submission deadline of 31 October 2026.
The Annual Organisational Audit (AOA) report is produced on an annual basis with the next reporting cycle commencing in April 2027. The recommendations and actions arising from the report will be monitored and progressed throughout the year.

Acronyms

AOA	Accountable Officer Appraisal
ASPAT	Appraisal Summary and PDP Audit Tool
BMA	British Medical Association
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
CPD	Continuing Professional Development
CPO	Chief People Officer
DATIX	Incident Reporting System (former system replaced by RADAR)
DERIIC	Digital, Education, Research, Innovation and Improvement, and Commercialisation Committee
DMG	Decision Making Group
DR360	Edgecumbe 360 Degree Feedback System

EDI	Equality, Diversity and Inclusion
ELA	Employer Liaison Adviser (GMC)
ESR	Electronic Staff Record
FQAI	Framework of Quality Assurance Information
FTSU	Freedom to Speak Up
GMC	General Medical Council
HLRO	Higher Level Responsible Officer
HPAN	Healthcare Professionals Alert Notice
HR	Human Resources
IPC	Infection Prevention and Control
LNC	Local Negotiating Committee
MAID	MIAD Healthcare Company
MHPS	Maintaining High Professional Standards in the Modern NHS
MPIT	Medical Practice Information Transfer
MSF	Multi-Source Feedback
NED	Non-Executive Director
NHS	National Health Service
PDP	Personal Development Plan
POL	Policy
PSIRF	Patient Safety Incident Response Framework
QIA	Quality Improvement Activity
RADAR	Risk and Incident Reporting System
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital
RO	Responsible Officer
ROH	Royal Orthopaedic Hospital
R&S	Recruitment and Selection
SPA	Supporting Professional Activities
TIO	Transfer of Information

Attachments

Attachment A Annual Organisational Audit (AOA) Report

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of: The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	Dr Ruth Longfellow is the appointed Chief Medical Officer and undertakes the role of Responsible Officer. She has held this post throughout the review period.

Comments:	The Responsible Officer is supported in her role by the Associate CMO / Medical Appraisal Lead (Mr Nilesh Makwana) and Kate Emery (Medical Appraisal Coordinator).
Action for next year:	No further action currently.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	A peer review with a Trust of similar size and function to benchmark the processes at RJAH.
Comments:	A peer-to-peer review with The Royal Orthopaedic Hospital (ROH) has taken place. This found differences in resources and processes which have been reviewed and some adopted. An example includes classifying specialty for doctors on the appraisal system to help in data management. Appraiser numbers are sufficient to ensure the number of appraisals per year is manageable. A dedicated software for appraisal and 360 feedback is used by the Trust and updated regularly. Governance and Recruitment checking is resourced and remains largely unchanged.
Action for next year:	To continue our link with ROH. Medical Appraiser coordinator role is currently seconded role, until November, plan to make this permanent.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	Links between the appraisal coordinator and staff records has improved the recording of starters/leavers to improve the data quality of connected doctors.
Comments:	The appraisal coordinator maintains an accurate record of connected doctors with HR/ESR and the Postgraduate centre. Doctors who leave are disconnected appropriately. The record is maintained on Premier IT and linked with GMC connect.

Action for next year:	Continue to maintain accurate appraisal data using ESR, appraisal system and GMC Connect.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Review and update process and policies in accordance with the Trusts policy framework and national guidance.
Comments:	Medical Staff Appraisal Policy (POL036) was reviewed and updated January 2026 (People committee – 22.1.2026).
Action for next year	Review and update process and policies in accordance with the Trusts policy framework and national guidance.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes
Action from last year:	Report on the peer review of the organisation appraisal and revalidation process.
Comments:	RJAH and ROH have undertaken a peer-to-peer review between administration teams followed by regular discussion meetings. The review highlighted similar benchmarking and that standards between the Trust are similar and being maintained.
Action for next year:	Continue links with ongoing collaboration with neighbouring organisation (Royal Orthopaedic Hospital, Birmingham).

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes

Action from last year:	Continue to ensure CPD opportunities for all locum and short-term placement doctors working in the organisation are supported in line with Trust policies
Comments:	An accurate database has been established for all those doctors who have a prescribed connection to RJAH and those with a prescribed connection to another organisation but have clinical commitments here. Appraisals and revalidation processes are managed as per employed staff. SPA time is provided for medical staff to support governance activities and information relating to their practice is provided to them from the relevant departments. MPIT forms are shared with other Trust when locums are connected to another organisation. In addition to this, the Trust complete a quarterly review of Resident Doctors safe working hours, in addition to progress of work in line with the 10Point Plan. This is presented to the People and Culture Committee for oversight and assurance.
Action for next year	Continue to ensure CPD opportunities for all locum and short-term placement doctors working in the organisation are supported in line with Trust policies. A review of recruitment and onboarding of short-term placements and locum doctors to be performed to ensure adequate induction and awareness of governance processes.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	Continue to improve the quality of Trust provided governance data and activity data. Continue to use systems in place including Premier IT and DR360.
Comments:	Relevant information- Governance data (Complaints, compliments, QIA, audit and Trust activity), Activity data and training compliance are provided by the relevant departments. Additional governance data is provided by the

	Appraisee from external organisations. This is discussed at the annual whole of practice appraisal.
Action for next year:	Continue work to improve access to data required by all connected doctors. Continue to use the NHS approved Premier IT and Edgecumbe DR360.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	All relevant information is reviewed at appraisal and if this is not provided at appraisal the doctor is supported to provide this before the appraisal can be approved, as per the Appraisal Policy. The Quality Assurance (ASPAT) checks ensure that external organisation information is also provided and reviewed at appraisal.
Comments:	Medical staff are encouraged to report circumstances that may provide a barrier to the completion of their appraisal. Support is provided by the Appraisal Coordinator and Appraisal Lead. In the rare occasion of failure to engage, escalation processes are in place.
Action for next year:	Continue to support doctors to complete their annual appraisals.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	Maintain the policy in line with the Trust Governance and policy framework. It has been updated.
Comments:	Medical Staff Appraisal Policy (POL 036) updated January 2026
Action for next year:	Maintain the policy in line with the Trust Governance and policy framework.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year:	We have 29 appraisers and this is kept under review to ensure a sufficient ratio so that doctors do not have the same appraiser for more than 3 consecutive appraisals. New appraisers are formally trained and approved before being added to the pool of appraisers.
Comments:	The Appraisal policy advises that doctors perform between 3-5 appraisal per year, with some appraisers performing more. Recently 2 appraisers have demitted, and they are being replaced with 2 new appraisers who are in the process of undergoing training.
Action for next year:	No additional action required at this time.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	Medical appraisers are required to participate in ongoing performance review and network/development sessions which are organised quarterly. All appraisers must attend at least one network/development session per year to maintain competency. Attendance is monitored. Invited speakers included the HLRO, and MAID training for appraisers.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Comments:	Review of 2025-26 Appraisal Network Development Meeting attendance. Attendance record is held and maintained by the appraisal coordinator. In more recent meetings the attendees have been provided with updates from Premier IT, DR 360, Governance, Learning & Development & Information departments. The September 2026 meeting was supported by the GMC. ASPAT audit has shown consistent satisfaction with the appraisal process, and scores are consistently high for quality. All appraisers receive an annual report of their feedback.
Action for next year:	Plan and arrange the programme content for the network/development sessions for 2026/27 including monitoring of attendance.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	The appraisal system is quality assured on a continuous basis by the Medical Appraisal Lead who audits all submitted appraisals using the widely used Appraisal Summary and PDP Audit Tool (ASPAT), produced by NHS England. An annual report of the findings is provided to the medical appraisers and submitted annually to People and Culture Committee and then to the Board.
Comments:	Audits of quality assurance have been completed and highlighted no concerns or issues identified. An additional auditor has been appointed to assist the appraisal lead.
Action for next year:	Continue to monitor and quality assure process.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes

Action from last year:	Timely recommendations are made to the GMC about fitness to practice of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and Responsible Officer protocol.
Comments:	Revalidation tracker has been set up by the Appraisal Coordinator which ensures all appraisals, and 360 feedback is completed prior to revalidation.
Action for next year:	To continue monitoring and ensure all doctors have sufficient evidence in place in advance of their revalidation date.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Revalidation recommendations made to the GMC are confirmed with the doctor. Reasons for deferred recommendations are discussed with the doctor by the Chief Medical Officer and confirmed in writing prior of the revalidation date.
Comments:	The Trust has a set of criteria in line with GMC requirements which doctors are required to meet before a recommendation for revalidation is submitted. Failure to meet the set criteria will mean the revalidation recommendation will be deferred until it is met. Any revalidation recommendations that need to be deferred are discussed with the doctor and plans agreed to address the short fall. Doctors receive communication from the GMC to confirm revalidation has been processed following a positive recommendation.
Action for next year:	Continue to monitor and maintain early engagement/ communication with doctor if deferment is likely outcome.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	The organisation aims to ensure all doctors practice in accordance with the principles and values set out in the Good Medical Practice and participate in the revalidation and appraisal process. The Trust also requires doctors to participate in those systems and processes put in place to protect and improve patient care.
Comments:	Doctors continue to receive their governance data from the governance and information team. Mandatory training is provided through ESR. Clinical governance arrangements exist across the organisation to support safe provision of clinical care. Learning from adverse events and from excellence in healthcare is promoted and shared in local governance meetings. Complaints collected through RADAR are responded to promptly and learning shared with staff. Medical staff undertake colleague and patient feedback in each revalidation cycle.
Action for next year:	To continue to ensure all doctors practice in accordance with the principles and values set out in the Good Medical Practice and participate in the revalidation and appraisal processes.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	All doctors are provided with all relevant information relating to the doctor's fitness to practice and which relates to their work carried out in the organisation, e.g. information about complaints, significant events and outlying clinical outcomes. This data is reviewed and discussed at their annual appraisal.

Comments:	The Trust has a formal process to manage all complaints made by patients. All clinicians are provided with a copy of any complaints received regarding them or their practice or that of their registrars. All complaints are included in the doctor's clinical governance report for their appraisal and is then reflected on at their appraisal. Concerns raised within the Trust are addressed with the doctor, by the doctor's clinical lead, with an opportunity for reflection. Any concerns are escalated to the RO by the appraiser electronically through the platform or directly if needed. Doctors are asked to discuss and reflect on significant concerns during their appraisal by the RO, and this discussion is recorded in the appraisal document.
Action for next year:	Continue to monitor and no action planned in this area

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	Doctors are provided with clinical governance data prior to their appraisal and monthly activity data to review at departmental meetings. The Information department provide annual activity information. Mandatory training completion is provided through ESR and by the Learning and Development department.
Comments:	Governance department and Premier IT are now linked so that information is provided in a timely manner
Action for next year:	Continue with the process and no action planned in this area.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes

Action from last year:	The Professional Standards group continues to meet on a monthly basis, and any areas of concern are escalated via the correct governance routes.
Comments:	A process for managing concerns raised for medical staff is detailed in policies including MHPS (Policy 114), and FTSU (Policy 175). The Chief Medical Officer/RO has also put in place a Professional Standards Group to comply with the above requirements. Close liaison with the GMC ELA is in place with regular meetings and engagement with HLRO network events. NHS resolution is consulted where indicated.
Action for next year:	Continue with Professional Standards group meetings and ensure ongoing attention to fairness in escalation and cultural awareness training for decision makers. New CPO commencing in post in November 2026, therefore will take this opportunity to review process, to assess for improvements in process.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	The People and Culture Committee will continue to receive a summery report annually. Future reports will include protected characteristics and country of primary qualifications.
Comments:	A summary report of the number and reasons for concerns raised regarding doctors is reported through the People and Culture Committee, including data on protected characteristics.
Action for next year:	Review this reporting process with the new CPO commencing in November 2026. The People and Culture Committee will continue to receive a summary report annually. Future reports will include protected characteristics and country of primary qualification.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	The Appraisal Coordinator to continue to follow the formal transferring of information using the GMC MPIT forms between relevant RO.
Comments:	An accurate record of this data is maintained by the appraisal coordinator. In addition to the official GMC Medical Practice Information Transfer (MPIT) form, some Trusts send TIO (Transfer of Information) forms. These aid the transfer of information and concerns effectively between organisations and RO.
Action for next year:	No changes anticipated

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	Processes for managing initial concerns carefully with consideration and promotion of equal and fair treatment for all staff subject to it. Any concerns are initially managed informally by the doctor's Clinical Lead / or by the Deputy CMO as appropriate. This is supported by the Chief Medical Officer/Responsible Officer, People Services Department if required. The Professional Standards Group keeps an update record of concerns raised, and any actions taken.
Comments:	MHPS policy is followed when responding to concerns about a doctor's practice. This is policy includes reference to 'Just

	Culture' and the process includes a DMG (Decision Making Group) which includes an impartially element/check. This policy/process has recently been reviewed and updated with significant input from LNC/BMA. Concerns raised about doctors are considered by diverse senior clinical and non-clinical staff advising the RO. Decisions to proceed to formal investigation under MHPS are considered in line with Just Culture and with due consideration for unconscious bias.
Action for next year:	Continue monitoring to ensure actions and policies are fair and free from bias or discrimination.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	The NHS Resolution Framework: 'Fairness and Proportionality: Principles and framework for healthcare organisations managing performance concerns' to be communicated amongst clinical leads and embedded into policies.
Comments:	MHPS policy is followed when responding to concerns about a doctor's practice. This policy includes reference to DMG (Decision Making Group) which include an impartially element/check. This policy/process has recently been reviewed and updated with significant input from LNC/BMA. National reviews and learning are fed through relevant workstreams, clinical through the CNO and culture via Chief People Officer, in addition to other local learning identified through our internal governance processes, such as IPC improvements and PSIRF.
Action for next year:	Continue to monitor and incorporate national reviews and standards. Review process with new CPO starting in November 2026.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Continue to support and meet these standards
Comments:	The Trust agrees and aspires to support these recommendations a. Collaborative Leadership and Organisation Values – Strategic 5-year Plan. b. Positive EDI action with staff network. c. Our electronic appraisal system meets national standard. d. Effective Recruitment of NED`s e. The Trust have capability and conduct policies in place for medical and non-medical healthcare professionals for individuals to be managed accordingly against their professional standards. There are also processes in place for raising concerns through our incident reporting system RADAR and Freedom to Speak up which colleagues and others are encouraged to utilise. Any areas relating to professional standards are then referred to the appropriate process to support.
Action for next year:	Continue to support and meet these standards.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	The Trust has a comprehensive recruitment process in place which adheres with all legislation and NHS requirements for appropriate pre-employment checks to ensure all doctors including locum and short-term doctors have the qualifications and are suitably skilled and knowledgeable to undertake their professional duties.
Comments:	Audits of the R&S procedures are undertaken periodically by the Trust's official auditors. The recruitment team are forwarded HPAN information when relevant to the Trust workforce.
Action for next year:	Continue to work with recruitment team to monitor and factor in receipt of MPIT form and last appraisal.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	More use of Improve well engagement platform, to use as mini surveys and sentiment tracker
Comments:	Trust Vision statement and Values updated. Implementation of sub-board DERIIC committee, which promotes Digital, Education, Research, Innovation and Improvement, and Commercialisation support, by clinical staff. Clinical Staff are invited to present work they have undertaken. The Committee has created an infrastructure for each element to facilitate development and enhancement of each area in the Trust.
Action for next year:	Use of 'positive incident' reporting through RADAR.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	More publication of how to report incidents through FTSU.
Comments:	We actively utilise and promote the Dignity and Respect in the Work policy, which aims to ensure that all staff are at all times treated with dignity and respect within the workplace. Results from Staff Survey have been reviewed and a working group set up to address areas of focus where support is required, and actions taken for areas of focus.
Action for next year:	Continue to address concerns raised via the staff survey, or from other sources.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	Continue with action plans and reports. Communications through internet via COMMS/Percy. Ongoing Human Factors training
Comments:	EDI strategy and action plans: Support through staff Networks Publishing Annual reports Opportunities for training

	Revised Trust vision statement and launch of revised Values in September 2025
Action for next year:	Continue leadership development for staff, opportunity to attend Improvement Advocates and Human Factors training which includes discussion and around behaviour and civility.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	Continue to build on these areas
Comments:	Currently the process is informal and ad hoc, other than use of the grievance process. The Trust has an active MHPS policy for management of concerns relating to medical staff. In addition, there is a capability and conduct policy in place.
Action for next year:	Improvement of feedback mechanism for doctors following involvement in professional standards process.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	The Trust has incorporated a new reporting system RADAR that has replaced DATIX. This will allow data to be reviewed to ensure there is parity for doctors involved in these processes and allow the ability to compare protected characteristics and primary qualifications. This work is ongoing.

Comments:	This is an area we currently are aware of, and do undertake case work review against protected characteristics, but not currently undertaking primary medical qualification
Action for next year:	No changes anticipated. This needs to be included in the Professional Standards Group metrics.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	A peer review meeting with a Trust of similar size and function was undertaken with the ROH Birmingham.
Comments:	The Trust have a similar size and set up. Multiple shared meetings have taken place sharing best practice and adopting areas to improve the revalidation system Communication between the RO, GMC and NHS Resolution has been used to ensure a process that is consistent with the broader national approach from peers The RO and appraisal lead maintain good relationships with other RO through individual casework and national and regional network meetings. RO and Deputy RO attend network meetings, in addition to reginal GMC meetings.
Action for next year:	Continue with the strong links between each Trust and share best practice.

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	148
Total number of appraisals completed	133
Total number of appraisals approved missed	14
Total number of unapproved missed	1
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	9
Total number of late recommendations	0
Total number of positive recommendations	8
Total number of deferrals made	1
Total number of non-engagement referrals	1
Total number of doctors who did not revalidate	1
Total number of trained case investigators	9
Total number of trained case managers	4
Total number of concerns received by the Responsible Officer[2]	5
Total number of concerns processes completed	3
Longest duration of concerns process of those open on 31 March (working days)	150
Median duration of concerns processes closed (working days)[3]	18
Total number of doctors excluded/suspended during the period	1
Total number of doctors referred to GMC	1

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	42
Total number of new employment checks completed before commencement of employment	42
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
The Trust has fully integrated an electronic appraisal system to utilise the Medical Appraisal System, Premier IT. The Trust has continued to utilise DR360 to provide a MSF electronic feedback system. Both systems are regularly updated in line with national standards and guidance An accurate record of all licensed medical practitioners with a prescribed connection to the designated body was fully maintained throughout the year. The Chief Medical Officer / RO ensures that the revalidation process adheres to Trust policy and GMC guidelines. The Medial Appraisal Lead undertakes an annual review of the medical appraisal process, data and feedback which is presented to the Board. No issues have been identified.
Actions still outstanding
The People and Culture Committee will continue to receive a summary report annually. Future reports will include protected characteristics and country of primary qualification
Current issues

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Medical Appraiser coordinator role is currently seconded role. Actions and discussions ongoing to convert to a permanent post.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

1. To continue to collaborate and share learning with our neighbouring Trust, ROH.
2. Medical Appraiser coordinator role is currently seconded role, until November, plan to make this permanent.
3. Continue to maintain accurate appraisal data using ESR, appraisal system and GMC Connect.
4. Review and update process and policies in accordance with the Trusts policy framework and national guidance.
5. Continue links with ongoing collaboration with neighbouring organisation (Royal Orthopaedic Hospital, Birmingham)
6. Continue to ensure CPD opportunities for all locum and short-term placement doctors working in the organisation are supported in line with Trust policies.
7. A review of recruitment and onboarding of short-term placements and locum doctors to be performed to ensure adequate induction and awareness of governance processes.
8. Continue work to improve access to data required by all connected doctors. Continue to use the NHS approved Premier IT and Edgecumbe DR360.
9. Continue to support doctors to complete their annual appraisals.
10. Maintain the policy in line with the Trust Governance and policy framework.
11. Plan and arrange the programme content for the network/development sessions for 2026/27 including monitoring of attendance.
12. Continue to monitor and quality assure process.
13. Continue to monitor and maintain early engagement/ communication with doctor if deferment is likely outcome.
14. To continue to ensure all doctors practice in accordance with the principles and values set out in the Good Medical Practice and participate in the revalidation and appraisal processes.

15. Continue with Professional Standards group meetings and ensure ongoing attention to fairness in escalation and cultural awareness training for decision makers.

16. New CPO commencing in post in November 2026, therefore will take this opportunity to review process established for responding to concerns about a medical practitioner's fitness to practise, to assess for improvements in process.

17. The People and Culture Committee will continue to receive a summary report annually. Future reports will include protected characteristics and country of primary qualification

18. Continue monitoring to ensure actions and policies are fair and free from bias or discrimination and incorporate national reviews and standards. Review process with new CPO starting in November 2026

19. Continue to work with recruitment team to monitor and factor in receipt of MPIT form and last appraisal.

20. Use of 'positive incident' reporting through RADAR.

21. Continue to address concerns raised via the staff survey, or from other sources.

22. Continue leadership development for staff, opportunity to attend Improvement Advocates and Human Factors training which includes discussion and around behaviour and civility.

23. Improvement of feedback mechanism for doctors following involvement in professional standards process.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
The Trust has maintained ongoing professional development of medical staff and the maintenance of a fair and robust procedure for managing concerns which are described in the report. Permanency of the Medical Appraisal Coordinator will enable the organisation to maintain high standards of medical performance and quality assurance. The new CPO commencing in post in November 2026, will take the opportunity to review the process established for responding to concerns about a medical practitioner's fitness to practise, to assess for improvements in process. The quality of appraisal outputs has been good, and the recruitment processes are effective. Medical concerns are handled sensitively and professionally, in collaboration with external bodies, in a timely manner and reported to the Trust board.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

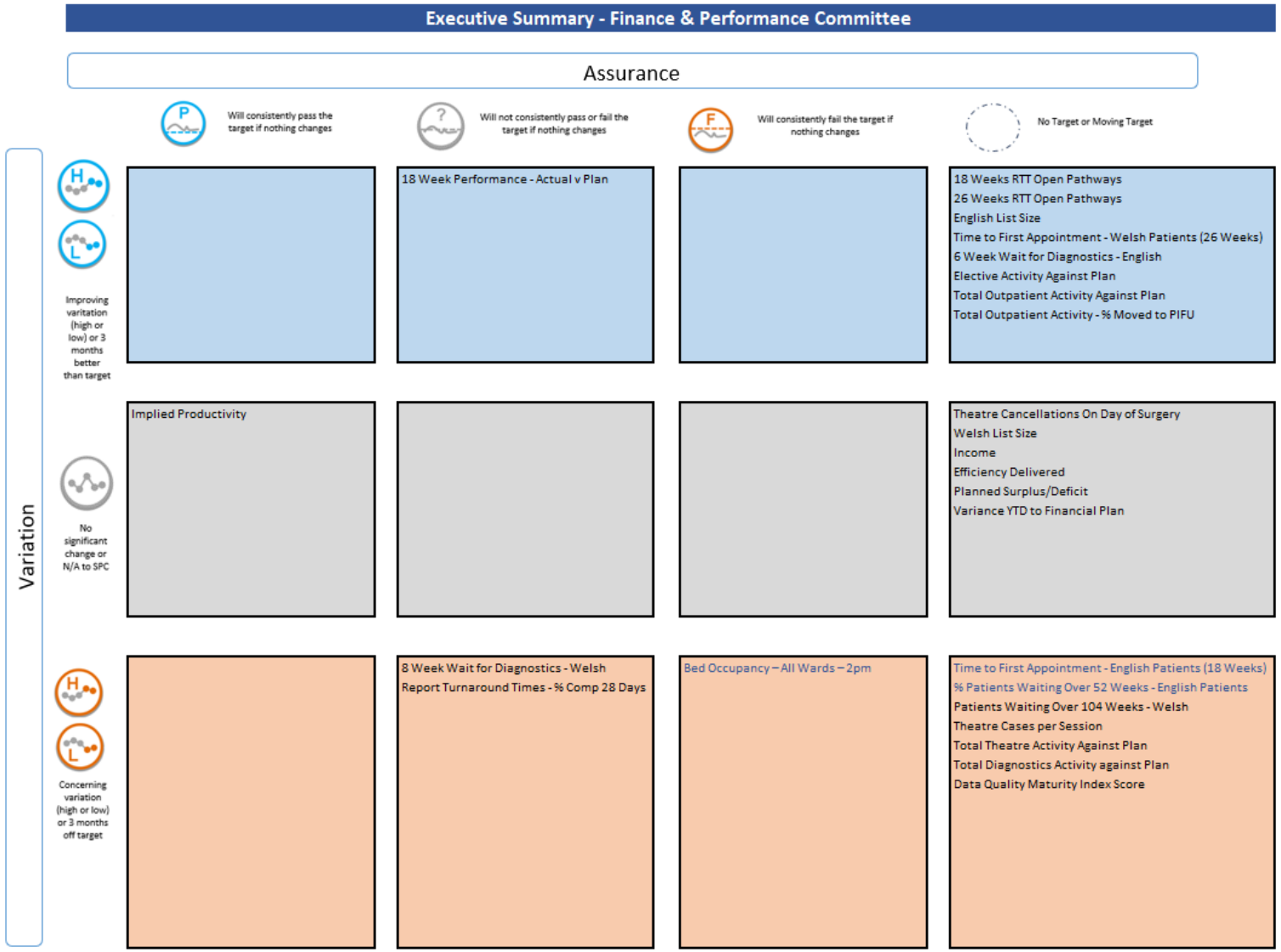
[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

Executive Summary - Finance & Performance Committee



Please note - this is defined by the associated SPC graph within the IPR. Many KPIs show as a moving target due to the change of targets/plans as we moved into new financial year and monthly phasing.
Metric placed in boxes above based on the variation icon for latest data point, but over-ridden by whether meeting/failing target for last three months.
If metric placed in a box based on meeting/failing plan, but does show improvement or deterioration - text colour will indicate that.

Trust Board - Performance
August 2026 – Month 5

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust



Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

SPC charts are line graphs that employ statistical methods to aid in monitoring and controlling processes. An area is calculated based on the difference between points, called the control range. 99% of points are expected to fall within this area, and in doing so are classed as 'normal variation'. There are a number of rules that apply to SPC charts designed to highlight points that class as 'special cause variation' - abnormal trends or outliers that may require attention.

There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

The rules that are currently being highlighted as 'special cause' are:

- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of the control range (with the mean considered the centre)

Different colours have been used to separate these trends of special cause variation:



Blue Points highlight areas of improvement



Orange Points highlight areas of concern



Grey Points indicate data points within normal variation



White Points are used to highlight data points which have been excluded from SPC calculations

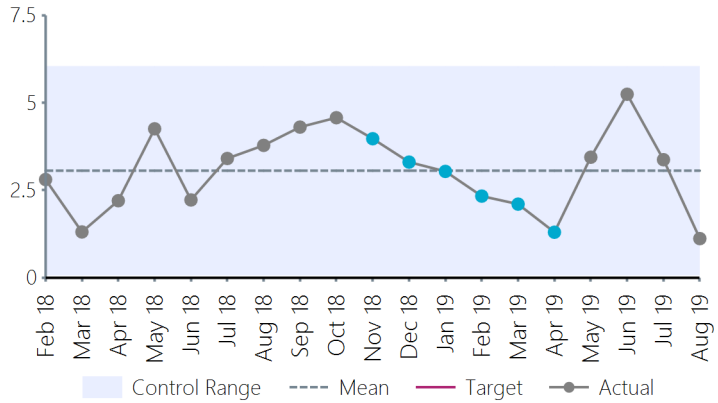
Some examples of these are shown in the images to the right:

a) shows a run of improvement with 6 consecutive descending months.

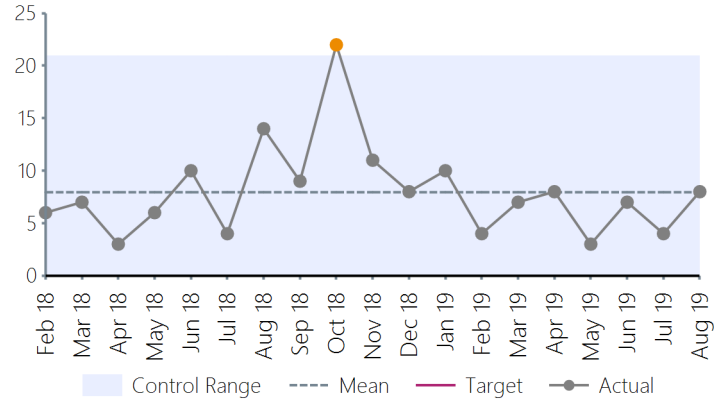
b) shows a point of concern sitting above the control range.

c) shows a positive run of points consistently above the mean, with a few outlying points that are outside the control limits. Although this has highlighted them in red, they remain above the target and so should be treated as a warning.

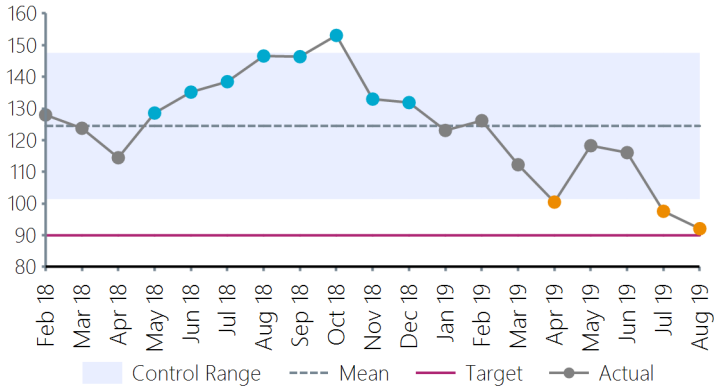
a)



b)



c)



Summary Icons Reading Guide

With the redesign of the IPR you will now see 2 summary icons against each KPI, which have been designed by NHSI to give an overview of how each measure is performing at a glance. The first icon is used to show whether the latest month is of concerning or improving nature by using SPC rules, and the second icon shows whether or not we can reliably hit the target.

Exception Reporting

Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually set as an execption if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

For KPIs that are not applicable to SPC; to identify exceptions we look at performance against target over the last 3 months - automatically assigning measures as an exception if the last 3 months have been falling short of the target in line with how we're calculating the assurance icon for non-SPC measures.

Variation Icons

Are we showing improvement, a cause for concern, or staying within expected variation?



Orange variation icons indicate special cause of **concerning nature** or high pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.



Blue variation icons indicate special cause of improving nature or lower pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.



A grey graph icon tells us the variation is common cause, and there has been no significant change.

For measures that are not appropriate to monitor using SPC you will see the "N/A to SPC" icon instead.

The special cause mentioned above is directly linked to the rules of SPC; for variation icons this is if the latest point is outside of the control range, or part of a run of consecutively improving or declining points.

Assurance Icons

Can we expect to reliably hit the target?



An orange assurance icon indicates consistently (F)alling short of the target.



A blue assurance icon indicates consistently (P)assing the target.



A grey assurance icon indicates inconsistently passing and falling short of the target.



For measures without a target you will instead see the "No Target" icon.



Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months in comparison to the target, showing F or P icons if consistently passing of falling short.

Data Quality Rating Reading Guide

The Data Quality (DQ) rating for each KPI is included within the 'heatmap' section of this report. The indicator score is based on audits undertaken by the Data Quality Team and will be further validated as part of the audit assurance programme.

Colours

When rated, each KPI will display colour indicating the overall rating of the KPI

Blue	Green	Amber	Red
No improvement required to comply with the dimensions of data quality	Satisfactory - minor issues only	Requires improvement	Siginficant improvement required

Dates

The date displayed within the rating is the date that the audit was last completed.

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
31 Day General Treatment Standard*	96.00%	100.00%	100.00%	H	?			
62 Day General Standard*	85.00%	50.00%	50.00%		?	+		
28 Day Faster Diagnosis Standard*	77.00%	84.21%	87.18%		?			
18 Weeks RTT Open Pathways	63.78%	63.95%		H	Moving Target	+		+
18 Week Performance - Difference Between Planned and Actual	0.00%	0.17%			?	+		
26 Weeks RTT Open Pathways		53.85%		H	No Target	+		
Time to First Appointment - English Patients (18 Weeks)	85.29%	77.35%		H	Moving Target	+		
Time to First Appointment - Welsh Patients (26 Weeks)		64.25%		H	No Target	+		
% of Patients Waiting Over 52 Weeks - English	0.74%	1.72%		L	Moving Target	+		+
Patients Waiting Over 104 Weeks - Welsh (Total)	0	310		H	F	+		

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
6 Week Wait for Diagnostics - English Patients	95.00%	85.66%	95.33%		Moving Target	+		+
8 Week Wait for Diagnostics - Welsh Patients	100.00%	87.52%				+		

Summary - Caring for Finances

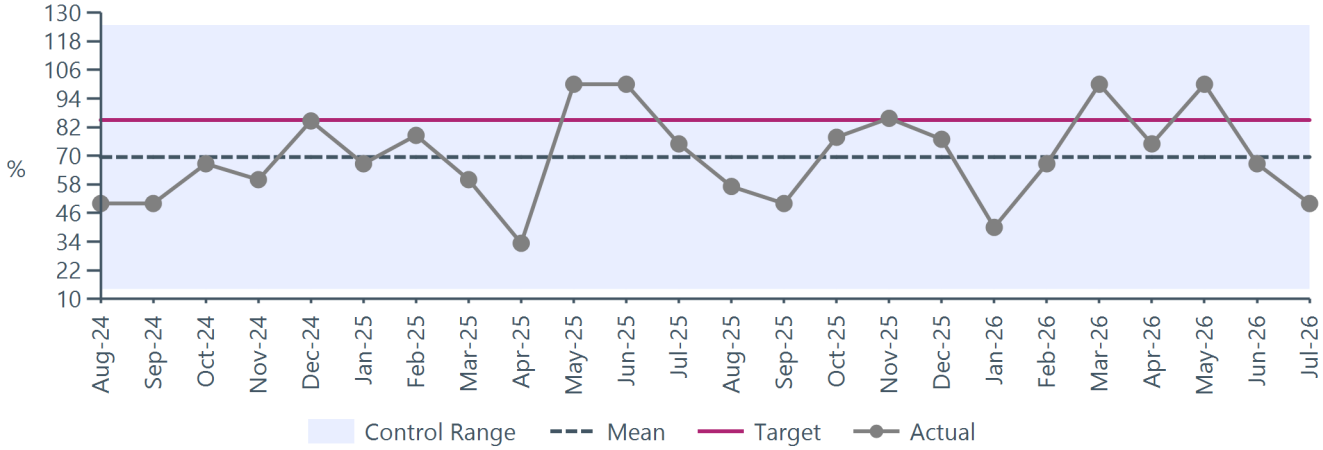
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
Elective Activity Against Plan (volumes)	1,060	1,156		H	Moving Target	+		
% Combined BADS Performance	85.00%	39.47%			F			
Total Outpatient Activity against Plan (volumes)	13,259	13,302			Moving Target	+		
Total Outpatient Activity - % Moved to PIFU Pathway	7.50%	7.92%		H	Moving Target	+		
Total Diagnostics Activity against Plan - Catchment Based	2,612	2,358			Moving Target	+		

62 Day General Standard*

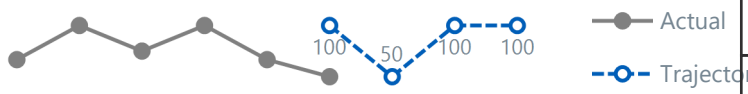
From receipt of an urgent GP referral for urgent suspected cancer, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer. National Target. Trajectory as per Trust's Operational Plans. 217831

Exec Lead
Chief Operating Office

Target/Plan	Latest Value	Variation	Assurance	NOF
85%	50%			



Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

The 62 Day General Standard is reported at 50% in July; this is reported in arrears. There were two patients who breached the standard with reasons outlined below:
* 0.5 breach - patient delays
* 0.5 breach - Service Manager liaising with another provider regarding the allocation of the breach

Actions

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
57.14%	50.00%	77.78%	85.71%	76.92%	40.00%	66.67%	100.00%	75.00%	100.00%	66.67%	50.00%	

18 Weeks RTT Open Pathways

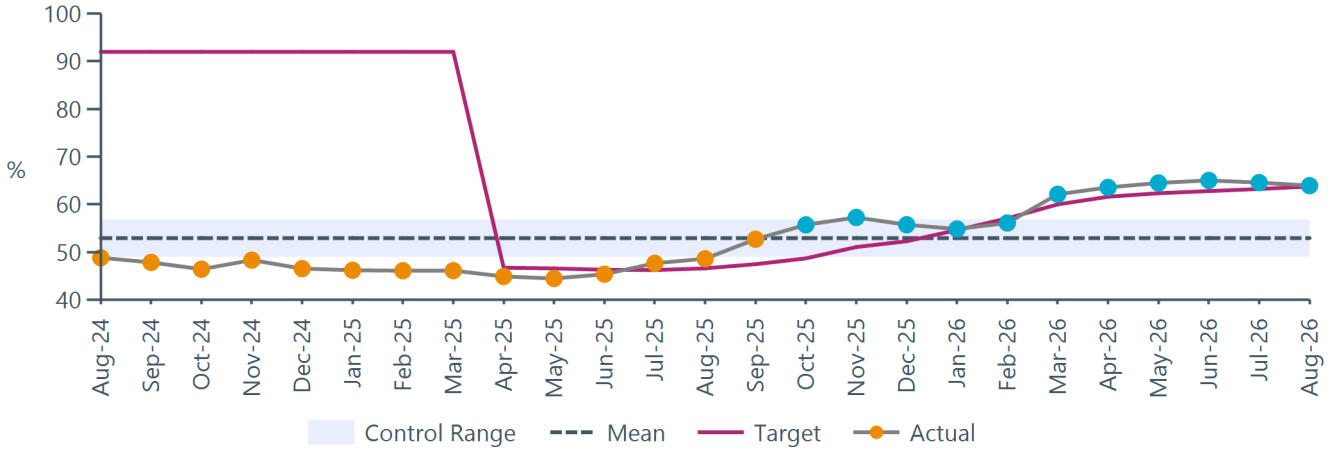
% of English patients on waiting list waiting 18 weeks or less 211021

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
63.78%	63.95%	H	Moving Target	+

Trajectory





What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric has a moving target; in line with the Trust's Operational Plan.

Narrative

The NHS England Medium-Term Planning Framework stipulates that in 2026/27 Trusts should improve the % of patients waiting no longer than 18 weeks for treatment by 7% or reach 65% (whichever is greater). The 2028/29 expectation is to reach 92%. The Trust's Operational Plan forecasts a position of 67% by the end of March 2027.

The August month-end position is 63.95% for patients waiting 18 weeks or less to start their treatment. As shown on the SPC above, this metric remains reported as special cause of an improving nature. The performance breakdown by milestone is as follows:
* MS0 - 157 patients of which 14 are breaches
* MS1 - 7414 patients waiting of which 1708 are breaches
* MS2 - 1157 patients waiting of which 643 are breaches
* MS3 - 4452 patients waiting of which 2387 are breaches

This metric is included in the NOF where the latest position for June scored the Trust at 2.69.

Actions

For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
* Work towards internal ambitions where sub-speciality level targets have been set
* Reducing 1st Outpatient Waits below 18/26 weeks
* Prioritisation of Welsh 104+ and English 52+ waits
* Applying productivity improvements from recent reviews. There is now a comprehensive improvement plan for Theatres and Outpatient productivity.
* Increased capacity coming on board throughout remainder of the year as a result of additional theatre and clinical recruitment
* Delay to commencement of Insourcing Contract that will contribute to full levels of activity - action to establish a proposed start date
* Advanced Physiotherapy clinics began in August within Spinal Disorders

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
48.64%	52.72%	55.74%	57.29%	55.76%	54.86%	56.13%	62.15%	63.58%	64.52%	65.05%	64.59%	63.95%

18 Week Performance - Difference Between Planned and Actual

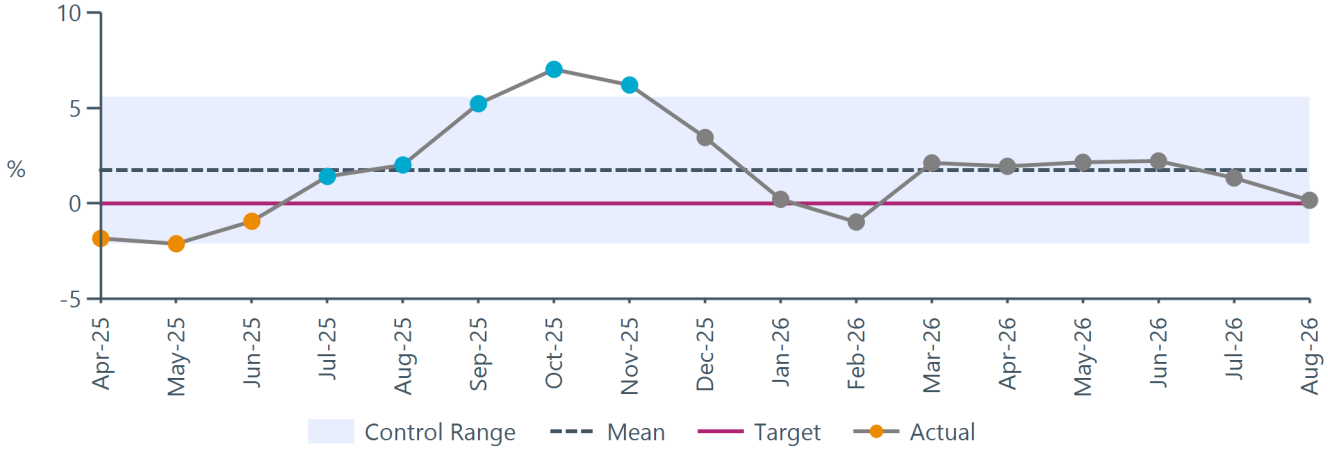
Difference between planned and actual 18 week performance 217889

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
0.00%	0.17%			

Trajectory





What these graphs are telling us

Metric is experiencing common cause variation. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

This metric forms part of the IPR to ensure it encompasses all metrics that form part of the National Oversight Framework (NOF). The latest publication received in September no longer includes this metric as part of the framework therefore it is proposed it is removed from next month.

At the end of August, the position reported for month end is 63.95%; above the plan of 63.78%.

Actions

For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
* Work towards internal ambitions where sub-speciality level targets have been set
* Reducing 1st Outpatient Waits below 18/26 weeks
* Prioritisation of Welsh 104+ and English 52+ waits
* Applying productivity improvements from recent reviews. There is now a comprehensive improvement plan for Theatres and Outpatient productivity.
* Increased capacity coming on board throughout remainder of the year as a result of additional theatre and clinical recruitment
* Delay to commencement of Insourcing Contract that will contribute to full levels of activity - action to establish a proposed start date
* Advanced Physiotherapy clinics began in August within Spinal Disorders

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
2.02%	5.23%	7.03%	6.21%	3.46%	0.22%	-0.97%	2.13%	1.95%	2.16%	2.23%	1.34%	0.17%

26 Weeks RTT Open Pathways

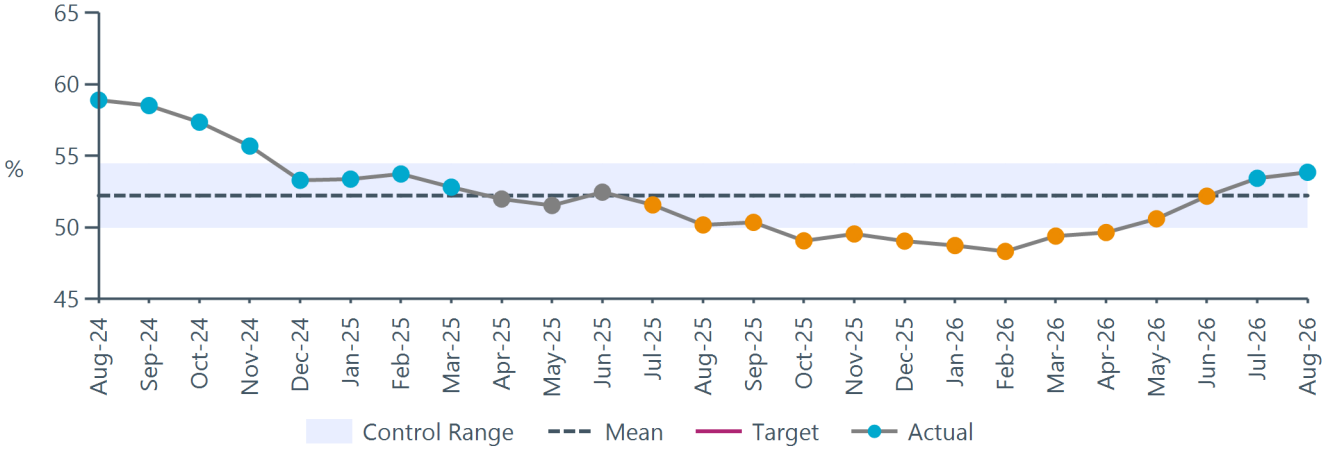
% of Welsh patients on waiting list waiting 26 weeks or less 217917

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
-	53.85%	H	No Target	

Trajectory





What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. There is no target for this measure.

Narrative

The NHS England Medium-Term Planning Framework stipulates that in 2026/27 Trusts should improve the % of patients waiting no longer than 18 weeks for treatment by 7% or reach 65% (whichever is greater). The 2028/29 expectation is to reach 92%. The Trust's Operational Plan forecasts a position of 67% by the end of March 2027.

The August month-end position is 53.85% for Welsh patients waiting 26 weeks or less to start their treatment. As shown on the SPC above, this metric is now reporting special cause variation of an improving nature with the last two months reported above the mean.

The performance breakdown by milestone is as follows:
* MS0 - 19 patients of which 8 are breaches
* MS1 - 6069 patients waiting of which 2192 are breaches
* MS2 - 800 patients waiting of which 460 are breaches
* MS3 - 2569 patients waiting of which 1704 are breaches

Actions

For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
* Work towards internal ambitions where sub-speciality level targets have been set
* Reducing 1st Outpatient Waits below 18/26 weeks
* Prioritisation of Welsh 104+ and English 52+ waits
* Applying productivity improvements from recent reviews. There is now a comprehensive improvement plan for Theatres and Outpatient productivity.
* Increased capacity coming on board throughout remainder of the year as a result of additional theatre and clinical recruitment
* Delay to commencement of Insourcing Contract that will contribute to full levels of activity - action to establish a proposed start date
* Advanced Physiotherapy clinics began in August within Spinal Disorders

Specifically for our Welsh patients:
* Dedicated focus on patients waiting for DEXA following an improved position for English patients
* Increased oversight of Welsh RTT performance through Senior Operational Delivery Group

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
50.17%	50.35%	49.06%	49.54%	49.04%	48.73%	48.32%	49.39%	49.64%	50.60%	52.18%	53.43%	53.85%

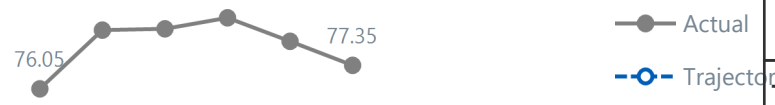
Time to First Appointment - English Patients (18 Weeks)

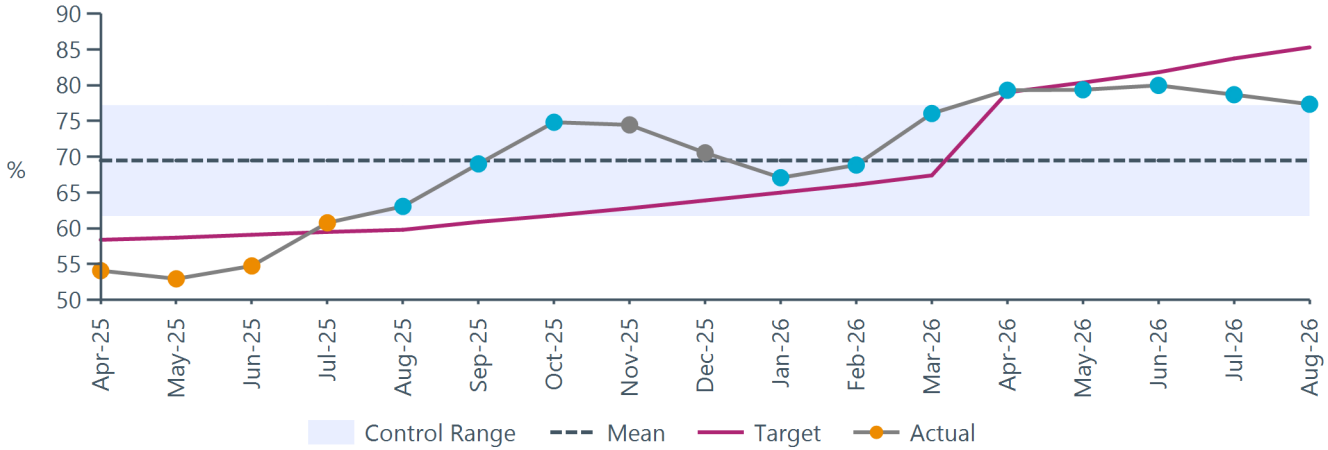
The denominator is the count of incomplete outpatient pathways waiting for a first appointment at the snapshot date. The numerator is the count of incomplete pathways waiting for a first appointment at the snapshot date that have been waiting less than 18 217875

Exec Lead
Chief Operating Office

Target/Plan	Latest Value	Variation	Assurance	NOF
85.29%	77.35%	H	Moving Target	

Trajectory





What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric has a moving target; in line with the Trust's Operational Plan.

Narrative

This metric focuses on the time to first appointment waiting for first event and of those patients, the % waiting less than 18 weeks. The reported position is taken from the Waiting List MDS position for week ending 30th August 2026. NHSE Guidance stipulates the week ending positions we should officially report that fall closest to month end. This is an unvalidated position.

For week ending 30th August 77.35% of patients waiting for first appointment were under 18 weeks; below the 85.29% plan. Performance ranges from 28.57% in Neurology to 100% in Metabolic Medicine.

Actions

For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
* Work towards internal ambitions where sub-speciality level targets have been set
* Reducing 1st Outpatient Waits below 18/26 weeks
* Prioritisation of Welsh 104+ and English 52+ waits
* Applying productivity improvements from recent reviews. There is now a comprehensive improvement plan for Theatres and Outpatient productivity.
* Increased capacity coming on board throughout remainder of the year as a result of additional theatre and clinical recruitment
* Delay to commencement of Insourcing Contract that will contribute to full levels of activity - action to establish a proposed start date
* Advanced Physiotherapy clinics began in August within Spinal Disorders

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
63.07%	69.01%	74.83%	74.46%	70.56%	67.08%	68.85%	76.05%	79.30%	79.37%	79.98%	78.68%	77.35%

Time to First Appointment - Welsh Patients (26 Weeks)

The denominator is the count of incomplete outpatient pathways waiting for a first appointment at the snapshot date. The numerator is the count of incomplete pathways waiting for a first appointment at the snapshot date that have been waiting less than 2 217916

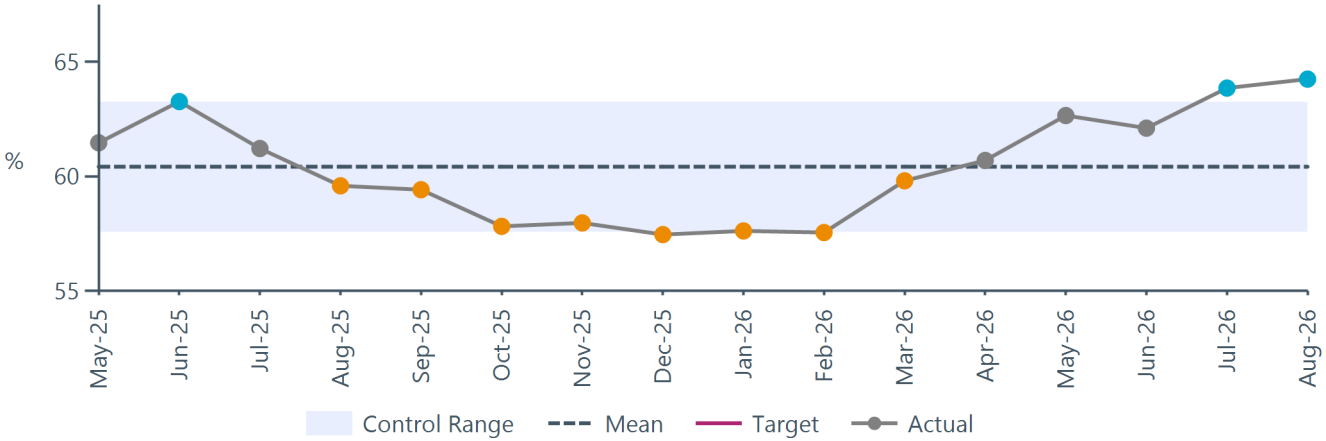
Exec Lead
Chief Operating Office

Target/Plan	Latest Value	Variation	Assurance	NOF
-	64.25%	H	No Target	

Trajectory



Actual
Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature.

Narrative

The NHS Wales Performance Framework for 2026/27 outlines an expectation that no patients should be waiting more than 26 weeks for a new outpatient appointment.

For week ending 30th August 64.25% of patients waiting for first appointment were under 26 weeks. Performance ranges from 14.29% in Neurology to 100% in Elderly Medicine, Muscle, Occupational Therapy and Physiotherapy. As demonstrated on the SPC above, this latest data point remains special cause variation of an improving nature. There has been consistent improvement each month since February.

Actions

For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
* Work towards internal ambitions where sub-speciality level targets have been set
* Reducing 1st Outpatient Waits below 18/26 weeks
* Prioritisation of Welsh 104+ and English 52+ waits
* Applying productivity improvements from recent reviews. There is now a comprehensive improvement plan for Theatres and Outpatient productivity.
* Increased capacity coming on board throughout remainder of the year as a result of additional theatre and clinical recruitment
* Delay to commencement of Insourcing Contract that will contribute to full levels of activity - action to establish a proposed start date
* Advanced Physiotherapy clinics began in August within Spinal Disorders

Specifically for our Welsh patients:
* Dedicated focus on patients waiting for DEXA following an improved position for English patients
* Increased oversight of Welsh RTT performance through Senior Operational Delivery Group

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
59.59%	59.42%	57.82%	57.97%	57.46%	57.62%	57.55%	59.81%	60.70%	62.66%	62.11%	63.86%	64.25%

% of Patients Waiting Over 52 Weeks - English

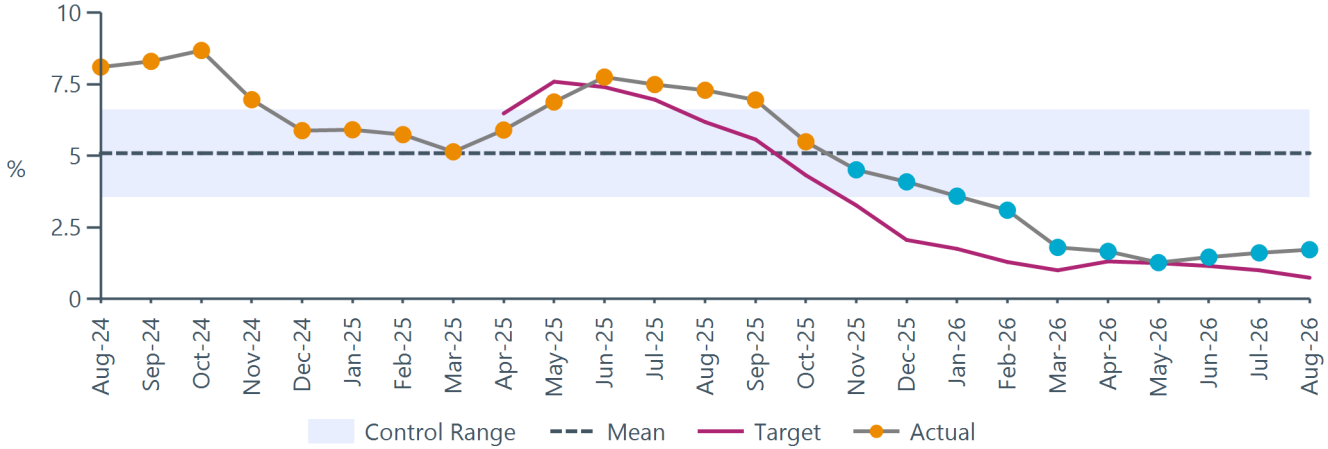
The number of English patients waiting over 52 weeks as a proportion of the English List Size. 217874

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
0.74%	1.72%	L	Moving Target	+

Trajectory





What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric has a moving target; in line with the Trust's Operational Plan.

Narrative

At the end of August, 227 patients were waiting over 52 weeks, this equates to 1.72% of the English list size. As shown on the SPC above, there has been a period of sustained improvement since November-25.

Patients waiting, by weeks brackets is:
* >52 to <=65 weeks - 211 patients
* >65 to <=78 weeks - 9 patients
* >78 weeks - 7 patients
* No patients waiting >104 weeks

This metric is part of the NOF, with the latest score for Quarter 1 reported at 3.26 for the June month end position of 1.46%.

Actions

For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
* Work towards internal ambitions where sub-speciality level targets have been set
* Reducing 1st Outpatient Waits below 18/26 weeks
* Prioritisation of Welsh 104+ and English 52+ waits
* Applying productivity improvements from recent reviews. There is now a comprehensive improvement plan for Theatres and Outpatient productivity.
* Increased capacity coming on board throughout remainder of the year as a result of additional theatre and clinical recruitment
* Delay to commencement of Insourcing Contract that will contribute to full levels of activity - action to establish a proposed start date
* Advanced Physiotherapy clinics began in August within Spinal Disorders
* Targeted work for our longest waiting patients

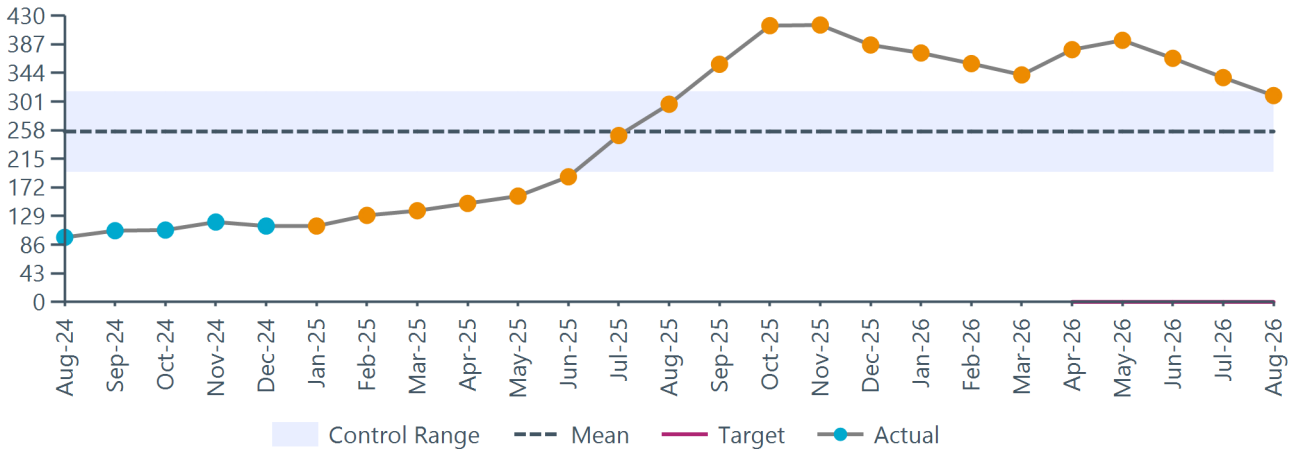
Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
7.29%	6.95%	5.49%	4.51%	4.09%	3.59%	3.10%	1.80%	1.66%	1.27%	1.46%	1.61%	1.72%

Patients Waiting Over 104 Weeks - Welsh (Total)

Number of Welsh RTT patients waiting 104 weeks or more at month end 217803

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
0	310	H	F	



Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. There is no target for this metric.

Narrative

At the end of August there were 310 Welsh patients waiting over 104 weeks. The patients are under the care of these sub-specialities; Spinal Disorders (149), Foot & Ankle (64), Knee & Sports Injuries (44), Hand & Upper Limb (37), Arthroplasty (12), Neurophysiology (1), Paediatric Orthopaedics (1), Rheumatology (1) and Veterans (1).

An internal trajectory is now in place to get to a position of zero Welsh patients waiting over 104 weeks by the end of 2026/27. This aligns with the Welsh framework.

Actions

For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
* Work towards internal ambitions where sub-speciality level targets have been set
* Reducing 1st Outpatient Waits below 18/26 weeks
* Prioritisation of Welsh 104+ and English 52+ waits
* Applying productivity improvements from recent reviews. There is now a comprehensive improvement plan for Theatres and Outpatient productivity.
* Increased capacity coming on board throughout remainder of the year as a result of additional theatre and clinical recruitment
* Delay to commencement of Insourcing Contract that will contribute to full levels of activity - action to establish a proposed start date
* Advanced Physiotherapy clinics began in August within Spinal Disorders

Specifically for our Welsh patients:
* Dedicated focus on patients waiting for DEXA following an improved position for English patients
* Increased oversight of Welsh RTT performance through Senior Operational Delivery Group
* Working closely with Powys Health Board with joint validation of their patients

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
297	357	415	416	386	374	358	341	379	393	366	337	310

6 Week Wait for Diagnostics - English Patients

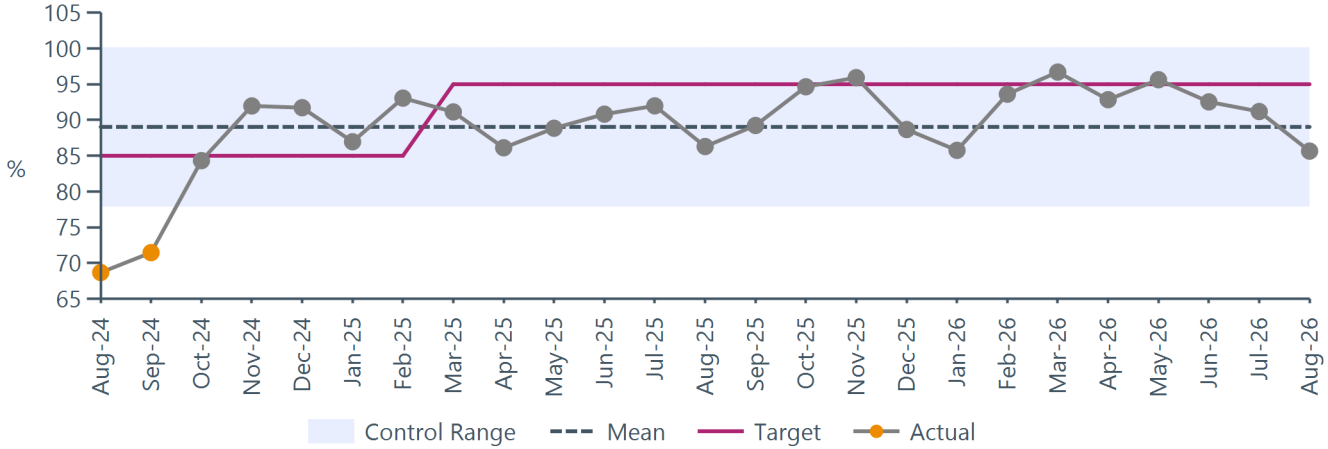
% of English patients currently waiting less than 6 weeks for diagnostics. National Target with Trajectory as per Trust's Operational Plans. 211026

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
95.00%	85.66%		Moving Target	+

Trajectory





What these graphs are telling us

Metric is experiencing common cause variation. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

The NHS England Medium-Term Planning Framework stipulates that in 2026/27 all Trusts should deliver a 3% improvement, or 20% overall performance (whichever is greater). The 2028/29 target is to reach less than 1% waiting beyond 6 weeks.
Performance for August is 85.66% against the 95% target. As demonstrated in SPC chart, performance fell below the mean for the first time since January 2026. The trajectory for August month end was 95.33%; this reflects the Trust's submitted Operational Plans. Reported position relates to 218 patients who waited beyond 6 weeks. Of the 6-week breaches; 8 are over 13 weeks, 7 in MRI and 1 in CT.
Performance and breaches by modality:
* MRI – 79.62% - D2 (Urgent - 0-2 weeks) – 4 dated, D4 (Routine – 6-12 weeks) – 201 with 197 dated
* CT – 88.04% - D2 (Urgent - 0-2 weeks) – 1 undated, D4 (Routine - 6-12 weeks) – 10 with 7 dated
* Ultrasound – 99.51% - D4 (Routine - 6-12 weeks) – 2 dated
* DEXA – 100%

Following the latest publication in September, this metric is now part of the NOF with the latest score for Quarter 1 reported at 1.62 in relation to June month-end.

Actions

Underperformance against both the national standard and the planned trajectory is primarily attributable to MRI waiting times. The planned level of MRI activity was not achieved during August because the mobile MRI scanner was not available on site. The mobile MRI schedule delivered differed from that assumed during the activity planning process. The mobile MRI scanner is scheduled to return in September, which is expected to support improved performance and reduce the number of patients waiting longer than six weeks.

Further actions include:
* Midlands Centre for Spinal Injuries (MCSI) patient transfer breaches — The Trust is investigating discharge lounge space to help avoid long waiting times to support spinal injuries patients for MRI.
* Booking delays — This will be addressed as vacancies are recruited to through the phased pipeline. Interviews imminent.
* The Radiology Service is working with the Information Team to set up routine forecasting information for Imaging Services.
* Mobile MRI scanner scheduled to return in September; this was not available in August.

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
86.30%	89.24%	94.65%	95.93%	88.67%	85.77%	93.61%	96.70%	92.84%	95.64%	92.53%	91.19%	85.66%

8 Week Wait for Diagnostics - Welsh Patients

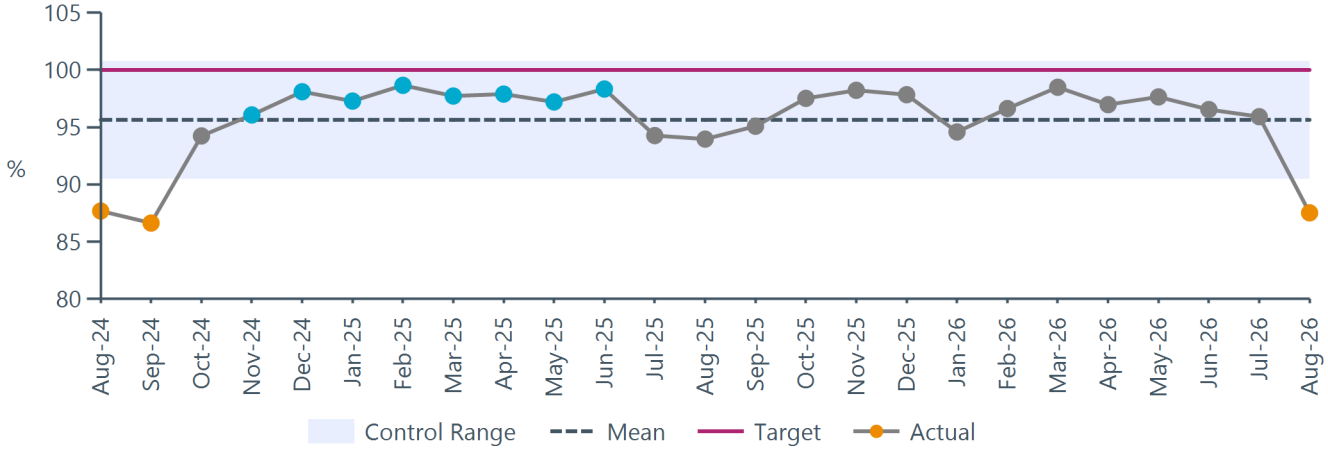
% of Welsh patients currently waiting less than 8 weeks for diagnostics 211027

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
100.00%	87.52%			

Trajectory





What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

The NHS Wales Performance Framework for 2026/27 outlines the expectation that no patients should wait more than 8 weeks for a specified diagnostic.

The 8-week standard for diagnostics is reported at 87.52%. This is the lowest reported position since September 2024 and falls below the long-term average performance. The reporting position includes 81 patients who waited beyond 8 weeks.
Performance and breaches by modality:
* MRI – 85.22% - D2 (Urgent - 0-2 weeks) – 4 with 3 dated, D4 (Routine - 6-12 weeks) – 77 with 75 dated
* CT – 100%
* Ultrasound – 100%
* DEXA Scans - 100%

Actions

Underperformance against both the national standard and the planned trajectory is primarily attributable to MRI waiting times. The planned level of MRI activity was not achieved during August because the mobile MRI scanner was not available on site. The mobile MRI schedule delivered differed from that assumed during the activity planning process. The mobile MRI scanner is scheduled to return in September, which is expected to support improved performance and reduce the number of patients waiting longer than eight weeks.

Further actions include:
* Midlands Centre for Spinal Injuries (MCSI) patient transfer breaches — The Trust is investigating discharge lounge space to help avoid long waiting times to support spinal injuries patients for MRI.
* Booking delays — This will be addressed as vacancies are recruited to through the phased pipeline. Interviews imminent.
* The Radiology Service is working with the Information Team to set up routine forecasting information for Imaging Services.
* Mobile MRI scanner scheduled to return in September; this was not available in August.

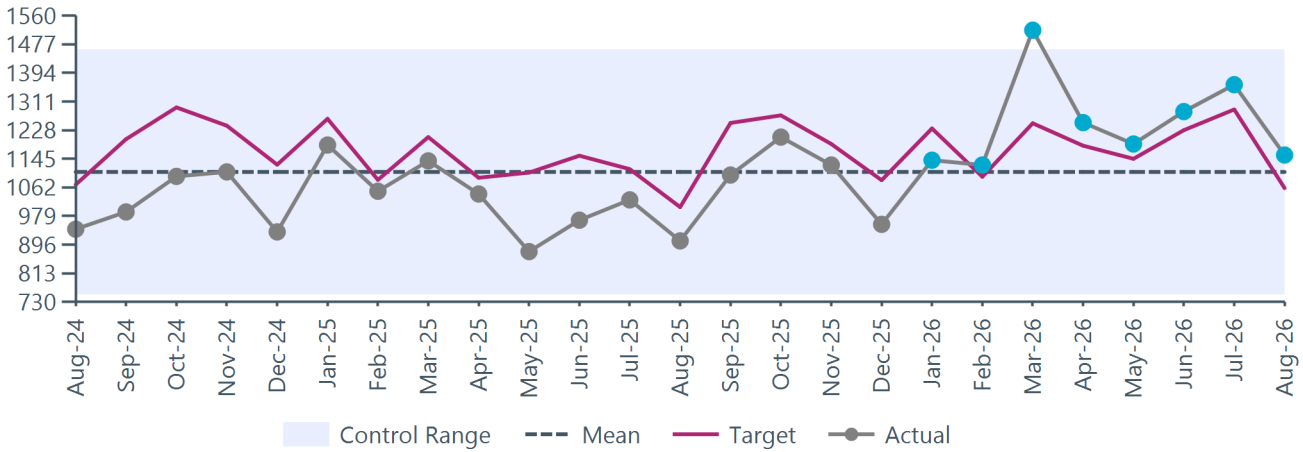
Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
93.96%	95.09%	97.52%	98.22%	97.84%	94.58%	96.63%	98.49%	96.97%	97.64%	96.54%	95.92%	87.52%

Elective Activity Against Plan (volumes)

Total elective activity rated against plan. Target as per Trust's Operational Plans. 217796

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
1,060	1,156	H	Moving Target	



Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric has a moving target; derived from the Trust's Operational Plan.

Narrative

Total elective activity is monitored against the 2026/27 elective spells plan as set out in the Trust's Operational Plan submitted to NHSE.

In August, the Trust planned for 1,060 elective spells and delivered 1156 spells, achieving 109.06% of plan and 96 spells above target.

This includes 40 patients who were treated by other providers on behalf of RJAH.

August's performance remains above target and continues to report special cause variation of an improving nature with eight points above the mean.

Actions

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
907	1098	1208	1127	955	1141	1127	1518	1250	1188	1282	1360	1156

Total Outpatient Activity against Plan (volumes)

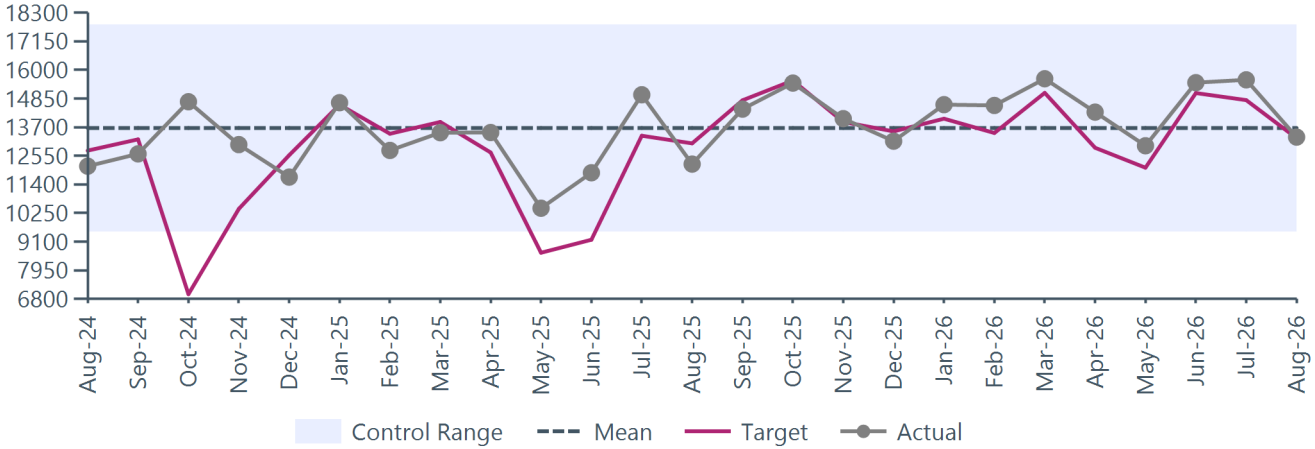
Total outpatient activity (consultant led and non-consultant led) against plan. Target as per Trust's Operational Plans. 217795

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
13,259	13,302		Moving Target	

Trajectory





What these graphs are telling us

Metric is experiencing common cause variation. Metric has a moving target; in line with the Trust's Operational Plan.

Narrative

The Outpatient Activity plan was met in August with +43 attendances over plan and the position reported at 100.32%. It must also be noted, at the point of IPR production and when this data was extracted on 5th working day, there still remained outcomes to be processed on Careflow so this position will continue to increase as they are transacted.

A breakdown of Outpatient activity below:
* IJP activity was +127 at 100.99%, * OJP activity was -65 at 77.74%, * Insourcing activity was -32 at 77.93% * 13 appointments were delivered via Outsourcing that had no plan
* New activity 99.26%, * Follow Up activity 100.77%

Monitoring of delivered activity against plan remains under focus at weekly activity meeting with close scrutiny of the various elements that form the overall plan, i.e. IJP/OJP/Insourcing and First/Follow-Up.

Actions

Some areas fell behind plan in August with reasons outlined below:
* Knee & Sports - Consultant leave was higher than anticipated
* Metabolic Medicine / DEXA - Service Manager and Finance reviewing the recording of FLS activity
* Paediatric Orthopaedics - No insourcing activity throughout August and plan included additional consultant that has not started until early September.
* Spinal Disorders - 3 new AHP roles were part of planning assumptions from April; positions now recruited to with clinics beginning in September.
* Spinal Injuries - Two short notice periods of leave in August that were not anticipated.
* Physiotherapy - Activity lost due to pool maintenance that was unplanned and further activity lost due to heat.

* Delay to commencement of Insourcing Contract that will contribute to full levels of activity - action to establish a proposed start date

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
12218	14427	15472	14044	13140	14605	14574	15646	14306	12954	15489	15603	13302

Total Outpatient Activity - % Moved to PIFU Pathway

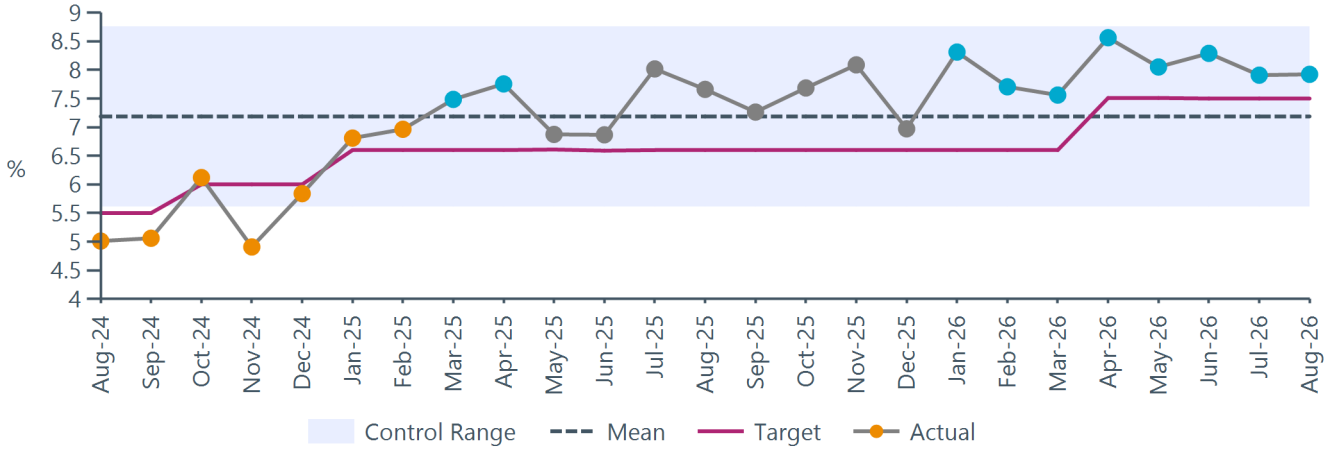
Total Outpatient Activity - % Moved to Patient Initiated Follow Up Pathway against plan. Target as per Trust's Operational Plans. 217715

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
7.50%	7.92%	H	Moving Target	

Trajectory





What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. This measure has a moving target.

Narrative

The target for the number of episodes moved to a PIFU Pathway is 7.50% of all outpatients attendances. In August this was exceeded with 7.92% of total outpatient activity moved to a PIFU pathway. As demonstrated on the SPC above, this has now been reported as sustained improvement since January-25.

Since the implementation of our new EPR system on 12th May 2025, we have seen an expected increase in the number of patients discharged to PIFU and an expected decrease in the number of patients moved to PIFU.

Patients reported as moved to PIFU in our submissions May 2025 and previous were due to the limitations of our old PAS system. Our submission now captures all patients who are put on PIFU through their outcome of their last appointment.

Actions

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
7.66%	7.26%	7.68%	8.09%	6.97%	8.31%	7.71%	7.56%	8.56%	8.05%	8.29%	7.91%	7.92%

Total Diagnostics Activity against Plan - Catchment Based

Total Diagnostic Activity against Plan - (MRI, U/S and CT activity) against plan. Target as per Trust's Operational Plans. 217794

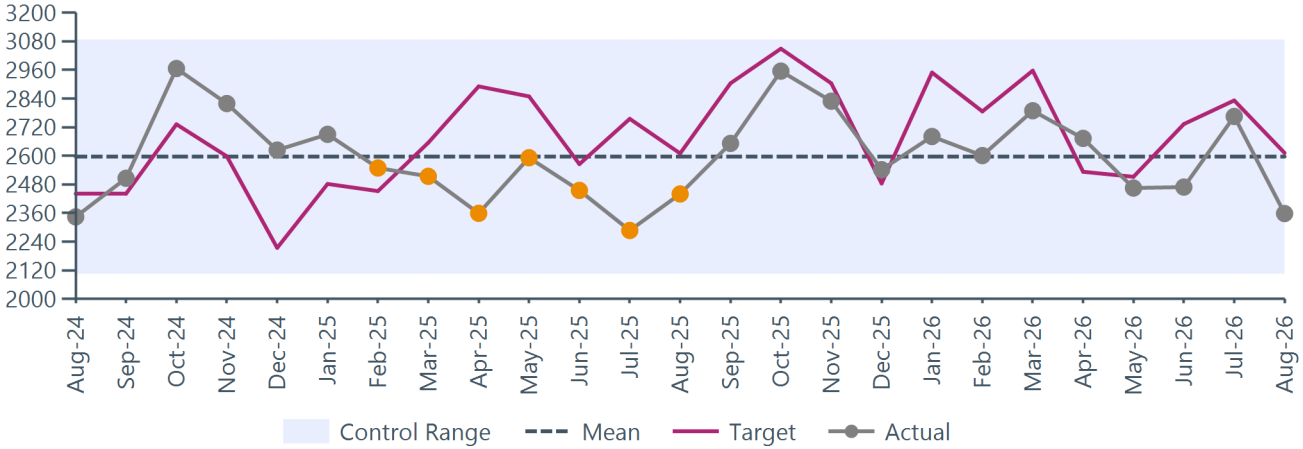
Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
2,612	2,358		Moving Target	

Trajectory



Actual
Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. Metric has a moving target; in line with the Trust's Operational Plan.

Narrative

The Diagnostic activity plan was not met in August. Overall activity is reported at 90.28% with a breakdown as follows:
- MRI - 1181 against plan of 1408; equating to 83.88%
- U/S – 762 against 860; equating to 88.60%
- CT – 415 against plan of 344; equating to 120.64%

The planned level of MRI activity was not achieved during August as the mobile MRI scanner was not available on site. The mobile MRI schedule delivered differed from that assumed during the activity planning process. Ultrasound activity also fell below plan, largely as a result of increased levels of annual leave, which reduced available capacity during the month.

Actions

Mobile MRI scanner scheduled to return in September.

Ultrasound capacity expected to return to normal in September and forecast to meet plan.

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
2440	2652	2955	2829	2542	2681	2601	2789	2673	2465	2469	2765	2358


NHS
The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust
Financial Performance
August 2026, Month 5
Improving lives through excellent and innovative care
NHS

Key Messages

Statement of Comprehensive Income

Financial Position: £0.9m deficit in month

For August 2026, the Trust is reporting:

- A £0.95m deficit in-month compared to a planned £1.03m deficit; **£0.08m favourable to plan**
- A £2.34m deficit year-to date against a planned deficit of £2.34m**; £0.04m adverse to plan**

Key Drivers of the Financial Variance

Income for the month is £13.5m; an adverse variance to plan of (£0.6m) driven by clinical activity being below planned levels:

- Elective Theatre activity is 101% in-month and 93% year to date (excluding insourcing & MCSI)
- Private Patients activity is 71% of plan in month and 80% year to date
- Insourcing theatre activity is 7% of plan in month and 45% year to date

Non-Clinical & Other income in-month is £0.6m, this is broadly in line with plan.

The (£0.6m) income variance in-month is off-set by favourable expenditure movement in Pay £0.4m and Non-Pay £0.2m (including drugs, prosthesis, consumables)

Efficiency delivery in-month actual is £0.1m adverse to plan, £0.2m adverse to plan year-to-date.

Year to Date

The Trust is (£0.04m) adverse to plan bottom line; driven by (£3.6m) under delivery in Income which is offset in expenditure management.

£3.6m variance in Income: driven by NHS clinical income variance of (£2.1m) and a further (£1.5m) variance in Private Patient income. Both driven by reduced Theatre activity underperformance, and movement in mix of patient activity (reducing the rate).
Corporate departments are reporting year-to date £0.5m favourable to plan including £0.2m linked to Pay underspends and Efficiency achievement on plan.

Statement of Financial Position

Cash and Working Capital Position

The cash balance at 31st August was £17.5m, a reduction of £1.3m since the end of March 2026. This equates to approximately 39 days (38 days Month 4) of operational cash.

The Better Payment Practice Code (BPPC) performance in August was 99% (volume) and 98% (value) against a target of 95% across both metrics

Capital

- Capital expenditure YTD to August totalled £3.0m against an indicative YTD plan of £5.8m.
- Capital forecast for the year is £7.8m which includes an unallocated central provision of £1.3m

Other Key Information

Efficiencies - Value Improvement Programme

- 2026/27 £8.4m Trust Target, £3.2m Actual delivered YTD versus plan of £3.4m
- £0.26m delivered non-recurrently, and £0.6m unidentified schemes

Variable Pay

Trust wide variable pay total £0.5m in month, approximately 5.5% of total employee pay spend.

- Agency expenditure of £0.05m is favourable to plan and systems level target of £0.09m
- Bank expenditure of £0.47m is adverse to plan and systems level target £0.46m. Workforce have initiated plans to focus on high usage areas with divisions to understand the usage, reason and enact supportive actions plans.
- The reported bank expenditure includes £0.17m of non recurrent benefits in-month.

Trust Income and Expenditure Performance Statement

Statement of Comprehensive Income (SOCI)

£'m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
Income									
NHS Commissioned	£168.1	£12.5	£12.3	(£0.3)	£66.5	£64.3	(£2.1)	(3.2%)	
Other NHS Clinical	£0.0	£0.0	£0.0	(£0.0)	£0.1	£0.1	(£0.0)	(4.9%)	
Private Patient	£12.3	£1.0	£0.6	(£0.3)	£5.2	£3.7	(£1.5)	(29.0%)	
Research & Development	£0.8	£0.1	£0.1	(£0.0)	£0.3	£0.3	(£0.1)	(19.1%)	
Other Income	£6.8	£0.5	£0.5	(£0.0)	£2.8	£2.9	£0.2	5.5%	
TOTAL INCOME	**£188.0**	**£14.1**	**£13.5**	**(£0.6)**	**£74.9**	**£71.3**	**(£3.6)**	**(4.8%)**	
Operating Expenses									
Pay	**(£116.6)**	**(£9.6)**	**(£9.3)**	**£0.4**	**(£48.4)**	**(£46.3)**	**£2.1**	**4.3%**	
Substantive	*(£109.4)*	*(£9.1)*	*(£8.7)*	*£0.4*	*(£45.2)*	*(£43.1)*	*£2.1*	*4.7%*	
Bank	*(£6.1)*	*(£0.5)*	*(£0.5)*	*(£0.0)*	*(£2.7)*	*(£3.0)*	*(£0.2)*	*(8.5%)*	
Agency	*(£1.0)*	*(£0.1)*	*(£0.0)*	*£0.0*	*(£0.4)*	*(£0.3)*	*£0.2*	*35.0%*	
Non-Pay									
Clinical Supplies and Services	(£38.2)	(£2.9)	(£2.6)	£0.3	(£15.1)	(£13.5)	£1.6	10.4%	
Drugs	(£10.4)	(£0.9)	(£0.9)	(£0.1)	(£4.3)	(£4.2)	£0.1	1.7%	
Other Non-Pay	(£20.7)	(£1.6)	(£1.6)	£0.0	(£8.6)	(£8.8)	(£0.2)	(2.8%)	
TOTAL OPEX	**(£185.8)**	**(£15.0)**	**(£14.3)**	**£0.6**	**(£76.3)**	**(£72.8)**	**£3.5**	**(4.6%)**	
EBITDA	**£2.2**	**(£0.8)**	**(£0.8)**	**£0.0**	**(£1.4)**	**(£1.5)**	**(£0.1)**	**6.6%**	
Finance Costs	(£2.2)	(£0.2)	(£0.1)	£0.0	(£0.9)	(£0.9)	£0.1	6.0%	
Capital Donations	£3.4	£0.3	£0.2	(£0.1)	£1.9	£1.1	(£0.8)	40.7%	
Operational Surplus	**£3.4**	**(£0.7)**	**(£0.8)**	**(£0.0)**	**(£0.4)**	**(£1.3)**	**(£0.8)**	**181.8%**	
Remove Capital Donations	(£3.4)	(£0.3)	(£0.2)	£0.1	(£1.9)	(£1.1)	£0.8		
Control Total Surplus / (Deficit)	**£0.0**	**(£1.0)**	**(£0.9)**	**£0.1**	**(£2.3)**	**(£2.4)**	**(£0.04)**	**(1.7%)**	

RAG Ratings: Red > 3% Adverse Variance, Amber < 3% Adverse Variance, Green Favourable Variance, Grey Not Applicable

Month 5, August Overall Finance Position;
The Trust is reporting £0.1m favourable variance to plan; (£40k) adverse YTD

Income:
£13.5m actual reported which is (£0.6m) / 4.1% adverse to plan in month; (£3.5m) adverse YTD

- Clinical NHS Income £0.2m adverse driven by Theatre activity
- Private patient Income £0.3m adverse driven by Theatre volume

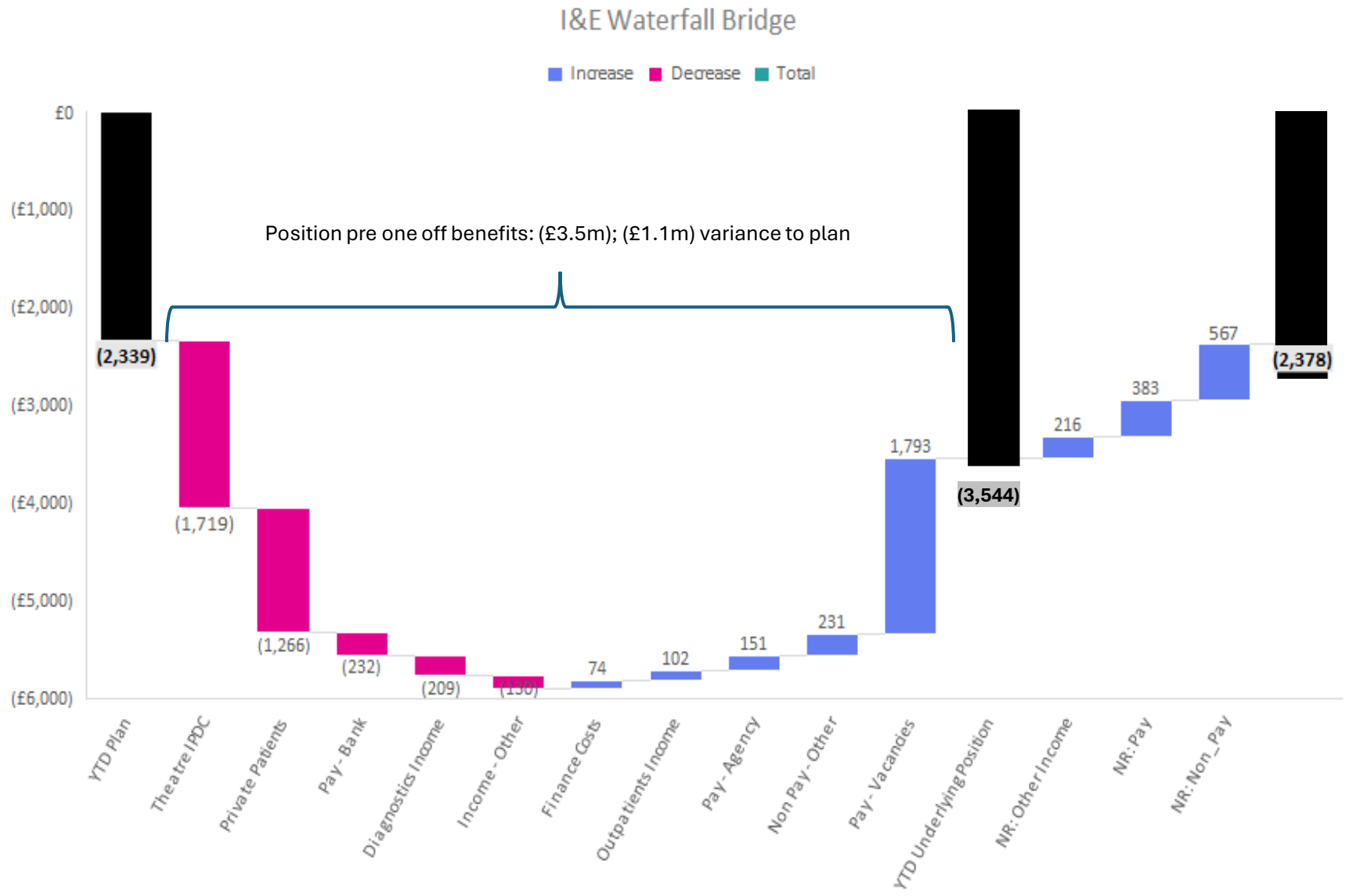
Employee Expenses:
£9.6m actual reported which is £0.4m / 4.2% favourable to plan in month; £2.1m favourable YTD

- Substantive pay costs £8.8m, £0.3m favourable to plan
- Bank pay costs £0.47m, £0.01m adverse to plan
- Agency costs £0.05m, £0.04m favourable to plan.

Non-Pay Expenditure : £0.3m favourable to plan in month / £1.4m / 5% favourable YTD

- Position support by flex in costs associated, and no-recurrent benefits £0.6m.

Bridge from Planned Control Total to Actual YTD



YTD Position : £2.4m deficit / £0.04m adverse to plan

The position before Non-Recurrent benefits would bring the YTD position to £3.5m deficit which is a £1.1m / 45% variance to plan

Key bridging items:

Pressures:

- Theatre activity (£1.7m)
- Private Patients (£1.3m)
- Pay bank costs (£0.2m)

Offsetting Mitigations:

- Pay Vacancies £1.8m
- Pay Agency reducing run rate £0.2m
- Non recurrent benefits and balance sheet movements totalling £1.2m

Capital and Cash

Capital Summary

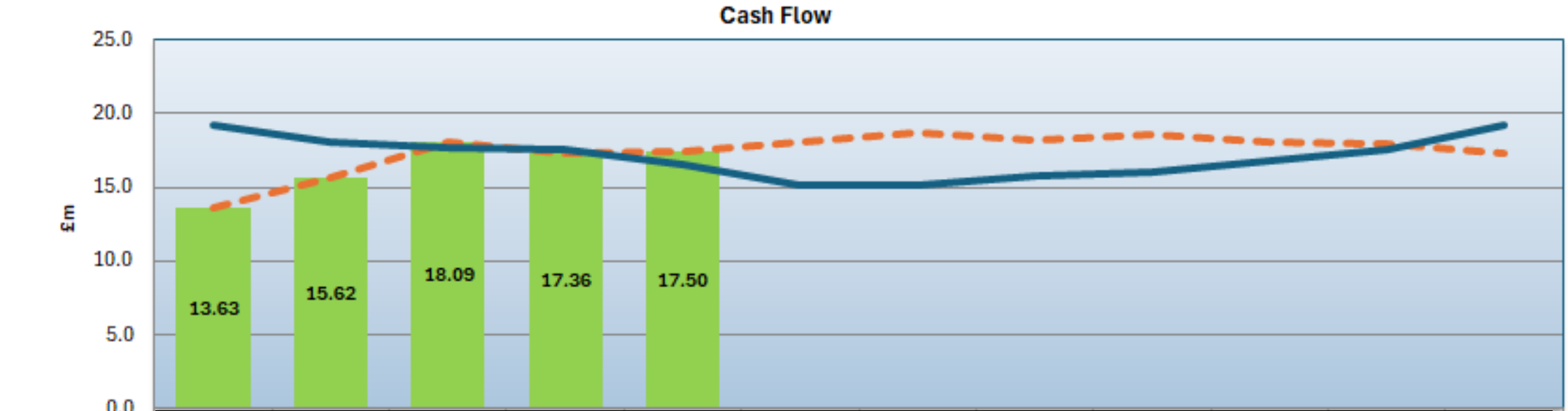
Capital Programme Position as at 2627-05								
Project	**Annual Plan £000s**	**Month Plan £000s**	**Month Actual £000s**	**Month Variance £000s**	**YTD Plan £000s**	**YTD Actual £000s**	**YTD Variance £000s**	**Forecast Outturn £000s**
Backlog maintenance	300	15	2	13	105	28	77	400
Digital investment & replacement	400	0	15	(15)	200	36	164	400
Capital project management	180	15	16	(1)	75	81	(6)	192
Equipment replacement	900	110	1	109	280	148	132	950
Diagnostic equipment replacement	500	0	116	(116)	330	116	214	300
Compliance (IPC/health & safety/quality)	200	20	1	19	60	12	48	200
Estates reconfiguration	150	0	4	(4)	60	31	30	150
Developments subject to business cases	1,180	100	156	(56)	200	156	44	1,430
Theatre replacement strategy	2,950	400	641	(241)	2,000	1,222	778	2,087
Energy/decarbonisation plan (internal)	100	0	0	0	40	0	40	100
Apollo EPR improvement programme	0	0	0	0	0	87	(87)	320
Charitable donations to support capital	150	8	0	8	94	41	53	150
Rheumatology hub (charitable elements)	800	80	(21)	101	800	380	420	655
Energy/decarbonisation plan (grant)	2,400	200	205	(5)	1,000	703	297	2,415
Critical infrastructure funding (CIR)	1,304	120	7	113	480	16	464	1,304
Menzies lease	833	0	0	0	0	0	0	1,164
Leased vehicles & equipment	117	0	0	0	50	0	50	117
Total Capital Funding	**12,464**	**1,068**	**1,144**	**(76)**	**5,774**	**3,058**	**2,716**	**12,334**
Less donated / grant capital	(3,350)	(288)	(184)	(104)	(1,894)	(1,124)	(770)	(3,220)
NHS Capital Funding - Charge to CDEL	**9,114**	**780**	**961**	**(181)**	**3,880**	**1,934**	**1,946**	**9,114**
Less PDC funded schemes	(1,304)	(120)	(7)	(113)	(480)	(16)	(464)	(1,304)
Charge to Operational Capital	**7,810**	**660**	**954**	**(294)**	**3,400**	**1,918**	**1,482**	**7,810**

Capital spend this month increased as both the Rheumatology Hub and Theatre 12 schemes near completion, but overall year to date capital spend remains behind plan by £2.7m.

This is due to amended profiling of capital schemes. The forecast is for breakeven on our operational capital and PDC funded schemes by year end, with an underspend on donated capital due to expenditure on the Rheumatology Hub brought forward into 25/26 financial year.

Forecasts for each scheme have been reviewed and bids continue to be received, prioritised and approved for uncommitted capital.

Cash Forecast



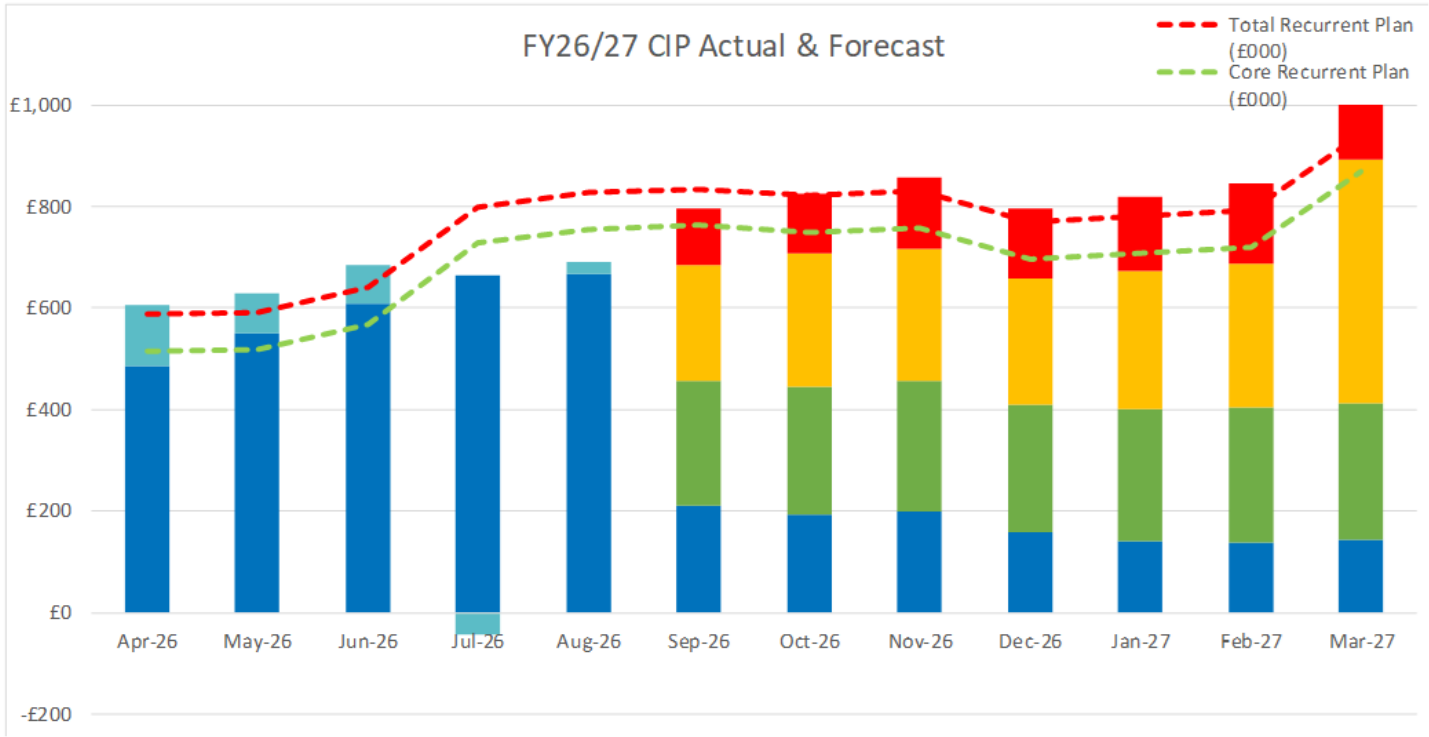
	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Actual	19.22	18.11	17.73	17.56	16.52	15.09	15.14	15.78	16.00	16.80	17.59	19.21
Forecast	13.63	15.62	18.09	17.36	17.50							
Plan	13.63	15.62	18.09	17.36	17.50	18.13	18.71	18.18	18.55	18.04	17.94	17.30

Cash levels remain steady at £17.5m, exceeding plan by £1m in August due to continued lower capital expenditure over the first 5 months of the year.

The capital spend for the year has been re-profiled. A year end cash balance of £17.3m is expected as reported in previous months.

Efficiency

Efficiency Plan Delivery and Risk-Rated Forecast



	Delivered					Forecast							
	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	FY26-27
Core Recurrent Plan (£000)	**£516**	**£518**	**£569**	**£728**	**£755**	**£763**	**£750**	**£759**	**£696**	**£707**	**£719**	**£870**	**£8,350**
Stretch Target (£000)	**£72**	**£72**	**£72**	**£72**	**£72**	**£72**	**£72**	**£73**	**£73**	**£73**	**£73**	**£73**	**£869**
Total Recurrent Plan (£000)	**£588**	**£590**	**£641**	**£800**	**£827**	**£835**	**£822**	**£832**	**£769**	**£780**	**£792**	**£943**	**£9,219**
Forecast													
Red	£0	£0	£0	£0	£37	£113	£118	£138	£137	£146	£157	£156	**£1,002**
Amber	£117	£162	£153	£154	£146	£227	£264	£260	£250	£272	£284	£478	**£2,768**
Green	£294	£264	£327	£261	£303	£247	£250	£260	£251	£259	£265	£270	**£3,251**
Delivered - recurrent	£76	£122	£127	£249	£182	£210	£194	£198	£158	£142	£138	£143	**£1,939**
Delivered - non-recurrent	£120	£81	£77	-£43	£23	£0	£0	£0	£0	£0	£0	£0	**£259**
TOTAL	**£607**	**£630**	**£685**	**£621**	**£691**	**£797**	**£826**	**£856**	**£796**	**£819**	**£844**	**£1,047**	**£9,219**

- Of the forecast delivery for the remainder of the year, £0.96m is Red rated (16% of total) and £2.04m is Amber rated (34%). This includes £0.8m associated with a post planning stretch target adjustment, based on receipt of supportive ICB funding support delivery.
- Of the delivery of green schemes – based on the year to date these have contributed more than plan. These schemes will be reviewed before Month 6 to assess for future mitigation in the forecast.
- Delivered schemes includes FYE of 2025/26 schemes, identified reserves released, plus non-recurrent delivery in 2026/27.
- Focus remains on delivery assurance for high-risk schemes through PFIG and identification of new schemes to meet the stretch target and recurrent shortfalls for the year to date.

	M01-M05			M06-M12	
RAG	**Plan**	**Actual**	**Risk**	**Forecast**	**Risk**
Red	£695	£37	95%	£965	£914
Amber	£1,101	£733	33%	£2,035	£680
Green	£645	£1,449	0%	£1,802	£0
Delivered	£1,005	£1,015	0%	£1,183	£0
	£3,446	£3,234		£5,985	£1,594

Appendix: Finance Dashboard

Financial Performance Dashboard

TOP LINE FINANCIAL

	Month var to Plan £'m	Month var to Plan %	RAG	YTD var to Plan £'m	YTD var to Plan %	RAG
INCOME	(£0.57)	(4.1%)		(£3.57)	(4.8%)	
EXPENDITURE	£0.64	(4.2%)		£3.53	(4.6%)	
NET OPERATING POSITION	£0.06	(6.3%)		(£0.04)	(1.7%)	

RAG Ratings: Red > 3% Adverse Variance, Amber < 3% Adverse Variance, Green Favourable Variance, Grey Not Applicable

FINANCIAL PERFORMANCE

Financial Performance £'m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
Clinical & Pvt Income	£180.4	£13.5	£12.9	(£0.6)	£71.7	£68.0	(£3.7)	(5.1%)	
Other Income	£7.7	£0.6	£0.6	(£0.0)	£3.2	£3.3	£0.1	2.6%	
Pay	(£116.6)	(£9.6)	(£9.3)	£0.4	(£48.4)	(£46.3)	£2.1	4.3%	
Non-Pay	(£69.2)	(£5.4)	(£5.1)	£0.3	(£27.9)	(£26.5)	£1.4	5.0%	
Financing & Adjustments	(£2.2)	(£0.1)	(£0.1)	(£0.0)	(£0.9)	(£0.9)	£0.1	6.0%	
CONTROL TOTAL	**£0.0**	**(£1.0)**	**(£0.9)**	**£0.1**	**(£2.3)**	**(£2.4)**	**(£0.0)**		

PAY AND WORKFORCE

Pay & Workforce £'m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
Substantive	(£109.4)	(£9.1)	(£8.7)	£0.3	(£45.2)	(£43.1)	£2.1	4.7%	
Bank	(£6.1)	(£0.5)	(£0.5)	(£0.0)	(£2.7)	(£3.0)	(£0.2)	(8.5%)	
Agency	(£1.0)	(£0.1)	(£0.0)	£0.0	(£0.4)	(£0.3)	£0.2	35.0%	
Other	(£0.0)	£0.0	£0.0	£0.0	(£0.0)	£0.0	£0.1	360.0%	
TOTAL PAY	**(£116.6)**	**(£9.6)**	**(£9.3)**	**£0.4**	**(£48.4)**	**(£46.3)**	**£2.1**	**4.3%**	
WTE	1,752	1,727	1,747	20.2					
Total Pay % Income	(64.6%)	(71.4%)	(71.7%)	(0.3%)					
Pay Cost / WTE (£'k)	(£5.5)	(£5.6)	(£5.3)	£0.3					

TOP LINE ACTIVITY

	Month var to Plan activity	Month var to Plan %	RAG	YTD var to Plan activity	YTD var to Plan %	RAG
THEATRES IPDC	(37)	(4.7%)		(383)	(8.7%)	
NEW OUTPATIENTS	(320)	(7.8%)		(669)	(3.2%)	
DIAGNOSTICS	(149)	(6.1%)		(2,112)	(19.3%)	

INCOME BREAKDOWN RELATED TO ACTIVITY

Financial Performance £'m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
NHS Commissioned Income	£168.0	£66.5	£64.3	(£2.1)	(3.2%)	
Other NHS Clinical Income	£0.0	£0.1	£0.1	(£0.0)	(4.9%)	
Private Patient Income	£12.3	£5.2	£3.7	(£1.5)	(29.0%)	
Research & Development	£0.8	£0.3	£0.3	(£0.1)	(19.1%)	
Other Income	£6.9	£2.8	£2.9	£0.1	3.0%	
INCOME	**£188.0**	**£74.9**	**£71.3**	**(£3.6)**	**(4.9%)**	

CASH, CAPITAL AND OTHER KPI'S

Capital Programme £'m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	Forecast Plan	Forecast Actual	Forecast Variance
Trust Funded	£7.8	£3.4	£1.9	(£1.5)	£7.8	£7.8	£0.0
Donated/Externally Funded	£4.7	£2.4	£1.1	(£1.3)	£4.7	£4.5	-£0.2
TOTAL	**£12.5**	**£5.8**	**£3.0**	**(£2.8)**	**£12.5**	**£12.3**	**(£0.2)**

Key Metrics	Plan	Actual	RAG
Cash	£19.0	£17.0	
Debtor Days	45	20	
Creditor Days	45	55	
PP Debtor Days			

Better Payment Practice (YTD)	Previous Month	Current Month		
BPPC - NHS (YTD) by number	99.1%	98.60%	(0.5%)	
BPPC - NHS (YTD) by value	99.6%	99.60%	0.0%	
BPPC - Non-NHS (YTD) by number	98.2%	98.00%	(0.2%)	
BPPC - Non-NHS (YTD) by value	97.7%	97.70%	0.0%	

Trust Board - Finance
August 2026 – Month 5

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust



Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

SPC charts are line graphs that employ statistical methods to aid in monitoring and controlling processes. An area is calculated based on the difference between points, called the control range. 99% of points are expected to fall within this area, and in doing so are classed as 'normal variation'. There are a number of rules that apply to SPC charts designed to highlight points that class as 'special cause variation' - abnormal trends or outliers that may require attention.

There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

The rules that are currently being highlighted as 'special cause' are:

- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of the control range (with the mean considered the centre)

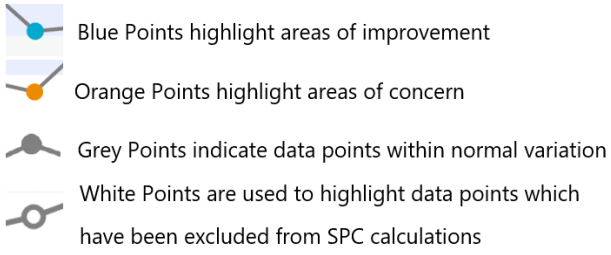
Different colours have been used to separate these trends of special cause variation:

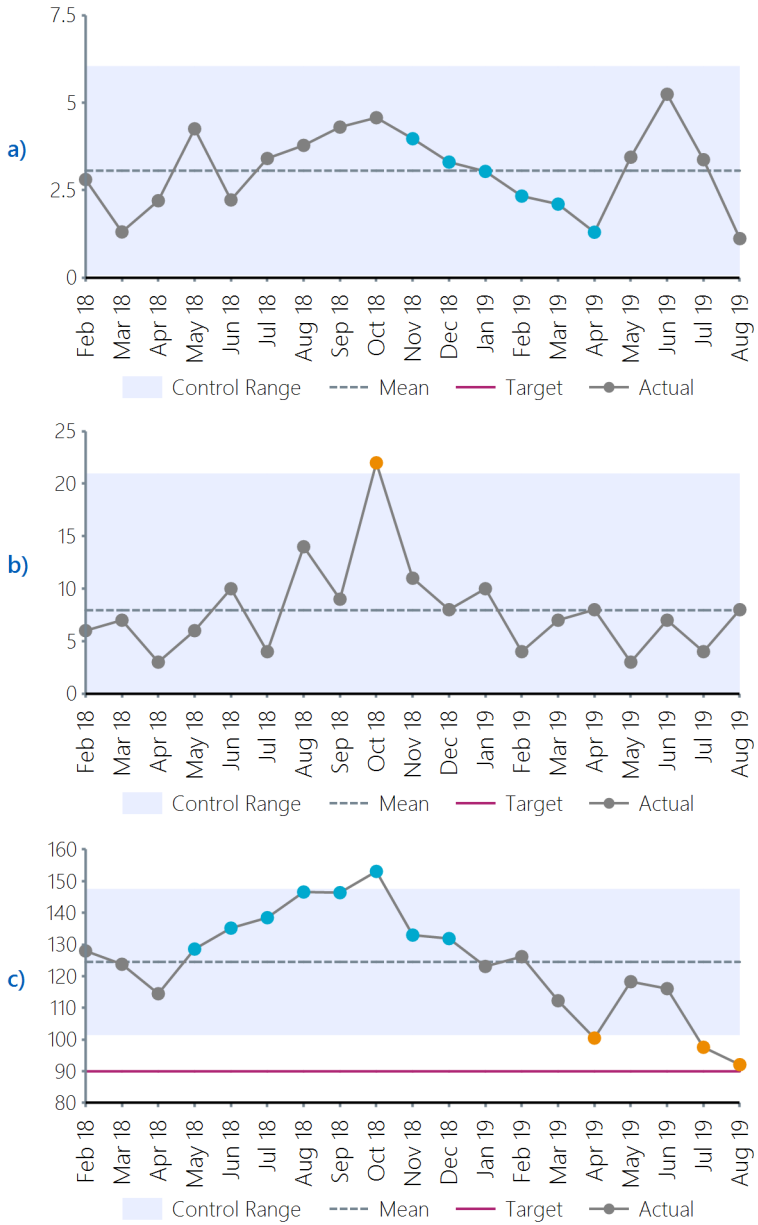
Some examples of these are shown in the images to the right:

a) shows a run of improvement with 6 consecutive descending months.

b) shows a point of concern sitting above the control range.

c) shows a positive run of points consistently above the mean, with a few outlying points that are outside the control limits. Although this has highlighted them in red, they remain above the target and so should be treated as a warning.





Summary Icons Reading Guide

With the redesign of the IPR you will now see 2 summary icons against each KPI, which have been designed by NHSI to give an overview of how each measure is performing at a glance. The first icon is used to show whether the latest month is of concerning or improving nature by using SPC rules, and the second icon shows whether or not we can reliably hit the target.

Exception Reporting

Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually set as an execption if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

For KPIs that are not applicable to SPC; to identify exceptions we look at performance against target over the last 3 months - automatically assigning measures as an exception if the last 3 months have been falling short of the target in line with how we're calculating the assurance icon for non-SPC measures.

Variation Icons

Are we showing improvement, a cause for concern, or staying within expected variation?



Orange variation icons indicate special cause of **concerning nature** or high pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.



Blue variation icons indicate special cause of improving nature or lower pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.



A grey graph icon tells us the variation is common cause, and there has been no significant change.

For measures that are not appropriate to monitor using SPC you will see the "N/A to SPC" icon instead.

The special cause mentioned above is directly linked to the rules of SPC; for variation icons this is if the latest point is outside of the control range, or part of a run of consecutively improving or declining points.

Assurance Icons

Can we expect to reliably hit the target?



An orange assurance icon indicates consistently (F)alling short of the target.



A blue assurance icon indicates consistently (P)assing the target.



A grey assurance icon indicates inconsistently passing and falling short of the target.



For measures without a target you will instead see the "No Target" icon.



Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months in comparison to the target, showing F or P icons if consistently passing of falling short.

Data Quality Rating Reading Guide

The Data Quality (DQ) rating for each KPI is included within the 'heatmap' section of this report. The indicator score is based on audits undertaken by the Data Quality Team and will be further validated as part of the audit assurance programme.

Colours

When rated, each KPI will display colour indicating the overall rating of the KPI

Blue	Green	Amber	Red
No improvement required to comply with the dimensions of data quality	Satisfactory - minor issues only	Requires improvement	Siginficant improvement required

Dates

The date displayed within the rating is the date that the audit was last completed.

Summary - Caring for Finances

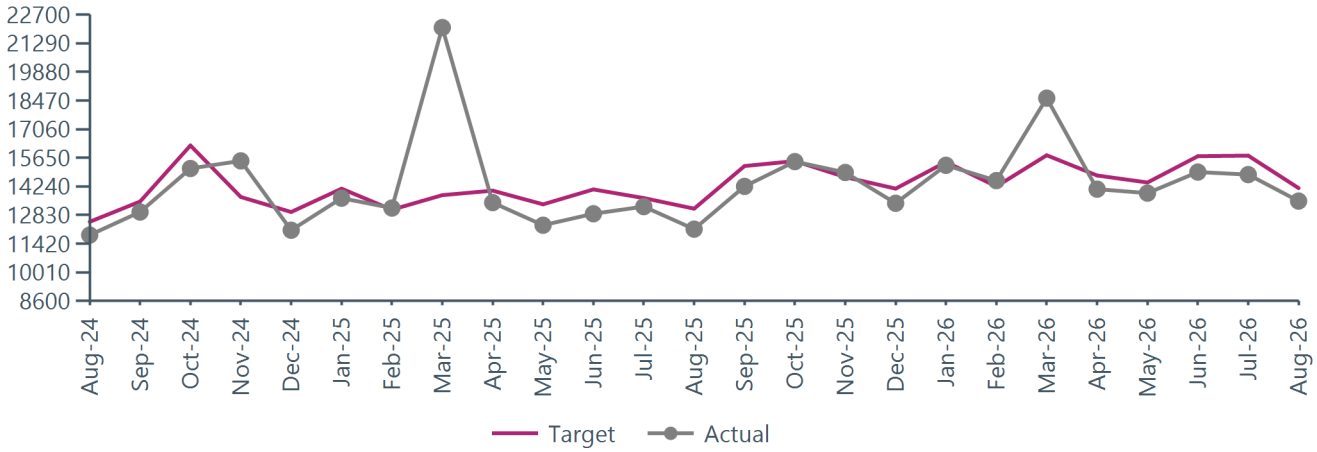
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
Financial Control Total	-1,026	-948	-1,026	N/A to SPC	Moving Target			
Income	14,158	13,519	14,158	N/A to SPC	Moving Target	+		
Expenditure	15,185	14,466	15,185	N/A to SPC	Moving Target			
Efficiency Delivered	827	691	827	N/A to SPC	Moving Target	+		
Cash Balance	16,518	17,499			Moving Target			
Capital Expenditure	1,068	1,145		N/A to SPC	Moving Target			
Performance (£'000k) against Low Value Agreement Block	0	117		N/A to SPC	Moving Target			
Planned Surplus/Deficit	-2,339	-2,378		N/A to SPC	Moving Target	+		+
Variance Year-to-Date to Financial Plan	0	-39		N/A to SPC	?	+		+
Implied Productivity	2.00%	10.80%		N/A to SPC	P	+		+

Income

All Trust Income, Clinical and Non-Clinical 216333

Exec Lead
Chief Finance & Commercial Office

Target/Plan	Latest Value	Variation	Assurance	NOF
14,158	13,519	N/A to SPC	Moving Target	



Trajectory



What these graphs are telling us

This measure is not appropriate to display as SPC. Metric has a moving target.

Narrative

Overall income £639k adverse to plan:

NHS Clinical income £270k adverse to plan:
- Theatre performance £431k adverse (14 cases favourable internally & 51 cases adverse insourcing)
- Outpatients and radiology procedures delivery £16k adverse driven by volume
- Non theatre procedures and stays £86k favourable (driven by metabolic medicine)
- Theatres outsourcing £171k favourable driven volumes offset in spend.

Non NHS income £369k adverse to plan: driven by shortfalls on private patient delivery and efficiency slippage

Actions

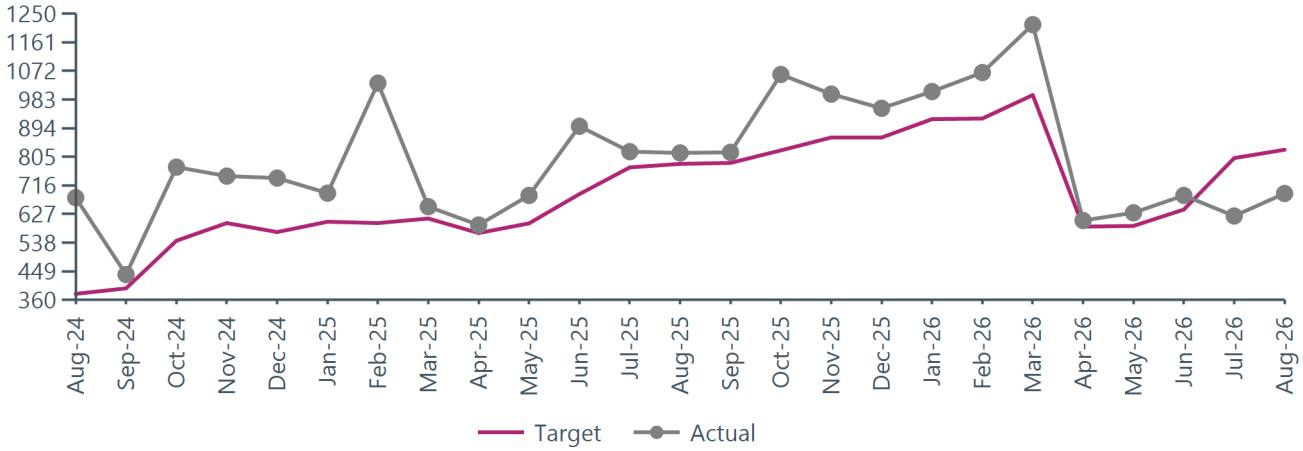
Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
12137	14242	15463	14928	13410	15282	14527	18589	14106	13910	14948	14824	13519

Efficiency Delivered

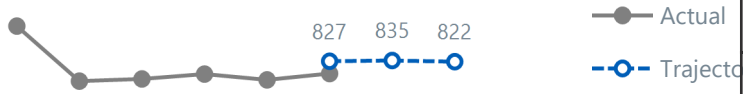
Efficiency plan delivery 215298

Exec Lead:
Chief Finance & Commercial Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
827	691	N/A to SPC	Moving Target	



Trajectory



What these graphs are telling us

This measure is not appropriate to display as SPC. Metric has a moving target.

Narrative

The efficiency programme was £136k adverse to plan in month

In month performance:
- £668k of recurrent schemes recognised, £159k adverse to plan. Note this includes post plan efficiency stretch target.
- £23k of non recurrent schemes, £23k favourable to plan.
- Total efficiency savings recognised of £691k, £136k adverse to plan.

Actions

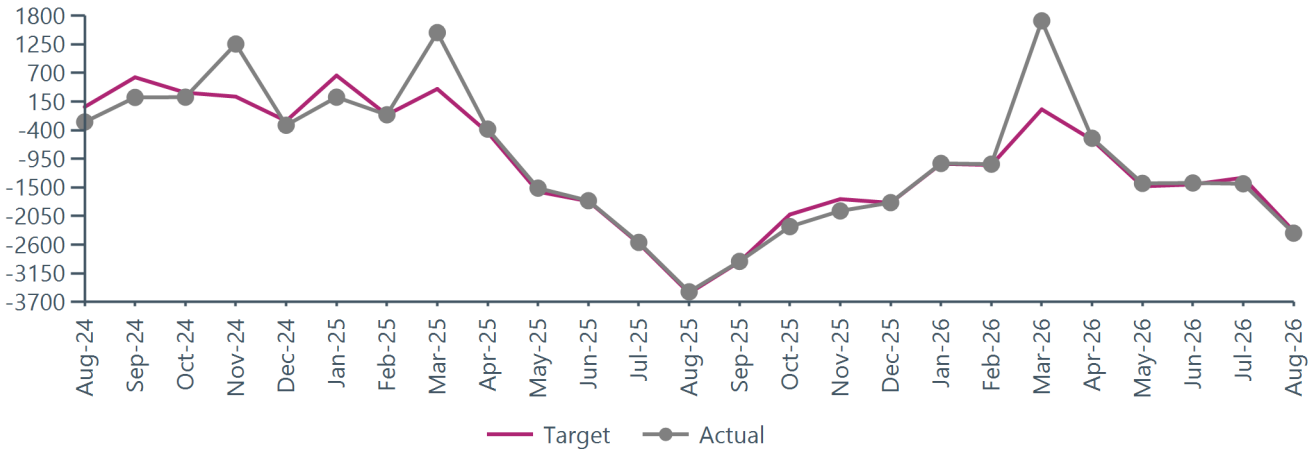
Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
817	819	1061	1000	956	1008	1067	1216	607	631	685	621	691

Planned Surplus/Deficit

Determined from the planned financial position for the year 217899

Exec Lead:
Chief Finance & Commercial Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
-2,339	-2,378	N/A to SPC	Moving Target	+



Trajectory



What these graphs are telling us

This measure is not appropriate to display as SPC. Metric has a moving target.

Narrative

YTD position £39k adverse to plan resulting in a NOF score of 1.

Actions

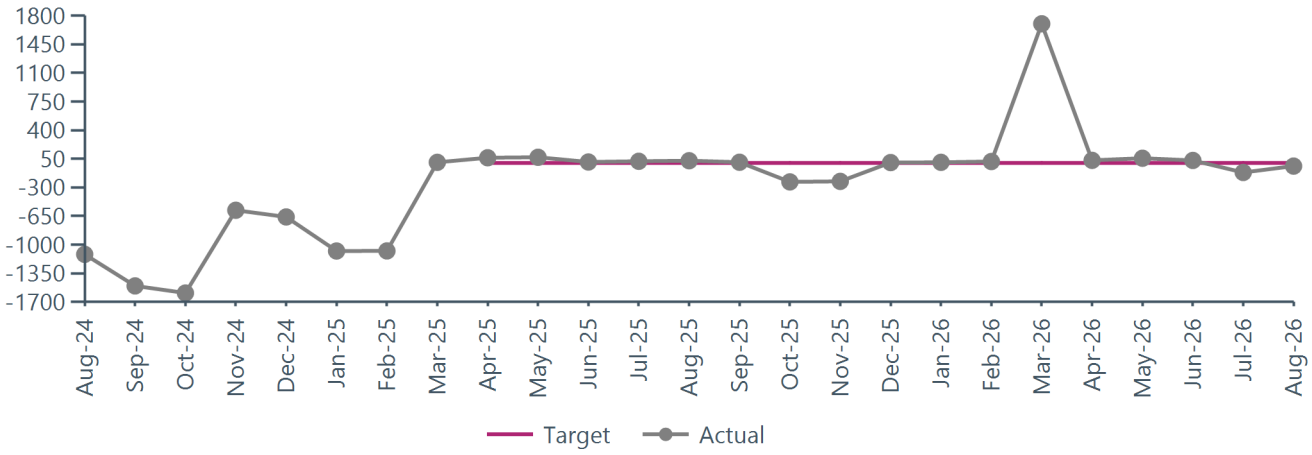
Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
-3506	-2921	-2253	-1951	-1792	-1039	-1053	1701	-555	-1422	-1414	-1430	-2378

Variance Year-to-Date to Financial Plan

Determined from the variance to the planned financial position for the year 217900

Exec Lead:
Chief Finance & Commercial Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
0	-39	N/A to SPC	?	+



Trajectory



What these graphs are telling us

This measure is not appropriate to display as SPC. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

The performance is adverse to plan YTD by 0.01% resulting in a NOF score of 1.

Actions

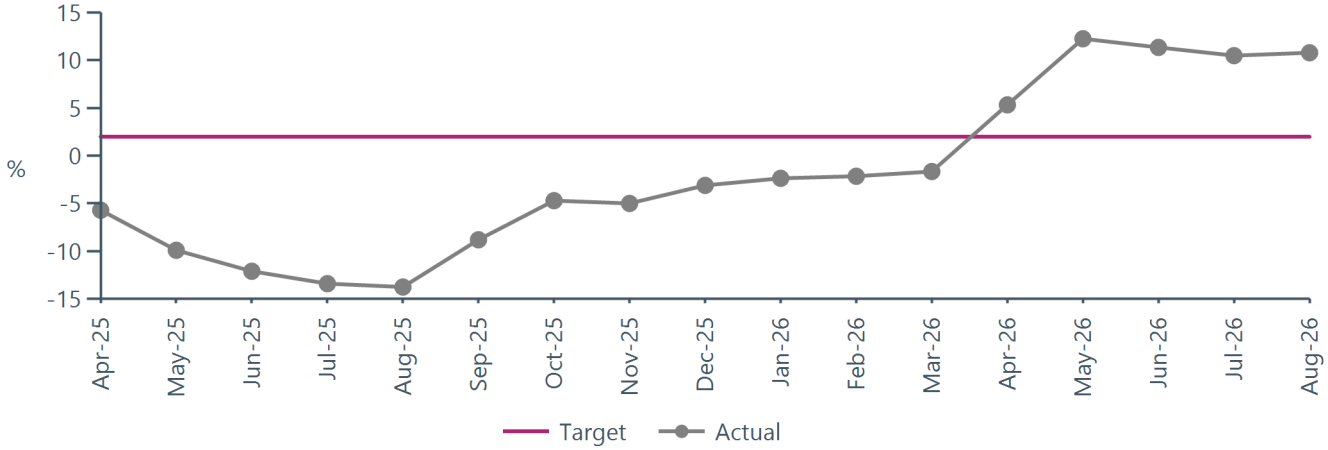
Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
27	8	-232	-226	4	7	17	1701	31	57	30	-117	-39

Implied Productivity

Calculated using cost weighted activity growth divided by real terms cost growth. Cost weighted activity is calculated from activity in the period multiped by national average costs at HRG level. Real terms costs is total operating expenditure over the pe 217901

Exec Lead
Chief Finance & Commercial Office

Target/Plan	Latest Value	Variation	Assurance	NOF
2.00%	10.80%	N/A to SPC	P	+



Trajectory



What these graphs are telling us

This measure is not appropriate to display as SPC. Assurance indicates metric is consistently failing the target.

Narrative

Implied productivity is 10.8% YTD when comparing M5 26/27 with M5 25/26, driven by the Apollo EPR implementation in 25/26 - at M5 26/27 there has been a comparative increase of 7% theatre activity and 9% outpatient activity when compared to the previous year.

The implied productivity metric indicates that year-to-date activity has increased more quickly than expenditure. However, the measure is sensitive to the comparison period and to changes in activity recording and methodology. The current improvement is influenced by comparison against a prior year period, and the previous month of previous year was affected by the Apollo implementation. For this reason, it will be important to look at trends over several months rather than interpreting any single month's result as evidence of a sustained change in productivity. This metric is under consultation for change nationally - consultation ended 1st September and we fed back in to that process for the Trust.

Actions

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
-13.75%	-8.80%	-4.70%	-4.99%	-3.10%	-2.36%	-2.14%	-1.65%	5.34%	12.27%	11.36%	10.50%	10.80%

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Finance and Performance Committee

Committee / Group / Meeting, Date

Board of Directors – Wednesday 7th October 2026

Author: **Contributors:**

Name: Larissa McElroy
Role/Title: Executive Assistant

Report sign-off:

Sarfraz Nawaz, Chair of the Finance and Performance Committee

Is the report suitable for publication?:

Yes

1. Key issues and considerations:

The Trust Board has established a Finance and Performance Committee. According to its terms of reference: "The Board of Directors has delegated responsibility for the oversight of the Trust's financial performance to the Finance and Performance Committee. This Committee is responsible for seeking assurance that the Trust is operating within its financial constraints, and that the delivery of its services represents value for money. Further it is responsible for seeking assurance that any investments again represent value for money and delivery the expected benefits. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board."

In order to fulfil its responsibilities, the Committee has established a number of sub-committees (known as "Meetings") which focus on particular areas of the Committee's remit. The Finance and Performance Committee receives regular assurance reports from each of these "Meetings" and escalates issues to the Board as necessary via this report.

This report provides a summary of the items considered at the Committee meeting held on 25th September 2026. It highlights the key areas the Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

The following strategic objectives, developed in light of national and system priorities, are relevant to the content of this report:

	Trust Objectives	
1	Deliver high quality clinical services	
2	Develop our veterans service as a nationally recognised centre of excellence	✓
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	✓
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	

This report relates to the following Board Assurance Framework (BAF) themes and associated strategic risks:

	Board Assurance Framework Themes	
1	Continued focus on excellence in quality, safety and patient experience.	
2	Focus on equity of service and addressing health inequalities	✓
3	Effective engagement with the workforce to support a positive staff experience and a culture of continuous improvement	
4	Delivering financial sustainability	✓
5	Delivering the required levels of productivity, performance and activity	✓
6	Delivering innovation, improvement and growth	
7	The challenges of operating in both the Welsh and English health systems	✓
8	Responding to a significant disruptive event	✓
9	Security of digital, data and AI systems and ability to respond to cyber threats	

Chair's Assurance Report
Finance and Performance Committee

Trust values:

The content of this report reflects / supports the following Trust values:

Trust Values		
1	Professional	✓
2	Excellence	✓
3	Respect	✓
4	Friendly	✓
5	Inclusive	✓
6	Caring	✓

3. Assurance Report from Finance and Performance Committee

3.1 Areas of non-compliance/risk, matters to be addressed urgently, or other significant developments

ALERT - The Finance and Performance Committee wishes to bring the following issues to the Board's attention as they:
Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address;
Represent significant developments / improvements that will help the Trust deliver its objectives; AND / OR
Require the approval of the Board for work to progress.

Financial forecast and activity delivery: The Committee reviewed the year-end forecast, which identified a likely adverse variance of £1.8m before mitigations. Mitigations of approximately £1.3m have been identified, leaving a residual risk of around £0.5m. The principal driver is under-delivery of planned theatre activity and the associated income impact. The Committee requested continued monthly scrutiny of the operational and financial recovery position, including clear ownership, delivery trajectories and quantified mitigations.

Theatre performance and operational resilience: Core theatre delivery remains below plan, with performance affected by workforce availability, delayed recruitment, pre-operative assessment pressures, case mix and the mobilisation of insourcing. The Committee emphasised the need to strengthen workforce planning, operational resilience and performance management, and to ensure that estates and enabling functions support delivery of the recovery plan.

Contract overperformance risk: The Trust is overperforming against English contracts, particularly Shropshire, Telford and Wrekin, while underperforming against Welsh contracts. The Committee noted the risk that English overperformance may not be fully funded and requested clearer triangulation of activity, performance and financial consequences, alongside active management of the balance between English and Welsh activity.

Activity recovery programme: The unmitigated full-year theatre shortfall was forecast at approximately 1,240 cases. Confirmed and developing recovery actions include opening the new theatre, targeted insourcing, additional evening and weekend sessions, optimisation of theatre and outpatient procedure capacity, activity-based contracts and actions to improve cases per session. The Committee requested that progress and the financial impact of these measures are reported monthly.

3.2 Areas of on-going monitoring with new developments

ADVISE - The Finance and Performance Committee wishes to bring the following issues to the Board's attention as they represent areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives:

Efficiency programme: The full-year efficiency target remains £8.3m. Delivery is broadly on trajectory, but a number of schemes remain at risk and the unidentified stretch requirement continues to present a material challenge. The Committee requested clearer assessment of movements in red and amber schemes, delivery timescales and further opportunities, including outpatient transformation and procurement.

Chair's Assurance Report
Finance and Performance Committee

Corporate Risk Register: The Committee received the revised one-page risk assurance summaries. Risk 140, relating to Radiology digital order communications, and Risk 353, relating to Welsh contract overperformance, had reduced following mitigation and recent developments. Risk 152 was being redrawn to focus on inappropriate outpatient follow-up dates, and Risk 352 had been added in relation to English contract overperformance. Dates will be added to risk scores in the next report to show movement over time.

Long waits and specialty capacity: Overall waiting list performance continues to improve, but the Committee requested further assurance on the trajectory for eliminating 52-week English waits and reducing Welsh 104-week waits. Capacity pressures in sports, foot and ankle, and spinal services remain under review, with recruitment and targeted activity intended to improve resilience.

Service line reporting and contribution: The Committee reviewed negative contribution positions in Diagnostics, Therapies, other MSK and Research. Work is underway to understand cost drivers, improve coding and income capture, reduce implant costs, review pathways and strengthen the financial contribution of private patient activity.

3.3 Areas of assurance

ASSURE - The Finance and Performance Committee considered the following items and did not identify any issues that required escalation to the Board.

Operational performance: The overall waiting list position continues to improve. At the end of August there were 4,781 patients waiting over 18 weeks, 863 fewer than planned. The RTT profile was healthier than the same point in the previous year, with reductions reported across a number of specialties and across pathway milestones.

Patient access: The outpatient DNA rate was reported at 3.7%, the Trust's best recorded position, supported by digital appointment reminders and the ability for patients to request cancellation or rearrangement through the patient portal.

Financial controls: The Month 5 position remained broadly in line with plan, supported by favourable pay and non-pay performance. Agency expenditure remained well controlled, cash and payment performance were strong, and capital remained within plan, with slippage attributed to reprofiling rather than overspend.

Productivity: The Committee received a clearer analysis of implied productivity and noted that, after adjusting for transformation and other factors, underlying productivity had improved by approximately 6%. The Trust was reported as the best in the region and 24th nationally on the referenced productivity measure. The Committee requested that this clearer contextual analysis is reflected in future Board reporting.

Risk reporting: The revised one-page Corporate Risk Register summaries were positively received and considered to provide a clearer basis for assurance and challenge.

Annual Board assessment: The Committee reviewed the relevant domains of the annual Board assessment and supported progression to Board sign-off, subject to the agreed updates on efficiency delivery, financial plan performance, collaboration, innovation and productivity.

Recommendation

The Board is asked to:

1. CONSIDER the overall assurance level listed at section 2,
2. CONSIDER the content of section 3.1 and agree any action required;
3. NOTE the content of section 3.2 and CONSIDER whether any further action is required; and
4. NOTE the content of section 3.3.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
DERIC Committee

Committee / Group / Meeting, Date

Board of Directors - Public Meeting, 07 October 2026

Author: **Contributors:**

Name: Larissa McElroy
Role/Title: Executive Assistant

Report sign-off:

Martin Evans, Chair of the DERIC Committee

Is the report suitable for publication?:

Yes

1. Key issues and considerations:

The Trust Board has established a Digital, Education, Research Innovation and Commercial (DERIC) Committee. According to its terms of reference: "The Board of Directors has delegated responsibility for the oversight of the Trust's Digital, Education, Research performance to the Digital, Education, Research, Innovation and Commercialisation Committee. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board."

In order to fulfil its responsibilities, the Committee has established a number of sub-committees (known as "Meetings") which focus on particular areas of the Committee's remit. The Digital, Education, Research, Innovation and Commercialisation Committee receives regular assurance reports from each of these "Meetings" and escalates issues to the Board as necessary via this report.

This report provides a summary of the items considered at the Committee meeting held on 24th September 2026. It highlights the key areas the Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

The following strategic objectives, developed in light of national and system priorities, are relevant to the content of this report:

	Trust Objectives	
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	
4	Grow our services and workforce sustainably	
5	Innovation, education and research at the heart of what we do	✓

This report relates to the following Board Assurance Framework (BAF) themes and associated strategic risks:

	Board Assurance Framework Themes	
1	Continued focus on excellence in quality, safety and patient experience.	✓
2	Focus on equity of service and addressing health inequalities	✓
3	Effective engagement with the workforce to support a positive staff experience and a culture of continuous improvement	✓
4	Delivering financial sustainability	✓
5	Delivering the required levels of productivity, performance and activity	✓
6	Delivering innovation, improvement and growth	✓
7	The challenges of operating in both the Welsh and English health systems	
8	Responding to a significant disruptive event	
9	Security of digital, data and AI systems and ability to respond to cyber threats	✓

Trust values:

Chair's Assurance Report
DERIC Committee

The content of this report reflects / supports the following Trust values:

Trust Values		
1	Professional	✓
2	Excellence	✓
3	Respect	✓
4	Friendly	✓
5	Inclusive	✓
6	Caring	✓

3. Assurance Report from DERIC Committee

3.1 Areas of non-compliance/risk, matters to be addressed urgently, or other significant developments

ALERT - The DERIC Committee wishes to bring the following issues to the Board's attention as they:
Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address;
Represent significant developments / improvements that will help the Trust deliver its objectives; AND / OR
Require the approval of the Board for work to progress.

Electronic Patient Record (EPR): The Apollo Workspace upgrade has moved from September to quarter 3, with delivery expected during November/December. Re-planning is under way with clinical and operational input to support a safe and successful go-live. Overdue follow-up appointments, system reliability and performance remain under focused oversight, and the EPR Implementation Assurance Meeting will continue in the short term.

Cybersecurity and organisational resilience: A review against the requirements set out by NHS England has identified gaps in assurance arrangements. An outline of the gaps and actions required will be considered through Digital Operational, Information Governance and Executive forums before returning to DERIC to strengthen assurance to the Board.

3.2 Areas of on-going monitoring with new developments

ADVISE - The DERIC Committee wishes to bring the following issues to the Board's attention as they represent areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives:

Digital, Data and AI strategic development: The current Board-approved Digital Strategy runs to 2027. The Committee supported the longer-term development of an integrated Digital, Data and AI Strategy, with the 2027/28 business planning process used to establish clearer medium-term objectives, outcomes and deliverables.

Microsoft Copilot and AI governance: Copilot is in use, although national usage information remains limited. The Trust does not currently have an AI policy. Interim one-page guidance on safe use, including clear dos and don'ts, will be considered by the Information Governance Group in October, alongside development of a policy, local education and adoption support. National funding for Copilot ends on 31st March 2027 and future funding options will need to be considered through business planning.

Commercial performance: Private Patient Surgical Services remain significantly behind plan despite generating a net surplus. Performance is affected by activity volumes, including approximately 111 cases below plan, and case-mix issues which remain under investigation. Recovery and mitigation are being overseen through PFIG and wider organisational planning.

Research performance and culture: Commercial research activity and value have reduced while home-grown research activity has increased. The Committee requested clearer benchmarking, aspirations and contextual measures to show the Trust's position against appropriate specialist organisations. Nursing engagement, time and recognition remain areas for development following the Research Capability and Culture Survey – this work is being led by the CNO.

Integrated performance reporting: Further work is required to develop meaningful performance measures across the five DERIC strands with timelines agreed with each Exec lead.

Education Centre: The planned update had been deferred while priority was given to the University Hospital Status application. Executive colleagues to agree a realistic timeframe for progression of the work around an Education Centre and update DERIC accordingly.

3.3 Areas of assurance

ASSURE - The DERIC Committee considered the following items and did not identify any issues that required escalation to the Board.

University Hospital Status: The Board has endorsed the Trust's intention to apply. The self-assessment indicates that all 19 essential criteria and 5 of the 7 desirable criteria are met, and the application is supported by Keele University. Contributions will be brought together from early October, with the aim of progressing the application by the end of 2026.

Commercial Strategy: The approved strategy has been translated into an accessible summary leaflet and is being communicated through organisational forums. A prioritised pipeline of approximately 35 opportunities has been developed and will be overseen through the Commercial Delivery Group. Recruitment is under way to strengthen private patient leadership and commercial finance capacity.

Corporate Risk Register: The revised one-page reporting format was welcomed and is generating more focused Committee discussion. Further refinements will strengthen explanations where confidence in controls is low, clarify ownership and include the date risks were first entered onto the register. All risks were reviewed and no new risks added.

Well-Led Action Plan: Sufficient progress has been made to close the overarching action plan, subject to outstanding actions transferring to the appropriate workstreams and governance routes so that delivery and audit trails are maintained.

Capability Self-Assessment: The Committee reviewed the working draft and requested that evidence across all five DERIC strands is fully reflected, particularly university partnerships, joint working, supporting services and Improvement and Innovation activity.

Improvement Week: The week was positively received, with good engagement across training sessions and walkabouts. Learning and selected activities will be taken forward through ongoing arrangements, including development of a monthly approach.

Recommendation

The Board is asked to:

1. CONSIDER the content of section 3.1 and agree any further action required;
2. NOTE the content of section 3.2 and CONSIDER whether any further action is required; and
3. NOTE the content of section 3.3.