The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors | Public Meeting

MEETING

5 November 2025 09:30 GMT

PUBLISHED

5 November 2025

Agenda

Location	Date	Time
Meeting Room 1, Main Entrance	5 Nov 2025	09:30 GMT

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1	Welcome and Introduction	Chair	09:30	-
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3	Chair and CEO Update	Chair and Chief Executive Officer	10:00	46
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4	Risk Management		10:20	-
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5	Quality and Safety		10:35	-
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5.2	Chair Report from Quality and Safety Committee	Non-Executive Director		88
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7	Performance and Finance		11:25	-
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7.3.1	Green Plan 2025 - 2028	Interim Chief Nurse and Patient Safety Officer		279

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8	Chair Report from Digital, Education, Research, Innovation and Commercialisation Committee	Non-Executive Director	11:55	282
9	Questions from the Governors and Public	Chair	12:05	-
10	Any Other Business	All	12:15	-
10.1	Next Meeting: 07 January 2026 at 9:30am			-

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	Harry	Turner		Chairman	Financial Interests	In Form Solutions Management Consultancy	01/02/2024	Ongoing
Board	Sarfraz	Nawaz		Non Executive Director	Financial Interests	Wakefield Council – Chief Finance Officer	01/09/2025	Ongoing
Board	Sarfraz	Nawaz		Non Executive Director	Non-Financial Professional Interests	Member of CIPFA	01/01/2021	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	Non-Executive Director – British Dietetic Association, 3rd Floor Interchange Place, 151 – 165 Edmund Street, Birmingham B3 2TA. Sit on the Board of Directors of the BDA.	01/06/2020	01/10/2024
Board	Penny	Venables		Non Executive Director	Non-Financial Personal Interests	Chair Sandwell Leisure Trust, 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 director 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 NED at Birmingham and Solihull ICB		Ongoing
Board	Darius	Mirza		Non Executive Director	Financial Interests	Chair, SPLIT Charity – Supporting Paediatric Liver and Intestinal Transplantation, Birmingham	02/02/2016	Ongoing
Board	Darius	Mirza		Non Executive Director	Financial Interests	Trustee – THTPF (Transplants Help the Poor Foundation, Mumbai, India)	01/04/2016	Ongoing
Board	Darius	Mirza		Non Executive Director	Financial Interests	Vice Chair, George Eliot School Board of Governors, Nuneaton	01/04/2023	01/04/2026
Board	Darius	Mirza		Non Executive Director	Financial Interests	Shareholder, Organox Ltd, Oxford (Machine Perfusion Device Manufacturer, Oxford)	01/09/2018	Ongoing
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	Senior Advisor for Primary Care (Department of Health	01/03/2023	31/07/2024
Board	Paul	Maubach		Associate Non Executive Director	Financial Interests	Senior Advisor 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 – through which I provide management consulting and advisory services to different organisations.If it transpires either at a committee or Board meeting of the Trust, the meeting is either discussing or engaging with an organisation that my company is also engaged with, then I will declare a potential conflict of interest to the Chair.	01/03/2023	Ongoing
Board	Atif	Ishaq		Associate Non Executive Director	Financial Interests	Enterprise AI & Advanced Analytics Director at Mars Inc	04/2025	Ongoing
Board	Atif	Ishaq		Associate Non Executive Director	Financial Interests	Owner of Digital Clinician Ltd	01/01/2018	Ongoing
Board	Atif	Ishaq		Associate Non Executive Director	Financial Interests	Digital Advisor and Webmaster to Quest Legal Advocates LTD	01/01/2011	Ongoing
Board	Atif	Ishaq		Associate Non Executive Director	Financial Interests	Webmaster for Shrawley, North Claines and Hanbury Parish Councils	01/01/2011	Ongoing
Board	Atif	Ishaq		Associate Non Executive Director	Financial Interests	Self-employed webhosting provider	01/01/2011	Ongoing
Board	Atif	Ishaq		Associate Non Executive Director	Non-Financial Personal Interests	Justice of the Peace for West Mercia Judiciary	01/01/2017	Ongoing
Board	Stacey	Keegan		Chief Executive Officer	Non-Financial Professional Interests	STW ICB Partner Member	01/07/2022	Ongoing
Board	Stacey	Keegan		Chief Executive Officer	Non-Financial Professional Interests	A member of the National Orthopaedic Alliance Board	03/05/2024	Ongoing
Board	Ruth	Longfellow		Chief Medical Officer	Financial Interests	Private Practice work for RJAH	01/01/2011	Ongoing
Board	Ruth	Longfellow		Chief Medical Officer	Financial Interests	Member of GAS (Gobowen Anaesthetic Services)	01/11/2019	01/06/2025
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 a senior partner at Johnson Fellows Charter House, Birmingham, Ad hoc HR consultancy Johnson Fellows		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	Sarah	Needham		Interim Chief Nurse and Patient Safety Officer	No interest to declare	N/A		

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

BOARD OF DIRECTORS | PUBLIC MEETING
WEDNESDAY 03 SEPTEMBER 2025 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	×
Stacey Keegan (SK)	Chief Executive Officer	✓
Angela Mulholland-Wells (AMW)	Chief Finance and Commercial Officer	✓
Paul Kavanagh Fields (PKF)	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	✓
Atif Ishaq (AI)	Associate Non-Executive Director	✓
Denise Harnin (DH)	Chief People and Culture Officer	×
Dylan Murphy (DM)	Trust Secretary	✓
Mary Bardsley (MB)	Assistant Trust Secretary (minutes)	✓
Kirsty Foskett (KF)	Assistant Chief Nurse and Patient Safety Officer	✓
Chris Hudson (CH)	Head of Communications	✓
Andrea Martin (AM)	Deputy Chief People Officer	✓
Colin Chapman (CC)	Governor – Shropshire (observing)	✓
Kate Betts (KB)	Governor – Staff (observing)	✓
Jan Greasley (JG)	Governor – (observing)	✓
Neil Turner (NT)	Governor – Cheshire (observing)	✓
Victoria Sugden (VS)	Governor – Shropshire (observing)	✓

Ref	Discussion and Action Points
1.0	**Welcome and introductions**
	The Chair welcomed all attendees to the meeting and a special welcome to Deborah who joined the Board meeting to share her patient story.
1.1	**Apologies**
	Apologies for absence were received from Penny Venables, Denise Harnin, Martin Evans and Paul Kavanagh-Fields. On behalf of the Board, HT extended a warm welcome to KF, who joined the meeting as the representative for the nursing portfolio and AM who joined the meeting as the representative for the people service portfolio. 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.

Ref	Discussion and Action Points
	On behalf of the Board, HT informed the members of the meeting of ME new appointment as Coach for the National Neighbourhood Health Implementation Programme, which has since been recorded on the register.
1.3	**Minutes of the previous meeting**
	The minutes of the Board of Directors (Public) Meeting held in 03 September 2025 were approved as an accurate record subject to the following amendments: • Page 2 – RSP Exit and System Level Engagement amended to '*The System has successfully achieved the required criteria to exit the Recovery Support Programme (RSP), representing a significant milestone for both the Integrated Care System (ICS) and the wider health system. The Trust has played a key role in supporting the System to reach this milestone, which will be further discussed during the upcoming performance meeting with Dale Bywater, scheduled for tomorrow.'*
1.4	**Matters Arising and Action Log**
	There were no further matters to raise or actions to follow up.
2.0	**Staff Story**
	RL introduced Deborah Morris, whose story had been circulated ahead of the meeting for Board oversight. Deborah was thanked for attending and sharing her experience before she shared the following key points with the Board: **Patient Experience** - Deborah began by expressing her appreciation for the hospital, describing it as a "gold standard" organisation. Over the past nine years, she has undergone multiple surgeries at RJAH. She praised the clinical excellence, the professionalism of the domestic team, and the overall environment, noting that even the smallest details, such as cleanliness and food quality and how they contribute to a sense of safety and care. However, she noted a recent decline in patient experience, particularly over the past 12–18 months: • Clinics being cancelled more frequently. • A subtle decline in staff friendliness. • A lack of communication regarding appointments and waiting times. **Spinal Care Journey** - Deborah's primary concern relates to her spinal condition: • After an MRI revealed significant spinal degeneration, she was referred urgently but received no follow-up communication. • Over several months, she made more than 20 phone calls seeking updates, but not once was she contacted proactively. • Deborah opted for a private consultation with Mr. Balain, who confirmed the severity of her condition but reassured her it was not an urgent case. • She was placed on a waiting list with an estimated wait of 52 weeks. Without going private, she believes she would still be waiting for an initial appointment. **Emotional Effects** - Deborah described the emotional toll of this experience: • The lack of communication left her feeling unsupported. • She expressed concern for other patients who may not have the resources, knowledge or confidence to follow up the process. • She reflected on the psychological impact of prolonged pain and uncertainty, noting that such experiences could have serious consequences for vulnerable individuals. **Constructive Suggestions** - Deborah offered several thoughtful recommendations for the Trust to consider: • Transparent communication at the point of referral, including realistic wait times and alternative options (e.g., referral to other Trusts). • Regular updates to patients on waiting lists, even if only to acknowledge their continued presence and pain management support. • Patient involvement in designing solutions, such as forming a focus group to explore how to make waiting more tolerable.

Ref	Discussion and Action Points
	On behalf of the Board, HT thanked Deborah for taking her time to attend the meeting and to share her experience which supports the Trust in implementing improvements for patient care and experience. The Board discussed the following: • **Spinal Demand**– MC provided context on the surge in demand for spinal services, with a 50% increase in outpatient referrals compared to pre-COVID levels and acknowledged this is a national issue and note one only for the Trust. • **Current action** – MC explained some of the current mitigations to improve the spinal waiting times includes the appointment of a new spinal consultant, recruitment of locums, nurses, and AHPs to expand outpatient capacity, regional collaboration to ensure only surgical cases are referred to RJAH and reintroduction of a pain management service in October to support non-surgical patients. Deborah queried whether patients are being appropriately triaged and whether some may be on the list unnecessarily and emphasised the need for early and honest communication with patients about their options and expected timelines. • The Trust acknowledged that while progress has been made in reducing long waits (from 104 weeks to 65 weeks), these figures remain unacceptable. One of the key reflections for the Board included the distress caused to patient by communication failures from the Trust and highlighted the importance of proactive engagement with patients, especially those facing long waits. • **Finance and Performance Committee** – Members of the Board thanks Deborah for humanising the spinal waiting list issue which is noted to be a regular Board update, and the Finance and Performance Committee regularly reviews statistics, stories like Deborah's bring the data to life. • **Waiting Well Programme –** The Trust shared an update on the work has begun on a "Waiting Well" initiative, aimed at helping patients manage their health and wellbeing while awaiting surgery and suggested consideration is to be given as to whether this initiative should be implemented from the point referral and not just after a surgical decision. • **Digital platforms** – noted that there is more the Trust can do to utilise the digital tools available to gather patient feedback and improve communication • **Gold Standard** – Noted that Deborah describes the Trust as "gold standard' and the Board queried the reasons why. Deborah responded that it's the clinical excellence, the friendly and professional staff along with the safe, clean environment that set the hospital apart. • **Quality and Safety Committee** – KF confirmed that the Quality and Safety Committee were committed to the actions raised at the meeting and asked for Deborahs support in reviewing the action being implemented outside the meeting. Deborah noted that, unlike other hospitals, staff here are friendly and welcoming. HT thanked Deborah and assured her that actions would be taken forward. **ACTION: Update report to be presented back to the Board via the Quality and Safety Chairs Assurance Report. It was agreed the QS Committee would receive an update progress report on the actions which are to be undertaken to improve the process following the discussion at the Board meeting.**
3.0	**Risk Management**
3.1	**Board Assurance3 Framework**
	The Board received an update on the current status of the Board Assurance Framework (BAF), which continues to be subject to regular review and oversight. Each individual risk element has been considered through the appropriate committee structures, ensuring robust scrutiny and assurance. However, two exceptions were noted: • **BAF 5,** has not been reviewed by the DERIC Committee due to the absence of the committee meeting in August. • **BAF 6**, which is directly owned by the Board, was last reviewed in June 2025. It was clarified that this review did not take place in March 2025 as previously recorded – noting this was a typing error within the paper.

Ref	Discussion and Action Points
	At present, there are no proposed changes to the scoring of any BAF entries. The current assessments remain valid and reflective of the organisational risk status. The Board acknowledged the need for a comprehensive review of the BAF to ensure it is fully aligned with the organisation's 10-Year Strategic Plan, as well as the corporate objectives. This review should also consider how the identified risks may impact the delivery of those objectives, particularly in light of evolving system pressures and strategic priorities. It was reaffirmed that any issues or concerns relating to the BAF should be escalated through the Committee Chair Reports, which remain the formal route for raising matters to the Board. To support deeper engagement and reflection, it was proposed that the Board dedicate a focused session within the Private Board Meeting (approximately two hours) to undertake a more detailed review of the BAF and its strategic alignment. In relation to BAF 6, the Board noted that there are currently no concerns with the content being reported. However, given the changing external environment, it was suggested that it would be beneficial to map out the organisation's strategic relationships, including: • Musculoskeletal (MSK) services • The Royal Orthopaedic Hospital (ROH) • Wider system working arrangements This mapping exercise would help contextualise BAF 6 within the broader strategic framework and support future decision-making. Finally, the Chair encouraged active input from all Board members during the upcoming review session, emphasising the importance of collective ownership and strategic foresight in shaping the organisation's risk management approach.
3.2	**Corporate Risk Registe**
	DM presented the summary of the Corporate Risk Register, highlighting the risks considered during the August cycle of Board sub-committees, following their review at the August meeting of the Risk Management Group (RMG). DM reminded the Board that points of escalation are raised through individual Committee Chair Assurance Reports, where each committee has oversight of relevant risks in greater detail. These reports serve to bring specific matters to the Board's attention. The Board discussed the following key points: • **Apollo-related risks**: These are currently being integrated into the Trust's usual risk management process and aligned with the Trust's risk management framework. These risks were reviewed by the Quality and Safety Committee and are expected to be reflected in the Corporate Risk Register (CRR) in future iterations. • **Ongoing risk reviews**: The Trust continues to undertake regular reviews of risks to ensure they remain current and appropriately managed. • **Risk Management Group (RMG)**: Meetings are held monthly and continue to evolve to strengthen oversight and governance. • **Board member reflections**: PM shared that, as a member of certain committees, they have a clear understanding of the risks discussed within those forums. However, for risks overseen by other committees, the narrative alone does not always provide sufficient clarity. PM expressed confidence in colleagues' oversight but highlighted the importance of collective understanding of all risks at Board level. The Board requested that future Chair Assurance Reports include more detailed information to support Board-level discussions and enhance transparency around risk escalation or for members of the meeting to refer back to the summary when holding further discussion on the risks.
4.0	**Chair and CEO Update**
	Chair Update HT provided the Board with the following updates: • **Oversight and System:** Further clarity regarding the role of the System is awaited, and developments are expected over time. Ian Green has been appointed Chair of the

Ref	Discussion and Action Points
	Staffordshire and Shropshire cluster. The Chief Executive Officer (CEO) position within the cluster remains vacant, and recruitment has commenced. The Board extended its congratulations to Ian Green on his recent appointment. • **Royal Orthopaedic Hospital (ROH) Appointment:** Simon Page has been appointed as Chair, and Matthew Hartland as Chief Executive Officer. Arrangements are underway to facilitate a visit and strengthen collaborative working relationships. The Board congratulated both Simon and Matthew on their recent appointments. **CEO Update** SK provided the Board with the following updates: • **Performance and Patient Care** - Over the summer months, the Trust has seen encouraging improvements in performance, driven by the unwavering commitment of its teams. The focus remains firmly on supporting patients who have been waiting the longest, ensuring they receive timely, high-quality care. • **Strategic Objectives 2025/26** - This month marked a proud milestone as the Trust launched its strategic objectives for the year. These goals are rooted in a bold five-year strategy and represent purposeful steps toward long-term ambitions. The next phase is about embedding these objectives across the organisation, empowering every colleague to understand how their role contributes to the Trust's shared vision. • **Portland Clinical Insourcing Partnership** - To accelerate progress in reducing waiting lists and increasing clinical activity, the Trust has partnered with Portland Clinical through a new insourcing contract. Services are delivered outside core hours, including evenings and weekends—maximising clinical capacity and ensuring patients receive care without delay. This initiative complements the Trust's broader strategy of sustainable workforce growth, pathway redesign, and targeted infrastructure investment. • **NHS Staff Survey 2025 – Every Voice Matters** - The Trust is preparing to launch the NHS Staff Survey 2025, a vital opportunity to hear directly from its people. With last year's response rate at 47%, the aim is to significantly improve participation. A new communications toolkit and insight pack have been developed to highlight how staff feedback has led to meaningful change. All staff are encouraged to participate. • **Visit from Ian Green OBE -** In August, the Trust was honoured to welcome Ian Green OBE, Chair of NHS Shropshire, Telford and Wrekin Integrated Care Board. His visit included a roundtable discussion and site tour, offering a valuable opportunity to showcase achievements, share future plans, and discuss current challenges. • **Pioneering Hip Treatment -** RJAH is proud to be the first NHS hospital in the UK to offer focused shockwave therapy for patients with Greater Trochanteric Pain Syndrome (hip bursitis). This innovative, non-invasive treatment, introduced following a two-year study led by Consultant Orthopaedic Surgeon Mr Robin Banerjee, has shown remarkable results, with 80% of patients reporting significant improvement. Supported by the League of Friends, this advancement reflects the Trust's commitment to delivering world-class care. • **Cavell Star Award for Spinal Injury Sister -** The Trust is delighted to celebrate Cath Roberts, Sister at the Midland Centre for Spinal Injuries, who received a prestigious Cavell Star Award. Nominated by Student Nurse Associate Sophie Podmore, Cath was recognised for her exceptional care of a patient with learning difficulties who became a high tetraplegic. Her compassion and professionalism exemplify the very best of nursing. • **RJAH Stars Award -** Each month, the Trust honours individuals who go above and beyond. The latest RJAH Star is Steve Humphreys, Scrub Nurse, recognised for his outstanding contributions to hip arthroscopy procedures. Nominated by Consultant Mr Rajpal Nandra, Steve's innovation and leadership have made a tangible impact on surgical efficiency and patient outcomes. Congratulations, Steve, your dedication truly embodies the values celebrated through the RJAH Stars Award. The Board noted the updates and there were no specific questions raised.
4.1	**System Integrated Improvement Plan**
	DM presented the paper to the Board, highlighting the following key points Executives from RJAH were invited to attend a session hosted by NHS England (NHSE) and the Integrated Care Board (ICB) on 3 October 2024. The session focused on RJAH's contribution to the system-wide "transition plan," which aims to support the ICB and Shrewsbury and Telford

Ref	Discussion and Action Points
	Hospital NHS Trust (SaTH) in progressing from Level 4 to Level 3 of the NHS Oversight Framework (NOF). The transition plan is structured around five key domains: Finance, Workforce, Urgent and Emergency Care (UEC), Governance and Leadership This plan is regularly reviewed at both Board and committee levels. A summary is included within the associated action plan, which is treated as a live working document, reflecting progress at a specific point in time. Progress is tracked using a colour-coded system: • Blue – Actions completed and supported by evidence. • Green – Actions on track but awaiting supporting evidence. • Red – Issues within the UEC domain, where actions are dependent on SaTH and outside RJAH's direct control. • Amber – Development of a system-wide risk governance policy; while providers are aligned in principle, overarching documentation is still pending. **The Board discussed the following:** • The Board acknowledged the Trust's ongoing contribution to the system improvement plan, which supports the ICB and SaTH in achieving Level 3 status under the NOF. • It was noted that while the transition plan primarily relates to the ICB and SaTH, RJAH's involvement is essential to system-wide progress. • Under the revised NOF, organisations are assessed individually. However, system-level performance can still impact individual ratings. • RJAH continues to contribute to the plan, particularly in areas where collaboration is required to complete outstanding actions. • No significant issues were raised. • It was confirmed that amber ratings reflect dependencies on other system partners rather than internal concerns. • It was suggested that future updates be included in the CEO's report or Chair's report by exception, rather than as a standing item. The Board agreed with this approach and acknowledged the progress made.
4.2	**Provider Capability Self-Assessment**
	The revised version of the Provider Capability Self-Assessment has been published for NHS provider organisations. This is intended to be a self-assessment exercise in the first instance, which will then be reviewed by NHS England (NHSE). Based on this review, a capability rating will be applied using a four-point scale. The assessment must be completed by 22nd October. As part of the NHS Oversight and Assessment Framework, NHS England will assess NHS trusts' capability, using this alongside providers' NOF segments to judge what actions or support are appropriate at each trust. As a key element of this, NHS boards will be asked to assess their organisation's capability against a range of expectations across six areas derived from The Insightful Provider Board, namely: • 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 process includes a sign-off and approval stage, which involves a Board-level self-assessment. It is recommended that the timeline for completion and approval be discussed outside of formal meetings and confirmed at the end of the private Board meeting. The Board welcomed the revised self-assessment and noted that this should not be treated as a one-off annual exercise. Instead, organisations should consider what has already been embedded within existing processes.

Ref	Discussion and Action Points
	Additionally, the most recent Well-Led Review commissioned by the Trust can be used to support the self-assessment by providing relevant information and evidence. The Board noted the publication of the capability assessment for NHS organisations; and agreed the sign-off process for the capability self-assessment and Board certification.
4.3	**Winter Planning Statement**
	MC explained the winter planning statement is based on three main planning priorities: • **Prevention** – Achieve at least a 5% improvement on last year's flu vaccination rate for frontline staff by the start of flu season. Staff sickness trajectories aligned to seasonality with sufficient workforce to meet capacity requirements. • **Capacity** - Ensure that the demand profile for elective and non-elective patients is understood with appropriate capacity in place to meet demand. Confirm that the RTT and cancer trajectories signed off and returned to NHSE in April 2025 are not impacted by winter pressures and winter preparedness plans with any risks associated with winter pressures mitigated. • **Infection Prevention and Control (IPC)** – All systems should test their winter virus resilience plans against the IPC mechanisms available both in and out of hospital. This includes making sure they have identified cohorting spaces ready to be actioned, explored the direct admission of flu patients into community bedded capacity and followed appropriate policies and procedures. The Board discussed the following: • **Capacity** - Kenyon Ward will *not* be opened as an additional non-medical ward this winter, due to the increase in overall bed capacity across the system. The Orthopaedic service at Telford is closing; our Trust will support the elective orthopaedics programme locally while also providing assistance to SaTH as part of the system-wide response. • **Prevention and System Coordination** - A Confirm and Challenge session is scheduled with the System Meeting tomorrow to review and align winter planning assumptions. The impact on our Trust is expected to be limited, with our contribution focused on supporting the wider system, as previously agreed. • **Governance and Assurance** - PM queried whether a formal report exists confirming that our Trust will not be required to provide additional support. SK clarified that this decision is *not explicitly written into the Winter Plan*, but was minute at the UEC Programme Board. It was noted due to time pressure of the reporting route the planning statement have not been presented to the assurance committee ahead of the Board. The Board reviewed and approved the Board Assurance Statements based in the winter planning update provided. The Trust will share the Winter preparedness update and board assurance statements with the ICB to support their winter plan assurance via the ICB Board on the 24th September 2025. The Trust is required to submit the Board Assurance Statements to NHSE on the 30th September 2025.
4.0	**Quality and Safety**
4.1	**Performance Report – Quality and Safety Committee**
	The following points were highlighted from the Quality and Safety performance report (by exception only): • **Complaints:** 19 complaints were received in July. The main themes related to cancellations of clinical appointments and surgical procedures. A deep dive has been completed and is being overseen by the Patient Experience team. • **Deteriorating Patients:** 10 cases were reported, with 5 specifically linked to the High Dependency Unit (HDU) and issues around patient stabilisation. The Board noted the performance report.

Ref	Discussion and Action Points
4.2	**Chair's Assurance Report – Quality and Safety Committee**
	LW highlighted the following key points from the Quality and Safety Committee Chairs Assurance report: • **Powys Commissioning Intentions Restrictions**: Powys Teaching Health Board is again considering restrictions on both elective and outpatient activity due to financial pressures. Specifically, a cap on outpatient appointments (first appointments restricted to 52 weeks) and inpatient admissions limited to those waiting 100–104 weeks. These restrictions are not aligned with NHS England targets and pose a direct risk to patient safety, particularly for new patients who may present with undiagnosed or deteriorating conditions. The Trust has taken a principled decision not to implement these restrictions and to continue to prioritise based on clinical need. Partner medical directors across the region share our concerns. The Committee recommends the Board formally support and endorse the Trust's position to resist the imposition of a 52-week cap, to provide organisational clarity and keep patient safe. • **Apollo Risk**: Concerns have been raised regarding the Apollo system. Teams are actively working to support staff, and it was noted that this matter will be discussed further in the private forum. • **HSE Improvement Notice**: While the Trust is awaiting the full report, it has proactively established a working group and identified actions aligned with the required improvements. Oversight of Occupational Health is being managed by the People Committee. • **MHRA Licensing**: The Trust is progressing with the cessation of licenses and has commissioned EPIC to support the process. The Committee received assurance on the progress, and a closure report is expected next month. • **Modern Slavery Statement**: The revised statement is recommended to the Board for approval. • **Terms of Reference (TOR)**: The revised Terms of References are recommended to the Board for approval. The Board considered and approved the revised Terms of Reference. The Board held a detailed discussion regarding Powys' commissioning intentions. Key points included: • **Clinical Concerns** - The proposal to cap outpatient first appointments at 52 weeks is contrary to national standards aiming for 18-week pathways. While paediatric cases are typically seen within 100 weeks, the Committee expressed concern about the clinical risks of patients remaining unseen for extended periods. This is a proposal which the Trust does not wish to support. • **Mitigation Measures** – Following consideration, the Trust's could mitigate the long waiting inpatient cap by ensuring patients are seen and continuously monitored. The Trust would be proactive in ensuring a red flag symptoms are communicated to patients, and regular harm reviews are conducted. Urgent cases are escalated appropriately. • **Service-Specific Concerns** - Initial agreements excluded rheumatology and metabolic medicine from the cap due to clinical risk. The Trust now seeks to extend this exclusion to all services, as the Trust is not comfortable with patients being added to the Trust's waiting list with not having any initial discussion. • **Collective Response -** A joint letter from Medical Directors across border hospitals has been sent in response to Powys' intentions. The Trust is seeking clarity on the specific elements being proposed and objected to particularly the outpatient appointment cap due to the clinical risk of having unseen patients waiting. • **Public Perception and Communication** – the Trust highlighted the need for a conversation with Powys Health Board regarding the impact on a large volume of patients. The Trust is responding to commissioners' decision and proposal and reiterated this is not something the Trust has initiated. • **Toolkit and Implementation** – Powys has provided a patient-facing toolkit, which the Trust agreed to review. However, concerns were raised regarding the lack of clear implementation guidance, particularly for actions expected in July. The Trust questioned whether it is now being perceived as non-compliant with commissioner expectations

Ref	Discussion and Action Points
	• **Patient Communication** – The Board stressed the importance of clearly articulating the Trust's position to patients affected by delays, ensuring transparency and reassurance regarding the Trust's commitment to their care. The Board agreed on the importance of maintaining oversight of this issue and commended the collaborative response from Medical Directors. The Trust reaffirmed its commitment to patient safety and The Trust reaffirmed its commitment to patient safety and endorsed the Trust's position to resist the imposition of a 52-week cap in order to and keep our patients' safe.
4.2.1	**Learning from Deaths Report**
	RL presented the Learning from Deaths Report to the Board and expressed appreciation to James Niel, Mortality Lead, for leadership within this role. The following was highlighted: • During the reporting period, there were two expected deaths. • In both cases, no concerns were raised by the families. • Feedback indicated that end-of-life care was delivered to a high standard, with families expressing gratitude for the compassionate and supportive care provided by staff. The Board extended its sincere condolences to the families following the loss of their loved ones and conveyed heartfelt thanks to the ward team for their continued dedication to delivering high-quality, person-centred care at the end of life.
4.2.2	**Controlled Drug and Accountable Officer Annual Report**
	RL presented the annual report which provides an overview of the Trust's compliance and governance arrangements in relation to the management of Controlled Drugs. The report outlines assurance received on the safe handling, prescribing, and administration of CDs, with particular reference to the Trust's performance against the Safety compliance framework. The following was reported: • Robust monitoring and oversight of CD usage across clinical areas. • Identification of opportunities for improvement, with actions taken to address any areas of concern. • Ongoing policy review and updates, particularly in light of the implementation of the e-Scribe electronic prescribing system, which has necessitated revisions to several existing procedures to ensure continued compliance and safety. This report was reviewed in detail by the Quality and Safety Committee, where assurance was received regarding the effectiveness of current controls and the proactive approach to continuous improvement. The Board noted the report and assurances received.
4.2.3	**Security Annual Report**
	KF presented the Security Annual Report, highlighted the following: • The Security Annual Report provides a comprehensive overview of security-related matters and associated influences across the Trust. • The report has been formally approved and presented to the Board of Directors for information and oversight following a recommendation from the Quality and Safety Committee were assurance was obtained. • There has been a noticeable improvement in the way managers conduct investigations into security incidents, reflecting enhanced accountability and responsiveness. • A decrease in non-physical incidents reported on the MSCI wards has been observed, supported by proactive work undertaken to support staff wellbeing and safety. The Quality ns Safety Committee confirmed there were content of the report highlights key trends, actions taken, and areas for continued focus to ensure a safe and secure environment for staff, patients, and visitors. The Board noted the report and thanked all staff for the improvement reported.
4.2.4	**Safeguarding Annual Report**

Ref	Discussion and Action Points
	KF presented the Annual Safeguarding Report following prior consideration at the Quality and Safety Committee. The Committee received assurance on the robustness of the processes in place to safeguard patients across the Trust. Over the past 12 months, there has been a positive improvement in safeguarding practices, notably led by Named Nurse. Key developments include the introduction of a complex care pathway, the launch of a Champion Programme, and the implementation of a Reasonable Adjustment Plan. Phase 2 of the Child Protection initiative has also been rolled out, further strengthening the Trust's safeguarding framework. The report outlines activity aligned with safeguarding policy and includes benchmarking against national training requirements, ensuring compliance and continuous improvement. The report has also provided assurance on previously identified gaps, with clear actions taken to address these areas. The Board noted the report and assurances received.
4.2.5	**Modern Slavery Statement**
	This statement has been endorsed by the Quality and Safety Committee and recommended to the Board for approval. The Board approved the revised modern slavery statement.
5.0	**People and Workforce**
5.1	**Performance Report**
	The following points were noted from the latest People and Workforce performance report: • **Staff Retention**: Performance remains above target, indicating strong retention across the Trust. • **Personal Development Reviews (PDRs)**: The target was successfully met in July. • **Statutory and Mandatory Training**: Compliance continues to exceed the target and has remained consistently high for the past 12 months. • **Vacancies**: Vacancy rates are currently above the target threshold and remain an area of focus. • **Bank Spend**: Increased bank spend is linked to the waiting list initiative. • **Job Planning Compliance**: Significant progress has been made in job planning compliance. Ongoing management and oversight will be provided through the People Committee. The Board noted the performance report.
5.2	**Chair's Assurance Report – People and Culture Committee**
	PM provided an overview of key matters discussed at the People and Culture Committee, highlighting the following points for Board assurance: • **Healthcare Assistant (HCA) Support Worker Vacancies**: Recruitment activity remains high in this area. However, concerns have been raised regarding the current Occupational Health contract, which is not meeting expected standards. As a result, the contract has been temporarily extended while preparations are underway to tender for a new provider. The Committee is also awaiting the outcome of a forthcoming review report, which may influence future contractual arrangements. This issue is being closely monitored. • **Triangulation of Workforce Reporting**: A discrepancy has been identified between the workforce trajectory data reported to the People and Culture Committee (PC) and the financial efficiency forecasts presented to the Finance and Performance Committee (FP). Specifically, the FP has reported a potential shortfall of approximately £250k against the plan, which is not reflected in the workforce planning data. The Executive Team is actively addressing this triangulation issue, and a formal report will be presented to both the FP and PC. Actions are being tracked through both committees to ensure resolution. It was noted that the financial forecast is currently the most up-to-date, and workforce data must be updated concurrently to ensure consistency. This alignment will be addressed through the triangulation report mentioned above. • **Health and Safety Executive (HSE) Inspection**: The Committee confirmed that the HSE inspection report has been received and that work has commenced in response to its findings.

Ref	Discussion and Action Points
	The Board thanked PM for the update and there were no specific questions raised.
5.2.1	**Freedom to Speak Up Report**
	The Freedom to Speak Up (FTSU) report was reviewed by the People and Culture Committee prior to being presented at the public Board meeting. The Committee considered the report and confirmed there were no issues to escalate, and the report was formally endorsed. The report outlines a number of next steps, detailed on page 200. These include a commitment to continue developing and reviewing the reporting mechanisms and processes to ensure they remain effective and responsive. There is also an intention to consider wider indicators that may help capture feedback more comprehensively, particularly in relation to how and where staff are raising issues and concerns. It was noted during the discussion that it is critically important for staff to see that the issues they raise are being addressed. This visibility is essential to building trust in the FTSU process and encouraging more staff to speak up. Staff need to see a clear benefit to engaging with the process, and the organisation must demonstrate that concerns are taken seriously and lead to meaningful action. At present, there are no significant trends emerging from the data. SN and DM agreed to meet outside of the Board meeting to discuss any operational matters or themes that may require further attention. HT emphasised the importance of triangulating the data, particularly with the results of the staff survey, to ensure a robust and transparent approach to understanding the issues being raised. While most categories remained stable over the reporting period, bullying and harassment was highlighted as an area of interest. HT observed that this category had shown a decline over the last three reporting periods, and queried whether increased pressure within teams at year-end may have contributed to earlier spikes. PM responded that the changes were not statistically significant and cautioned against drawing assumptions without further evidence. HT reiterated the need for triangulation, suggesting that the staff survey should be used as a key source of insight. SN added that other forums could also be explored to collect relevant data and feedback. SK requested that future reporting incorporate protected characteristics, and asked how this could be aligned with staff experience reports to ensure that the perspectives of all staff groups are adequately represented. The Board noted the report.
5.2.3	**Guardian of Safe Working Hours Report**
	RL presented the paper to the Board, highlighted the following points: • No exception reports were submitted from RJAH during the reporting period, reflecting continued compliance with safe working hour standards. • The electronic reporting system has now been fully embedded, providing streamlined support for monitoring and managing junior doctors' working hours. • The introduction of the Resident Doctors 10-Point Plan marks a significant development. This new role is being actively integrated within the Guardian of Safe Working Hours framework, with close collaboration involving the Director of Medical Education and the Freedom to Speak Up (FTSU) Guardian. • A dedicated working group has been established to oversee the implementation and alignment of the Resident Doctors initiative. Progress updates will be presented to the People and Culture Committee as the work evolves. • Mr. Chris Marquis, Lead Guardian of Safe Working Hours, was commended for his continued dedication and leadership in this role. The Board noted the report and commended the Trust on another exceptional performance.
6.0	**Performance and Finance**
6.1	**IPR Exception Report (inc. Long Waiting Patients)**
	MC presented its performance report to the Board, highlighting several key areas of progress and ongoing challenges:

Ref	Discussion and Action Points

	• **Organisational Performance and Focus** - During July, the Trust recorded an improvement of just over 2% against the operational plan. This reflects a strong organisational focus and coordinated effort. While this progress is encouraging, the Board was reminded not to become complacent, as there are still challenges to address. Performance is monitored weekly, and the current trajectory remains positive.
	• **Sustainable Actions Driving Improvement** - The improvements observed are largely the result of sustainable actions that have been developed and embedded over the past year. These include:
	  ○ Successful recruitment of clinicians now in post.
	  ○ In-sourcing initiatives within rheumatology, which have significantly reduced waiting lists.
	  ○ Implementation of a DEXA scanner.
	  ○ Appointment of three Whole Time Equivalent (WTE) consultants in arthroplasty and spinal disorders.
	  ○ Additional support for specialist spinal nurses to increase service capacity.
	• **Patient Initiated Follow-Up (PIFU)** - The positive trend in PIFU continued through August, with improvements averaging one percentage point per week.
	• **Impact of Incoming Support Measures** - The Trust is beginning to see the benefits of recently implemented support measures, which are contributing to improved performance across several areas.
	• **Outpatient Appointments for Welsh Patients** - The time to first outpatient appointment for Welsh patients has deteriorated. This is linked to issues previously raised with Powys, and discussions are ongoing to resolve these concerns.
	• **52-Week Waits** – There has been an increase in 52 week waiters however this continues to reduce in August.
	• **Elective Activity**: - Elective activity remains behind plan. In July, the Trust did not meet its 100% theatre utilisation target, primarily due to shortfalls in outsourced activity.
	• **British Association of Day Surgery (BADS) Metrics** - BADS rates have been low since the introduction of new metrics for hip and knee procedures. Current day case rates are at 46.9%, compared to a target of 58.8%. There is a noticeable gap between intended and actual day case rates. The Trust is working with clinical teams to build confidence in booking patients as day cases, supported by procurement efforts.
	• **Outpatient Activity** - Outpatient activity is ahead of plan, with an improved trajectory noted.
	
	The Board acknowledged the current performance improvements and reaffirmed the importance of maintaining momentum to ensure full delivery of the operational plan.

6.1.1	**Long Waiters Presentation**
	The long waiters discussion has been captured within the IPR performance report agenda item as a key performance indicator for the Trust.
6.2	**Finance Performance Report**
	AMW confirmed that the Trust remains on plan for Month 4, with the core financial objectives met. The financial trajectory continues to be refined and is currently in working draft form. • Activity and Income - Months 2 and 3 were challenging due to reduced activity linked to the Apollo programme. By the end of Month 4, the Trust is £3.6m behind plan on income, primarily due to continued activity reductions. This shortfall has been partially offset by favourable variances in pay and non-pay expenditure. • Efficiency Delivery - The Trust's £9m efficiency programme is on track year-to-date, with some over-delivery in non-recurrent schemes. A risk of £460k has been reported within the period, including £250k related to corporate workforce reduction. • Planning for 2025/26 - Development of next year's efficiency programme is underway. A headline draft plan is scheduled for submission to the system by the end of September. • Cash Position - The Trust continues to hold a positive cash balance. • Capital Programme - The capital plan is on track and within budget, although there are phasing differences between the initial and completed plans. • Forecast and Risk Assessment - A full-year forecast has been reviewed, based on the recovery activity plan and current run rates. The financial trajectory includes a range of

Ref	Discussion and Action Points
	scenarios, Worst-case: £4.4m deficit (excluding mitigations) and Best-case: £200k surplus ahead of plan The recovery plan remains in development and does not yet reflect all potential mitigations. A risk assessment has been completed by the operational team, considering amber and red-rated mitigations. The Board noted the financial performance and highlighted the interdependencies between operational and financial plans.
6.3	**Chair Report from Finance and Performance Committee**
	SN presented the Chair's report, highlighting the following key points: • **Forecast and Recovery Plan**: Echoing AMW's comments, significant work has gone into developing the financial forecast and recovery plan to ensure delivery against the agreed targets. • **Spinal Pathway**: A recent patient story powerfully illustrated the challenges within the spinal service, particularly around long waits and referral pressures. Business case options are being explored to address these issues. It is important that all Board members are aware of the system-level discussions underway to develop a more sustainable spinal service at RJAH. There was a query regarding whether the Improvement Team could support enhancements in patient experience and pathway development. The Board discussed the following: • **Diagnostics**: There has been improvement in the 6-week diagnostic wait position. However, activity levels are decreasing against plan, and referral volumes are trending downward. This raises concerns about potential resilience issues within the diagnostics team. While anticipated hours are being delivered, patient throughput is lower due to increasing complexity. There is a need to ensure equitable access across the country. The Committee identified an opportunity to explore imaging performance in more detail at future meetings. A request was made for support from the Quality and Safety Committee regarding imaging. It was confirmed that a focused deep dive on diagnostics has been tabled for further discussion at the Performance and Financial Improvement Group. • **BADs Performance**: Concerns were raised about booking processes and performance against the 85% target. Actions are underway, and the team is considering how close we can get to achieving this. There is a need to better understand patient volumes and refine metrics. The Trust continues to lead nationally in length of stay for arthroplasty, supported by enhanced recovery pathways. The mix of day case and inpatient procedures is not selected but based on clinical need. There is a challenge to define the appropriate metrics for the Trust and align them with national BADs metrics. It was noted that the target is national set. The Trust is struggling with the definition of day case mix. An additional Trust-specific metric is being considered to sit alongside reporting the national BADs metrics. • **Workforce Planning**: Reflections were shared on the financial position and its triangulation with workforce planning. A push is needed on workforce reduction, which has a lead time. Greater oversight is required in the coming month. AMW confirmed that actions have been implemented to support delivery of the workforce reduction, with the £500k programme target, with £280k achieved to date. While not yet on plan, the forecast remains at risk. • **Underlying Run Rate**: There is concern about delivery risk, particularly as the plan assumes private patient income will remain on target for the rest of the year, despite only one month meeting the target so far. The year-to-date run rate aligns with the assumed plan, which is considered less risky than Q1. • **NOF Financial Impact**: The importance of understanding the financial implications of NOF procedures and the differences between types 1 and 2 was noted. • **Financial Position**: The Committee acknowledged the tight financial position. The PFIG has been implemented and its Terms of Reference updated accordingly. The Trust are developing a Finance and Performance dashboard to be presented weekly to support ongoing monitoring. • **Specialty-Level Performance**: There was a request for clearer visibility of performance and risk levels across specialties. Understanding how improvement teams are being supported and how underperforming teams are being developed is key.

Ref	Discussion and Action Points
	Following consideration at the Finance and Performance Committee, the revised Terms of Reference were recommended to the Board for approval.
6.3.1	**Activity Recovery Committee (Terms of Reference)**
	Following a recommendation from the finance and performance committee, the board approved the revised terms of reference for the activity recovery committee. It was reiterated that the activity recovery committee will continue to report directly into the finance and performance committee monthly. The Board approved the terms of reference.
7.0	**Chair Report from Digital, Education, Research, Innovation and Commercialisation Committee**
	On behalf of ME, AI presented the Chair's Report, highlighting the following key updates: • **Apollo:** The Electronic Patient Record (EPR) programme has identified that not all clinical firms are currently represented within the Clinical Reference Group. While it is beneficial that this group meets during the selection process, further assurance is required regarding the completeness and inclusivity of engagement across all specialties. Additional assurance is needed around the effectiveness and consistency of communication with consultants regarding digital developments and clinical system changes. Regarding the Clinical Safety Officer role, 14 to 16 additional staff members are scheduled to be trained. This aims to enhance resilience and provide robust support to frontline staff. System delivery responsibilities within System C require further clarification to ensure accountability and alignment with implementation timelines. **PAC System:** For the Picture Archiving and Communication System (PACS), efforts are underway to ensure alignment with procurement processes. Due to the urgency of delivery, there is a need to diverge from the national framework. Engagement with SaTH (Shrewsbury and Telford Hospital NHS Trust) is necessary to explore collaborative opportunities. The Committee queried whether a more formal approach should be taken in engaging with SaTH to support shared digital objectives. • **The Improvement and Innovation Strategy:** The strategy has been formally approved by the Committee. • **Digital KPIS:** A digital Key Performance Indicator (KPI) framework is under consideration. Metrics will be divided into operational-level and Board-level indicators to ensure appropriate oversight and accountability. • **Digital Strategy Update: The** Year One Plan of the Digital Strategy has been shared. It provides transparency on the prioritisation of initiatives, with a clear focus on patient safety and operational support. The Board noted the report .
8.0	**Chair Report from Audit and Risk Committee**
	MN presented the Chair's Report, outlining the following key updates: • **Committee Annual Report and Terms of Reference:** The Committee received and reviewed its Annual Report and Terms of Reference. The Terms of Reference were formally endorsed by the Committee and were recommended to the Board for approval. There were no concerns to raise to the Board. • **Information Governance:** The committee received an update on Information Governance, including the completion of the self-assessment using the Data Security and Protection Toolkit. Internal auditors have been asked to review the outcomes of this assessment. • **Financial Governance:** The Committee reviewed the aged debt report, which included ongoing issues related to unpaid invoices for veteran services. Despite non-payment, the Trust continues to provide these services. This matter has been escalated to the Finance and Performance Committee for oversight. The Board discussed the following: • **Veterans Services**: It was confirmed that three Integrated Care Boards (ICBs) are currently not making payments in relation to the veterans' service. The Committee discussed the need to clarify the process for recovering these payments. A position was

Ref	Discussion and Action Points
	agreed that if payments are not received, the Trust may need to consider pausing acceptance of new referrals. This issue has been escalated through the relevant ICBs to initiate further dialogue and follow-up. • **Annual Report and Terms of Reference:** The Committee's Annual Report was noted as demonstrating strong performance and effective governance throughout the year. The Board noted the update from the Chair of the Audit and Risk Committee and formally approved the Terms of Reference.
9.0	**Questions from the Governors and Public**
	HT encouraged questions and comments from the members of the governors: • **Patient Feedback and Surveys:** KB raised the idea of collecting patient feedback more frequently, such as every other month, including from those on waiting lists. It was noted that patients who have attended outpatient appointments or undergone surgery receive SMS messages via IQVIA. Any negative feedback or emerging themes are reviewed through the Patient Experience Group. Patients can be contacted directly if they express a wish to discuss their experience further. • **Appointment Communication:** Most appointment reminders are now sent via text or email, with patients encouraged to opt into digital communications. Outpatient appointments are followed up with booking reminders. NT raised concerns about poor communication, including missing letters and lack of follow-up conversations. MC highlighted that DNA (Did Not Attend) and "Was Not Brought" rates are above national benchmarks. There was discussion around how the Trust can better measure outpatient performance, including cancellation timeliness and communication assurance. • **Staff Behaviour and Policies:** Governors discussed the impact of staff behaviour on patient experience, including the use of mobile phones and adherence to the uniform policy. It was agreed that staff should lead by example to promote a positive experience. • **Staff Wellbeing and Recognition:** VS raised concerns about staff wellbeing and the reduction in goodwill. The Stars Awards received a high number of nominations, and there was interest in sharing and recognising these achievements more widely. • **Booking System and Communication:** CC raised concerns about missed calls and the effectiveness of the booking system. MC explained that booking clerks have now been aligned to firm-level booking teams to improve continuity and offer more options. This change was implemented on Monday and will be reviewed over time. HT thanked the Governors for their comments.
10.0	**Any Other Business**
	There were no further items of business for discussion HT thanked all attendees for their time and contribution to the discussion before closing the meeting.
10.1	**Date and time of next meeting:** Wednesday 05 November 2025 at 9:30am

Board of Directors Meeting

Updated: 28 October 2025

Action Log No.	Original Meeting Date	Minute reference	Action	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
2	03-Sep-2025	**Patient Story**	Update report to be presented back to the Board via the Quality and Safety Chairs Assurance Report. It was agreed the QS Committee would receive an update progress report on the actions which are to be undertaken to improve the process following the discussion at the Board meeting.	Interim CNO / Chair of QS Committee	**05-Nov-2025**	**Complete** - progress report shared at the QS Committee and reported within the Chairs Assurance Report.	COMPLETED

NHS Shropshire, Telford and Wrekin

Integrated Care System
Shropshire, Telford and Wrekin

Musculoskeletal Services
Shropshire & Telford

MSK System Collaboration and Neighbourhood Working

Aligning MSK Innovation with National Priorities for Integrated, Preventive, and Community-Based Care

Date: 05/11/25

System, Place and Neighbourhood

System Level

Population size: 500,000–3 million people (the STW ICS footprint).
Focus: Strategic planning and resource allocation across the whole system.
Key features: Sets overall strategy, manages financial control totals, and oversees performance. Plans specialist services, workforce, digital infrastructure, and estates. Accountable to NHS England for outcomes and delivery of the NHS Long Term Plan.

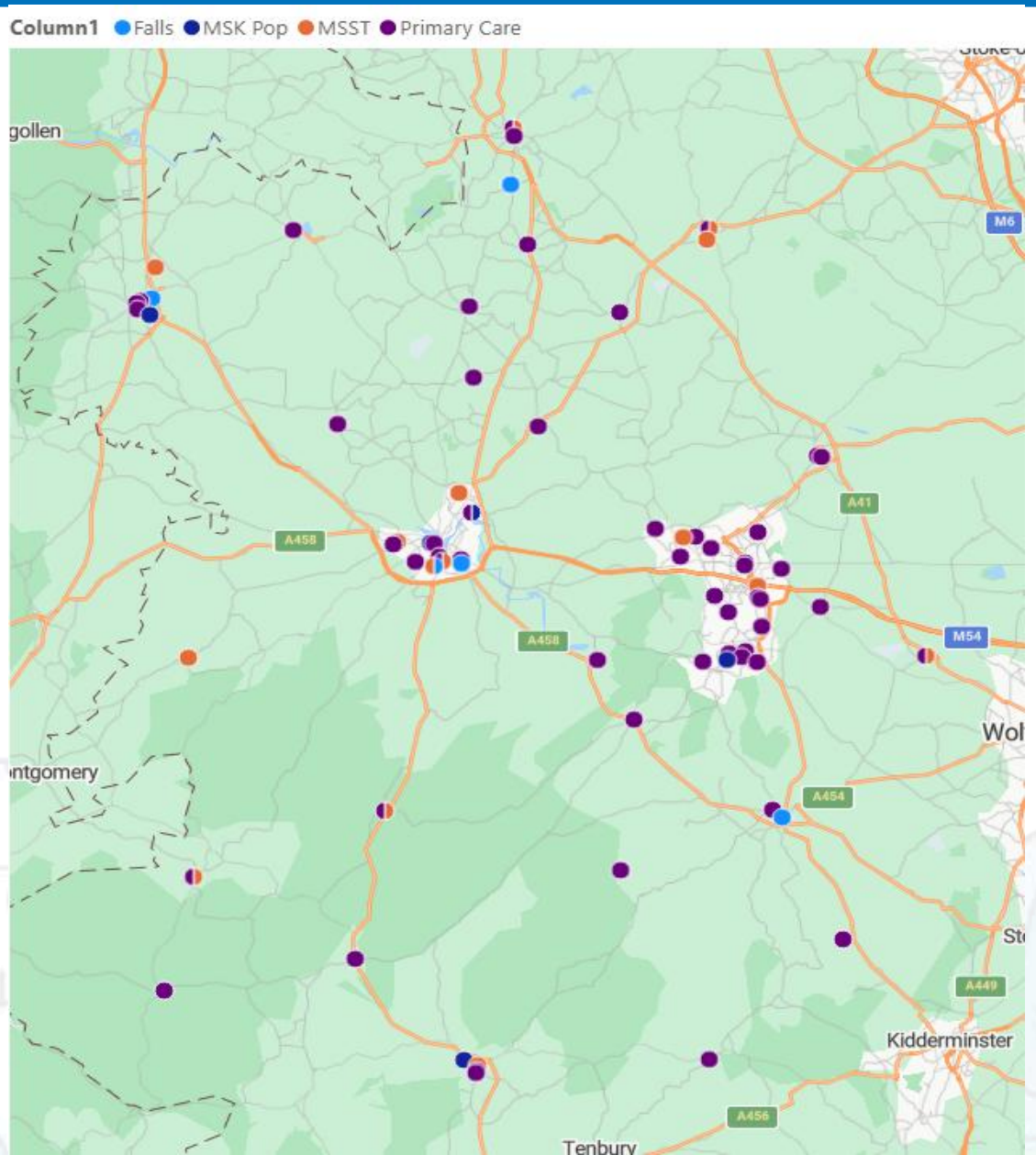
Place Level

Population size: Around 250,000 people (Telford & Wrekin and Shropshire local government districts).
Focus: Integration of health and care services across a town, city, or district.
Key features: Partnerships between NHS providers, local authorities, voluntary and community organisations and social care.
Responsible for designing and delivering integrated care pathways, tackling wider determinants of health (housing, employment, education).

Neighbourhood Level

Population size: Typically, 30,000–50,000 people.
Focus: Day-to-day, personalised, and proactive care close to home.
Key features: Delivered through Primary Care Networks (PCNs) and multi-agency neighbourhood teams. Brings together GP practices, community health services, social care, and voluntary sector. Aims to integrate care for people with long-term conditions, reduce hospital admissions, and address local health inequalities.

Where are MSK venues located at these levels?



MSK healthcare already occurs in these three levels:

- ***System:***
  RJAH, SaTH Hospitals - RSH & PRH. (no dots)
- ***Place:***
  MSST Community MSK Pathways, Falls clinics
- ***Neighbourhood*** :
  First Contact Practitioners (MSK FCP)
  Good Boost or Escape Pain

The National Direction

NHS 10-Year Plan

- **From hospital to community**

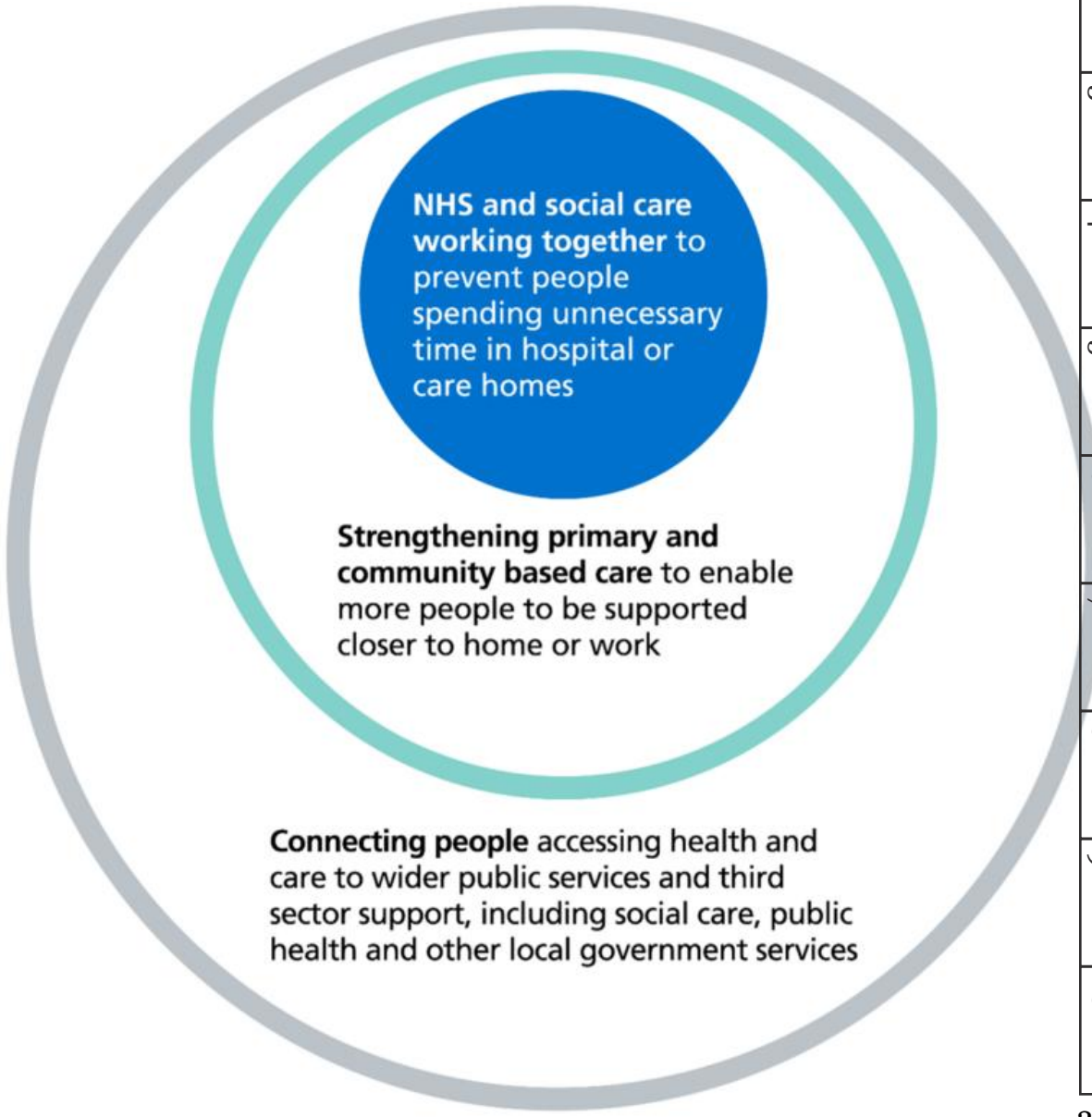
  A shift in focus from hospital-based care to more integrated, community-based services.

- **From analogue to digital**

  Embracing digital transformation to improve access, efficiency, and patient experience.

- **From sickness to prevention**

  Prioritizing preventive care and population health to reduce the burden of disease



The Whole Pathway
End to end thinking as a collaborative system

- There has been a growing movement over recent years to be involved in parts of musculoskeletal pathways (MSK – therapy, advanced interface, orthopaedics, rheumatology, pain management) outside the immediate concerns of an organisation.
- Achieving the NHS 10 year aims will involve "doubling down" on this system approach to MSK pathways.
- We have laid the foundations down for MSK in Shropshire, Telford & Wrekin ICS by establishing a single point of referral and triage, standardised MSK pathways and an integrated, multi-organisation collaborative approach to Community MSK pathway (MSST - Musculoskeletal Services, Shropshire & Telford)

End to end MSK pathways

The new challenges for RJAH as MSK Transformation system lead

Neighbourhood Health: A Radical Shift

Transforming culture, resource allocation, and ways of working

Focused on proactive, person-centred care rooted in local communities

- This part of the so-called "Left Shift" of resources and activity in the 10 Year plan.
- It is coupled with the already establishing movement from analogue methods of communication and health delivery to digital approaches.

The Neighbourhood Implementation Programme

How STW is mobilising for delivery

Programme Mobilisation

Emma Pyrah (ICB Head of System Development) is SRO and Naomi Roche ICB Neighbourhood Lead

Establishing a place-based team of 18 stakeholders to lead neighbourhood model development

PCN Led Multistakeholder Integrated Neighbourhood Teams Project Groups

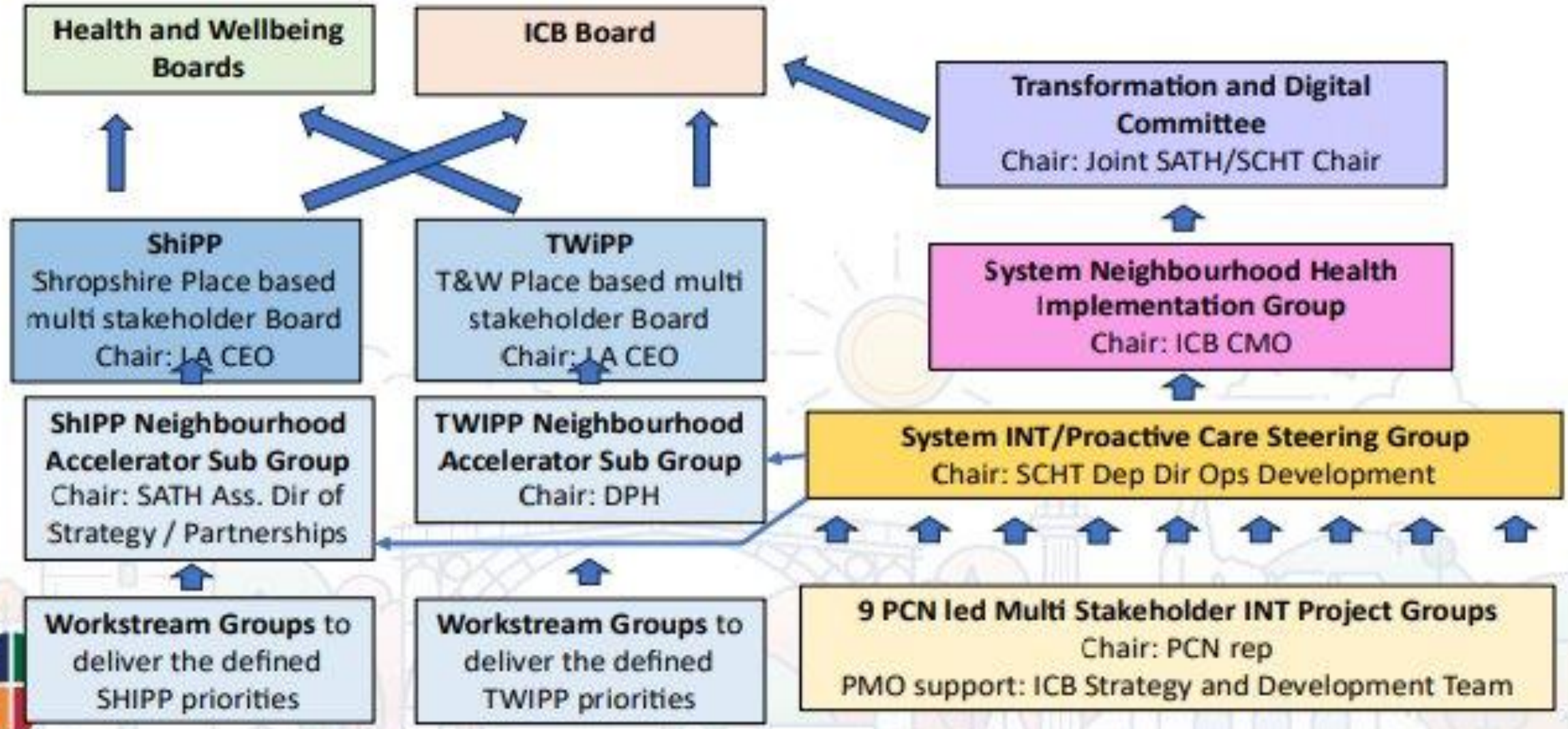
PCN-led, multi-stakeholder project groups are forming across Shropshire and Telford

Focused on developing place-based, proactive care models based on PCN data and intel coupled with ICS level population health data

Strategic Role of RJAH as MSK Transformation lead

RJAH contributes MSK expertise and system level resources. Aligns with national goals of *Hospital to Community* and *Sickness to Prevention.* Chairs the MSK Population Health and Health Inequalities Group

STW Governance Structure and Neighbourhood Health and INT Development



RJAH & MSK Representation

STW ICB Engagement

- Applications submitted for Shropshire and Telford & Wrekin
- Shropshire selected as one of 42 national pilot areas for 25/26
- Telford not accepted this year

Regional Workshop session 1 on 23rd Oct 25

- 3 briefing days in Leicester, starting 23 October 2023
- RJAH and STW MSK Transformation were represented by *Geraldine Vaughan MSK Transformation PMO*

Current MSK Transformation and RJAH Involvement

- Membership and representation at both *ShiPP* and *TwiPP Neighbourhood Accelerator Sub-Groups*
- Active in *PCN-led Integrated Neighbourhood Teams Project Groups* and pending greater and wider involvement

PCN Led Multistakeholder Integrated Neighbourhood Teams Project Groups

- Attended North Shropshire INT meeting
- Attended Teldoc meetings and engaged with MSK and digital co-working
- Due to attend Newport and Central
- Engaged with Shrewsbury PCN for MSK and digital co-working

RJAH and MSK Transformation
Neighbourhood Health Programme inputs 1

Strategic Contributions

- ***MSST Community MSK Service*:** supports community-based MSK care, reducing reliance on hospital services
- ***First Contact Practitioners (FCPs)*:** RJAH employs FCPs and aims to expand their presence in primary care, enhancing early access and triage
- ***Good Boost Partnership*:** Promoting physical activity and rehabilitation through tech-enabled, community-based programmes
- ***Health Inequality Focus*:** actively working to address disparities in access, outcomes, and experience across its services
- ***My Recovery App:*** for end-end MSK pathway digital support.

Alignment with "Hospital When Necessary"

- Delivers care closer to home, reserving hospital for complex or specialist interventions
- Supports *virtual wards*, *urgent community response*, and *rehab at home* models (to be further developed)

RJAH and MSK Transformation
Neighbourhood Health Programme inputs 2

Enabling Neighbourhood MDTs

- MSK clinicians contribute to *proactive, planned care* for frailty, chronic pain, and mobility issues
- MSK expertise enhances *multidisciplinary working* across teams

Innovation & Workforce Development

- RJAH leads in *digital MSK care* and supports *upskilling* of primary care and community teams
- FCP expansion aligns with *Modern General Practice* and *standardised community health services*

Population Health & Prevention

- MSK conditions are a major driver of disability and inequality
- RJAH uses *data-driven approaches* to target high-risk groups and improve outcomes (aim to get SaTH and SCHT to develop this approach too).

1) Community Pain Service Transformation

Hospital to Community & Prevention

Moving to a *holistic model* of support for people to live well with pain, once diagnosis is given

1) **Delivered *closer to home***, supporting the shift from hospital-based care
2) **Pain Support Advisors** Similar to *Social Prescribers* Trained in *Motivational Interviewing*, *CBT techniques*, and *local signposting* Provide *6 months of support* to help patients make sustainable changes
3) **Education & Empowerment** 10-module programme covering: Sleep, Eating, Exercise, Anxiety, Pain Management *Personalised Pain Support Plans* developed for each patient
4) **Community Integration & Safeguarding** Access to: Exercise programmes, Peer support groups, Mentors
5) **MDT involvement**: Pharmacists (opioid reduction), GPs, RJAH Pain Specialists, Physiotherapists, Counselling services

2) Strengthening FCPs in Primary Care

Hospital to Community, Prevention, Digital

RJAH FCP Employment Model

- RJAH currently provides FCPs to *North PCN*, alongside FCPs from a private provider
- *North PCN* keen to recruit an additional *2.1 FCP capacity* from RJAH
- Agreement to share *impact data* from RJAH-employed FCPs with other STW PCNs
- Evidence will support development of a *Trust-employed FCP model* across the system

Digital Integration – MyRecovery App

- *MyRecovery dashboard* provides personalised exercise plans for MSK patients
- Aim to expand app usage among FCPs in primary care • Ensure all digitally-enabled patients are onboarded and receive tailored plans
- Supports *secondary prevention* and streamlined referrals to community and secondary care

Strategic Alignment

- Supports NHS goals of *Hospital to Community*, *Sickness to Prevention*, and *Analogue to Digital*
- Enhances early access, patient empowerment, and continuity of care

3) MyRecovery App

Strategic Focus: Analogue to Digital & Secondary Prevention

- *MyRecovery app* available to the general public, Primary Care, Community, and RJAH
- Offers MSK exercise plans, education, and signposting to local services
- Supports patients to *self-manage conditions* and *wait well* if on NHS waiting lists
- Boosting Population Health & Supporting NHS Sustainability

Population Reach & Opportunity

Potential to support *31,081+ individuals* with MSK and broader health needs

Wider health modules included or to include:

- Smoking cessation services
- Blood pressure monitoring (Public Health partnership)
- MSK & employment module (MSK is 2nd leading cause of long-term sickness)
- Falls prevention programme
- Social prescribing referrals
- Mental health support
- Weight management advice
- Diabetes checks

Strategic Impact • Empowers patients • Reduces demand on acute services • Supports *economic growth* through improved health and employment outcomes

From sickness to prevention: power to make healthy choices via digital means

Number of patients engaged with myrecovery app	
Programmes	**Number**
MSST	12100
Primary Care	1599
Elective	17382
Total	**31,081**

Success in identifying and supporting smokers			
Services	Surveys completed	Smokers Identified	Want Support to help stop
Elective	6406	524	n/a
MSST	8174	854	159
Primary Care	684	64	9
Total	15,264	1.442	168

Economic cost of people who smoke on health is £1.82 billion and economic productivity cost of £27.6 billion in missed productivity

Good Boost – a pilot in a "Shift Left" using digital AI individualised exercise in the community

Good Boost – Community-Based MSK Exercise Programme

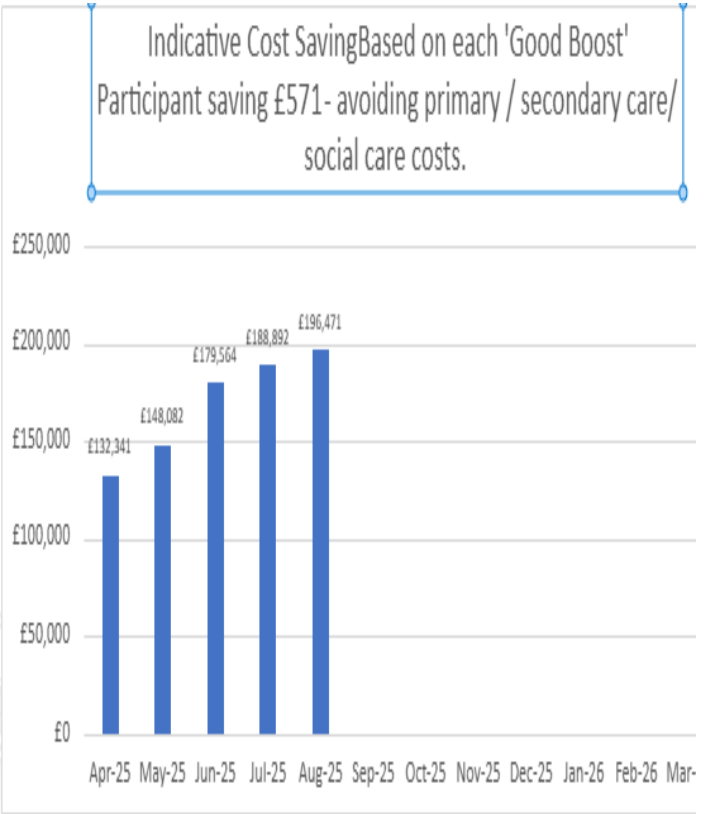
Strategic Focus: Hospital to Community & Sickness to Prevention

Good Boost AI MSK Exercise Programme delivered in partnership with Leisure Centres and Local Councils

Sessions held at *5 Leisure Centres* across STW: –

- Whitchurch
- Oswestry
- Telford
- Ludlow
- Shrewsbury

353 participants* engaged since *April 2024



Strategic Impact

- Promotes physical activity and self-management
- Reduces demand on hospital services
- Builds local capacity for prevention and rehabilitation

The Spinal pathways

The Spinal pathways

Existing Pathway -

Referrals accepted into secondary care from a number of referral routes with a requirement of an up-to-date MRI scan. Main routes:

- GP's
- Interface services
- Specialist opinions (tertiary referrals)

Referral volumes over previous years (& % increase year on year):

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
English	2991	3296	3251	3228	3616	4242	4021
Welsh	1543	1507	1470	2215	2105	2588	2781
Total	**4534**	**4803**	**4721**	**5443**	**5721**	**6830**	**6802**

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
English		10%	-1%	-1%	12%	17%	-5.21%
Welsh		-2%	-2%	51%	-5%	23%	7.46%
Total		**6%**	**-2%**	**15%**	**5%**	**19%**	**-0.41%**

The Spinal pathways

Existing Pathway -

The existing pathway and the consistent increase of referrals being seen from both England & Wales presents a problem for the service. There is a significant capacity & demand imbalance.

English referrals saw significant growth in 2022/23 and again in 2023/24 with 2024/25 levelling off a bit but not dropping to pre-2022/23 levels.

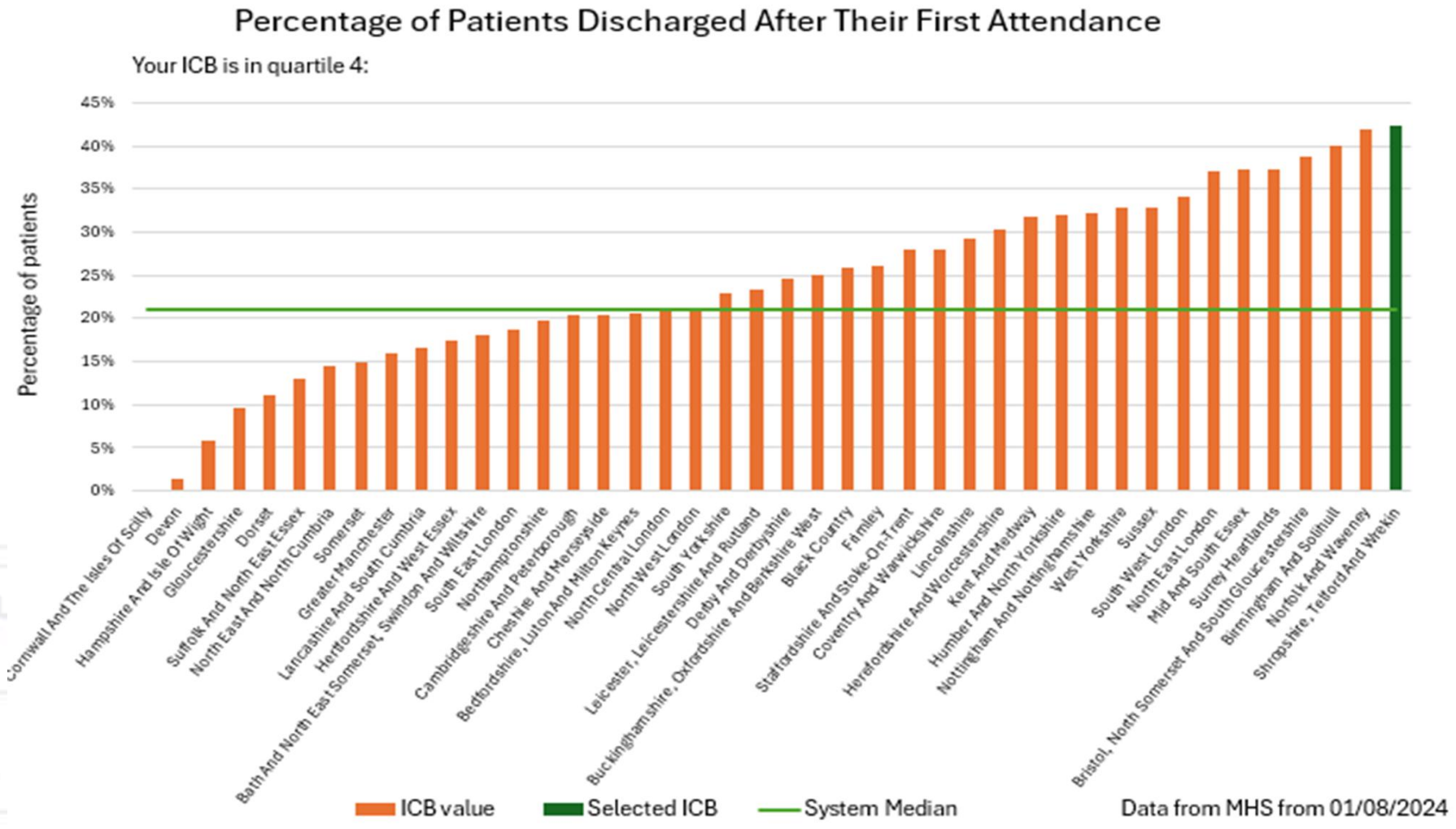
Welsh referrals saw a 50% increase in 2021/22, another 23% increase in 2023/24 and another increase of 7.5% in 2024/25.

The current rate of discharge from 1st OPD appointment is around 33% (see table). This arguably demonstrates the rate of referrals not necessarily required to come into secondary care, which presents an opportunity for us to review the pathways in place.

*Conversion rate from new appointment 12m from Dec 2023 to Nov 2024:

Consultant	Added to Diagnostic WL	Added to FU WL	Added to IPWL	Discharged
Mr B Summers	57.41%	18.98%	0.00%	23.61%
Mr Birender Balain	41.00%	26.84%	14.45%	17.70%
Mr D Jaffray	26.56%	5.41%	0.16%	67.87%
Mr J Trivedi	38.57%	27.65%	6.48%	27.30%
Mr Matthew Ockendon	38.18%	16.10%	10.13%	35.58%
Mr Mohamed MOHAMED	35.34%	26.30%	12.60%	25.75%
Mr N T Davidson	29.46%	31.25%	7.59%	31.70%
Mr Philip Brown	36.15%	30.95%	14.50%	18.40%
Mr Sarfraz Ahmad	23.46%	21.30%	13.27%	41.98%
Mr Shashank D Chitgopkar	41.88%	15.74%	8.63%	33.76%
Mr Sudarshan Munigangaiah	48.32%	16.16%	7.91%	27.61%
Mr Sujaya Kumar Dheerendra	47.44%	22.01%	6.83%	23.72%
Total	39.39%	20.22%	8.04%	32.36%

The Spinal pathways



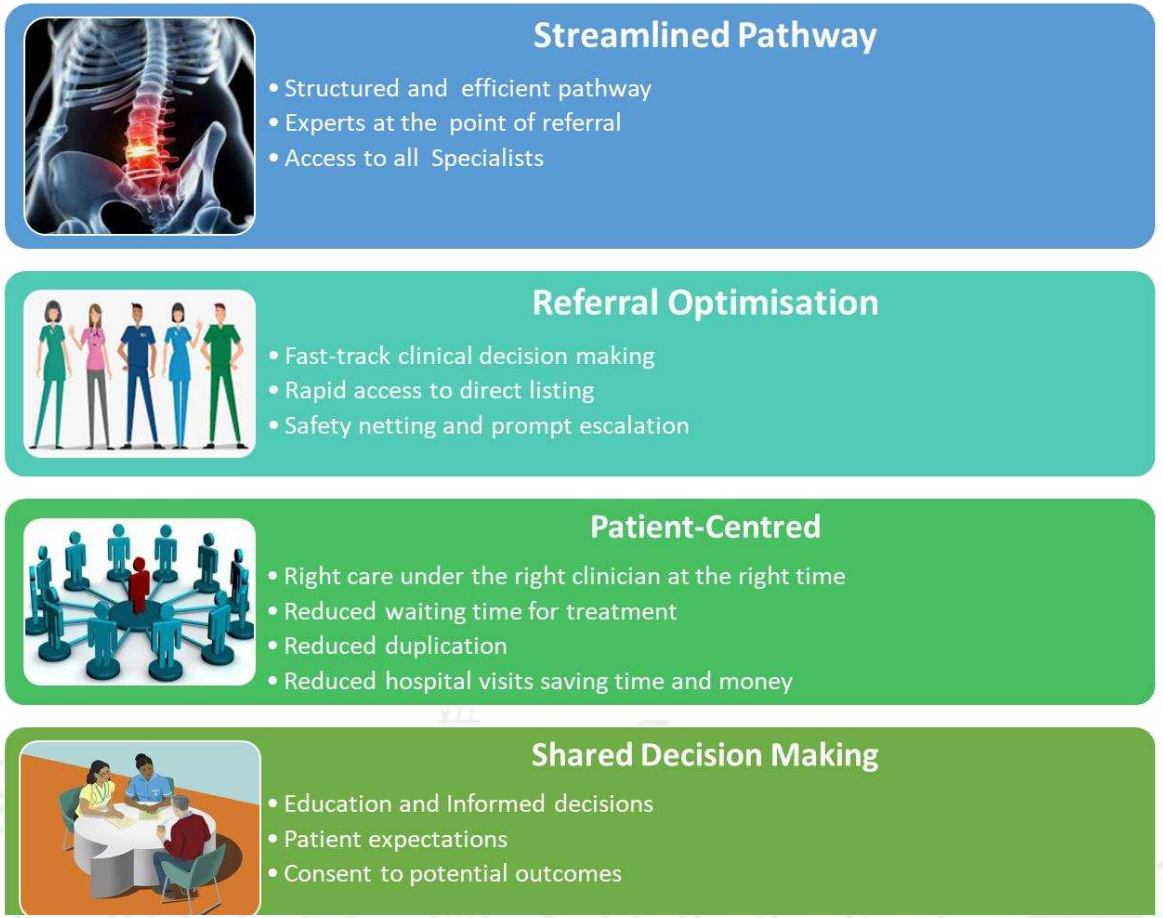
The Spinal pathways - GIRFT

GIRFT Back Pain Pathway – Right Care, Right Place, Right Time.

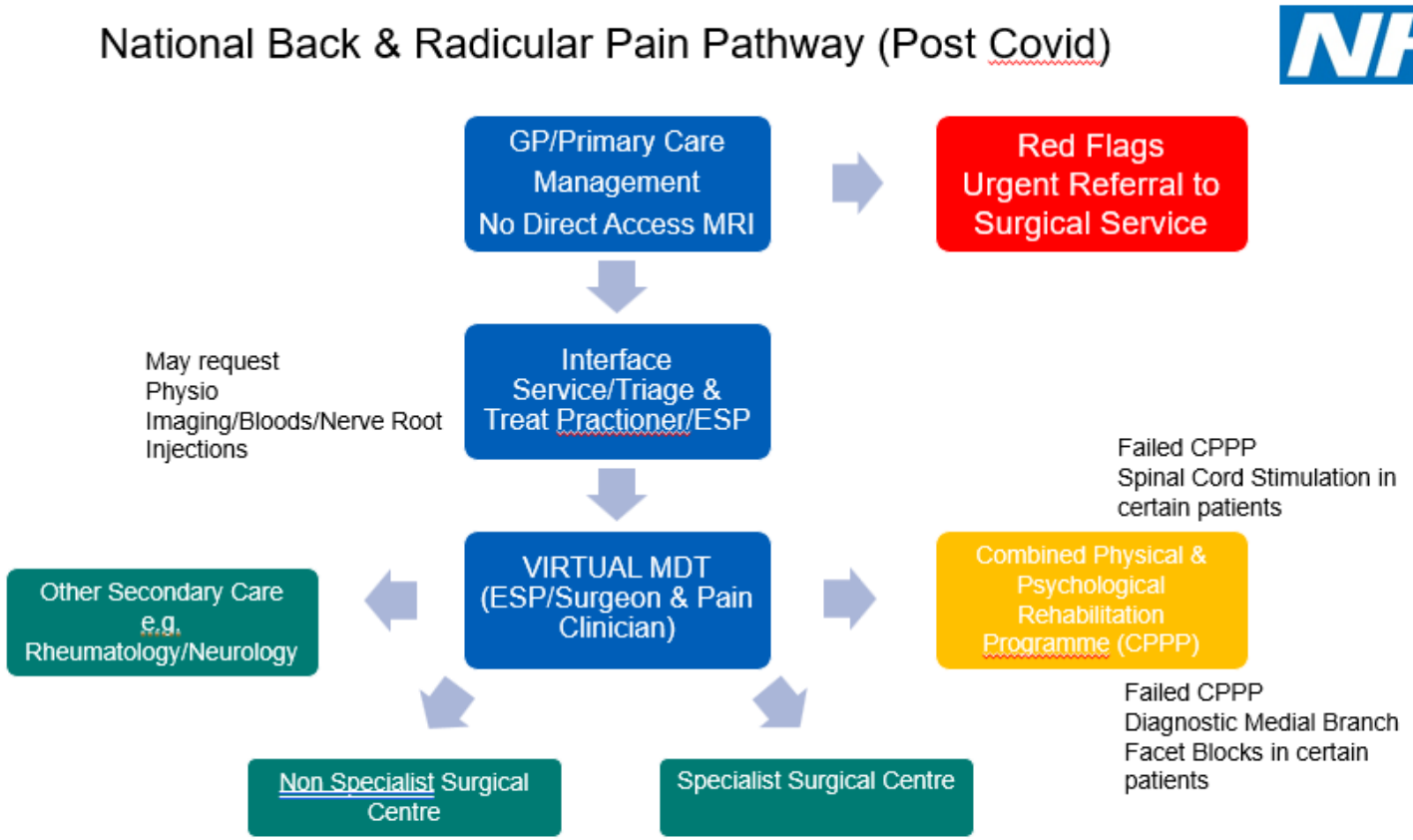
January 2025 GIRFT visited and presented a new back pain pathway with a **single point of access** that has been implemented successfully at SWELOC.

The pathway can be seen on the following slide, but has the following benefits:

- Streamlined pathway
- Referral optimisation
- Patient-centred
- Shared decision making



The Spinal pathways – GIRFT



The Spinal pathways – GIRFT

Implementation of GIRFT Pathway –

Large-scale pathway change, requires multiple stakeholder engagement.

Things already in place:

- Virtual MDT's – 2 per month with 2 x spinal disorders consultants
- Pain Service – being recruited to November 2025 with a view to commencing March 2026
- Updated secondary care acceptance criteria

Immediate Work ongoing:

- Demand & Capacity for interface service at each level once single point of access is live

The Spinal pathways – GIRFT

Implementation of GIRFT Pathway –Next Steps

1. Implementation of updated criteria within MDT for patients already within MSST:

- Confirmation from triage teams and MSST on readiness to implement now criteria finalised.
- Aiming for start date of December
- Regular review once live to assess any nuances requiring adjustment

This should reduce demand into secondary care and ensure patients that don't require to be n secondary care are seen and treated quicker.

2. Single point of access – Go Live

- Requires demand & capacity work to be completed (to be completed by December) and any required recruitment from this
- By this point the teams will be used to the new pathway and we will have addressed teething issues from this model before the volume of referrals increase. GP's will also have assurance of the shorter wait times and other benefits within the service to support in the loss of direct access to MRI.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Thank you

Chief Executive Officer Update

Committee / Group / Meeting, Date

Board of Director, Public Meeting, 05 November 2025

Author:

Name: Stacey Keegan
Role/Title: Chief Executive Officer

Contributors:

Chris Hudson,
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 to Board members on key local activities across several business areas not covered within the main agenda.

This paper provides an update regarding some of the most noteworthy events and updates 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
BAF	Board Assurance Framework
CEO	Chief Executive Officer
CQC	Care Quality Commissioners
DHSC	Department of Health and Social Care
DMD	Duchenne Muscular Dystrophy
EAP	Early Access Programme
EPR	Electronic Patient Record
FoSH	Federation of Specialist Hospitals
GBE	Great British Energy
ICB	Integrated Care Board
NHS	National Health Service
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust

Chief Executive Officer Update

1. Medium Term Planning Framework 2026-2029

On 24 October 2025 NHS England (NHSE) and the Department of Health and Social Care (DHSC) jointly published the Medium-Term Planning Framework covering the financial years 2026/27 to 2028/29. The framework commits to more ambitious targets across cancer, urgent care, waiting times, access to primary and community care, mental health, learning disabilities and autism, and dentistry, with an ambition to achieve constitutional standards by 2028/29 where possible. It also incorporates expectations around patient and staff feedback and aims to support delivery of the ambitions in the 10-year health plan.

2. NHS 10-Year Plan and our Trust Strategy

At the end of September, we held a valuable planning workshop to consider in detail the NHS's 10-Year Plan and to consider how we may need to adjust or adapt our own Five-Year Trust Strategy to ensure it is fully aligned with that wider plan. The half day workshop was attended by a range of senior clinical and operational leads, with representation across all Units. A very useful discussion was had, where we covered a wide range of areas including national, system and Trust Strategy alignment; supporting strategies alignment and 5-year service plans; the financial medium-term plan and productivity; and the opportunities and risks of the new operating model. The Trust will be taking forward the strategy and board assurance framework (BAF) refinement informed by the discussion and the development of the Trust's 5-year plan in accordance with the planning framework timescales set out by NHSE.

3. National and Regional meetings

Since the last Public Board meeting there have been various meetings attended both NHSE National and Regional leadership meetings and NHS Providers CEO and Chair network, topics and discussions focused on delivery and priorities of this year's plan as we enter H2 (quarter 3 and 4 25/26) and the 10 year health plan delivery.

4. NHS Operating Model

It has now been confirmed that Shropshire Telford and Wrekin ICB will cluster with Staffordshire Stoke-on-Trent ICB. The two organisations are working closely together and are expected to move to a single leadership structure over the next few months.

5. Federation of Specialist Hospitals

During October, the Federation of Specialist Hospitals (FoSH) met with Wes Streeting, Secretary of State for Health and Social Care. to speak about how specialist hospitals are helping to implement the 10-year health plan and identify more we can do to deliver the government ambitions, making the most of specialist hospitals' leadership. The meeting was positive and provided some next steps for FoSH to take forward with its members.
The Federation of Specialist Hospitals was founded in 2009 and is a coalition of 17 of the country's best known and regarded specialist hospitals - centres of excellence which provide specialist services to patients drawn from all parts of the UK.

6. Publication of Care Quality Commission (CQC) Report

Since we last met in public as a Board of Directors, we have seen the publication of our CQC Report, following a two-day visit by inspectors earlier in the year. That report has seen our Surgical and Critical Care Services have been rated 'Good' overall. The report shines a specific spotlight on the overall care that was observed, noting that people were treated with kindness and compassion, and that staff protected patients' privacy and dignity and treated them as individuals. Inspectors noted that leaders and staff at RJAH have a shared vision and culture based on listening, learning and trust. We still await our Well Led Review and have had indications that this is likely to be in January 2026.

7. CQC Adult Inpatient Survey

Another report to be published since we last met in public was the annual Adult Inpatient Survey, and again the details make pleasant reading for all of us at RJAH. The Trust was singled out as one of the very best hospitals in the country – indeed, patient feedback saw the organisation named as one of just eight providers producing results "much better than expected", with patient experience that is substantially better than elsewhere. The survey is based on feedback from more than 63,500 people

who had a spell as a hospital inpatient during November 2024. More than 1,200 RJAH patients were invited to take part in the survey, and the response rate of 70% was the best in the country and well above the national average of 41%. Other highlights included our wards and rooms being rated as the cleanest in the country for the fifth year in a row.

8. Trust Values given an inclusive refresh

Board members will know that we took a decision to refresh our Trust Values, following extensive engagement with our staff. The official relaunch took place at the end of September, to coincide with our Annual General meeting. Staff told us we had it about right. This is a **caring** organisation, one where we value **professional** conduct and **excellence**. They told us **respect** was important, and that the **friendly** nature of RJAH is one of the things that still makes it so special. As such we have retained all five of our current values. However, a theme that came out via our conversations was that there was a gap. Staff told us our inclusivity was something else that made us special, as such, '**inclusive'** has becomes our sixth value. For each of our values, we have a set of behaviours aligned to them. These set our things we *will* do in the workplace, and things we *will not* do.

9. Same day bilateral joint replacements

We recently took the opportunity to celebrate two patients who have made history at RJAH, becoming the first at the hospital to be discharged on the same day as having bilateral hip and knee replacement procedures respectively. Ruth Denney and Paul Garstone went home on the same day having been treated through the hospital's Enhanced Recovery Programme.

10. Headley Court Charity relocates to RJAH

We are delighted that the Headley Court Charity will now be based out of the Headley Court Veterans' Orthopaedic Centre that bears its name at RJAH. Board members will recall that Headley Court was a military rehabilitation centre near Epsom, Surrey, but closed in 2018 when services moved to a new facility at Stanford Hall near Loughborough. Following the move, the charity's chair Air Vice Marshal Anthony Stables said it was using its resources to fund projects that "honoured the legacy of Headley Court". One of those projects was at RJAH, with the charity agreeing to award the hospital a grant of £6 million back in 2020 to build the UK's first dedicated veterans' orthopaedic centre. That building opened in late 2021. Now the charity is providing further funding to pilot a veterans' rehabilitation programme out of the centre, which will run for an initial 18 months.

11. Successful conclusion to Operation Lazurite

I recently attended an event to mark the end of Operation Lazurite in Shropshire. Operation Lazurite was the code name given to a military operation to relocate and rehome thousands of Afghan civilians whose life had been put in danger in their homeland as a result of work they had done alongside the British Armed Forces. More than 1,500 of them came to Shropshire as part of this operation, being housed in the camp at Nesscliffe. RJAH took the lead in overseeing the health needs of the camp, though this was a true partnership effort between all health and care providers in Shropshire, Telford and Wrekin.

12. 'Oswestry Model' of palliative care set to go global

Board members may recall that we once had a presentation given to us by Professor Tracey Willis about the 'Oswestry Model' of palliative care that has been devised here at RJAH in partnership with Severn Hospice. That model has since been adopted by other centres in the UK and was last month showcased at the World Muscle Society's annual conference in Vienna. Prof. Willis is hopeful that this will lead to it being adopted further afield as well, really spreading the impact of good work being done right here in Shropshire. The Oswestry Model is an approach developed to support adults with neuromuscular conditions such as Duchenne Muscular Dystrophy (DMD). It uses a traffic light system to help neuromuscular teams identify key stages in a patient's journey in which hospice involvement would improve their quality of life.

13. Young DMD patients getting early access to life-changing drug

Prof. Willis' team has also been at the forefront of other significant work of late, with young DMD patients at RJAH being among some of the first in the country to be getting access to a new drug called givinostat, which could slow the progression of their disease. Givinostat, also known as

Duvyzat, was conditionally approved by the Medicines and Healthcare products Regulatory Agency (MHRA) in the UK in December 2024. However, it is not yet available for routine use on the NHS. For this to happen, it must be recommended by the National Institute for Health and Care Excellence (NICE). NICE review how effective the treatment is and weigh it against the cost of the treatment. The process has started for givinostat, but a decision will not be made until later. However, the company which manufactures the drug is making it available free of charge to children and young people in the UK right now via an Early Access Programme (EAP) until the regulators make a decision about approval. RJAH is one of the first hospitals to have accessed this programme.

14. Solar panel investment

We are delighted to have secured £2.4 million to significantly expand the amount of self-generated renewable energy we produce. The money is coming from Great British Energy (GBE), which has launched a first ever solar investment programme for the NHS, which is providing £100 million to NHS Trusts across the UK. The project will include three solar carports in staff and patient parking areas, as well as roof-mounted panels on hospital buildings. By expanding our solar capacity, we will reduce carbon emissions by approximately 230 tonnes annually and save around £300,000 a year. It also helps prepare us for the reduced reliance on imported electricity and the future transition from fossil fuel heating systems.

15. Celebrating our Allied Health Professionals

Last month, we took the opportunity to celebrate the contribution of Allied Health Professionals (AHPs) at RJAH, as part of AHPs Day 2025. AHPs are so vital to our organisation, and I commend the AHP Council for the event they put on to celebrate, which included an insightful and well attended half day conference. I enjoyed taking time to look at the poster presentation, as did other members of the Executive Team, and I know they had a packed agenda of activities and speakers to celebrate the vital role of AHPs and look at the career pathway for existing and student AHPs in this organisation.

16. 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 October winner was **Tamika Roberts**, a Staff Nurse on the Midland Centre for Centre Injuries, who was nominated for her work on the Trust's Improvement Champions programme, and her commitment via that to improving patient care. Tamika's project to improve the delivery of patient education for spinal injury patients has been inspiring and she was a worthy recipient.

- Our September winner was **Hannah Winter**, a Digital Trainer in our Apollo Electronic Patient Record (EPR) team. Hannah was nominated in recognition of her support for staff during the go-live of the new EPR system. She was particularly hailed for the grace and kindness she showed, and the positive way she shared her knowledge to ensure that everyone she interacted with felt positive about the change.

Congratulations to both — your dedication and care truly embody the spirit of the RJAH Stars Award.

13. Conclusion

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

To: ICB, NHS Trust and Foundation Trust:
- Chairs
- Chief Executives
- Chief People Officers

cc. NHS England regional directors
Commissioning support units

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

16 October 2025

Dear colleagues,

Request for action on racism including antisemitism

We write to ask for your assistance in implementing important initiatives that support our shared commitment to fostering an inclusive, respectful, and professional environment – for colleagues, patients and visitors – across the NHS and assuring our communities of our commitment to tackling hatred in all its forms.

We want to reiterate our zero tolerance stance to all forms of hatred, antisemitism, Islamophobia, racism and to any form of discriminatory behaviour. We reiterate our commitment to creating workplaces and services where everyone feels safe, valued and supported, regardless of their background, faith or identity.

In line with this, NHS England is formally and actively adopting the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism.

Th UK Government adopted the definition in 2016 and the Secretary of State has today reaffirmed the Department of Health and Social Care's commitment to it. The Secretary of State has asked that other DHSC Executive Agencies and Arms-Length Bodies adopt this.

The definition includes illustrative examples of how antisemitism may manifest in contemporary settings, including but not limited to denial of the Holocaust, accusations of Jewish conspiracy, and the targeting of Israel as a proxy for Jewish people. Criticism of Israel similar to that levelled against any other country, however, cannot be regarded as anti-Semitic.

We strongly encourage all NHS organisations to adopt this definition and to note the associated commitments to free speech in order to reinforce our collective stance against antisemitism – whether experienced by our colleagues, our patients, our communities or partners.

We need to demonstrate equal rigour in tackling all other forms of hatred and racism. During the race riots of 2024, local NHS organisations acted as beacons of hope in their local communities – supporting staff in taking an active stance against racism, in particular at that time against Islamophobia.

The current climate in some of our communities means we need to redouble our efforts to create workplaces where our staff and patients alike feel safe and welcome.

The government is also reviewing the recommendations of the independent working group on Islamophobia.

Uniform and workwear guidance update

Ensuring everybody feels safe to present for care and treatment when they need it and in working environments for our colleagues is a patient safety matter.

Working with stakeholder groups, we will update our existing uniform and workwear guidance, drawing on the policies developed in Manchester, UCLH and other good practice. The guidance will continue to uphold the principles that underpinned its creation including freedom of religious expression, ensuring patients feel safe and respected at all times, and that staff political views do not impact on patients' care or comfort.

Antiracism including antisemitism training

We are also updating the existing NHS Core Skills Framework module on Equality, Diversity and Human Rights, extending the section on discrimination and content on antisemitism and Islamophobia, and including new questions on this in the assessment. We are working to ensure all NHS organisations are aligned to the Framework to ensure that all 1.5m NHS staff are required to complete this training as part of their mandatory training.

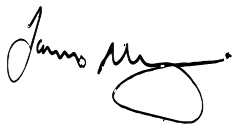
Working with Lord Mann, we will update the content developed with EDI, racism, antisemitism and Islamophobia subject matter experts and aligned to the core skills training framework.

The existing training is completed by staff every three years, but we are asking for your help and support to ensure that all staff in your organisation refresh their EDI training as soon as this content is available rather than waiting for the prompt in the current three-year cycle.

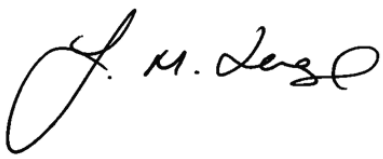
Separately, work is underway to draft a new Statutory and Mandatory Training competency framework which will replace the Core Skills Training Framework (CSTF) – setting out all nationally recommended subjects to be mandated and is due to go live by April 2026.

We appreciate your leadership in implementing these changes and we ask you to support all staff in feeling safe and valued at work and also to support our communities accessing NHS services. We also recognise the importance of supporting NHS organisations in implementing these important initiatives and look forward to working with you to do this.

Yours sincerely,



Sir James Mackey
Chief Executive
NHS England



Jo Lenaghan
Chief Workforce Officer
NHS England

NHS Oversight Framework, including capability assessment

Committee / Group / Meeting, Date

Board of Directors, November 2025

Author: **Contributors:**

Name: Dylan Murphy
Role/Title: Trust Secretary

Report sign-off:

Name: Stacey Keegan
Role/Title: Chief Executive Officer

Is the report suitable for publication?:

YES

Key issues and considerations:

Performance Assessment

In September 2025, NHS England published the first set of quarterly results under the revised NHS Oversight Framework (NOF). The results reflect performance for measures under a number of "domains":

- Access to services
- Effectiveness and experience of care
- Patient safety
- People and workforce
- Finance and productivity

Those performance scores are then aggregated and translated into a "segmentation" rating for the organisation. That rating is applied on a five-point scale:

1 The organisation is consistently high-performing across all domains, delivering against plans.
2 The organisation has good performance across most domains. Specific issues exist.
3 The organisation and/or wider system are off-track in a range of domains or are in financial deficit.
4 The organisation is significantly off-track in a range of domains.
5 The organisation is one of the most challenged providers in the country, with low performance across a range of domains and low capability to improve, or, the organisation is a challenged provider where NHS England has identified significant concerns.

Trusts' results are published by NHSE, and are presented in a performance table. The Trust was informed of its results on 4th September 2025:

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust		
Average Metric Score	**Segment**	**League table position (*out of 134*)**
2.31	**2**	**27**

Capability Assessment

As well as a performance rating, NHS organisations are subject to a capability rating. ***Assessing provider capability: Guidance for NHS trust boards*** was published by NHS England on 26th August 2025. The outcome of the assessment will be published alongside (and may ultimately affect) the Trust's performance segmentation rating under the NOF.

The introduction to the guidance explains that:
"*As part of the NHS Oversight and Assessment Framework, NHS England will assess NHS trusts' capability, using this alongside providers' NOF segments to judge what actions or support are appropriate at each trust. As a key element of this, NHS boards will be asked to assess their*

organisation's capability against a range of expectations across six areas derived from The Insightful Provider Board, namely:

- *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 six domains are broken down into sixteen "self-assessment criteria". For each of the criteria, the guidance suggests multiple examples of "indicative evidence or lines of enquiry".

Boards were asked, by 22nd October 2025, to:

1. Confirm that the criteria under each domain had been met (or provide mitigating/contextual factors to explain why they were "not met", or partially met");
2. Provide narrative that supports the assessment for each of the domains, which sets out the rationale and the evidence that underpins that assessment;
3. Provide links to / copies of key sources of evidence (with a direction that the number of documents submitted should be kept to a minimum).

NHSE would then consider that submission, alongside "third party" information in arriving at a rating. The guidance states that "*third-party information relating to the organisation's governance and risk profile, staff morale and quality of care provided may inform NHS England's view of NHS trust capability. We expect that where trusts receive information that impacts on their self-assessment they should share this with NHS England*".

The Trust's submission was developed and agreed as described in the "Report development and engagement history" section of this report. **The submission confirms that the Board is satisfied that the requirements of each criteria have been met.**

The self-assessment overview narrative that supports that position is included at Attachment 1. That documents includes links to the CQC Inpatient survey, the recent CQC inspection reports, and the Annual Report and Accounts (to provide details of the Head of Internal Audit Opinion). A copy of the independent well-led developmental review was also provided.

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	✓

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:

That the Board:

1. NOTE the outcome of the NOF performance assessment.
2. NOTE the outcome of the capability self-assessment and the content of the supporting narrative approved by the Chief Executive and Chair on behalf of the Board;
3. NOTE that the Trust is awaiting the outcome of NHSE's review of the submission; and

4. CONSIDER the level of assurance provided by:
   - The NOF performance assessment, and
   - The capability self-assessment process and its outcome.

Report development and engagement history:

Following a period of engagement, NHSE published the revised NHS Oversight Framework on 26th June 2025. The revised Oversight Framework indicated that NHSE would use a "capability assessment" to determine its oversight arrangements with organisations. NHSE indicated that, in exceptional circumstances, where NHS England identifies concerns about a provider's capability, it can place an organisation in segment 5 (regardless of its segmentation rating based on the performance and finance elements of the Framework).

The "capability assessment" was published on 26th August 2025. The content was reported to the Board on 3rd September 2025.

NHSE ran a "Provider Capability" webinar on 26th September. The Trust's approach to completing the submission was informed by that session and that approach was agreed by the Board at the private session on 1st October 2025.

Initial comments were invited from the Board at the meeting on 1st October and Lead Execs / NEDs were asked to comment in more detail on the particular domains they had been assigned to lead.

The Board agreed that authority to approve the submission be delegated to the Chief Executive, in consultation with the Chair, but any concerns raised during the review process should be escalated to the Board before approval / submission.

Following that engagement, as no concerns were raised, the Chief Executive and Chair agreed the content of the final submission.

The Chief Executive signed the declaration on behalf of the Board and it, along with supporting narrative / evidence, was submitted on 22nd October.

Next steps:

The NHSE oversight team will review the self-assessment and:

- Triangulate it with other information, including the trust's recent operational history and track record of delivery and third-party intelligence to develop a "holistic view of capability".
- Assign a capability rating to the Trust, on a four-point scale:
  - **Green**: High confidence in management
  - **Amber–green**: Some concerns or areas that need addressing
  - **Amber–red**: Material issue needs addressing or failure to address major issues over time
  - **Red:** Significant concerns arising from poor delivery, governance and other issues
- Discuss the capability rating with the Trust and consider the principal challenges the organisation faces.
- Use the capability assessment to inform oversight / support arrangements, for example where:
  - risks flagged in the self-assessment are a concern (e.g. inability to make 1 or more certifications); or
  - annual self-assessments do not tally with oversight team's views or information from third parties; or
  - subsequent performance/events at the trust or third-party information are a cause for concern such that elements of the self-assessment are no longer valid and, in order to assess 'grip', teams may wish trusts to review the basis on which they made the initial assessment.

ATTACHMENT 1: Self-assessment supporting narrative.

Attachment: RJAH self-assessment supporting narrative

I. Strategy, leadership and planning
Exec Lead - Stacey Keegan; NED lead - Board Chair

The Board is satisfied that:
• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners
• The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE
• The board has the skills, capacity and experience to lead the organisation
• The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served
Status and supporting narrative:

CONFIRMED

The Trust's five strategic objectives are aligned to the strategic objectives outlined in the STW Integrated Care Strategy. The Board is looking to develop a "golden thread" from the national objectives and ambitions, through:

- system or other partnership plans;
- the Trust's strategic objectives, operational plans and priorities; into
- team and individual objectives.

The Trust is not subject to any enforcement action from NHSE but has responded constructively and quickly to any requests for assurance.

The Chair undertakes an annual assessment of Board performance and competencies. Where particular experience or skill gaps have been identified, Associate Directors have been appointed to strengthen the Board.

The Board is committed to continuous improvement and commissioned an external agency to undertake a "Developmental Well-led Review" during the summer of 2025. A copy of the report produced following that review has been provided to accompany this submission. The Board will develop an action plan to implement the recommendations of that Review.

To date, the Board has engaged in externally facilitated development sessions which include:

- Executive team development – facilitated by Commissioning Support Unit (CSU) 2024/25
- Good Governance Institute (GGI) - Clinical Governance review 2023/24
- NHS Providers – Bespoke Development Session on Risk Management 2023
- Good Governance Institute (GGI) – Board Development Session on Risk Appetite 2023
- NHS Providers – Digital Board Session 2022

As the next phase in an ongoing process of reflection and improvement activity, the Trust has applied to take part in NHSE's new Board Development Programme.

The Head of Internal Audit Opinion for the Trust in 2024/25 was that "***Substantial Assurance****, can be given that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently*." Please see page 83 of the Trust's Annual Report for more information.

Attachment: RJAH self-assessment supporting narrative

The Board is satisfied that:
• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners
• The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE
• The board has the skills, capacity and experience to lead the organisation
• The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served
Status and supporting narrative:
There are constructive relationships with partners within the system. The Trust is the strategic lead on MSK for the system. Co-operative arrangements are also in place with neighbouring Welsh providers. In addition, the Trust has recently entered a "strategic alliance" with the Royal Orthopaedic Hospital NHS Foundation Trust. The alliance provides a framework to collectively identify and deliver opportunities to share learning, increase resilience, improve efficiency / productivity, drive innovation, and improve patient experience. Board members also take a wider leadership role in the system, including executive leadership on "workforce" and "wating well" initiatives and non-executive Board members play a key role, particularly in chairing the People, Culture and Inclusion Committee. There is clear recognition of the importance of building and maintain effective collaborative arrangements. This was recognised in the recent CQC inspection: Surgery - **Partnerships and communities**: *"Evidence shows a good standard of care. The service understood its duty to collaborate and work in partnership, so services worked seamlessly for people. Staff shared information and learning with partners and collaborated for improvement. Leaders understood their duty to collaborate and work in partnership with other organisations so that services worked well for people. Leaders shared information and learning with partners for improvement. Leaders recognised their need to work with their neighbouring NHS trusts and integrated care systems."*

Attachment: RJAH self-assessment supporting narrative

II. Quality of care

Exec Leads – Ruth Longfellow / Sarah Needham; NED lead – Q&S Committee Chair

The Board is satisfied that:
• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients
• Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board
Status and supporting narrative:
CONFIRMED The Trust has a robust Quality Governance Framework that ensures the right oversight arrangements are in place to identify and constructively challenge substandard performance and monitor the improvement actions being taken. The Quality and Safety Committee has oversight of this Quality Governance Framework. In performing its role, the Committee receives reports on issues within its remit, as well as assurance reports from groups that focus on certain elements in more detail including: the Patient Safety Meeting; Patient Experience Meeting; Infection Prevention and Control Meeting; Safeguarding Meetings; the Regulatory Oversight Meeting; the Clinical Effectiveness Meeting; and the Drugs and Therapeutics Meeting. Board members are directly involved in, and receive reports on the outcome of, various visits focussed on the quality of service provided. These include: Patient Safety Visits; Board Visits; and Executive Buddy Visits. The Board also considers "Patient Stories" at its public Board meetings, to hear directly from patients and learn from their experiences. The Board has approved a Quality Strategy for the period 2024-27 which sets out its priorities and approach to delivering "*a culture of continuous improvement to increase and sustain the quality of our services for our patients, people and stakeholders*". All significant decisions are subject to Equality & Quality Impact Assessments to gauge their impact and ensure a continued focus on quality, safety, and patient experience. The Trust has a Patient Safety Incident Response Framework Policy and Patient Safety Incident Response plan which define the national and local patient safety priorities for the Trust. The response plan also sets out the learning response methods to patient safety events and is underpinned by the guiding principles of compassionate engagement with staff and patients when things go wrong. As part of staff induction to the organisation, sessions are provided on Freedom to Speak Up (FTSU) and reporting of Patient Safety Events. In the event of a staff member being involved in a patient safety event, they are offered support by their line manager, engagement leads and should they require it, the Trust FTSU Guardian. All staff are required to complete Level 1 of the Patient Safety Syllabus Training, to understand the importance of speaking up for patient safety. The safeguarding team supports a learning culture through education initiatives like Lunch and Learn, workshops, and simulation-based MCA training. Advocacy is provided for vulnerable patients, including independent services, reasonable adjustments, and schemes like dementia passports and the Butterfly scheme. An open reporting culture, supported by Datix, ensures staff can report incidents without fear. Staff affected by safeguarding incidents receive debriefs, supervision,

Attachment: RJAH self-assessment supporting narrative

The Board is satisfied that:
• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients
• Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board
Status and supporting narrative:
and emotional support. Safeguarding Champions are being recruited and trained to strengthen the Trust's safeguarding culture, focusing on domestic abuse and mental health. Reflective practice ensures incidents inform learning and improvement. The Trust is committed to delivering exceptional patient care through robust safety policies, prioritising quality, dignity, and well-being. This was recognised in the recent CQC inspection: Critical Care - **Monitoring and improving outcomes**: *"Evidence shows a good standard of care. The service routinely monitored people's care and treatment to continuously improve it. They ensured that outcomes were positive and consistent, and that they met both clinical expectations and the expectations of people themselves."* Surgery - **Governance, management and sustainability**: *"Evidence shows a good standard of care. The service had clear responsibilities, roles, systems of accountability and good governance. Staff used these to manage and deliver good quality, sustainable care, treatment and support. Staff acted on the best information about risk, performance and outcomes, and shared this securely with others when appropriate."* In the 2024 **CQC inpatient survey**, 1,250 of our patients were invited to complete the survey and 863 did so – that 70% response rate was the best in the country. Of the results for the questions: • 27 were "*much better than expected*"; • 11 were "*better than expected*"; • 1 was "*somewhat better*", and • 6 were "*about the same*". Overall, the Trust was one of just eight categorised as having achieved **"***much better than expected***"** results.

Attachment: RJAH self-assessment supporting narrative

III. People and culture

Exec Lead – Denise Harnin; NED lead – P&C Committee Chair

The Board is satisfied that:
• Staff feedback is used to improve the quality of care provided by the trust
• Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels
• Staff can express concerns in an open and constructive environment
Status and supporting narrative:

CONFIRMED

The Board reviews the results of the staff survey and the Trust has identified areas of focus to drive improvement in response to the results. One of the identified areas of focus for the Trust following the 2024 Staff Survey was to improve staff awareness of the various channels to raise concerns.

The Trust uses the staff engagement platform, *ImproveWell* which can provide real time daily feedback, and can be used for team surveys. Users are able to contribute ideas for improvement which can be quickly responded to. The Trust will re-introduce the People Pulse Survey, to take place quarterly from January 2026 to gain further timely insights from staff feedback.

The Trust supports a culture of openness and has recently launched a revised set of Values. Following feedback from staff, 'Inclusion' has been added to the Trust's values. The associated "behaviours" are that:
"We will…

- *actively support colleagues' differences*
- *create a safe and respectful environment*
- *encourage open communication*
- *be allies for all*
- *provide equal opportunities and access to all"*

The Board has established a People and Culture Committee. The broad purpose of the Committee is to assist the Board in 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.

Amongst other things, the Committee reviews compliance with statutory and mandatory training, considers quarterly reports from the Freedom to Speak Up Guardian, and oversees work in relation to delivery of the Equality, Diversity and Inclusion Strategy (the importance of which is reinforced in the Trust's values). The Committee provides upward assurance on these matters to the Board.

A number of recent external reviews have commented positively on the Trust's supportive, open, culture which supports quality of care:

Well-led Developmental Review, **Shared Direction and Culture**:
"*The culture of the Trust has evolved positively. Staff described a shift away from previous issues, with a move towards a more open, transparent, and constructive environment. Interview feedback consistently highlighted that the Trust prioritises people and culture. This is led from the top and has shaped a friendly, supportive, and caring organisation focused on delivering high-quality patient care.*"

Attachment: RJAH self-assessment supporting narrative

The Board is satisfied that:
• Staff feedback is used to improve the quality of care provided by the trust
• Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels
• Staff can express concerns in an open and constructive environment
Status and supporting narrative:
CQC, **RJAH location findings**, **Safe**: "*The service had a good learning culture and people could raise concerns. Managers investigated incidents thoroughly. People were protected and kept safe. Staff understood and managed risks. The facilities and equipment met the needs of people. The building was clean and well-maintained with risks well controlled. Managers made sure staff received training and regular appraisals to maintain high-quality care. Staff managed medicines well. Managers involved people in planning any changes.*" CQC, **RJAH location findings**, **Well-led**: "*Leaders and staff had a shared vision and culture based on listening, learning and trust. Leaders were visible, knowledgeable and supportive, helping staff develop in their roles. Staff felt supported to give feedback and were treated equally, free from bullying or harassment. People with protected characteristics felt supported. Staff understood their roles and responsibilities. Managers worked with the local community to deliver the best possible care and were receptive to new ideas. There was a culture of continuous improvement with staff given time and resources to try new ideas.*"

IV. Access and delivery of services

Exec Lead – Mike Carr; NED lead – F&P Committee Chair

The Board is satisfied that:
• Plans are in place to improve performance against the relevant access and waiting times standards
• The trust can identify and address inequalities in access/waiting times to NHS services across its patients
• Appropriate population health targets have been agreed with the ICB
Status and supporting narrative:

CONFIRMED

The Board is fully sighted on the performance challenges facing the Trust and continues to give it the utmost attention. The Finance and Performance Committee and Board scrutinised and approved the Trust's plans and continue to monitor delivery of the plans, as well as the progress of the plans established to support that delivery.

The Board also established a dedicated "Activity Recovery Committee" to:

- Review the development and progress of actions / initiatives to improve performance and drive delivery of the activity plan.
- Oversee the implementation of short, medium and longer-term plans to improve productivity and increase activity. This includes, but is not limited to, work focussing on:
  - Improving RTT performance;
  - Reducing the number of long waiters;
  - Managing demand;
  - Implementing GIRFT recommendations (as they relate to activity recovery);
  - Recruitment / workforce (as they relate to activity recovery).
- Consider "deep dives" for further assurance on issues relating to its remit, including progress in reducing waits for the very longest waiting patients.
- Receive Assurance Reports from groups that support the work of the Committee, including those relating to:
  - Mutual aid arrangements;
  - Waiting list management / initiatives;
  - Theatre staffing / productivity;
  - Insourcing arrangements.
- Provide assurance to the Finance and Performance Committee / Board on matters relating to the Committee's remit, escalating any areas of concern.

Progress in recent months has seen performance improve for:

- RTT 18 week%, with an 11.1% improvement in WLMDS data during the last 4 months.
- Waits for first OPAs now exceeding the 2025/26 operational standard of 67% (at 69% end of September)

Total waiting list size, and an improved rate of reduction for long waits (52 & 65 week+) remains the focus though Q3, with the expectation that the Trust will eliminate 65+ waits by the end of December, and return to the 1% >52 week plan by March 2025.

The Trust is aware of the impact that inequalities can have when accessing healthcare. There is an established RJAH working group with system partner representation to review health inequalities. Some examples of work undertaken / underway to improve population health and address health inequalities include:

Attachment: RJAH self-assessment supporting narrative

The Board is satisfied that:
• Plans are in place to improve performance against the relevant access and waiting times standards
• The trust can identify and address inequalities in access/waiting times to NHS services across its patients
• Appropriate population health targets have been agreed with the ICB
Status and supporting narrative:
• Reviewing Paediatric WNB rates from a Health Inequalities perspective and addressing barriers to access, leading to a decrease in the WNB rate to less than 5%, from a high of 11%. • Close work with Local Authority colleagues to improve access to healthy lifestyle service, ensuring these are embedded within patient pathways where appropriate. • Transport: There is a recognised difference in the volume of patients from the most deprived areas not attending an appointment. We have consistently seen statistically significant differences in the DNA rates of patients in different IMD quintiles. The Trust is working with charity partners to support with transport where required. • System working and impacts of transfers: Following a transfer of the Rheumatology service from another STW system provider, patients from the most deprived quintile were waiting longer for treatment. This has reduced significantly over the past 12 months and is now aligned with other deprivation groups, following targeted interventions in these areas.

Attachment: RJAH self-assessment supporting narrative

V. Productivity and value for money

Exec Leads – Mike Carr / Angela Mulholland-Wells; NED leads – F&P / ARC Committee Chair

The Board is satisfied that:
• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant
Status and supporting narrative:
CONFIRMED The Trust reports productivity and efficiency through efficiency programme updates. The efficiency programme is reported monthly to Unit Boards, Trust Performance Board, Finance and Performance Committee and Trust Board. High risk areas, exceptions and adverse performance is specifically addressed through challenge and is subject to additional oversight of mitigating actions through the Performance & Financial Improvement Group and the Finance and Performance Committee. Schemes are identified using benchmarking, peer review, national best practice i.e. GIRFT, to establish a robust programme of productivity and efficiency to enable the Trust to deliver financial and performance targets. The implied productivity scoring as part of the revised National Oversight Framework scoring will form part of monthly reporting to the Finance and Performance Committee and Trust Board along with drivers for performance changes and mitigating actions as required. As part of 2025/26 planning, the Trust will focus on specifically identifying and tracking individual productivity schemes as part of a sub-set of the efficiency programme to ensure that anticipated benefits and opportunities are delivered. The Finance and Performance Committee will be monitoring the following metrics within its integrated performance report (IPR) from October onwards: • Combined finance score • Planned surplus/deficit • Variance year-to-date to financial plan • Implied productivity level Examples of continuous improvement activities that support productivity at RJAH include: • Enhanced recovery implementation: RJAH went live with this in 2023/24. RJAH now benchmarks with one of the lowest length of stays nationally for primary hip and primary knee replacements. This was at 1.6 days for both at the end of Q1, 2025/26. • One stop clinics: During 2024/25, the Trust introduced same day 'see and treat' sessions for carpal tunnel, providing patients with treatment on the day of their first outpatient appointment. • Establishment of the diabetic foot service was undertaken in January 2025. • Theatres: Theatre utilisation focus and oversight e.g. There is a focus on reducing cancellations, including a theme on 'medically unfit'. This has led to transformation of our pre-operative pathways. 'Golden patient' plans are also underway. The Trust currently benchmarks within the top performing quartile on Model Health System, at 84% for September 2025. • The Trust works closely with colleagues from GIRFT on a range of subject matters including Rheumatology pathways and outpatient processes. A GIRFT review is planned in November to support identification of further opportunities for Theatres and pre-operative areas.

Attachment: RJAH self-assessment supporting narrative

The Board is satisfied that:
• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant
Status and supporting narrative:
• Outpatients: Continuous improvement is underway. PIFU benchmarks within the top quartile nationally at 7.7% (August 2025) on Model Health System. Additional reviews are underway to further improve performance. DNAs are also within the top performing quartile at 5.5% (August 2025) and this is continuously reviewed. The Trust is currently working with the GIRFT team to identify and take forward further opportunities for outpatients e.g. clinic templates and clinical pathway reviews. • Sickness absence: During 2025/26, a step change (improvement) has been seen for short-term sickness. People Services have supported managers and support in place includes signposting to wellbeing resources and support services. There is continued monitoring of sickness absence to enable timely interventions / support. • Job plan oversight and sign-off: The Trust is aiming for >90% of staff to have an active E-job plan. In September this was at 83.2%. This further supports the delivery of job plans.

Attachment: RJAH self-assessment supporting narrative

VI. Financial performance and oversight

Exec Lead – Angela Mulholland-Wells; NED leads – F&P Committee Chair

The Board is satisfied that:
• The trust has a robust financial governance framework and appropriate contract management arrangements
• Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes
• The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn
Status and supporting narrative:
CONFIRMED The Trust received a "**High**" assurance rating in a *Key Financial Processing Controls Review* undertaken by internal audit during 2024/5. The 2024/5 Head of Internal Audit Opinion reported a "**Substantial Assurance**" rating on the organisation's risk management, control and governance processes. Please see page 83 of the Trust's Annual Report for a summary of the 2024/25 internal audit report outcomes. The Trust has signed contracts for all commissioners for 2025/26. Commissioner performance and any required escalation is presented to the Finance and Performance Committee on a monthly basis. There is triangulation between the financial, workforce and activity plans – variances are described in relation to these three factors. Any queries are addressed through the appropriate oversight group, for example September 2025 query on the triangulation of financial and workforce plans presented to the People and Culture Committee and obtained assurance from the Non-executive Directors. The Trust has a Performance & Financial Improvement Group in place with weekly attendance by senior management and the Executive for oversight of the delivery of activity and financial plans. The efficiency programme forms a key part of Trust processes, it is part of daily conversations between multi-disciplinary teams and is reported through the Unit Boards, Trust Performance Board, Finance and Performance Committee, and Trust Board. All schemes have a Project Initiation Document and an Equality & Quality Impact Assessment undertaken before proceeding. The unit senior leadership, consisting of Managing Director, Assistant Chief Nurse and Clinical Director, collectively oversee efficiency performance. The monthly financial position and forecast is presented in detail to the Performance & Finance Improvement Group, Unit Boards, Finance and Performance Committee and Trust Board. This includes a detailed description of the drivers for any variances triangulated with the workforce and activity. Adverse performance requires mitigating actions to be identified and agreed, the financial forecast is a product of the operational delivery plan forecast. The Trust is a partner in the STW ICS and financial performance is discussed and managed alongside system partners. Regular meetings take place between senior representatives of all organisations to ensure close alignment of resources, planning and delivery. These include: bi-monthly Financial Improvement Programme focused on efficiency delivery; monthly System Finance Committee; monthly Productivity Oversight Group; monthly Capital Oversight Group; and bi-weekly senior finance team touch points. The Trust financial plan is part of the system Medium Term Financial Plan, assumptions and modelling are agreed across all system partners. The financial plans are approved by the internal organisation governance and the system governance.

Corporate Risk Summary

Committee / Group / Meeting, Date

Board of Directors, 05 November 2025

Author:		Contributors:
Name:	Dylan Murphy	-
Role/Title:	Trust Secretary	

Report sign-off:

N/A

Is the report suitable for publication:

Yes

Key issues and considerations:

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 Arrangements

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

The Group has considered the process for reviewing and escalating risk within the Trust to clarify the various checkpoints through which a risk should pass before agreed "corporate risks" are presented to the Board committees.

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;
- the Digital Transformation Meeting, informed by the Clinical Reference Group, will start to play a key role in overseeing risks that have a digital component, whether that relates to:
  - The functionality of the Apollo system;
  - The interoperability of digital systems; and / or
  - Any other risk where mitigations / potential resolution are dependent on a digital solution.

  Those arrangements are in development.

A summary of the risks considered at the October round of committee meetings is attached. The Committees also noted emerging / developing risks which do not yet feature on the corporate risk register. These are not listed in this report.

Particular issues of escalation from the committees will be captured in individual committees' assurance reports to the Board.

"Corporate risks" previously considered by Board committees that remained live in October 2025:

Risk ref.	Headline risk	Ctte	Inherent Risk	June 24	Aug 24	Oct 24	Dec 24 / Jan 25	Mar 25	May 25	Aug 25	Nov 25	Notes
1511	Compromise to patient data due to cyber attack (Malware)	DERIC	C4 x L5 = 20	C4 x L4 = 16	-	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	Retain the risk, in line with national expectations, linked to BAF 7 (re.ability to respond to a major, unforeseen event).
2281	Impact of potential failure of the Orthotics System (and resultant lack of historical data)	DERIC / F&P	C4 x L4 = 16	n/a	n/a	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	Orthotics risks to be further reviewed to potentially consolidate into one relating to the system and its capabilities (covering 2281 and 3181), and another around the demand / capacity challenge and its impact on waiting times (covering 2897, 3007 and 3346).
3007	Ability of orthotics team to respond to increasing diabetic demand into the service	F&P / P&C / Q&S	C4 X L5 = 20	C4 x L4 = 16*	-	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	
3181	Implications of the lifetime advisory on a particular suppliers' Orthoses (which requires review / potential replacements)	Q&S	C4 x L5 = 20	n/a	n/a	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	
3096	There is a risk that the current Picture Archive and Communication system (PACs) and Radiology information system (RIS) servers will not be replaced within the required timeframe due to delays in the procurement.	DERIC / F&P	C4 x L5 = 20	C4 x L5 = 20	-	C4 x L5 = 20	C4 x L5 = 20	C4 x L5 = 20	C4 x L5 = 20	C4 x L5 = 20	C4 x L5 = 20	To be considered at Digital Transformation Board. The existing system is supported. Following review, it is anticipated that the score will decrease.
3150	Inadequate general paediatric cover	P&C / Q&S	C4 x L5 = 20	C4 x L4 = 16*	-	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	Interviews planned. College approval of the position awaited (but that should be a formality, and no challenges were anticipated).

Risk ref.	Headline risk	Ctte	Inherent Risk	June 24	Aug 24	Oct 24	Dec 24 / Jan 25	Mar 25	May 25	Aug 25	Nov 25	Notes
3186	Medicines Supply shortages - lack of resilience to national supply chain issues	Q&S	C4 x L5 = 20	C4 x L5 = 20	-	C4 x L5 = 20	C4 x L5 = 20	C4 X L4 =16	C4 X L4 =16	C4 x L4 = 16	C4 x L4 = 16	An ongoing issue with national supplies. Issues with internal storage capacity resulting in ability to hold 7.2 days' supplies, versus recommended 15 days. Options being explored but would require capital investment.
3203	There is a risk that deteriorating patients at the weekend will receive sub optimal management	Q&S	C5 X L4 = 20	n/a	n/a	C5 X L3 = 15	C5 X L3 = 15	C5 X L3 = 15	C5 X L3 = 15	C5 X L3 = 15	C5 X L3 = 15	Risk description to be reviewed / revised to reflect the focus on anaesthetic cover and the level of risk presented.
3238	Occupational Health surveillance insufficient to provide assurance that employees are having their occupation health surveillance needs assessed against the agreed health and safety matrix	P&C / Q&S	C4 X L4 = 16	n/a	n/a	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L5 = 20	H&S manager now has direct access to data. Contract performance is now monitored via weekly meetings. A tender exercise for future provision to be undertaken within the next month or so. Continues to be monitored via the H&S Meeting – It is anticipated that these mitigations will enable a reduction in the risk score in the coming weeks.
3265	Absence of robust system to provide assurance that requested radiology images are tracked and the results are viewed, acted upon and recorded accordingly.	Q&S	C4 X L5 = 20	n/a	n/a	C4 x L4 = 16	C4 X L4 = 16	C4 X L4 = 16	C4 X L4 = 16	C4 x L4 = 16	C4 x L4 = 16	This relates to systems in operation at ShropCom. Digital colleagues are to meet to consider options.

Risk ref.	Headline risk	Ctte	Inherent Risk	June 24	Aug 24	Oct 24	Dec 24 / Jan 25	Mar 25	May 25	Aug 25	Nov 25	Notes
3343	Failure to deliver planned activity increase linked to consultant capacity leading to income loss	F&P	**C4 X L5 = 20**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**C4 x L4 = 16**	Description / scope to be reviewed as not just dependent on consultant capacity.

"Corporate risks" considered by Committees for the first time in October 2025:

Risk ref.	Headline risk	Ctte	Inherent Risk	June 24	Aug 24	Oct 24	Dec 24 / Jan 25	Mar 25	May 25	Aug 25	Nov 25	Comments
3252	ASIA (neurology) assessments on spinal cord injury patients	Q&S	**C4 X L5 = 20**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**C4 x L4 = 16**	An audit has been completed and scores have improved significantly. The risk to be retained until a sustained improvement has been seen. Can then REDUCE.
3365	Bluespier connectivity via Careflow	DERIC / Q&S	**C4 X L5 = 25**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**C4 x L5 = 20**	3365 and 3373 are linked. Situation being monitored by the Clinical Reference Group. Bluespier upgrade is planned – awaiting an update from System C.
3373	Clinical Risk of procedure requirements stock/ instruments being missed due to inconsistencies with new EPR system	DERIC / Q&S	**C4 x L5 = 20**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**C4 x L5 = 20**	3365 and 3373 are linked. Situation being monitored by the Clinical Reference Group. Bluespier upgrade is planned – awaiting an update from System C.

Strategic objectives and associated risks:

This work supports all of the Trust's objectives and feeds the Board Assurance Framework.

Recommendations:

That the Board:

1. NOTE the risks rated at 15 or above, and the movement in any such risks, as considered by the Board Committees during October 2025; and
2. CONSIDER any risk-related escalations from the October round of Committee meetings; and
3. CONSIDER the level of assurance provided by the risk management arrangements, as reflected in the corporate risk register.

Report development and engagement history:

The Risk Management Group meets on a monthly basis to ensure appropriate check and challenge of high rated risks.

The Board sub-committees considered the detail of each risk they oversee during the October round of meetings. This report provides a summary of the content considered in more detail at the committee meetings.

Next steps:

- The Risk Management Group will continue to meet on a monthly basis and work with staff to deliver the Trust's risk management arrangements.
- Risk Management training will continue, including targeted support to key individuals / teams.
- Work to align the review and reporting of Apollo-related risks with the regular risk management process continues.
- The Digital Transformation Meeting will develop its role in overseeing risks with a digital component.
- To support the work of the Risk Management Group, and provide additional scrutiny, consideration is being given to regular collective, executive-level review of:
  - all risks rated at 15 and above; and
  - the overall risk profile of the Trust.

Executive Summary - Quality & Safety 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				
No significant change or N/A to SPC	RJAH Acquired MRSA-12 Mths Rolling Count RJAH Acq Pseudomonas-12 Mths Rolling Count	Surgical Site Infections Medication Errors with Harm Total Deaths 62 Day General Standard	RJAH Acquired MSSA-12 Mths Rolling Count	Number of Patient Safety Reviews Complaints Re-opened Discharge Ready Date to Actual Discharge Surgical Site Infections RJAH Acquired C.Difficile-12 Mths Rolling Count RJAH Acquired E.Coli-12 Mths Rolling Count RJAH Acquired Klebsiella spp-12 Mths Rolling Count Medication Errors 28 Day Faster Diagnosis Standard
Concerning variation (high or low) or 3 months off target		Number of Complaints Standard Complaints Response Rate - 30 Days No of Spinal Injury Patients Fit for Admission		Theatre Cancellations On Day of Surgery

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.

Trust Board - Quality & Safety
September 2025 – Month 6

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

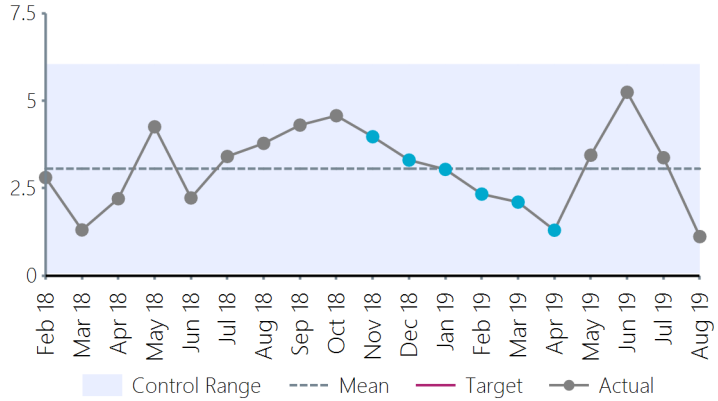
Some examples of these are shown in the images to the right:

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

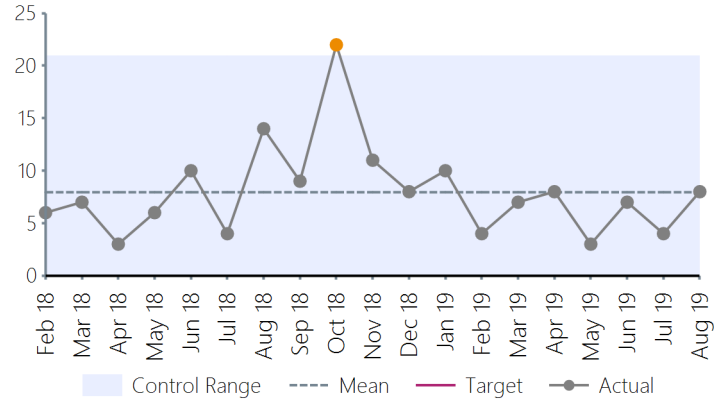
b) shows a point of concern sitting above the control range.

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.

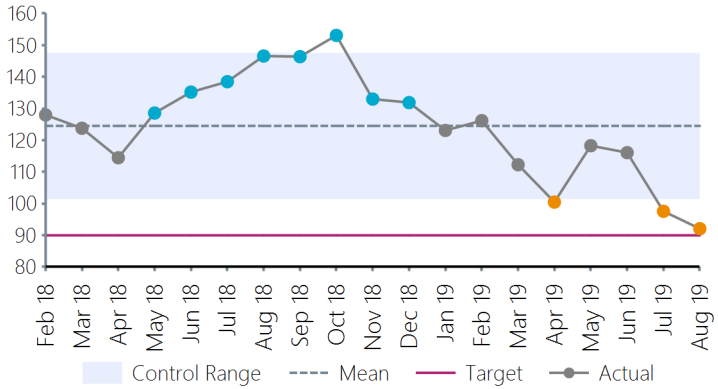
a)



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
Patient Safety Incident Investigations		0		N/A to SPC	No Target		
Number of Complaints	8	19			?	+	
Discharge Ready Date to Actual Discharge Date		0.45		N/A to SPC	No Target	+	
RJAH Acquired C.Difficile - 12 Months Rolling Count	3	3		N/A to SPC	Moving Target	+	
RJAH Acquired E. Coli Bacteraemia - 12 Months Rolling Count	5	2		N/A to SPC	Moving Target	+	
RJAH Acquired MRSA Bacteraemia - 12 Months Rolling Count	0	0		N/A to SPC	P	+	
RJAH Acquired MSSA Bacteraemia - 12 Months Rolling Count	0	4		N/A to SPC	F	+	
RJAH Acquired Klebsiella spp - 12 Months Rolling Count	1	1		N/A to SPC	Moving Target	+	
RJAH Acquired Pseudomonas - 12 Months Rolling Count	0	0		N/A to SPC	P	+	
Surgical Site Infections	0	1			?	+	04/03/24

Summary - Caring for Patients

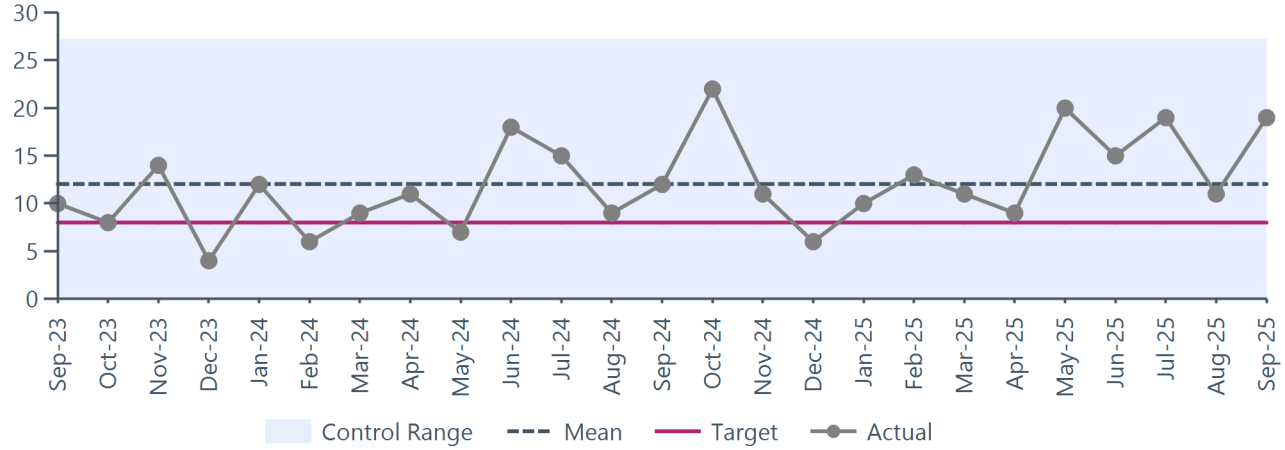
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Outbreaks	0	0		N/A to SPC	P		04/03/24
Number of Deteriorating Patients	5	8			?		
Total Deaths	0	1		N/A to SPC	?	+	12/09/23
WHO Quality Audit - % Compliance against NatSSIPs 2	95%	100%		N/A to SPC	P		

Number of Complaints

Number of complaints received in month 211105

Exec Lead
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
8	19		



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

There were nineteen complaints received throughout September and the volume has now exceeded the tolerance of eight since January. A breakdown of reasons:

* Waiting times (6)
* Care received (6)
* Waiting list removal (2)
* Cancelled appointment (2)
* Concerns not addressed (1)
* Delay in treatment (1)
* Meal provided (1)

Actions

An increase in the volume of complaints has been seen throughout the past year. A deep dive was presented to the Quality & Safety Committee in July. Output actions will be monitored through Patient Experience Committee.

Following the recent patient story presentation at Trust Board in September, opportunities for improvement within Patient Access to be explored.

Learning is identified for each complaint as part of the complaints response. Any themes are shared at Unit level and through Patient Experience Committee.

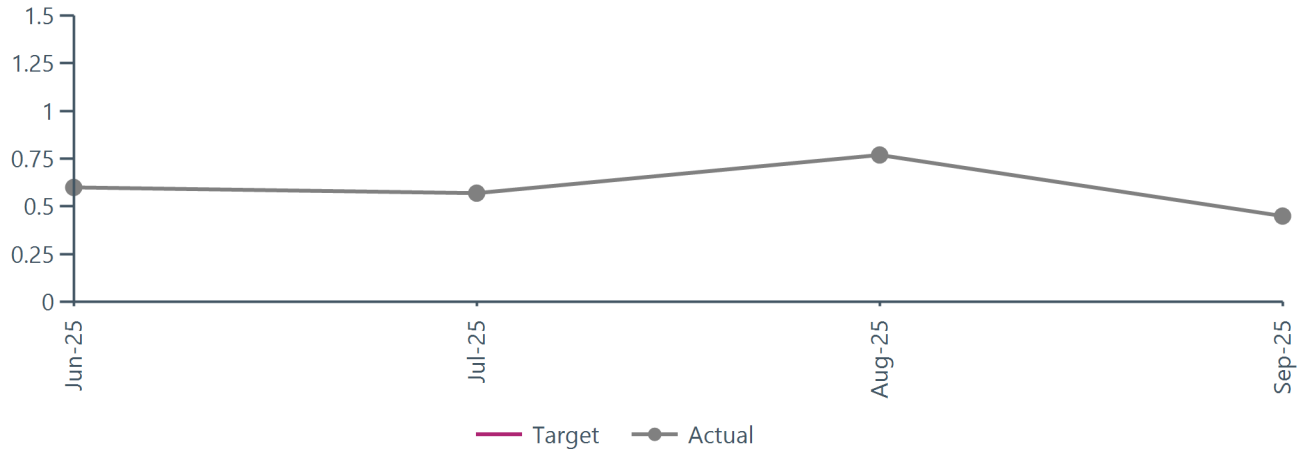
Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
12	22	11	6	10	13	11	9	20	15	19	11	19

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 Officer

Target/Plan	Latest Value	Variation	Assurance
-	0.45	N/A to SPC	No Target



Trajectory

Actual
Trajectory

What these graphs are telling us

This is currently reported as a line graph until there are sufficient data points to transition it to SPC.

Narrative

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 September the average days was 0.45 days. Since this measure was introduced to the IPR last month, the Information Department has now set up additional supporting data to report at ward and unit level.

A target will be determined once there are six months' worth of data to assess.

The latest NOF Publication relates to Quarter 1 where the NOF score for this metric is 1.91. Indication from a recent Model Hospital Masterclass on NOF advised that the next publication is likely to be the end of November.

Actions

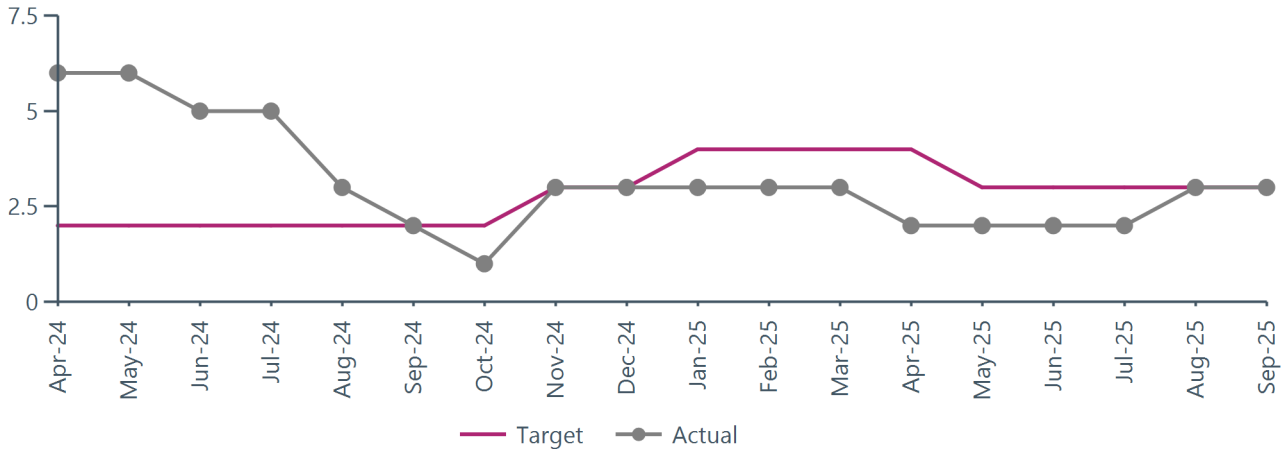
Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
									0.60	0.57	0.77	0.45

RJAH Acquired C.Difficile - 12 Months Rolling Count

12 Months Rolling Count of RJAH Acquired C.Difficile cases 217891

Exec Lead:
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
3	3	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

The new National Oversight Framework (NOF) contains metrics on infections but based on a rolling 12 months position rather than the in-month position. To align with that, the IPR has been amended this month so that all RJAH Acquired infection metrics relate to the rolling 12 months-position.

The latest NOF Publication relates to Quarter 1 where the NOF score for this metric is 1. Indication from a recent Model Hospital Masterclass on NOF advised that the next publication is likely to be the end of November.

The latest rolling twelve month period relates to October-24 to September-25 where there have been three RJAH Acquired C.Difficile; 2x November-24 and 1x August-25. This is in line with the threshold set for this period of 3.

Actions

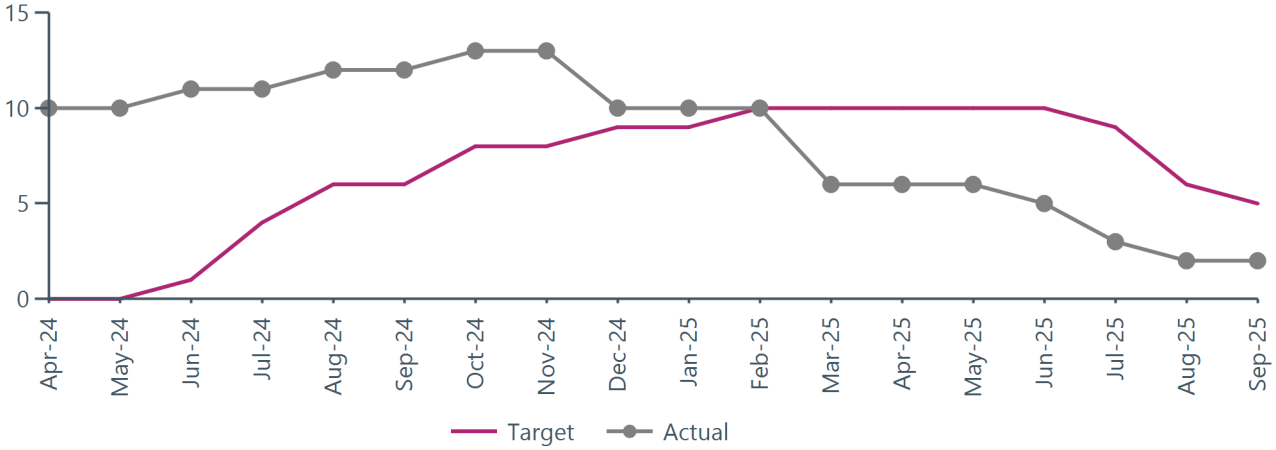
Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
2	1	3	3	3	3	3	2	2	2	2	3	3

RJAH Acquired E. Coli Bacteraemia - 12 Months Rolling Count

12 Months Rolling Count of RJAH Acquired E. Coli Bacteraemia cases 217892

Exec Lead:
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
5	2	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

The new National Oversight Framework (NOF) contains metrics on infections but based on a rolling 12 months position rather than the in-month position. To align with that, the IPR has been amended this month so that all RJAH Acquired infection metrics relate to the rolling 12 months-position.

The latest NOF Publication relates to Quarter 1 where the NOF score for this metric is 1. Indication from a recent Model Hospital Masterclass on NOF advised that the next publication is likely to be the end of November.

The latest rolling twelve month period relates to October-24 to September-25 where there have been two RJAH Acquired E. Coli Bacteraemia; both in October-24. This is below the threshold set for this period of 5.

Actions

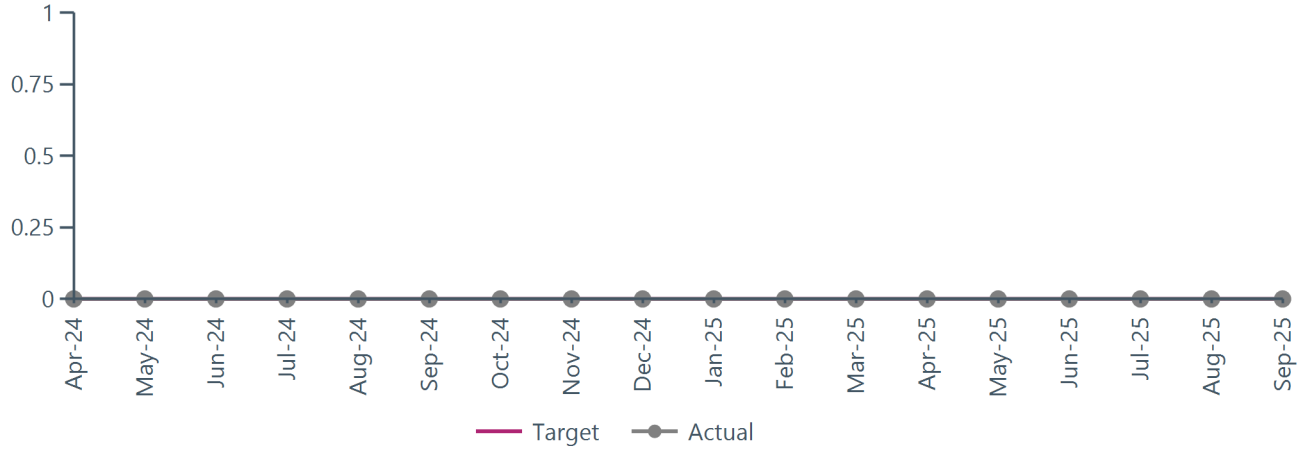
Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
12	13	13	10	10	10	6	6	6	5	3	2	2

RJAH Acquired MRSA Bacteraemia - 12 Months Rolling Count

12 Months Rolling Count of RJAH Acquired MRSA Bacteraemia cases 217893

Exec Lead:
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
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

The new National Oversight Framework (NOF) contains metrics on infections but based on a rolling 12 months position rather than the in-month position. To align with that, the IPR has been amended this month so that all RJAH Acquired infection metrics relate to the rolling 12 months-position.

The latest NOF Publication relates to Quarter 1 where the NOF score for this metric is 1. Indication from a recent Model Hospital Masterclass on NOF advised that the next publication is likely to be the end of November.

The latest rolling twelve month period relates to October-24 to September-25 where there have been no RJAH Acquired MRSA Bacteraemia. This is in line with the threshold set for this period of 0.

Actions

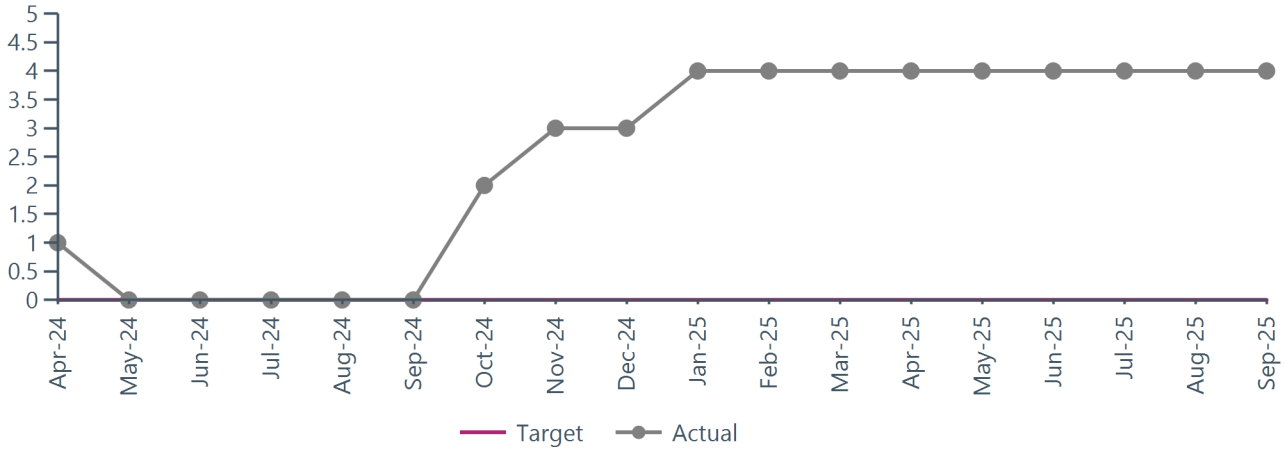
Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
0	0	0	0	0	0	0	0	0	0	0	0	0

RJAH Acquired MSSA Bacteraemia - 12 Months Rolling Count

12 Months Rolling Count of RJAH Acquired MSSA Bacteraemia cases 217894

Exec Lead:
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
0	4	N/A to SPC	F



Trajectory

What these graphs are telling us

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

Narrative

The new National Oversight Framework (NOF) contains metrics on infections but based on a rolling 12 months position rather than the in-month position. To align with that, the IPR has been amended this month so that all RJAH Acquired infection metrics relate to the rolling 12 months-position.

This infection does not form part of the NOF.

The latest rolling twelve month period relates to October-24 to September-25 where there have been four RJAH Acquired MSSA Bacteraemia; 2x October-24, 1x November-24 and 1x January-25. This is above the threshold set for this period of 0.

Actions

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
0	2	3	3	4	4	4	4	4	4	4	4	4

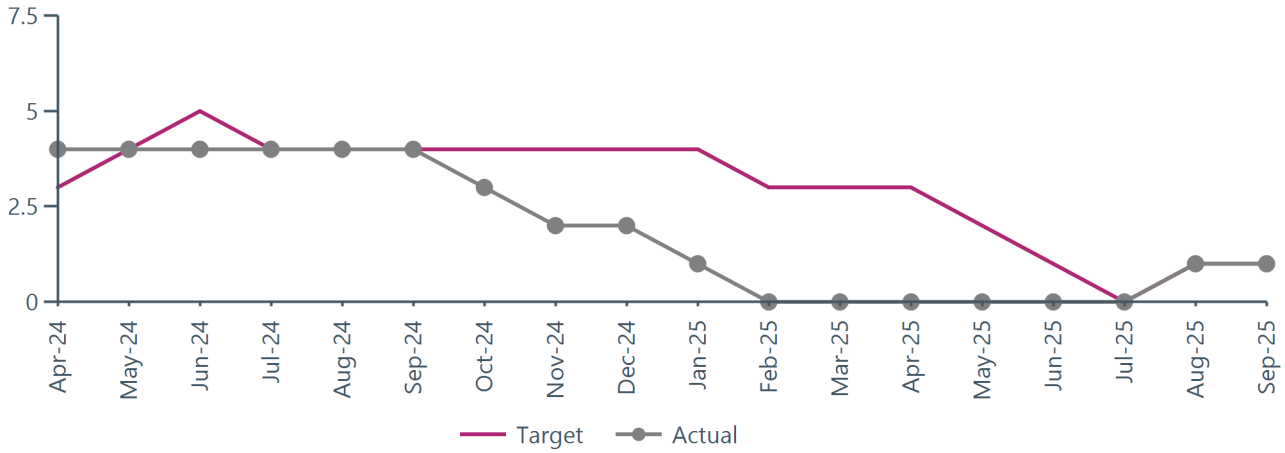
RJAH Acquired Klebsiella spp - 12 Months Rolling Count

12 Months Rolling Count of RJAH Acquired Klebsiella spp cases 217895

Exec Lead:
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
1	1	N/A to SPC	Moving Target

Trajectory



What these graphs are telling us

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

Narrative

The new National Oversight Framework (NOF) contains metrics on infections but based on a rolling 12 months position rather than the in-month position. To align with that, the IPR has been amended this month so that all RJAH Acquired infection metrics relate to the rolling 12 months-position.

This infection does not form part of the NOF.

The latest rolling twelve month period relates to October-24 to September-25 where there has been one RJAH Acquired Klebsiella spp in August-25. This is in line with the threshold set for this period of 1.

Actions

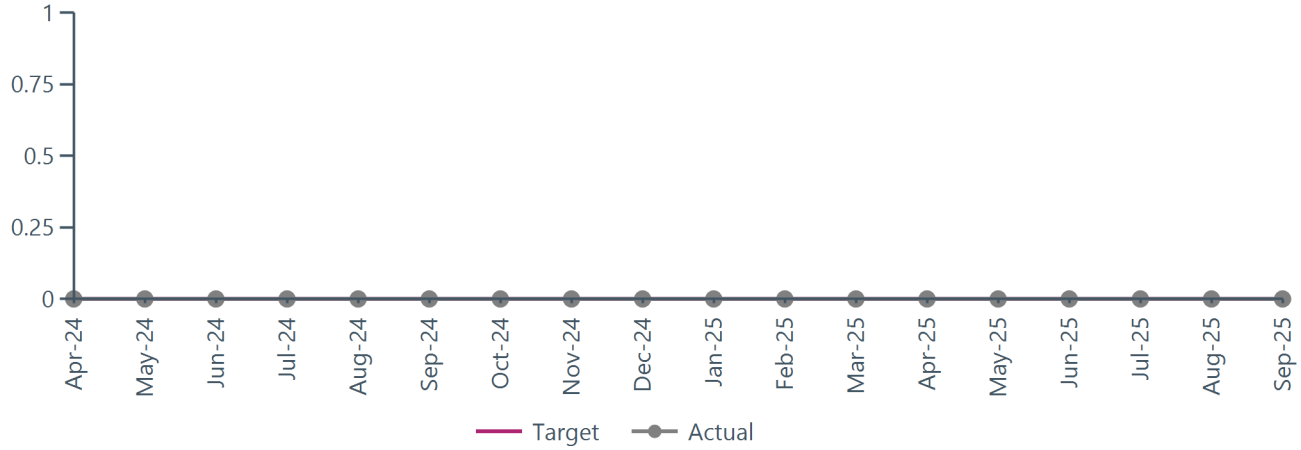
Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
4	3	2	2	1	0	0	0	0	0	0	1	1

RJAH Acquired Pseudomonas - 12 Months Rolling Count

12 Months Rolling Count of RJAH Acquired Pseudomonas cases 217896

Exec Lead:
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
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

The new National Oversight Framework (NOF) contains metrics on infections but based on a rolling 12 months position rather than the in-month position. To align with that, the IPR has been amended this month so that all RJAH Acquired infection metrics relate to the rolling 12 months-position.

This infection does not form part of the NOF.

The latest rolling twelve month period relates to October-24 to September-25 where there have been no RJAH Acquired Pseudomonas. This is in line with the threshold set for this period of 0.

Actions

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
0	0	0	0	0	0	0	0	0	0	0	0	0

Surgical Site Infections

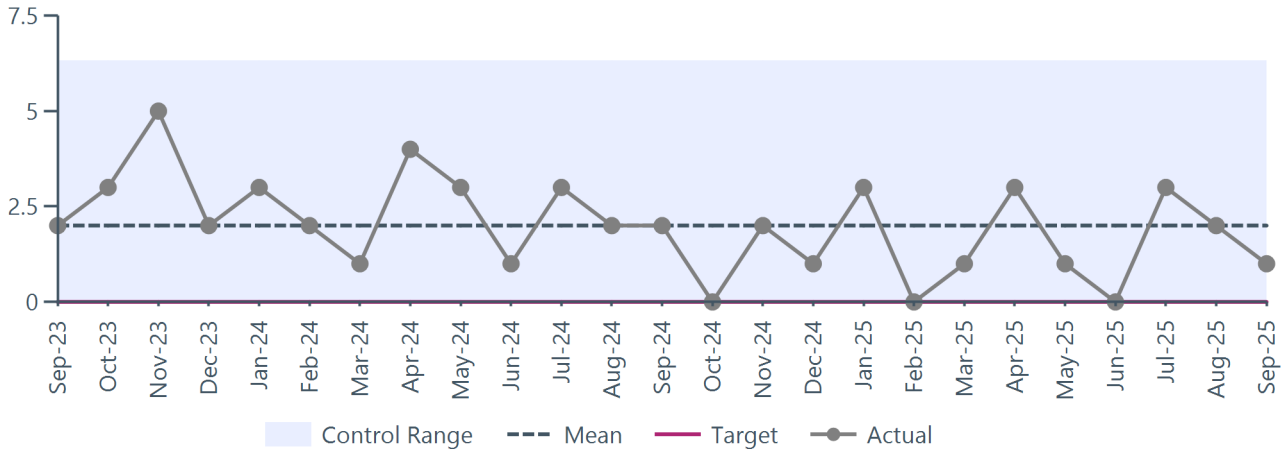
Surgical Site Infections reported for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement in previous twelve months.

217727

Exec Lead
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
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 five infections confirmed in September, as outlined below:
* 1 THR surgery in July - Ludlow Ward
* 1 TKR surgery in July - Clwyd Ward
* 1 THR surgery in August - Clwyd Ward
* 1 Spine surgery in August - Powys Ward
* 1 TKR surgery Sept - Ludlow Ward

At time of IPR production, SSI case reviews are underway.

Actions

The IPC team continue to conduct quarterly MDT reviews, with findings reviewed and reported to both the IPC&CM and IMDT meetings.

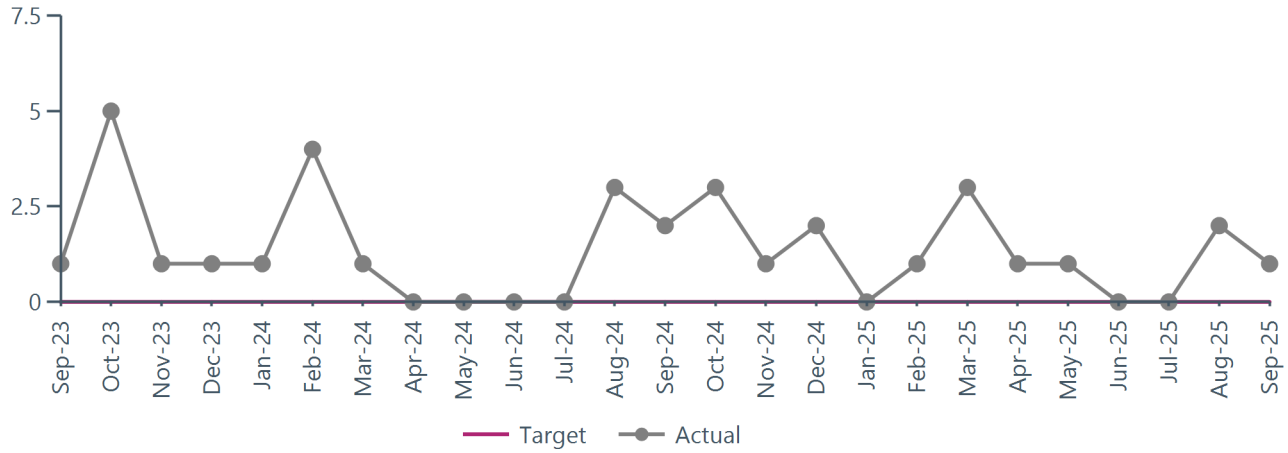
Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
2	0	2	1	3	0	1	3	1	0	3	2	1

Total Deaths

Number of Deaths in Month 211172

Exec Lead:
Chief Medical Officer

Target/Plan	Latest Value	Variation	Assurance
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 death within the Trust in September; this has been classified as an Expected Death.

Actions

Learning from Deaths Reviews are completed by the Trust Lead.

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
2	3	1	2	0	1	3	1	1	0	0	2	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 Meeting, 5 November 2025

Author: **Contributors:**

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Report sign-off:

Lindsey Webb, Non-Executive Director (Chair of the QS 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."*

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 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 18 September and 23 October. It highlights the key areas the Quality and Safety 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	

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	

The following strategic themes, as outlined in the Board Assurance Framework, are overseen by this Committee. The relevant themes, and the Committee's overall level of assurance on their delivery is:

Assurance framework themes		Relevant	Overall level of assurance
1	Continued focus on excellence in quality and safety.	✓	MEDIUM
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.	✓	MEDIUM

3. Assurance Report from Quality and Safety Committee

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

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, OR
Require the approval of the Board for work to progress.

PSIRF Report (September and October)
A Never Event was reported involving the use of an incorrect implant size. A full report will be presented to the committee in due course.

HSE Inspection Report (September and October)
The recent inspection highlighted several areas of concern, including skin surveillance and risk assessments and concerns regarding the adequacy of information provided by the occupational health provider. In response, the Committee has requested a governance review and a comprehensive audit to evaluate the effectiveness of newly implemented processes and ensure sustainable improvements. The Trust is on track to meet HSE notice requirements within the required timescales.

Apollo – Risks (October)
The Committee reviewed the Apollo risk profile and noted that 12 risks remain open, with 7 rated as high or very high. Concerns have been raised regarding the integrity of the waiting list data, particularly due to review dates. There is ongoing uncertainty about the completeness and accuracy of the validation work, which limits confidence in the current dataset. The Committee requested further assurance that the associated risks are being adequately mitigated.

The Clinical Reference Group now meets weekly with improved attendance and is actively prioritising high-impact risks.

CQC Report
The final report and action plan was shared for the committee for comments:

- Recommendation for Internal Workforce Review - Proposal to conduct a workforce review aligned with GPICS (Guidelines for the Provision of Intensive Care Services) standards to ensure optimal staffing and service delivery.
- Enhancement of CQC Action Plan - Request to incorporate a *Mitigations* column into the CQC action plan to better capture risk management strategies and provide clearer accountability.
- Development of Critical Care Practitioner Model - Ongoing work to establish a sustainable and effective model for critical care practitioners, supporting service resilience and workforce flexibility.
- Recognition of Critical Care Improvements - Notable improvements in critical care services have been acknowledged, reflecting progress in quality and patient outcomes.

- Safeguarding Compliance Progress - Compliance with safeguarding standards is nearing full completion. The safeguarding dashboard indicates strong performance across most compliance areas.

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
A comprehensive review of the Corporate Risk Register has been completed, ensuring alignment with current priorities and operational realities.

- Orthotics risks have been consolidated for clarity and improved tracking.
- Risk descriptions are under review to ensure accuracy and inclusion of projected resolution timelines.
- Movement observed in several risks, prompting potential discussions around risk tolerance thresholds.
- DTG input is being sought for emerging digital-related risks. Apollo programme risks are now integrated into the Corporate Risk Register.

Bone Tumour Action Plan (September)
The previously identified risk regarding consultant capacity has been successfully mitigated through the appointment of a third substantive consultant. Collaborative working across the five nationally commissioned centres continues to strengthen, with formalised pathways with Birmingham nearing final agreement. The only outstanding unmet need remains the provision of dedicated psychological support, which has been acknowledged as a broader Trust-wide issue requiring strategic attention.
The Committee approved the action plan.

QIA – Portland Out-of-Hours Safety (September)
The QIA has confirmed that weekend surgical activity at Portland, including complex procedures, is being delivered safely with appropriate mitigations in place. Recruitment efforts are ongoing to address the limited availability of anaesthetists outside standard weekday hours. Consultant-led patient selection continues to serve as a critical safeguard in ensuring clinical appropriateness. The Committee received assurance that enhanced recovery pathways and radiology support are available during weekends, further underpinning the safety of surgical activity. A formal review mechanism is in place to ensure robust case selection and consultant sign-off for all weekend procedures.

Performance Report (October)
There has been an increase in medication errors, with a total of 55 incidents reported. Notably, 19 of these errors were associated with the rheumatology homecare service. A total of 38 theatre cancellations occurred on the day of surgery, indicating a need for further investigation into scheduling and operational efficiency. Concerns have been raised regarding compliance with Healthcare Associated Infection (HCAI) targets, due to low numbers and potential impact on NOF ratings.

Learning from Deaths (October)
Gaps in respiratory care for patients with spinal fractures prior to transfer to RJAH have been identified and require attention. Concerns have also been raised regarding the safe transfer of frail patients. A missed observation in an elective surgical case has been noted and reviewed. The committee have requested postoperative mortality trends be reported through the Clinical Effectiveness Meeting. There has been a noticeable decrease in postoperative mortality compared to the previous year.

Delivery Model Assurance Report (October)
The report demonstrates alignment with both national guidance and the organisation's evolving cultural values, indicating a meaningful shift in approach. The initial draft of the transformation report has been received positively, marking a constructive step forward in the delivery model's development. It is recommended that progress against the transformation objectives be reviewed on a six-monthly basis to ensure continued alignment and momentum.

3.3 Areas of assurance

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

Performance Report (September and October)
The IPR now aligned with national oversight metrics and incorporates patient survey data. Notable improvements were observed in discharge metrics, attributed to a revised methodology. Efforts continue to reduce day-of-surgery cancellations, with contributing factors identified and mitigation actions underway. Infection Prevention and Control (IPC) issues are being actively managed, and the majority of medication errors reported were of low harm.

Patient Story and Improvement Approach (September)
Following a patient story presented at Trust Board, actions have been developed with the patient involved in reviewing their impact. A review of outpatient KPIs is underway, focusing on appointment rescheduling and communication improvements, particularly for spinal disorder patients. Updates will be monitored through the Patient Experience Meeting and reported back to the Committee.

Quality Strategy Action Plan (October)
All elements of the strategy are now in place. The current focus is on ensuring timely and effective delivery of each action within the established timelines.

Quality Accreditation Q2 Update (October)
There has been positive progress in the ongoing theatre developments, contributing to improved service delivery and patient experience. The quality dashboard continues to provide robust assurance regarding the standard of care being delivered across the Trust.

Recommendation

The Board is asked to:

1. CONSIDER the overall assurance level listed at section 2 and;
2. CONSIDER the remaining 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.

CQC Report (Critical Care and Surgery)

Committee / Group / Meeting, Date

Board of Directors – Public Board Meeting, 05 November 2025

Author: Contributors:

Name: Care Quality Commission

Report sign-off:

Sarah Needham, Interim Chief Nurse and Patient Safety Officer
Ruth Longfellow, Chief Medical Officer

Is the report suitable for publication?:

Yes

Key issues and considerations:

The Trust was last inspected by the Care Quality Commission (CQC) in November and December 2019, when it received an overall rating of 'Good'.

The most recent announced inspection took place on 22 and 23 May 2025, focusing on Critical Care and Surgery (Adult Services) under the Single Assessment Framework.

We are pleased to confirm that the Trust has once again received an overall rating of 'Good'. The Trust acknowledges the recommendations provided by the CQC and is committed to implementing improvements that will further enhance the quality of patient care.

Location Findings:

Overall	Good
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-Led	Good

Critical Care Ratings:

Overall	Good
Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Good
Well-Led	Good

Surgery Ratings:

Overall	Good
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-Led	Good

Critical Care – Areas for Improvement

The CQC identified the following areas requiring improvement within Critical Care services and were reported as noncompliance against the standards:

- **Regulation 12 - Safe care and treatment**:
  - The trust must ensure that after-hours communication, particularly for nurses needing to contact the specialist team when anaesthetists are not present, requires a clear solution to ensure timely and safe patient care (Regulation 12).
  - The trust must ensure that all staff have completed their mandatory training (Regulation 12).
- **Regulation 18 – Staffing**:
  - The trust must discuss and plan for increasing the number of medical and nursing staff to improve care quality and safety. There is a need to clarify the required increase in medical and nursing staff for the unit, including specific roles, numbers, and timelines, to ensure the quality and safety of care as patient volume and complexity rise; (Regulation 18).

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 CQC report is shared with the Board of Directors for information and oversight.

Report development and engagement history:

Prior to the publication of the final report, the Trust was given the opportunity to review and provide feedback on any factual inaccuracies. The Trust's comments were taken into consideration, and the report was amended accordingly. However, these amendments did not affect the overall inspection rating.

The action plan supported the implementation of the recommendation outlined within the report was presented at the most recent meeting and reporting within the Chairs assurance report.

Next steps:

The Trust has commenced compiling an action plan following the receipt of the report. The implementation and monitoring of this action plan will be operationally overseen by the Quality

Standards Working Group, with overall assurance reported to the Board of Directors via the Quality and Safety Committee.

Acronyms

CQC	Care Quality Commission

Appendices

Appendix A	CQC Assessment Report (inspection date 23/05/2025*)*

The Robert Jones and Agnes Hunt hospital

LAP Assessment Report ID : LAP-01544

Inspection visit date(s): 23/05/2025

Table of contents

The Robert Jones and Agnes Hunt hospital

Location findings

Ratings for this location

Overall	Good
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Overall location summary

We last inspected the hospital in November and December 2019. Where it was rated good overall.

We carried out this announced inspection on the 22 and 23 May 2025. We inspected this service using our single assessment framework and looked at all the key questions.

The main service provided by the hospital was surgery for adult patients. During this inspection we also inspected critical care core service.

Safe

Rating Good

The service had a good learning culture and people could raise concerns. Managers investigated incidents thoroughly. People were protected and kept safe. Staff understood and managed risks. The facilities and equipment met the needs of people. The building was clean and well-maintained with

risks well controlled. Managers made sure staff received training and regular appraisals to maintain high-quality care. Staff managed medicines well. Managers involved people in planning any changes.

However,

There was not always enough medical cover for the hospital out of hours.

Effective

Rating Good

People were involved in assessments of their needs.

Staff reviewed assessments taking account of people's communication and personal health needs.

Care was based on the latest evidence and good practice.

People always had enough to eat and drink to stay healthy.

Staff worked with all organisations involved in people's care for the best outcomes and smooth transitions when moving services.

They monitored people's health to support healthy living. Staff made sure people understood their care and treatment to enable them to give informed consent.

Caring

Rating Good

People were treated with kindness and compassion. Staff protected their privacy and dignity. They treated them as individuals and supported their preferences.

People had choice in their care and were encouraged to maintain relationships with family and friends.

Staff responded to people in a timely way.

The service supported staff wellbeing.

Location findings

Responsive

Rating Good

People were involved in decisions about their care.

The service provided information people could understand.

People knew how to give feedback and were confident the service took it seriously and acted on it.

The service was easy to access and worked to eliminate discrimination.

People received fair and equal care and treatment.

The service worked to reduce health and care inequalities through training and feedback.

People were involved in planning their care and understood options around choosing to withdraw or not receive care.

Well-led

Rating Good

Leaders and staff had a shared vision and culture based on listening, learning and trust.

Leaders were visible, knowledgeable and supportive, helping staff develop in their roles.

Staff felt supported to give feedback and were treated equally, free from bullying or harassment.

People with protected characteristics felt supported.

Staff understood their roles and responsibilities.

Managers worked with the local community to deliver the best possible care and were receptive to new ideas.

There was a culture of continuous improvement with staff given time and resources to try new ideas.

Critical care

Overall	Good
Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Our view of the service

The on-site assessment took place on the 23 May 2025. The assessment took place due to overdue inspection and out of date ratings. We have rated the service as Good overall.

The high dependency unit at The Robert Jones and Agnus Hunt Orthopaedic Hospital NHS Trust provides a service to patients who need high dependency care (described as level two). Care is provided to patients who have undergone extensive or complicated orthopaedic surgery, or who have been identified at their pre-operative assessment clinic as maybe requiring closer post-operative nursing care. The high dependency unit also provides care to patients who are being nursed on the general wards and whose condition is deteriorating clinically or are causing concern. Patients are also admitted in the event of surgical emergencies.

An outreach service is provided within the trust, which operates 24 hours a day, 7 days a week. The team follows up all patients upon discharge from the high dependency unit to one of the wards, during service hours, to ensure good clinical progress continues. They attend to deteriorating patients on the general and surgical wards. The outreach role is a dual one as they also provide nursing cover to the

whole hospital at night.

As of 30 March 2025, there were 4 adult critical care beds, of which 1 was occupied. Between 25 November 2024 and 30 March 2025, the trust has had between four to six open beds with an average monthly bed occupancy rate of 58%. The trust has had a comparable number of open critical beds and bed occupancy, over the past three years. Between January 2024 and January 2025, the High Dependency Unit (HDU) Hospital had an average of 21.96 care hours per patient day.

April 2025 figures:

Weekday bed occupancy at 2pm 48.51% against target 87.00%

Weekend bed occupancy at 2pm 40.63% against target 87.00%

Weekday bed occupancy at midnight 66.67% against target 87.00%

Weekend bed occupancy at midnight 38.71% against target 87.00%.

People's experience of the service

Overall, people's experience of the service was positive. Patients and relatives spoke positively about staff, who were kind, explained their care and treatment, answered call bells quickly and provided pain relief when required. Patients consistently rated feeling able to talk to staff and feeling they were treated with dignity and respect above the national average in surveys. We viewed a number of thank you cards from patients and their loved ones on display.

Safe

Rating Requires improvement

Training and regular updates on systems and processes which helped to keep people safe were available to all staff. Safeguarding systems, processes and practices were effective, and staff demonstrated good understanding of their responsibilities. Cleanliness and hygiene were well maintained and there were reliable systems to prevent and protect people from healthcare-associated infections. Staff kept detailed records of patient care and treatment. The service followed best practice when prescribing, giving, recording and storing medicines. The service managed patient safety

incidents well. The trust had made significant improvements since the 2019 inspection; they now had a highly motivated and respectful intensivist lead in place. Safeguarding policies were in place and staff gave us examples of when they would raise a safeguarding concern. Risk assessments were completed consistently in patient records including sepsis risk assessments. The service audited documentation and key risks were discussed in various meetings. The service employed 1 full time professional development nurses.

However,

The service did not have enough intensivists to provide continuous cover as per the GPICS standards.

Not all staff had completed their safeguarding training against trust target.

Learning culture

Score

3. Evidence shows a good standard of care

The service had a proactive and positive culture of safety, based on openness and honesty. Staff listened to concerns about safety and investigated and reported safety events. Lessons were learnt to continually identify and embed good practice.

Staff we spoke with knew what incidents to report and how to report them. Staff informed us they were confident in reporting incidents. They were also encouraged to report incidents and received feedback on them. Staff were aware of the incidents that had been reported on the unit as they were displayed on a notice board and discussed at their team meetings.

All incidents are reported through the trusts incident management system. If a level of harm is reported as moderate or above then these incidents are discussed at the Patient Safety Incident Review Group, chaired by the Assistant Chief Nurse and Patient Safety Officer. Any patient safety reviews are investigated by a staff member outside of the unit to maintain a fresh eyes approach.

Investigations into any themes or trends were carried out and shared with staff at their daily safety briefings. All commissioned patient safety reviews, including never events were escalated by a senior member of the unit, who was advised and supported by the Unit Governance Lead. Between 1 April 2024 and 29 April 2025, there were no Patient Safety Incident Investigations reported via the Strategic Executive Information System (StEIS) at the trust.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The unit had applied the duty of candour in applicable situations we were made aware of. Staff were aware of their responsibilities and when the duty applied. The duty of candour policy was easily accessible for staff and was in date.

Safe systems, pathways and transitions

Score

3. Evidence shows a good standard of care

The service worked with people and healthcare partners to establish and maintain safe systems of care, in which safety was managed or monitored. Staff made sure there was continuity of care, including when people moved between different services.

The service's referral and admission processes ensured that all essential information about the patient was received to determine if the patient's needs could safely be met. All patients attending the trust were elective patients and consultants booked patients during their pre-operative clinic. If a patient was required to stay at the unit for post operative care this was booked in advance.

There was an outreach team within the hospital, who provided a 24-hour cover 7 days a week. The band 7 high dependency unit manager managed the team. The staffing of the team comprised of dedicated band 6 high dependency unit nurses, who worked on a monthly rota. If the nursing cover was short on the high dependency unit or across the hospital wards, the outreach nurse would be pulled on to the unit or ward to provide support. The nurses on the outreach team also provided a hospital cover role at night. This required them to respond to

hospital wide issues.

Staff involved all the necessary healthcare and social care services to ensure patients had continuity of safe care, both within the service and post-discharge. There was a standard operating procedure for the safe inter and intra hospital transfer of adults receiving critical care support. Leaders were working to introduce a critical care informational system with their partnering trust.

The hospital was part of a pilot for Martha's rule, staff told us they had awareness through posters and support from the outreach team.

Safeguarding

Score

2. Evidence shows some shortfalls in the standard of care

Not all staff had completed their safeguarding mandatory training.

Safeguarding policies were in place for children and adults, these were in date and version controlled; they contained links to legal, professional and national guidelines.

Not all staff had completed their safeguarding mandatory training; The lowest compliance level for level 3 adult safeguarding as of March 2025 was 72% of which only 59% of medical staff had completed this, against trust target of 92%. However, staff were able to demonstrate how to make a safeguarding alert when appropriate.

Within the trust, there were 2 named nurses for safeguarding and 2 safeguarding practitioners. The named nurses provided staff with expert advice and support regarding safeguarding children issues when required. The unit had a link nurse with experience in safeguarding and staff could approach them for advice and guidance. The link nurse was responsible for sharing learning with staff and linked with the safeguarding lead within the trust

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies.

Involving people to manage risks

Score

3. Evidence shows a good standard of care

The service worked with people to understand and manage risks by thinking holistically. Staff provided care to meet people's needs that was safe, supportive and enabled people to do the things that mattered to them.

We reviewed 7 samples of patient records and found risk assessments including sepsis risk assessments and subsequent planning were consistently completed. Risk assessments included but were not limited to the prevention of venous thromboembolism, pressure ulcers, malnutrition and falls. Where risks were Identified, actions from the assessments were noted and implemented. It was clear within the records we reviewed, that patients were assessed by a consultant anesthetist within their first 12 hours of admission on the unit.

Handover documentation from the high dependency unit to the wards was safe. There was a formal handover document for people being stepped down from the high dependency unit. When patients were transferred from the unit to a ward, the nurses completed a formal handover clinical transfer to ward form.

Patients were typically managed on the unit until transfer; long-term ventilation was not standard practice, but there were discussions about potentially providing 24-hour cover in the future. Staff with anesthetic backgrounds were generally comfortable with ventilator management. Some staff identified as anesthetists with intensive care skills, highlighting the distinction between intensivists and anesthetists. The unit did not routinely have ventilated patients for extended periods; transfers were arranged as soon as possible, though delays could occur due to bed availability at receiving units, some examples were shared with us and staff told us the unit managed challenges extremely well.

Patients were increasingly frail, with requirements for longer hospital stays, presenting

additional management challenges.

Safe environments

Score

3. Evidence shows a good standard of care

The evidence showed a good standard. The service detected and controlled potential risks in the care environment. They made sure equipment, facilities and technology supported the delivery of safe care.

The high dependency unit (HDU) was secure. Access to HDU was restricted by an intercom, the entrance to the unit could only be granted to those who were allowed in by staff. Once access to the unit was granted, visitors could enter the clinical areas of the unit without any further restrictions. There was a waiting area which visitors could use before accessing the unit.

HDU was designated for up to 6 patients, with 1 spare bed; occasionally, capacity stretched to 7. At maximum capacity, decisions were made about which patient could be moved to accommodate new admissions, often based on clinical stability.

Staff consistently carried out daily and weekly checks of emergency equipment including resuscitation trolleys. The unit had 4 ventilators and considered to be of good quality.

Staff told us there was a need for more space and resources to accommodate increasing patient numbers and complexity. Staff told us that lack of space was a limiting factor for further expansion.

Each bed space was specifically built with negative air pressure, ensuring compliance with Health Building Notes (HBN) standards. There was a HDU emergency evacuation plan which included actions to be taken upon hearing the fire alarm and evacuation procedures.

Safe and effective staffing

Score

2. Evidence shows some shortfalls in the standard of care

The service made sure staff were qualified, skilled and experienced. Staff received effective support, supervision and development. Staff worked together well to provide safe care that met people's individual needs. However, there was no consultant available on-site overnight; consultant response time was 30 minutes, with on-call duty from 6pm to 8am. The trust had 1 intensivist for the whole trust.

Staff on shift included 3 registered nurses, a unit manager, consultant anesthetist and 2 healthcare assistants. Staff told us how staffing on the inspection day was at full capacity. At the time of inspection, 3 patients were staying in the unit with 3 patients due to be transferred out. The unit had a direct connection to the operating theaters, with proximity facilitating transfers, this allowed additional staffing support if required.

We saw the unit's April 2025 figures around effective staffing: sickness absence was 6.11% against target 5.04%. The vacancy rate of 7.15% of which nursing vacancy was 6.81%. Senior leaders told us the unit required a further 20%- 25% to support rotation skills for staff; 53% of staff had critical care qualifications and inductions and 6 weeks supernumerary was given. Staff were required to complete a monthly simulation session to ensure they were kept up to date with their clinical skills and any changes or updates were managed during simulation training (SIM).

The service employed 1 full time professional development nurse. They told us they facilitated learning events including monthly simulation sessions for nursing staff, bi-monthly simulations for the whole critical care team, as well as study days.

Staff told us that staffing concerns were mainly an issue after 6pm, with only one intensivist and reliance on the on-call anesthetists after 6pm. This was known to the senior leadership and a recruitment drive was underway, 18 specialties of doctors were being interviewed in June 2025.

The anaesthetic on-call team consisted of 16 anesthetists, resulting in each being on-call for

one weekend (Friday to Monday morning) every 16 weeks. The on-call duty required staff to be available by phone and to come in as needed for patient care; staying on-site was not mandatory unless necessary. Staff who lived further away utilised free accommodation during their on-call period. Some staff told us that there was a perception that those living closer may be asked to cover more frequently, potentially affecting the fairness of on-call duty distribution.

Staff we spoke with told us there had been an increase in emergency spinal procedures, particularly out of hours, over the past 2 to 3 months. Typical emergencies include cauda equina syndrome, infections, and bleeding. On-call responsibilities focussed more on managing the patients on the high dependancy unit in particular those on organ support. Airway management was handled initially by medics and the outreach team with the support of the on-call anaesthetist. There was an on-call anesthetist support available if there was an emergency.

We saw the unit's latest figures for April 2025 for staff personal development review was at 88% against the trust target of 93%.

The unit had skilled nursing staff, with regular input from medical and surgical registrars, who were described as capable of making appropriate decisions. Some staff told us that having an anesthetist on-site 24 hours would be beneficial, especially as the unit aspired to become a national spinal unit. Some senior leaders we spoke with told us that there could be a cost implication of sourcing a 24-hour anesthetist coverage.

The outreach team provided 24-7 coverage and acted as site managers overnight, with a team of 6 members. However, there is no consultant available on-site for the outreach team overnight; consultant response time was 30 minutes, with on-call duty from 6pm to 8am. The external review 12 months ago noted sufficient oversight by a senior nurse at night but highlighted the absence of on-site consultant cover.

Staff told us that the presence of fellows and trainees was beneficial to the unit and there were more fellows expected to be interviewed early 2026. Junior medics were present with varying levels of experience and engagement; some were highly capable and contributed significantly. Ongoing discussions were held about the need for more junior staff to support the unit, with recruitment efforts underway. We saw that the unit valued the contribution of junior staff and were actively seeking to expand the team to support increasing workload and complexity.

There was no dedicated critical care pharmacy service, although a pharmacist visited the unit daily. Similar gaps existed with dedicated services for occupational therapists, physiotherapists, psychologists, and microbiologists, which were recognised as areas needing further workforce development in the workforce plan. However, staff told us they could access these services if required.

We observed a physiotherapist attending a patient post operatively, patients told us they were visited daily. When we spoke with the physiotherapist, they told us they were informed of patients requiring a visit through the trust daily huddles and the operating theatre scheduling list.

Some staff were up to date with appropriate mandatory training, 89% had completed statutory and mandatory training against trust target of 92%. The lowest compliance of training was within immediate life support at 68%; However, 100% of staff had completed advance life support (ALS) and European paediatric advance life support (EPALS). Other mandatory training was within target or near target. The unit had action plans in place to ensure mandatory training was completed.

Infection prevention and control

Score

3. Evidence shows a good standard of care

The evidence showed a good standard. The service assessed and managed the risk of infection. They detected and controlled the risk of it spreading and shared concerns with appropriate agencies promptly.

Staff maintained equipment well and kept it clean. Any ‘clean’ stickers were visible and in date. All ward areas appeared to be clean, had required furnishings and were well-maintained. Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly. April 2025 unit cleanliness audit was 99.49% against trust target of 98%.

The equipment storage room was small but functional for its use. We found some critical

machines and non-invasive mask and suction catheters were stored here and if required urgently could make access time difficult.

Infection prevention and control (IPC) practices were consistently followed. All high dependency unit staff were bare below the elbow to enable effective handwashing. Hand hygiene audits results as of April was 98.50% with bare below the elbow at 98.50% against trust target of 95%

Adequate personal protective equipment was available at the end of each bed space, which included disposable gloves and aprons. We observed staff using equipment appropriately during each patient interaction.

Signage and guidance reminding staff and visitors to wash their hands and use the hand sanitising gel that was present on the unit.

Staff adhered to infection control principles, including handwashing. There were reliable systems, processes and practices to prevent and protect people from healthcare-associated infections.

Performance relating to IPC was regularly monitored. The unit manager received a monthly performance report of their areas with a view to implementing any action plans for areas that did not achieve the 92% target. A copy of the audit results was also sent to the infection control link nurses. We saw 92.3% of staff were compliant as of April 2025.

Medicines optimisation

Score

3. Evidence shows a good standard of care

The service made sure that medicines and treatments were safe and met people's needs, capacities and preferences. They involved people in planning, including when changes happen.

Staff followed good practice in medicines management and did it in line with national

guidance. All appropriate medicines and fluids were stored securely in locked cupboards.

Prescription charts used on the unit were complete and included all the relevant information. Prescription charts we reviewed; were all clear on who prescribed a medication. Patients with a known drug allergy were wearing a red wristband as required.

The trust had recently introduced a new system for the prescribing and administration of medicines (EPMA). Staff were still familiarising with this new system.

The medication trolley had recently been fitted with digital secure lock. Medication main keys were always held by the nurse in charge.

Effective

Rating Good

The trust participated in national audits and benchmarked against similar units.

We observed critical care ward rounds, which occurred twice daily, staffing handovers and safety huddles and found them to be thorough, with an integrated approach.

Records were comprehensive and easy to follow. Patients' physical, mental health and social needs were assessed. Staff screened patients for pressure ulcers, falls, venous thromboembolism (VTE) and delirium on admission and throughout their stay on the unit.

Assessing needs

Score

3. Evidence shows a good standard of care

The service made sure people's care and treatment was effective by assessing and reviewing their health, care, wellbeing and communication needs with them.

Staff kept detailed records of patient care and treatment. Within the high dependency unit,

patient records were kept on an electronic patient records system and on paper, this had not changed since the last inspection. Staff told us, and we saw a new IT system had recently been implemented, and it was their second week.

Most information relating to patient care was recorded, either electronically or paper-based, from admission and updated throughout admission on the unit. Patients had individual care plans which were revised and adapted as treatment progressed.

Records were comprehensive and easy to follow. Patient record audits were carried out every month.

Delivering evidence-based care and treatment

Score

3. Evidence shows a good standard of care

The service planned and delivered people's care and treatment with them, including what was important and mattered to them. Staff did this in line with legislation and current evidence-based good practice and standards.

Patients' physical, mental health and social needs were assessed. Staff screened patients for pressure ulcers, falls, VTE and delirium on admission and throughout their stay on the unit. April 2025 figures showed us that the unit had reported 0 falls, 0 deep vein thrombosis and 0 Pulmonary embolism.

We saw that any new guidance and best practice was discussed at some clinical governance meetings, and we observed staff providing care and treatment which was in line with best practice.

We were provided with a standard operating procedure for the transfer of adult patients. Staff told us hospitals within the critical care network, who could provide level 3 care, would be contacted to identify if a bed was available. Policy stated a transfer decision should only be made by the covering consultant anesthetist, only if there was absolutely no possibility of an

internal placement for the patient, such as the requirement for level 3 care or specialist intervention. No critically ill patient would be transferred without first being appropriately assessed by the on-call consultant anesthetist for the “transferring” hospital.

Staff assessed and met patients’ needs for food and drink. There was not a designated dietitian assigned to the unit who was involved in the assessment, implementation and management of patient with specialist nutritional support; however, the unit had access to a dietician when patient's on the unit require their input.

Staff participated in clinical audit, benchmarking and quality improvement initiatives. The high dependency unit’s participation in quality improvement initiatives had improved significantly since last inspection, such as benchmarking, accreditation schemes and peer review, which were not done at the previous inspection.

The unit audited themselves against the Guidelines for the Provision of Intensive Care Services (GPICS) however, it was felt that not all aspects of GPICS requirement fitted a level 1 and 2 unit. However, the unit continued to self-assess as part of their participation in the regional critical care network, which incorporated guidelines. The self-assessment required the unit to assess their facilities, operations, governance, staffing, additional services and relationships. The unit was due an external review by the regional critical care network this year.

How staff, teams and services work together

Score

3. Evidence shows a good standard of care

The service worked well across teams and services to support people. They made sure people only needed to tell their story once by sharing their assessment of needs when people moved between different services.

Staff of different levels worked together as a team to benefit patients. The service accepted level 1 and 2 patients There was guidance in place when considering whether admission to the high dependency unit was required.

Elective patients were pre-booked for a bed at the unit during their pre-operative appointment with their consultant. Some staff told us they sometimes treated level 3 patients. However, the unit was not commissioned or currently able to manage level 3 patients, but this was something the unit was hoping to be able to provide in the near future. Between April 2024 and May 2025 12 patients were transferred out of the hospital to neighbouring trust for additional care, of which 4 patients were ASA 2 and ASA 3.

There was now a consistent daily ward round and handover including different specialties, this was an improvement from the last inspection. However, not all allied healthcare attended.

Access to clinical investigation was available. Services included, X-rays, magnetic resonance imaging (MRI) scans and computerised tomography (CT or CAT) scans.

There were some services on the high dependency unit which were not available seven days a week, such as the speech and language team, dietician and physiotherapist. Many staff told us they had to call for allied staff to visit the unit if needed.

Supporting people to live healthier lives

Score

3. Evidence shows a good standard of care

The service supported people to manage their health and wellbeing to maximise their independence, choice and control. The service supported people to live healthier lives and where possible, reduced their future needs for care and support.

There was a recovery guide for patients. The guide contained advice and information on different aspects of health following a stay in critical care. It included topics such as mobility and physical activity, including exercises, nutrition and relaxation. It also contained contact details of other services and sources of support.

Patients who may have needed extra support were identified during their pre-operative appointment.

Monitoring and improving outcomes

Score

3. Evidence shows a good standard of care

The service routinely monitored people's care and treatment to continuously improve it. They ensured that outcomes were positive and consistent, and that they met both clinical expectations and the expectations of people themselves.

The high dependency unit routinely collected and monitored some information about the outcomes of patient's care and treatment. The unit participated and contributed data to the Intensive Care National Audit and Research Centre (ICNARC) and Guidelines for the Provision of Intensive Care Services (GPICS). We used data from April 2025 that showed ICNARC Audits was 98.50% against 95.00% target. GPICS standards were not all met, however trust told us not all standards were easily met due to the size and complexity of their unit.

The unit was now benchmarking themselves against similar units. There had been a recent review of the high dependency unit by the external members of the regional critical care network.

Staff used recognised tools to improve the detection and response to clinical deterioration in patients as a key element of patient safety and improving patient outcomes.

The trust commissioned an external review 12 months prior to our inspection. Senior leaders told us that this was extremely helpful and had supported them when reviewing their GPICS standards, which many are not within their operational scope. We reviewed this external report and found that some of the recommendations related mainly to children's services than critical care; however, we noted anaesthetic medical cover was mentioned within the review along with simulation (SIM) recommendation for improvement, such as increasing the frequency of SIM and scenario education within the department. We had a tour of the SIM room along with taking part in some of the scenarios and found this to be educational and highly thought of. SIM training, or simulation training, a method used by the NHS to enhance healthcare professionals' skills and competencies in a safe and controlled environment.

A network adult critical care unit peer review visit was scheduled for 2026. Senior leaders told us that they did not feel as a network there was strong collaborative working. They also felt they as a trust should be taken seriously as a critical care service and be seen as being a unit that was able to support other trusts within the network. A collaborative network group meeting was arranged for June 2025. The trust looked forward to their peer review in 2026.

The 24-7 outreach and the improved communication systems had led to better patient outcomes and workflow, with early identification and management of deteriorating patients.

Consent to care and treatment

Score

3. Evidence shows a good standard of care

The service told people about their rights around consent and respected these when delivering person-centered care and treatment.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients said staff explained all care and procedures to them, including where written consent was required.

Staff could describe the process for completing a mental capacity assessment and took all practical steps to enable patients to make their own decisions.

For those patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately.

Caring

Rating Good

The service treated people with kindness, empathy and compassion and respected their privacy and dignity. Patients said staff responded quickly to their call bells.

In April, the friends and family test (FFT) data showed that 97.69% of patients would rate their

experience as good or very good and 0.95% patients reported a negative FFT score for the unit with 16 negative comments received. 13 were received for main outpatients, 2 in ORLAU, and 1 in orthotics. 8 patients mentioned waiting times, 4 patients were unhappy with the outcome of their appointment, 2 left no comments and 2 were compliments. These figures were not broken down to each ward and were overall figures from FFT.

Kindness, compassion and dignity

Score

3. Evidence shows a good standard of care

The service treated people with kindness, empathy and compassion and respected their privacy and dignity. Staff treated colleagues from other organisations with kindness and respect.

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it.

There was private space available on the unit for relatives. There were open visiting times for visitors. Patients and relatives were kept fully informed and staff treated them with kindness and understanding.

All relatives we spoke with told us that they were very happy with the level of compassion and commitment of staff and they felt their relatives were in good hands. We observed good attention from all staff to patient privacy and dignity. Curtains were drawn around patients and doors or blinds were closed in private rooms when necessary. Voices were lowered to avoid confidential or private information being overheard.

Treating people as individuals

Score

3. Evidence shows a good standard of care

The service treated people as individuals and made sure people's care, support and treatment met people's needs and preferences. Staff took account of people's strengths, abilities, aspirations, culture and unique backgrounds.

Staff were supportive and responsive to patients' individual needs. The service adjusted for patients, by ensuring easy access to premises for people and by meeting patients' specific communication needs. Staff ensured that patients had easy access to interpreters and/or signers.

We observed interactions between staff, patients and relatives, and saw a consistent approach to open and honest communication that was sensitive and empathic.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. Staff maintained the confidentiality of information about patients.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups and to account for allergies and intolerances.

Independence, choice and control

Score

3. Evidence shows a good standard of care

The service promoted people's independence, so people knew their rights and had choice and control over their own care, treatment and wellbeing.

There was an adult organ and tissue donation guideline which was updated and amended as and when required.

Responding to people's immediate needs

Score

3. Evidence shows a good standard of care

The service listened to and understood people's needs, views and wishes. Staff responded to people's needs in the moment and acted to minimise any discomfort, concern or distress.

Staff were aware of and dealt with any specific risk issues, such as falls or pressure ulcers and care planned for these accordingly. The unit carried out regular checks and patients were always visible.

Staff identified and responded to changing risks to patients such as deterioration in their National Early Warning Score.

There were 24 actions scheduled to be completed by the end of May 2025 according to the trust patient safety improvement plan, of which 10 related to High Dependency Unit many relating to medical rota/cover.

Workforce wellbeing and enablement

Score

3. Evidence shows a good standard of care

The service cared about and promoted the wellbeing of their staff and supported and enabled staff to always deliver person-centred care.

Staff felt positive and proud about working for the trust and their team. Staff told us they had managed through COVID since the last inspection and had created a better work environment of appreciation of the team and workplace.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

The service's staff sickness and absence were similar to the average for the provider.

Staff appraisals included conversations about career development and how it could be supported.

WhatsApp system was used for real-time updates on staff rota's and assignments, allowing staff to see who was on duty and where.

Handover between on-call staff typically occurred between 5pm and 6pm, with flexibility based on theater schedules and emergencies, with face-to-face handover as standard unless scheduling conflicts arose. Nurses sometimes found it difficult to contact the specialist team, particularly surgeons, after 6 pm, especially when anesthetists were not present, as surgeons may be busy on the ward or assisting at theatres.

Some staff told us that the current HDU capacity and space limitations posed a risk to accommodating increasing patient numbers, complexity and could impact staff workload. The consultant emphasised that without addressing staffing, space, and resource limitations, the unit's vision for national specialisation and advanced care would be difficult.

One patient we spoke with told us that staff were caring and doing the best they could, they said that they wish staff could work sensible hours as they could see them under pressure, tired, and working long shifts

Responsive

Rating Good

The premises were accessible, with services located on one level. People could access the service when they needed it.

Leaders audited ReSPECT forms, and we saw evidence of audit completion.

Leaders organised learning disability and mental health training; 90% of staff had completed Tier 1 Oliver McGowan learning. However, only 37.5% had completed Oliver McGowan Tier 2.

Person-centred care

Score

3. Evidence shows a good standard of care

The service made sure people were at the centre of their care and treatment choices and they decided, in partnership with people, how to respond to any relevant changes in people's needs.

Patient bays were situated along the same side of the unit and none of the bays looked into each other. If there were any concerns, the isolation rooms on the unit could be used. Although the high dependency unit was not able to accommodate patients in single sex areas, the facilities were designed to ensure patient dignity and respect were always protected.

The high dependency unit was accessible to people who had mobility difficulties. The unit was situated on the first floor but there were lifts to the unit, the doors were wide enough to admit a wheelchair and there was flat access to the unit and patient areas.

Care provision, integration and continuity

Score

3. Evidence shows a good standard of care

The service understood the diverse health and care needs of people and their local communities, so care was joined-up, flexible and supported choice and continuity.

High dependency unit beds were booked for most patients at pre-operative assessments when they were identified as requiring them. This meant patients who required the beds were usually identified at the earliest opportunity, and patients knew when they were to have their procedure, this enabled them to make personal arrangements around their elective procedure.

The admission criteria stated that bookings for beds for elective cases must be made as far in

advance as possible and booking on the morning of a procedure for an elective case was not acceptable.

The bed occupation was at 5.3, but the unit typically had 6 patients, reflecting the need for better definition of bed requirements through pre-operative risk scoring and intervention data collection. Of the 6 beds, 5 were booked for elective patients and the 6th were kept free in the event of an emergency.

The unit was located next to the operating theatres, which was recognised as good practice. There were facilities for relatives or carers to stay on the hospital premises overnight if needed. Services within the high dependency unit were coordinated and delivered to ensure they were accessible and responsive to patients with complex needs.

The ReSPECT form and frailty assessment were in use for patient documentation. The medical team and leaders of the unit were responsible for implementing policies, including DNACPR decisions and frailty documentation decisions.

The ReSPECT process was initiated to “improve the quality and consistency of emergency care planning by promoting shared decision-making and ensuring that patients' preferences were clearly documented and respected across all healthcare settings”. We reviewed the trust ReSPECT process audit summary for 2024; we found that ReSPECT forms (97%) were completed and correctly scanned to the electronic patient record. Validation of historical ReSPECT forms accompanying patients on transfer from other healthcare settings had improved, rising from 10% from 0% in 2023 to 88% in 2024. This reflected a significant progress in recognising, reviewing, and appropriately integrating existing advance care plans into local clinical practice.

HDU had improved significantly since the last inspection, transitioning from managing routine, low-risk patients to handling more complex ASA 3 cases, due to changing patient demographics and NHS operational demands. (ASA 3 patients have conditions that impact on their overall health, such as poorly controlled diabetes, hypertension, or COPD).

The unit operated as an enhanced care area, primarily managing ASA 1 (patients who had no underlying medical conditions, are not taking any medications, and do not have any functional limitations) and ASA-2 patients (Mild systemic disease) but the unit were increasingly receiving

sicker ASA 3 patients.

An external review by a former professor of intensive care was conducted 12 months before the inspection, guiding improvements in line with GPICS standards and leading to significant operational improvements.

Providing information

Score

3. Evidence shows a good standard of care

The service supplied appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

Staff had access to information. Staff had their own trust email account and received regular updates on training courses they could attend, and they could view whether their mandatory training was due or had expired.

Staff had access to an electronic personal development page on the trust's intranet, where they could access training and review their personal performance records. They could also access policies, practices and guidance using the intranet.

Staff made information leaflets available in languages spoken by patients.

Translation services were available to patients whose first language was not English. Staff were aware of how to access the service and confirmed the service had been used in all applicable circumstances. If interpreters were required, this was identified during pre-operative assessments.

Listening to and involving people

Score

3. Evidence shows a good standard of care

The service made it easy for people to share feedback and ideas, or raise complaints about their care, treatment and support. Staff involved people in decisions about their care and told them what had changed as a result.

HDU as of April 2025 had received 0 complaints. People who used the service were aware of how to make a complaint or raise concerns and were encouraged to do so. There were posters on the high dependency unit, waiting area and around the hospital publicising the complaints process.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. Complaints received by the high dependency unit were handled confidentially, with complainants provided with regular updates.

We saw leaflets in the waiting area, providing information on how to make a complaint and details of patient advice and liaison service.

Equity in access

Score

3. Evidence shows a good standard of care

The service made sure that people could access the care, support and treatment they needed when they needed it.

Patients with communication challenges could access the services of interpreters and advocates to enable them to understand the care and treatment being offered and provided.

This service provides specialist treatment and is known as a specialist orthopaedic hospital,

which gives access to services for patients referred from across the country.

Equity in experiences and outcomes

Score

3. Evidence shows a good standard of care

Staff and leaders actively listened to information about people who are most likely to experience inequality in experience or outcomes and tailored their care, support and treatment in response to this.

Staff within the service and the wider organisation promoted a culture in which the people using the service felt empowered to give their views.

The provider had undertaken equality impact assessments of their policies and procedures to ensure they did not place vulnerable people or people with protected characteristics at a disadvantage.

Systems ensured there was no discrimination, including on the grounds of protected characteristics under the Equality Act, when making care and treatment decisions. All staff (100%) underwent equality and diversity training as part of the mandatory training programme.

Planning for the future

Score

3. Evidence shows a good standard of care

People were supported to plan for important life changes, so they could have enough time to make informed decisions about their future, including at the end of their life.

Resuscitation trolleys and defibrillators were accessible to all staff. This was in line with Resuscitation (UK) guidance which states 'All clinical service providers must ensure that their staff have immediate access to appropriate resuscitation equipment and drugs to facilitate rapid resuscitation of the patient in cardiorespiratory arrest'.

Patients could bring items from home to help make their stay more comfortable as the staff recognised the need for home comforts as being important for people's rehabilitation.

The service had enhanced recovery pathways in place for all patients as standard, following surgery. This enabled a standardised approach for all patients and included the multi-disciplinary team involvement to optimise the rehabilitation process and reduce the time patients spent in hospital.

Well-led

Rating Good

During the assessment we found that policies and documents were in date. Staff were able to show us how they accessed documents and policies on the intranet.

Staff were aware of the Freedom to Speak Up (FTSU) service through posters and training.

Leaders completed various leadership courses. Staff we spoke with told us they were able to raise concerns to their managers, who they felt were visible and approachable.

Various critical care team meetings took place. Meetings reported on quality issues such as medicine management and standard operating procedures.

Shared direction and culture

Score

3. Evidence shows a good standard of care

The service had a shared vision, strategy and culture.

The trust had a clear set of values, with quality and sustainability as the top priorities. Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

Staff demonstrated the trust values during our inspection, as all were friendly and caring to patients, relatives/carers and each other. Staff were observed to be carrying out their role to the best of their abilities; demonstrated professionalism and respect to others.

The clinical lead maintained an honorary contract to stay current in intensive care practice and was exploring a shared contract model to attract additional intensivists, ideally with ortho-geriatrics expertise. The unit addressed the rising complexity of patients by commissioning an external review and aligning with broader NHS changes, ensuring contractual requirements for complex orthopedic hip revisions, spinal services, and enhanced care were met.

The last staff survey dated 2024 identified that 74% recommended the trust as a place to work; 92% of staff said they were happy with the standard of care provided by the trust if a friend or relative needed treatment and 75% of staff said they felt valued by their team. However, only 68.4% of staff said they felt secure about raising concern about unsafe clinical practice, and 59.6% felt confident the trust would address concerns. Almost 30% of non-white staff responded to the survey they had experience harassment, bullying or abuse from patients, relatives or the public compared to 18% of white staff that responded. however, this was not critical care specific. Working groups and action plans had been implemented and improvements was a working progress.

Capable, compassionate and inclusive leaders

Score

3. Evidence shows a good standard of care

The service had inclusive leaders at all levels who understood the context in which they delivered care, treatment and support and embodied the culture and values of their workforce and organisation. Leaders had the skills, knowledge, experience and credibility to lead.

Leaders had the skills, knowledge and experience to perform their roles. Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff told us they felt supported, respected, valued and proud to work in the high dependency unit.

Leaders were visible in the service and approachable for patients and staff. Morale within the high dependency unit was high. Staff felt they were being supported to provide care and treatment which was both safe and of high quality.

Freedom to speak up

Score

3. Evidence shows a good standard of care

The evidence showed a good standard. The service fostered a positive culture where people felt they could speak up and their voice would be heard.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

Effective speaking up arrangements were in place to protect patients and improve the experience of the trust's workers. Staff had access to Freedom to speak up guardians so staff could speak up about any issues of patient care, quality or safety.

Workforce equality, diversity and inclusion

Score

3. Evidence shows a good standard of care

The service valued diversity in their workforce. Staff work towards an inclusive and fair culture by improving equality and equity for people who work for them.

Equality and diversity were reported and monitored through the quality and safety committee. There were equality and diversity champions within the service. A multi-disciplinary equality and diversity steering committee considered equality, diversity and inclusion matters for patients and staff and reported to the quality and safety committee. The trust had actions in place to ensure they followed the workforce race equality standard (WRES), the 9 Indicators-actions required were against standards 6, 9, 4, 8 and 7.

There was an equality diversity and inclusion policy with the purpose of ensuring fairness for all in addition to an equality impact assessment policy whose purpose was to help to evidence and understand the differential impact that a decision may have on different groups of people covered under the Equality Act 2010.

Governance, management and sustainability

Score

3. Evidence shows a good standard of care

The service had clear responsibilities, roles, systems of accountability and good governance. They used these to manage and deliver good quality, sustainable care, treatment and support.

A trust-wide governance structure was in place with all individual services feeding into it. We saw information was documented in unit, divisional and board meeting minutes and was cascaded up and down.

Various critical care team meetings took place. Meetings reported on quality issues such as medicine management and standard operating procedures. The meeting looked at areas such as governance reports and performance reports, finances and IT systems. Band 7 meetings included areas such as complaints, compliments and incidents.

The critical care service sat within the Musculoskeletal unit and had a triumvirate in place. There was a critical care unit risk register. The risk register was red, amber, green rated and contained controls as well as a risk review date. The risks at the time of the assessment

included risks around staffing, out of hours anaesthetist cover, risk around non-compliance with GPICS standards and limited number of staff in possession of critical care post registration qualifications.

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

There were 29 full-time anesthetists (the highest workforce in the hospital), with 75% of the work done by anesthetists. However, anesthetics and critical care were embedded within a surgeon-led framework, staff told us that this was not fully appreciative of their contribution. The current model relied heavily on anesthetics intensivists, but there were plans for future towards a more practitioner-led unit, supported by both local and remote intensivist input. Senior staff told us that plans were being developed to create an opt-in location for developing critical care practitioners and to expand the HDU as a training ground and safety net for deteriorating patients.

Plans were in place to rotate nurses to other neighbouring trusts to improve experience and highlight their value, as well as to integrate acute care cases such as acute spinal admissions and establish a regional spinal injury weaning unit.

The clinical lead advocated for a structural reform, such as establishing a division of perioperative medicine to ensure proper investment and leadership in critical care, and to address the limitations of the current surgeon-led structure.

The clinical lead told us they were currently building a financial case for the investment required for a well-staffed critical care unit. Viability of the unit depends on maintaining and developing specialist services to provide the case mix and funding to support a well-resourced critical care unit.

ICNARC data demonstrated good performance, but broad standards hinder the identification of specific improvement areas. The clinical lead said there was a need for more specific standards for smaller critical care units, to drive progress and ambition, as the broad standards did not pinpoint areas for improvement and may lead to lack of ambition.

The senior leaders believed that current patient outcomes were satisfactory but emphasised

the need for improvement and expansion to meet growing demands and future standards such as GPICS 3. The clinical lead expressed pride in the highly engaged team and the one-to-one patient care provided in a well-controlled environment. Some senior staff also expressed their concern about the risk of relying on a single intensivist's innovation and the necessity for continuous innovation to meet growing critical care demands.

Partnerships and communities

Score

3. Evidence shows a good standard of care

The service understood their duty to collaborate and work in partnership, so services work seamlessly for people. Staff share information and learning with partners and collaborate for improvement.

Directorate leaders engaged with external stakeholders, such as commissioners and Healthwatch. Patients and staff could meet with members of the provider's senior leadership team and commissioners to give feedback. Many positive examples were shared with us during the inspection.

Improvements were noted since the previous 2018 inspection, which included commissioning an external review and comprehensive assessment against GPICS standards. Developing a structured critical care improvement plan and an interactive dashboard of standards. A regular submission and review of ICNARC data was discussed at patient safety and quality meetings, leading to enhanced clinical governance and regular board-level discussions.

Emphasis was placed on wanting to develop a strong network partnership, particularly with West Midlands critical care networks, to ensure patient safety, effective transfers, and recognition as a serious critical care unit. Senior leaders told us that they wanted to Improve collaboration with partnering trusts. The clinical lead stresses the need for the network to recognise and partner with the hospital as a serious critical care unit.

Learning, improvement and innovation

Score

3. Evidence shows a good standard of care

The service focused on continuous learning, innovation and improvement across the organisation and local system. Staff encouraged creative ways of delivering equality of experience, outcome and quality of life for people. Staff actively contribute to safe and effective practice.

There was evidence of improved culture across the service and there was strong leadership. The divisional leaders and ward managers acted to make improvements in the running of the critical care services. They had regular meetings where learning was discussed in a variety of forums.

All staff we spoke with were passionate about the care and treatment delivered. Steps had been taken since last inspection, although at early stages the trust were now benchmarking themselves against other similar units. Staff participated in national audits and learned from them. Staff used quality improvement methods and knew how to apply them.

Senior staff had an interest in expanding the unit to become a national spine unit, which would require additional staffing and resources. The need for more intensivists was noted, given the increased complexity and frailty of patients. The unit leaders stated they may need to become more advanced to meet these challenges, also mentioned by clinical leads. Justification for further specialisation and resources allocation was necessary, especially in comparison to larger specialised units.

The unit aspired to expand its capability for longer-term ventilation and more advanced care as part of its development goals. During 2023/24 the trust went live with 'enhanced recovery'. This had seen significant improvements in length of stay (LOS). Trust overall elective LOS was 3.24 days (February 2024.) Improvements sustainability was a significant part of focus for 2024/25 plans and HDU was a big part of this initiative to drive patient outcomes.

Surgery

Surgery

Overall	Good
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Our view of the service

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has approximately 200 inpatient and critical care beds across 9 wards.

The hospital is a single site hospital based in Oswestry, Shropshire. It provides specialist and routine orthopaedic care to its local catchment area, and specialist services both regionally and nationally. The hospital is a specialist centre for the treatment of spinal injuries and disorders and provides specialist treatment for children with musculoskeletal disorders. Additionally, the trust works with partner organisations to provide specialist treatment for bone tumours and community based rheumatology services. The trust is part of the National Orthopaedic Alliance (NOA), an acute care collaboration vanguard designed to improve orthopaedic care quality across England.

The surgical services at The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust are comprised of 5 inpatient wards:

Kenyon ward – 22 beds

Surgery

Powys ward – 22 beds

Clwyd ward – 22 beds

Ludlow ward – 16 beds (private patients) NOT assessed

Oswald ward - oncology ward, 10 beds en-suite. NOT assessed.

The trust's theatre suite comprises of 12 operating theatres, including 2 day-surgery theatres located in the Menzies unit.

During the inspection we visited 3 wards, the surgical admissions and day case unit, the operating theatres and the recovery unit.

We spoke with 29 patients and visitors and 40 members of staff. These included senior managers, all grades of nursing staff, healthcare assistants, domestic staff, consultant surgeons, anaesthetists, and other grades of doctors.

We last inspected the hospital in November and December 2019. Where it was rated good overall.

We carried out this announced inspection on the 22 and 23 May 2025.

We inspected this service using our single assessment framework and looked at all the key questions and 33 quality statements. The main service provided by the hospital was surgery for adult patients.

There were effective systems to ensure that standards of cleanliness and hygiene were maintained.

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

The service made sure staff were competent for their roles.

All staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Patients told us they felt involved in their own care and treatment as staff took time to explain what

was happening and why.

We saw examples where staff had gone above and beyond what was expected to support patients.

The trust planned and provided services in a way that met the needs of local people.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Managers and senior leaders had the right skills to perform their roles effectively.

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

There was evidence of improved culture across the service and there was strong leadership. Staff told us they felt supported, respected, valued and were proud to work at the trust.

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research, and innovation.

People's experience of the service

Overall, people's experience of the service was positive. Patients and relatives spoke positively about staff, who were kind, explained their care and treatment, answered call bells quickly and provided pain relief when required. Patients consistently rated feeling able to talk to staff and feeling they were treated with dignity and respect above the national average in surveys. We viewed a number of thank you cards from patients and their loved ones on display.

Safe

Rating Good

We looked for evidence that safety was a priority for everyone, and leaders embedded a culture of openness and collaboration. We checked that people were safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination.

At our last assessment we rated this key question as good. At this assessment we rated this key

question as good. This meant people were safe and protected from avoidable harm.

Learning culture

Score

3. Evidence shows a good standard of care

The service had a proactive and positive culture of safety, based on openness and honesty. Staff listened to concerns about safety and investigated and reported safety events. Lessons were learnt to continually show and embed good practice.

Managers and staff recorded accidents, incidents and complaints. Staff knew how to report incidents and understood the process. Staff used reflective accounts to learn from incidents and lower the risk of the same incidents being repeated.

Outcomes from incident investigations were shared both internally and externally to ensure lessons learned were widely shared. This minimised the risk of reoccurrence.

The service managed patient safety incidents well.

Staff received information on incident investigation outcomes during department meetings and by email.

The service had applied the duty of candour in all applicable situations we were made aware of. Staff were aware of their responsibilities and when the duty applied. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw evidence of the duty of candour being applied if appropriate when patients and/or their relatives made complaints but also when an incident occurred. The documentation we reviewed set out what went wrong, why and what was being done to reduce the risk of it occurring again. An apology and the opportunity to discuss the issue with the matron or senior nurses was offered to the patient and relatives.

Leaders could describe the duty of candour process. We were told how a specific staff member would also be allocated as the family liaison contact to support and answer any questions throughout the process.

Safe systems, pathways and transitions

Score

3. Evidence shows a good standard of care

The service worked with people and healthcare partners to keep safe systems of care, in which safety was managed or monitored. Staff made sure there was continuity of care, including when people moved between different services.

Staff from the bookings team provided information needed for the safe admission of people to the service. Information on procedures was explained and available to be reviewed at home.

People were given a pre-assessment prior to their surgery to ensure they met the safety criteria for treatment at the hospital. A pre-assessment is an appointment that looks at a person's suitability for surgery, which looks at a full medical, social and nursing history of the patient. This was conducted in a clinic environment led by a nurse and healthcare assistants.

Safeguarding

Score

3. Evidence shows a good standard of care

Most nursing staff had received their up-to-date training on how to recognise and report abuse, and they knew how to apply it in line with local and national safeguarding procedures. However, medical staff compliance with annual refresher training fell below the target of 92% with safeguarding children level 2 at 79% and adult level 2 at 84% compliance.

The trust set a target of 92% for the completion of safeguarding training.

Where this target was not met, we saw a plan to capture those staff that were not compliant. If a member of staff was not up to date with training, the plan would be discussed during supervision sessions or at annual appraisals.

The training figures showed that staff were complaint with adult safeguarding, at 92.2% and safeguarding children at 94%.

All staff required to be level 3 safeguarding trained, for example specialist paediatric nurses, were trained at the time of inspection.

The trust had link nurses with experience in safeguarding that staff could approach for advice and guidance. Link nurses were responsible for sharing learning with staff in their areas and supported the main safeguarding lead within the trust.

Involving people to manage risks

Score

3. Evidence shows a good standard of care

Staff used nationally recognised tools to assess patient's risk of developing pressure ulcers, infections and identified nutritional risks and risks of falls. There was a hospital-wide standardised approach to detecting deteriorating patients.

The National Early Warning Score (NEWS2) was used for patients across the trust. The early warning score is a tool used to help identify when a patient might be deteriorating due to complications such as sepsis. Clinical observations like blood pressure, heart rate, and respiration's were recorded and contributed to a total score. Once a certain score was reached, a clear escalation of treatment was commenced. Patients with a raised NEWS2 score were automatically screened for sepsis.

All wards that we visited used sepsis 6. Sepsis 6 is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. Nursing staff on surgical

wards confidently described the signs of sepsis and what action they would take. For example, completing the sepsis 6 pathway in the patient's notes and immediate escalation to the nurse in charge and medical staff.

If patients were identified as having pressure ulcers, the incident was reported, and a body map was completed to show the area(s) affected.

Nursing staff on the surgical wards had daily 'safety huddles', where staff highlighted ward issues, patients due for discharge and high-risk patients who required extra monitoring. We observed the safety huddles on 3 different wards and noted consistency across all areas.

The trust uses the '8 Steps for Safer surgery' in line with the revised NatSIPSS2 standards in line with NHSE guidance and guidance from the centre of perioperative care. The theatre staff complete monthly audits to establish if the 8 steps to safer surgery are being completed in line with the recommendations.The process had been reviewed, compared with other specialist hospitals and a bespoke version developed, following the WHO principles. Managers had concentrated on developing a consistent approach to the WHO checklists.

The checklist comprised of the 5 steps to safer surgery; brief, sign in, time out, sign out and de-brief. Changes were made to the existing brief and de-brief checklist to make it flow better and be more useful to staff. This was achieved by combining the operation list and briefing form together and adding patient specific prompts.

Managers were examining the possibility of including the WHO checklist within the electronic system that currently managed patient flow to and from theatres.

There was a monthly audit done for the completion of the WHO checklists and results were compiled into a quarterly report that was reviewed at clinical audit meetings. We saw examples from monthly WHO checklist audits and found compliance to be improving since July 2024, when compliance was 78%. However, the fifth standard, 'de-brief', was lower than the 4 other components of the WHO checklist. An improvement made in this one component improved the overall compliance. An action plan had been created to address the non-compliance. The service also shared experiences with other surgical services across other trusts, to aid in improving the use of WHO checklists and this resulted in the development of the new version that was now being used.

Surgery services were fully engaged in the implementation of the national safety standards for invasive procedures (NatSSIPS2), which were published in September 2024 to support hospitals to provide safer surgical care. All NHS organisations are expected to develop their own local safety standards for invasive procedures (LocSSIPs) and to allocate responsibility for each clinical speciality that carried out procedures. Staff understood these processes which had been implemented across the service.

We saw noticeboards displaying information about WHO checklists, NatSSIPS2 and LocSSIPs and staff could describe the processes.

Safe environments

Score

3. Evidence shows a good standard of care

All wards were clearly signposted from main corridors, and each area was in a zone that was communicated to patients and visitors on arrival at the hospital. Reception areas had directions to each zone and a map to guide visitors.

During the inspection we checked resuscitation equipment and trolleys on every ward and in clinical areas. We found them all to be clean, correctly stocked with equipment and had tamper-evident seals. There were daily check logs for each trolley, and they were signed and dated to indicate that daily checks had been done.

Hoists were stored appropriately when not in use and maintenance logs were regularly reviewed and signed. Hoists had “I am clean” stickers indicating the time and date of cleaning.

Patient call bells were checked daily and signed for, and any malfunction was reported to the estates and facilities team for repair.

On Oswald ward there were 10 en-suite rooms, each one had a daily cleaning and maintenance checklist completed. Daily checks had been completed and signed for appropriately, for the last 12 months.

All areas visited had appropriate facilities to dispose of waste. Sharps bins were regularly monitored and were not overfull. There was a process to report when a bin needed removing and staff could request removal at any time during the day. Nurses completed daily checks and would ensure that waste was removed at the end of every shift.

Safe and effective staffing

Score

3. Evidence shows a good standard of care

Staffing levels and skill mix were managed in line with national guidance and theatres were staffed appropriately according to the type and amount of surgery planned.

Although there were some vacancies, the service maintained safe levels of staff by using bank and agency staff. Nursing staffing was planned and reviewed to ensure people received safe care and treatment, using an acuity tool to determine safe levels of staffing and appropriate skill mix.

The vacancy rate for nursing staff for April 2025 was 8.23% against a target of 8%. The reason for this was an increase in establishment following financial reconciliation for the year-end and the alignment with the new 2025/2026 trust workforce plan. The service expected to see the vacancy rate reduce as recruitment into the new posts continued.

Most staff had received an appraisal to review work performance and to provide support and monitor the effectiveness of the service. Staff told us their appraisals were effective because they helped them to identify and plan their development needs. Staff also told us they accessed regular supervision sessions with senior staff/managers which provided them with the support and feedback needed to enable them to work effectively in their roles. For April 2025 93.3% of nursing staff had had an appraisal, against a target of 92%.

Infection prevention and control

Score

3. Evidence shows a good standard of care

There were effective systems to ensure standards of cleanliness and hygiene were maintained. We observed the wards, reception areas, and treatment areas to be visibly clean during our inspection.

Staff received training about infection prevention and control and hand hygiene training during their initial induction and annual mandatory training.

Hand hygiene gels were available for use at the entrance and exit of the wards, bays, theatres and the pre-operative assessment areas. Personal protective equipment such as gloves and disposable aprons were used in accordance with the trust's infection control policy.

We saw staff and visitors using sanitising hand gel before entering and when leaving clinical and ward areas. There were signs in place to remind people to use the gels and to be "arms bare below the elbows", when in contact with patients or in a specified zone.

Medicines optimisation

Score

3. Evidence shows a good standard of care

Nurses that were administering medication wore a red apron to indicate they were performing a task that required them not to be disturbed. This system was an aid to reducing errors at a time when staff needed to concentrate and staff and patients had a visual reminder not to disturb the person.

Pharmacy staff checked (reconciled) patients' medicines on admission to wards and worked in the pre-operation assessment clinic. This ensured patients were taking the right medicines they

needed for other conditions while in hospital.

Wards had security keypads on the doors to all medication storage rooms and locked cabinets within the room. Medications were stored in cabinets and there was a process to check stock and monitor the use of medication. Two members of staff were required to sign out medication before being used and we saw that in all cases the checks had been completed.

Medication requiring to be stored in a cooler environment was kept in fridges. We saw temperatures were checked and signed for daily to ensure the correct temperature was monitored. In most cases there was an alarm fitted to the fridges which would alert staff if the temperature changed and was out of tolerance.

Medicine stock levels were checked weekly. Controlled drugs (CDs), which are controlled under the Misuse of Drugs legislation (and subsequent amendments), were disposed of appropriately by trained staff. All CD destruction was logged in an ongoing record and monitored by the pharmacy team.

We observed staff accessing CDs and they followed the correct procedure. Expiry date checks were done on fentanyl medication and guidelines were checked for diluting the medication.

There was a reminder notice attached to the CD cupboard with actions from a CD audit to aid staff. Information from audits had been shared with staff at meetings and information displayed.

Effective

Rating Good

We looked for evidence that people and communities had the best possible outcomes because their needs were assessed. We checked that people's care, support and treatment reflected these needs and any protected equality characteristics, ensuring people were at the centre of their care. We also looked for evidence that leaders instilled a culture of improvement, where understanding current outcomes and exploring best practice was part of their everyday work.

At our last assessment effective was rated as good. At this assessment, we rated this key question as good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing needs

Score

3. Evidence shows a good standard of care

We looked at a sample of policies and found some were out of date and had not been reviewed on the set date. We spoke with senior leaders who knew of the issue and had already set up a programme to review all documents and instructions to staff, to ensure they were updated.Managers and staff showed us several assessment tools used in their assessment of patient needs at all stages of care. Staff recorded patient needs clearly and aligned these to care plans. Staff ensured patient needs from their pre-assessment had been included in their assessment plans.

Patients reviewed and discussed their authorised care plans to ensure they had an opportunity to contribute to their care. This included communication and wellbeing needs that patients may have needed during their stay.

Managers used an audit schedule to ensure staff were implementing and completing documentation that promoted a person-centred approach to care. These audits included personal care needs, patient repositioning, clinical needs and risk assessments. The audits completed promoted safe care which met the expected standards.

Managers completed the audit schedule every month. The audits showed good compliance with all areas.

Staff completed patient records on the ward that had up to date risk assessments for vital signs, falls, nutrition, skin integrity, and venous thromboembolism (VTE) risk. VTE is the risk of a patient developing a blood clot after surgery.

Delivering evidence-based care and treatment

Score

3. Evidence shows a good standard of care

The service planned and delivered people's care and treatment with them, including what was important and mattered to them. Staff did this in line with legislation and current evidence-based good practice and standards.

Managers referenced National Institute of Health and Care and Excellence (NICE) guidelines. Medical staff and managers followed accreditation schemes that enhanced evidence-based practice. Staff showed a good understanding of evidence-based practice and understood national tools such as the malnutrition universal screening tool and how to apply it.

There were 2 main clinical pathways for patients, a major and a minor pathway and all patients would be on one of them. A clinical decision was made at the pre-operative stage to determine which pathway was appropriate. Following surgery, the patient would be monitored on a pathway and information and assessments completed in the appropriate pathway booklet. Patient information was mainly electronically stored and written notes would be scanned into the patient electronic records. Pathways were in line with evidence-based practice guidelines.

The service had enhanced recovery pathways for all patients following surgery. This enabled a standardised approach for all patients and included multidisciplinary team involvement to optimise the rehabilitation process and reduce the time patients spent in hospital. Patients were encouraged to mobilise as soon as possible or as directed by the consultant. There was an initiative in place called "eat, drink and move", which reminded staff and patients the importance of rehabilitation.

At their pre-operative assessment, patients saw members of the multidisciplinary team including nurse, anaesthetist, and pharmacist. All patients for joint replacements were offered a 'joint school' following their pre-operative assessment. Joint school provided information about the procedures and included post operative advice. These sessions were held twice a week in the lecture theatre at the day unit. We were told of plans to increase the frequency of the joint school to eventually be available daily, Monday to Friday.

Medical staff followed professional guidance and recorded medical device implants using the National Joint Registry (NJR). The NJR collects information on joint replacement surgery and monitors the performance of joint implants. This helps to inform on a national level, if there were concerns raised about joint replacement.

Staff understood nutrition requirements for patients that had medical conditions such as diabetes and could refer to services such as speech and language therapy for patients who had swallowing difficulties.

Managers received and managed safety alerts efficiently. Safety alerts are notifications sent to providers that give them information they may need to consider action for. Managers explained that each alert was triaged and sent to the most suitable department head for distribution. Managers confirmed they had feedback mechanisms to show that the information had been received by tracking responses using a separate spreadsheet which highlighted any needed actions. For example, a national prompt was received for an epidural medication. The alert was sent to all medical consultants and anaesthetists.

How staff, teams and services work together

Score

3. Evidence shows a good standard of care

The service worked well across teams and services to support people. Staff shared their assessment of people's needs when people moved between different services.

Staff worked closely with hospital teams both internally and externally. Staff welcomed collaborative working with multidisciplinary teams from the neighbouring NHS trust who helped support patient recovery.

Staff who cared for patients on the ward had access to their pre-assessment information. This supported them in making informed decisions about their needs in the ward environment. Staff knew what areas of care they handled and knew how to escalate queries and concerns.

Staff handed over key information about patients at handover meetings which meant patient needs were documented and discussed between shift changes.

Staff communicated patient needs with each other through face to face and telephone communication on the ward and pre-assessment areas. These conversations were performed discreetly and ensured confidentiality was maintained.

Management teams met with local NHS trust managers to provide support for extra bed capacity. This included transferring patients that met the inclusion criteria of the hospital.

Supporting people to live healthier lives

Score

3. Evidence shows a good standard of care

The service supported people to manage their health and wellbeing to maximise their independence, choice and control. The service supported people to live healthier lives and where possible, reduce their future needs for care and support.

Safety was prioritised at the earliest phase of care given. Staff at the pre-assessment department took an interest in patients to make sure they were healthy enough to have the surgery they needed. For example, patients could not move beyond the pre-assessment phase of their assessment if a physical concern such as high blood pressure was identified.

Staff offered post operative guidance through leaflets and discharge documentation. Medical staff arranged follow up appointments when needed where further signposting for rehabilitation occurred.

Smoking and alcohol usage were used as parameters for the clinical risk to patients and this was assessed at both the pre-assessment and admission stages of treatment.

Information was available about long term conditions, such as diabetes. Patients told us they had been given advice about their lifestyle choices that could affect health after surgery. Information was displayed in ward areas for patients and staff to access.

Patients were appropriately encouraged to mobilise, eat and get dressed, as soon as possible after surgery. This was to help with recovery and ensure the patient could return to a regular routine after surgery.

Monitoring and improving outcomes

Score

3. Evidence shows a good standard of care

The service routinely monitored people's care and treatment to continuously improve it. Staff ensured outcomes were positive and consistent, and met both clinical expectations and the expectations of people themselves.

Managers and staff understood what positive outcomes looked like and contributed to schemes to support positive outcomes for patients.

Post general anaesthetic audits took place for every patient. The audit included standards such as pain scores, nausea, temperature, discomfort in recovery and assessed readiness for transfer to the wards. The audit also measured the confidence of the patient in the care they received. Actions from this audit included the introduction of more warming blankets, due to patient responses to temperature standard questions. Results were shared with staff at recovery team meetings and results were also discussed during consultant meetings.

The service took part in national audits, such as the elective surgery patient recorded outcomes (PROMs) programme. The hip replacement average result for the trust, was 22.3 against the England average of 14.3. However, the knee revision result was 13.5 against the England average of 14.6. All other results, the trust performed better than the England average for PROMs.

The service acted to improve services and made recommendations following analysis of the results. Managers followed performance schemes such as the National Joint Registry (NJR). Managers used these schemes to assess their performance and improve. Both registers, which included NHS and private patients, were designed to aid early reviews of patient groups for

monitoring performance. This review included the implant, potential side effects and potential complications. The data also allowed patients to be contacted in case the implant was recalled for safety reasons. Data from these schemes showed that the main surgical operations conducted at the hospital were hip and knee replacement surgery. Shoulder and ligament realignment surgery were also included in this data. Medical consultants followed the National Ligament Registry (NLR) and the Breast/Cosmetic Implant Registry (BCIR) to support data capture in this area.

From June 2023 to May 2024, patients at the trust had a lower-than-expected risk of readmission for elective admissions, and similar to expected risk of readmission for non-elective admissions when compared to the England average.

Consent to care and treatment

Score

3. Evidence shows a good standard of care

The service told people about their rights around consent and respected these when delivering person-centred care and treatment.

We saw consent to treatment was obtained and checked in line with legislation and guidance.

Consultants or a member of the surgical team would gain consent before any procedure and often this was sought at pre assessment when the procedures were discussed.

Checks were completed to ensure the patient understood all aspects of the surgery and recovery.

Patients that did not have capacity to give valid informed consent were assessed following the requirements in the Mental Capacity Act 2005.

Staff understood the requirements in Mental Capacity Act 2005 and knew how to support patients who lacked the capacity to make decisions about their care. Training compliance for mental capacity and Deprivation of Liberty was just above the trust target of 92%, at 92.6%.

Caring

Rating Good

We looked for evidence that people were always treated with kindness, empathy and compassion. We checked that people's privacy and dignity was respected, that they understood that their experience of how they were treated and supported mattered. We also looked for evidence that every effort was made to take people's wishes into account and respect their choices, to achieve the best possible outcomes for them.

At our last assessment we rated this key question as good. At this assessment, we rated this key question as good. This meant people felt well-supported, cared for, and treated with dignity and respect.

Kindness, compassion and dignity

Score

3. Evidence shows a good standard of care

The service treated people with kindness, empathy and compassion and respected their privacy and dignity. Staff treated colleagues from other organisations with kindness and respect.

We spoke with patients during our visits and received positive remarks about care. One patient told us they felt well cared for and their relative also praised the staff for the care they received.

We reviewed data from the most recent annual patient experience report which showed that The Robert Jones and Agnes Hunt was rated as the best in the country for the third year in a row for patient experience.

The trust was named as 1 of just 8 organisations placed in the top band of trusts delivering results that were considered "much better than expected," with patient experience that was substantially better than elsewhere.

The trust's NHS friends and family test score was 98% and it received 1,071 compliments for the month of March 2025.

Treating people as individuals

Score

3. Evidence shows a good standard of care

The service treated people as individuals and made sure people's care, support and treatment met people's needs and preferences. Staff took account of people's strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Staff were aware of patients' individual needs. Risk assessments and pre-assessment processes showed this. Managers felt their pre-assessment processes used a structured approach which recorded individual needs and preferences of patients while still ensuring safety. Staff applied this information to the care they gave. Patients and relatives told us they were involved in the review of their care and that staff would listen to them. Consultants would discuss all aspects of the procedures, and we were told that all staff cared about them.

We were told that family members could discuss the care and were included in discussions about discharge.

Staff understood the equality, diversity and inclusion policy which promoted equality values, religious beliefs, and the disability needs of patients. Care plans reflected these considerations.

Staff supported patients' aspirations for their recovery. Support was given through information sharing and onward care planning for patients' discharges including follow up appointments.

Independence, choice and control

Score

3. Evidence shows a good standard of care

The service promoted people's independence, so people knew their rights and had choice and

control over their own care, treatment and wellbeing.

Staff promoted patient independence. Staff had processes which ensured patients had up to date information about the decisions involving their care.

Staff welcomed visitors and relatives of patients on the wards. Relatives said they felt welcomed by staff.

Staff and support teams had access to suitable equipment with a separate gym facility with a large hydrotherapy swimming pool to help patients in their recovery. This included early mobilisation exercises under the aid of qualified physiotherapists and occupational therapists.

Responding to people's immediate needs

Score

3. Evidence shows a good standard of care

The service listened to and understood people's needs, views and wishes. Staff responded to people's needs in the moment and acted to minimise any discomfort, concern or distress.

The service used patient feedback as a key measure of monitoring the quality of care, this was an important "health check" for the services it provided as well as promoting a strong culture of listening to patients to help improve services.

The service offered many opportunities for patients and carers to give their feedback including email, and social media. Also, local and national patient feedback surveys, NHS friends and family test survey, patient stories, patient forums, trust governor forums and comments received directly.

All feedback was shared with the clinical areas and was responded to by the communications team or the patient advice and liaison service team.

NHS friends and family test data was collected in real time using an innovative clinical research patient feedback system and patients were sent a text to invite them to complete a survey

electronically after discharge or clinic appointment. For 2023/24, 24,081 patients completed the survey and 98.2% of patients (inpatients and outpatients) said they would rate their experience as good or very good. Staff were sent an email alert in real time as soon as a low score was received, and comments were immediately uploaded into the electronic system for staff to respond to within department. The results were shared with the wards, and specialty level governance quality reports with trends of low scores monitored monthly.

The annual patient experience report highlighted results showing that the trust had the cleanest wards and rooms in the NHS for the fourth year in a row. Its food was also rated the best in the country – for the 17th time in the past 18 years.

Staff responded promptly to call bells. Concerns were escalated and quickly actioned. Any concerns were shared through handover documentation at the changing of staff shifts.

Workforce wellbeing and enablement

Score

3. Evidence shows a good standard of care

The service cared about and promoted the wellbeing of their staff and supported and enabled staff to always deliver person-centred care.

Over 20 staff members were interviewed during this inspection to support our findings. Staff told us they felt supported, respected, valued and were proud to work at the trust. We were told local leaders supported them in carrying out the best possible patient care and treatment.

Staff could raise concerns with senior leaders and managers on the wards and were comfortable in approaching any staff member to discuss concerns. They told us this had been an improvement over the last 2 years and described other staff as being part of a family.

Staff felt able to raise concerns. Managers had an open-door policy. Freedom to speak up guardians were active within the organisation. There was a dedicated guardian section on the staff intranet and posters around the site providing information and contact details.

There was an active programme of staff briefing and engagement sessions, by newsletter, other publications and meetings held both face to face and virtually.

Staff took needed breaks despite a busy environment and had a quiet space to take these. Staff felt the workload for the service was busy but enjoyed the environment and felt they had what they needed to perform their roles.

Staff felt safe when doing their work. Staff were supported if they were struggling at work, and this had an impact on the care they delivered. Managers offered support for occupational health needs and provided signposting where needed.

Staff had easy access to personalised support that recognised the diversity of the workforce. Managers recognised the value of a diverse workforce and embraced this.

All trust staff were invited to participate in the National NHS Staff Survey between October and November 2024. The survey results were reported in a benchmark format, with the trust benchmarked against 13 other acute specialist trusts. Fifty two per cent of trust staff participated in the 2024 survey, an increase of forty questionnaires compared to the previous year.

The trust was proud that its staff recommend the hospital as a place to work, with a response rate of 75.63%, an increase of 9.74%on 2022 data.

The trust had the best result nationally (in benchmark group of 13) on the standard of care provided if a friend or relative needed treatment. Response rate 94% (2022 data – 91.2% increase of 2.8%).

The trust had recognised that there were other areas that needed further focus and attention, such as the response rate on career development opportunities, and discrimination on the grounds of protected characteristics. It had set up a monthly staff survey focus group where staff could review areas of good practice and areas that needed greater support and improvement for the workforce.

Responsive

Rating Good

We looked for evidence that people and communities were always at the centre of how care was planned and delivered. We checked that the health and care needs of people and communities were understood, and they were actively involved in planning care that met these needs. We also looked for evidence that people could access care in ways that met their personal circumstances and protected equality characteristics.

At our last assessment we rated this key question as good. At this assessment, we rated this key question as good. This meant people's needs were met through good organisation and delivery.

Person-centred care

Score

3. Evidence shows a good standard of care

The service made sure people were at the centre of their care and treatment choices and they decided, in partnership with people, how to respond to any relevant changes in people's needs.

Staff offered patients options for care, support and treatment and helped patients feel empowered to make decisions about how this was delivered. This included making reasonable adjustments if patients met the criteria for the service.

Staff worked with patients when their needs changed to consider the care and treatment options that best met their changing needs. Staff responded to changes in patients after their surgery and when patients' needs changed. For example, staff adjusted patient pain assessments during the first 24 hours on the ward and adjusted their care plans for any new care needs.

Staff completed care plans that looked at patient needs and preferences. Staff delivered care in line with care plans and records of care reflected this. Care plans reflected physical and emotional needs.

Warning markers were used to indicate if a patient had extra needs or was vulnerable. The

markers were visible on screen and notes could be typed next to a patient's name to indicate any concerns. For example, a patient with diabetes or other comorbidities, would have an indicator by their name.

The trust provided dementia awareness training for clinical staff and dementia friends information sessions for non-clinical staff. The trust also provided additional training on learning disabilities and mental health. During the inspection we saw that 94.4% of staff had completed the training. This had improved since the last inspection.

All patients located in the waiting areas received a leaflet that gave some simple information for patients and those waiting for family members to be seen. There were visiting times for wards, Wi-Fi password information, important telephone numbers and a reminder to tell staff about any concerns.

Translation services were available to patients whose first language was not English and staff were aware of how to access the service. If interpreters were required, this was identified during pre-operative assessments and then booked to suit.

Chaplaincy services were available to patients 24 hours a day. Patients with different cultural or religious needs could request support as required. In most cases these requirements would be discussed at the preoperative assessment and staff told us it would be noted in the care plan or general patient notes.

Patient care and treatment was accessible, prompt and in line with evidence-based practice. Reasonable adjustments were made to ensure equal access to the service. Staff took account of both physical needs and cognitive needs including specific fears and preferences associated with healthcare conditions. This included learning disabilities, autism spectrum disorder and neurodiverse needs. Managers and staff had training on the awareness of these needs. Managers highlighted their private rooms would be used, which would be more suitable for patients who needed a quieter environment for their recovery.

Care provision, integration and continuity

Score

3. Evidence shows a good standard of care

The service understood the health and care needs of people, so care was joined-up, flexible and supported choice and continuity.

Staff understood the health and social care needs of patients by ensuring their surgery was suitable and within the inclusion criteria of the service.

We saw examples where the trust had considered not only the needs of local people but provided services for patients throughout England and Wales.

When a patient was supported by more than 1 service, staff worked in a collaborative way to make sure care was joined up. Staff worked with staff teams from their neighbouring NHS trust. This included teams from tissue viability, physiotherapy, and occupational therapy. Managers and staff acted when discharge needs changed from their pre-assessment.

Providing information

Score

3. Evidence shows a good standard of care

The service supplied appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

Information was available to patients through the trust's website and leaflets. The information was accessible and followed accessible information standard guidelines which included font enlargement, Braille, and translation services including British Sign Language. There were some staff within the service that could speak Welsh, and staff would speak to patients in Welsh, if it was their preferred language.

Managers provided information in line with information governance policies. This included security and access considerations and followed general data protection regulations (GDPR). Managers ensured compliance by completing a data security and protection toolkit to ensure compliance with GDPR and other relevant laws.

Listening to and involving people

Score

3. Evidence shows a good standard of care

The service made it easy for people to share feedback and ideas, or raise complaints about their care, treatment and support. Staff involved people in decisions about their care and told them what had changed as a result.

Information was available for patients on how to raise concerns or make a complaint. There were posters on the wards, waiting areas and around the hospital publicising the complaints process.

We also saw leaflets in the waiting areas providing information on how to make a complaint and contained the details of the patient advice and liaison service.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. Complaints were discussed at quality improvement meetings and learning from complaints was discussed at staff safety huddles and staff meetings. We saw information regarding complaints was shared with staff in regular meetings and displayed on noticeboards and in staff areas.

Lessons learned from complaints were identified, we saw learning had been discussed and an action plan had been written to address concerns locally.

Patients and their family understood how to give feedback or complain about their care. Managers provided complaints data from December 2024 to April 2025 which showed 49 complaints had been reported so far for the whole service. The service had a tolerance target of

8 complaint per month; the latest value was 9 for April 2025. The trust was planning a 'deep dive' into the reason for the increase. Learning would be identified for each complaint, and any themes would be shared at ward level and through the patient experience committee.

Managers supported people to give their feedback to a complaint. Managers acknowledged written complaints within 48 hours and answered in full within 30 working days. Where this was not possible, a further letter would be sent to explain why.

People felt confident in the service to take the right action if they raised a concern or complaint. This included looking into the issue thoroughly, communicating what was happening, being open about what had been found out and what the outcome was.

The service worked with people to agree solutions to the concerns they raised and measured the impact of the changes made. Staff accepted feedback as an opportunity to improve the service, and the quality of care people received.

Equity in access

Score

3. Evidence shows a good standard of care

The service made sure that people could access the care, support and treatment they needed when they needed it.

Surgical patients were usually booked a bed at pre-operative assessment, following review by a surgeon and anaesthetist. Patients were admitted to the hospital through the admission unit and supported in preparation for a procedure.

The process for booking beds for elective surgical patients worked well and was managed through the electronic bed booking system.

Patients would be assessed and prepared for theatre and located in a room or "pod" to wait for their slot in theatre. Each room had a number which generally corresponded to the number of the theatre to be used for the operation.

The potential need for a high dependency bed was discussed at pre-operative assessment and consultants would risk assess the procedure to determine if a bed needed to be booked.

Managers held weekly theatre planning meetings to ensure theatres were optimised. This meant that scheduling ensured any cancellation of surgery could be filled quickly by a patient who needed it. However, managers acknowledged that some cancellations could not be avoided. There were 41 reported theatre cancellations for April 2025. This represented 4.5% of the total theatre activity. The primary reason for cancellation was the patients not being medically fit. There were clear action plans looking at the cancellations on the day of surgery.

Baschurch day unit was suitably equipped to care for patients if they needed a longer recovery period or transfer to a ward was delayed.

Equity in experiences and outcomes

Score

3. Evidence shows a good standard of care

Staff and leaders actively listened to information about people who were most likely to experience inequality in experience or outcomes and tailored their care, support and treatment in response to this.

Staff had a good understanding of patients that used the service and were most likely to experience inequality in their care. Staff completed equality, diversity and inclusion training as part of their mandatory training.

Planning for the future

Score

3. Evidence shows a good standard of care

People were supported to plan for important life changes, so they could have enough time to make informed decisions about their future, including at the end of their life.

Patients were supported to plan for life changes following surgery if this was suitable. Patients were given a cooling off period before starting their care to make sure the surgery was the correct decision for their medical and psychological needs. Staff ensured patients were informed about all aspects of the surgery and this started at the booking stage of their care. Staff approached these conversations in a sensitive manner and supported patients to feel as well as possible prior to their surgery.

Well-led

Rating Good

We looked for evidence that there was an inclusive and positive culture of continuous learning and improvement that was based on meeting the needs of people who used services and wider communities. We checked those leaders proactively supported staff and collaborated with partners to deliver care that was safe, integrated, person-centred and sustainable, and to reduce inequalities.

At our last assessment we rated this key question as good. At this assessment, we rated this key question as good. This meant there was good service leadership across all levels. Leaders and the culture they created assured the delivery of high-quality care.

Shared direction and culture

Score

3. Evidence shows a good standard of care

The service had a shared vision, strategy and culture. This was based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and their communities.

The service had a clear vision and values. Leaders led by example and checked practice against

the values. The service values were, friendly, excellence, caring, professional and respect. Surgery services promoted these values.

There were posters displayed with the trust vision, values and corporate objectives identified for staff and patients to see.

There were copies of the trust strategy 2023-2028 available for all staff to access through the intranet and with some copies in ward areas. The strategy described its vision and goals for the trust as: Vision - Aspiring to deliver world class patient care.

There were also a set of strategic objectives: ‘Deliver high quality clinical services, develop our Veterans' Service as a nationally recognised centre, Integrate the MSK pathway across Shropshire, Telford and Wrekin, grow our services and our workforce sustainably and innovation, education and research at the heart of what we do’.

Leaders ensured any risks to delivering the strategy were understood and had an action plan to address them. They checked and reviewed progress against delivery of the strategy.

Surgeons told us the culture had improved, and morale was high. They told us the team ethos had been nurtured, and everyone aspired to be the best at what they did. Training and teaching were part of the culture at the trust.

Theatre staff told us the environment they worked in was excellent and the facilities and equipment to do their job were good. The support from managers within theatres was highlighted as being good and staff generally felt proud to be part of the team.

Almost all staff told us they felt respected and valued by their colleagues and the leadership team within the trust. There was a strong sense of teamwork, which encouraged candour, openness, and honesty.

We were told most staff had attended human factors training as part of the initiative to improve working relationships and the culture within the service.

Capable, compassionate and inclusive leaders

Score

3. Evidence shows a good standard of care

The service had inclusive leaders at all levels who understood the context in which they delivered care, treatment and support. They embodied the culture and values of their workforce and organisation. Leaders had the skills, knowledge, experience and credibility to lead effectively. They did so with integrity, openness and honesty.

Managers and senior leaders had the right skills to perform their roles effectively. The leaders reported a positive working relationship with each other and were dedicated to their role and responsibilities. They understood the division's performance, the challenges faced, and the actions needed to address those challenges. We saw leaders were enthusiastic in their approach to improving the service and they shared the same vision with all staff.

Staff told us leaders in the surgery services, regularly made themselves available and visited wards and theatres frequently.

Nursing staff said they saw the matron on the wards and would approach them with concerns.

Leaders were visible and available. They lead by example, modelling inclusive behaviours, and nurtured open and co-operative relationships. Leaders took account of their staff's specific needs. For example, managers intervened when staff were struggling. Managers explored contributing factors to difficulties and arranged support when needed.

Managers looked at options for flexible working and helped staff as they received feedback from their work.

Leadership was sustained through suitable recruitment and succession planning. Leaders at all levels were knowledgeable about issues and priorities for the quality of services and could access support and development in their role.

Freedom to speak up

Score

3. Evidence shows a good standard of care

The service fostered a positive culture where people felt they could speak up and their voice would be heard.

Staff culture of speaking up was strong. Staff raised concerns and were supported without fear of consequences. Staff felt managers had been more responsive and supportive over the last few years.

Staff and leaders actively promoted staff empowerment to drive improvement. Staff encouraged each other to raise concerns and promote the value of doing so. Staff were confident that their voices would be heard.

Leaders were open to feedback. When concerns were raised, leaders investigated sensitively and confidentially, and lessons were shared and acted on.

Workforce equality, diversity and inclusion

Score

3. Evidence shows a good standard of care

The service valued diversity in their workforce. Leaders worked towards an inclusive and fair culture by improving equality and equity for people who work for them.

Diversity and inclusion was valued in in the workforce. Leaders supported work towards an inclusive and fair culture by improving equality and equity for staff. The service recruitment policy showed that equality and diversity was valued in the recruitment process. Managers completed workforce race equality standard data collection monthly. Staff came from a variety of ethnic backgrounds and there was an inclusive culture.

Staff said they felt like part of a family and were recognised for their contribution by both their managers and their peers.

Leaders acted to continually review and improve the culture of the organisation in the context of equality, diversity, and inclusion. Leaders prevented and addressed bullying and harassment at all levels.

Leaders made reasonable adjustments to support disabled staff to carry out their roles well. Managers took account of their staff's neurodiversity needs and supported staff when needed.

Governance, management and sustainability

Score

3. Evidence shows a good standard of care

The service had clear responsibilities, roles, systems of accountability and good governance. Staff used these to manage and deliver good quality, sustainable care, treatment and support. Staff acted on the best information about risk, performance and outcomes, and shared this securely with others when appropriate.

There were structures, processes and systems of accountability to support the delivery of good quality and sustainable services.

The quality strategy was available to staff across all areas of surgery services and managers understood the priorities outlined within it. Staff had recognised the need to improve in some areas and told us improvements had been seen across their areas.

There were monthly clinical governance and quality committee meetings, which included representatives from the surgery, theatres and anaesthetics directorates.

Minutes from divisional governance meetings reported on risks, incidents, complaints and performance against national and local assessments. Meetings were well attended by members from all areas within the division.

The service maintained a divisional risk register, which defined the severity and likelihood of risks. The leadership team reviewed the risk register monthly and severe risks were escalated to the trust board, when necessary, through the corporate risk register. Risks were discussed and agreed at the divisional governance meetings before a risk was put on the register.

Managers and ward staff could describe the risks associated with their areas and we were told information was shared through regular safety huddles and staff meetings. The ward managers would email the staff with updates from staff meetings.

Risks were owned by senior staff and those we reviewed were manged effectively. However, we noted a new risk by speaking with clinical leads, where there was no consultant on site overnight, only on call. This had been already identified and was on the risk register. Various actions were in place, including recruitment into this role, which was ongoing during the time of the assessment.

The clinical governance meeting oversaw the development of the organisation's clinical quality strategy. Managers used information from the analysis of adverse incidents, complaints and clinical data through audits to find risks and make needed improvements. This data was presented in a quality and safety report through the quality and safety committee.

Staff understood their roles and responsibilities. Staff attended department meetings monthly to ensure they received information needed for their role and responsibility. These meetings were held both in person and online to aid flexible working. Meeting minutes from different departments supported the governance structures and messaging further up the organisation. Managers accounted for the actions, behaviours, and performance of staff during these meetings.

Leaders had effective plans for business continuity in case of emergency or natural disasters, such as adverse weather events. Staff were confident about these arrangements and knew how to begin them. The plan outlined suitable plans for the sustainability of the business if external events affected the running of the hospital.

Partnerships and communities

Score

3. Evidence shows a good standard of care

The service understood its duty to collaborate and work in partnership, so services worked seamlessly for people. Staff shared information and learning with partners and collaborated for improvement.

Leaders understood their duty to collaborate and work in partnership with other organisations so that services worked well for people. Leaders shared information and learning with partners for improvement. Leaders recognised their need to work with their neighbouring NHS trusts and integrated care systems.

Leaders were open and transparent, and they worked well with relevant external stakeholders.

The service gathered feedback from staff through discussions and scheduled meetings which were minuted and available for those that could not attend. Along with staff meetings, the service used the daily safety huddles, held in all areas including wards and theatres, as the main method to share important messages.

Patients were given the opportunity to provide feedback about their care and we saw patient feedback questionnaires that had been completed by patients. The trust had a patient engagement group that met quarterly to discuss trust policies, plans and developments.

There was some evidence that the views and experiences of patients and others were gathered and acted on to shape and improve the service. For example, the quality accreditation programme involved patient representation and independent staff in the assessment process for the ward. This awarded the area with a rating of satisfactory, good, great or outstanding.

Learning, improvement and innovation

Score

3. Evidence shows a good standard of care

The service focused on continuous learning, innovation and improvement across the organisation and local system. Staff encouraged creative ways of delivering equality of experience, outcome and quality of life for people. Staff actively contributed to safe, effective practice and research.

There was evidence of improved culture across the service and there was strong leadership. Divisional leaders and ward managers acted to make improvements in the running of surgery services. They had regular meetings where learning was discussed.

The trust was accredited as an elective surgical hub delivering high standards in clinical and operational practice. The scheme, which was run by NHS England's Getting It Right First-Time programme in collaboration with the Royal College of Surgeons of England, assessed hubs against a framework of standards to help hubs deliver faster access to some of the most common surgical procedures such as cataract surgeries and hip replacements. It also sought to assure patients about the high standards of clinical care.

The trust held an event to mark the end of the 'ASCOT Trial' – a major clinical trial which helped to transform the lives of people suffering with damage to their knee joint or cartilage. It had been running in partnership with Keele University and supported by the Orthopaedic Institute Charity, Versus Arthritis and the Medical Research Council.

The trust received the NHS Pastoral Care Quality Award in recognition of its efforts and commitment to providing gold standard quality pastoral care to international recruits. In 2023, the organisation welcomed 22 international nurses to its workforce, from countries including Kenya, India, Saudi Arabia, Jamaica.

In April 2023, the trust launched an enhanced recovery programme for all arthroplasty patients, which aimed to get patients back to full health as quickly as possible following surgery. Research around enhanced recovery has shown that the earlier a person gets out of bed and starts walking, eating, and drinking after an operation, the shorter their recovery time will be.

The programme had seen more than 1,000 patients before the end of the year.

Service

Regulated activities

How the regulation was not being met

Service

Regulated activities

How the regulation was not being met

Regulation 12: Safe care and treatment

Service

Critical care

Regulated activities

- Treatment of disease, disorder or injury

How the regulation was not being met

- The trust must ensure that after-hours communication, particularly for nurses needing to contact the specialist team when anesthetists are not present, requires a clear solution to ensure timely and safe patient care (Regulation 12).
- The trust must ensure that all staff have completed their mandatory training (Regulation 12).

Regulation 18: Staffing

Service

Critical care

Regulated activities

- Treatment of disease, disorder or injury

How the regulation was not being met

- The trust must discuss and plan for increasing the number of medical and nursing staff to improve care quality and safety. There is a need to clarify the required increase in medical and nursing staff for the unit, including specific roles, numbers, and timelines, to ensure the quality and safety of care as patient volume and complexity rise; (Regulation 18).

Learning From Deaths

0. Reference Information

Author:	Dr James Neil	Paper date:	23-10-2025
Executive Sponsor:	Dr Ruth Longfellow	Paper Category:	Governance and Quality
Paper Reviewed by:	Mortality Steering Group	Paper Ref:	To be inserted by the person collating the agenda
Forum submitted to:	Quality and Safety	Paper FOIA Status:	Full / Partial / Non-disclosure Delete as appropriate

1. Purpose of Paper

1.1. Why is this paper going to Trust and what input is required?

Learning from Deaths summary report to Q and S.

After deaths are reported on Datix, a decision is made as to whether it is a serious incident 'SI' or not.

A structured judgement review is carried out in timely manner using the SJR Plus methodology developed by NHSE.

Deaths are reported through the Board of Directors.

They are also reported and discussed at the Multi-disciplinary Clinical Audit Meeting.

A detailed discussion occurs in the Mortality Steering Group at quarterly intervals and the Governance team will continue the bereavement process with the family.

MSG report discussed at Patient Safety committee.

2. Executive Summary

2.1. Context

To report the current numbers and trends in Q2 2025 for In-patient Learning from Deaths (LFD).

2.2. Summary

See Numbers Below.

2.3. Conclusion

No trends identified.

Learning from deaths identified (see below).

3. The Main Report

3.1. Introduction

NHSE asks that we have an update for the board on the current state of LFD investigations/numbers/actions and themes identified.

3.2. Learning From Deaths Summary.

Date	Total In-patient Deaths	Number for case record (SJR) review	Death likely due to problems with care	ME review/Family feedback.	Coroner review.
July 25	0	0	0	N/a	N/a
August 25	2 (1 expected, one sudden but not unexpected)	2	0	No concerns	Referred due to sudden death and short stay at RJAH. Coroner COD after PM. Natural causes, no concerns.
September 25	1 (unexpected)	Awaited	SJR awaited	No Concerns	CN1A. No concerns with care.

Expected/Sudden but not unexpected/Unexpected deaths are NHSE definitions reflecting whether a death is predictable related to the medical condition or not.

3.3. Associated Risks.

None.

3.4. Next Steps

Discussions complete with SATH concerning a link with their Medical Examiner and Bereavement system. This service commenced June 2023.

LFD lead now working as a Medical Examiner at SATH.

3.5. Learning from SJR's.

There is an outreach visit to UHNM documented in the notes for 13/5/25. Nurse, Trust doctor and physio. This visit was documented by the Physio. He was seen by consultant within 24 hours of admission. Holistic input, dietician, psychology, medical, nursing all within 48hours of admission. End of life care appears exemplary. Frank discussion of expectations re respiratory care and patient wishes occurred only after several deterioration. Difficulty in obtaining timely respiratory review via existing pathways. No respiratory plan followed patient on transfer from UHNM. MCSI to perform case review.
Overall excellent care from admission review and plan to care after deterioration and EOL process. Excellent documentation of plans in rapidly changing situation. Good documentation of family discussions at appropriate times.

All learning passed on to consultant teams.

All to be discussed at Mortality steering group and MDCAM in 2025.

Plan going forward to use NHSE dashboard to generate LFD reports, although these are not designed for our limited numbers per se. (Not currently available due to change in IT system over December).

Further IT change with transfer of system (May 2024) to external provider from NHSE likely to further delay dashboard.

Appendix 1: Acronyms

LFD	Learning From Deaths
SJR	Structured Judgment Review
MSG	Mortality Steering Group

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	% of Staff on E-Rostering System	Personal Development Reviews	Staff Retention % of Staff with an Active E-Job Plan	
No significant change or N/A to SPC	Statutory & Mandatory Training E-Rostering Level of Attainment		% of E-Rosters Approved 6 Weeks Ahead E-Job Planning Level of Attainment	Sickness Absence Sickness Absence - Short Term
Concerning variation (high or low) or 3 months off target	Vacancy Rate AHPs Vacancy Rate			HCSW Vacancy Rate % Staff Availability

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.

Trust Board - People & Workforce
September 2025 – Month 6

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

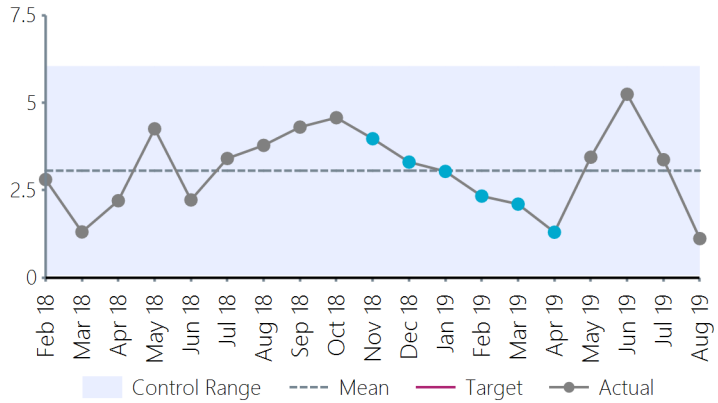
Some examples of these are shown in the images to the right:

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

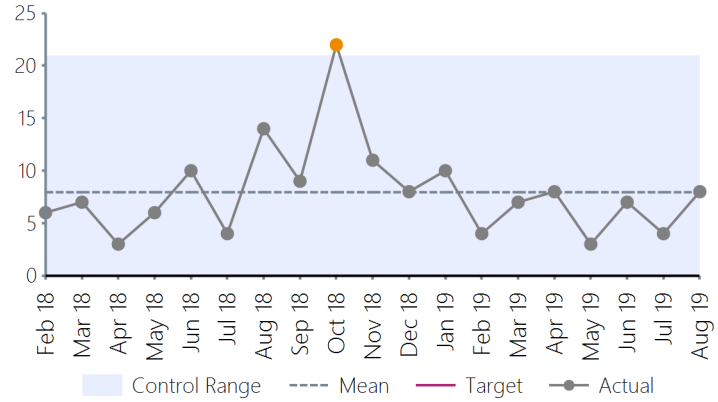
b) shows a point of concern sitting above the control range.

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.

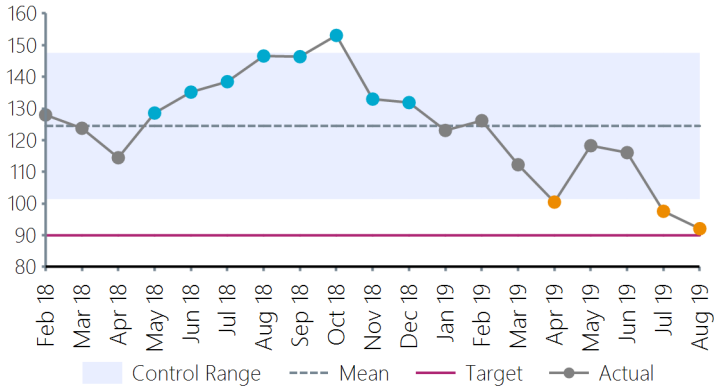
a)



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
Sickness Absence	4.96%	4.91%			Moving Target	+	
Staff Turnover - FTE	9.98%	9.91%			?		
Leavers per Month	12	9			?		
Vacancy Rate	8.00%	7.18%		H	P	+	15/04/24

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Agency Spend against Plan	1.30	0.90		N/A to SPC	Moving Target		
Proportion of Temporary Staffing as a % of the Trust Pay Costs	7.10%	7.00%		N/A to SPC	Moving Target		
Bank Spend against Plan	5.80	5.90		N/A to SPC	Moving Target		

Sickness Absence

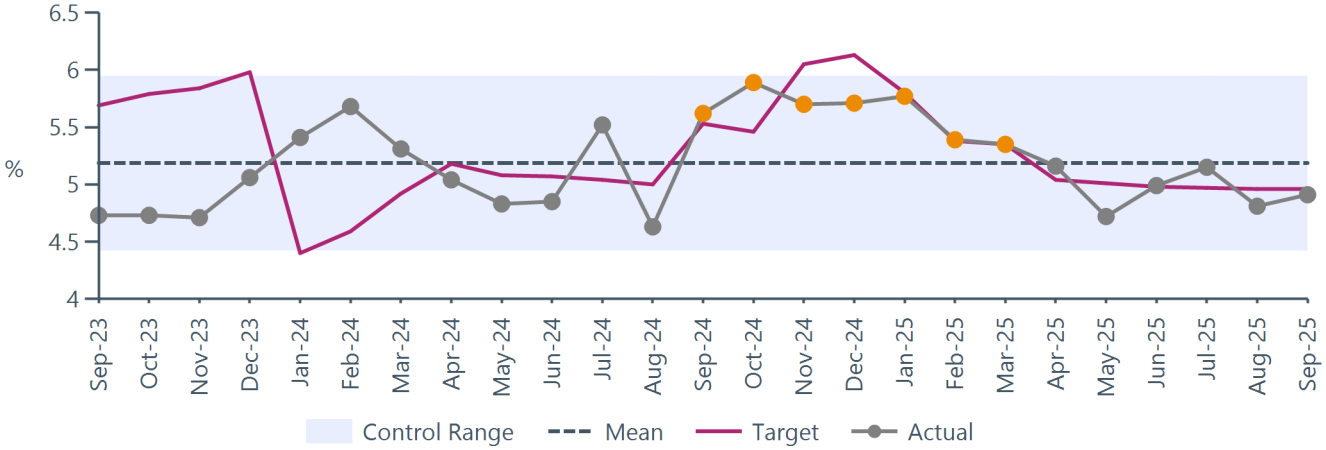
FTE days lost as a percentage of FTE days available in month. Target as per Trust's Operational Plans. 211161

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
4.96%	4.91%		Moving Target

Trajectory

Actual
Trajectory



What these graphs are telling us

Metric is experiencing common cause nature. Metric has a moving target; in line with the Trust's Operational Plan.

Narrative

Overall Sickness Absence is reported at 4.91% for September; below the 4.96% plan and reported as common cause variation on the SPC above.

The metric has been included as an exception this month to highlight that Sickness Absence forms one of the NOF metrics that the Trust is monitored against. The latest NOF Publication relates to Quarter 1 where the NOF score for this metric is 2.69; this relates to the 5.49% sickness absence for the quarter ending March-25 as the methodology used represents a quarter of aggregated monthly figures.

Indication from a recent Model Hospital Masterclass on NOF advised that the next publication is likely to be the end of November. Below is the Sickness Absence rates for more recent quarters:
* Q1 April-25 to June-25 - 4.95%
* Q2 July-25 to September-25 - 4.97%

Actions

Following the recent SPC session delivered to Trust Board by NHSE; Exec Team to consider a fixed target for this metric rather than the moving target from the Trust's Operational Plan.

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
5.62%	5.89%	5.70%	5.71%	5.77%	5.39%	5.35%	5.16%	4.72%	4.99%	5.15%	4.81%	4.91%

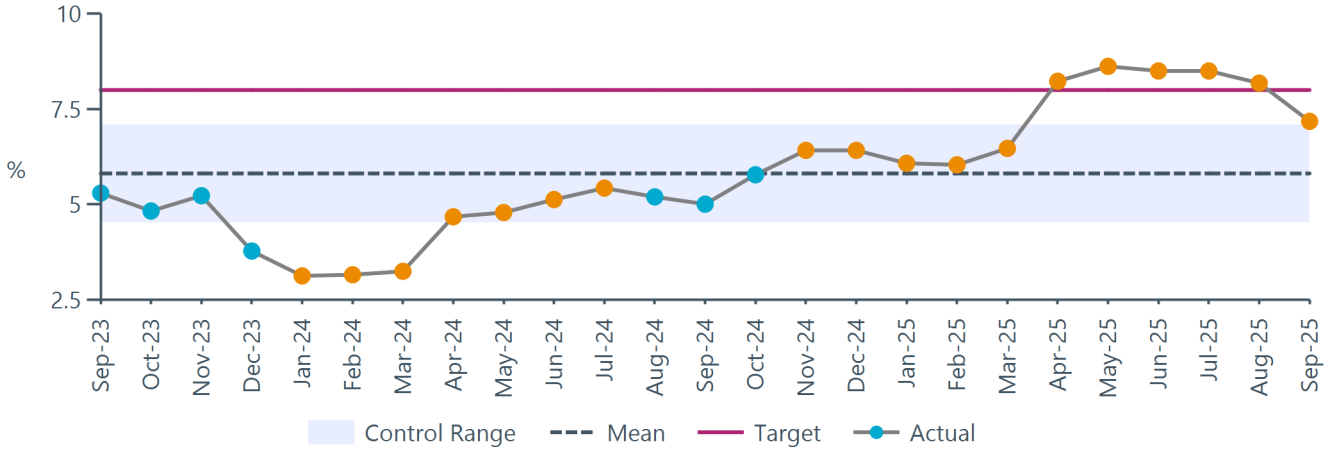
Vacancy Rate

% of Posts Vacant at Month End 211183

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
8.00%	7.18%	H	P

Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. Metric is consistently meeting the target.

Narrative

The Vacancy Rate reported for the end of September is 7.18%, below the 8% target. The metric is reported as special cause variation of a concerning nature with data points over the last twelve months all above the mean. As shown in the graph above, there was an increase in April attributable to a budget increase in line with financial reconciliation and workforce plan submission.

Budgeted establishment has been reconciled with Finance in Month 6 which has seen a reduction in establishment of 7.46WTE. Staff in post has increased which has filled existing vacancies.

Actions

The vacancy rate is expected to reduce as recruitment to new posts forms part of the Workforce Plan.

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
5.01%	5.78%	6.42%	6.42%	6.08%	6.04%	6.47%	8.23%	8.62%	8.50%	8.50%	8.18%	7.18%

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, 05 November 2025

Author: **Contributors:**

Name: Amber Scott
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 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 People and Culture Committee on 18 September 2025 and 23 October 2025. 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	

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	

The following strategic themes, as outlined in the Board Assurance Framework, are overseen by this Committee. The relevant themes, and the Committee's overall level of assurance on their delivery is:

Assurance framework themes		Relevant	Overall level of assurance
1	Continued focus on excellence in quality and safety.		
2	Creating a sustainable workforce.	✓	STRONG
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.		

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 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, OR
- require the approval of the Board for work to progress.

E-Job Planning Attainment (September and October Meeting)
The Committee remains concerned about persistent delays in resolving e-job planning implementation. Despite repeated actions, progress remains slow, attributed to ongoing system and process challenges. Members reiterated that this should be a straightforward management task, and the delay risks affecting service planning, productivity, and compliance with NHS England expectations. The Executive team to provide a clear recovery plan with timelines for full implementation.

Workforce Planning and Infrastructure Reduction Targets (September and October Meeting)
The Trust has not yet achieved the NHS infrastructure reduction target and currently lacks a clear workforce plan to meet this requirement. This presents a potential risk to the Trust's financial sustainability and regulatory compliance. The Workforce plan to be developed and brought to the Board for review, including timelines and impact assessment. Further reporting to be presented to committee in November on how workforce targets are being met. A mismatch was identified between early reporting on workforce compared to financial forecasts. This has now been resolved. However, this will therefore now require some accelerated actions and decisions on workforce plans in order to meet financial targets by the year-end. The Committee endorsed the Mars Scheme outcomes, approving seven staff departures with positive financial impact expected within the year. Further actions to meet workforce reduction targets will be reviewed at the next Executive meeting.

Premium Costs and Overtime Overspend (September and October Meeting)
A significant overspend is forecast in agency, bank, and overtime costs, particularly linked to waiting list initiatives and operational recovery. Overtime is not explicitly planned within financial forecasting, increasing budgetary pressure. A deeper analysis of the underlying causes, and incorporation of overtime planning into future financial plans. Reporting to include pressure points by department and detail how much of the cost is driven by activity vs insufficient controls of usage.
Recruitment is underway for both paediatric and rheumatology posts, with two potential candidates for paediatrics. The expectation is that agency usage in these areas will be eliminated within six months, aligning with improvements in waiting times and skill mix adjustments (e.g., advanced pharmacy roles).

Training Compliance and Data Visibility (October Meeting)
Gaps remain in mandatory training compliance, particularly in safeguarding (adults level 3 and children) and basic life support. Data accessibility for managers is limited, reducing the ability to target interventions. Concerns are ongoing on the growing list of mandatory training topics and the operational impact of training requirements, with a need for a more proportionate and risk-based approach. A revised compliance reporting to include departmental-level breakdowns, with actions to mitigate patient safety risks.

Safe Staffing and Education Reports (October Meeting)
The non-surgical safe staffing and education reports were noted, providing assurance on compliance, staff development, and integration of safe staffing data into IPR metrics. The following table is shared with the Board to ensure timely reporting of compliance.

Ward	Safe Staffing for April 2025	Day				Night				Day		Night			Care Hours Per Patient Day		
		Registered		Care Staff		Registered		Care Staff									
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses / midwive...	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwive...	Average fill rate - care staff (%)	At midnight (monthly total)	CHPPD Registered Midwives / Nurses	CHPPD Care Staff	CHPPD Overall
Alice	110 - TRAUMA & ORTHOPAEDICS	968.50	977.25	0.00	0.00	744.00	744.00	0.00	0.00	100.9%	-	100.0%	-	130	13.2	0.0	13.2
Clwyd	110 - TRAUMA & ORTHOPAEDICS	1150.50	1142.75	1029.50	977.00	756.75	763.75	611.50	651.50	99.3%	94.9%	100.9%	106.5%	438	4.4	3.7	8.1
MCSI Inpatients	400 - NEUROLOGY	2971.00	3018.75	4865.00	4255.92	2232.00	2254.00	1778.32	1683.00	101.6%	87.5%	101.0%	94.6%	1,381	3.8	4.3	8.1
Kenyon	110 - TRAUMA & ORTHOPAEDICS	162.00	162.00	144.00	132.00	144.00	144.00	72.00	72.00	100.0%	91.7%	100.0%	100.0%	44	7.0	4.6	11.6
Oswald	110 - TRAUMA & ORTHOPAEDICS	744.00	744.00	589.50	533.50	744.00	744.50	0.00	0.00	100.0%	90.5%	100.1%	-	212	7.0	2.5	9.5
Ludlow	110 - TRAUMA & ORTHOPAEDICS	931.00	886.00	521.00	480.50	636.00	650.50	336.00	336.00	95.2%	92.2%	102.3%	100.0%	234	6.6	3.5	10.1
Powys	110 - TRAUMA & ORTHOPAEDICS	1098.00	1098.00	903.50	866.00	744.00	745.00	744.00	737.50	100.0%	95.8%	100.1%	99.1%	331	5.6	4.8	10.4
Sheldon	300 - GENERAL MEDICINE	1207.50	1211.00	1479.50	1706.25	756.00	768.00	1104.00	1284.00	100.3%	115.3%	101.6%	116.3%	509	3.9	5.9	9.8
HDU	110 - TRAUMA & ORTHOPAEDICS	1054.00	923.00	190.25	123.25	953.50	828.00	12.00	36.00	87.6%	64.8%	86.8%	300.0%	54	32.4	2.9	35.4
Totals		10286.50	10162.75	9722.25	9074.42	7710.25	7641.75	4657.82	4800.00	98.8%	93.3%	99.1%	103.1%	3333	5.3	4.2	9.5
MSK Unit		4395.50	4211.75	2788.25	2578.75	3234.25	3131.25	1775.50	1833.00	95.8%	92.5%	96.8%	103.2%	1101	6.7	4.0	10.7
Specialist Unit		5891.00	5951	6934	6495.67	4476	4510.50	2882.32	2967	101.0%	93.7%	100.8%	102.9%	2232	4.7	4.2	8.9
Trust Total			97.8%														

3.2 Areas of on-going monitoring with new developments

ADVISE - The People and Culture 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 (October Meeting)
A resolved health and safety risk (main stores staffing) has been removed from the corporate risk register. Four new risks remain under development but currently present no material concern requiring escalation.

Annual Board Report Submission and Appraisal Process (October Meeting)
The Committee considered the proposed return in detail and endorsed its submission to NHSE by the deadline. That was done on the understanding that formal approval to make the submission would be requested from the Board (on the recommendation of the Committee) at the 3 November meeting. As the submission deadline was unexpectedly brought forward, the submission has been made prior to the Board meeting. As such, the Board is asked to ratify the decision to submit the return. That decision was made following review by the Medical Appraisal Lead, the relevant executive leads, and on the endorsement of the People and Culture Committee.

Induction and Support for New Managers (October Meeting)
Feedback from the Leadership Development Programme highlighted the lack of structured induction for staff transitioning into management roles. This may affect consistency and effectiveness in management practice. The Trust should explore formal onboarding processes for internal promotions to ensure new leaders are adequately supported.

Professional Nurse Advocate (PNA) Role Challenges (October Meeting)
While the PNA role contributes positively to staff wellbeing, issues persist around lack of allocated time, insufficient confidential spaces, and absence of incentives for staff to take up the role. Further work is required to address barriers to effective implementation of the PNA role.

Job Planning Equity (October Meeting)
Concerns were raised regarding new recruits being allocated more unsociable hours than existing staff. The Committee noted this could impact morale and retention if not addressed. A trust-wide review of job planning and demand alignment is needed to ensure fairness and transparency.

Nursing and Midwifery Job Evaluation (October Meeting)
Uncertainty remains around national deadlines for job evaluation completion and potential back pay requirements, particularly regarding bank staff. Financial risks could arise if national expectations mandate completion within the current financial year. HR Directors' network to provide clarification and update the Board on financial implications once available.

Sexual Safety Self-Assessment (October Meeting)
The Trust's self-assessment against national sexual safety standards is progressing, with areas of ongoing development in policy, reporting, and training. The Committee agreed to bring back a populated action plan with clear timelines in December. Continued Board monitoring is recommended given the national sensitivity and potential regulatory scrutiny. The Trust current policies are aligned with national requirements, and a review has been completed to identify gaps.

Apollo System Issues(October Meeting)
The JCG Chair Report alerted the Committee on the ongoing technical problems with the Apollo system that are impacting both clinical and non-clinical teams. The inability to extract cohort 7 patient data is preventing progression of the harms review process, posing a significant clinical risk.

Vacancy Rates & Workforce Reductions (September Meeting)
While sickness rates are below target, vacancy rates remain slightly above target, and achieving WTE reduction targets by January will require decisive executive action. Delays may impact financial alignment efforts.

Occupational Health Contract Monitoring (September Meeting)
The contract with Optima is under ongoing review. The committee recommends tightening monitoring of vaccination records and improving reporting to support workforce wellbeing.

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.

Leadership Development Programme Impact (October Meeting)
Participants, including Louise and Carolina, reported positive outcomes from the leadership course, including improved communication, team engagement, and cross-departmental collaboration. The programme has strengthened compassionate leadership and staff wellbeing, contributing positively to patient care.

Delivery Model Progress (October Meeting)
The Committee noted positive progress in increasing theatre activity, recruitment into key specialties, and efforts to align service delivery with demand. Data transparency on consultant job plans will be enhanced in future reporting.

Shared Services Collaboration (October Meeting)
Ongoing shared services workstreams in occupational health, recruitment, and education continue, with attention to cultural and accountability considerations to ensure effective joint working.

Policy Reviews and Ratifications (October Meeting)
Updated policies on on-call, pay protection, grievance, smoke-free, and management change were reviewed and ratified, with minor benchmarking actions to be completed.

Sickness Metrics (September Meeting)
Overall and long-term sickness absence rates are below target, indicating effective health and attendance management across the workforce.

Resident Doctor 10-Point Plan (September Meeting)
The trust has established a working group and assigned executive responsibility to ensure progress toward compliance with the national 10-point plan for resident doctors.

Staff Survey Preparation (September Meeting)
Preparations for the 2025 national staff survey are well underway, with a comprehensive communication plan aimed at increasing participation across all staff groups.

Retirement Planning Strategy (September Meeting)
With a detailed analysis of the workforce age profile and retirement trends, there is an opportunity to develop tailored support strategies for older workers and proactively plan succession in high-risk areas.

Chair's Assurance Report
People and Culture Committee

Mentor Engagement Strategy (September Meeting)
Further work is needed to clarify reporting lines and outcome measures for the mentor engagement strategy to ensure alignment with broader trust objectives.

Recommendation

The Board is asked to:

- CONSIDER the overall assurance level listed at section 2,
- 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.

Annual Report for Appraisal

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Committee / Group / Meeting, Date

Board of Directors, 05 November 2025

Author:

Name: Nilesh Makwana
Role/Title: Medical Appraisal Lead

Contributors:

Name: Kate Emery
Role/Title: Medical Appraisal Administrator

Report sign-off:

Name: Denise Harnin, Chief People and Culture Officer
People and Culture Committee, 23 October 2025

Is the report suitable for publication?:

Yes

Key issues and considerations:

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 standard.

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

This report summarises the feedback on the appraisal software, appraisers and the experience of apprassess from 31/3/24 to 1/4/2025.

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	✓

Recommendations:

Due to the reporting requirements, the People and Culture Committee are asked to review and support the annual report ahead of submission. The Boad of Directors are asked to note the 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 2024 – 31 March 2025

1A – General

The board/executive management team of:
THE ROBERT JONES AND AGNES 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.

Comments:	The Responsible Officer is supported in her role by the Associate CMO / Medical Appraisal Lead (Mr Nilesh Makwana) and Kate Emery (Medical Appraisal Administrator)
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:	The Trust has appointed a Medical Appraisal administrator to address the resilience of the administration team. Her appointment replaces the previous temporary person.
Comments:	The appointment is fixed and will ensure stability of the administration process
Action for next year:	A peer review with a Trust of similar size and function to benchmark the process at RJAH

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:	An accurate record of all licensed medical practitioners with a prescribed connection to the designated body was fully maintained throughout the year. A Direct link between Premier IT and GMC has been established.
Comments:	The administrative process will be managed via the new medical appraisal software. Appointment of new doctors will be accurately notified and recorded by HR
Action for next year:	Maintain accurate record using 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:	The Chief Medical Officer / RO ensures that the revalidation process adheres to the Trust policy and GMC guidelines already in place.
Comments:	A review of the Medical Staff Appraisal policy(POL036) is currently being updated.
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:	The Medical 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.
Comments:	A peer review with a Trust of similar size and function to benchmark the process at RJAH is currently being undertaken.
Action for next year:	Report on the peer review of the organisation appraisal and revalidation process.

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:	All locum and short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development via the Study Leave for Consultant and Medical Staff policy and process and the appraisal and revalidation process which includes the provision of

	governance data and intelligence.
Comments:	In addition to this, the Trust complete a quarterly review of Junior Doctors safe working hours which 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

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:	All doctors have been transferred to an electronic appraisal system, Premier IT system, which is GMC approved and mandated by the Trust. This has been updated taking into account the new GMP document by the GMC. This has ensured that all doctors have an effective annual appraisal which meets GMC requirements.
Comments:	Relevant information- Governance data (Complaints, compliments, QIA etc) are provided by the Trust and by the Appraisee form external organisations if required.
Action for next year:	Continue to use systems in place including PremierIT and 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 completed, as per the Appraisal Policy. This Quality Assurance checks ensures that external organisation information is also provided and reviewed at appraisal.
Comments:	The Appraisal process is working efficiently with minimal delay in Appraisals
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:	Medical Staff Appraisal Policy is being updated in accordance with Trust governance and policy process. The policy adheres to GMC guidelines
Comments:	
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

[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.

Action from last year:	The Trust has a total of 29 trained medical appraisers, with representatives from each of the different specialities This ensures the same appraiser doesn`t appraise the same doctor more than 3 times in a revalidation cycle.
Comments:	A ratio to ensure doctors do not have the same appraiser for more than 3 consecutive appraisals will be maintained.
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 MIAD training for appraisers.
Comments:	Recent training with an invited speaker Dr Luqman Rajput on Neurodiversity applicable to appraisals. This was favourably received
Action for next year:	Plan and arrange the programme content for the network/development sessions for 2025/26 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 the Board.
Comments:	Audits of quality assurance have been completed and highlighted no concerns or issues
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:	
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 to the revalidation date.
Comments:	The Trust has a set of criteria 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.
Action for next year:	Continue to monitor and 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 are provided with Governance data prior to their appraisal and monthly activity data to review at departmental meetings. The Information department provide annual activity information. Mandatory training is provided through ESR.
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 to the Trust. All clinicians are provided with a copy of any complaints received regarding them or their practice or that of their registrars. This is reflected at their appraisals. Any concerns are escalated to the RO by the appraiser if required electronically through the platform.
Action for next year:	Continue to monitor.

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 Governance data prior to their appraisal and monthly activity data to review at departmental meetings. The Information department provide annual activity information. Mandatory training is provided through ESR
Comments:	Governance department and Premier IT are now linked so that information is provided in a timely manner
Action for next year:	Continue with processes.

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:	

Comments:	Policies in place include 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.
Action for next year:	Ensure Professional Standards group continues to meet and any areas of concern are escalated via the correct governance routes.

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:	See below
Comments:	I can confirm that a summary report of the number and reasons for concerns for Doctor's was reported through the People and Culture Committee in December 2024. The December report outlined that in the period 2023/24 a total of 15 cases had been processed, summarised as follows:

	Closed	Ongoing
9 Conduct Cases	7	2
1 GMC Self-Referral	0	1
4 Grievance Cases	3	1
1 Occupational Health Self-Referral	1	0

Action for next year:	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 Medical Appraisal coordinator has started to create formal process especially with SaTH and Alderhey where we hold joint appointments. Informal process is in place.
Comments:	The Medical Practice Information Transfer (MPIT)form is provided by NHS Revalidation Support team to aid the transfer of information and concerns effectively between organisations.
Action for next year:	Medical Appraisal coordinator to continue to follow the formal transferring documentation process

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:	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 Director/Responsible Officer, People Services Department if required. The Professional Standards Group keeps an update record of concerns raised and any actions taken.
Comments:	
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:	Collated through appraisal documentation and appraisal discussion with reflection
Comments:	National reviews and learning is fed through relevant workstreams, clinical through the CNO and culture via Chief People Officer other local learning identified through our internal governance processes, such as IPC improvements and PSIRF.
Action for next 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

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:	
Comments:	The Trust agrees and aspires to support the 7 recommendations 1. Collaborative Leadership and Organisation Values – Strategic 5 year Plan. 2. Positive EDI action 3. Management standards delivered by accredited training- MIAD training and National. 4. Appraisal system that is standard- Our electronic software meets national standards 5. A new career and talent management function for managers

	6. Effective Recruitment of NED`s 7. Encourage top talent into challenging parts of the system 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 such as Datix, Freedom to Speak up and Whistleblowing, 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.
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:	Staff network groups engagement on culture Stakeholders encouraged to participate in reviewing HR policies
Comments:	Trust Vision statement updated and Values to be relaunched in September Expected behaviours are communicated Leaders are active in managing areas where there is improvement to be made Learning/training opportunities/recognise the value of SPA for medical colleagues at higher proportion than some Trusts Inappropriate behaviour is managed with aims of corrective actions Feedback is encouraged with improvements fed back to colleagues
Action for next year:	More use of Improve well engagement platform, to use as mini surveys and sentiment tracker

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:	WRES/WDES action plans and reports published Feedback from staff survey – and values reviewed

Comments:	Results from Staff Survey and actions taken for areas of focus
Action for next year:	More publication of how to report incidents through FTSU

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:	Staff survey focus action plans published and shared with staff, including how to report bullying and harassment, support for burnout and how to raise concerns
Comments:	1. EDI strategy and action plans 2. Support through staff Networks 3. Publishing Annual reports 4. Opportunities for training Revised Trust vision statement and launch of revised Values in September 2025
Action for next year:	Continue with action plans and reports. Communications through internet via COMMS/Percy. Ongoing Human Factors training

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:	Promotion of process

Comments:	A formal complaints policy (PoI 055) is followed. Formal complaints and PALS are discussed with individuals through the medical appraisal process. The clinical governance team will monitor for any themes/trends and if concerns are identified escalate to the appropriate individual.
Action for next year:	Continue to build on these areas

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	**Y**
Action from last year:	HR team monitor protected characteristics
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:	This is not something we currently do but can build on through the implementation of Radar.

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 with a Trust of similar size and function to benchmark the process at RJAH

Comments:	This has been initiated with The Royal Orthopaedic Hospital Birmingham with support from Dr Mohammed Saqib Anwar (Medical Director System Improvement & Professional Standards and Responsible Officer)
Action for next year:	Complete report and review recommendations

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

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	135
Total number of appraisals completed	134
Total number of appraisals approved missed	0
Total number of unapproved missed	0
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	44
Total number of late recommendations	1
Total number of positive recommendations	37
Total number of deferrals made	7
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	1
Total number of trained case investigators	8
Total number of trained case managers	6
Total number of concerns received by the Responsible Officer[2]	11
Total number of concerns processes completed	5
Longest duration of concerns process of those open on 31 March (working days)	224
Median duration of concerns processes closed (working days)[3]	56
Total number of doctors excluded/suspended during the period	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 doctors referred to GMC	1
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	34
Total number of new employment checks completed before commencement of employment	34
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. 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. All locum and short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development. The Trust has a total of 29 trained medical appraisers which is a decrease of 1 from previous year (30).

[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 appraisers are encouraged to participate in ongoing performance review and network/development sessions which are organised quarterly.

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.

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.

Revalidation recommendations made to the GMC are confirmed with the doctor.

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.

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 and forms part of their annual appraisal review.

The Chief Medical Officer/RO has established a monthly Professional Standards Group to comply with the above requirements, and record when concerns are raised.

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 Director/Responsible Officer, People Services Department if required. The Professional Standards Group keeps an update record of concerns raised, and any actions taken.

Medical Staff Appraisal Policy has been update July 2025 in accordance with Trust Governance and policy framework.

Actions still outstanding

Review and update process and policies in accordance with Trust policy framework and national guidance.

To create and agree a formal process regarding transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers in local hospitals where our doctors also work.

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.
Current issues
• The Medical Appraisals administrative staff have experienced multiple staff changes from 2021 to 2025, in temporary roles. The Administration is now supported by a substantive member of staff, appointed in October 2025. It has been a challenge for new staff who will require a period of time to familiarise themselves to the Medical Revalidation system and process. They are supported by the Medical Appraisal Lead and RO.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
To continue communication, training and monitoring of Premier IT. Ensure doctors are confident to complete their appraisals in a timely manner. Link Premier IT with GMC record of all licensed medical practitioners with a prescribed connection to the Trust. Plan and arrange the content programme for the network/development sessions for 2025/26.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

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

Name:	Stacey Keegan
Role:	CEO
Signed:	
Date:	

Name of the person completing this form:	Mr Nilesh Makwana Associate CMO and Deputy RO
Email address:	Nilesh.Makwana@nhs.net

Report on the Appraisal System at The Robert Jones and Agnes Hunt Hospitals NHS Foundation Trust

This report summarises the feedback on the appraisal software, appraisers and the experience of apprassess from 31/3/24 to 1/4/2025.

1. Screen shot of rating of appraisers from Premier IT for all appraisers.

Q1: Management of the Appraisal System

Q2: Access to the necessary information.

Q3: Their Preparation of appraisal.

Q4: Their ability to conduct the appraisal.

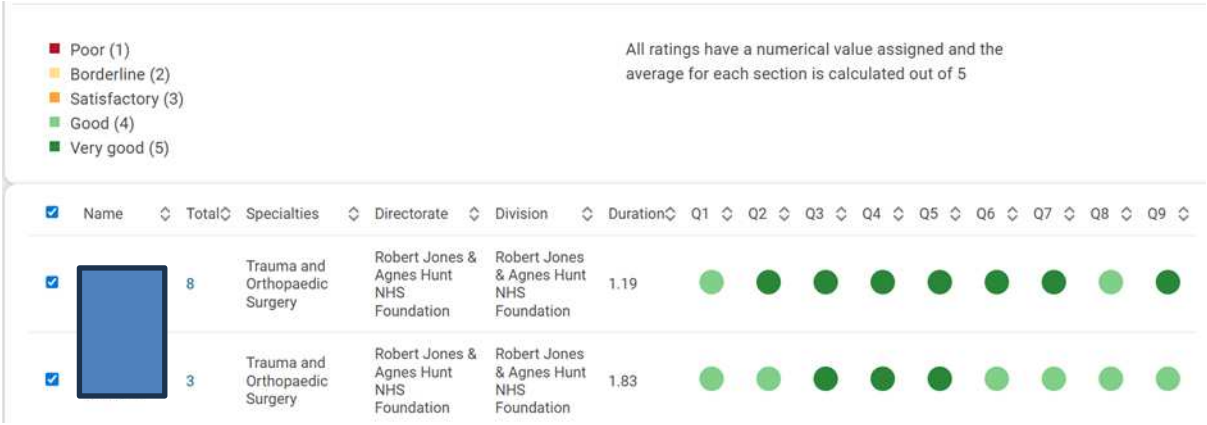
Q5: Their ability to review my progress from last year

Q6: Their ability to review my practice.

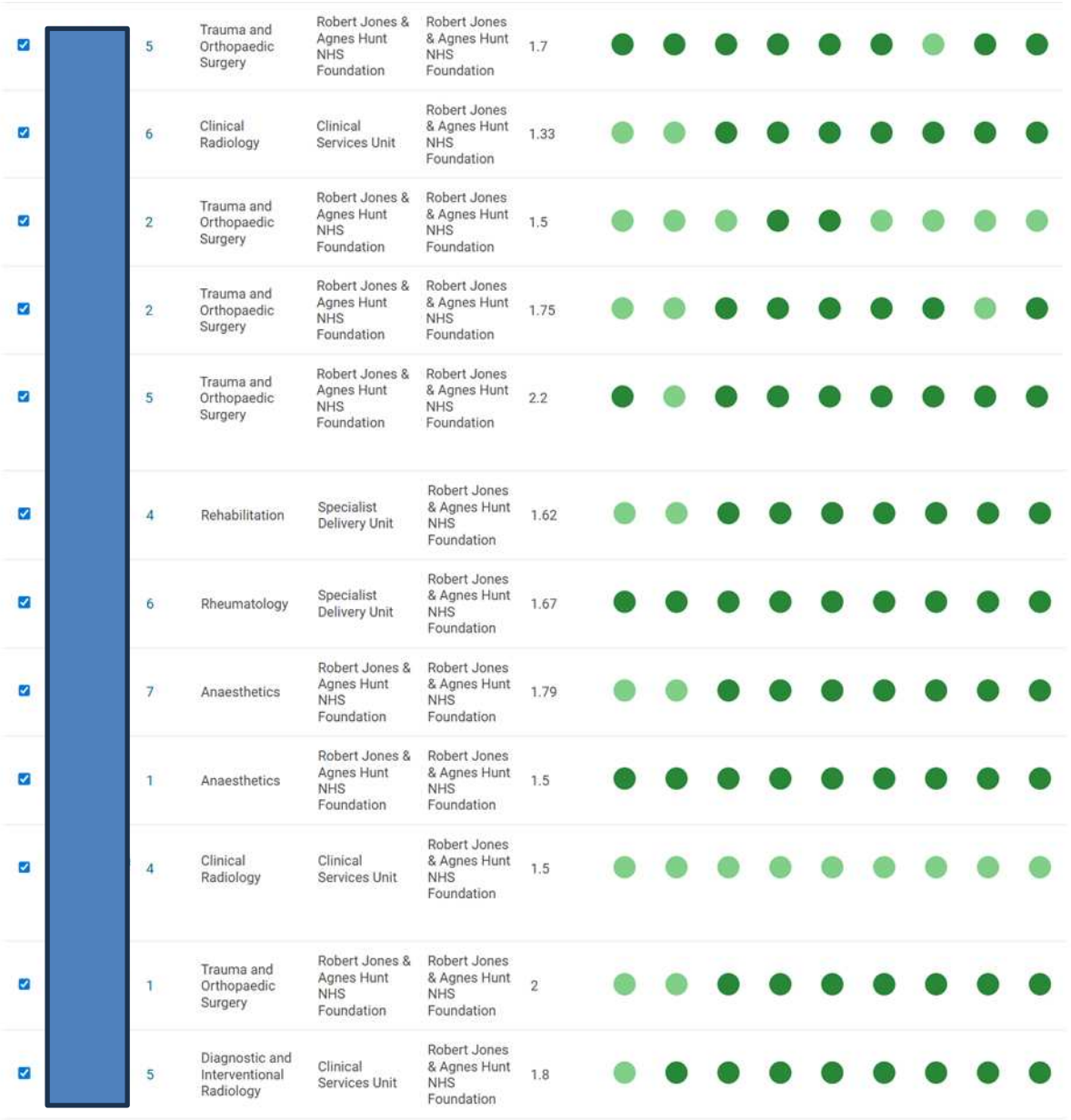
Q7: Usefulness for my development

Q8: Usefulness for my revalidation.

Q9: Usefulness for my PDP



1	Trauma and Orthopaedic Surgery	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	1.5		
2	Rehabilitation	Specialist Delivery Unit	Robert Jones & Agnes Hunt NHS Foundation	1.5		
1	Diagnostic and Interventional Radiology	Clinical Services Unit	Robert Jones & Agnes Hunt NHS Foundation	1		
3	Trauma and Orthopaedic Surgery	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	2.17		
4	Trauma and Orthopaedic Surgery	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	1.5		
4	Trauma and Orthopaedic Surgery	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	2.75		
3	Trauma and Orthopaedic Surgery	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	2.83		
6	Trauma and Orthopaedic Surgery	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	1.25		
3	Trauma and Orthopaedic Surgery	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	2		
18	Anaesthetics	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	1.75		
7	Trauma and Orthopaedic Surgery	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	2.21		
9	Elderly Care Medicine	Specialist Delivery Unit	Robert Jones & Agnes Hunt NHS Foundation	1.28		
1	Anaesthetics	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	2		
6	Anaesthetics	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	1.83		
1	Other	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	2.5		



[redacted]	5	Trauma and Orthopaedic Surgery	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	1.7	
	6	Clinical Radiology	Clinical Services Unit	Robert Jones & Agnes Hunt NHS Foundation	1.33	
	2	Trauma and Orthopaedic Surgery	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	1.5	
	2	Trauma and Orthopaedic Surgery	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	1.75	
	5	Trauma and Orthopaedic Surgery	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	2.2	
	4	Rehabilitation	Specialist Delivery Unit	Robert Jones & Agnes Hunt NHS Foundation	1.62	
	6	Rheumatology	Specialist Delivery Unit	Robert Jones & Agnes Hunt NHS Foundation	1.67	
	7	Anaesthetics	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	1.79	
	1	Anaesthetics	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	1.5	
	4	Clinical Radiology	Clinical Services Unit	Robert Jones & Agnes Hunt NHS Foundation	1.5	
	1	Trauma and Orthopaedic Surgery	Robert Jones & Agnes Hunt NHS Foundation	Robert Jones & Agnes Hunt NHS Foundation	2	
	5	Diagnostic and Interventional Radiology	Clinical Services Unit	Robert Jones & Agnes Hunt NHS Foundation	1.8	

Most comments are complimentary of the system and above light green values demonstrate good to very good experience.

We have had no yellow values that signify borderline results with management of the appraisal system(software) and access to supporting information. This is an improvement from the last report. This indicates that doctors have adapted to the electronic system.

[redacted]

ASPAT (Appraisal Summary and PDP assessment Tool) Feedback Report

Doctors appraisal output forms are assessed using the national ASPAT score. This is a quality assurance tool to check appraisals meet a national standard. The domains assessed are

1. Overview of Serious Incidents (max score 18)

2. Reflection (Max score 6)

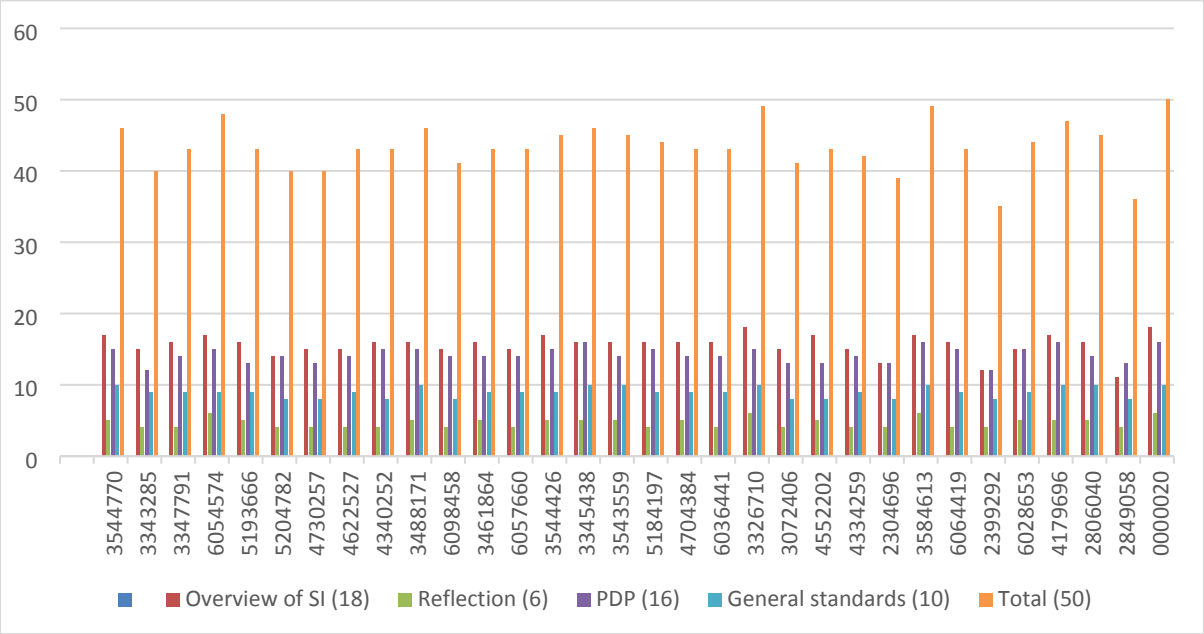
3. PDP (Max score 16)

4. General standard (max score 10)

5. Total score (Max 50)

Overall most total scores are above 40 indicating good quality.

Graph of medical appraisal feedback score using the ASPAT tool by appraiser. Total score out of 50.



The average duration of appraisal was 1.77 hrs (range 1 – 2.83hrs). The number of Appraisals per appraiser was an average 4.7 (range 1-18) during the year.

The graph below shows the average feedback for the management and personal development for doctors. The management of the system is lower due to the transition from the old MAG to the new Premier IT system. The score for supporting information provided to doctors was low which led to changes in the governance department. They now have direct access to PremierIT to provide data in a timely manner.

Graph showing overall feedback for all 9 domains (0-5 (max))

1.Access to the necessary supporting information

2.Their preparation for my appraisal

3.Their ability to conduct my appraisal

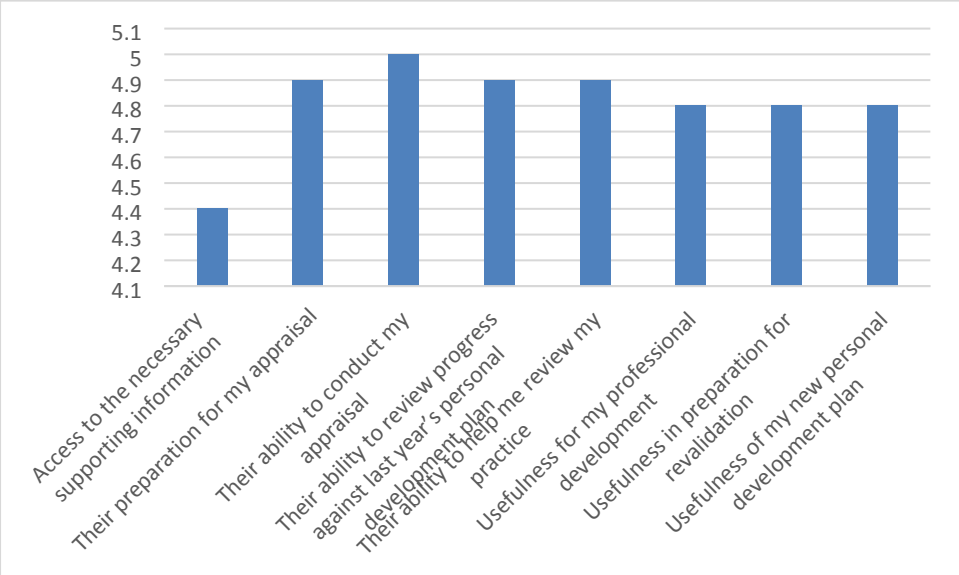
4.Their ability to review progress against last year's personal development plan

5.Their ability to help me review my practice

6.Usefulness for my professional development

7.Usefulness in preparation for revalidation

8.Usefulness of my new personal development plan



Feedback comments from Appraisers 31/3/24 to 1/4/25

Management of the appraisal system & Access to the necessary supporting information

The supporting information was excellent. i did lack Trust assistance in negotiating the appraisal computer system. I did find help in the end but i had to find it myself

Much better than that terrible PDF document!

getting data from the trust was too slow

The form is complex, repetitive and doesn't take into account the seniority of the appraisee.

[redacted] was very well prepared. He had read my appraisal thoroughly and we had a very meaningful and thoughtful conversation.

Some data missing such as infection reports. Fortunately, we know our own outcomes all too well.

The website requires a bit of learning experience before using all of its features correctly.

An excellent appraisal system, which is much more intuitive than the last program I have used.

Great inputs and discussions about the PDP

Data provided by the organisation of mixed quality and limited value as has been aired at previous Appraiser network meetings the lack of standardised timeframe for reports causes major issues.

Plenty of time to prepare.

The software has not changed since last year. It remains rather difficult to find ones way around and is not very satisfactory to my mind although I usually just about manage to navigate it in the end. It ought not to be a hurdle in itself.

"I do not understand why the Trust takes such a long time to sign off a straightforward and uncontentious appraisal. This has been the case for a number of years.

"Well organised.

Flexible."

The MSF system is a weak link and should 'just work' but caused me a great deal of trouble.

Very user friendly and straight forward format.

As always [redacted] undertook a very professional appraisal.

I had a lot of support in preparing the appraisal at the new hospital. It was very well organised, friendly, and professional in a confidential private secure environment

would be good to have more information re clinical activity

late receiving governance data from RJAH

"Training log a mess and disappointing as i have made an effort to keep on top of it this year

I had registered for Apollo training and this was then cancelled by the Trust.

Not all info previously available was provided. e.g. appraisals performed.

Having said that enough information to complete the appraisal"

It would be helpful to get information on Theatre activity and inpatient activity for the appraisal period is provided by the Informations department. I had to create my own from Bluespier for theatre activity.

[redacted] is very organised and methodical.

Information was a little late arriving (activity info)

Well prepared

really good support to access info

Well versed in the system and the documentation provided (despite the poor system itself)

It was organised at a conducive time

A very useful appraisal meeting with [redacted].

The trust in now providing Theatre case mix data/ complaints/ training etc all in good time which is a noticeable improvement.

I found this appraisal system rather different from the previous appraisal systems that I have had to use over the years and not quite as straight forward. In fact, had I not coincidentally spoken to [redacted] on the Friday before the appraisal, I would have missed the final steps I needed to complete prior to the submission of my initial appraisal paperwork.

All the trust information was provided to me in a timely manor.

Unfortunately attempts(by me and my secretary) at uploading most of the relevant supporting documents repeatedly failed.

Unable to obtain data from SATH this year.

a rather long time consuming process but support from from [redacted] was outstanding

Appraisee feedback on Appraisers Ability to prepare review and help with development.

[redacted] is an excellent appraiser

Good preparation prior to meeting
a very good appraiser, well prepared, gave helpful guidance for pdp
no complaints
[redacted] has been patient and supportive in his guidance to help me with my appraisal. His evaluation has been extremely thorough and without bias. I have enjoyed the appraisal once the form was done.
I was put to ease right from the beginning. We discussed my PDP and I received lot of insight into my practice and also was encouraged to reflect on my practice.
My fault that the appraisal documents were late arriving with [redacted].
My appraiser had clearly gone through my input form in much detail. This allowed a constructive review to take place.
[redacted] is a very thorough appraiser. There is no rush during the process. He listens and gives sensible and workable feedback. A strongly recommended appraiser.
[redacted] successfully identified the potential challenges at this period of my life. Well done for steering the conversation in encouraging and friendly manner.
Extremely engaging and useful appraisal discussion. Was very accommodating, and provided a useful platform for shared reflection on my first year as a consultant. Achievable PDP goals which will help to benefit my practice.
[redacted] explained the process to me in advance and helped me to prepare accordingly. The process was smooth and helpful. Thank you very much.
Really meaningful discussion and mentoring by my appraiser.
Well prepared and good understanding of the Prem IT interface
"Was able to identify areas that we needed to discuss.
Open conversation.
Realistic debate. "
[redacted] is a very positive and kind appraiser!
[redacted] is a very thorough, conscientious and supportive appraiser.
[redacted] was very well prepared and had obviously read all my submitted information and was genuinely interested in the work and the clinics that we run within the trust. He had a very good grasp of the complexity of the [redacted] patients and the requirements of the MDT and overall was a very helpful and well lead appraisal meeting.
I cannot overstate how good my appraiser is. He has great understanding of the importance of the process and undertakes it diligently.
"Well prepared and professional.
Good empathy and constructive feedback."
[redacted] has appraised me for 4 consecutive years. He has been very flexible in accommodating my requests and dates for my appraisals especially when I had to defer my date due to illness. [redacted] has been very understanding and empathic and has a lot of patience to listen to my side of the story and give a positive feedback. He has been very professional as a appraiser. He is also a very good colleague that I can count on when I need sound anaesthetic advice professionally.
Robust and personable approach.
[redacted] is a very experienced appraiser with a holistic view of the appraisal process.
[redacted] had prepared thoroughly and ensured reflection on my practice during the appraisal.
[redacted] was very professional and, at the same time, he helped to relax and focus on reflections and discussion. Questions were open and allowed sufficient time and independent reflection.

[redacted] is an excellent and experienced appraiser .
I appreciate having a wise and senior colleague to review my practice.
[redacted] was very thorough and constructive in the appraisal process
Helpful and holistic review
Excellent appraiser
[redacted] was very thorough. He had already gone through the form and was well prepared for the appraisal discussion.
[redacted] is very helpful and goes through all the input form in details and also has detailed review of the supportive documents attached. He encourages the appraisee to talk and also mentors in a way that appraisee feels supported. I have learned a lot by my all my recent appraisals and it helped me to improve. His lovely and supportive conduct encourage the best out of the appraisal.
Excellent appraiser. Enjoyed the informal setting and discussion whilst ensuring all topics are thoroughly covered. Insightful reviewer
Excellent communication skills
excellent appraiser, listened, asked appropriate questions, supportive
Excellent appraisal, [redacted] had reviewed all my information before hand and the appraisal was more of a chat and discussion. Nicely done.
An excellent appraisal that covered the breadth of my practice. [redacted] was superb in his insightful approach to my PDP and the challenges of my professional life.
Constructive comments made. Provided a good oversight of my current practice
"Very specific to point
He highlighted my achievements over alst year and half and encouraged me to achieve further and have a right direction in my career"
Many thanks for very supportive discussion.
"excellent, thorough appraisal
[redacted] had spent time, at short notice preparing for my appraisal and was very well informed in terms progress from my appraisal last year"
[redacted] took the time to discuss with me key points in not only improving my practise but documenting and presenting my improvement, quite important for future appraisals especially in a senior role.
very knowledgeable and competent appraisor
[redacted] was very professional and empathetic throughout the meeting. He has strong organisational skills and a very good methodical approach.
Amol is thorough and very organised. He was very supportive.
It has been difficult to find time to complete the appraisal, in part because doing appraisals is not job-planned for appraiser
"[redacted] as a colleague is good in his clinical acumen.
This is my first appraisal with him and he helped me to improve my documentation during the feedback and the meeting . He has a thorough and detailed approach "
[redacted] is an excellent appraiser. She is well prepared, takes time, is fair and approachable. She helps see through complex issues and is able to help me keep things in perspective.
[redacted] is without doubt one of the best appraisers that I had over the years. She was genuinely interested in my career and she made the best possible use of the inherent appraisal system that I have experienced so far.
[redacted] had clearly done lots of preparation for the appraisal and I was really grateful for her time and experience.

I truly appreciate her work as a medical appraiser. She was well-prepared and conducted a thorough assessment with empathy, aiming to foster continuous improvement while upholding the highest standards of care. Additionally, she was extremely supportive and constructive, providing feedback in a way that encouraged growth and professional development. She effectively identified strengths and addressed areas for improvement, always focusing on helping me advance in my practice.
I have a good personal and professional relationship with Hany.
Excellent appraiser.
[redacted] was very thorough and made sure that all relevant criteria was included in the discussion. She was kind and made me feel at ease whilst the discussion was taking place.

Appraisee`s feedback comment on usefulness of Appraisal.
same old
Very fruitful discussion and an outcome which was satisfactory to both of us. It is pity that [redacted] is leaving the organisation as he was a very good appraiser
Very professional and thorough. No stone left unturned.
The pdp is a useful check point to put myself in perspective.
clear goals for next year.
Really meaningful discussion and mentoring by my appraiser.
timely and useful
It is always useful to reflect on the past year, both from a professional and personal development plan. The achievements and the aspirations for the next year and look at achievable goals. It was good to discuss these and take time to think about what would be my next step and next projects to focus on.
[redacted] is a very supportive and thorough appraiser.
The value of an appraisal by a non surgical medical colleague is high. Perspective is probably the most useful element.
An enjoyable and beneficial appraisal as with all my appraisals with [redacted].
The discussion was appropriate and focused on GMC-defined pillars defining good medical practice. It also allowed personal reflection. It was not rushed and allowed appropriate time for reappraisal.
[redacted] always helped me with my future personal and professional development plan.
Helpful to reflect on a wide variety of issues with a senior colleague,
I don't find appraisals especially useful
A very enjoyable discussion. Many thanks for your time
"[redacted] has been very thorough in the appraisal discussion process and planning for the PDP for the next year. We had a very healthy discussion and he was very supportive. He advice me on my PDP also.
A very efficient and capable appraiser. "
"[redacted] was prepared well for my appraisal and has helped me to develop next your next years PDP and suggested how to prepare for revalidation.
Overall appraisal has been a wonderful experience due to [redacted] mentorship during appraisal process."
Very helpful to be appraised by a colleague who is not a surgeon. Provided insights and insightful discussion
Excellent appraiser! Felt at ease and could discuss any work related topic without time pressures.
Very comfortable and useful session, good discussion and advice from [redacted].
The prep work put in by [redacted] prior to the meeting facilitated a comprehensive review of my supporting information and my practice

"I now know the Revalidation and Renewal are two different entities of GMC.
My revalidation is due in Oct 2026"
Thank you
Genuine and constructive discussion.
very positive
The appraisal helped me to improve my professional development and prepare for revalidation. The new PDP involved around NICE guidelines which would be very helpful to the trust.
Very happy with the appraisal.
Our face-to-face appraisal discussion was very useful for aspect mentioned above.
[redacted] has excellent communication skills, it was a privilege to have a one to one discussion covering my practice in the last year[redacted] made a number of useful suggestions for my progress in the next year.
Excellent appraiser and appraisal process. Thank you. [redacted]er was knowledgeable in the appraisal process and the appraisal discussion was very helpful. I appreciate the time, effort and expertise required.
My recent appraisal discussion was well-structured, supportive, and reflective, with a focus on both professional development and improving patient care. It helped me recognize my strengths as well as the areas that need enhancement. Additionally, it enabled me to set a clear plan for my future development.
Detailed and very good discussion, which analyzed my fellowship program, daily work, personal development, progress, challenges, future and my integration into the department.

Executive Summary - Finance & Performance 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 varitation (high or low) or 3 months better than target				18 Weeks RTT Open Pathways Time to First Appointment - English Patients Total Outpatient Activity - % Moved to PIFU Pathway
No significant change or N/A to SPC	18 Week Perf - Difference Planned v Actual	Report Turnaround Times		Total Theatre Activity Against Plan Total Outpatient Activity Against Plan Financial Control Total Income Efficiency Delivered Capital Expenditure Implied Productivity
Concerning variation (high or low) or 3 months off target		New to Follow Up Ratio	% Combined BADS Performance Bed Occupancy - All Wards - 2pm	English List Size Welsh List Size Time to First Appointment - Welsh Patients % Patients Waiting Over 52 Weeks - English Patients Patients Waiting Over 104 Weeks - Welsh 6 Week Wait for Diagnostics - English 8 Week Wait for Diagnostics - Welsh Theatre Cases per Session Touchtime Utilisation Elective Activity Against Plan Total Outpatient Activity - % Virtual Total Diagnostic Activity Against Plan

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.

Trust Board - Performance
September 2025 – Month 6

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

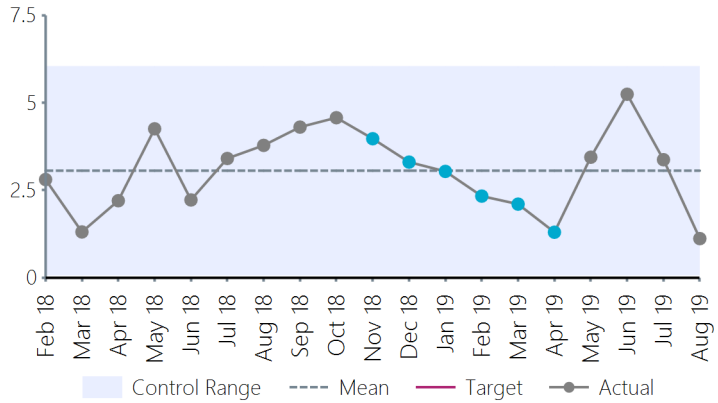
Some examples of these are shown in the images to the right:

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

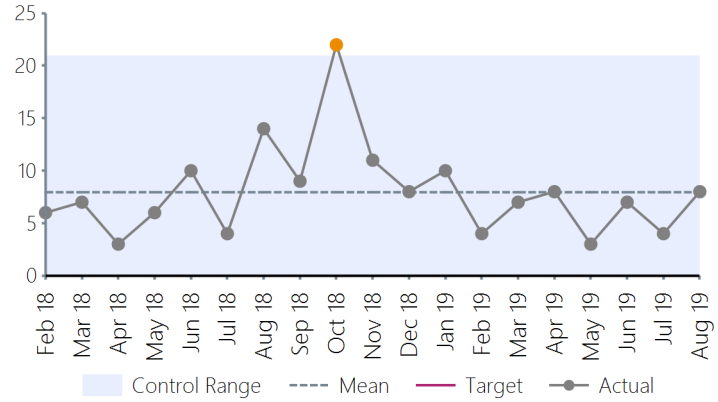
b) shows a point of concern sitting above the control range.

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.

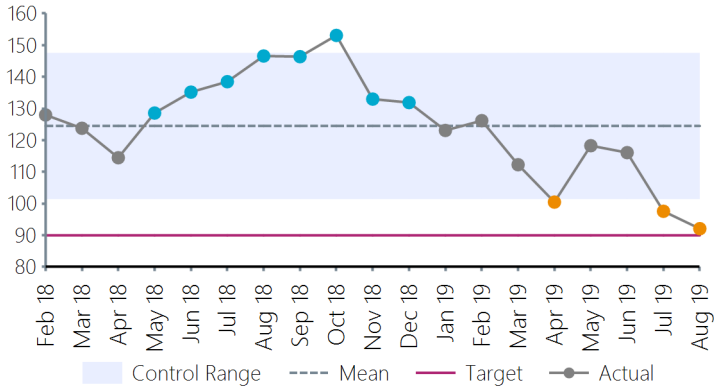
a)



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
31 Day General Treatment Standard*	96.00%	100.00%		H	?		
62 Day General Standard*	85.00%	44.44%	100.00%		?	+	12/09/23
28 Day Faster Diagnosis Standard*	77.00%	79.66%	83.33%		Moving Target	+	12/09/23
18 Weeks RTT Open Pathways	47.49%	52.72%		H	Moving Target	+	24/06/21
18 Week Performance - Difference Between Planned and Actual	0.00%	5.23%		N/A to SPC	P	+	
Time to First Appointment - English Patients	60.90%	69.01%		N/A to SPC	Moving Target	+	
Time to First Appointment - Welsh Patients		45.20%		N/A to SPC	No Target	+	
% of Patients Waiting Over 52 Weeks - English	5.57%	6.95%			Moving Target	+	
Patients Waiting Over 104 Weeks - Welsh (Total)		357		H	No Target	+	
6 Week Wait for Diagnostics - English Patients	95.00%	89.24%	79.38%	H	Moving Target	+	04/03/24

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
8 Week Wait for Diagnostics - Welsh Patients	100.00%	95.09%		H	F	+	04/03/24

Summary - Caring for Finances

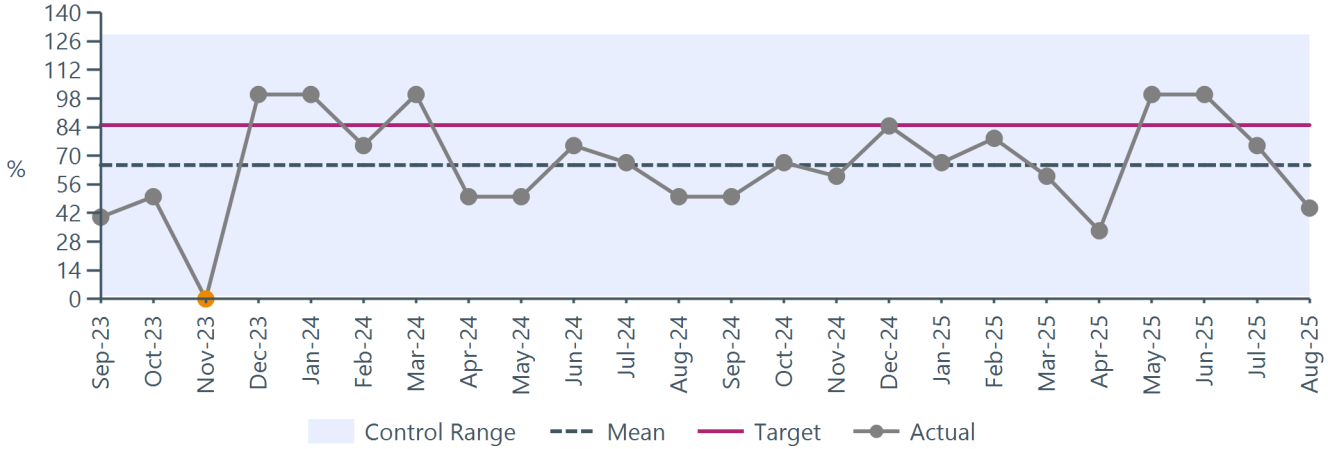
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Elective Activity Against Plan (volumes)	1,249	1,091			Moving Target	+	24/06/21
% Combined BADS Performance	85.00%	39.10%			F	+	
Total Outpatient Activity against Plan (volumes)	14,780	13,620			Moving Target	+	24/06/21
Total Outpatient Activity - % Moved to PIFU Pathway	6.60%	7.53%		H	Moving Target	+	
Total Diagnostics Activity against Plan - Catchment Based	2,904	2,649			Moving Target	+	

62 Day General Standard*

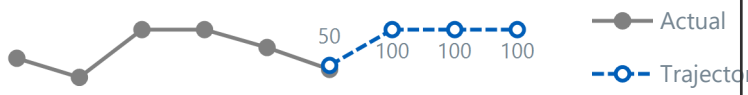
From receipt of an urgent GP referral for urgent suspected cancer, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer. National Target. Trajectory as per Trust's Operational Plans. 217831

Exec Lead: Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	44.44%		



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 44.44% in August; this is reported in arrears. Of the patients reported against this standard, RJAH was accountable for the following breaches:
* 0.5 - Patient referred out to other Provider on day 50, 12 days after the cut off point of day 38. Patient required MRI which patient received on day 19 due to MRI capacity, USS biopsy and an off-diary CT, this was then discussed at GMOSS and referred to GMOSS on day 50.
* 1.0 - Tumour Assistant Service Manager to query this with other Provider as we believe the whole breach should not be allocated to RJAH. Patient was informed of a diagnosis on day 26 and was sent to other Provider on day 30 which is before the day 38 cut off point.
* 1.0 - Tumour Assistant Service Manager to query this with other Provider as we believe the whole breach should not be allocated to RJAH. Patient was informed of a diagnosis on day 38, then referred to other Provider on day 39 where they were treated by day 53.

Actions

Assistant Service Manager for Tumour Service to liaise with other Trusts regarding allocation of breaches.

Robust process now in place with radiology to ensure MRIs are dated at the earliest opportunity.

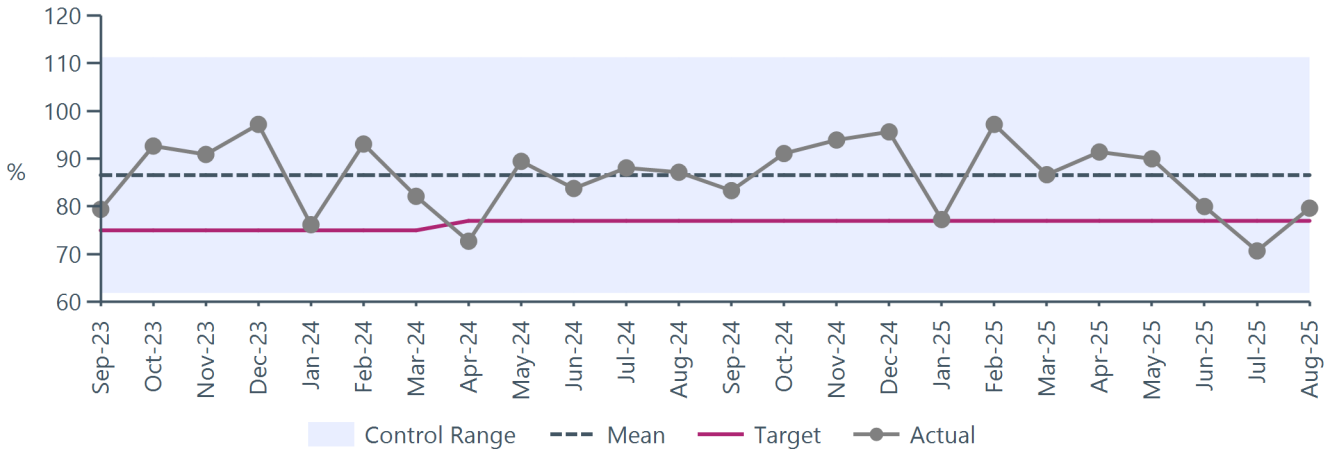
Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
50.00%	66.67%	60.00%	84.62%	66.67%	78.57%	60.00%	33.33%	100.00%	100.00%	75.00%	44.44%	

28 Day Faster Diagnosis Standard*

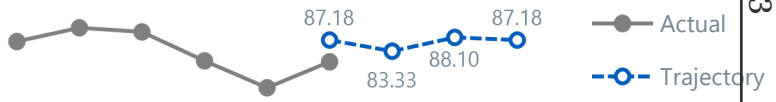
% of patients informed of a diagnosis or ruling out of cancer within 28 days. National Target. Trajectory as per Trust's Operational Plans. 217484

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
77.00%	79.66%		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 28 Day Faster Diagnosis Standard is reported at 79.66% in August; this is reported in arrears. This meets the national target of 77% but the Trust had forecast 87.18% within the Operational Plan. There were 59 patients throughout the month, where 12 of those were breaches due to:

* MRI capacity delays (6)
* Awaiting histology results from biopsies after multiple diagnostics (2)
* Patients delays / DNAs (3)
* Late referral from another Provider (1)

Actions

Robust process now in place with radiology to ensure MRIs are dated at the earliest opportunity. August was impacted by scanner availability.

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
83.33%	91.11%	93.94%	95.65%	77.27%	97.22%	86.67%	91.43%	90.00%	80.00%	70.69%	79.66%	

18 Weeks RTT Open Pathways

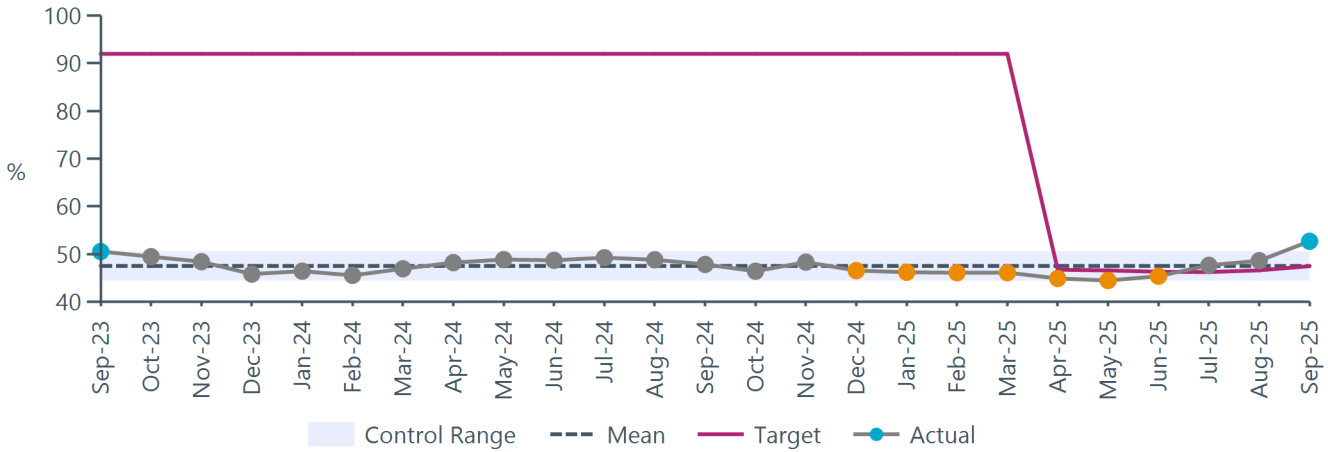
% of English patients on waiting list waiting 18 weeks or less 211021

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
47.49%	52.72%	H	Moving Target

Trajectory

Actual
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

2025/26 English National Planning Guidance stipulates that every organisation should improve their 18-week performance by 5% as a minimum and all Trusts to achieve 60%. The Trust's Operational Plan forecasts a position of 60% by the end of March 2026 and is visible in the graph above.

Our September performance was 52.72% for patients waiting 18 weeks or less to start their treatment. This was 5.23% better than the position of 47.49% that was planned for the end of September. As shown on the SPC above, this metric is now indicated as special cause of an improving nature. There has been a 7.80% improvement from the end of April to this latest position. This metric is included in the NOF where the latest position for June scored the Trust at 4.

The performance breakdown by milestone is as follows:
* MS0 - 131 patients of which 15 are breaches
* MS1 - 9395 patients waiting of which 2965 are breaches
* MS2 - 1893 patients waiting of which 1284 are breaches
* MS3 - 5666 patients waiting of which 3814 are breaches

Actions

Ongoing actions includes the following:
* Close working with the GIRFT team continues as part of a continuous improvement focus. The Trust has more recently worked with the GIRFT team for a bespoke review of our outpatient areas. Recommendations were reviewed with the team in September 2025 and are being progressed with dedicated GIRFT leads to support. A bespoke review of our Theatres and pre-op services is also planned for. This is scheduled for November 2025.
* Insourcing work continues.
* Validation work ongoing; this encompasses clinical and technical validation at a patient level.
* Additional booking support from MBI to support increased activity.
* Development of complex Pain Service continues with a plan to roll out the service in Quarter Three. Range of recruitment is underway.

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
47.86%	46.44%	48.35%	46.57%	46.22%	46.12%	46.14%	44.92%	44.49%	45.39%	47.68%	48.64%	52.72%

18 Week Performance - Difference Between Planned and Actual

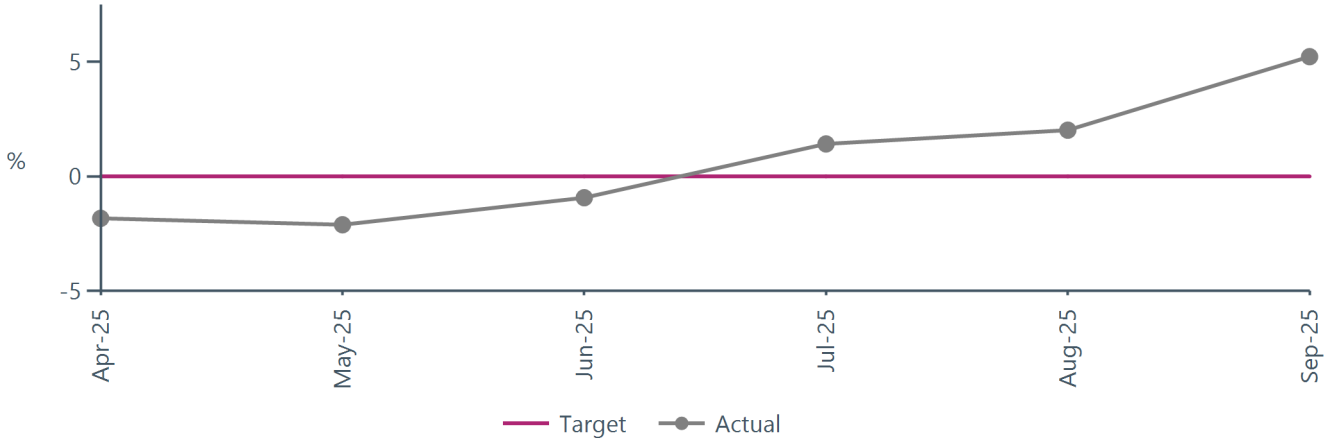
Difference between planned and actual 18 week performance 217889

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0.00%	5.23%	N/A to SPC	P

Trajectory

Actual
Trajectory



What these graphs are telling us

This is currently reported as a line graph until there are sufficient data points to transition it to SPC. Metric is consistently meeting the target.

Narrative

This is a new metric added this month to ensure the IPR reflects those that form part of the National Oversight Framework (NOF).

The latest NOF Publication relates to Quarter 1 where the NOF score for this metric is 3; this reflected the June-25 position where the Trust was 0.93% less than it planned to be.

At the end of September, the position reported at September month end is 52.72%; this is 5.23% better than the plan of 47.49%. Indication from a recent Model Hospital Masterclass on NOF advised that the next publication is likely to be the end of November and it will be this September month end position reported.

Actions

Ongoing actions includes the following:
* Close working with the GIRFT team continues as part of a continuous improvement focus. The Trust has more recently worked with the GIRFT team for a bespoke review of our outpatient areas. Recommendations were reviewed with the team in September 2025 and are being progressed with dedicated GIRFT leads to support. A bespoke review of our Theatres and pre-op services is also planned for. This is scheduled for November 2025.
* Insourcing work continues.
* Validation work ongoing; this encompasses clinical and technical validation at a patient level.
* Additional booking support from MBI to support increased activity.
* Development of complex Pain Service continues with a plan to roll out the service in Quarter Three. Range of recruitment is underway.

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
							-1.83%	-2.11%	-0.93%	1.42%	2.02%	5.23%

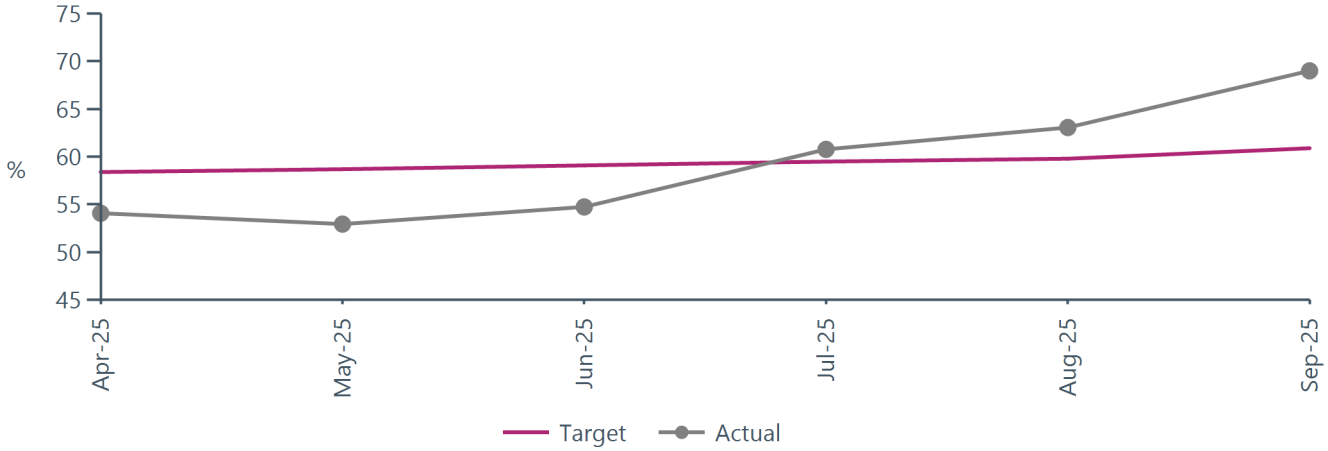
Time to First Appointment - English Patients

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 Officer

Target/Plan	Latest Value	Variation	Assurance
60.90%	69.01%	N/A to SPC	Moving Target

Trajectory



What these graphs are telling us

This is not applicable to SPC until there are sufficient data points. 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 28th September 2025. NHSE Guidance stipulates the week ending positions we should officially report that fall closest to month end. This is an unvalidated position.

2026/26 English National Planning Guidance stipulates that every organisation should improve their 18-weeks for a first appointment performance by 5% as a minimum and all Trusts to achieve 67%. The Trust's Operational Plan forecasts a position of 67% by the end of March 2026.

For week ending 28th September 69.01% of patients waiting for first appointment were under 18 weeks; 8.11% above the 60.90% plan. As shown on the SPC graph above, we've now been reporting this since April where in that period there has been a 14.92% improvement. The data is reviewed at the weekly Outpatient Activity meeting at sub-speciality level. Performance ranges from 52.20% in Spinal Disorders to 100% in Occupational Therapy & Paediatric Rheumatology.

Actions

Ongoing actions includes the following:
* Close working with the GIRFT team continues as part of a continuous improvement focus. The Trust has more recently worked with the GIRFT team for a bespoke review of our outpatient areas.
* Insourcing work continues.
* Validation work ongoing; this encompasses clinical and technical validation at a patient level.
* Additional booking support from MBI to support increased activity.
* Development of complex Pain Service continues with a plan to roll out the service in Quarter Three. Range of recruitment is underway.
* List size increase in Metabolic Medicine/DEXA - not yet had the full benefit of additional scanner due to sickness and vacancies. Anticipate this to improve from October. Following this, some work on pathway redesign to be undertaken.

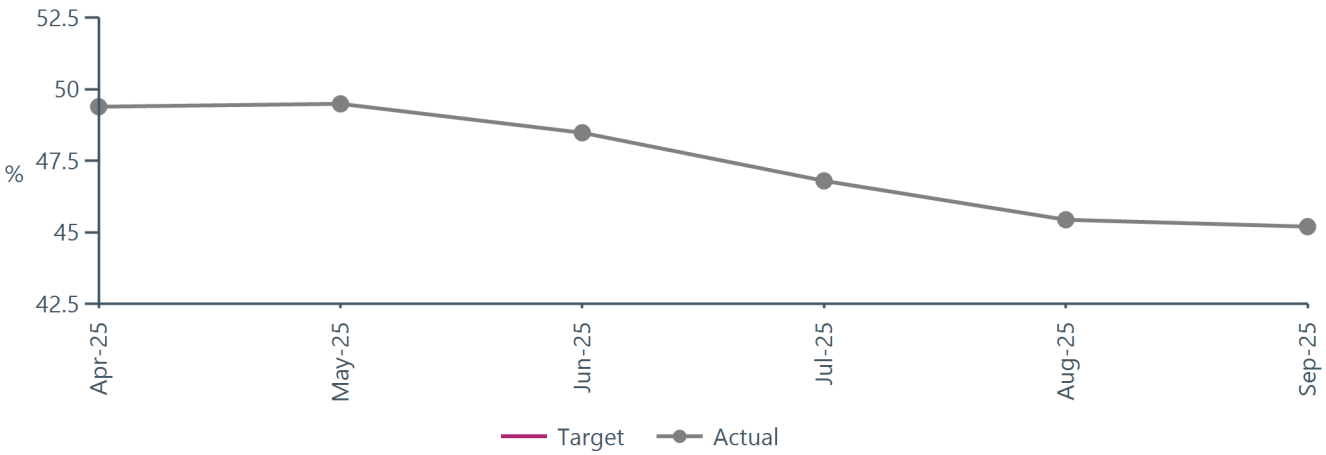
Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
							54.09%	52.95%	54.75%	60.78%	63.07%	69.01%

Time to First Appointment - Welsh Patients

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 that 1 217880

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	45.20%	N/A to SPC	No Target



Trajectory

Actual
Trajectory

What these graphs are telling us

This is not applicable to SPC until there are sufficient data points. The metric has no target.

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 28th September 2025. NHSE Guidance stipulates the week ending positions we should officially report that fall closest to month end. This is an unvalidated position. This metric forms part of English expectations. For week ending 28th September 45.20% of Welsh patients waiting for first appointment were under 18 weeks; there is no plan for Welsh patients. Performance ranges from 23.17% in Spinal Disorders to 100% in Occupational Therapy, Paediatric Rheumatology, Occupational Therapy & Spinal Injuries.

2025/26 Welsh activity profiles continue to be discussed with Welsh Health Boards, that will impact list size. Since July there are expectations from Powys Health Board to provide first appointment no sooner than 52 weeks that the Trust is not in agreement with due to the potential for clinical risk. Despite Exec to Exec discussions, there is still no agreement on this.

For other Welsh Health Boards, the Trust continues to work with maximum waits standards set out in Welsh Assembly expectations of 52 weeks for Outpatient Activity and 104 weeks for Inpatient Activity.

Actions

Ongoing actions includes the following:
* Close working with the GIRFT team continues as part of a continuous improvement focus. The Trust has more recently worked with the GIRFT team for a bespoke review of our outpatient areas.
* Insourcing work continues; from October the Trust has extended this for Welsh patients in Rheumatology and Paediatric Orthopaedics
* Validation work ongoing; this encompasses clinical and technical validation at a patient level.
* List size increase in Metabolic Medicine/DEXA - not yet had the full benefit of additional scanner due to sickness and vacancies. Anticipate this to improve from October. Following this, some work on pathway redesign to be undertaken.
* Deep dive into Welsh patients has been prepared by Special Unit General Manager for oversight and discussion at ARC. This outlines the position by milestone. Spinal Disorders and Paediatric Orthopaedics are the two areas with the biggest pressures in milestone 1. For Paediatrics, a deep dive has been undertaken to assess the clinics required to bring Welsh waits down in milestone 1 with a trajectory to be in place by the end of October. Within Spinal Disorders, the demand continues to outweigh our capacity.

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
							49.39%	49.49%	48.48%	46.80%	45.44%	45.20%

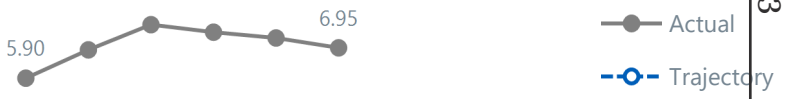
% of Patients Waiting Over 52 Weeks - English

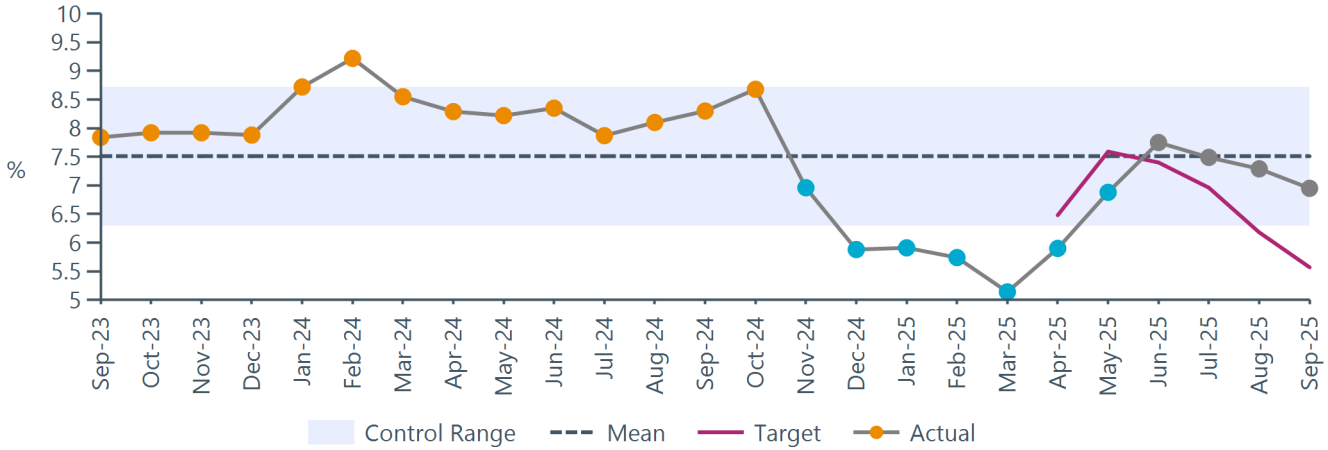
The number of English patients waiting over 52 weeks as a proportion of the English List Size. 217874

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
5.57%	6.95%		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

2025/26 English National Planning Guidance stipulates that every organisation should reduce the volume of patients waiting over 52 weeks to <1% of their list size. The Trust's Operational Plan forecasts a position of 1% by the end of March 2026. As the graph shows, there was substantial reduction at the end of last year but that has gradually increased between April and June. At the end of September 6.95% of the English list size is patients waiting over 52 weeks, this is above our plan of 5.57% (negative). This metric is part of the NOF, with the latest score for Quarter 1 reported at 3.98 for the June month end position of 7.75%. Indication from a recent Model Hospital Masterclass on NOF advised that the next publication is likely to be the end of November and it will be this September month end position reported.

The volume of patients waiting over 52 weeks equates to 1188, a reduction of 51 from the end of August. The sub-specialties with the highest volume of patients are; Spinal Disorders (319), Arthroplasty (274) and Knee & Sports Injuries (211). Patients waiting, by weeks brackets is:

* >52 to <=65 weeks - 1041 patients
* >65 to <=78 weeks - 140 patients
* >78 weeks - 7 patients

Actions

Ongoing actions includes the following:

* Close working with the GIRFT team continues as part of a continuous improvement focus. The Trust has more recently worked with the GIRFT team for a bespoke review of our outpatient areas. Recommendations were reviewed with the team in September 2025 and are being progressed with dedicated GIRFT leads to support. A bespoke review of our Theatres and pre-op services is also planned for. This is scheduled for November 2025.
* Insourcing work continues.
* Validation work ongoing; this encompasses clinical and technical validation at a patient level.
* Additional booking support from MBI to support increased activity.
* Development of complex Pain Service continues with a plan to roll out the service in Quarter Three. Range of recruitment is underway.
* List size increase in Metabolic Medicine/DEXA - not yet had the full benefit of additional scanner due to sickness and vacancies. Anticipate this to improve from October. Following this, some work on pathway redesign to be undertaken.

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
8.30%	8.68%	6.96%	5.88%	5.91%	5.74%	5.14%	5.90%	6.88%	7.75%	7.49%	7.29%	6.95%

Patients Waiting Over 104 Weeks - Welsh (Total)

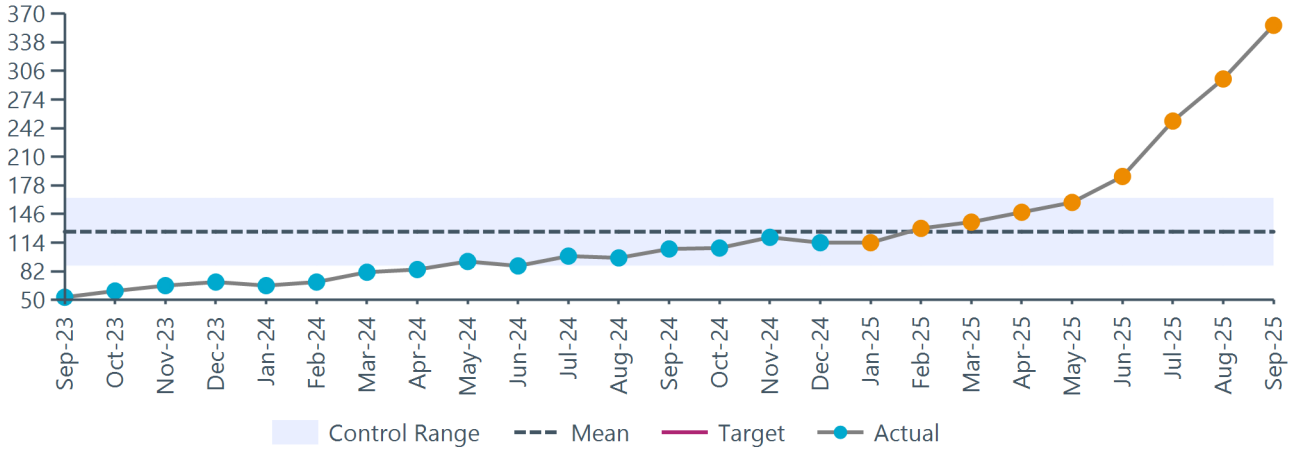
Number of Welsh RTT patients waiting 104 weeks or more at month end 217803

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	357	H	No Target

Trajectory

Actual
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 September there were 357 Welsh patients waiting over 104 weeks. The patients are under the care of these sub-specialities; Spinal Disorders (249), Knee & Sports Injuries (42), Arthroplasty (32), Foot & Ankle (31), Hand & Upper Limb (2) and Neurology (1).

2025/26 Welsh activity profiles continue to be discussed with Welsh Health Boards, that will impact list size. Since July there are expectations from Powys Health Board to provide first appointment no sooner than 52 weeks that the Trust is not in agreement with due to the potential for clinical risk. Despite Exec to Exec discussions, there is still no agreement on this.

For other Welsh Health Boards, the Trust continues to work with maximum waits standards set out in Welsh Assembly expectations of 52 weeks for Outpatient Activity and 104 weeks for Inpatient Activity.

Actions

Ongoing actions includes the following:
* Close working with the GIRFT team continues as part of a continuous improvement focus. The Trust has more recently worked with the GIRFT team for a bespoke review of our outpatient areas. Recommendations were reviewed with the team in September 2025 and are being progressed with dedicated GIRFT leads to support. A bespoke review of our Theatres and pre-op services is also planned for. This is scheduled for November 2025.
* Insourcing work continues; from October the Trust has extended this for Welsh patients in Rheumatology and Paediatric Orthopaedics
* Validation work ongoing; this encompasses clinical and technical validation at a patient level.
* List size increase in Metabolic Medicine/DEXA - not yet had the full benefit of additional scanner due to sickness and vacancies. Anticipate this to improve from October.
* Deep dive into Welsh patients has been prepared by Special Unit General Manager for oversight and discussion at ARC. This outlines the position by milestone. Spinal Disorders and Paediatric Orthopaedics are the two areas with the biggest pressures in milestone 1. For Paediatrics, a deep dive has been undertaken to assess the clinics required to bring Welsh waits down in milestone 1 with a trajectory to be in place by the end of October. Within Spinal Disorders, the demand continues to outweigh our capacity.

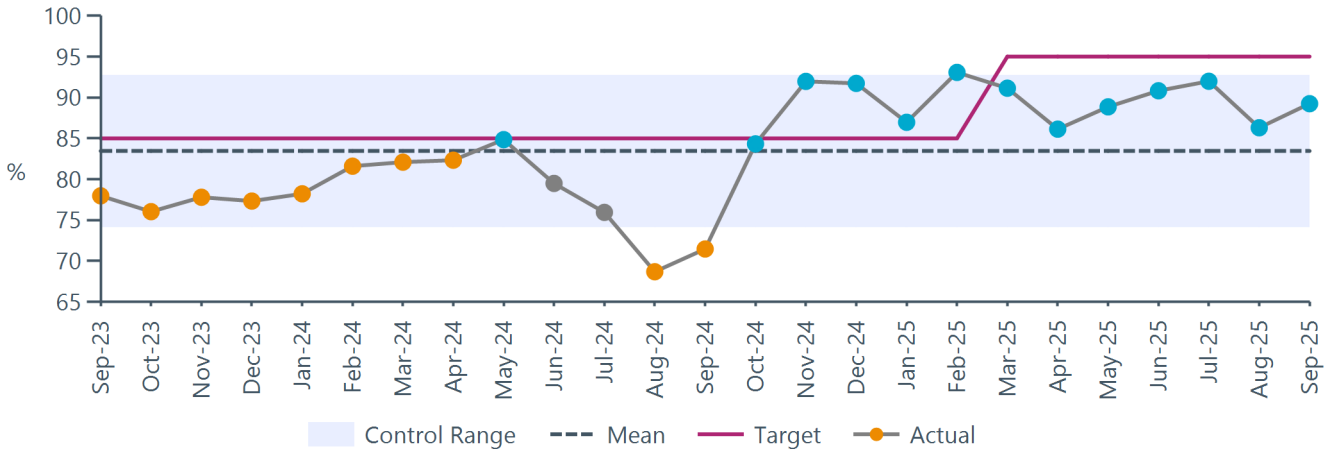
Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
107	108	120	114	114	130	137	148	159	188	250	297	357

6 Week Wait for Diagnostics - English Patients

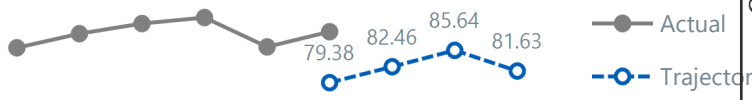
% of English patients currently waiting less than 6 weeks for diagnostics. National Target with Trajectory as per Trust's Operational Plans. 211026

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
95.00%	89.24%	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.

Narrative

Performance for September is 89.24% against the 95% target. This position is above the trajectory for September month end that was planned at 79.38% in the Trust's submitted Operational Plans. Reported position relates to 155 patients who waited beyond 6 weeks. Of the 6-week breaches; 16 are over 13 weeks, all within MRI.

Performance and breaches by modality:
* MRI – 90.23% - D2 (Urgent - 0-2 weeks) – 5 with 4 dated, D3 (Routine - 4-6 weeks) - 1 dated, D4 (Routine – 6-12 weeks) – 80 with 56 dated
* CT – 100%
* Ultrasound – 84.03% - D2 (Urgent - 0-2 weeks) - 6 dated, D4 (Routine - 6-12 weeks) - 63 with 60 dated
* DEXA Scans – 100%

None of the activity plans were met in September. National target – 0 patients waiting over 13 weeks by end of September 2024 and 95% against the 6-week standard within all modalities.

Actions

Ultrasound - New consultant has resumed full clinical duties. Additional weekend clinics are still being offered.

MRI - Staffing case of need has been completed and approved. Case for permanent MRI capacity aims to enhance service flexibility. Funding secured for additional mobile MRI activity for the current financial year. Working alongside MCSI to minimise future 13 week breaches.

CT – DM01 performance stands at 100%, indicating strong compliance – no immediate actions required.

Skill-mix optimisation within modalities to maximise efficiency and productivity.

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
71.47%	84.33%	91.97%	91.72%	86.97%	93.07%	91.13%	86.13%	88.85%	90.82%	91.98%	86.30%	89.24%

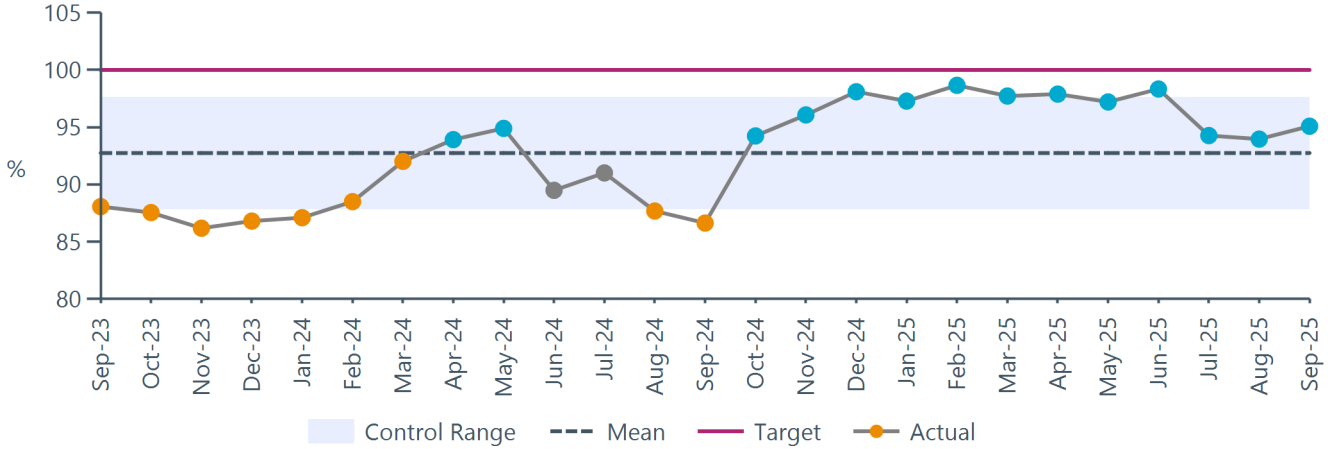
8 Week Wait for Diagnostics - Welsh Patients

% of Welsh patients currently waiting less than 8 weeks for diagnostics 211027

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
100.00%	95.09%	H	F

Trajectory



What these graphs are telling us

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

Narrative

The 8-week standard for diagnostics is reported at 95.06%. The reporting position includes 23 patients who waited beyond 8 weeks.

Performance and breaches by modality:
* MRI – 94.26% - D2 (Urgent - 0-2 weeks) - 1 dated, D4 (Routine - 6-12 weeks) – 28 with 22 dated
* CT – 100%
* Ultrasound – 98.21%
* DEXA Scans - 100%

None of the activity plans were met in September.

Actions

Ultrasound - New consultant has resumed full clinical duties. Additional weekend clinics are still being offered.

MRI - Staffing case of need has been completed and approved. Case for permanent MRI capacity aims to enhance service flexibility. Funding secured for additional mobile MRI activity for the current financial year. Working alongside MCSI to minimise future 13 week breaches.

CT – DM01 performance stands at 100%, indicating strong compliance – no immediate actions required.

Skill-mix optimisation within modalities to maximise efficiency and productivity.

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
86.63%	94.24%	96.07%	98.10%	97.28%	98.66%	97.72%	97.89%	97.20%	98.33%	94.27%	93.96%	95.09%

Elective Activity Against Plan (volumes)

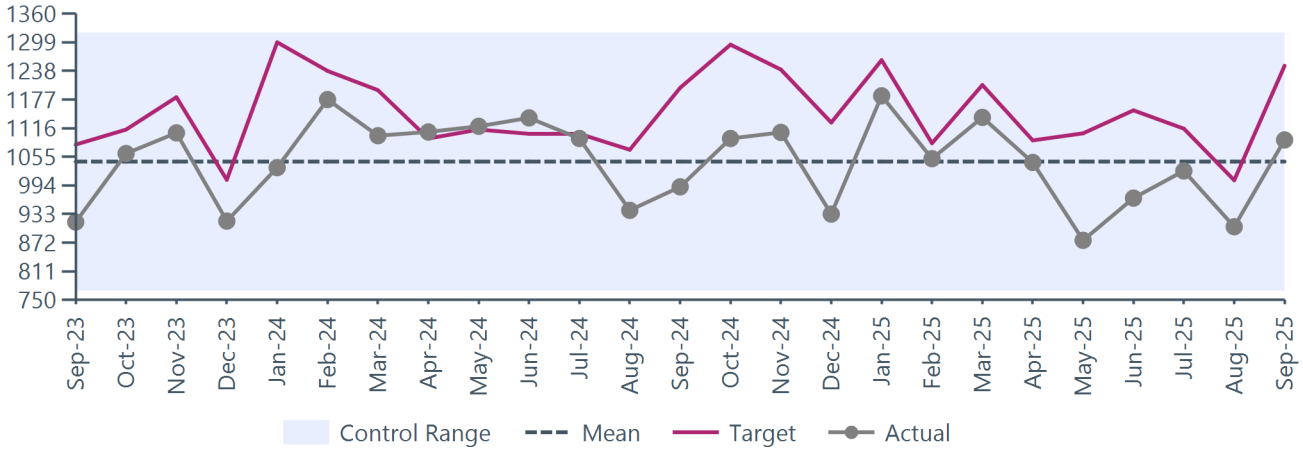
Total elective activity rated against plan. Target as per Trust's Operational Plans. 217796

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
1,249	1,091		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

Total elective activity is monitored against the 2025/26 elective spells plan set out in the NHSE activity submission.

For September 2025, the Trust planned for 1,249 elective spells, achieving 1091 spells, which equates to 87.35% performance — 158 spells below plan.

While some teams exceeded their planned activity levels in September, overall performance was offset by underachievement in some areas:

Spinal Injuries – 58.62%
Knee & Sports Injuries – 62.37%
Spinal Disorders – 68.42%

September's performance returned above the mean, with data remaining within statistical control limits. This indicates the presence of common cause variation.

Actions

* Theatre Availability in progress with focus on fixed sessions for weekends and evenings.
* Specific actions in relation to PP activity that will influence overall Theatre Activity.
* Limited levels of activity being undertaken at Independent Sector providers - this is not expected to deliver the levels of activity originally anticipated. Delivered activity in September was Nuffield Shrewsbury - 6 patients and Spire Yale - 8 patient. Ongoing usage of Independent Sector is to be reviewed to ensure it aligns with Insourcing arrangements and income.
* Insourcing with Portland Clinical commenced 20th September for additional Theatre Activity.
* Ongoing work regarding the temporary transfer of Orthopaedic activity from PRH to RJAH; commenced with regular sessions offered through 6-4-2 process.

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
991	1094	1107	933	1185	1051	1139	1043	877	967	1025	906	1091

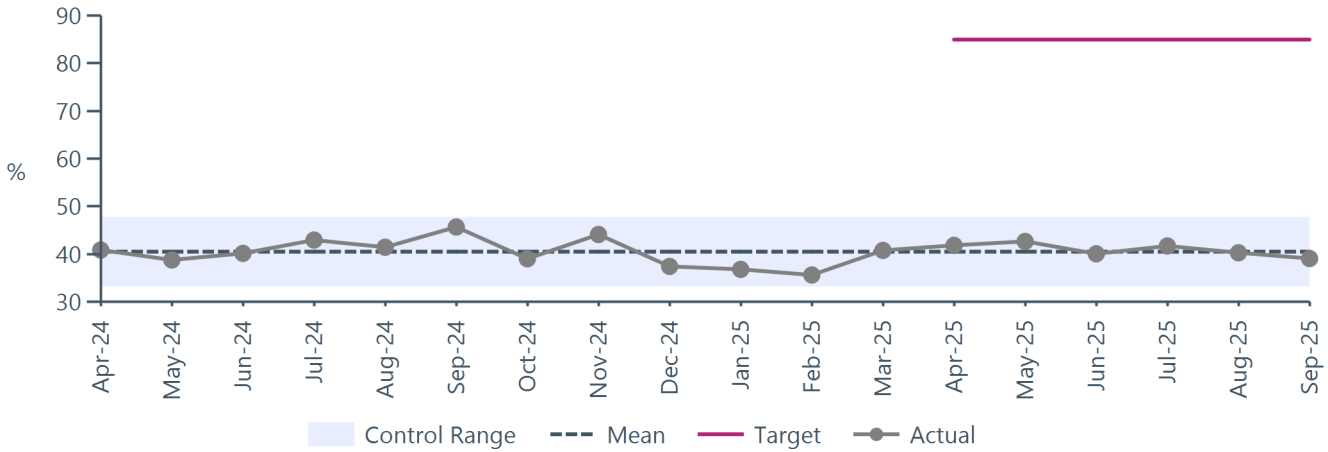
% Combined BADS Performance

Percentage of surgical procedures completed as a day case as a proportion of all procedures aligned with the British Association of Day Surgery (BADS) directory of procedures September 2024 Edition

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	39.10%		F

Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. Assurance indicates metric is consistently failing the target.

Narrative

This is a new metric for the 2025/26 period, using a revised methodology compared to previous reports. Historical data has been recalculated based on this new methodology and presented in the graph above.

The metric measures the percentage of Combined BADS Performance, aligned with the Orthopaedic and Urology sections of the BADS Directory of Procedures (September 2024 Edition). It continues to be monitored against the overall 85% target, set under the 2023/24 elective care NHSE planning guidance, reflecting the Trust's delivery of BADS day cases as a proportion of all BADS procedures undertaken.

In September, BADS performance was reported at 39.1%. If patients discharged on day zero—regardless of their intended management—were included, the metric would have reached 52.78%.

Although this metric consistently fails to meet the target it does report common cause variation with performance remaining stable around the mean since March 2025.

Actions

Since day-case rates vary significantly across different surgical procedures, it is recognised that, as a Specialist Orthopaedic Trust, the volume of Total Hip, Total Knee, and Uni-Knee arthroplasties performed at RJAH will impact the Trust's ability to achieve the overall 85% target. This makes it more challenging to attain high day-case rates compared to other surgical specialties. This has been raised and discussed with GIRFT and NHSE where it is recognised that this measure is not appropriate for this Trust. Alternative measure to be considered with assessment of what is monitored through the Model Health System.

The Trust is aiming for continuous improvements with Clinically led monthly day case surgery meeting. Data quality issues have been identified with Clinical audits and further investigations being undertaken:
* Focus on correct booking of high volume BADS procedures e.g. carpel tunnels.
* Retrospectively corrections have been made to obvious data quality errors but need to assess if Careflow allows this.
* Clinical Leads to raise correct booking of BADS procedures at team meetings.
* Case by case reviews on day case conversions.

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
45.71%	39.05%	44.14%	37.45%	36.83%	35.65%	40.80%	41.86%	42.69%	40.09%	41.74%	40.31%	39.10%

Total Outpatient Activity against Plan (volumes)

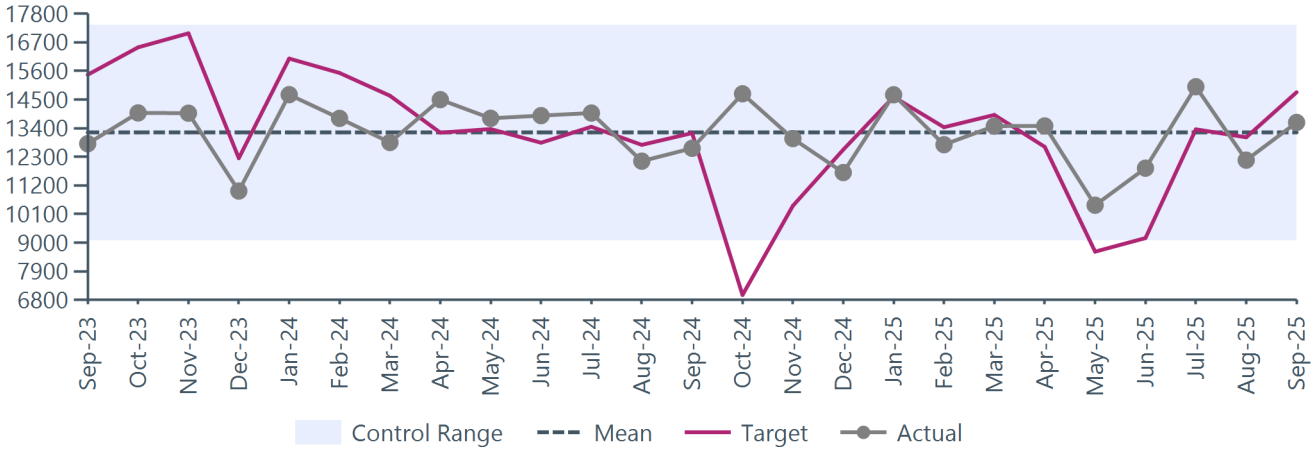
Total outpatient activity (consultant led and non-consultant led) against plan. Target as per Trust's Operational Plans. 217795

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
14,780	13,620		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 outpatient activity plan was not met in September and is reported -1160 of plan at 92.15%. A breakdown of Outpatient activity below:
* IJP activity was -1196 at 91.50%, * OJP activity was -24 at 93.58%, * Insourcing was +56 at 116.67%
Areas/reasons for under-performance includes:
* Rheumatology -lost capacity from sickness and missing outcomes; now actioned
* Some consultants continue to work to reduced clinic templates following implementation of the Apollo system (Arthroplasty & Paediatric Orthopaedics)
* Arthroplasty - Enhanced Recovery activity is not all recorded due to administrative capacity. Clinic template capacity - unlikely to return to FU capacity after Apollo implementation but addressing a return to levels of New appointments.
* Orthotics - Three clinical staff down with recent interviews not successful. Continue to experience issues with DNAs for activity undertaken at SATH as their text messaging process is not in place.
* Physiotherapy - the highest variance below plan (-564) - plan increased from Q3 following summer period. Review of activity undertaken has been carried out by Therapies Manager; issues identifying unbooked slots and assumption that MSST activity is displacing RJAH activity in group and hydro sessions.

Actions

* Apollo Impact - An options paper is being prepared by the Apollo Team to explore some of the processes in using Apollo that impact activity levels. It is anticipated this paper will be completed in October and taken to Clinical Reference Group, followed by Digital Transformation Board for discussions/decisions.
* Arthroplasty - Service Manager to liaise with Access Team to assess if there is any spare resource to log Enhanced Recovery activity, alternatively may need to explore training amongst the Enhanced Recovery Team. Additional Apollo training for consultants to address clinic template capacity and this remains a topic of discussion at firm meeting. Two new consultants were assumed in plan from September; these will now be in place in quarter four.
* Orthotics - Currently scoping Locum through Portland to address clinical capacity. Datix raised for issues with SATH appointments but no engagement yet. Unlikely to achieve October plan also.
* Physiotherapy - Assumed displacement of activity by MSST to be escalated to MSST delivery group, gaps in MSST reporting has already been escalated. Optimised booking staff to compensate for lengthy process for unbooked slots, but no additional capacity.

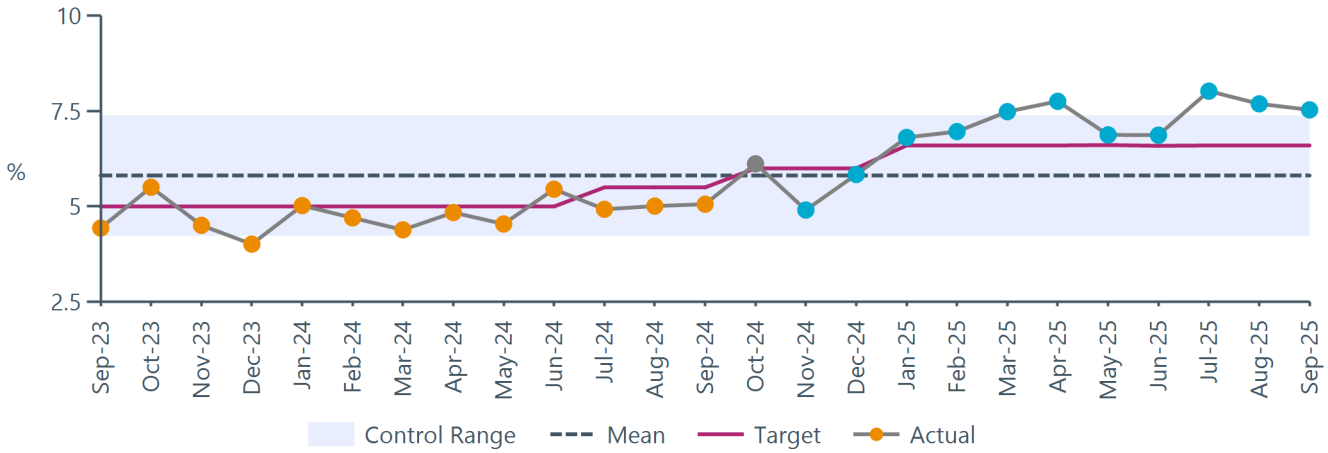
Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
12628	14723	13000	11696	14685	12767	13480	13486	10440	11863	14993	12171	13620

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
6.60%	7.53%	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 6.60% of all outpatients attendances. In September this was exceeded with 7.53% of total outpatient activity moved to a PIFU pathway. As demonstrated on the SPC above, this is the 9th month above target and displayed as special cause variation of an improving nature.

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.

As a Trust we have few very patients who are moved to PIFU as opposed to discharged to PIFU. Since go-live there has been some configuration issues with the outcome of attendance but the impact on our reported numbers is minimal.

Actions

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
5.06%	6.12%	4.91%	5.84%	6.81%	6.96%	7.49%	7.76%	6.88%	6.87%	8.02%	7.69%	7.53%

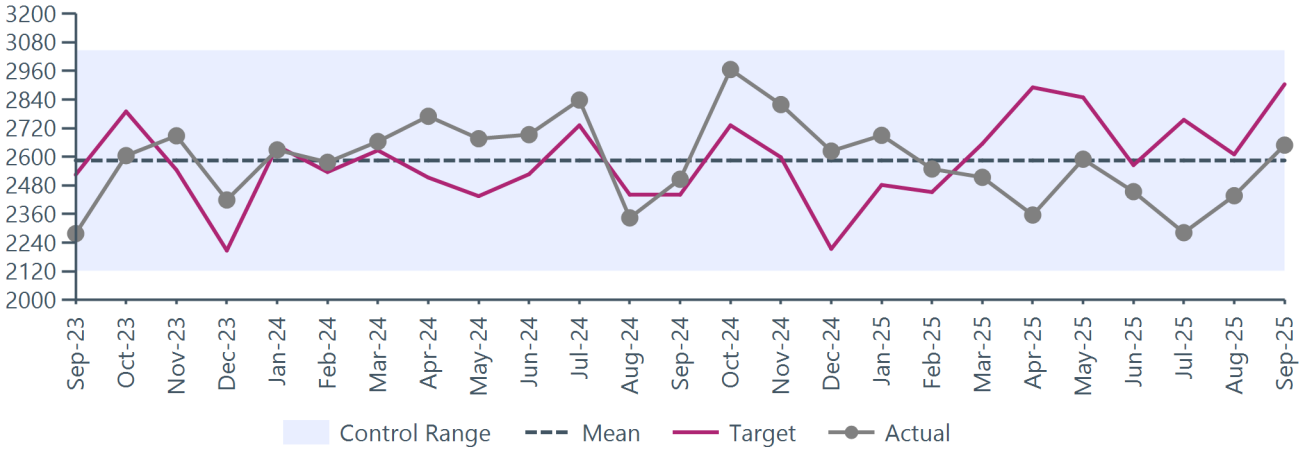
Total Diagnostics Activity against Plan - Catchment Based

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
2,904	2,649		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 Diagnostic activity plan was not met in September. Overall activity is reported at 91.22% with a breakdown as follows:
- MRI - 1494 against plan of 1503; equating to 99.40%
- U/S – 739 against 946; equating to 84.46%
- CT – 356 against plan of 455; equating to 78.24%

Actions

Ultrasound – New consultant has resumed full clinical duties. Additional weekend clinics are still being offered.

MRI - Staffing case of need has been completed and approved. Case for permanent MRI capacity aims to enhance service flexibility. Funding secured for additional mobile MRI activity for the current financial year.

CT – Funding for Locum/In-sourcing support to improve interventional activity.

Skill-mix within modalities to maximise efficiency and productivity.

The approval process for annual/study leave is under-review by Clinical Lead and Service Manager; meeting arranged to assess.

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
2506	2966	2819	2624	2690	2549	2514	2356	2590	2454	2282	2437	2649

Trust Board - Finance
September 2025 – Month 6

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

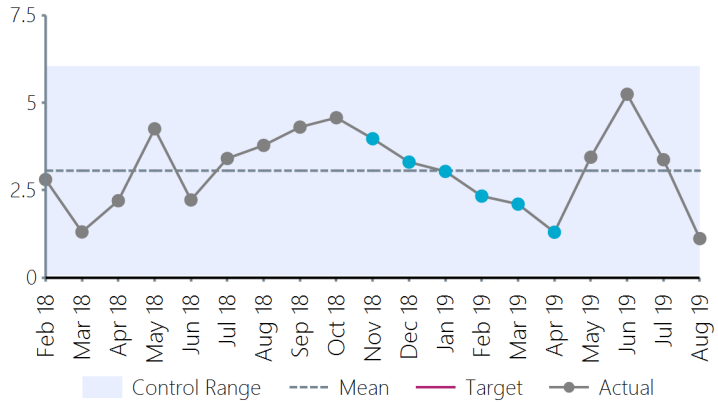
Some examples of these are shown in the images to the right:

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

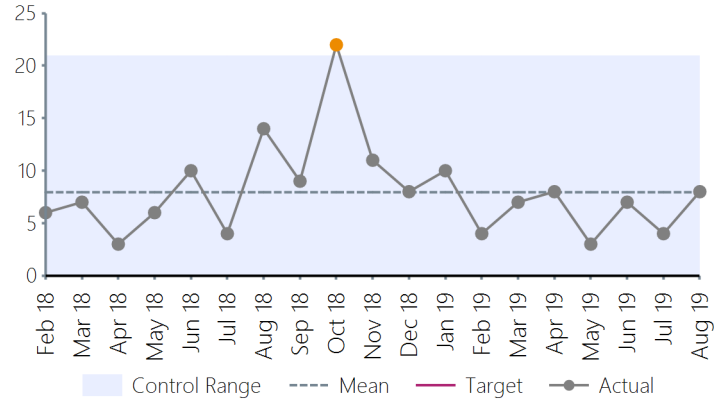
b) shows a point of concern sitting above the control range.

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.

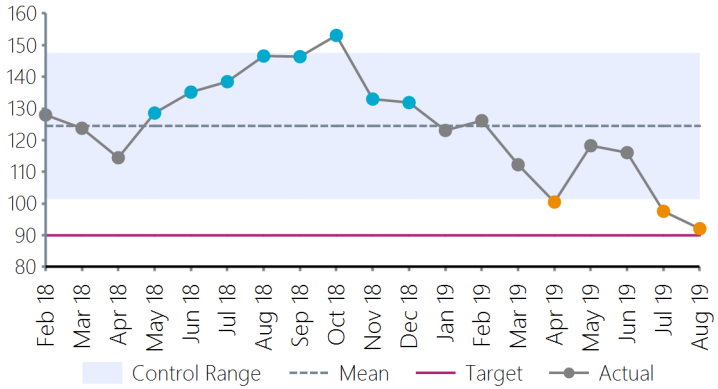
a)



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 Finances

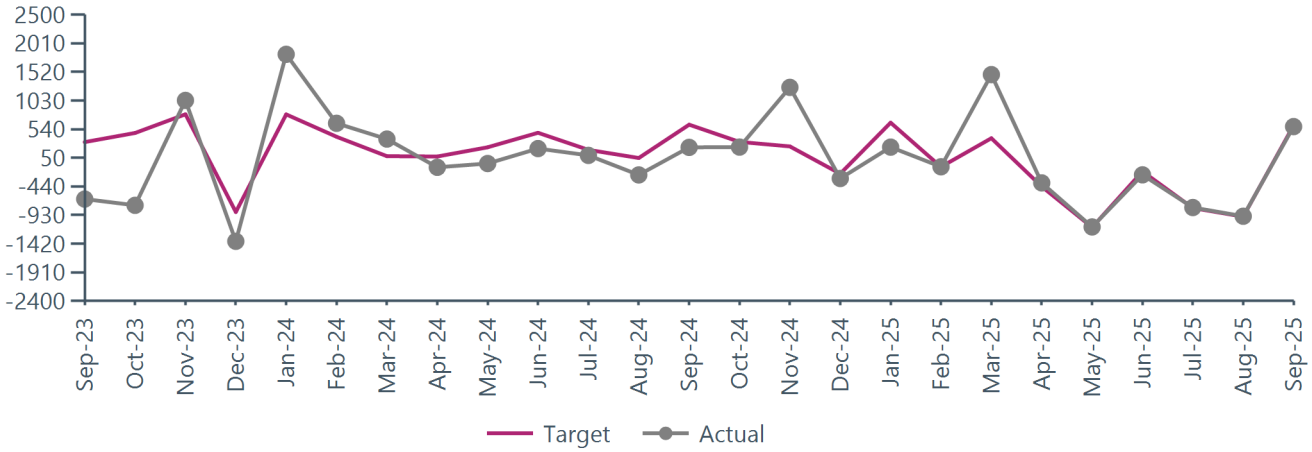
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Financial Control Total	604	584.50		N/A to SPC	Moving Target	+	
Income	15,261	14,242.30		N/A to SPC	Moving Target	+	
Expenditure	14,656	13,657.90		N/A to SPC	Moving Target		
Efficiency Delivered	786	819		N/A to SPC	Moving Target	+	
Cash Balance	13,769	20,427		H	Moving Target		
Capital Expenditure	860	1,358		N/A to SPC	Moving Target	+	
Performance (£'000k) against Low Value Agreement Block	67	25		N/A to SPC	Moving Target		
Planned Surplus/Deficit	-2,928.00	-2,920.30		N/A to SPC	Moving Target		
Variance Year-to-Date to Financial Plan	0	8		N/A to SPC	P		
Implied Productivity	2.00%	-4.57%		N/A to SPC	F	+	

Financial Control Total

Surplus/deficit position adjusted for donations 215290

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
604.00	584.50	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

£585k surplus in month, £20k adverse to plan. YTD £2,920k deficit, £8k favourable to plan.

In month adverse performance in clinical income primarily driven by elective theatre activity lower than planed is offset by favourable positions on pay and non pay driven by a combination of marginal cost reductions, beneficial grip & control actions and utilisation of non recurrent flexibility (final prior year balance sheet adjustments).

Actions

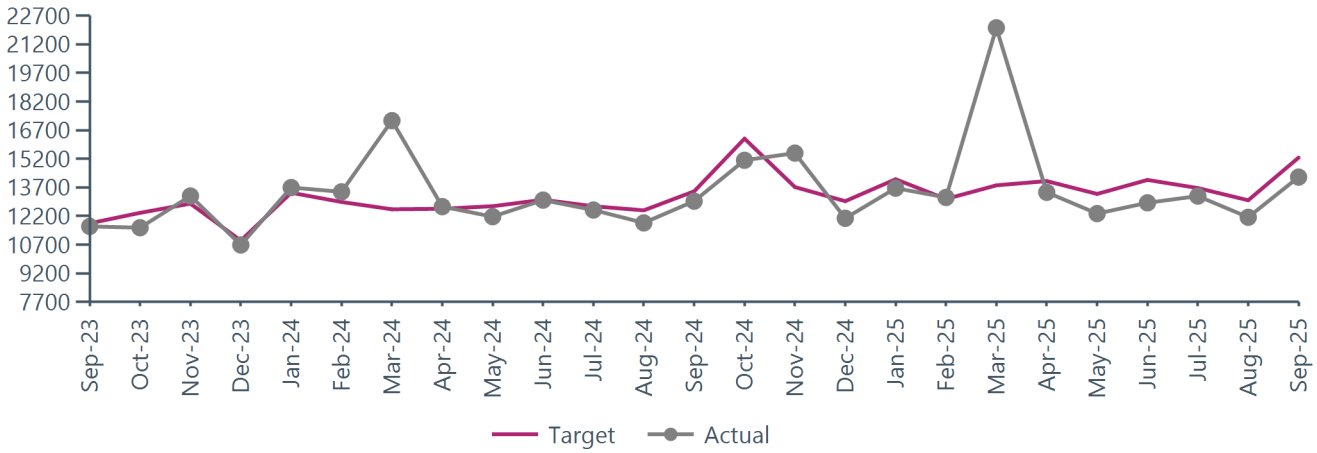
Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
228	233	1256	-304	232	-103	1474	-379	-1133	-241	-800	-950	584

Income

All Trust Income, Clinical and Non-Clinical 216333

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
15,261.00	14,242.30	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 £1,018k adverse to plan:

NHS Clinical income £982k adverse to plan:
- Theatre activity 118 cases adverse to original plan and 21 cases adverse to forecast
- Diagnostics unbundled activity adverse
- External outsourcing delivery £105k adverse to plan (offset in expenditure)

Non NHS income £36k adverse to plan: driven by Private Patients income £28k adverse

Actions

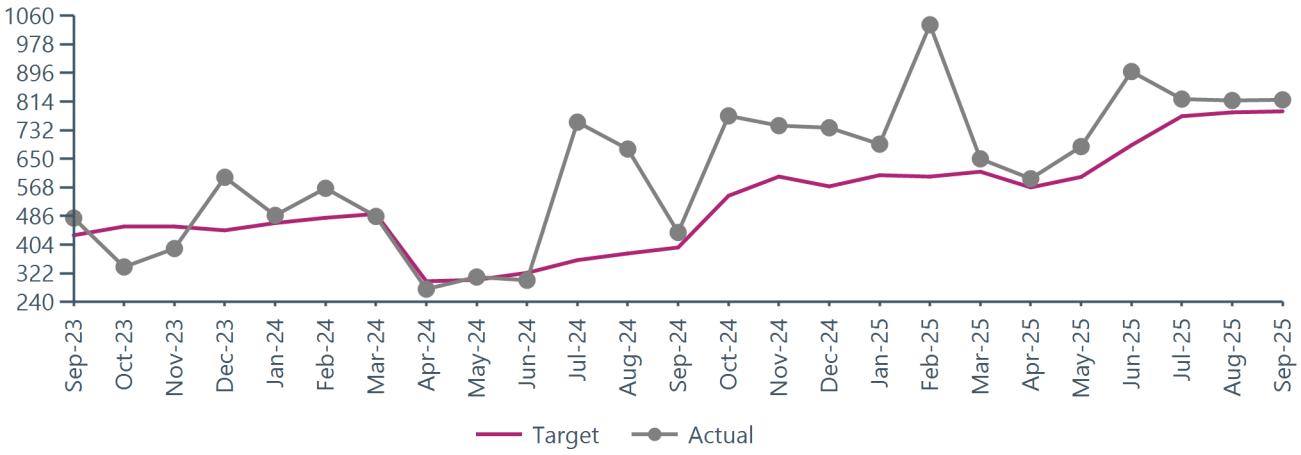
Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
12980	15124	15498	12083	13662	13175	22066	13444	12330	12895	13246	12137	14242

Efficiency Delivered

Efficiency plan delivery 215298

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
786	819	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 is £29k favourable to plan in month, £438k favourable year to date and forecast to deliver in full.

In month performance:
- £755k of recurrent schemes recognised, £31k adverse to plan.
- £60k of non recurrent schemes, £60k favourable to plan.
- Total efficiency savings recognised of £815k, £29k favourable to plan.

Year to date performance:
- £4,108k of recurrent schemes recognised, £88k adverse to plan.
- £526k of non recurrent schemes, £526k favourable to plan.
- Total efficiency savings recognised of £4,634k, £438k favourable to plan.

Actions

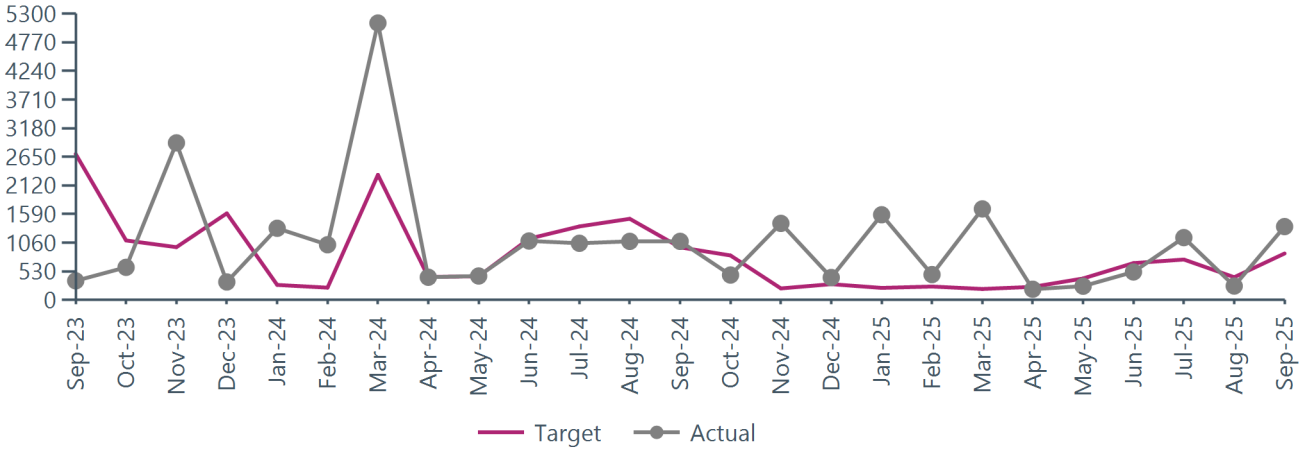
Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
439	773	745	739	692	1034	650	593	685	900	821	817	819

Capital Expenditure

Expenditure against Trust capital programme 215301

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
860	1,358	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

Capital expenditure is £391k above plan YTD. This is due to earlier than planned expenditure on surgical innovations (spinal navigation equipment) and solar works, partially offset by slippage on diagnostic equipment and digital investment.

The forecast is £54k above plan due to additional external funding for Electric Vehicle Charge Points and Cyber Security.

Actions

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
1085	461	1418	415	1577	469	1686	198	255	518	1154	258	1358

Implied Productivity

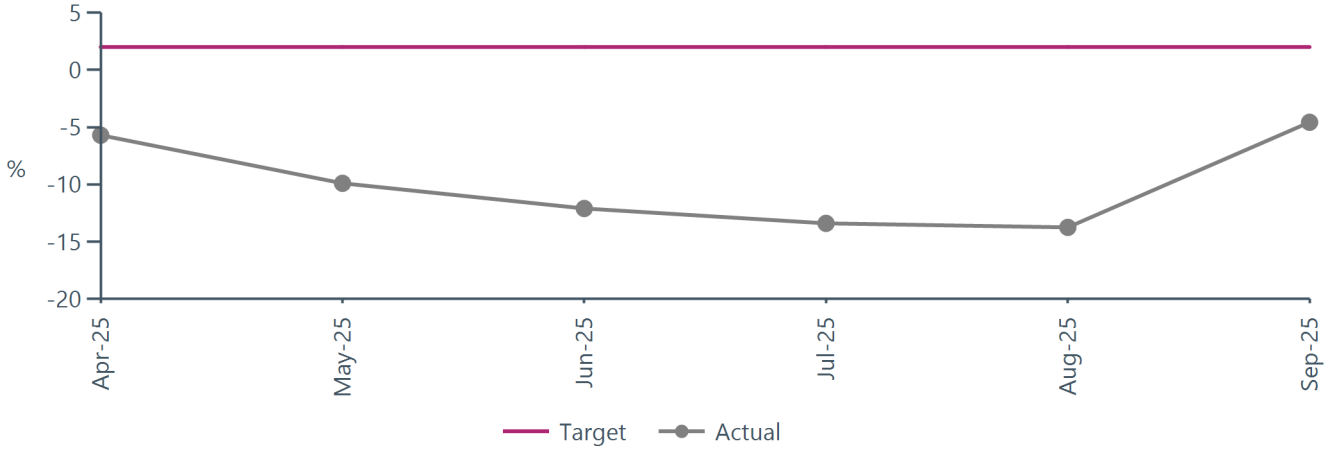
Calculated using cost weighted activity growth divided by real terms cost growth. Cost weighted activity is calculated from activity in the period multiped by national average costs at HRG level. Real terms costs is total operating expenditure over the pe 217901

Exec Leadr
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
2.00%	-4.57%	N/A to SPC	F

Trajectory

Actual
Trajectory



What these graphs are telling us

This measure is not appropriate to display as SPC. Metric has no target.

Narrative

Implied productivity is -4.6% YTD when comparing M6 25/26 with M6 24/25. The main drivers of the reduced performance are activity driven due to the cessation of the LLP contract (which has Q1 activity in 24/25), the impact of the EPR implementation in 25/26 (in particular M2 & 3) partially offset by the increase in in job plan capacity from recruitment. Costs remain fairly flat.

Actions

Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
							-5.70%	-9.90%	-12.10%	-13.40%	-13.75%	-4.57%

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

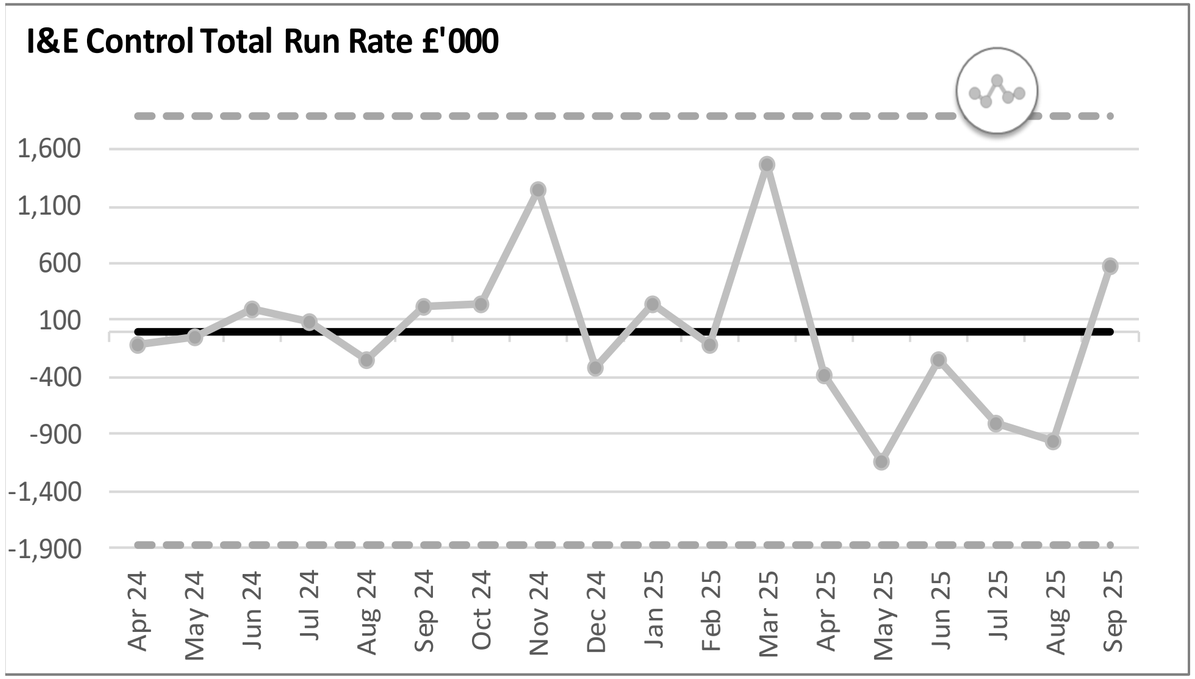
M06 Financial Position Update

Improving lives through excellent and innovative care

NHS

Income & Expenditure Position September 2025

	Annual Plan	In Month Position			YTD Position		
		Pass through adj Plan	Actual	Variance	Pass through adj Plan	Actual	Variance
Clinical Income	153,952	13,699	12,717	(982)	74,060	68,745	(5,315)
Private Patient income	11,987	996	968	(28)	6,023	5,359	(664)
Other income	6,849	566	558	(8)	3,899	4,193	294
Pay	(107,400)	(9,029)	(8,705)	324	(53,835)	(51,659)	2,176
Non-pay	(56,910)	(4,886)	(4,260)	626	(28,983)	(25,729)	3,254
EBITDA	8,478	1,346	1,278	(68)	1,164	909	(255)
Finance Costs	(9,285)	(807)	(763)	44	(4,491)	(4,246)	245
Capital Donations	1,620	130	0	(130)	170	207	37
Operational Surplus	813	669	515	(154)	(3,157)	(3,130)	27
Remove Capital Donations	(1,620)	(130)	0	130	(170)	(207)	(37)
Add Back Donated Dep'n	809	66	70	4	399	417	18
Control Total	0	604	584	(20)	(2,928)	(2,920)	8



In month: £0.6m surplus, £0.02m adverse to plan

- **NHS Clinical Income £1.0m adverse -** driven by £0.8m adverse theatre performance (118 cases) & unbundled diagnostics £0.05m (Dexa & MRI) along with £0.15m adverse on outsourcing (21 cases)
- **Non-NHS income £0.03m adverse -** due to pricing efficiency slippage (private patient activity plan delivered.
- **Pay expenditure £0.3m favourable -** £0.1m workforce recruitment slippage, £0.1m non recurrent balance sheet mitigations, £0.1m I&I interventions (vacancy controls & cost pressures), £0.06m non recurrent revenue to capital transfer catch up M4-6 partially offset by £0.1m adverse bank (outpatient and anaesthetic OJP)
- **Non-Pay £0.6m favourable -** £0.18m implants/consumables, £0.15m outsourcing, £0.12m slippage on cost pressures/inflation/RTT plan stretch contribution, £0.1m non recurrent balance sheet mitigations, £0.05m old year waste credit

YTD: £2.9m deficit, £0.008m favourable to plan.

YTD Bridge

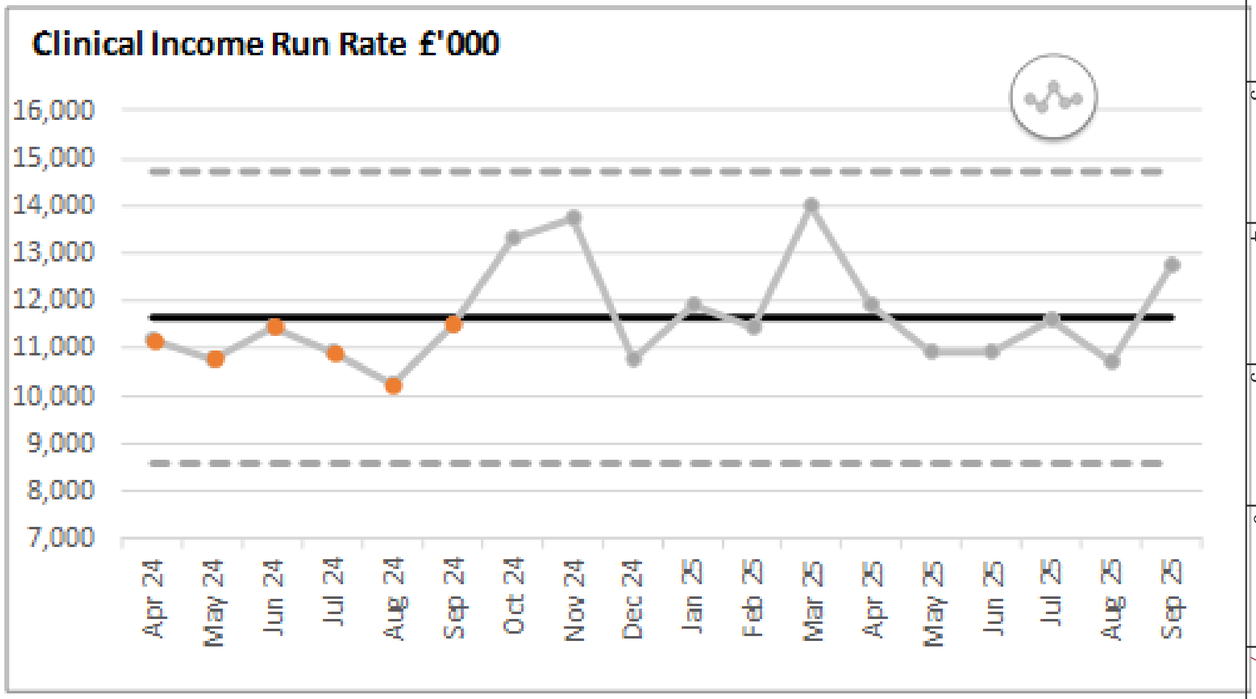
The bridge shows the key drives of the variances to plan YTD.

The primary driver is adverse income performance linked to lower than planned elective theatre activity, outpatients and diagnostics which is largely offset by lower than planned pay & non pay expenditure.

Further to this £1.1m of balance sheet mitigations and £0.3m of interest receivable are supporting the overall position.

Clinical Income Run Rate

Summary Income Position	2025-26 Month 6 YTD						
	Plan Activity	Actual Activity	Variance	Plan income £m	Actual Income £m	Fixed Adjustment £m	Variance £m
Variable Contract Income							
Elective Day case	2,571	2,216	(355)	6.75	5.87	(0.04)	(0.92)
Elective Inpatient	2,968	2,537	(431)	21.97	18.39	0.17	(3.41)
Elective Inpatient & Day case	1,546	1,482	(64)	1.60	1.20	(0.03)	(0.43)
Outpatient First Attendance	21,943	21,783	(160)	4.80	5.13	(0.02)	0.30
Outpatient Procedures	4,559	4,468	(91)	1.37	1.22	(0.01)	(0.15)
Diagnostics	24,665	18,137	(6,528)	2.28	1.73	0.01	(0.54)
High Cost Drugs/Devices				4.58	4.46	0.12	(0.01)
Total Variable Contract Income	**58,253**	**50,623**	**(7,630)**	**43.35**	**38.00**	**0.19**	**(5.16)**
Fixed Contract Income							
Non Elective Inpatients	308	326	18	2.22	2.74	(0.52)	(0.00)
Regular Day case	1,097	967	(130)	1.04	0.89	0.15	0.00
Critical Care				1.09	0.92	0.17	0.00
Outpatient Follow Ups	44,832	50,527	5,695	4.87	5.11	(0.24)	0.00
Elective Recovery Funding				4.73	4.73	0.00	0.00
Other Fixed Income				16.75	10.92	5.68	(0.15)
Total Fixed Contract Income	**46,237**	**51,820**	**5,583**	**30.71**	**25.32**	**5.23**	**(0.15)**
Total Clinical Income from Contracts	**104,490**	**102,443**	**(2,047)**	**74.06**	**63.32**	**5.42**	**(5.31)**



Clinical Income by Point of Delivery (POD)

Clinical income is £5.3m adverse to plan YTD

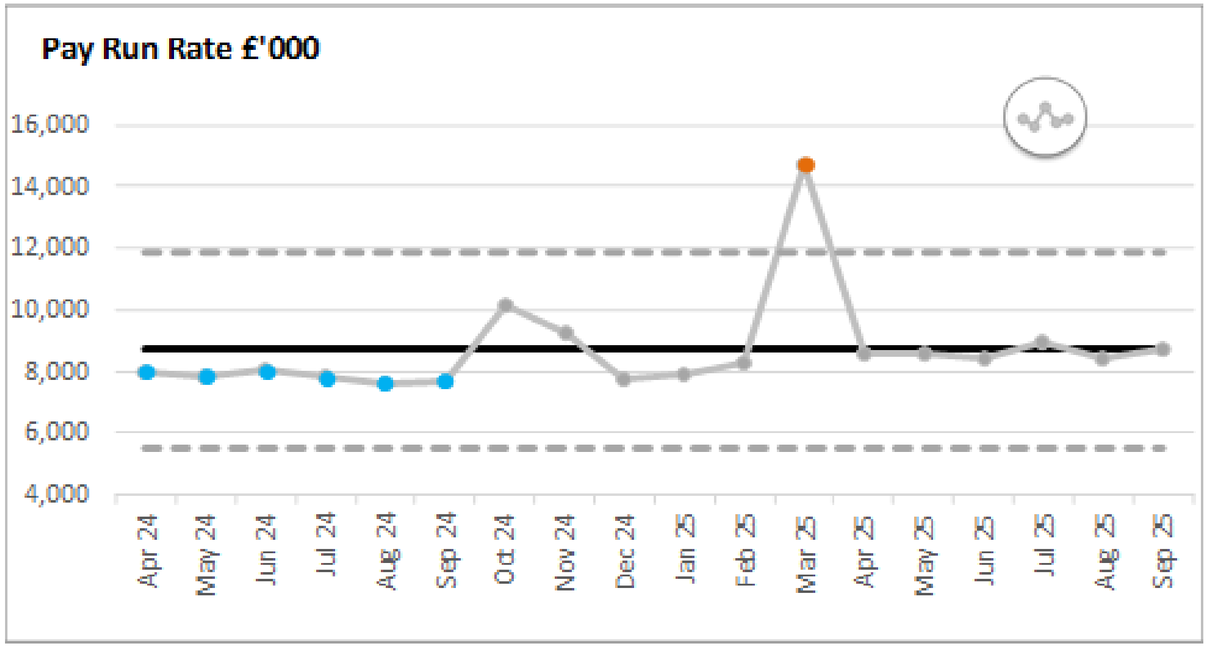
- Elective inpatient and day case performance is £4.8m adverse to plan driven by adverse theatre activity delivery (EPR impact, flexible capacity, SaTH transfers)
- Outpatient first attendances and procedures are £0.15m favourable to plan due to lower than anticipated impact from EPR in M2&3 along with insourcing capacity for neurology and rheumatology
- Diagnostics assessments are £0.5m adverse to plan due to lower than planned unbundled scans and radiology procedures

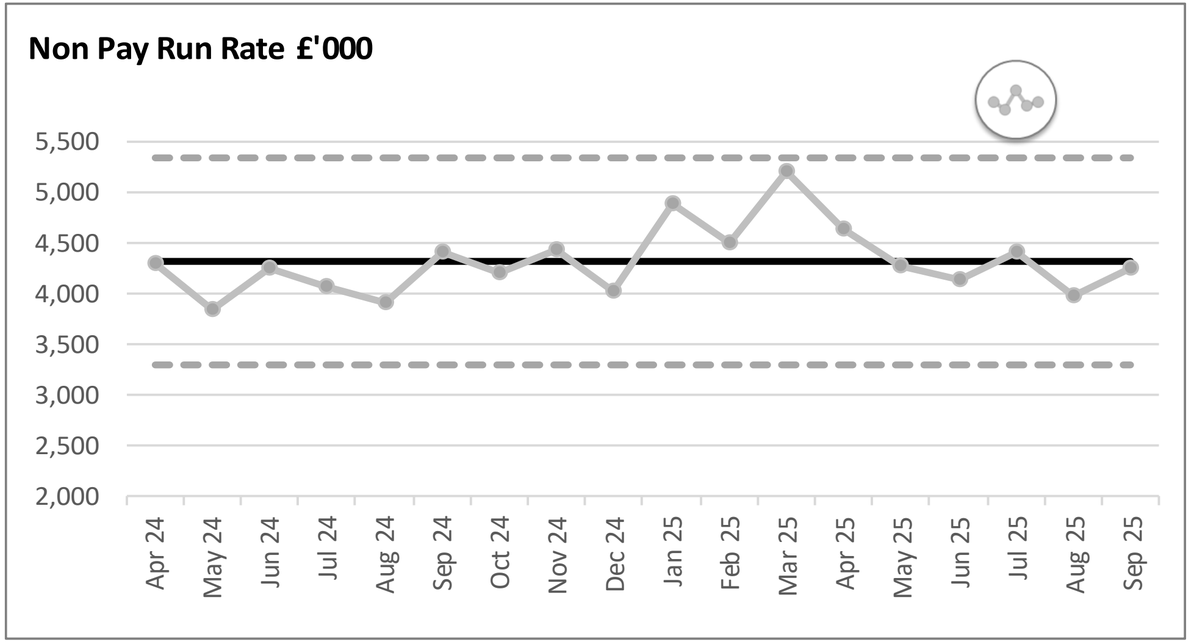
Clinical Income Run Rate

The clinical income run rate is driven by elective activity delivery in month, 25/26 is showing common cause variation despite challenges with delivering activity to plan.

The 24/25 assigned cause variation is linked to the cessation of insourcing capacity through the OO LLP contract.

Expenditure Run Rate





Pay Run Rate

The spike in pay in M4 recognises the 25/26 pay award back pay

The spike in M12 24/25 relates to the central pension contribution for the Trust accounts and HCSW pay provision

Enhanced pay controls are in place :

- Vacancies are all agreed through the Performance and Financial Improvement Group (PFIG) and must be agreed by the ICS Vacancy Control panel before advertising
- Clinical and non-clinical overtime, bank and agency are subject to approval by the PFIG on a weekly basis
- Agency must operate within the agency caps set by NHSE unless authorised by the CEO

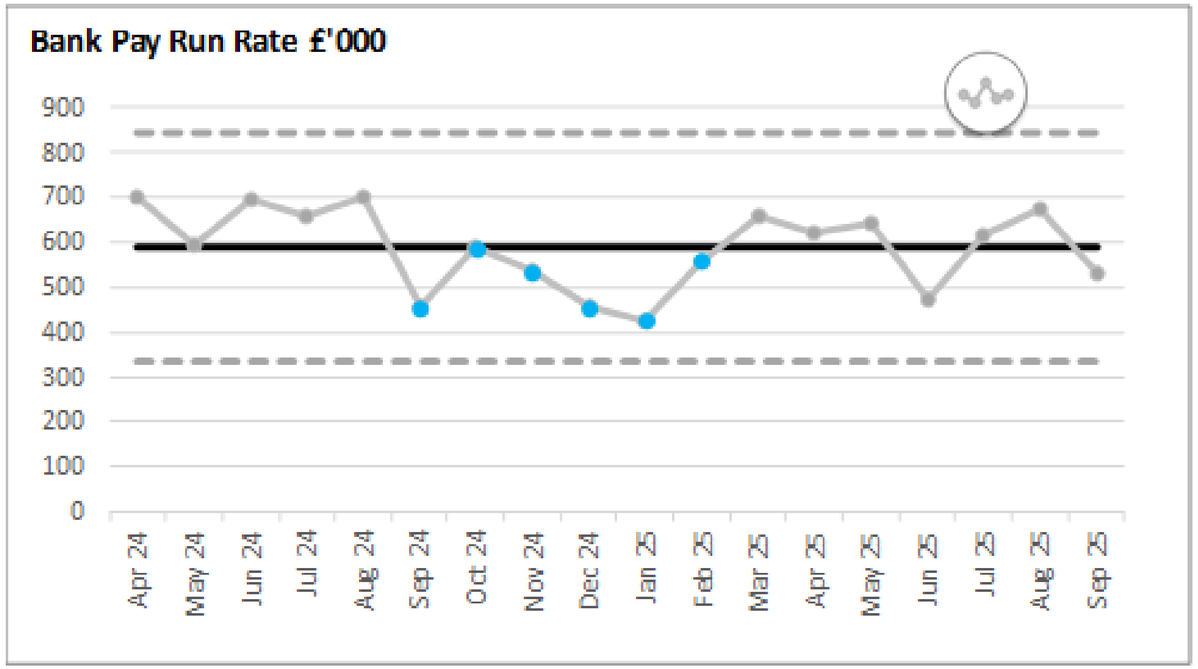
Non-Pay Run Rate

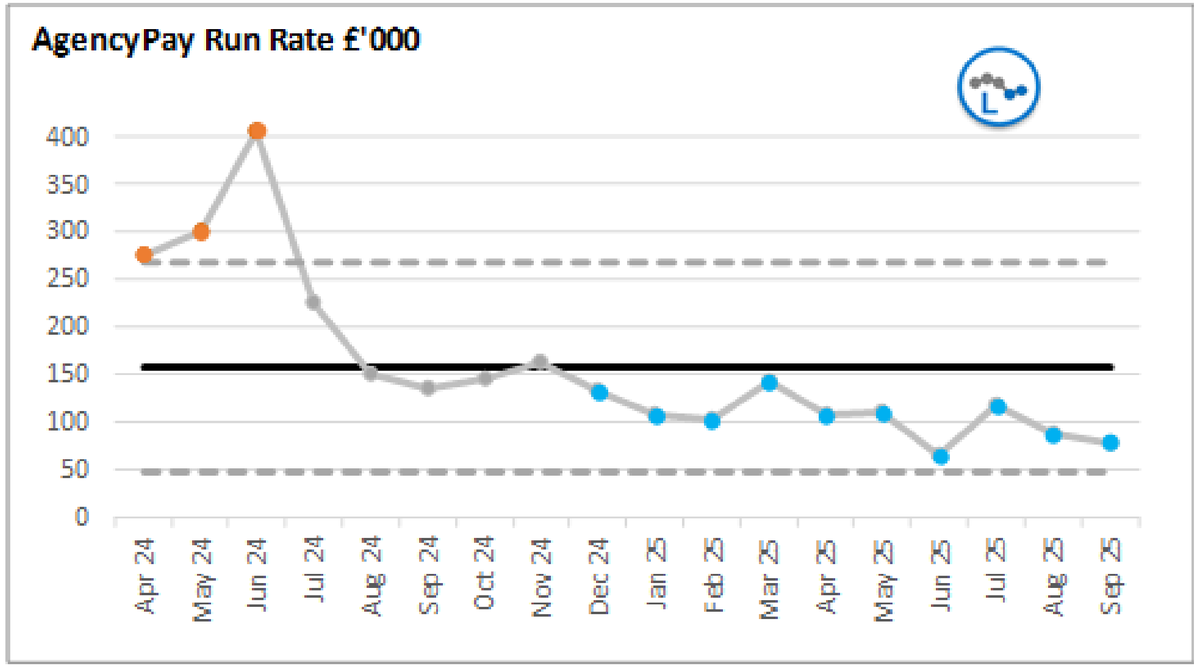
The non pay run rate is showing common cause variation despite the lower than planned levels of marginal cost spend YTD. The run rate for Jan25 to Apr25 is heightened due to EPR implementation.

Enhanced controls are in place :

- Non-clinical orders >£10k must be approved by the PFIG on a weekly basis
- Discretionary non-clinical orders will be reviewed by a non pay panel before proceeding

Bank & Agency Run Rate





Bank Run Rate

Bank run rate showed assignable cause variation in 24/25 linked to the reduction in bank rates and implementation of enhanced controls. 25/26 shows common cause variation.

Enhanced bank controls are in place :

- Clinical staff bank is managed through e-roster, shifts are approved by senior members of the clinical nursing team
- Bank shifts are presented to PFIG weekly as part of the agency request process

Agency Run Rate

Agency run rate shows assignable cause variation for end of 24/25 and 25/26 due to reduction in bank usage linked to hourly cap compliance, recruitment, onboarding long term agency and enhanced sign off.

Enhanced bank controls are in place :

- The engagement of off-framework agency providers is banned as per NHSE guidelines.
- The process of requesting agency staff engagement is set out in the Trust's Agency and Temporary Staffing Policy. 1) Framework suppliers within price cap if no take up of the shift through the bank; 2) Framework suppliers escalated rates for short notice bookings (24-72 hours before shift);
- Sign off arrangements are as follows: If shift is above £100 hour (to be signed off by CEO), If framework shifts exceeds price cap by more than 50% (to be signed off by relevant Exec Director).

Commissioner Performance

NHS Clinical Income - by Contract									
Contracts	Contract Type	Month 6 - September 2025				Month 6 YTD 2025/26			
		Plan £'000	Actual Exc Pass Through £'000	Pass Through £'000	Variance £'000	Plan £'000	Actual Exc Pass Through £'000	Pass Through £'000	Variance £'000
Shropshire, Telford & Wrekin ICB	API	6,949	6,747	0	-202	36,088	33,368	1,641	-1,079
NHS England Contract	API	1,798	1,490	210	-97	10,399	7,714	2,084	-601
Cheshire & Merseyside ICB	API	967	935	0	-31	5,331	4,851	52	-428
Staffordshire & Stoke-on-Trent ICB	API	288	371	0	83	1,602	1,617	14	29
Herefordshire & Worcestershire ICB	API	260	311	0	51	1,423	1,739	10	326
Black Country ICB	API	102	110	0	8	582	558	2	-22
Betsi Cadwaladr UHB	API	1,503	1,229	32	-241	8,167	6,717	308	-1,141
Powys TLHB	API	853	714	47	-92	5,158	4,777	445	63
Hywel Dda UHB	API	63	30	0	-33	350	171	31	-148
English Contracts Total		12,783	11,938	289	-555	69,100	61,513	4,587	-3,000
Low Value Activity (LVA)	Block	416	417		0	2,170	2,170		0
Joint Commissioning Wales (JCW)	Block	155	156		0	904	904		0
Welsh Contracts Total		572	572	0	0	3,074	3,074	0	0
Other Non Commissioned Activity (NCA)		19	11	0	-8	98	70	0	-28
Overperformance Reserve		351	0	0	-351	2,176	0	0	-2,176
Other		20	-93	0	-114	-390	-499	0	-110
Other Subtotal		391	-82	0	-473	1,884	-430	0	-2,314
Total		13,745	12,428	289	-1,028	74,059	64,158	4,587	-5,314

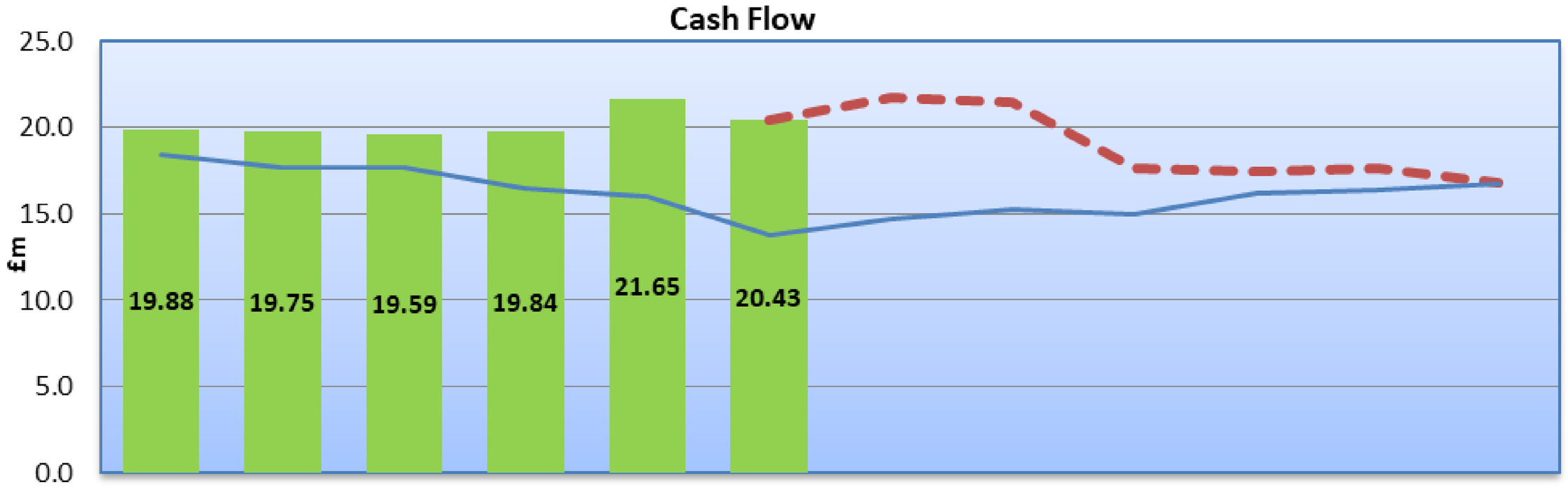
M6 performance £1,028k adverse (lower) to plan: £46k pass through driven and £982k driven by under delivery of activity.

YTD £5,314k adverse to plan £150k pass though driven, £5,164k driven by under delivery of activity.

- Largest underperformance is with Betsi Cadwaladr UHB £1.1m and our host commissioner Shropshire, Telford & Wrekin ICB £1.1m.
- Overperformance with Powys THB is £63k and will need managing down by the year end due to cap on the contract.
- Overperformance on Hereford & Worcester £326k is significant on the contract value, this has been shared with the ICB through monthly contract monitoring.

The overperformance reserve represented the planned level of activity within the operational plan required to achieve the performance standards which commissioners have not included in contracts as allocations are based on 24/25 forecast outturn. Commissioners have set up RTT reserves to fund variable activity up to the constitutional standards, this will be picked up through regular contract monitoring. This corresponds to the risk on the risk register in relation to associate ICB's.

Cash Position



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Actual	19.88	19.75	19.59	19.84	21.65	20.43						
Forecast						20.43	21.79	21.49	17.66	17.43	17.69	16.80
Plan	18.42	17.71	17.66	16.52	16.06	13.77	14.75	15.27	14.99	16.17	16.37	16.80

The cash balance of £20.4m is £6.6m above plan:

- £2.7m 25/26 commissioner underperformance paid in cash through mandates
- £2.0m non pay reductions
- £1.8m 24/25 under-performance on contract income not yet recovered by commissioners
- £0.8m Headley Court deferred income Veterans Rehab Pilot

Capital Investment

Project	Annual Plan £000s	In Month Plan £000s	In Month Completed £000s	In Month Variance £000s	YTD Plan £000s	YTD Completed £000s	YTD Variance £000s	Forecast Outturn £000s	Forecast Variance £000s
Backlog maintenance	500	50	23	27	250	155	95	500	0
Digital investment & replacement	500	82	86	-4	246	102	144	450	-50
Capital project management	170	14	14	-0	84	86	-2	170	0
Equipment replacement	1,000	100	121	-21	360	449	-89	950	-50
Diagnostic equipment replacement	700	154	69	85	700	159	541	635	-65
Compliance (IPC/health & safety/quality)	360	20	13	7	240	170	70	360	0
Estates reconfiguration	206	20	0	20	110	7	103	206	0
PACS/RIS replacement	200	45	0	45	110	0	110	0	-200
Invest to save	200	50	0	50	100	0	100	165	-35
Digital & innovation strategy	500	160	0	160	320	0	320	500	0
Surgical innovations	750	0	-8	8	0	725	-725	725	-25
EPR implementation	500	0	0	0	500	503	-3	503	3
Rheumatology hub	500	0	1	-1	0	14	-14	500	0
Rheumatology hub (donated element)	500	0	0	0	0	0	0	500	0
Donated / Granted medical equipment	220	130	0	130	170	207	-37	220	0
Energy/decarbonisation plan (grant)	900	0	0	0	0	0	0	900	0
Critical infrastructure funding (CIR)	500	0	0	0	0	0	0	500	0
Solar works (GBE funding)	2,407	0	939	-939	0	939	-939	2,407	0
Leases (IFRS16)	250	35	20	15	160	146	14	300	50
Electric Vehicle Charge Points (PDC)	0	0	0	0	0	0	0	14	14
Cyber	0	0	0	0	0	0	0	40	40
Contingency	0	0	80	-80	0	80	-80	372	372
Total Capital Funding	**10,863**	**860**	**1,358**	**-498**	**3,350**	**3,741**	**-391**	**10,917**	**54**
Less donated / grant capital	-1,620	-130	0	-130	-170	-207	37	-1,620	0
NHS Capital Funding - Charge to CDEL	**9,243**	**730**	**1,358**	**-628**	**3,180**	**3,534**	**-354**	**9,297**	**54**
Less PDC funded schemes	-2,907	0	-939	939	0	-939	939	-2,921	-14
Charge to System Operational Capital	**6,336**	**730**	**419**	**311**	**3,180**	**2,595**	**585**	**6,376**	**40**

- The capital plan for 25/26 is £10.9m, made up of £6.3m internally funded schemes, £2.9m from external funding (PDC) and £1.6m from grants and donations.
- Capital expenditure is £391k above plan YTD. This is due to earlier than planned expenditure on surgical innovations (spinal navigation equipment) and solar works, partially offset by slippage on diagnostic equipment and digital investment.
- The forecast is £54k above plan due to additional external funding for Electric Vehicle Charge Points and Cyber Security.

Financial Risk: scoring >12

Risk Type	Category	Risk name	Risk Description	Estimated Value Methodology	Risk ID	Pro Rata Remaining Risk £'000	Mitigations £'000	Residual Risk £'000	Likelihood	Consequence	Residual Risk Rating	Mitigations / actions	SRO
Income	Internally Driven	Non delivery of planned elective activity levels leading to income loss	The financial plan triangulates directly with the operational activity plan, non delivery of the elective activity due to risks with EPR, capacity, cancellations and recruitment slippage will result in reduced PbR income.	Based on most likely scenario intervention risks, majority is Portland insourcing and SaTH transfers.	3343	£ 1,500	£ 929	£ 571	4	4	16	Financial Improvement group overseeing activity delivery weekly Operational re-forecast plan oversight Focus on key intervention risks through PFIG, ARC and Performance Boards	Mike Carr - Chief Operating Officer
Income	Internally Driven	Non delivery of private patient income stretch	The plan includes a stretch target for private patient delivery (based on the H2 delivery of 24/25 mitigation) generating a surplus contribution of £1.1m.	Remaining risk for the year based on average run rate delivery to date.	3429	£ 554	£ -	£ 554	4	4	16	Financial Improvement group overseeing activity delivery weekly Specific private patient forecast updates reviewed and challenged All available scheduled sessions sent out to clinicians for uptake	Mike Carr - Chief Operating Officer
Expenditure	Internally Driven	Efficiency Programme Slippage leading to increased cost	The efficiency programme is set at a highly challenging 6% target, slippage or non delivery of schemes will result in a deterioration in the Trust financial position.	Risk based on red schemes at 100% and amber schemes at 25% aligned to ICS methodology from PwC	3341	£ 396	£ -	£ 396	3	4	12	Financial Improvement Group review of efficiency plans including executive oversight and identification of 20% contingency Monthly review of performance through TPOIB. Monthly assurance through F&P. System Financial Improvement Programme oversight of efficiency progress. Continue to de-risk schemes from red and amber to green and identify mitigating opportunities in year WIG oversight of corporate infrastructure reductions	Angela Mulholland-Wells, Chief Finance and Commercial Officer
				Total		**£ 2,450**	**£ 929**	**£ 1,521**					

Risks >12 total £2.5m gross risk with £1m mitigations leaving £1.5m residual risk requiring further mitigating action.

There are two risks >15 risk rating :

1. Non delivery of planned elective activity levels leading to income loss
2. Non delivery of Private Patient stretch target

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The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

FY25-26 Efficiency Plan

M6 update

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Month 6 Performance Summary

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

25/26 Month 6 Planned Savings	25/26 Month 6 Actual Savings	25/26 Month 6 Savings Variance
£786k	£815k	£29k

25/26 Full Year Planned Savings	25/26 Full Year Forecast Savings	25/26 Full Year Savings Variance
£9,594k	£10,152k	£558k

Internal Plan & Actuals	Month 6			YTD			Forecast		
	Plan	Actual	Variance	YTD Plan	YTD Actual	Variance	Plan	Forecast	Variance
MSK	398	332	-65	2,106	1,909	-197	4,611	4,541	-70
Spec	257	252	-5	1,295	1,173	-122	3,377	3,270	-107
Corporate	131	171	40	795	1,025	231	1,606	1,783	177
Total Recurrent	**786**	**755**	**-31**	**4,196**	**4,108**	**-88**	**9,594**	**9,594**	**0**
YTD Non-Recurrent	**0**	**60**	**60**	**0**	**526**	**526**	**0**	**558**	**558**
Total including Mitigations	**786**	**815**	**29**	**4,196**	**4,634**	**438**	**9,594**	**10,152**	**558**

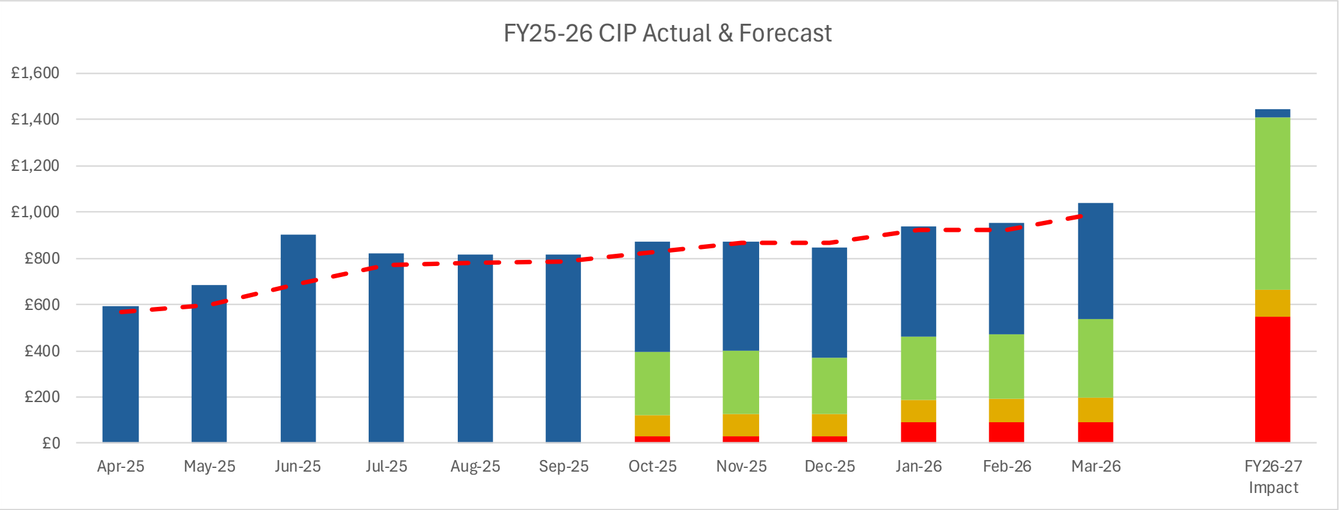
Unit	Planned £000's	Forecast £000's	Delivered £000's	Low Risk £000's	Medium Risk £000's	High Risk £000's	Unidentified £000's	% Identified
Corporate	1,606	2,224	2,077	89	57	0	0	100%
MSK	4,611	4,586	3,248	1,071	269	0	0	100%
SPEC	3,377	3,342	2,196	529	249	367	0	100%
Total	**9,594**	**10,152**	**7,521**	**1,689**	**575**	**367**	**0**	**100%**

Performance

- Overall £815k efficiencies achieved, £29k favourable to plan.
- Recurrent delivery £31k adverse to plan, offset by £60k of non recurrent mitigations recognised in month.
- YTD £4,634k efficiencies achieved, £438k favourable to plan.
- Recurrent delivery £88k adverse to plan, offset by £526k non recurrent mitigations.
- Following a review of risk scored the level of red rated schemes stands at £367k, representing just under 4% of the total forecast value for the year.
- In total almost 91% of the forecast total is flagged as either delivered or green rated for low risk.

Full Year impact of schemes delivered in Month 6, and RAG rating of future months

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26		FY26-27 Impact
Target (£000)	**£568**	**£598**	**£689**	**£772**	**£783**	**£786**	**£826**	**£866**	**£866**	**£923**	**£925**	**£992**		
% of total plan	*6%*	*6%*	*7%*	*8%*	*8%*	*8%*	*9%*	*9%*	*9%*	*10%*	*10%*	*10%*		
Forecast														
Red							£31	£31	£32	£89	£91	£93		**£550**
Amber							£89	£93	£92	£98	£100	£103		**£114**
Green							£277	£274	£248	£272	£279	£339		**£747**
Delivered	£593	£684	£900	£823	£817	£815	£474	£473	£474	£481	£482	£503		**£36**
TOTAL	**£593**	**£684**	**£900**	**£823**	**£817**	**£815**	**£871**	**£871**	**£846**	**£940**	**£952**	**£1,038**		**£1,447**

Risk Profile of Plan

Delivered £7.5m / 74.1%
Green (low) risk £1.7m / 16.6%
Amber (medium) risk £575k / 5.7%
Red (high) risk £367k / 3.6%

FY26-27 full year impact FY25-26 schemes

- This year's schemes are forecast to have a continuing full year impact upon delivery of £1.4m in financial year 2026/27.
- This will support delivery of the efficiency programme for that year / reduce the underlying deficit position.
- Initial planning for FY26-27 is underway, currently targeting a programme of efficiency at similar level to this year

Month 6 : Additional Schemes identified during this year

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Mitigations:

- Included within the M6 actual and forecast position are additional recurrent opportunities for efficiency recognition which have been identified since the start of the financial year.
- These are summarised below and have provided opportunities totalling £937k to offset schemes which are now deemed unlikely to achieve their planned values, and so de-risk the efficiency programme.
- Further pipeline schemes have also been identified. Work is ongoing to finalise timelines and financial impacts prior to inclusion within the efficiency programme, as well as the identification of further potential schemes.

Unit	Scheme Title	(£000)
Confirmed		
Corporate	Car Park Management	77
All	Various SLAs	107
Spec	Spinal SLA - Alder Hey	25
Corporate	Corporate costs review	110
MSK	Temp staffing costs - agency	95
Spec	Temp staffing costs - agency	142
Corporate	Rateable value review	53
Spec	Psychosexual Therapist	7
Spec	Orthotics 3D Printer	36
Spec	Blood products	40
MSK	PP fixed cost prices	78
Spec	Dexa FLS	40
Spec	Rheumatology Redesign	94
Corporate	Energy tariffs	33
		937
Pipeline		
Spec	Spinal navigation equipment	tbc
Corporate	Powys THB Administration Funding	80

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The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

FY26-27 Efficiency Plan

In Progress

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Forward Look FY26-27

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

- Final guidance regarding NHSE expectations for efficiency programmes for 26/27 are still outstanding.
- Draft plans are currently being developed against an indicative £8.6m/ 5% target.
- Finance Business Partners have led discussions with Managing Directors and other departmental leads, examining key strategic themes:
    - Unit / department level specific opportunities
    - Elective transformation schemes – GIRFT improvements etc
    - Outpatient transformation – GIRFT improvements etc (FU outpatients key area of focus)
    - Diagnostics – cost, productivity
    - Pathology optimisation – this is on the national agenda
    - Digital strategy – EPR benefits, AI opportunities, process improvement
    - Shared services – corporate functions
    - Administration review (structure, processes and digital enablers)
    - Temporary staffing – reduce bank & agency reliance
    - Workforce improvements
    - Invest to save (either capital or revenue to unlock further benefits)

Forward Look FY26-27

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Draft plans have been presented for review and discussion to:

- Performance & Finance Improvement Group (PFIG) 09/09/25
- System Productivity and Oversight Group 06/10/25

- Current summary position is as below:

26/27 Draft	G £000's	A £000's	R £000's	U £000's	Total £000's
Productivity	1580	497	1015	0	3092
Efficiency	819	1843	0	2846	5508
Total	**2399**	**2340**	**1015**	**2846**	**8600**
%	**28%**	**27%**	**12%**	**33%**	**100%**

Next Steps:

- Further discussions with managers to identify additional schemes to fill the 33% of the programme which remains unidentified
- Ongoing development of proposals identified to de-risk the programme
- Updated draft plans to be presented to PFIG on 4/11/25, including proposals to align Executive as SRO leaders for larger impact improvement programmes, with greater governance and PMO support to monitor and report delivery

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, 05 November 2025

Author: **Contributors:**

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

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 Finance and Performance Committee on 22 September and 24 October 2025. It highlights the key areas the Finance and Performance 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	

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	✓

The following strategic themes, as outlined in the Board Assurance Framework, are overseen by this Committee. The relevant themes, and the Committee's overall level of assurance on their delivery is:

	Assurance framework themes	Relevant	Overall level of assurance
1	*Continued focus on excellence in quality and safety.*		

2	*Creating a sustainable workforce.*		
3	*Delivering the financial plan.*	✓	LOW
4	*Delivering the required levels of productivity, performance and activity.*	✓	LOW
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.*		

3. Assurance Report from Finance and Performance Committee

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

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, OR
Require the approval of the Board for work to progress.

Spinal Disorders Improvement Plan
The committee has expressed concerns regarding the lack of clarity in how the integrated system-wide plan will effectively reduce the Trust's spinal waiting list. The previous options appraisal is now considered obsolete following feedback from the ICB, and there remains an absence of defined, measurable objectives and impact trajectories.
At present, the committee is not assured of the long-term sustainability of the proposed delivery model for spinal services. The removal of direct access to MRI is anticipated to place additional pressure on MSST services. Although short-term sessions are being introduced to mitigate immediate challenges, a clearly articulated long-term vision is still lacking. To address this, an action has been agreed to meet with SN to develop and communicate this vision, with consideration being given to convening a system-wide workshop. Future updates must include clearly defined impact trajectories, measurable outcomes and assurance regarding the effectiveness of proposed interventions
Engagement with primary care is underway through the ICB GP lead, and efforts to expand community MDT capacity are ongoing.

Activity Recovery Risks
Progress toward achieving 100% of planned activity by year-end is at risk due to delays in insourcing mobilisation and continued reliance on transfers from SaTH. These dependencies may adversely affect both income generation and operational delivery.
The committee has requested specialty-specific objectives and trajectories for admitted and non-admitted pathways to better understand and manage recovery progress. While a temporary dip in outpatient activity is being monitored, it is currently considered non-critical.
A notable increase in referrals, particularly related to DEXA scanning and metabolic medicine, is placing pressure on administrative capacity and threatens to reverse recent gains in waiting list reduction. Without these additional referrals, the waiting list would have decreased by an estimated 200–300 patients.
September activity fell short of plan, primarily due to recruitment delays and underperformance in both insourcing and SaTH-related activity. These factors continue to represent significant risks to the Trust's financial and operational recovery.

Financial Forecast
The Trust delivered a £0.6m surplus in Month 6, in line with the financial plan. Cash and capital positions remain stable, with low-risk slippage identified to support business cases. Despite this, the Trust continues to operate within a planned year-to-date deficit of £3.5m.
Key risks to the forecast include; Delivery of planned efficiencies, Transfers from SaTH, Mobilisation of insourcing arrangements and Private patient income performance.
Failure to meet the Month 6 financial plan could negatively impact the Trust's NOF segment rating.
To strengthen financial and operational accountability, ownership is being reinforced at the clinical team level. The Trust is prioritising improvements in core productivity and reducing dependency on external

solutions. Measures such as vacancy freezes and non-pay panels have been introduced to manage expenditure while safeguarding clinical safety and service delivery.
The latest financial reforecast indicates a most likely year-end deficit of £1.9m, a deterioration from the previous month. This places Q3 performance at risk of breaching the 1% variance threshold, which could further affect the NOF rating. While £1.3m of non-recurrent benefits have been released to support the position, this flexibility has now been fully utilised, increasing pressure on recurrent financial performance.

Theatre business case
The Committee supported the business case, acknowledging its financial robustness, including a projected surplus and a positive return on investment. Since its initial presentation in September, workforce modelling has been further refined, and capital funding is largely secured, pending final confirmation of allocations.
While the Committee expressed overall support for the development of a new theatre, members raised concerns regarding optimism bias and the potential risk of not achieving the projected activity levels. Consequently, a sensitivity analysis has been requested to evaluate these risks more thoroughly.
Members emphasised that investment in new theatre infrastructure must be underpinned by clear evidence of improved utilisation and performance standards. A detailed plan to optimise current theatre usage is required ahead of full mobilisation, scheduled for October 2026.
It was noted that the business case will be discussed further in the private forum to explore the identified risks and mitigation strategies in greater detail.

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:

Corporate Risk Register
The committee received a comprehensive update, noting consolidation of orthotics risks and progress on radiology service risk (3096), which is expected to reduce in score. The register is being actively managed and reviewed.
Risk 3343 has been broadened to reflect non-delivery of the elective activity plan. This change removes specificity and may dilute targeted mitigation efforts. The committee noted this and expects future updates to reflect the broader scope.

Green Plan 2025/28
Energy consumption, particularly from gas-fired boilers, remains a significant challenge for the Trust. Alternative technologies are currently under review to identify viable replacements. This Green Plan is aligned with guidance from NHS England (NHSE) and the Integrated Care System (ICS), with progress monitored by the Sustainability Working Group.
The Trust has successfully secured £2.4 million in GBE funding to support the implementation of solar energy solutions. The Green Plan was formally approved by the Board in October and is now presented in the public forum for noting, in accordance with NHSE requirements.

Efficiency Programme
Year-to-date delivery stands at £7.5m, with the majority of savings being recurrent. The current risk profile is more favourable than in previous years, and £900k of new schemes have been identified during the year.
However, further work is required to de-risk amber and red-rated schemes. Workforce remains a key area of focus, with the MARS review nearing completion.
While the overall programme remains on track, MSK and specialist units are forecast to under-deliver, with £1.2m in medium to high-risk schemes still requiring mitigation.
Early planning for 2026/27 is underway, with £5.7m in potential opportunities identified against a £2.8m gap. A three-year plan is currently being developed in alignment with NHS requirements.

Productivity Improvements
Benchmarking via the Model Health System is informing targeted interventions at firm and consultant level. Executive portfolios will lead on major programmes to ensure sustained gains

Chair's Assurance Report
Finance and Performance Committee

Shared Services Collaboration
A system-wide programme is underway, with 17 task and finish groups evaluating opportunities across finance, workforce, and digital. Participation will be based on assessed benefits.

Planning
The accelerated national planning cycle requires submission of a draft plan by the end of November, followed by a final version in mid to late December. To meet these deadlines, extraordinary governance meetings may be necessary. The Committee supports aligning the planning process with existing governance structures to streamline approvals and minimise duplication, while maintaining flexibility to accommodate national requirements.
The Committee also recommended that each service area, including spinal disorders, develop a three-year plan to effectively balance demand and capacity. These service-level plans should be integrated into the Trust's overarching planning cycle to ensure coherence and strategic alignment.

Digital Risk Oversight
The Digital Transformation Group will increasingly oversee risks with digital components, such as Apollo functionality and system interoperability. This is a positive development, and the committee advises continued integration of digital oversight into risk governance.

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.

Performance
RTT performance is ahead of plan, and rheumatology and neurology waiting lists have improved due to insourcing. Theatre activity reached 97.53% in August, with efforts underway to reduce cancellations. RTT performance is 52.72%, exceeding plan by 5.2%, and time to first outpatient is 69.01%, above the national target. Paediatric milestone one performance has improved from 48% to 58%.

Financial Position
Despite the planned deficit, the Trust has a strong cash position and capital spend is on track. Veterans LVA billing risk has significantly reduced.

The Committee received the following Chairs' Assurance Reports:

- **Trust Performance and Operational Improvement Group** – expected and improved position in relation to radiology at the next meeting
- **Activity Recovery Committee** - Assurance was provided that all specialties except spinal are on trajectory to meet the 21st December waiting list target. NHSE is aware of the spinal exception, and detailed performance data will be reviewed at the next ARC meeting.
- **Capital Management Group** – the Committee noted the report, there were no issues to escalate to the Committee.
- **Veterans Strategy Oversight Group** – the Committee noted the report, there were no issues to escalate to the Committee.
- **Procurement Working Group** – the Committee noted the report, there were no issues to escalate to the Committee.
- **Performance and Financial Improvement Group** – the Committee noted the report, there were no issues to escalate to the Committee that were no capture separately within the FP agenda. The revised Terms of Reference were approved by the Committee which has revised the membership to ensure enhanced focus on specific items
- **STW MSK Provider Collaborative Board** – the Committee noted the report, there were no issues to escalate 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.

Green Plan 2025 - 2028

Committee / Group / Meeting, Date

Board of Directors, 05 November 2025

Author:

Name: Sian Langford
Role/Title: Facilities Compliance & Sustainability Manager

Contributors:

Name: Estates and Facilities Team

Report sign-off:

Name: Nick Huband, Director of Estates and Facilities
Executive Team Meeting, 16 September 2025
Finance and Performance Committee, 22 September 2025
Board of Directors, 01 October 2025

Is the report suitable for publication?

Yes

Key issues and considerations:

NHS England require all Trusts to review and refresh their Green Plan, to be published by 31st October 2025.

In collaboration with key members of the Sustainability Delivery Group, the focus areas, content and actions of the Green Plan 2025-28 reflect progress to date, key legislative and best practice guidance, and provides a framework of actions to ensure the Trust can meet its Carbon reduction targets within expected timescales.

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	✓

Green Plan 2025 - 2028

Report development and engagement history:

The Trust Plan has been drafted with a view to meeting the requirements of NHS England Green Plan refresh 2025; reviewed by the Trust Sustainability Delivery Group and Executive Team.

The Trust plan compliments focus areas and actions identified through the updates STW ICS Green Plan (2025).

The plan has been considered at the Executive Team Meeting on 16 September where it was requested further information relating to greener surgery was incorporated into the document.

It has also been considered and endorsed by the Finance and Performance Committee members following presentation on 22 September ahead of final approval at the Board of Directors on 01 October 2025.

Recommendations

The Green Plan was presented to the Trust Board on 01 October prior to publication on the Trust Website (by 31 October.) It is acknowledged that this is presented to the private forum to achieve the publication date and will also be shared at the public Trust Board meeting on 05 November.

1	2	3	4	5	6	7	8	9	10

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee

Committee / Group / Meeting, Date

Board of Directors Meeting, 5th November 2025

Author: **Contributors:**

Name: Felicity Kipling
Role/Title: Executive Assistant

Report sign-off:

Martin Evans, Non-Executive Director, 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 Commercialisation 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 22nd May and 19th June 2025. 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 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	✓

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	✓

The Board Assurance Framework themes overseen by this Committee and the Committee's overall level of assurance on their delivery is outlined in the table below in **bold text**.

The table also identifies BAF themes which are primarily overseen by other Committees but are also relevant to the work of the Committee. Those assurance ratings relate only to those themes as they apply to the remit of the Committee, e.g. assurance on the Trust's ability to create a "sustainable workforce" that can deliver the DERIC agenda.

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

3. Assurance Report from Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee

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

ALERT - The Digital, Education, Research, Innovation and Commercialisation (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, OR
Require the approval of the Board for work to progress.

- **EPR assurance and operational risks**
  The Committee noted that the EPR Implementation Assurance Meeting is not yet able to provide full assurance. Key assurance gaps remain in clinical risk visibility, supplier engagement and contract management, staff communication, and benefits realisation planning. Twelve open Apollo-related risks remain active, several rated major or very high, with issues concentrated around waiting lists and backlogs, Bluespier integration, theatre functionality, and CMM reliability. A backlog of patient record validation continues to present a resource and cost challenge. A business case for additional administrative and clinical support is being developed to address this. The Committee agreed this should be prioritised to maintain data quality and operational resilience. It also highlighted the need for clearer accountability and KPI monitoring of System C's contractual responsibilities to ensure appropriate supplier performance management.

- **Research and clinical audit data access from Apollo**
  There remains no functional route to access Apollo data for research and audit activity, which poses a material risk to research delivery, NIHR funding readiness, and clinical audit compliance. The Committee agreed that resolving this must be a priority and acknowledged that enabling compliant research access may require investment or a supplier change request.

- **Governance and action management discipline**
  The Committee remains concerned by repeated deferrals of action-log deadlines, which weakens assurance and tracking of progress. A review is under way to tighten processes, including clearer accountability and escalation for repeated slippage. Strengthened oversight of Committee actions is supported.

3.2 Areas of on-going monitoring with new developments

ADVISE - The Digital, Education, Research, Innovation and Commercialisation (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:

- **Cyber security posture**
  The cyber security environment remains high-risk regionally, although local controls are improving. Recent Oracle vulnerabilities were managed effectively through system-wide supplier coordination, and multi-factor authentication has now been implemented for remote access. Participation in the national Cyber Security Operations Centre (CSOC) continues to enhance detection and response capability, with further monitoring functionality in development. The Committee agreed that staff education and awareness remain critical, and plans are in progress to embed cyber awareness and digital safety into workforce training and mandatory learning.

- **Windows 11 rollout and system usability**
  Deployment continues across non-clinical areas, but remains paused in clinical environments pending resolution of application compatibility issues. Feedback indicates frustration with usability and configuration defaults; targeted support and communication are being arranged.

- **Digital Transformation governance and shared services**
  The re-named Digital Transformation Group continues to oversee progress against the digital strategy, including cyber posture and shared services work on federated data platforms and system integration. A consolidated shared services report and regular progress updates are now scheduled for each DERIC meeting.

- **Integrated Performance and Digital Dashboard**
  Development continues to ensure alignment with Apollo metrics and Board Assurance Framework measures. Demonstration was requested for the next meeting to review data quality and reporting maturity.

- **Pre-operative optimisation pathway**
  The new patient optimisation process, aligned with Apollo rollout, continues to demonstrate improved early assessment and pathway management. Approximately 7,000 patients remain unscreened, and a digital screening pilot using MyRecovery (200 patients) is pending governance approval. The Committee will continue to monitor inclusion, impact on theatre utilisation, and data automation.

- **Digital and cyber workforce development**
  A joint plan between Digital and Workforce teams is being formed to expand digital skills and cyber safety within mandatory training. Opportunities to utilise national training resources and system-level materials are being explored.

- **Private Patient Unit Independent Review**
  Feedback has been received from the independent review, further work is being developed and this will be an agenda item at a future Private Board meeting.

3.3 Areas of assurance

ASSURE - The Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee considered the following items and did not identify any issues that required escalation to the Board.

- **Corporate Risk Register and Board Assurance Framework**
  Corrections to risk scoring were confirmed (BAF 1 = 20, BAF 3 = 10). The Committee retains oversight of BAF 5 – Innovation and Growth and BAF 7 – Ability to Respond to Unforeseen Events. A full BAF review is in progress to reflect changes in the digital and innovation landscape.

- **Cyber security operations and controls**
  Patching remains on schedule, CSOC monitoring and alerting are active, and participation in

the Cyber Associates Network continues to support shared learning. Multi-factor authentication is fully operational. Cyber resilience exercises are planned across the system in the coming months.

- **Education and Simulation**
  The SimLab programme continues to expand its digital learning offer through interactive tools, gaming, VR/AR applications, and 360° video content. The use of Medtribe software has streamlined event management and reduced administrative burden by up to 70%. Commercial development opportunities are being integrated into the wider Commercial Strategy, with assurance provided on progress.

- **Research Strategy**
  The new Research Strategy was approved, subject to refinement to improve outcome focus, measurable impacts, and clearer alignment to long-term objectives.

- **Apollo user engagement and collaboration**
  The Clinical Reference Group now meets weekly with good engagement, and collaboration with other System C sites (including peer visits) is under way to support configuration and learning.

- **Development of commercialisation capability**
  The Committee received an overview of the work to date on the development of the commercialisation capability and next steps. It was acknowledged that there are already some really good examples of where commercial opportunities are being developed such as the Orthotics 3-D Printing progressing of registration for inclusion on the national framework as a supplier. The Committee were updated on the planning milestones which includes the imminent recruitment of a Commercial Director, the development of the Commercial strategy and development of the Commercial Framework and Governance which collectively should provide the structure, prioritisation and focus required to develop and implement a number of commercial opportunities.

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.