The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Quality Account
2024/2025

Contents

Introduction

The safety and quality of the care that we deliver at Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is our highest priority. To support this, we undertake a review of the quality of our services on an annual basis and outline the progress we have made against our agreed quality priorities. As well as this we take the opportunity to acknowledge the challenges that we have faced in delivering care to the standard to which we aspire.

Each NHS Trust is required to produce an annual report on quality as outlined in the National Health Service (Quality Account) Regulations 2010. A Quality Account is a published report about the quality of services and improvements offered by an NHS healthcare provider.

The quality of services is measured by looking at:

- patient safety
- how effective patient treatments are
- patient feedback about care provided

The quality account is published every year on our website and enables us to explain our progress to the public and allows leaders, clinicians, governors, and staff to demonstrate their commitment to continuous, evidence-based quality improvement.

Through increased patient choice and scrutiny of healthcare service, patients have rightfully come to expect a higher standard of care and accountability from the providers of NHS services. Therefore, a key part of the scrutiny process is the involvement of relevant stakeholders. To that end, one of the requirements for inclusion with the quality account is a statement of assurance from these key stakeholders and evidence of how the stakeholders have been engaged.

In addition, as NHS Foundation Trust we are required to follow the guidance set out by NHS England regarding the quality account and for which there are several national targets set each year which we monitor the quality of the services we provide.

Through this quality account, we aim to show how we have performed against these national targets. We will also report on locally set targets and describe how we intend to improve the quality and safety of our services moving forward.

Foreword from the Chief Nurse and Patient Safety Officer and the Chief Medical Officer

The Trust's aspiration is to improve lives through excellent and innovate care; with quality, safety, and patient experience sitting firmly at the core of this.

During 2024/25 our focus has been to continue reducing our waiting times across all our specialities, working with the Getting it Right the First Time (GiRFT) teams to ensure our patient pathways are effective, to optimise both patient experience and our operational capacity that will enable to see our patients quicker. The Trust continues to build on the significant improvements made in relation to Infection Prevention and Control, to ensure that providing quality care remains at the heart of everything we do, every day.

Despite these challenges we continued with our aim to deliver outstanding patient care to every patient, every day. Our staff have adapted and continue to deliver the high level of care of which we are so proud. This has been reflected in the feedback received from our patients.

As we move into 2025/26 our focus will be to deliver on the Trust strategic objective of delivering high quality clinical services by:

- Ensuring the highest standards of care for our patients.
- Empowering departments to develop services.
- Optimise productivity and efficiency within our services.
- Ensure a fair, equal and inclusive culture across the Trust.

PART 1
Statement on Quality from the Chief Executive Officer

It gives me great pleasure to introduce our annual Quality Account, sharing with you our achievements and celebrations over the past year, as well as the challenges and the improvements made. This Quality Account sets out our key achievements in 2024/25, as well as sharing our priorities for 2025/26.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has recently redefined its vision, stating a goal of improving lives through excellent and innovative care. It is a clear statement – and one that we have shaped in collaboration with our own staff. Having launched it recently, it will be a statement that guides us in our work. Our Quality Strategy is at the core of our vision, as it ensures that quality and patient safety are at the heart of everything we do.

This year has been a milestone year for RJAH. Our efforts to reduce waiting times and improve access to care were given a major boost with the official opening of a new theatre, which will play a key role in our ability to meet government targets for elective recovery in the coming months.

Among the other notable highlights, our commitment to improving end-of-life care was reinforced as we pledged our support to the national Swan Model of Care. This initiative will enhance the experience of patients and families during the end-of-life journey, with a focus on personalised, compassionate care.

The Trust's unwavering support for Armed Forces personnel was also reinforced as we renewed our commitment to the Armed Forces Covenant. This reaffirmation underscores our dedication to veteran care and supporting Armed Forces staff transitioning into NHS roles.

We also saw validation of our work from a number of staff and patient surveys. The National NHS Staff Survey, which is undertaken by more than 300 NHS organisations, again provided very positive feedback. We were ranked third nationally for overall patient experience. Our dedication to excellence in cleanliness and food standards was also once again recognised. We are proud to have achieved the distinction of having the cleanest wards and rooms in the NHS for the fourth consecutive year, and our food was rated the best in the country for the 18th time in the past 19 years. This continues to reinforce our commitment to providing an environment that promotes patient safety and comfort.

September 2024 saw the publication of the Care Quality Commission Adult Inpatient Survey 2022. Once again, we were delighted with the excellent feedback we received from our patients over the past year. We were ranked second for overall care and treatment and, additionally, we were named one of only nine Trusts in

England delivering results "much better than expected,". This is a testament to the hard work and dedication of our staff.

Quality is at the heart of every decision we take and, with the significant contribution of staff from across the hospital, we will strive to keep improving in 2025/26 to deliver ever higher levels of patient experience and care.

I confirm that to the best of my knowledge the information outlined in this document is true.

Stacey Keegan,
Chief Executive Officer
XX June 2025

PART 2
Priorities for improvement

Our Quality Improvement Priorities for 2025/26

Deciding on our quality priorities for the coming year

This part of the report describes the areas for improvement that the Trust have identified for the year 2025/26. The quality priorities have been derived from a range of information sources, including any emerging national quality priorities, learning from patient safety reviews and improvements that have been identified as part of introducing the Trusts Quality Accreditation Programme.

This year saw the introduction of the Trusts Quality Accreditation Programme. The Quality Accreditation Programme is quality assurance audit based upon the five key lines of enquiry as set by the CQC. Each ward has now received their first assessment, and this will be rolled out to other departments in 2025/26.

Each of the quality priorities outlined below were monitored throughout the year via existing governance structures which will be described in more detail below.

Patient Safety	
1. Inpatient Falls Prevention	
Objectives	• To improve documentation and record keeping in relation to falls risk assessments and management plans. • To Improve the use of visual aids that highlight if a patient is at risk of falls. • To introduce the new post-fall toolkit
Rationale	An area of improvement identified through the quality accreditation programme, was the need the need to improve record keeping in relation to falls prevention and to ensure visual aids that highlights a patient being at risk of falling is consistent across all inpatient wards.
Measures	• Improved compliance with completion of risk assessments and management plans. • Improved compliance with the use of visual aids.
Board Sponsor	Sam Young, Interim Chief Nurse, and Patient Safety Officer
Oversight Committee	Patient Safety Meeting with upward reporting to Quality and Safety Committee.

Patient Safety	
2. Recognising and Managing Deteriorating Patient	
Objectives	• To introduce a deteriorating patient simulation study day, to improve the early recognition and management of the unwell patient • To improve the use of fluid balance charts across the Trust
Rationale	An area identified through completed patient safety reviews and the quality accreditation programme, is the need to support staff in the early recognition of

	a deteriorating patient and to improve the use of fluid balance charts, across the Trust, ensuring their use is meaningful and when used, that they are comprehensively completed.
Measures	• Reduction in the number of patient safety reviews requested due deterioration • Uptake of simulation training amongst clinical staff • Improved compliance (through Tendable audit) in the completion of fluid balance charts
Board Sponsor	Ruth Longfellow, Chief Medical Officer
Oversight Committee	Patient Safety Meeting with upward reporting to Quality and Safety Committee.

Clinical Effectiveness	
3. Improving the effectiveness of clinical information sharing	
Objectives	• To introduce bedside nursing handovers • To introduce visual Quality Dashboards in ward/departmental areas • To review the effectiveness of safety huddles in the ward environment • To review the effectiveness of "Link Nurse" meetings • To introduce new patient bed boards across the trust
Rationale	An area of improvement identified through the quality accreditation programme, was the need the need to improve communication across clinical staff in a variety of ways, as outlined in the above objectives.
Measures	• Improved communication with staff in understanding ward (quality) performance • Reduction in incidents relating to communication in ward area • Improved scores through Well-led on the quality accreditation assessment
Board Sponsor	Sam Young, Interim Chief Nurse, and Patient Safety Officer
Oversight Committee	Patient Safety Meeting with upward reporting to Quality and Safety Committee.

Patient Experience	
4. Introduction of a complex care pathway for patients with mental health needs, learning disability and/or autism	
Objectives	• Improving the experience of those patients with LD&/or A or mental health needs
Rationale	Learning from patient safety reviews and patient experience has identified the need to introduce a pathway for patients with additional needs. Identifying patients who require reasonable adjustments earlier in their patient pathway will offer a more co-ordinated and positive experience, when visiting the hospital.
Measures	• Reduction in the number of communication incidents reported • Reduction in the number of patient complaints
Board Sponsor	Sam Young, Interim Chief Nurse, and Patient Safety Officer
Oversight Committee	Patient Experience Meeting with upward reports to Quality and Safety Committee.

Statements of Assurance from the Board

In this section we report on matters relating to the quality of NHS services provided as stipulated in regulations. The content is common to all providers so that as can be compared across NHS Trusts.

Review of Services

During 2024/25, The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust provided three NHS services, in Musculo-skeletal surgery, medicine and rehabilitation.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in all these health services.

The income generated by the relevant health services reviewed in 2024/25 represents 100% of the total income generated from the provision of NHS services by The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust for 2024/25.

Participation in Clinical Audit

During 2024/25, 11 National clinical audits covered NHS services that the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust provides.

During that period, The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust participated in 11 out of 11 (100%) National Clinical Audits that it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust participated in during 2024/25 were as follows:

- National Falls & Fragility Fracture Audit Programme - National Audit of Inpatient Falls
- Learning from lives and deaths - People with a learning disability and autistic people (LeDeR)
- KO41A Return - NHS Complaints
- NCEPOD - Emergency (non-elective) procedures in children and young people
- NCEPOD - Blood Sodium
- Perioperative Quality Improvement Programme
- National Joint Registry
- ICNARC Case Mix Programme (CMP)
- National Comparative Audit of Blood Transfusions
- Epilepsy 12: National Clinical Audit of Seizures and Epilepsies for Children and Young People
- National Early Inflammatory Arthritis Audit (NEIAA)

The reports of 16 local clinical audits were reviewed by the provider in 2024-2025 and The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust intends to take the actions set out in below to improve the quality of healthcare provided.

No.	Project Ref	Action Plan
1	2223_037 Blood Sample Collection and Labelling National Comparative Audit of Blood Transfusion	1. Training new medical professionals – addition to medical professional induction 2. Include in venepuncture skills training 3. Visual aid to be put on all blood trolleys
2	2324_022 Compliance with NG 199: Clostridioides difficile infection: antimicrobial prescribing	1. Quicker access to antibiotics for CDI diagnosis 2. Immediate prescribing of antibiotics when a confirmed diagnosis of CDI 3. Medication review and fluid chart to be undertaken for all patients with CDI 4. Delays of antibiotics for CDI patients should be reported as a patient safety incident
3	2223_032 Epidemiological Study of OPLL in a Western Tertiary Hospital	1. Share findings with the Unit
4	2223_052 Clinical Audit of adult cardiac surveillance in DMD	1. Discuss with bookings team to speak to patients about bringing their slings to appointments when confirming booking 2. Liaise with ECHO techs to find out when patients are seen locally for deep dive
5	2324_025 Tofacitinib prescription and NICE guidance	1. Better documentation of DAS-28 / PsARC scores 2. Education on including lipid screening and CVS risk assessments for patients starting JAKi
6	2425_003 Outcomes of new patient referrals to Spinal Disorders at RJAH	1. More timely investigations to be included with referral 2. Vetting referral form to be completed by the referrer
7	2324_012 The Rheumatology Advice Line	1. Share findings with team 2. Update patient information leaflet 3. Review messaging for service on website and voicemail service
8	2425_009 Documentation of relevant comorbidities on discharge summaries at RJAH	1. Co-morbidity recording to be mandatory on patient records 2. Discharge summary to include co-morbidities
9	2021_038 Audit of the Critical Care Operational Policy	1. Improve documentation of time and decision to admit patient on HDU note 2. Identify patients at pre-op stage who needs a HDU stay – implement frailty scoring
10	2324_021 Timing of the most recent imaging of patients undergoing elective Foot & Ankle surgery	1. Ask Bookings to plan x-ray for same day as pre-op 2. Review date of scan at pre-op to ensure it is within 6 months 3. Sharing findings with medical professionals

11	2425_015 Re-audit of compliance with IR(ME)R procedure	1. Maintain compliance following the introduction of e-referrals 2. Maintain IRMER training for radiographers
12	2223_048 Bilateral Knee Replacements - A review of immediate post-surgical outcomes	1. Share findings with unit
13	2324_032 Post Operative Blood Test SOP Audit	1. Share findings at MDCAM 2. Add guidelines in medical professional induction
14	2425_010 Upper GI Bleed Re-Audit 2021_001	1. Present at medical weekly lunchtime meet to share the need for a risk assessment 2. Share the need to contact Gastroenterology team if upper GI bleed is possible 3. Share the need to inform GP if patient is considered to have upper GI bleeding
15	2425_019 Soft Tissue Cryoablation Treatment Procedure Safety at RJAH	1. Arrange baseline MRI with contrast 2. Schedule follow up scans at 3, 6 and 12 months 3. Improve documentation of patient pain before and after procedure
16	2425_037 Learning Response Review	1. Improve information available to individuals invited to AAR/MDTs 2. Continuously capture feedback from key stakeholders about process 3. Include Quality Improvement initiatives to agenda for Patient Safety, SNAHP and Unit Governance 4. Update the PSIRP plan with revised patient safety priorities

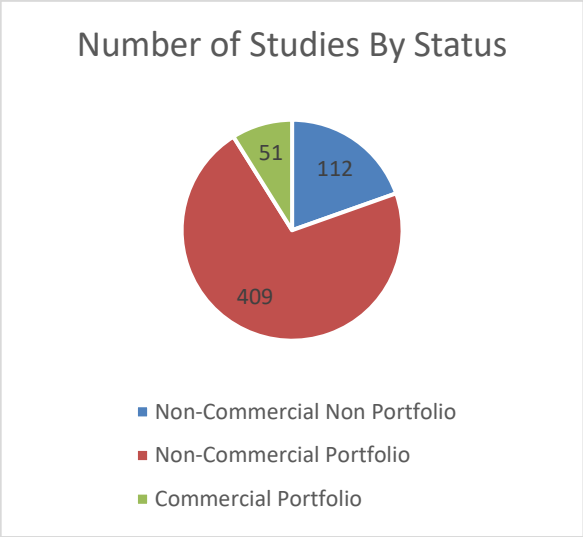
12 Service Evaluation projects reports were reviewed by the provider in 2024 – 2025 as follows:

No.	Project Ref	Action Plan
1	2324_029 Evaluation of surgical booking length of stay for paediatric patients	1. Review Trust data to compare to national metrics 2. Ensure Bluespier consultant templates are accurate, and IP/DC status is considered when booking
2	2324_011 The effect of the inability to alter and supply same day insoles to HBC patients	1. Improve direct communication between admin, workshop, and orthotic assistants for 1-week urgent referral patients 2. Submit an insole technician mini workshop business care at SaTH
3	2324_017 Patient outcomes from Offloading knee braces for uni-compartmental Osteoarthritis	1. Change OA knee brace stock to Unireliever
4	2425_001 Patient & Parent/Care Service Feedback Audit	1. Produce patient information leaflet 2. Improve provisions for teenagers admitted onto the ward

		3. Arrange paediatric specific pain training
5	2425_020 Patient Centred Care within Radiology Service Evaluation	1. Develop clear and agreed standards for patient-centred care 2. Improve reception and waiting area signage
6	2223_006 An Evaluation of Operative Rates in Osteochondritis Dissecans of the Knee	1. Agree pathway between Paediatrics and Knee Sports departments 2. Follow up MRI requests
7	2324_031 Service Evaluation of the Safeguarding Checklist for Inpatients	1. Create a resource bank for patients and visitors 2. Create CPD resource bank for staff to increase awareness around reasonable adjustments 3. Record any reasonable adjustment requirements on new EPR 4. Distinguish complex care from safeguarding concerns 5. Capture feedback from LD&A patients about their experience at RJAH
8	2223_043 Service Evaluation of major paediatric surgery at RJAH	1. Create a flow chart for SOP, to indicate pre-op assessment pathways for all paediatric major surgery 2. Anaesthetic day 1 index review documented in standardised place
9	2425_013 Mepilex Border Post-Op Evaluation	1. Share findings at Patient Safety Working Group
10	2223_053 Service Evaluation for implementation of Enhanced Recovery Arthroplasty	None
11	2324_020 Assessing patient perspective of being in research study in the ASCOT Clinical Trial	None
12	2425_002 Radiological investigations in children - the role of the play specialist	1. Develop standardised pathway for referrals 2. Plan for the future; need and expansion of play specialist input 3. Understand patient/parental views of service

Participation in Clinical Research

Research at The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) continues to grow. The total number of studies active at the Trust during 2024/25 was 76, representing a 1.3% increase from the previous year. 54 of these were adopted onto the National Institute for Health Research (NIHR) portfolio, representing a 2% increase from the previous year.



The number of participants that were enrolled in research eligible for inclusion in the NIHR portfolio was 460 (Figure 1). This represents a 14% reduction on 2023/24 (538). The total number of patients recruited in 2024/25 was 572 (Figures 1 and 2). This is a 57% reduction on 2023/24 and reflects a reduction in the number of studies with large recruitment targets in 2024/25. For FY 2023/24, the number of patients approached and offered the opportunity to participate in research accounted for 2.5% of total patient episodes. Recruitment to research opportunities accounted for 2.3% of total patient episodes. At the time of preparing this report, data for 2024/25 was not available. Increasing the number of patients being offered particpation in research as a percentage of total patient episodes, and thereby, increasing the number of patients participating in research as a percentage of total patient episodes remain clear objectives of the Research Department going forward.

Overall, across the West Midlands RRDN (Regional Research Delivery Netwrok), recruitment is 5% lower than last year with non-acute, primary care and wider care settings being most impacted. This is further reflected in the overall reduction is commercial recruitment in 2024/25 which is 75% behind on 2023/24 across the West Midlands RRDN. Non-actue settings are 46% behind on commercial studies and 1% behind on non-commercial activity compared to 2023/24. Recruitment/100k of population is third lowest in the West Midlands compared to other regions although the percentage of recruitment in interventional studies is second highest, and the actual number is fourth highest compared to other regions.

Balancing the portfolio of commercial and non-commercial studies will be an important focus over the coming years and we continue to support home-grown studies sponsored by the Trust. These studies accounted for 21% of our research in 2024/25 and when this extended to include collaborations between clinicians and local academics, sponsored studies accounted for 25% of research studies in 2024/25. 62% of our projects are hosted studies and involve academic and non-academic sponsors. Commercial studies, which bring in the most money for the Trust, made up 22% of RJAH based projects in FY 2024/25. These studies fall into the RRDN speciality areas of Cancer, Children, Dementia and Neurodegeneration, Neurology, Public Health, Trauma and Emergency Care, Surgery, Musculoskeletal and Orthopaedics, and Anaesthesia, Peri-operative Medicine, and Pain Management.

The West Midlands has had its highest ever annual number of responses (49% ahead of 1533 target) to the PRES survey (Participant in Research Experience Survey) which had a stretch target of 2,000 responses. RJAH remains in the top third for PRES numbers. This is reflective of engagement between the researchers, the research Department and research participants at RJAH.

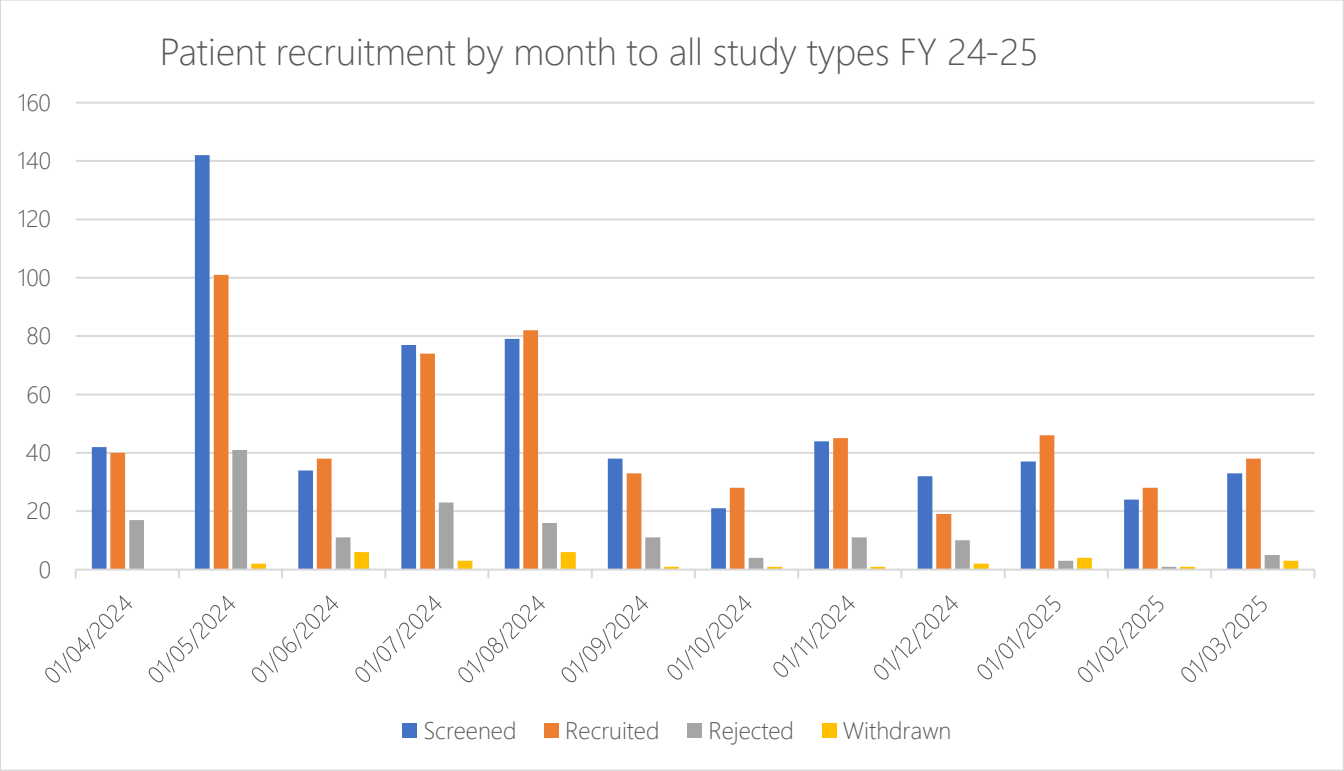


Figure 2. Patient recruitment by month to all study types for the year 24/25.

John Charnley Laboratory and MHRA Inspection

The John Charnley Laboratory is a licensed manufacturing unit under the Medicines and Healthcare products Regulatory Agency (MHRA) that produces Oscell used in Autologous Chondrocyte Implantations (ACI) for articular cartilage lesions.

The MHRA is an executive agency of the Department of Health and Social Care, responsible for ensuring that facilities involved in the manufacturing of medicines and medical devices comply with good manufacturing practice (GMP). Any facility with a MHRA licence must demonstrate evidence of GMP compliance as a minimum standard. The activities concerning manufacturing process within the laboratory are therefore regulated under the MHRA licence. In addition, the unit has MHRA MIA (IMP) licence for manufacturing advanced therapy medicinal product (ATMP) under which the unit is able to manufacture chondrocyte preparations for clinical trials.

Following inspection in September 2024 by the MHRA, the unit was considered to have unsafe practices and procedures with two critical and two major deficiencies identified. The unit was referred to the MHRA Action group and both licences for the Trust have been suspended until September 2025. This has meant that the unit has ceased manufacturing cells for surgical procedures, although manufacturing for research purposes (using cadavers) has been continued as this does not fall under the licence of the MHRA. In view of the MHRA licence

suspension, the business continuity plan for treating patients with ACI has commenced using an external provider (Spherox). Spherox are a manufacturing company based in Europe who provide the cell manufacturing element of the ACI procedure and are not subject to MHRA licencing in the United Kingdom.

In response to the inspection findings the Trust has commissioned an expert external provider (EPIC) to review the findings of the MHRA inspection and to support the Trust with a gap analysis and actions required to regain the licence to manufacture. EPIC have advised the Trust that to regain the MHRA licence the unit requires significant investment involving workforce, equipment, and quality assurance.

In addition to the Trust commissioning a review by EPIC, the trust has internally reviewed governance arrangements for service areas that are strictly regulated and the function of the Regulatory Oversight Group. The terms of reference for the meeting have been revised and re-established as the Regulatory Oversight Meeting, chaired by the Chief Medical Officer, which now directly reports to the Quality and Safety Committee.

The Trust are currently scoping most cost-effective options available to maintain the Trusts ability to provide an ACI service and understand the impact on research within the unit.

CQC registration

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration is without conditions. The Care Quality Commission has not taken any enforcement action against The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in 2024/25.

During December 2018, the CQC conducted an inspection of the Trust and at this time, the Trust was given an overall rating of 'Good' with care found to be 'Outstanding', with the breakdown of ratings show in the table below:

Ratings for The Robert Jones and Agnes Hunt Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Surgery	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019
Critical care	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Requires improvement ↓ Feb 2019	Requires improvement →← Feb 2019
Services for children and young people	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Outpatients	Good Feb 2019	N/A	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Diagnostic imaging	Good Feb 2019	N/A	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Overall*	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019

The full CQC inspection report can be found at the following link: https://www.cqc.org.uk/provider/RL1/services

In response to the inspection report from February 2019, the Trust put in place and completed a robust action plan to address the areas for improvement highlighted by the CQC. A further inspection was planned during 2020 however this continues to be deferred by the CQC.

Secondary Uses Service Submission

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust submitted records during 2024/25 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the latest published data (December-24) which included the patient's valid NHS number was:

- 99.8% for admitted patients care.
- 99.5% for outpatient care

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 100% for admitted patients care.
- 100% for outpatient care

The following has been maintained throughout 2024/25:

Continuing to raise the awareness and profile of data quality, developing within the Trust a positive culture, through encouraging best practise and promoting new processes, and ensuring that all staff recognise that they have a responsibility for ensuring a high standard of data quality.

- Regular Data Quality Assurance Group meetings held.
- A robust Audit framework that provides assurance for key performance indicators as reported in the Trust's Integrated Performance Report (IPR).
- Compliance with all data quality standards as specified within the Data Security and Protection Toolkit.

Throughout 2024/25 the major focus for Data Quality has been the support provided to implementation of the new EPR system (Apollo). This includes:

- Validation and testing of migrated data from current EPR to new EPR
- Support to Apollo and Operational Teams with configuration of new system
- Dashboards built in readiness for Go Live to monitor data quality throughout implementation period.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, personal identifiable information. The NHS Information Governance Framework is supported by a data security and protection toolkit and the annual submission process provides assurances to the Trust, other organisations and to individuals that personal information is dealt with legally, securely, efficiently, and effectively.

The Trust has an established information governance management framework and continues to develop information governance processes and procedures in line with the Data Security and Protection Toolkit (DSPT). The Trust`s Information Governance status is the subject of ongoing review by the Information Governance Meeting which is responsible for reviewing policy and monitoring compliance with Department of Health and Social Care Guidelines. This process is overseen by the Audit and Risk Committee which also has a role in ensuring that all serious data governance risks or incidents are brought to the attention of the appropriate Board Committee. The Trust has in place the Chief Medical Officer as the Caldicott Guardian, and the Director of Digital as the Senior Information Risk Owner (SIRO). Further, Trust Secretary is the Data Protection Officer.

The requirements of the Data Security and Protection Toolkit (DSPT) are designed to encompass the National Data Guardian review's ten data security standards.

The Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust's Information Governance DSPT score overall for 2024/25 has not yet been determined as the final submission date is 30 June 2024.

For 2023/24 the Trust's score was STANDARDS MET.

During 2023/24 the Trust identified and reported no serious IG breaches.

Seven Day Working

The seven-day services programme has been designed to ensure patients receive high quality consistent care across all seven days of the week. As an elective centre, the Trust does not receive emergency admissions in the same way as an acute hospital, being aware of emergency admissions in advance which enable the Trust to ensure appropriate multidisciplinary teams are in place. The Trust offers several seven-day services appropriate to the service requirements of an orthopaedic elective centre. This is regularly reviewed based upon patient requirements and feedback, to ensure our services reflect the needs of our patients.

NHS Outcomes Framework: Review of performance against mandated indicators

Summary

The NHS Outcomes Framework (NHS OF) is a set of indicators developed by the Department of Health and Social Care to monitor the health outcomes of adults and children in England. The framework provides an overview of how the NHS is performing. This report provides information about the indicators updated in this release.

Proposals for changes to the NHS Outcomes Framework were proposed as part of a wide-ranging consultation on statistical outputs that ran from December 2023 to March 2024. The results of this consultation are now in their final stages of approval.

The latest publication updates five of the NHS OF indicators that are expected to continue in future, regardless of the results of the consultation.

Highlights

The February 2025 release provides new data for the following indicators:

- 2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions
- 2.3.ii Unplanned hospitalisation for asthma, diabetes, and epilepsy in under 19s
- 3a Emergency admissions for acute conditions that should not usually require hospital admission
- 3.2 Emergency admissions for children with lower respiratory tract infections (LRTIs)
- 5.1 Deaths from venous thromboembolism (VTE) related events within 90 days post discharge from hospital

Mortality

The Trust has a Learning from Deaths Policy in place in line with national requirements. This policy ensures that the Trust reviews all deaths in line with the NHSE framework and supports the requirements of the new Medical Examiner Service. We record all our expected and unexpected deaths, and all have a mortality review completed. These results are reviewed through the Trust Mortality and Resus Meeting. We have a lead consultant who chairs this meeting and reports to the Patient Safety Meeting. A quarterly Learning from Deaths report is presented at Trust Board.

Due to the small numbers of deaths across the organisation the HSMR and SHIMI are not monitored by the Trust. Further, the standardised mortality rates for hospitals, produced nationally by Dr Foster are not applicable to small specialist Trusts like The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, again because the numbers of deaths that occur are too small for change to be statistically significant. However, there is ongoing monitoring of all deaths which occur within the Trust with oversight by the Quality and Safety Committee, which reports to the Trust Board.

During 2024/25 fifteen patients of Robert Jones and Agnes Hunt Orthopaedic Hospital died. This comprised of the following number of deaths which occurred in each quarter of that reporting period: zero in the first quarter; five in the second quarter; six in the third quarter and four in the fourth quarter.

As of 31 March 2025, eleven case record reviews and two coroner's investigations have been conducted (case review outstanding in four cases from March 25) in relation to the fifteen deaths. In all cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was conducted were: zero in the first quarter; five in the second quarter; six in the third quarter and zero in the fourth quarter.

No patient deaths, representing 0% of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. Due to the small number of deaths that occur in the hospital, it is possible for every death to be tracked and reviewed and the data provided above is therefore accurate.

In 2024/25 the trust had zero deaths where COVID appeared on the death certificate.

Through the case record reviews and investigations the Trust identified an opportunity to improve liaison between the wards and critical care around the planning of limits for treatment. This has prompted a discussion between the MCSI Clinical Lead and HDU Clinical Lead for providing an opinion on treatment limits planned. A newly formed working group has reviewed the end-of-life care process, improving both training and links with local hospice.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described due to the small numbers of death that occur at the hospital it is possible for every death to be reviewed in detail. The Trust has continued with the implementation of the ongoing Learning from Deaths Policy including Medical Examiner Service introduced during 2023.

Helping people recover from episodes of ill health or following injury.

Readmission Rates

During 2024/25 the percentage of patients aged 0-15 years old, readmitted to the hospital within 28 days of discharge was 0% and for 16+ years old it was 0.55%.

Activity	No. of readmissions	% readmissions
01/04/2024	6	0.91%
01/05/2024	6	0.87%
01/06/2024	10	1.44%
01/07/2024	4	0.64%
01/08/2024	2	0.35%
01/09/2024	0	0.00%
01/10/2024	1	0.15%
01/11/2024	2	0.30%
01/12/2024	0	0.17%
01/01/2025	7	0.97%
01/02/2025	2	0.29%
01/03/2025	2	0.29%

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- No comparative data is currently available.
- Data is submitted and checked monthly as part of regular performance reporting

Quality Outcomes

The Trust contributes to the National Registries to collect outcomes data. Currently these include:

- British Spine Registry (BSR)
- National Ligament Registry
- UK Hand Registry
- Foot and Ankle Registry (BOFAS)
- British Hip Registry (NAHR)
- National Joint Registry (NJR)

RJAH continues to be awarded the 'NJR Quality Data Provider' award. This scheme has been devised to offer hospitals public recognition for achieving excellence in supporting the promotion of patient safety standards through their compliance with the mandatory National Joint Registry (NJR) data submission quality audit process and by awarding certificates the scheme rewards those hospitals who have met the targets. From the 2022/23 audit year onwards, a new three-tier, gold, silver, and bronze awarding system is being applied. The Trust achieved Gold-level in the last audit period and demonstrates the high standards being met towards ensuring compliance with the NJR.

The Trust also collects large volumes of PROMs (patient reported outcome measures) for total hip and knee procedures to submit to the national PROMS programme. The programme led by NHS England focuses on specific procedures. Health gains are monitored and reported on based on patient responses to a questionnaire before and after surgery. Published Patient Reported Outcome Measures (PROMS) data is available:

The data shows the scores for all the Trusts involved in the NHS PROMS programme in England. This programme monitors the improvement seen in joint replacements. Patient data is collected within a 12-week timeframe before their operation and 6-9 months following their surgery. Data is only representative of questionnaires that have been populated both before and after surgery. This does mean that the number of modelled records is less than the number of procedures actually carried out in that period.

Four areas are reported on by NHS England, Primary Hip replacements, Revision Hip replacements, Primary Knee replacements and Revision Knee replacements.

Oxford Hip Score (OHS) and Oxford Knee Score (OKS) are short 12-item questionnaires that are developed and designed specifically to assess patients function and pain. Each question can have a score of 0-4 and the overall total can provide a score from 0-48, the higher the score resulting in the best possible outcome. The EQ5D is a

separate questionnaire providing a quality-of-life score and is used wider than orthopaedics, similarly the higher the number the better the score.

The Trust's most recent data was published in July 2023 and provides the latest figures for 2020/21. Due to the pandemic, there are a lower number of submissions for this year, but the results still show that the Trust achieves good outcomes for its patients, particularly given the complex nature of the procedures it carries out.

The published data is shown below and provides the National Average for all NHS Trust involved in the National NHS PROMs programme in England. It also provides the Highest Score achieved and the Lowest Score achieved within England. Over the years the Trust is seen to be exceeding or meeting the National Average.

Primary Hip Replacement

	EQ5D Index						Oxford Score					
	2016/17	2017/18	2020/21	2019/20	2020/21	2021/22	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
National Average	0.445	0.468	0.465	0.459	0.472	0.462	21.8	22.68	22.68	22.687	22.981	22.847
Highest Score	0.537	0.566	0.557	0.539	0.574	0.534	25.123	26.299	25.376	25.547	25.702	26.004
Lowest Score	0.310	0.376	0.348	0.352	0.393	0.376	16.428	18.871	18.752	17.059	17.335	7.310
Robert Jones and Agnes Hunt	0.453	0.489	0.496	0.468	0.470	0.522	22.211	23.574	24.429	24.135	24.129	24.933

Revision Hip Replacement

	EQ5D Index						Oxford Score					
	2016/17	2017/18	2020/21	2019/20	2020/21	2021/22	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
National Average	0.290	0.289	0.287	0.307	0.336	0.317	13.512	13.901	13.864	14.065	15.445	14.624
Highest Score	0.362	0.322	0.396	0.38	0.413	0.402	16.504	17.664	18.961	16.130	17.328	17.301
Lowest Score	0.239	0.142	0.206	0.238	0.253	0.323	10.253	10.735	7.853	10.648	13.338	13.724
Robert Jones and Agnes Hunt	0.334	0.298	0.248	0.297	*	*	13.719	15.912	10.387	14.177	*	*

Primary Knee Replacement

	EQ5D Index											
	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2021 /22	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2021 /22
National Average	0.325	0.338	0.338	0.335	0.315	0.324	16.546	17.259	17.330	17.486	16.886	17.625
Highest Score	0.404	0.417	0.405	0.419	0.403	0.417	19.884	20.635	20.011	20.688	20.25	20.634
Lowest Score	0.242	0.234	0.266	0.215	0.181	0.246	12.335	13.156	13.774	12.622	11.916	14.267
Robert Jones and Agnes Hunt	0.318	0.354	0.361	0.364	0.358	0.350	17.843	18.541	17.74	19.188	19.681	19.547

Revision Knee Replacement

	EQ5D Index						Oxford Score					
	2016 /17	2017/ 18	2018/ 19	2019/ 20	2020 /21	2021 /22	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2021 /22
National Average	0.273	0.292	0.288	0.295	0.299	0.317	12.346	13.124	13.598	13.840	13.499	14.624
Highest Score	0.296	0.328	0.297	0.394	0.230	0.323	13.781	15.444	15.784	16.384	12.425	13.772
Lowest Score	0.156	0.196	0.196	0.168	0.207	0.303	8.602	9.374	9.014	8.650	8.701	11.726
Robert Jones and Agnes Hunt	0.251	0.328	0.279	0.326	*	*	10.946	14.392	15.113	12.439	*	*

The above data is no longer published by NHS England but over the past couple of years work has taken place to expand our outcomes collection throughout the organisation and ensure that these measures are collected and analysed across all procedures and treatment taking place in the trust. Electronic data collection has allowed us to further expand to all teams within the organisation and any services that patients may require along the pathway. Regular data collection is now evolving for all teams and services that are listed below. We continue to work with other areas to ensure the work supports outcomes monitoring for all areas.

- Hip & Knee Arthroplasty
- Upper Limb
- Knee & Sports Injuries
- Foot and Ankle
- Spinal Disorders
- Physiotherapy
- Anaesthetics

Outcomes data is being used regularly in the organisation to monitor patients pain scores and quality of life while on the waiting list and following surgery/treatment. Data collected will support identifying areas of improvement for patient care and services. Patients signed up to the electronic data collection platform can monitor their own scores and can submit pains scores daily. The uptake of electronic data collection from patients is continuing to improve. Out of the four teams that are onboarded onto Myrecovery Upper Limb, Knee & Sports Injuries, Foot and Ankle and Hip & Knee Arthroplasty the below table displays the overall uptake.

	Financial Year	
	23/24	24/25
Patients Invited	9887	9575
Patient Registered	4268	5421
Registered %	43%	57%

As the PROMs data now starts to filter in to monitor health gains post operatively, regular reports on this data are currently in development and will be singed of in the next financial year. This data will be presented in the 2025/26 trust reporting.

Shared Decision Making

CollaboRATE is a questionnaire used to measure and support the evidence that shared decision making is taking place in the trust. Patients are asked three questions after their initial outpatient appointment has taken place about whether they have understood their health issues; how much effort was made to listen and how included patients felt when working through their options. The total score can range from 27 to 0, higher the score represents the more shared decision making took place. The table below displays the total amount completed and average score, split by the financial year the initial outpatient appointment took place.

	Financial Year	
	23/24	24/25
Patients Invited	9887	9575
Patient Registered	4268	5421
Registered %	43%	57%

The overall average is displaying as a positive score and that a satisfactory level of shared decision making is taking place with our patients overall. Further work is taking place to increase patient uptake.

NHS National Staff Survey

The principal aim of the staff survey is to gather information which will help the Trust to improve the working lives of our staff and so help to provide better care for patients. The staff survey provides the Trust with a wealth of information detailing staff views about working at the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust.

In 2024 the staff survey is aligned to the NHS People Plan, and the People Promise. The Trust holds monthly focus groups to look at the top three concerns, areas to focus on and good practice.

Key headlines:

- Completed questionnaires = 851

- Response rate = 47%
- Recommended as a place to work = 74% *(2023 data = 75.63%)*

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described as the Trust continues to participate and improve the Staff survey results.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by

- Implementation of the NHS People Plan
- Holding myth busting and 'it's ok to ask' sessions
- Monthly Staff Survey Focus Group
- Staff Network Groups

Ensuring that people have a positive experience of care.

Responsiveness to Inpatient's Personal Needs

The table below presents patient experience measured by scoring the results of a selection of questions from the National Inpatient Survey focussing on the responsiveness to personal needs.

	2018	2019	2020	2021	2022	2023	2024
National Average	8.1	8.1	8.4	8.1	8.1	8.1	Data not published until July 25
RJAH ORTHOPAEDIC HOSPITAL NHS TRUST	9.1	9.2	9.5	9.4	9.4	9.3	
Highest	9.1	9.2	9.5	9.4	9.4	9.3	

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described as the Trust has a robust patient experience programme in place that facilitates learning and implementing changes based on patient experience.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve its performance:

- Monitoring delivery of the Patient Experience Strategy
- Continued use of real time feedback on patient experiences
- Improved patient involvement in the review of patient safety events
- The production and completion of action plans in response to complaints

Patient Friends and Family Test

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. Patients are asked to answer the following question: "How likely are you to recommend our organisation to friends and family if they needed similar care or treatment" on the day of discharge or after they have had a clinic appointment. They are invited to respond to the question by choosing one of six options, ranging from "Very good" to "Very poor".

	2020/21	2021/22	2022/23	2023/24	2024/25
National Average	94%	94%	94%*	94%*	94%*
Highest Score	100%	100%	100%*	100%*	100%*
Lowest Score	65%	64%	73%*	75%*	69%*
The Robert Jones and Agnes Hunt	98%	98%	98%	98%	98%

**Data only available nationally up to Jan 25*

Treating and caring for people in a safe environment and protecting them from avoidable harm

VTE Assessment

Our patients often have difficulties mobilising which places them at an increased risk DVT or PE and as such the Trust's VTE assessment is of utmost importance to ensure that patients do not develop an avoidable DVT or PE.

The Trust has in place a robust system of audit to measure compliance with the VTE assessment process. Further, any incidence of DVT or PE is subject to a full incident analysis review to ensure that learning is taken. The Quality and Safety Committee receives regular reports on the Trust's work on VTE prevention.

The chart below outlines the percentage compliance for VTE assessments for the year (up to March 2025).

	2018-19	2020-21	2021-22	2022-23	2023-24	2024-25
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS TRUST	99.90%	99.90%	99.72%	99.80%	99.78%	99.83%
NHS England						90.6% *
HIGHEST	100%	100%				100% *
LOWEST	63.20%	67.50%				0% *

** Based on Q3 2024/25 Published data - Release Date 10 April 2025*

There was no national data comparison from 2020/21 to 2023/24. In 2024/25 the national submission was reinstated, therefore data for Q3 2024/25 is included for comparison in the table above.

The Trust monitors the monthly performance through its Integrated Performance Report and VTE Committee

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has in place a clinical lead for VTE who champions the VTE process amongst the clinical staff.
- Regular reviews and audits are undertaken to check compliance with follow up actions where required.
- The Quality and Safety Committee through the Patient Safety Meeting, receives regular reports on compliance with VTE assessments.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:
Established a VTE Group which reviews all events relating the VTE.

- Any themes or trends are monitored through this group and recommendations for improvement are shared with the Patient Safety Meeting members.

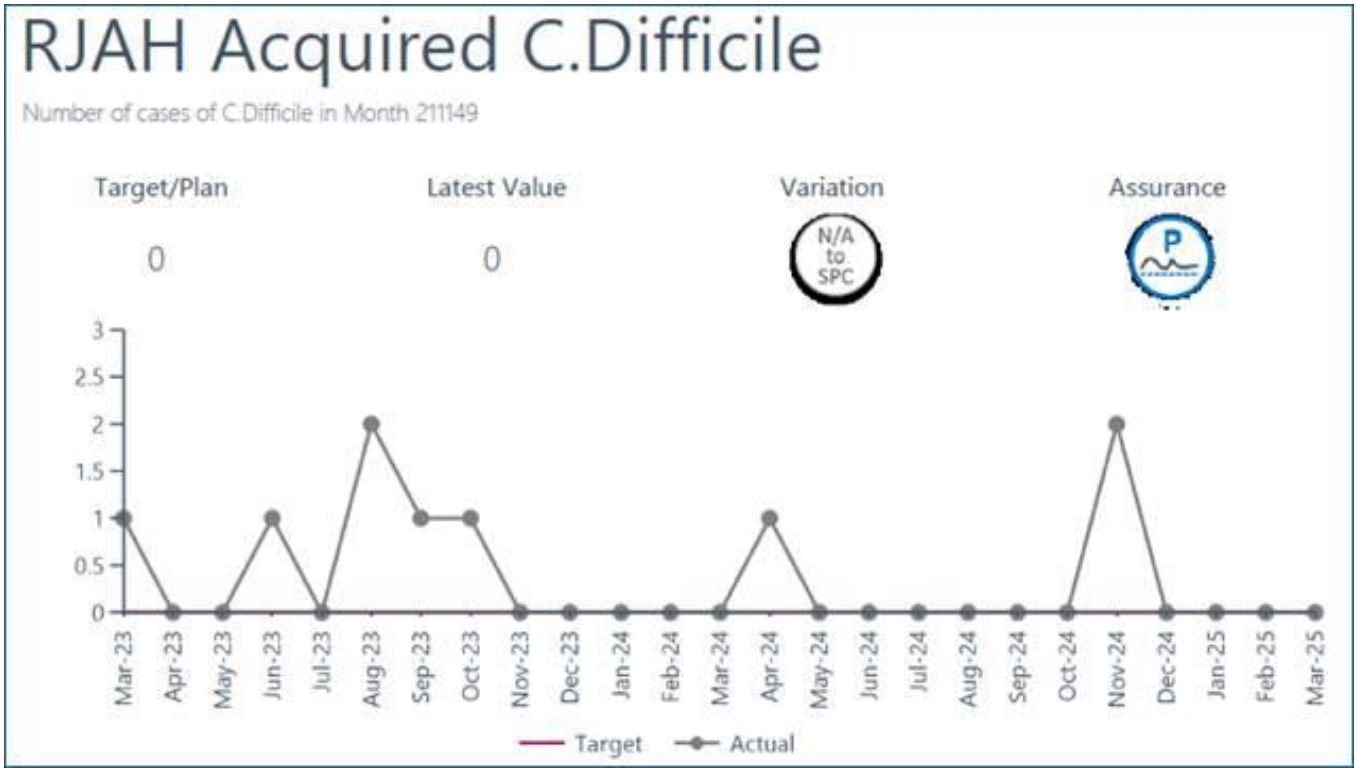
Clostridioides Difficile Infections (CDI)

The Trust measures infection control performance as a rate of Trust apportioned cases per 100,000 bed days of cases amongst patients.

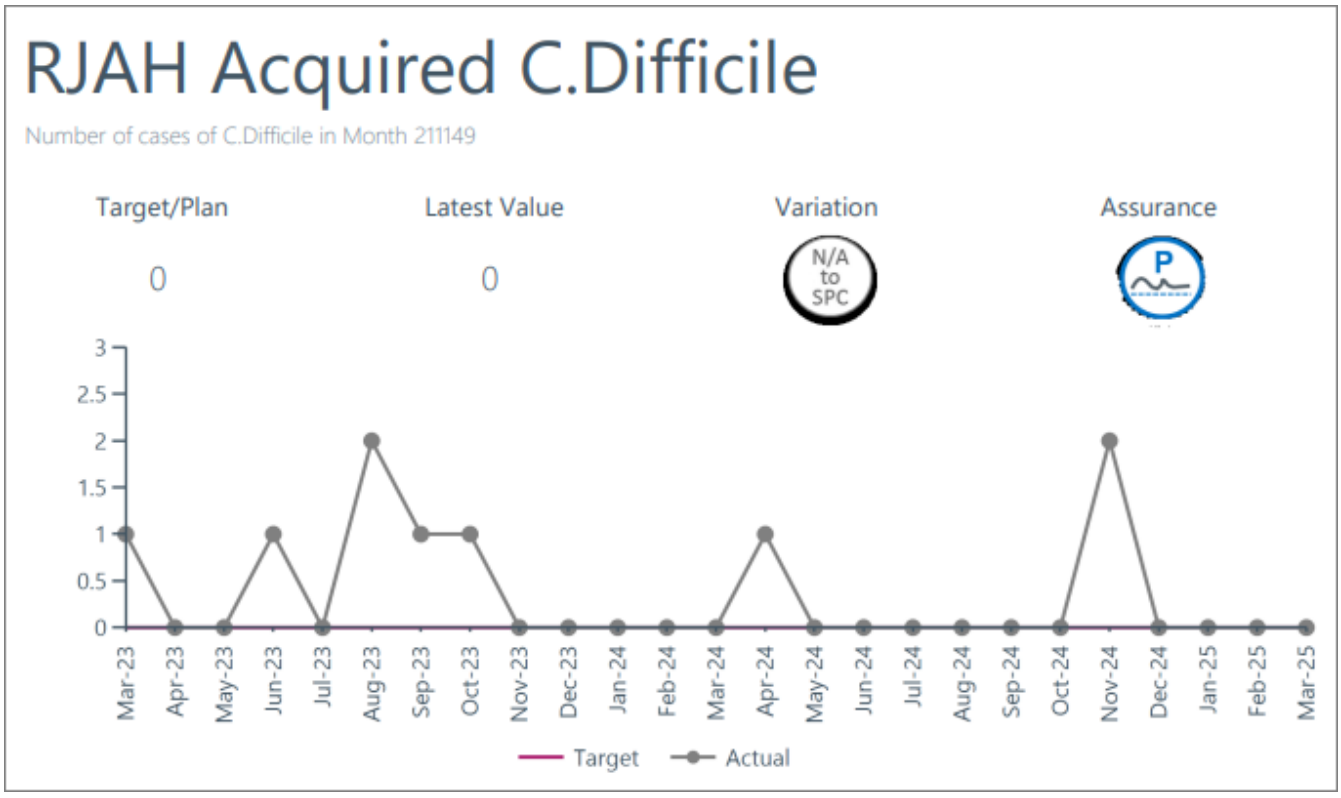
The Trust has had two attributable cases of CDI for the year 2024/25. This was against a target of four. Post infection reviews for both cases concluded that both cases were unavoidable.

A rise of hospital onset CDI has been observed nationally following the COVID-19 pandemic, whereas prior to this, rates were declining with some fluctuations. This change in trend to a steady increasing trajectory is of major concern and is the only data collection where there has been a major shift post pandemic. The UKHSA is conducting a review of the current surveillance dataset for CDI, to ensure the current questions are still relevant for the intended purpose.

Number of RJAH Acquired CDI



CDI Rates Per 100,000 Bed Days



The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described due to the data is reported and monitored monthly.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by:

- Continuing to conduct individual case reviews on all hospital acquired infections to ensure the Trust can learn and improve the quality of its care, and to share our findings with other NHS providers and NHSE.

Number of patient safety incidents and percentage resulting in severe harm/death

The hospital has a robust and established incident management process in place. The Trust uses an electronic reporting system which enables all incidents to be tracked from the point of reporting and on-going monitoring until closure of an incident, therefore promoting a timely response to notifiable incidents.

The tables below show the number of patient safety incidents reported each month during the reporting period and a breakdown by severity grading for these, including the proportion of incidents resulting in severe harm or death.

Patient Safety Incidents Reported per 1000 Bed Days

Period of Coverage	Rate of incidents	Number of incidents
Oct 24 - Mar 25	53.3	1397
Apr 24 - Sep 24	57.9	1527
Oct 23 - Mar 24	56.2	1480
Apr 23 - Sep 23	45.4	1196
Oct 22 - Mar 23	44.9	1176
Apr 22 - Sep 22	42.5	1119
Oct 21 - Mar 22	42.6	1116
Apr 21 - Sep 21	41.4	1092
Oct 20 - Mar 21	27.3	716

Patient Safety - Severe Harm / Death

Period of Coverage	Rate of incidents	Number of incidents	Comments
Oct 24 - Mar 25	0.34	9	9 deaths (3 end of life and 6 expected) and no severe harm incidents
Apr 24 - Sep 24	0.23	6	5 deaths (3 end of life and 2 expected) and 1 severe harm incident
Oct 23 - Mar 24	0.27	7	7 deaths (3 unexpected and 4 expected) and no severe harm incident.
Apr 23 - Sep 23	0.23	6	5 deaths (3 unexpected and 2 expected) and 1 severe harm incident.
Oct 22 - Mar 23	0.31	8	6 deaths (1 unexpected and 5 expected) and 2 severe harm incidents
Apr 22 - Sep 22	0.23	6	6 Deaths (3 unexpected and 3 expected) and 0 severe harm incidents
Oct 21 - Mar 22	0.38	10	10 Deaths (1 unexpected, 9 expected) and 0 severe harm incidents
Apr 21 - Sep 21	0.04	1	1 Deaths (1 expected) and 0 severe harm
Oct 20 - Mar 21	0.34	9	6 Deaths (1 unexpected, 5 expected) and 3 severe harm incidents

Footnote: Definition of Severe Harm/Death:

- Severe Harm: Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons.
- Death: Any unexpected or unintended incident that directly resulted in the death of one or more persons.

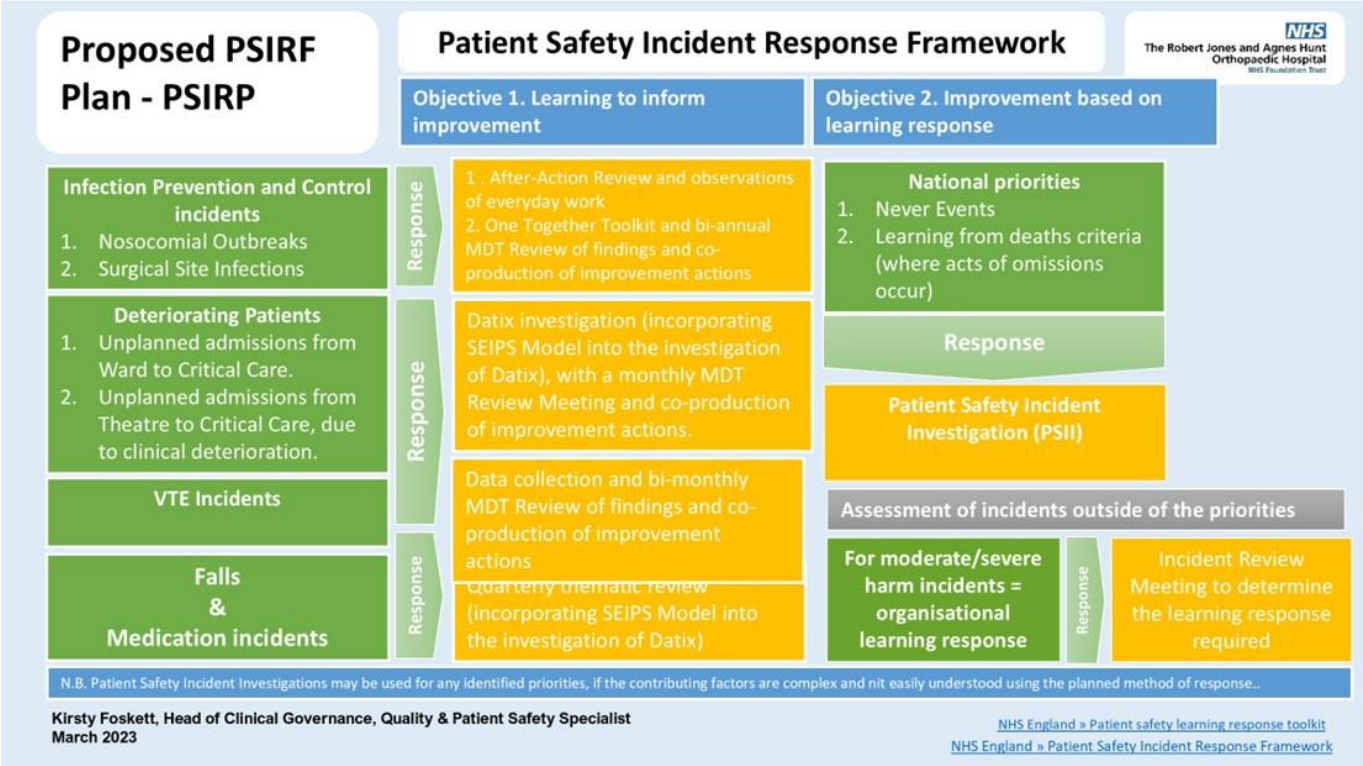
Patient Safety Incident Response Framework (PSIRF)

In October 2023, the Trust transitioned to the new Patient Safety Incident Response Framework (PSIRF), as part of NHS England's patient safety strategy. The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS.

PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

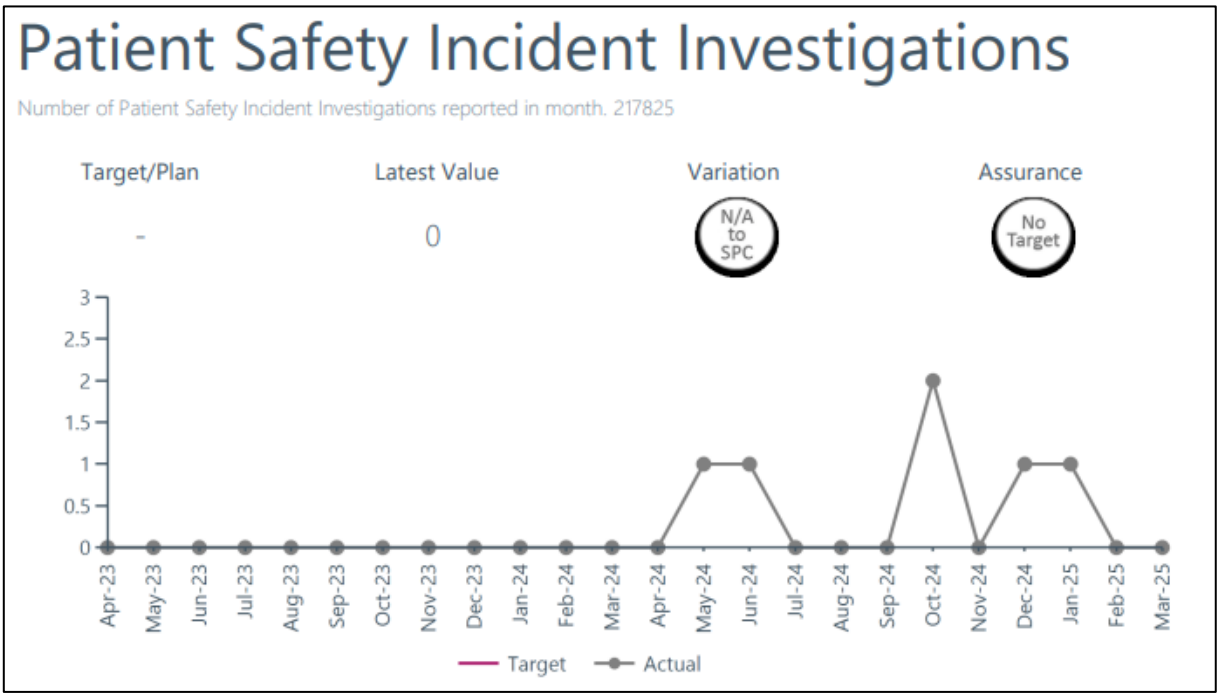
- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approached to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement.

Across 2024/25 the Trust has worked hard to embed the Trusts PSIRF policy and the deliver the priorities as outlined in the Trusts Patient Safety Incident Response Plan.



National PSIRF Priorities

Under PSIRF, the Trust are required to undertake a full Patient Safety Incident Investigation (PSII) if a patient safety event aligns with a national priority. There are several national priorities, two of which are particularly relevant for this Trus - Never Events and Learning from deaths criteria, where acts or omissions may have contributed to a patient's death.



In 2024/25 the Trust commissioned 4 PSII's that align the national PSIRF priorities, all of which were Never Events. Never Events are events that are considered to be wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

The four reported Never Events pertained to:

- Wrong Implant/Prothesis (2)
- Retained foreign object post procedure (2)

In comparison to 2023/24 only one never event was reported, relating to a wrong sided block.

A key learning point for the Trust from the PSII's that have been completed has been to introduce the revised National Safety Standards for Invasive Procedures (NatSIPPS2) across all departments in the Trust. As part of updating current practice to be in line with the revised standards, there has also been a focus on ensuring there is a robust audit process of the NatSIPPS2, as a source of ongoing assurance that the required standards are being met.

It is recommended that Trusts review their response plans, every 12-18 months to ensure that local priorities under PSIRF reflect the patient safety profile of the organisation. An evaluation of PSIRF was conducted through Q3 and small working group formed to review the outputs of the evaluation and to the local priorities to be included in the response plan.

In March 2025, the Trust Board received a presentation on the evaluation of PSIRF and recommendations to the update the Trusts Patient Safety Incident Response Plan, which were approved from April 2025 onwards.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has continued to undertake reconfiguration work on Datix to ensure more accurate capture of themes and trends in the categories of incident.
- Through the Patient Safety Meeting, the Trust is provided an overview of incident management within its Units.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by:

- Benchmarking of incident reporting against other Specialist Trusts
- Inclusion of patient safety events in the Multi-Disciplinary Clinical Audit Meeting attending by a cross section of clinical staff
- Embedding the principles of NatSIPPS2 and establishing a robust audit process as a source of ongoing assurance.

PART 3
Review of Quality

Summary of Performance Status for Quality Priorities Set for 2024/25

In line with the Trust's Quality Improvement Strategy, and in discussion with the Board of Directors, Council of Governors and other relevant stakeholders, the Trust identified the following key priorities for 2024/25:

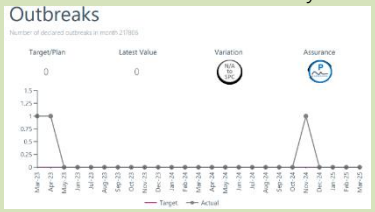
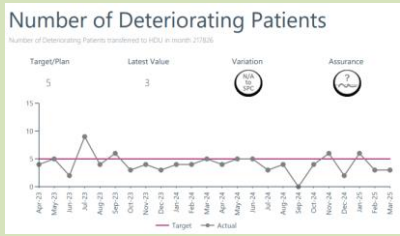
- Patient Safety: Learning from Infection Prevention and Control patient safety events, including Surgical Site Infections (SSIs) and nosocomial outbreaks
- Patient Safety: Learning from deteriorating patient, patient safety events
- Patient Safety: Learning from incidents of VTE
- Patient Safety: Learning from Medication safety events
- Patient Safety: Learning from Inpatient falls
- Clinical Effectiveness: Implementation of the GIRFT Pre-op Improvement Plan
- Patient Experience: Enhancing the experience of patients with Learning Disabilities, Autism and Dementia, who access our services.

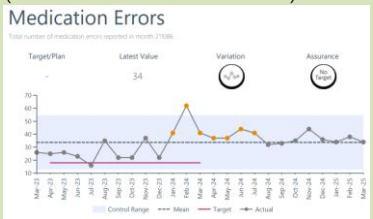
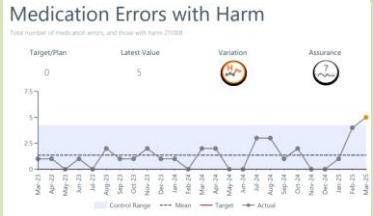
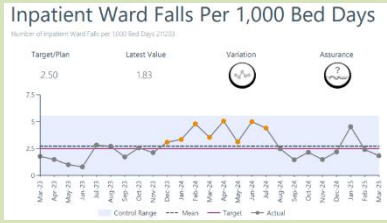
Progress made for quality priorities 2024/25

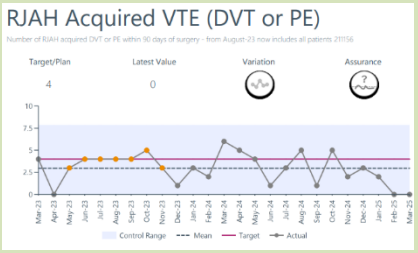
The following table gives an overview of the progress we have made for each of the quality priority areas and how the improvement work will be maintained in the coming year or continued.

It is important to remember that even though some priorities may be retired, this is not to say that the work ceases, but rather that the processes and systems for continued management of the improvement goal are well established and can be maintained outside of the Quality

Account process.

Priority	Objective	Measure of Success	Actions completed/taken	Achieved
PATIENT SAFETY				
1. Learning from Infection Prevention and Control patient safety events, including Surgical Site Infections (SSIs) and nosocomial outbreaks	To ensure that a systems-based approach is embedded in our learning response methods used to review SSIs or nosocomial outbreaks.	• A reduction in the number of SSIs • A reduction in the number of nosocomial outbreaks • Evidence of learning from safety events to identify areas for improvement.	• A well-established infection MDT is now in place, ensuring consistency in the cases defined as an SSI. • A review of the One Together pathway • Each patient confirmed to have an SSI has a review against the One Together standards. • Introduction of six-monthly SSI reviews using a systems-based approach to identify learning for improvement. • Introduction of After-Action Reviews, in line with PSIRF for all nosocomial outbreaks.	Fully achieved.  A decreased in surgical site infections has been noted across the year.  There was only 1 outbreak reported in 2024-25
2. Learning from deteriorating patient, patient safety events	To ensure that a systems-based approach is embedded in our learning response methods used to review deteriorating patient, patient safety events.	• Annual Deteriorating Patient Audit • Increase in NEWS2 Audit compliance. • Monitoring of the Deteriorating Patient KPI • Evidence of learning from safety events to identify areas for improvement. • Reduction in the number of deteriorating patient events, associated with the management of diabetes.	• Established weekly Patient Safety Incident Review Group, where all incidents of note are discussed and agreed if a further review is required. • Learning from deteriorating patient reviews has led to the implementation of guidance in pre-op to include frailty scoring and a review of how patients are booked for a critical care stay, post-surgery. • A review of diabetic policies, including variable infusion rates. • Learning from deteriorating patient reviews led to a review of the non-elective surgical admission passport.	Partially Achieved. NEWS2/Deteriorating patient Audit planned to be completed in Q1 2025/26. The number of deteriorating patients remains static across 2024-25. Through patient safety reviews the learning identified has been used to shape the Trusts quality priority for 25/26 

Priority	Objective	Measure of Success	Actions completed/taken	Achieved
3. Learning from Medication Safety Events.	To ensure that a systems-based approach is embedded in our learning response methods used to review medication safety events.	• Reduction in number of medication incidents with harm • Evidence of learning from safety events to identify areas for improvement.	• Established weekly Patient Safety Incident Review Group, where all incidents of note are discussed and agreed if a further review is required. • Introduction of quarterly thematic reviews of all medication events, using a systems-based approach to identify learning for improvement. • Introduction of MSO/Matron task and finish group to address improvements from learning reviews • Medication event categories on Datix updated to reflect the contributing factors such as, administration, prescribing, storage, or supply of medications.	Partially Achieved. While we have seen a reduction in the number of medication errors being reported. In Q4 we saw an increase in the errors with harm being reported (albeit a low level of harm).  
4. Learning from Inpatient Falls	To ensure that a systems-based approach is embedded in our learning response methods used to review inpatient falls.	• Inpatient falls per 1000 bed days • Reduction in the number of falls resulting in harm. • Evidence of learning from safety events to identify areas for improvement.	• Introduction of quarterly thematic reviews of all medication events, using a systems-based approach to identify learning for improvement. • Established weekly Patient Safety Incident Review Group, where all incidents of note are discussed and agreed if a further review is required. • Specific improvement project established focused on reducing falls in inpatient bathrooms.	Fully Achieved.  The trust has achieved a sustained reduction in the number of inpatient falls, per 1000 bed days and the number of falls resulting in harm.

Priority	Objective	Measure of Success	Actions completed/taken	Achieved
5. Learning from VTE events	To ensure compliance against the Trusts VTE policy.	• Number of VTE events • To achieve 100% compliance with the Trusts VTE Policy • Evidence of learning from safety events to identify areas for improvement.	• Established weekly Patient Safety Incident Review Group, where all incidents of note are discussed and agreed if a further review is required. • VTE Group reviews all RJAH acquired VTE, with shared learning feedback to colleagues. • Launch of the new VTE policy. • Retrospective Audit of VTE compliance underway	Fully Achieved.  The trust has seen a reduction in the number of RJAH acquired VTE and on review of VTE incidents, an increase in compliance with the VTE Policy.
CLINICAL EFECTIVENESS				
6. Implementation of the Getting It Right First Time (GIRFT) Preoperative Improvement Plan	To deliver the GIRFT preoperative improvement plan	• Reduction of cancellations on the day due to medical reasons. • Improved patient experience • Implement streamed pathway at decision to treat - increasing the % of patients who commence optimisation (where required) at that point."	• Workforce review in pre-op to enable changes and different ways of working. • Established working group, with clear project plan to deliver key deliverables in relation to demand and capacity, booking and access, clinical care, and early optimisation.	Partially achieved.  The trust continues to work through the identified improvement opportunities for perioperative services. The work remains a priority for the Trust and will be monitored through Patient Safety and the Trusts Operational Performance Meeting.

Priority	Objective	Measure of Success	Actions completed/taken	Achieved
PATIENT EXPERIENCE				
7. **Enhancing the experience of patients with Learning Disabilities and Autism and Dementia who access our services.**	Improve patient experience with patients with learning disabilities and autism and patients with dementia who access our services.	• Improved % with training compliance for dementia awareness. • Increased feedback from patients with LD, Autism and Dementia • Improved scores in the disability and dementia domains on the PLACE audit for 2024	• LD and Autism tier 1 awareness training rolled out and now achieving >90% compliance trust wide. • NHS Benchmarking audit completed for 2024/25 • Patient video 'What to expect when visiting the hospital' filmed and available to patients accessing RJAH services on Trust Internet. • Commenced implementation of Oliver McGowan training with good compliance trajectories noted.	Fully Achieved

Local Quality Indicators

In addition to the Quality Priorities for 2024/25 the Trust has selected a number of local quality indicators that have continued to be monitored throughout the year and continued to embed the national Patient Safety Strategy.

Safety

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is committed to continuously improve patient safety and delivering the NHS Patient Safety Strategy.

The NHS Patient Safety Strategy describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems. RJAH have three members of staff who adopt the role of patient safety specialist, allowing them to oversee and support patient safety activities across our organisation. The patient safety specialists help to embed the strategy providing dynamic, senior leadership, visibility, and expert support to the patient safety work at RJAH. The aim of the patient safety specialists is to support the development of a patient safety culture and ensure that systems thinking, human factors understanding and just culture principles are embedded in all patient safety processes.

A Patient Safety Meeting forms part of the quality governance framework and is led by the Chief Nurse and Patient Safety Officer; this is a multi-disciplinary meeting which monitors patient safety improvement action plans, risks, and associated policies. The Patient Safety Meeting receives upward reports from the Patient Safety Working Group which supports the work in relation to the Trusts Patient Safety Incident Response Plan.

A key focus for the patient safety specialists this year has been to embed the Patient Safety Incident Response Framework, which the trust adopted in October 2023.

Introducing Martha's Rule

This year the Trust were successful in our application to be considered as part of the phase one role out of Martha's Rule.

Martha's Rule is a patient safety initiative led by NHS England that grants patients, families, and staff a rapid review from a critical care outreach team if they have concerns about a patient's rapidly deteriorating condition. There are three components to Martha's Rule:

1. Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.
2. All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.

3. This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital

The Trust went 'live' with Call for Concern in December 2024, which provides patients, families, and carers with direct access to our Critical Care Outreach Team, should they feel that their (or family members) condition is deteriorating. This was shortly followed by the introduction of daily Wellness Checks on our inpatient wards across February 2025.

Patient Harm reviews

At RJAH, we are committed to ensuring the safety and well-being of our patients. Since 2021, we have been conducting patient harms reviews to monitor and address any potential risks for our long waiters.

Any patient waiting over 52 weeks receives a clinical 'harms review,' and those identified as potentially coming to harm are expedited and seen in clinic within 3 weeks.

As part of our commitment, we have been actively participating in ICS wide harms review meetings, with a particular focus on 104 weeks and cancer targets. Our dedication and progress in addressing patient harms have been recognised by the system.

For the MSK cohorts, we are pleased to report that cohorts 1 and 2 have been fully completed without any need for re-prioritisation or identification of harms. This demonstrates our effective management and monitoring processes.

Regarding the Specialist Cohorts, we have successfully completed and closed cohorts 1, 2, and 3. Cohorts 4 and 5 are currently being finalised, with the remaining patients primarily being those we have been unable to contact. Cohort 6 was released in January 2025, and we are on track to complete it by the end of June 2025.

To date, we have completed over 15,000 harms reviews and successfully expedited a small number of patients that had the potential to come to harm.

Considering recent national guideline changes, we are reviewing our policy and plan to submit it to the Quality and Safety (Q&S) Committee in April 2025.

As a Trust, we remain committed to continuing with this process until we no longer hold a backlog waiting list - this is vital to ensure those in our care receive the treatment they require with a timeframe that does not negatively impact on their health or the outcome.

Safeguarding

The Children Act 1989, and the 2004, the Mental Capacity Act 2005, the Care Act 2014, Working Together to Safeguarding Children Statutory Guidance (2023), Statutory Guidance for Integrated Care Boards (ICBs) and the England Safeguarding Accountability and Assurance Framework (SAAF 2022) places a duty on all partners across the safeguarding platform to protect and promote the welfare of children, young people and adults at risk.

At RJAH, national and local safeguarding laws and policies are strictly followed. The Trust has made significant investments in the Safeguarding Team, including the recruitment of a dedicated Named Nurses for Adults and Children, to enhance and support the organisational safeguarding agenda. In addition, the Domestic Abuse and Sexual Violence Lead has been appointed.

Improvements have been observed across the organisation regarding the safeguarding priorities for 2024/2025, with a steady increase in mandatory safeguarding children training throughout the year. There was

an evident growth in awareness and confidence across the Trust in recognising and reporting and potential safeguarding concerns, including domestic abuse. The patient facing Trust website with Learning Disability resources have been set up with the support of the Trust's communication team.

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

- Mandatory Training
- Deprivation of Liberty Safeguards (DoLS) Applications.
- Referrals to Adult Social Care
- Referrals to Children Social Care
- Section 42 Enquiries
- SARs and DHRs
- Prevent/Channel Pannel requests.
- Domestic Abuse Stalking and Harassment (DASH) Risk Assessments.
- Safeguarding Activity for children and adults
- Domestic Abuse Stalking and Harassment (DASH) Risk Assessments
- Safeguarding supervision and advice given to staff
- LADO and PIPOT
- WNB rates

Safeguarding Training

Safeguarding training compliance is monitored through the Trust Safeguarding Meeting. In line with the intercollegiate document, different levels of training are required based on the role of individual.

Training	Trust wide compliance position for 24/25
Level 3 Safeguarding Adults	71%
Level 3 Safeguarding Children	82%
Child Sexual Exploitation	88.7%
Oliver McGowan Training Part 1	89.5%
Oliver McGowan Teir 1	41%
Oliver McGowan Tier 2	37%
PREVENT training	96%

Level 3 safeguarding is currently below the 92% target set by the Trust, although the Trust has seen an improvement in compliance across children's safeguarding.

Discussions with Education, Training, and Development have identified that the decline in compliance was significantly impacted by:

- Staff sickness during winter months.
- Winter pressures leading to low attendance
- Training cancellation by the external provider in quarter four

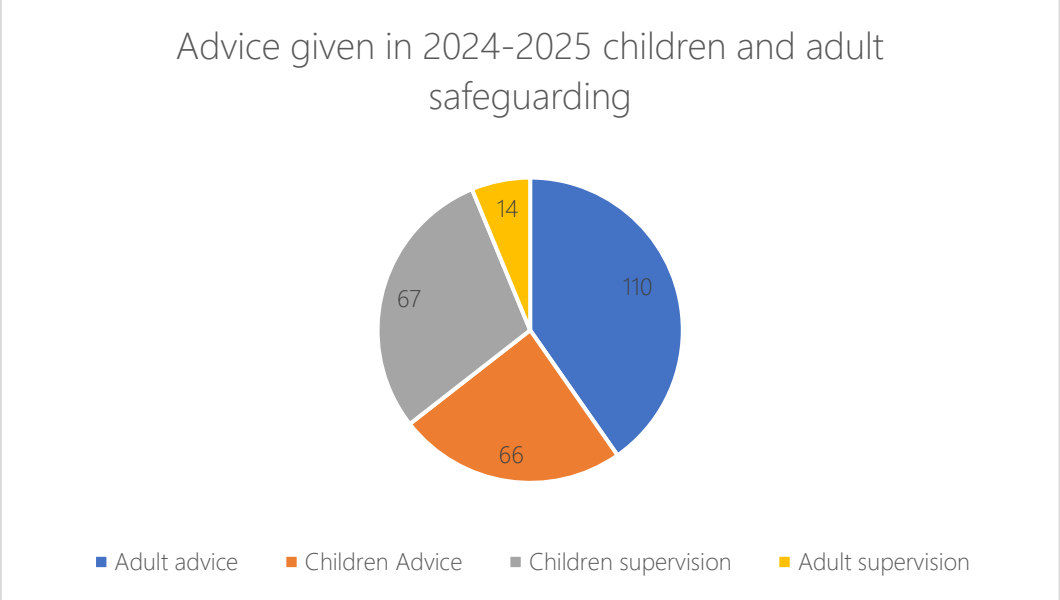
With the expanded classroom capacity and improved communication, compliance for Level 3 Safeguarding Adults training is expected to recover steadily. Full compliance is projected by July 2025.
In July 2024 Child Sexual Exploitation (CSE) online training was introduced onto ESR and has been meeting its training trajectory at the expected level

Additional Safeguarding Training and Development introduced across 2024-2025

- ✓ Mental Capacity Training
- ✓ Dementia Training for Health Care Assistant
- ✓ Butterly Scheme Re- Launch
- ✓ Dementia Communication Training
- ✓ Conflict Resolution Training and De-escalation training delivered by the Innovation Team
- ✓ Communication in Dementia Care and Management of a patient who requires Enhanced Supervision
- ✓ Consent and Legal Responsibility co-delivered by the Safeguarding Team and the Trust Solicitors
- ✓ Mental Capacity and Best Interest Toolkit Lunch and Learn
- ✓ Study day on Alice Ward on Children as stand-alone victims of Domestic Abuse
- ✓ Lunch and Learn sessions or Safeguarding and Parental Responsibility
- ✓ Child and young person neglect training (half day)

Safeguarding Supervision and Advice

In 2024-2025 we provided a total of 177 instances of advice or supervision to staff across various clinical areas regarding adult and children safeguarding concerns. Of which 110 were related to adults and 56 related to children.



Safeguarding group supervision was accessed by 91 staff across the Trust with children supervision delivered to ORLAU, MUSCLE and Orthotics team (67 staff attended). And 14 staff accessing adult group supervision on Sheldon Ward.

Safeguarding Activity

Children who were not brought to their appointment. (WNB)

The WNB figures remained around 5.7%, there has been an excellent work undertaken in the health inequality workstream to reduce the WNB rate and update from colleagues was requested to be shared with the Safeguarding Meeting.

Safeguarding children 0-19 Liaison Forms

The liaison forms were created to follow up children with two or more Was Not Brought (WNB), pattern of WNB or any other safeguarding concerns and from June to March 2025- so many liaisons have been completed which resulted in referral to children social care for one child and attending Child in Need (CIN) meeting for one child. The named nurse liaised with the 0-19 teams regarding 41 children and young people.

Deprivation of Liberty Safeguards (DoLS) Applications

There were 49 DoLS applications have been completed during in RJAH in 2024-2025

Local authority Adult Safeguarding referrals

There have been 19 referrals to the Local Authority Adult Safeguarding. For one of the referrals the trust reported itself as a potential source of harm, and the case has since been closed by the local authority safeguarding team.

Children Social Care referrals

There have been 5 referrals to children social care as well as two referrals to the Early Help service.

Section 42 Enquiries

Safeguarding Team is aware of two cases referred to Adult Social Care regarding care undertaken at RJAH. In accordance with the Care Act 2015, Section 42, all agencies have a statutory requirement to engage with social care and respond to allegations or concerns made in relation to adults at risk. Both cases were responded to within the agreed timescale and to date neither of these cases have concluded. Both referrals made to the local authority in quarter 2 have now been closed with no further action.

Staff Allegations

There was a total of seven staff allegations- two led to PIPOT referral in accordance with Person in a Position of Trust processes and two being referred to the Local Authority Designated Officer (LADO), of which both cases are now closed. Two of these staff allegations led to staff being referred to the professional body.

Pressure Ulcers

In accordance with national guidance (*Safeguarding Adults Protocol: Pressure Ulcers and the Interface with a Safeguarding Enquiry Process*), where staff identify multiple category 2, category 3 or 4 pressure ulcer, the protocol should be accessed and scored against the decision guide. 15 of the ulcers were within these criteria; 13 did not have the pressure ulcer protocol completed and two did. Neither necessitated a referral to Adult Social Care.

- Q1: 27 pressure ulcers reported; 5 acquired at RJAH, 22 pre-admission
- Q2: 4 identified in outpatients; 5 patients admitted with existing ulcers
- Q3: 41 total; 12 RJAH-acquired, 29 pre-admissions. None met safeguarding thresholds.
- Q4: 26 total; 2 RJAH-acquired, 24 pre-admission (13 from MCSI).

17 were complex (multiple or category 3+); 15 triggered safeguarding questions on Datix. Two cases escalated to safeguarding: one (Birmingham) closed after initial review, one (Shropshire) closed on receipt, with further internal review ongoing.

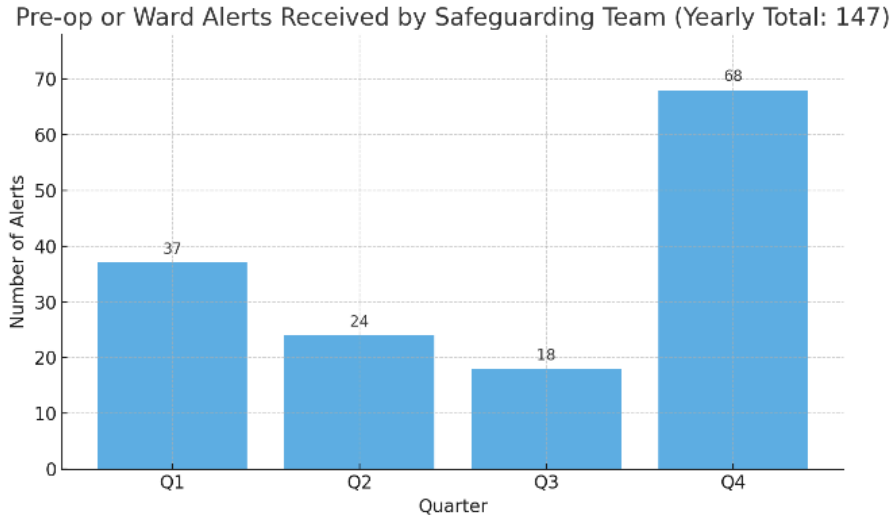
Prevent /Channel requests

There were 21 requests for information, made under Section 26 of the Counter Terrorism and Security Act 2015; i.e. Prevent requests with 13 requests related to children.

Complex Care

All patients who attend Pre-Operative Assessment Clinic and who require, or may require, reasonable adjustments, or who have (or potentially have) a safeguarding concern, will have a pre-op alert form completed, which is then emailed to the Booking Office and Safeguarding Team. The team subsequently monitors these alerts, reviewing patients as required and providing specialist support and advice to ward staff where appropriate.

Over the year, a total of 147 pre-op or ward alerts were received by the Safeguarding Team for patients requiring additional support. This includes:



Safeguarding Adult Reviews and Domestic Homicide Reviews

Domestic Homicide Reviews (DHRs) and Safeguarding Adult Reviews (SARs). Under the Domestic Violence Act 2004 and Care Act 2014, DHRs and SARs are undertaken when serious harm or death has occurred. In 2024–2025, the Safeguarding Team responded to multiple review requests:

- Q1: Two scoping requests (1 DHR, 1 SAR); outcomes pending.
- Q2: One SAR involving RJAH, with learning around self-neglect and mental health. RJAH also contributed to three DHRs (2 Telford & Wrekin, 1 Cheshire West).
- Q3: Three scoping requests (2 DHRs, 1 SAR); outcomes pending.

Learning Reviews

There have been no children safeguarding reviews that RJAH was involved in.

Initial scoping reviews

There has been one scoping review for a child known to RJAH

Domestic Abuse (DA)

There were 27 disclosures of domestic abuse made by service users and staff. Of these, 9 Caada DASH Risk Assessment were completed. There has been a significant increase in completion of Caada Dash risk assessments completed in quarter 3 following disclosures of DA.

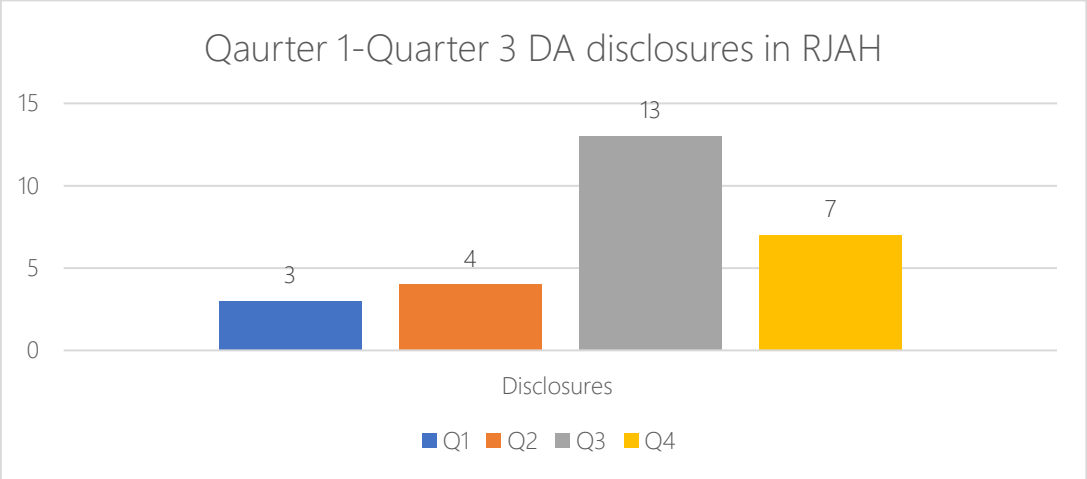


Table 3. DA disclosures in 2024-2025

Learning Disability & Autism

- The Safeguarding Team has been actively involved in The Oliver McGowan Mandatory Training STW Stakeholder Group.
- The Carers Policy has been presented to the Patient Experience group and references the Triangle of Care.
- Reasonable adjustment flagging system has been agreed with the Apollo team.
- The team continued attending the LeDeR Governance Panel and LeDeR steering committee and shared good practice and innovations Trust Wide.
- The patient facing RJAH Learning Disabilities and Autism website has been launched and is updated regularly as recent updates emerge. In the future the website will link in with the ICB LD&A webpage once that is developed. The awareness of this resource has been raised through the Patient Engagement Group and SNAHP.

Mental Health

Mental health liaison continues to support the inpatient service, on a 24/7 telephone contact and face to face visit on a weekly basis.

Infection Prevention and Control

Infection Prevention and Control (IPC) is a key priority for the Trust and every member of our staff is committed to following safe and effective IPC practices and procedures.

Following the launch of the IPC strategy in January 2023, throughout 2024/25, the Trust has been working toward achieving excellence in IPC practice. Progress has been achieved through all 4 domains of integrated working; education; digital technology and enhanced engagement.

Challenges in the management of infections have been experienced nationally with not only an increase in resistant micro-organisms, but also the number of patients experiencing infections. Despite this, the Trust has remained below target threshold for all mandatory reportable infections. We continue to investigate and share learning from all healthcare associated infections and have supported a group who have led on several

workstreams with a focus on preventing bloodstream infections. We continue to share our learning with our system colleagues in the Integrated Care System and have led on the development of a system wide CDI improvement plan.

The IPC Team have redesigned the audit system to align all questions to national standards of IPC, and followed a peer audit approach to allow a fresh lens upon each area, providing an objective approach to audits. The IPC team have supported clinical teams to enhance auditing skills and increase confidence amongst colleagues. Ward/department managers and Matrons take ownership for IPC within their respective areas and show great understanding of roles and responsibilities for IPC. This has provided opportunities to identify and rectify IPC issues in a timely way.

We continue to monitor Surgical Site Infections through Statistical Process Control charts. These allow us to track trends and variations and triggering investigations when our control limits are reached. The IPC Team conduct in-depth reviews into all surgical site infections to establish any learning or quality improvements. The Theatres team are fully engaged with all aspects of surgical site infection prevention strategies. We have also been collaborating closely with colleagues from the Royal Orthopaedic Hospital to share best practice on infection prevention.

It was a pleasure to welcome our NHSE and ICB colleagues to the Trust to showcase our improvements within the Therapies department. They noted significant improvements to the estate, including new floors, walls, and improvements to the hydrotherapy pool. The Therapies team used a 'productive ward' approach to reviewing their storage, which has improved the environment and reduced clutter.

The IPC Team have been revised all IPC policies to align with the National IPC Manual for England. This strengthens our Trust's IPC practices and procedures, guiding our staff with the most up to date information and advice on IPC prevention and management.

The IPC Quality Management system continues to strengthen assurance to processes and compliance to national requirements including the Health and Social Care Act, National IPC Manual, and the IPC Board Assurance Framework. In addition, the system also captures all actions and improvements on the Trusts IPC Quality Improvement Plan. The data warehouse consolidates all IPC related data and displays a dashboard providing a live position for IPC governance.

The continues to be evidence of increased ownership and engagement from teams around IPC. The improvements made could not have been achieved without the continued dedication and commitment from staff across all disciplines across the organisation.

Medication Incidents

Medication incidents are any patient's safety incidents (PSIs) where there has been an error in the process of prescribing, preparing, dispensing, and administering, monitoring, or providing advice on medicines. Within the Trust there is an open dialogue and reporting culture relating to medication incidents. A repot is produced monthly detailing any harms, number of incidents, key incident themes, and sharing of identified learning. This is shared across the Trust.

Medication incidents are identified as a local priority in the Trusts PSIRP. As outlined in the Trusts PSIRP a quarterly thematic review, using a systems-based approach is completed. The aim of the thematic review is to identify areas of improvement in relation to medicines safety, which are shared at the Trusts Patient Safety Meeting and safety actions agreed for implementation.

The Trust benchmark and share medicines safety themes through the Shropshire Telford and Wrekin ICB Medicines Safety Group, the regional Medicines Safety Officer Group and the CD Lin with the Chief Pharmacist network having oversight of all groups.

Learning Lessons from incidents

- The learning from the patient safety reviews are shared widely across the Trust via relevant meetings such as the Patient Safety meeting, Unit Governance meetings and at the Trusts Multi-disciplinary Clinical Audit Meeting (MDCAM) ensuring that shared leaning and awareness of issues is cascaded across all areas.
- The Trust continues to involve patients in patient safety reviews with a nominated Patient/Family Liaison person for each learning response that is conducted. The learning responses are shared with patients and where applicable their families and opportunities are provided for the investigation to be discussed with clinical and governance staff.
- The Trust holds debrief meetings with relevant teams and support from the Clinical Governance Team in which the reports are shared with the staff involved. These are conducted in a way that promotes the principles of PSIRF, compassionately engaging with those affected by patient safety incidents.
- Areas of good practice are shared following any patient safety review, focusing the learning on both good practice and areas of improvement that may be required.
- Over the last year there has been an increased focus on improving the quality of the incident investigations and the Trust have introduced a framework on our internal reporting system, which promotes a systems-based approach to investigating and learning.
- Infographics are produced, following patient safety reviews to aid dissemination of learning throughout the organisation. These are shared at unit governance, patient safety, and senior nursing meetings.

Quality Accreditation Programme

During 2024/25 the Trust saw the introduction of a local Quality Accreditation Programme.

All wards, units, and departments at RJAH will aim to achieve the highest level of quality accreditation to improve efficiency, productivity, patient outcomes and to enhance patient and staff experience. This underpins the goals of the RJAH Nursing and AHP Strategy, RJAH Quality Strategy and wraps a framework around demonstrating regulatory compliance and best practice.

The objective of this assessment was to assess the ward for the newly developed quality accreditation aligned to the CQC key principles of Safe, Effective, Caring, Responsive and Well Led.

The assessment is based on the criteria tabled below.

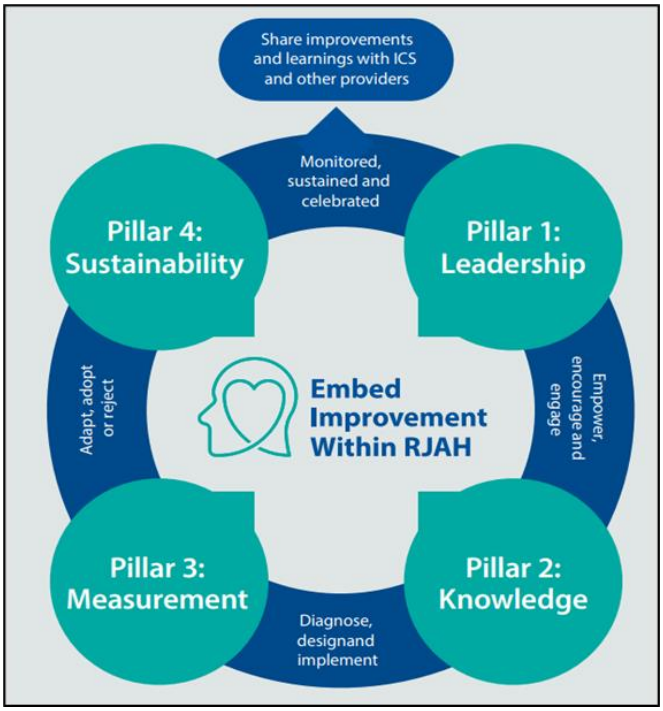
Rating system	Criteria	Frequency of Peer Review	Description	Award period
Outstanding	4 Reports at GREAT	1 year	Significantly exceeds the RJAH standard expectation of what a ward or unit should achieve	1 year
Great	2 areas of partial compliance per domain	6 months	Greatly exceeds the RJAH standard expectation of what a ward or unit should achieve. Some measures may require improvement	1 year
Good	6 areas of partial compliance per domain	6 months	Exceeds the satisfactory standard. Some measures require improvement	6 months
Satisfactory	Any number of areas of partial compliance, 1 or more areas of no compliance	3 months	Minimum standard expected from a ward or unit. Some measures require improvement	3 months

Quality Improvement

At the end of 2022/23, The Trust launched its Quality Improvement (QI) Framework to support embedding improvement within our organisation. The Trust has further progressed its improvement journey during 2024/25. The Trust's ambition is to develop and evolve improvement-led delivery through effective leadership behaviours and by building capabilities. This will improve the quality, safety, productivity and experience of our patients and workforce.

The QI framework describes the approach to improvement which highlights four instrumental pillars to support the embedment:

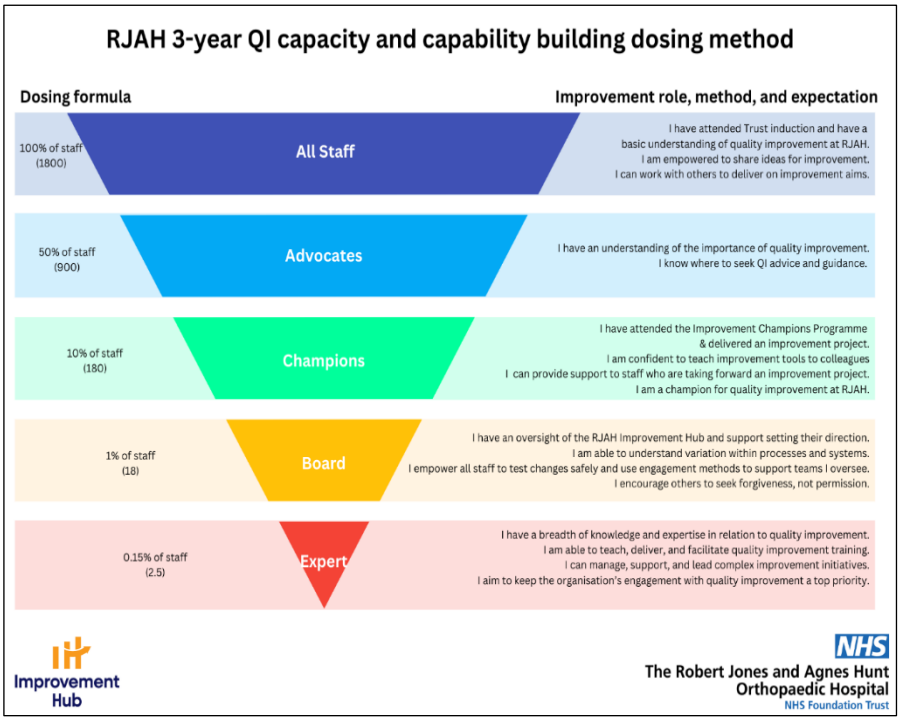
- Leadership: Embedding effective leadership behaviours to understand and champion improvement.
- Knowledge: Developing our staff's knowledge on improvement and ensuring we are building on the capacity and capability for continuous improvement.
- Measurement: Evidence driven improvements using quantitative and qualitative intelligence.
- Sustainability: Learn, share, and celebrate our improvements whilst continually checking changes are still having the desired effect.



During 2024/25 the Quality Improvement journey has involved:

- Improvement in job descriptions and Personal Development Reviews (PDRs): A commitment to continuous improvement is now listed in all new job descriptions and retrospectively in PDRs. This ensures improvement is seen as everybody's responsibility and begins the conversation to discuss improvements which could be made within services.

- Improvement Champions: Following a hugely successful cohort 5 in 2023, another three cohorts have taken place through this financial year. The Improvement Champions course runs across four days with staff working on a specific improvement project whilst learning about topics such as the history of improvement, improvement in healthcare, improvement tools and techniques, emotional intelligence and resilience, and measurement. All cohorts have a celebration event whereby they present their project posters to the Board of Directors and other senior leaders.
- Improvement Advocates: The success of Improvement Champions has seen a new one-day training programme developed which provides an overview and understanding of improvement.
- Dosing Model: Recognising that not everyone in the organisation needs to know or do the same things to contribute to improvement initiatives. NHS IMPACT suggests at least 80% of our staff should have some form of improvement training. Therefore, the Improvement Team have developed a dosing approach to suit RJAH. This will be monitored.



- Legacy Nurse Mentor in Quality Improvement: The Trust have been extremely fortunate to have a Legacy Nurse join the Improvement Team in July 2024. A legacy mentor within the NHS are experience nurses, or colleagues in other professions, usually in late career, who provide coaching and mentoring to support other NHS staff. They provide essential advice, education, and guidance and pass on a 'legacy.' This has provided the team with a clinical link for improvement and further supporting the improvement agenda at RJAH.
- #ImproveTheNextJourney: As part of our co-production agenda, this initiative was launched for our post-operative patients. The feedback from patients is hugely positive and there has been little opportunity for improvement with our patients to date under this initiative. However, the initiative is going to be launched into our Therapies team in the coming year to identify improvements which can be co-produced with our patients. The #ImproveTheNextJourney initiative has increased awareness of co-production across teams with patients being contacted for their thoughts.

The Trust will further assess its progress against the NHS England's NHS IMPACT (Improving Patient Care Together) domains released during 2023/24 (NHS England » NHS IMPACT). An NHS IMPACT self-assessment

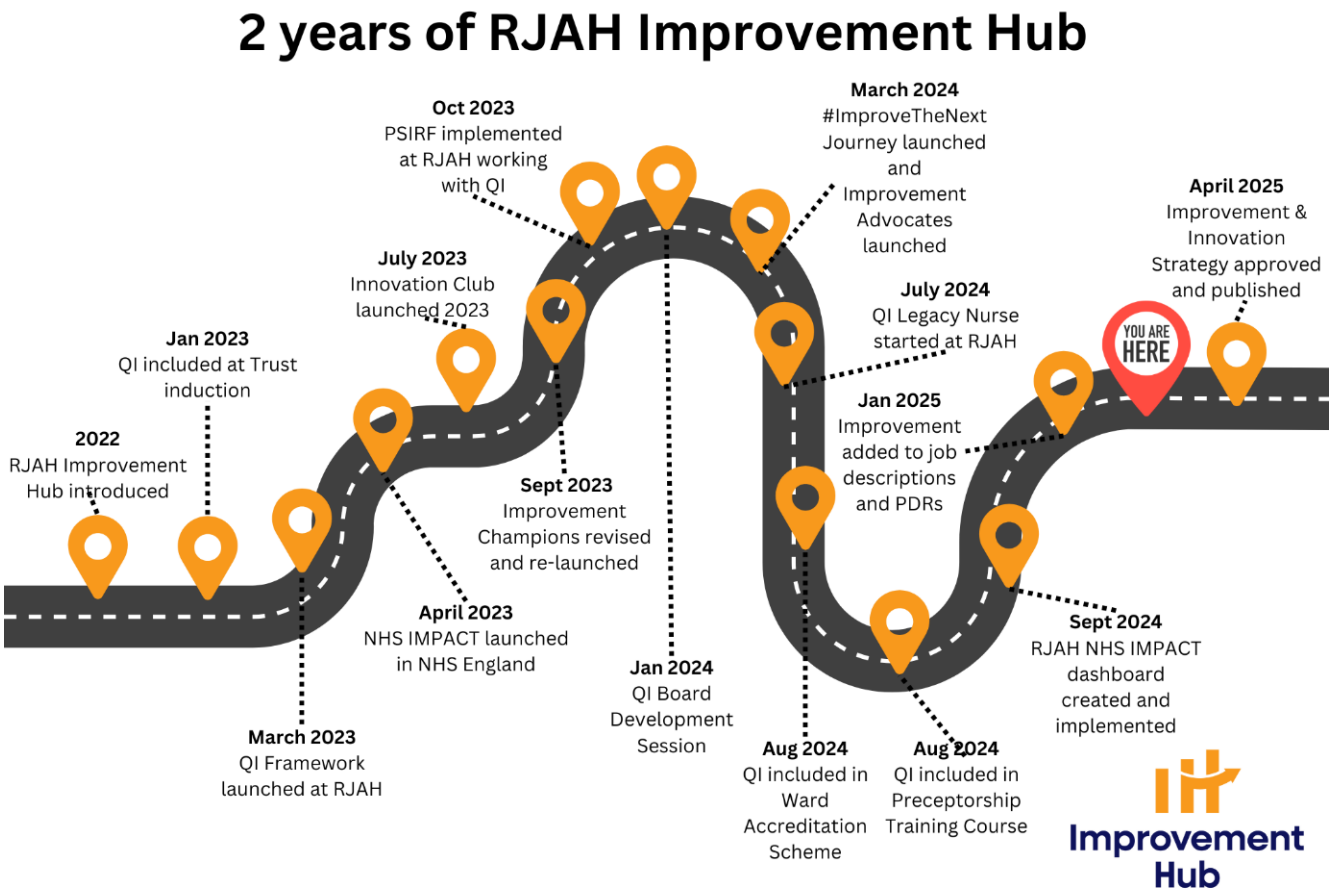
supporting some of the actions and focus to date was undertaken in October 2023 with a further self-assessment planned in May 2025. NHS IMPACT's five components form the 'DNA' of all evidence-based improvement methods, these principles underpin a systematic approach to continuous improvement:

1) Building a shared purpose and vision
2) Investing in people and culture
3) Developing leadership behaviours
4) Building improvement capability and capacity
5) Embedding improvement into management systems and processes

Early 2025 will see the Quality Improvement (QI) Framework replaced with first combined Improvement and Innovation Strategy further outlining and supporting our approach to improvement and ambition for innovation.

We also aim to have both Improvement Advocates and Improvement Champions CPD certified by the end of 2025.

The below road map shows the incredible journey of improvement at RJAH to date:



Staff Survey results further support and contribute to monitoring the progress the Trust is making on its improvement journey to date. For 2024, the Staff Survey results against 3) improvement related questions were:

- 76.22"% of staff feel they can make suggestions to improve the work of their team / department.
- "56.41"% of staff feel they are involved in deciding on changes introduced that affect their work area / team / department,
- "59.43"% of staff feel they can make improvements happen in their area of work.

Patient Safety Visits

The programme provides an opportunity for members of the Trust Board to engage with patients, relatives, and staff through regular visits to clinical areas. The purpose of the visits is to provide visible leadership by the Board on quality and safety and to talk to patients, families, and staff about their experience of care in the Trust.

Leadership walk rounds are recognised nationally as a critical leadership intervention, as described by the Institute of Health Improvements (IHI). Regular walk rounds are a sign of the Trust's safety culture and approach to improving quality in the organisation. This has provided members of the Board with the opportunity to talk to staff specifically about quality, safety, and improvement programmes and to get feedback to help achieve these improvements across the organisation. The programme provides the Non-Executive Directors, Executive Directors and Governors the opportunity to engage with patients, relatives, and staff and to discuss standards relating to quality and safety with clinicians and managers during the visits.

The purpose is:

- Demonstrate commitment to safety.
- Fuel culture for change pertaining to patient safety.
- Provide opportunities for senior executives to learn about patient safety.
- Identify opportunities for improving safety.
- Establish lines of communication about patient safety among employees, executives, managers, and employees
- Establish a plan for the rapid testing of safety-based improvements.

There are five key lines of enquiry the walkabout investigates which mirror Care Quality Commission (CQC) questions; safe, effective, caring, responsive, well led. Staff from across the organisation are asked what is going well in their opinion and areas which require a more sustained focus of improvement. Any actions following the visits are brought to the attention of the relevant Executive Director to consult with their team. A quarterly presentation shared with the Quality and Safety Committee and Council of Governors, highlighting positive feedback and areas of improvements.

Effectiveness

The National Institute for Health & Clinical Excellence (NICE) guidance -

All published NICE Guidance was reviewed monthly by Clinical Audit Quality Lead and the Consultant Lead for NICE Guidance. A total of 142 guidelines were reviewed, to which 136 were deemed not applicable to the services provided to RJAH; one is currently under review for whether it is relevant to the Trust and five of the guidelines were deemed applicable.

There have been four clinical audits completed or started in 2024/2025 in relation to our compliance to published NICE guidelines.

- 2324_025 Adherence to NICE guidelines in Management of inflammatory Arthritis with Tofacitinib (JAK inhibitor)
- 2425_010 Upper GI Bleed Re-Audit
- 2425_026 Delirium Re-Audit
- 2223_017 BSG, NICE & Scottish for suspected cancer for pelvic & appendicular sarcomas

List of NICE publications received and considered applicable to RJAH (5).

Date Issued	Ref	Title	Outcome
31/07/2024	QS119	Anaphylaxis	BAT Completed – Fully Compliant
07/08/2024	TA991	Abaloparatide for treating osteoporosis after menopause	Approved to Trust Formulary
07/08/2024	TA993	Burosumab for treating X-linked hypophosphataemia in adults	Approved to Trust Formulary
03/09/2024	IPG793	Single-step scaffold insertion for repairing symptomatic chondral knee defects	For information only – confirmed by clinical audit lead
16/10/2024	NG148	Acute kidney injury: prevention, detection, and management	Audit Results – 98.2%

Health and Safety

The Chief Finance and Planning Officer retained Board-level responsibility for health and safety. The Trust employed a health and safety team comprising of a manager and an advisor to comply with the requirement to appoint a competent person under section 7(1) of the Management of Health and Safety Regulations 1999.

The Trust's health and safety performance was reported to, and monitored by, the Health and Safety Meeting which escalated any issues of concern to the Quality and Safety Committee via a Chair report. The Health and Safety Meeting met bi-monthly, chaired by the Director of Estates and Facilities, and included health and safety representatives from staff side unions in compliance with the Safety Representatives and Safety Committees Regulations, 1977.

Incidents involving specified injuries, occupational disease, or resulting in a member of staff taking more than seven days off work because of a work-related accident, were also reported to the Health and Safety Executive (HSE) under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). During 2024/25 there were six incidents reported to the HSE under the requirements of the RIDDOR regulations. No regulatory action or sanction was received in respect of the reported incidents.

RIDDOR Description	2024-25	2023-24	2022-23
Occupational Disease	0	4	0
Slips, Trips and Falls	1	2	2
Lifting and handling injuries	5	1	5

Patient Experience

Listening to Patients and Carers

Listening to people's experience of care plays a crucial part in delivering services that are truly safe, effective, and continuously improving.

The experience that a person has of their care, treatment and support is one of the three parts of high-quality care, alongside clinical effectiveness, and safety. A person's experience starts from their very first contact with the health and care system, right through to their last contact of their patient journey.

Collecting patient experience data is an important part of monitoring the quality of care provided at the RJAH and helps promote an open learning culture by identifying and sharing examples of good complaints practice and learning that was identified through patient feedback.

The table below shows overall patient feedback in 2024/25 compared to 2023/24:

Feedback	2023/24	2024/25	Diff from 2023/24 to 2024/25	% Change
Complaints	98	144	46	47%
PALS concerns	424	618	194	46%
PALS enquiries	4483	5413	930	21%
Compliments	13189	13207	18	0%
FFT result	98%	98%	-	-

Learning from Patient Feedback

Listening and acting on patients and carers experience of care plays a crucial part in delivering services that are truly safe, effective, and continuously improving.

The experience that a person has of their care, treatment and support is one of the three parts of high-quality care, alongside clinical effectiveness, and safety. A person's experience starts from their very first contact with the health and care system, right through to their last contact of their patient journey.

In 2024/25 the Trust has continued to work towards achievement of the commitments identified in our Patient Experience Strategy, to provide the best experience of care at each phase of the patient pathways and interactions with our staff to ensure that patient centred care is provided to all our patients.

Patient Experience Strategy commitments are:

1. We will work in partnership with our patients and actively involve them in decisions about their care.
2. We will communicate to our patients in a manner that is accessible and appropriate to their own individual needs whilst listening to our patients about their priority of care and what matters most to them.
3. We will involve our patients and services users and the public in decisions regarding the way we deliver services and any future developments.
4. We will engage with our patients to facilitate patients to manage their own health conditions and get the best out of their wellbeing.
5. We will further develop the role of volunteers to ensure we maximise their input to enhance patient experience.

Insight on what our patient thinks of using our Services does not come from a single source. Patient insight and feedback is not just about collecting performance data. The Trust uses the data collected to help improve the quality of every person's experience, particularly looking at how people feel about hugely important issues such as dignity, compassion, and respect.

The Trust offers many opportunities for patients and carers to give their feedback including Trust email, Twitter and Facebook, local and national patient feedback surveys, Friends, and Family Test (FFT) survey, patient stories, patient engagement forums, Trust Governor forums and comments received direct. All feedback is shared with the clinical areas and is responded to by the Communications Team or the Patient Advice and Liaison Service (PALS) Team.

The Trust uses Patient feedback as a key measure of monitoring the quality of care, this an important "health check" for the services we provide as well as promoting a strong culture of listening to patients to help improve services.

In addition, the Trust has robust processes in place which enables patients to raise their concerns formally via the Complaints process and informally via the Patient Advice and Liaison Service (PALS). These concerns are investigated in with the Trust's complaints policy and action plans are put in place (where applicable), to ensure learning and improvement.

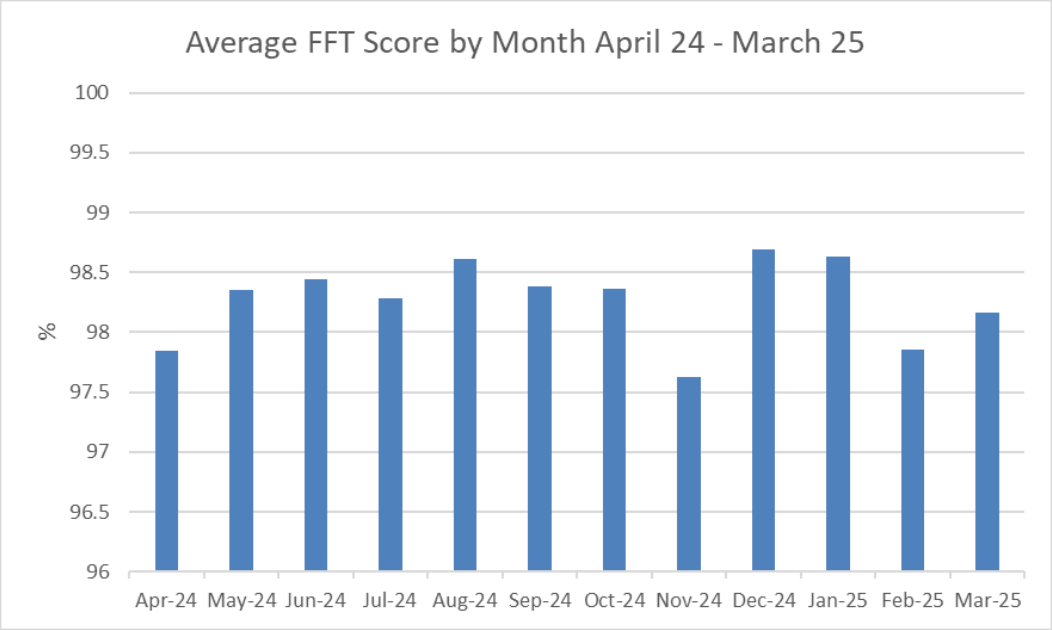
Patient Friends and Family Test

The NHS Friends and Family Test (FFT) "Overall, how was your experience of our service" was created to help Trusts understand whether patients are happy with the service provided, or to provide suggestions on any improvements needed. It's a quick and simple way for patients to give their views after receiving NHS care or treatment.

The results from FFT provides insights into how we can improve or celebrate the positive patient feedback received with the staff delivering the services.

FFT data is collected in real time using the IQVIA patient feedback system and patients are sent a text to invite them to complete a FFT survey electronically (after discharge or clinic appointment).

For 2024/25, 25,035 patients completed a FFT survey and 98.27% of patients (inpatients and outpatients) said they would rate their experience as good or very good. The chart below shows the average FTT score per month:



The Trust is committed to improving the percentage of patients who would rate their experience as good or very good.

Staff are sent an email alert in real time as soon as a low FFT score is received, and comments are immediately uploaded into IQVIA for staff to respond to within department. The FFT results are shared in Unit, department, and Speciality level Governance Quality reports with trends of low scores monitored monthly.

The results for the Trust over the last five years are as follows based on the average percentage of FFT score (inpatients and outpatients).

	2020/21	2021/22	2022/23	2023/4	2024/25
National Average	94%	94%	94%*	94%*	94%*
Highest Score	100%	100%	100%*	100%*	100%*
Lowest Score	65%	64%	73%*	75%*	69%*
The Robert Jones and Agnes Hunt	98%	98%	98%	98%	98%

*For 2023/23 and 2023/24 national data includes up to January

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is due to the Trust having a robust patient experience programme in place, which facilitates learning and implementing changes based on patient experience

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this percentage:

- In 2024/25 the Trust has continued to work towards achievement of the commitments identified in our Patient Experience Strategy
- Continuous monitoring and collection of real time FFT patient feedback and sharing any negative FFT scores and comments with the relevant Departmental Manager for their action
- Robust reporting of the FFT results and trends at departmental/Speciality and Unit Governance meetings.

Patient Led Assessments of the Care Environment (PLACE)

PLACE assessments are conducted annually, providing a patient's perspective on the patient environment. The assessment captures responses to questions on cleanliness; food; privacy, dignity, and wellbeing; condition, appearance, and maintenance; dementia and disability.

Each year questions are updated/added to reflect what is deemed as best practice - ensuring safe, supportive, and high-quality patient experiences are advocated through the associated action plan.
The Trust uses the outcome of PLACE less as a benchmarking tool, more as a tool to actively drive improvement of the patient experience, this has been called out as part of the Exemplar Trust recognition as one of the strengths of the Trust.

The feeling of the teams on the day was very positive, and all groups noted where recent refurbishments have improved the overall environment in specific clinical areas. Scoring was negatively impacted by questions which bridged multiple criteria, particularly actions relating to Dementia & Disability. Over thousands of questions asked there were 131 resulting actions, with these actions monitored regularly through the Patient Experience Meeting. Outside of the scores detailed below, patient assessors noted that whilst many wards and departments felt modern and refreshed, some further focus on use of colour, muras and/poor lighting would ensure areas are consistently welcoming for all service users.

Domain	2022	2023	2024	Indication
Cleanliness	99.91%	98.84%	100%	↑
Food	93.85%	88.60%	94.82%	↑
Privacy, Dignity & Wellbeing	92.38%	91.84%	87.97%	↓
Condition, Appearance & Maintenance	99.04%	95.75%	98.71%	↑
Dementia	83.11%	79.40%	76.76%	↓
Disability	83.21%	80.42%	78.35%	↓

In 2024, the assessment panel included representatives from Healthwatch, Trust volunteers and students from The Marches sixth form, offering differing perspectives, ensuring the Trust assessment remains well rounded and representative of our patient population. For the first time, the improvement team were represented as part of the staff panel and are working collaboratively to identify where actions can be embedded into existing improvement projects or included in upcoming Quality Improvement Champion projects.

Health Inequalities

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. In March 2021, NHS England set out five national priorities for tackling health inequalities.

- Priority 1: Restoring NHS services inclusively.
- Priority 2. Mitigating against digital exclusion.
- Priority 3. Ensuring datasets are complete and timely.
- Priority 4. Accelerating preventative programmes.
- Priority 5. Strengthening leadership and accountability.

For the period of 2023-24 and 2024-25 NHS England's views on how relevant NHS bodies should exercise their powers to collect, analyse and publish information on health inequalities include the need to:

- Understand healthcare needs including by adopting population health management approaches, underpinned by working with people and communities.
- Understand health access, experience and outcomes including by collecting, analysing, and publishing information on health inequalities set out in the Statement.
- Publish information on health inequalities within or alongside annual reports in an accessible format.
- Use data to inform action including as outlined in the Statement.

The Trust has in place a Health Inequalities & Population Health working group. This group scopes opportunities alongside available health inequalities intelligence to further understand health access, experience, and outcomes. The group is a multi-disciplinary working group with attendance from system partners too; this is in recognition that to serve communities well, relevant NHS bodies and partner organisations should work together to understand the collective health and care needs of local people and populations, as well as healthcare access, experience, and outcomes. Some areas of focus through this group for 2024/25 have included:

Prevention and waiting well initiatives to improve health and wellbeing.

As referenced by The State of Musculoskeletal Health 2024: - Data Versus Arthritis report (the-state-of-musculoskeletal-health-2024.pdf):

"People who experience more deprivation are more likely to be overweight or obese than those experiencing less deprivation. Deprived areas have increased prevalence of osteoarthritis. The increased prevalence of obesity in these areas accounts for 50% of the extra risk for knee osteoarthritis."
Local Authority colleagues from Shropshire and Telford have been in attendance of the working group as part of discussions and action to signpost to available services i.e. smoking cessation and weight management. This work will further evolve as part of ongoing transformation to improve the pre-operative pathway for our patients.

Did Not Attend (DNA) / Was Not Brought (WNB)

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 with different IMD quintiles, and that has persisted in March 2025. For example, the most deprived English quintile had a DNA rate of 7.07%, whereas the most affluent English quintile had a DNA rate of 2.50%. This was not seen however in Welsh patients, with no significant difference in the DNA rates of patients with different IMD quintiles.

The Trust has processes in place to support patients who are financially struggling, and work is ongoing with local charities to further support access for patients.

While the Trust's overall DNA rates remain low, we are making efforts to understand health inequalities experienced by our patients that may cause disparities in the DNA rates seen in different demographics. In particular, the Trust has been focusing on its paediatric WNB rates. Our Paediatric Orthopaedics team was identified as an outlier for its high WNB rates compared to other teams in the Trust, which the team has been working to reduce.

The Trust is currently collecting and investigating data on why these patients are not being brought, to understand the root causes and help deliver targeted improvement work. Work is also being done to strengthen relationships between our paediatric teams and both Shropshire Council and Telford & Wrekin Council. The aim is to use the work already done in councils to support children and their families in attending their appointments, whether that be using existing close relationships with a social worker, or services offered by councils that support families

System Transfer Health Inequalities Assessments

Assessments have involved understanding datasets split by Index of Multiple Deprivation (IMD). This is a relative measure of deprivation. This means it can tell you if one area is more deprived than another. Out of all RJAH teams, Rheumatology is the only one with a significantly different IMD distribution in its English referral-to-treatment (RTT) waiting list compared to pre-pandemic. This is following a transfer of the service from another system provider to RJAH. In January 2024, the proportion of these Rheumatology patients living in the most deprived quintile was 7.9%. Then in February 2024, after the system transfers had begun, this shot up to 18.5%. It has since slowly decreased to 14.3% at February 2025 month end. The monitoring of this impact alongside further intelligence is ongoing.

Alongside the healthcare intelligence the Trust also recognises its place as an Anchor Institution with community engagement activities regularly undertaken at RJAH. Other activities are inclusive of local procurement with the Trust now being recognised as a Love British Food hero in recognition of our procurement practices to support local suppliers. The Trust also participates in programmes supporting our population back into work, as part of this the Trust has successfully engaged with the 'Stepping in To Work' programme ran by Telford College within estates and facilities workforce.

During July 2025, a presentation was given to the Trust Public Board describing some of the work that had taken place to date. Health inequalities intelligence and programmes of work are continuously reviewed and form part of plans for 2025/26 to continue and further evolve. The Trust's Health Inequalities & Population Health working group updates are reported through the Quality and Safety committee which is a sub-committee of the Trust Board. In addition, Health Inequalities disaggregated intelligence is presented as part of performance report updates to both the Quality and Safety and Finance and Performance committees.

Freedom to Speak Up Guardians

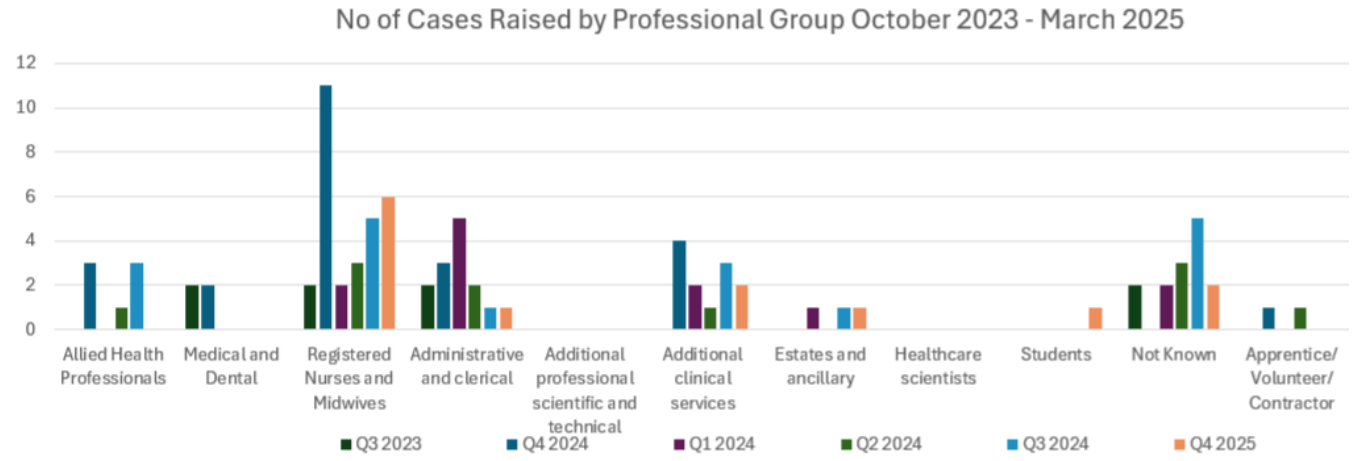
In 2024/2025 The FTSU Portfolio sits under Corporate, with the Chief Nurse as the Executive Lead for FTSU. The Freedom to Speak Up at RJAH reports into the People committee on a quarterly basis.

The role of FTSU is to encourage staff to speak up about anything that gets in the way of patient care or affects staff working life. It encourages a culture where staff feel safe and confident to raise concerns about patient care, safety, or workplace issues, ensuring that lessons are learned, and improvements are made.

The Trust currently has twelve FTSU Champions across the organisation. This year we have recruited several champions from the global majority, and several champions with protected characteristics.

The total number of cases raised in 2024-25 was 54 cases, compared with 46 cases in 2023/24. This is 20% increase on last year.

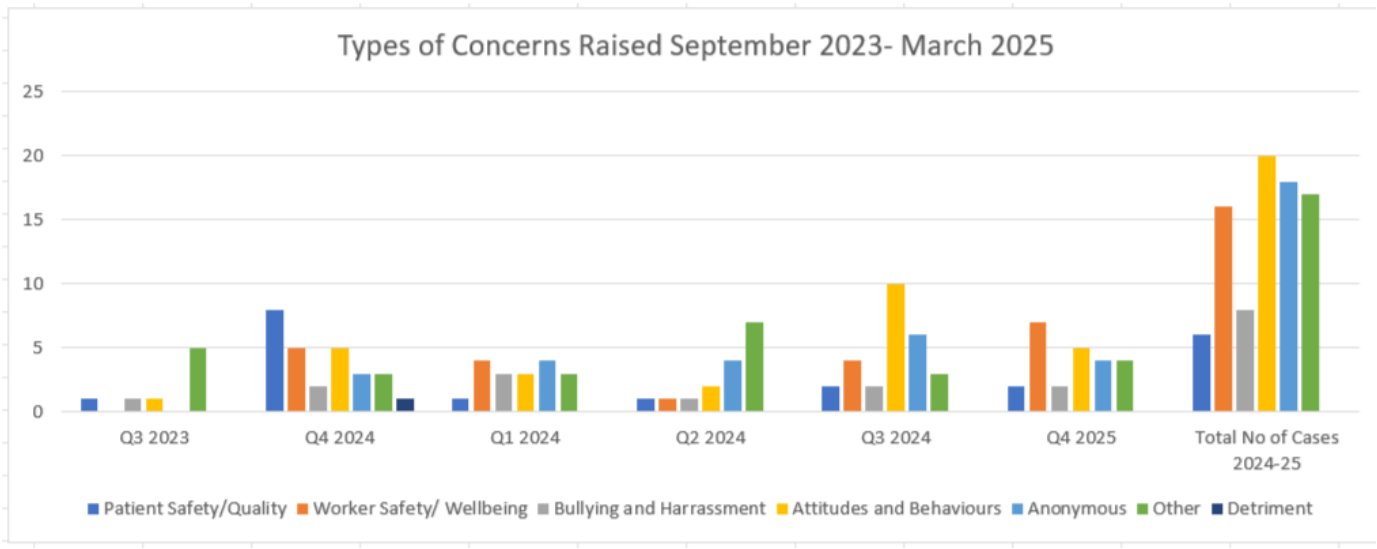
The FTSU team have received concerns from a broad range of professional groups across the Trust. Registered Nurses raised the most concerns with 29.63%, followed by Administration and Clerical 16.66% and then Additional clinical services with 14.81%. Twenty-two percent of concerns did not wish to share their professions or were anonymous concerns.



Below is the data required of the different 'Types of concerns' raised. The National Guardian Office have categorized concerns, under Patient Safety/Quality, Attitudes and Behaviours, Worker Safety and Wellbeing, Bullying and Harassment, Other (procedures, policies, fraud etc) and the number of anonymous concerns.

When staff raise a concern, it can have more than one element to the concern and therefore would be enter into several categories. In 2024-25 Attitudes and behaviours have been the most consistent concerns raised followed by Other concerns.
Attitudes and behaviours = 29.85%, Patient Safety 8.96%, bullying and harassment 11.94%, Other 25.37%, Detriment 1.49% and anonymous 26.87% of the total number of types of concerns raised over this last 12 months.

Cases have taken from one day to four months to close over the past year.



In 2024/25 the FTSU RJAH have promoted FTSU across the Trust by updating Posters of the Champions and Non-exec, executive lead, and Guardian for FTSU. In October, the Champions and Guardians promoted FTSU by having a walk about, explaining about FTSU and explaining how they can raise a concern.

Mandatory FTSU e-learning was introduced last year. This included three modules and is a one-off training session. Speaking Up is for every member of staff, Listening Up is an additional module for Managers and the Follow Up module is for senior manager/ executive managers as well as the other two modules.

This year 92.2% of staff have completed the Speaking Up module, 83.4% have completed the Listening Up module and 81.6% have completed the Follow up module. FTSU Champions are also asked to complete all three modules.

The introduction of QR code for a Microsoft FTSU raising concerns form has been completed. This form enables anyone wishing to raise a concern either anonymously or by name can do so by scanning the code. Once the person has submitted the form this is sent directly to the Guardian, computer identification is not traceable, therefore if some wishes to stay anonymous they can. If contact detail is added then the Guardian can contact the person to discuss the concern, signpost them to appropriate departments and give feedback, as necessary.

Completed actions for 2024-25

- Completion of the National Guardian Office Reflection and planning tool.
- The additional appointment of three global majority FTSU champions, bringing the total of champions up to twelve. The Champion's role is to raise the profile of FTSU in their department and signpost staff to an appropriate person for advice or escalation.
- The Guardian has introduced a closed, information portal, for the Champions. The Guardian can share updates from the National Guardian Office. There is also a separate digital chat room and What's App group, so Champions can ask questions and gain support from each other. Bi-monthly face to face meetings are also available.
- A Microsoft from for Champions to record concerns raised to them has been developed. This enables accurate data to be collected and shared with the Guardian in real time.

- Ensuring face to face presentations on FTSU at Trust induction and development days, and Preceptorship programme.
- The implementation of a staff survey feedback form. This form is sent in batches, to staff who have raised concern, and the cases have been closed. The feedback form is anonymous so that staff can give honest feedback about the FTSU service.
- Additional data are being collected around protected characteristics, if any staff with protected characteristics are raising more concerns than staff without.

National Quality Indictors

Staff Survey Results

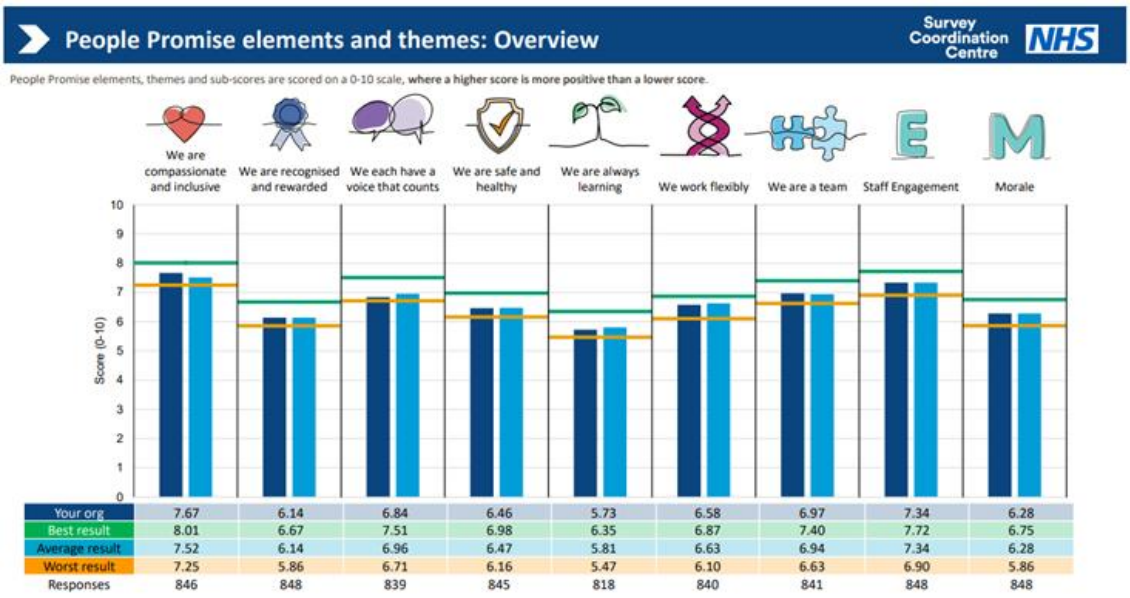
In the 2024 NHS Staff Survey, 92% of respondents said they would be happy with the standard of care provided if a friend or relative needed treatment.

Key headlines:

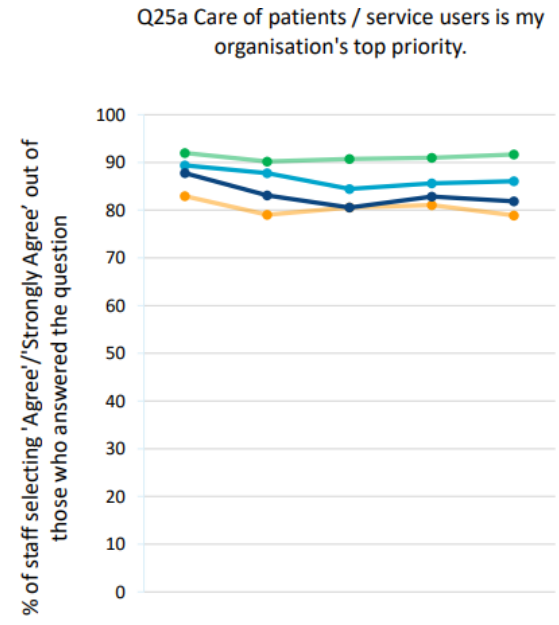
- Recommended treatment to a friend or relative = 92% (2023 data = 94.02% slight decline) but above the average result of 89%

The overall response rate, and themed results are detailed below:

Response Rate	2018	2019	2020	2021	2022	2023	2024
	44.9%	62%	57%	52%	52%	52%	47%



Our overall staff engagement score was comparable with other acute specialist trusts.



	2020	2021	2022	2023	2024
Your org	87.75%	83.09%	80.54%	82.87%	81.87%
Best result	91.98%	90.20%	90.74%	90.97%	91.69%
Average result	89.38%	87.74%	84.45%	85.64%	86.06%
Worst result	82.94%	79.02%	80.54%	81.07%	78.89%
Responses	893	840	834	902	845

Oversight Framework

The following section outlines the Trust's performance against the relevant indicators and performance thresholds set out in the NHS Improvement Oversight Framework where this data does not appear elsewhere in the report.

	Info taken from the published annual accounts							
Indicator for Disclosure	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate	89.49%	90.26%	88.85%	54.41%	55.96%	53.45%	49.06%	47.62%
All cancers: 62day wait for first treatment from: * Urgent GP referral for suspected cancer * NHS Cancer Screening Service referral	75.76%	73.91%	86.84%	75.00%	65.63%	80.85%		
62 Day General Standard							75.44%	65.88%
Maximum 6 week wait for diagnostic procedures	99.57%	98.97%	97.94%	59.00%	77.45%	64.68%	81.88%	83.10%
Venous thromboembolism (VTE) risk assessment	99.90%	99.88%	99.89%	99.74%	99.77%	99.80%	99.78%	99.83%

NHSE issued updated Cancer Waits Guidance in 2023/24 and now reporting is against the 62 Day General Standard, as presented in the table above.

Statement of Directors' responsibility in respect of the Quality Account

Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50 and NHS income greater than £130k per annum

NHSE has issued guidance NHS foundation trusts are no longer required to produce a Quality Report as part of their annual report. NHS foundation trusts will continue to produce a separate quality account. The National Quality Board has approved a refresh of Quality Accounts to update and improve the process, bringing it in line with changes to legislation and NHS structures and policy.

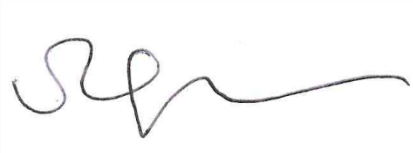
to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust guidance.
- The content of the Quality Report is consistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2024 to March 2025
  - Papers relating to quality reported to the board over the period April 2024 to March 2025
  - Feedback from Shropshire Telford and Wrekin ICS
  - Feedback from the Trust's Lead Governor
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - The latest national patient survey 2024 and national staff survey 2024
  - The most recent CQC inspection report
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Report has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board



Harry Turner, Chairman

Stacey Keegan, Chief Executive Officer

NHS Shropshire, Telford and Wrekin

RJAH Quality Account Statement from Shropshire Telford and Wrekin ICB 2024/25

Re: Quality Account 1 April 2024 - 31 March 2025

NHS Shropshire Telford and Wrekin Integrated Care Board (the ICB) are pleased to have had the opportunity to review the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) Quality Account for 2024/25.

The ICB supports the Trust's quality priorities for 2025/26 including falls and further supporting those with complex needs including those with mental health challenges and people with a

Learning Disability and Autism.

The ICB was pleased to note RJAH's ongoing commitment to supporting local and national audits demonstrated though participation in the11 National audits they were eligible to participate in as well as 16 local clinical audits. RJAH also completed 12 service evaluation

projects which identified opportunities to improve the provision of urgent orthotics and creation of a safeguarding checklist, contributing the integrated care system's ambitions to drive

continuous quality improvement.

Maintaining attention on the experience of the workforce, the NHS staff survey results for 2024 were extremely positive showing that 74% of staff would recommend RJAH as a place to work. Actions identified from the survey included implementation of the NHS People Plan, focus groups and staff network groups. Actions taken forward include real time feedback on patient experiences, patient involvement in safety events and completion of action plans in response to complaints. RJAH Friends and Family Test also remains consistently above 95% of patients

scoring the Trust very good or good.

The management of healthcare acquired infections is an area that the ICB has worked closely with RJAH and the system on in recent years. Reporting was pleasing. The ICB is pleased to see the ongoing priority in this area with positive outcomes including only 2 cases of *Clostridioides difficile* Infections (CDI) in 2024/25 against a target of 4.

RJAH reported four Never Events for 2024/25. These were investigated using the Patient Safety Incident Response Framework (PSIRF) principles. Key learning identified from the investigations included the introduction of the revised National Safety Standards for Invasive Procedures

(NatSIPPS2) across all departments in the Trust.

Longer waiting times for some appointments has been a challenge and RJAH have been undertaking harm reviews to monitor and address potential risk following a local policy. The ICB is keen to continue to understand the learning from these and how any harm can be minimised.

The ICB was delighted that RJAH was identified as an early implementor site for Martha's rule. The patients/family and staff can request a review from the Critical Care Outreach Team with plan from February 2025 to introduce daily wellness checks on inpatient wards. This is an

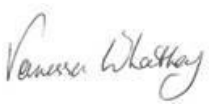
important national development, and we look forward to further sharing of this experience in the system.

In conclusion, the ICB views the 2024/5 Quality Account as an accurate picture of the challenges the Trust faces and evidence of improvements in key quality and safety measures.

The ICB supports the trust priorities for 25/26 and recognises the Trust's commitment to

working as a partner in the system to ensure the ongoing delivery of safe, high-quality services for the population of Shropshire Telford and Wrekin.

Yours sincerely,



Vanessa Whatley, Chief Nursing Officer, NHS STW

Lead Governor's Submission on the Quality Account Report for 2024/25 of the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

The Quality Account Report 2024/25 demonstrates the continued significant achievements the Trust has made over the last year in despite of the challenges faced. This is particularly evident through the Inpatient Survey Results there is continued evidence of the Trust's work to strive for improvement.

The Governors continue to support the Trust and partake in patient safety visits, attending committees meeting and holding governors' surgery. Within 2024/25, the Governors have been more involved in events, patient safety and patient experience initiatives, and they welcome these opportunities to provide input on behalf of their members. In addition, seeing how the services run and hearing directly from patients about their experiences provides assurance to the Council of Governors that the patient needs are consistently being met.

It is reassuring that the hospital continues to be a place staff would recommend to their friends and family as a place of treatment and further as a place to work. This really is testimony to the quality of the care that the Trust continues to provide.

On behalf of the Council of Governors, I would like to congratulate the Trust on its quality performance for 2024/25.

Victoria Sugden, Lead Governor
DD June 2025

Acronyms

ACL	Anterior Cruciate Ligament
ASIA	American spinal injury association
BBE	Bare below the elbow
BMI	Body Mass Index
BOFAS	British Orthopaedic Foot & Ankle Society
BSCOS	British Society for Children's Orthopaedic Surgery
BSR	British Spinal Registry
CAP	Community required Pneumonia
CD	Controlled Drug
CDI	Clostridioides Difficile Infections
CEO	Chief Executive Officer
CLD	Criteria Led Discharge
CMC	Carpometacarpal
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSP	Chartered Society of Physiotherapist
CURB-65	Severity Score for Pneumonia
DIPC	Director of Infection Prevention and Control
DMARDS	Disease-modifying anti-rheumatic drugs
DMD	Duchenne Muscular Dystrophy
DSPT	Data Security and Protection Toolkit
DVT	*Deep vein thrombosis*
EDD	Estimated Date of Discharge
EPR	Electronic Patient Record
EQ5D	Equality Health Index Score
FFFAP	Falls, Fragility Fracture Audit Programme
FFT	Family and Friends Test
FTSU	Freedom to Speak Up
GIRFT	Getting It Right First Time
HCAI	Healthcare Acquired Infection
HCPC	Health and Care Professionals Council
HDU	High Dependency Unit
HSE	Health and Safety Executive
HSIC	Health and Social Care Information Centre
HSMR	Hospital Standardised Mortality Ratio
ICB	Integrated Care Board
ICS	Integrated Care System
IG	Information Governance

IHI	Institute of Health Improvement
IHOT	Intensive Health Outreach Teams
IM	Intramuscular
IPC	Infection Prevention and Control
IPR	Integrated Performance Report
IQVIA	Patient Experience monitoring system
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
ISNCSCI	International Standards for Neurological Classification of Spinal Cord Injury
KLOEs	Key Line of Enquiry's
KPI	Key Performance Indicator
LD	Learning Disabilities
LOS	Length of Stay
MADE	Multi Agency Discharge Event
MAHR	Non-Arthroplasty Hip Registry
MDT	Multidisciplinary Team
MPFT	Midland Partnership Foundation Trust
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphylococcus Aureus
MSCI	Midlands Spinal Cord Injury
NDFA	National Diabetes Foot Audit
NEIAA	National Early Inflammatory Arthritis Audit
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NIHR	National Institute of Health Research
NJR	National Joint Register
NMR	Non-medical Referrer
OHS	Oxford Hip Score
OKS	Oxford Knee Score
OT	Occupational Therapist
PALS	Patient Advice and Liaison Service
PE	pulmonary embolism
PEoLC	Palliative and End of Life Care
PLACE	Patient Led Assessment of the Care Environment
PQIP	Peri-operative Quality Improvement Programme
PR	Peri Rectum Examination
PROMs	Patient Reported Outcomes Measures
PSAG	Patient Status at a Glance
PSI	Patient Safety Incident
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan

QI	Quality Improvement
RCA	Route Cause Analysis
RCOT	Royal College of Occupational Therapists
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RJAH	Robert Jones and Agnus Hunt
RSH	Royal Shrewsbury Hospital
RTT	Referral to Treatment Time
SCI	Spinal cord injury
SCIM	Spinal cord independence measure
SEIPS	System Engineering Imitative for Patient Safety
SHMI	Summary Hospital-level Mortality Indicator
SHOT	Serious hazards of transfusion
SI	Serious Incident
SIF	Serious Incident Framework
SIRO	Senior Information Risk Owner
SOF	Single Oversight Framework
SOOS	Shropshire Orthopaedic Outreach Service
SSCP	Shropshire Safeguarding Community Partnership
SSI	Surgical Site Infections
SWAN	Signs Words Actions Needs
TER	Total Elbow Replacement
THR	Total Hip Replacement
TIF	Targeted Investment Fund
TKR	Total Knee Replacement
TQ Pressure	Tourniquet Pressure
TSR	Total Shoulder Replacement
VTE	*Venous Thromboembolism*
WTE	Whole Time Equivalent