The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Quality Account
2025/2026

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 a 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 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

Sam Young
Interim Chief Nurse and
Patient Safety Officer
February 2025 – June 2025

Sarah Needham
Interim Chief Nurse and
Patient Safety Officer,
September 2025 – May 2026

Ruth Longfellow
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 2025/26 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 us 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 our challenges with waiting times, 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.

In 2025/26 the Trust invested in a new Quality Management System, Radar Healthcare that supports the organisation to have data in relation to patient safety incidents, risk management, patient experience, clinical and quality audits on one digital platform, to enhance our ability in understanding the quality and effectiveness of the

services the Trust provides. As we move into 2026/27 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.
- Address equity of access and health inequalities for our catchment population
- Develop our services through partnership and shared decision-making
- Create a compassionate, inclusive and engaging cultural environment for our staff
- Recruit, retain and transform our workforce to provide an exemplar experience for our staff and patients

PART 1
Statement on Quality from the Chief Executive Officer

It gives me great pleasure to introduce our annual Quality Account, This Quality Account sets out our key achievements in 2025/26, as well as sharing our priorities for 2026/27.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has recently redefined its vision, '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 and associated recruitment, which will play a key role in our ability to meet government targets for elective recovery in the coming months.

The Trust's Critical Care and Surgery services were inspected by the CQC in May 2025. The CQC used its single assessment framework for this inspection and looked at all key questions, it published its report in October 2025. Other services were last inspected during a full inspection in October 2018, with the report published in February 2019.

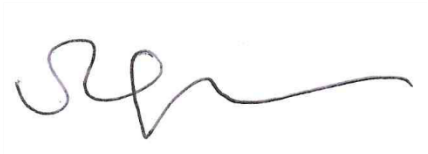
The latest service inspections saw Surgery retain the 'Good' rating it achieved in 2019. Critical Care demonstrated evidential improvement, having been rated 'Requires Improvement' in 2019 but now being upgraded to Good. The Trust's overall rating remains as Good, with care rated as Outstanding.

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.

September 2025 saw the publication of the Care Quality Commission Adult Inpatient Survey. 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 contribution of staff from across the hospital, we will strive to keep improving in 2026/27 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
11 May 2026

PART 2
Priorities for improvement

Our Quality Improvement Priorities for 2026/27

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 2026/27. 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 we have continued to build on 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. Since April 2024, 84% of wards and departments assessed have achieved a rating of Good or higher, exceeding the Trust's internal target of 60% for 2025/26. This reflects the continued embedding of quality standards and improvement across services. Focus has also been on developing a bespoke accreditation the Peri-operative and Theatre pathways, in line with AFFP guidance.

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. Upskilling ward teams to safely manage high-acuity patients and reduce unnecessary admissions to HDU	
Objectives	• Establish a comprehensive baseline of MSK-to-HDU admissions to understand current transfer patterns and identify opportunities to reduce avoidable escalations. • Strengthen MSK ward staffing models to ensure the workforce, skill mix, and shift patterns safely support the care of higher-acuity patients. • Develop and implement targeted, competency-based training for ward staff to enhance: o Early recognition of patient deterioration o Use and interpretation of enhanced monitoring o Safe management of higher-acuity patients • Ensure medical and on-call support structures are aligned with the ward's acuity capability, enabling timely senior decision-making and escalation. • Introduce ongoing monitoring and review of MSK-to-HDU admissions to identify avoidable transfers and drive continuous improvement in ward-level care.
Rationale	By ensuring our ward staff have the right clinical skills, we can reduce the number of inappropriate admissions to critical care and that we align to our Critical Care Operational Policy.

Measures	• Reduction in on the day cancellations due to lack of HDU beds • Increase compliance in line with the Critical Care Operational Policy relating to admissions to HDU • Reduction in unplanned admission to HDU from MSK wards • Positive staff feedback on confidence managing high-acuity patients
Board Sponsor	Clair Hobbs, Interim Chief Nurse, and Patient Safety Officer
Oversight Committee	Patient Safety Meeting with upward reporting to Quality and Safety Committee.

Patient Safety	
2. Implement Actions associated with the new Patient Safety Healthcare Inequalities Reduction Framework	
Objectives	• Scope the using EIDO which is a repository for patient information leaflets as our main resource to ensure our communications are accessible and clear • Health inequalities training to be delivered to all Ward/Departmental/Service leads to improve awareness and understanding of healthcare inequalities to related patient safety risks. • Using Radar Healthcare and LFPSE to understand the Trusts data on health inequalities to improve safe care
Rationale	A review of NHSE Patient Safety Healthcare Inequalities Reduction Framework, the Trust have identified opportunities for improvement.
Measures	• Improved compliance against the accessible information standard. • Understanding incident reporting and patient safety data through the lens of health inequalities
Board Sponsor	Clair Hobbs, Interim Chief Nurse, and Patient Safety Officer
Oversight Committee	Patient Safety Meeting with upward reporting to Quality and Safety Committee.

Patient Safety	
3. Improve knowledge and compliance in relation to blood transfusion practices	
Objectives	• Increase awareness of Transfusion-Associated Circulatory Overload (TACO) risk assessment form and its need for completion • To ensure information regarding blood transfusion summary in patients discharge summary • Audit programme to be established • Review training material around blood transfusions
Rationale	An area of improvement identified through completed patient safety reviews and clinical audit.
Measures	• Improved audit compliance • Reduction in reporting SHOT incidents • Training compliance in relation to Blood Transfusion Practices.
Board Sponsor	Ruth Longfellow, Chief Medical Officer
Oversight Committee	Patient Safety Meeting with upward reporting to Quality and Safety Committee.

Clinical Effectiveness	
4. 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	Clair Hobbs, Interim Chief Nurse, and Patient Safety Officer
Oversight Committee	Patient Safety Meeting with upward reporting to Quality and Safety Committee.

Clinical Effectiveness	
5. To review nursing documentation on Apollo to ensure it is proportionate and led by professional judgement	
Objectives	• To review nursing risk assessments used on Apollo, to ensure they are intuitive and led using professional judgement. • To implement the use of Fluid Balance Charts, Sepsis Screening and Patient Wellness Questionnaires through Vitals.
Rationale	Through the implementation of Apollo, we recognise the need for nursing documentation to be streamlined and proportionate to individual patient needs.
Measures	• Improved satisfaction from nursing staff on the volume of documentation to complete • Completion of nursing documentation through the quality accreditation process.
Board Sponsor	Clair Hobbs, Interim Chief Nurse, and Patient Safety Officer
Oversight Committee	Patient Safety Meeting with upward reporting to Quality and Safety Committee.

Clinical Effectiveness	
6. Increase the use of Patient Reported Experience Measures (PREMS) alongside PROMS to understand the effectiveness of our service	
Objectives	• To ensure the Trust captures PREMS for each of our services and that this is reported at service and Unit level meetings. • To develop an accreditation process for our services, that incorporate, PREMS, PROMS, GIRFT accreditation, Clinical Audit and if applicable, research activity.
Rationale	We recognise that while patients have excellent clinical outcomes, we need to ensure that the experience of the patient is equally as positive, ensuring our services are safe, effective and responsive.

Measures	• PREM and PROM Scores • Service Accreditation Scores
Board Sponsor	Clair Hobbs, Interim Chief Nurse, and Patient Safety Officer & Ruth Longfellow, Chief Medical Officer
Oversight Committee	Patient Safety Meeting with upward reporting to Quality and Safety Committee.

Patient Experience	
7. To review and improve our booking and scheduling processes to help improve the experience of our patients	
Objectives	• Introduction of acknowledgment letters to patients on receipt of referral and when scheduled for surgery. • Improve signposting to services to ensure our patients are waiting well for surgery • Review booking procedures to reduce the volume of rescheduled appointments. • Improve communication (both internally and externally) regarding waiting times for English and Welsh waiting times, ensuring consistent messaging to our patients. • Continue to improve our RTT performance so patients are waiting in line with national standards
Rationale	Learning from patient feedback has identified a need for us to improve processes within patient access, to help improve the way in which we communicate with our patients and ensure they are waiting well, while waiting for an appointment or procedure.
Measures	• Improved RTT position • Reduction in the number of Complaints and PALS concerns relating to waiting times and scheduling of appointments • From a PREMS perspective measure improvements against 'Access and Timelines'
Board Sponsor	Clair Hobbs, Interim Chief Nurse, and Patient Safety Officer & Mike Carr, Chief Operating 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 2025/26, 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 2025/26 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 2025/26.

Participation in Clinical Audit

During 2025/26, 10 National clinical audits covered NHS services that the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust provide.

During that period, The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust participated in 10 out of 10 (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 2025/26 were as follows:

- Intensive Care national audit and research Centre (ICNARC) Case Mix Program (CMP)
- Medical and Surgical Clinical Outcome Review Program – Managing acute illness people with learning Disability
- Epilepsy 12: National Clinical Audit of Seizures and Epilepsies for Children and Young People
- National Comparative Audit of Blood Transfusion – 2025 Major Hemorrhage Audit
- National Diabetes Audit (adults) – National Diabetes Inpatient Safety Audit (NDISA)
- National Early Inflammatory Arthritis Audit (NEIAA)
- National Falls & Fragility Fracture Audit Program – National Audit of Inpatient Falls
- National Joint Registry
- Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)
- KO41A Return – NHS Complaints

The reports of 34 local clinical audits were reviewed by the provider in 2025-2026 and The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust intend to take the actions set out in below to improve the quality of healthcare provided.

No.	Project Ref	Action Plan
1	2324_035 Estimated Dates of Discharge (EDD) audit	1. Identify factors for EDD not being set in meeting. To do a deep dive of EDD delay factors to provide a better service for patients
2	2425_004 Assessing the Psychological service for Midland Centre for Spinal Injuries (MCSI) inpatients	1. Regular email communication between Psychology & Ward Managers 2. Patient handover sheets to be updated with regards to Psychology support being provided
3	2425_008 Pressure Ulcers prevention and management in neuromuscular disorders	1. Develop Pressure Ulcer Prevention Patient Information Leaflet and disseminate to patients for awareness and knowledge
4	2425_016 EXOGEN ultrasound bone healing system Audit	1. Accurate documentation of use of exogen - Email the team explaining the importance of documenting the use of Exogen
5	2425_018 Getting It Right First Time (GIRFT) Ankle Arthritis Service Evaluation	1. Electronic uniform application of recording of Patient Reported Outcome Measures (PROM) score which is now being captured on myRecovery 2. Review cases of non-union following arthrodesis – via a separate service evaluation 3. Review pathway of long Length of Stay (LOS) patients to identify any delays – via a separate service evaluation
6	2425_025 Effect of National Institute of Clinical Excellence (NICE) Guidance on indication outcomes of Lumbar Fusion Surgery	N/A Standards met
7	2425_026 Delirium NICE Guidance CG103 Re-Audit 1920_032	1. Baseline cognitive assessment, either Abbreviated Mental Test (AMT) or Rapid clinical test (4AT) at admission for patients ≥ 75years - Inform pre-op clinic, and nursing staff/OT/Doctors on wards to screen ≥ 75years and Document baseline AMT or 4AT on electronic case notes 2. Use of delirium screening tools like Confusion Assessment Method (CAM) or 4AT - Inform doctors/ surgeons to use CAM or 4AT to exclude delirium 3. Inform GP about the confusion state at discharge - Inform doctors involved with discharging patients
8	2425_029 Management of Young Adult Hip Patients with Femoroacetabular Impingement (FAI)	1. Improve collection and recording of EQ-5D-5L and iHOT-12 (PROMS) scores - Submit re-audit proposal once pathway is set up
9	2425_030 Management of Young Adult Hip Patients with Hip Dysplasia	1. Contribute data to Non-Arthroplasty Hip Registry (NAHR) - Develop a work plan to submit data to NAHR
10	2425_039 Venous Thromboembolism (VTE) Policy Assurance Audit	1. Review patient information delivery - Produce leaflet around VTE risks and management

11	2425_048 Clubfoot Talipes Equinovarus (CTEV) Audit	1. Improve parent information available – Create a patient information leaflet 2. Snapshot audit to determine whether tenotomy % rate is affected by milder cases and not truly defined clubfoot diagnosis
12	2425_049 Nuclear Magnetic Resonance (NMR) Compliance Re-Audit	1. Ensure that current practice continues following the introduction of new trust Electronic Patient Record 2. More robust method of recording acknowledgment and action of radiology reports from MSST and MIU referrers - Discussion with NMR in MSST and MIU regarding methodology 3. Develop NMR personal ESR training record for 3 yearly refresher training - Explore the possibility of developing a refresher training module for ESR for NMRs
13	2425_050 Deteriorating Patient Compliance and NEWS2 Audit	1. Graded response - Review escalation and clinical response
14	2425_051 Effects of Peripheral Nerve Blocks on Outcomes of Total Knee Replacement (TKR) Enhanced Recovery	1. Share findings at Arthroplasty meeting for ensuring process is consistent
15	2425_054 Re-Audit of 2122_035 Blood Transfusion Process in the Tumour Unit	N/A Significant progress in blood product management following the implementation of targeted interventions. Annual Audit for monitoring purpose.
16	2425_055 Image Quality of First post-op x-ray for anterior-posterior (AP) pelvis patients on Enhanced Recovery (ER) pathway	1. Provide guidance to radiographic staff, with support from recovery teams, to remove artifacts whilst maintaining normothermia 2. Ensuring patient thermoregulation is sufficient in the X-ray room whilst positioning - Discuss with recovery team benefit of auditing patient thermoregulation in the X-ray room 3. Improve patient positioning to reduce rotational discrepancies on radiographs - Provide a CPD activity for radiographers, highlighting discrepancies and importance of utilising positioning aids, and sharing best practice 4. Input from referrers into immediately post-operative AP pelvis imaging standard - Discuss with referrers participating in the enhanced recovery pathway, on their objectives in image assessment for immediately post-operative hip arthroplasty radiographs. Share imaging standard with referrers utilising the enhanced recovery pathway for input. 5. Assessment of the impact enhanced recovery imaging has had on the Radiology department - Commencement of a multifaceted service evaluation involving staff feedback, image quality assessment, and departmental equipment use in relation to imaging patients in the immediate post-operative period.

17	2526_004 Re-Audit of 2324_018 International Standards for Neurological Classification of Spinal Cord Injury (ISNCSCI) assessment during rehabilitation phase in MCSI	1. Review SOP, Update, send for approval and disseminate to all staff concerned to ensure consistent process
18	2526_006 Retrospective analysis of total hip replacement dislocations at RJAH	1. Analyse impact of lipped liners and head sizes - Deep dive into cases for whole population regarding the impact of lipped liners and head size 2. Analyse most recent available National Consultant Information Programme (NCIP) data - Deep dive into recent data
19	2526_008 Re-Audit of 2324_028 Audit of Hand Trauma Referrals	1. Referrals to be scanned onto Apollo - Email Baschurch to remind team of importance of scanning referrals onto patient Apollo 2. Referral form to be consistent across both sites - Email Royal Shrewsbury Hospital (RSH) to provide updated referral form 3. Referrals sent by email in the incorrect format to be rejected - Email to Baschurch manager to confirm that referrals are to be rejected if in incorrect format
20	2526_010 Recording of clinical observations in MCSI Outpatient Clinic (OPD)	1. Ensure all documentation is completed on Apollo digital system - Send email reminder 2. SOP Creation - Create an SOP to outline mandatory baseline obs, pre and post clinic obs and recording protocol 3. Observation forms to capture all relevant data - Raise concern with Apollo team to ensure obs forms are capturing relevant data
21	2526_013 Atrial Fibrillation (AF) among inpatients at RJAH	1. All patients with AF must be risk stratified - Present at medical weekly lunchtime meeting 2. All patients with AF who are eligible for anticoagulation must be counselled - Present at Clinical Effectiveness Meeting 3. All patients must have clear management plan for rate and/or rhythm control of AF - Email all medical team members with reminder 4. GP must be informed about the new AF and subsequent plan
22	2526_014 Safe and Secure Handling of Medicines Audit	1. MCSI Compliance, submission of business case
23	2526_016 Rheumatology Referral Triage Audit	1. Improve adherence to triage criteria - Send reminder out to all consultants of triage criteria
24	2526_019 Transfusion-associated circulatory overload (TACO) Risk Assessment Assurance Audit	1. Awareness of TACO risk assessment form and how to fill it in - Provide wards with example TACO Risk Assessment form and visit all wards to share 2. Inclusion of blood transfusion summary in patient discharge summary - Present to Apollo team and share at unit meetings 3. Monitor risks to patient safety. - Add to risk register

		4. Ward managers to complete blood transfusion audits on Radar System. - Monitor Radar audits weekly 5. Review training material around blood transfusions - Develop training content around blood transfusions
25	2526_020 Haemoglobin (Hb) Threshold Compliance Audit	1. The prescription of red cell transfusion when HB is not below target of 70g/l. - Attend doctors' induction. Present at Multi-Disciplinary Clinical Audit Meeting (MDCAM) and attend ward meetings. 2. Pre-op anaemia needs to be treated before surgery. Defer if not treated. - Offer patients IV infusions to optimise red cell mass. Discuss with pre-op their process of identifying pre-op anaemia and treatment. 3. Reduce use of blood transfusion for weaning off metaraminol - Speak to HDU/anaesthetist on use of blood to wean patient off metaraminol 4. Disseminate findings with Chief Medical Officer. - Email and discuss results
26	2526_021 Recording of Clinical Observations in MCSI OPD	N/A 100% compliance to SOP and 100% standards met. Assurance to be gained with additional re-audit after 3 months to ensure the actions are still being implemented
27	2526_022 Controlled Drugs Audit Q1 2025-2026	1. Matrons/Unit Managers to be sent the signature list for sharing with managers - Share signature list with managers/matrons
28	2526_023 Pharmacy Intervention Audit	1. Embed the new Apollo/Electronic Prescribing and Medicines Administration (EPMA) to enable smarter worker. Complete a reaudit post implementation to assess the benefits of the EPMA against intervention activities. - Complete Re-Audit to evidence effectiveness
29	2526_025 Orthopaedic Therapies Documentation Audit	1. Improve Consent Documentation - Create standardised box on Apollo 2. Standardise Documentation of Clinical History - Provide SOAP note training 3. Strengthen Treatment Plan Clarity and Delegation - Create standardised specific plan on Apollo 4. Enhance Optimal Performance and Physical Therapies (OPPT) Documentation Accuracy - Arrange Apollo to autogenerate OPPT referrals 5. Improve Equipment Documentation Compliance - Create equipment form on Apollo
30	2526_048 Paediatric Dysplasia of the Hip (DDH) Audit	1. Dual consultant operating documentation - Ensure all consultants present in theatre documented

		2. MDT discussion documentation - Ensure all patients discussed in the MDT have documented evidence of this in the notes 3. Record of procedures to be logged - Maintain a logbook of procedures and complications
31	2526_051 Recording of Clinical observations in MCSI OPD Re-Audit (2526_021)	1. Accessing the SOP and observation form - Make the SOP and observation form easily accessible 2. Mandatory clinical observation form - Make the completion of the observation form compulsory in processing an out-patient admission 3. Recording of clinical observations in the proforma - Inform colleagues of SOP and observation form
32	2526_052 Oncology Post-Op Blood Tests Audit	1. Develop SOP for post-op blood testing for Musculoskeletal (MSK) Oncology inpatients - Create an SOP to determine when a patient required post-op blood tests
33	2526_059 Re-Audit of ISNCSCI Assessment during rehabilitation phase in MCSI (2526_004)	N/A 100% compliance in monthly ISNCSCI assessments. Audit has been scheduled for 2026 to ensure improvements have been sustained

16 Service Evaluation projects reports were reviewed by the provider in 2025 – 2026 as follows:

No.	Project Ref	Action Plan
1	2425_011 Mid-Term outcomes of bone marrow concentrate treatment for ankle cartilage defects - Service Evaluation	1. International Presentation to increase awareness – Poster for ICRS World Congress - Share findings
2	2425_012 Quality of Documentation within Anaesthetics Department	1. Minor design corrections of anaesthetic chart - Propose amendments to charts 2. Introduction of electronic anaesthetic record-keeping - Support the rollout of the electronic record system
3	2425_014 Spasticity service within MCSI	1. To improve the quality of care and adherence to national guidelines, it is recommended to ensure that all key personnel are present in a higher percentage of MDTs. - To create a business plan for a spasticity service to support MDT presence in outpatient clinic
4	2425_017 Methicillin-resistant Staphylococcus (MRSA) Swab Service Evaluation	1. The Microbiology department recommends that the Trust's current MRSA admission screening protocol is reviewed to include swabbing patients from at least two sites – preferably nose and groin
5	2425_027 Day Case Shoulder Arthroplasty Study	1. Develop criteria for patients to be eligible for same day discharge for shoulder arthroplasty - Develop criteria for patients to be eligible for same day discharge

6	2425_034 Learning Disability & Autism Patient Feedback Service Evaluation	1. Increased use and awareness of Hospital passports. - Promote the use of hospital passports across Trust 2. Improved knowledge of Learning disabilities & neurodivergence. - Promote the Oliver McGowan training for all staff
7	2425_038 MCSI Psychological screening effectiveness service evaluation	Recommendations identified has identified the same themes as 2425_004 Assessing the Psychological service for MCSI patients. Assurance of these actions have been implemented, and effectiveness will be gained through reauditing this audit.
8	2425_041 Evaluation of patient experience and education about implementation of VTE policy	1. Improve consistency of verbal information provided, document when patients receive patient information - Document when patients receive patient information
9	2425_043 Post-Op Bloods in Total Shoulder Replacement service evaluation	1. Share findings with Unit - Evidence: Minutes from meeting
10	2425_052 Audit of femoral modular endoprosthesis replacement following change of implant	N/A No actions required
11	2526_001 Review of nurse-led virtual appointments for post-operative patients in the Montgomery Unit	1. Scheduling of appointments from 2 weeks to 3 weeks, Increase the time between operation and the Clinical Nurse Specialist (CNS) OPA from 2 weeks to 3 weeks - Increase the time between operation and the CNS OPA from 2 weeks to 3 weeks
12	2526_024 Orthopaedic Therapies Patient Feedback Service Evaluation	1. Standardise Physiotherapy Introduction - Develop standard scripts for introduction to ensure consistency “Hello, my name is” 2. Improve clarity of communication - Therapy video and information to be uploaded onto the ER / therapy webpage on trust website. Link to ongoing work with outpatient. 3. Increase patient engagement in feedback surveys - Attach patient feedback QR code to patient handouts 4. Enhance Therapist Professionalism and friendliness - Develop recognition system to reward therapists who receive outstanding patient feedback 5. Improve Consent Documentation - Create standardised box on Apollo 6. Standardise Documentation of Clinical History - Provide SOAP note training 7. Strengthen Treatment Plan Clarity and Delegation - Create standardised specific plan on Apollo

		8. Enhance OPPT Documentation Accuracy - Arrange Apollo to autogenerate OPPT referrals 9. Improve Equipment Documentation Compliance - Create equipment form on Apollo
13	2526_029 Hand and Upper Limb Unit (HULU) Theatre List Service Evaluation	1. Share findings with HULU firm meeting - Report findings at an upcoming HULU meeting
14	2526_044 Powys Therapies Service Evaluation	1. Neurological assessments and intervention upskilling staff that may not have recent neuro experience - Develop in-service training for all grades. 2. Confidence of therapy support workers when treating and assessing spinal disorder patients - Develop competency documents to ensure standardisation across all members of the therapy support staff. 3. Structured and up to date SOP for bed rest patients. - Develop up to date SOP in line with national best practice. 4. Development of a bed rest checklist to standardise care for all patients on bed rest. - Checklist outlining therapy interventions patients should receive when on bed rest.
15	2324_026 Re-Audit 1718_56 Evaluation of Outpatient Letters to the GP	1. Prioritise Placement of Key Information - Ensure diagnosis, prescription changes, and medication details are placed at the beginning of the letter. 2. Enhance Letter Clarity - Revise formatting to improve clarity of information in letters.
16	2425_046 End of Life Care Service Evaluation	1. Streamline the process to ensure all patient care actions are documented accurately 2. Implement targeted end-of-life care training for all staff, with follow-up on skill improvement 3. Increase bereavement referrals and ensure families receive after-death bags in all cases 4. Improve documentation and communication of patient preferences and advanced care plans 3. Ensure all staff involved in patient deaths offered/attend timely debriefs

Clinical Audit and their impact

Good practice in clinical audit requires an action plan that is supported by the team with named individuals who take responsibility. The clinical audit tracker logs the actions, and these are monitored and updated to reflect the

progress of actions through the Trusts unit governance structure, ensuring the clinical audit cycle is completed in a timely manner. Project leads are supported to ensure that their actions are Specific, Measurable, Achievable, Realistic and Timely (SMART).

During 2025/26 we have continued to encourage staff to engage in clinical audit and service evaluation improvement projects to gain quality assurance and effectiveness that we are monitoring national and local recommendations and policies. We have focused on the quality of projects ensuring we are undertaking projects to gain the best outcome. To ensure this is being done we have used national sample size calculator to identify the compliance rate, identify the most effective method to obtain data and validating data to ensure we are submitting reliable data.

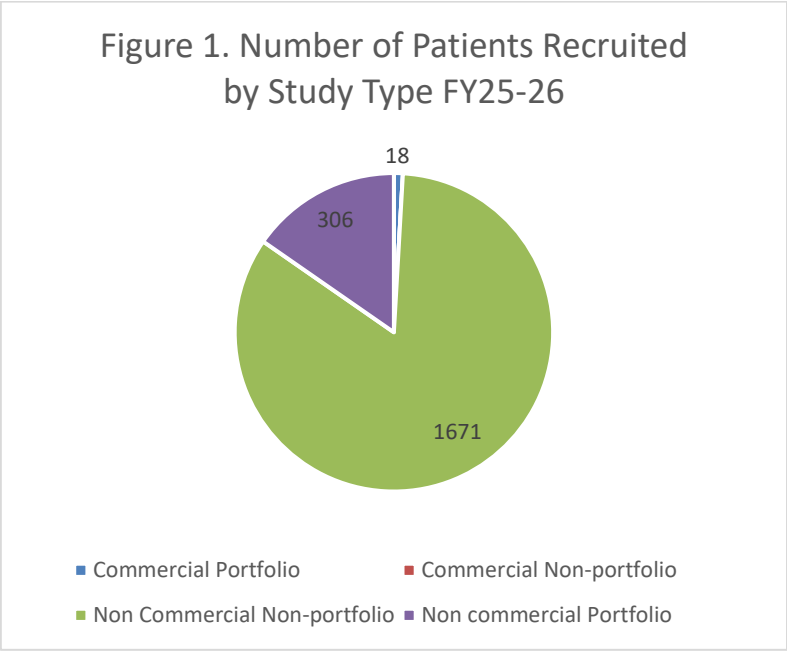
Alongside this, we have ensured all key stakeholders are included in projects and all staff members that should be involved in projects and action planning are being included. This is to make sure that projects and action plans are completed in the most appropriate way ensuring the effectiveness of the projects and the closing of the clinical audit cycle is acted upon.

With the implementation of Radar Healthcare—replacing Datix for incident and risk management, IQVIA for patient feedback, Tendable for quality audits, and CARMS for clinical audits—the new system will create a single platform for learning and improvement. By bringing together incidents, complaints, and patient feedback, we will be able to identify themes more effectively and use these insights to drive clinical audits and service evaluations. This will support meaningful improvements in our services, and where changes have been made, the ability to audit quality will provide assurance that we are actively learning from day-to-day practice and focusing on the areas that matter most to delivering the best possible care and experience for our patients.

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 2025/26 was 81, representing a 6.6% increase from the previous year. 50 of these were adopted onto the National Institute for Health Research (NIHR) portfolio, representing a 7.4% reduction from the previous year.

The number of participants that were enrolled in research eligible for inclusion in the NIHR portfolio was 324 (Figure 1). This represents an 29.5% reduction on 2024/25 (460). The total number of patients recruited in 2025/26 was 1995 (Figures 1 and 2). This is a 248.8% increase on 2024/25 and reflects a high level of recritment to a single Trust sponsored non-commercial, non-portfolio study. For FY 2024/25, the number of patients approached and offered the opportunity to participate in research accounted for 1.9% of total patient episodes. Recruitment to research opportunities accounted for 1.3% of total patient episodes. At the time of preparing this report, data for 2025/26 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.



Overall, across the West Midlands RRDN (Regional Research Delivery Netwrok), recruitment is 32% lower than last year with acute, non-acute, and wider care settings being most impacted, although recruitment to Primary Care increased. For England as a whole, recruitment is 26% lower than 2024/25. The West Midlands has the second highest proportion of interventional recruits and interventional studies account for 68% of recruitment. This reduction in recruitment is further reflected in the overall reduction in commercial recruitment in 2025/26 which is 22% behind on 2024/25 across the West Midlands RRDN. Recruitment/100k of population ranks last in the West Midlands compared to other regions although the percentage of recruitment in interventional

studies is second highest. The West Midlands region accounts for 4.2% of recruitment to commercial studies and 7% of the recruitment to non-commercial studies, as a percentage of England.

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 62% of our research in 2025/26 and when this extended to include collaborations between clinicians and local academics, sponsored studies accounted for 25% of research studies in 2025/26. 75% 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 2025/26. These studies fall into the RRDN speciality areas of Children, Neurology, Trauma and Emergency Care, and Musculoskeletal and Orthopaedics.

The West Midlands Regional Research Delivery Network retained their previous target of 1533 responses to the Research Experience Survey (PRES), although targets have not been set nationally. The PRES survey is now known as the My Research Experience Survey and has exceeded its target number of responses and is 15% ahead of target (1,763 responses in the West Midlands region) 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.

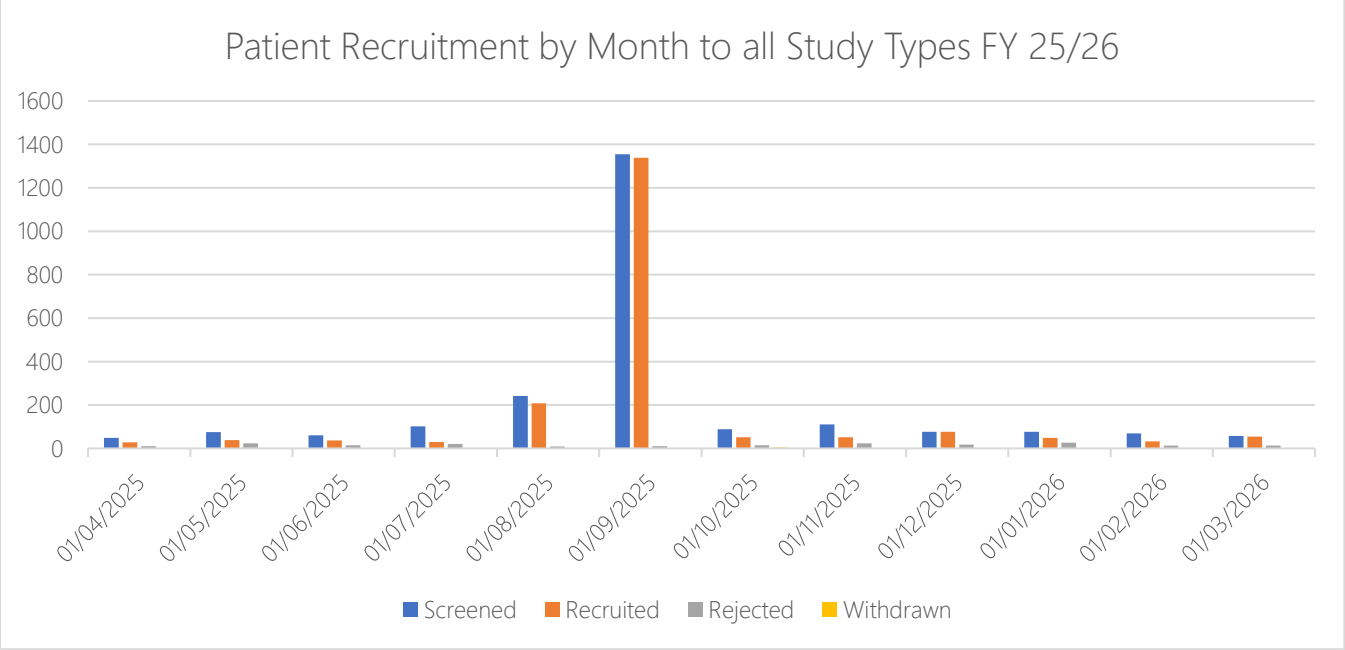


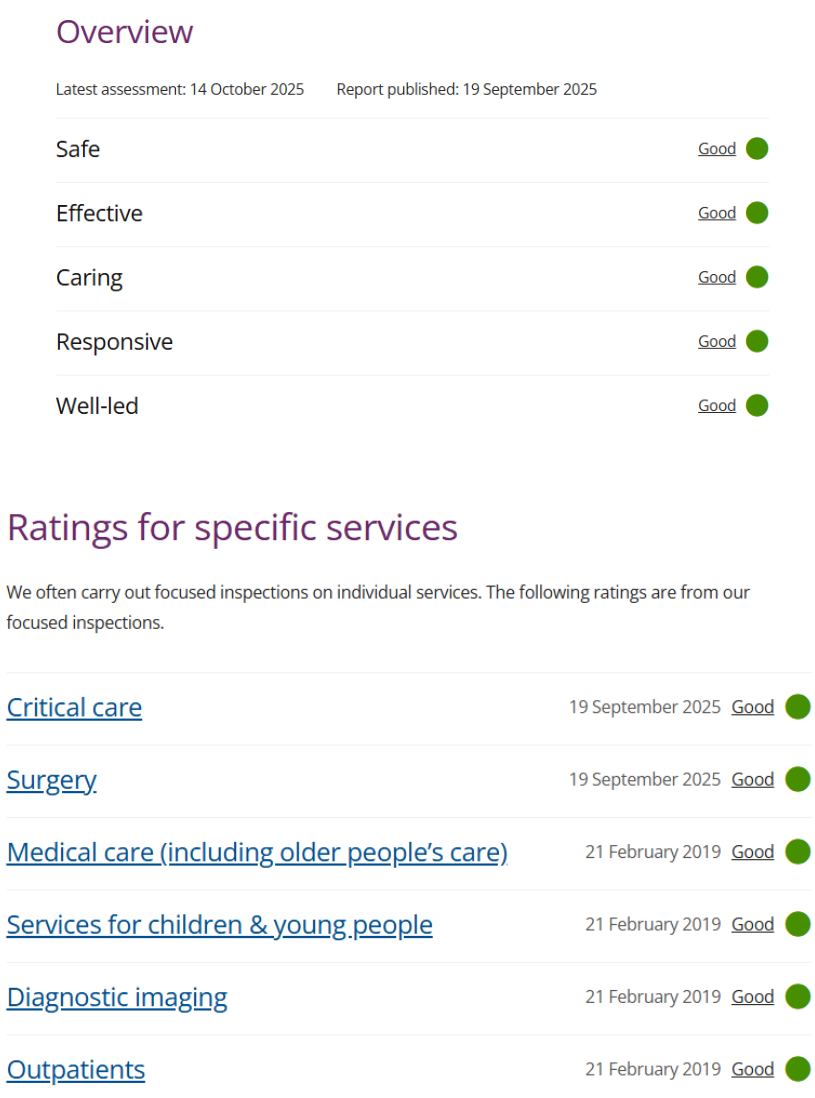
Figure 2. Patient recruitment by month to all study types for the year 25/26.

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 2025/26.

The Trust's Critical Care and Surgery services were inspected by the CQC in May 2025. The CQC used its single assessment framework for this inspection and looked at all key questions, and it published its report in October 2025. Other services were last inspected during a full inspection in October 2018, with the report published in February 2019.

The latest service inspections saw Surgery retain the 'Good' rating it achieved in 2019. Critical Care demonstrated evidential improvement, having been rated 'Requires Improvement' in 2019 but now being upgraded to Good. The Trust's overall rating remains as Good, with care rated as Outstanding. The breakdown of ratings is shown below:



The full CQC inspection report can be found at the following link: https://www.cqc.org.uk/location/RL131

Secondary Uses Service Submission

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust submitted records during 2025/26 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 (November-25) which included the patient's valid NHS number was:

- 100% for admitted patients care.
- 100% 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 Trust's admitted patient care dataset is reported at 99.9% for November-25's publication against a national average of 90.0%.

For the outpatient dataset, in the same November-25 publication, the Trust is reported at 98.0% against a national average of 86.4%.

The Trust has maintained this high compliance despite the introduction of a new EPR system.

Throughout 2025/26 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
- Responding to Data Quality issues as a result of the new system and ensuring the accuracy of Trust reporting was maintained following implementation

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 Chief Finance and Commercial Officer as the Senior Information Risk Owner (SIRO). Further, the 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 2025/26 has not yet been determined as the final submission date is 30 June 2026.

For 2024/25 the Trust's score was APPROACHING STANDARDS.

During 2025/26 the Trust reported two serious IG breaches, neither of which resulted in action from the ICO.

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 Oversight Framework

NHS England's NHS Oversight Framework 2025/26 is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to 1 of 5 'segments'.

Segmentation indicates performance and whether improvement is required, from high performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

- Its segment derived from scored metrics under 5 performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)
- considering financial override which may limit a segment to be no better than 3
- contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality)
- capability assessments which consider the organisation's leadership and governance.

Segmentation

The most recently published segmentation information relates to quarter 4, 2025/6 and was published in June 2026. For that quarter, the Trust was placed in segment 1 of the Oversight Framework. The definition of

segment 1 is: "The organisation operates with maximum autonomy, facing minimal external oversight, and boast the narrowest range of challenges.". That places the Trust at 17 out of 134 in the acute trust league table.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website. The trust is included on the acute hospital trust dashboard.

Under the capability assessment, the Trust was rated AMBER / GREEN.

SUB-CATEGORY	OVERALL DOMAIN SCORE	Score			Performance			Rank		
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
Elective Care	Percentage of people waiting less than 18 weeks score	4	3.62	3.45	45.39%	52.72%	55.8%	131/131	123/131	107/131
	Difference between planned and actual 18 week performance score	3	1	1	-0.93%	5.23%	3.46%	108/131	11/131	15/131
	Percentage of patients waiting over 52 weeks score	3.98	3.94	3.85	7.75%	6.95%	4.09%	130/131	128/131	124/131
Access to Services Overall Segment		4	4	3	**3.66**	**2.92**	**2.77**	**131/131**	**109/131**	**95/131**
Patient experience	CQC Inpatient survey satisfaction rate score	1	1	1						
Effective flow and discharge	Average number of days from discharge ready date to actual discharge date score	1.91	1.7	3.36	0.60	0.44	1.28	39/126	30/125	100/127
Effectiveness and experience of care Overall Segment		1	1	2	**1.46**	**1.35**	**2.18**	**15/134**	**12/134**	**62/134**
Patient safety	NHS Staff Survey - raising concerns sub-score score	2.17	2.17	2.17	6.51	6.51	6.51	53/134	53/134	53/134
	CQC safe inspection score (if awarded within the preceding 2 years)									
	12 month rolling count of MRSA cases score	1	1	1	0.00	0.00	0.00			
	12 month rolling count of C. difficile cases as a proportion of trust threshold score	1	3.7	1	1.00	1.50	0.50			
	12 month rolling count of E. coli cases as a proportion of trust threshold score	1	1	1	0.67	0.22	0.11			
Patient Safety Overall Segment		1	1	1	**1.59**	**2.04**	**1.59**	**3/134**	**21/134**	**3/134**
Retention and Culture	Sickness absence rate score	2.69	2.66	2.19	5.49%	4.97%	5.01%	87/134	86/134	67/134
	NHS staff survey engagement theme score	1.2	1.2	1.2	7.34	7.34	7.34	10/134	10/134	10/134
People and Workforce Overall Segment		1	1	1	**1.95**	**1.93**	**1.7**	**38/134**	**35/134**	**27/134**
Finance	Combined finance score	1	1	1						
	Planned surplus/deficit score	1	1	1	0	0	0	12/134	12/134	12/134
	Variance year-to-date to financial plan score	1	1	1	0.03	0.01	0.00	25/134	30/134	33/134
Productivity	Implied productivity level score	3.44	3.98	3.91	-0.27	-13.82	-4.90	109/134	133/134	130/134
Finance and Productivity Overall Segment		3	3	3	**2.22**	**2.49**	**2.45**	**59/134**	**72/134**	**56/134**
OVERALL SEGMENT, AVERAGE METRIC AND LEAGUE TABLE POSITION		**2**	**2**	**2**	**2.31**	**2.22**	**2.19**	**27/134**	**25/134**	**22/134**

Key:
Low performing
Below average
Above average
High performing

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 2025/26 ten 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: two in the first quarter; three in the second quarter; one in the third quarter and four in the fourth quarter.

As of 31 March 2026, nine case record reviews (one outstanding from March 26) and four coroner's investigations have been conducted in relation to the ten 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: two in the first quarter; three in the second quarter; one in the third quarter and three 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 2025/26 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 2025/26 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 0.37%.

Activity	No. of Readmissions	% Readmissions
01/04/2025	4	0.62%
01/05/2025	0	0.00%
01/06/2025	1	0.17%
01/07/2025	4	0.65%
01/08/2025	1	0.18%
01/09/2025	2	0.31%
01/10/2025	3	0.39%
01/11/2025	6	0.77%
01/12/2025	1	0.16%
01/01/2026	1	0.14%
01/02/2026	2	0.29%
01/03/2026	4	0.53%

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.

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 were 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. 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. The published data is currently unavailable for 2022/23 onwards; previous data collected for the trust can be found on the PROMs section of the NHS England's website.

As this data is no longer published it is collected, analysed and reported on internally instead. 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
- 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.

	2023/24		2024/25	
	Invited	% Registered	Invited	% Registered
RJAH Arthroplasty	6702	49%	3508	66%
RJAH Foot and ankle	2283	46%	1144	63%
RJAH Knee and Sports Injuries	2876	55%	1880	71%
RJAH Upper limb	459	55%	4184	62%

2023/24 now provides a full year of our PROMs collection completed electronically. The below table displays the PROMs participation rates for the various teams split by Pre and Post 1 Year collection. Upper Limb will not be included in this year's report due to their patients onboarding onto myrecovery later as a phased implementation process therefore not yet displaying a full year of collection.

	2023/24	
Speciality	Pre Operation	Post 1 Year

Arthroplasty	81%	57%
Foot & Ankle	76%	38%
Sports Injuries	84%	48%

Various PROMs are collected depending on the clinical team and procedure. For Arthroplasty and Sports Injuries, the national Oxford scores and EQ5D are used, scoring for these are explained above. The following tables display the average score change for the scores completed by patients before their operation and 1 year after their operation, split by procedure taken place 2023/24.

Arthroplasty

	Average Score Change (Pre & Post 1 Year)		
	2023/24		
	Oxford Hip	EQ5D3L Index	EQ5D3L VAS
Hip Arthroscopy	-3.500	-0.122	-2
Hip Injection	4.368	-0.102	-7
Hip Replacement	24.341	0.430	21
Revision Hip Replacement	20.009	0.328	23

Sports Injuries

	Average Score Change (Pre & Post 1 Year)		
	2023/24		
	Oxford Knee	EQ5D3L Index	EQ5D3L VAS
Knee Arthroscopy	1.000	-0.010	-17
Partial Knee Replacement	21.667	0.233	17
Revision Knee Replacement	5.833	0.442	22
Total Knee Replacement	21.288	0.341	16

As well as the EQ5D the foot and ankle team use the Manchester Oxford Foot Questionnaire (MOXFQ). This is a 16 item measure that is designed to assess foot and ankle surgery outcomes. When scoring the 16 items they are separated into 3 different domains, Walking/Standing, Pain, and Social Interaction. The overall score for the 3 domains is converted to a 0-100, 0 (No limitation) to 100 (Maximum Limitation).

Foot and Ankle

	Average Score Change (Pre & Post 1 Year)				
	2023/24				
	MOXFQ WS	MOXFQ P	MOXFQ SI	EQ5D5L Index	EQ5D3L VAS
Ankle Fusion	25	27	18	0.264	6
Ankle Replacement	63	43	45	0.307	15
Big Toe Fusion	33	33	27	0.203	7

Foot & Ankle Surgery	22	20	19	0.104	6

All score changes above, across the various teams and different procedures, are showing an improvement in health gains. As electronic collection becomes more embedded into the patient pathway work is being completed to support more of an engagement and uptake of using this method.

Quality of Recovery-15 (QOR-15)

The QOR-15questionnaire is a widely used patient-reported outcome measure designed to assess how well someone has recovered after surgery, especially focusing on their overall well-being in the early postoperative period. The questionnaire is given to patients to complete pre surgery and day 1 and 2 post surgery. Currently this is only given to our patients who are having hip and knee replacement surgery.
The questionnaire has 15 items providing an overall score from 0 – 150. The higher the score displays the best recovery.

	2023/24	
	Total Completed	Average Score
Pre	32	82.531
Post Day 1	236	85.000
Post Day 2	72	86.106

Musculoskeletal Health Questionnaire (MSK-HQ)

The MSK–HQ is a short questionnaire for patients with MSK conditions to report on their symptoms and quality of life in a more consistent, holistic way helping better management as a wider range of issues may be highlighted and addressed. It gives an overall rating of a patients MSK health enabling monitoring of progress and response to treatment as well providing information on how well MSK services improve quality of life for people with these conditions. The MSK HQ is made up of 14 questions that ask patients how they are feeling about their muscle and joint pain. The individual questions can have a total score of 0 to 4, 0 being the worst possible score. The total of all of these scores will give the overall result of the MSK-HQ ranging from of 0-56, with a better score indicating better MSK-HQ health status at a 3-to-6-month collection point.

The below table categorise the patients based on their score change following treatment/advice. It includes total patients with and pre and post questionnaire completed, total percentage improved and improved percentage with the Minimally Important Clinical Difference (MICD) applied as recommended by the MSK-HQ guidance. A patient is only considered to have improved here if their score change is >=6.

	MSK-HQ Data Overview	
	2023/24	2024/25
Total Completed	105	306
Percentage Improved	81%	78%

Percentage Improved (MICD)	65%	62%

Improvement rates have decreased slightly for 2024/25, and scores will be continued to be monitored as the uptake of collection improves.

Shared Decision Making

The CollaboRATE questionnaire is a questionnaire to measure and support the evidence that shared decision making is taking place in the trust. This data is collected electronically, and patients are asked three questions after their initial outpatient appointment has taken place. The three questions asked to patients are as follows:
Thinking about the appointment you have just had …
1. How much effort was made to help you understand your health issues?
2. How much effort was made to listen to the things that matter most to you about your health issues?
3. How much effort was made to include what matters most to you in choosing what to do next?
Each question can be scored from 0-9, 0 meaning 'No effort was made', 9 meaning 'Every effort was made'. The total score can range from 27 to 0, higher the score represents the more shared decision making took place.

	Average CollaboRATE Score	
	2023/24	2024/25
Total Completed	541	357
Understand Score	7.05	7.93
Listen Score	7.14	8.00
Include Score	7.00	7.98

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 and have improved this financial year. 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 2025 the staff survey is aligned to the NHS People Plan, and the People Promise with additional socio-economic questions. The Trust holds monthly focus groups to look at the top three concerns, areas to focus on and supporting managers with next steps to implement changes

Key headlines:

- Completed questionnaires = 823
- Response rate = 45%

- Recommended as a place to work = 69.18% *(2024 data = 74%)*

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' drop in sessions
- Walk rounds to clinical areas on evenings and weekends
- Monthly Staff Survey Focus Group
- Engagement with 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	2025
National Average	8.1	8.1	8.4	8.1	8.1	8.1	8.2	Data not published until July 26
RJAH Orthopaedic Hospital NHS Trust	9.1	9.2	9.5	9.4	9.4	9.3	9.4	
Highest	9.1	9.2	9.5	9.4	9.4	9.3	9.4	
Lowest	7.3	7.4	7.5	7.4	7.4	7.5	7.4	

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".

	2021/22	2022/23	2023/24	2024/25	2025/2026
National Average	94%	94%	94%	94%	94%*
Highest Score	100%	100%	100%	100%	100%*
Lowest Score	64%	73%	75%	69%	56%*
The Robert Jones and Agnes Hunt	98%	98%	98%	98%	98%
* data only available nationally up to Feb 26					

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

Venous Thromboembolism (VTE) Assessment

Our patients often have difficulties mobilising which places them at an increased risk deep vein thrombosis (DVT) or pulmonary embolism (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 2026).

	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS TRUST	99.90%	99.72%	99.80%	99.78%	99.83%	99.81%
NHS England					90.6% *	92% *
HIGHEST	100%				100% *	100% *
LOWEST	67.50%				0% *	0% *

** Based on Q3 2025/26 Published data - Release Date 12 March 2026*

There was no national data comparison from 2021/22 to 2023/24. In 2024/25 the national submission was reinstated.

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 members of the Trusts Patient Safety Meeting.

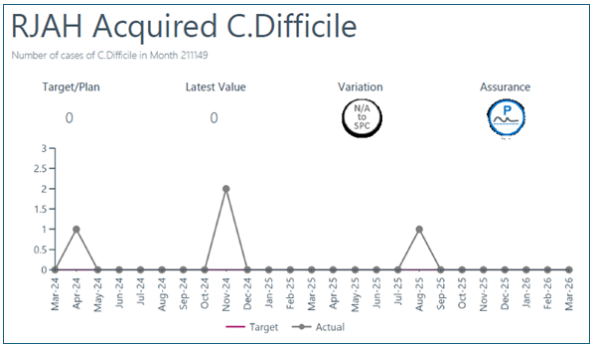
Clostridioides Difficile Infections (CDI)

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

The Trust has had one attributable case of CDI for the year 2025/26. This was against a target of two. An After Action Review concluded that this case was 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
C Diff Graphs:



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.

In January 2026, the Trust introduced a new reporting system designed to provide a comprehensive and collaborative perspective on patient safety and experience. Radar integrates several components, including incident management, risk assessment, claims, complaints, PALS, patient feedback, audits, and document management.

Patient Safety Incidents Reported per 1000 Bed Days

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.

Period of Coverage	Rate of incidents	Number of incidents
Oct 25 - Mar 26	59.5	1552
Apr 25 - Sep 25	57.1	1496
Oct 24 - Mar 25	53.6	1397
Apr 24 - Sep 24	58.3	1527
Oct 23 - Mar 24	56.5	1480
Apr 23 - Sep 23	45.6	1196
Oct 22 - Mar 23	45.1	1176
Apr 22 - Sep 22	42.7	1119
Oct 21 - Mar 22	42.8	1116

Apr 21 - Sep 21	41.7	1092

Patient Safety - Severe Harm / Death

Period of Coverage	Rate of incidents	Number of incidents	Comments
Oct 25 - Mar 26	0.23	6	5 deaths (0 unexpected and 5 expected) and no severe harm incident
Apr 25 - Sep 25	0.19	5	4 deaths (0 end of life and 4 expected) and 1 severe harm incidents
Oct 24 - Mar 25	0.35	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 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.

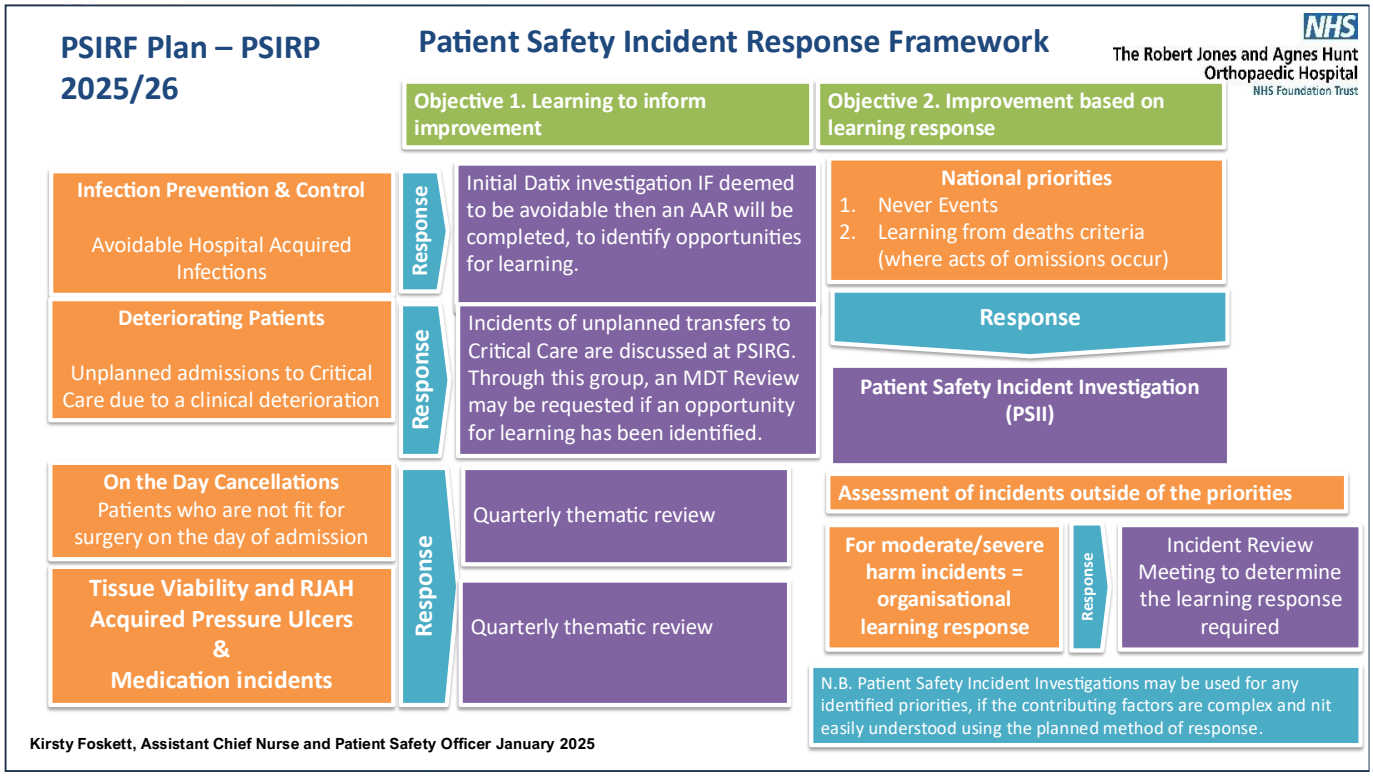
Patient Safety Incident Response Framework (PSIRF)

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:

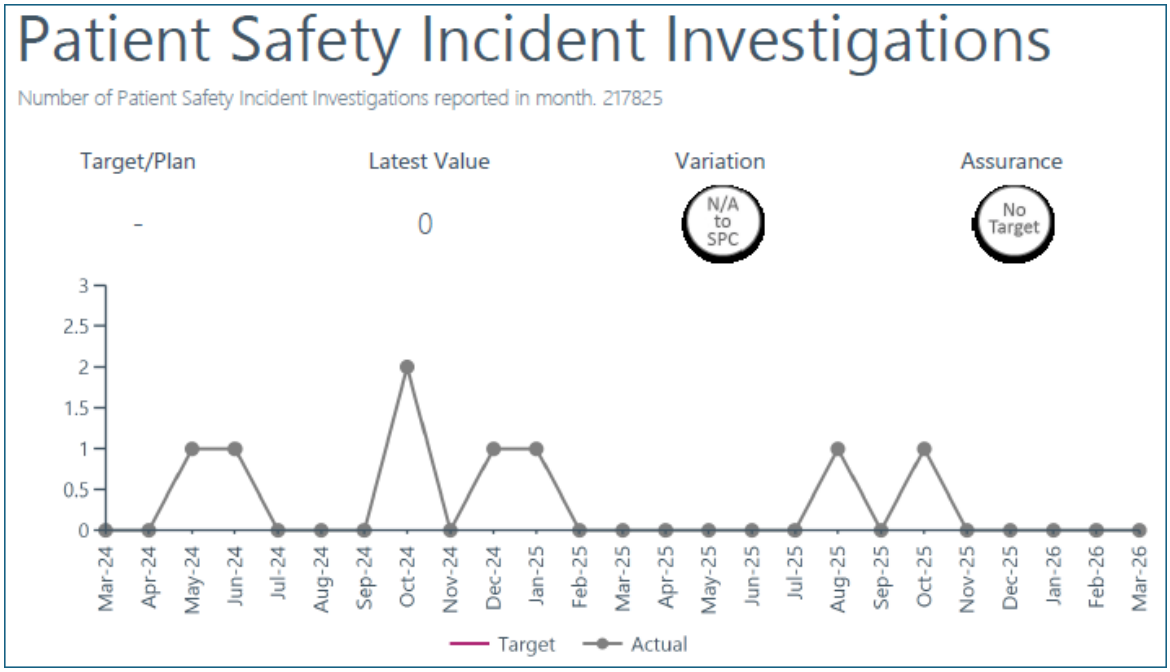
- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approached to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening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

It is recommended that Trusts review their Patient Safety Incident Response Plan every 12-18 months. In April 2025 the Trust Board endorsed the revised Patient Safety Incident Response Plan, identifying the following priorities as areas of focus.



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 Trust - Never Events and Learning from Deaths criteria, where acts or omissions may have contributed to a patient's death.



In 2025/26 the Trust commissioned 2 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 two reported Never Events pertained to:

- Wrong Implant/Prothesis (1)
- Wrong side injection (1)

In comparison to 2024/25, the Trust reported four Never Events relating to Wrong Implant/Prothesis (2) and Retained Foreign Objects (2).

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 implemented a new Quality Management System, Radar Healthcare
- 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 2025/26

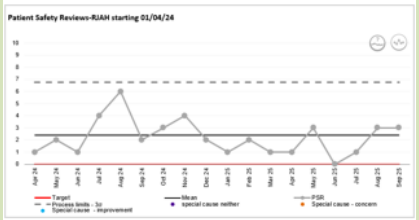
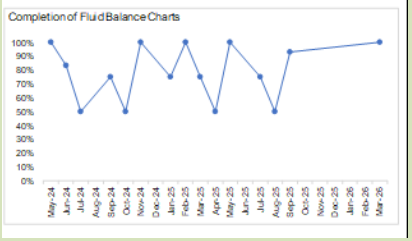
In line with the Trust's Quality Improvement Strategy, and in discussion with the Board of Directors, Council of Governors and other relevant stakeholders, the Trust identified the following key priorities for 2025/26:

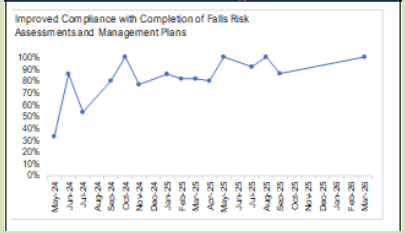
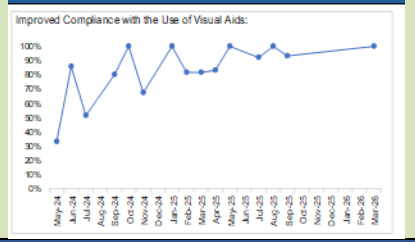
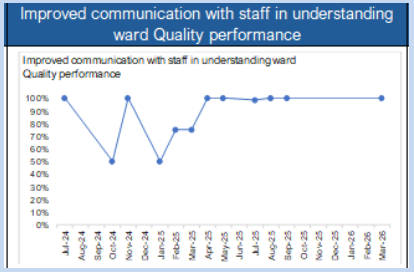
- Patient Safety: Managing the deteriorating patient
- Patient Safety: Learning from Inpatient falls
- Clinical Effectiveness: Improving information sharing
- Patient Experience: Introducing a complex care pathway for patients with mental health, learning disability, and/or autism.

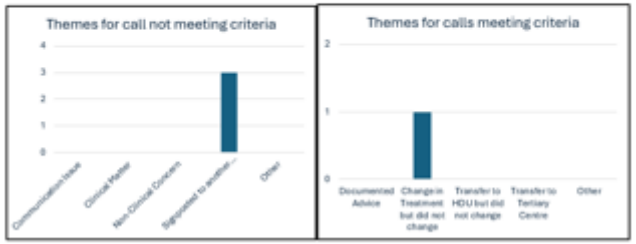
Progress made for quality priorities 2025/26

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. Managing the deteriorating patient	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.	• Reduction in the number of patient safety reviews requested due to deterioration. • Uptake of simulation training amongst clinical staff. • Improved compliance (through Tendable audit) in the completion of fluid balance charts.	Significant progress has been made on initiatives supporting early recognition of the deteriorating patient and improvements to fluid balance monitoring. Key achievements include: • Delivery of simulation training programmes in theatres and study days for staff. • Continued embedding of "Call for Concern" and observational training such as "Pete's Problems." • Establishment of standardised venepuncture trolleys, ICNARC data access, and monitoring systems to support oversight of deteriorating patients.	*Overall Completion: 86% (Partially Achieved* Reduction in the no of Patient Safety Reviews  Improved Compliance Through Tendable Audit In the Completion of Fluid Balanace Charts 

Priority	Objective	Measure of Success	Actions completed/taken	Achieved
2. Learning from Patient Falls	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.	• Improved compliance with completion of risk assessments and management plans. • Improved compliance with the use of visual aids.	Significant progress has been made on falls prevention initiatives, with many actions completed and embedded into practice. Key achievements include: • Completion of the Falls Policy review aligned to NICE guidance. • Establishment of the Task & Finish (T&F) stakeholder group. • Development of patient information resources ready for publication. Core interventions such as training, awareness campaigns, visual cues, and communication processes remain in place and sustained across clinical areas.	*Overall Completion: 77% (Partially Achieved)* Improved Compliance with Completion of Risk Assessments and Management Plans  Improved Compliance with the Use of Visual Aids 
CLINICAL EFECTIVENESS				
3. Improving Information Sharing	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.	• Improved communication with staff in understanding ward (quality) performance. • Reduction in incidents relating to communication in ward areas. • Improved scores through Well-led of the	Significant progress has been made on Information Sharing initiatives, with key elements now established and embedded. Achievements include: • Implementation of the Quality Dashboard proof of concept and rollout of agreed ward metrics. • Integration of feedback systems into digital displays. • Launch of the Link Programme with supporting structures, meetings, communication processes, and a trust-wide newsletter. • Bedside handovers implemented across multiple wards as part of a phased pilot.	***Overall Completion (%): 72% (Partially Achieved – this will continue to be a Quality Priority for 2026/27)*** Improved communication with staff in understanding ward Quality performance 

Priority	Objective	Measure of Success	Actions completed/taken	Achieved
	To review the effectiveness of "Link Nurse" meetings. To introduce new patient bed boards across the Trust.	quality accreditation assessment.		Improved scores through well - led of the quality accreditation asessment 
PATIENT EXPERIENCE				
4. Introduction of a complex care pathway for patients with mental health, learning disability and/or autism.	Improving the experience of those patients with LD&/or A or mental health needs.	• Reduction in communication incidents. • Reduction in complaints.	Significant progress has been made on initiatives to improve the patient experience for those with complex care needs. Key achievements include: • Implementation of reasonable adjustment processes. • Integration of training on safeguarding versus complex care. • Updates to patient letters to support communication of additional needs. • Weekly coordination between safeguarding and the coordination centre established for proactive patient management. • Core elements such as pathway mapping, alert standardisation, and engagement with external organisations have been completed, supporting improved identification and care for patients.	*Overall Completion: 81% (Partially Achieved)* Implementation and adoption of the Call for Concern/Marthas Rule. 

Local Quality Indicators

In addition to the Quality Priorities for 2025/26 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

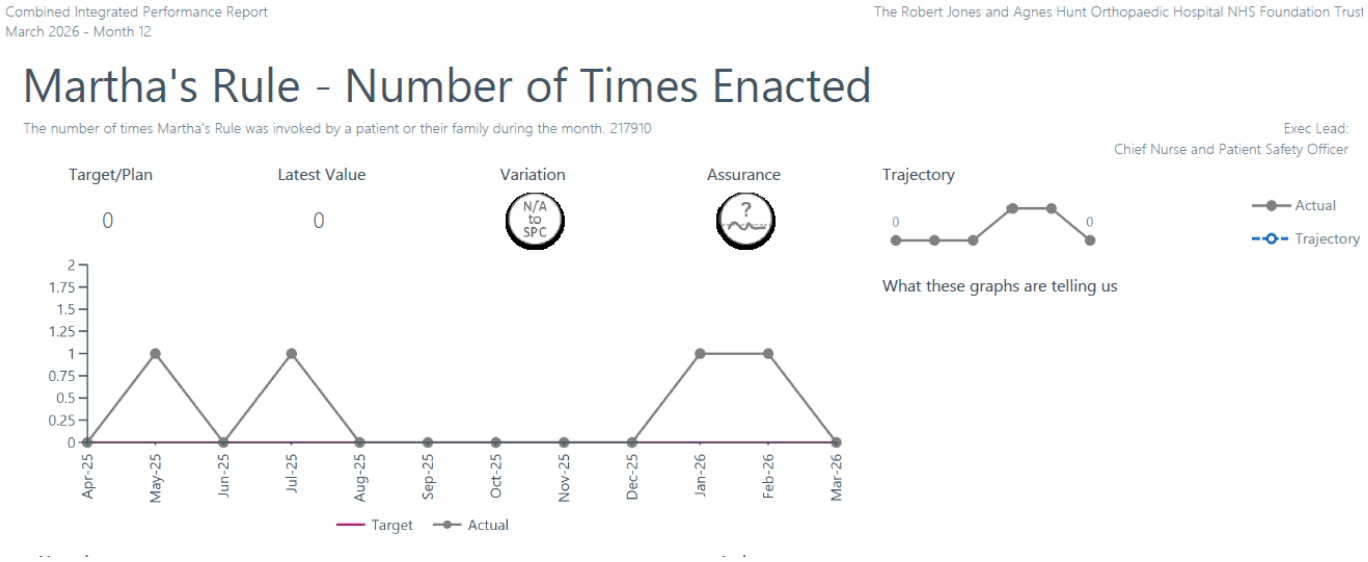
Martha's Rule

In December 2024 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.

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

This year we have continued to focus on embedding Martha's Rule into our processes for managing deteriorating patients and continued to roll out of 'Patient Wellness Questionnaires' across all of our inpatient wards. The number of call for concerns activated by patients, families or advocates is monitored through the Trusts Patient Safety Committee.



Introducing Radar Healthcare

This year the Trust has invested in a new Quality Management System, Radar Healthcare that supports the organisation to have data relation to patient safety incidents, risk management, patient experience, clinical and quality audits on one digital platform, to enhance our ability in understanding the quality and effectiveness of the services the Trust provides. Radar Healthcare replaces the current systems

Current Systems	Radar Healthcare
Datix	Base Radar Package (Action plans, notices, analytics)
IQVIA	Events (Incident reporting, complaints PALS, staff feedback, patient feedback)
CARMS	Risk Register
Tendable	Audits
AQUA (SJRs)	Document Management
	Bereavement
	Litigation and Claims
	SJRs/Mortality Reviews
	Safety Alerts / CAS

Patient Harm Reviews

The Trust remains firmly committed to safeguarding patient safety and ensuring timely, effective care. Since 2021, RJAH has implemented a structured programme of patient harm reviews to identify, assess, and mitigate risks for patients experiencing extended waits for assessment or treatment.

In 2025, following sustained evidence demonstrating the absence of clinical harm within the arthroplasty cohort, and with approval from the Quality and Safety Committee, the review process for this cohort transitioned to assessment at the next point of patient contact. No harm-related escalations have been identified to date.

This approach has enabled increased focus on patient groups where harm had previously been identified, notably within spinal disorders, spinal injuries, and rheumatology. Patients in these specialties who experience waits in excess of 52 weeks continue to receive a formal clinical harm review, with any identified risk resulting in expedited assessment within three weeks. Cohorts 1–6 have been completed. The release of Cohort 7 data was delayed due to system changes associated with the implementation of the new electronic patient record (Apollo); however, mitigating actions are underway to ensure momentum is maintained and further delays are avoided.

The Trust remains fully committed to sustaining this programme until elective backlog waits are eliminated, ensuring patients receive care within timescales that protect both clinical outcomes and patient wellbeing.

Safeguarding

Safeguarding at RJAH continues to be governed by the Children Act 1989 and 2004, Mental Capacity Act 2005, Care Act 2014, the Domestic Abuse Act 2021, Working Together to Safeguarding Children 2023, Statutory Guidance for Integrated Care Boards 2022, and the Safeguarding Accountability and Assurance Framework (SAAF) 2022. These frameworks collectively place a shared responsibility on all partners to protect and promote the welfare of children, young people and adults at risk. The Trust also remains committed to the principles of the NHS Sexual Safety in Healthcare Charter, reinforcing its duty to provide a safe environment for patients, visitors and staff.

Safeguarding Governance and Assurance

Safeguarding governance continues to play a central role in the Trust's internal and external quality assurance processes. This includes compliance with the requirements of the Care Quality Commission (CQC), the Shropshire Safeguarding Community Partnership (SSCP), the Telford and Wrekin Safeguarding Partnership (TWSP), and the wider Integrated Care System (ICS). These partnerships ensure that safeguarding activity is monitored, scrutinised, and aligned with the statutory responsibilities and best practice across both Shropshire and Telford & Wrekin.

The Trust's safeguarding governance framework is supported by robust safeguarding policies, which are regularly reviewed and updated to reflect national legislation, local multi-agency procedures, and emerging learning. These policies underpin safe practice across the organisation and ensure staff have clear guidance on recognising, responding to, and escalating safeguarding concerns.

Safeguarding governance is also embedded within the Trust quality metrics and performance monitoring arrangements, ensuring safeguarding is consistently reflected in organisational quality dashboards, risk registers,

and assurance reports. These metrics support early identification of trends, enable targeted improvement actions, and provide assurance to the Board and external partners that safeguarding responsibilities are being met.

The Trust maintains oversight of a wide range of safeguarding indicators, including:

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

This governance structure ensures that safeguarding remains visible, accountable and embedded across all areas of Trust activity. It supports the delivery of safe, high-quality care for children, young people, and adults at risk, and ensures the Trust meets its statutory duties across local authority areas.

Safeguarding Training

Safeguarding Level 3 (L3) training compliance was identified as a key priority for 2025/2026, prompting a sustained programme of improvement actions. Compliance is monitored monthly basis, with additional quarterly reporting the Trust Safeguarding Committee, Quality and Safety Committee and via the SAAF dashboard to the ICB. These measures have in an enhanced rise in both adult and children's L3 training compliance.

Whilst Adult L3 compliance remains below KPI, performance has reached its highest level to date at 85%. Compliance for Oliver McGowan Training Part 2 (Tier 1 and Tier 2) continues to exceed expectations, remaining significantly above ICB KPI of 30%.

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

Safeguarding Activity

Referrals to Adult Social Care / Local Authority

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

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

Deprivation of Liberty Safeguards (DoLS) Applications

Throughout 2025/2026, staff completed 35 DoLS applications in line with statutory requirements. Of these, 24 were submitted to Shropshire as the supervisory body, with further applications made to authorities outside of Shropshire, which reflects that we take patients from across the country.

Additional Safeguarding Training and Development introduced across 2025-2026

- ✓ 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 Children Advice and Supervision

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

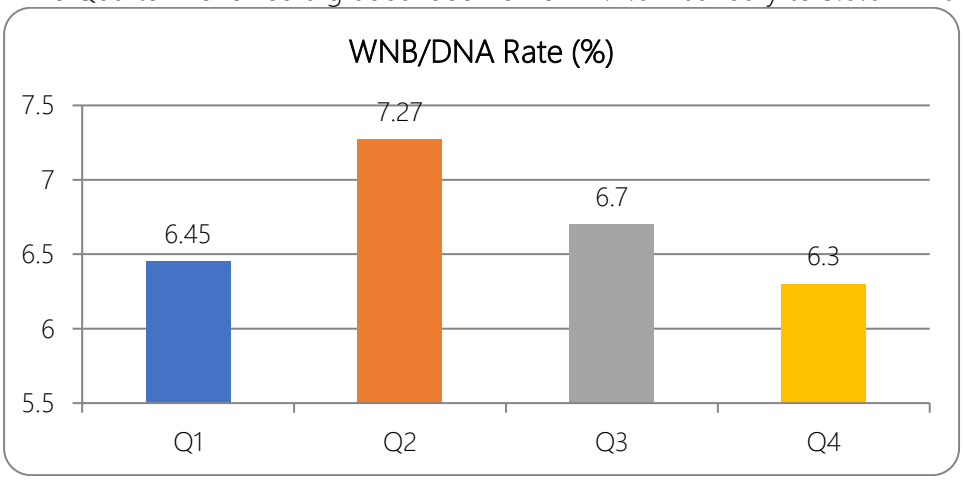
Quarter	Advice Sessions	Supervision Sessions	Total
Q1	15	0	15
Q2	14	12	26
Q3	23	0	23
Q4	12	18	30
Total	**64**	**30**	**94**

A total of 64 advice sessions was given to staff and 30 staff received supervision.

Safeguarding Activity

Children Not Brought to Appointments (WNB)

WNB/did not attend (DNA) rates stayed mostly steady over the reporting year. Quarter 1 saw a mild rise, reaching 6.8% in May. Rates peaked in Quarter 2 at 8.3% in July, then averaged 7.27%. Quarter 3 was relatively stable, while Quarter 4 showed a gradual decline from 7.4% in January to 5.6% in March.



Safeguarding Children 0-19 Liaison Forms

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

Quarter	Number of 0-19 Liaison Forms
Q1	5
Q2	3
Q3	5
Q4	2
Total	15

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

Referrals to Adult Social Care / Local Authority

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

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

Staff Allegations

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

Pressure Ulcers / Safeguarding

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

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

Quarter	Total PU Reported	Occured Prior to Admission	MET PUSG Threshold	SG Referral Made	LA
Q1	17	16	10	0	-
Q2	14	13	8	0	-
Q3	30	27	16	1	Shropshire
Q4	22	19	12	0	-
Total	61	56	34	1	Shropshire

As previously note the Safeguarding Team is not aware of any ongoing Section 42 enquiries, indicating that cases were either not progressed following initial review or subsequently being closed by the Local Authority.

Prevent / Channel Requests

In accordance with Section 38 of the Counter Terrorism and Security Act 2015, the organisation continues to meet its statutory duty to share information that supports the prevention of radicalisation and potential exploitation of children, young people and adults at risk. Prevent / Channel information-sharing requests increased significantly during 2025/2026, rising from 17 in the previous year to 44; an increase of 159%

Quarterly monitoring shows that requests related to both adults and children, with a small number of individuals known to RJAH services. There were no requests for the Safeguarding Team to attend any Channel Panels during the reporting period. All requests were reviewed and responded to appropriately, ensuring timely engagement with multi-agency partners and adherence to national Prevent guidance.

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

Complex Care

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

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

Learning Reviews

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

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

Quarter	Scoping Requests	DHR	SAR	CSPR	Review to Proceed
Q1	1	1	0	0	1
Q2	6	0	4	2	3
Q3	3	0	1	2	1
Q4	6	5	1	0	TBC

Total	16	6	6	4	5

Table 3. DA disclosures in 2024-2025

Domestic Abuse

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

- 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 Liaison

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

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

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.

Throughout 2025/26, 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 continue to be 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 RJAH acquired infections. We continue to investigate and share learning from all healthcare associated infections to support improvements. Outbreaks of infections have remained low and expected within the Trust, in line with local prevalence.

The IPC Team has developed a variety of learning packages and materials to support both clinical and non-clinical teams (including volunteers) to practice IPC in line with the National IPC Manual for England; increasing 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. Key relationships between IPC and Estates & Facilities remain strong; with the IPC & Cleanliness Working Group working together to support a variety of improvements such as new floor coverings, Theatre kitchen refurbishment, replacement sinks, and replacement theatre operating lights. All works completed have improved IPC compliance and in turn, contributed to protecting patients from avoidable infections.

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, with engagement and support from departments across the whole surgical pathway.

The introduction of the Trust's new electronic patient record system in May 2025, has supported the IPC Team and the Pre-operative Assessment Unit by adding alerts to patient records before admission; supporting better communication and patient placement upon admission to the wards. IPC updates are uploaded digitally to Apollo to allow more effective communication of IPC across the Trust. The IPC Team have also revised the IPC intranet pages; updating and sharing key IPC information to staff.

The IPC Quality Management system continues to support 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.

There continues to be evidence of increased proactive leadership, ownership, and engagement from clinical teams and support services around the Trust. 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 introduced a local Quality Accreditation Programme, which continues to be embedded and operational throughout 2025/26.

All wards, units, and departments at The Robert Jones and Agnes Hunt Orthopaedic Trust (RJAH) are working towards achieving the highest level of quality accreditation. The programme is designed to improve efficiency, productivity, and patient outcomes, while enhancing both patient and staff experience. It supports the delivery of the RJAH Nursing and AHP Strategy and the RJAH Quality Strategy, providing a clear framework to demonstrate regulatory compliance and best practice.

The accreditation assessments are aligned to the Care Quality Commission (CQC) key principles of Safe, Effective, Caring, Responsive and Well-Led, ensuring a consistent and robust approach to quality assurance across the organisation.

The programme operates on a rolling assessment cycle, with frequency determined by the level of accreditation achieved. While this presents some challenges in reporting within a fixed timeframe, overall performance demonstrates a clear and sustained improvement trajectory.

Since April 2024, 84% of wards and departments assessed have achieved a rating of Good or higher, exceeding the Trust's internal target of 60% for 2025/26. This reflects the continued embedding of quality standards and improvement across services.

Importantly, the programme continues to inform Trust-wide decision making, providing insight into areas of strength and identifying themes that shape annual quality priorities and focus areas.

The programme also demonstrated significant value during the Care Quality Commission (CQC) inspection in May 2025. Due to its alignment with CQC domains, staff reported feeling more confident and less intimidated when responding to inspection questions, as they were already familiar with the format and expectations through participation in the accreditation process.

Overall, the Quality Accreditation Programme is demonstrating a positive impact, supporting continuous improvement and strengthening assurance processes across the Trust. It continues to promote a culture of high-quality care, accountability, and excellence in line with regulatory expectations.

Quality Improvement

At the beginning of 2025/26 the Trust launched its first Improvement & Innovation Strategy (2025 – 2030) to support embedding improvement within our organisation. The Trust has further progressed its improvement journey during 2025/26. The Trust's ambition is to develop and evolve improvement-led delivery through effective leadership behaviours and by building capabilities. Ultimately this will improve the quality, safety, productivity and experience of our patients and workforce.

The Improvement & Innovation Strategy sets out how the Trust will embed continuous improvement as "*how we do things every day*" – while also accelerating innovation – to deliver clinically excellent, safer, more efficient and more person-centred care.

During 2025/26 the Quality Improvement journey has involved:

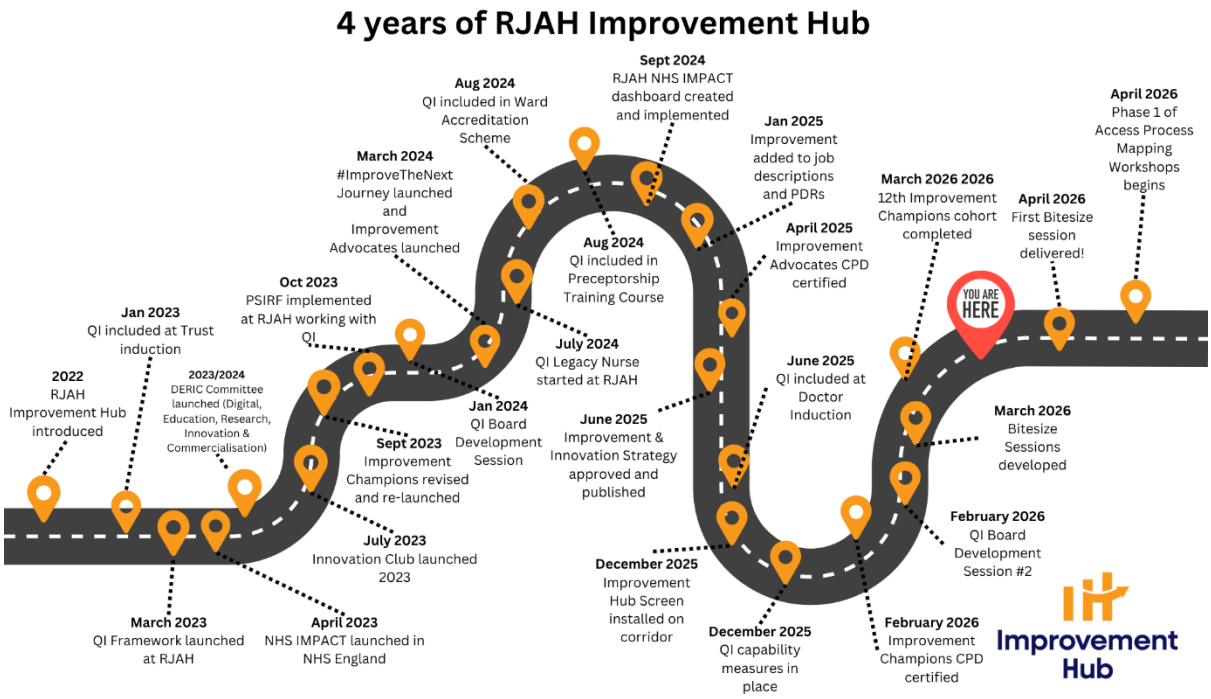
- Improvement Advocates & Improvement Champions CPD Certified: The Trust's Improvement Advocates & Improvement Champions training programmes achieved CPD certification, marking a significant milestone and formally recognising the quality and professional value of the Trust's internal improvement training offer.

- Improvement at Induction: Improvement training is now included in both Trust induction and Doctors' induction, ensuring new staff receive an early and consistent introduction to quality improvement principles.
- Measuring Improvement Capability: A key achievement has been the formal reporting of staff receiving a defined dose of improvement training, with this measure now embedded in reporting to the Digital, Education, Research, Innovation and Commercialisation (DERIC) committee, strengthening oversight and assurance of improvement capability across the Trust.
- #ImproveTheNextJourney: This has continued to progress as part of the Trust's co-production agenda, supporting patients to shape future improvements. During the year, feedback for one of our services highlighted a need for clearer information and reassurance around recovery expectations. This insight led to the patient supporting the development of a group education clinic with one of our Improvement Champions. #ImproveTheNextJourney will continue to grow and remain a priority in 2026/27, with a continued focus on embedding meaningful co-production with patients across services.
- Board Development Training: Building senior leadership understanding and capability in Improvement continues. The latest Board Development Session focused on Go-See, supporting Board members to strengthen their understanding of frontline systems, observe work as it happens, and identify opportunities for improvement through direct engagement with teams.

A key priority for 2026/27 will be on further embedding a sustainable improvement culture across the organisation. This will include the rollout of one-hour improvement bite-size training sessions covering productivity, the Model for Improvement, change and transition, and Go-See visits, enabling more staff to access practical improvement tools and knowledge aligned to their role.

The consistent application of the quality improvement tool 'Go-See' into everyday practice is also progressing. This will commence with the introduction of Go See approaches by Senior Leadership Teams, creating a clear and structured feedback loop to identify opportunities for improvement and drive action at pace.
Improvement will also play a central role in supporting the Trust's productivity agenda in 2026/27, beginning with a focus on access and administrative processes, ensuring improvement methods are used to support efficiency, flow and patient experience in all areas.

It is to note that the Trust continues to have a Legacy Nurse Mentor in Quality Improvement. 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.
The below road map shows the incredible journey of improvement at RJAH to date:



Staff Survey results further support and contributes to monitoring the progress the Trust is making on its improvement journey to date. For 2025, the Staff Survey results against 3 improvement related questions were:

- 72.08% of staff feel they are able to make suggestions to improve the work of their team / department.
- 51.70% of staff feel they are involved in deciding on changes introduced that affect their work area / team / department,
- 53.51% of staff feel they are able to make improvements happen in their area of work.

We recognise these results have reduced compared to the previous year and that there may be multiple contributing factors influencing staff experience and confidence to improve. As a result, further work will be taken to drill down into local variation, gather qualitative feedback, and identify targeted actions. The Improvement Hub will work alongside teams and leader to better understand barriers and provide the right support, tools, and coaching to enable staff-led improvement.

Patient Safety Visits

The Patient Safety Visits programme enables members of the Trust Board to engage directly with patients, relatives, and staff through regular visits to clinical areas. These visits provide visible leadership on quality and safety, offering Board members the opportunity to hear first-hand about people's experiences of care across the Trust.

Leadership walk rounds are recognised nationally as a key driver of safety culture, as highlighted by the Institute for Healthcare Improvement (IHI). Regular walk rounds demonstrate the Trust's commitment to safety and continuous improvement. They allow Board members to speak with staff about quality, safety, and improvement initiatives, and to gather feedback that supports ongoing organisational learning.

The programme gives Non-Executive Directors, Executive Directors, and Governors meaningful opportunities to discuss quality and safety standards with clinicians and managers, and to understand how these are being applied in practice.

Purpose of the Programme

- Demonstrate visible commitment to patient safety
- Strengthen a culture of safety and continuous improvement
- Provide senior leaders with insight into frontline safety challenges
- Identify opportunities to enhance safety and quality
- Build open communication channels between staff, managers, and executives
- Support rapid testing and implementation of safety-focused improvements

Focus of the Walkabouts

Walkabouts explore five key lines of enquiry aligned with the Care Quality Commission (CQC) domains: Safe, Effective, Caring, Responsive, and Well-Led. Staff across the organisation are asked to share, what is working well and what are the areas requiring further improvement or sustained focus.

Any actions identified during the visits are escalated to the relevant Executive Director for follow-up with their teams. A quarterly report is presented to the Quality and Safety Committee and the Council of Governors, highlighting positive feedback, themes, and areas for improvement.

Future Developments

Following the Trust's Well-Led Review in 2025, a refreshed Patient Safety Visits programme will launch in April 2026. Training is already underway for the new 'Go See' approach, which will further strengthen leadership visibility and learning across the organisation.

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 173 guidelines were reviewed, to which 151 were deemed not applicable to the services provided to RJAH; 5 are currently under review for whether it is relevant to the Trust and 17 of the guidelines were deemed partially or fully relevant to the Trust.

There have been three clinical audits completed or started in 2025/2026 in relation to our compliance to published NICE guidelines.

- 2526_013 Atrial Fibrillation among inpatients at RJAH (NG196)
- 2526_020 Hb Threshold Compliance Audit (NG24 and QS138)
- 2526_034 Sheldon Ward Therapies Pre-Admission Falls Audit (NG249 and QS86)

List of NICE publications received and considered applicable to RJAH. A total of 17 publications were considered relevant or partially relevant to the Trust, which can be found below;

Relevant/Partially relevant to the Trust but awaiting evidence of compliance (7);

Date Issued	Ref	Title
02/09/2025	QS110	Pneumonia in adults

15/10/2025	NG252	Rehabilitation for chronic neurological disorders including acquired brain injury
19/11/2025	NG253	Suspected sepsis in people aged 16 or over: recognition, assessment and early management
19/11/2025	NG254	Suspected sepsis in under 16s: recognition, diagnosis and early management
19/11/2025	QS213	Suspected sepsis in over 16s
26/02/2026	NG24	Blood transfusion
26/02/2026	QS138	Blood transfusion

Relevant/Partially relevant to the Trust and a response has been received on evidencing compliance (10)

Date Issued	Ref	Title	Outcome
17/04/2025	HTE22	Robot-assisted surgery for orthopaedic procedures: early value assessment	Fully compliant, for information only
29/04/2025	QS86	Falls	Statement of local practice confirming compliance
29/04/2025	NG249	Falls: assessment and prevention in older people and in people 50 and over at higher risk	BAT completed – fully compliant
09/07/2025	HTE28	Intermittent urethral catheters for chronic incomplete bladder emptying in adults: late-stage assessment	Statement of local practice confirming compliance
05/08/2025	IPG793	Single-step scaffold insertion for repairing symptomatic chondral knee defects	Statement of local practice confirming compliance
05/08/2025	QS212	Overweight and obesity management	Statement of local practice confirming compliance
27/08/2025	HTE32	Compression products for treating venous leg ulcers: late-stage assessment	Statement of local practice confirming compliance
27/08/2025	HTE33	Bed frames for adults in acute medical or surgical hospital wards: late-stage assessment	Statement of local practice confirming compliance
03/12/2025	CG89	Child maltreatment: when to suspect maltreatment in under 18s	BAT completed – fully compliant
17/12/2025	NR2	DMD Care UK's guideline on respiratory care: NICE review	Fully compliant, for information only

Health and Safety

The Interim Chief Nurse held Board-level responsibility for health and safety. The Trust employed a health and safety team comprising of a Health and Safety Manager, a Health and Safety Advisor, and a Health and Safety Officer to comply with the requirement to appoint a competent person under section 7(1) of the Management of Health and Safety Regulations 1999.

In addition to general health and safety management, the team also undertook the roles of Medical Devices Safety Officer, Central Alerting System Liaison Officer, Emergency Preparedness, Resilience and Response Lead, Premises Assurance Model Compliance Lead, and Violence Prevention & Reduction Lead. The team also provided health and safety, security management, and medical devices management support to Shropshire Community Health NHS Trust via a service level agreement.

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 as a result 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 2025-26 there were three incidents reported to the HSE under the requirements of the RIDDOR regulations, a significant reduction on the previous year. No regulatory action or sanction was received in respect of the reported incidents.

RIDDOR Description	2025/26	2024/25	2023/24
Occupational Disease	1	0	4
Slips, Trips and Falls	1	1	2
Lifting and handling injuries	1	5	1

The Trust received an Improvement Notice and a Notice of Contravention following a Health and Safety Executive inspection related to management of sharps and management of dermatitis. All required actions were completed prior to respective deadlines, and no further regulatory action was taken.

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 2025/26 compared to 2024/25

Feedback	2024/25	2025/2026	Diff from 2024/25 to 2025/2026	% Change
Complaints	144	202	58	40%
Local Resolution	51	118	67	131%
PALS concerns	618	763	145	24%
Trust enquiries (via RJAH emails, PALS email, PALS telephone and website). Not PALS concerns	6211	6875	664	11%
Compliments	13207	9835*	-3372	-26%
FFT result	98%	98%	0	-

* compliments were low in May 25 and June 25 due patient feedback texts not being sent

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 2025 the Trust completed a review of the NHSE Experience in Care Improvement Framework . The framework which is split into five sections; leadership, organisational culture, collecting feedback, analysing feedback and learning for improvement, can be used as a tool to improve outcomes and experiences for people using services, unpaid carers, staff, volunteers and communities as a whole and can help organisations to:

- strengthen a culture of listening to encourage continuous improvement
- use an in-depth experience of care diagnostic tool to support organisational development
- improve the ability to deliver high-quality experience of care for staff, volunteers and people using services, as well as unpaid carers
- begin an ongoing process to better understand experiences of care
- work in partnership with people using services, unpaid carers, communities and the integrated care system, including voluntary and community sector partners
- learn from people who do not currently access services but have a need to or are expected to in the future

From this the Trust has revised the Patient Experience objectives within the Trusts Quality Strategy, to include:

1. To ensure patient/carer feedback is collected in a way that allows the Trust to understand feedback from an EDI and health inequalities perspective.

2. Expansion of Patient Engagement Group to include external stakeholders and community partnerships, demonstrating that the Trust works in partnership with people and our local community.

3. To ensure information regarding shared decision making is collected in a way that identifies opportunities for improvement.

4. To facilitate co-production with patients, families, carers and volunteers to implement actions that will lead to sustainable improvements

5. To ensure the Trust has a robust EQIA process that helps to identify how changes to services can potentially impact both patients and carers.

.

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.

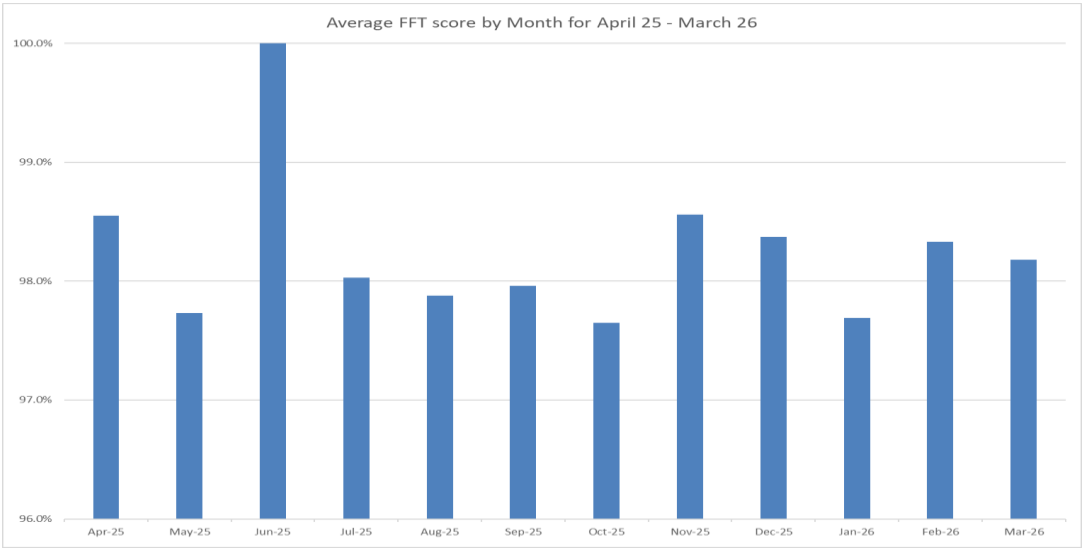
Specifically for 2025/26 the Trust has identified opportunities for improvement in relation to improving communication with our patients regarding appointments and waiting times and ensuring that our patients are supported to wait well, signposting to support services that can help optimise their health while waiting for their procedure to be undertaken. This work will continue throughout the 2026/27 and has been identified as key quality improvement priority for the Trust.

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 Radar Healthcare and patients are sent a text to invite them to complete a FFT survey electronically (after discharge or clinic appointment).

For 2025/26, 18,804 patients completed a FFT survey and 98.24% 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 automatically uploaded to Radar Healthcare 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).

	2021/22	2022/23	2023/24	2024/25	2025/2026
National Average	94%	94%	94%	94%	94%*
Highest Score	100%	100%	100%	100%	100%*
Lowest Score	64%	73%	75%	69%	56%*
The Robert Jones and Agnes Hunt	98%	98%	98%	98%	98%
* data only available nationally up to Feb 26					

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 2025/26 the Trust has revised our Patient Experience objectives as part of the Trusts Quality Strategy, aligning them to the outputs of a self-assessment against the NHSE Experience in Care Framework.
- 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. Questions have remained by large consistent since 2022.

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 consistently 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 86 resulting actions, with these actions monitored regularly through the Patient Experience Meeting.

Domain	2022	2023	2024	2025	2025 National Average
Cleanliness	99.91%	98.84%	100%	**99.93%**	98.55%
Food	93.85%	88.60%	94.82%	**93.22%**	92.13%
Privacy, Dignity and Wellbeing	92.38%	91.84%	87.97%	**92.23%**	89.37%
Condition, Appearance	99.04%	95.75%	98.71%	**98.76%**	97.00%

and Maintenance					
Dementia	83.11%	79.40%	76.76%	**87.98%**	85.68%
Disability	83.21%	80.42%	78.35%	**88.35%**	87.12%

Outside of the scores detailed below, patient assessors noted the positive use of colour throughout the site, enhancing the welcoming atmosphere in all areas. Provision of food was highlighted as an area of excellence, with options available to suit a range of patient's needs.

In 2025, the assessment panel included representatives from Healthwatch, Trust volunteers and peers from ICS partners, offering differing perspectives, ensuring the Trust assessment remains well rounded and representative of our patient population.

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 2025/26 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 2025/26 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.

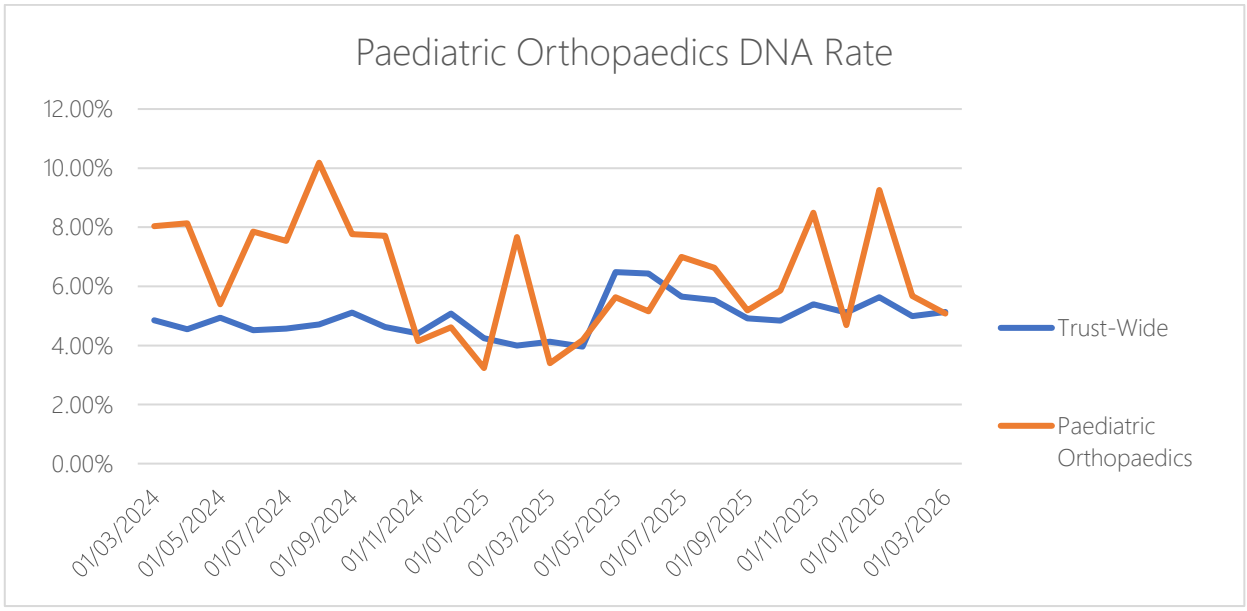
While the Trust's overall DNA rates remain low, we are making efforts to understand health inequalities experienced by our patients that may cause disparities in the DNA rates seen in different demographics. In particular, the Trust has been focusing on its paediatric WNB rates. Our Paediatric Orthopaedics 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.

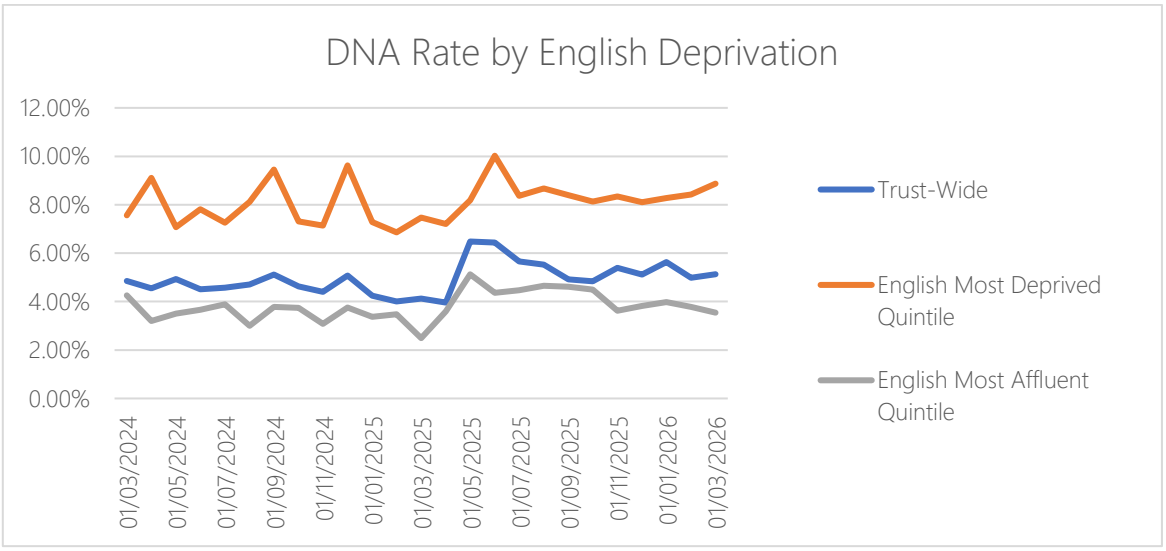
While the Trust's overall DNA rates remain low, we are making efforts to understand possible health inequalities experienced by our patients that may cause disparities in the DNA rates seen in different demographics.

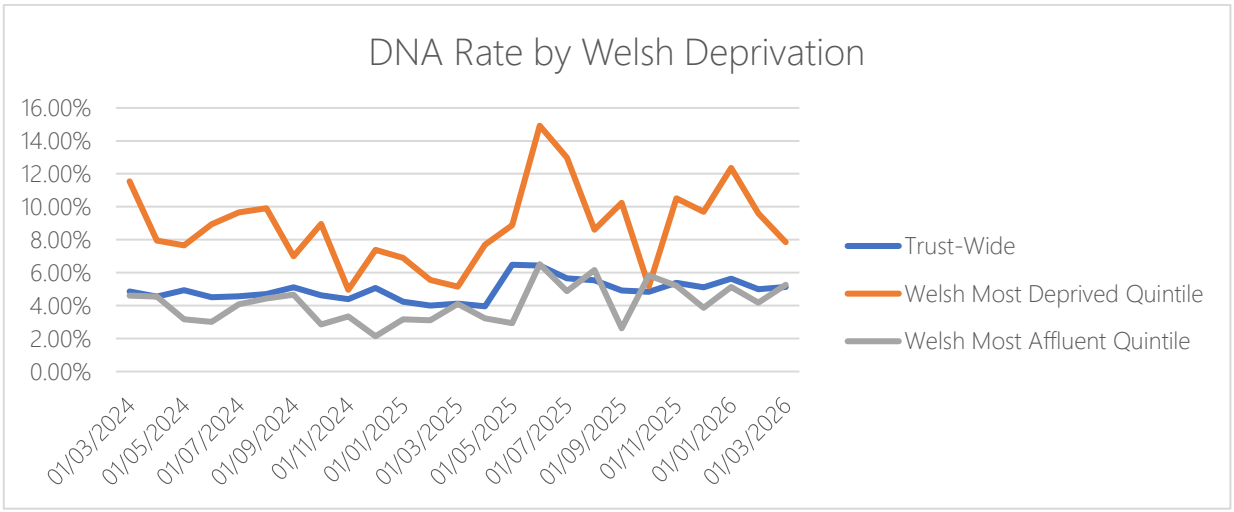
In particular, the Trust has been focusing on its paediatric DNA or Was Not Brought (WNB) rates. Our Paediatric Orthopaedics team was identified as an outlier for its high DNA rates compared to other teams in the Trust, which the team has been working to reduce. In the month of March, there is no significant difference between the 5.19% DNA rate of our paediatric orthopaedics team and the total DNA rate for all other teams.

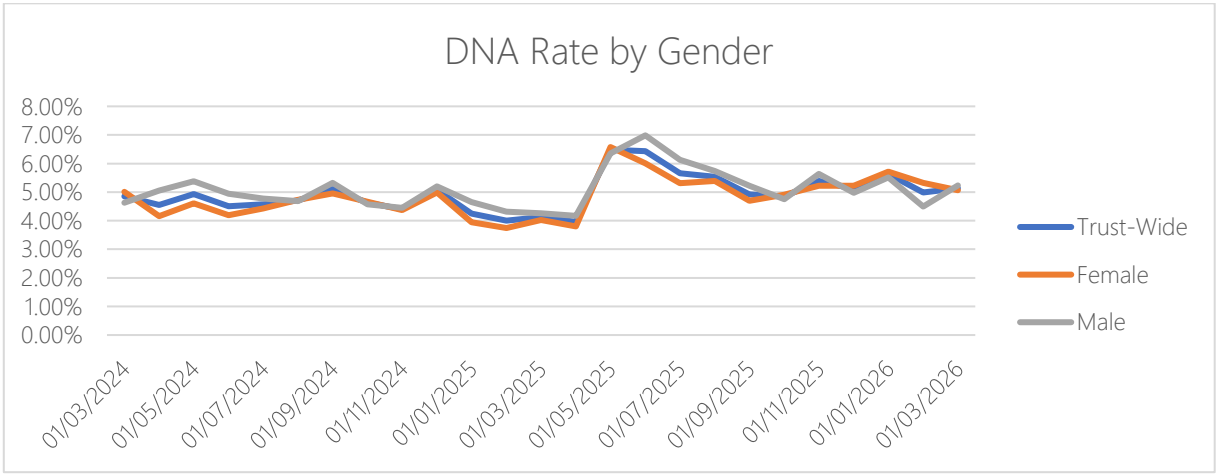
NB, there are separate indices of multiple deprivation (IMD) for English and Welsh postcodes, and it is not appropriate to directly compare the two. For example, we can't group the English most deprived quintile and the Welsh most deprived quintile to form a combined most deprived quintile. It is also not possible to have a complete dataset for either English or Welsh IMD. The indices of multiple deprivation were published in 2019, so any new postcodes created since then will not have an index of multiple deprivation.

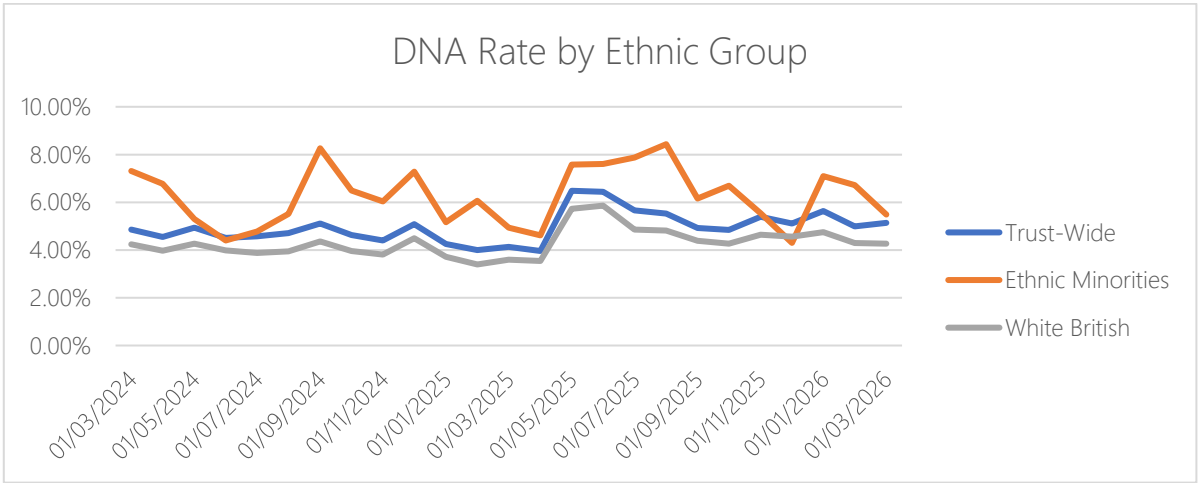


We have consistently seen statistically significant differences in the DNA rates of patients with different IMD quintiles, and that has persisted in March. For example, the most deprived English quintile had a DNA rate of 8.39%, whereas the most affluent English quintile had a DNA rate of 4.61%. The most deprived Welsh quintile had a DNA rate of 10.2%, whereas the most affluent Welsh quintile had a DNA rate of 2.63%. Patients from ethnic minority backgrounds had a DNA rate of 6.16%, whereas White British patients had a DNA rate of 4.38%. This difference is statistically significant. There is no significant difference in the DNA rates of male and female patients, with male patients having a DNA rate of 5.22% and female patients having a DNA rate of 4.70%.




DNA Rate by Welsh Deprivation
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
01/03/2024
01/05/2024
01/07/2024
01/09/2024
01/11/2024
01/01/2025
01/03/2025
01/05/2025
01/07/2025
01/09/2025
01/11/2025
01/01/2026
01/03/2026
Trust-Wide
Welsh Most Deprived Quintile
Welsh Most Affluent Quintile


DNA Rate by Gender
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
01/03/2024
01/05/2024
01/07/2024
01/09/2024
01/11/2024
01/01/2025
01/03/2025
01/05/2025
01/07/2025
01/09/2025
01/11/2025
01/01/2026
01/03/2026
Trust-Wide
Female
Male


DNA Rate by Ethnic Group
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
01/03/2024
01/05/2024
01/07/2024
01/09/2024
01/11/2024
01/01/2025
01/03/2025
01/05/2025
01/07/2025
01/09/2025
01/11/2025
01/01/2026
01/03/2026
Trust-Wide
Ethnic Minorities
White British

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 (FTSU)

The role of the FTSU service is to encourage staff to speak up about anything that gets in the way of patient care or affects their ability to perform their role. 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.

During the year, the Trust had a Freedom to Speak Up Guardian (FTSUG) whose sole role was to act as the Guardian. The FTSUG was supported by a dozen FTSU Champions across the organisation. Champions were drawn from a range of roles and departments. Several champions were from the global majority, and several champions had protected characteristics. There is an identified non-executive Board member who leads on FTSU, and the function sits within the portfolio of the Trust Secretary.

The Freedom to Speak Up Guardian reports into the People and Culture Committee on a quarterly basis. FTSU reports are also considered by the Trust Board each quarter.

Staff have multiple ways of contacting the service. These include direct contact with the Guardian, or Champions; a dedicated FTSU email inbox; a QR Code for submitting anonymous concerns; and a post box for submitting concerns. The service is promoted by posters across the site, regular communications, and the physical presence of the Guardian and Champions. There is also a programme of mandatory training (with multiple modules that are appropriate to individuals' roles).

Cases handled

During the year, there were 47 contacts with the FTSU service. These contacts are referred to as "cases" in this report. In 2024/25 the figure was 54. In 2023/4 it was 46.

The National Guardian's Office (NGO) sets a number of categories that FTSU Guardians should record. Those categories are:

- Attitudes and behaviours
- Worker Safety / wellbeing
- Patient Safety / quality
- Bullying and Harassment
- Detriment
- Anonymous
- Other

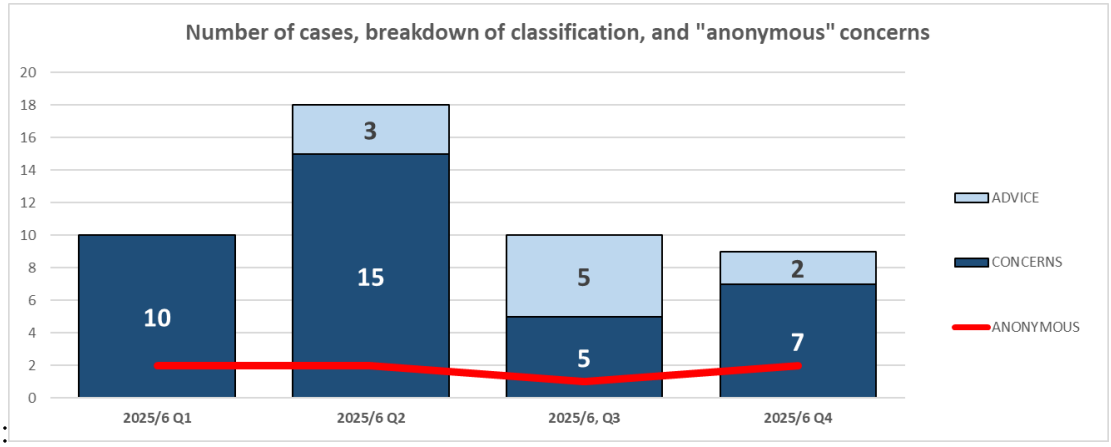
Cases raised via the FTSU service may involve multiple categories. For example, one case may have elements that relate to patient safety and elements that relate to attitudes and behaviour. As a result, the number of "concerns by category" (which focuses on the content of concerns) is greater than the number of cases, or contacts made with the service (as this focuses on the number of individuals that have engaged the FTSU service).

The number of anonymous contacts is recorded by the Trust, but it is not presented as a category of concern in its own right in this report.

Graph 1 shows the total of cases raised during each quarter of 2025/6, and how many:

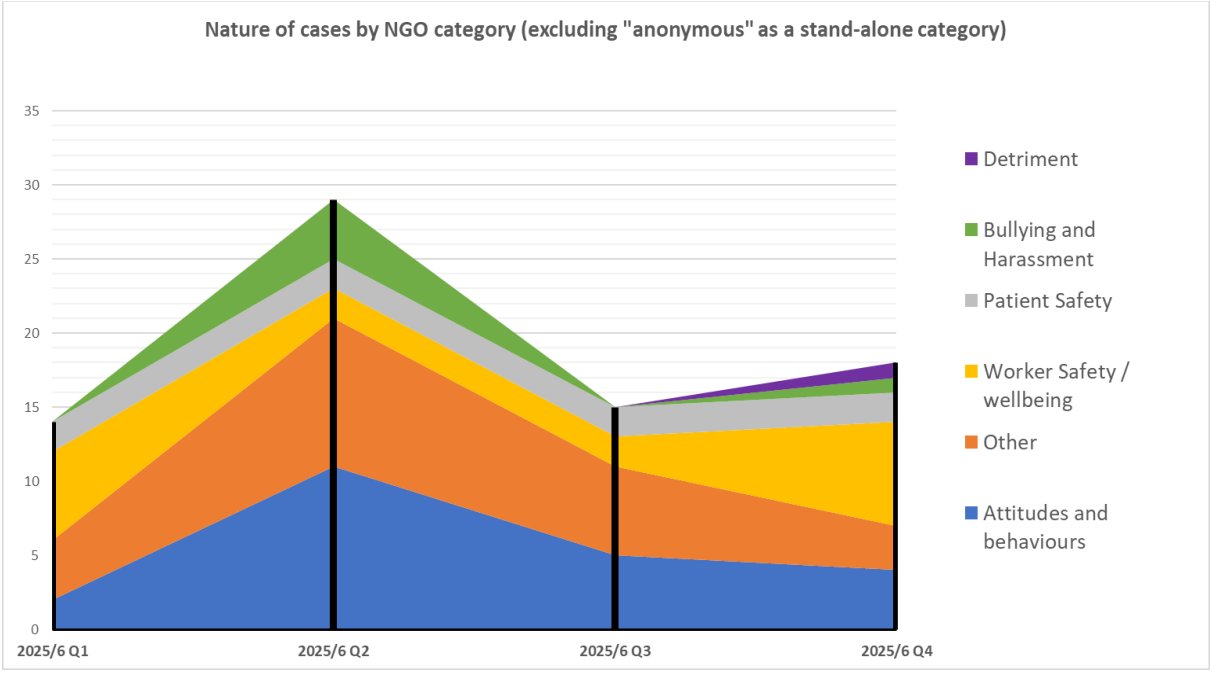
- Were treated as "concerns" (i.e. the cases were escalated for action),
- Resulted in "advice" only (i.e. people were advised or redirected as appropriate and no further action was required),
- Were received as anonymous concerns.

Graph 1:



How those cases were broken down by category of concern, on a quarterly basis, is shown in graph 2.

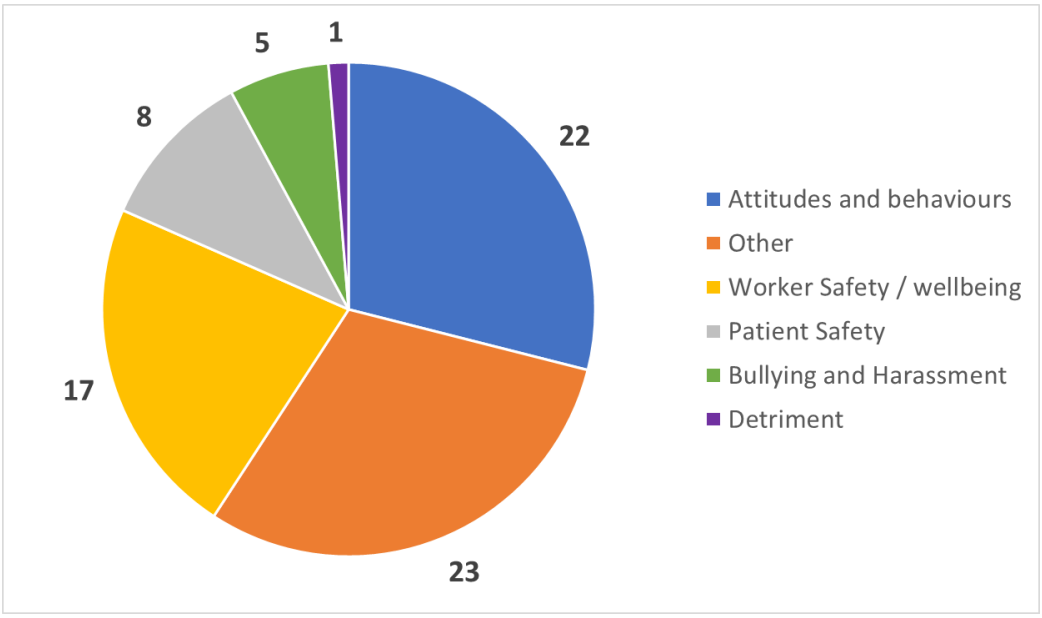
Graph 2:



When looked at across the year as a whole, the three most frequently cited categories of concern related to: "Other" (often relating to policy / procedural / contractual queries); "Attitudes and behaviours"; and "Worker safety / wellbeing". Many cases record "Worker safety / wellbeing" as a constituent element of their concern – if an individual reports that their mental health has affected by their concern, that will be captured under the "welfare" element of the "worker safety / wellbeing" category.

Graph 3 shows the breakdown of categories of concern raised over the full year.

Graph 3:



As well as recording the number of contacts, and the breakdown of the cases by category of concerns, the Trust records and reports on:

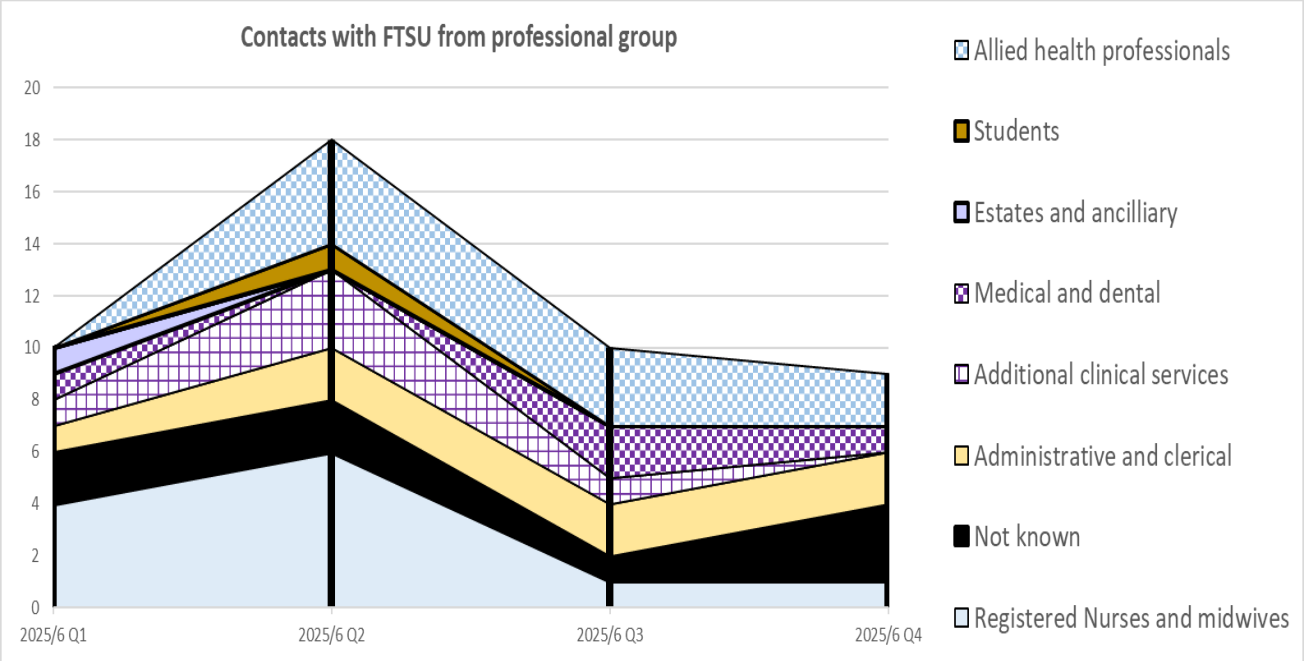
- The professional groups using the service – as shown by quarter in graph 4; and
- The categories of concern being raised by each group – as shown for the year in graph 5.

The groups most likely to contact the service were:

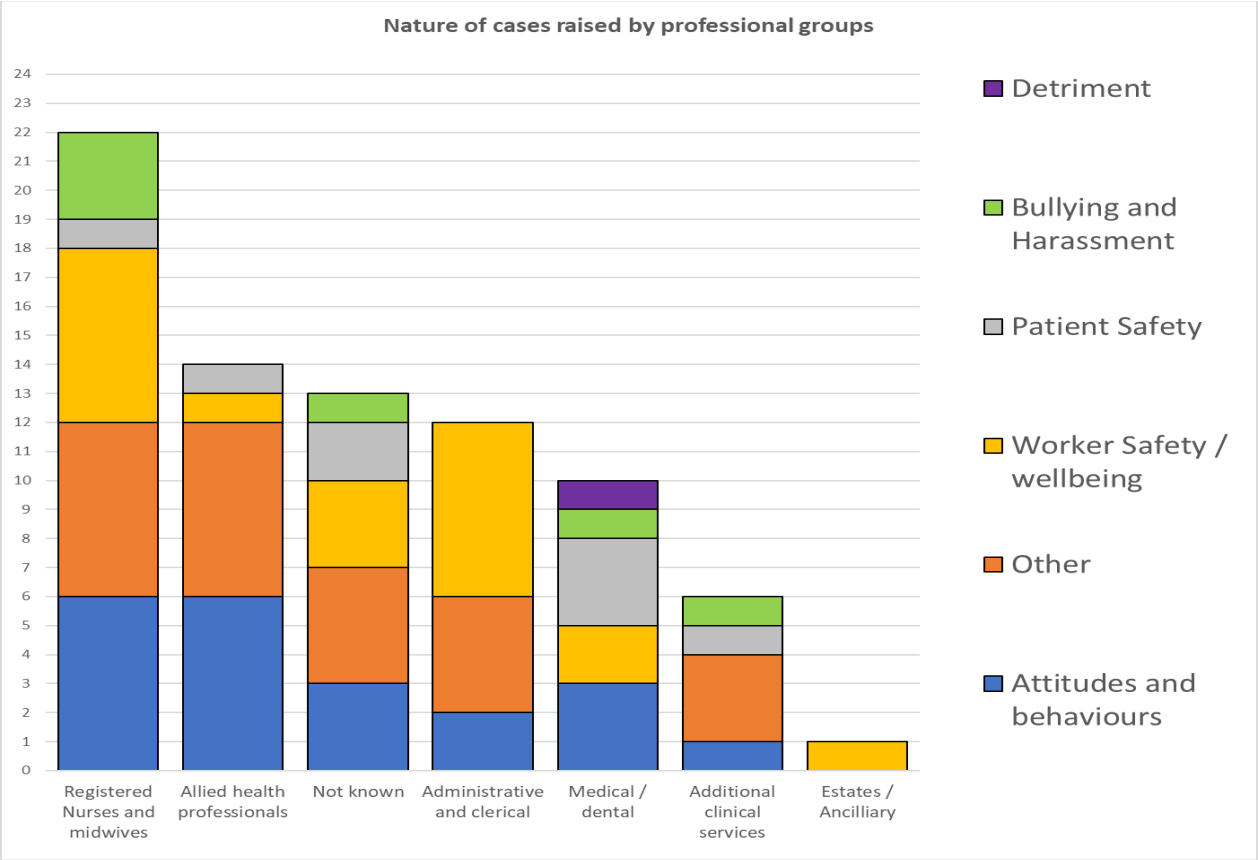
- Nurses, with 12 contacts;
- Allied Health Professional, with 9 contacts;
- Administrative and clerical staff, with 7 contacts;
- Additional clinical services, with 5 contacts; and
- Medics, with 4 contacts.

(The professional group of 8 individuals who contacted the service is not known).

Graph 4:



Graph 5:



External well-led review

During the summer of 2025, an independent developmental well-led review was undertaken. That review considered arrangements around speaking up and the report noted that:

- *"There has been a positive shift towards creating an engaging and open culture."*
- *"The Trust has focused on strengthening risk management, the Board Assurance Framework, transitioning to two business units, and developing the freedom to speak up function".*
- *"The culture has evolved positively… becoming more open, transparent, and constructive. There was consistent messaging from interviews that the Trust focuses on its people and culture, led from the top down, creating a friendly, welcoming, supportive, and caring organisation that values patient care."*

Other activities undertaken

During the year, the FTSU Guardian undertook the following activities:

- Completion of the mandatory annual NGO annual training by the Guardian.
- Completion of a review in line with the NGO's *Freedom to Speak Up Development Guide* and the identification of improvement actions (subsequently delivered or planned).
- Attendance at the Regional NGO meetings and FTSU bi-monthly meetings.
- Roll out of a learning and improvement tool. This tool is sent to the manager with the initial e-mail escalating a concern. The form has four boxes for the manager to complete and return once the concern has been action and learning has been identified. These forms allow the anonymised learning to be shared, where applicable, across the Trust. It also allows the manager to implement their own improvements and promote the education of staff.

- Routine recording of cases with elements of racism, sexism, or inappropriate sexual conduct to support initiatives around sexual safety and the promotion of equality.
- During Speak Up Month in October the FTSU Champions and Guardian did a walk about to introduce themselves and explain about the FTSU service available at RJAH.
- Engagement with the Violence and Prevention & Reduction Standards Group to share data around bullying and harassment, attitudes and behaviours and detriment.

Wider "speaking up" developments

As part of the staff survey action plan, a working group met to consider how the Trust can best:

- Provide and promote opportunities to "speak up";
- Capture the information gathered from various existing sources – including the FTSU function, people services, and the clinical governance teams, but also mechanisms such as the Exec "Buddy" visits, Patient Safety Visits, Board visits, etc;
- Identify and learn the lessons from that information and act accordingly;
- Provide feeding back to people who "speak up"; and
- Feed key message and learning back into the wider organisation.

This work will be further developed during 2026/27.

National Quality Indictors

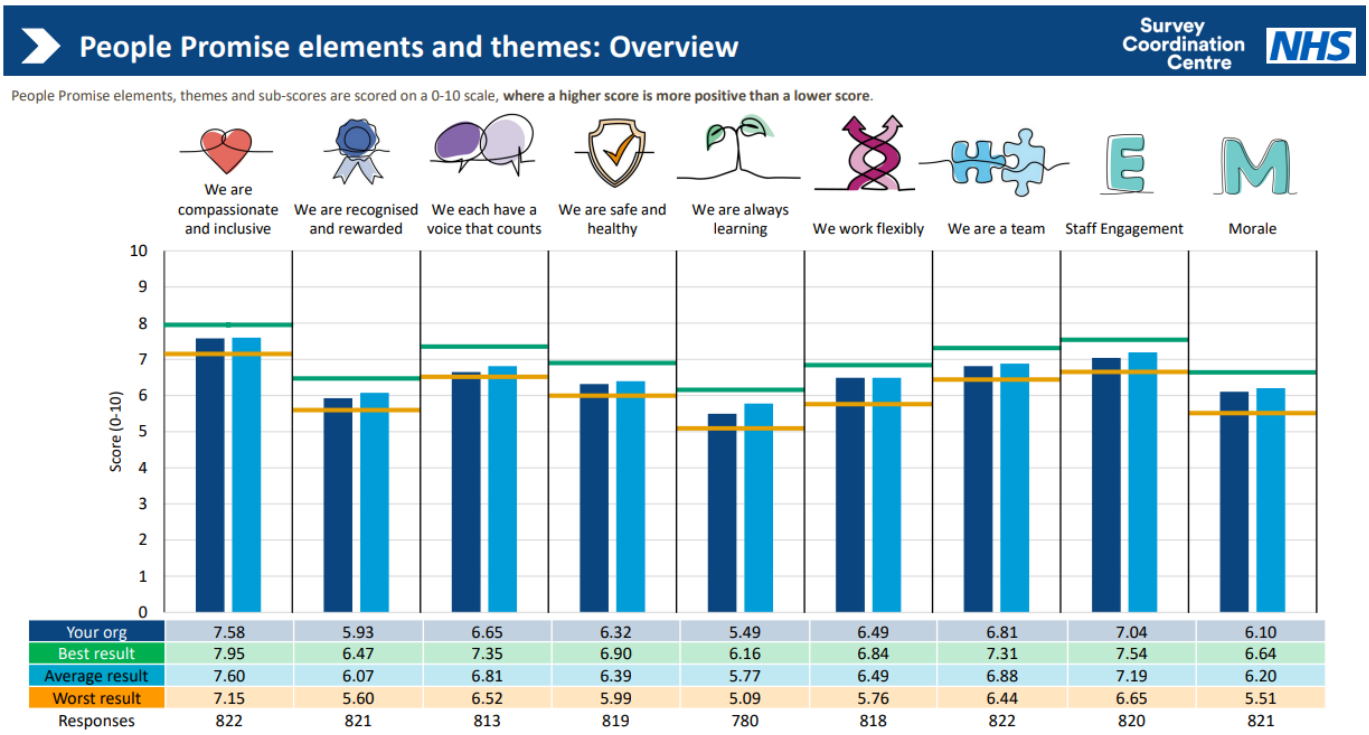
Staff Survey Results

In the 2025 NHS Staff Survey, 91.61% 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 = 91.61 % (2024 data = 92%) but above the average group results of 88.80%

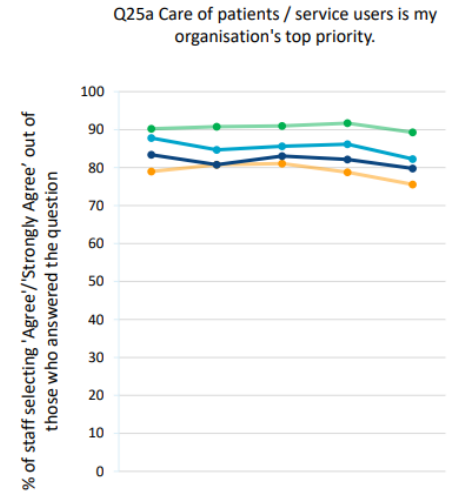
The overall response rate, and themed results are detailed below:

Response Rate	2018	2019	2020	2021	2022	2023	2024	2025
	44.9%	62%	57%	52%	52%	52%	47%	45%



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.58	5.93	6.65	6.32	5.49	6.49	6.81	7.04	6.10
Best result	7.95	6.47	7.35	6.90	6.16	6.84	7.31	7.54	6.64
Average result	7.60	6.07	6.81	6.39	5.77	6.49	6.88	7.19	6.20
Worst result	7.15	5.60	6.52	5.99	5.09	5.76	6.44	6.65	5.51
Responses	822	821	813	819	780	818	822	820	821

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



	2021	2022	2023	2024	2025
Your org	83.37%	80.77%	83.02%	82.13%	79.78%
Best result	90.24%	90.79%	90.99%	91.70%	89.28%
Average result	87.79%	84.68%	85.61%	86.18%	82.26%
Worst result	78.96%	80.77%	81.07%	78.79%	75.56%
Responses	840	834	902	845	818

Statement of Directors' responsibility in respect of the Quality Account

Organisations are required under the Health Act 2009 and the Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, employ more than 50 staff, and receive NHS income greater than £130,000 per annum.

NHS England has issued updated guidance confirming that NHS foundation trusts are no longer required to produce a Quality Report as part of their annual report. However, they must continue to produce a separate Quality Account. The National Quality Board has approved a refresh of the Quality Accounts process to ensure it reflects current legislation, NHS structures, and policy developments.

This guidance sets out expectations for NHS foundation trust boards regarding the form and content of annual Quality Reports (which incorporate the above legal requirements) and the arrangements boards should establish to ensure the quality and accuracy of data used in preparing the report.

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust guidance.
- The content is consistent with internal and external sources of information, including:
    - Board minutes and papers from April 2025 to March 2026
    - Quality-related papers presented to the board during the same period
    - 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 (2025) and national staff survey (2025)
    - The most recent CQC inspection report
- The Quality Report presents a balanced and accurate picture of the Trust's performance over the reporting period.
- Performance information included in the report is reliable and accurate.
- Appropriate internal controls exist for the collection and reporting of performance measures, and these controls are subject to review to ensure they operate effectively.
- Data underpinning reported performance measures is robust and reliable, conforms to required data quality standards and definitions, and is subject to appropriate scrutiny and review.
- The Quality Account has been prepared in accordance with NHS England's Annual Reporting Manual and supporting guidance, including the Quality Accounts regulations and the standards for data quality.

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

By order of the Board

Harry Turner, Chairman

Stacey Keegan, Chief Executive Officer

RJAH Quality Account Statement from Shropshire Telford and Wrekin ICB 2025/26

NHS Shropshire, Telford and Wrekin

Re: Quality Account 1 April 2025 – 31 March 2026

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 2025/26.

The ICB supports the Trust's quality priorities for 2026/27 across patient safety, clinical effectiveness and patient experience.

The ICB was pleased to note RJAH's ongoing commitment to audit and service evaluation with action plans being monitored along with the implementation of Radar Healthcare, the new system to create a single platform for learning and improvement. By bringing together incidents, complaints, and other patient feedback identifying themes more effectively and use these insights to drive clinical audits and service evaluations.

It was good to note the Trust has revised the Patient Experience objectives within the Trust's Quality Strategy and opportunities have been recognised for improvement in relation to improving communication with patients regarding appointments and waiting times, and ensuring that patients are supported to wait well, signposting to support services that can help optimise their health while waiting for their procedure to be undertaken.

Maintaining attention on the experience of the workforce, the NHS staff survey results 2025 91.61% of respondents said they would be happy with the standard of care provided if a friend or relative needed treatment which is a good result.

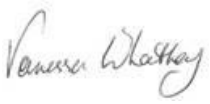
The management of healthcare acquired infections is an area the ICB is pleased to see the ongoing priority in this area with continued evidence of increased proactive leadership, ownership, and engagement from clinical teams and support services around the Trust.

The ICB note the revised Patient Safety Incident Response Plan in line with the national guidance requirements. Along with further progression of its improvement journey during 2025/26.

In conclusion, the ICB views the 2025/26 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 2026/27 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

4 June 2026

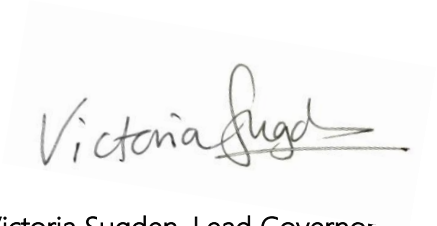
Lead Governor's Submission on the Quality Account Report for 2025/26 of the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

The Quality Account for 2025/26 highlights the significant progress the Trust has continued to make over the past year, despite the challenges faced. This is particularly evident in the Inpatient Survey results, which again demonstrate the Trust's commitment to continuous improvement and high-quality patient care.

The Council of Governors remains fully supportive of the Trust and continues to play an active role through patient safety visits, attendance at committee meetings, and by holding Non-Executive Directors to account. Throughout 2025/26, Governors have been increasingly involved in events, patient safety initiatives, and patient experience activities. They value these opportunities to represent members' views and gain first-hand insight into how services operate. Hearing directly from patients about their experiences provides meaningful assurance that their needs are being met consistently and compassionately.

It is also reassuring to note that staff continue to recommend the hospital both as a place for treatment and as a place to work. This is a powerful reflection of the Trust's culture and the quality of care delivered across the organisation.

On behalf of the Council of Governors, I would like to congratulate the Trust on its quality performance for 2025/26.



Victoria Sugden, Lead Governor
23 April 2026

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 Spine Registry
CAP	Community Acquired 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 Physiotherapists
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 / EuroQol 5 Dimensions
FFFAP	Falls and Fragility Fracture Audit Programme
FFT	Friends and Family Test
FTSU	Freedom to Speak Up
GIRFT	Getting It Right First Time
HCAI	Healthcare Acquired Infection
HCPC	Health and Care Professions 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 for Healthcare 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 Lines of Enquiry
KPI	Key Performance Indicator
LD	Learning Disability
LOS	Length of Stay
MADE	Multi-Agency Discharge Event
MAHR	Non-Arthroplasty Hip Registry
MDT	Multidisciplinary Team
MPFT	Midlands 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	NHS England
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NJR	National Joint Registry
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	Per Rectum Examination
PROMs	Patient-Reported Outcome 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	Root 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 Agnes Hunt Orthopaedic Hospital
RSH	Royal Shrewsbury Hospital
RTT	Referral to Treatment
SCI	Spinal Cord Injury
SCIM	Spinal Cord Independence Measure
SEIPS	Systems Engineering Initiative 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 Infection
SWAN	Signs, Words, Actions, Needs
TER	Total Elbow Replacement
THR	Total Hip Replacement

TIF	Targeted Investment Fund
TKR	Total Knee Replacement
TQ	Tourniquet Pressure
TSR	Total Shoulder Replacement
VTE	Venous Thromboembolism
WTE	Whole-Time Equivalent