The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors | Public 07.05.2025

MEETING

7 May 2025 09:30 BST

PUBLISHED

6 May 2025

Agenda

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Board Members and Senior Leaders Declarations of Interests

First Name	Surname	Position	Type of Interest	Description of Interest (including for indirect interests, details of the relationship with the person who has the interest)	Date interest relates From & To dd-mm-yy		Comments, including action taken to mitigate any potential conflict of interest.
					From	To	
Harry	Turner	Chairman	Non-Financial Personal Interests	Presiding Justice West Mercia judiciary	October 2006	Ongoing	
			Financial Interests	In Form Solutions Management Consultancy	February 2024	Ongoing	
Sarfraz	Nawaz	Non Executive Director / SID	Financial Interests	Executive Director of Finance at National Citizens Trust	18/09/2023	Ongoing	No conflict between role at NCS and RJAH
			Non-Financial Professional Interests	Member of CIPFA	01/2021	Ongoing	
Martin	Evans	Non Executive Director	Financial Interests	Non-Executive Director at North Staffordshire Combined Healthcare NHS Trust	28/08/2024	Ongoing	
			Financial Interests	Director at MJE Associates Ltd. (Role includes European rep at Washington State Department of Commerce – area of work focused within the energy industry)	01/04/2020	Ongoing	
Penny	Venables	Non Executive Director	Financial Interests	Consultant – In-Form Solutions Ltd, Lichfield Business Hub, Lichfield Council House, 20 Frog Lane, Lichfield, Staffordshire, WS13 6YY. Work as a management consultant via this business.	January 2021	Ongoing	
			Financial Interests	Trustee Board of Birmingham University Guild of Students	January 2025	Ongoing	
			Financial Interests	Member of the Members Council of the West Bromwich Building Society	October 2024	Ongoing	
			Non-Financial Professional Interests	Non-Executive Director – British Dietetic Association, 3rd Floor Interchange Place, 151 – 165 Edmund Street, Birmingham B3 2TA. Sit on the Board of Directors of the BDA.	June 2020	Oct-24	
			Non-Financial Personal Interests	Chair Sandwell Leisure Trust, Tipton Sports Acadamy, Wednesbury Oak Road, Tipton, West Midlands DY4 0BS.	November 2023	Ongoing	
Martin	Newsholme	Non Executive Director	Financial Interests	Non executive director of Shropshire Doctors Co-operative Limited	01/08/2019	Ongoing	To my knowledge Shropdoc and RJAH do not trade with each other
			Financial Interests	None executive director at Warrington Housing Association	01/09/2018	Ongoing	Warrington Housing is not in the healthcare section and doesn't trade with RJAH
Lindsey	Webb	Non Executive Director	Indirect Interests	Husband is a NED at Birmingham and Solihull ICB		Ongoing	
John	Pepper	Associate Non Executive Director	Financial Interests	NHS England GP Appraiser	01/07/2022	Ongoing	
Paul	Maubach	Associate Non Executive Director	Non-Financial Professional Interests	Member of CIPFA	01/03/2023	Ongoing	
			Financial Interests	Senior Advisor for Primary Care (Department of Health	01/03/2023	31/07/2024	
			Financial Interests	Senior Advisor for Neighbourhood Health (Department of Health	01/08/2024	Ongoing	
			Financial Interests	Director and Owner of Maubach Consulting Ltd – through which I provide management consulting and advisory services to different organisations.If it transpires either at a committee or Board meeting of the Trust, the meeting is either discussing or engaging with an organisation that my company is also engaged with, then I will declare a potential conflict of interest to the Chair.	01/03/2023	Ongoing	
Atif	Ishaq	Associate Non Executive Director	Financial Interests	Data Product Director at Haleon Plc	2022	2025	No conflict between role at Haleon and RJAH
			Financial Interests	Enterprise AI & Advanced Analytics Director at Mars Inc	04/2025	Ongoing	
			Financial Interests	Owner of Digital Clinician Ltd	2018	Ongoing	
			Financial Interests	Digital Advisor and Webmaster to Pharmacy Care Matters LTD	2011	2025	
			Financial Interests	Digital Advisor and Webmaster to Quest Legal Advocates LTD	2011	Ongoing	
			Financial Interests	Webmaster for Shrawley, North Claines and Hanbury Parish Councils	2011	Ongoing	
			Financial Interests	Self-employed webhosting provider	2011	Ongoing	
			Non-Financial Personal Interests	Justice of the Peace for West Mercia Judiciary	2017	Ongoing	
Stacey	Keegan	Chief Executive Officer	Non-Financial Professional Interests	STW ICB Partner Member	01/07/2022	Ongoing	
			Non-Financial Professional Interests	A member of the National Orthopaedic Alliance Board	03/05/2024	Ongoing	
Ruth	Longfellow	Chief Medical Officer	Financial Interests	Member of GAS (Gobowen Anaesthetic Services)	November 2019	Ongoing	GAS was set up as an LLP, but no longer functions as an LLP since the recent pension rule changes
Mike	Carr	Chief Operating Officer	Indirect Interests	Parent is Chief Executive of Midlands Partnership NHS Trust.	May 2022	Ongoing	Withdraw from discussions as appropriate.
			Non-Financial Personal Interests	Member of the Labour party.	2017	Ongoing	Withdraw from discussions as appropriate
			Non-Financial Personal Interests	Trustee at Stay Charity	February 2025	Ongoing	Withdraw from discussions as appropriate
Denise	Harnin	Chief People and Culture Officer	Non-Financial Personal Interests	Spouse is a senior partner at Johnson Fellows Charter House, Birmingham, Ad hoc HR consultancy Johnson Fellows		Ongoing	
Samantha	Young	Deputy Chief Nurse&Chief Nursing Information Officer	Non-Financial Personal Interests	Army reservist	2010	Ongoing	
Angela	Mulholland-Wells	Chief Finance and Commerical Officer	Non-Financial Professional Interests	BOARD TRUSTEE AND CHAIR OF AUDIT, FINANCE AND RISK COMMITTEE FOR MINES ADVISORY GROUP	Oct-23	Ongoing	

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING
WEDNESDAY 05 MARCH 2025 AT 09:30AM IN BOARD ROOM AT RJAH
MINUTES OF MEETING

Voting Members in Attendance

Name	Role	Attending
Harry Turner	Chair	✓
Sarfraz Nawaz	Non-Executive Director	×
Martin Newsholme	Non-Executive Director	✓
Penny Venables	Non-Executive Director	✓
Lindsey Webb	Non-Executive Director (via MS Teams)	×
Martin Evans	Non-Executive Director	×
Stacey Keegan	Chief Executive Officer	✓
Craig Macbeth	Chief Finance and Planning Officer	✓
Paul Kavanagh Fields	Chief Nurse and Patient Safety Officer	×
Ruth Longfellow	Chief Medical Officer	✓
Mike Carr	Deputy CEO and Chief Operating Officer	✓

Others in Attendance

Name	Role	Attending
Paul Maubach	Associate Non-Executive Director	✓
John Pepper	Associate Non-Executive Director	×
Atif Ishaq	Associate Non-Executive Director	✓
Denise Harnin	Chief People and Culture Officer	✓
Sam Young	Deputy Chief Nurse and DIPC	✓
Dylan Murphy	Trust Secretary	✓
Mary Bardsley	Assistant Trust Secretary (minute secretary)	✓
Chris Hudson	Head of Communications	✓
Neil Turner	Governor (observing)	✓
Peter David	Governor (observing)	✓
Sheila Hughes	Governor (observing)	✓
Jan Greasley	Governor (observing)	✓
Victoria Sugden	Governor (observing)	✓
Karina Wright	Governor (observing)	✓
Kirsty Foskett	Assistant Chief Nurse for Clinical Governance (item 5.5)	✓

Ref	Discussion and Action Points
1.0	**Welcome and introductions**
	The Chair welcomed all attendees to the meeting.
1.1	**Apologies**
	Apologies were noted from Martin Evans, Sarfraz Nawaz, Lindsey Webb, John Pepper, and Paul Kavanagh-Fields. On behalf of the Board, HT welcomed SY to the meeting who joined to represent the nursing portfolio. The Board was confirmed as quorate.
1.2	**Declarations of Interest**
	The Chair reminded attendees of their obligation to declare any interest which may be perceived as a potential conflict of interest with their Trust role and their role on this Board. There were no conflicts of interest identified in relation to the items for discussion which required members to withdraw from discussion or decision-making.
1.3	**Minutes of the previous meeting**
	The minutes of the Board of Directors (Public) Meeting held on 08 January 2025 were approved as an accurate record.

Ref	Discussion and Action Points
1.4	**Matters Arising and Action Log**
	There were no further matters to raise. The Board agreed the following in relation to the action plan: • **Action 24 – Chairs Assurance Report (QS).** The Board agreed to close the action relating to the past patient story as Alison has agreed to attend the public Board meeting to share the second half of her journey at the Trust. • **Action 25 - Trust Constitution.** Following consideration, a reference has not been added to the constitution the Board agreed to close the action. The constitution outlines the legal framework within which the Trust operates. It reflects the statutory requirements around the composition of the Board, the Council of Governors, the Foundation Trust Membership etc. Technically, Associate NEDs are not part of the legal framework that the Trust must operate within. There is no reference to Associate NEDs in the model constitution. Nor are there references elsewhere in the Trust's constitution, or the Trust's wider governance framework. The terms of Associate NED engagement are issues for local discretion, dependent on an assessment of need at any given time. By contrast, there are set requirements around the appointment of the non-executive board members required by statute which need to be reflected in the constitution.
2.0	**Service Story Muscular Dystrophy, Centre of Excellence**

	RL introduced Professor Tracey Willis to the Board who joined the meeting to present on MDUK centre of excellence award for paediatrics and adults with research / DMD accredited centre – DMD international programme. Tracey delivered a presentation, sharing the following:
	• The core MDT team
	• RJAH muscle service was established many years ago, with Prof Edwards and continues by Prof Ros Quinlivan. Significant changes were made from 2012.
	  ○ Clinics and how they were run.
	  ○ Equipment investment in clinic; ceiling track hoists with weighing scales, larger plinths
	  ○ Joint clinics and MDT – one stop shop
	  ○ Mobile muscle clinics
	  ○ Transition
	  ○ Palliative care
	  ○ COVID adaptions; more Holter monitors and Bluetooth spirometers that connect via mobile phone.
	• DMD, Duchenne muscular dystrophy - at diagnosis; support and home visit, signposting and introducing to the difference groups. International Standards of Care Considerations for DMD, part 3 (2018) "Primary care, emergency management, psychosocial care and transitions of care across the lifespan'
	• The Team support with Transition of care, emotional and psychological needs, and Quality of life.
	• Discussed the challenges of initiating discussion around palliative care.
	• Symptom control clinics
	• Accreditation programme – 3rd in the world and 1st and only in the UK
	• Award from Muscular D UK award in May 2024
	
	In summary, Tracey concluded her presentation explaining the Trust has unique service as it is seamless from paediatrics to adults; same neuromuscular team, but changing teams for rest, cardiac, endo and bone etc – continuity of care.
	
	HT thanked Tracey for joining the Board, comments from the following:
	• commended the continuation of care and highlighted the support provided to patients during the transition of care.
	• inquired about the instance of the condition, noting that there are 1.5 million patients (both children and adults) with neuromuscular dystrophy. When asked if there are issues with early diagnosis. It is not as prevalent here as it is across the rest of the UK. However, for conditions like SMA and Duchenne, there is more work that can be done to support newborn screening.
	• noted that gene therapy in the UK is not as supported compared to other countries. It was emphasised that patients have better outcomes with earlier diagnosis.

Ref	Discussion and Action Points
	• discussed the timeline for diagnosing Duchenne, which is currently around the age of 5, and questioned whether it could be brought earlier. It was mentioned that newborn screening was offered in Wales due to the lack of effective treatment available at the time. • Gene therapy was acknowledged as a treatment, but further work is needed to understand its long-term effects on patients. In conclusion, a message of gratitude was expressed, highlighting the great leadership and the pride in being part of the Trust. Thanks were extended to everyone for their hard work and dedication.
2.0	**Chair and CEO Update**
2.1	**Chair Update** HT informed the Board of the following: • **NEDS Sponsorship and Training** - over the winter period, the Non-Executive Directors (NEDS) were sponsored for the Management Executive program, specifically the aspiring chair program, which lasts 18 to 24 months. HT was pleased to confirm ME has joined the programme and the organisation will continue to support ME in his training. • **Changes in NHS Leadership** - significant changes have occurred within the NHS leadership over the past weeks, with Penny Dash and Jim Mackey being appointed as CEOs. • **10-Year Plan** - a 10-year plan is expected to be released in the coming months. The trust needs to remain agile to adapt to any forthcoming changes. • **Meetings with Interim Chair of ICS** - meetings with the interim chair of the Integrated Care System (ICS) have reinforced the focus on productivity. A preferred candidate for the substantive chair of the Shropshire, Telford, and Wrekin (STW) has been shared with the Secretary of State and will be confirmed towards the end of the month. • **Meeting with Andrew Morgan** - a meeting with Andrew Morgan, chair in common for Shropshire Community Health NHS Trust (SCHT) and Shrewsbury and Telford Hospital NHS Trust (Sath), highlighted positive reactions and partnerships with the Trust to develop and improve patient journeys. • **Craig Macbeth Retirement** - CM will step down as Director of Finance (DOF) in April and HT took the opportunity to thank him for his continued professionalism, leadership and commitment to the Trust and the NHS. The Trust will continue to extend best wish to CM throughout the month with more time to celebrate his contributions. **CEO Update** SK highlighted the following key points as part of the CEO report: • **Long waiters** – the Trust is pleased to confirm that the long waiter's trajectory continues to be reporting positively, and the teams continued to consider new ways to mitigate the long waiting list. • **Trust Strategy -** a Trust Strategy session was held and attended by the full Board of Directors and senior leaders to complete a check and challenge of the objectives. It reviewed progress against the five pillars of the five-year strategy and included feedback and challenges on the plans. There is more work for the Trust to complete and this will be shared in due course. • **Human Factors training – t**he Board participated in a full day of Human Factors training as part of the Board development programme. This training is available to all staff and focuses on improving patient safety by addressing human factors. • **Launched the improvement champions –** the Improvement Champions programme continues to thrive, with recruitment for a ninth cohort. Participants bring forward problems to solve using improvement methodology to enhance patient or staff experience, processes, or safety. • **Apollo Update – t**he new Go Live date for the Apollo Electronic Patient Record system is set for Sunday, 11 May. The delay was due to addressing significant activity challenges within the organisation. • **Cavill Award** - Clare Lewis, a Student Nurse Associate, received a Cavell Star Award for her exceptional support to a PTSD patient during knee surgery. Congratulation to Clare! • **NOA Awards** - four entries from the Trust were shortlisted for the National Orthopaedic Alliance's (NOA) Excellence in Orthopaedic Awards. These included OurSpace – Workforce Initiatives category, Operation Lazurite – Partnerships and Integration Initiative category, improving pre-admission and procedure experiences for children – Supporting Patients on

Ref	Discussion and Action Points
	their Pathway category and the Assistive Technology Service – Supporting Patients on their Pathway category. The Trust look forward to celebrating the innovations later in the year. • **January RJAH STAR** – was awarded to the High Dependency Unit for their extraordinary efforts during a medical emergency. Congratulations to the HDU Team! • **February RJAH STAR** – was awarded to Discharge Co-ordinator Pauline Hughes for her outstanding efforts in managing complex discharges. Congratulations to Pauline! HT thanked SK for the update, there were no comments raised by the members of the Board.
3.0	**Risk and Governance**
3.1	**Board Assurance Framework**
	The Board considered the Corporate Risk Register, DM highlighted the following key points: • The Board received the framework in its entirety after being reported and reviewed to the assurance Committees throughout the month of February. • A reflection of the discussion from the Committees will be reported through the Chairs assurance reports. • The Board is asked to consider and review BAF risk 6 'responding to opportunities and challenges in the wider health and care system' in full as the aligned oversight meeting. PM noted that the heat map is helpful, however expressed concern that risks 3 'Delivering the financial plan' and risk 4 'Delivering the required levels of productivity, performance and activity' are rising. There is ongoing work to mitigate these risks, and PM queried the effectiveness of the system and innovation efforts. Both agendas contribute to addressing these issues. PM questioned the level of confidence in these matters and the energy levels dedicated to them. Innovation work is expected to support the financial benefits for the system. DM commented on the heat map and the movement of risks since the BAF strategic risk was agreed upon. There has been positive movement, but it has not been reduced until the Trust is comfortable that this improvement is being sustained. PV mentioned that innovation work is being reporting to the DERIC committee, and they are considering strategies. There may be business cases necessary to address productivity requirements. PV also discussed BAF 4, noting changes in relation to the Activity Recovery Committee meeting. There are discussions about standing down the meeting, and some of the BAF information and future need to be aligned with other assurance committee meetings. As part of the strategic review coming to the end of the year, it was suggested to include a narrative to explain the heat map. In relation to BAF 6 'responding to opportunities and challenges in the wider health and care system' the following comments were noted: • Changes within the national and system levels will be amended to reflect the current situation. • It is essential to be clear on what will be delivered and how this will benefit the Trust. • Likely changes are expected to come in April. When the Trust are clear on the direction of travel and the priorities for the NHS, this will be reflected across all risks. The Board thanked DM for his continued support in providing an overview of the Board Assurance Framework before noting the report.
5.0	**Quality and Safety**
5.3	**Performance Report – Quality and Safety Committee**
	The following points were highlighted from the Quality and Safety performance report (by exception only): • In January, there was an avoidable MSA bacteraemia incident. Following an investigation, a new catheter policy has been introduced to prevent future occurrences. • There were three SSI cases, which were compliant with the One Together audit. • In November, one D&V outbreak was reported in the Sheldon Ward and the teams were commended on their efforts to contain the infection. The Board noted the performance report, and no concerns were raised.
5.4	**Chair's Assurance Report – Quality and Safety Committee**
	MN highlighted the following key points from the Quality and Safety Committee Chairs Assurance report:

Ref	Discussion and Action Points
	• **Board Assurance Framework** – the Committee recommended the changes as presented in the board paper. • **PSIRF** - to be presented in detail to the Board however following consideration the Committee recommend approval. • **Learning from Death** – the quarterly report was received and considered by the Committee and assurance was provided in detail during the meeting. • **EPRR annual report** – the Trust completed a self-assessment, and it was acknowledged that further work is needed to understand and receive assurance that action plans are in place. The Committee noted that some actions are interdependent upon the system working. • **PSII never event** - assurance was taken from the actions and outcomes presented. This is being reported through the theatre culture group, and there is no evidence that the patient has come to harm. • **Long waiting times** – the long waiting lists issue continues to be covered across the committees, however, the QS committee sough assurance specifically on harm process for the patients. It was noted that there are no issues to raise with the Board. HT thanked MN for the update and encouraged questions or comments from the Board. There were no questions raised. The Board noted the Chairs assurance report.
5.5	**EPRR Annual Report**
	The EPRR annual report was presented to both the Quality and Safety Committee and the Audit and Risk Committee throughout February. The annual report for EPRR was completed in September 2024 and the following was highlighted from the report: • The annual report reports a non-compliance rate at 64% (the rate for partial compliance is 77%) • Due to the organisation being within the acute Trust cohort, we will not be able to achieve full compliance because of the areas being assessed. • The key focus areas include business continuity planning, training, and policy documents. • Work is ongoing to develop each of these focus items. • One of the issues since the previous review is that the Trust are light on resources, with only two individuals managing this element as part of their role. • The Trust continue to strengthen collaborative working within the System and seek to sharing learning, knowledge, and experience which have re-energised in recent months. • The EPRR agenda is being considered as part of the shared services review within the system. • The Trust confirmed an action plan has been compiled and will be reported through the Quality and Safety Committee on a quarterly basis. On behalf of the Quality and Safety Committee, MN confirmed with the report was considered at the meeting and agreed for the action plan to be presented to provide assurance on the progress. The Board discussed the following: Questions: • It was noted that some standards have been signed off by the board, but it is partial now. Further work needs to be completed on the documents which need to come to the board for formal approval. • The Board requested confirmation that all actions will be completed by the end of August to which the Trust confirmed that currently, there is partial completion with full completion expected by August. • It was noted that there have been discussions as part of the objectives setting and it was noted that other providers within the system have EPRR managers within their teams. The Trust explained that those provided also include A&E and first responder/community units. It would be difficult to justify spending on a manager within our Trust. PV added that although the Trust are not a first responder, there are colleagues on the trauma rotas which will support this effort, and this should be reflected. • MC mentioned that resources have increased within the past 12 months, and support from other providers is available to support the remit. It was acknowledged that documentation should align across the system and not have individuals working in silos as this would be a benefit for all organisations.

Ref	Discussion and Action Points
	• AI highlighted the business continuity plans for Apollo, and its impact going forward. The Trust confirmed that a session is committed to being held at the end of March for consideration, this will be supported by the Executive Team along with clinical colleagues. The report was noted by the Board and acknowledged the reporting will continue to be aligned to the Quality and Safety Committee.
5.6	**PSIRF Evaluation and Revised Patient Safety Incident Response Plan**
	The Board welcomed KF, Assistant Chief Nurse for Clinical Governance to the meeting. KF joined the share the highlights from the report: • In October 2023, the Trust moved away from the Serious Incident Framework, to align to NHS England's Patient Safety Incident Response Framework. • As part this, the Trust is required to review its Patient Safety Incident Response Plan, to ensure the patient safety priorities reflect the current issues based on patient safety incidents, reviews, quality KPI's and complaints data. • In October 2024, a series of meetings were set up to firstly complete an evaluation of the PSIRF process and then to review our patient safety data and from that, advise what the new priorities should be. • The presentation provided an overview of the evaluation feedback and suggested improvements, as well as an overview of our patient safety data to demonstrate how the group have concluded what the Trusts PSIRF priorities should be for 2025/26. The Board discussed the following: • The Board commended the positive and welcomed oversight as it is essential to ensure transparency and accountability within the organisation. • The survey results are encouraging as they highlight areas where there are issues and show that actions are being taken to address them. It was queried about the number of people who said they did not have the opportunity to respond to the patients, and there is more the Trust are doing to improve on this. The Trust is also considering what training and development the organisation offers to support. • Staff feedback indicates that the Trust are not sharing the good news stories as much as the challenges. The Trust need to ensure that our actions are comprehensive and collectively address both positive and negative feedback. • A quarter of the respondents did not think managers participated in the PSIRF assessment. We want every manager to be involved, and consideration is being given to what is our dialogue with managers and how are we enhance their involvement in the process? • The work undertaken is excellent, and although it is a difficult area to report on, the work being completed is making a difference and the transparency is commended. • Regarding patient engagement, clinical governance managers are trained to have those conversations effectively. • On a positive note, the SNAHP (senior nurse and allied health profession meeting) is being refreshed. The teams have the opportunity for good news stories to be shared, and the Quality Improvement team has been invited to attend the patient experience meeting. • Whether the feedback is positive or negative, what we want to do is ensure there is engagement from the people involved within the incident. The Board acknowledges that managers do not necessarily have to be involved in every detail and the people involved in the incidents are active members of the response framework. • The Board inquired about the Trusts ambition to in these areas within the system. All providers partners have transitioned to the new framework, and the Trust have embraced changes focusing on patient safety. The team has received national feedback through the Chief Pharmacist and have been asked to support in medication management. • The Trust also confirmed that we changed the IPC process to support the IPC nationally and are ahead of the curve in this regard. The Board thanked KF for joining the meeting and approved the Patient Safety Incident Response Plan.
5.6	**Learning from Deaths (Q2 Report)**
	RL presented the Q3 report, highlighting the following from the report: • There has been a total of 6 deaths reported throughout quarter 3 (5 expected, 1 sudden and unexpected)

Ref	Discussion and Action Points
	• All 6 deaths were reviewed with by the medical examiner and the Trust, and no concerns were raised. • Positive learning from the process includes good utilisation of multi-disciplinary teams to support an effective assessment. MN confirmed the report had been presented and discussed at the Quality and Safety Committee within the month with no concerns to raise to the Board. The Board discussed the helpful and transparent report and noted that no learning has been generated following the review however queried the reference to 'Question remains over whether patient was appropriate for rehab.' The Trust confirmed this was feedback from the clinical teams and related to the transfer of the patients. The Trust agreed to strengthen the narrative in future reports to ensure clarity. The Board were assured following the presentation of the report noted the expected / unexpected definition when reporting. The Trust confirmed this is the NHS national definition utilised when reporting deaths. There Board have previously agreed to include a footnote for future reference particularly when reporting into the public domain. *(footnote: 'expected' is the national NHS definition utislised in reporting deaths – 'a death that is anticipated to occur in the near future')
6.0	**People and Workforce**
6.1	**Workforce – Performance Report**
	DH highlighted several key areas from the workforce performance report. • Firstly, there is good progress overall against all the performance indicators aligned to the people and workforce remit. • Additionally, efforts are ongoing to continue developing the processes. • A recruitment day is scheduled for 23 March, with the aim of conducting interviews and making offers on the same day. • Furthermore, there is a strategic outlook being taken across the year. • Although the national targets for the time to hire are set at 8 weeks, the current average for the Trust is being reported at 9.5 weeks. HT thanked DH for the update and commended the strong position. The Board noted the workforce performance report, and no concerns were raised.
6.2	**Chair's Assurance Report – People and Culture Committee**
	PM provided the following updates from the People and Culture Committee: • There are no major alerts. • Adjustments to the controls on the Board Assurance Framework are as noted within the paper. Overall, the framework indicate that the controls are in a p place. • A lot of positive and constructive reports are being reported. • The Committee discussed the job planning attainment which is currently being reporting at level 0/4. The Trust have been asked to consider how we provide assurance to the board on the narrative. Although the compliance rates are good, the threshold is 90%, despite the level rating, the Committee were assured that the Trust continues to work on achieving the target. HT thanked PM for the update and encouraged questions and comments from the Board: • The Trust confirmed that the disciplinary case summary specifically presented a review of the medical staff cases. • Regarding medical engagement and leadership strategy, the work is ongoing, with a report expected at the March Board meeting. There is a need to confirm the date for the final version, which is expected in a few months. PM mentioned that there was helpful analysis of the staff perspective on medical leadership, an action plan has been delivered, and progress is being made. • It was suggested to include the strategy within the Board development session which is scheduled for April. The Board noted the chair report, and no concerns were raised.
6.3	**Freedom to Speak Up Report**
	SY presented the freedom to speak up Q3 report, highlighting several key points.

Ref	Discussion and Action Points
	• The report was presented to the People and Culture Committee January. • Highlighted the typing error in the first line of the report, which should state that the report covers the reporting period October to December for Q3. • There has been a total of 18 concerns were raised, with 11 involving the guardian and 2 with the champions. • There has been an increase in registered nurses and other professionals. • A QR code has been circulated across the organisation, which can be used anonymously report. • There is an increase in concerns regarding behaviours, which can be attributed to a rise in violence among patients. • A Survey Monkey is set to be launched in Q1. • Feedback to SNAHP has been completed, and posters have been updated following the addition of new champions. The Board discussed attitudes and behaviours, noting that the survey will help gain further information. While general information from the staff survey is available, more detailed data is needed to help the Trust further. The Board expressed interest in the staff survey results and the triangulation with the FTSU concerns being raised. The Board noted the good reporting culture within the organisation.
6.4	**Guardian of Safe Working Hours (Q3 Report)**
	RL highlighted the following points to the Board: • There have been 0 exceptions reporting within quarter 3. • The Trust continues to manage the process well which is a credit to Chris Marquis – the Trusts' guardian of safe working hours. • There continues to be ongoing issues regarding the rota with Wales due to the difference guidance. There is work ongoing to review working hours and diary exercises being completed. The Board discussed the following commended another great performance by the Trust and thanked Chris Marquis for his continued support. The Board noted the Q3 report.
7.0	**Operations and Finance**
7.1	**Performance Report (including long waiting patients)**
	MC highlighted the following key points from the performance report which included an update on the long waiter's presentation: • **Performance** - the presentation will change once there have been several months of consecutive good performance. • **Insourcing contract** - January reported the highest month of activity. • **Elective activity -** 1085 cases were reported in January, marking the highest number in a month for some time. • **Insourcing contract** – progress has been made in closing the insourcing gap. • **Reduction in overall waiting list** - a 2% reduction in the overall waiting list has been achieved. • **RTT (Referral to Treatment)** - currently at 6.2%, with a target to reach 60% by next March. There has been a welcome change from NHSE regarding the discussion on the whole pathway. • **Sustaining delivery** - efforts continue to sustain the delivery. • **Diagnostics** - performance is above the plan, but variability exists due to pathway changes within the system. Patients are coming from further east than expected, raising planning challenges with the system. • **TMG follow-up review** – the follow-up reviews have increased since summer. There is a need to transform follow-up pathways, with opportunities to revise and standardise processes across all specialties. Currently, the performance is above the national expectation. • **BADS (British Association of Day Surgery)**: Some data from inpatient surgery is not included in the dataset due to reporting issues. The Board noted the verbal update, and no further queries were raised.

Ref	Discussion and Action Points
7.3	**Finance Report**
	CM provided the following key highlights from the finance report: • It is important to note the achievements considering the ongoing struggles. • Before the adjustment, this was the strongest month of the year with a £1 million surplus, which is £400k ahead of the plan. This was driven by an increase in activity, overachievement in CIP, and effective controls and temporary staffing measures. The benefits of process changes are being seen. • ERF funding rules have changed, resulting in a cap on the system. Consequently, the Trust has lost out on £1.7m. • Therefore, there is a £1.7m reduction that we are unable to recover. • The Trust can mitigate £700k and the Trust are liaising with the ICB and SCHT for support. • Currently, the Trust is our reporting £1m lower than the plan, which is not being challenged now. • The team are still working through the submission, reporting a £1.9m surplus. The Board discussed the following: • The Board raised a concern about when the changes were notified since the last meeting, noting that it was a few weeks ago. It is frustrating that changes are shared late within the month, affecting reporting. • The environment is recognised as difficult to plan within. • It is very challenging for the Board to take control over the finance position when the main income flow is changed. • PM followed up, noting that the trajectory has changed, and the position has increased. They asked about realistic time limits to address the issue, mentioning that the increase is due to a reduction in activity and 3500 transfers from rheumatology. The Trust are liaising with clinical leads to discuss changes to the pathways, and there will be some challenges on follow-up protocols. • There is a need for increased support for rheumatology to clear the backlog of patients. • In the area of spines, the Trusts follow up figures are more frequently compared to other providers and therefore, benchmarking against other providers is being completed. • Some firms have championed standardisation across consultants, which the Trust will continue to develop. • More work is needed on data quality and validation. • Consideration of time limits will be part of the planning process. The Trust reiterated their commitment to continue to review the mitigations and improve the overall financial position for the Trust.
7.4	**Chairs' Assurance Report – Finance and Performance Committee**
	MN presented the Chairs assurance report, highlighting the following to the Board: • The focus of the Board are items which are aligned to the Finance and Performance Committee and therefore a lot of the discussion may have already taken place throughout the meeting. • The Committee received assurance on the forecast which has taken place in the recent months. • The Committee felt that the Trust could achieve the £1.9m (£1m below plan). A discussion was held on the areas which could be options. • At the extraordinary board meeting, it was confirmed that all avenues have been explored and support the Trust to reporting £1m short of plan. • The level of challenges was noted, and it was appropriate for the Trust to revise the forecast and confirmed the rationale for submitting. • The 25/26 plan is being completed – operational, workforce and finance plans have been shared. • It was confirmed that the draft numbers are in a deficit, and this will be sense-checked further. • The Committee approved the business case for the 8 middle grade roles. • The Committee requested the EPR costing as there is a significant hit against activity since the implementation has been moved. The Trust are committed to continue to actively focus on mitigating the financial and operational plans and conversations continue with NHSE who have also acknowledged the position in relation.

Ref	Discussion and Action Points
	The Board thanked the Trust for the update.
7.5	**Long Waiters Presentation**
	MC provided an overview of the long waiting presentation and highlighted the following: • There has been a significant improvement reported as of the end of Q2 however, there has been an increased risk with mutual aid within the independent sectors. • NHS England has been informed, and this was discussed through the Tier 1 call. • There are concerns about the long wait times for Welsh patients, and more details have been shared at the FP meeting, including historical and referral trends. • Addressing these issues will require collaborating with local teams and MSK pathways, integrating into MSST referrals, ensuring patients are supported closer to home, completing a re-evaluation, increasing clinical activity, and continuing to scrutinise the longest waiting patients. • This has been reported to Activity Recovery Committee and Quality and Safety Committee. • In relation to the spine cases, the waiting lists are being pooled to support the throughput of patients. The Board noted the updated.
7.5	**Activity Recovery Committee**
	PV presented the Chairs' assurance report, highlighting the following to the Board: • The Committee continues to meet fortnightly and discuss various topics, including the progress with relationships. • At each meeting, a prediction of the end-of-month figures is provided and the Committee has asked for a narrative on the changes in these figures, which are related to the fragility of the insourcing work. • The Committee sought assurance on the insourcing tender, asking for information on the flexibility of the specifications and the process for awarding the tender. External support has been included, and the Committee has been assured of the process. • The GIRFT action plan will be presented at the next meeting. • The Committee regularly reviews QIA. • The situation with Welsh waiter positions is not improving, with some patients waiting up to 200 weeks. Eleven patients are being tracked, and reassurance has been if they are primarily under one consultant. These patients have been offered the option to transfer to other consultants. • Regarding the future of the committee, meetings are scheduled until the end of March, and DERIC and FP actions have been realigned. • The GIRFT operating model and the success of the insourcing tender will also be discussed. The Board acknowledged that over the last three years, issues have often been related to long waits. The Trust need to ensure effective governance is in place and the team are committed to meeting fortnightly until the end of the month. By the April board meeting, the Board will have decided on whether to continue with the Activity Recovery Committee.
7.5	**Digital, Education, Research, Innovation and Commercialisation Committee**
	AI presented the Chair Report to the Board and highlighted several key points from the report: • The digital strategy, which was due in January, has not been delivered. Concerns were raised regarding the lack of progress, and it is expected to be received in March. However, assurance has still not been received, and development of the quality is required. • A number of strategies are expected in the coming months, and therefore, a timetable was requested from the Trust to confirm when the documents will be presented to the Committee for consideration. • In relation to the Board Assurance Framework risk 5 'delivering innovation, growth and achieving systemic improvements', the scoring remains the same, but the assurance has changed from amber to red. • The Corporate Risk Register was considered, there have been no changes to the scores. The Committee discussed the orthotics system risk further which is noted to be in progress. There is a £0.5 million fund, and it is on the list for prioritisation for the next year, with capital funding to support the digital funding going forward. • A research innovation story was presented Geraint Thomas concerning abnormal tests. The Committee referred the presentation to the Quality and Safety Committee as there was reference to unnecessary blood transfusions.

Ref	Discussion and Action Points
	HT thanked AI for the update. The Board noted the Chair Report, and there were no questions raised.
7.6	**Audit and Risk**
	MN presented the chair report to the Board, highlighted the following from the report: • **Standing Financial Instruction and Scheme of Delegation** – following consideration of the documentation, the Committee recommended approval at the Board meeting. • **External Audit** – following a competitive tender exercise, the Council of Governors formally approved the appointed of KMPG to become the external audits from 2025/26. Deloitte (current external auditors) will continue to support the final stages of this year audit. • **Conflict of Interest** - the Committee received an update on the conflict-of-interest process. • **Internal Audit** – the Committee received one new internal audit report, Research Governance Review which was awards a moderate assurance rating. The Committee held a discussion on the narrative aligned to the recommendation and had asked for the RJAH team to work with MIAA to review again. The Board noted the Chair Report – there were no further questions.
7.6	**Standing Financial Instruction and Scheme of Delegation**
	CM presented the documents highlighted that there have been no material changes to the documents following a review. It was confirmed that the documents had been discussion through the Audit and Risk Committee. HT encouraged comments from the members of the Board, the following was discussed: • **Corporate credit card** – the process of governance relating to the corporate credit card was queried following a review of the procedure in September. The Board asked for confirmation on who reviewed the documents and the approval process. Following a recommendation from the Audit and Risk Committee, the Board approved the SFI and SD.
8.0	**Any Other Business**
8.1	**Questions and Committee from the Public**
	The Board welcomed comments and questions from governors in attendance at the meeting and responded to the queries raised: • **Staff Service Story** – the Governors commended the excellent presentation which was noted to be interesting and provided a good example of MDT working. On behalf of the Board, HT thanked all the attendees for their contribution.
8.2	**Any Other Business**
	Annual report and Annual Accounts Timetable HT confirmed that the relevant meetings have been placed in the diary to support for governance process of the consideration and approval of the Annual Report and Annual Accounts. The timetable within the pack has been circulated for information only.
8.3	**Date and time of next meeting**
	Public Board of Directors Meeting | 06 November 2024 | RJAH Conference Suite, Main Entrance

Chief Executive Officer Update

Committee / Group / Meeting, Date

Board of Director – Public Meeting, 7 May 2025

Author:

Name: Stacey Keegan
Role/Title: Chief Executive Officer

Contributors:

Chris Hudson,
Head of Communications

Report sign-off:

Stacey Keegan, Chief Executive Officer

Is the report suitable for publication:

YES

Key issues and considerations:

This paper provides an update to Board members on key local activities across several business areas not covered within the main agenda.

This paper provides an update regarding some of the most noteworthy events and updates since the last Board from the Chief Executive Officer.

Recommendations:

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

Acronyms	
NHS	National Health Service
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust
ICS	Integrated Care Systems
CEO	Chief Executive Officer
DHSC	Department of Health and Social Care
RAF	Royal Air Force
MCSI	Midland Centre for Spinal Injuries

Chief Executive Officer Update

1. NHS climate

Board members will be aware of the significant changes happening across the NHS. Most notable was the government announcement in March that NHS England would be abolished and brought back into the Department of Health and Social Care (DHSC). Alongside this, we know changes are planned for Integrated Care Systems (ICS), both with their function and with an expectation to cut head count by about 50%. We especially think of our colleagues at NHS Shropshire, Telford and Wrekin, and are mindful of the uncertainty this is creating for them. It's telling of the environment we are in, and it is impacting on all parts of the NHS, including ourselves. Providers will also be impacted by changes, having to reduce headcount growth and cost in corporate and support staff. We are starting to consider what that will mean for ourselves, and it will doubtless mean some difficult decisions.

2. NHS England CEO

Sir James Mackey commenced as Transitional CEO for NHS England on the 1 April 2025, following Amanda Pritchard's decision to stand down.

3. Unveiling our new Trust vision statement

A little while ago, we asked all staff to have their say on the Trust's vision statement, and to vote on what they wanted it to be. Hundreds took part in the ballot, and there was a clear winner. Receiving more than 50 per cent of all the ballots cast, the choice being: **Improving lives through excellent and innovative care**.

We wanted a vision statement that really reflected who we are as an organisation. We went out to vote with a number of options, and I am delighted with the one that our staff have chosen. We pride ourselves on the excellence of the care we provide to patients here at RJAH, and we strive to be at the forefront of innovation so that we can maximise our potential. This new vision statement really captures that drive and that ambition, and it aligns perfectly with our five-year strategy.

4. Welcome to our new Chief Finance and Commercial Officer

I am delighted that we have been able to secure the appointment of Angela Mulholland-Wells as our new Chief Finance and Commercial Officer, and that she has now started in post. Angela brings with her more than 15 years' experience in the healthcare sector, having held a number of senior finance leadership positions. Her career has spanned both the independent sector, where she's serviced as regional finance director of private hospitals, and the NHS, most recently as Director of Finance at an NHS acute Trust. In her role at RJAH, she will be responsible for shaping and delivering the Trust's financial strategy and supporting commercial development opportunities. Angela's strong commercial insight and her commitment to public service values make her a fantastic addition to our Board of Directors and Executive Team.

5. Sexual Safety training launched for staff

Last year we launched the Sexual Safety Charter – pledging as an organisation to foster a safe and respectful workplace. As part of this ongoing commitment, we are offering a series of sexual safety training sessions. Sexual safety at work remains a priority at RJAH, and we take a zero-tolerance approach to any unwanted, inappropriate or harmful sexual behaviours. We are actively encouraging all staff to take advantage of these training sessions to help create a safer workplace for all. Some behaviours that were once seen as acceptable or 'banter' are not tolerated in today's world, and these sessions will help navigate right and wrong, with open sessions, open learning, and no judgment.

6. Cost of living initiatives

We have recently carried out a detailed review of all our cost-of-living initiatives, including carrying out a staff survey gaining valuable feedback on what matters to our people. In what is a challenging financial climate right now we knew we would have to make difficult decisions but we were also determined to do the right thing by our people. Following the survey, we re-committed to maintaining free staff car parking, making us one of only a dozen or so Trusts in the country still doing this, offering free sanitary products and a new £3 meal deal. These measures have been well received.

7. New solar panel funding awarded to RJAH

The Department for Energy Security and Net Zero recently announced a package of £100 million from Great British Energy for the NHS to install solar power and battery storage solutions to help drive down energy bills, offering better value for the taxpayer. As part of this groundbreaking new funding and following a successful bid, RJAH has been awarded £2.4million to install additional solar panels. Investing in renewable energy generation will deliver reductions in energy costs that can be redirected into front line care. RJAH has plans to significantly expand our solar energy capacity, adding a further 1.2MW system to our existing 2MW installation. This expansion is projected to deliver an additional £300,000 in annual electricity savings and reduce the hospital's carbon emissions by 220 tonnes each year.

8. Apollo Electronic Patient Record update

At the time of writing, we are just days away from going live with our Apollo Electronic Patient Record. This project has been many months in the planning. It represents the single largest investment the Trust has ever made in a technological solution, and we are excited to bring it into operation and to start to utilise the benefits for both our patients and our staff. It represents a big change in the way we work, so we know there will be a period of adaption after we go live on Monday 12 May, but those benefits should really start to become clear in the coming weeks and months.

9. RAF Shawbury selects RJAH Veterans' Centre as Charity of the Year

I am delighted that the Headley Court Veterans' Orthopaedic Centre has been chosen as one of RAF Shawbury's three Charities of the Year for 2025. The announcement was made during a visit to the hospital by Flight Lieutenant Adrian Vine, who was welcomed to the state-of-the-art centre by the Veterans' Orthopaedic Team. Each year, RAF Shawbury supports three causes that reflect personal, local and military connections – and the Veterans' Orthopaedic Centre ticked all three. As well as fundraising events held throughout the year, RAF Shawbury plans to support RJAH with hands-on help through community-based projects.

10. Thank you to all our London Marathon 2025 runners

A huge thank you and congratulations to each and every runner who represented RJAH Charity in the London Marathon this year. Having done it myself in the past, I know what it takes to complete the course, so I am grateful to each and every one of them – and the cumulative tens of thousands of pounds that they have raised will have a lasting impact on the patient care we can offer. I look forward to meeting some of the runners at our annual post-event reception soon.

11. RJAH Charity launches 20Thrive

RJAH Charity is calling on people to get sporty, challenge themselves, and make a difference with its exciting new fundraising initiative – 20Thrive. The charity is encouraging supporters to take on a fitness challenge in 2025. This series of sporting events offers participants the chance to get active, set personal goals and raise vital funds to support patients and staff at RJAH. Whether it's running, cycling, swimming, or another challenge, 20Thrive provides an opportunity for people of all abilities to take part, have fun and make a real difference. The charity already offers spaces with TCS London Marathon – which proves popular amongst supporters and often has a waiting list each year. 20Thrive aims to build on this, offering up different opportunities for those wishing to support RJAH in this way.

12. RJAH Stars Award

Every month, I present an RJAH Stars Award to one individual or team, in recognition of outstanding achievement or performance. There have been two winners of the RJAH Stars Award since our last public Board meeting:

- The April winner was Quality Assurance Lead Hayley Gingell, in recognition of the key role she has played in the management and use of data across the Trust.

Her five nominations praised her for her significant role in designing and implementing digital systems and dashboards that support a wide range of assurance processes. Her work includes an electronic business continuity plan toolkit and tailored dashboards to support the Getting It Right First Time further faster programme, Care Quality Commission standards, and Trust policies. The nominations also praised Hayley for her support, can do attitude and for being a fantastic colleague!

- The March winners were Mark Grainger and Fred Jones, two Healthcare Assistants who work in the Midland Centre for Spinal Injuries. They were nominated for going above and beyond to support long-stay patients.

  The duo formed a strong bond with a patient who had spent several months on MCSI. When the patient became unwell and was transferred to the Royal Shrewsbury Hospital, Mark and Fred selflessly took time out of their own schedules to visit the patient, ensuring he had familiar faces by his side during his stay.

Congratulations to our latest winners!

13. Conclusion

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

Executive Summary - Quality & Safety Committee

Assurance

Variation	Will consistently pass the target if nothing changes	Will not consistently pass or fail the target if nothing changes	Will consistently fail the target if nothing changes	No Target or Moving Target
Improving variation (high or low) or 3 months better than target				
No significant change or N/A to SPC		Surgical Site Infections Pt Safety Alerts Not Completed by Deadline Total Deaths		Number of Patient Safety Reviews Medication Errors Volume of Theatre Cancellations
Concerning variation (high or low) or 3 months off target	Safe Staffing	Number of Complaints No of Spinal Injury Patients Fit for Admission Medication Errors with Harm 62 Day General Standard	Complaints Re-opened % Delayed Discharge Rate	Overdue Follow Up Backlog

Please note - this is defined by the associated SPC graph within the IPR. Many KPIs show as a moving target due to the change of targets/plans as we moved into new financial year and monthly phasing.

Trust Board - Quality & Safety

March 2025 – Month 12

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

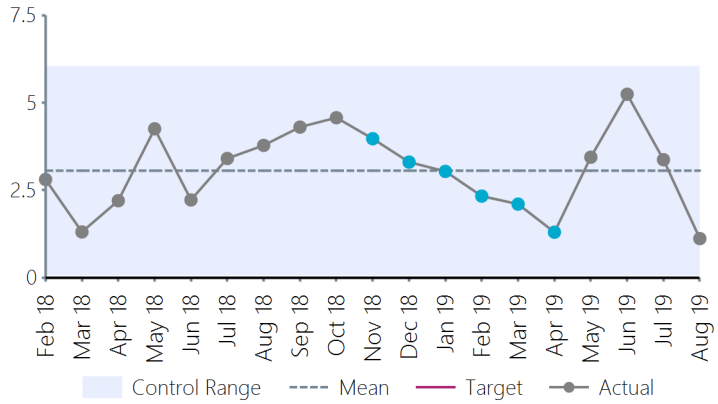
Some examples of these are shown in the images to the right:

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

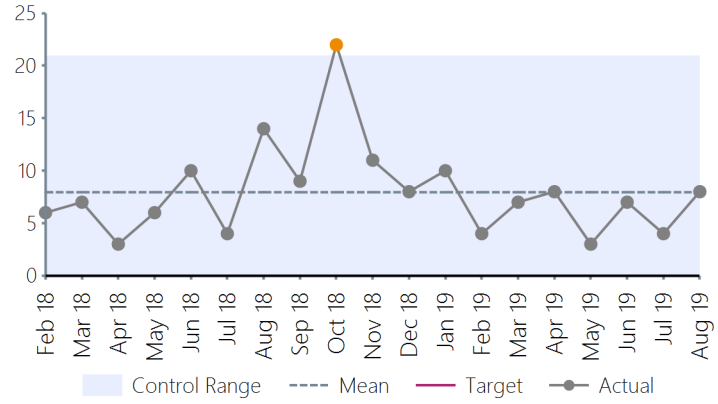
b) shows a point of concern sitting above the control range.

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

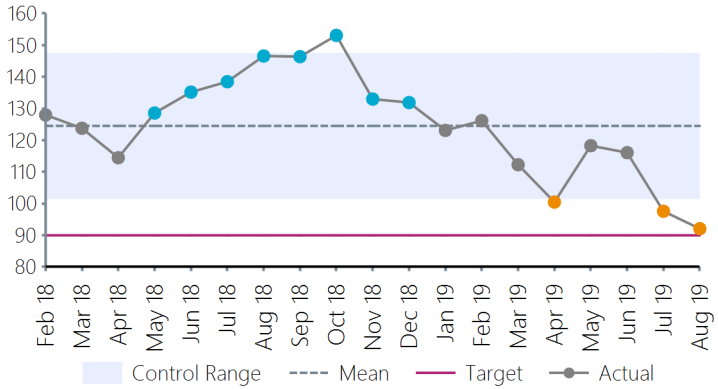
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Patient Safety Incident Investigations		0		N/A to SPC	No Target		
Number of Complaints	8	11			?	+	
RJAH Acquired C.Difficile	0	0		N/A to SPC	P		04/03/24
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	P		04/03/24
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		04/03/24
RJAH Acquired MSSA Bacteraemia	0	0		N/A to SPC	?		04/03/24
RJAH Acquired Klebsiella spp	0	0		N/A to SPC	P		04/03/24
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		04/03/24
Surgical Site Infections	0	0			?	+	04/03/24
Outbreaks	0	0		N/A to SPC	P		04/03/24

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Number of Deteriorating Patients	5	3		N/A to SPC	?		
Total Deaths	0	3		N/A to SPC	?	+	12/09/23
WHO Quality Audit - % Compliance	100.00%	100.00%			P		

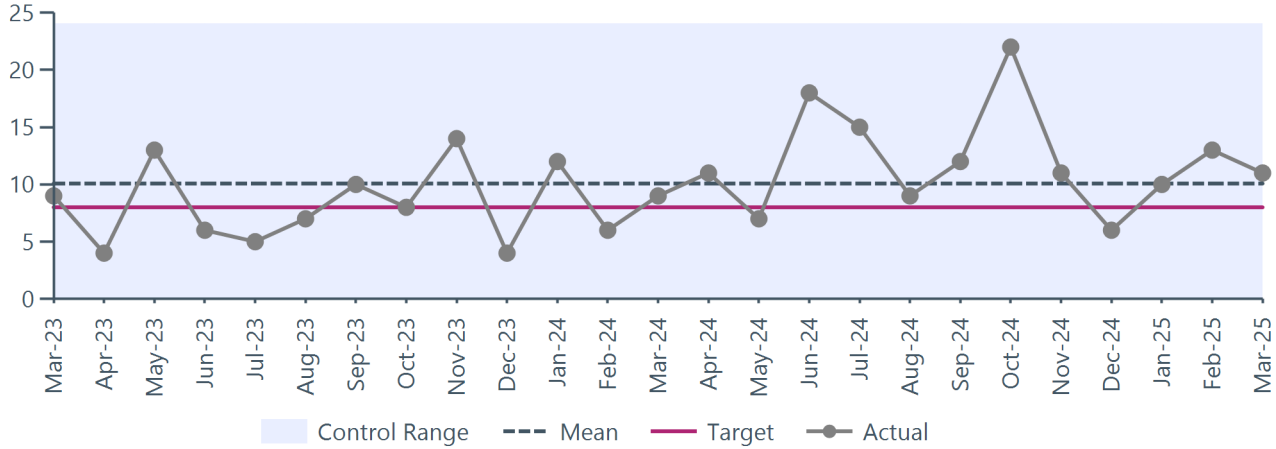
Number of Complaints

Number of complaints received in month 211105

Exec Lead
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
8	11		

Trajectory



What these graphs are telling us

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

Narrative

There were eleven complaints received in March. This metric is included as an exception as it has exceeded the tolerance of eight for three consecutive months. The reasons for complaints were associated with care provided (6), waiting times (3), communication issues (1) and cancellation (1).

Actions

An increase in the volume of complaints has been seen throughout this financial year. Learning is identified for each one as part of the complaints response. Any themes are shared at Unit level and through Patient Experience Committee.

Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
9	11	7	18	15	9	12	22	11	6	10	13	11

Surgical Site Infections

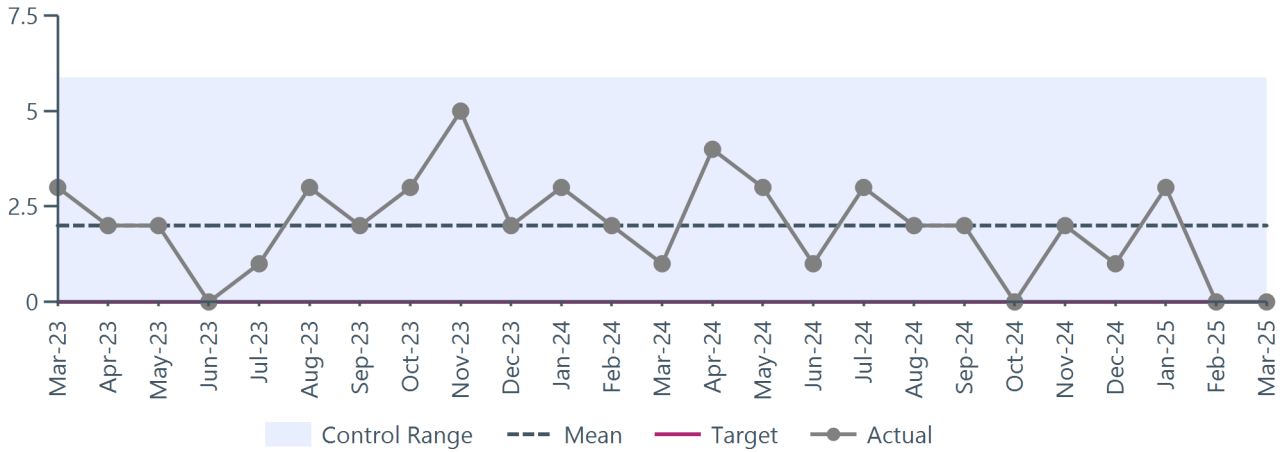
Surgical Site Infections reported for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement in previous twelve months.

Exec Lead
Chief Nurse and Patient Safety Officer

217727

Target/Plan	Latest Value	Variation	Assurance
0	0		

Trajectory



What these graphs are telling us

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

Narrative

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

There was one infection confirmed in March, relating to a procedure that took place in January-25.

Actions

An SSI case review was completed, which concluded that there was good compliance to the OneTogether principles. The patient had multiple risk factors and several falls which could have contributed to the SSI. The case was reviewed at the Patient Safety Incident Response Group which determined no moderate harm.

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

Total Deaths

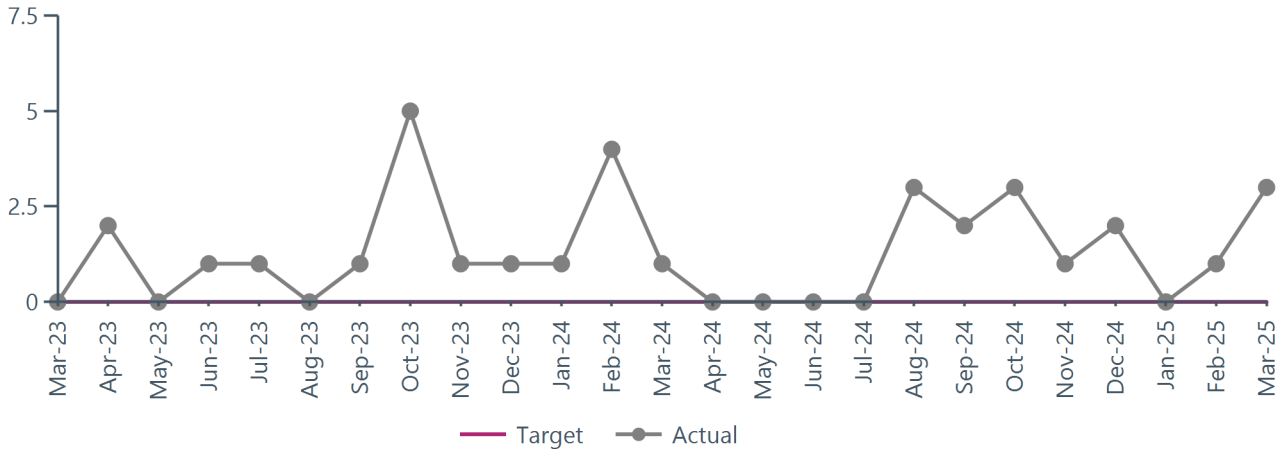
Number of Deaths in Month 211172

Exec Lead:
Chief Medical Officer

Target/Plan	Latest Value	Variation	Assurance
0	3	N/A to SPC	?

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

There were three deaths throughout the Trust in March; all have been classified as Expected Deaths.

Actions

Learning from Deaths Reviews are completed by the Trust Lead.

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Quality and Safety Committee

Committee / Group / Meeting, Date

Board of Directors Meeting, 07 May 2025

Author: **Contributors:**

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Report sign-off:

Ruth Longfellow, Chief Medical Officer
Sam Young, Interim Chief Nurse and Patient Safety Officer
Lindsey Webb, Non-Executive Director

Is the report suitable for publication:

Yes

1. Key issues and considerations:

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

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

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

This report provides a summary of the items considered at the Quality and Safety Committee on 20 March 2025 and 24 April 2025. It highlights the key areas the Quality and Safety Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

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

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

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

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

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

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

3. Assurance Report from Quality and Safety Committee

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

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

KPI Proposal 2025/26 (April Meeting) - Report presented to the Board of Directors
The Committee reviewed the submitted paper, which highlighted several proposed changes to Key Performance Indicators (KPIs) as outlined within the Board paper.

Learning from Deaths Q4 Report (April Meeting) – Report presented to the Board of Directors
There were 4 expected deaths during Q4 with no issues of care identified. 1 NHS to NHS concern was raised to SATH around 1 death where a patient was moved from SATH to RJAH while on an end-of-life care pathway and passed away within 12 hours. The Committee are assured with the process in relation to learning from deaths.

3.2 Areas of on-going monitoring with new developments

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

Corporate Risk Register (March Meeting)
The Committee discussed each risk on an individual basis to gain oversight. There were no concerns to escalate to the Board in relation to the risks however, the Committee requested further assurance on the following as part of the next review:

- The Trust is to review the potential levels of harms coming to patients due to the increased waiting times.
- The Executive team to review all risks scoring a 12 or higher which have not reported movement over the past 12months.
- Extend an invitation to the Head of Orthorics to present the further detail on risk 2281- The Orthotics System.

Deep Dive – Pre-Op GIRFT / on the day cancellations (March Meeting)
The Committee raised several concerns regarding the on-target status for some actions, noting that these may not be fully visible and implemented by the target dates set. It was suggested that a follow-up discussion with the pathway leads would be valuable to ensure a clearer understanding of the progress and the tangible outcomes expected.
The importance of developing comprehensive KPIs to measure the impact of the project, track progress, and identify areas for further improvement was emphasised. It was noted that the main aim of the project is to enhance patient outcomes and surgical efficiency, with a focus on measurable impacts. While the GIRFT standards are helpful, they are not tailored to the Trust's specific needs, and therefore there is a need for more focused KPIs that reflect the true goals of the project.

The Committee agreed that next steps should include revisiting the objectives, developing relevant quality KPIs, reassessing the GIRFT standards, and gathering baseline data to track progress over time. An update progress reported is scheduled to be presented to the Committee May.

Clinical Safety Case Report (verbal) (April Meeting) / (March Meeting)
The report was submitted to NHSE and approved as being acceptable for go live, is reporting an improved position. The 2 previously identified substantial risks have now been resolved or effectively mitigated. The formal case report is scheduled for consideration and approval at the Joint QS and DERIC Committee on 1st May 2025.
The draft clinical safety case was also received by the Committee in **March** where the Committee was informed that a dedicated team of staff has been assigned to support the go-live process for 2 months. It was noted that training compliance and engagement levels have been disappointing. However, efforts are being made to address this issue, including further communication and incorporating attendance at upcoming firm meetings to reach more staff. The delay in the go-live date has provided more time for increased engagement and experience with the new system.

Performance Report (March and April Meeting)

- **Cancellations**: 15 cancellations on the day due to a double-booked surgeon, noting that this issue was also caused by an NHS booking at Alder Hey.
- **Safe Staffing Levels**: A question was raised regarding safe staffing levels and whether the narrative would be updated with the introduction of the updated tool. The Committee was informed that an audit would be carried out throughout April. The updated approach will continue to track staffing data based on nursing hours available and bed occupancy requirements, with a revised method for evaluating overall establishments and staffing safety.
- **Validation of Overdue Follow-Ups**: It was confirmed that a cost has been obtained for the validation of overdue follow-ups and will be included in future narratives.
- **Waiting Lists**: It was noted that in February, when the waiting lists for Telford and Shropshire were combined, there was a notable increase in the representation of the most deprived quintile. However, this has since reduced by 4%, indicating improved access to services for Telford residents and highlighting a positive impact.
- **Medication Errors**: Additional assurance was given that medication errors resulting in harm are classified as low harm, with extra measures in place to monitor patients and prevent harm. The Committee requested that definitions of harm be added to the IPR.
- **Validation Exercise**: An external company is conducting a validation exercise to ensure consistency in the waiting list. To date, 890 records over 50 weeks have been validated with only 3 issues identified, providing confidence in the internal validation process. Further results are expected as the external team begins validating records in the 20–50-week range. This will be monitored by the Finance and Performance Committee.
- **Follow Ups** - A new project is underway focusing on improving follow-ups across the organisation with consultant engagement to standardise and cleanse data, allowing for benchmarking with peers and ensuring reliable follow-up information for better patient care.

PSIRF Report (March and April Meeting)
The Committee were assured of the current process. The patient safety improvement plan is progressing, although there are currently five actions that are behind schedule, including access to diabetic specialists and stock holding in the pharmacy. The Committee requested that updates on overdue actions be included in future papers.
It was noted that the Standard Operating Procedures related to the transfer out to Level 3 care are in progress, alongside ongoing work with pre-operative (pre-op) and High Dependency Unit (HDU) care. An update will be provided on this. Following the consideration of the report and subsequent discussion, the Committee noted the report and acknowledged the ongoing efforts and improvements in patient safety and service delivery.

Quality Priorities 2025/26 (March Meeting)
The priorities were shaped by insights gained from the PSIRF over the past 18 months and findings from the quality accreditation programme. The identified priorities are:

- Inpatient falls

- Managing the deteriorating patient
- Improving information sharing
- Introducing a complex care pathway

After considering the report and subsequent discussion, the Committee approved the 2025-26 Quality Priorities to be included in the Quality Account

Critical Care Review (April Meeting)

- **Compliance Concerns**: A question was raised about the consequences of non-compliance. The Committee was informed that while national critical care standards must be met, many are not fully applicable to specialist secondary care providers like this Trust. The lack of a formal distinction between essential and non-relevant standards poses challenges in compliance and reporting.
- **Collaboration with Other NHS Trusts**: The Trust is collaborating with other NHS Trusts to create a more practical approach, focusing on ensuring compliance with essential standards for patient safety and operational needs.
- **Future Reports**: The Committee requested that future reports include an outline of risks and mitigations, ensuring they are documented and, where relevant, reflected in the risk registers.
- **Consultant Involvement**: The importance of increased consultant involvement in critical care decision-making was emphasised, highlighting the need for a cultural shift towards a more balanced approach to critical care resource use, moving away from a risk-averse mindset.
- **Pre-Op Assessments**: The importance of timely pre-op assessments to anticipate critical care needs and ensure proper rehabilitation for patients was stressed.
- **GPICS Standards**: The GPICS standards are being overseen at the Regulatory Oversight Meeting, Patient Safety Meeting, and Trust Management Group.
- **Follow-Up**: The Committee requested that this matter be revisited in six months' time, with a progress report being scheduled for October 2025.

Quality Strategy Progress Report (April Meeting)

There is 1 action currently behind plan which relates to accessible information and is hoped to be completed upon the implementation of Apollo. There is an ongoing action around clinical audit with next steps planned.

Committee Annual Report (inc. self-assessment and terms of reference) (April 2025)

The Committee received the annual report for comments ahead of approval at the Board of Directors. It was noted that there were no issues to escalate to the Board and the Committee;

- encouraged members to share any feedback or suggestions related to chairing and agenda structure.
- noted that agenda-setting meetings are held, and any ideas for changes, whether additions, removals, or improvements, are welcome.
- agreed that the MHRA Meeting, which is a task and finish group, will report into the Regulatory Oversight Meeting.
- requested for the terms of reference to be amended to include the following key responsibilities' Clinical Audit, Health and Safety, Safeguarding and Emergency Planning

The Committee annual report and terms of reference will be presented to the public Board in July. This is to allow for all assurance Committees to complete their reviews and present to the Board in its entirety.

3.3 Areas of assurance

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

PSIRF Internal Audit (MIAA) Review (April Meeting)

The recent audit provided positive assurance for the Trust, with no significant issues identified. There were 3 recommendations which have an action plan for completion. The Committee agreed that the recommendations did not need to return to the Committee as they were already being addressed.

Clinical Audit Annual Report 2025/26 (April Meeting)

The Committee received a comprehensive paper and presentation on the work being undertaken within Clinical Audit providing an oversight of local and national audits. The report also presented information on the forward plan for 2026/27. The Committee acknowledged the significant improvement made over the past 12months as shown in the annual report and thanked the team for there work in this area.

IPC Q4 Report
The Committee's review and discussions highlighted the proactive measures taken to update IPC policies, implement new catheterisation policies, and investigate SSI rates. Continuous monitoring and training are in place to ensure compliance and address any emerging issues. Further data collection over the coming months will be crucial in assessing the long-term impact of these initiatives.

Chair Report from Patient Safety Meeting (March and April Meeting)

- A discussion was held in relation to the Theatre Safety Culture Review Group regarding the drop-in sessions not being well received and the Committee was informed further work is being undertaken to allow the leadership team to gain 360 leadership feedback.
- The metal-on-metal process was agreed to continue as business as usual.
- Confirmed 5 Welsh patients are now waiting over 200 weeks all with harm reviews completed and deemed as low harm. 2 are on active monitoring due to self-chosen delays.

Chair Report from Health Inequalities and Population Health Working Group (March Meeting)

- There were no concerns to raise to the Board.

Chair Report from IPCC Meeting (March and April Meeting)

- The Committee was informed that there is lots of work undertaken around SSI prevention with increased positive engagement from surgical and theatre colleagues.
- The 6 monthly MDT reviews of SSIs will continue despite not being a PSIRF priority as this has been found to be beneficial.
- A query was raised regarding the recent failure involving the TSSU and the reverse osmosis unit. It was clarified that the issue was related to ageing equipment, which may require replacement and is potentially nearing end-of-life. It will be confirmed whether this is in the estate's capital plan. However, business continuity plans are in place and these measures have thus far prevented theatre cancellations.

Chair Report from the Drugs and Therapeutics Meeting (March Meeting)

- The Committee discussed the lack of attendance at the Meeting and raised this should be added to the risk register until this has improved.
- A question was raised whether there are any measures to flag underusage of antimicrobial agents, and this will be reviewed.

Chair Report from Clinical Effectiveness Meeting (April Meeting)
There has been an issue in relation to the Quality Health and NHSE's data publication delays which has been escalated.

Chair Report from Regulatory Oversight Meeting (April meeting)

- The Trust currently does not have an MDSO role in place. As the role is not required on a full-time basis, collaboration with SATH is being explored and a business case is being developed in the interim.
- A question was raised regarding orthotics compliance. Assurance was given that the issue affects non-RJAH patients only, and work is ongoing to ensure compliance to provide orthoses to those outside the Trust. The service for RJAH patients is compliant.

Chair Report from MHRA Working Group (March and April Meeting)
The business case and options appraisal/quality impact assessment will return to Committee in May.

Recommendation

The Board is asked to:

Chair's Assurance Report
Quality and Safety Committee

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

0. Reference Information

Author:	Dr James Neil	Paper date:	24-4-2025
Executive Sponsor:	Dr Ruth Longfellow	Paper Category:	Governance and Quality
Paper Reviewed by:	Mortality Steering Group	Paper Ref:	To be inserted by the person collating the agenda
Forum submitted to:	Quality and Safety	Paper FOIA Status:	Full / Partial / Non-disclosure Delete as appropriate

1. Purpose of Paper

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

Learning from Deaths summary report to Q and S.

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

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

Deaths are reported through the Board of Directors.

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

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

MSG report discussed at Patient Safety committee.

2. Executive Summary

2.1. Context

To report the current numbers and trends in Q4 for In-patient Learning from Deaths (LFD).

2.2. Summary

See Numbers Below.

2.3. Conclusion

No trends identified.

Learning from deaths identified (see below).

3. The Main Report

3.1. Introduction

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

3.2. Learning From Deaths Summary.

Date	Total In-patient Deaths	Number for case record (SJR) review	Death likely due to problems with care	ME review/Family feedback.	Coroner review.
January 2025	0	0	0	N/a	N/a
February 2025	1 (Expected)	1	0	No concerns	N/a
March 2025	3 (Expected)	3	0	No concerns	N/a

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

All four patients at end of life on SWAN pathway.

3.3. Associated Risks.

None.

3.4. Next Steps

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

LFD lead now working as a Medical Examiner at SATH.

LFD lead at RJAH now attends Mortality steering group at SATH.

3.5. Learning from SJR's.

Good family communication with remote relatives.
Has been fed back to SATH as NHS-to-NHS concern due to transfer of patient unconscious on EOL pathway who passed away within 12 hours.
Very good MDT involvement. **Very good documentation of discussions with patient and distant family members.**
Overall good care with wide MDT involvement and regular family discussions.

All learning passed on to consultant teams.

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

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

Further IT change with transfer of system (May 2024) to external provider from NHSE likely to further delay dashboard.

Appendix 1: Acronyms

LFD	Learning From Deaths
SJR	Structured Judgment Review
MSG	Mortality Steering Group

Executive Summary - People Committee

Assurance

Variation

	Will consistently pass the target if nothing changes	Will not consistently pass or fail the target if nothing changes	Will consistently fail the target if nothing changes	No Target or Moving Target
Improving variation (high or low) or 3 months better than target	% of Staff on E-Rostering System	Nursing Vacancy Rate Personal Development Reviews	% of E-Rosters Approved 6 Weeks Ahead	Staff Turnover - Headcount Staff Retention
No significant change or N/A to SPC	E-Rostering Level of Attainment		E-Job Planning Level of Attainment	Total Headcount in Post % Staff Availability
Concerning variation (high or low) or 3 months off target		Time to Hire	% of Staff with an Active E-Job Plan	Sickness Absence Sickness Absence - Long Term In Month Leavers HCSW Vacancy Rate

Please note - this is defined by the associated SPC graph within the IPR. Many KPIs show as a moving target due to the change of targets/plans as we moved into new financial year and monthly phasing.

Trust Board - People & Workforce
March 2025 – Month 12

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

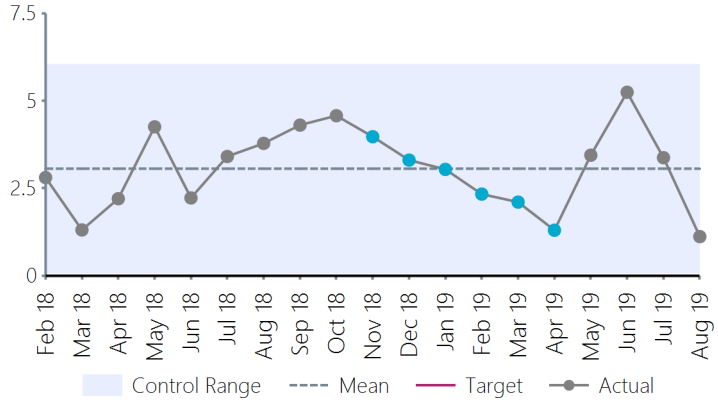
Some examples of these are shown in the images to the right:

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

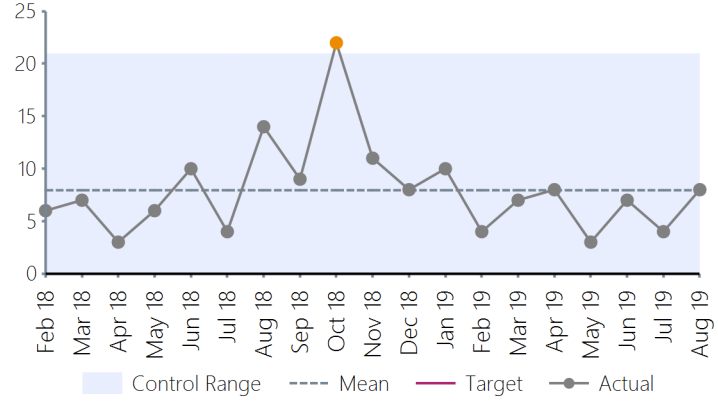
b) shows a point of concern sitting above the control range.

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

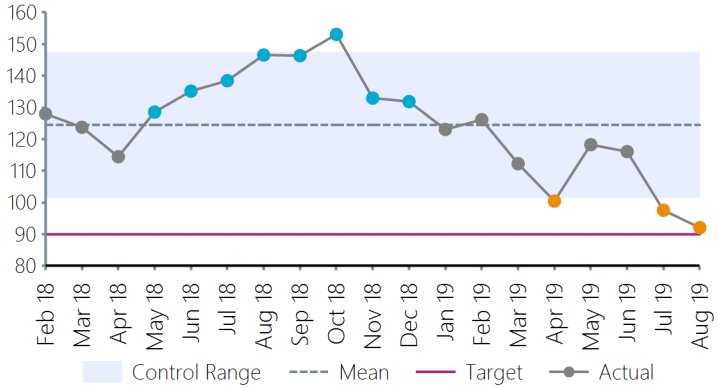
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Staff

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Sickness Absence	5.35%	5.35%		H	Moving Target	+	
Staff Turnover - Headcount	7.86%	8.81%		L	Moving Target	+	04/06/24
In Month Leavers	12	14			Moving Target	+	
Vacancy Rate	8.00%	6.47%			P		15/04/24

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Agency Proportion of Pay Plan							

Sickness Absence

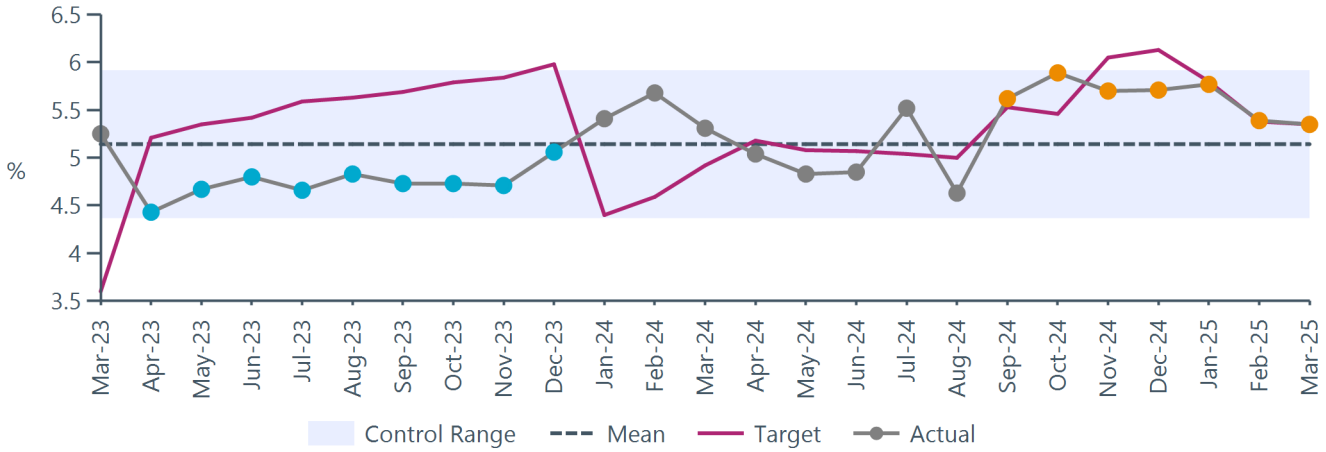
FTE days lost as a percentage of FTE days available in month. Target as per Trust's Operational Plans. 211161

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
5.35%	5.35%	H	Moving Target

Trajectory

Actual
Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. Metric has a moving target.

Narrative

The Sickness Absence for March is reported at 5.35%; exactly in line with the plan for this month. Although the graph above indicates a period of special cause variation of concern, the absence has aligned with the plan and over the last six months has been close to plan, or below it. Whilst short term absence has reduced month on month since October, long term absence has remained the key driver.

Throughout March the top three reasons for absence were; 'Anxiety/stress/depression/other psychiatric illnesses', 'Other known causes - not elsewhere classified' and 'Other musculoskeletal problems'.

The top three hotspot areas were: Theatre Support Workers - 16.34%, Ward Housekeepers - 15.29% and MCSI Resettlement Team - 14.12%.

Actions

The HR Team have oversight of the drivers of high absence in the identified areas and are working closely with managers to ensure appropriate management plans are in place, however, a number of the long term absence cases are for reasons in the areas highlighted are difficult to influence though HR management processes.
Ongoing Actions:

* ER Team fortnightly deep-dive review into long term absence cases with a particular focus on absence through stress
* 12 month review of areas with persistently high absence presented to People Committee in March 25 – actions underway
* Bespoke HR 101 absence training provided to managers into areas where absence is high
* Bespoke 'Managing absence related to Mental Health' HR masterclass in the planning
* Work underway with Optima Health and Moving and Handling team to triangulate MSK absence and potential absence (where staff are in work with MSK issues) to try to predict hotspots in advance and implement proactive plans

Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
5.31%	5.04%	4.83%	4.85%	5.52%	4.63%	5.62%	5.89%	5.70%	5.71%	5.77%	5.39%	5.35%

Staff Turnover - Headcount

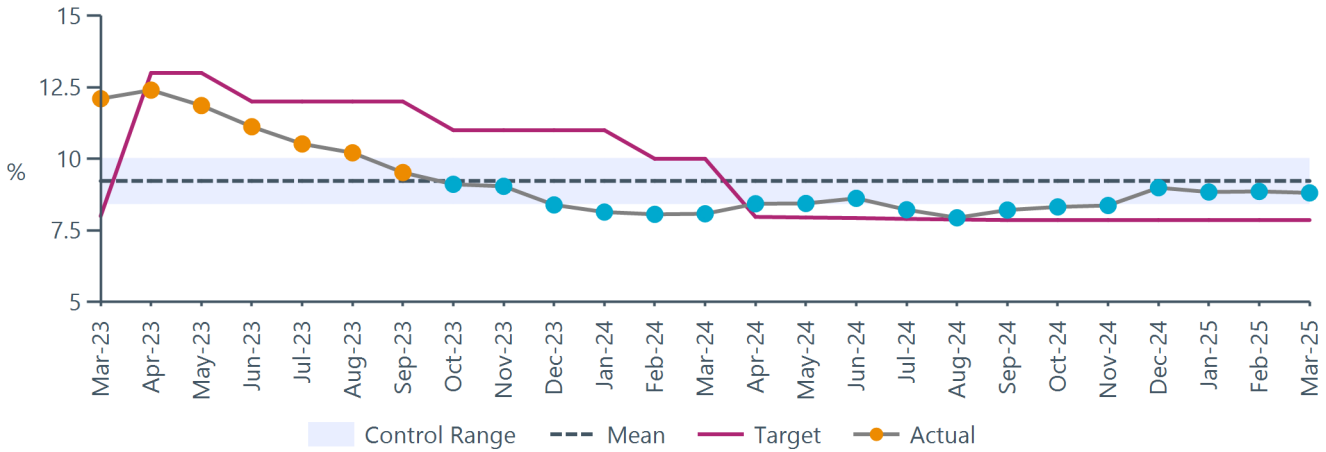
Total numbers of voluntary leavers in the last 12 months as a percentage of the total employed. Target as per Trust's Operational Plans. 217394

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
7.86%	8.81%	L	Moving Target

Trajectory

Actual
Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric has a moving target.

Narrative

Staff Turnover is reported at 8.81% for March, above the 7.86% plan. The 24/25 target was reduced to reflect what was submitted in the Trust's Operational Plans. The 24/25 target is aligned with the 23/24 outturn.

As demonstrated on the graph above, the reported position has maintained the period of sustained improvement that has been maintained since October-23.

This metric relates to the leavers over the past twelve months. For the period of April-24 to March-25 there have been 162 leavers as a proportion of the month end headcount.

Actions

Ongoing Long-Term Retention Activities in place to support staff:
*Developing role competencies and career pathways for progression, Theatres and MCSI focus
*Introduction of Legacy Mentors to support departments with high turnover and leavers
*Revised and improved staff induction
*System Retention Strategy in Development
*People Promise Programme activity
* Workforce profiling to assess succession planning in progress

Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
8.08%	8.43%	8.44%	8.62%	8.22%	7.94%	8.21%	8.32%	8.37%	8.99%	8.84%	8.86%	8.81%

In Month Leavers

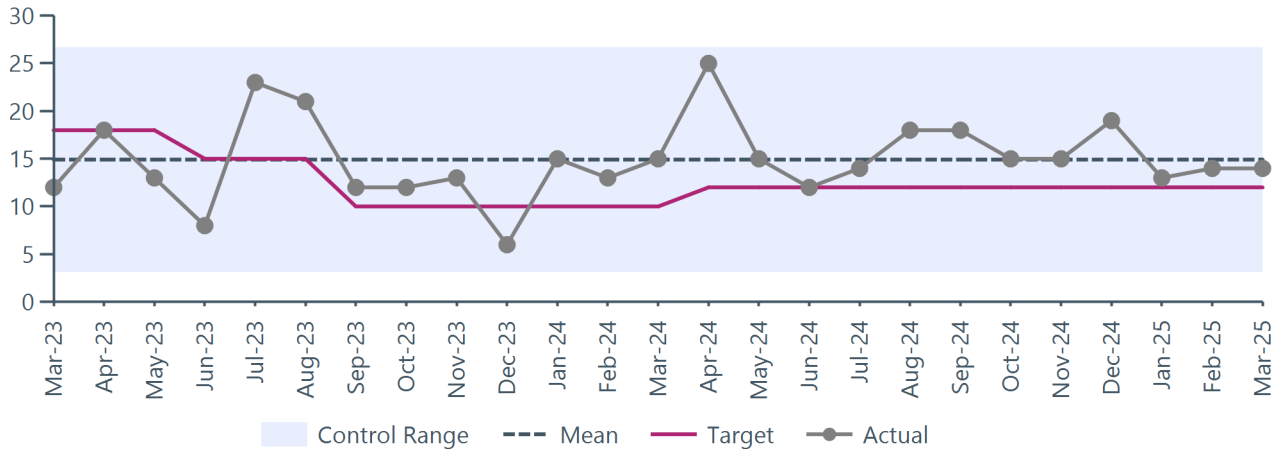
Number of leavers in month - excluding medical rotational staff 217809

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
12	14		Moving Target

Trajectory

Actual
Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. Metric has a moving target

Narrative

There were 14 staff who left the Trust throughout March. This metric is included as an exception as it has consistently been above the target throughout this financial year with only June-24 reported below.

The leavers were from the following staff groups; Administrative & Clerical (6), Additional Clinical Services (3), Allied Health Professionals (3), Estates & Ancillary (1) and Medical & Dental (1).

The reasons for leaving were recorded as:
* Voluntary Resignation (9)
* Retirement/Flexi Retirement (3)
* End of Fixed Term Contracts (2)

Actions

Ongoing Long-Term Retention Activities in place to support staff:
*Developing role competencies and career pathways for progression, Theatres and MCSI focus
*Introduction of Legacy Mentors to support departments with high turnover and leavers
*Revised and improved staff induction
*System Retention Strategy in Development
*People Promise Programme activity
* Workforce profiling to assess succession planning in progress

Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
15	25	15	12	14	18	18	15	15	19	13	14	14

Chair's Assurance Report
People and Culture Committee

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Committee / Group / Meeting, Date	
Board of Directors Meeting, 07 May 2025	
Author:	**Contributors:**
Name: Mary Bardsley Role/Title: Assistant Trust Secretary	
Report sign-off:	
Paul Maubach, Chair of the People and Culture Committee	
Is the report suitable for publication:	
Yes	

1. Key issues and considerations:

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

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

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

This report provides a summary of the items considered at the People and Culture Committee on 20 March 2025 and 24 April 2025. It highlights the key areas the People and Culture Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

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

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

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

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

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

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

3. Assurance Report from People and Culture Committee

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

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

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

KPI Proposal 2025/26 (April Meeting) - **report presented to the Board of Directors**

The Committee reviewed the submitted paper, which highlighted several proposed changes to Key Performance Indicators (KPIs) as outlined within the Board paper.

Staff Survey Presentation (March Meeting) - **report presented to the Board of Directors**

The Committee's consideration and subsequent discussion highlighted the need for focused efforts to address the identified issues and improve overall staff engagement and satisfaction.

- **Response Rate** - the decline in response rate is concerning and should be addressed through targeted communication and engagement strategies.
- **Global Majority Staff Feedback** - a deeper dive into the feedback from global majority staff is essential, particularly regarding bullying, harassment, and raising concerns. This should be a priority in the action plan.
- **People Promise and Learning** - the low scores in the "people promise" and "always learning" categories indicate areas for improvement. The Committee suggested conducting a deep dive and communicating the importance of non-classroom learning will be crucial.
- **Action Plan** - the bi-monthly action plan focus meetings and support for managers are positive steps and the Committee highlighted the importance of ensuring that the top three actions are clearly defined and communicated to all relevant stakeholders.

3.2 Areas of on-going monitoring with new developments

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

Corporate Risk Register (March Meeting)

The Committee considered the risk register. There were no concerns to escalate to the Board in relation to the risks however, the Committee requested further assurance on the following as part of the next review:

- The Executive team to review all risks scoring a 12 or higher which have not reported movement over the past 12months.
- The lack of escalation process from provider to System level is to be discussed with the System.
- To ensure all mitigations actions are reviewed ahead of presentation at the Committee.

Committee Annual Report (inc. self-assessment and terms of reference) (April 2025)

The Committee received the annual report for comments ahead of approval at the Board of Directors. It was noted that there were no issues to escalate to the Board and the Committee.

- noted the survey results which presented which were positive

- discussed the placement of the education elements within the People and Culture Committee agenda and which elements should be aligned to the DERIC Committee which would be considered outside of the meeting.
- considered the membership of the meeting and acknowledged the time which the Chief Medical Officer had attended throughout the year to provide assurance on medical aspects of the agenda.

The Committee annual report and terms of reference will be presented to the public Board in July. This is to allow for all assurance Committees to complete their reviews and present to the Board in its entirety.

Workforce Performance Report (March and April Meeting)
The Committee reviewed the Workforce Performance report. Overall, the Committee gained assurance from the data reported within the performance report as all metrics continue to record a positive trend.
To greater understand the data being presented, the Committee have requested:

- **Leaver Categories** – it was suggested to exclude retirements and returns from the leaver figures to provide a more accurate view of voluntary turnover.
- **Job Planning Attainment** - the importance of integrating team job planning into the delivery model was emphasised. The Committee expressed interest in understanding the Trust's progress with a clear trajectory to provide further assurance. The Level of Attainment remains at level 1. To achieve level 4, active job plans must be above 90%, while the latest position is 17.42%. The Trust is to provide a clear trajectory for job planning compliance to ensure the committee can be assured of progress.
- **Staff Sickness** – a total of 7 departments were identified as having recurring sickness issues, and it was agreed that management should actively address these problems.
- **Corporate Reduction** - the Committee discussed that the Trust requirement to reduce staff numbers to 2022 levels through vacancy management, ending fixed-term contracts, and digital post-Apollo. The Committee asked for this to be included into the KPI measures for oversight.

Core Training Compliance Report (April Meeting)
The Committee discussed the importance of training compliance and raised concerns about how non-compliance, especially with critical training like safeguarding, could affect safe working practices. The Committee emphasised the need for the Quality and Safety Committee to review which training is most critical and when non-compliance should trigger escalation. Medical and dental staff were noted as having the highest non-compliance rates, with a call for managers to take responsibility for their teams. The discussion highlighted the need for a clear process to manage non-compliance and ensure staff understand the consequences, supporting a more structured and accountable approach to training. The Trust agreed to reviewing the new national frameworks for statutory and mandatory training to identify the required areas and assess the Trust's compliance rates.

System Integrated Improvement Plan (SIIP) (March Meeting)
The Committee received and considered elements of the improvement plan within its remit. The Committee will receive an update on the action plan at the next meeting, and particularly the development of the provider collaboratives.

2025/26 Workplan Plan (March Meeting)
The workforce plan demonstrates a strong commitment to reducing reliance on temporary staff through significant reductions in agency, bank, and NHS infrastructure staff. The reductions exceed the required targets, indicating effective planning and implementation strategies. Regular tracking and review of these reductions will ensure that the plan remains on course and its impact on the forecast is closely monitored.

Absence Management Report (March Meeting)
The Committee considered the submitted paper and noted several key points regarding sickness absence management over a 12-month period to December 2024, with benchmarking against similar Trusts for comparison.

- **Training Development** - the Trust will continue to support and develop manager within this area. The Committee requested additional assurance to ensure progress in a few

months. Tailored training and support will be provided to these managers, though additional resources may be required to manage this effectively.

- **Understanding Underlying Reasons** – a further question was raised about understanding the underlying reasons for absence and whether it would be worthwhile investing in treatment or support to help staff return to work. The Trust offers self-referral to physiotherapy. It was suggested that investing in psychological support for staff could be beneficial. It was noted that a project is underway to gather intelligence on MSK absences, with the aim of identifying the measures needed to increase support.

3.3 Areas of assurance

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

Premium Workforce Report (M11 – March Meeting / M12 – April Meeting)
The Committee considered the update and subsequent discussion, noting the strategic steps being taken by the Trust to manage workforce costs, address staffing challenges, and meet financial targets. The Committee was reassured by the Trust's understanding of the challenges and its proactive approach to tackling them.

Guardian of Safe Working Hours (Q4 Report) (April Meeting)
Following the review and discussion, the Committee noted the update and expressed confidence in the ongoing efforts and compliance with the requirements. The new exception reporting framework is expected to streamline processes but will require careful management and reliable systems to handle the increased workload.

Anti-Racism Strategy (April Meeting)
A verbal update was provided, highlighting that a more rounded and final draft of the strategy will be presented to the Committee's for consideration at the next meeting.

Personal Development Review Proposal (March Meeting)
The PDR process has been completely refreshed, incorporating feedback from the Committee and stakeholder engagement, and aligning it with the Trust's values. The new document has been trialled within teams, and feedback indicates it is clear, easy to understand, provides helpful prompts, and facilitates reflective conversations. Moving forward, the goal is for the PDR process to be completed through the Electronic Staff Record (ESR) system. This is essential to prevent it from becoming a tick-box exercise and to enable the Trust to monitor how many people are achieving their objectives and identify any necessary course of action. The Committee requested confirmation that the current ESR system has the necessary capabilities to support the PDR process.

People Promise Update (March Meeting)
The 12-month funded NHSE initiative was concluded at the beginning of March. Several strategic objectives were signed and approved by NHSE. The initiatives under the people promise to have been incorporated into the ongoing plans as part of the business-as-usual operations. This demonstrates a commitment to maintaining and embedding the principles of the people promise into the organization's regular activities. The Committee took the opportunity to thank Mandee Worrall for her for their positive contributions within this remit.

HR System Review (March Meeting)
A verbal update was provided, and the Committee were informed of the HR System Review which has been commissioned. Further work is to be undertaken to strengthen priorities, governance and escalation processes and the correct resources to support the remit.

Retain Workstream SRO Update (March Meeting)
The teams are addressing key priority areas within the retain workstream. The structured 90-day plan and the progress made despite the lack of PMO support are positive indicators. Additionally, the suggestion to involve social care providers and the voluntary sector could further strengthen the system's leadership and support.

The Committee considered the following policies:

- **Internal Transfer Policy (April Meeting)** – the Committee requested further amendments to the document before endorsing. This is to: include all staff groups; clarify the purpose and timing of the interest register (eg: do people express an interest in advance or only when a new job is available); give consideration as to whether this would have unintentional consequences to the time to hire KPI (eg: if it adds an additional stage at the start of any recruitment); to ensure the process compliments the PDR process.
- **Special Leave Policy (April Meeting)** - the Committee requested further amendments to the document before endorsing. This is to: include auditing the application of the policy to ascertain how it is being used; amend the policy so that it is less open to individual interpretation and therefore avoid inconsistent adherence throughout the Trust; provide clearer guidance in relation to the 'paid / unpaid' table and how this is applied.
- **Fixed Term** Contract Policy (March Meeting) - the Committee requested further amendments to the document before endorsing. This is to include; a process flowchart; a clear escalation process for extending contracts (particularly beyond 2 years); reviewing the reference to extended contracts for 2years and whether this should be allowable.
- **National Pregnancy and Baby Loss People Policy (March Meeting)** – the Committee supported the policy.

Chair Report Non-Medical Staffing Subgroup (March Meeting)
The Committee noted the report, there were no items to escalate.

Chair Report Local Negotiating Meeting (April Meeting)
TOIL was raised as a concern and taken as an action for the Team to investigate any potential discrepancies.

Chair Report Multi Professional Education Strategy Meeting (March Meeting)
The Committee noted the report, there were no items to escalate.

Chair Report Joint Consultancy Meeting (April Meeting)
The Committee noted the report, there were no items to escalate

Chair Report Trust Performance and Operational Improvement (April Meeting)
The report is shared with the Committee for noting only and is formally reported through the Finance and Performance Committee.

Recommendation

The Board is asked to:

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

Safe Working Hours: Doctors in Training

0. Reference Information

Author:	Chris Marquis, Guardian of Safe Working	Paper date:	14 April 2025
Executive Sponsor:	Chief Medical Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	People and Culture Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Board of Directors is asked to ***consider*** and ***note*** the Trust's position in relation to safe working hours for doctors in training. This report provided the required annual summary data.

2. Executive Summary

2.1. Context

As part of the 2016 Terms and Conditions for Resident Doctors it was agreed that additional safeguards would be put in place to protect the working hours of doctors in training. This included a Guarding of Safe Working to champion safe working hours and provide assurance to the Board in this regard.

2.2 Summary

The Trust has in place a Guardian of Safe Working and this paper presents the April 2025 annual summary report from the Guardian. It outlines the work that has been undertaken to date and highlights some of the issues being faced. The report provides the data currently available in relation to rota vacancies and agency and locum usage.

2.3. Conclusion

The Board is asked to ***consider*** and ***note*** this report from the Guardian of Safe Working.

3. The Main Report

3.1. Introduction

This paper sets outs the background and context around the introduction of the Guardian of Safe Working as part of the 2016 Terms and Conditions for Resident Doctors and implementation of that role in the Trust.

The 2016 national contract for resident doctors encourages stronger safeguards to prevent doctors working excessive hours. During negotiations on the resident doctor contract, agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS (National Health Service) trainee doctors to oversee the process of ensuring safe working hours for resident doctors. The Guardian role was introduced with the responsibility of ensuring doctors are properly paid for all their work and by making sure doctors are not working unsafe hours.

The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the resident doctors employed by it. The work of the guardian will be subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by the continued scrutiny of the quality of training by Health Education England (HEE). These measures should ensure the safety of doctors and therefore of patients.

The Guardian will:

- Champion safe working hours.
- Oversee safety related exception reports and monitor compliance.
- Escalate issues for action where not addressed locally.
- Require work schedule reviews to be undertaken where necessary
- Intervene to mitigate safety risks.
- Intervene where issues are not being resolved satisfactorily.
- Distribute monies received because of fines for safety breaches.
- Give assurance to the board that doctors are rostered and working safe hours.
- Identify to the board any areas where there are current difficulties maintaining safe working hours.
- Outline to the board any plans already in place to address these
- Highlight to the board any areas of persistent concern which may require a wider, system solution.

The Board will receive a quarterly and annual report from the Guardian, which will include:

- Aggregated data on exception reports (including outcomes), broken down by categories such as specialty, department, and grade.
- Details of fines levied against departments with safety issues.
- Data on Rota gaps / staff vacancies/locum usage
- A qualitative narrative highlighting areas of good practice and / or persistent concern.

Other new features of the 2016 contract include:

Work scheduling – resident doctors and employers will be required to complete work schedules for the doctors in training. This will begin as a generic schedule setting out the hours of work, the working pattern, the service commitments, and the training opportunities available during the post or placement.

Exception reporting – enabling doctors to raise exception reports where their work schedules do not reflect their work, and to ensure that a work schedule remains fit for purpose, this is beneficial to employers as it will give real-time information and be able to identify key issues

as they arise. It also benefits doctors, as issues over safe working or missed educational opportunities can be raised and addressed early on in a placement, resulting in safer working and a better educational experience.

Requirement for resident .doctor forums to be set up - principally these forums will advise the Guardian of Safe Working who will oversee the processes in the new contract designed to protect junior doctors from being overworked. The Guardian and Director of Medical Education in each Trust and relevant organisation shall jointly enable a nomination/election process to establish a Resident Doctors Forum (or fora) to advise them and make appropriate arrangements to enable the elected representatives time off for their activities & duties in connection with their role. Election onto the forum will be for the period of rotation and replacements must be sought for any vacancies.

3.2 Guardian of Safe Working Report

3.2.1 High level data

For the period April 2025 – Data not updated by HR – based on previous submission

Specialty	Contract	Headcount
Orthopaedics	Training posts	18
	Of which Doctors in training on 2016 contract	15
Rehabilitation/Spinal Injuries	Training posts	2
	Of which Doctors in training on 2016 contract	1

3.2.2 Exception reports (regarding working hours)

The exception reporting system is designed to allow employers to address issues and concerns as they arise, in real time, and to keep doctors' working hours, both rostered and actual, within safe working limits. If the system of work scheduling and exception reporting is working correctly, in anything other than truly exceptional circumstances, the levying of a fine indicates that the system has failed or that someone – the supervisor, Guardian or the individual doctor concerned – has failed to discharge his or her responsibilities appropriately.

Any levying of a fine should therefore be followed by an investigation in to why it was necessary and remedial action to ensure that it does not happen again. The most important thing to remember is that fines should rarely, if ever be applied at all.

The trust continues to engage with the resident doctors regarding rotas and via the Resident Doctor Forum. At all stages care is taken to ensure hour's compliance is achieved without compromise to patient safety and our training responsibilities.

During the financial year we have received an exception report from a trainee in a Welsh placement, on a centralised contract with RJAH. We have engaged with the trainee,

responsible department and HR to ensure the issue raised is being addressed. TOIL was provided and a diary exercise instigated.

As it stands the Trust can be reassured, we are compliant with the demands placed upon us.

Please see challenges at the end of the report, for further discussion on changes to the ER system.

3.2.3 Work schedule reviews

Please see above.

Work schedule reviews are triggered by repeat exception reporting highlighting an issue with a position or rota. There have been no formal work schedule reviews.

3.2.4 Resident Doctor Agency and Locum usage and Rota Vacancy Report

Trauma and Orthopaedics

Number of Vacancies (28 posts)

April24	0
May 24	0
June 25	0
July	0
Aug 24	0
Sept 24	0
Oct 24	4
Nov 24	1
Dec 24	4
Jan 25	2
Feb 25	3
Mar 25	3

Vacant shifts

April24	6
May 24	2

June 25	3
July	6
Aug 24	6
Sept 24	6
Oct 24	4
Nov 24	1
Dec 24	3
Jan 25	2
Feb 25	3
Mar 25	11

Total cost - £32370

Medicine

Number of Vacancies (12 posts)

April24	3
May 24	3
June 24	3
July 24	3
Aug 24	2
Sept 24	2
Oct 24	2
Nov 24	1
Dec 24	1
Jan 25	1
Feb 25	1
Mar 25	1

Vacant shifts

April24	25
May 24	27
June 24	21
July 24	23
Aug 24	31
Sept 24	16
Oct 24	10
Nov 24	3
Dec 24	16
Jan 25	7
Feb 25	4
Mar 25	0

Total Cost £106350

MCSI

Number of Vacancies (9 posts)

April24	0
May 24	0
June 24	0
July 24	1
Aug 24	1
Sept 24	1
Oct 24	1
Nov 24	1
Dec 24	1
Jan 25	1
Feb 25	1
Mar 25	1

Vacant Shifts

April24	1
May 24	0
June 24	0
July 24	8
Aug 24	10
Sept 24	12
Oct 24	11
Nov 24	14
Dec 24	14
Jan 25	10
Feb 25	11
Mar 25	4

Total cost - £ 22936.80

Long Term Vacant Shifts

One in Medicine (no GP trainee)
One in MCSI (empty post as successful candidate declined position)

3.2.5 Fines

None – please see exceptions report section 3.2.2

3.3 Challenges

3.3.1 New Framework Agreement for Exception Reporting

A new framework for ER has been agreed by the Resident Deal Implementation Group (RDI), including representatives from NHS Employers and the BMA. A copy of the document is included for reference. There are significant fines associated with an information breach or an access and completion breach (£250-500). These will apply from the 12/09/2025, with the higher threshold applied from 01/02/2026.

A significant change in the process will be exception reports for two or less additional hours, which will move to a streamlined process for TOIL or payment. This will be coordinated by HR directly.

There is clearly additional workload associated with the new framework for HR, the need for a robust electronic ER system and an expectation that the new process may lead to an increase in ER for two hours or less additional work.

It is expected that further guidance will be published around this.

3.3.2 Software System

Progress has been made in establishing an electronic ER system. This has been highlighted in view of the new ER framework. A failure to implement this prior to the September deadline would expose the Trust to significant potential fines of £250-500 per doctor per week.

It is expected that ER software will need to be developed to address the new framework.

Associated Risk

We need to establish an electronic reporting system as a matter of priority.

Next Steps

The Board is asked to ***consider*** and ***note*** this report from the Guardian of Safe Working.

3.4. Conclusion

The Trust has had no exception reports this financial year. The new ER framework terms need addressed to ensure the organisation fulfils its obligations.

The Trust continues to work hard to fulfil its responsibilities under the terms of the new junior doctors' contract and based on available information and assessments appear to be compliant.

Christopher Marquis

Guardian of Safe Working

Framework agreement

Exception reporting

Introduction

This framework has been agreed by the Resident Deal Implementation Group (RDI), including representatives from NHS Employers and the British Medical Association (BMA), in order to reform exception reporting (ER) processes through changes to the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (2016 TCS), based on the terms of the agreed pay offer of July 2024.

All parties agree that ER is a joint mechanism to ensure that safe working hours are maintained, protecting patients, regulating doctors' workload, safeguarding the delivery of educational opportunities as outlined in the 2016 TCS, and ensuring that doctors receive compensation for all additional work undertaken. Doctors should be enabled and encouraged to exception report. All parties recognise that current practice leads to underreporting exceptions to safe working practice. None of the changes proposed will obstruct the guardian of safe working hours' (GOSWH) ability to undertake their role and identify unsafe working practices.

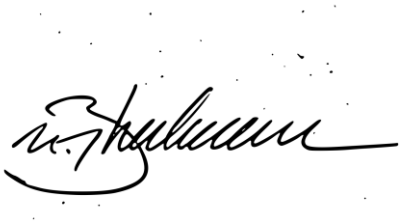
The underlying ethos to these changes should be to empower and trust doctors to conduct themselves professionally, and to remove wherever possible, and minimise wherever it is not, the time-consuming aspects of the ER process.

Danny Mortimer, Chief Executive,
NHS Employers

Dr. Melissa Ryan, Co-Chair,
BMA Residents Doctor Committee

Dr. Ross Nieuwoudt, Co-Chair,
BMA Residents Doctor Committee

Dr. Keith Farrell-Dillon, Deputy Co-Chair,
Terms and Conditions of Service and
Negotiations, BMA Residents Doctor Committee



Dr. U Bhalraam, Deputy Co-Chair,
Terms and Conditions of Service and
Negotiations, BMA Residents Doctor Committee

1. Throughout this framework agreement, the following meanings apply:
   - All days are referring to calendar days.
   - 'Guidance' in every case refers to documents both co-produced and subsequently modified only with consensus agreement of BMA and management side stakeholders of RDI. The RDI group will continue to oversee all monitoring and publications produced, including guidance, until the initial implementation phase is concluded, and further ongoing oversight has been agreed between BMA and NHS Employers.
   - Any reference to an LNC refers to the medical staff side.
   - 'HR' indicates HR/Medical Workforce HR. Wherever possible, HR involved in the ER process should not be co-located with the clinical workforce.

2. There will also need to be appropriate mechanisms for legitimate concerns defined through mutual agreement by the BMA and management side after further consideration.

Scope

3. RDI's remit in respect of ER is reform of the 2016 TCS. These changes will apply to all doctors in training who are substantively employed under that contract, collectively referred to in this framework as 'residents'. As a safety-critical process, it is intended that all doctors in training in England should have access to a GOSWH to ensure safe working hours. It is recognised that the 2016 TCS are widely mirrored in other employment contexts, and we encourage employers in England to make every effort to extend the reforms set out in this framework agreement. For example:
   - Academic trainees who hold a National Training Number/Deanery Number and are substantively employed by universities. For these doctors, RDI encourage that their ER

provision should be extended by clinical employers through a standardised contract.

- Armed forces trainees who hold a National Training Number/Deanery Number.
- Public health trainees.
- Locally employed doctors whose terms of employment substantively mirror the 2016 TCS.
- Locally employed doctors whose terms of employment do not substantively mirror the 2016 TCS, but to whom ER has already been extended at a local level by their employers.

Access (Principle 1)

4. Residents have a contractual right to be able to access and complete ERs. It is recognised that residents not having access to ER is a safety issue. Employers will be instructed to provide access to residents within seven days of starting work, changing work site, employer, or any other related transition. Access should be validated by submission of a 'test' ER within those seven days, monitored by the GOSWH and their deputies. Residents must not be prevented from completing exception reports due to issues with the system, such as errors regarding incomplete rotas or unlisted data. Where rotas are a required selection in the process of ER, the specific name of the relevant rota on the ER system must be listed within a doctor's work schedule.

5. Residents must be provided with a simple way (such as email or quick access link) to raise to the GOSWH and HR after the initial seven days of starting work, changing work site, changing employer, or any other related transition, if they are unable to access the ER system or complete, an exception report. If problems with accessing or completing an exception report are not remedied within seven days of being raised, the GOSWH must levy a fine as outlined in the fines section below. Fines will

then be payable by the responsible party listed below on a recurring seven-day basis until the issue is resolved.

6. For residents working with host employers, including GP practices, their lead employer will carry the responsibility for provisioning the ER process and for any fines incurred as a result. Where residents work across multiple employers, their substantive employer will carry this responsibility, except in cases where the substantive employer is non-clinical, for example, university employees, in which case the clinical employer will carry this responsibility.

7. In addition to local onboarding processes, a list of all eligible employed residents, their contract type and grade must be generated by HR from Electronic Staff Record data (ESR) within a month of major rotation dates and circulated to the GOSWH for cross-validation with a list of doctors with access to ER systems. For those groups outlined in the scope, RDI encourages information to be provided for onboarding to this process, for example through addition to ESR.

Time off in lieu

8. All residents must receive their choice of either payment or time off in lieu (TOIL) for all time worked above contracted hours following ER, except when a breach of safe working hours mandates the award of TOIL. Guidance will detail the specific scenarios where rotation within or across employers precludes direct award of TOIL, and the steps to follow. All resulting payments and TOIL must be facilitated by responsible parties and must not be substituted without residents' consent.

9. When a resident elects to receive TOIL, or TOIL is mandated by the GOSWH, an award of TOIL must be communicated electronically to the resident. The resident will then select an appropriate member of their clinical team to share that communication and enable TOIL to be taken. TOIL must be arranged (that is booked and agreed) within one day of award if

mandatory, and 10 days of award if requested. The resident may escalate to the GOSWH for remediation if these time limits are breached, or if agreed TOIL is not facilitated. After taking TOIL, the resident must record its completion.

10. In those cases where TOIL must be taken immediately to protect patient safety, for example following an overnight breach of safe working hours, residents will directly contact their clinical team, who must facilitate the award. The resident should subsequently record the exception for GOSWH review.

Detriment and information control (Principle 2)

11. The 2016 TCS will be updated to state that residents must not be discouraged from submitting ER and should not suffer detriment as a result of engaging with ER processes. Guidance may be developed to provide resident doctors with information on local grievance processes and procedures and how they can be used in the event of detriment experienced as a result of ER. Categories of detriment may be elaborated on in guidance. To protect residents, ER data must be treated as confidential and cannot be accessed, shared or requested to be shared beyond specific pathways listed in this framework and subsequent guidance without a resident's freely given consent. Proven violations will be subject to information breach penalty.

12. The list of approved categories of individuals who have access to ER data may be added to only by mutual agreement between BMA and management side stakeholders (RDI).

13. Identifiable data for educational exception reports can only be shared with the director of medical education and their deputies (DME) and, at the academic trainees' discretion, a nominated academic supervisor. If remediation of an educational opportunity is possible, the DME will share further information as required for that purpose with the resident's consent.

14. Identifiable data (specifically identifying the individual) related to number or content of exception reports for additional hours

worked may only be shared to or accessed by appropriate HR signatories, GOSWH, their nominated deputies and payroll, unless specifically detailed in a pathway elsewhere in this framework. The list of individuals with direct access to a doctor's ER data must be communicated to the doctor by email at onboarding, and when new individuals are granted access. Details around implementation of ER system notification will be given in guidance.

15. Non-identifiable data derived from ER may be shared for audit and financial purposes to appropriate recipients. Identifiable data, explicitly excluding the exception report number or content, (for example salary) may be used for normal financial management and audit processes and will not be constrained. There are no restrictions on access to those whose job roles are related to professional auditing.

16. Residents must be provided with the identity of the individuals with access to exception report derived data at their request co-ordinated by HR. Information regarding a resident's exception report may not be accessed by individuals outside of this list of people fulfilling these roles (outside of those pathways in this framework agreement).

17. In certain circumstances, a resident may decline to share ER data without prejudice, with details to be set out in guidance.

18. Residents may report a suspected information breach to the GOSWH for investigation, and if proven, the GOSWH must levy a fine per instance per resident as outlined in the fines section below. Residents may be invited to provide additional details on the information breach and may decline. The GOSWH will oversee quarterly surveys of breach of access, breach of information and actual or threatened detriment, with results included in the quarterly GOSWH reports.

19. For residents working in small departments or in community settings, such as GP registrars, broad agreement has been reached that collection and disbursement of fines, payment for

additional hours worked and guidance around rostering, will be implemented to allow improvement of residents' working practices by employers, without breaching confidentiality or risking detriment to residents.

Penalties and distribution

20. Penalties of £500 per resident per instance for proven information breach, and £250 per resident per week for an 'access and completion' breach will be applied from 12 September 2024 to 31 January 2026. Both fines will be set at £500 from 1 February 2026.

21. If approved by LNC or equivalent, an access fine will not be levied where the delay has been caused by an event beyond the control of the employer, for example cyber-attack, as set out in guidance.

22. An 'instance' of information breach is described as follows:

- If multiple doctors are affected in a single leak, a separate penalty will be applied for each affected doctor.
- If multiple leaks occur over time related to a single doctor, a separate penalty will be applied for each individual instance.
- If information related to multiple exception reports from a single doctor is leaked to multiple individuals in a single instance, a single penalty will be applied for that instance.

23. 'Access or completion' fines shall accumulate as a central single pot. The 'information breach' fine will accrue at a granular level unless affected doctors choose for it to go to the central single pot instead. This would take the form of GOSWH managed distinct sub-accounts intended to provide more equitable outcomes, smaller quorums and more agile disbursement. These sub-accounts, for example, should correspond to clinical departments in secondary care or geographical regions for

community settings. Should these more granular fines be unspent within four months of being accrued, they will be transferred to the central pot. Guidance will be provided to support the granular distribution.

Fines cannot be reclaimed by employers for any purpose. Disbursement of fines will be made more flexible, with a focus on initiatives that enhance residents' wellbeing, to be described in guidance. Money paid to the GOSWH fund will not be paid directly to doctors; existing penalty rates paid to doctors will be maintained. Existing accumulated fines via the 2016 TCS will carry over to the GOSWH's single pot. Hourly Penalty Rates paid to doctors under Schedule 02 Paragraph 77 and Annex A of the 2016 TCS will be unchanged. Hourly GOSWH Fines under Schedule 02 Paragraph 77 and Annex A of the 2016 TCS will accrue at a granular level unless affected doctors choose otherwise.

Exception report processing – role and responsibilities (Principles 4, 6, 10)

24. Residents, unless prevented by reasons outside their control as determined by the GOSWH, will be required to submit exception reports as soon as possible but no later than 28 days from the day they occurred. Timings for exception reports involving immediate safety concerns will no longer have a special time submission requirement and residents should continue to follow local processes to raise safety concerns as required. All exception reports must be reviewed independently of budgetary constraints.

25. All submitted exception reports should be reviewed and actioned as soon as possible but no later than 10 days exception reports for more than two additional worked hours should be investigated to ensure safe staffing is maintained and should be subject to a locally determined process, which must be agreed upon with LNC or equivalent. All ER data will be shared directly with the GOSWH for oversight.

26. With reference to exception reports showing that a doctor worked two or less additional hours in one occurrence, the only determination the employer will seek to reach when deciding to pay the doctor is whether or not the additional hours were indeed worked.

27. To maintain financial standards, there needs to be a robust sign-off process but the perceived retrospective merits of the doctors' decision to work the additional hours should not be considered when determining whether to make payment for the additional hours.

28. The doctor will confirm via self-declaration that the information they are submitting adheres to the reasons for exception reporting as currently set out in the 2016 TCS and is accurate.

Processing of ERs by HR for additional hours worked

29. In order to meet the principles above, the following checking process will apply.

Level 0 - To occur in all ER cases and is expected to be sufficient for the vast majority of ER.

A doctor submits an exception report to HR for processing.

- HR will consider three pieces of information:

1) Exception report data confirming category of exception and duration.

2) Evidence of additional hours worked. Time, date and location will be required with further detail to be set out in guidance. In cases where time and location evidencing has been facilitated by employers, but a doctor has declined or cannot do so, they may choose to ask another regulated professional to corroborate their work

done by email, but this corroboration cannot be made a default requirement. This evidence will be provided using a technological solution, for example email, commercial or custom mobile or web app, with implementations expanded on in guidance.

3) The doctor's rota. Current rota information must be accessible to HR for these checks, with mechanisms defined during the drafting of the contract. The RDI strongly encourages employers to move to a system of live rostering which will allow for automatic provision of live roster data and doctors will no longer need to include live rota information.

- HR will cross-check these pieces of information and if the information provided is accurate, they will send information to payroll for processing or approve TOIL. In cases where HR does not have delegated budget holder authority, budget holders will need to be engaged as required.

- If there are errors in the information provided, HR will move to a level one check.

- For instances where a doctor is working off site, such as providing NROC or patient home visits, further guidance on evidence of additional hours worked for ER will be provided. For example, in these instances doctor telephone call log evidence may be used to support the checking process. Until guidance is provided, doctors may not be prevented from completing exception reports on this basis.

Level 1 - Only to occur when the information submitted above provided does not align.

- HR will contact the doctor via email or ER platform to clarify the inaccuracies provided. Guidance will be provided to define the scope of this contact.

- The doctor may then:

  - correct the error and resubmit the ER to HR
  - acknowledge the error and withdraw the ER
  - acknowledge the accuracy of the ER content.

- When errors are rectified, HR will complete the payment/TOIL as per Level 0.
- If the information provided is not satisfactory to progress, HR will move to a level 2 check.

Level 2 - This level is reached only if a doctor states that their ER is accurate (and is continuing to pursue their claim), and HR has rejected its approval as in level 1.

- HR contact the GOSWH to review the exception report.
- The GOSWH may review the submitted evidence and instruct HR to complete the Exception Report at this stage if they believe the evidence is accurate.
- The GOSWH can discuss with HR and may choose to contact the doctor (in-person meeting not required) to discuss the ER.
- If the GOSWH is satisfied following that contact, they instruct HR to complete the ER report as appropriate.
- If the information provided is not satisfactory to progress, the GOSWH will reject the ER.

30. The doctor can choose to withdraw from the ER process at any time, however the ER case data must remain with the GOSWH to allow them to continue in their role and check for potential safety implications and report in their quarterly board reports.

31. Any other contact related to identifiable information related to ER by HR with a doctor's department or practice, or with any excluded individual will incur an information breach fine. The

mechanisms for limiting any other ER related contact outside of the verification process between HR and a resident will be set out during the redrafting of the contract.

32. Queries around patterns of accuracy may be escalated only to the GOSWH. The GOSWH will continue to review the reports as per the current process, to highlight trends or concerns. If during this process HR and the GOSWH have concerns over ER data (not individual ER cases), further checks as per local processes may apply. Please see section on safeguarding public funds for further information.

33. In the temporary absence of an appropriate HR signatory, their ER related duties must be delegated to a nominated HR deputy a member of the GOSWH's support staff or the GOSWH.

34. ER rejections must be recorded on a departmental level in quarterly reports and patterns should be scrutinised and jointly explored by the LNC and employer, to ensure that proper process is being followed.

35. Where an employer is unable to appoint to a GOSWH role they must ensure that alternative arrangements are in place. These arrangements should be jointly produced with LNC and/or RDF and are intended to be interim arrangements with the aim of appointing a GOSWH at the earliest possible opportunity.

Safeguarding public funds

36. As per the current process, the GOSWH will continue to monitor exception reporting data as part of their role. In parallel to the checking hours worked process, all reports will be shared directly with the GOSWH. If, as part of this process the GOSWH has concerns over ER data, including confirming the validity of the reports (to note this process is separate to checking individual reports, which is set out above. Contact via these processes will not incur an information breach fine.

37. If there are concerns with patterns arising in ER data, the GOSWH should take the following steps:

The GOSWH will discuss their concerns with any resident doctor involved to understand the patterns in the reports and ensure that necessary measures are in place to support safe working practices for the doctor.

If following this conversation, the GOSWH has further concerns including, for example, about whether all hours were worked, the GOSWH may ask the resident to nominate a regulated professional to affirm that the claimed hours were worked. The resident may choose to decline. If the nominated professional can verify the claimed hours, this process will conclude.

If the GOSWH has persistent concerns, or the resident declines to nominate, the GOSWH may make contact with a senior clinician in the department to affirm the accuracy of the patterns worked. The GOSWH should make every effort to mutually agree with the resident doctor an appropriate senior clinician to provide relevant information.

If the senior clinician can verify the claimed hours, this process will conclude.

If the senior clinician in the department is unable to verify hours, then the GOSWH can choose to take action to escalate, following local processes and procedures.

38. In the unlikely event there are safeguarding public funds concerns relating to exception reporting, escalation should follow the usual local processes and procedures, such as those outlined in local counter fraud policies.

    The GOSWH should be noted as a key individual within the process and their views should be sought as part of the process.

Local processes (Principle 7)

39. No changes should be mandated that constrain a working local process that enjoys the confidence of the resident doctor workforce and complies with the principles. Such processes may be validated by electronic ballot of the RDF, LNC or equivalent.

Exception report content (Principles 5, 8, 12)

40. Exception report submission must follow a simple, straightforward process that meets agreed accessibility standards. When designing a local system or contracting with a third-party ER provider, compliance with contractual language and guidance must be a factor in the design or choice of provider. Access to ER should be available remotely. Authentication must be user-friendly. ER categories must include at a minimum reports for: an unscheduled early start, an unscheduled late finish, the inability to take contractual breaks, the inadequacy of clinical support, the inadequacy of rostered skills mix, missed educational opportunities, breaches of non-resident on-call patterns, raising concerns of a suspected uncompliant rota pattern, detriment or threat of detriment, information breach, 'access and completion test' and optional free text box. Multiple occurrences in a single working shift should ideally be facilitated in a single form.

41. Mandatory input fields will be limited to: an identifier for the doctor, including name and/or email address (unless auto populated), the date of start of shift incurring exception, name of rota, category of exception, immediate safety concern

(retrospective), the minimum information required to calculate the hours claimed, and choice of payment or TOIL if reporting additional hours worked, with additional mandatory fields requiring mutual agreement from all parties. Further optional fields to add context on review may be agreed in national guidance or agreed at a local level, but such fields cannot be required for completion. Checkboxes and elements of auto population will be encouraged. Systems must be assessed for accessibility and equity in use. NHS Employers and the BMA will engage with software providers on the necessary changes.

Non-resident on call (NROC)

42. All hours worked NROC above what is stated in the work schedule will be subject to ER. If no hours are stated, then all NROC hours are subject to ER. The HR signatory pathway for up to two additional hours in one occurrence is explicitly affirmed as applicable to NROC.

Educational exceptions (Principle 9)

43. Reports of a solely educational nature are sent to DME, or DME deputies. The DME can take action to replace or reinstate any missed educational opportunities. If HR or the GOSWH identifies an educational component in other reports, they must obtain the resident's explicit consent before any communication with the DME. Academic residents with national training numbers/deanery number must have recourse to educational ER if clinical activities impinge on academic time. Employers should encourage departments and practices to roster adequate time for educational and ARCP outcomes. Doctors have the right to exception report for additional hours worked on Quality Improvement and other required activities as outlined in the 2016 TCS.

Monitoring, audit and implementation (Principle 3)

44. Monitoring of the implementation of these reforms will fall to the RDI until the initial implementation phase is concluded and consensus is reached on ongoing oversight. The GOSWH's quarterly reports (including annual summary reports) will be standardised to a national template co-produced in guidance to allow central data processing. Guidance will be provided that specifies the data to be included in these reports, including detriment, the perceived threat of detriment via survey, and confirmed information and access breaches. Quarterly reports must be made available by all employers to agreed national stakeholders, including RDI (or its successor, as per our RDI terms of reference) on completion and made available online to the public as soon as practicable but no later than one month after the report was generated. Quarterly reports must be sent directly to the LNC Chair, at least one nominated LNC resident, and to RDF representatives on completion.

Implementation and review

45. The latest date of full implementation of these reforms for every employer and under any circumstance will be 12 September 2025.

46. Should employers be able to do so, they can adopt the provisions early ahead of this date. Guidance will be produced as quickly as possible, to an agreed publication plan in order to provide information to employers and doctors as soon as is practicable. The RDI group will continue to oversee all monitoring and publications produced until the initial implementation phase is concluded and further ongoing oversight has been jointly agreed upon as per RDI terms of reference. Local monitoring may involve collaboration between employer-based task forces and BMA representatives, for example LNC. These ER reforms will be evaluated by the Department of Health and Social Care, the BMA (represented by the UKRDC), NHS Employers (and employer representatives) and NHS England starting from August 2027, with any resulting changes to contract or guidance requiring all-party consensus.

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Overview report - NHS Staff Survey 2024

Board of Directors Meeting, 07 May 2025

Aspiring to deliver world class patient care

Headlines – results released on 13th March 2025

- Completed questionnaires: 851 (907 in 2023)
- Response rate: 47% (52% in 2023)
- Recommend as a place to work: 74% (75.63% in 2023)
- Recommend treatment to a friend or relative: 92% (94.02% in 2023) one of the best scores in the country

NHS Staff Survey for bank only workers (NSSB) – 2024

- Response rate 23% (no comparison date, 2024 first year) the Trust had the highest response rate by organisation type
- Further details released in April 2025

Organisation Type	TOP	BOTTOM	AVERAGE
Acute and Acute and Community Trusts	35%	8%	19%
Acute Specialist Trusts	23%	12%	16%
Ambulance Trusts	30%	23%	25%
Community Trusts	39%	21%	30%
Mental Health Learning Disability Community Trusts	35%	13%	23%

We are compassionate and inclusive

We are Compassionate & Inclusive	
2023	2024
7.68%	7.67%

We are recognised and Rewarded	
2023	2024
6.26%	6.16%

We each have a voice that counts	
2023	2024
6.89%	6.84%

We are safe and Healthy	
2023	2024
No data	6.47%

We are always Learrning	
2023	2024
5.67%	5.74%

We work Flexibly	
2023	2024
6.43%	6.61%

We are a Team	
2023	2024
7.03%	6.99%

Staff Engagement	
2023	2024
7.35%	7.31%

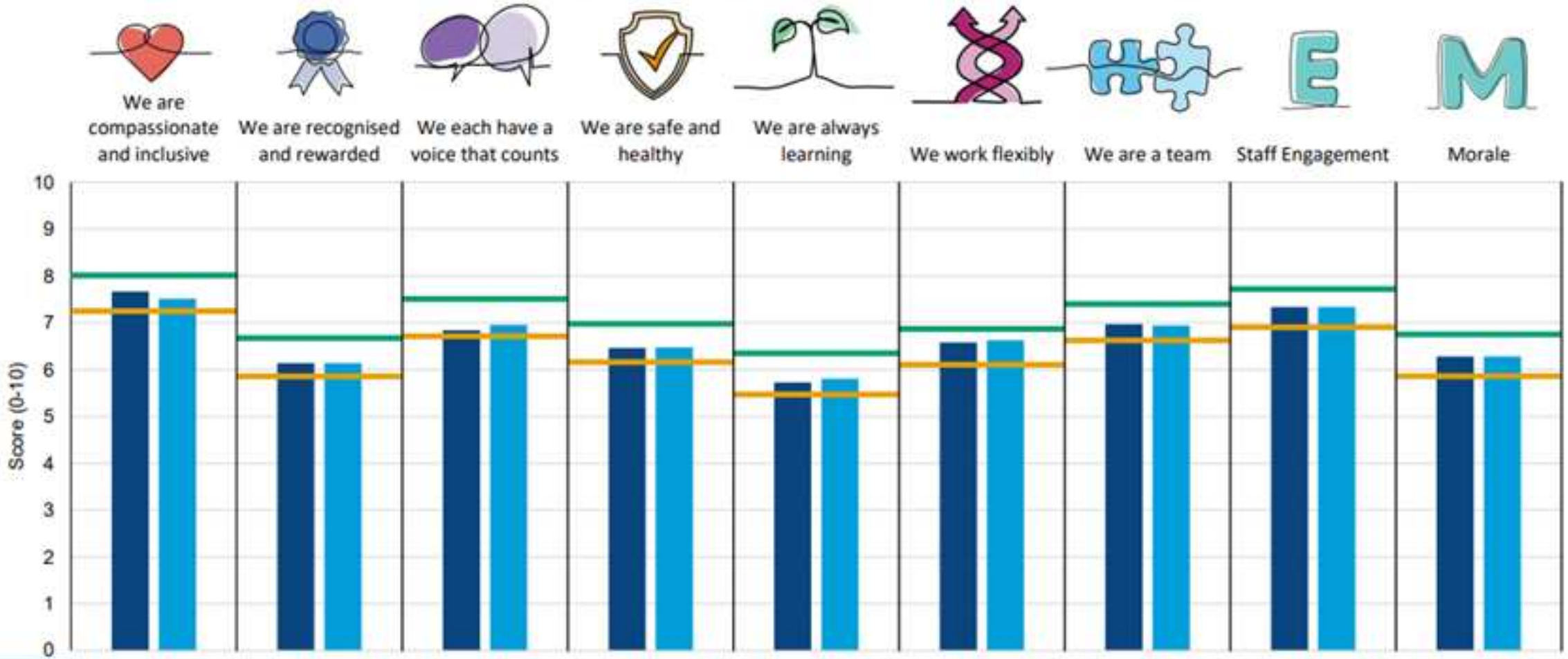
Morale	
2023	2024
6.33%	6.31%

People Promise elements and themes: Overview

Survey Coordination Centre

NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score.**



	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	7.67	6.14	6.84	6.46	5.73	6.58	6.97	7.34	6.28
Best result	8.01	6.67	7.51	6.98	6.35	6.87	7.40	7.72	6.75
Average result	7.52	6.14	6.96	6.47	5.81	6.63	6.94	7.34	6.28
Worst result	7.25	5.86	6.71	6.16	5.47	6.10	6.63	6.90	5.86
Responses	846	848	839	845	818	840	841	848	848

Organisation details

Survey Coordination Centre NHS

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

2024 NHS Staff Survey

Organisation details

Completed questionnaires	851
2024 response rate	47%

Survey details

Survey mode	Mixed

This organisation is benchmarked against:

Acute Specialist Trusts

2024 benchmarking group details

Organisations in group: 13

Median response rate: 57%

No. of completed questionnaires: 17667

For more information on benchmarking group definitions please see the Technical document.

Significance Testing 2023 vs 2024

Appendix B: Significance testing – 2023 vs 2024

Survey Coordination Centre

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2023 and 2024*. For more details, please see the technical document.

People Promise elements	2023 score	2023 respondents	2024 score	2024 respondents	Statistically significant change?
We are compassionate and inclusive	7.68	904	7.67	846	Not significant
We are recognised and rewarded	6.24	904	6.14	848	Not significant
We each have a voice that counts	6.87	894	6.84	839	Not significant
We are safe and healthy	6.48	901	6.46	845	Not significant
We are always learning	5.66	872	5.73	818	Not significant
We work flexibly	6.44	893	6.58	840	Not significant
We are a team	7.04	902	6.97	841	Not significant
Themes					
Staff Engagement	7.37	904	7.34	848	Not significant
Morale	6.33	905	6.28	848	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.
Note: 2023 results for 'We are safe and healthy' are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Next Steps

ACTION PLANNING FOCUS MEETING – BI MONTHLY

SUPPORT FOR MANAGERS ON AREAS OF FOCUS OR CONCERN

AGREE TOP 3 ACTIONS

Executive Summary - Finance & Performance Committee

Assurance

Variation	Will consistently pass the target if nothing changes	Will not consistently pass or fail the target if nothing changes	Will consistently fail the target if nothing changes	No Target or Moving Target
Improving variation (high or low) or 3 months better than target		Outpatient DNA Rate		IJP Activity - Theatres PP Activity - Theatres Total Outpatient Activity - % Moved to PIFU Pathway
No significant change or N/A to SPC			Outpatient Procedures - ERF Scope	Volume of Theatre Cancellations 6 Week Wait for Diagnostics - English Theatre Cases per Session Against Plan Total Outpatient Activity IJP Activity - Outpatients Total Diagnostics Activity against Plan Expenditure Capital Expenditure Value Weighted Assessment
Concerning variation (high or low) or 3 months off target		No of Spinal Injury Patients Fit for Admission Overall BADS %	18 Weeks RTT Open Pathways Patient Waiting Over 65 Weeks - Welsh	English List Size Welsh List Size Patient Waiting Over 52 Weeks - English Patient Waiting Over 52 Weeks - Welsh Patient Waiting Over 65 Weeks - English Overdue Follow Up Backlog 8 Week Wait for Diagnostics - Welsh Total Theatre Activity Against Plan OJP Activity - Theatres Elective Activity Against Plan OJP Activity - Outpatients

Please note - this is defined by the associated SPC graph within the IPR. Many KPIs show as a moving target due to the change of targets/plans as we moved into new financial year and monthly phasing.

Trust Board - Performance
March 2025 – Month 12

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

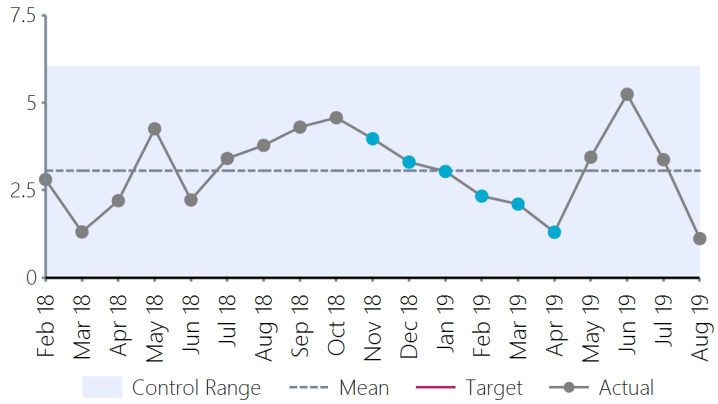
Some examples of these are shown in the images to the right:

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

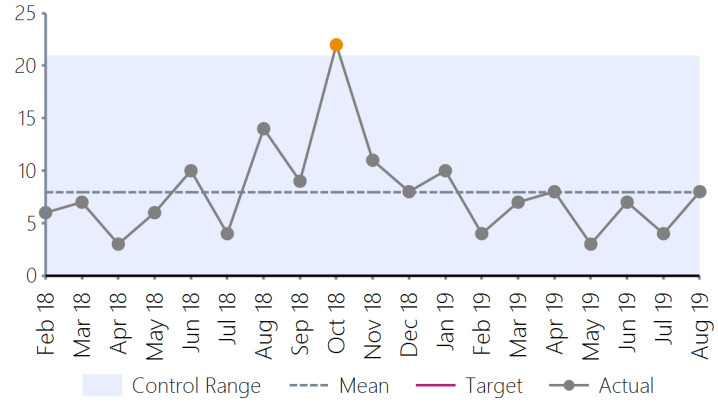
b) shows a point of concern sitting above the control range.

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

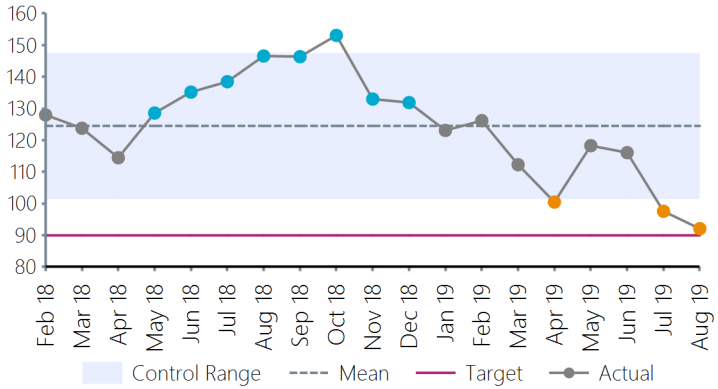
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
31 Day General Treatment Standard*	96.00%	100.00%	100.00%		?		
62 Day General Standard*	85.00%	78.57%	100.00%		?	+	12/09/23
28 Day Faster Diagnosis Standard*	77.00%	97.22%	94.12%		Moving Target		12/09/23
18 Weeks RTT Open Pathways	92.00%	46.14%		L	F	+	24/06/21
Patients Waiting Over 52 Weeks – English	519	882		L	Moving Target	+	24/06/21
Patients Waiting Over 52 Weeks - Welsh (Total)		1,674		H	No Target	+	24/06/21
Patients Waiting Over 65 Weeks - English	0	32		L	Moving Target	+	
Patients Waiting Over 65 Weeks - Welsh	0	1,069		H	F	+	
Overdue Follow Up Backlog	5,697	14,551		H	Moving Target	+	
6 Week Wait for Diagnostics - English Patients	95.00%	91.13%	95.75%		Moving Target	+	04/03/24

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
8 Week Wait for Diagnostics - Welsh Patients	100.00%	97.72%		H	F	+	04/03/24

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Elective Activity Against Plan (volumes)	1,208	1,139			Moving Target	+	24/06/21
Overall BADS %	85.00%	83.65%			?	+	
Total Outpatient Activity against Plan (volumes)	13,910	13,297			Moving Target	+	24/06/21
Total Outpatient Activity - % Moved to PIFU Pathway	6.60%	7.54%		H	Moving Target	+	
Total Diagnostics Activity against Plan - Catchment Based	2,655	2,515			Moving Target	+	

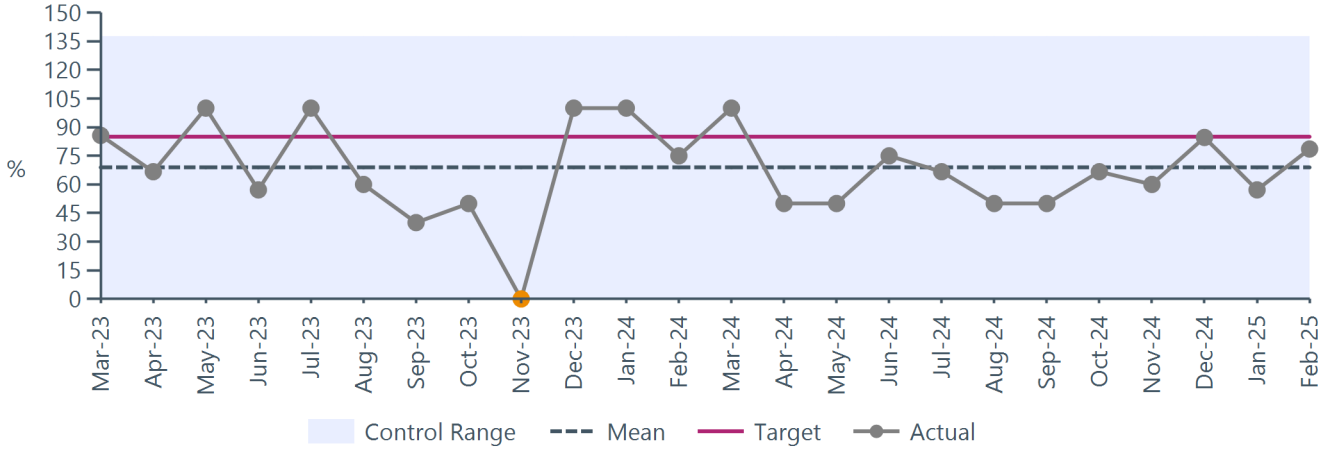
62 Day General Standard*

From receipt of an urgent GP referral for urgent suspected cancer, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer. National Target. Trajectory as per Trust's Operational Plans. 217831

Exec Lead: Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	78.57%		

Trajectory



What these graphs are telling us

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

Narrative

The 62 Day General Standard is reported at 78.57% in February; this is reported in arrears. There were two patients who were reported as breaches this month as they both had complex pathways; one requiring multiple diagnostics, and one requiring complex joint surgery.

Actions

Six-month thematic review is due to be presented at TPOIG.

Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
100.00%	50.00%	50.00%	75.00%	66.67%	50.00%	50.00%	66.67%	60.00%	84.62%	57.14%	78.57%	

18 Weeks RTT Open Pathways

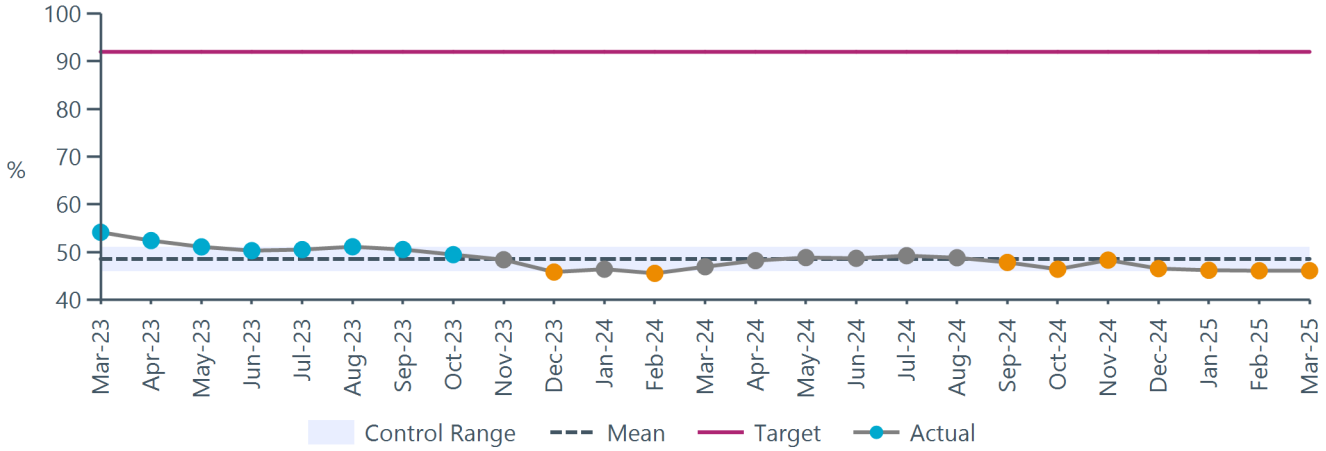
% of English patients on waiting list waiting 18 weeks or less 211021

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
92.00%	46.14%	L	F

Trajectory

Actual
Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. Metric is consistently failing the target.

Narrative

Our March performance was 46.14% against the 92% open pathway performance for patients waiting 18 weeks or less to start their treatment. The performance breakdown by milestone is as follows:
* MS1 - 10377 patients waiting of which 4632 are breaches
* MS2 - 1523 patients waiting of which 1027 are breaches
* MS3 - 5272 patients waiting of which 3589 are breaches

Reduced activity levels since July has impacted services with long waits. Month-end position is inclusive of patients being progressed at mutual aid providers.

2024/25 English National Planning Guidance expectations are for Providers to reach zero 65+ weeks waits. For Welsh patients', national expectations are in reducing 104+ weeks waits and overall long waits for those patients awaiting a new outpatient appointment.

Actions

An intensive improvement programme continues as part of elective recovery supported by GIRFT and NHSE. The Trust is well underway with a revised delivery model. Key delivery themes are: - Clinical pathway transformation; Workforce optimisation; Workforce growth; Non-recurrent backlog reduction initiatives; Improving operational processes.

The Trust will be commencing a validation exercise with an external company in April with a focus on our longest waits. Rheumatology Insourcing due to commence w/c 21 April. Order for additional DEXA scanner now secured and due to be operational from quarter two.

2025/26 planning is now submitted and will be reflected throughout the futures months' IPR. There are three main focuses for 25/26, full details provided in the covering paper.

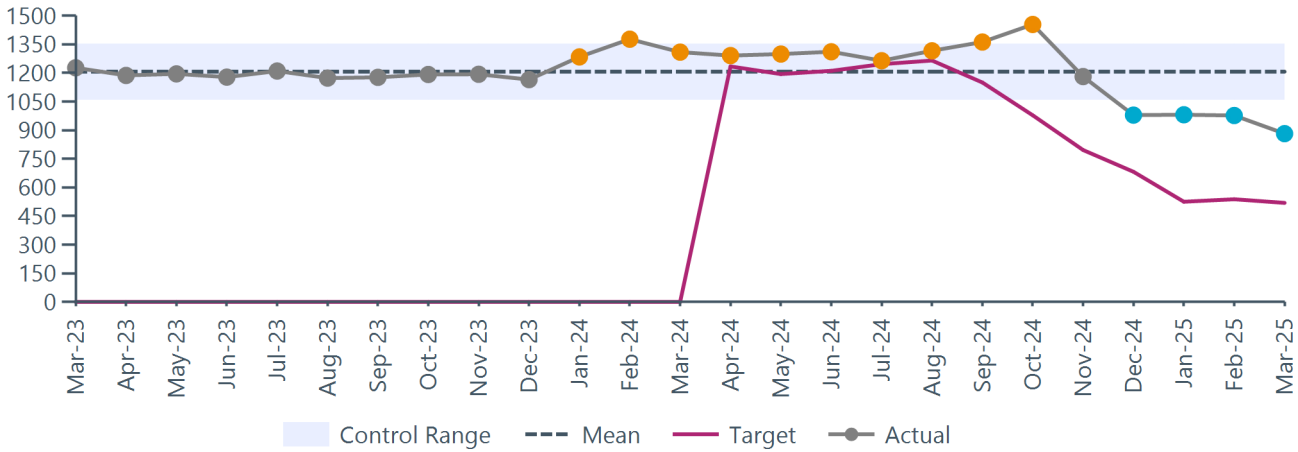
Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
46.96%	48.24%	48.88%	48.73%	49.27%	48.84%	47.86%	46.44%	48.35%	46.57%	46.22%	46.12%	46.14%

Patients Waiting Over 52 Weeks – English

Number of English RTT patients waiting 52 weeks or more at month end. Target as per Trust's Operational Plans. 211139

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
519	882	L	Moving Target



Trajectory

What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric has a moving target.

Narrative

At the end of March there were 882 English patients waiting over 52 weeks; above our plan of 519 by 363. Target reflects the Trust's Operational plans.

The patients are under the care of these sub-specialities; Spinal Disorders (312), Arthroplasty (209), Knee & Sports Injuries (106), Foot & Ankle (75), Rheumatology (64), Veterans (48), Upper Limb (30), Metabolic Medicine (16), Paediatric Orthopaedics (6), ORLAU (4), Orthotics (4), Tumour (2), Physiotherapy (2), Occupational Therapy (2), Neurology (1) and Spinal Injuries (1).

Patients waiting, by weeks brackets is:
* >52 to <=65 weeks - 850 patients
* >65 to <=78 weeks - 28 patients
* >78 weeks - 4 patients

The number of English patients waiting over 52 weeks represents 5.14% of the English list size.

Actions

An intensive improvement programme continues as part of elective recovery supported by GIRFT and NHSE. The Trust is well underway with a revised delivery model. Key delivery themes are: - Clinical pathway transformation; Workforce optimisation; Workforce growth; Non-recurrent backlog reduction initiatives; Improving operational processes.

The Trust will be commencing a validation exercise with an external company in April with a focus on our longest waits.

Focus on clearing sub-specialities with low numbers in month.

2025/26 planning is now submitted and will be reflected throughout the futures months' IPR. There are three main focuses for 25/26, full details provided in the covering paper.

Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
1309	1291	1299	1311	1264	1316	1362	1454	1181	979	981	977	882

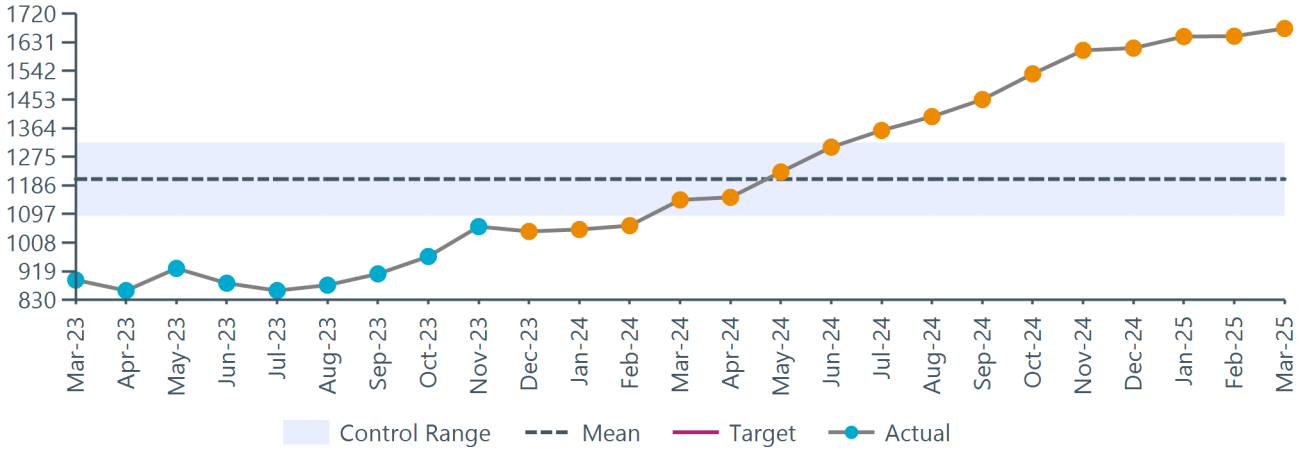
Patients Waiting Over 52 Weeks - Welsh (Total)

Patients Waiting Over 52 Weeks - Welsh (Total) - Welsh and Welsh (BCU Transfers) combined 217788

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	1,674	H	No Target

Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature.

Narrative

At the end of March there were 1674 Welsh patients waiting over 52 weeks. The patients are under the care of the following subspecialties; Spinal Disorders (964), Arthroplasty (376), Knee & Sports Injuries (120), Foot & Ankle (101), Upper Limb (51), Veterans (20), Paediatric Orthopaedics (14), Metabolic Medicine (11), Rheumatology (9), Tumour (3), Physiotherapy (3), Spinal Injuries (1) and ORLAU (1). The number of patients waiting, by weeks brackets is:

* >52 to <=65 weeks - 605 patients
* >65 to <=78 weeks - 415 patients
* >78 to <=95 weeks - 419 patients
* >95 to <=104 weeks - 98 patients
* >104 weeks - 137 patients

Those patients waiting over 52 weeks represents 18.53% of the Welsh list size. Welsh long waiters is experiencing a sustained period of increase, partly due to reduced activity levels since July impacting services. Analysis of Spinal Disorders referrals for Welsh patients identifies a large % increase with 2023/24 23% higher than the previous year. Supporting information included in the covering paper for F&P Committee.

Actions

An intensive improvement programme continues as part of elective recovery supported by GIRFT and NHSE. The Trust is well underway with a revised delivery model. Key delivery themes are: - Clinical pathway transformation; Workforce optimisation; Workforce growth; Non-recurrent backlog reduction initiatives; Improving operational processes.

The Trust will be commencing a validation exercise with an external company in April with a focus on our longest waits.

Discussions continue with Welsh Commissioners to provide clarity on 25/26 targets and expectations.

Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
1141	1149	1228	1305	1357	1400	1453	1533	1606	1613	1649	1650	1674

Patients Waiting Over 65 Weeks - English

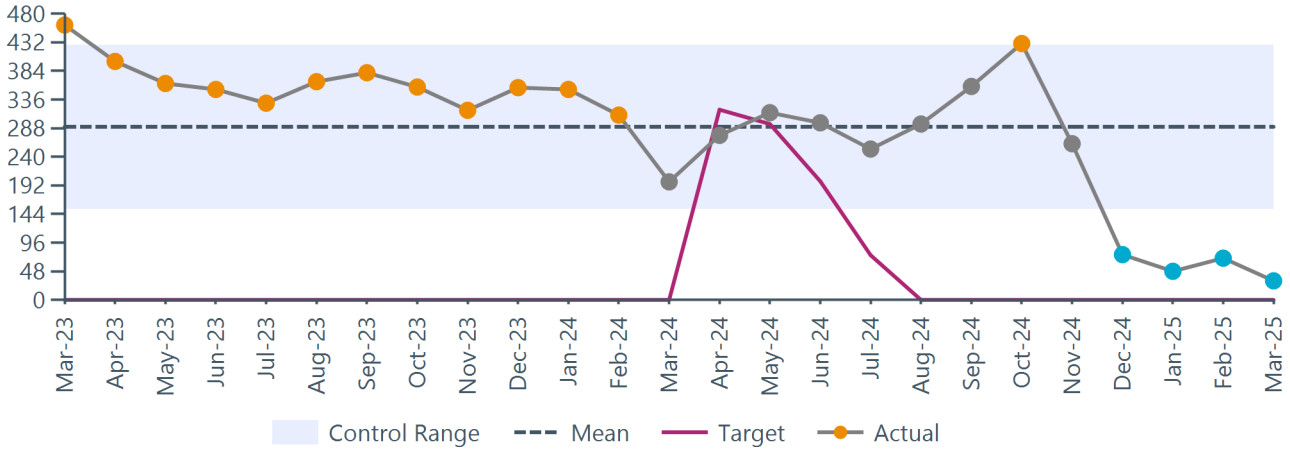
Number of English RTT patients waiting 65 weeks or more at month end. Target as per Trust's Operational Plans. 217858

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	32	L	Moving Target

Trajectory

Actual
Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric has a moving target.

Narrative

At the end of March there were 32 English patients waiting over 65 weeks, of which 12 at mutual aid providers. Target of zero reflects the Trust's Operational Plans. The patients are under the care of these sub-specialities; Spinal Disorders (24), Arthroplasty (3), Knee & Sports Injuries (3) and Foot & Ankle (2). Patients waiting, by weeks brackets is:

* >65 to <=78 weeks - 28 patients
* >78 to <=95 weeks - 4 patients

The Trust is now reporting 78+ weeks to NHSE by exception. At March month end there were four patients, of which 1x patient is at a mutual aid provider with operational pressures (UHNM), 2x patients are spinal disorders patients, 1x patient has moved from a Welsh to English GP.

2024/25 English National Planning Guidance expectations are for Providers to reach zero 65+ weeks waits. For Welsh patients', national expectations are in reducing 104+ weeks waits and overall long waits for those patients awaiting a new outpatient appointment.

Actions

An intensive improvement programme continues as part of elective recovery supported by GIRFT and NHSE. The Trust is well underway with a revised delivery model. Key delivery themes are: - Clinical pathway transformation; Workforce optimisation; Workforce growth; Non-recurrent backlog reduction initiatives; Improving operational processes.

The Trust will be commencing a validation exercise with an external company in April with a focus on our longest waits.

2025/26 planning is now submitted and will be reflected throughout the futures months' IPR. There are three main focuses for 25/26, full details provided in the covering paper.

Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
198	276	314	297	253	295	358	430	262	76	48	70	32

Patients Waiting Over 65 Weeks - Welsh

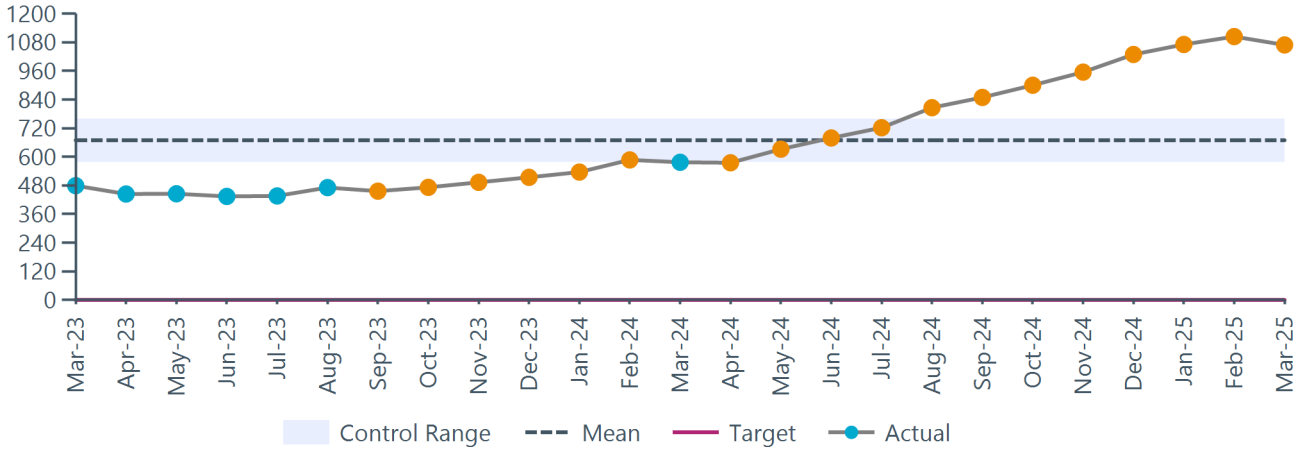
Number of Welsh RTT patients waiting over 65 weeks or more at month end 217859

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	1,069	H	F

Trajectory

Actual
Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature.

Narrative

At the end of March there were 1069 Welsh patients waiting over 65 weeks. The patients are under the care of the following subspecialties; Spinal Disorders (649), Arthroplasty (233), Knee & Sports Injuries (90), Foot & Ankle (61), Upper Limb (15), Veterans (12), Paediatric Orthopaedics (5), Tumour (2), Spinal Injuries (1) and ORLAU (1).
The number of patients waiting, by weeks brackets is:
* >65 to <=78 weeks - 415 patients
* >78 to <=95 weeks - 419 patients
* >95 to <=104 weeks - 98 patients
* >104 weeks - 137 patients

Welsh long waiters is experiencing a sustained period of month on month increases, partly due to reduced activity levels since July impacting services. Analysis of Spinal Disorders referrals for Welsh patients identifies a large % increase with 2023/24 23% higher than the previous year. Supporting information included in the covering paper for F&P Committee.

Actions

An intensive improvement programme continues as part of elective recovery supported by GIRFT and NHSE. The Trust is well underway with a revised delivery model. Key delivery themes are: - Clinical pathway transformation; Workforce optimisation; Workforce growth; Non-recurrent backlog reduction initiatives; Improving operational processes.

The Trust will be commencing a validation exercise with an external company in April with a focus on our longest waits.

Discussions continue with Welsh Commissioners to provide clarity on 25/26 targets and expectations.

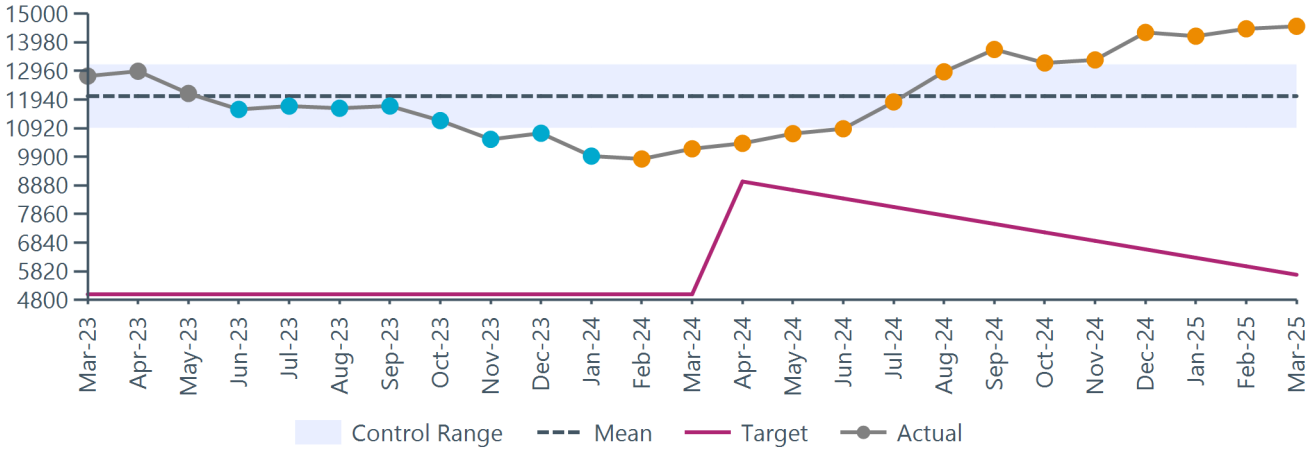
Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
577	575	632	679	722	806	849	900	955	1029	1071	1104	1069

Overdue Follow Up Backlog

All dated and undated patients that are overdue their follow up appointment. Target as per Trust's Operational Plans. 217364

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
5,697	14,551	H	Moving Target



Trajectory

What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. This metric has a moving target.

Narrative

At the end of March, there were 14551 patients overdue their follow up appointment, consistently remaining above target. The target forms part of the Trust's Operational Plans. In recent months the Trust has focused on it's RTT long waits.

This backlog is broken down by:
- Priority 1 – 8821 with 1194dated (13.54%) (priority 1 is our more overdue follow-up cohort)
- Priority 2 – 5730 with 903 dated (15.76%)

The sub-specialities with the highest volumes of overdue follow ups are: Rheumatology (3703), Arthroplasty (2186) and Spinal Disorders (1921).

Actions

The Managing Director of Special Unit recently presented data on overdue follow ups by firm to Trust Management Group and Clinical Leads. The Specialist Unit Managing Director and MSK Unit Clinical Chair will now work alongside Clinical Leads, with support from PMO. A Task and Finish Group has been set up and bi-weekly meetings will commence in April. As an initial action, all consultants have been communicated with in order to seek their input into exploring new ways of working that would assist with this backlog and avoid it growing. Agreement has been reached within Arthroplasty to change their post op routine and move patients to PIFU following their six-week follow up appointment.

The Trust will be commencing a validation exercise with a company that has been used by other Providers within the System to cleanse the waiting list. This is due to begin week commencing 14th April.

Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
10186	10380	10726	10900	11856	12930	13726	13244	13353	14331	14199	14461	14551

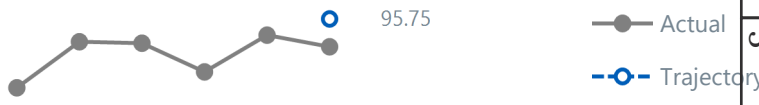
6 Week Wait for Diagnostics - English Patients

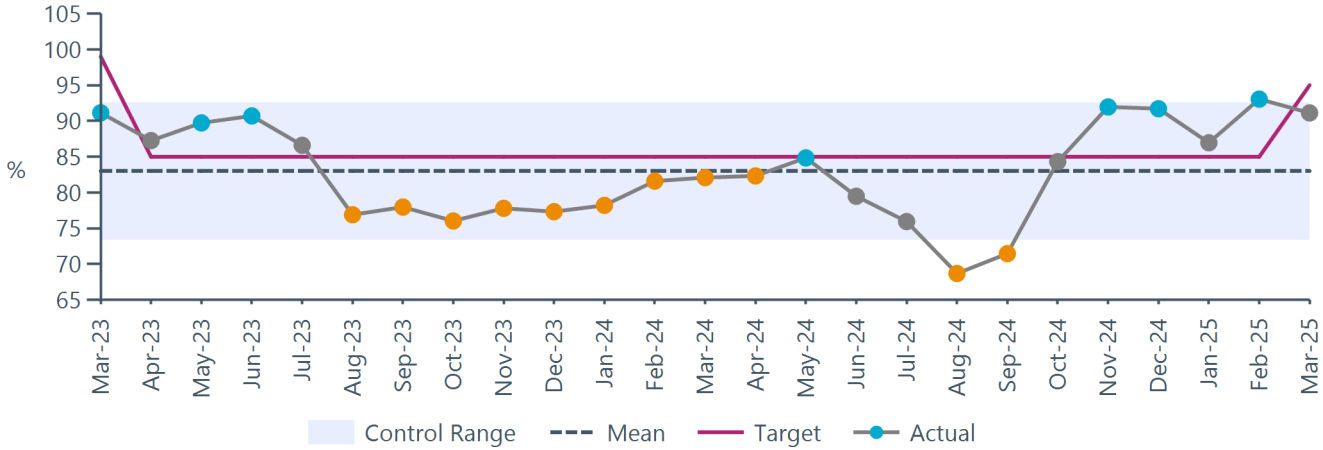
% of English patients currently waiting less than 6 weeks for diagnostics. National Target with Trajectory as per Trust's Operational Plans. 211026

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
95.00%	91.13%		Moving Target

Trajectory





What these graphs are telling us

Metric is experiencing common cause variation. Metric has a moving target.

Narrative

Performance for March is 91.13% against the 95% target. The trajectory for March month end was 95.75%; this reflects the Trust's submitted Operational Plans. Reported position relates to 122 patients who waited beyond 6 weeks. Of the 6-week breaches; 1 is over 13 weeks (MRI).
Performance and breaches by modality:
* MRI – 95.85% - D2 (Urgent - 0-2 weeks) - 6 dated, D4 (Routine – 6-12 weeks) – 27 with 25 dated
* CT – 98.17% - D2 (Urgent - 0-2 weeks) - 1 undated, D4 (Routine - 6-12 weeks) - 1 dated
* Ultrasound – 80.89% - D2 (Urgent - 0-2 weeks) – 2 dated, D4 (Routine - 6-12 weeks) - 84 with 77 dated
* DEXA Scans – 95.45% - 1 dated

None of the modality activity plans were met in March.
National target – 0 patients waiting over 13 weeks by end of September 2024 and 95% against the 6-week standard within all modalities.

Actions

Ultrasound – weekend clinics being utilised to increase activity levels until additional capacity in place from new consultant in mid-May.

MRI – Continued Increase in demand across ICS. Staff shortages have increased agency. ACTIONS - Business case in progress to increase skills mix; due for presentation to Execs in April. Case to increase mobile activity by 68%.

CT- Any opportunities to reduce in-month 65+ weeks wait RTT breaches are being adopted (validation)

Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
82.09%	82.33%	84.85%	79.49%	75.95%	68.69%	71.47%	84.33%	91.97%	91.72%	86.97%	93.07%	91.13%

8 Week Wait for Diagnostics - Welsh Patients

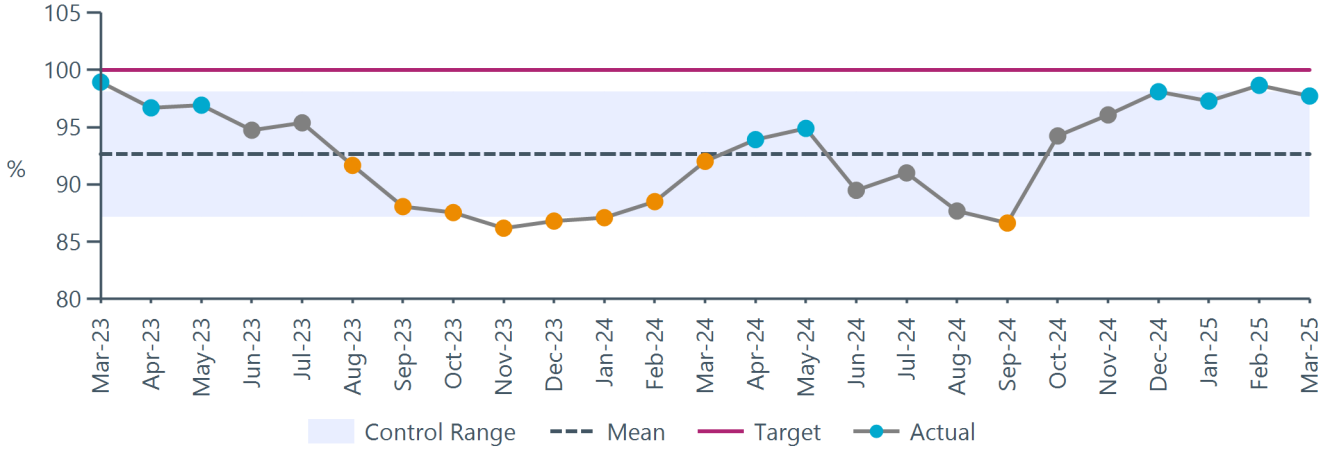
% of Welsh patients currently waiting less than 8 weeks for diagnostics 211027

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
100.00%	97.72%	H	F

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

The 8-week standard for diagnostics is reported at 97.72%. The reporting position includes 9 patients who waited beyond 8 weeks.
Performance and breaches by modality:
* MRI – 98.71% - D2 (Urgent - 0-2 weeks) - 2 dated, D4 (Routine - 6-12 weeks) - 2 dated
* CT – 100%
* Ultrasound – 90.74% - D4 (Routing - 6-12 weeks) - 5 dated
* DEXA Scans - 100%

None of the modality activity plans were met in March.

Actions

Ultrasound – weekend clinics being utilised to increase activity levels until additional capacity in place from new consultant in mid-May.

MRI – Continued Increase in demand across ICS. Staff shortages have increased agency. ACTIONS - Business case in progress to increase skills mix; due for presentation to Execs in April. Case to increase mobile activity by 68%.

CT- Any opportunities to reduce in-month 65+ weeks wait RTT breaches are being adopted (validation)

Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
92.02%	93.92%	94.90%	89.48%	91.01%	87.68%	86.63%	94.24%	96.07%	98.10%	97.28%	98.66%	97.72%

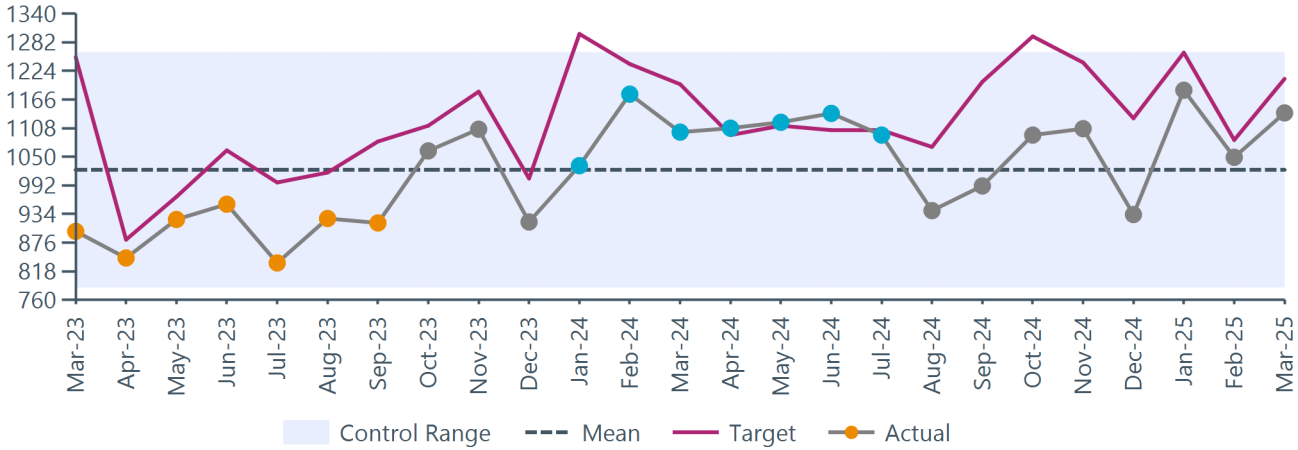
Elective Activity Against Plan (volumes)

Total elective activity rated against plan. Target as per Trust's Operational Plans. 217796

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
1,208	1,139		Moving Target

Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. This measure has a moving target.

Narrative

Total elective activity as reported externally against plan for 2024/25.

The plan for March was 1208 elective spells of which the Trust achieved 1139 equating to 94.29% (69 cases below plan).
Elective spell activity is broken down as follows:
- Elective patients discharged in reporting month following operation - plan was 1004; 863 delivered (85.96%)
- Elective patients discharged in reporting month, no operation - plan was 204; 276 delivered (135.29%)
- Non-theatre activity accounted for 24.23% of elective spells this month; plan was 16.89%.

This metric is reporting normal variation. To note; the original plan included an assumed level of OJP activity and Bank/agency to support performance through workforce availability and flexibility. Following changes to bank enhancement and off-framework agency this support has lessened. The Theatres IJP activity was close to plan in March (99.12%).

Actions

Ongoing review to maintain performance.
* Patients are being treated in Theatre 11 following commencement of TIF2 in November; bookings are becoming routine, and usage is increasing and running according to staffing capacity.
* Commencement of mutual aid by RJAH Consultants being undertaken at Independent Sector providers and logged back to RJAH systems:
- Nuffield Shrewsbury: 22 patients treated in March
- Spire Yale: 15 patients treated March
- Nuffield North Staffs: 4 patients treated in March

Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
1100	1108	1120	1138	1094	941	991	1094	1107	933	1185	1049	1139

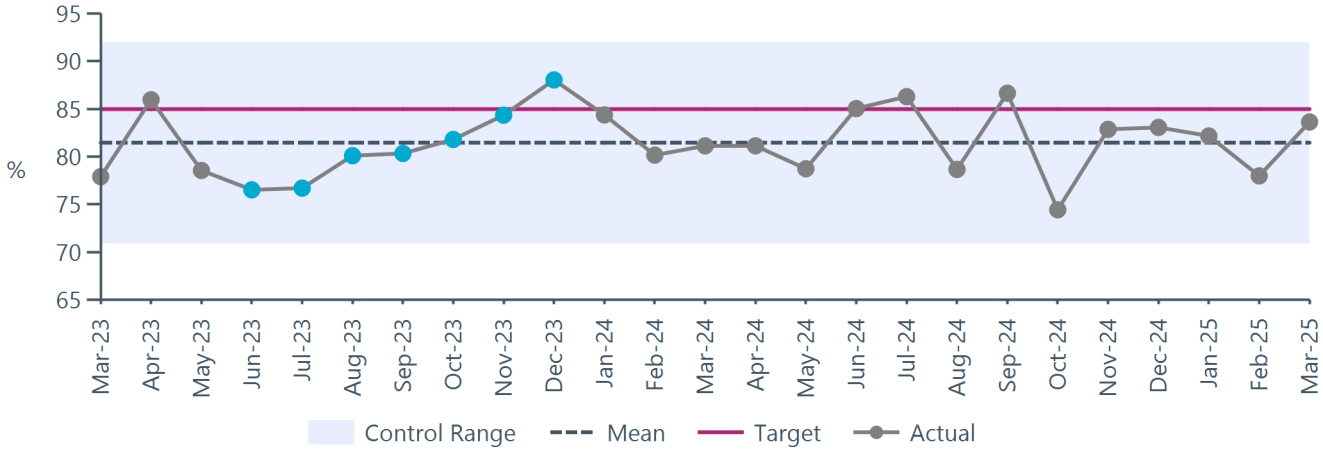
Overall BADS %

% of BADS procedures performed as a day case. National Target. 217813

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	83.65%		

Trajectory



What these graphs are telling us

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

Narrative

BADS %; this measure continues to be monitored against the 85% target set under 2023/24 elective care NHSE planning guidance and reflects the Trusts delivery of day cases against the latest online British Association Of Day Surgery directory of procedures; Orthopaedic and Urology pages.

In March the 85% target was not met and is reported at 83.65%.

Common booking issues continue to impact on the BADS %, which if addressed, would have resulted in achieving target.

Actions

The Trust is aiming for continuous improvements with Clinically led monthly day case surgery meeting. Data quality issues have been identified with Clinical audits and further investigations being undertaken:
* Focus on correct booking of high volume BADS procedures e.g. carpel tunnels.
* Retrospectively corrections being made to obvious data quality errors.
* Clinical Leads to raise correct booking of BADS procedures at team meetings.
There continues to be case by case reviews on day case conversions.

Actions also align to, and support with, the GIRFT recommendation following accreditation as a surgical hub for "A plan and review of clinical pathways that will support the Trust ambition to increase day case rates."

Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
81%	81%	78%	85%	86%	78%	86%	74%	82%	83%	82%	78%	83%

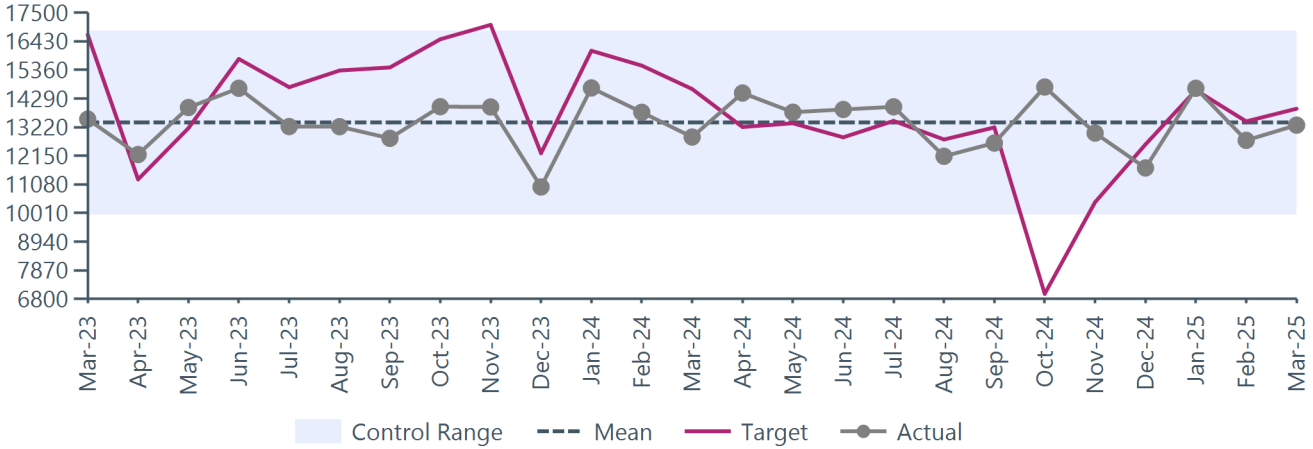
Total Outpatient Activity against Plan (volumes)

Total outpatient activity (consultant led and non-consultant led) against plan. Target as per Trust's Operational Plans. 217795

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
13,910	13,297		Moving Target

Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. This measure has a moving target.

Narrative

Total outpatient activity was 13297 attendances against the Trust's Operational Plan of 13910; equating to 95.59% of plan (-6138 attendances). In March the IJP activity was 100.65% of plan, whilst OJP was at 35.22%. Following changes to bank enhancement and off-framework agency this support has lessened and so the split of IJP/OJP is consistent across most firms.

Some sub-specialities did not meet the IJP plan at 100%.
* In Metabolic Medicine, the plan for this part of year included the assumption that the 2nd scanner would have been in place however the Trust have faced difficulties securing a delivery date. Progress has been made in March and the order is now placed with additional scanner expected to be operational in quarter two.
* Within Paediatrics/Muscle and Spinal Disorders the plan included additional capacity in quarter four that was not in place.
* Activity remained behind plan in Therapies with sickness a contributory factor.

Year to date performance is reported above plan at 107%.

Actions

Assurance of actions and mitigations reviewed weekly at FIG. The Outpatient Activity Meeting continues to meet on a weekly basis to focus on in-month and future month's activity. An expectation has been set whereby in the first week of the month, the current month should be booked to approximately 75%, and the following month to 50% - recognising that there will be different booking practices within firms due to the nature of their activity.

As at 14th April the forecast positions are:
* April – overall Outpatient Activity at 97.12% with IJP at 99.50%
* May – overall Outpatient Activity at 63.51% with IJP at 65.72%

Order of DEXA scanner now confirmed and due to be operational within quarter two. Insourcing for Neurology and Rheumatology expected to begin in April.

Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
12852	14497	13781	13882	13982	12133	12628	14723	13000	11696	14676	12728	13297

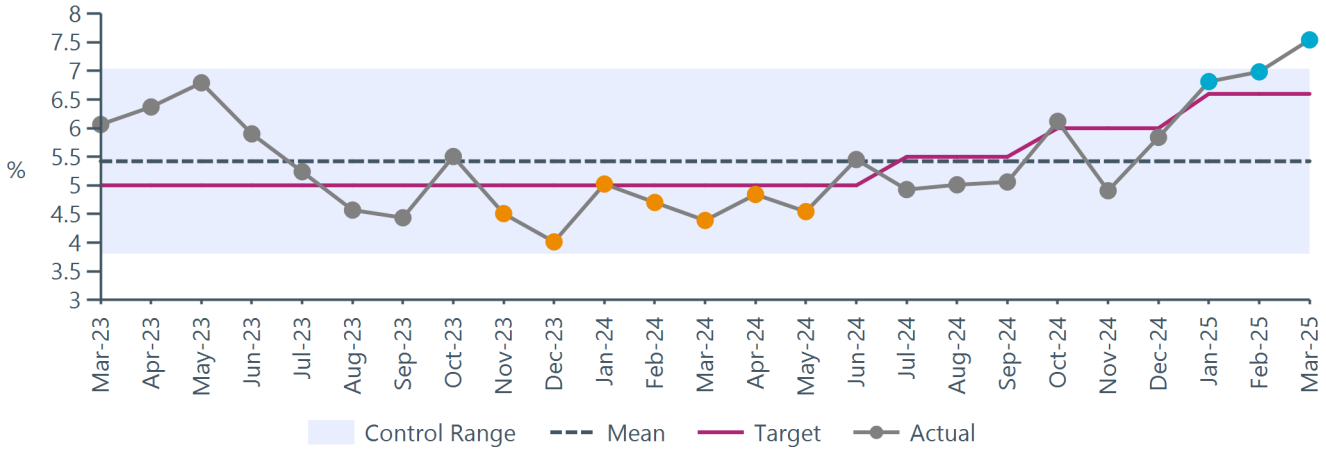
Total Outpatient Activity - % Moved to PIFU Pathway

Total Outpatient Activity - % Moved to Patient Initiated Follow Up Pathway against plan. Target as per Trust's Operational Plans. 217715

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
6.60%	7.54%	H	Moving Target

Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. This measure has a moving target.

Narrative

The target for the number of episodes moved to a PIFU Pathway is 6.60% of all outpatients attendances. In March this was exceeded with 7.54% of total outpatient activity moved to a PIFU pathway. As demonstrated on the SPC above, this is now the highest reported position and displayed as special cause variation of an improving nature.

There has been a significant increase since January due to the metric now including activity carried out at SaTH within Orthotics, Speech & Language Therapy and Dietetics.

Actions

Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
4.39%	4.84%	4.54%	5.45%	4.93%	5.01%	5.06%	6.12%	4.91%	5.84%	6.81%	6.98%	7.54%

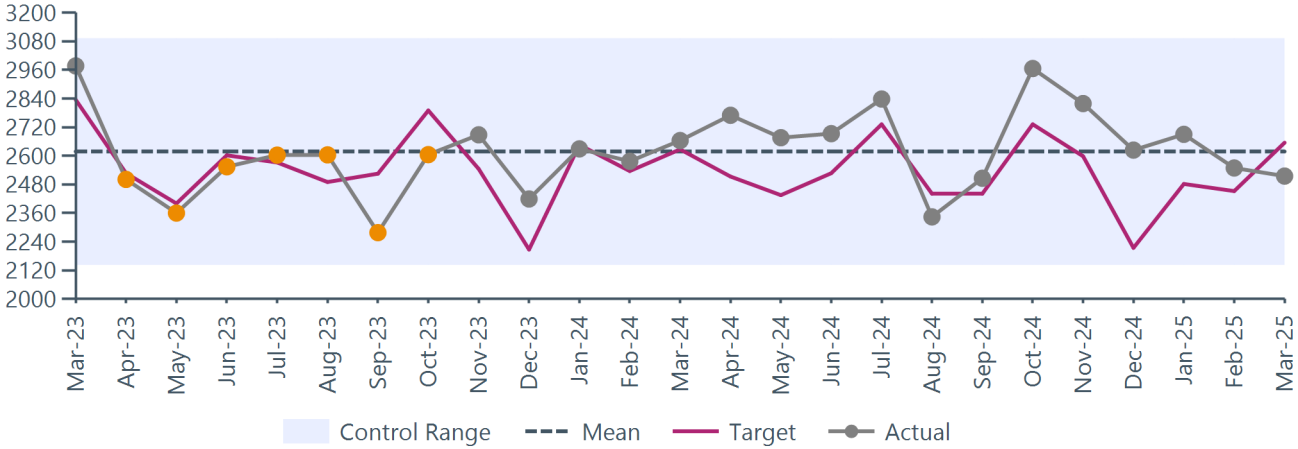
Total Diagnostics Activity against Plan - Catchment Based

Total Diagnostic Activity against Plan - (MRI, U/S and CT activity) against plan. Target as per Trust's Operational Plans. 217794

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
2,655	2,515		Moving Target

Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. This measure has a moving target.

Narrative

The Diagnostic activity plan was not met in March, with all three modalities behind plan. Overall activity is reported at 94.73% with a breakdown as follows:
- CT – 369 against plan of 430; equating to 85.81%
- MRI - 1336 against plan of 1376; equating to 97.09%
- U/S – 810 against 849; equating to 95.41%

Reduced activity levels in Ultrasound had been anticipated due to the volume of annual leave, that in turn, also reduced weekend clinics. Within MRI, there were increased cancellations and lost capacity due to staffing.

Actions

Actions in this area include:
* Ultrasound - weekend clinics being utilised to increase activity levels until additional capacity in place from new consultant in mid-May.
* MRI - Business case in progress to increase skills mix; due for presentation to Execs in April.

Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
2664	2770	2676	2693	2838	2344	2506	2966	2819	2624	2690	2549	2515

Trust Board

RJAH Long Waiters Update

7th May 2025

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Improving lives through excellent and innovative care

2024/25 March and 2025/26 April** Performance

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

		Plan	Actual	Difference
March	English 104+ Weeks	0	0	0
	Welsh 104+ Weeks	-	137	
	English 78+ Weeks	0	4	4
	Welsh 78+ Weeks	-	654	
	English 65+ Weeks*	-	32	32
	Welsh 65+ Weeks	-	1069	

		Plan	Forecast**	Difference
April**	English 104+ Weeks	-	0	0
	Welsh 104+ Weeks	-	145	
	English 78+ Weeks	-	6	6
	Welsh 78+ Weeks	-	690	
	English 65+ Weeks*	-	58	58
	Welsh 65+ Weeks	-	1115	

**Forecast position

Long Wait Updates:

System mutual aid: - Patients transferred from SaTH to RJAH during 2022/23. 2023/24 RJAH supported Shropshire Community. During 2024/25 SaTH utilisation of RJAH Theatre lists have continued.

External mutual aid: - Cannock, Nuffield, ROH, Spire and UHNM continue to support with RJAH long waits.

2024/25 TeMS Rheumatology System Transfer. Patients are now included within RJAH waiting lists.

NHS England 2025/26 plans (next slide) focus on:

- % within 18-weeks
- % waiting for 1st attendance within 18-weeks
- >52 weeks and % of overall waiting list

NHS Welsh commissioners

- Welsh 2025/26 commissioning discussions continue

2025/26 NHS England Guidance RTT Waiting Times

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Operational Planning 2025/26 – Key Elective and Outpatient Metrics

Headline Elective metrics for 2025/26

Reduce the time people wait for elective care

- Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement*
- Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement*
- Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026

*Against the November 2024 baseline, with all providers required to increase their RTT performance to a minimum of 60% and performance on wait for first appointment to a minimum of 67%

IPR Annual Review

Committee / Group / Meeting, Date

- People and Culture Committee – 24/04/2025
- Quality and Safety Committee – 24/04/2025
- DERIC Committee – 24/04/2025
- Finance and Performance Committee – 28/04/2025
- Board of Directors – 07/05/2025

Author:

Name: Mike Carr
Role/Title: Chief Operating Officer

Contributors:

Claire Jones, Principal Analyst & Data Quality Lead

Report sign-off:

Mike Carr, Chief Operating Officer

Is the report suitable for publication?:

Yes

Key issues and considerations:

Discussion and agreement on proposed changed outlined in the paper are required.

Strategic objectives and associated risks:

The Integrated Performance Report provides overall performance oversight to support the delivery of all Trust objectives:

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

System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system.

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

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

Recommendations:

The Board and it's sub-committees are asked to discuss and consider the proposals made in section 3 before implementation into IPR in 25/26.

Report development and engagement history:

Proposed changes that are outlined in this report are a result of discussions with key stakeholders in the Trust such as Unit Managing Directors and Assistant Chief Nurses, Executive Leads of reporting areas and Non-Executive Directors who Chair committees.

Acronyms

IPR	Integrated Performance Report

Appendices

Appendix A	Proposed Executive Summary/Icon Summary
Appendix B	KPIs Reported per Committee

IPR Annual Review

1. Background / Context

This paper provides details on the changes that have taken place in the Integrated Performance Report (IPR) throughout the 2024/25 financial year and references future changes and proposals to be made for 2025/26.

This paper is submitted to all sub-committees, as well as Board of Directors, to ensure full oversight across metrics and committees.

The purpose of the Integrated Performance Report (IPR) is to provide the Board and sub-committees with the evidence of achievement against the national regulatory standards, identifications of key risks impacting our performance and the key initiatives and improvements in place that positively impact our performance.

This paper outlines the changes made to IPR reporting throughout 2024/25 and a number of proposals for 2025/26. Where changes relate to mandated reporting, these will be reflected in month 1 IPR. Due to workload associated with Apollo go live, further changes will then be phased in throughout quarter one reporting.

If approved, proposed changes for 2025/26 would mean volume of KPIs changing as follows:

- People & Workforce – same number of KPIs
- Quality & Safety – 2 additional KPIs
- Performance – 1 additional KPI
- Finance – 2 additional KPIs
- DERIC - tbc

2. Introduction

The principles of the IPR are to ensure it contains the appropriate and focused metrics that allow the Board, and its sub-committees, to seek assurance and instigate actions where required. The metrics included reflect the following:

- Those outlined in the National Oversight Framework
- National planning stipulations
- National reporting requirements
- System reporting requirements
- Those determined appropriate to our organisation

As a result of both national and internal drivers, there have been changes to the IPR throughout the 2024/25 financial year. These are all outlined in the paper below.

The Principal Analyst has carried out a review of the IPR to ensure it meets all the areas stipulated in the NHS Oversight Framework.

In addition to this, Principal Analyst has met with key stakeholders within the Trust and Executive Directors who lead on reporting areas. In addition, the Chief Operating Officer and Principal Analyst have met with the Sub-Committee Chairs to discuss and review each committee-version of the IPR.

3. Summary of Changes Made Throughout 2024/25

3.1 People & Workforce

The table below outlines the KPIs that have been added or removed, in relation to People & Workforce throughout this financial year:

KPIs Added	KPIs Removed
Time to Hire' - based on Vacancy Created to Conditional Offer	

The following reporting changes have been made:

- In Month Leavers
  - Based on annual review last year, target was changed to 12 per month; based on the average throughout 2023/24
  - Rotational staff were removed from data
- Sickness & Staff Turnover – targets aligned to Trust's submitted operational plan
- % of E-Rosters Approved Six Weeks Before E-Roster Start Date – target updated to 90%
- % of System-Generated E-Roster (Auto Rostering) – target updated to 40%

3.2 Quality & Safety

The table below outlines the KPIs that have been added or removed, in relation to Quality and Safety, throughout this financial year:

KPIs Added	KPIs Removed
Number of Compliments	
Number of Patient Safety Reviews	
Medication Errors with Harm	

The following reporting changes have been made:

- Medication Errors – target removed
- RJAH Acquired VTE - data changed to capture all RJAH acquired VTE - not just those within 90 days of surgery

3.3 Performance

The table below outlines the KPIs that have been added or removed, in relation to Performance, throughout this financial year:

KPIs Added	KPIs Removed
Patients Waiting Over 65 Weeks - English	Patients Waiting Over 78 Weeks - English
Patients Waiting Over 65 Weeks - Welsh	Patients Waiting Over 78 Weeks - Welsh
Patients Waiting Over 65 Weeks - Combined	Patients Waiting Over 78 Weeks - Combined
Outpatient Procedures - ERF Scope	Patients Waiting Over 104 Weeks - English
	Patients Waiting Over 104 Weeks - Welsh
	Patients Waiting Over 104 Weeks - Combined

The following reporting changes have been made:

- Overall BADS – this was added to the IPR for F&P, in addition to Board
- As per Operational Planning – targets were changed/aligned for the following:
  - Electives/Theatres activity
  - Outpatients activity
  - Diagnostics activity
  - RTT
  - 28 Day Faster Diagnosis

3.4 Finances

The table below outlines the KPIs that have been added or removed throughout this financial year:

KPIs Added	KPIs Removed
Agency Proportion of Pay Plan	Agency - On Framework
	Agency - Off Framework
	Agency - Insourcing

4. Proposal of Changes for 2025/26

4.1 Overall IPR

Proposed changes that reflect overall IPR:

- **Committee Oversight Dashboard (COD)**
  - This is currently included in the covering papers for F&P and People Committees; proposal to remove this for 25/26
- **Covering Papers**
  - IPR covering papers to continue providing supporting information and analysis to support the exceptions reported within the IPR
  - Remove any duplication that repeats what is already included in the exception pages
- **SPC / Exception Reporting**
  - Arrange for NHSE 'Making Data Count' Team to facilitate a session to support with understanding of SPC and determining exceptions

4.2 People & Workforce

KPIs with proposed changes are outlined below:

- **Time to Hire**
  - The current measure is based on 'Vacancy Created to Conditional Offer'. It is proposed to change this to 'Advertising Start Date to Conditional Offer'.
  - This then mirrors the metric submitted in the PWR. The PWR requests a rolling 3 months whilst the proposal for the IPR is to include the starters from the reporting month.
  - Target proposed at 56 days.
- **Staff Turnover**
  - Current methodology uses headcount, exluding fixed term leavers
  - Revised methodology for this metric, as aleady agreed through System Workforce Group 4th February 2025.
  - The revised methodology will use the following principles:
    - Rolling/cumulative 12-month figure using latest full calendar month's data
    - Calculated using FTE
    - Inclusing all substantive staff (permanent and fixed term) except junior doctors
  - Target will be aligned with Operational Plan
- **In Month Leavers**
  - Current metric includes all leavers in reporting month, excluding medical rotational staff
  - Revised metric to exclude medical rotation staff and those staff that retire and return.
  - Target to be based on 24/25 average (with the new exclusions)
- **Vacancy Rate**
  - At present, Trust wide target is 8%. This also reflects in the metrics for Nursing and Allied Health Professionals.
  - Target for Healthcare Support Workers formed part of the 24/25 Opertional Plan. This is not stipulated in the 25/26 submission; therefore propose target to 8%.
- **Staff Retention**
  - Metric currently reported with no target.
  - Propose target be based on 24/25 actual average; 81.44%.

- **Headcount**
  - Propose the 'Total Headcount in Post' metric is removed from main IPR.
  - Covering paper to include a summary that outlines this position, in line with the PWR submission. Summary would include plan v actual for substantive, bank and agency staff

- **Review of NHS Oversight Framework (NOF)**
  - Review of the metrics outlined in this framework identified the following measures not already reported through IPR:
    - Percentage of Afc 8c and above that are Female
    - Percentage of Afc 8c and above that have a Disability
    - Percentage of Afc 8c and above that are BAME
  - Annual update on EDI is presented through People Committee however, NOF dashboard reports on % Female on a monthly basis therefore committee asked to consider if this should be added as a monthly metric within IPR

- **Sickness Absence**
  - Overall target will be aligned with Operational Plan
  - Short/long term targets will be derived from overall plan, with % split based on actuals reported throughout 24/25

4.3 Quality & Safety

KPIs with proposed changes are outlined below:

- **Complaints**
  - Response rate for Standard complaints changing from 25 days to 30 days
  - Response rate for Complex complaints changing from 40 days to 45 days
  - Already agreed through revised Complaints Policy
  - Proposal to update target on Re-opened complaints – based on average for 24/25 target would be 2

- **PALs Contacts**
  - New KPI to monitor this within IPR. Has historically always been reported at Unit level

- **RJAH Acquired Tissue Viability Incidents**
  - New KPI to monitor this

- **Proportion of Quality/Safety Incidents**
  - Proposal to remove 'C Diff Infection Rates per 100,000 Bed Days'
  - Proposal to remove 'E Coli Infection Rates per 100,000 Bed Days'
    - Monitoring in this way is not comparable with data supplied by NHSE and comparative regional data is discussed at ICB IPC Meetings
  - Where appropriate, supporting analysis to be provided in IPR covering paper showing proportion of incidents in relation to activity levels

From engagement with Clinical leadership, the following two metrics were proposed:

- **% Uptake to MyRecovery of Appropriate Patients**
  - Confirmed there is a data source to add this as a new metric

- **Return to Theatre within 30 Days**
  - Need to explore if able to extract data to add this metric

4.4 Performance

KPIs with proposed changes are outlined below:

- **Activity**

- All activity measures will have targets as per Operational Plan, or derived from the plan

- **RTT**
  - In line with NHSE English expectations, new metrics:
    - Time to 1st Appointment – target of 67%
    - % 52+ Weeks of English List Size
  - In line with Welsh expectations, new metric:
    - Patients Waiting Over 104 Weeks
  - Metrics to be removed from IPR:
    - Patients Waiting Over 52 Weeks – English & Welsh
    - Patients Waiting Over 65 Weeks – English & Welsh
  - List Size metrics to remain
  - Monitoring of Under 18s to be provided as additional analysis in IPR covering paper
  - All targets to be aligned with Operational Plan

- **Cancellations**
  - Current metric includes both on the day cancellations, and those within 7 days of surgery
  - Proposal to revert back to on the day only, as reported in previous financial years
  - Covering paper will continue to provide supporting analysis with a full breakdown of reasons for any reported cancellations
  - Target to be based on 24/25 Q4 run rate

- **Spinal Injury Patients Fit for Admission to RJAH**
  - Current metric reports on the number of patients waiting for admission as at month end
  - Proposed change, to instead report on the average number of weeks waiting for admission

- **Diagnostics**
  - New metric to report on Reports Turnaround Times

- **Outpatients Clinic Utilisation**
  - New metric to report on clinic utilisation – this is not possible from current PAS system so will need to be introduced once stable data available from Apollo

- **% Delayed Discharge Rate**
  - Target review required, taking into consideration planned System improvement that involves beds on Sheldon, alongside MCSI and T&O beds

- **% Bed Occupancy**
  - Current Bed Occupancy metric is based on a manual data collection done at 2pm snapshot each day
  - Following implementation of Apollo, will assess if any new reporting possible from the patient flow section

4.5 Finances

The proposed changes to Finance metrics are outlined in the table below:

New KPIs		KPIs Removed
Agency spend % reduction relative to 24/25	Replacing →	Agency Proportion of Pay Plan
Proportion of temporary staffing as a % of the Trust pay costs	Replacing →	Proportion of Temporary Staff
		Value Weighted Assessment
Bank spend % reduction relative to 24/25		
Performance (£) against elective funding cap		
Performance (£) against Low Value Agreement block		

4.6 DERIC

- Paper went to DERIC committee on 27th February outlining proposed measures for a new IPR specific to this committee
- Currently assessing feedback from that discussion
- Strategies for areas such as Research, Digital and Improvement are currently under review with an aim to finalise by end of quarter one
- Those strategies all include KPIs and measures of success
- Once Strategies are finalised, IPR for DERIC can then align with them and likely to be implemented throughout quarter two

5. NHS Performance Assessment Framework

An updated draft NGS Performance Assessment Framework was published 27 March 2025. The tables below outline the proposed 'high-level delivery metrics' with notes alongside indicating status of reporting within out IPR – colour coded as follows:

Proposed change for 25/26

Already incorporated into IPR reporting / annual reporting

Further assessment required

Not Applicable

2025/26 operating priorities

Subject Area	Metric
Elective care	Percentage of patients treated within 18 weeks – proposed change for 25/26
	Percentage of patients waiting over one year – already included within IPR
	Estimated time it would take to clear the waiting list if no new patients were added – methodology to be determined
Cancer care	Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks – already included within IPR
	Percentage of patients treated for cancer within 62 days of referral – already included within IPR
Urgent and emergency care	Percentage of emergency department attendances admitted, transferred or discharged within four hours – N/A to RJAH
	Percentage of emergency department attendances spending over 12 hours in the department – N/A to RJAH

IPR Annual Review

Finance and productivity metrics

Subject Area	Metric
Financial balance	Planned surplus/deficit Integrated Care Boards and all trusts – already included within IPR/Financial reporting
	Variance year-to-date to financial plan Integrated Care Boards and all trusts – already included within IPR/Financial reporting
	Level of confidence in delivery of financial plan – methodology to be determined
Productivity	Rate of productivity – Finance dept to assess

Public health and patient outcome metrics

Subject Area	Metric
Outcomes	Percentage of patients admitted as an emergency within 30 days of discharge – proposed change to 30 days rather than 28 days currently reported within IPR
	Summary Hospital Level Mortality Indicator – volume of deaths currently reported in IPR – low numbers
Prevention of ill-health	Percentage of inpatients referred to stop smoking services – TBC if applicable to RJAH
	Percentage of patient-facing staff to receive a flu vaccination - already included within IPR – reported seasonally
	Percentage of people waiting over six weeks for a diagnostic procedure or test – already included within IPR

Quality and inequalities metrics

Subject Area	Metric
Patient safety	NHS staff survey raising concerns sub-score - annually reported through committees
	CQC safe inspection score
	Rate of inpatients to suffer a new hip fracture (TBC) – TBC if applicable
	Rate of inpatients to suffer a new pressure ulcer Acute trusts - already included within IPR
	Rates of MRSA, C-Difficile and E-Coli – already included within IPR
Patient experience	CQC inpatient survey satisfaction rate - annually reported through committees
	National maternity survey “looking after you” sub score – N/A to RJAH
	Number of mental health patients spending over 12 hours in A&E – N/A to RJAH
Workforce and people	Percentage of NHS Trust staff to leave in the last 12 months – proposed change for 25/26 – new methodology for turnover proposed that will align with this
	Sickness absence rate – already included within IPR

	NHS staff survey engagement theme score - annually reported through committees
	National Education and Training Survey satisfaction rate – TBC if applicable
Reducing inequality	Percentage of over 65s attending emergency departments to be admitted – N/A to RJAH
	Percentage of under 18s attending emergency departments to be admitted – N/A to RJAH
	Rate of annual growth in under 18s elective activity – to be incorporated into 25/26 IPR reporting

6. Recommendation

The Board and its sub-committees are asked to discuss and consider the proposals made in section 3 before implementation into IPR in 2025/26.

NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
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M12 Financial Position

Improving lives through excellent and innovative care

NHS

I&E Position

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Performance Against Plan £'000s									
Category	Annual Plan	In Month Position			YTD Position				
		Plan	Pass through Adj Actual	Variance	Plan	Actual	Pass through	Pass through Adj Actual	Variance
Clinical Income	143,904	12,396	13,550	1,154	143,904	141,017	(248)	140,769	(3,135)
Private Patient income	8,535	777	1,018	241	8,535	9,930	0	9,930	1,395
Other income	8,609	637	705	68	8,609	15,785	(6,977)	8,808	199
Pay	(97,807)	(8,200)	(8,483)	(283)	(97,807)	(105,002)	6,629	(98,373)	(566)
Non-pay	(52,770)	(4,550)	(4,687)	(137)	(52,770)	(56,864)	1,345	(55,519)	(2,749)
EBITDA	10,471	1,060	2,103	1,043	10,471	4,866	749	5,615	(4,857)
Finance Costs	(8,368)	(745)	(1,368)	(623)	(8,368)	(7,553)	(749)	(8,302)	66
Capital Donations	120	10	129	119	120	229	0	229	109
Operational Surplus	2,223	325	863	538	2,223	(2,459)	0	(2,459)	(4,682)
Remove Capital Donations	(120)	(10)	(129)	(119)	(120)	(229)	0	(229)	(109)
Add back Impairments	0	0	679	679	0	4,779	0	4,779	4,779
Add Back Donated Dep'n	806	74	67	(7)	806	794	0	794	(12)
Add Back centrally procured PPE	0	0	0	0	0	31	0	31	31
Control Total	2,909	389	1,481	1,092	2,909	2,916	0	2,916	7

- **£1,481k surplus in month, £1,092k favourable to plan**
- NHS Clinical Income £1,154k favourable:
  - £610k adverse theatres – 111 NHS cases shortfall
    - OJP adverse – 113 cases (136 historical LLP capacity)
    - IJP favourable - 2 cases (including mitigations of 45 cases)
  - £93k adverse new Dexa scanner slippage
  - £82k adverse outpatients & diagnostics
  - £1,367k favourable additional ERF STW and Spec Comm
  - £606k favourable mitigations (ERF, coding & devices)
- Private Patient Income £241k favourable – driven by activity volumes
- Other Income £68k favourable - driven by dental SLA efficiency recognition
- Pay £351k adverse :
  - £306k adverse net movement in employment provisions
  - £155k adverse TOIL accrual
  - £100k adverse OJP
  - £97k favourable I&I interventions
  - £113k favourable OO LLP
- Non-Pay £66k adverse:
  - £152k adverse year end accruals aligned to agreement of balances
  - £75k adverse EPR Go live slippage
  - £75k favourable OO LLP
  - £69k favourable implants/consumables volumes
- Finance Costs £52k favourable driven by interest receivable & PDC
- Agency spend £142k spend in month, £107k favourable to plan
- **YTD £2,916k surplus, £7k favourable to plan**

Efficiencies

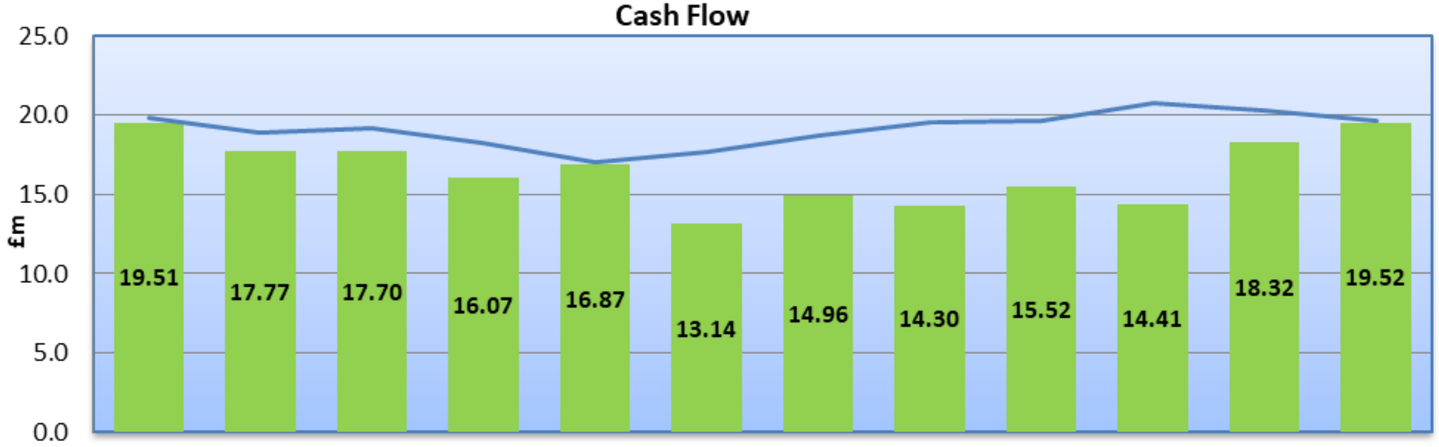
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Category	2024/25 Total Plan £000's	March YTD Plan £000's	March YTD Actual £000's	YTD Variance £000's
Commercial Income	162	162	26	-136
Digital Improvement	7	7	7	0
Drugs Saving	264	264	57	-207
Enhanced Recovery	279	279	279	0
Estates and Facilities	67	67	61	-6
Mattress Hire Savings	135	135	135	0
Other Non Pay	110	110	155	45
Private Patients	1,154	1,154	1,164	10
Procurement	670	670	578	-92
Productivity	845	845	1,810	965
Review of Service Level Agreements	406	406	487	81
Salary Sacrifice	50	50	52	2
Service Growth	570	570	380	-190
Solar Panels Savings	215	215	109	-106
Trainee Nurse Associates	122	122	60	-62
Unidentified	33	33	0	-33
Workforce establishment review	500	500	231	-269
Total Recurrent	**5,589**	**5,589**	**5,592**	**3**
Commercial Income - Non Recurrent	0	0	36	36
Interest Receivable - Non Recurrent	0	0	425	425
Other Non Pay - Non Recurrent	0	0	41	41
Private Patients - Non Recurrent	0	0	909	909
Procurement - Non Recurrent	0	0	60	60
Drugs Saving - Non Recurrent	0	0	294	294
Workforce establishment review - non recurrent	0	0	39	39
Total Non Recurrent	**0**	**0**	**1,803**	**1,803**
Grand Total	**5,589**	**5,589**	**7,394**	**1,806**

- Full year efficiency plan delivered recurrently £5.6m
- Full year non recurrent efficiencies delivered £1.8m supporting the delivery of the overall financial position
- Focus is now on de-risking the 25/26 efficiency programme through completion of all PID's by 30th April and reviewing delivery risks

Cash Position

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Actual	19.51	17.77	17.70	16.07	16.87	13.14	14.96	14.30	15.52	14.41	18.32	19.52
Forecast												
Plan	19.82	18.87	19.18	18.27	17.02	17.73	18.76	19.59	19.69	20.73	20.29	19.66

- Cash increased by £1.2m in month due to receipt of expected PDC capital funding for EPR and receipt of clinical income due.
- The year end cash balance was £19.5m which was just £0.2m below plan.

Capital

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Position as at	2425-12 Capital Programme 2024/25						
Project	**Annual Plan £000s**	**In Month Plan £000s**	**In Month Completed £000s**	**In Month Variance £000s**	**YTD Plan £000s**	**YTD Completed £000s**	**YTD Variance £000s**
Backlog maintenance	400	20	108	-88	400	400	-0
I/T investment & replacement	400	0	-7	7	400	385	15
Capital project management	150	13	12	1	150	149	1
Equipment replacement	935	0	228	-228	935	815	120
Compliance (IPC/health & safety/quality)	300	40	107	-67	300	267	33
Invest to save	300	30	0	30	300	388	-88
New theatre completion	3,400	0	0	0	3,400	3,306	94
EPR implementation	1,000	0	638	-638	1,000	4,056	-3,056
EPR implementation go-live slippage	300	0	-4	4	300	296	4
	250	100	0	100	250	107	143
Donated medical equipment	0	0	121	-121	0	121	-121
Leases (IFRS16)	200	0	33	-33	200	253	-53
Contingency	200	0	38	-38	200	244	-44
PACS/RICS replacement	0	0	412	-412	0	412	-412
Total Capital Funding	7,835	203	1,686	-1,483	7,835	11,200	-3,365
Less donated capital	-250	-100	-121	21	-250	-228	-22
NHS Capital Funding - Charge to CDEL	7,585	103	1,565	-1,462	7,585	10,972	-3,386
Less PDC funded schemes	-1,000	0	-1,050	1,050	-1,000	-4,468	3,468
Charge to System Operational Capital	6,585	103	515	-412	6,585	6,504	82

- Full year capital expenditure of £11.2m was overspent against the original plan by £3.4m. This was funded through additional PDC allocations of £3.1m for EPR and £0.4m for PACs, both of which were fully spent.
- All other capital allocations were spent broadly in line with adjusted plans, with minor underspends totalling £0.1m.

Trust Board - Finance
March 2025 – Month 12

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

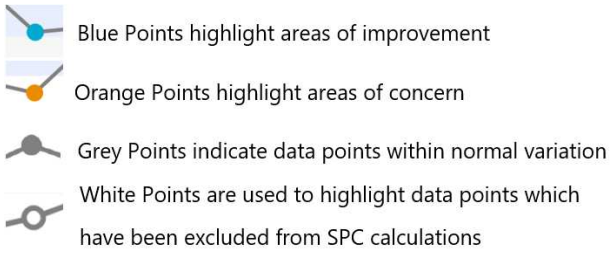
Different colours have been used to separate these trends of special cause variation:

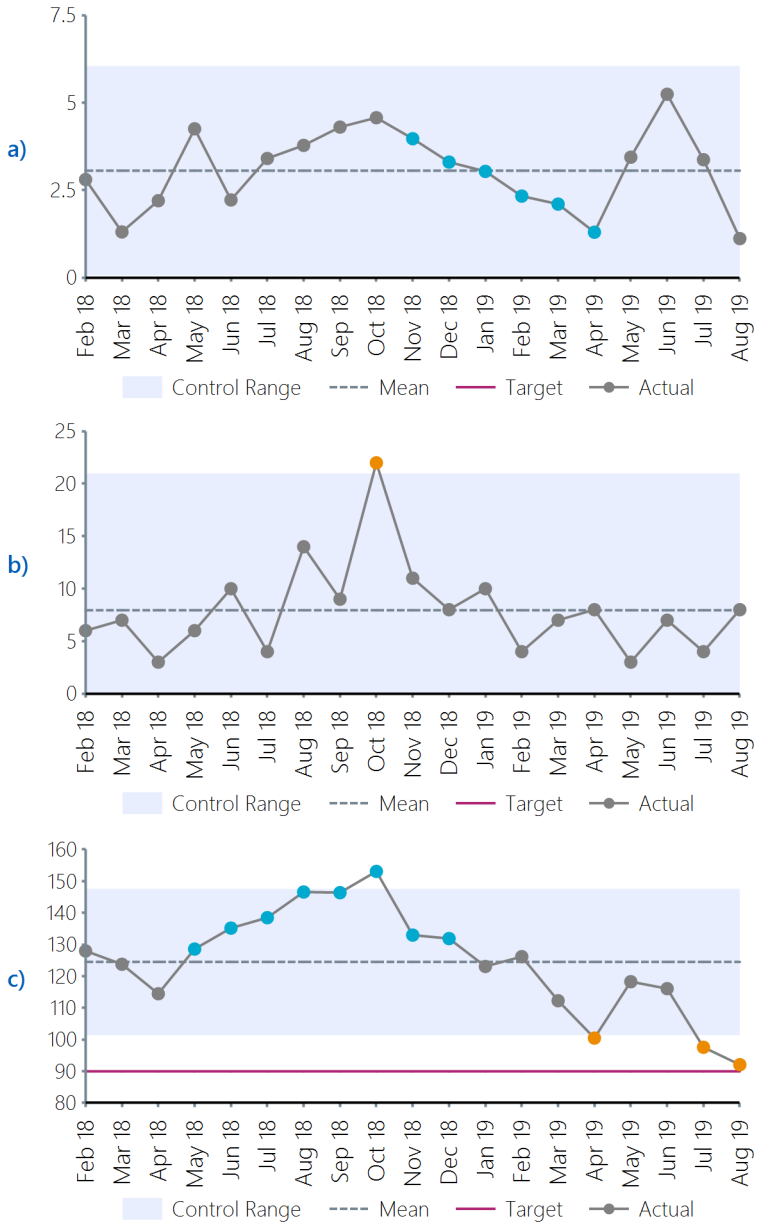
Some examples of these are shown in the images to the right:

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

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

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





Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Finances

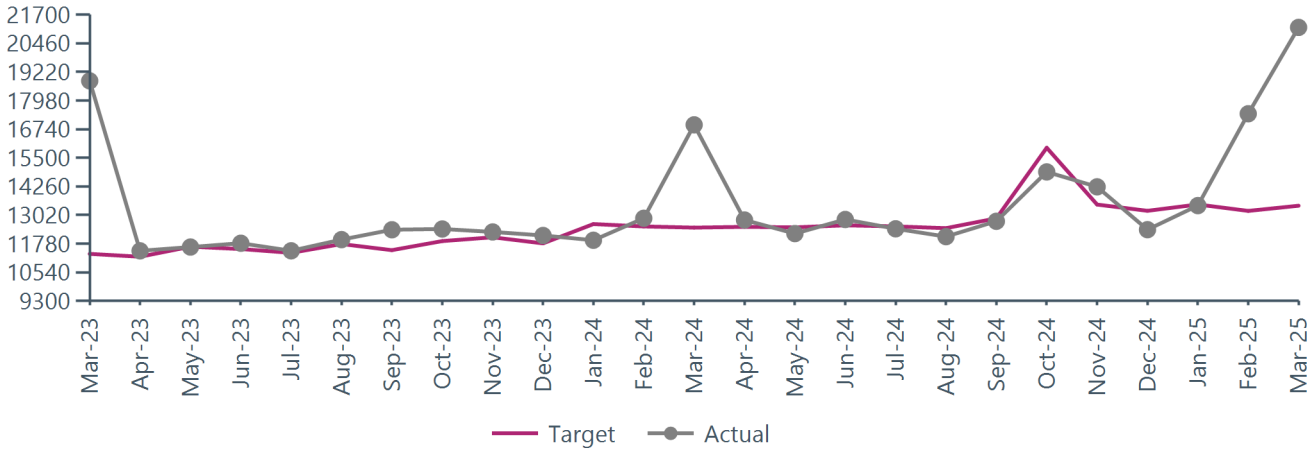
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Financial Control Total	385	1,474.70		N/A to SPC	Moving Target		
Income	13,809.40	22,066.40		N/A to SPC	Moving Target		
Expenditure	13,424.30	21,149.30		N/A to SPC	Moving Target	+	
Efficiency Delivered	613	650		N/A to SPC	Moving Target		
Cash Balance	19,663	19,519		L	Moving Target		
Capital Expenditure	203	1,686		N/A to SPC	Moving Target	+	
Value Weighted Assessment	120.43%	116.38%		N/A to SPC	Moving Target	+	

Expenditure

All Trust expenditure including Finance Costs 216334

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
13,424.30	21,149.30	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Overall expenditure £371k adverse to plan, £6,034k pension pass through adjusted

- Pay position £351k adverse to plan driven by net movement in employment provisions
- Non-Pay position £66k adverse driven by EPR go live slippage
- Finance costs £52k favourable to plan due to depreciation and interest receivable

Actions

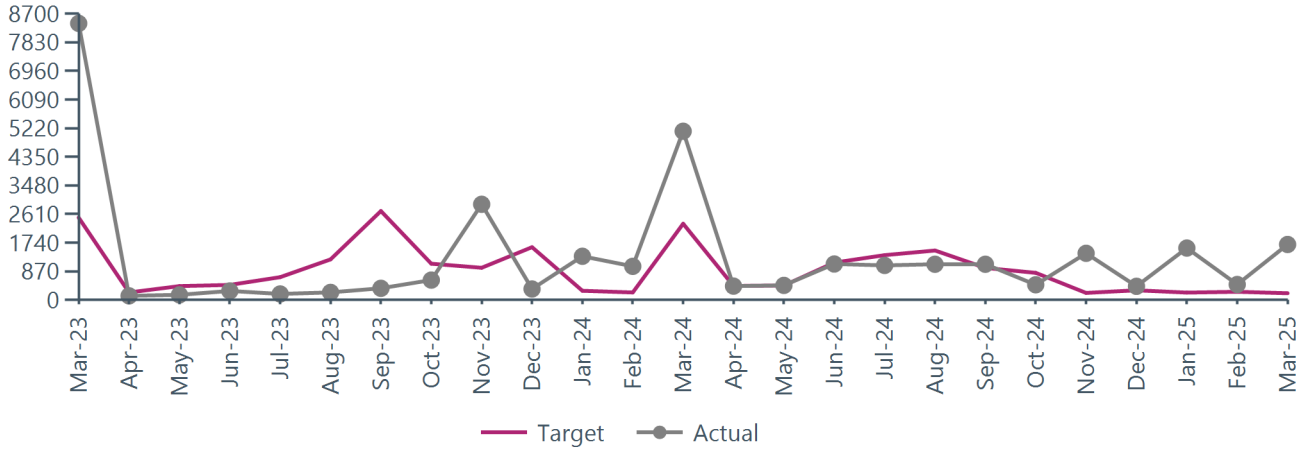
Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
16929	12806	12216	12829	12426	12085	12751	14890	14242	12387	13429	17409	21149

Capital Expenditure

Expenditure against Trust capital programme 215301

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
203	1,686	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Full year capital expenditure of £11.2m was overspent against the original plan by £3.4m, this was funded through additional PDC allocations of £3.1m for EPR and £0.4m for PACs, both of which were fully spent. All other capital budgets were spent broadly in line with adjusted plans, with minor underspends totalling £0.1m.

Actions

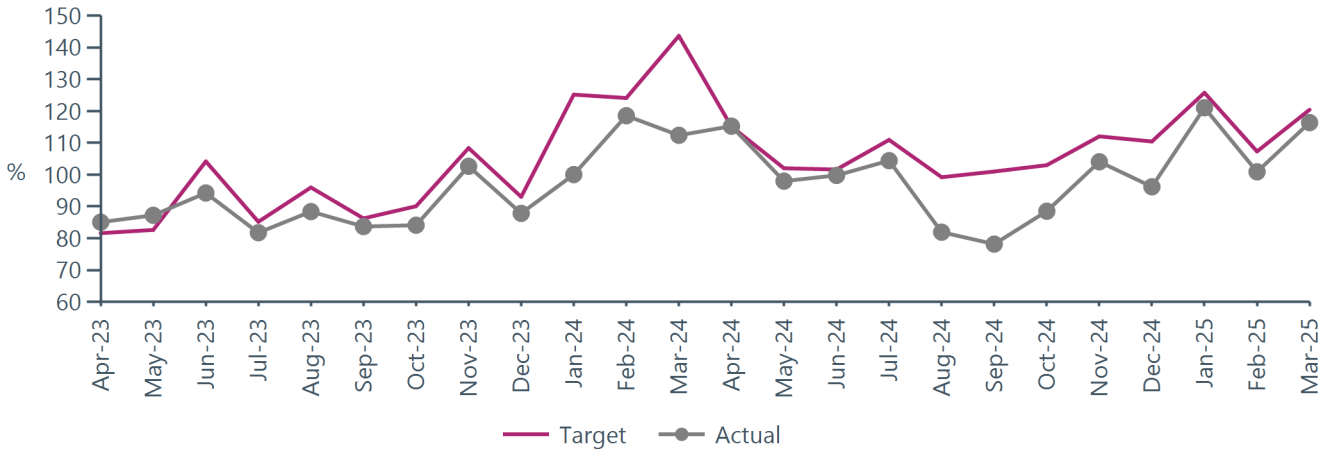
Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
5127	420	443	1092	1049	1085	1085	461	1418	415	1577	469	1686

Value Weighted Assessment

Percentage recovery of patient activity in financial terms from the 2019/20 baseline to in year actual delivery (English only) 217818

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
120.43%	116.38%	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Full year position is 103% of 19/20 baseline against a planned performance of 113%.
Theatre activity shortfalls impacted the full year performance for VWA

Actions

Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
112.40%	115.26%	97.98%	99.79%	104.42%	81.93%	78.18%	88.52%	104.08%	96.21%	121.06%	100.91%	116.38%

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Finance and Performance Committee

Committee / Group / Meeting, Date

Board of Directors, 07 May 2025

Author: **Contributors:**

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Report sign-off:

Martin Newsholme, Deputy Chair of the Finance and Performance Committee
Mike Carr, Chief Operating Officer and Deputy Chief Executive Officer

Is the report suitable for publication?

Yes

1. Key issues and considerations:

The Trust Board has established a Finance and Performance Committee. According to its terms of reference: *"The Board of Directors has delegated responsibility for the oversight of the Trust's financial performance to the Finance and Performance Committee. This Committee is responsible for seeking assurance that the Trust is operating within its financial constraints, and that the delivery of its services represents value for money. Further it is responsible for seeking assurance that any investments again represent value for money and delivery the expected benefits. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board."*

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

This report provides a summary of the items considered at the Finance and Performance Committee on 25 March 2025 and 28 April 2025. It highlights the key areas the Finance and Performance Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

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

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

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

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

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

Assurance framework themes	**Relevant**	**Overall level of assurance**

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

3. Assurance Report from Finance and Performance Committee

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

ALERT - The Finance and Performance Committee wishes to bring the following issues to the Board's attention as they:
Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address, OR
Require the approval of the Board for work to progress.

KPI Proposal 2025/26 (April Meeting) - Report presented to the Board of Directors
The Committee reviewed the submitted paper, which highlighted several proposed changes to Key Performance Indicators (KPIs) as outlined within the Board paper.

3.2 Areas of on-going monitoring with new developments

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

Performance Report; including long waiters update (March and April Meeting)
The committee noted the performance report, including long waiters, and congratulated all teams involved on the latest performance update. The assurance report highlights significant improvements in theatre cancellations, pre-operative planning, and staffing, whilst addressing ongoing issues such as day-of surgery cancellations, waiting times, and late starts.

Corporate Risk Register (March Meeting)
The Committee discussed each risk on an individual basis to gain oversight. There were no concerns to escalate to the Board in relation to the risks however, the Committee requested further assurance on the following as part of the next review:

- The Executive team to review all risks scoring a 12 or higher which have not reported movement over the past 12months.
- Noted that the scores of the risk are reflective of the current position, and this is likely to change throughout the year.

Efficiency Unit Plans (April Meeting)
All targets have been identified, totalling £9.6m. The importance of monitoring progress and addressing issues promptly was emphasised due to the scale of the efficiency plans this year. To provide further assurance on the delivery of the plans, the Committee requested a risk scheduled with emerging risk is to be incorporated into the report.

Service Line Reporting (April Meeting)
The committee noted the Service Line Report update and acknowledged the efforts to improve financial performance and efficiency. The actions agreed upon will enhance transparency and provide valuable insights for future decision-making. To support further papers, the Committee requested the Trust to:

- circulate a detailed explanation of the cost allocation process and its impact on service line profitability.
- to include a benefits tracker in future SLR updates.

Corporate Cost Reduction (April Meeting)
The Trust has been instructed to reduce the NHS infrastructure whole time equivalents back to 2021 levels, resulting in a cost saving of £0.5m included in the final workforce and financial plans. Further guidance from NHSE requires all providers to reduce corporate cost growth by 50% with the base year being 2018/19. The Trust's cost growth from 2018/19-2023/24 is £3.2m, therefore there is a target of reducing corporate costs by £1.6m for 2025/26. The next steps involve identifying SROs and governance, alongside reporting forums. A return needs to be presented back to NHSE by the end of May, requiring a system response that includes reduction and delivery from quarter 3.

Committee Annual Report (inc. self-assessment and terms of reference) (April 2025)
The Committee received the annual report for comments ahead of approval at the Board of Directors. It was noted that there were no issues to escalate to the Board and the Committee.

- requested minor amendments to the survey and self-assessment outputs following minor housekeeping amendments.
- Requested for the Trust to have a discussion with the Chair in relation to the Activity Recovery Committee.

The Committee annual report and terms of reference will be presented to the public Board in July. This is to allow for all assurance Committees to complete their reviews and present to the Board in its entirety.

Operational Plan; April Submission (April Meeting)
An update on the final operational plan submission, focusing on the revised RTT (Referral to Treatment) and 52-week trajectories was presented to the Committee. This included planned interventions to achieve the targets, such as additional Saturday clinics and regional support. The final operational plan submission and the revised 52-week trajectory have been thoroughly reviewed and approved by the Board of Directors. The Trust has complied with NHSE's requests and has planned several interventions to achieve the targets. The Committee requests minor amendments ahead of submission following the meeting.

Salix Decarbonisation Bid (March Meeting)
The Committee approved the bid in principle and looked forward to seeing the business case in the future. The plan presented outlined a clear and structured approach to achieving significant carbon emissions reduction by 2032. The focus on energy emissions, supported by the Carbon Energy Fund and additional solar projects, demonstrates a strong commitment to sustainability and cost-efficiency. The comments from members highlight the importance of timely action and the potential benefits of the proposed initiatives. The Trust's proactive steps towards renewable energy and decarbonisation are commendable and align with broader environmental goals.

Theatre Activity Forecast Including Mitigations (March Meeting)
This report highlights the improvements in the theatre activity forecast, the mitigation efforts undertaken by the Trust, and the overall performance against the plan. The Trust has shown significant efforts in mitigating below-plan activities and has set a positive context for the next year's plan.

3.3 Areas of assurance

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

Financial Performance Report (March and April Meeting)
The Trust ended the year with a £2.9m surplus, which aligns with the planned budget. This achievement is notable given the challenging year. Key highlights include the successful mitigation of insourcing capacity loss, delivery of the efficiency plan, and progress in recovering income from commissioners under ICB billing arrangements. Further assurance was sought on the following on the adverse net movement in provisions, the Trust explained that there is a provision to address an ongoing banding challenge for Healthcare Support Workers due to changes in job descriptions. The Trust is currently unsure how many staff members or how far back this will go however, this work is being undertaken in parallel with System partners to ensure a consistent response.

Capital Plan 2025/26 (March Meeting)

Chair's Assurance Report
Finance and Performance Committee

The capital plan has been thoroughly reviewed and approved the plan which totalled £6.4m. The Trust confirmed that the plan is aligned with the planning submission. This provides a high level of assurance regarding the integrity and reliability of the capital plan.

System Integrated Improvement Plan (March Meeting) – the Committee received and considered elements of the improvement plan within its remit. The committee expressed concerns regarding the actions reported as red without accompanying dates. Certain actions with assigned dates were found to be inconsistent with the planning submission. System oversight and timely action alignment still need improvement.

Business Case and Investment Policy (March Meeting)
The Committee reviewed and approved the business case and investment policy.

The Committee considered the following Chairs' assurance reports:

- **Capital Management Group (March and April Meeting)** - the Trust delivered in line with the capital plan and the positive response for grant funding to build additional solar panels over the patient car park was noted.
- **Financial Improvement Group (March and April Meeting)** - the Committee noted the chair report, there were no issues to raise. The group has continued to support and improve the finance agenda.
- **Activity Recovery Meeting (April Meeting)** – noted that the Activity Recovery Group is still set up as a Committee of the Board but reports via Finance and Performance. The Trust wished to discuss this further with the Board of Directors meeting to ensure the meeting complement one another.
- **Procurement Group (April Meeting)** - the Committee noted the chair report, there were no issues to raise.
- **Veterans Strategy Oversight Group (April Meeting)** - the Committee noted the chair report, there were no issues to raise.
- **Trust Performance and Operational Improvement Group (March and April Meeting)** - the Committee noted the chair report, there were no issues to raise as the report related to March's meeting and actions have since progressed.
- **STW MSK Provide Collaborative Board (March and April Meeting)** – the first meeting started with discussion regarding the terms of reference and key priorities, there were no areas to escalate to the Committee. Going forward there will be more focus over the course of the next 12 months. It was noted that the legal framework is yet to be determined, however providers are accountable for their own performance.

Chair's Assurance Report
Finance and Performance Committee

Recommendation

The Board is asked to:

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

Chair's Assurance Report
Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee

Committee / Group / Meeting, Date

Board of Directors Meeting, 07 May 2025

Author: **Contributors:**

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Report sign-off:

Ruth Longfellow, Chief Medical Officer
Martin Evans, Non-Executive Director, Chair of the DERIC Committee

Is the report suitable for publication:

Yes

1. Key issues and considerations:

The Trust Board has established a Digital, Education, Research, Innovation and Commercialisation Committee. According to its terms of reference: *"The Board of Directors has delegated responsibility for the oversight of the Trust's Digital, Education, Research performance to the Digital, Education, Research, Innovation and Commercialisation Committee. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board."*

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

This report provides a summary of the items considered at the Committee meeting held on 27 March and 24 April 2025. It highlights the key areas the Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

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

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

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

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

The Board Assurance Framework themes overseen by this Committee and the Committee's overall level of assurance on their delivery is outlined in the table below in **bold text**.

The table also identifies BAF themes which are primarily overseen by other Committees but are also relevant to the work of the Committee. Those assurance ratings relate only to those themes as they apply to the remit of the Committee, e.g. assurance on the Trust's ability to create a "sustainable workforce" that can deliver the DERIC agenda.

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

3. Assurance Report from Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee

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

ALERT - The Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee wishes to bring the following issues to the Board's attention as they:
Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address, OR
Require the approval of the Board for work to progress.

Digital Strategy (April Meeting) – reported to the Board of Directors
The Committee endorsed the Strategy and suggested it is recommended to the Board for approval. The strategy was formulated through extensive consultations across the Trust, including various meetings and drop-in sessions with staff and patients to gather their feedback. The vision is to provide the best digital experience for patients and staff, supported by technology to deliver better patient care. The Committee will review the delivery plan including budget requirements at the next meeting and will monitor progress quarterly.

3.2 Areas of on-going monitoring with new developments

ADVISE - The Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee wishes to bring the following issues to the Board's attention as they represent areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives:

ICS Digital Strategy and Peer Review with David Maruta (March Meeting)
The Integrated Care System (ICS) strategy aims to align with national priorities and improve overall system efficiency. The strategy includes key pillars such as frontline digitisation, digital inclusion, interoperability, virtual wards, and cybersecurity. The committee discussed, peer review alignment, data sharing, co-ordination challenges and supply chain vulnerabilities along with an update on cyber assurance framework. A gap analysis will be completed, and the group will conduct a gap analysis based on the National Cyber Security Centre (NCSC) framework to identify areas where controls and capabilities are lacking. This analysis will inform the development of the cybersecurity strategy and the implementation of necessary controls. An update on the progress of working across the system in relation to cybersecurity will be brought back to committee in June.

Corporate Risk Register (March Meeting)
The Committee considered the risk within its remit and confirmed there were no items to escalate to the Board. However, the Committee requested further assurance on;

- The orthotics system related risk is high. The Trust confirmed an overview is being reported through the Quality and Safety Committee.
- The Executive team to review all risks scoring a 12 or higher which have not reported movement over the past 12 months to ensure they are accurately represented, along with the actions needed to address them.
- Suggested reported which risks rely on mitigations outside of the Trust, within the System, and efforts are ongoing to identify these.

Chair's Assurance Report
Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee

Chair Report from EPR Implementation Assurance Meeting (March Meeting)

The Apollo EPR Programme is making considerable progress, with a strong emphasis on critical areas:

- **Staff Training**: Ensuring that all staff members are adequately trained is a primary focus. This preparation is crucial for a smooth transition to the new system.
- **Operational Readiness**: The programme is also concentrating on operational readiness, which involves making sure that all systems and processes are in place and functioning correctly before the go-live date.
- **Post-Go-Live Support:** Plans are in place to provide support after the system goes live, ensuring that any issues that arise can be promptly addressed.

The Trust has expressed confidence in the build and the clinical safety case, indicating that they believe the system is robust and safe for use. Overall, efforts are being made to ensure that all staff are well-prepared for the transition, which should help to minimise any disruptions and ensure a successful implementation.

Chairs Report from Multi-disciplinary Education Working Group (March Meeting)

The Committee emphasised the ambition for the Education Centre, recommending that the group should focus on various educational areas, specifically targeting both undergraduate and postgraduate medical education.

The committee recognised the need to agree with the People and Culture committee which elements of the education strategy report to which committee. It was recognised that there could be real value in DERIC overseeing those areas of the strategy that are closely aligned with the Digital, Innovation, Research and Commercial strategies and the future ambitions and development of the Trust.

Chair Report from Research Meeting (March and April Meeting)

There were no concerns to escalate to the Committee however the Committee noted the following:

- further progress has been made, including an additional 12k improvement in the worst-case scenario and the annual forecast is expecting £63K adverse from plan.
- Efforts are being made to improve transparency in research reporting, with new processes and requirements for starting studies becoming embedded. This has led to an increasing trend in the open publication of trials.

Research Strategy (March Meeting)

The Committee reviewed and agreed to approve the Research Strategy. Some of the key discussion which took place included:

- A proposal for revised research strategic objectives which included clarifying research roles, updating job descriptions to highlight research expectations, and ensuring person specifications reflect a commitment to research.
- An additional KPI within the strategy has been embedded around all consultant appointment person specification to include evidence of a substantive commitment to research beyond publication as a desirable characteristic.
- Discussions took place regarding the Orthopaedic Institute to identify potential mutual benefits. It was felt that an overview of their work should be provided to DERIC to explore potential collaborations, particularly linking to innovation and research.
- A comment was made regarding the four enabling programmes, highlighting that the initiatives for the facility enabling programme were unclear.
- A discussion took place regarding international research, given the Trust's specialist focus.

Innovation and Improvement Strategy (April Meeting)

The strategy outlines primary and secondary drivers to achieve continuous improvement and innovation. It aligns with national directives such as the "Getting the Right First Time" program and productivity benchmarking. The Committee discussed the content and a number of suggestions were made for inclusion.The Committee deferred the approval of the strategy for further work to be carried out in line with discussions, to be reviewed again at the next meeting.

Development of Dashboard KPI's (April Meeting)

The development of the dashboard KPIs is ongoing, with some work already completed. The aim is to integrate this into the monthly papers once finalised.

3.3 Areas of assurance

ASSURE - The Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee considered the following items and did not identify any issues that required escalation to the Board.

Chair Report from Digital Transformation Programme Board
There were no issues to escalate to the Committee - capital bids processes are underway including the orthotics system for next year and new bleeps.

PACs Update (March Meeting)
A verbal update provided assurance that the high risk has been addressed, a new supplier solution is being planned, and a long-term strategy is in development. Furthermore, there is support for creating a specification and options appraisal, and regular updates will be provided to ensure transparency and progress tracking.

Sim Lab Demonstration and Presentation (March Meeting)
A demonstration of the Sim Lab was given to highlight how the interactive training operates. It was agreed that the Sim Lab's work should be integrated into DERIC to support its further development.

Innovation Story – Commercialisation of the Orthotic CCD Lever (April Meeting)
The Orthotic CCD Lever was developed to address the clinical need for stretching devices for patients with contracted muscles. The main challenge was to keep the device open for easy use. The team developed a lever system that disconnects the gas spring, making the device more user-friendly. Initially, an aluminium lever was used, but collaboration with Ricoh led to the creation of a 3D printed version, which enhanced both functionality and appearance. The lever system was commercialised as a kit of parts, which Ricoh now sells, providing a reliable supply for orthotic devices. RJAH receive 2% of the value of each sale. The new system has greatly improved device usability, with around 150 kits sold to date. The team is also working on other devices and potential future collaborations with Ricoh. The Orthotic CCD Lever's development and commercialisation have been successful, with significant improvements in device usability and ongoing work on other devices. The Trust's ownership of the IP and potential future patent protection were clarified, and the importance of marketing and innovation in radiology was discussed. The Committee acknowledged the value of partnerships and the Trust's strategic approach to innovation.

Digital Security Report (April Meeting)
A phishing and spam campaign was conducted just before Easter, which elicited interesting responses. Many employees contacted the payroll department to verify the legitimacy of the emails, indicating good awareness and caution. It was highlighted that the phishing simulation was very realistic and emphasised the need for more such exercises to educate employees about increasingly sophisticated phishing attempts. The analysis of the phishing campaign will be reported to a future DERIC.

Recommendation

The Board is asked to:

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