

**THE ROBERT JONES AND
AGNES HUNT
ORTHOPAEDIC HOSPITAL
NHS FOUNDATION TRUST**

**ANNUAL REPORT AND
ACCOUNTS 2025/26**

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

**Annual Report and Accounts for the
period of 1 April 2025 to 31 March 2026**

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Contents

Annual Report 2025/26

Performance Report	Statement of Chief Executive and Chair	5
	Performance Overview	7
	Performance Analysis	12
Accountability Report	Directors' Report	30
	Remuneration Report	49
	Staff Report	59
	Code of Governance for NHS Provider Trusts	68
	NHS Oversight Framework	73
	Statement of Accounting Officer's Responsibilities	74
	Annual Governance Statement	75

Independent Auditor's Report 2025/26 95

Annual Accounts 2025/26 101

ANNUAL REPORT

2025/26

PERFORMANCE REPORT

Statement from the Chief Executive Officer and Chair

The Robert Jones and Agnes Hunt (RJA) NHS Foundation Trust remains committed to providing world-class orthopaedic care, ensuring our patients receive the highest standards of treatment, comfort, and support. Our continued focus on innovation, excellence, and compassionate care has enabled us to make significant strides in both patient outcomes and the overall experience at our Trust.

The following Annual Report provides a detailed account of our performance throughout the 2025/26 financial year. It highlights our key achievements, the progress we have made against our objectives, our governance arrangements, and a focus on the important aspects of quality and finance that support our success. The full performance report across all these areas can be found within this document.

A real highlight for the year was the publication of our first Care Quality Commission (CQC) inspection report in more than six years. CQC inspectors visited the hospital in May 2025 to take a look at our Surgical and Critical Care services, using their single assessment framework which looks at all key questions. The report came out in October 2025 and saw Surgery retain the 'Good' rating it achieved in 2019. Critical Care demonstrated evidential improvement, having been rated 'Requires Improvement' in 2019 but now being upgraded to 'Good'. The Trust's overall rating remains as 'Good', with care rated as 'Outstanding', which is something about which we are very proud.

This year has marked a significant milestone in our commitment to reducing waiting times and enhancing access to care. At the outset of the financial year, our Referral to Treatment (RTT) performance ranked among the lowest nationally, with approximately 44% of patients receiving treatment within the 18-week standard. The nationally mandated target for the year required us to improve this figure to 60%. While this represented a considerable challenge, we developed and implemented a focused strategy to achieve this goal. By the end of March 2026, we not only met but surpassed the target, attaining an RTT performance of 62.15%. This level of improvement places us among the top performers nationally. Looking ahead, we are committed to sustaining this momentum and further advancing our performance in the coming year.

The progress achieved is particularly noteworthy given the simultaneous rollout of our new Electronic Patient Record (EPR) system, Apollo. Typically, when Trusts introduce a new EPR, there is an inevitable dip in activity as staff adapt to the substantial changes in their workflow. Anticipating these challenges, we implemented proactive measures, which enabled us to not only recover but accelerate activity levels faster than we anticipated. In fact, our current activity has returned to the levels seen at the start of 2020, prior to the onset of the coronavirus pandemic, underscoring the resilience and adaptability of our team.

Although the implementation of Apollo has presented its share of challenges, with several notable setbacks along the way, our team remains committed to ongoing enhancements. Despite these obstacles, we are steadily making progress, and our confidence in the system's future continues to grow. We believe Apollo will evolve as planned and ultimately provide the advantages originally envisioned, positively impacting both patients and staff as it matures.

Finally on performance, it is important to call out the hard work that has culminated in successful delivery of our break-even financial plan for 2025/26. At a time when NHS finances are under more pressure and more scrutiny than ever before that is no mean achievement, and has opened the door to the Trust being eligible for bonus payments from NHS England. We also delivered a £9.6 million recurrent efficiency programme and our lowest Agency expenditure in over five years.

We were delighted to finish the year rated in segment 1 of the NHS Oversight Framework. That rating is applied to trusts considered to be "High Performing", based on a series of performance measures, and is the highest segment rating that can be applied.

Among other notable highlights, we were proud to be named one of only eight Trusts in England delivering results “much better than expected” in the CQC’s Adult Inpatient Survey 2024, which was published in September 2025. This was a testament to the hard work and dedication of our staff. The same report also gave us the distinction of having the cleanest wards and rooms in the NHS for the fifth consecutive year.

Something that we were especially pleased to progress in 2025/26 was a new strategic alliance with our partners at The Royal Orthopaedic Hospital (ROH) in Birmingham. This alliance, sealed by the joint signing of a Memorandum of Understanding, will help us tackle shared challenges and unlock new opportunities to deliver world-class care. In different departments right across the hospital, we already see great examples of where close collaboration with ROH is generating ideas and raising standards to the benefit of our patients. Through this strategic alliance, we will take that further.

It was also pleasing that the organisation was reaccredited for another three years with Veteran Aware status, from the Veterans Covenant Healthcare Alliance. Veteran Aware status signifies the Trust’s commitment to providing the best standards of care to the Armed Forces community, past and present, and their families, based on the principles of the Armed Forces Covenant. We were one of the very first Trusts to get this accreditation when it was launched back in 2018, and by the end of this next three years we will have held it for more than a decade.

Our green agenda also got a boost in 2025/26 as we secured £2.4 million in funding to significantly expand the amount of self-generated renewable energy we produce on site. The money came from Great British Energy (GBE), which has launched a first ever solar investment programme for the NHS, which is providing £100 million to NHS Trusts across the UK. The project included three solar carports in staff and patient parking areas, as well as roof-mounted panels on hospital buildings. Most of these are now completed.

As we look to the year ahead, our focus remains on reducing waiting times, improving patient care, and supporting our staff. We are confident that with continued dedication and the right support, we will meet our goals and provide the high-quality care that RJAH is known for. We are deeply grateful to our staff for their unwavering commitment and to our patients for their trust in us.

We remain committed to achieving even greater things in our mission to be a leading provider of orthopaedic care. Thank you to everyone who has contributed to our success.



Harry Turner
Chair



Stacey Keegan
Chief Executive Officer

Overview of Performance

This section of the report provides an opportunity to highlight some of the considerable work that has been undertaken to enhance the Trust's services and to improve patient care and experience in the last year, centred on our key strategic themes. It also highlights the key risks to the achievement of the Trust's objectives.

Highlights of the year

The Trust had plenty of reasons to celebrate in 2025/26. Here are just a few of our many achievements from the year:

- Surgical and Critical Care services were both rated Good by the Care Quality Commission in an extremely positive inspection report which was published in October 2025. It means the Trust is now rated Good across all of its services, and it rates as 'Outstanding' for care.
- New [league tables](#) published as part of the new National Oversight Framework saw RJAH ranked inside the top 15% of all Trusts in the country. The tables were first published in September 2025 and are updated every three months. RJAH has improved its ranking in every iteration, sitting at 17th out of 134 Trusts in the most recent published version (covering Q4 of 2025/6).
- The Trust received an AMBER/GREEN rating from NHSE in the first "Provider Capability Assessment" under the new National Oversight Framework.
- In the 2024 Care Quality Commission Adult Inpatient Survey, published in 2025, RJAH was named one of only eight Trusts in England delivering results "much better than expected" with the hospital ranking third nationally for overall patient experience and second for overall care and treatment.
- The same report showed that RJAH patient ratings for the cleanliness of wards and rooms were the highest in the NHS for the fifth year in a row.
- RJAH entered into a strategic alliance with our partners at The Royal Orthopaedic Hospital in Birmingham. The two Trusts signed a Memorandum of Understanding that will see them work closely on several key initiatives around delivery, workforce and efficiency.
- A new award celebrating innovation and improvement was introduced in memory of former Interim Chief Nurse and Patient Safety Officer Sam Young, who passed away following a tragic accident. Lisa Davies-Jones, Pre-Operative Assessment Unit Manager, was the inaugural winner of the award in recognition of her leadership on an innovative health screening initiative.
- RJAH was reaccredited – for the second time – with its Veteran Aware status, from the Veterans Covenant Healthcare Alliance (VCHA). Veteran Aware status, which is awarded by the VCHA, signifies the Trust's commitment to providing the best standards of care to the Armed Forces community, past and present, and their families, based on the principles of the Armed Forces Covenant.
- RJAH secured £2.4 million to significantly expand the amount of self-generated renewable energy it produces. The money came from Great British Energy (GBE), which has launched a first ever solar investment programme for the NHS, which is providing £100 million to NHS Trusts across the UK. The project included three solar carports in staff and patient parking areas, as well as roof-mounted panels on hospital buildings.
- The Trust solidified its reputation as a powerhouse in education and training – ranking first in the Midlands and second nationally in the prestigious National Education and Training Survey (NETS).
- Our Enhanced Recovery Programme continued to go from strength to strength – hitting a major milestone as it passed 1,000 patients being discharged on the same day as receiving a new knee or hip.
- Our Paediatric Team earned national recognition – being named winners of the Supporting Patients of their Pathway Award at the prestigious National Orthopaedic Alliance (NOA) Excellence in Orthopaedics Awards. This was for their work on improving pre-admission and procedure experiences for children, a project that has transformed pre-operative services for young patients and their families

Purpose and Activities

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAHH) is one of the UK's five Specialist Orthopaedic Centres. It is a leading orthopaedic centre of excellence with a reputation for innovation.

The Trust provides both specialist and routine orthopaedic care to its local catchment area and nationally. It is a specialist centre for the treatment of spinal injuries and disorders and also provides specialist treatment for children with musculoskeletal disorders.

The hospital has nine inpatient wards including a private patient ward; 13 operating theatres, including a day case surgery unit; and full outpatient and diagnostic facilities.

In addition to the above, the Trust works with partner organisations to provide specialist treatment for bone tumours and community-based rheumatology services.

The Trust is based on a single site in Oswestry, close to the border with Wales. The surrounding geographical area includes Shropshire, Wales, Cheshire, and the Midlands. As such, we serve the people of both England and Wales, as well as a wider national catchment. We also host some local services which support the communities in and around Oswestry. We value our links with the local community, who are strong supporters of the hospital. The Trust has contracts with a number of commissioners.

The highest value commissioner of services from the Trust in 2025/26 was NHS Shropshire, Telford and Wrekin Integrated Care Board. The Betsi Cadwaladr University Health Board was the highest value Welsh commissioner, followed by Powys Teaching Health Board.

Commissioning for our specialised services is undertaken by NHS England.

Brief History and Background

The Orthopaedic Hospital has been in existence as an independent hospital since 1900. It was taken into the NHS in 1948 and achieved NHS Trust status in 1994. In August 2011 the hospital was awarded NHS Foundation Trust status. This means that RJAHH can better shape healthcare services around local needs and priorities and the requirements of commissioners of healthcare.



Sir Robert Jones



Dame Agnes Hunt

The Vision and Goals of the Trust

Our staff want an innovative future for our patients, our colleagues and our communities. We know this because they have told us so in numerous forums. In December 2023, we were delighted to launch our new five-year strategy, which sets out how we will look to begin the journey of delivering that innovative future through to 2028.

We have created a Strategy section on our Trust website, where interested parties can download a copy of the strategy document and also read all about our Strategic Objectives.

A set of strategic objectives were agreed for the period to March 2026. These align with our longer-term strategy (through to 2028) and support delivery of the NHS's ["10 Year Health Plan for England: fit for the future"](#).

The measures of success are:



The work to develop both our strategy and our strategic objectives has been done within the context of the wider NHS landscape. We operate within the Shropshire, Telford and Wrekin Integrated Care System and are a full and active partner within that system. We have also developed partnerships outside of that system, for example with our peers in the National Orthopaedic Alliance. Collaborative working is at the heart of our strategy as we look to the future, and is reflected strongly in our approach.

Our strategy presents us with an exciting opportunity over the next five years to build on what we already have here at RJA, and ensure we continue to grow and continue to thrive long into the future.

Principal Risks

The Trust aims to deliver high quality healthcare services; however, it is recognised that there are inherent risks with providing these services.

The Board Assurance Framework (BAF) captures the risks to delivery of the Trust's strategic objectives. The highest scoring risks captured in the BAF towards the end of 2025/6 related to:

- delivery of the financial plan;
- delivering the required levels of productivity, performance and activity; and
- ability to respond to a significant disruptive event.

Each of the BAF strategic risks are aligned to the Trust and system objectives. Each also refers to the relevant risk appetite target score(s). BAF strategic risk reports include consideration of the controls – including the intended impact of the controls and the level of confidence in those controls; current gaps in those controls - and actions required to address them; the overall risk score – and the rationale for that score. There were no significant changes to the risk profile during the year but the Board has reviewed the BAF as it moves into 2026/7 and has proposed a number of changes of focus. These include:

- A clearer focus on patient experience, as well as the quality and safety of services.
- A focus on addressing inequity of service provision, particularly the disparity between English and Welsh patients.
- A more strategic focus on the development of the workforce, developing a culture that supports innovation and the delivery of transformational change.
- A more strategic focus on financial sustainability, rather than a narrow focus on delivering the financial plan.
- A particular focus on the use of digital technologies.
- A dedicated emphasis on risks relating to digital, data and AI.

More detail on the BAF, including revision to the BAF to reflect the updated strategic objectives, is included within the Accountability Report.

Overview of Financial Performance

The Trust experienced significant financial challenges during the year due to a number of factors including the implementation of a new Electronic Patient Record (EPR) system causing higher than planned activity disruption (loss of income), combined with slippage on consultant recruitment and use of flexible capacity planned to support delivery of the new operating model. While part of the activity income loss is mitigated by direct cost reductions, the reduced contribution earned from core activity generated a financial pressure.

The pressures were mitigated through the efforts of a Performance and Financial Improvement Group (PFIG) which led on the stabilisation and recovery of activity, flexing of the cost base and oversight of enhanced financial controls. This was underpinned by full delivery of a £9.6m (6%) recurrent efficiency programme along with £1.4m of additional non recurrent efficiency.

As a result, the Trust ended the year slightly ahead of the planned breakeven position generating a £64k control total surplus. Achieving plan made the Trust eligible for the receipt of Deficit Support Funding (DSF) provided by NHSE which was a re-distribution of central funding from organisations which did not achieve plans and redistributed to organisations which successfully delivered plan. The additional funding totals £1,638k allowing the Trust to post a control total surplus of £1,702k.

Shropshire, Telford, and Wrekin Integrated Care System continues to be under financial pressure, however due to material recovery in 25/26 the system is no longer in segment 4 of the NHS Oversight Framework and is making progress to delivering a breakeven plan over the medium term. This is important to RJAHS as a partner in the system the Trust and the Trust continues to be committed to

improving the financial position collaborating with partners and leading key areas of development such as MSK Transformation.

Through the strong financial performance the Trust is rated a financial National Oversight Framework (NOF) score of 1 which contributes to the overall score for the Trust.

The Trust has invested £12.0m in the capital programme in year, with notable projects including:

- Decarbonisation/energy improvements aligned to NHS carbon reduction strategy £3.5m (grant funded)
- Critical infrastructure backlog across the site £1.8m (supported through additional central funding)
- Digital infrastructure replacement and improvements £1.7m (including the Go Live of new Electronic Patient Record)
- Surgical improvements and equipment replacement programme £1.6m
- New elective theatre £0.9m (to open in 26/27)
- Rheumatology hub development £0.5m (to open in 26/27)

Cash balances remain healthy at £16.2m which supports the Trust's day to day operating expenses and capital investment.

Going concern disclosure

In accordance with the requirements of the Department of Health and Social Care Group Accounting Manual (GAM), the Trust has prepared its accounts on a going concern basis, applying the 'continuing provision of services' approach, reflecting the anticipated continued provision of the Trust's services (rather than necessarily the financial position of the Trust as a legal entity).

The Trust's cash balances are expected to remain sufficient to meet its working capital requirements for 12 months from the date of the approval of the financial statements. The Trust Board monitors financial performance using the monthly performance report. The key risks to the Trust's financial stability are included in the Board Assurance Framework and are monitored at the Finance & Performance Committee and the Audit & Risk Committee.

The directors having taken assurance from this and, having reviewed future plans and financial forecasts for a period of at least one year, have agreed the following statement: "After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts".

Performance Analysis

Delivery of the Strategic Plan

The Trust has set the following objectives in its five-year Strategic Plan:

- Deliver high quality clinical services.
- Develop our Armed Forces and Veterans Service as a nationally recognised centre of excellence.
- Integrate the MSK pathway within and across Shropshire, Telford and Wrekin.
- Grow our services and workforce sustainably.
- Innovation, education and research at the heart of what we do.

These objectives cover the five years of the Plan, from 2023 to 2028. The overarching strategic objectives are underpinned by more detailed **annual** objectives. Each of these objectives have associated “measures of success”. These are supported by detailed key performance indicators that are reported to the Board of Directors and its committees.

Updates on delivery of these measures of success at the end of 2025/26 are included in the following tables:

Corporate Objectives 2025/26



1

Deliver high quality clinical services



Recognised as outstanding
for quality of care

How we will do it	Measure	Target Date	SRO	Delivery Lead	Progress report as at the end of March 2026
Ensure the highest standards of care for our patients	60% of our wards will achieve a rating of good or above on their Quality accreditation	March 2026	CNO	ACN and Patient Safety Officer	84% of wards and departments assessed have achieved a rating of Good or higher,
	Sign off the Trust's new 3 year patient experience strategy	Sept 2025	CNO	ACN and Patient Safety Officer	Patient experience objectives included within the Quality Strategy
	No Welsh patients to be waiting over 104 weeks for treatment or over 52 weeks for their first outpatient appointment in line NHS Wales government standards	March 2026	COO	MD Specialist Unit	There were 341 patients waiting over 104 weeks for treatment and 1026 Welsh patients waiting over 52 weeks for their first outpatient appointment at the end of March 2026. This objective will be a corporate priority for 2026/27.
	60% of English patients waiting less than 18 weeks from referral to treatment, with less than 1% waiting over 52 weeks in line with NHS England government standards	March 2026	COO	MD Specialist Unit	Our March performance was 62.15% exceeding the Q4 stretch target set at 62.02%. 254 patients were waiting over 52 weeks, this equates to 1.80% of the English list size.
	Maintain top quartile performance for theatre services against Model Health system benchmarking for theatre utilisation.	March 2026	COO	MD MSK Unit	Capped theatre utilisation at end of March 2026 84.0% maintaining top quartile performance.
	67% of English patients waiting no longer than 18 weeks for a first appointment in line with NHS England government standards.	March 2026	COO	MD Specialist Unit	For week ending 29th March 76.05% of patients waiting for first appointment were under 18 weeks; 8.65% above the 67.40% plan.

How we will do it	Measure	Target Date	SRO	Delivery Lead	Progress report as at the end of March 2026
Address health inequalities for our catchment population	Health inequalities data embedded into performance reporting with quarterly board level reporting.	March 2026	COO	Head of Information & Head of Improvement and Business Insights	Inclusion of Health inequalities focus sections within IPR reports that are received by Committees and Board
	Plan services and target investment based on health inequalities	March 2026	COO	MD Planning & Strategy	Targeted additional insourcing provision into rheumatology to address disparity across the STW geographical catchment. Targeted additional paediatric services to reduce waiting times for children awaiting assessment in 2025/26.
	Working with system partners to establish preventative programmes	March 2026	COO	MD MSK Unit	The rollout of the My Recovery programme has supported direct access within primary care, alongside implementation of the Good Boost programme to help patients wait well. This has been complemented by closer integration with local authority weight management and smoking cessation services.
Develop our services through partnership and shared decision-making	Target improvements to reduce variation between departments for shared decision-making outcomes against the 3 reportable domains of listening, understanding and inclusion	March 2026	CMO	Deputy CMO	The performance against each of the domains at Trust levels remains high. The data shows a small percentage of patients scoring under 4. The two service areas with the highest percentage knee & Sports and Upper limb have seen improvements with a reduction in scores below 4 across all 3 domains
Ensure there is an inclusive culture across the Trust	Implement actions to increase staff confidence in arrangements for raising and addressing concerns by end of September 2025, as evidenced by improvement in the staff survey results in the "raising concerns" category relative to the RJA score in 2024.	March 2026	CP&CO	Trust Secretary Freedom to Speak Up Guardian	The staff survey category does not demonstrate improvement against this metric as compared to previous years and will be a corporate priority for 2026/27.
	Implement actions to support our non-white ethnic staff groups by reducing the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months as evidenced in the staff survey results relative to the RJA score in 2024.	March 2026	CP&CO	Associate CP&CO ACN and Patient Safety Officer	The staff survey shows that there has been an improvement in this metric from 29.82% to 13.79%
Recruit, retain and transform our workforce to provide an exemplar experience for our staff and patients	Aligning our enhanced and advanced practice roles to national standards	March 2026	CNO	Nursing & Allied Professions Lead - Workforce	The Advanced Practice workforce review is strengthening governance for advanced and consultant roles and ensuring staff are aligned to national capability standards. Progress to date includes establishing oversight arrangements, analysing the workforce, engaging stakeholders, and putting in place recruitment processes and a generic job description. Next steps are to complete role

How we will do it	Measure	Target Date	SRO	Delivery Lead	Progress report as at the end of March 2026
					analysis, identify education and workforce needs, map service changes, and finalise an action plan.
	Sustain improved staff retention rates for 2025/26.	March 2026	CP&CO	Associate CP&CO	The Trust achieved its target pf 82% with a retention rate of 82.19% at the end of March 2026.
	Actively recruit to substantive staff establishment to reduce reliance on bank shifts.	March 2026	CP&CO	Deputy CP&CO	The Trust achieved its target level of substantive staff in post at the end of March 2026. Month 12 headlines: • Substantive staff in post (excluding Finance adjustments) above plan by 2.62 FTE • Bank over plan by 25.76 FTE • Agency below plan by -4.83 FTE



2

Develop our Veterans Service as a nationally recognised centre of excellence



Centre of Excellence for Veterans rehabilitation

How we will do it	Measure	Target Date	SRO	Delivery Lead	Progress report at the end of March 2026
Veterans strategy in place that sets out the sustainable future model for veterans services.	Veterans strategy to be agreed by October 2025 that sets out: - Clinical model for veterans services based on best practice guidance, supporting their broader wellbeing and social needs. - Demand and capacity assessment for Veterans activity outlining the requirements for each department - Veteran affiliated Workforce plan to reflect capacity requirements - Sustainable financial model and commissioning arrangements	Oct 2025 July 2025	COO	MD Specialist Unit	This objective is being carried over into 2026/27. The Trust is adopting a veteran affiliated approach to surgical recruitment, with successful appointments in 2025/26.
		August 2025	COO	MD Planning & Strategy	
		September 2025	COO	MD MSK Unit	
		September 2025	CF&CO	Deputy CFO	
Develop our veterans rehabilitation pathway	Headley Court Veteran rehabilitation Programme Pilot to commence in December 2025 and be implemented for an 18-month period with monitoring and evaluation throughout the pilot phase to inform future decision making.	December 2025	COO	MD Specialist Unit MD MSK Unit	Preparatory work for the Headley Court Veterans Rehabilitation Programme pilot is complete, with delivery activity commencing in line with revised timescales of May 2026. Monitoring arrangements are in place to support evaluation throughout the pilot period.



3

Integrate the MSK pathways across Shropshire, Telford and Wrekin



Single seamless local MSK service

How we will do it	Measure	Target Date	SRO	Delivery Lead	Progress report at the end of March 2026
Develop a single seamless MSK service working collaboratively with our partners	Establishing RJAHS as the lead provider for MSK services with governance structure in place through the establishment of the MSK provider collaborative board.	March 2026	COO	Assistant Chief Executive	Provider Collaborative governance arrangements continue to mature, with RJAHS operating as lead provider for MSK services.
	Develop a 5 year plan for MSK across Shropshire, Telford and Wrekin.	March 2026	COO	Assistant Chief Executive	STW Trauma & Orthopaedics Clinical Model evolving to provide clear articulation of the future emergency and planned care site roles, alongside a defined end to end patient flow model. Collaborative clinical engagement remains ongoing through the clinical services transformation group, and site visit arrangements are progressing to support operational readiness.
Deliver an MSK service that ensures equity of access and improves population health by meeting the needs of our population	Ensure prioritised waiting list linked to health inequalities and addressing an inclusive approach to access.	March 2026	COO	MD MSK Unit MD Specialist Unit Head of Patient Access	Key developments included targeted service development in collaboration with local authorities, with a particular focus on areas of higher deprivation. Service provision was also mapped against rural isolation to improve coverage across the county. In addition, detailed analysis was undertaken to better understand health inequalities in access to MSST services.
	Improvements in access times for the MSST service appointment by March 2026.	March 2026	COO	MD MSK Unit	Sustained RTT performance improvement through the Further Faster programme.
	Pain service provision to be agreed across STW, inclusive of complex pain service provision.	October 2025	COO	MD MSK Unit	The complex pain service at RJAHS will commence in 2026/27 and the Community pain provision specification for tier 2 level pain services is currently progressing through procurement tender stages by the ICB for planned commencement of services from April 2027
	All Rheumatology patients for STW to be waiting less than 18 weeks for their first	March 2026	COO	MD Specialist Unit	The Trust achieved 97.7% of patient waiting less than 18 weeks for their first appointment at the end of March 2026 a significant improvement in year.



4

Grow our services and workforce sustainably



Outreach of our specialist expertise

How we will do it	Measure	Target Date	SRO	Delivery Lead	Progress report at the end of January 2026
Delivering our services sustainably to meet the needs of our patients.	Increase substantive job planned plan capacity through consultant recruitment, team job planning, and increasing flexible sessions.	March 2026	COO	MD Specialist Unit MD MSK Unit	The Trust has successfully increased its medical workforce in 2025/26 with new job plans including flexible sessions in line with expectations. The workforce plan for 2026/26 includes further recruitment aligned to the theatre development.
	Implementation of outpatient follow up pathway protocols in line with GIRFT and other benchmarked best practice.	March 2026	CMO	Deputy CMO	The Trust has an outpatient transformation programme in place following dedicated GIRFT support to benchmark Trust practices. This programme will continue into 2026/27
	Spinal Disorders delivery model agreed that sets out the sustainable clinical, workforce and financial future model	August 2025	COO	MD Specialist Unit	Progress has been made against this objective in 2026/27 working at Regional and local level. At system level, the Trust has focused on SPOA spinal pathways to manage demand, MDT approach to service delivery with recruitment into AHP posts.
	Meet the Trusts Cost Improvement programme efficiency target of 6%.	March 2026	CF&CO	MD Specialist Unit MD MSK Unit Corporate Directors	The Trust achieved its efficiency plan in 2025/26. Full year £10,941k efficiencies achieved, £1,347k favourable to plan
Develop our commercial and business strategy to enable services to thrive	Commercial Income strategy to be signed off.	December 2025	CF&CO	Deputy CFO MD Planning & Strategy	Commercial strategy with draft shared at DERIC committee in December 2025. This will be developed further in 2026/27 following the commencement in post of the newly appointed Commercial Director.
	Recruit and develop the skills and resources required to strengthen commercial and business expertise within the organisation.	March 2026	CF&CO	Deputy CFO MD Planning & Strategy	Successful appointment into Commercial Director role due to commence in post in Q1 2025/26.
	Deliver the planned level of private patient activity growth for 2025/26.	March 2026	COO	MD MSK Unit	The Trust increased private patient activity in 2025/26 as compared to previous year but did not fully achieve the planned private patient income as set out in the plan, £889k adverse full year.
Expanding our reach and specialist expertise to other providers and sectors	Provision of speciality leadership for orthopaedics to input into the governance and assurance of existing Powys Teaching Health Board delivered orthopaedic activity.	June 2025	CMO	Deputy CMO	RJAH speciality lead clinical leadership for orthopaedics for Powys Teaching Health Board commenced in June 2025 with immediate service benefits recognised
	Joint Orthopaedic Consultant post appointment with Powys teaching Health Board outreaching into Llandrindod Wells Hospital.	September 2025	COO	MD MSK Unit	This post has not commenced in 2025/26 with MSK Unit working with the Specialty lead to secure the workforce capacity.

How we will do it	Measure	Target Date	SRO	Delivery Lead	Progress report at the end of January 2026
	Utilising the Memorandum of Understanding with Royal Orthopaedic Hospital to collaborate and identify shared objectives and enable particular project workstreams to be delivered collaboratively.	March 2026	CEO	Managing Directors & Corporate Directors	MOU between ROH and RJA setting out their strategic alliance. Board session in March 2026 sharing activities completed to date with priority workstream for 2026/27 being finalised.



5 Innovation, education & research at the heart of what we do



Hospital University level
education, research and
innovation

How we will do it	Measure	Target Date	SRO	Delivery Lead	Progress report at the end of January 2026
Create the cultural environment to promote continuous Improvement	Over 50% of all staff to have received quality improvement training	March 2026	COO	Head of Improvement and Business Insights	At the end of March 2026, 37.17% of all staff have received a "dose" of improvement training. QI training available Trust wide with CPD accredited courses. QI dosing is to all levels i.e. board development and at Induction.
	Utilisation of the Clinical Innovation fund to implement Innovation initiatives.	March 2026	CF&CO	Deputy CFO	Introduction of robotic surgery at RJA for spinal surgery and arthroplasty.
	Increased engagement by all professions with the Trust's Innovation Club.	March 2026	CMO	Head of Improvement and Business Insights	The Trust reviewed it's in year approach to increasing engagement across the Trust with a focus on expanding the Innovation Hub. RJA has an 'Improvement Hub' consisting of both clinical & non-clinical staff. The Trust's 'Improvement Hub' team delivers improvement training and improvement project support.
Enhance Leadership and Management capabilities	Deliver the Internal leadership programme to 5 additional cohorts in 2025/26	March 2026	CPO	Associate CP&CO	The Trust has delivered it's the training programme to 5 additional cohorts for staff ion 2025/26.
	Develop a Trust competency framework for all management posts within the organisation.	November 2025	CPO	Associate CP&CO	This metric was set out prior to the national guidance, and whilst activities are progressing the timeline for achievement of this target has been aligned to the NHSE programme.
Enhance capability and opportunities for research across all professions	Increase the number of patients being offered participation in research to 1.8% of total patient episodes.	March 2026	CMO	Research Manager	2024/25 = 1.9% of total patient episodes 2025/26 = 5.7% of total patient episodes The increase in the number approached was due to two retrospective data collection studies that each looked at data from a large number of patients.
	Increase the number of studies developed to full grant application by 5%.	March 2026	CMO	Research Manager	The Trust has developed 12 grant application to full application during 202526.

How we will do it	Measure	Target Date	SRO	Delivery Lead	Progress report at the end of January 2026
	Increase the number of peer reviewed publications by 5%.	March 2026	CMO	Research Manager	In 2025/26 there were 82 peer reviewed publications as compared to 77 in 2024/25. This is a 6.5% increase. It should be noted that this does not give an indication of when the research had been carried out.
Optimise the potential of digital technologies to transform care and improve outcomes	Full implementation of Radar Healthcare to provide comprehensive quality management system.	March 2026	CNO	ACN and Patient Safety Officer	Digital transformation continues with progress on Radar Healthcare, Power BI reporting, and preparatory work for ambient AI in outpatient services.
	Implementation of power Business Intelligence solution.	March 2026	COO	Head of Information	Business Intelligence reporting became operational in Q3 of 2025/26 with roll out being phased across the Trust's services. This will continue into 2026/27.
	Implementation of an ambient AI solution for outpatient services.	March 2026	CFO	Digital Director	The introduction of AI in outpatients is currently at pilot stage at the end of 2025/26 with feedback from the pilot to inform roll out in 2026/27.
Enhance capabilities and opportunities for Education to hospital university level standards	Work collaboratively with Keele university to develop an agreed joint research strategy	March 2026	CMO	Research Manager	The Trust continues to have a strong partnership working arrangement with Keele university and will continue to work on ensuring that this is reflected in the Trust's strategy development.
	Increase the core number of university clinical academics by 3 posts.	March 2026	CMO	Research Manager	The Trust has undertaken active recruitment into posts with dedicated academic/research time within its rheumatology and metabolic services. Posts are progressing through the recruitment process with appointments planned to be in post in 2026/27.
	Work towards increasing the Trust's Research Capability Funding (RCP) in line with meeting hospital university level standards	March 2026	CMO	Research Manager	Initial guidance from the University Hospital Association indicated that Trusts should demonstrate average Research Capability Funding (RCF) of at least £100k per annum over the preceding two years. However, discussions with Trusts that have secured University status suggest that a credible long-term plan to achieve this threshold may be sufficient. In 2025/26 the RJA Trust was allocated £27,500 RCF funding.

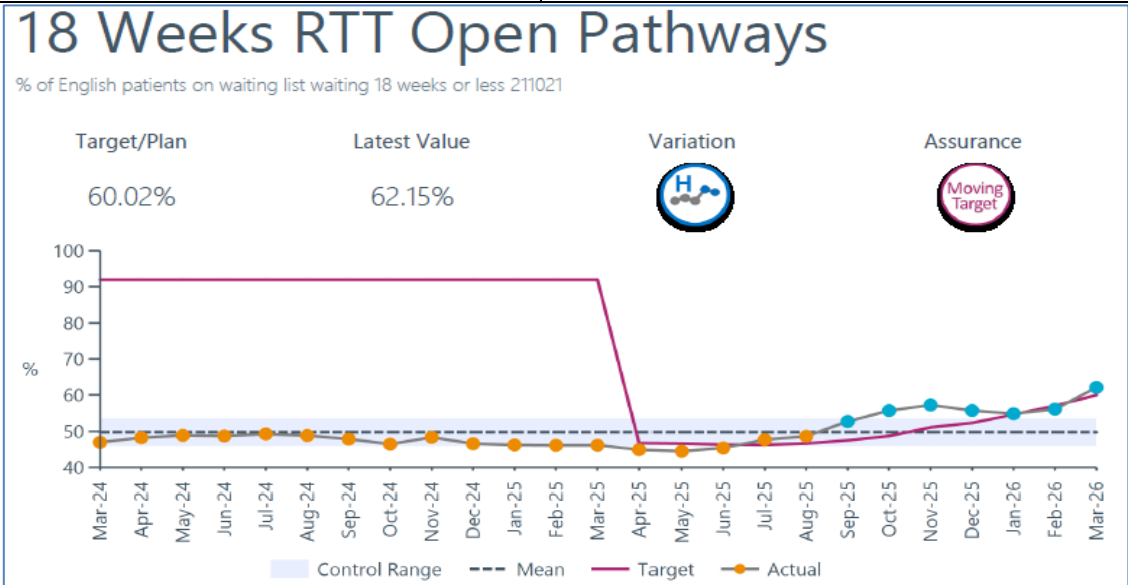
A number of key performance indicators are considered at the Board and its committee meetings each month. Performance measures considered at public meetings of the Board during the year can be viewed on the Trust’s website at: [2025 - 2026 Trust Board Meeting Papers - RJA](#)

The publicly available NHS England National Oversight Framework has seen RJA ‘Access to Services’ move from segment 4 to segment 3 during 2025/26.

A number of key measures discussed throughout the year, showing how performance has changed over time, is presented below

These included a number of year-end priorities identified by NHSE:

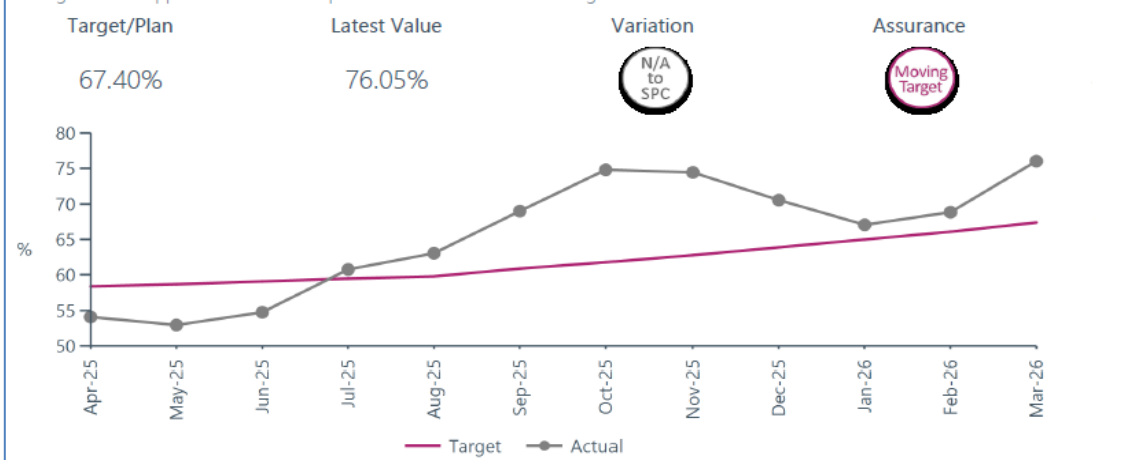
NHSE year-end priority	RJA performance
“Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement against the November 2024 baseline, with all providers required to increase their RTT [referral to treatment] performance to a minimum of 60%”	The March month-end position is reported at 62.15%; this meets the Trust’s original Operational Plan of 60.02% and exceeds the Q4 stretch target of 62.02%. There has been a 16.01% improvement throughout this year, and it is the best RTT position reported by the Trust since May 2020.



NHSE year-end priority	RJA performance
“Improve the percentage of patients waiting no longer than 18 weeks for a first appointments to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement against the November 2024 baseline, with all providers required to increase their RTT [referral to treatment] performance to a minimum of 67%”	This was a new metric for 2025/26 where our Organisation was given a target of 67% and there was a national task to reach 72%. We have exceeded both of these. The position for week-ending 29th March was 76.05%.

Time to First Appointment - English Patients

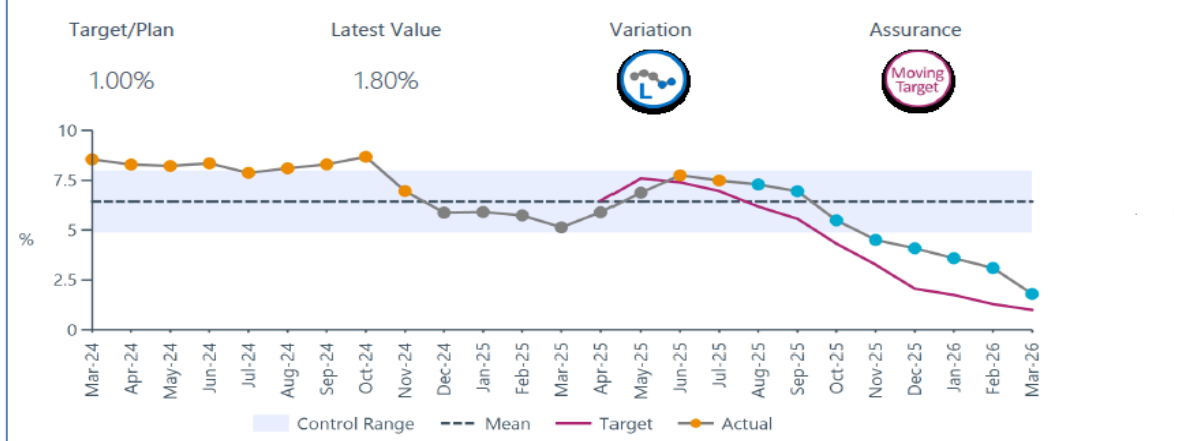
The denominator is the count of incomplete outpatient pathways waiting for a first appointment at the snapshot date. The numerator is the count of waiting for a first appointment at the snapshot date that have been waiting less than 18 217875



NHSE year-end priority	RJAH performance
“Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026”.	- The Trust has not reduced the volume of patients waiting over 52 weeks to less than 1%, however, substantial improvement has been made. - At the end of April-25 there were 1003 English patients waiting over 52 weeks, equating to 5.90%. - This position deteriorated throughout quarter one, rising to a peak of 1343 patients / 7.75% at the end of June. - Since then, there has been month on month reductions with the position for the end of March reporting 254 patients waiting over 52 weeks that equates to 1.80% of the list size.

% of Patients Waiting Over 52 Weeks - English

The number of English patients waiting over 52 weeks as a proportion of the English List Size. 217874

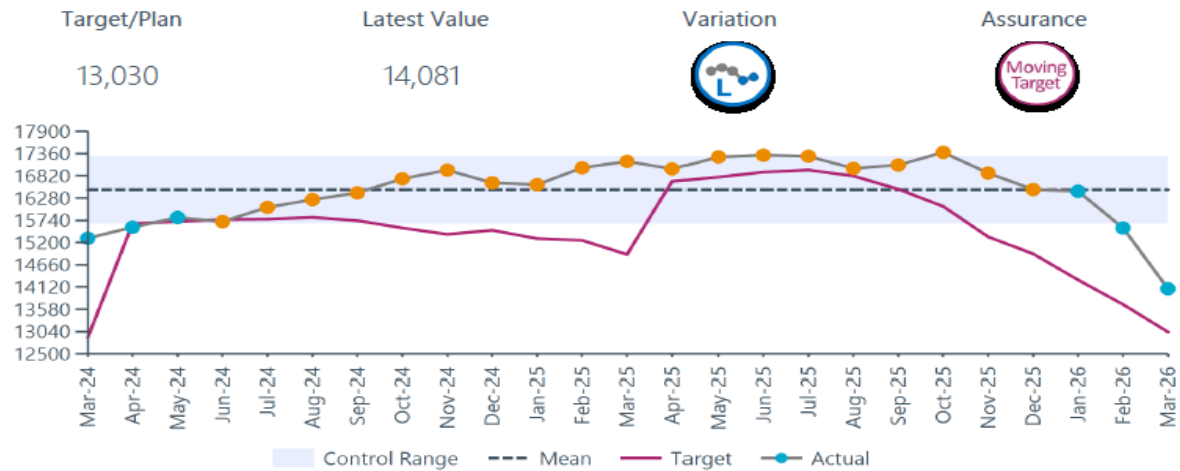


A number of other key measures discussed throughout the year, showing how performance has changed over time, are also presented below.

English and Welsh list sizes both peaked in October 2025. At the end of March 2026, the English list size had reduced by 3,310 patients and the Welsh list size had reduced by 473 patients since the peak.

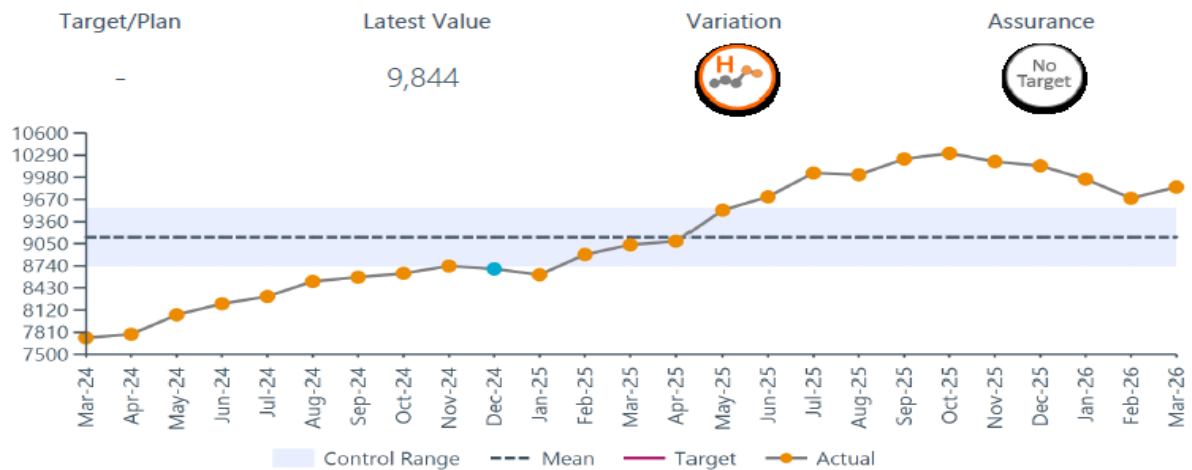
English List Size

Number of English patients currently waiting. Target as per Trust's Operational Plans. 215282



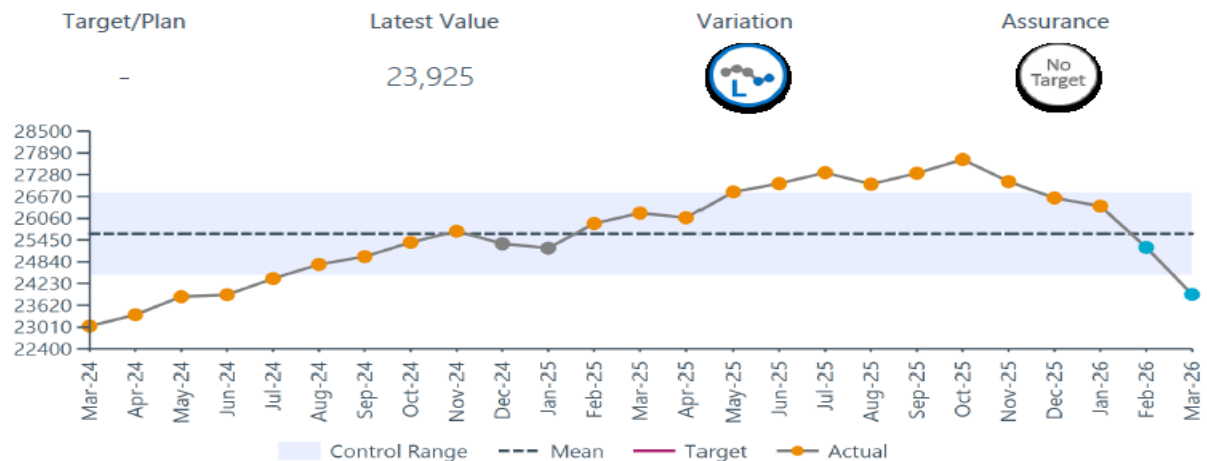
Welsh List Size

Number of Welsh patients currently waiting 217614

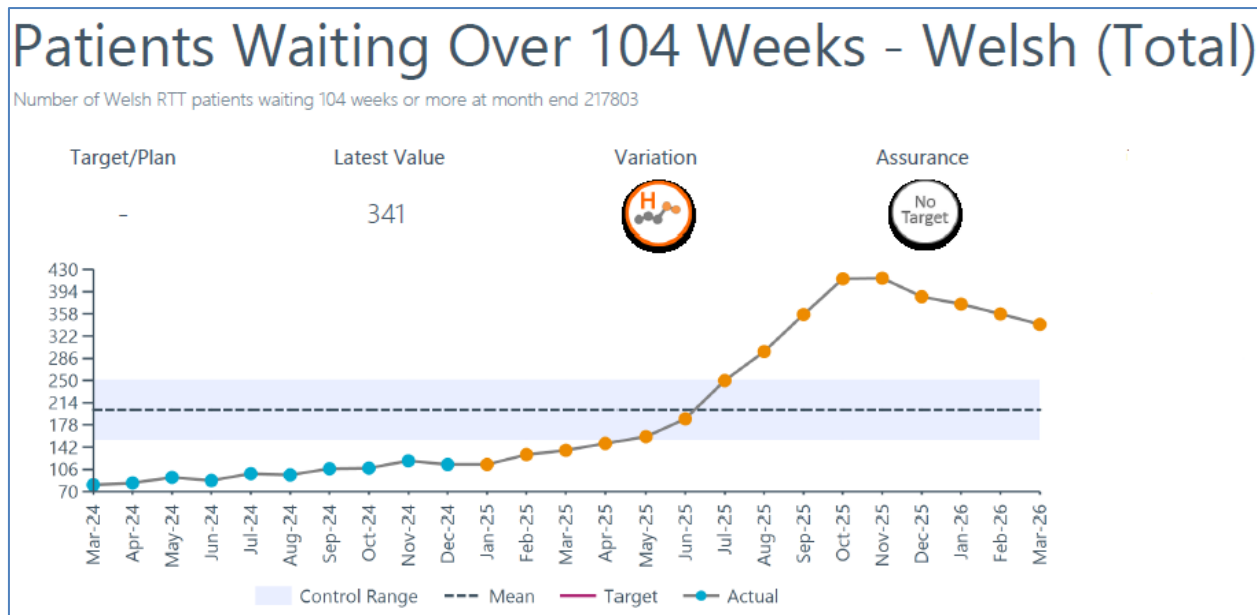


Combined List Size

Number of English and Welsh patients currently waiting 217615



At the end of March 2026, there were 341 Welsh patients waiting over 104 weeks. This peaked at 416 patients at the end of November but as shown below, there has been a gradual decrease each month since. This will remain a priority for 2026/27.



Task force on climate-related financial disclosures (TCFD)

NHS England's NHS foundation trust annual reporting manual adopted a phased approach to incorporate the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures are as interpreted and adapted for the public sector by HM Treasury. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

These disclosures are provided below.

Governance pillar

The Trust Board maintains oversight of climate related issues through the Finance and Performance Committee. The Committee receive updates via Chair's reports from the Trust's Sustainability Delivery Group.

The Trust publishes an Annual Report which quantitatively and qualitatively demonstrates progress that the Trust is making against its Green Plan, as outlined in the "Sustainable Development" section below.

The sustainability agenda is overseen by the Estates and Facilities department. Reporting to the Board, through the Chief Financial Officer, who is the Executive Accountable Officer for Sustainability, the department is led by the Director of Estates and Facilities and delivered by the Head of Estates and Facilities.

The Trust is an active member of the ICS Climate Change Group, who hold the Trust to account for delivering the ICS Climate Change agenda.

Department leads are allocated responsibility to propose and deliver a three-year strategy relating to their area, that aligns to National Net Zero priorities. These drive the Trust's Green Plan, through the Sustainability Delivery Group, which is used as a siphon to disseminate information relating to climate

change matters. The Trust is further informed on climate change matters through the Midlands Net Zero Delivery Group.

Governance of risks relating to climate change are overseen by the Sustainability Delivery Group. Leads bring risks to the group for consideration and oversight. The Trust analyses its risks through the Risk Management Group, at an operational level, and through the Trust Performance and Operational Improvement Group, at a strategic level in line with the Trusts governance process.

Strategy and Risk Management pillars

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Climate change related risks are identified and assessed by subject specialists, with the Sustainability Delivery Group holding management oversight. These risk assessments consider the effects of climate change and severe weather, alongside the Trust's obligations under the Climate Change Act and Adaptation Reporting requirements. These risk assessments inform development and review of our Green Plan, and ensure that relevant risks are reviewed through the Trusts established governance structure.

The Trust has not identified any high risks relating to climate change. Advances in future technology are foreseen to support progress towards Net Zero targets. The Trust is monitoring extreme weather-related risks with this being an emerging area. Risks are captured, monitored and reported in line with the Trust's general risk management arrangements (as described in the Accountability Report).

Metrics and target pillar

The Trust invested in a supply chain audit, also utilising individual contractor-based reports to understand its carbon footprint. This gave the Trust specific quantifiable data. In order to benchmark and work towards delivery of 2028-2032 and 2040 targets, the Trust utilises the Green Plan Support Tool, alongside industry specific dashboards, including Waste and Energy, published by NHS England.

Key achievements and progress made against the targets set out in the Trust Green Plan are described in the "Sustainable Development" section below. The Plan was due for renewal in 2024 but the Board agreed that the existing Plan would remain live until anticipated revised guidance was issued. That Guidance was subsequently issued in early 2025. The Plan was reviewed in light of the revised Guidance and was approved by the Board in October 2025. The Plan was subsequently published by 31 October 2025.

Sustainable Development

The NHS has committed to achieving Net Zero carbon emissions as part of its Greener NHS initiative, recognising the critical role healthcare must play in mitigating climate change. In alignment with the NHS Net Zero Carbon strategy, two key milestones have been established: to reach Net Zero for the NHS Carbon Footprint by 2040, with an interim reduction of 80% by 2032, and to achieve Net Zero for the NHS Carbon Footprint Plus—accounting for wider supply chain and patient-related emissions—by 2045, with an interim reduction of 80% by 2039.

These ambitious targets require a comprehensive and sustained effort across energy use, transport, procurement, waste management, and clinical practices. As part of this national commitment, the Trust continues to implement strategic initiatives that drive carbon reduction, enhance sustainability, and improve resilience, ensuring that healthcare delivery remains both environmentally responsible and future-proofed.

The Current Trust Position and Future Targets

At the beginning of 2025, recorded data indicated that the Trust produced 5,627 tCO₂e (tonnes of carbon dioxide equivalent) emissions. In line with the national requirement to reduce 80% of 1990 emissions by 2028-2032, the Trust must deliver a reduction of at least 2,399 tCO₂e to achieve its target of 3,288 tCO₂e or less. The majority of the Trust's carbon emissions originate from energy consumption; this therefore represents an area of focus, as work is undertaken to deliver the Trust target.

Green Energy Electrical Energy

The Trust already procures the electricity it imports from the National grid from renewable sources only, this offsets a potential carbon footprint of 1,000 tCO₂e.

Over the last 5 years the Trust has had a number of successful grant fund bids to install solar photovoltaics; it is believed that the Trusts delivery of projects on time, specification and budget have given fund holders confidence in new funding applications.

In 2025/26 the Trust was awarded a further £2.4 million in grant funding through the Great British Energy scheme, to further expand the existing on-site solar PV infrastructure and install battery energy storage units.

This investment will not only enhance energy security but also generate cost savings that will help mitigate the financial pressures associated with heat decarbonisation, in alignment with the Trust's Heat Decarbonisation Plan.

Decarbonisation of Building Infrastructure

The single biggest contributor to the Trust's carbon footprint is its gas-powered heating network. The Trust has been successful in its bid for Salix funding which, supported by The Carbon Energy Fund (CEF), will begin the process of electrifying the heating network, resulting in an approximately reduction of 2,400 tCO₂e, delivering the national 2032 goal ahead of schedule.

The Trust continues to explore opportunities to improve insulation, minimize heat loss, and implement programmed equipment downtime to optimize energy efficiency.

Journeys and Transport

The Trust conducts an annual travel survey and leverages insights to collaborate with system partners in promoting active travel.

The Trust's pool vehicle fleet is now 100% electric. Over the next year, plans are in place to transition additional on-site vehicles, such as waste collection trucks, to electric alternatives.

In line with NHS England's Travel and Transport Strategy, 2026 will see the launch of the Trust Sustainable Travel Plan. By December 2026, the Trust will offer EV vehicles only as part of its salary sacrifice scheme.

This year, the Trust has installed 6 additional EV charging points, complementing existing provisions for fleet, staff, and visitor use, bringing the site total to 40.

Food and Nutrition

The Trust had made significant progress across these focus areas including:

- Achieving a zero waste to landfill
- Utilised the Guardians of Grub approach to introduce food waste monitoring. This increased monitoring has delivered a 10% reduction in food waste year on year.
- The Trusts bold approach to reducing single use plastic in catering, including removal of disposable takeaway containers in retail, has been recognised Nationally, with the approach and

ethos used at RJAH noted by NHS England as a beacon of good practice through the Exemplar Trust Programme.

Waste Management

Following NHS England's Clinical Waste Strategy, the Trust has achieved clinical waste segregation levels above the Nationally set target (20% incineration, 20% infectious and 60% offensive waste segregation), minimising the carbon impact of high temperature waste disposal.

We reported in March 2025 that segregation achieved 13% incineration, 10% infectious and 77% offensive.

Wellbeing

The Trust has enhanced green spaces by renovating courtyard gardens including opening the Garden for Alice, promoting the benefits of nature for both patients and staff. These initiatives have been funded through contributions from contractor Social Values commitments and charitable donations. Green spaces across site have this year benefitted from the introduction of a dedicated volunteer team, enabling a focus on maximising these spaces across site, ensuring they are accessible and enjoyable for all.

Medicines

The Trust has utilised NHS England's Nitrous Oxide Waste Reduction Toolkit to identify and action opportunities for reducing nitrous oxide use on-site, with full decommissioning of Nitrous Oxide manifolds completed in 2025.

Procurement

The Trust has embedded social value weighting into all contract awards, aligning with the Net Zero Supplier Roadmap to ensure sustainable procurement practices.

The Trust remains committed to delivering on its sustainability targets and will continue to identify and implement strategic initiatives that drive progress toward a net-zero future.

Health Inequalities

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

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

The Trust reports Health Inequalities updates against its priorities through its Quality and Safety Committee which is a sub-committee of the Board. The Trust is also continuing to focus on treatment of its longest waiting patients, as well as working to identify any health inequalities that may be impacting them. Health Inequalities data continues to be assessed through different lens and reported through both our Quality and Safety Committees and Finance and Performance Committees.

The Trust has in place a Health Inequalities & Population Health working group. The data and assessments through working groups and committees is to support identification of opportunities, share learning and wherever possible to take actions that are consistent with narrowing existing health inequalities and inequalities in access.

The Trust is taking multiple steps to support addressing health inequalities. During 2025/26 updates to note include:

- **Disaggregated Health Inequalities data** has been displayed and discussed within the Trust's Health Inequalities and Population Health working group. It is noted that English deprivation scoring differs to Welsh deprivation scoring and this is considered when developing reports. An example of a team with a significantly different IMD (Index of Multiple Deprivation) distribution was seen in the English referral-to-treatment (RTT) waiting list for Rheumatology. In January 2024, at RJA, the proportion of Rheumatology patients living in the most deprived quintile was 7.9%. Then in February 2024, following a system transfer this shot up to 18.5%. In July 2025 this had decreased to 12.3%. This was the result of improvements to reduce the Rheumatology English waiting list size. Improvements have been seen across all IMD scores.
- **Did Not Attend (DNA) / Was Not Brought (WNB)** There is a recognised difference in the volume of patients from the most deprived areas not attending an appointment. For example, for March 2026 the most deprived English quintile had a DNA rate of 8.39%, whereas the most affluent English quintile had a DNA rate of 4.61%. The most deprived Welsh quintile had a DNA rate of 10.2%, whereas the most affluent Welsh quintile had a DNA rate of 2.63%. Patients from ethnic minority backgrounds had a DNA rate of 6.16%, whereas White British patients had a DNA rate of 4.38%. Exploring options to support reductions in patients not attending and children not being brought continues. The Trust has processes in place to support patients who are financially struggling. The Trust as part of continued improvement focus for 2025/26 has had targeted improvement programmes for children and why they are not being brought.
- **There are ongoing data quality assessments.** The Trust saw a drop in ethnic category recording following 'go live' of the new electronic patient hospital system that was implemented May 2025. Ongoing monitoring and actions to support improvements continue.
- **Digital Exclusion.** The Trust is exploring opportunities to support 'digital inclusion' and networks that can support this. Work also continues to develop/explore digital tools to support elective waiting list management.
- **There is Local Authority and other STW provider involvement in internal working groups.** This is recognising health inequalities are driven by a variety of factors. To serve communities well, relevant NHS bodies and partner organisations should work together to understand the collective health and care needs of local people and populations, as well as healthcare access, experience and outcomes. Collaborative working has enabled actions that support signposting to smoking cessation and weight management support where required as an example.
- **NHS England Patient Safety Healthcare Inequalities Reduction Framework.** A self-assessment against this framework has been completed during 2025/26 and will be part of assessments for RJA Quality Priorities for 2026/27.

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

Looking ahead to 2026/27

Looking ahead, the strategic objectives will continue to be based on the Trust's ambition to be the leading centre for high quality, sustainable orthopaedic and related care, achieving excellence in both experience and outcomes for our patients.

The next financial year will also focus on building on the great work of the last three years in delivering against the NHS national standards. It will involve looking at those performance targets that have not been achieved in 2025/26 and what actions need to be taken to achieve these. The Trust will ensure

that patient safety and quality standards are maintained and continue to be at the forefront of its business.

Key priorities for the Trust in 2026/27 will be to:

- Reduce waiting times to achieve English and Welsh national standards.
- Maintain performance against the cancer waiting times standard.
- Optimise productivity and efficiency within our services.

Conclusion of the Performance Report

I have presented this report in my capacity as the Accounting Officer and confirm that the Trust's auditors have reviewed the Performance Report for consistency with the financial statements.



Stacey Keegan
Chief Executive Officer
24 June 2026

ACCOUNTABILITY REPORT

Directors' Report

Meet the Board

The directors present their annual report together with the audited financial statements for the year 01 April 2025 to 31 March 2026.

As can be seen from the directors' biographies below and from our compliance with the requirements of the Foundation Trust Code of Governance, the Board has an appropriate composition, balance of skills and depth of experience to lead the Trust for the good of patients, staff and the communities it serves. The Chair keeps this balance under review during the annual appraisal of Non-Executive Directors.

Details of the directors who held office at 31 March 2026 are listed below and unless specified, have held office for the full financial year. Any directors who held office during the period but left during the financial year are cited later in the report:



Harry Turner
Chair

Harry joined the RJA Trust in January 2017 as a Non-Executive Director and was subsequently appointed Chairman on 1 February 2022.

He has held a number of other Chair roles, including with the Birmingham Hospice Group, Dudley and Walsall Mental Health Trust, and Dudley Integrated Health and Care NHS Trust. He also served on the Board of the Worcestershire Acute NHS Trust, initially as a Non-Executive Director and later as Chair.

Alongside his NHS leadership roles, Harry has served as a Presiding Justice in Worcestershire Courts for more than a decade. Earlier in his career, he worked as an Executive Director in the hotel industry for major brands such as Premier Inn, Travelodge and Marriott International.



Stacey Keegan
Chief Executive Officer

Stacey joined RJA Trust as Chief Nurse and Patient Safety Officer in November 2019. Between March and October 2020, she served as Interim Chief Executive before returning to her Chief Nurse and Patient Safety Officer role. In August 2021, she was again appointed Interim Chief Executive, and in December 2022 she moved into the substantive Chief Executive position.

Stacey is an NHS Trust Partner Member on the Shropshire, Telford and Wrekin Integrated Care Board and a Board Member of the National Orthopaedic Alliance.

A registered and practising trauma and orthopaedic nurse, Stacey has held a range of senior leadership and management roles across multiple NHS Trusts. She holds an MSc in Senior Healthcare Leadership and is a graduate of the NHS Leadership Academy's Elizabeth Garrett Anderson Programme.



Sarfraz Nawaz
Non-Executive Director

Sarfraz joined the RJA Trust Board of Directors on 1 October 2021. He serves as Chair of the Trust's Finance and Performance Committee and is also the Trust's Vice Chair. He previously held the role of Senior Independent Director until earlier this year.

A qualified accountant and member of the Chartered Institute of Public Finance and Accountancy (CIPFA), Sarfraz is currently the Corporate Director of Resources and Finance at Wakefield Council. He has extensive experience in senior financial leadership and Board-level roles across the public sector, having worked in both local and central government.



Martin Newsholme
Non-Executive Director

Martin was appointed as a Non-Executive Director at RJAHS on 4 May 2022. A chartered accountant by profession, he spent the majority of his career at KPMG, where he served as an audit partner for 15

years.

He currently holds several Trustee and Non-Executive positions, including roles with Warrington Housing Association and the Shropshire Doctors' Co-operative, bringing extensive financial and governance expertise to each organisation.



Penny Venables
Non-Executive Director

Penny joined the RJAHS Board of Directors on 19 June 2022 as a Non-Executive Director. She brings almost 40 years of experience in health service management, including senior leadership roles as

an Executive Director and Chief Executive across the NHS, with significant experience in specialist hospital settings.

Penny currently works as a Consultant with In-Form Solutions, where she provides specialist support and expertise to organisations across health and social care, drawing on her extensive background in health service management.



Lindsey Webb
Non-Executive Director

Lindsey joined the RJAHS Board as a Non-Executive Director in July 2023. A registered nurse with 43 years of NHS experience, she has held senior leadership positions

including Executive Director roles in other specialist orthopaedic hospitals.

She has also served as a trustee and Vice Chair of Birmingham Hospice for seven years,

contributing to governance and strategic oversight within the charity sector.



Martin Evans
Non-Executive Director

Martin joined RJAHS on 6 September 2022 as an Associate Non-Executive Director and was subsequently appointed as a Non-Executive Director in July 2023. Martin has recently been appointed as

Senior Independent Director for the Trust.

He has spent over 35 years working in the public sector, building a distinguished career in the Police Service. Martin served most recently as Assistant Chief Constable of West Mercia Police, where he oversaw the delivery of 24/7 policing across Shropshire, Telford, Worcestershire and Herefordshire. Since leaving policing, he has held Non-Executive Director roles at three NHS Trusts and has supported both the Home Office and the Department for Transport in developing new approaches to improving road safety and reducing deaths and serious injuries.

As well as his NED roles, Martin is currently a national coach on the NHSE National Neighbourhood Health Implementation Programme

In 2025, Martin was selected for and successfully completed the NHS Aspiring Chairs programme, recognising his leadership capability and commitment to public service.

Martin is a people-focused leader with a strong passion for continuous improvement.



Mike Carr
Chief Operating Officer / Deputy CEO

Mike joined RJAHS in July 2022 as Chief Operating Officer. He started his career in healthcare as a Mental Health Support Worker for a charity in Staffordshire, after

graduating from Keele University he joined the NHS Graduate Management Training Scheme in 2011. Mike has an MSc in Leadership and Service Improvement from the University of

Manchester and in 2021 completed The King's Fund Leadership for Population Health programme which is a specific area of interest for him.

Mike has held a number of senior operational leadership roles which have focused on planned care and more recently community services. Mike is also the Accountable Emergency Officer and Deputy Chief Executive Officer for the Trust.



**Ruth Longfellow
Chief Medical Officer**

Ruth has been Chief Medical Officer at RJAH since April 2021.

Ruth graduated from the University of Edinburgh with her Bachelor of Medicine and Bachelor of

Surgery (MB ChB) degree. She then completed her Fellow of the Royal College of Anaesthetist (FRCA) examination in 2006 and a Diploma in Medical Education at Nottingham University in 2011.

In 2011, she was appointed to RJAH as a Consultant Anaesthetist. In April 2019, she became the Associate Medical Director for the Trust.

Ruth's interests include patient safety and Human Factors, medical education and regional anaesthesia.



**Paul Kavanagh Fields
Chief Nurse and Patient
Safety Officer**

Paul joined RJAH in April 2023. He brings a wealth of leadership experience to the Board of Directors, having previously worked in a number of Board and sub-Board level positions across

acute hospital services, public health, local and strategic commissioning, primary care, service improvement and modernisation and education.

Paul was responsible for the roll out of the Bowel Cancer Screening Programme in Northern Ireland and has developed a number of workforce strategies, including job planning for clinical nurse specialists.

More recently Paul has supported the North Wales Covid-19 Response Service at a strategic level, engaging with local authorities, Welsh government and education.



**Angela Mulholland-Wells,
Chief Finance and
Commercial Officer**

Angela joined RJAH as Chief Finance and Commercial Officer in April 2025. She has worked across a variety of private sector industries, including

over 15 years in senior finance leadership roles within healthcare for the Independent Sector as regional finance director of private hospitals, and more recently in NHS Acute Trusts as director of finance.

Angela is a Fellow of the Association of Chartered Certified Accountants (FCCA). In her role at RJAH, Angela leads on the financial strategy for the Trust, including commercial developments and digital programme.

She is a trustee and Chair of the Audit, Finance and Risk Committee of the global humanitarian mine action charity, Mines Advisory Group. Angela joined RJAH from a Health and Wellbeing Community Interest Company where she held the position of Executive Director of Finance and Resources.

The following Directors served on the Board in an interim capacity during the year:



Sam Young, Interim Chief Nurse and Patient Safety Officer

Sam Young served RJAHS with dedication and distinction during her years in senior nursing roles, including as Interim Chief Nursing Officer from February to June 2025.

She brought extensive experience from primary, secondary and community care across Scotland, England and the Military, including more than 16 years of service with the Armed Forces.

She continued to serve as a Senior Officer in the British Army Reserve, where she was Infection Prevention and Control Lead for 202 (M) Multi-Role Medical Regiment.

Sam was widely respected for her clinical expertise, her commitment to high-quality patient care and the warmth and compassion she showed to colleagues at every level.

Her sudden passing was a profound loss to our organisation. Sam's professionalism, kindness and leadership leave a lasting legacy, and she is deeply missed.



Sarah Needham, Interim Chief Nurse and Patient Safety Officer

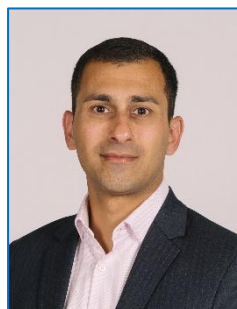
Professor Sarah Needham joined the Trust in September 2025 as Interim Chief Nurse and Patient Safety Officer.

Sarah joins from Moorfields Eye Hospital NHS Foundation Trust, where she has been Deputy Chief Nurse since 2018 and served as Interim Chief Nurse in 2022. She has also held a national role as Head of Innovation for NHS England's New Hospital Programme, leading work on new models of care and digital transformation.

Sarah is recognised for her collaborative approach, her commitment to tackling inequalities, and her ability to lead large-scale

improvement across local, regional, and national systems.

Although not formal members of the Board, the following Associate Directors, appointed to bring particular skills and knowledge, supported the Board of Directors during the year:



**Atif Ishaq
Associate Non-Executive Director**

Atif joined the RJAHS Board as an Associate Non-Executive Director in July 2023. He is a clinical pharmacist with more than two decades of experience across both primary and

secondary care. In secondary care, he specialised in critical care, surgery, and parenteral nutrition, and has worked within both large teaching hospitals and district general trusts.

After a successful clinical career, Atif transitioned into technology, spending the past decade leading product management and the implementation of clinical digital solutions. He now serves as Enterprise AI & Advanced Analytics Director for a global consumer goods company, where he leads teams developing machine learning and AI-driven capabilities.

Atif brings a blend of clinical insight and technological expertise to the Board, supporting the Trust's strategy and governance as it advances its digital ambitions.



**Paul Maubach
Associate Non-Executive Director**

Paul joined the Board of Directors in March 2023. Paul has over 30 years' experience of working in NHS management, the last ten years of which were in Chief Executive roles, and

over his career worked with all aspects of the NHS from primary care through to specialised services.

He is a qualified Accountant with the Chartered Institute of Public Finance and Accountancy

(CIPFA) and holds a Masters in Leadership and Organisational Development. As well as working for RJA, he is also currently the Director for Neighbourhood Health at the Department of Health and Social Care.

In a previous role, Paul used to organise the funding for the specialised services provided by RJA and, so he is keen to support the Trust in continuing to develop as a centre of excellence, both locally and nationally.



Denise Harnin
Chief People Officer

Denise started at RJA on 14 July 2022.

She is a highly experienced human resources practitioner, having worked initially in the private sector before joining the NHS in

1988 where she has worked in large acute hospitals across the West Midlands area.

The following Directors left the organisation during 2025/6.



John Pepper
Associate Non-Executive Director

Dr John Pepper joined the RJA Board in July 2022 as an Associate Non-Executive Director. A former GP in Shropshire, he also previously served as Chair of the Shropshire,

Telford and Wrekin Clinical Commissioning Group (CCG).

In his role as Associate Non-Executive Director, Dr Pepper is committed to supporting RJA through the rapidly evolving challenges facing the NHS, while maintaining a strong focus on delivering high-quality care for both patients and staff.

John completed his initial tenure on the Board in summer 2025.



Craig Macbeth,
Chief Finance and Planning Officer

Craig joined the Trust in 2008 as Deputy Director of Finance and was appointed Chief Financial Officer in 2017 following a period of acting up.

In this role, he oversaw a broad portfolio including Finance, Planning, Contracting, Procurement, Counter Fraud, Project Management, and Estates and Facilities.

Throughout his tenure, Craig played a pivotal role in steering the Trust through numerous challenging periods, helping to secure its long-term sustainability. He retired in April 2025.



Darius Mirza, Non-Executive Director

Professor Darius Mirza joined the Trust in July 2025 and left in February 2026.

A leading hepatobiliary and transplant surgeon, he has over 30 years of experience, more than 5,000 liver transplants to his name, and a strong record of research and leadership within the European Liver and Intestine Transplant Association, the British Transplantation Society, and other international societies.

Declarations of Interest of the Board of Directors

The Board regularly reviews its Register of Declared Interests. The register is appended to the agenda of each meeting of the Board and there is a standing agenda item requiring all directors to declare any interests they hold which relates to the business to be discussed.

The Register is available for inspection during normal office hours in the Trust Secretary's office and is also published on the Trust's website.

Independence of Non-Executive Directors

As part of their role as members of the unitary Board, Non-Executive Directors have a particular duty to ensure that the decisions of the Board are subject to constructive challenge and to scrutinise management performance in meeting agreed goals and objectives.

Non-Executive Directors are appointed on the basis that they are "independent in character and judgement and free from any business or other relationship which could materially interfere with the exercise of their judgement". Non-executive directors chair the committees of the Board which are responsible for:

- Monitoring the integrity of financial, clinical, and other information.
- Ensuring that financial and clinical quality controls and systems of risk management are robust.
- Determining appropriate levels of remuneration of executive directors.
- Playing a supporting role in appointing and, where necessary, removing Executive Directors, and in succession planning.

Cost allocation and charging guidance

The Trust has complied with the above guidance issued by HM Treasury.

Modern Slavery Act 2015

In accordance with the Act, the Trust has agreed and published its statement. This can be viewed at: [Modern Slavery Act 2015 - RJAH](#)

Political Donations

The Trust can confirm that no political donations were made in the current or prior year.

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay invoices within 30 days of receipt of the goods or receipt of the invoice, whichever is later, with performance being measured in terms of both number and value of invoices.

During 2025/26 the Trust paid 98% of the number of invoices and 98% of the value of invoices within the target. No late payment interest was due.

	2025/26		2024/25	
	Number of invoices	Value in £000s	Number of invoices	Value in £000s
Total invoices paid	44,243	121,685	45,590	120,427
Invoices paid within target	43,280	118,673	44,183	117,703
Percentage paid within target	98%	98%	97%	98%

Governance using the Well-Led Framework

The Board of Directors ensures that the principles set out in the well-led framework not only inform their work but are also embedded across the organisation. The governance structures support delivery of the principles outlined in the framework to ensure they remain effective and support good governance and high quality, sustainable services. The Trust commissioned an independent developmental well-led review during the year and has established an action plan to deliver the nine recommendations made. Each recommendation has been aligned to a Board committee which oversees progress in delivering the actions.

Quality Governance

Quality in the NHS encompasses three domains – Patient Safety, Patient Experience and Clinical Effectiveness. The Trust's work in this area embraces several strands of work including complaints, patient outcomes and risk. All these elements are critical in ensuring our patients and their carers receive excellent care, and the Trust continues to meet its core values.

All staff have responsibility for safety and quality. There are, however, designated roles within the Trust who have led or are directly involved in these activities under the executive lead of the Chief Nurse and Patient Safety Officer, the Chief Medical Officer, with the Chief Executive Officer being ultimately responsible.

The Trust has in place a robust governance framework to underpin the delivery of enhanced quality and further detail on this framework is contained within the Annual Governance Statement.

Quality Governance Framework

The Quality Governance framework has been further assessed and is part of the Quality account declaration. The Trust remains compliant with this framework, and this is supported by internal audit reviews during 2025/26.

The Trust was last inspected by the Care Quality Commission May 2025. The focus of the inspection was on the Trusts Surgical Services, including Theatres and Critical Care. The findings in the five domains of the assessment framework were:

Safe	GOOD
Effective	GOOD
Caring	GOOD
Responsive	GOOD
Well-led	GOOD (2019)

The Trust have yet to have the Well-led part of the inspection completed but anticipate that this will take place across 2026/27.

As described in the Board Assurance Structure section of this Report, the Trust has a Quality and Safety Committee which is responsible for ensuring effective clinical governance are in place and high standards of care are provided.

Quality Outcomes

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

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

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- British Spine Registry

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

The Trust also collects large volumes of Patient Reported Outcome Measures (PROMs) for total hip and knee procedures to submit to the national PROMS programme. The programme led by NHS England mainly focuses on those specific procedures.

Over the past couple of years work has taken place to expand our outcomes collection throughout the organisation and ensure that these measures are collected and analysed across all procedures and treatment taking place in the trust. Electronic data collection has allowed us to further expand to all teams within the organisation and any services that patients may require along the pathway. Regular data collection is now evolving for all teams and services that are listed below. We continue to work with other areas to ensure the work supports outcomes monitoring for all areas.

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

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

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

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

Speciality	2023/24	
	Pre Operation	Post 1 Year
Arthroplasty	81%	57%
Foot & Ankle	76%	38%
Sports Injuries	84%	48%

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

Arthroplasty

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

Sports Injuries

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

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

Foot and Ankle

	Average Score Change (Pre & Post 1 Year)				
	2023/24				
	MOXFQ WS	MOXFQ P	MOXFQ SI	EQ5D5L Index	EQ5D3L VAS
Ankle Fusion	25	27	18	0.264	6
Ankle Replacement	63	43	45	0.307	15
Big Toe Fusion	33	33	27	0.203	7
Foot & Ankle Surgery	22	20	19	0.104	6

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

Quality of Recovery-15 (QOR-15)

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

The questionnaire has 15 items providing an overall score from 0 – 150. The higher the score displays the best recovery.

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

Musculoskeletal Health Questionnaire (MSK-HQ)

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

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

	MSK-HQ Data Overview	
	2023/24	2024/25
Total Completed	105	306
Percentage Improved	81%	78%
Percentage Improved (MICD)	65%	62%

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

Shared Decision Making

The CollaboRATE questionnaire is a questionnaire to measure and support the evidence that shared decision making is taking place in the trust. This data is collected electronically, and patients are asked three questions after their initial outpatient appointment has taken place. The three questions asked to patients are as follows:

Thinking about the appointment you have just had ...

1. How much effort was made to help you understand your health issues?
2. How much effort was made to listen to the things that matter most to you about your health issues?
3. How much effort was made to include what matters most to you in choosing what to do
4. next?

Each question can be scored from 0-9, 0 meaning 'No effort was made', 9 meaning 'Every effort was made'. The total score can range from 27 to 0, higher the score represents the more shared decision making took place.

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

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

Patient Care Activities

We are aligned to the requirements of national strategy in that quality is at the core of all we do. Our aim is to continue delivering outstanding patient care to every patient every day. We pride ourselves in the standards we achieve and in the feedback from our patients on the quality of our services.

We aim to safeguard our patients, both adults and children, at all times. This is achieved through clear policies and procedures that protect and support patients and their families during their stay and beyond. This also means working in partnership with other agencies to get the right outcome for our patients.

For quality to flourish we need to recognise the need to change and to improve where systems and processes are hindering our staff to deliver high quality care to patients every day. We need to set a clear vision so staff and patients understand what our aims and goals in delivering that high quality service look like and how they can contribute to enhancing our services.

There needs to be clear lines of responsibility for safety and quality from board to ward/departments with each person including those using our services understanding their roles and responsibilities in ensuring improvements are made. Even the smallest change can make a difference to the patient, carer or staff experience.

The quality of the services we provide to patients is routinely reviewed by the Integrated Care System (ICS) through contract meetings that consider performance on Trust wide quality issues. Through the introduction of the Patient Safety Incident Response Framework (PSIRF), oversight arrangements have been changed to reflect the principles of PSIRF, and these provide the ICS with the opportunity for any areas of concern to be discussed and reviewed.

Quality risks are identified from the Trust's risk management processes and are monitored, managed and mitigated at local, delivery unit and corporate levels. Each risk is clearly defined and includes clear action plans to control and mitigate the risk.

The corporate risk register and Board Assurance Framework are reviewed quarterly by the Board and identify the key quality risks for the organisation with clear mitigations and action plans.

Performance Against Key Health Care Targets

The Trust publishes information on its performance against a number of key measures within integrated performance reports that are considered by the Board of Directors and its sub-committees. Information on the quality of services provided by the Trust is also presented in the Annual Quality Account. That document is published on the Trust's website. Trust performance against the [NHS Oversight Framework metrics](#) is published by NHS England.

Quality Strategy

The Trust's Quality Strategy is set to be delivered across 2024 to 2027 and is underpinned by the national NHS Patient Safety Strategy and its 3 strategic aims:

- Insight Improve our understanding of quality and safety by drawing insight from multiple sources of patient safety and outcome information.
- Involvement: People have the skills and opportunities to improve the quality of care provided throughout the services we offer.
- Improvement: Improvement programmes enable effective and sustainable change in the most important areas.

Our Quality Strategy sets out six objectives that embeds the Trust's appetite for continuous improvement and change to ensure that we maintain our excellent standards for quality.



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

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

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

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

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

1. To ensure patient/carers feedback is collected in a way that allows the Trust to understand feedback from an EDI and health inequalities perspective.
2. Expansion of Patient Engagement Group to include external stakeholders and community partnerships, demonstrating that the Trust works in partnership with people and our local community.
3. To ensure information regarding shared decision making is collected in a way that identifies opportunities for improvement.
4. To facilitate co-production with patients, families, carers and volunteers to implement actions that will lead to sustainable improvements
5. To ensure the Trust has a robust EQIA process that helps to identify how changes to services can potentially impact both patients and carers.

Listening to Patients and Carers

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

The table below shows overall patient feedback in 2025/26 compared to 2024/25:

Feedback	2024/25	2025/2026	Difference between 2024/25 and 2025/2026	% Change
Complaints	144	202	58	40%
Local Resolution	51	118	67	131%
PALS concerns	618	763	145	23%
Trust enquiries (via RJAH emails, PALS email, PALS telephone and website). Not PALS concerns	6211	6875	664	11%
Compliments	13207	9835*	-3372	-26%
FFT result	98%	98%	0	-

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

The increase in the number of complaints and PALS concerns received primarily relate to waiting times and scheduling of appointments. The Trust have worked tirelessly this year to reduce the time our patients are having to wait for surgery, however we recognise that more improvements are required in how we communicate with patients about their appointments and waiting time and helping our patients to wait well, while waiting for their procedure to be undertaken.

Key Highlights

CQC Registration

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration is without conditions. The Care Quality Commission has not taken any enforcement action against The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in 2025/26.

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

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

Overview

Latest assessment: 14 October 2025 Report published: 19 September 2025

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

Ratings for specific services

We often carry out focused inspections on individual services. The following ratings are from our focused inspections.

Critical care	19 September 2025	Good 
Surgery	19 September 2025	Good 
Medical care (including older people's care)	21 February 2019	Good 
Services for children & young people	21 February 2019	Good 
Diagnostic imaging	21 February 2019	Good 
Outpatients	21 February 2019	Good 

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

Patient Feedback

This year the Trust updated our patient experience objectives, incorporating these into the Trusts Quality Strategy. These objectives continue to build on the Trust's commitments to provide patients, carers, their relatives with world class care.

We know that a positive experience during a care episode promotes a positive clinical outcome. If a patient feels listened to and involved in their care they will respond better to medical, nursing and therapy interventions and be better able to manage their own journey of care.

Our objectives for 2025-27 are:

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

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

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

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

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

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

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

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

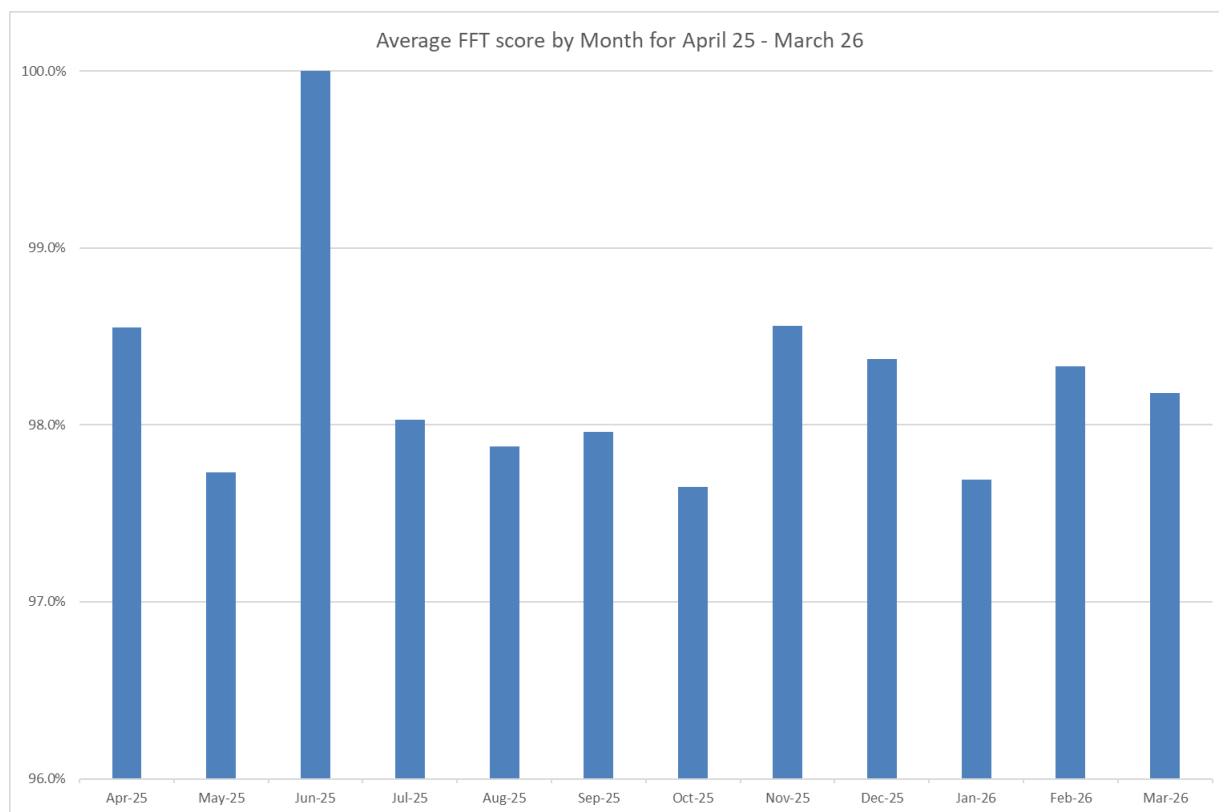
Friends and Family Test

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

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

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

For 2025/26, 18,804 patients completed a FFT survey and 98.24% of patients (inpatients and outpatients) said they would rate their experience as good or very good. The chart below shows the average FFT score per month:



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

Staff are sent an email alert in real time as soon as a low FFT score is received, and comments are automatically uploaded to the Trust's quality management system for staff to respond to within department. The FFT results are shared in Unit, department, and Speciality level Governance Quality reports with trends of low scores monitored monthly

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

	2021/22	2022/23	2023/24	2024/25	2025/26
National Average	94%	94%	94%	94%	94%
Highest Score	100%	100%	100%	100%	100%
Lowest Score	64%	73%	75%	69%	56%
The Robert Jones and Agnes Hunt	98%	98%	98%	98%	98%

Engagement mechanisms / Collaborative Arrangements

Stakeholder relationships have continued to be positive during 2025/26.

The Trust has been a member of Shropshire, Telford and Wrekin Integrated Care Board (STW ICB) since 1 July 2022. The Trust Chief Executive was a member of the ICB Board and members of the Trust Board have played an active role supporting system-wide initiatives.

The Chief Executive met with her peers within the system, and within other specialist providers, on a regular basis. Officers of the Trust also met with their peers in other organisations to progress work / share ideas as required.

The Chair, Chief Executive and others have met with colleagues from the ICB, NHSE and the Care Quality Commission throughout the year.

The Trust continued to work closely with colleagues in NHS Wales to deliver services to Welsh patients.

Representatives of Healthwatch attend the Trust's Patient Experience Meetings and the patient engagement group where they share intelligence with the Trust. If Healthwatch have any concerns they wish to raise outside those fora, they can contact the Chief Nurse and Patient Safety Officer directly. At system level, Healthwatch representatives attend monthly communications and engagement meetings, and meetings of the system quality group, where they provide feedback to the Trust and system partners.

The Council of Governors monitored progress against its Public Membership Development and Engagement Strategy during the year. The aim of the strategy is to grow the Trust's public membership and ensure that FT members are engaged both directly and through their elected public governors, in the development of the Trust's services. FT public membership grew from a total of 5,629 public members in April 2025 to 5,735 public members in March 2026.

The Trust Chair plays a key role in chairing meetings of the Council of Governors, ensures their effectiveness in all aspects of their role and agenda. Key responsibilities include:

- Ensuring the provision of accurate, timely and clear information to Directors and Governors
- Facilitating the effective contribution of Non-Executive Directors, Executive Directors and Governors and ensuring constructive relations between them

Non-Executive Directors attend meetings of the Council of Governors, to report on the work of the Board committees. Governors are also invited to observe meetings of the Board committees and regularly do so.

The Annual Meeting of the Foundation Trust took place on 29 September 2025. Items considered included:

- Chair's welcome and introduction;
- The Pre-Operative Process and Waiting Well initiative
- The Annual Report and Accounts, 2024/25
- A review of the year, 2024/25
- The Quality Accounts
- The Annual Accounts
- A presentation from the External Auditors
- Chair's Report from the Council of Governors Chair
- Forward Look to 2025/26
- Questions from the Public

Section 43 (2A) NHS Act 2006 Statements Regarding Income Disclosures

The Trust has fulfilled its principal purpose as its total income from the provision of goods and services for the purposes of the health service in England has been greater than its total income for the provision of goods and services for any other purposes.

Private practice complements the NHS services provided by the Trust and makes up a very small amount of our overall activity. Private patients only use facilities when they are not required for the NHS and this generates extra income which is used to enhance services and, in turn, benefits NHS patients every year.

Statement as to disclosure to auditors

For each individual director who was a director at the time this report was approved:

- So far as the director is aware there is no relevant audit information of which the Trust's auditor is unaware; and
- The director has taken all the steps they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

A director is regarded as having taken all these steps that they ought reasonably to have taken as a director in order to do the things mentioned above and:

- Made such enquiries of his/her fellow directors and of the Trust's auditors for that purpose; and
- Taken such steps (if any) for that purpose, as are required by his/her duty as a director of the Trust to exercise reasonable care, skill, and diligence.



Stacey Keegan
Chief Executive Officer
24 June 2026

Remuneration Report

This report contains the annual statement from the Chair of the Remuneration Committee and includes details regarding senior managers' remuneration in accordance with:

- Sections 420 to 422 of the Companies Act 2006 as they apply to foundation trusts.
- Regulation 11 and Parts 3 and 5 of Schedule 87 of Large and Medium-Sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI2008/410).
- Parts 2 and 4 of Schedule 8 of the Regulations as adopted by Monitor; and
- Elements of the Code of Governance for NHS Provider Trusts.

The Trust considers that disclosures in this report and the staff report meet the requirements of the NHS Act 2006 on the work of the Trust's Remuneration Committee.

Annual Statement on Remuneration by the Chairman of the Nomination and Remuneration Committee (Trust Chair, Mr Harry Turner)

The membership of the Nomination and Remuneration Committee during the year was:

- Harry Turner, Chair
- Sarfraz Nawaz, Non-Executive Director
- Martin Newsholme, Non-Executive Director
- Penny Venables, Non-Executive Director
- Lindsey Webb, Non-Executive Director
- Martin Evans, Non-Executive Director
- Darius Mirza, Non-Executive Director

In addition, the Chief Executive Officer, Chief People Officer and Deputy Chief People Office have been in attendance as requested by the Committee along with Associate Non-Executive Directors.

The Nomination and Remuneration Committee met on four occasions during the year and considered the following matters:

- Board recruitment and appointment arrangements
- Very Senior Manager (VSM) pay
- Mutually Agreed Resignation Scheme (MARS) proposal

Name	Meetings attended	Attendance percentage
Total 2025/26		
Harry Turner, Chairman	04 / 04	100%
Sarfraz Nawaz, Non-Executive Director	02 / 04	50%
Martin Evans, Non-Executive Director	02 / 04	50%
Martin Newsholme, Non-Executive Director	04 / 04	100%
Penny Venables, Non-Executive Director	01 / 03	33%
Lindsey Webb, Non-Executive Director	04 / 04	100%
Darius Mirza, Non-Executive Director	00 / 03	0%

Senior Managers' Remuneration Policy

The remuneration of the Chief Executive Officer and Executive Directors directly accountable to the Chief Executive Officer is determined by the Remuneration Committee. Details of the membership of this Committee and attendance at its meetings are set out above and in the Foundation Trust Governance section of the report.

The new Very Senior Managers Framework, issued in May 2025, was considered and adopted by the Remuneration Committee and determines remuneration of the Chief Executive Officer and Executives directly accountable to the Chief Executive Officer. It includes a new structure which reverts from role-sizing matrices to a model based on organisational reporting lines. For a Trust of this size, the salary of a chief executive officer (CEO) appointed under the Framework is capped at £194k and the salaries of executive directors reporting to the CEO appointed under the

Framework is capped at £151k. Trusts are required to comply with, or explain any deviation from, these caps when agreeing the salary of directors appointed since the implementation of the Framework. The remuneration of all directors appointed by the Trust since the implementation of the Framework complies with its requirements.

NHS foundation trusts have the discretion to determine the remuneration, allowances, and other terms and conditions of office for their chairs and non-executive directors through their local Councils of Governors. However, NHS England issued a ***Structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts*** in November 2019 to promote consistency and fairness across the sector. That document states that: *“Notwithstanding the discretion afforded to them, it is anticipated that NHS foundation trusts will also demonstrate consistency with the provisions of the aligned structure.”* The Trust implemented a NED / Chair remuneration structure in line with the published NHSE structure.

The subsequent ***Code of Governance for NHS Provider Trusts***, published in May 2022, reinforced that expectation by stating that: *“Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.”*

Those provisions aimed to reduce disparities in remuneration across NHS trusts and foundation trusts, and ensure transparency, proportionality, and alignment with national standards.

National Context

The Committee will take into consideration any guidance given from the Department of Health and Social Care regarding public sector pay including the inflation uplifts.

Pay Comparators

Salaries are benchmarked against the NHS Chief Executives and Directors Salary Surveys and NHS Improvement Pay Comparators.

Further, the New VSM Framework sets out clearly defined pay ranges for Chief Executives and Directors in line with Executive Director salaries capped at £194k and direct reports at £151k.

The Council of Governors last reviewed and approved NED remuneration in line with NHSE's ***Structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts*** in September 2025.

Performance-Related Pay and Assessment Process

The New VSM Framework states that Directors may earn a maximum of 10% Performance-Related Pay annually for exceptional performance.

Awards of up to 10% will be available for 'exceptional contribution'. The intention is that the bonus is paid for the impact the VSM had on the organisation rather than meeting or exceeding personal business objectives.

The Framework states that performance-related pay will not be consolidated and is not therefore pensionable.

In practice, performance-related pay has not been implemented.

The majority of Directors hold permanent contracts, which include a six months' notice period.

None of the Directors' contracts include any provision for compensation for early termination of employment.

Future Policy

The Trust's policy is as outlined in the table below:

Item	Salary/Fees	Taxable Benefits	Annual Performance Related Bonus	Long Term Related Bonus	Pension Related Benefits
Support for the short- and long-term objectives of the Foundation Trust	Ensure the recruitment and retention of directors of sufficient calibre to deliver the Trust's objectives	All payments made relate to car lease or car allowance for staff with significant travel requirements for their role	As per the Performance Related Pay and Assessment Process section above	None paid	Employee and employer contributions
How the component operates	Paid in even twelfths	Paid in even twelfths	As per the Performance Related Pay and Assessment Process section above	None paid	Employee and employer contributions
Maximum payment	As set out in Senior Managers' Remuneration Table	As set out in Senior Managers' Remuneration Table	As per the Performance Related Pay and Assessment Process section above	None paid	As set out in Senior Managers' Remuneration Table
Framework used to assess performance	Trust appraisal system	Not applicable	As per the Performance Related Pay and Assessment Process section above	None paid	Not applicable
Performance measures	Tailored to individual posts	Not applicable	As per the Performance Related Pay and Assessment Process section above	None paid	Not applicable
Amount paid for minimum level of performance and any further level of performance	Salaries are agreed on appointment and set out in the contract of employment	Not applicable	As per the Performance Related Pay and Assessment Process section above	None paid	Not applicable
Explanation of whether there are any provisions for recovery of sums paid to directors or provisions for withholding payments	Any overpayments may be recovered	Any overpayments may be recovered	Any overpayments may be recovered	None paid	Any overpayments may be recovered

Non-Executive Directors are appointed on fixed terms contracts, normally three or four years in length. Non-Executive Directors are not employees of the Trust and therefore there is no entitlement to access the Pension Scheme as a result of this engagement. The fee payable to Non-executive

Directors is set out in the tables on the next pages. They do not receive any other payments from the Trust.

Any changes to the future policy will be discussed by the Remuneration Committee taking account of national arrangements.

Service Contract Obligations

There are no obligations on the Trust which could give rise to, or impact on, remuneration payments or payments for loss of office but which are not disclosed elsewhere in the remuneration report.

Policy on Payment for Loss of Office

Notice periods for all substantive Executive Directors are contractually set at six months. Any payments for loss of office will be made in accordance with NHS Terms and Conditions of Service and NHSE guidance on Exit Payments where appropriate.

Statement of Consideration of Employment Conditions

Employment terms and conditions for Very Senior Managers mirrors those set out in Agenda for Change. The remuneration policy takes account of national pay comparators provided by NHSE and the scale of any inflationary pay award.

Service Contracts

For each senior manager who has served during the year, the date of their service contract, the unexpired term and details of the notice period are set out below:

Officer	Start date	End date of current term	Notice period
Turner, H Chair	01 February 2022	31 January 2028	N/A
Nawaz, S Non-Executive Director	01 February 2022*	31 January 2028	N/A
Newsholme, M Non-Executive Director	04 May 2022	03 May 2028	N/A
Evans, M Non-Executive Director	10 July 2023*	09 July 2026	N/A
Venables, P Non-Executive Director	19 June 2022	18 June 2028	N/A
Webb L, Non-Executive Director	01 July 2023	30 June 2026	N/A
Mirza, D Non-Executive Director	30 July 2025	01 February 2026	Left the organisation in February 2026
Maubach, P Associate Non-Executive Director	30 March 2023	29 March 2029	N/A
Ishaq, A Associate Non-Executive Director	01 July 2023	30 June 2026	N/A
Pepper, J Associate Non-Executive Director	01 July 2022	30 June 2025	Term ended in June 2025
Keegan, S Chief Executive Officer	19 December 2022	N/A (as a permanent employee)	6 months
Macbeth, C Chief Finance and Planning Officer	01 April 2017	N/A (as a permanent employee)	Retired from the role as of 30 April 2025
Mulholland-Wells, A Chief Finance and Commercial Officer	28 April 2025	N/A (as a permanent employee)	6 months
Longfellow, R Chief Medical Officer	01 April 2021	N/A (as a permanent employee)	6 months
Carr, M Chief Operating Officer	04 July 2022	N/A (as a permanent employee)	6 months

Officer	Start date	End date of current term	Notice period
Kavanagh-Fields, P Chief Nurse and Patient Safety Officer	01 April 2023	N/A (as a permanent employee)	6 months
Harnin, D Chief People and Culture Officer **	14 July 2022	N/A (as a permanent employee)	N/A (as a permanent employee)

*In current Non-Executive Director role. SN and ME were Associate Non-Executive Director prior to this appointment.

**Chief People and Culture Office is not a substantive staff member.

Disclosures Required by Health and Social Care Act

The following information is required by section 156 (1) of the Health and Social Care Act 2012, which amended paragraph 26 of Schedule 7 to the NHS Act 2006

Senior Managers' Remuneration (*subject to audit*)

For the purposes of this report 'senior managers' are defined as 'those persons in senior positions having authority or responsibility for directing the major activity of the Trust. The Trust's Chief Executive has agreed the definition.

The value of pension related benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This derived value does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension entitlement table provides further information on the pension benefits accruing to the individual.

Senior Managers Remuneration 2025/26

Name and Job Title	Salary & fees (bands of £5,000) £'000	Taxable benefits (to nearest £100) Note 1 £	Sub total of remuneration paid by the Trust (bands of £5,000) £'000	All pension-related benefits (bands of £2,500) Note 2 £'000	Total (bands of £5,000) £'000
Harry Turner Chair	45 - 50		45 - 50		45 - 50
Martin Evans Non-executive Director	10 - 15		10 - 15		10 - 15
Darius Mirza Non-Executive Director (from Nov 25 to Feb 26)	5 - 10		5 - 10		5 - 10
Sarfraz Nawaz Non-executive Director	10 - 15		10 - 15		10 - 15
Martin Newsholme Non-executive Director	10 - 15		10 - 15		10 - 15
Penny Venables Non-executive Director	10 - 15		10 - 15		10 - 15
Lindsey Webb Non-executive Director	10 - 15		10 - 15		10 - 15
Stacey Keegan Chief Executive	165 - 170	4,600	170 - 175	57.5 - 60	225 - 230
Craig Macbeth Chief Finance Officer (to Apr 25)	10 - 15	400	10 - 15		10 - 15
Angela Mulholland-Wells Chief Finance & Commercial Officer	120 - 125		120 - 125	5 - 7.5	130 - 135
Ruth Longfellow Chief Medical Officer	225 - 230		225 - 230	70 - 72.5	295 - 300
Paul Kavanagh-Fields Chief Nurse & Patient Safety Officer	130 - 135		130 - 135	42.5 - 45	170 - 175
Sam Young Acting Chief Nurse & Patient Safety Officer (to Jun 25)	20 - 25		20 - 25		20 - 25
Sarah Needham Interim Chief Nurse & Patient Safety Officer (from Sep 25)	70 - 75		70 - 75	30 - 32.5	100 - 105
Mike Carr Chief Operating Officer	135 - 140		135 - 140	40 - 42.5	175 - 180

Notes

1. Taxable benefits relate to a car allowance.
2. Pension related benefits are based on the HMRC approved calculation and assume a pension will be drawn for 20 years from retirement. This excludes employee contributions.
3. The Chief Medical Officer's salary includes payments relating to clinical duties.
4. No pension figures for Craig Macbeth due to retirement or Sam Young due to death in service, with all benefits claimed/paid.

Senior Managers Remuneration 2024/25						
Name and Job Title	Salary & fees (bands of £5,000) £'000	Taxable benefits (to nearest £100) <i>Note</i> 1 £	Sub total of remuneration paid by the Trust (bands of £5,000) £'000		All pension- related benefits (bands of £2,500) <i>Note</i> 2 £'000	Total (bands of £5,000) £'000
Harry Turner Chair	45 - 50		45 - 50			45 - 50
Martin Evans Non-executive Director	15 - 20		15 - 20			15 - 20
Sarfraz Nawaz Non-executive Director	20 - 25		20 - 25			20 - 25
Martin Newsholme Non-executive Director	10 - 15		10 - 15			10 - 15
Penny Venables Non-executive Director	10 - 15		10 - 15			10 - 15
Lindsey Webb Non-executive Director	10 - 15		10 - 15			10 - 15
Stacey Keegan Chief Executive	160 - 165	4,600	165 - 170		25 - 27.5	190 - 195
Craig Macbeth Chief Finance Officer	120 - 125	4,600	125 - 130		15 - 17.5	140 - 145
Ruth Longfellow Chief Medical Officer	215 - 220	400	215 - 220		135 - 137.5	355 - 360
Paul Kavanagh-Fields Chief Nurse	125 - 130	100	125 - 130		0	115 - 120
Mike Carr Chief Operating Officer	130 - 135	0	130 - 135		25 - 27.5	155 - 160

Notes

1. Taxable benefits relate to a car allowance or lease car benefit.
2. Pension related benefits are based on the HMRC approved calculation and assume a pension will be drawn for 20 years from retirement. This excludes employee contributions.
3. The Chief Medical Officer's salary includes payments relating to clinical duties.

Governor and Director Expenses

The following table provides details of expenses claimed by either Directors or Governors during the reporting period and provides comparative data for the previous year. Most expenses relate to travel.

Name	Role	2025/26	2024/25
Directors			
Harry Turner	Chair	£4,011	£3,356
Martin Evans	Non-executive Director	£1,666	£1,166
Atif Ishaq	Associate Non-executive Director	£2,017	£1,869
Paul Maubach	Associate Non-executive Director	£2,166	£607
Sarfraz Nawaz	Non-executive Director	£1,764	£1,738
Martin Newsholme	Non-executive Director	£1,997	£1,752
John Pepper	Associate Non-executive Director	£391	£1,283
Penny Venables	Non-executive Director	£1,185	£1,376
Lindsey Webb	Non-executive Director	£2,247	£2,497
Stacey Keegan	Chief Executive	£2,280	£1,898
Craig Macbeth	Chief Finance & Planning Officer		£93
Angela Mulholland-Wells	Chief Finance & Commercial Officer	£596	
Mike Carr	Chief Operating Officer	£50	£35
Denise Harnin (note 1)	Chief People & Culture Officer	£11,696	£10,540
Governors			
Sheila Hughes	Governor	£37	£172
Katrina Morphet	Governor		£58
Total		£32,103	£28,440

Note 1 – expenses relate to reimbursement of accommodation costs

Pension Entitlement (subject to audit)

The CETV in the table below is the actuarially assessed capitalised value of the pension scheme benefits accumulated by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The disclosures include accrued benefits derived from the member's purchase of added years of service and any "transferred-in" service.

Senior Managers Pension Entitlement 2025/26							
Name and Job Title	Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at pension age at 31 March 2026 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2026 £'000	Cash Equivalent Transfer Value at 31 March 2025 £'000	Real increase in Cash Equivalent Transfer Value £'000
Stacey Keegan Chief Executive	2.5 - 5	0 - 2.5	55 - 60	130 - 135	1,188	1,092	57
Angela Mulholland-Wells Chief Finance & Commercial Officer	0 - 2.5	0	10 - 15	0	142	122	2
Ruth Longfellow Chief Medical Officer	2.5 - 5	2.5 - 5	75 - 80	185 - 190	1,665	1,532	76
Paul Kavanagh-Fields Chief Nurse & Patient Safety Officer	2.5 - 5	0 - 2.5	35 - 40	80 - 85	722	658	38
Sarah Needham Interim Chief Nurse & Patient Safety Officer (from Sep 25)	0 - 2.5	0	5 - 10	0	122	91	21
Mike Carr Chief Operating Officer	2.5 - 5	N/A	30 - 35	N/A	407	363	22

Information provided by the NHS Pensions Agency

No pension figures for 25/26 for Craig Macbeth due to retirement, with all benefits claimed

Senior Managers Pension Entitlement 2024/25							
Name and Job Title	Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at pension age at 31 March 2025 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2025 £'000	Cash Equivalent Transfer Value at 31 March 2024 £'000	Real increase in Cash Equivalent Transfer Value £'000
Stacey Keegan Chief Executive	2 - 2.5	0	50 - 55	125 - 130	1092	981	25
Craig Macbeth Chief Finance Officer	0 - 2.5	0	50 - 55	130 - 135	1204	1092	22
Ruth Longfellow Chief Medical Officer	7.5 - 10	10 - 12.5	70 - 75	180 - 185	1532	1283	133
Paul Kavanagh-Fields Chief Nurse	0 - 2.5	0	30 - 35	75 - 80	658	636	0
Mike Carr Chief Operating Officer	0 - 2.5	N/A	25 - 30	N/A	363	315	11

Information provided by the NHS Pensions Agency

Real increase in CETV re-stated since 24/25 annual report was published

Fair Pay Disclosure *(subject to audit)*

NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest paid director and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The remuneration figures include salary, non-consolidated performance related pay and benefits in kind, but not employer pension contributions and the cash equivalent transfer value of pensions. From 2025/26 Non-Executive Directors are not included.

The banded remuneration of the highest paid director in 2025/26 was £227,500 (2024/25 was £217,500). This is a change between years of 4.6%.

For employees of the Trust as a whole, the range of remuneration in 2025/26 was from £12,500 to £287,500 (2024/25 was from £12,500 (re-stated) to £292,500). Note the lower end of the range excludes staff contracted on zero hours, such as bank, whose irregular or limited hours would otherwise reduce the reported minimum remuneration and distort comparability across the workforce. This approach has been applied consistently across both periods.

The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years was 4.9% (5.7% for 2024/25).

15 employees received remuneration in excess of the highest paid director in 2025/26 (21 in 2024/25).

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

The calculation is based on annualised full-time equivalent pay and benefits of all staff at the reporting period end date.

2025/26	25th percentile	Median	75th percentile
Salary component of pay	26,701	35,139	50,273
Total pay & benefits (excluding pension benefits)	26,701	35,139	50,273
Pay & benefits (excluding pension) : pay ratio for highest paid director	8.5	6.5	4.5

2024/25	25th percentile	Median	75th percentile
Salary component of pay	25,870	32,647	48,407
Total pay & benefits (excluding pension benefits)	25,870	32,647	48,407
Pay & benefits (excluding pension) : pay ratio for highest paid director	8.4	6.7	4.5

Payments for Loss of Office

There were no payments for loss of office recorded in 2025/26.

Payments to Past Senior Managers

No payments have been made to past senior managers in 2025/26.

Staff Report

Staff Costs (subject to audit)

Staff costs are shown in the table below. Costs have increased mainly due to pay awards and an increase in the employer's national insurance rate.

	2025/26			2024/25
	Permanent £'000	Other £'000	Total £'000	Total £'000
Salaries & wages	82,817	779	83,596	80,613
Social security costs	10,530	-	10,530	7,899
Apprenticeship levy	396	-	396	372
Employer's contributions to NHS pensions	16,248	-	16,248	15,284
Pension cost - other	16	-	16	20
Termination benefits	331	-	331	8
Temporary staff		833	833	2,310
Total gross staff costs	110,338	1,612	111,950	106,506
Recoveries in respect of seconded staff	-608	-	-608	-430
Total staff costs	109,730	1,612	111,342	106,076
<i>Of which:</i>				
<i>Costs capitalised as part of assets</i>	668	-	668	1,245

Average number of employees (subject to audit)

The average number of employees on a whole-time equivalent basis (WTE) is shown in the table below, analysed over professional groupings.

	2025/26			2024/25
	Permanent Number	Other Number	Total Number	Total Number
Medical & dental	169	2	171	170
Administration & estates	602		602	606
Healthcare assistants & other support staff	318		318	318
Nursing, midwifery & health visiting staff	351	2	353	347
Scientific, therapeutic & technical staff	224	3	227	220
Healthcare science staff	13		13	14
Total average numbers	1,677	7	1,684	1,675
<i>Of which, numbers engaged on capital projects:</i>	10		10	21

Exit packages (subject to audit)

All exit packages agreed in 2025/26 and 2024/25 are shown in the table below:

Exit package cost band	2025/26			2024/25		
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000		2	2		2	2
£10,000 - £25,000		3	3			
£25,001 - £50,000		1	1			
£50,001 - £100,000		3	3			
Total number	0	9	9	0	2	2
Total cost		£331,000	£331,000		£8,000	£8,000

Analysis of the non-compulsory payments:

	2025/26		2024/25	
	Number of agreements	Value of agreements	Number of agreements	Value of agreements
Mutually agreed resignations (MARS) contractual costs	7	£328,000		
Contractual payments in lieu of notice	2	£3,000	2	£8,000
Total number of exit packages	9	£331,000	2	£8,000

Staff gender distribution

A breakdown of the number of persons who were directors of the Trust, senior managers, and other employees at 31 March 2026 is shown below:

	Female	Male
Executive Directors	4	2
Non-executive Directors (including Chair and Associate NEDs)	2	6
Other senior managers	16	8
Other employees	1561	502
Total	1583	518

Staff Sickness Absence

The sickness absence figures in the table below are provided to the Trust, calculated from statistics published by NHS Digital. They are for calendar years, due to timing difficulties with financial year data. The Department of Health & Social Care considers the figures to be a reasonable proxy for the financial year.

2025/26			2024/25		
Average FTE 2024	FTE Days Lost 2024	Average Sick Days per FTE 2024	Average FTE 2024	FTE Days Lost 2024	Average Sick Days per FTE 2024
1,584	18,442	11.6	1,572	19,007	12.1

Note: FTE = Full Time Equivalent

Staff Equality and Diversity

The age, ethnic breakdown, staff gender distribution and number of staff with recorded disabilities is shown below:

The Trust employed 2088 staff on 31st March 2026 (including Bank Staff).

The demographic profiles of our staff are shown below:

Age Range	Headcount	% Headcount
19 and below	11	1%
20 - 29 Years	282	13%
30 - 39 Years	474	23%
40 - 49 Years	475	23%
50 - 59 Years	531	25%
60 and above	328	16%
Total	2101	

Gender	Headcount	% Headcount
Female	1583	75%
Male	518	25%
Total	2101	

Part Time/Full Time	Full Time	Part Time	% of Gender Full Time	Total
Female	574	1009	36%	1583
Male	372	146	72%	518
Total	946	1155	45%	2101

Ethnicity	Headcount	% Headcount
Any Other Ethnic Group	25	1%
Asian or Asian British	144	7%
Black or Black British	61	3%
Chinese	4	0.2%
Mixed - Any mixed background	20	1%
Not stated	40	2%
White - British	1702	81%
White - Other	105	5%
Total	2101	

As described in the Equality, Diversity and Human Rights section of the Annual Governance Statement, the Trust publishes information on the gender pay gap.

Staff Turnover

Staff turnover continues to be monitored by the Board via reporting to the People and Culture Committee.

The Trust reported an average monthly voluntary turnover rate of 9.66% in 2025/26, with 9.37% reported in March 26. This is below the target agreed in workforce plan submission for 2025/26 at 9.98%.

Actions to support retention such as wellbeing support to staff, with focused and timely management interventions as well as promotion of available support systems continues to be a focus for to reduce sickness absence with the rate reported for 2025/26 at 5.08%, which is a reduction on the previous year at 5.38%.

Focused activity remains in place to recruit to vacancies, vacancy rate has reduced from 6.47% in April 25 to 6.19% in March 26, it is worth noting the budgeted establishment has grown by 8.08 WTE, with staff in post growing by 13.08 WTE.

Development of staff remains a Trust priority in line with RJAH People Plan as well as promotion of the Trust's study leave policy to support career development within our workforce. The Trust remain committed to work-life balance and promotes the utilisation of both flexible and agile working.

Supporting Staff with Disabilities

The Trust's policies ensure full and fair consideration is given to all job applications from people with a disability and ensures adaptations and support are available to facilitate the continued employment and training of staff with a disability. All job adverts contain a welcoming statement, and an additional document is provided to all candidates on the Equality, Diversity and Inclusion support, including the Disability Staff Network Group

Recruitment data is collected and analysed to ensure applicants to the Trust are free from any form of discrimination. Candidates who declare themselves as having a disability and who meet the essential requirements of the job description and person specification are guaranteed an interview by the Trust.

The EDI team have a regular monthly slot on the Trust's Induction programme for all new starters, which details the support open to all staff with disabilities and their allies

In the event that a staff member becomes disabled while employed by the Trust, the Trust's policies ensure support, reasonable adjustments to the role or alternative roles are offered to enable staff to remain in employment.

We have continued to support our Staff Network Group, which ensures the staff have a voice on ideas and innovation on improvements in the workplace, and we are in the final stages of developing a portable Staff Health passport. The Trust were also able to support the network group with guest speakers with lived experiences around invisible disabilities.

In March 2026 the Trust launched Health Passports for Staff, a new health passport for staff – providing a new way for colleagues to share information about how they work best and what support or adjustments may help them thrive at work

The health passport recognises that everyone is different and brings unique skills, experiences and strengths to work. For some, this may include living with a disability, long-term condition, or other circumstances that may affect how they work day to day. It has been developed in collaboration with the Disability Staff Network, drawing on lived experience and feedback from staff, and is designed to support open, meaningful conversations between colleagues and managers, while giving individuals control over what they choose to share.

Health and Safety

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

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

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

Incidents involving specified injuries, occupational disease, or resulting in a member of staff taking more than seven days off work as a result of a work-related accident, were also reported to the Health and Safety Executive (HSE) under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). During 2025-26 there were three incidents reported to the HSE under the requirements of the RIDDOR regulations, a significant reduction on the previous year. No regulatory action or sanction was received in respect of the reported incidents.

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

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

Staff Engagement

ImproveWell App, a digital solutions platform, has been introduced to some clinical and non-clinical areas within the Trust. The App provides real time engagement and feedback on areas for development and improvement, which means we are not waiting for responses on an annual basis from the National Staff Survey. Staff have been able to engage through surveys about improvements in their wards or departments, with thirteen improvements submitted so far.

As noted elsewhere in this report, the Trust encourages a culture of openness. As well as a Freedom to Speak Up (FTSU) Guardian, we have an Executive and Non-Executive lead for FTSU as well as a number of Freedom to Speak Up Champions across the Trust. There is a dedicated FTSU section on the staff intranet and posters around the site providing information and contact details. We have self-assessed against the National Freedom to Speak Up Guardian Reflection and Planning tool, which has helped us develop key actions. We have recently implemented a QR code that staff can scan and use to report any issues, which is completely anonymous and will help us understand any themes or areas that need further support.

There is an active programme of staff briefing and engagement sessions, by newsletter, other publications, and meetings (both virtual and face to face).

Countering fraud and corruption

The Trust has in place a Local Counter Fraud Specialist team who oversee any investigations of potential fraud. On an annual basis the Trust assesses the effectiveness of its counter fraud service, and this is reported to the Audit and Risk Committee. Both Lead and Support Local Counter Fraud Specialists at the Trust have access to the fraud case management system, CLUE, which will assist them in the investigation and reporting of allegations. During 2025/26, the Local Counter Fraud Specialist, supported by the Counter Fraud Champion, undertook a review of the organisation's preparedness for complying with the recently introduced corporate offence of Failure to Prevent Fraud – this included provided training to key personnel, review and updating policies, providing guidance to all staff, and undertaking a risk workshop to consider the Trust's exposure to the new legislation.

The Trust has in place security and counter fraud policies to ensure compliance with NHS Counter Fraud Authority guidance. The Trust has an established Counter Fraud Protocol which outlines the role of the Local Counter Fraud Specialist and the cross over and interaction with the Trust's Local Security Management Specialist. Awareness raising activities occur across the year to ensure that all staff understand how NHS fraud can happen and how they can raise any concerns.

In line with national guidance, the Trust maintains a Managing Conflicts of Interest Policy in order to provide a clear outline of the Trust's position on issues where there is the potential for conflict to arise such as through the acceptance of gifts and hospitality. The policy also outlines the requirements on senior staff, consultants, and approvers on the Trust's procurement system with regard to the declaration of interests.

Staff Survey Results

NHS staff survey

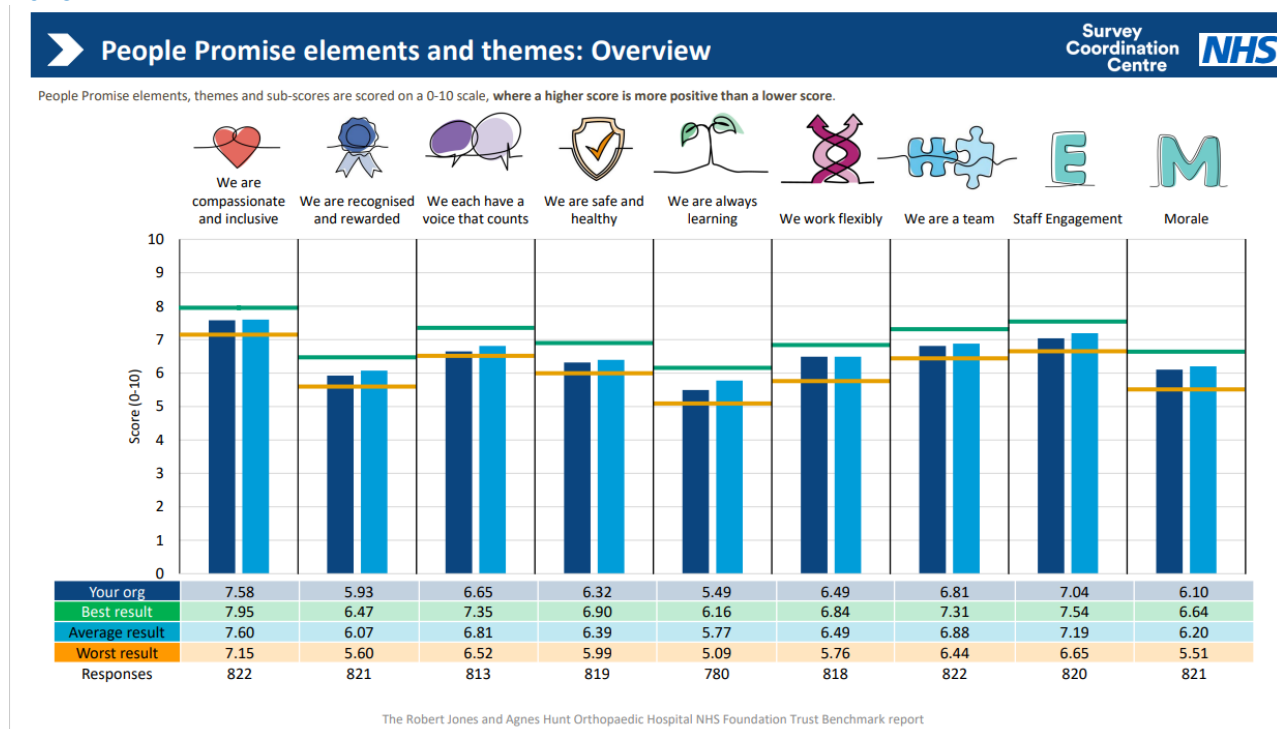
The NHS staff survey is conducted annually. From 2021/22 the survey questions align to the 7 elements of the NHS people promise, retaining 2 previous themes of engagement and morale. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The response rate to the 2025 survey for trust staff was 45% (2024/25: 47%).

Scores for each indicator together with that of the survey benchmarking group Acute Specialists Trust are presented below.

Indicators (‘People Promise’ elements and themes)	2025		2024/25		2023/24	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:						
We are compassionate and inclusive	7.58	7.60	7.67	7.52	7.68	7.51
We are recognised and rewarded	5.93	6.07	6.14	6.14	6.24	6.12
We each have a voice that counts	6.65	6.81	6.84	6.96	6.87	6.92
We are safe and healthy	6.32	6.39	6.46	6.47	6.49	6.41
We are always learning	5.49	5.77	5.73	5.81	5.66	5.71
We work flexibly	6.49	6.49	6.58	6.63	6.43	6.47
We are a team	6.81	6.88	6.97	6.94	7.04	6.95
Staff engagement	7.04	7.19	7.34	7.34	7.37	7.35
Morale	6.10	6.20	6.28	6.28	6.33	6.25

2025 results



Top 5 scores vs Organisation Average	Org	Picker Avg
Q11b. In last 12 months, have not experience MSK problems as a result of work activities	68%	64%
Q13d. Last experience of physical violence reported	78%	75%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
Q25f. Feel organisation would address any concerns I raise	47%	55%
Q4b. Satisfied with extend organisation values my work	41%	49%

Q24a. Organisation offers me challenging work	73%	70%
Q3h. Have adequate materials, supplies and equipment to do my work	69%	65%
Q16a. Not experience discrimination from patient/service users, their relatives or other members of the public	97%	95%

Q19c. organisation ensure errors /near misses/ incident do not repeat	65%	72%
Q20b. Would feel confident that organisation would address concerns about unsafe clinical practice	53%	61%
Q23c. Appraisals helped me agree clear objective for my work	30%	37%

Most Improved Scores	Org 2025	Org 2024
Q13d. Last experience of physical violence reported	78%	69%
Q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	81%	74%
Q24b. Organisation offers me challenging work	73%	70%
Q14a. Not experienced harassment, bullying or abuse from patient/ service users, their relative or members of the public	85%	81%
Q17a. Not experienced unwanted behaviour of a sexual nature from patient / service users, their relative or members of the public	95%	92%

Most Declined Scores	Org 2025	Org 2024
Q22. I can eat nutritious and affordable food at work	58%	68%
Q2a. Often/always look forward to going to work	50%	58%
Q11a. organisation takes positive action on health and well-being	57%	64%
Q25f. Feel organisation would address any concerns I raise	47%	55%
124b. There are opportunity for me to develop my career in this organisation	47%	54%

Future priorities and targets

The Trust will try and improve the response rate for the 2025 survey, and the response rates by People promise element, with continued engagement and promotion of the survey.

All RJAH colleagues were invited to participate in the National NHS Staff Survey between October and November 2025. The survey results are reported in a benchmark format, with our organisation benchmarked against 12 other Acute Specialist Trusts. 45% of our people participated in the 2025 survey, a slight decline of 56 responses compared to last year. Our response rate was lower than the median response rate in our benchmark group of 49%.

We are proud that our staff still recommend the Trust as a place to work, with a response rate of 69% (2024 data – 74% a slight decrease) and recommend treatment to a friend or relative: 91% (92% in 2024)

We have recognised that there are other areas that need further focus and attention. A Trust-wide steering group has been established to take this work forward. We have set up a bi-monthly Staff Survey Focus group where we can review areas of good practice and areas that need greater support and improvement for the workforce. Progress on that work is reported into the People and Culture Committee.

Survey results have also been circulated to managers across the Trust who have been asked to identify three priority actions in their own areas of work. They have also been asked to develop local action plans to cover how they will improve:

- the response rate for the 2026 National Staff Survey.
- how staff feel and confidence around speaking up.
- the engagement score.

Expenditure on consultancy - Off-payroll arrangements

Please note that the previous year's figures for the final question "**Number of individuals that have been deemed board members, and/or senior officials with significant financial responsibility during the financial year. NB includes both off-payroll and on-payroll engagements**" has been updated to include On-Payroll as the previous reports only included Off Payroll.

Off- payroll engagements as at 31 March 2025, for more than £245 per day and lasting more than six months	2025-26	2024-25	2023-24	2022-23	2021-22	2020-21	2019-20
Number of existing engagements as at 31 March 2025	4	12	21	28	12	2	13
Of which							
have existed for less than one year at the time of reporting	3	9	13	15	9	1	8
have existed for between one and two years at the time of reporting	1	3	3	12	2	1	2
have existed for between two and three years at the time of reporting	0	0	5	0	1	0	1
have existed for between three and four years at the time of reporting	0	0	0	1	0	0	2
have existed for four or more years at the time of reporting	0	0	0	0	0	0	0
Assurance has been sought and received from all of the individuals above that they have made appropriate arrangements for the payment of their tax liabilities							
New Off- payroll engagements or those that reached six months duration between 1 April and 31 March 2025, for more than £245 per day and lasting more than six months	2025-26	2024-25	2023-24	2022-23	2021-22	2020-21	2019-20
New Off- payroll engagements or those that reached six months duration between 1 April and 31 March 2025, for more than £245 per day and lasting more than six months	3	9	13	15	9	1	8
Number of the above which include contractual clauses giving the Trust the right to request assurance in relation to Income tax and National Insurance obligations	3	9	13	16	9	1	8
Number of whom assurance has been requested	3	9	14	16	9	1	8
Of which							
Assurance has been received	3	9	14	16	9	1	8
Assurance has not been received	0	0	0	0	-	-	-
have been terminated as a result of assurance not being received	0	0	0	0	-	-	-
Off- payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April and 31 March 2025	2025-26	2024-25	2023-24	2022-23	2021-22	2020-21	2019-20
Off- payroll engagements of board members, and/or senior officials with significant financial responsibility during the financial year	0	0	0	0	0	0	0
Number of individuals that have been deemed board members, and/or senior officials with significant financial responsibility during the financial year. NB includes both off-payroll and on-payroll engagements	14	11	13	12	14	12	14



Stacey Keegan
Chief Executive Officer
24 June 2026

Code of Governance for NHS Provider Trusts

Statement of compliance with the NHS Foundation Trust Code of Governance

The Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust has applied the principles of the Code of Governance for NHS Provider Trusts on a comply or explain basis. The Code of Governance, most recently revised in October 2022, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Trust is a public benefit corporation established under Section 35 of the National Health Service Act 2006. The Board attaches great importance to ensuring that the Trust operates to high ethical and compliance standards. In addition, it seeks to observe the principles set out in the NHS Foundation Trust Code of Governance.

The Board is responsible for the management of the Trust and for ensuring proper standards of corporate governance are maintained. The Board accounts for the performance of the hospital and consults on its future strategy with its members through the Council of Governors.

The Council of Governors' role is to influence the strategic direction of the Trust, to take into account the needs and views of the members, local community and key stakeholders, to hold the Board to account for its performance, to develop a representative, diverse and well-involved membership and to make a noticeable improvement to the patient experience. It also has to undertake other statutory and formal duties, including the appointment of the Chairman and Non-Executive Directors of the Trust and appointment of the external auditors.

In the event of a dispute between the Board and the Council a disputes procedure is described in the Constitution.

In accordance with its Licence, the Trust has in place mechanisms in its Constitution to ensure that no person who is an unfit person may become or continue as a governor, except with the approval in writing of NHS England.

The Board has established governance policies that reflect the principles of the NHS Foundation Trust Code of Governance. These are outlined within this Report and key elements are listed below:

The Directors' Report includes:

- Details of the chair, the deputy chair, the chief executive, the senior independent director

The Meet the Board and Meet the Trust's Council of Governors sections include:

- A brief biography of the board of directors, including their terms of appointment (if applicable).
- Details of the chair's other significant commitments which were disclosed to the council of governors before appointment.
- Details of the Trust's membership and Council of Governors, their appointments, attendance records and constituencies represented.
- Information on arrangements to ensure effective communication between the Council of Governors and the Board of Directors (particularly the non-executive directors)
- Information on how the public can contact the Board and the Governors.
- The Annual Governance Statement includes:
- A summary of the Trust's governance structure, including the maintenance of a schedule of matters reserved for the board of directors which includes a clear statement detailing the roles and responsibilities of the council of governors, the Board, and the Trust's Directors.
- The required statements on how directors have prepared the annual report and accounts, and that the annual report and accounts, taken as a whole, are fair, balanced, and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.
- The respective roles of the Board's committees, including the Audit and Risk Committee
- A summary of the Trust's approach to quality governance.

- A summary of the Trust's arrangements for the maintenance of an internal audit and an external audit function
- A section on the review of the effectiveness of its system of internal controls
- Information on the Trust's arrangements for maintaining an internal audit and an external audit function.
- Information on the annual reviews of committee effectiveness.
- Information on the maintenance and availability of the required registers of interests.
- Information on the Trust's arrangements for making appointments to the Board and for assessing directors' performance.

The Trust has undertaken a self-assessment against the requirements of the revised Code and the results were reported to the Audit and Risk Committee.

Accepted areas of non-compliance or partial compliance

Where the Trust is either partially, or non-compliant, with the requirements of the Code it is required to explain that variance. There are three areas where the Trust is partially compliant and has no plans to comply. The variance and explanation can be summarised as:

- Section C, 4.1, self-assessment reference 52 – The Trust complies with the requirements of the Fit and Proper Person Test (FPPT) framework but does not apply the FPPT to Governors. In accordance with the NHSE Guidance issued in 2023, the FPPT has been applied to the Board of Directors. The Governor nomination process involves a declaration covering key elements of the FPPT but Governors are not subject to annual FPPT tests.
- Section E, 2.7, ref.84 - The Trust has a Remuneration Committee that determines the remuneration of Executive Directors but the remit of the committee does not routinely extend to “*the first layer of management below board level*” though it does extend to a small number of staff at that level who are remunerated outside the NHS agenda for change structure. The Trust does not believe that it is appropriate, or necessary, for this organisation to apply this to all managers reporting to Board members.
- Section C, 4.12, ref.60 - The Trust's Executive Director Remuneration Committee / Board do not have a role in considering individual contractual discussions around matters such as executive directors “*serving their full notice period and/or material reductions in their time commitment.*” The Trust does not believe that is appropriate for this organisation and any such contractual discussions should take place between the individual and the Chief Executive (taking appropriate professional advice).

There is one area of the Code where the Trust is partially compliant, as it complies with the spirit of the requirement but not the exact process described in the Code:

- Section C, 2.2 ,ref. 45 – “*The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.*”

Existing Board members' skills / experience / performance are reviewed annually. This informs a review of the overall balance / diversity of the Board each time a vacancy becomes available. Consideration is also given to the skills / experience required to deliver the Trust's strategic objectives, when those objectives are reviewed. Where gaps have been identified but no vacancies existed, the Trust has appointed Associate Non-Executive Directors to supplement the skills / experience on the Board.

Meet the Trust's Council of Governors

The Council of Governors consists of nine Public Governors, three Stakeholder Governors and three Staff Governors. The Trust's Governors can be contacted via the following email address: rjah.governors@nhs.net



Victoria Sugden
Lead Governor – Public Governor –
Shropshire



Colin Chapman
Public Governor - Shropshire



Gill Pitcher
Public Governor - Shropshire



Neil Turner
Public Governor – Cheshire and Merseyside



Tony Wright
Public Governor - West Midlands



Russell Luckcock
Public Governor - Rest of England
& Wales



Jan Greasley
Public Governor – North Wales



Sheila Hughes
Public Governor – North Wales



Vacancy
Public Governor - Powys



Craig Emery
Stakeholder Governor – Shropshire Council



Karina Wright
Stakeholder Governor – Keele
University



Peter David
Stakeholder Governor – RJAHS
Voluntary Services



Joy Chowdhury
Staff Governor



Nicki Bellinger
Staff Governor



Kate Betts
Staff Governor

Council of Governors Terms of Office and Elections

Type of Governor	Constituency	Date of current appointment / election	Date term in office ends / ended
Stakeholder Governors (Appointed)			
Craig Emery	Shropshire Council	12 Jun 25	11 Jun 28
Karina Wright	Keele University	01 Jan 24	30 Dec 26
Peter David	Voluntary Services Committee	30 Jun 24	29 Jun 27
Staff Governors (Elected)			
Joy Chowdhury	Staff	04 Aug 25	03 Aug 28
Kate Betts	Staff	04 Aug 25	03 Aug 28
Nicki Bellinger	Staff	01 Nov 24	31 Oct 27
Public Governors (Elected)			
Colin Chapman	Shropshire	30 Jun 24	31 Oct 26
Victoria Sugden	Shropshire	30 Jun 24	29 Jun 27
Gill Pitcher	Shropshire	04 Aug 25	03 Aug 28
Sheila Hughes	North Wales	04 Aug 25	03 Aug 28
Jan Greasley	North Wales	01 Nov 24	31 Oct 27
Tony Wright	West Midlands	01 Nov 24	31 Oct 27
Russell Luckock	Rest of England and Wales	01 Nov 24	31 Oct 27
Vacancy	Powys	N/A	N/A
Neil Turner	Cheshire and Merseyside	30 Jun 24	29 Jun 27

Council of Governor Meetings

During 2025/26 the Trust held six meetings of the Council of Governors (including Extra-Ordinary meetings). The Trust recognises the importance of these meetings in ensuring that the members of the Board of Directors, and in particular the Non-Executive Directors, develop an understanding of the views of the Governors and its members. Governors have been engaged in the development and review of the Trust's forward plan, including its objectives, priorities, and strategy. These views have been communicated to the board of directors.

The Trust Chair is also the chair of the Council of Governors so attends all meetings of the Council. The Chief Executive Officer and Trust Secretary are invited to attend meetings of the Council. Non-Executive Directors are invited to attend all regular meetings of the Council (of which there were four in 2025/6) and Executive Directors and other staff may attend by invitation to support particular agenda items.

Name	Meetings attended	Attendance percentage
Total 2025/26	6*	
Harry Turner, Chairman	05 / 06	83%
Sarfraz Nawaz, Non-Executive Director	02 / 04	50%
Martin Evans, Non-Executive Director	04 / 04	100%
Martin Newsholme, Non-Executive Director	04 / 04	100%
Penny Venables, Non-Executive Director	02 / 04	50%
Lindsey Webb, Non-Executive Director	02 / 04	50%
John Pepper, Associate Non-Executive Director	01 / 01	100%
Atif Ishaq, Associate Non-Executive Director	00 / 04	0%
Paul Maubach, Associate Non-Executive Director	00 / 04	0%
Stacey Keegan, Chief Executive Officer	03 / 04	75%
Trust Secretary Representation	06 / 06	100%

* NEDs were not invited to attend any extra-ordinary meetings that considered NED appointments. Collectively, NEDs were invited to four of the six meetings.

To ensure that the Board, and in particular the Non-Executive directors, develop an understanding of the views of governors and members, Board members attend meetings of the Council of Governors. Governors are also invited to attend meetings of the Board and its committees.

A survey of governors' opinions is also undertaken annually, and the lead governor has regular meetings with the Chair and the Trust Secretary to support effective communication between the membership, governors, and Board of Directors.

Membership

The Trust reviews its membership at each regular meeting of the Council of Governors. This review looks at the number of members and analyses the demographic information to ensure that, as far as possible, the membership remains representative of the community the Trust serves. The table below provides a breakdown of the membership by constituency for the financial year 2025/26. In addition, there were 1,399 staff members at the end of March 2026.

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Cheshire & Merseyside	400	401	402	401	401	400	406	406	407	408	407	408
North Wales	912	912	910	906	905	903	907	910	910	913	914	914
Powys	571	571	572	573	573	572	575	574	575	568	569	571
Shropshire	2,820	2,825	2,837	2,836	2,837	2,833	2,854	2,862	2,866	2,879	2,882	2,892
West Midlands	573	573	572	573	572	572	576	576	577	574	573	573
Rest of England & Wales	315	315	317	317	317	317	324	328	328	330	330	330
Out of Trust Area	38	38	38	38	38	38	40	40	40	46	47	47
Total	5,629	5,635	5,648	5,644	5,643	5,635	5,682	5,696	5,703	5,718	5,722	5,735

The Trust set a target to achieve a year-on-year increase in membership. In April 2025, overall membership stood at 7001. On 1 April 2026, overall membership stood at 7148. As such, there was a 2% increase over 2025/26.

NHS Oversight Framework

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

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

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

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

Segmentation

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

The definition of segment 1 is: **"High Performing"**.

Over the four periods of 2025/6, the Trust scores and league table positions were:

	Segment	Average Metric Score* (and improvement since previous quarter)	Metric improvement score since Q1	League table position out of 134 (and improvement since previous quarter)	League position improvement since Q1
2025/5, Q4	1	1.93 (0.26)	0.38	17 (+5)	+10
2025/6, Q3	2	2.19 (0.3)	0.12	22 (+3)	+ 5
2025/6, Q2	2	2.22 (0.9)	0.9	25 (+2)	+2
2025/6, Q1	2	2.31	-	27	-

*NOTE: low scores are better than high scores.

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

Under the capability assessment undertaken in 2025/6, the Trust was rated **AMBER / GREEN**.

Statement of the Chief Executive's Responsibilities as the Accounting Officer of The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England has given Accounts Directions which require The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the *Department of Health and Social Care Group Accounting Manual* and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.



Stacey Keegan
Chief Executive Officer
24 June 2026

Annual Governance Statement 2025/26

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in RJAH NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust considers that risk management is everyone's business, ranging from staff taking individual responsibility for the safety of themselves, their colleagues, or patients to Executive Director responsibility for strategic risks or the Non-Executive responsibilities for robust challenge of effective risk management and assurance of adequate control.

MIAA undertook a review of the Trust's Risk Management Core Controls in the final quarter of 2025 and provided a "High" assurance rating that *"There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed."*

All staff have a duty to manage risk but the following senior managers and Executive Directors have particular responsibilities for risk management:

Chief Executive Officer

- Accounting Officer
- Maintain a sound system of internal control.
- Prudent and economic administration of the organisation
- Strategic leadership for the Trust's Information Management and Technology infrastructure and services

Chief Finance and Commercial Officer

- Advise Board on Financial Strategy and Management
- Ensure sound financial management, including compliance with SFIs.
- Ensure that external financial reporting complies with the relevant standards.
- Ensure that there are systems in place to meet the Trust's operational targets and objectives.
- Ensure sound financial management of the Capital Programme

Chief Nurse and Patient Safety Officer

- Board lead for Quality and Safety (in conjunction with the Chief Medical Officer)
- Lead on clinical governance, accountability, and quality (in conjunction with the Chief Medical Officer)
- Professional Leadership of Nursing Staff and Allied Health Professionals
- Patient and Public involvement
- DIPIC (Director of Infection Prevention and Control)

- Safeguarding
- Oversight of risk management process
- Health and Safety management and compliance with statutory requirements

Chief Medical Officer

- Responsible Officer including the appraisal, revalidation, and performance management of medical staff.
- Professional Leadership of Medical Staff
- Ensure that medical staff have the requisite skills to provide high quality medical care.
- Lead on clinical governance, accountability, and quality (in conjunction with the Chief Nurse and Patient Safety Officer)
- Lead for the Clinical Services Strategy (in conjunction with the Managing Director of Strategy and Planning)
- Leading the Trust's relationships with General Practitioners and Medical Schools
- Lead medical input into litigation and claims management.
- Ensure that sound governance arrangements are in place for research.
- Caldicott Guardian / Information Governance
- Accountable Officer for controlled drugs

Chief People Officer

- Effective matching of workforce to activity
- Leading and facilitating continuous professional development
- Develop the leadership capacity and capability.
- Ensuring the development and implementation of the Organisational Development Strategy
- Equality, diversity, and inclusion
- Ensuring the Trust has adequate oversight of its performance.
- Fostering a culture that values continuing professional development and strives for excellence in service delivery and patient experience.

Chief Operating Officer and Deputy CEO

- Ensuring the delivery of operational activity in accordance with agreements between the Trust and its stakeholders and national targets.
- Provide executive leadership to the units for service delivery.
- Board level accountability for the delivery for operational performance standards and targets and achievement against local and national standards.
- Board level accountability for the delivery and management of partnerships and service/business development.
- Developing and implementing operational policies to achieve the Trust's strategic direction.
- Meet agreed targets and objectives, and deliver within defined costs, timescales and resources.
- EPRR Accountable Officer.
- Design and ensure the effective operation of the Trust's process of continuous improvement.
- Ensuring the Trust has adequate oversight of its performance.
- Strategic leadership for the Trust's service improvement framework and agenda.
- SRO for MSK Transformation
- Deputy Chief Executive Officer

Trust Secretary

- Provide central support and advice to the Board regarding the establishment of an effective system of internal control.
- Develop and maintain the Trust's Board Assurance Framework
- Data Protection Officer (DPO)
- Freedom to Speak Up

Deputy Chief Medical Officers / Managing Directors / Assistant Chief Nurses

- Manage risks at a local level and developing an environment where staff are encouraged to identify and report risk issues proactively.
- Maintain a risk register and presenting key risks to the Risk Management Group a monthly basis.
- Ensure that their staff report immediately any near-miss incidents, adverse incidents, and serious incidents, using the Trust's incident reporting procedure.
- Provide appropriate feedback regarding specific incidents reported and implement recommendations following investigations to reduce the likelihood of recurrence.
- Efficient delivery of operational and clinical support services
- Implementation of national policy on waiting list targets
- Ensure that there are systems in place to meet the Trust's operational targets and objectives.

Director of Digital

- As Senior Information Risk Owner (SIRO) ensuring that risks to data security are recognised and managed.
- Lead for Cyber Security

Risk awareness is promoted throughout the organisation with all staff expected to have an understanding of the Trust's incident reporting procedure and knowledge of the process for escalating risks. There is a comprehensive programme of risk management training for staff.

The Risk and Control Framework

Risk Management Policy

The Trust's Risk Management Policy sets out the framework and systems for implementation of risk management and governance in the Trust. The policy clearly defines how risks are identified, reviewed, managed and, where appropriate, escalated. Further, it sets out individual and committee roles and responsibilities and defines the levels of authority for the management of identified levels of risk. It also describes the Trust's interpretation and definition of 'acceptable risk' via its risk appetite statement.

The Good Governance Institute (GGI) supported the Trust to develop a revised risk management policy during 2022/23. This policy, supported by a programme of risk management training, was implemented during 2023/4 and has been kept under review since.

The Trust uses an online risk management system to record and escalate risks through the organisation in accordance with the matrix outlined in the Risk Management Policy.

The policy includes the following key elements:

- It describes what is meant by 'risk management'.
- It identifies the roles and responsibilities of all staff within the Trust.
- It clearly describes the roles and responsibilities of the key accountable officers.
- The training requirements for staff

It sets out the process of risk management as follows:

- i. Risk identification
- ii. Risk evaluation
- iii. Risk recording
- iv. Risk treatment and escalation

Risk Appetite

The Board-agreed risk appetite statement for 2025/6 was:

Risk category	Risk appetite	Risk tolerance - target	Rationale
Quality	Cautious	6	The trust exists to provide optimal clinical care and treatment. Therefore, we take a cautious approach – we prefer to avoid risks which would adversely affect the quality of services but recognise that it is rarely possible to develop new services or change pathways without some degree of risk. We will pursue innovation in order to make improvements but when making significant decisions about clinical services, we will carefully assess any associated risks to patient safety, patient experience and clinical effectiveness, and put in place control measures to mitigate them. We continuously monitor the impact on quality, using both statistical data and feedback from patients and carers.
Finance	Open	9	We are an ambitious organisation which plans for the future. Many of our initiatives and innovations will generate additional income and efficiencies in the longer term but require financial investment to get started. We also recognise that the cheapest option is not always the most effective. We are therefore open to financial risk. This is dependent on financial forecasting which allows us to quantify the level of risk, and applying robust budgetary controls as set out in our standing financial instructions and scheme of delegation.
Workforce	Seek	12	We aim to provide a supportive workplace in which employees can thrive and which people choose as a great place to work. For these reasons, and to fulfil our ambitions of growing and transforming our services, we will pursue new ways of working. We seek risk in that we recognise that the prospect of change can be disruptive and unsettling but are willing to accept this risk where there are longer term gains, including improved recruitment and retention, and widening the skills and capabilities of staff.
Regulatory	Open	9	It is important for us to remain in good standing with regulatory bodies because this provides assurance over the quality of our services and reinforces public confidence in our trust. However, we recognise that regulators will closely scrutinise and challenge significant changes and innovations to our services. We are open to this risk in cases where we are confident that we are acting in the interests of patients and can demonstrate that our actions are consistent with relevant legislation and professional standards.
Reputational	Open	9	We are an outward-looking organisation which works in partnership with healthcare, educational and charitable organisations in Shropshire and further afield. Patient and community involvement is very important to us. We believe that stakeholders of all kinds recognise our commitment to maintaining good working relationships with them. We are, however, open to reputational risk in that we are prepared to take decisions which may attract scrutiny or opposition when we can clearly demonstrate that they will achieve better outcomes for patients.

Oversight of operational risk management

The Risk Management Group, chaired by the Chief Nurse, oversees the effectiveness of the operational management of risk and reviews the risk profile of the Trust, as well as individual risks rated at 15 or above. These risks are then considered by committees of the Board (and the Board itself) to provide visibility and enable appropriate scrutiny. The Audit and Risk Committee oversees the effectiveness of the governance framework and controls.

Other sources of information / assurance

In addition, there are other sources of assurance gained throughout the year, including:

Internal assurances

- Strategic and business planning
- Adverse incident analysis
- Complaints
- Claims
- Analysis of compliance with statutory duties and guidance
- Intelligence from internal health and safety, fire or security inspections
- Internal Audit

External assurances

- Safety alerts or hazard warnings
- External body recommendations
- External inspections or assessments
- External Audit
- Regulatory reviews

Risk assessment and review

The Trust uses a risk assessment matrix to ensure a consistent approach is taken to assessing the potential consequences and likelihood of risks and that appropriate action is taken to address each risk. This process of assessment is conducted via the online risk management system referenced previously. Consistent application of this approach is supported by advice from the clinical governance team; a risk management training programme; peer challenge and review (at unit level); and Trust-wide review at the Risk Management Group.

The Trust is committed to ensuring that any potential risks are mitigated to the lowest possible level and where possible negated altogether and uses both internal and external expertise, as required, to decide on the most appropriate treatment of identified risks.

Governance Framework of the Organisation

The Trust has continued to develop its governance structures over the last 12 months in line with internal and external audit recommendations. The structures in place are aimed at delivering an integrated governance agenda. Integrated governance is the combination of systems, processes, and behaviours which the Trust uses to lead, direct and control its functions in order to achieve its organisational objectives.

The Board Assurance Framework

The Board Assurance Framework (BAF) captures the risks to delivery of the Trust's strategic objectives. The BAF was reviewed for 2025/6 to ensure it continued to reflect the Trust's strategic objectives and risk appetite statement.

The BAF identifies a number of high-level BAF themes, each of which has a strategic risk associated with it. Each strategic risk sets out the contributory factors that are relevant to that theme / strategic risk and outlines the mitigations that should reduce the risk and threats that could potentially increase the risk.

Each BAF theme / strategic risk is aligned to:

- The Trust's strategic objectives;
- The system's strategic objectives; and
- The Trust's stated risk appetite (as far as possible).

Each of the risks captured in the BAF are overseen by one of the Board's assurance committees. More information on the committees in operation during the year is included in the Board Assurance structure section.

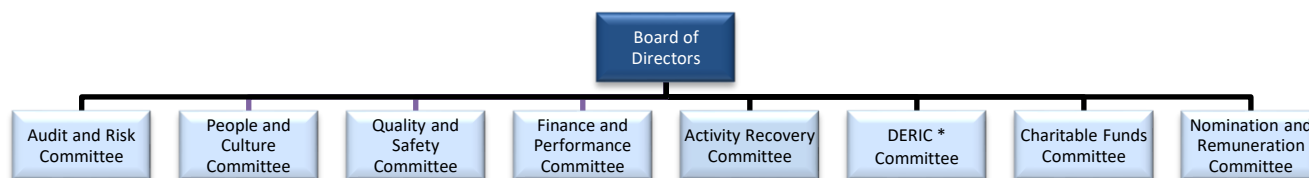
The BAF themes, strategic risks and oversight committees at the close of 2025/6 are outlined in the table below. This also shows the emerging BAF themes for 2026/7:

Themes / Lead “Committee”	Strategic Risk
1. Continued focus on excellence in quality and safety. Q&S	• If the Trust does not have robust policies, procedures and practices in place to promote the quality and safety of services • Then there is a risk that insufficient organisational focus is placed on the quality and safety of services • Resulting in increased incidence of avoidable harm, reduction in patient satisfaction and failure to deliver excellent standards of care
Draft equivalent themes for 2026/7: 1a) Continued focus on excellence in quality, safety and patient experience. AND 1b) Focus on equity of service and addressing health inequalities	
2. Creating a sustainable workforce. P&C	• If the Trust does not attract and retain staff with the appropriate skills and values, embrace equality, diversity and inclusion, and be regarded as an employer of choice • Then it will be unable to deliver planned activity and/or promote an inclusive, supportive culture for staff • Resulting in reduced patient satisfaction; an inability to address inequality of service provision; reputational damage, adversely affecting efforts to retain/recruit staff
Draft equivalent theme for 2026/7: Effective engagement with the workforce to support a positive staff experience and a culture of continuous improvement	
3. Delivering the financial plan. F&P	• If the Trust is unable to deliver its financial plan • Then it will lead to regulatory intervention and impact on future investment • Resulting in the Trust being unable to deliver its objectives, which will have an adverse impact on patient care / patient experience etc
Draft equivalent theme for 2026/7: Delivering financial sustainability	
4. Delivering the required levels of productivity, performance and activity. F&P	• If the Trust does not have sufficient capacity to deliver the activity plan within agreed resourcing levels • Then it will be unable to address waiting list targets and will face a shortfall in income / fail to deliver the financial plan • Resulting in increased waiting times; an adverse impact on patient experience, potentially resulting in patient harm; increased scrutiny from system partners / regulators (leading to burdensome reporting requirements and/or enforcement action which reduce capacity and place constraints on the Trust’s ability to act independently in pursuit of its objectives).
Draft equivalent theme for 2026/7: Delivering the required levels of productivity, performance and activity.	

Themes / Lead "Committee"	Strategic Risk
5. Delivering innovation, growth and achieving systemic improvements. DERIC	• If the Trust does not have the required infrastructure / capacity / expertise to support innovation / growth; or governance processes / funding regimes place constraints on the Trust's ability to act • Then it will not be able to identify / pursue opportunities to innovate, develop commercial opportunities and deliver systemic improvements • Resulting in a failure to maximise opportunities to improve staff experience, clinical outcomes, patient satisfaction and increase income (which could be reinvested in services).
Draft equivalent theme for 2026/7: Delivering innovation, growth and improvement	
6. Responding to opportunities and challenges in the wider health and care system. Board of Directors	• If the Trust does not strengthen its joint-working arrangements with partners governance processes / funding regimes place constraints on the Trust's ability to implement such arrangements • Then it will not maximise opportunities to address health inequalities; improve outcomes / services for patients; support national and system priorities; enhance staff experience; or deliver efficiencies • Resulting in lost opportunities to contribute to the delivery of national and local objectives; potential loss of accreditation status; and potential failure to achieve NHS oversight framework targets (leading to burdensome reporting requirements and/or enforcement action / constraints on the Trust's ability to act independently in pursuit of its objectives).
Draft equivalent theme for 2026/7: The challenges associated with serving patients across both the English and Welsh health systems.	
7. Responding to a significant disruptive event. Q&S / DERIC	• If the Trust does not have adequate plans in place to respond to a significant disruptive event beyond the control of the Trust, such as a pandemic, or cyber-attack • Then it will be unable to provide an adequate response to the immediate need and/or maintain other key services due to unavailability of the required resources / staff • Resulting in potential patient harm, increased waiting times etc
Draft equivalent themes for 2026/7: Responding to a significant disruptive event AND Security of digital, data and AI systems and ability to respond to cyber threats	

Board Assurance Structure

The Board of Directors leads on integrated governance and delegates key duties and functions to its committees whilst retaining certain decision-making powers on strategy and aspects of financial management. All Committees are accountable to the Board of Directors. The diagram below sets out the committee structure during 2025/26:



**Digital, Education, Research, Innovation and Commercialisation.*

Each of the Committees receive assurance reports from a range of supporting meetings relevant to their remit. In turn, those meetings are informed by a series of operational groups that relate to their remit.

On behalf of the Board of Directors, all Committees of the Board also:

- Ratify policies in accordance with the Trust's Policy Approval Framework;
- Review corporate risks and Board Assurance Framework risks relevant to their remit;
- Consider progress against internal audit report recommendations where the audit opinion is lower than "Substantial Assurance".

The roles and responsibilities of the Board Committees are described more fully below. Each committee undertakes a self-assessment each year and reports this to the Board. During the year, the integrated performance report and the committee oversight dashboards, were reviewed and updated to ensure the Board committees received the information they required in order to perform their functions.

Board members must comply with the requirements of the Fit and Proper Persons Test (FPPT) framework and checks are undertaken annually to ensure this remains the case.

Board of Directors

The Board meets regularly to discuss an agenda based on four key elements:

- Strategy and Policy
- Performance and Governance
- Quality and Safety
- People and Workforce

The Board is responsible for setting the organisation's strategy and for ensuring that the Trust meets its statutory duties and effectively manages risk. The Board gains assurance through the Board Assurance Framework. The Board holds prime responsibility for corporate governance and the development of systems and processes for internal control, including risk management, the Board Assurance Framework and compliance with Care Quality Commission (CQC) regulations. The Board Assurance Framework is considered on a quarterly basis. The Committees review the BAF risks reflect on the risks aligned to their remit and recommend any amendments before presentation to the Board of Directors on a quarterly basis.

The Board maintains responsibility for setting and approving work plans and monitoring the delivery of planned objectives. The Board of Directors regularly receives reports from its committees on the business covered, risks identified, and action taken as well as regular performance related reports.

The Board is responsible for ensuring the financial viability through the establishment of effective financial stewardship.

Membership of the Board comprises the Trust Chairman, Chief Executive, Non-Executives and Executive Directors with attendance from non-voting Directors and the Trust Secretary.

Audit and Risk Committee

The Audit and Risk Committee is chaired by a Non-Executive Director and membership consists solely of Non-Executive Directors with Board Executives invited to attend.

The Committee is responsible for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation (clinical and non-clinical) that supports the achievement the organisations objectives.

The Committee's responsibilities included the following:

- Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisations (clinical and non-clinical) that supports the achievement the organisation's objective.
- Ensuring that there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2017 and provide appropriate independent assurance to the Committee, Chief Executive Officer, and the Board of Directors
- Reviewing and monitoring the external audits' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditor and consider the implications and management's responses to their work
- Satisfying itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcome of work in these areas.
- Monitoring the integrity of the financial statements of the origination and any formal announcements relating to its financial performance
- Ensuring that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.
- Reviewing, as appropriate, reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- Reviewing the annual report and before submission to the Board, focusing particularly on:
 - The wording in the annual governance statement and other disclosures relevant to the relevant to the terms of reference of the Committee
 - Changes in, and compliance with, accounting policies, practices, and estimation techniques
 - Unadjusted misstatements in financial statements
 - Significant judgments in preparation of the financial statement
 - Significant adjustment resulting from the audit
 - Letters of representation
 - Explanation for significant variances

Quality and Safety Committee (Q&S)

The Quality and Safety Committee is chaired by a Non-Executive Director and is attended by a two other Non-Executive Directors and members of the Executive Team.

The Committee assists the Board in obtaining assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. Key responsibilities of the Committee are to:

- Promote excellence in patient care in all aspects of quality and safety, and monitor and review the "Quality Improvement Strategy".
- Ensure the Trust is meeting core standards and is compliant with national guidelines to include (but not be limited to) prevention and control of infection and effective and efficient use of resources through evidence based clinical practice.
- Consider NHSE Quality Governance Framework in the delivery of its key responsibilities
- Receive an agreed level of clinical data and trend analysis from clinical forums and working groups, which provide adequate clinical matrix to inform and analyse the clinical services provided at the Trust.

- Ensure that the Committee has adequate information on which to advise and assure the Board on standards of care provision.
- Review the draft Quality Accounts before submission to the Trust Board
- Monitor the effectiveness of the Trust's arrangements for the systematic monitoring of mortality and other patient outcomes.
- Receive and comment on action plans and progress reports proposed by management in response to monitoring data on patient outcomes.
- Monitor the effectiveness of the Trust's compliance with the requirements of the Patient Safety Incident Response Framework.
- Review the outcomes of investigations, ensuring that the information is presented in sufficient detail to enable systemic failings in patient care to be identified; receiving and commenting on action plans and progress reports proposed by management in response to SIs, near misses and other incidents.
- Monitor the effectiveness of the Trust's systems for complaints handling and reviewing complaints for trends and themes.
- Monitor the effectiveness of the Trusts systems for advocacy and the encouragement of feedback from patients and relatives.
- Review compliance with statutory and regulatory requirements relevant to the remit of the Committee, including CQUIN and CQC requirements.
- Monitor the arrangements to ensure the security of personally identifiable data.

Finance and Performance Committee (F&P)

The Finance and Performance Committee is chaired by a Non-Executive Director and attended by two other Non-Executive Directors and members of the Executive Team.

The Committee supports and advises the Board on all aspects of the Trust's Annual and Long-Term Financial Plans and recommends adoption of the plans to the Board of Directors. The purpose and key responsibilities of the Committee, according to the TOR, are to:

Strategy

- Consider and approve the key planning and financial assumptions to be used in the five-year strategy and annual operational plan.
- Oversee strategic issues related to income e.g., changes to tariff, commissioning intentions, tendering for new services, risks from competition and market share.
- Consider recommendations of investment and disinvestment of Trust sub-specialty / service reviews ensuring strategic steer in keeping with the Trust strategy and objectives.
- Oversee capital planning, ensuring forward planning, regular review and recommendations including acquisitions and disposal of assets, in line with the Trust strategy and objectives.
- Consider, evaluate and if appropriate recommend for Board approval commercial developments and partnerships opportunities in keeping with the Trust strategy and objectives.
- Consider and recommend Board approval of material business cases as defined by the Trust SFI's (currently investments above c£250k).
- Consider post project evaluation reports on significant capital investments. This will include all schemes over £250k and other schemes which are considered to represent a significant risk to the Trust.

Oversight and Scrutiny

- Receive regular reports on financial performance including the overall financial performance against plan and associated risk rating, performance of Capital programme and the performance of activity against contract.
- Evaluate progress and recommend further actions from the review of in year financial, CIP, activity, RTT and productivity performance information, including SLR review.
- Review the Trust's investment register of cash investment as required.
- Evaluate progress of service transformation and investment plans, ensuring establishment of models of best practice in line with the Trust strategy.
- Promote sustainability and receive sustainability KPIs.

- Provide oversight in respect of all aspects of business planning, partnerships, and development.
- Provide oversight of the Trust annual plan and its subsequent delivery.
- Receive deep dives for scrutiny and further assurance into key performance areas.

People and Culture Committee (P&C)

The People and Culture Committee is chaired by a Non-Executive Director and is attended by two other Non-Executive Directors and members of the Executive Team.

The Committee assists the Board in obtaining assurance that the Trust's workforce strategies and policies are aligned with the Trust's strategic aims and support a patient-focused, performance culture where staff engagement, development and innovation are supported. The Committee works 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.

The role of the Committee includes:

- Ensuring the Trust is meeting its statutory and regulatory requirements in relation to workforce management.
- Overseeing the development and implementation of the People Plan and any related workforce plans.
- Monitoring and developing the Trust's plans for talent management, succession planning, staff engagement, performance, reward and recognition strategies and policies.
- Receiving an agreed level of workforce data and trend analysis to inform and analyse workforce issues.
- Ensuring that the Committee has adequate information on which to advise and assure the Board on 'Caring for Staff'.
- Reviewing progress made in delivering key enabling workforce strategies, raising any significant risks regarding their delivery to the Board.
- Assuring and advising the Board on any issues of significance relating to the Committee's remit.

Digital, Education, Research, Innovation and Commercialisation Committee (DERIC)

The DERIC Committee is chaired by a Non-Executive Director and attended by two other Non-Executive Directors and members of the Executive Team. The role of the Committee is to:

- Consider the development of the Trust's strategies in relation to:
 - Digital and data;
 - Education;
 - Research, and Innovation;
 - Opportunities for commercialising activity.
- Consider the underpinning governance arrangements to support delivery of those strategies and monitor the associated delivery plans.
- Review and ratify the Trust's digital, research, innovation, education, training and business development policies.
- Monitor progress in delivering relevant internal audit report recommendations.

Activity Recovery Committee (ARC)

The Activity Recovery Committee was first established in November 2024 following the increased scrutiny on the Trust's performance in relation to its longest waiting patients. The purpose of the Activity Recovery Committee is to assist the Board in obtaining assurance on the delivery of the operational plan and that any risks to delivery are identified and robustly addressed. The Committee did this by:

- Monitoring the delivery of the Trust's operational plan and the effectiveness of plans to recover performance, particularly in relation to long waiting patients.

- Overseeing the implementation of the delivery model improvement plan covering short, medium and longer-term plans to improve productivity and increase activity, providing appropriate assurances to the Board and escalating any areas of concern.
- Reviewing the governance arrangements in place to drive delivery of the operational plan and recover performance.
- Receive Assurance Reports from groups that support the work of the Committee
- Consider “deep dives” for scrutiny and further assurance into key performance areas.

During the year, the Committee reviewed its term of reference and subsequently focussed on overseeing performance in delivering the four key constitutional standards:

- 65 week waits;
- 52 week waits;
- 18 week waits; and
- Time to first outpatient appointment.

Non-Executive Directors Remuneration and Appointment Committee

The Committee is responsible for appointing Non-Executive Directors, including the Chair, to the Board of Directors. It shall ensure there is a formal, rigorous, and transparent procedure for the appointment of new Directors and that Directors are ‘fit and proper’ to meet the requirements of the general conditions of the Trust’s provider licence.

The Committee will also periodically consider the plans in place for orderly succession to Non-Executive positions, so as to maintain an appropriate balance of skills and experience on the board.

The Committee will recommend to the Council of Governors remuneration and terms of service policy for Non-Executive Directors, taking into account the views of the chair (except in respect of his own remuneration and terms of service) and the chief executive and any external advisers.

The Committee will agree the process and receive and evaluate reports about the performance of individual Non-Executive Directors and consider this evaluation output when reviewing remuneration levels.

Executive Directors’ Remuneration and Appointments Committee

The Committee is responsible for identifying and appointing candidates to fill Executive Director positions on the board.

When appointing the Chief Executive, the Committee shall perform the role described in Schedule 7, 17(3) of the National Health Service Act 2006 (the Act). When appointing other Executive Directors, the committee performs the role described in Schedule 7, 17(4) of the Act.

The Committee shall ensure there is a formal, rigorous, and transparent procedure for the appointment of new Directors and that Directors are ‘fit and proper’ to meet the requirements of the general conditions of the Trust’s provider licence.

Council of Governors

The Trust’s governors are elected representatives of the local communities the Trust serves and together they form the Council of Governors which is an integral part of the Trust’s governance framework. They are not responsible for the operational management of the Trust but rather are responsible for challenging and holding to account the Board of Directors.

They plan an active role in the development of the Trust and its activities and are included in the initiatives and collaborative committees run throughout the year. The statutory powers and duties of the Council of Governors include:

- To appoint, remove and decide upon the terms of office of the Chair and Non-Executive Directors of the Trust
- To determine the remuneration of the Chair and Non-Executive Directors
- To appoint or remove the Trust’s auditor
- To approve or not approve the appointment of the Trust’s Chief Executive

- To receive the annual report and accounts and auditor's report at a general meeting
- To hold the Non-Executive Directors to account for the performance of the Board
- To represent the interests of members and the public
- To approve or not approve increases to non-NHS income of more than 5% of total income.
- To approve or not approve acquisitions, mergers, separations, and dissolutions.
- To jointly approve changes to the Trust's constitution with the Board
- To express a view on the Board's plans for the Trust in advance of the Trust's submission to NHS England
- To consider a report from the Board each year on the use of income from the provision of goods and services from sources other than the NHS in England

The Trust has a duty to ensure that governors are equipped with the skills to perform this role. Governors are supported and encouraged to attend NHS providers training for Foundation Trust Governors. Governors have instigated a "buddying" arrangement to support more recent appointees and the induction programme has been strengthened to ensure Governors have a consistent, structured introduction to their role and to the organisation. Governors are also encouraged, and supported, to engage in national training and development programmes. To help develop their knowledge of the work of the Trust, Governors receive regular presentations / updates at meetings of the Council of Governors and are invited to attend meetings of the Board and its committees.

The Board works closely with the Council of Governors. The Trust's Chairman is also the Chair of the Council of Governors and is supported at each meeting by other members of the Board. The Chairman works closely with the nominated Lead Governors. Governors meet prior to each meeting of the Council to agree items to be discussed and review key issues.

[Attendance at Board and regular Board committee meetings](#)

Attendance at the Trust's Board of Directors and Board level committees is monitored on a monthly basis and the table below outlines the attendance for the year. In the event that attendance fell below expected levels this would be addressed on an individual basis. When Executive Directors were absent, deputies attended to represent the portfolio. All Board and Committee meetings were quorate throughout 2025/26.

	Board of Directors – Private	Board of Directors – Public	Audit and Risk Ctte	Quality and Safety Ctte	Finance and Performance Ctte	Activity Recovery Ctte	People and Culture Ctte	DERIC Ctte
Meetings held in 2025/26		6	5	13	11	12	12	10
Harry Turner, Chair	12 / 12 100%	06 / 06 100%						
Martin Evans, Non-Executive Director	08 / 12 67%	04 / 06 67%				03 / 06 50%	10 / 12 83%	09 / 10 90%
Sarfraz Nawaz, Non-Executive Director	10 / 12 83%	06 / 06 100%	03 / 05 60%		09 / 11 82%		02 / 05 40%	05 / 06 83%
Martin Newsholme, Non-Executive Director	10 / 12 83%	05 / 06 83%	05 / 05 100%	11 / 13 85%	11 / 11 100%			
Penny Venables, Non-Executive Director	07 / 09 78%	04 / 05 80%		09 / 09 100%		07 / 08 88%		07 / 07 100%
Lindsey Webb, Non-Executive Director	12 / 12 100%	06 / 06 100%	05 / 05 100%	13 / 13 100%	10 / 11 91%	12 / 12 100%		
Darius Mirza, Non-Executive Director	04 / 06 67%	03 / 03 100%		01 / 06 8%			01 / 04 25%	03 / 04 75%
John Pepper, Associate Non-Executive Director	03 / 03 100%	01 / 01 100%		02 / 03 67%			02 / 03 67%	02 / 03 67%
Atif Ishaq, Associate Non-Executive Director	10 / 12 83%	05 / 06 83%				06 / 07 86%	10 / 12 83%	10 / 10 100%
Paul Maubach, Associate Non-Executive Director	10 / 12 83%	06 / 06 100%	02 / 03 67%		11 / 11 100%	09 / 12 75%	12 / 12 100%	
Stacey Keegan, Chief Executive Officer	12 / 12 100%	06 / 06 100%		* 07 / 13 54%	* 10 / 11 91%	* 06 / 12 50%	* 08 / 12 67%	* 05 / 10 50%
Craig Macbeth, Chief Finance and Planning Officer	01 / 01 100%						01 / 01 100%	
Angela Mulholland-Wells, Chief Finance and Commercial Officer	10 / 11 91%	06 / 06 100%	04 / 05 80%		11 / 11 100%	08 / 11 73%	03 / 04 75%	07 / 09 78%
Ruth Longfellow, Chief Medical Officer	11 / 12 92%	06 / 06 100%	00 / 05 0%	11 / 13 85%		07 / 12 58%		08 / 10 80%
Paul Kavanagh Fields, Chief Nurse and Patient Safety Officer	00 / 12 %	00 / 06 0%	00 / 05 0%	00 / 13 0%		00 / 12 0%	00 / 12 0%	
Sam Young / Sarah Needham, Acting Chief Nurse and Patient Safety Officer	09 / 12 75%	04 / 06 67%	00 / 05 0%	10 / 13 77%		01 / 12 8%	08 / 12 67%	
Denise Harnin, Chief People Officer	11 / 12 92%	05 / 06 83%					11 / 12 92%	09 / 10 90%
Mike Carr, Chief Operating Officer	12 / 12 100%	06 / 06 100%		08 / 13 62%	10 / 11 91%	11 / 12 92%	09 / 12 75%	

Footnote: grey box = not a member of the meeting / * = open invitation to the meeting

Internal Audit

The Trust's internal auditors are the Mersey Internal Audit Agency (MIAA). MIAA meets the mandatory NHS Internal Audit Standards and provides independent assurance to the Audit and Risk Committee, the Chief Executive and the Board.

The Board of Directors approved the appointment of MIAA as the Trust's internal audit and counter-fraud provider for three years from 1 April 2022, with an option to extend to March 2026, which has since been exercised.

Following a tender process involving providers within the System, MIAA was awarded a further contract running from August 2025 to July 2028, with an option to extend for an additional year. Both RJAH and STW were named as future beneficiaries and joined the contract from April 2026 without the need for a separate procurement. The RJAH contract therefore runs from April 2026 to July 2028, in line with neighbouring providers.

The internal auditor's primary role is to provide an independent and objective opinion to the Board on the extent to which the Trust's risk management, control and governance processes support the achievement of its objectives.

External Audit

The Trust's external auditors are KPMG LLP. The Council of Governors approved the appointment of KPMG LLP in 2025/26 following a competitive tender exercise. External audit is an essential element of corporate governance, contributing to the stewardship and process of accountability for use of resources. The scope of audits is extended to cover not just financial statements but the arrangements to secure value for money. The Trust's external auditors report into the Audit and Risk Committee.

Quality Governance

The Board is responsible for ensuring that the Trust has sound Quality Governance arrangements in place. It is supported in this by the Quality and Safety Committee which reviews evidence from a number of sources including specialist meetings, clinical audit reports and patient feedback. It receives reports on patient safety reviews and reviews in full, all Patient Safety Incident Investigations. The committee has oversight of all relevant learning from patient safety reviews, including progress on associated actions for improvement.

The Trust continues to deliver on its Quality Strategy with objectives to be delivered across 2024 to 2027. Progress against the key objectives identified within the strategy is monitored through the Trusts Quality and Safety Committee with regular updates provided to the Board.

Staff are required to report all incidents through a formal system, and these are reviewed by the Clinical Governance Team who are responsible for ensuring that all learning is shared, and actions agreed and implemented as per the Trust's Incident Management policy and the Trusts Patient Safety Incident Response Policy.

The Trust reviews all the complaints it receives, and the results of this review are reported to the Quality and Safety Committee and the Board.

The Trust promotes a culture of openness. The Trust has an "Openness / Whistleblowing" Policy as well as a "Freedom to Speak Up" Policy. Arrangements for "speaking up" are included in the staff induction training programme for all staff and the Trust has a Freedom to Speak Up (FTSU) Guardian, Executive and Non-Executive leads for FTSU, as well as a number of Freedom to Speak Up Champions across the Trust. There is a dedicated FTSU section on the staff intranet and posters around the site providing information and contact details.

A rigorous process is in place for doctors' appraisals, supported by the production of a comprehensive data set for each doctor. In addition, the Trust is compliant with the doctors' revalidation programme.

The Trust was subject to a planned inspection by the CQC in May 2025 following which it received an overall rating of 'Good'. The Trust devised an action plan to address the recommendations from the inspection, where completion has been overseen by the Quality and Safety Committee, with updates to the Board of Directors.

Leading up to the inspection the Trust established a CQC engagement group. The purpose of this group was to review the new quality statements from the CQC that form part of their new approach to undertaking CQC inspections. A CQC dashboard has now been developed, and the Trust has a sound understanding of how we comply with the key statements and areas to focus. While the CQC engagement group has now been stood down, monitoring of compliance against the CQC dashboard now takes place through the Regulatory Oversight Meeting.

Use of the Care Quality Commission (CQC)'s Well-Led Framework

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission, and its current registration is without conditions (meaning there are no issues of concern affecting its ability to operate which the Trust must address in order to comply with its license to operate).

Managing Conflicts of Interest

In accordance with NHSE guidance on managing conflicts of interest, and as reflected in the Trust's policy on Managing Conflicts of Interest, the Trust publishes:

- A register of gifts and hospitality; and
- A register of interest for staff deemed to be in decision-making roles – this includes Board members, other senior members of staff and those with access to payment systems.

These are available on the Trust's website.

The Trust has a dedicated "Managing Conflicts of Interest" section on its intranet. This includes the Standards of Business Conduct and Managing Conflicts of Interest Policy, associated return paperwork, and a series of guidance documents (including Q&As and role-specific guidance notes).

The Trust's policy was updated during the year to amalgamate the "Standards of Business Conduct Policy" and "Managing Conflicts of Interest Policy". The policy was also updated during the year to:

- Clarify that indirect interest: *"could include decisions you make at work that relate to members of your team, or other colleagues, with whom you have a close association (including a familial or marital relationship) – examples of that could include involvement in recruitment, appraisal or HR processes."*
- Expand the previous section on dealings with the pharmaceutical industry to cover *"dealings with companies that manufacture / supply medical products or services, such as orthopaedic implants etc. or any companies that provide other products or services to the Trust"*.
- Update references to the Economic Crime and Corporate Transparency Act 2023.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past 12 months as required by the [Managing conflicts of interest in the NHS guidance](#).

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are

complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. More information on the Trust's work to address health inequalities and promote equality and inclusion is included within the Performance Report. More information on the Trust's approach to equality and diversity, including its Equality and Diversity Annual Report can be accessed at: <https://www.rjah.nhs.uk/about-us/equality-and-diversity/>

We have co-produced with our Staff Network groups, the Workforce Race Equality Standard and Workforce Disability Equality Standard, reports and action plans which are available on the Trust website:

<https://www.rjah.nhs.uk/about-us/publications/trust-documents/equality-diversity-and-inclusion-documents/>

The Trust has published its Gender Pay Gap report on its website.

The Trust will also be publishing an Ethnicity and Disability Pay Gap report for the first time for 2025.

Both reports are published on the Trust website at:

<https://www.rjah.nhs.uk/about-us/publications/trust-documents/equality-diversity-and-inclusion-documents/>

Our EDS2 (Equality Delivery System) scoring of domains 1, 2 and 3 events took place in 2025, which provided feedback from key stakeholders on wellbeing and leadership. The Report is available on the website: [eds2-2024-25-domain-2-scoring-report.pdf](#)

The Trust continues to make significant advances in our work on Equality, Diversity and Inclusion, including the publication of a quarterly EDI newsletter available to all staff. We regularly celebrate calendar events, in particular celebrating Staff Network Day in May 2025. Our Staff Networks are established with a Chair and Executive sponsor, and meetings takes place monthly, or quarterly, encouraging lived experience conversations and welcoming allies to the groups. The network groups have contributed to the improvement of HR policies, to avoid any unintended consequences from groups with protected characteristics

Emergency Preparedness and Civil Contingency

The Trust is identified as a Category One responder under the Civil Contingencies Act 2004. The Trust is legally required to assess risks, develop and maintain emergency and business continuity plans, ensure the continuity of critical services, communicate effectively with the public, and work collaboratively with partner agencies to manage and respond to major incidents.

These arrangements are designed to ensure the continuation of critical functions in the event of significant emergencies or disruptions, such as infectious disease outbreaks, severe weather conditions, fuel shortages, industrial action, loss of accommodation, critical information failures, information and communication technology (ICT) outages, or supply chain disruptions.

To support this responsibility, the Trust continues to ensure it meets the requirements set out in the current NHS Core Standards for Emergency Preparedness, Resilience and Response (Core Standards). These Core Standards are in accordance with the CCA 2004, 2005 Regulations and the NHS Act 2006. These frameworks set out the procedures and coordinated response measures

to be enacted in circumstances where service disruption impacts the Trust's ability to fulfil its standard operational commitments.

Workforce Strategies and Safeguards

The Trust ensures that short, medium and long-term workforce strategies and staffing systems are in place which assure the Board that staffing processes are safe, sustainable and effective. This assurance is obtained in a number of ways:

- The development and implementation the Workforce operational plan and the People Plan
- Regular reporting on safe staffing and junior doctor working to the Quality and Safety Committee, People and Culture Committee and Board of Directors
- Staff survey results
- Internal audit
- Board Assurance Framework

Review of economy, efficiency and effectiveness of the use of resources

The Trust sets targets for improvements of economy, efficiency and effectiveness in its Operational Plan. Target improvements are set alongside ICS partners and cascaded internally through Unit Managing Directors and Corporate Service Leads, performance is monitored as part of the Board performance report and the system of unit/service performance reviews. These programmes are also approved by the Chief Medical Officer and Chief Nursing Officer to ensure that they have no adverse effect on quality. The Trust's efficiency process has been benchmarked against national data sets including model hospital and corporate services while utilising GIRFT best practice principles. The Trust operated a Performance and Financial Improvement Group (PFIG) during the year. The purpose of PFIG was to provide additional oversight, scrutiny and challenge to the development and delivery of the Trust's financial and activity plans. It did so by pro-actively reviewing actions required to deliver improvements and agreeing any additional controls or mitigations required to ensure the Trust delivered its financial plan and activity trajectory.

During 2025/26 the Trust tracked its financial performance, including the economic, efficient and effective use of resources via the Finance and Performance Committee and the Board received regular updates on the Trust's financial performance along with a chair's report from the Finance and Performance Committee.

There was a full programme of internal audit reviews during the year, the results of which are outlined in the Review of Effectiveness section of this report. This resulted in an overall **"Substantial Assurance"** Opinion.

Information Governance

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

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

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

Data Security and Protection Standards for health and care sets out the National Data Guardian's (NDG) data security standards. These standards are covered by the Data Security and Protection Toolkit (DSPT). NHS Trusts are required to undertake a self-assessment against the requirements of the Toolkit, and demonstrate that they are either compliant with, or working towards compliance with, the NDG standards.

The DSPT is in its second year of its new format encompassing the Cyber Assessment Framework (CAF) requirements. The DSPT sets a minimum achievement level for a range of defined outcomes, and produce a "CAF profile". For many outcomes a level of 'Partially Achieved' is proportionate, and in some cases 'Not Achieved' may be appropriate (for example – some CAF outcomes represent capabilities only normally held by organisations with very high cyber security maturity and resources). The Trust continues to assess its compliance with the new framework and this is reviewed via the Information Governance Meeting.

The Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust's Information Governance DSPT score overall for 2025/26 has not yet been determined as the final submission date is 30 June 2026.

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

Data Quality and Governance

Trust Board and each of its Committees reviews quality performance at each meeting and a data quality rating for each KPI is included within the summary sections of the Integrated Performance Report (IPR).

The indicator score is based on audits undertaken by the Data Quality Team and are further validated as part of the audit assurance programme.

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

The Trust continues to format its Integrated Performance Report on the NHSE 'Making Data Count' principles by utilising SPC charts and icons. The variation icon is used to show whether the latest month is of a concerning or improving nature by using SPC rules, and the assurance icon shows whether we can reliably hit the target or not.

Throughout 2025/26 the major focus for Data Quality has been the support provided to implementation of the new EPR system (Apollo). This includes:

- Validation and testing of migrated data from current EPR to new EPR
- Support to Apollo and Operational Teams with configuration of new system
- Responding to Data Quality issues as a result of the new system and ensuring the accuracy of Trust reporting was maintained following implementation

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by

comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit and Risk Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust gains assurance on the maintenance of an effective system of internal control in a number of ways:

- The maintenance of a Board governance pack detailing the key governance structures and their interrelationships.
- Regular internal and external review of risk management and governance arrangements, as described throughout this report.
- A programme of Internal Audit reviews, the findings of which inform the head of Internal Audit Opinion.

Progress against the management actions agreed in response to the recommendations of internal audit reviews is monitored by the Audit and Risk Committee.

The Trust's Head of Internal Audit provides an annual opinion on the assurance framework. For 2025/26, this can be summarised as follows:

"Substantial Assurance, can be given that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently."

The Trust has in place a robust governance structure with clear responsibilities delegated to Board Committees and Executive Directors. There is a process in place to assess the effectiveness of the Board Committees and this is reported to the Board for assurance.

During 2025/26 all the Executive Directors have completed appraisals which have included reflections on the discharging of their duties as Directors. The Chair has also conducted appraisals with Non-Executive Directors and uses these appraisals to consider the overall mix of skill and experience on the Board. As described in the Directors' Report, Associate Non-Executive Members have been appointed to bring particular skills and knowledge and inform the work of the Board.

During the year, the Trust deliver the requirements of the Fit and Proper Person Test Framework (FPPT), the NHS Leadership Competency Framework (LCF) and the Chair's Appraisal Framework (CAF).

Conclusion

I can confirm that no significant internal control issues have been identified. My review confirms that The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

To the best of my knowledge and belief I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.



Stacey Keegan
Chief Executive Officer
24 June 2026

Independent Auditor's Report 2025/26

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2026 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2026 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2026 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Trust's services or dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit and Risk Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance because of the need to achieve financial performance targets delegated to the Trust by NHS England
- Reading Board and Audit and Risk Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls in particular the risk that Trust management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the nature of the funding provided to the Trust during the year. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

We also identified a fraud risk related to completeness of expenditure recognition in response to the financial performance target by NHSE. We identified that non-pay expenditure, excluding depreciation, may be manipulated in order to report that the control total has been met.

In determining the audit procedures we took into account the results of our evaluation and testing of the operating effectiveness of some of the Trust-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual combinations with a debit or credit to cash, unusual combinations with a debit or credit to borrowings and period 12 debits to accruals with a credit to expenditure.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Inspecting a sample of invoices of expenditure and payments made in the period after 31 March 2026, to determine whether expenditure has been recognised in the correct accounting period.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer and management (as required by auditing standards), and discussed with the Accounting Officer and management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit

The potential effect of these laws and regulations on the financial statements varies considerably.

The Trust is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accounting Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2025/26.

Accounting Officer's and Audit and Risk Committee's responsibilities

As explained more fully in the statement set out on page 73,, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of its services to another public sector entity.

The Audit and Risk Committee is responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 74, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006; or
- we make a referral to the Regulator under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2026 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.



Catherine Henry

for and on behalf of KPMG LLP

Chartered Accountants

1 Snow Hill Queensway,

Birmingham

B4 6GH

25 June 2026

Annual Accounts 2025/26



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

Annual Accounts

for the year ended 31 March 2026



The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

Foreword to the Accounts

These accounts, for the year ended 31 March 2026, have been prepared by the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust. They have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

Signed	
Name	Stacey Keegan
Job title	Chief Executive & Accounting Officer
Date	24 June 2026

Statement of Comprehensive Income

	Note	2025/26 £000	2024/25 £000
Operating income from patient care activities	3	169,468	157,823
Other operating income	4	8,655	9,138
Operating expenses	8&10	(174,308)	(167,706)
Operating surplus/(deficit)		3,815	(745)
Finance income	12	957	1,025
Finance expenses	13	(73)	(63)
PDC dividends payable		(2,638)	(2,659)
Net finance costs		(1,754)	(1,697)
Other gains / (losses)	14	3	(17)
Surplus / (deficit) for the year		2,064	(2,459)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	9	(2,604)	-
Revaluations	18	27	878
Total other comprehensive income for the period		(2,577)	878
Total comprehensive income / (expense) for the period		(513)	(1,581)

All income and expenditure is derived from continuing operations.

Statement of Financial Position

	Note	31 March 2026 £000	31 March 2025 £000
Non-current assets			
Intangible assets	15	15,063	14,885
Property, plant and equipment	16	98,730	96,707
Right of use assets	19	1,143	913
Receivables	21.1	927	1,004
Total non-current assets		115,863	113,509
Current assets			
Inventories	20	1,612	1,631
Receivables	21.1	10,958	8,549
Cash and cash equivalents	24	16,191	19,519
Total current assets		28,761	29,699
Current liabilities			
Trade and other payables	26	(17,877)	(18,390)
Borrowings	28	(434)	(850)
Provisions	29	(840)	(2,816)
Other liabilities	27	(1,395)	(751)
Total current liabilities		(20,546)	(22,807)
Total assets less current liabilities		124,078	120,401
Non-current liabilities			
Borrowings	28	(631)	(291)
Provisions	29	(564)	(755)
Total non-current liabilities		(1,195)	(1,046)
Total assets employed		122,883	119,355
Financed by			
Public dividend capital		61,158	57,117
Revaluation reserve		29,166	31,743
Income and expenditure reserve		32,559	30,495
Total taxpayers' equity		122,883	119,355

The notes on pages 108 to 146 form part of these accounts.

The financial statements on pages 104 to 107 were approved by the Board and signed on its behalf by:

Signed:



Name:

Stacey Keegan

Position:

Chief Executive & Accounting Officer

Date:

24 June 2026

Statement of Changes in Equity

For year ended 31 March 2026

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2025 - brought forward	57,117	31,743	30,495	119,355
Surplus for the year	-	-	2,064	2,064
Impairments	-	(2,604)	-	(2,604)
Revaluations	-	27	-	27
Public dividend capital received	4,041	-	-	4,041
Taxpayers' equity at 31 March 2026	61,158	29,166	32,559	122,883

For year ended 31 March 2025

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2024 - brought forward	52,649	30,865	32,954	116,468
Deficit for the year	-	-	(2,459)	(2,459)
Revaluations	-	878	-	878
Public dividend capital received	4,468	-	-	4,468
Taxpayers' equity at 31 March 2025	57,117	31,743	30,495	119,355

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note	2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating surplus / (deficit)		3,815	(745)
Non-cash income and expense:			
Depreciation and amortisation	8	7,025	5,855
Net impairments	9	-	4,778
Income recognised in respect of capital donations and grants	4	(1,202)	(228)
(Increase) / decrease in receivables and other assets		(2,188)	(2,643)
(Increase) / decrease in inventories		19	(190)
Increase / (decrease) in payables and other liabilities		710	1,062
Increase / (decrease) in provisions		(2,167)	2,004
Net cash flows from operating activities		6,012	9,893
Cash flows from investing activities			
Interest received		977	1,057
Purchase of intangible assets		(1,761)	(5,954)
Purchase of PPE and investment property		(9,902)	(7,043)
Sales of PPE and investment property		5	4
Receipt of cash donations and grants to purchase assets		977	228
Net cash flows used in investing activities		(9,704)	(11,708)
Cash flows from financing activities			
Public dividend capital received		4,041	4,468
Movement on loans from DHSC		-	(1,180)
Movement on other loans		(277)	(277)
Capital element of lease rental payments		(750)	(617)
Interest on loans		-	(17)
Other interest		-	(3)
Interest paid on lease liability repayments		(73)	(46)
PDC dividend paid		(2,577)	(2,737)
Net cash flows from / (used in) financing activities		364	(409)
Decrease in cash and cash equivalents		(3,328)	(2,224)
Cash and cash equivalents at 1 April - brought forward		19,519	21,743
Cash and cash equivalents at 31 March	24	16,191	19,519

Notes to the Accounts

Note 1 : Accounting Policies

1.0 **Accounting Policies**

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health & Social Care Group Accounting Manual (GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26, issued by the Department of Health & Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected.

The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention, modified to account for the revaluation of property, plant and equipment.

1.3 **Consolidation**

The Trust is the Corporate Trustee to The Robert Jones & Agnes Hunt Orthopaedic Hospital Charity, which is registered with the Charity Commission under registration number 1058878. The Trust has assessed its relationship to the Charity and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund, and has the ability to affect those returns and other benefits through its power over the fund.

Up to and including 2024/25, the Charity was consolidated into the main Trust accounts. However, as the charity is not material to either the Trust or the reader of the accounts, for 2025/26 the charity has not been consolidated.

1.4 **Income**

Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enable an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Note 1 : Accounting Policies (continued)

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard were employed. These are as follows:

- As per paragraph 121 of the Standard the Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of 1 year or less.
- The Trust does not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The GAM mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to Trusts for NHS-funded secondary healthcare.

Aligned payment and incentive (API) contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from national price calculations are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under this scheme is part of how care is provided to patients. As such, BPT payments are not considered distinct performance obligations in their own right. Instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Note 1 : Accounting Policies (continued)

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme (ICR), designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form, and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts, in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Grants and donations

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition of the benefit.

1.5 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments, such as social security costs and the apprenticeship levy, are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Note 1 : Accounting Policies (continued)

Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. The schemes are not designed in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.6 Other Expenses

Other operating expenses are recognised when, and to the extent that, they have been received, and are measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- the item has a cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their individual useful lives.

Note 1 : Accounting Policies (continued)

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

All property, plant and equipment is measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus, with no plan to bring them back into use, are measured at fair value where there are no restrictions on sale at the reporting date, and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current value in existing use is defined as market value except where a building is so specialised in nature that no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the service being provided. Assets held at DRC can be valued on an alternative site basis where this would meet the location requirements. The Trust has elected to use an optimised approach for a modern equivalent asset valuation at its current site, accounted for as a single integrated asset for the purpose of revaluation.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Note 1 : Accounting Policies (continued)

1.8 **Intangible Assets**

Recognition

Intangible assets are non-monetary assets without physical substance, controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business, or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust, where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Software which is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset where it meets recognition criteria.

Expenditure on research is not capitalised. It is recognised as an operating expense in the period in which it is incurred.

Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and impairments were treated in the same way as property, plant and equipment. On 1 April 2025, the carrying value was carried forward as deemed cost' and any related surpluses in the revaluation reserve transferred to the I&E reserve.

1.9 **Depreciation & Amortisation**

Freehold land (as it is considered to have an infinite life), assets under construction/development, and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

1.10 **Impairments**

At each financial year end, the Trust checks whether there is any indication that any of its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is an indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

Note 1 : Accounting Policies (continued)

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of:

- The impairment charged to operating expenses; and
- The balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenses to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

1.11 Non-Current Assets Held for Sale

Non-current assets intended for disposal are re-classified as Held for Sale once all of the following criteria in IFRS 5 are met:

- The sale must be highly probable;
- The asset is available for immediate sale in its present condition.

Following re-classification, the assets are measured at the lower of their existing carrying amount and their "fair value less costs to sell". Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as Held for Sale. Instead, it is retained as an operational asset and its useful life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.12 Donated & Grant Funded Assets

Donated and grant funded non-current assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities, and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other purchased assets.

1.13 Inventories

Inventories are valued at the lower of cost and net realisable value using the First In First Out (FIFO) method.

Inventory stocks are valued at current prices as, due to the high turnover of stocks, this is considered by the Trust to be a reasonable approximation to fair value using the FIFO method.

The Trust does not consider it appropriate to account for inventory stocks where the total value of a particular stock is less than £10k, so their transactions are accounted for in revenue.

Note 1 : Accounting Policies (continued)

1.14 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.15 **Financial Assets & Financial Liabilities**

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs, except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets and financial liabilities are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition. All the Trust's financial assets and liabilities are measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Note 1 : Accounting Policies (continued)

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses.

Receivables are assessed and expected credit losses determined, so a provision for impairment can be made, based on the following criteria:

- A provision for impairment for outstanding Injury Cost Recovery (ICR) notifications of 24.62% as notified by the Compensation Recovery Unit. This has been reviewed and judged as a reasonable estimate against local claim withdrawal history.
- Receivables relating to invoices raised by the Trust to Welsh, Scottish and Northern Irish NHS bodies are discussed with these bodies and specific provisions made where required.
- All other receivables relating to invoices raised by the Trust are reviewed and specific provisions made where applicable with the remainder provided for on the basis of customer type and local receipting history.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.16 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

Note 1 : Accounting Policies (continued)

The Trust as lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Note 1 : Accounting Policies (continued)

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.17 **Provisions**

The Trust recognises a provision where it has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates. The Trust has not applied these discount rates because either settlement is expected within one year and/or the impact of discounting is not material.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to them, and in return they settle all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 29 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1 : Accounting Policies (continued)

1.18 **Contingencies**

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust; or
- a present obligation that arises from past events that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is not recognised but is disclosed at Note 30.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed at Note 30 where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.19 **Public Dividend Capital (PDC) & PDC Dividend**

Public dividend capital (PDC) is a type of public sector equity finance, which represents the Department of Health & Social Care's investment in the Trust. It was originally based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health & Social Care as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>

In accordance with the requirements laid down by the Department of Health & Social Care (as the issuer of PDC) the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.20 **Value Added Tax**

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 **Corporation Tax**

The Trust has determined that it has no corporation tax liability as its income generation activities are all ancillary to its core health objectives and not in competition with the private sector.

Note 1 : Accounting Policies (continued)

1.22 Foreign Currencies

The functional and presentational currency of the Trust is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise.

A transaction which is denominated in a foreign currency is translated into sterling at the spot exchange rate on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are re-translated at the spot exchange rate on 31 March.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Income in the period in which they arise.

1.23 Third Party Assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. If there are any at 31 March, they are disclosed in Note 25 to the accounts.

1.24 Losses & Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.26 Early adoption of standards, amendments & interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1 : Accounting Policies (continued)

1.27 **Standards, amendments & interpretations in issue but not yet effective or adopted**

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed. [

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements. From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE assets currently subject to revaluation have a total book value of £83.7m as at 31 March 2026.

1.28 **Critical Accounting Judgements and Key Sources of Estimation Uncertainty**

In the application of the Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Critical accounting judgements

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

1. Charitable funds

Determining whether charitable funds are a subsidiary of the Trust, and whether they are material, to determine whether or not to consolidate. The judgement for these accounts is that they are not consolidated as the balances and transactions are not material (see Note 1.3).

Key sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amount of assets and liabilities within the next financial year.

Note 1 : Accounting Policies (continued)

1. Valuation of land and buildings

As detailed in Note 18, Avison Young provided the Trust with a full revaluation as at 31 March 2026 of land and building assets (estimated fair value and remaining useful life), based on depreciated replacement value, using the modern equivalent asset method of valuation. The valuation uses an estimate of the theoretical configuration of the hospital site if we built it from new, with an optimised layout with no wasted space or infrastructure. The valuer makes assumptions about build costs and uses location-based industry data to determine the valuation.

Any significant variations on the valuation estimates, which by their nature include an element of subjectivity, could have an effect on the financial position of the Trust. If the valuations were 1% different, this would amount to £0.8m. The valuations would have to be different by 5.1% (£4.3m) to be considered material.

2. Depreciation

Management uses their best estimate of the useful lives of assets, which together with the valuation, determines the depreciation charge to expenditure. With equipment, there is often a degree of uncertainty over the usage of the asset and the amount of wear and tear. In addition, due to the constraints on capital funding, equipment assets may be kept longer than originally planned. Estimated remaining lives of assets are reviewed regularly.

Note 2 : Operating Segments

The Trust has one operating segment, which is the provision of healthcare. This is in line with the management reporting structure.

Note 3 : Operating Income From Patient Care Activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.

Commissioner requested services are defined within the Foundation Trust's provider licence and are services that commissioners believe would need to be protected in the event of provider failure. All the acute services income in the table below is derived from commissioner requested services.

Note 3.1 : Income from patient care activities (by nature)

	2025/26 £000	2024/25 £000
Acute services		
Income from commissioners under API contracts - variable element* (note 1)	75,717	72,797
Income from commissioners under API contracts - fixed element* (note 1)	64,646	55,388
High cost drugs income from commissioners	5,226	5,667
Other NHS clinical income	5,381	7,165
All services		
Private patient income	11,098	9,930
National pay award central funding (note 2)	-	130
Additional pension contribution central funding (note 3)	6,421	6,034
Other clinical income	979	712
Total income from activities	169,468	157,823

Note 1 - Aligned payment and incentive (API) contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.
<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

Note 2 - Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3 - Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

Note 3.2 : Income from patient care activities (by source)

	2025/26 £000	2024/25 £000
Income from patient care activities received from:		
NHS England	25,966	27,003
Integrated care boards	103,854	93,003
Other NHS providers	538	497
Non-NHS: private patients	11,098	9,930
Injury cost recovery scheme (note 1)	377	159
Non NHS: other (note 2)	27,635	27,231
Total income from activities	169,468	157,823

Note 1 - injury costs recovery scheme income is subject to a provision for impairment of receivables of 24.62% to reflect expected rates of collection.

Note 2 - the majority of the non-NHS other income is from Welsh NHS bodies for patients referred by Welsh GPs, not necessarily living in Wales, and with a Welsh postcode (2025/26: £27,529k and 2024/25: £27,074k).

Note 3 - there was no income from overseas visitors in either 2025/26 or 2024/25.

Note 4 : Other Operating Income

	2025/26 £000	2024/25 £000
Contract income		
Research and development	628	807
Education & training (excl. notional apprenticeship levy income)	2,441	2,008
Sale of goods & services	604	977
Catering	369	393
Car parking	302	269
Other contract income (note 1)	2,304	3,661
Non-contract income		
Education & training - notional apprenticeship fund income	343	301
Receipt of capital grants and donations (note 2)	1,202	228
Charitable and other contributions to expenditure	186	230
Revenue from operating leases	276	264
Total other operating income	8,655	9,138

Note 1 - other contract income includes contributions to services and sponsorship income. In addition, in 2024/25 £1,117k funding for the EPR implementation was received).

Note 2 - in 2025/26 £857k was received from Salix for decarbonisation works. This is part of a total grant of £7,145k to be received over the next 3 years.

Note 5 : Additional Information on Contract Revenue Recognised In The Period

	2025/26 £000	2024/25 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end (i.e. release of deferred income)	577	621

Note 6 : Fees & Charges

There are no fees or charges where individually the full costs exceed £1m.

Note 7 : Operating Leases - Trust as a Lessor

This note discloses income generated in operating lease agreements where the Trust is the lessor.

The Trust rents out a small proportion of the hospital buildings to partner organisations which complement the service it provides.

	2025/26 £000	2024/25 £000
Lease receipts recognised as income in year:		
Minimum lease receipts	276	264
Total in-year operating lease income	276	264
Future minimum lease receipts due in:		
- not later than one year	277	267
- later than one year and not later than two years	202	227
- later than two years and not later than three years	67	194
- later than three years and not later than four years	51	65
- later than four years and not later than five years	51	49
- later than five years	44	91
Total	692	893

Note 8 : Operating Expenses

Note 8.1 : Analysis of operating expenses

	2025/26 £000	2024/25 £000
Purchase of healthcare from non-NHS/non-DHSC bodies (note 1)	3,796	1,225
Staff and executive directors costs	109,771	103,925
Remuneration of non-executive directors	167	172
Supplies and services - clinical (excluding drugs costs)	26,133	25,834
Supplies and services - general	1,835	1,947
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	10,358	9,826
Inventories written down	200	196
Consultancy costs	575	316
Establishment	1,909	1,739
Premises	6,593	6,521
Transport (including patient travel)	420	415
Depreciation on property, plant and equipment	6,103	5,552
Amortisation on intangible assets (note 2)	922	303
Net impairments (note 3)	-	4,778
Movement in credit loss allowance: contract receivables / contract assets	(41)	34
Decrease in other provisions	(93)	(57)
Statutory audit fees paid to the external auditor	228	167
Internal audit costs	73	86
Clinical negligence	1,833	1,728
Legal fees	153	(268)
Insurance (as a policy holder)	183	160
Research and development	913	930
Education and training	804	698
Lease expenditure - short term leases	47	57
Lease expenditure - low value leases	61	86
Lease expenditure - irrecoverable VAT	158	128
Car parking & security	68	117
Losses, ex gratia & special payments	5	12
Other support services (note 4)	821	731
Other	313	348
Total	174,308	167,706

Note 1 - purchase of healthcare from non-NHS/non-DHSC bodies relates to the purchase of additional clinical capacity from the independent sector and insourcing providers, to support a reduction in long wait patients. There was an increase in rheumatology and orthopaedic insource capacity following successful tenders during the year.

Note 2 - the increase in amortisation on intangible assets relates to the go-live of a new Electronic Patient Record (EPR) digital system during 2025/26.

Note 3 - the impairment in 2024/25 related to the downward revaluation of the new Theatre building following completion of the building works. More detail is in note 9.

Note 4 - other support services includes payroll, procurement, recruitment and occupational health.

Note 8.2 : Other auditor remuneration

There was no other auditor remuneration paid to the external auditor in either 2025/26 or 2024/25 other than the statutory audit fee.

The limitation on auditor's liability for external audit work, in accordance with their engagement letter, is £1m.

Note 9 : Impairment of Assets

	2025/26 £000	2024/25 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	-	4,778
Total net impairments charged to operating surplus / deficit	-	4,778
Impairments charged to the revaluation reserve	2,604	-
Total net impairments	2,604	4,778

The impairment in 2025/26 relates to the downward revaluation of the Trust's land and buildings following the full revaluation as at 31st March 2026.

The impairment in 2024/25 related to the downward revaluation of the new theatre complex following completion of the building works. The Trust valuers stated that the actual build costs of £11.3m were broadly in line with the current valuation of the building when considered in isolation. However, as the Trust site is valued on a Modern Equivalent Asset (MEA) basis, this accounts for the building on an optimum plan basis, which factors in improved economies of scale and optimum site layout of the utilised environment. The valuation for accounting purposes therefore resulted in a material impairment to the fair value of the asset.

Note 10 : Employee Benefits

Note 10.1 : Staff costs

	2025/26 £000	2024/25 £000
Salaries and wages	83,596	80,613
Social security costs	10,530	7,899
Apprenticeship levy	396	372
Employer's contributions to NHS pensions	16,248	15,284
Pension cost - other	16	20
Termination benefits	331	8
Temporary staff (including agency)	833	2,310
Total gross staff costs	111,950	106,506
Recoveries in respect of seconded staff	(608)	(430)
Total staff costs	111,342	106,076
Of which		
Costs capitalised as part of assets	668	1,245

Note 10.2 : Retirements due to ill-health

During 2025/26 there were 4 early retirements from the Trust on the grounds of ill-health (1 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £126k (£25k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 11 : Pension Costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

The Trust also makes contributions to the National Employment Savings Trust (NEST) pension scheme. This is a defined contribution scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008.

Note 12 : Finance Income

Finance income represents interest received on assets and investments in the period.

	2025/26 £000	2024/25 £000
Interest on bank accounts	957	1,025
Total finance income	957	1,025

Note 13 : Finance Expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025/26 £000	2024/25 £000
Interest expense:		
Interest on loans from the Department of Health and Social Care	-	14
Interest on lease obligations	73	46
Total interest expense	73	60
Other finance costs	-	3
Total finance costs	73	63

There was no interest payable in 2025/26 or 2024/25 under the Late Payment of Commercial Debts (Interest) Act 1998 / Public Contract Regulations 2015.

Note 14 : Other Gains / Losses

	2025/26 £000	2024/25 £000
Gains on disposal of assets	4	1
Losses on disposal of assets	(1)	(18)
Total gains / (losses) on disposal of assets	3	(17)

Note 15 : Intangible Assets

Note 15.1 : Intangible assets - 2025/26

	Software licences £000	Intangible assets under construction £000	Total £000
Cost at 1 April 2025 - brought forward	4,937	13,992	18,929
Additions	1,100	-	1,100
Reclassifications	13,867	(13,867)	-
Disposals / derecognition (note 3)	(1,190)	-	(1,190)
Cost at 31 March 2026	18,714	125	18,839
Amortisation at 1 April 2025 - brought forward	4,044	-	4,044
Provided during the year	922	-	922
Disposals / derecognition (note 3)	(1,190)	-	(1,190)
Amortisation at 31 March 2026	3,776	-	3,776
Net book value at 31 March 2026	14,938	125	15,063
Net book value at 1 April 2025	893	13,992	14,885

Note 1 - minimum and maximum useful economic lives of the software licences are 2 years and 15 years respectively. Useful economic lives reflect the total life of an asset, not the remaining life.

Note 2 - the majority of the intangible assets relates to the new Electronic Patient Record (EPR) system, for which implementation was completed in 2025/26.

Note 3 - on go-live of the new EPR system, the old legacy system stopped being used, so is shown as a disposal in 2025/26.

Note 15.2 : Intangible assets - 2024/25

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2024 - brought forward	4,637	10,037	14,674
Additions	300	3,955	4,255
Valuation / gross cost at 31 March 2025	4,937	13,992	18,929
Amortisation at 1 April 2024 - brought forward	3,741	-	3,741
Provided during the year	303	-	303
Amortisation at 31 March 2025	4,044	-	4,044
Net book value at 31 March 2025	893	13,992	14,885
Net book value at 1 April 2024	896	10,037	10,933

Note 16 : Property, Plant & Equipment

Note 16.1 : Property, plant & equipment - 2025/26

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2025 - brought forward	1,893	83,091	243	-	18,597	36	4,465	470	108,795
Additions	-	4,057	-	2,924	2,245	-	758	-	9,984
Impairments (note 1)	(62)	(2,542)	-	-	-	-	-	-	(2,604)
Revaluations (note 1)	-	(2,998)	15	-	-	-	-	-	(2,983)
Disposals / derecognition	-	-	-	-	(318)	-	(162)	-	(480)
Valuation/gross cost at 31 March 2026	1,831	81,608	258	2,924	20,524	36	5,061	470	112,712
Accumulated depreciation at 1 April 2025 - brought forward	-	9	-	-	9,068	9	2,634	368	12,088
Provided during the year	-	2,989	12	-	1,712	4	628	37	5,382
Revaluations (note 1)	-	(2,998)	(12)	-	-	-	-	-	(3,010)
Disposals / derecognition	-	-	-	-	(316)	-	(162)	-	(478)
Accumulated depreciation at 31 March 2026	-	-	-	-	10,464	13	3,100	405	13,982
Net book value at 31 March 2026	1,831	81,608	258	2,924	10,060	23	1,961	65	98,730
Net book value at 1 April 2025	1,893	83,082	243	-	9,529	27	1,831	102	96,707

Note 1 - the full revaluation of land and buildings by Avison Young resulted in an impairment of land and buildings excluding dwellings, and an upward revaluation of dwellings.

Note 16.2 : Property, plant & equipment - 2024/25

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2024 - brought forward	1,893	76,206	236	9,350	18,046	36	3,739	447	109,953
Additions	-	4,537	-	-	1,406	-	726	23	6,692
Impairments (note 1)	-	(4,778)	-	-	-	-	-	-	(4,778)
Revaluations (note 2)	-	(2,224)	7	-	-	-	-	-	(2,217)
Reclassifications	-	9,350	-	(9,350)	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(855)	-	-	-	(855)
Valuation/gross cost at 31 March 2025	1,893	83,091	243	-	18,597	36	4,465	470	108,795
Accumulated depreciation at 1 April 2024 - brought forward	-	306	-	-	8,312	5	2,130	333	11,086
Provided during the year	-	2,786	12	-	1,590	4	504	35	4,931
Revaluations (note 2)	-	(3,083)	(12)	-	-	-	-	-	(3,095)
Disposals / derecognition	-	-	-	-	(834)	-	-	-	(834)
Accumulated depreciation at 31 March 2025	-	9	-	-	9,068	9	2,634	368	12,088
Net book value at 31 March 2025	1,893	83,082	243	-	9,529	27	1,831	102	96,707
Net book value at 1 April 2024	1,893	75,900	236	9,350	9,734	31	1,609	114	98,867

Note 1 - the impairment related to the downward revaluation of the new Theatre building following completion of the building works.

Note 2 - the revaluation is was a result of a desk-top revaluation of land and buildings by Avison Young.

Note 16.3 : Property, plant & equipment financing - 2025/26

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned - purchased	1,831	61,435	258	1,957	9,384	-	1,914	22	76,801
Owned - donated/granted	-	20,173	-	967	676	23	47	43	21,929
Total net book value at 31 March 2026	1,831	81,608	258	2,924	10,060	23	1,961	65	98,730

Note 16.4 : Property, plant & equipment financing - 2024/25

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned - purchased	1,893	62,975	243	-	8,912	-	1,736	33	75,792
Owned - donated/granted	-	20,107	-	-	617	27	95	69	20,915
Total net book value at 31 March 2025	1,893	83,082	243	-	9,529	27	1,831	102	96,707

Note 16.5 : Economic lives of property, plant & equipment

The minimum and maximum useful economic lives of each class of asset are given in the table below. Useful economic lives reflect the total life of an asset, not the remaining life.

	Min Life Years	Max Life Years
Land	N/A	N/A
Buildings excluding dwellings	5	70
Dwellings	13	48
Plant & machinery	3	31
Transport equipment	10	10
Information technology	3	10
Furniture & fittings	5	35

Note 17 : Donations of Property, Plant & Equipment

Cash donations were received by the Foundation Trust to purchase medical and other equipment. All cash received was utilised for this purpose. Donations were received from:

The RJAH charity - £249k

The League of Friends - £81k

Note 18 : Revaluations of Property, Plant & Equipment

For 2025/26, a full revaluation of land and buildings was undertaken by Avison Young with an effective date of 31 March 2026. This resulted in an overall decrease in value of £2,577k.

The valuations were undertaken in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the NHS, and the requirements of the RICS Valuation Professional Standards.

The valuations are carried out on a Modern Equivalent Asset (MEA) basis, using an optimised approach to land and building constitution.

Note 19 : Leases - Trust as a Lessee

This note details information about leases for which the Trust is a lessee.

The Trust has 2 significant leases - an operating theatre modular building (Menzies Day Case Unit) and a spinal robot. The lease for the robot commenced in 2025/26. Other smaller leases relate to medical equipment (including a CT scanner and theatre equipment), I/T equipment and pool vehicles.

Note 19.1 : Right of use assets - 2025/26

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000
Valuation / gross cost at 1 April 2025 - brought forward	1,961	673	52	2,686
Additions	-	920	11	931
Remeasurements of the lease liability	21	-	-	21
Disposals / derecognition	-	(25)	(16)	(41)
Valuation/gross cost at 31 March 2026	1,982	1,568	47	3,597
Accumulated depreciation at 1 April 2025 - brought forward	1,262	468	43	1,773
Provided during the year	462	249	10	721
Disposals / derecognition	-	(24)	(16)	(40)
Accumulated depreciation at 31 March 2026	1,724	693	37	2,454
Net book value at 31 March 2026	258	875	10	1,143
Net book value at 1 April 2025	699	205	9	913

No leases were with DHSC group bodies.

Note 19.2 : Right of use assets - 2024/25

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000
Valuation / gross cost at 1 April 2024 - brought forward	1,911	495	56	2,462
Additions	-	194	-	194
Remeasurements of the lease liability	59	-	-	59
Disposals / derecognition	(9)	(16)	(4)	(29)
Valuation/gross cost at 31 March 2025	1,961	673	52	2,686
Accumulated depreciation at 1 April 2024 - brought forward	824	326	31	1,181
Provided during the year	447	158	16	621
Disposals / derecognition	(9)	(16)	(4)	(29)
Accumulated depreciation at 31 March 2025	1,262	468	43	1,773
Net book value at 31 March 2025	699	205	9	913
Net book value at 1 April 2024	1,087	169	25	1,281

No leases were with DHSC group bodies.

Note 19.3 : Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the Statement of Financial Position. A breakdown of borrowings is disclosed in Note 28.

	2025/26 £000	2024/25 £000
Carrying value at 1 April	725	1,089
Lease additions	931	194
Lease liability remeasurements	21	59
Interest charge arising in year	73	46
Early terminations	(1)	-
Lease payments (cash outflows)	(823)	(663)
Carrying value at 31 March	926	725

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 8. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 19.4 : Maturity analysis of future lease payments

	31 March 2026 £000	31 March 2025 £000
Undiscounted future lease payments payable in:		
- not later than one year;	340	601
- later than one year and not later than five years;	694	164
Total gross future lease payments	1,034	765
Finance charges allocated to future periods	(108)	(40)
Net lease liabilities at 31 March 2026	926	725

Note 20 : Inventories

All inventories are finished goods.

	31 March 2026 £000	31 March 2025 £000
Drugs	205	252
Consumables	1,356	1,315
Energy	51	64
Total inventories	1,612	1,631

Inventories recognised in expenses for the year were £16,230k (2024/25: £15,762k). Write-down of inventories recognised as expenses for the year were £200k (2024/25: £196k).

Note 21 : Receivables

Note 21.1 : Analysis of receivables

	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables (note 1)	9,243	7,540
Capital receivables	225	-
Allowance for impaired contract receivables / assets	(475)	(518)
Prepayments	1,456	1,122
Interest receivable	69	89
PDC dividend receivable	37	98
VAT receivable	329	173
Other receivables	74	45
Total current receivables	10,958	8,549
Non-current		
Contract receivables	641	700
Allowance for impaired contract receivables / assets	(158)	(171)
Prepayments	209	198
Other receivables	235	277
Total non-current receivables	927	1,004
Of which receivable from NHS and DHSC group bodies:		
Current	6,261	4,499
Non-current	235	277

Note 1 - contract receivables for 2025/26 includes redistributed Deficit Support Funding (DSF) of £1,638k. This is central funding from NHS England distributed late in the year to providers that achieved their financial plans.

Note 21.2 : Allowances for credit losses

All credit losses relate to contract receivables.

	31 March 2026 £000	31 March 2025 £000
Allowances as at 1 April - brought forward	689	658
New allowances arising	8	34
Changes in existing allowances	(28)	10
Reversals of allowances	(21)	(10)
Utilisation of allowances (write offs)	(15)	(3)
Allowances as at 31 March 2026	633	689

Note 22 : Finance Leases - Trust as a Lessor

There were no finance leases in either 2025/26 or 2024/25.

Note 23 : Non-Current Assets Held for Sale

There were no non-current assets held for sale in either 2025/26 or 2024/25.

Note 24 : Cash & Cash Equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2025/26 £000	2024/25 £000
At 1 April	19,519	21,743
Net change in year	(3,328)	(2,224)
At 31 March	16,191	19,519
Broken down into:		
Cash at commercial banks and in hand	6	7
Cash with the Government Banking Service	16,185	19,512
Total cash and cash equivalents as in SoFP	16,191	19,519

Note 25 : Third Party Assets Held by the Trust

There were no third party assets held in either 2025/26 or 2024/25.

Note 26 : Trade & Other Payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables (note 1)	3,291	1,843
Capital payables	2,317	1,952
Accruals (note 2)	3,875	8,477
Social security costs	1,233	972
Other taxes payable	1,263	1,098
Pension contributions payable	1,368	1,292
Other payables (note 3)	4,530	2,756
Total current trade and other payables	17,877	18,390
Of which payables from NHS and DHSC group bodies:		
Current	692	4,742

Note 1 - the large increase in trade payables is due to several large invoices being received in March.

Note 2 - the large decrease in accruals is due to significant contract underperformance and year end agreements with commissioners at the end of 2024/25.

Note 3 - the large increase in other payables is mainly due to an accrual for healthcare support workers pay re-bandings.

Note 27 : Other Liabilities

	31 March 2026 £000	31 March 2025 £000
Current		
Deferred income: contract liabilities (note 1)	577	695
Deferred grants (note 2)	818	56
Total other current liabilities	1,395	751

Note 1 - the majority of these liabilities relate to research funding, fees received from private patients in advance of treatment, and funding for staffing where the posts cover more than one year.

Note 2 - the grants include a £750k grant from the Headley Court Charity for a Veterans Rehabilitation Pilot.

Note 28 : Borrowings

Note 28.1 : Analysis of borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Other loans (note 1)	139	277
Lease liabilities	295	573
Total current borrowings	434	850
Non-current		
Other loans (note 1)	-	139
Lease liabilities	631	152
Total non-current borrowings	631	291

Note 1 - Salix is a government-funded organisation which provides interest-free loans to the public sector to improve energy efficiency. The principal is repaid over 5 years at 6 monthly intervals until September 2026.

Note 28.2 : Reconciliation of liabilities from financing activities

2025/26	Loans from DHSC £000	Other loans £000	Lease liabilities £000	Total £000
Carrying value at 1 April 2025	-	416	725	1,141
Cash movements:				
Financing cash flows - payments and receipts of principal	-	(277)	(750)	(1,027)
Financing cash flows - payments of interest	-	-	(73)	(73)
Non-cash movements:				
Additions	-	-	931	931
Lease liability remeasurements	-	-	21	21
Application of effective interest rate	-	-	73	73
Early terminations	-	-	(1)	(1)
Carrying value at 31 March 2026	-	139	926	1,065
2024/25	Loans from DHSC £000	Other loans £000	Lease Liabilities £000	Total £000
Carrying value at 1 April 2024	1,183	693	1,089	2,965
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,180)	(277)	(617)	(2,074)
Financing cash flows - payments of interest	(17)	-	(46)	(63)
Non-cash movements:				
Additions	-	-	194	194
Lease liability remeasurements	-	-	59	59
Application of effective interest rate	14	-	46	60
Carrying value at 31 March 2025	-	416	725	1,141

Note 29 : Provisions for Liabilities & Charges

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Pay-related claims (incl. Agenda for Change) £000	Other £000	Total £000
At 1 April 2025	42	373	60	2,544	552	3,571
Change in the discount rate	-	-	-	-	(19)	(19)
Arising during the year	28	-	33	574	-	635
Utilised during the year	(31)	(26)	(6)	(1,426)	(8)	(1,497)
Reversed unused	-	-	(6)	(1,118)	(178)	(1,302)
Unwinding of discount	-	-	-	-	16	16
At 31 March 2026	39	347	81	574	363	1,404
Expected timing of cash flows:						
- not later than one year;	33	24	81	574	128	840
- later than one year and not later than five years;	6	96	-	-	38	140
- later than five years.	-	227	-	-	197	424
Total	39	347	81	574	363	1,404

The pensions relate to NHS pensions payable to staff given early retirement prior to 1995, and an injury benefit for a previous employee of the Trust. These are administered and invoiced for by the NHS Business Services Agency Pensions Division with total liability estimated based on life expectancy.

The legal claims relate to employer's and public liability claims handled by NHS Resolution. Liability is limited to the scheme excess.

The pay-related claims relate to back pay for re-banding claims, which are subject to agreement of scope and duration.

"Other" relates to clinician pension tax reimbursement and the dismantling charges for the day case unit at the end of the lease.

At 31 March 2026, £12,671k was included in the provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust (31 March 2025: £11,943k).

Note 30 : Contingent Assets & Liabilities

There were no contingent assets in 2025/26 or 2024/25.

	31 March 2026 £000	31 March 2025 £000
Value of contingent liabilities		
NHS Resolution legal claims	(29)	(16)
Total value of contingent liabilities	(29)	(16)

Note 31 : Contractual Capital Commitments

	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment (note 1)	10,698	148
Intangible assets	-	17
Total	10,698	165

Note 1 - The commitments at 31st March 2026 relate mainly to decarbonisation works and the new theatre building works.

Note 32 : Other Financial Commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2026 £000	31 March 2025 £000
Not later than 1 year	1,153	1,231
After 1 year and not later than 5 years	892	1,786
Paid thereafter	-	-
Total	2,045	3,017

Note 33 : Financial Instruments

Note 33.1 : Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Foundation Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust's investment policy limits the investment of surplus funds to institutions with a low risk rating. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust treasury management operations are carried out by the finance department. This is within parameters defined formally within its Standing Financial Instructions and policies agreed by the board of directors. Treasury activity is subject to review by the Group's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. There are no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust holds a Salix loan which is interest free. The Trust therefore has no exposure to interest rate fluctuations.

Credit risk

As the majority of income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2026 are in receivables from customers, as disclosed in the receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with commissioning organisations, which are financed from resources voted annually by Parliament. Capital expenditure is funded from resources voted annually by parliament, internally generated surpluses, donations, and through allocations from the Department of Health and Social Care. The Trust is not, therefore, exposed to significant liquidity risks.

Note 33.2 Carrying values of financial assets

All at amortised cost under IFRS 9	31 March 2026 £000	31 March 2025 £000
Trade and other receivables excluding non financial assets	9,854	7,962
Cash and cash equivalents	16,191	19,519
Total at 31 March 2026	26,045	27,481

Carrying value (book value) of these financial assets is assumed to be a reasonable approximation of fair value.

Note 33.3 Carrying values of financial liabilities

All at amortised cost under IFRS 9	31 March 2026 £000	31 March 2025 £000
Obligations under leases	926	725
Other borrowings	139	416
Trade and other payables excluding non financial liabilities	14,013	15,018
Provisions under contract	120	120
Total at 31 March 2026	15,198	16,279

Carrying value (book value) of these financial liabilities is assumed to be a reasonable approximation of fair value.

Note 33.4 : Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This may differ to the amounts recognised in the Statement of Financial Position which are discounted to present value.

	31 March 2026 £000	31 March 2025 £000
In one year or less	14,612	15,896
In more than one year but not more than five years	694	423
Total	15,306	16,319

Note 34 : Losses & Special Payments

	2025/26		2024/25	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	2	-	1	-
Bad debts and claims abandoned	62	14	56	3
Stores losses and damage to property	2	201	4	205
Total losses	66	215	61	208
Special payments				
Ex-gratia payments	127	11	73	27
Total special payments	127	11	73	27
Total losses and special payments	193	226	134	235

Losses and special payments are accounted for on an accruals basis, excluding provisions for future losses.

Note 35 : Related Parties

During the year no Department of Health & Social Care ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Group.

The Department of Health is regarded as a related party. During the year the Group has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. The most significant are:

- Cheshire & Merseyside ICB
- Herefordshire & Worcestershire ICB
- NHS England
- Shrewsbury & Telford Hospitals NHS Trust
- Shropshire, Telford & Wrekin ICB
- Staffordshire & Stoke on Trent ICB

The Group has had a number of material transactions with UK devolved governments. These transactions have been for the provision of healthcare, mainly with Welsh NHS bodies which are funded by the Welsh Assembly.

- Betsi Cadwaladr University LHB
- Powys LHB

The Group has also had a number of material transactions with other government departments and other central and local government bodies. Most of these have been with Shropshire Council in respect of non-domestic rates.

The Trust's linked NHS charity (The Robert Jones and Agnes Hunt Orthopaedic Hospital Charity) is a related party, and is not consolidated into these accounts. The Trust Board is the Corporate Trustee for the Charity. The Trust received income from the Charity of £401k in 2025/26.

Note 36 : Events After the Reporting Date

There were no events after the reporting date.

Note 37 : Adjusted Financial Performance

The table below shows the Trust's adjusted financial performance.

	2025/26 £000	2024/25 £000
Retained surplus / (deficit) for the year	2,064	(2,459)
Remove net impairments	-	4,778
Remove I&E impact of capital grants and donations	(362)	566
Remove net impact of DHSC centrally procured inventories	-	31
Adjusted financial performance surplus	1,702	2,916

The adjusted financial performance of £1,702k surplus in 2025/26 (£2,916k in 2024/25) was in line with the Trust's financial plan to generate a surplus of £1.6m (£2.9m in 2024/25). This is the measurement used by NHS England to monitor financial delivery.

