The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors | Public Meeting 07.01.2026

MEETING

7 January 2026 09:30 GMT

PUBLISHED

7 January 2026

Agenda

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Meeting Room 1, Main Entrance	7 Jan 2026	09:30 GMT

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6	Chair Report from Digital, Education, Research, Innovation and Commercialisation Committee	Non-Executive Director	11:20	124
7	Chair Report from Audit and Risk Committee	Non-Executive Director	11:30	129
8	Questions from the Governors and Public	Chair	11:35	-
9	Any Other Business	All	11:45	-
9.1	Next Meeting: 04 March 2026 at 9:30am			-

Member	First Name	Surname	Position	Type of Interest	Description of Interest (including for indirect interests, details of the relationship with the person who has the interest)	Date interest relates From	Date interest relates To
Board	Harry	Turner	Chairman	Non-Financial Personal Interests	Presiding Justice West Mercia judiciary	01/10/2026	Ongoing
Board	Harry	Turner	Chairman	Financial Interests	In Form Solutions Management Consultancy	01/02/2024	Ongoing
Board	Sarfraz	Nawaz	Non Executive Director	Financial Interests	Wakefield Council – Chief Finance Officer	01/09/2025	Ongoing
Board	Sarfraz	Nawaz	Non Executive Director	Non-Financial Professional Interests	Member of CIPFA	01/01/2021	Ongoing
Board	Sarfraz	Nawaz	Non Executive Director	Non-Financial Professional Interests	S151 Officer for West Yorkshire Joint Services, and YPO	01/09/2025	Ongoing
Board	Martin	Evans	Non Executive Director	Financial Interests	Non-Executive Director at North Staffordshire Combined Healthcare NHS Trust	28/08/2024	Ongoing
Board	Martin	Evans	Non Executive Director	Financial Interests	Director at MJE Associates Ltd.	01/04/2020	Ongoing
Board	Martin	Evans	Non Executive Director	Financial Interests	Coach for the National Neighbourhood Health Implementation Programme	01/09/2025	Ongoing
Board	Penny	Venables	Non Executive Director	Financial Interests	Consultant – In-Form Solutions Ltd, Lichfield Business Hub, Lichfield Council House, 20 Frog Lane, Lichfield, Staffordshire, WS13 6YY. Work as a management consultant via this business.	01/01/2021	Ongoing
Board	Penny	Venables	Non Executive Director	Financial Interests	Trustee Board of Birmingham University Guild of Students	01/01/2025	Ongoing
Board	Penny	Venables	Non Executive Director	Financial Interests	Member of the Members Council of the West Bromwich Building Society	01/10/2024	Ongoing
Board	Penny	Venables	Non Executive Director	Non-Financial Professional Interests	Non-Executive Director – British Dietetic Association, 3rd Floor Interchange Place, 151 – 165 Edmund Street, Birmingham B3 2TA. Sit on the Board of Directors of the BDA.	01/06/2020	01/10/2024
Board	Penny	Venables	Non Executive Director	Non-Financial Personal Interests	Chair Sandwell Leisure Trust, Tipton Sports Acadamy, Wednesbury Oak Road, Tipton, West Midlands DY4 0BS.	01/11/2023	Ongoing
Board	Martin	Newsholme	Non Executive Director	Financial Interests	Non executive director of Shropshire Doctors Co-operative Limited	01/08/2019	Ongoing
Board	Martin	Newsholme	Non Executive Director	Financial Interests	Non executive director at Warrington Housing Association	01/09/2018	Ongoing
Board	Lindsey	Webb	Non Executive Director	Indirect Interests	Husband is a Deputy Chair at Birmingham, Black Country and Solihull ICB	17/11/2025	Ongoing
Board	Lindsey	Webb	Non Executive Director	Indirect Interests	Husband is a NED at Birmingham and Solihull ICB		16/11/2025
Board	Darius	Mirza	Non Executive Director	Non-Financial Professional Interests	Chair, SPLIT Charity – Supporting Paediatric Liver and Intestinal Transplantation, Birmingham	02/02/2016	Ongoing
Board	Darius	Mirza	Non Executive Director	Non-Financial Professional Interests	Trustee – THTPF (Transplants Help the Poor Foundation, Mumbai, India)	01/04/2016	Ongoing
Board	Darius	Mirza	Non Executive Director	Non-Financial Professional Interests	Vice Chair, George Eliot School Board of Governors, Nuneaton	01/04/2023	01/04/2026
Board	Darius	Mirza	Non Executive Director	Non-Financial Professional Interests	Shareholder, Organox Ltd, Oxford (Machine Perfusion Device Manufacturer, Oxford)	01/09/2018	01/11/2025
Board	Paul	Maubach	Associate Non Executive Director	Non-Financial Professional Interests	Member of CIPFA	01/03/2023	Ongoing
Board	Paul	Maubach	Associate Non Executive Director	Financial Interests	Senior Advisor for Primary Care (Department of Health)	01/03/2023	31/07/2024
Board	Paul	Maubach	Associate Non Executive Director	Financial Interests	Director for Neighbourhood Health (Department of Health)	01/08/2024	Ongoing
Board	Paul	Maubach	Associate Non Executive Director	Financial Interests	Director and Owner of Maubach Consulting Ltd – through which I provide management consulting and advisory services to different organisations.If it transpires either at a committee or Board meeting of the Trust, the meeting is either discussing or engaging with an organisation that my company is also engaged with, then I will declare a potential conflict of interest to the Chair.	01/03/2023	Ongoing
Board	Atif	Ishaq	Associate Non Executive Director	Financial Interests	Enterprise AI & Advanced Analytics Director at Mars Inc	04/2025	Ongoing
Board	Atif	Ishaq	Associate Non Executive Director	Financial Interests	Owner of Digital Clinician Ltd	01/01/2018	Ongoing
Board	Atif	Ishaq	Associate Non Executive Director	Financial Interests	Digital Advisor and Webmaster to Quest Legal Advocates LTD	01/01/2011	Ongoing
Board	Atif	Ishaq	Associate Non Executive Director	Financial Interests	Webmaster for Shrawley, North Claines and Hanbury Parish Councils	01/01/2011	Ongoing
Board	Atif	Ishaq	Associate Non Executive Director	Financial Interests	Self-employed webhosting provider	01/01/2011	Ongoing
Board	Atif	Ishaq	Associate Non Executive Director	Non-Financial Personal Interests	Justice of the Peace for West Mercia Judiciary	01/01/2017	Ongoing
Board	Stacey	Keegan	Chief Executive Officer	Non-Financial Professional Interests	STW ICB Partner Member	01/07/2022	Ongoing
Board	Stacey	Keegan	Chief Executive Officer	Non-Financial Professional Interests	Lead CEO for the NOA	01/12/2025	Ongoing
Board	Stacey	Keegan	Chief Executive Officer	Non-Financial Professional Interests	A member of the National Orthopaedic Alliance Board	03/05/2024	Ongoing
Board	Ruth	Longfellow	Chief Medical Officer	Financial Interests	Private Practice work for RJAH	01/01/2011	Ongoing
Board	Ruth	Longfellow	Chief Medical Officer	Financial Interests	Member of GAS (Gobowen Anaesthetic Services)	01/11/2019	01/06/2025
Board	Mike	Carr	Chief Operating Officer	Indirect Interests	Parent is Chief Executive of Midlands Partnership NHS Trust.	01/05/2022	Ongoing
Board	Mike	Carr	Chief Operating Officer	Non-Financial Personal Interests	Trustee at Stay Charity	01/02/2025	Ongoing
Board	Denise	Harnin	Chief People and Culture Officer	Non-Financial Personal Interests	Spouse is a senior partner at Johnson Fellows Charter House, Birmingham, Ad hoc HR consultancy Johnson Fellows		Ongoing
Board	Angela	Mulholland-Wells	Chief Finance and Commerical Officer	Non-Financial Professional Interests	Board Trustee and chair of the Audit, Finance and Risk Committee for Mines Advisory Group.	01/10/2023	Ongoing
Board	Paul	Kavanagh-Fields	Chief Nurse and Patient Safety Officer	Non-Financial Professional Interests	Chair of the NOA workforce network	01/06/2024	Ongoing
Board	Paul	Kavanagh-Fields	Chief Nurse and Patient Safety Officer	Non-Financial Professional Interests	Member of the Cavell Advisory Panel, supporting a UK charity that assists nurses, midwives, and maternity support staff facing financial hardship.	01/10/2024	Ongoing
Board	Sarah	Needham	Interim Chief Nurse and Patient Safety Officer	No interest to declare	N/A		

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

BOARD OF DIRECTORS | PUBLIC MEETING
WEDNESDAY 05 NOVEMBER 2025 AT 9:30AM AT RJAH ORTHOPAEDIC HOSPITAL
MINUTES OF MEETING

Voting Members in Attendance

Name (and identifying Initials)	Role	Attending
Harry Turner (HT)	Chair	✓
Sarfraz Nawaz (SN)	Non-Executive Director	✓
Martin Newsholme (MN)	Non-Executive Director	✓
Penny Venables (PV)	Non-Executive Director	×
Lindsey Webb (LW)	Non-Executive Director	✓
Martin Evans (ME)	Non-Executive Director	✓
Stacey Keegan (SK)	Chief Executive Officer	✓
Angela Mulholland-Wells (AMW)	Chief Finance and Commercial Officer	✓
Paul Kavanagh Fields (PKF)	Chief Nurse and Patient Safety Officer	×
Ruth Longfellow (RL)	Chief Medical Officer	✓
Mike Carr (MC)	Deputy CEO and Chief Operating Officer	✓

Others in Attendance

Name (Initial)	Role	Attending
Paul Maubach (PM)	Associate Non-Executive Director	✓
Atif Ishaq (AI)	Associate Non-Executive Director	×
Denise Harnin (DH)	Chief People and Culture Officer	✓
Dylan Murphy (DM)	Trust Secretary	✓
Mary Bardsley (MB)	Assistant Trust Secretary (minutes)	✓
Chris Hudson (CH)	Head of Communications	✓

Ref	Discussion and Action Points
1.0	**Welcome and introductions**
	The Chair welcomed all attendees to the meeting and a special welcome to Gemma Brett, Deputy General Manager for Specialist Unit and Richard Fallows, STW ICS MSK Transformation Clinical Lead who joined the meeting to deliver a presentation on MSK System Collaboration and Neighbourhood Working.
1.1	**Apologies**
	Apologies for absence were received from Penny Venables, Atif Ishaq and Paul Kavanagh-Fields. It was formally confirmed that the Board was quorate, enabling the meeting to proceed with full decision-making authority.
1.2	**Declarations of Interest**
	The Chair reminded attendees of their obligation to declare any interest which may be perceived as a potential conflict of interest with their Trust role and their role on this Board. There were no conflicts of interest identified in relation to the items for discussion which required members to withdraw from discussion or decision-making.
1.3	**Minutes of the previous meeting**
	The minutes of the Board of Directors (Public) Meeting held on 03 September 2025 were approved as an accurate reflection of the meeting.
1.4	**Matters Arising and Action Log**
	The Board discussed the following actions: • **Action 2; Patient Story** – the Board agreed to close the action as a report has as the QS Committee received an update progress report on the actions which are being undertaken to improve the process following the discussion at the Board meeting.
2.0	**Presentation**

Ref	Discussion and Action Points

	MC introduced Gemma Brett, Deputy General Manager for the Specialist Unit, and Richard Fallows, STW ICS MSK Transformation Clinical Lead, who joined the meeting to deliver a presentation on MSK System Collaboration and Neighbourhood Working.
	
	The MSK service is a collaboration between provider organisations, charities, community partners, and others. The presentation outlined the current position and the progress being made.
	
	The work aligns with the NHS Long Term Plan, with a particular focus on spinal services specific to RJAH.
	
	Gemma ns Richard delivered a presentation highlighting the following:
	• **System, Place, and Neighbourhood:** The difference between **system**, **place**, and **neighbourhood** was outlined. Locations of MSK (Musculoskeletal) venues within the region were identified, along with how they operated in partnership with neighbourhood teams.
	• **Strategic Alignment:** The 10-year plan was presented and aligned to delivery objectives. A whole pathway approach was emphasised with end-to-end delivery. A single pathway and multi-organisation collaboration within the community pathway had already been implemented.
	• **New Challenges:** The Neighbourhood RJAH / MSK Transformation was introduced. Representation and engagement included STW engagement, A regional workshop was launched, supported by a wide range of MDT teams (ShiPP and Twipp.)
	• **Neighbourhood Health Programme:** Inputs included Strategic contributions and Community pain service transformation and delivery of specialist services through RJAH.
	• **Patient Support Initiatives:** MyRecovery expanded patient support and included additional information on available resources, there has been a **Good Boost** utilised digital AI solutions.
	
	Spinal Pathway
	• Challenges included:
	  ○ Specialist performance and long waiting times.
	  ○ A significant increase in referrals in recent years.
	  ○ Capacity and demand imbalance, particularly due to increased Welsh referrals.
	• Discharge rate:
	  ○ 33% of patients were discharged at the first appointment, indicating potential inappropriate referrals.
	• Considerations:
	  ○ Pathways were reviewed to ensure the right patients were seen at the right time by the right people.
	  ○ The GIRST spinal pathway was triaged through one system to streamline processes for patients.
	• Implementation:
	  ○ Immediate work was underway.
	  ○ Next steps include Implementing updated criteria within the MSST system and using the criteria effectively to support patients.
	• Single Point of Access going live will further support patient's journey.
	
	On behalf of the board Harry thanked Gemma and Mike for the presentation and encouraged comments and questions from the members of the board. The following was noted:
	• A significant amount of work has been undertaken over the years, improving patient care. This aligns with the 10-year plan and complements our strategic objectives.
	• MC commended the team and was pleased to see strong support for the interdependencies within the spinal pathways.
	• ME added that as a national coach for NHS work, as an organisation, it's great news that RJAH are part of the programme within Shropshire. However, there is a collective challenge to complete wider collaborative work and seize opportunities to progress. More work is needed to support this initiative. Nationally, the NHS must use the programme to ensure momentum and deliver tangible improvements in the coming months, ultimately benefiting patients in the years ahead.

Ref	Discussion and Action Points
	• PM agreed with ME comments and noted that it's great to see NHS representation at the Board. It's also encouraging to see this first step, especially given the recent rise in referrals. One of the most powerful tools is sharing performance and discharge data and queried whether there is an option do something similar with GPs and first contact points? There should be consideration to these referrals and explore ways to improve working practices. • Richard explained that this work is data-driven, and as an organisation we are examining several aspects. We can review single points of contact and compare different patient cohorts and explained that we currently use various templates, which will be updated to enable better data sharing. For first contact practitioners, we should obtain comparative data and present it to the Board to support a richer understanding. We already have information by PCN and patient cohorts. • Regarding PROMS and PREMS, the team aim to have these fully implemented by 2029. This service can help us understand patient experiences. It's great to see this developing. As a Trust, we have been proactive in embedding PROMS into the patient pathway through MyRecovery, and we will continue improving patient tracking. • MSK HQ has been included in primary and community care, and we are starting to receive data as it has recently been implemented. This is an important development. • SNe thanked the team for the insightful presentation. How do we target global majority groups and homeless populations? How do we address inequalities? In the future, having neighbourhood hubs and centres for people to attend will help us reach these communities. We need to make care accessible as possible for all people. MC added that in relation to health inequalities, the MSK group is an advanced meeting within the system, and mapping is already in place. The MSST service has supported this work. The Board also thanked MC for his leadership within this area of work.
3.0	**Risk Management**
3.1	**Corporate Risk Registe**
	DM presented a summary of the Corporate Risk Register, highlighting the risks considered during the October cycle of Board sub-committees and subsequently reviewed at the October meeting of the Risk Management Group (RMG). DM reminded the Board that points of escalation are raised through individual Committee Chair Assurance Reports. Each committee has detailed oversight of relevant risks, and these reports ensure that significant matters are brought to the Board's attention. **The Board discussed the following key points:** • Additional steps are being taken to address long-standing risks, with further review and follow-up at executive meetings. • The developing role of the Digital Transformation Group, which will be an important forum for reviewing digital risks as the group becomes established. • HT welcomed the housekeeping comments and noted that some items may represent issues rather than risks. The Board noted the summary report and agreed to pick up discussion as part of the Chair Assurance Report if applicable.
4.0	**Chair and CEO Update**
	Chair Update HT informed the Board that there were no specific items to share. **Chief Executive Officer Update** The Chief Executive provided the Board with the following updates: • **NHS 10-Year Plan:** A planning workshop was held at the end of September to review the NHS 10-Year Plan and consider alignment with the Trust's Five-Year Strategy. The session involved senior clinical and operational leads across all Units and covered national, system, and Trust strategy alignment; supporting strategies; financial medium-term planning; productivity; and risks and opportunities of the new operating model. Outcomes will inform refinement of the Trust's strategy and Board Assurance Framework (BAF) in line with NHSE planning timescales.

Ref	Discussion and Action Points
	• **SToT Collaboration with STW:** It has been confirmed that Shropshire, Telford and Wrekin ICB will cluster with Staffordshire and Stoke-on-Trent ICB. Work is underway towards a single leadership structure over the coming months. Executive recruitment has commenced. • **Federation of Specialist Hospitals (FoSH):** FoSH met with the Secretary of State for Health and Social Care in October to discuss the role of specialist hospitals in delivering the 10-Year Plan. The meeting was positive and identified next steps for FoSH members. • **CQC Reporting and Inspection**: The CQC report following a two-day inspection earlier in the year has been published. Surgical and Critical Care Services were rated 'Good' overall. The report highlighted compassionate care, respect for privacy and dignity, and a shared vision and culture among staff. The Well-Led Review is anticipated in January 2026. • **Adult Inpatient Survey**: The annual survey results were published, with RJAH rated among the best hospitals nationally. The Trust was one of eight providers achieving "much better than expected" results. RJAH achieved the highest response rate nationally (70%) and was rated as having the cleanest wards and rooms for the fifth consecutive year. • **Headley Court Charity**: Headley Court Charity is now based at the Veterans' Orthopaedic Centre at RJAH. The charity will fund a pilot veterans' rehabilitation programme for 18 months, building on its previous £6m grant for the centre's development. • **Research and Partnerships**: Prof. Tracey Willis' team is providing early access to young DMD patients under the MHRA Early Access Programme. NICE approval is pending. RJAH is among the first hospitals to access this programme. • **AHP Day:** The Trust celebrated Allied Health Professionals Day with a well-attended conference and poster presentations. The event highlighted the vital role of AHPs and career pathways. • **RJAH Stars Awards October:** Tamika Roberts, Staff Nurse, recognised for her work on the Improvement Champions programme and patient education for spinal injury patients. • **RJAH Stars Awards September:** Hannah Winter, Digital Trainer, commended for her support during the EPR go-live and her positive approach to staff training. The Board noted the updates and there were no specific questions raised.
4.1	**National Oversight Framework – Capability Self-Assessment**
	Performance Assessment: NHS England published the first quarterly results under the revised NHS Oversight Framework (NOF) in September 2025. Trust's Results (Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust): • Average Metric Score: 2.31 • Segment: 2 (Good performance, some issues) • League Table Position: 27 out of 1 **Capability Self-Assessment:** NHS England undertakes an assessment of organisational capability alongside performance segmentation to determine the level of support required. The Trust considers six Capability Domains: • Strategy, leadership and planning • Quality of care • People and culture • Access and delivery of services • Productivity and value for money • Financial performance and oversight DM explained that the Board were required to complete a self-assess against 16 criteria, with evidence submitted by 22 October 2025. The submission included confirmation of compliance, a narrative rationale, and supporting documentation. The next step is for NHS England to review the submission alongside third-party information (e.g., governance arrangements, staff morale, and quality of care). DM confirmed that the Trust's submission indicated all criteria were met. Evidence provided included CQC reports, inpatient survey results, the Annual Report, and an independent well-led review.

Ref	Discussion and Action Points
	The Board discussed the following: • The organisation is currently in Segment 2, and the team understands what is required to move to Segment 1. The Board's aim is to achieve this transition before the end of Q4. • Progress on same-day bilateral hip replacements was highlighted, with emphasis on tracking the patient journey and completing the feedback loop, including reporting through the Quality and Safety Committee. • The Board noted the solar panel investment and the social media engagement it generated regarding the site's field. It was explained that planning permission was requested for the entire field due to time pressures linked to the grant submission. The green space is an important area for staff and patients, and it was acknowledged that lessons have been learned—particularly that improved communication would have been beneficial. • Concerns were raised about health inequalities, especially for patients from deprived areas who are waiting for services. It was suggested that further discussion take place at Board level, supported by data, to ensure the right conversations are happening about organisational actions. The Board confirmed that the Quality and Safety and Finance and Performance Committees include KPIs against relevant measures, with data available for review. The Board also referenced its Health Inequalities work programme, highlighting initiatives undertaken for children, patients, and rheumatology services. The Board noted the Chair and CEO updates.
4.2	**Letter: Request for action on racism including antisemitism**
	The letter was shared with the members of the Board for information. The letter requests NHS organisations to strengthen efforts against racism, antisemitism, Islamophobia, and all forms of hatred by adopting the IHRA definition of antisemitism, updating equality and diversity training, and ensuring inclusive workplace practices. It also outlines plans to refresh mandatory training, review uniform guidance to support religious expression, and calls for leadership in creating safe, respectful environments for staff, patients, and communities. The Board accepted the content and it was agreed the progress will be reported through People and Culture Committee.
5.0	**Quality and Safety**
5.1	**Performance Report – Quality and Safety Committee**
	The Board received the Quality and Safety performance report (by exception) and noted the following key points: • **Complaints:** 19 complaints reported against a target of 8. Learning has been identified and shared, with discussion held at the Patient Experience Committee. • **New Metric:** Introduction of a metric for same-day discharge. • **Infections:** 3 acquired *Clostridioides difficile* cases and 4 MSSA bacteraemia cases • **Surgical Site Infections (SSI):** 5 cases reported – 2 on July 2 in August, and 1 in September. Multidisciplinary reviews completed and learning shared. • **Mortality:** 1 death reported. The Board noted the performance report and discussed the current low tolerance levels in relation to IPC infections which impacts the NOF rating. This has been escalated, and a request made to reconsider due to the lower impact – the Trust is awaiting an update.
5.2	**Chair's Assurance Report – Quality and Safety Committee**
	LW highlighted the following key points from the Quality and Safety Committee Chairs Assurance report: • **Health and Safety Inspection**: A comprehensive action plan has been developed and is progressing well, with all milestones on track for delivery. The Committee's focus remains on ensuring robust assurance regarding the appropriateness and sustainability of these actions. • **Apollo Programme:** Key risks associated with the Apollo programme have been subject to detailed discussion. Further scrutiny and oversight will continue in the private session to ensure all risk mitigations are fully addressed. • **Care Quality Commission (CQC):** The Committee noted positive feedback and commendation, reflecting strong performance and compliance in this area. • **Corporate Risk Register (CRR):** Apollo-related risks are now embedded within Business-as-Usual (BAU) risk management processes. Assurance relating to orthotist risks has been reviewed and will be re-presented for further consideration. No items

Ref	Discussion and Action Points
	require escalation at this stage; however, newly emerging risks will undergo additional review to ensure comprehensive oversight. • **Bone Tumour Service:** The associated action plan has been successfully closed following the appointment of a substantive consultant, marking a significant achievement in service resilience and continuity. The Board expressed confidence in the current level of assurance provided across all areas, noting that governance processes remain robust and responsive to emerging challenges.
5.2.1	**CQC Inspection and Report**
	The Trust was last inspected by the Care Quality Commission (CQC) in November and December 2019, receiving an overall rating of 'Good'. The most recent announced inspection took place on 22 and 23 May 2025, focusing on Critical Care and Adult Surgery under the Single Assessment Framework. The Trust were pleased to confirm that once again the organisation achieved an overall rating of 'Good'. Staff have welcomed the CQC's recommendations and remain committed to implementing improvements that will further enhance the quality and safety of patient care. Since 2019, the Trust has made significant strides, particularly in areas previously identified for improvement. A recent peer-to-peer review has further helped to identify remaining gaps and inform our action planning. Highlights of good practice included: • A strong, positive culture across the organisation • Staff feel empowered to raise concerns. • Patients are treated with kindness and compassion. • Staff consistently go above and beyond to support patients. • Positive patient experience • A proactive and safety-focused culture • Patients are actively involved in decision-making. • Services are accessible, with efforts to eliminate discrimination and reduce health inequalities. • A shared vision and culture of listening and learning • Visible and engaged leadership. • A culture of continuous improvement HDU Specific improvements areas included: • **Regulation 12 – Safe Care and Treatment** - The Trust must ensure clear communication pathways for nurses needing to contact specialist teams when anaesthetists are unavailable, to support timely and safe care. • **Regulation 18 – Staffing** - Planning is required to increase medical and nursing staff to meet rising patient volume and complexity. Continuous intensivist cover is needed in line with GPICS standards. A financial case for investment is being developed. ICNARC data shows good performance, though broad standards limit identification of specific improvement areas. Expansion is needed to meet future demands and standards, including GPICS 3. Additional HDU Areas for Improvement • Safeguarding training compliance • Statutory and mandatory training compliance • 2024 Staff Survey: 30% of non-white staff reported harassment, bullying, or abuse from patients, compared to 18% of white staff. • Continued development of the financial case for investment. • Further alignment with GPICS 3 standards Surgery – highlighted of good practice: • Notice boards in theatres displaying NatSSIPs2 and LocSSIPs • Positive feedback from Joint School and excellent patient satisfaction • Cleanest wards and rooms in the NHS for the fourth consecutive year • Best hospital food in the country for 17 of the past 18 years • NHS Pastoral Care Quality Award for international recruits

Ref	Discussion and Action Points
	• Nationally recognised for outstanding patient experience RL confirmed the next steps for the Trust included developing a pathway to achieve an 'Outstanding' rating and the anticipated Well-Led inspection in early 2026. The Board formally noted the CQC inspection report and expressed sincere thanks to all staff members who supported the inspection visits earlier this year. The Board looks forward to receiving ongoing updates on the associated action plans through the Quality and Safety Committee Chair's Reports at future meetings.
5.2.2	**Learning from Deaths Report**
	RL presented the Learning from Deaths Report to the Board and expressed appreciation to James Neil, Mortality Lead, for his leadership in this role. Key points highlighted: • **Mortality Overview:** Three deaths occurred during the reporting period and positive feedback was received and shared with the teams involved. • **Learning Identified:** Management of deteriorating patients learning within MCSI to be completed. The Board extended its sincere condolences to the families following the loss of their loved ones and conveyed heartfelt thanks to the ward teams for their continued dedication to delivering high-quality, person-centred care at the end of life.
6.0	**People and Workforce**
6.1	**Performance Report**
	The following points were noted from the latest People and Workforce performance report: • **Staff Retention**: Performance remains above target, indicating strong retention across the Trust. • **Personal Development Reviews (PDRs)**: The target was successfully met in July. • **Statutory and Mandatory Training**: Compliance continues to exceed the target and has remained consistently high for the past 12 months. • **Vacancies**: Vacancy rates are currently above the target threshold and remain an area of focus. • **Bank Spend**: Increased banks spend is linked to the waiting list initiative. • **Job Planning Compliance**: Significant progress has been made in job planning compliance. Ongoing management and oversight will be provided through the People Committee. The Board noted the performance report.
6.2	**Chair's Assurance Report – People and Culture Committee**
	PM provided an overview of key matters discussed at the People and Culture Committee for Board assurance. The following points were highlighted: • **Job Planning Compliance**: Current attainment stands at 87.2%, with 22 job plans outstanding. Six of these are at the final stage since the last meeting. This remains a management responsibility and is actively being progressed to embed as standard practice. • **Workforce and Financial Planning**: A mismatch between workforce and financial forecasting for the year was identified but has now been addressed. Further work is required to align workforce reduction plans. • **Mutually Agreed Resignation Scheme (MARS)**: The scheme has been supported, and initial steps have been taken. Additional work is needed to ensure targets are met. • **Premium Costs Analysis**: A recent change in premium cost trends was noted. Further in-depth analysis is required to understand whether this is activity-driven and to identify actions to address the issue. • **Training Compliance**: A letter earlier in the pack referenced new national mandatory requirements on anti-racism training effective April 2026. The Trust has clear reporting processes and is moving towards a risk-based approach. Reporting has been re-evaluated and aligned with the new framework. The Committee noted the significant growth in statutory and mandatory training requirements over recent years and welcomed the review. • **Corporate Risk Register (CRR)**: No issues were raised. The Board thanked PM for the update. No specific questions were raised.

Ref	Discussion and Action Points
6.2.1	**Annual Appraisal Accountable Officer Annual Report**
	The People and Culture Committee received and reviewed the Annual Appraisal Report for the period 31 March 2024 to 1 April 2025. The report provides assurance that the designated body is compliant with statutory regulations and demonstrates a clear commitment to continuous quality improvement in the delivery of professional standards. The template used for reporting comprises: • Section 1: Qualitative narrative outlining key developments and feedback. • Section 2: Metrics evidencing compliance and performance. • Section 3: Summary and conclusion • Section 4: Statement of compliance Key highlights noted by the committee include: • Full compliance with professional standards confirmed and reported to NHSE Board. • Appraisal systems and access arrangements have been effectively implemented. • Comprehensive appraisal feedback has been undertaken and reviewed. • A peer-to-peer Responsible Officer review was successfully completed, reinforcing governance and best practice. • Ongoing support issues were identified, with remedial actions in place; additional support will also extend to medical job planning. • Oversight and endorsement provided by the People Committee, ensuring alignment with organisational priorities. The committee also noted a minor editorial issue: Page 211, bullet point 21 contains two distinct issues within a single bullet point. This requires amendment to separate them for clarity and accuracy. Following a recommendation from the committee, the Board gained assurance from the Annual Appraisal Report.
7.0	**Performance and Finance**
7.1	**IPR Exception Report (inc. Long Waiting Patients)**
	MC presented the Integrated Performance Report to the Board, providing an overview of current performance, areas of improvement, and ongoing challenges. • **Cancer Pathways:** MC reported that performance against the 62-day cancer standard has shown significant improvement, with breaches now at very low levels. This improvement reflects the effectiveness of recent interventions. Work is continuing to ensure better MRI provision within the cancer pathway, as delays in imaging have been identified as a potential bottleneck. The team is actively addressing this issue to maintain progress. Performance against the 28-day Faster Diagnosis Standard currently stands at 79.66%, and further improvement is anticipated through enhanced MRI access and pathway optimisation. • **Treatment Targets:** The Trust's performance on treatment targets has improved, with RTT compliance increasing to 52.72% in August. Confidence is growing that the 60% target will be achieved. Differential targets are being set at specialty level to ensure that services capable of faster progress can do so, thereby accelerating overall improvement. • **Outpatient Performance:** Outpatient performance is currently at 69.1%, which is ahead of the national standard. The Trust continues to focus on ensuring equity of access for Welsh patients. • **Long Waiting Patients:** The NHS England target for 52-week waits is to reduce to 1% by the end of the calendar year and 6% by the end of September. The current position is 5.6%, indicating progress towards these goals. In-sourcing initiatives have supported pathway improvements and will continue to play a key role. • **Spinal Disorders:** Year-on-year growth in spinal referrals was noted. Clinical validation of waiting lists is underway to ensure accuracy. Recruitment for an additional consultant is in progress, and pathway redesign work is ongoing to improve efficiency. • **Diagnostics:** A step-change introduced 12 months ago has delivered improvements, and compliance with the 99% diagnostic standard is anticipated as surgical activity resumes and the CT scanner supports increased throughput. • **Theatres:** Theatres have seen increased activity over the past year, supported by the implementation of the organisational delivery model. The transfer of orthopaedic work from

Ref	Discussion and Action Points
	RJAH to SATH has now been completed, although later than originally planned. Surgeon recruitment has been successful, but commencement delays were acknowledged. In-sourcing activity has increased since November. Same-day cancellations in September were noted to have risen; process improvements and evaluations are underway to address this. • **BADs Reporting:** Differences in reporting for hip and knee procedures were highlighted. The current KPI does not fully reflect the Trust's output, as it is based on a national standard that does not account for the length of stay for orthopaedic patients. The Board discussed the following: • HT emphasised the importance of resolving issues related to Welsh waiting lists. Activity agreements with Powys remain unsigned, and a Board-to-Board discussion is being undertaken. • MN queried compliance with national standards for 104-week and 52-week waits. The Trust has raised concerns about delayed outpatient appointments, particularly where earlier intervention is possible. • SNa highlighted that activity over the next six months is critical and represents a key risk. • HT confirmed that the current gap for 52-week waits is 5.9%, expected to reduce to 5.59% next week. • PM requested that future reports include projected trajectories and total waiting numbers to provide a forward-looking view. The Board acknowledged the significant progress achieved to date and reaffirmed the importance of maintaining momentum to ensure full delivery of the operational plan. The following were noted as areas of focus: • Consider how trajectory data can be presented more clearly to the Board. • Continue weekly email updates to Board members. • Review Tier One pack at Activity Recovery Meeting and share for information. • Finance and Performance Committee to provide assurance to the Board.
7.2	**Finance Performance Report**
	AMW provided assurance that the Trust remains on plan at Month 6, with core financial objectives achieved. • The financial trajectory is under refinement and currently in draft form. • The Trust has delivered the financial plan for the first six months, although not through the originally planned route. Savings have been achieved via reductions in pay and non-pay costs, including theatre-related expenditure and consumables. • Non-recurrent benefits of £1.1m have supported delivery to date. • The position remains on plan; however, challenges are anticipated in the second half of the year, requiring continued cost control and delivery assurance. • Performance is monitored through PFIG and Executive Team meetings. The following points highlighted: • **Bank Usage:** There is a continued upward trend in bank staff usage, primarily driven by recruitment challenges. While substantive recruitment remains constrained, this approach ensures service continuity. • **Agency Spend:** Agency expenditure remains below target, reflecting strong cost control measures and adherence to workforce planning strategies. • **Cash Position:** The Trust's current cash position is ahead of forecast, providing a positive liquidity outlook and supporting operational resilience. • **Capital Programme:** Delivery is on plan, with an active review underway to ensure full allocation of capital spend within the financial year. • Any material changes or risks identified during this review will be escalated promptly to the Finance and Performance Committee and the Board for oversight. • **Efficiency Programme:** The Trust is working towards a £9.5m efficiency target, the largest in its history. Progress to date has been supported by non-recurrent opportunities, but sustainability remains a challenge. • **Key Risk:** Workforce cost reduction remains a significant risk area. Enhanced financial controls and monitoring are being implemented, with updates scheduled for the People Committee. Planning assumptions for the next financial year are being developed, aligned to Model Hospital benchmarking to ensure realistic and evidence-based targets.

Ref	Discussion and Action Points
	• **Income Growth:** The Trust is actively exploring commercial opportunities to diversify income streams and strengthen financial sustainability. • **Year-to-Date Position:** A surplus was achieved at Month 6, in line with plan, demonstrating effective financial management. However, the overall year-to-date deficit of £3m remains consistent with planned trajectories. • **Underlying Position:** Excluding non-recurrent benefits, the Trust is £1.5m adverse against plan. This underlying position is a nationally reported metric and remains a key focus for efficiency improvement initiatives. • **Recovery Plan:** Development continues and does not yet reflect all mitigations. Operational risk assessment completed, with amber and red-rated mitigations identified. The Board noted the financial performance remains on plan and the interdependencies between operational and financial plans were highlighted.
7.3	**Chair Report from Finance and Performance Committee**
	SN presented the Chair's report and highlighted the following key points: • **Spinal Disorders Improvement Plan:** The recent presentation provided assurance on actions being implemented to improve the patient pathway for spinal disorders. The plan aligns with areas previously raised and demonstrates progress however, there are further actions which need to be embedded before further assurance is reported. • **Operational Challenges:** The Board agreed on the significant operational and financial challenges anticipated in the second half of the year. • **Rheumatology Business Case:** Supported in principle, with a request for further work on key assumptions to be addressed through the appropriate forum. • **Financial Forecast:** Commended the teams for achieving the first-half financial position without deterioration in quality standards, which is notable. Highlighted the underlying deficit of £1.5m and stressed that failure to address this will prevent the Trust from achieving financial balance. Income losses currently exceed the underlying deficit. • **Activity and Capacity:** Discussed the current protected activity and explored options to maximise delivery. Noted that the revised delivery model may take up to two years to fully implement. Emphasised the need to realise benefits from new recruits and demonstrate trajectory improvements in capacity and activity levels. A step change is required in the second half of the year, with increased activity being critical to achieving financial performance. • **Planning Allocations:** Awaiting confirmation of planning allocations for the coming year which will be discussed further ahead of submission. The Board discussed the following: • Explored flexibility in session scheduling and workforce optimisation to maximise theatre utilisation. • Considered benchmarking against other system trusts to identify potential risks. Year-to-date, SaTH is adverse, while SCHT and the wider system are ahead of plan. • No changes to financial forecasts have been reported beyond the operational plan; adjustments are anticipated in months 9 or 10. • The Trust is less exposed to system pressures compared to previous years, as NOF relates to providers. The Board noted the chair report.
7.3.1	**Green Plan**
	Following consideration, the Board approved the revised for the Green Plan, confirming alignment with the Trust's sustainability objectives and statutory requirements following a recommendation from the Finance and Performance Committee. It was noted that the Green Plan has now been approved and published, ensuring visibility and accountability across the organisation. There were no further comments were raised by members.
8.0	**Chair Report from Digital, Education, Research, Innovation and Commercialisation Committee**
	ME presented the Chair's Report and provided the following key updates: • **Electronic Patient Record (EPR):** The Committee discussed three critical areas relating to the EPR programme. These matters will be explored in greater detail during the private forum. Further work is ongoing to ensure successful delivery.

Ref	Discussion and Action Points
	• **Private Patient Review:** A comprehensive review of private patient services has been undertaken, generating a number of positive recommendations. Additional work is required to implement these improvements, and a full update will be presented to the Private Board in two months. This initiative is closely aligned with the Trust's wider commercial strategy. • **Commercialisation Capacity:** Assurance was received from AMW that a robust structure is being established to support the implementation of commercialisation initiatives. This framework will strengthen the Trust's ability to deliver on its strategic objectives. • **Research Strategy:** The Research Strategy was formally approved by the Board, marking a significant step forward in advancing the Trust's research ambitions. • **Corporate Risk Register (CRR):** There were no changes to existing risks and no new risks identified. The Committee discussed Apollo-related risks, which continue to be managed through established business-as-usual risk management processes. • **Committee Effectiveness:** Recommendations arising from the Well-Led Review are being actively considered to enhance the effectiveness of Committee meetings. Early signs indicate that these improvements are beginning to gain traction. • **Consultant Recruitment:** It was noted that shortlisted candidates for consultant roles have been made aware of the work of DERIC, ensuring alignment with the Trust's strategic priorities which is noted to be a positive step for the organisation. The Board noted the report and no specific questions were raised.
9.0	**Questions from the Governors and Public**
	There were no questions raised by the Governors or the members of the public.
10.0	**Any Other Business**
	There were no further items of business for discussion. HT thanked all attendees for their time and contribution to the discussion before closing the meeting.
10.1	**Date and time of next meeting:** Wednesday 07 January 2026, 2025, at 9:30am

Chief Executive Officer Update

Committee / Group / Meeting, Date

Board of Director - Public Meeting, 07 January 2026

Author:

Name: Stacey Keegan
Role/Title: Chief Executive Officer

Contributors:

Chris Hudson,
Head of Communications

Report sign-off:

Stacey Keegan, Chief Executive Officer

Is the report suitable for publication:

Yes

Key issues and considerations:

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

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

Recommendations:

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

Acronyms	
AHP	Allied Health Professional
NHS	National Health Service
NOF	National Oversight Framework
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust
ROH	Royal Orthopaedic Hospital
SaTH	The Shrewsbury and Telford Hospital NHS Trust

Chief Executive Officer Update

1. Christmas at RJAH

We have of course just celebrated the Christmas season, and once again all our people really pulled out the stops to make it as special as possible for those patients who had to spend it with us. I want to personally thank all staff who gave up time with their own family and friends to be on duty looking after patients. I also want to specifically call out the catering team who once again did such an incredible job. Feedback from patients was extremely positive, so well done to all.

2. Latest NHS 'league tables' published

December saw the publication of the latest iteration of NHS England's National Oversight Framework (NOF), which includes league tables allowing patients and the public to directly compare providers and rank them by performance. RJAH has ranked 25th out of all 134 NHS Acute Trusts in England – an improvement of two places on when the tables were first published back in September last year. Trusts have been placed into one of four core segments - segment 1 represents the organisations with the narrowest range of challenges while segment 4 contains those with the broadest. The dashboard shows what segment each trust is in as well as the data that has been used to make this decision. RJAH has been placed in segment 2. Only one in five Trusts (28) are in segments 1 or 2 in this second iteration of the league tables.

3. NHS Providers annual conference

In November, I alongside other RJAH Executives attended the two-day NHS Providers conference. This year's theme was 'recharge', fitting after a year of significant change. There were a series of roundtables, expert case studies, interactive debates and importantly an opportunity to connect and network with other provider colleagues.

4. ROH Strategic Alliance

In November myself and Harry Turner, Chair met with our counterparts at the Royal Orthopaedic Hospital, Birmingham to discuss areas of opportunity, potential priorities and next steps for the strategic alliance. A Board to Board is planned for April 2026.

5. RJAH and SaTH Pathology Lab partnership

The Trust was pleased last month to announce a collaborative partnership between the Cellular Pathology Departments of RJAH and The Shrewsbury and Telford Hospital NHS Trust (SaTH). This partnership builds on the cross-system partnership working that already takes place in the blood sciences laboratories. By working together, the Trusts will strengthen diagnostic capabilities and enhance patient care. A larger team will also provide resilience to our services and by sharing knowledge and facilities we will support training and adoption of new technologies.

6. Positive progress with our flu vaccination campaign

Going into the winter period, one of our key priorities this year was to oversee an improved uptake of the flu vaccine by staff. We know that the vaccine is the single most important thing we can do to protect ourselves, our patients and families alike, which is why we were so disappointed last year that only a little over one in four staff got the vaccination. This was a picture seen nationally, not just at RJAH, and we were given a target this year to improve by five percentage points. However, we were always more ambitious than that – and I'm pleased to say that we have more than exceeded that goal, with around 52% of staff so far taking up the offer. The vaccine remains available to those who have not had it yet, and with a cold snap and high community prevalence of flu right now, we will continue to promote it.

7. Interim Chief Nurse remembered with launch of new award

Last year of course saw the tragic and sudden death of our Interim Chief Nurse, Sam Young. We have been determined to ensure Sam's name and legacy lives on at the Trust, and to that end I was delighted last month to announce the launching of a new award, the Sam Young Innovation and Improvement Award. I am sure you will agree that this is a fitting way to remember her passion for continuous improvement and driving positive change. The inaugural award was presented to Lisa Davies-Jones, Pre-Operative Assessment Unit Manager, at the Annual Nursing and Allied Health Professionals Celebration Event in recognition of her leadership around a new innovative health screening initiative.

8. Launching Radar Healthcare, our new quality management system

RJAH will soon be introducing a new Trust-wide Quality Health management system, called Radar Healthcare, which will improve how we manage information relating to patient safety, patient experience, risk management and clinical and quality audits. Currently all these elements are managed by multiple digital systems, but Radar Healthcare brings all this information together into one easy-to-use system through a series of modules. Radar Healthcare also offers enhanced

analytics to help triangulate all this information to help us understand the quality of service that is being offered to our patients. The project will be delivered in three phases, with phase one due to go-live later this month.

9. Patient Communication via DrDoctor

We have partnered with DrDoctor to enhance our communication with patients regarding hospital visits, letters and general updates. DrDoctor provides a secure online platform for our patients to manage their appointments. They can also receive important information about their visit to our hospital via text messages and email. Patients can also log on to the DrDoctor online patient portal, where they can view their appointments, access any assessments or question the hospital has sent them, and view and download appointment letters. The patient portal ensures that appointment information is never lost and is easily accessible wherever they are and whenever they need it. Going paperless means that they are supporting the NHS to be more environmentally friendly.

10. Rare hospital baptism for patient

We had a rather unusual event just before Christmas, when patient Bill Starling, made a request of our hospital chaplain Simon Airey to be baptised. Bill came to RJAH under the care of Consultant Orthopaedic Surgeon, Mr Sudheer Karlakki, and underwent extensive orthopaedic surgery. Having come through that, he said the time felt right to get baptised, and Simon was happy to oblige. The service was the first of its kind at RJAH.

11. Chef serves up success at House of Commons

Congratulations to one of our hospital chefs, Gill Owen, who was invited to parliament at the end of autumn as part of an event to celebrate the NHS Chef of the Year competition. Gill, who competed in the competition back in 2021 and was invited to take part in a celebratory lunch alongside fellow NHS chefs from across the country and the House of Commons culinary team. The event brought together signature dishes from across the competition's five-year history, each plate celebrating the imagination, skill and dedication of chefs helping to transform the future of hospital food.

12. Dame Agnes Hunt Medals

The Sam Young Innovation and Improvement Award was presented as part of our annual Nursing and Allied Health Professions Celebration Event. This day also saw the presentation of our three annual Dame Agnes Hunt Medals. Craig Lammas, Resuscitation Officer, won the Nursing Medal for his exceptional training delivery and programmes, calm leadership in emergencies, and unwavering support for staff. The AHP Medal was awarded to Physiotherapist Rob Fox who runs the Intensive Inpatient Physiotherapy Service. He was awarded the medal for managing all aspects of the service single-handedly and the life-changing impact he has on patients. The Healthcare Support Worker Medal went to Becky Buckingham, an Orthotics Assistant for her work in supporting the diabetic foot clinic, including helping develop a new stock footwear system that is saving time. Finally, there was a Special Recognition Award for Ian Maclennan, Assistant Chief Nurse, who will soon retire after a distinguished NHS career spanning approximately four decades. Well done to all award winners!

13. RJAH Stars Award

Each month, I have the pleasure of presenting the RJAH Stars Award to an individual or team in recognition of exceptional achievement or performance. Since the Board last met in public I have presented two of these awards.

- Our December winner was **Dr Shu Ho**, one of our Consultant Physicians, who was put forward for the award by Dr Danielle Hilton in recognition of the positive and lasting impact he has on patients and colleagues alike. In her nomination, she wrote that Dr Ho fosters a

workplace which strives for excellence whilst empowering his team to work independently under his supervision. His positive attitude and always putting the patient first is exemplary. He speaks to all staff members as equals and looks after patients as though they were his own family.

- Our November winner was **Rima Chowdhury**, a booking clerk who was nominated in recognition of her outstanding commitment to patient care. She was put forward by Laura Crump and Rob Freeman, who wrote that Rima plays a key role within our service, and her resilience has been remarkable. She consistently looks for solutions to challenges, no matter how complex, and approaches her work with positivity and professionalism.

Congratulations to both — their dedication and care truly embodies the spirit of the RJAH Stars Award.

14. Conclusion

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

Executive Summary - Quality & Safety Committee

Assurance

Variation	Will consistently pass the target if nothing changes	Will not consistently pass or fail the target if nothing changes	Will consistently fail the target if nothing changes	No Target or Moving Target
Improving varitation (high or low) or 3 months better than target		RJAH Reported Tissue Viability Events		RJAH Acquired E. Coli Bacteraemia - 12 Mths Rolling
No significant change or N/A to SPC	RJAH Acquired MRSA - 12 Mths Rolling Count	Surgical Site Infections		Number of Patient Safety Reviews Complex Complaints Respone Rate - 45 Days Discharge Ready Date to Actual Discharge Date RJAH Acquired C.Difficile - 12 Mths Rolling Count Medication Errors 28 Day Faster Diagnosis Standard
Concerning variation (high or low) or 3 months off target		Total Patient Falls Inpatient Ward Falls per 1000 Bed Days Number of Complaints No of Spinal Injury Patients Fit for Admission 62 Day General Standard		Standard Complaints Respone Rate -30 Days Theatre Cancellations On Day of Surgery

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

Trust Board - Quality & Safety
November 2025 – Month 8

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

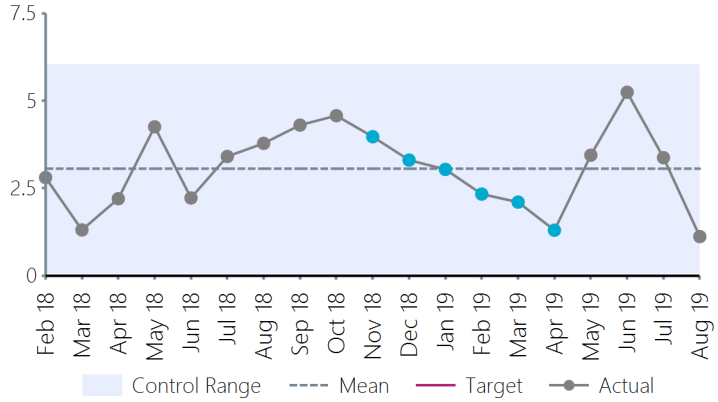
Some examples of these are shown in the images to the right:

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

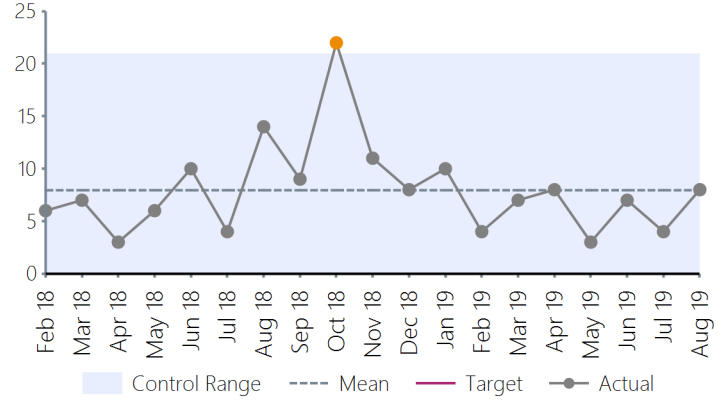
b) shows a point of concern sitting above the control range.

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

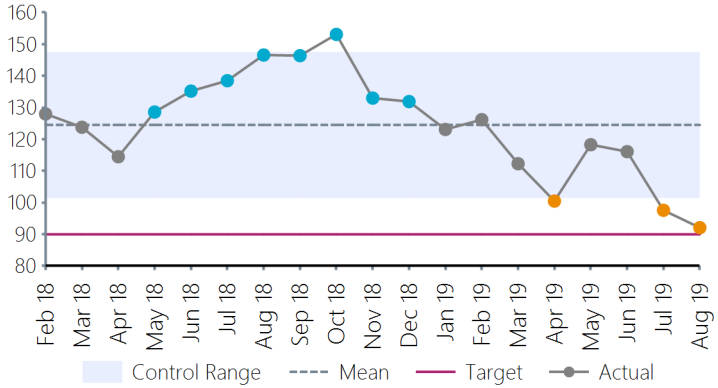
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Patient Safety Incident Investigations		0		N/A to SPC	No Target		
Number of Complaints	8	19			?	+	
Discharge Ready Date to Actual Discharge Date		0.49		N/A to SPC	No Target	+	
RJAH Acquired C.Difficile - 12 Months Rolling Count	3	1		N/A to SPC	Moving Target	+	
RJAH Acquired E. Coli Bacteraemia - 12 Months Rolling Count	7	1		N/A to SPC	Moving Target	+	
RJAH Acquired MRSA Bacteraemia - 12 Months Rolling Count	0	0		N/A to SPC	P	+	
RJAH Acquired MSSA Bacteraemia - 12 Months Rolling Count	0	1		N/A to SPC	F		
RJAH Acquired Klebsiella spp - 12 Months Rolling Count	1	1		N/A to SPC	Moving Target		
RJAH Acquired Pseudomonas - 12 Months Rolling Count	0	0		N/A to SPC	P		
Surgical Site Infections	0	0			?	+	04/03/24

Summary - Caring for Patients

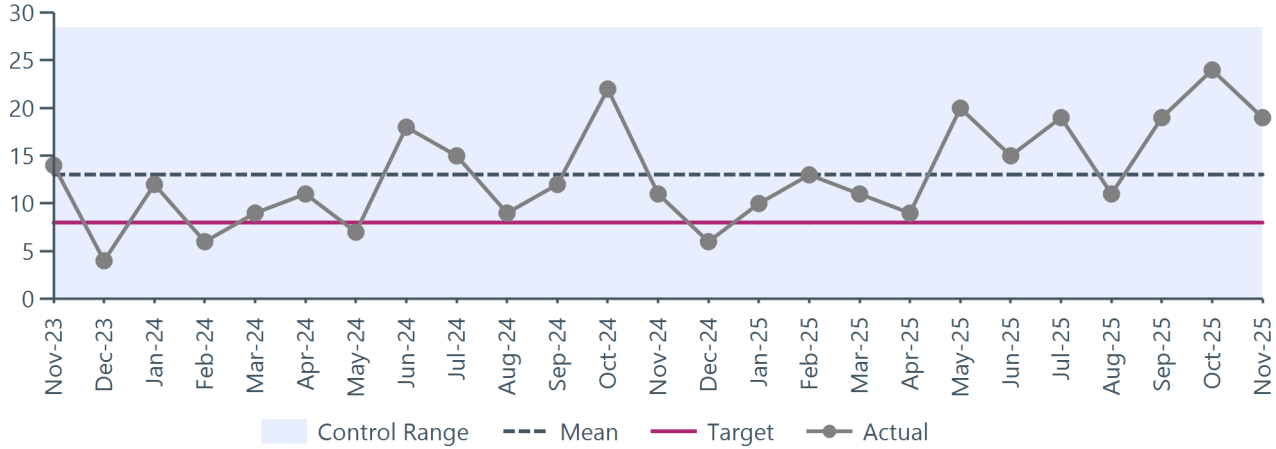
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Outbreaks	0	0		N/A to SPC	?		04/03/24
Number of Deteriorating Patients	5	9			?		
Total Deaths	0	0		N/A to SPC	?		12/09/23
WHO Quality Audit - % Compliance against NatSSIPs 2	95%	100%		N/A to SPC	P		

Number of Complaints

Number of complaints received in month 211105

Exec Lead
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
8	19		



Trajectory

What these graphs are telling us

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

Narrative

There were nineteen complaints received throughout November and the volume has now exceeded the tolerance of eight since January. A breakdown of reasons:
* Appointment/Surgery bookings process (5)
* Outcome of Surgery (4)
* Waiting times (4)
* Care received (2)
* Staff behaviour (1)
* Private Patient Service (1)
* Waiting list removal (1)
* Wheelchair issues (1)

Actions

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

A deep dive was conducted in the summer with patient access identified as a theme for complaints. Specific actions have been identified and the Chief Operating Officer will be leading a Task & Finish Group to address these actions.

The Clinical Governance Team are routinely benchmarking the level of complaints with other Trusts, paying particular attention to our most comparable Special Orthopaedic Hospital peer who also has a spinal injuries unit (RNOH) where the level is comparable.

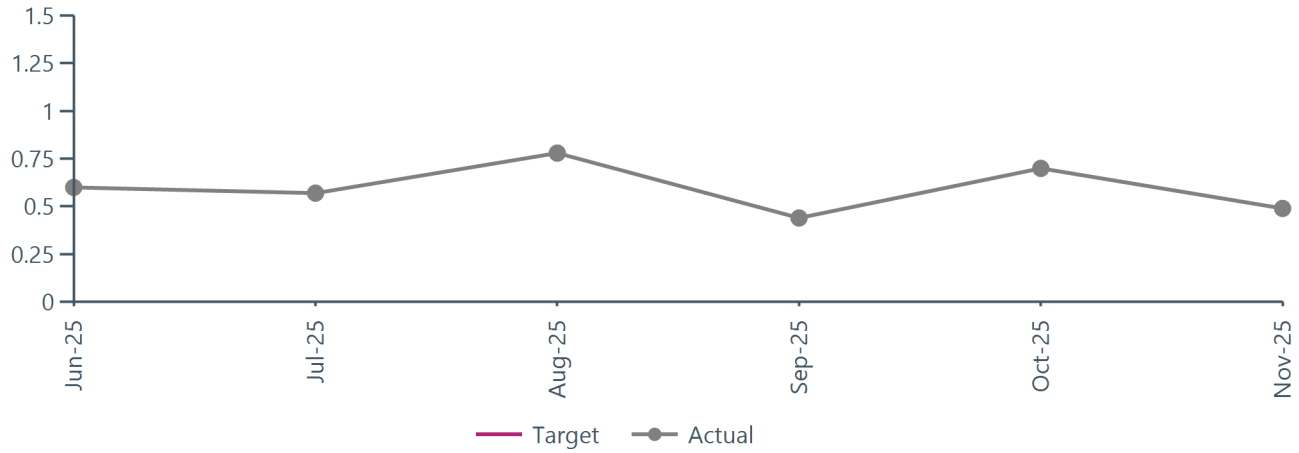
Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
11	6	10	13	11	9	20	15	19	11	19	24	19

Discharge Ready Date to Actual Discharge Date

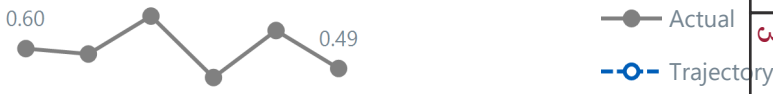
Average Number of Days from Discharge Ready Date to Actual Discharge Date - including zero days 217888

Exec Lead
Chief Nurse and Patient Safety Officer

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



Trajectory



What these graphs are telling us

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

Narrative

This metric reports on the 'Average Days from Discharge Ready Date to Actual Discharge Date'; it includes zero days - as per NHSE methodology. It measures the extent of delays experienced by patients who are medically ready for discharge but are unable to be discharged from hospital. For those patients discharged in November the average days was 0.49 days. Since this measure was recently introduced to the IPR , the Information Department has now set up additional supporting data to report at ward and unit level.

The latest NOF Publication relates to Quarter 2 where the NOF score for this metric is 1.7.

Actions

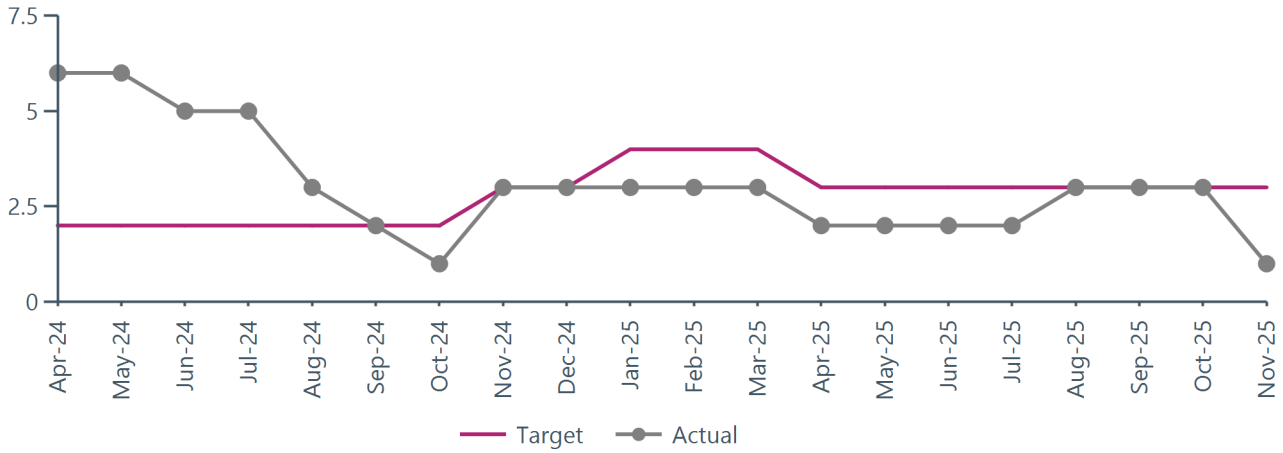
Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
							0.60	0.57	0.78	0.44	0.70	0.49

RJAH Acquired C.Difficile - 12 Months Rolling Count

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

Exec Lead
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
3	1	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

The National Oversight Framework (NOF) contains metrics on infections based on a rolling 12 months position rather than the in-month position. To align with that, the IPR was changed from the first NOF publication to ensure that all RJAH Acquired infection metrics relate to the rolling 12 months-position.

There are no new infections to report this month but the metric is included as an exception to reference the updated NOF publication. The latest NOF Publication relates to Quarter 2 where the NOF score for this metric is 3.7.

The latest rolling twelve month period relates to December-24 to November-25 where there has been one RJAH Acquired C.Difficile; 1x August-25. This is below the threshold set for this period of 3.

The IPR correctly reflects the same rolling twelve months period for the actual and threshold, whereas the NOF methodology looks at a rolling twelve months period up to the end of a quarter but compares it to the threshold for the current financial year.

Actions

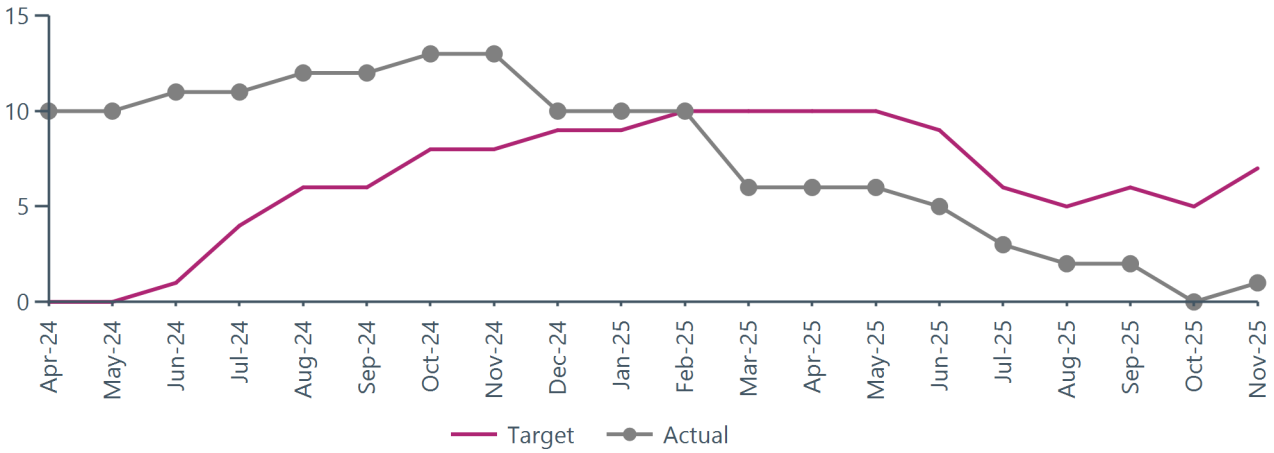
Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
3	3	3	3	3	2	2	2	2	3	3	3	1

RJAH Acquired E. Coli Bacteraemia - 12 Months Rolling Count

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

Exec Lead
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
7	1	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

The National Oversight Framework (NOF) contains metrics on infections based on a rolling 12 months position rather than the in-month position. To align with that, the IPR was changed from the first NOF publication to ensure that all RJAH Acquired infection metrics relate to the rolling 12 months-position.

The latest NOF Publication relates to Quarter 2 where the NOF score for this metric is 1.

The latest rolling twelve month period relates to December-24 to November-25 where there has been one RJAH Acquired E. Coli Bacteraemia; reported this month for November-25. This is below the threshold set for this period of 7.

The IPR correctly reflects the same rolling twelve months period for the actual and threshold, whereas the NOF methodology looks at a rolling twelve months period up to the end of a quarter but compares it to the threshold for the current financial year.

Actions

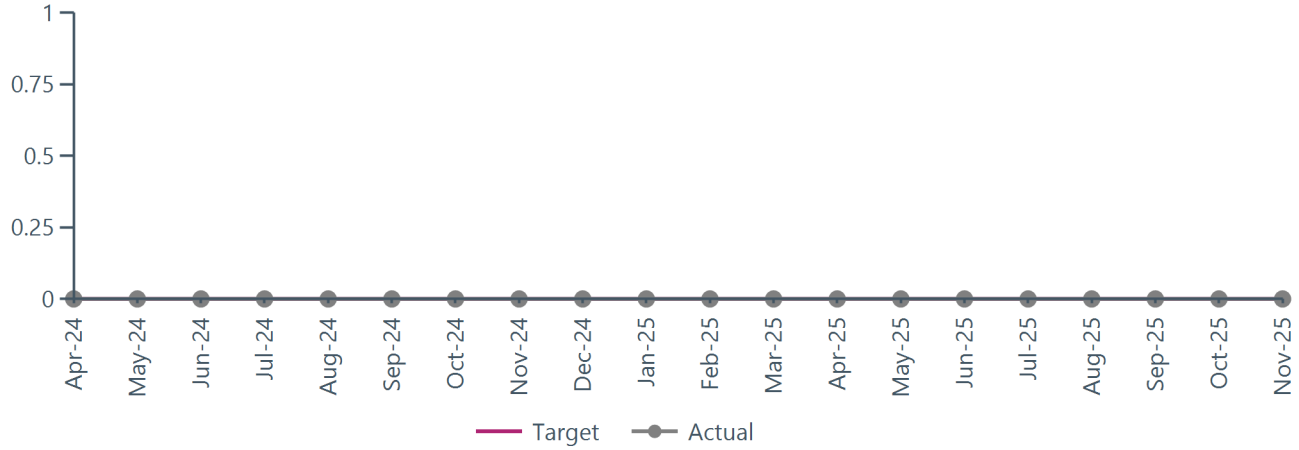
Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
13	10	10	10	6	6	6	5	3	2	2	0	1

RJAH Acquired MRSA Bacteraemia - 12 Months Rolling Count

12 Months Rolling Count of RJAH Acquired MRSA Bacteraemia cases 217893

Exec Lead:
Chief Nurse and Patient Safety Officer

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



Trajectory

What these graphs are telling us

This measure is not appropriate to display as SPC. Metric is consistently below the threshold.

Narrative

The National Oversight Framework (NOF) contains metrics on infections based on a rolling 12 months position rather than the in-month position. To align with that, the IPR was changed from the first NOF publication to ensure that all RJAH Acquired infection metrics relate to the rolling 12 months-position.

There are no new infections to report this month but the metric is included as an exception to reference the updated NOF publication. The latest NOF Publication relates to Quarter 2 where the NOF score for this metric is 1.

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

The IPR correctly reflects the same rolling twelve months period for the actual and threshold, whereas the NOF methodology looks at a rolling twelve months period up to the end of a quarter but compares it to the threshold for the current financial year.

Actions

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

Surgical Site Infections

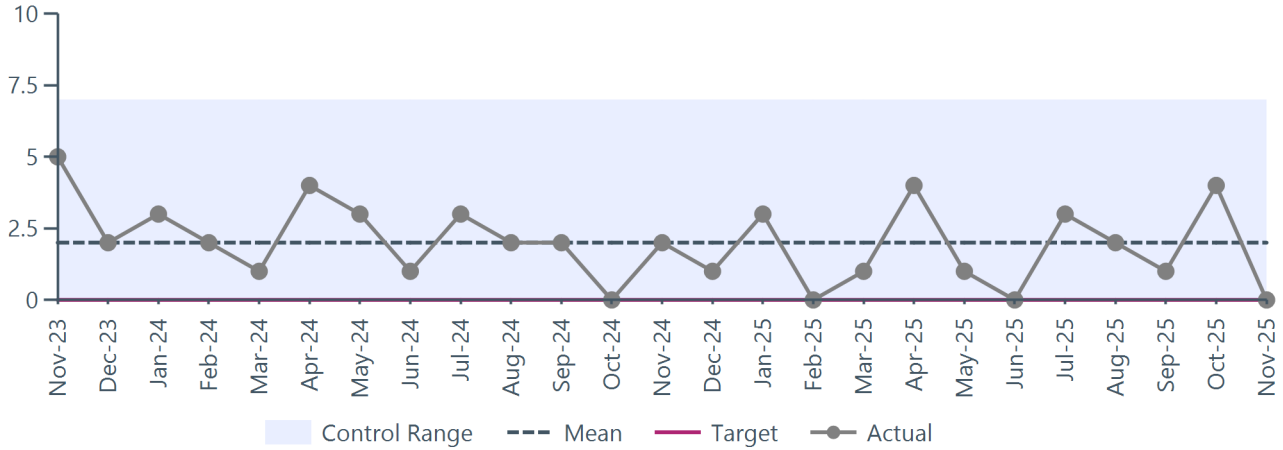
Surgical Site Infections reported for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement in previous twelve months.

217727

Exec Lead
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
0	0		

Trajectory



What these graphs are telling us

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

Narrative

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

There were four infections confirmed in November, as outlined below:
* 2x TKR -Clwyd Ward - surgery took place in October-25
* 2x Spinal Surgery - Powys Ward - surgery took place in October-25

Please note there has also been a correction to the data whereby one SSI was logged against surgery in November when it was actually April.

Actions

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

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Quality and Safety Committee

Committee / Group / Meeting, Date

Board of Directors Meeting, 07 January 2026

Author: **Contributors:**

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Report sign-off:

Lindsey Webb, Non-Executive Director (Chair of the QS Committee)

Is the report suitable for publication:

Yes

1. Key issues and considerations:

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

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

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

This report provides a summary of the items considered at the Quality and Safety Committee on 19 November and 18 December. It highlights the key areas the Quality and Safety Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

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

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

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

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

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

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

3. Assurance Report from Quality and Safety Committee

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

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

CQC Adult Inpatient Survey Results (November Meeting)

The Committee is assured that:

- The Trust continues to demonstrate excellent patient experience outcomes nationally. Members acknowledged the Trust's strong response rate and overall positive performance position.
- Improvement actions for identified areas, particularly waiting times, are in place and actively monitored.
- Governance arrangements ensure that results and actions are escalated appropriately to the Trust Board.
- It was confirmed that the results have been shared with the Trust Board, and ongoing improvement actions are monitored through the Patient Experience Meeting.

3.2 Areas of on-going monitoring with new developments

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

Board Assurance Framework (November Meeting)

- The Committee agreed on the following amendments:
  - BAF1 Reference 2 to reflect progress in the critical care workforce.
  - BAF1 Reference 6 to include blood transfusion management following a recent transfusion practitioner change and audit outcomes.
  - BAF7 to acknowledge the Trust's participation in system-wide EPRR exercises.
- A discussion was held regarding BAF1 Reference 3 completion status, with a consensus to maintain the amber rating pending the commencement of new staff. Full compliance is expected once those individuals are in post.
- It was noted that BAF7 Reference 1 status has shifted from green to amber due to delays in staff training and equipment updates, with plans underway to implement a "train the trainer" model and address compliance issues highlighted during a recent pandemic simulation.
- Consideration was given on whether current risks adequately reflect rising complaints and patient expectations around waiting times, prompting a review of communication strategies and a planned meeting to improve public messaging and patient engagement.
- The Committee agreed other areas to consider for the BAF include Apollo given the impact across multiple committees.

PSIRF Report (November and December Meeting)

- Patient safety reviews and improvement actions are actively managed.
- Governance processes are being strengthened at unit level.
- Delayed actions have clear plans for resolution.
- No new serious incidents or concerns were identified in November
- Wrong-level spinal surgery: Clarified that the latest case relates to reporting procedures, not clinical pathways. Assurance if reporting requirements apply equally to NHS and private patients; this has been reiterated to staff.
- Governance Strengthening: Increased focus on unit-level governance meetings led by ACNs, with escalation to Unit Board and involvement of MDs/clinical chairs as needed. This approach aims to ensure robust oversight and timely implementation of actions.

HTA Progress Report (November Meeting)

The Committee is partially assured that HTA compliance requirements are being met. Full assurance will be confirmed upon receipt and review of the written report at the next meeting.

EPRR Annual Report (November Meeting)

The Committee noted the report and expressed confidence in the progress made. Assurance was provided that:

- There is a clear improvement trajectory.
- No critical gaps exist.
- Ongoing monitoring and exercises support resilience.

The Committee thanked the teams for their efforts and commitment.

Performance Report (November and December Meeting)

The Committee noted the report and was assured that appropriate actions are being taken to address identified issues, with ongoing monitoring and improvement work in place.

- Cancer Standard: Committee acknowledged the impact of small patient numbers on compliance metrics. Agreed that future reports should highlight month-on-month improvements. Breaches reviewed in detail through TPOIG on a six-monthly basis.
- Readmission Rate: Positive performance noted for 28-day readmission following cancellations; all but one patient rebooked within target timeframe.
- Norovirus Outbreak: Committee assured that the outbreak was well managed, with positive IPC feedback.
- Blood Transfusion: Assurance provided that relevant incidents were reported and reviewed appropriately.
- Recruitment to address HCA vacancy gap.
- Continued monitoring of falls and pressure ulcer prevention measures.
- Accurate reporting of infection control data.
- Delivery of planned admissions strategy for MCSI.

EPR Apollo Report (November Meeting)

- Bluespier update confirmed as taking place today.
- Waiting list and vetting issues largely unrelated to Apollo but will continue to be reported to this Committee.
- New process for adding review dates agreed; active monitoring approach to be revisited.
- Emphasis on achieving improvements beyond restoring previous functionality, including better data insight and digital capabilities.
- Pharmacy post-implementation review shows positive impact on patient safety and changes in incident themes.
- Committee requested a one-page summary of quality and safety benefits in future reports

Chair Report EPR Implementation Meeting (December Meeting)

- The Committee acknowledged progress in reducing unvetted referrals and requested that this assurance be incorporated into future EPR reports.
- Members asked for oversight of benefits, particularly those linked to quality and safety, to be reflected in upcoming reports.

- It was suggested to add a horizontal line on graphs to make targets clearer. The rationale for the 2000-referral target was explained as representing approximately one week's referrals, and agreement was made to include this on graphs.

Health Inequalities Deep Dive (December Meeting)
The Committee observed the:

- Strong commitment and progress noted in tackling health inequalities.
- Value of partnership working and system-wide approach recognised.
- Continued focus required on patient safety, data quality, and addressing inequalities in access and experience.
- Moderate Assurance provided – Significant progress demonstrated through collaborative initiatives, targeted interventions, and measurable improvements (e.g., WNB rates, waiting times). Further work required on data quality, staff training, and accessibility improvements.

3.3 Areas of assurance

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

HSE Action Plan (November Meeting)
The Committee noted the report and acknowledged the actions in progress to ensure compliance and strengthen assurance.

- The Committee discussed how continued compliance will be ensured and monitored.
- It was confirmed that a dashboard is in development to provide real-time oversight.
- Formal audits will complement the dashboard to strengthen assurance mechanisms.

IPC Report (November Meeting)
Following a review of the paper, the Committee recommended to enhance assurance:

- Maintain regular monitoring of training compliance and audit completion.
- Continue engagement with universities to strengthen IPC education for students.
- Ensure timely resolution of off-site IPC concerns through Chief Nurses.
- Track and report progress against 2025–2027 ambitions via dashboards.

Cleanliness and Estates IPC Report (November Meeting)

- There are no significant IPC risks identified.
- Improvements in Legionella reporting enhance transparency and assurance.
- Equipment decontamination processes are under review and monitored for compliance.
- Residual Risk: Low, with continued oversight and reporting in place.

Legal Claims Report (November Meeting)
The Committee noted the report and confirmed that appropriate actions are in place to monitor and address legal claims and associated risks.

- Claims Activity: Three new CNST claims were reported this quarter; no new ELPL claims.
- Coroners' Inquests: Two remain open, one awaiting a hearing date and one scheduled for January as a joint case with SATH (attendance to be confirmed).
- Benchmarking: NHS Resolution benchmarking data is currently unavailable due to platform updates.
- Scorecard Review: The Trust has received its scorecard (April 2015–March 2025) and plans to meet with NHS Resolution to explore emerging themes, particularly post-COVID claims related to delays in treatment and waiting times, to identify improvement opportunities

Quality Priorities Update (November Meeting)

- Enhanced recovery pathway improvements noted, including clearer patient recall, reduced complications, and better VTE compliance. Statistical validation is pending.
- Risks identified: food waste, linen usage, and inconsistent fluid balance chart completion. Education planned to address these.
- Overall, progress aligns with strategic quality objectives, with proactive measures in place for identified risks.

Well Led Review Action Plan (November Meeting)
The committee reviewed the draft well led action plan in its entirety and emphasised the importance of mapping new actions to existing processes such as the staff survey and case management, to maximise value and avoid duplication. The committee endorsed the action plan.

Premises Assurance Model Report (December Meeting)
The Committee is assured that:

- The organisation has a robust process for monitoring estate and facilities compliance through PAM.
- Improvements have been implemented in response to previous findings, and proactive measures are in place for future regulatory changes.
- Governance arrangements are clear, and accountability is maintained through reporting to the Regulatory Oversight Meeting.
- Risks are being managed effectively, and the organisation is well-prepared for upcoming compliance requirements.

The next steps for the Trust to consider include:

- Continue monitoring progress against improvement goals for March 2026.
- Prepare for transition to the new PAM compliance model.
- Maintain readiness for Martyn's Law implementation.

The committee received the following chair reports:

- **IPCC Meeting** – there were no issues to escalate to the Committee.
- **Patient Safety Meeting** – there were no issues to escalate to the Committee.
- **Patient Experience Meeting** – the committee asked for an update on the review of communication with patients whilst on the waiting list to be provided in next months report.
- **Adult and Childrens Safeguarding Meeting -** there were no issues to escalate to the Committee.
- **Drugs and Therapeutics Meeting-** The Committee agreed there is a need for resilience beyond short-term fixes was highlighted, and the development of a longer-term rheumatology pathway was discussed. Estate development, including increased space and co-location, is expected to support delivery of best practice tariffs and pathway adherence. An update on the longer-term home care solution and rheumatology pathway to be brought back in 3 months.
- **Regulatory Oversight Meeting** - The Committee agreed that the Executive Team Meeting should discuss and reassess the requirement of an energy and waste manager role. A question was raised on when the MHRA license closure update will be brought back, and the Committee was informed that the Trust is awaiting clarification on some parts, after which the report can be provided to the Committee.
- Tru**st Performance and Operational Improvement Group** - A question was raised in relation to the orthotics harm review process, and it was noted this is being considered to provide assurance of patient safety during long waits as workforce expansion is not currently feasible, however will be discussed further. It was noted that the golden patient process has been approved, although it is not yet clear whether it has been utilised.
- **Health and Safety Meeting** - There were 2 dirty needle sticks with a process now in place to prevent this. There was high DNA rates for training, which is disappointing, however work ongoing to improve this. A number of policies were approved.
- **Non Medical Safe Staffing Group** – The following table on safe staffing is shared to ensure timely reporting to the Board.

Ward	Safe Staffing for October 2025	Day				Night				Day		Night			Care Hours Per Patient Day		
		Registered		Care Staff		Registered		Care Staff									
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	At midnight (monthly total)	CHPPD Registered Midwives / Nurses	CHPPD Care Staff	CHPPD Overall
										≥80%	≥80%	≥80%	≥80%				
Alice	110 - TRAUMA & ORTHOPAEDICS	1041.00	976.75	0.00	0.00	696.00	695.75	0.00	0.00	93.8%	-	100.0%	-	134	12.5	0.0	12.5
Clwyd	110 - TRAUMA & ORTHOPAEDICS	1156.00	1126.75	919.50	846.00	744.00	768.00	564.00	585.50	97.5%	92.0%	103.2%	103.8%	443	4.3	3.2	7.5
MCSI Inpatients	400 - NEUROLOGY	2996.00	3226.00	4807.25	4094.83	2249.50	2295.00	1737.00	1888.50	107.7%	85.2%	102.0%	108.7%	1,345	4.1	4.4	8.6
Kenyon	110 - TRAUMA & ORTHOPAEDICS	858.00	830.25	693.50	641.50	672.00	674.50	342.50	372.00	96.8%	92.5%	100.4%	108.6%	358	4.2	2.8	7.0
Oswald	110 - TRAUMA & ORTHOPAEDICS	746.00	745.00	557.00	425.00	744.00	744.00	0.00	0.00	99.9%	76.3%	100.0%	-	183	8.1	2.3	10.5
Ludlow	110 - TRAUMA & ORTHOPAEDICS	1021.50	981.08	664.50	520.33	720.00	751.50	348.00	344.00	96.0%	78.3%	104.4%	98.9%	297	5.8	2.9	8.7
Powys	110 - TRAUMA & ORTHOPAEDICS	1116.50	1125.75	851.00	919.50	756.00	756.00	688.00	784.00	100.8%	108.0%	100.0%	114.0%	368	5.1	4.6	9.7
Sheldon	300 - GENERAL MEDICINE	1283.00	1253.25	1438.50	1442.50	756.00	756.00	1104.00	1164.00	97.7%	100.3%	100.0%	105.4%	515	3.9	5.1	9.0
HDU	110 - TRAUMA & ORTHOPAEDICS	1065.50	983.25	204.00	101.50	1008.00	864.00	0.00	0.00	92.3%	49.8%	85.7%	-	88	21.0	1.2	22.1
Totals		11283.50	11248.08	10135.25	8991.16	8345.50	8304.75	4783.50	5138.00	99.7%	88.7%	99.5%	107.4%	3731	5.2	3.8	9.0
MSK Unit		5217.50	5047.08	3332.50	3028.83	3900.00	3814.00	1942.50	2085.50	96.7%	90.9%	97.8%	107.4%	1554	5.7	3.3	9.0
Specialist Unit		6066.00	6201.004	6802.75	5962.33	4446	4490.75	2841	3052.5	102.2%	87.6%	101.0%	107.4%	2177	4.9	4.1	9.1
	Trust Total		97.5%														

Recommendation

The Board is asked to:

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

CQC Adult Inpatient Survey 2024

Committee / Group / Meeting, Date

Board of Directors, Public Meeting – 07 January 2026

Author:	Contributors:
Name: Kirsty Foskett Role/Title: Assistant Chief Nurse and Patient Safety Officer	Alison Harper, Clinical Governance Manager

Report sign-off:

Name: Sarah Needham, Interim Chief Nurse and Patient Safety Officer
Meeting: Quality and Safety Committee, 19 November 2025

Is the report suitable for publication?:

YES

Key issues and considerations:

This report provides an overview of the CQC's Adult Inpatient Survey results for 2024, published in September 2025.

A total of 131 Trusts took part in the survey, which was taken (as usual) in November 2024. During that month, 1,250 of our patients were invited to complete the survey and 863 did so – a response rate of 70% which was the best in the country.

RJAH have been categorised as one of three Trusts, achieving "much better than expected". Overall, RJAH were ranked number 2.

For all questions answered as part of the survey, all responses were banded as better than other Trust's, with 6 responses on par with other Trusts and no responses were banded as worse than other Trusts.

Key Highlights

Notable practice

- The Trust scored "somewhat" to "much" better than expected in 87% (39/45) questions compared to other Trusts – the 6 remaining questions were scored as "about the same" as the other Trusts.
- Q37 – Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital – the trust has seen a significant improvement from 2023 survey where we scored 8.7 in comparison to this years results where we scored 9.4.
- Overall experience was scored 9.4, which shows an improvement from the previous survey where the Trust scored of 9.2 in 2023 and 9.3 in 2022.

Areas for Improvement

There was one question where the Trust scored below the national average.

- Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?

Strategic objectives and associated risks:

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

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

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

This report relates to the following Board Assurance Framework (BAF) themes and associated strategic risks:

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

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

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

Recommendations:

Actions to be established in relation to the areas identified for improvement through the Patient Experience Working Group and will be included as part of the revised Patient Experience Strategy.

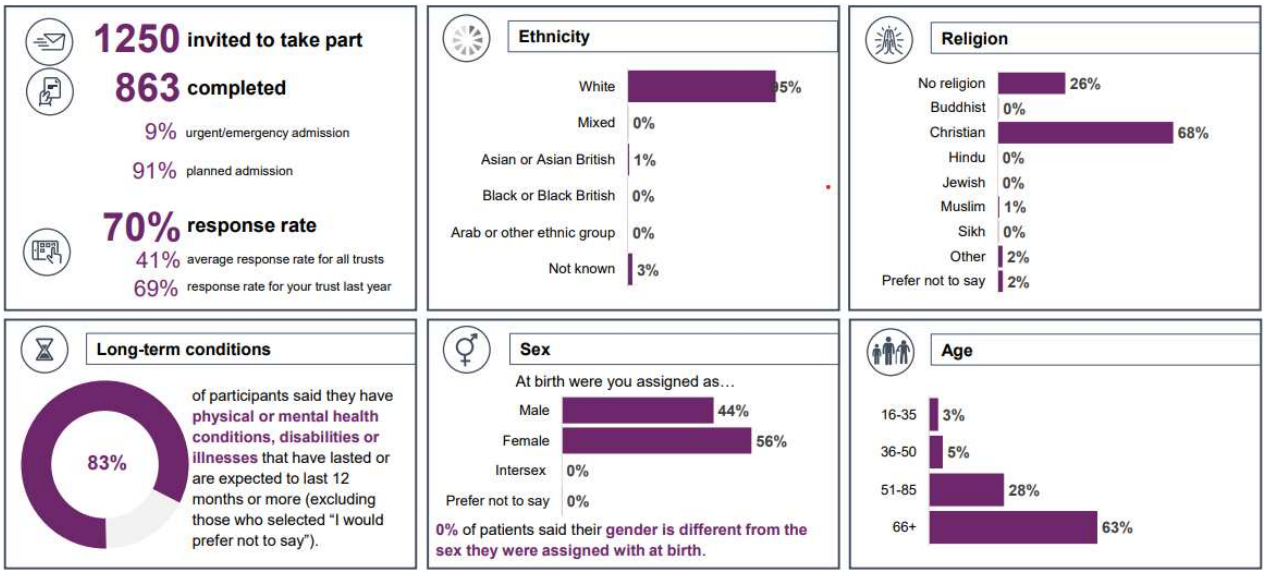
CQC Adult Inpatient Survey 2024

1. Main Report

This report provides an overview of the CQC's Adult Inpatient Survey results for 2024, which were published in September 2025. A total of 131 Trusts took part in the 2024 survey, which was taken (as usual) in November last year. During that month, 1,250 of our patients were invited to complete the survey and 863 did so – a response rate of 70% which was the best in the country.

RJAH have been categorised as one of three Trusts, achieving "much better than expected". Overall, RJAH were ranked number 2.

Response Rate & Demographic



Notable Feedback

Where patient experience is best

- ✓ **Wait to get a bed:** The wait to get a bed on a ward after arrival
- ✓ **Leaving hospital:** Family / carers being involved in discussions about the patient leaving hospital
- ✓ **Waiting in the hospital:** Length of time waited (in another location) before admission to a ward
- ✓ **Food:** Patients being able to get hospital food outside of set mealtimes
- ✓ **Leaving hospital:** Staff telling patients who to contact if worried about condition/treatment after leaving hospital

Where patient experience could improve

- ○ **Waiting list:** Length of time on waiting list before hospital admission
- ○ **Leaving hospital:** Patients able to understand information given about what they should/shouldn't do after leaving hospital
- ○ **Individual needs:** Staff taking into account patients' individual needs: Cultural needs
- ○ **Drink:** Patients getting enough to drink
- ○ **Sleeping:** Patients being prevented from sleeping at night due to room temperature

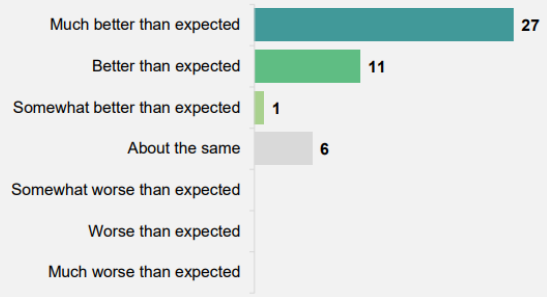
Comparison with other trusts and 2023 results

There were no areas identified as "worse than expected" when our scores were compared to all other trusts involved in the survey and no questions that were identified as "significantly worse" when compared to RJAH results from 2023.

CQC Adult Inpatient Survey 2024

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2024 vs 2023.

Best performing questions relative to the national average

The table below shows the areas that the Trust have scored highest against the national average.

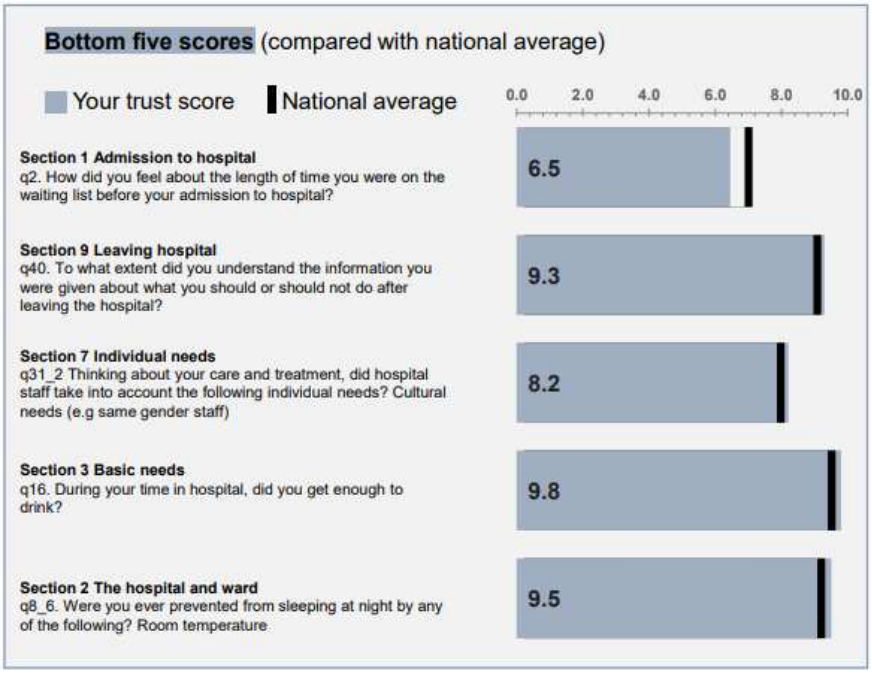
Areas for improvement

The table below shows the Trusts bottom five scores, albeit the scores for 4 out of the 5 questions are still slightly ahead of national average.

One question in relation to wating scored below the national average.

Section 1 – Question 2: How did you feel about the length of time you were on the waiting list before your admission to hospital?

CQC Adult Inpatient Survey 2024



To develop an understanding into the patient's experience while waiting for admission to hospital, a deep dive into the complaints received within the Trust was undertaken in Q1 of 2025/26. It identified that the number of complaints received due waiting times had increased considerably.

The deep dive highlighted that the main concern raised by patients was the length of time they must wait for an appointment or for their surgery. From the findings, the following recommendations were suggested to address the concerns;

Manage patient expectations regarding waiting times	
What was found	Identified Action for Improvement
Patients are often directed to the NHS App or My Planned Care link (NHS website) for an update on the average waiting times, but this is limited to Trauma and Orthopaedics as whole and not broken down by specialty.	• Encourage all Consultant teams to advise patient on their average waiting time when adding them to their inpatient waiting list and whether they are considered urgent or routine (rather than 'P' status). • To publish average waiting times per specialty on the Trust website.
Patients often feel like their referral has been 'lost' due to the time between referral and first appointment.	• On vetting of a referral, write to the patient to inform them that the Trust has received their referral and provide an average waiting time by specialty.

The deep dive also identified there was an increasing number of concerns being raised by patients and members of parliament on behalf of patients who fall under the remit of Welsh commissioning. These patients have often waited for less time than the stipulated commissioning arrangements, which means the Trust has limited influence in being able to manage the patient's concern, unless their case has become clinically urgent.

CQC Adult Inpatient Survey 2024

To review the complaints handling process for concerns relating to waiting times for patients who fall under Welsh commissioning.	
What was found	Identified Action for Improvement
Patients under the remit of Welsh commissioning are raising concerns, despite waiting for less time than the stipulated commissioning arrangements. The Trust has limited influence in being able to manage/address the concern, unless the patient's case has become clinically urgent.	Patients complaints should be redirected to their respective health board if it specifically relates to waiting time, and the patient has waited for less time than the commissioning arrangements

These actions are monitored through the Patient Experience Improvement Plan and updates are brought to the patient experience meeting.

Conclusion

The Board is asked to note content of the report and recommendation that ww continue to implement actions relating to improving communication with our patients while they are on the waiting list as, well as the efforts being made to reduce are overall waiting times.

CQC Adult Inpatient Survey 2024

Action Plan

Action	Action Driver	Action Source	Target Completion Date	Action Owner	Status	Progress Update
On vetting of a referral, write to the patient to inform them that the Trust has received their referral and provide an average waiting time by specialty.	Patient Experience Improvement Plan	Complaints Deep Dive	31/03/2026	Mel Brown	Not Started	First T&F Group Scheduled for 22/1/26
Encourage all Consultant teams to advise patient on their average waiting time when adding them to their inpatient waiting list and whether they are considered urgent or routine (rather than 'P' status).	Patient Experience Improvement Plan	Complaints Deep Dive	30/11/2025	Richard Potter & Birender Balain	Complete	Action complete
To publish average waiting times per specialty on the Trust website.	Patient Experience Improvement Plan	Complaints Deep Dive	31/03/2026	Chris Hudson & Mel Brown	Not Started	First T&F Group Scheduled for 22/1/26
Complaints that are specifically about waiting times and where a patient is less than 100 weeks, are to be directed to PHTB.	Patient Experience Improvement Plan	Complaints Deep Dive	30/09/2025	Kirsty Foskett & Nia Jones	Implemented	Action Complete

Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Report 2025

Committee / Group / Meeting, Date

Board of Directors, Public Meeting – 07 January 2026

Author:

Name: Hannah Howells
Role/Title: EPRR Lead

Contributors:

Larissa McElroy, Operations Business Manager
Mike Carr, Accountable Emergency Officer
Nick Huband, Director of Estates and Facilities

Report sign-off:

Mike Carr, Chief Operating Officer/Deputy CEO and Accountable Emergency Officer (AEO)
Quality and Safety Committee, Wednesday 19th November 2025
Board of Directors, 10th December 2025

Is the report suitable for publication?

Yes

Key issues and considerations:

This paper presents an update on the Trusts Emergency Preparedness, Resilience and Response (EPRR) function for Board scrutiny and assurance. The NHS England EPRR Framework, requires the Trusts EPRR service to report to Board annually on the state of its preparedness, detailing provision in several key areas.

This paper covers the September 2024 to August 2025 and includes an update on our most recent NHS England EPRR Core Standards assurance process.

There have been many positive changes over the calendar year with new plans and processes introduced.

- **The Trust achieved a rating of 83% (high partially compliant) increasing from last year's Non complaint score of 64%.**
- The Trust continues to work collaboratively with Shropshire, Telford and Wrekin (STW) System partners to align emergency planning arrangements and documentation, promoting consistency, shared learning, and strengthened system-wide resilience.
- New Emergency Preparedness, Resilience and Response (EPRR) plans have been developed and implemented in line with the Civil Contingencies Act 2024, ensuring compliance with statutory requirements.
- The Business Continuity Management System (BCMS) has been fully embedded across the Trust, supported by regular audits to maintain assurance and continuous improvement.
- A range of training and exercising sessions have been delivered to multiple staff groups, enhancing awareness, capability, and confidence in emergency response arrangements.
- Updated procedures/plans have been introduced, alongside the implementation of new equipment to support effective command and control during incidents.
- Partnership working and collaboration have been further strengthened across Shropshire, Telford and Wrekin partner organisations and system-wide multi-agency teams.
- Joint exercise planning has been undertaken and attended collaboratively across system partners to test and refine collective response and recovery arrangements.

The Trust has an Accountable Emergency Officer (AEO), which is a statutory role providing overall responsibility and accountability for the service.

The EPRR Lead role at RJAH continues to be undertaken by the Trust Health and Safety Advisor; managed by the Director of Estates and Facilities.

Commencing August 2024, the Operations Business Manager has taken on responsibility for business continuity planning at the Trust, with the oversight from the EPRR Lead.

Strategic objectives and associated risks:

The work of EPRR relates primarily to the Strategic objective: Delivery high quality clinical services.
The associated Board Assurance Framework risks / corporate risks considered by the Meeting are:

- Risk 822 - Failure to comply with statutory legislation and guidance relating to EPRR.

Recommendations:

The Quality and Safety Committee, and Trust Board is asked to note the EPRR annual position.

Report development and engagement history:

This report has been considered and approved by the Trust EPRR Working Group. No new key issues were raised other than items detailed within this report.

Next steps:

The EPRR Working Group have developed a detailed work programme for the next twelve months, focusing on elements identified as requiring improvement by NHS England during the EPRR Core Standards assurance process.

The EPRR Core standards are discussed with system partners (SaTH, SCHT, and ICB), where leads meet to identify elements which may require a collaborative approach or workaround. The Trust EPRR Working Group reports quarterly to Quality Safety and Committee presented by the Accountable Emergency Officer.

Acronyms

EPRR	Emergency Preparedness, Resilience and Response
AEO	Accountable Emergency Officer
RJAH	Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust
ICB	Integrated Care Board
CBRNe	Chemical Biological radiological nuclear and explosive
HAZMAT	Hazardous materials
SaTH	The Shrewsbury and Telford Hospital NHS Trust
SCHT	Shropshire Community Health NHS Trust
ICB	Integrated Care Board
STW	Shropshire, Telford and Wrekin
LHRP	Local Health Resilience Partnership

Appendices

Appendix A	EPRR annual assurance 2024/25: Confirm and challenge summary

Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Report 2025

1. Background / context

The Trust undertakes an annual assurance process for Emergency Planning, Resilience and Response (EPRR), using the NHS England EPRR Core Standards assurance framework as the benchmark for resilience.

These Standards outline the requirements for EPRR teams to report annually to the Board on progress and key themes across the EPRR workplan, ensuring continued assurance of the Trust's capability and preparedness.

In 2023, EPRR responsibility was successfully integrated within the Estates and Facilities structure, with the annual workplan now coordinated by the Health and Safety Advisor/EPRR Lead.

A strengthened meeting structure has been embedded to provide clear assurance to the Board through quarterly reports to the Quality and Safety Committee.

Developments within the EPRR service have resulted in a more operationally focused and responsive provision, supported by enhanced support mechanisms. Collaboration with health and multi-agency partners has been further strengthened through joint planning and exercising activities over the past 12 months.

Several new processes have become fully established, aligning with the required standards to provide a strong foundation for ongoing improvement. Continuous enhancements will be delivered throughout the next calendar year, guided by a detailed and closely monitored work programme overseen by the Trust EPRR Working Group.

2. EPRR Annual assurance

2.1 Resources and Structure

The Trust has an Accountable Emergency Officer (AEO), which is a statutory role providing overall responsibility and accountability for the service.

The Trust Health and Safety Advisor undertakes the role of EPRR Lead for RJAH, reporting to the Director of Estates and Facilities, reporting routinely to the Accountable Emergency Officer.

Governance structures have been amended, with EPRR updates being presented report form to the Quality and Safety Committee every quarter.

The Trust has a 24/7 On Call mechanism at both Strategic and Tactical levels. These have recently been bolstered with additional staff members.

The EPRR Core Standards require that the Board has assurance that the resources in place are sufficient to deliver the EPRR programme effectively.

2.2 Training and Exercising

Historically the Trust has relied on partner agencies to deliver EPRR training. During 2025, in-house training and exercises were produced/undertaken by the Trust Health and Safety Advisor/EPRR Lead and Operations Business Manager.

- 2x Business Continuity Plan awareness sessions with Trust senior management.
- Executive on Call training took place with two newly appointed Senior Leads.
- RJAH National Linen contractor shortage emergency scenario desktop training with Facilities Team.
- Trust wide Exercise Percy (Digital Disaster) annual desktop exercise took place following the implementation of Apollo EPR System.

- HCID (High Consequences Infectious Disease) desktop exercise was carried out by Assistant Chief Nurse.
- Apollo Business Continuity Plan desktop exercise
- RJAH Loggist training
- RJAH CBRNe/HAZMAT training – desktop exercise completed with Trust staff to bring awareness of self-presenters to the Trust in an CBRN incident and how they can assist with dry decontamination.
- RJAH communication system exercise including staff from Switchboard and Clinical Leads.
- Health and Safety Advisor/EPRR Lead commenced their MSc in Disaster Management and Resilience with the University of Wolverhampton.
- RJAH Leads attended various West Mercia Local Resilience Forum EXERCISE PEGASUS (Three phase infectious disease exercise).
- RJAH attended Shrewsbury and Telford Hospital Trusts EXERCISE Jupiter (CBRN/Decontamination) exercise, completed in collaboration with the RAF.

2.3 Business Continuity Planning

In August 2024 the Business Operations Manager took over the Business Continuity Planning element of the EPRR Core Standards assurance process. Progressed achieved so far is:

- A Trust Business Continuity Management System has been created to log, track and report all Business Continuity Plans throughout the Trust. The Management System was called out as 1 of 3 'areas of good practice' in the NHS England EPRR Core Standards Confirm and Challenge Meeting in October 2025.
- The management system is continuously evolving, and the tool has recently been further enhanced with the following features:
  - To strengthen the Trust's commitment to using data to drive improvement, data from the Quality Accreditation Management System automatically feeds into the business continuity system, providing real-time insights that support planning and targeted action. This direct data link eliminates duplication, ensures accuracy, and allows the Trust to respond proactively based on the most current information.
  - Works to enhance the system's usability have also been undertaken, with further insights added to the dashboard helping to streamline workflows that simplify reporting and make it easier to track progress and outstanding actions.
  - In addition, key themes collected through the Quality Accreditation Programme are now displayed within the BCP system. These themes will guide where support is needed across the Trust, help identify where audits should be prioritised, and inform how question sets are tailored, ensuring that improvement efforts are both focused and effective.
  - The BCP register has also been enhanced with automation to generate reminder emails for expiring Business Continuity Plans (BCPs) within the organisation. The system flags and identifies plans with review dates that have either lapsed or are due within the next 30 days. It extracts key details, including the BCP name, lead contact, and associated email addresses, before automatically generating and sending personalised Outlook notifications to the responsible individuals. These emails serve as formal reminders, prompting timely review and updates to maintain compliance, removing the manual task of chasing expired business continuity plans.
- An Executive and Senior Manager Critical Incident Extraordinary Teams Channel has been created for leads to log, report and escalate any incidents whilst on call.
- The Executive and Senior Manager on call rota continues to be reviewed and updated on a quarterly basis.
- The Senior Manager on call policy was also created and approved in October 2024 to ensure that there are clear, effective, and timely arrangements for Emergency Preparedness, Resilience, and Response (EPRR) for critical incidents, emergencies, or unforeseen events, outlining the responsibilities and procedures for staff designated on call.

- Following the implementation of the Senior Manager on call policy, quarterly senior manager meetings have also been set up to discuss incidents, business continuity activations, learning that has taken place over the last three-month period, with discussions for improvement over the next three months.
- All leads on the Executive and Senior Manager on call rota each now have their own Individual On-Call Contingency Handbooks which are regularly updated to include key FAQ's, relevant policies and SOPS, action cards and key information for when on call. These handbooks can be taken home by all leads to ensure they have support when away from the Trust when on call.
- All Senior Managers now have access to Resilience Direct should an exercise be initiated whilst on call.
- Within 2024-2025, two Business Continuity Training sessions have taken place; one in October 2024 and a further session in February 2025. The first session in October 2024 saw 36 departmental managers/deputies in one room to listen, discuss and learn all about a business continuity plan and its importance for their areas. Following this session, submission of business continuity plans to the Operations Business Manager increased.
- Business Continuity training sessions will continue with managers on an annual basis.
- As October 2025, there are now 52 live business continuity plans within the Trust.
- In line with Business Continuity Awareness Week from 19th May 2025, the Trust set up their own digital disaster exercise on 20th May called Exercise Percy to test elements of potential distribution within departmental/ward business continuity plans following the implementation of Apollo.
- The Operations Business Manager attended the SaTH Business Continuity Summit on 20th March 2025 to explore areas for learning and share ideas across both Trusts.
- There is also a scheduled session with Switchboard on 8th December 2025 to review and test their business continuity plan with the whole team.
- Since beginning in post in August 2024, the Operations Business Manager continues to work with the Trust's EPRR Lead to further improve and enhance business continuity elements throughout the Trust.
- Lessons learnt, escalations and achievements are also regularly reported to the Trust's Emergency, Preparedness, Resilience and Response Meeting.

2.4 Resilience plans

Throughout the year, the Health and Safety Advisor/EPRR Lead in collaboration with the EPRR working group, the Health and Safety Meeting, STW ICB EPRR Lead and NHS England (Midlands Region) have developed and improved Trust wide resilience plans, following learning from incidents, events and exercises in accordance with the EPRR Framework:

1. Trust Incident Response Plan (replaces Major Incident Plan)
2. Trust Adverse Weather and Health Plan
3. Mortuary Procedure
4. Mass Casualties Plan
5. Lockdown Plan
6. Incident Situation Report Plan
7. Incident Control Centre Guidance Booklet
8. Evacuation and Shelter Plan
9. EPRR Policy
10. Emergency Critical Incident Mutual Aid Plan
11. Countermeasures Plan
12. Corporate Business Continuity Plan
13. CBRN/HAZMAT Plan

All documents are stored on the staff accessible dedicated EPRR page on the Trust Intranet page Percy, as well as hard copies of documents be readily available in the Incident Control Centre (CSM Office. Location 21).

Continued collaboration between Shropshire, Telford and Wrekin (STW) System partners ensures the alignment and integration of emergency preparedness plans and supporting documentation. This ongoing joint approach promotes consistency across organisations, strengthens collective resilience, and enables a coordinated response to incidents and emergencies.

2.5 RJAH Incidents

To note; the Trust has not had to formally declare any incidents over the last 12 months, that may have affected or were likely to affect the Trusts ability to continue to delivery safe patient services.

Incidents that have been discussed at the EPRR Working Group however were:

- Switchboard BCP (business continuity plan) activated due to the voice over on blick paging system being extremely low, impacting the clarity of sound.
- Catering department prep fridge failure
- Fire alarm sounded, showed to be in the kitchen, fire service called on investigation was a call point inside the kitchen to the right of the door. Did not appear tampered with and door was locked prior to alarm sounding.
- Office space reported at peaking 26 degrees - uncomfortable for all staff / visitors.

All incidents are reported via the Trust DATIX system and discuss at the EPRR Group, identifying whether lessons learnt can be reviewed, and revised into departmental business continuity plans.

2.6 Lessons learnt from training, exercises and incident.

Throughout the past year, RJAH and System partners across Shropshire, Telford and Wrekin (STW) have undertaken a series of training and exercising activities designed to strengthen preparedness and response capability. These exercises have provided important learning opportunities, leading to the identification of several lessons to inform future improvement work.

- ***Exercise PERCY: Post Apollo implementation digital exercise (May 2025)***

Lessons identified several areas requiring further development to strengthen resilience and operational readiness. It was noted that greater representation from ward and departmental managers is needed to ensure comprehensive engagement and input across all service areas.

The Apollo Business Continuity Plan (BCP) requires updating to reflect learning and agreed changes arising from this exercise. In addition, clarity is required regarding the management of RL1 patients within Radiology and associated departments, noting some further support is needed from the Apollo Team. Finally, all departmental and ward-level BCPs should be reviewed and updated to include detailed procedures for maintaining operations beyond 24 hours in the event of an Apollo system outage.

- ***Linen Supply Disruption Exercise (April 2025)***

The Linen Supply Disruption desktop exercise, conducted in April 2025, provided valuable insight into the Trust's preparedness and response arrangements for supply chain interruptions. The exercise reinforced the importance of robust contingency planning and adequate on-site stock management, particularly for essential items such as scrubs.

Opportunities were identified to strengthen communication and escalation protocols, ensuring that daily updates and clear lines of accountability are maintained throughout any disruption. The value of proactive demand management—such as redistributing linen and reducing non-essential bed changes—was recognised as an effective operational mitigation. The exercise also highlighted the need for continued collaboration between Facilities, Infection Prevention and Control, and clinical teams to manage risks associated with reduced linen availability.

Additionally, the exploration of alternative laundering arrangements and suppliers was identified as a key area for further development to enhance resilience. Outcomes and agreed actions from the exercise will inform updates to the Business Continuity Plan (BCP) and associated departmental procedures to ensure lessons learned are embedded across the organisation.

- ***Shrewsbury and Telford Hospitals, Exercise TEMPESTES System Wide Severe Weather Exercise***

The exercise provided valuable insights into the collective preparedness and coordination of system partners during adverse weather events (Shrewsbury and Telford Hospital Trusts, Shropshire Community Health Trust, RJAH, Shropshire Council, The Met Office, Shropshire Fire and Rescue).

Key lessons centred around improving awareness, testing operational plans, and ensuring compliance with national standards. There is a continued need to strengthen awareness and understanding of the Met Office and UKHSA Severe Weather Warning systems among all partners. Improved dissemination and interpretation of warnings will enhance timely decision-making and response activation. The exercise successfully tested partner organisations' Adverse Weather Plans against NHS England's Core Standard 11. Lessons highlight the importance of regular reviews, clear escalation processes, and consistent communication protocols to ensure plans remain effective and aligned.

The activation and coordination of mutual aid during the simulated adverse weather event demonstrated the value of established partnerships. However, further refinement is required to ensure mutual aid requests and offers are efficiently managed, clearly documented, and communicated across all agencies. Overall compliance with NHS England's Core Standards was demonstrated, though the exercise identified areas for improvement in documentation, communication flow, and assurance reporting. Continued testing and evaluation will support full compliance and operational resilience.

2.7 EPRR Core Standards

As highlighted previously, the EPRR Core Standards is the Trusts annual self-assessment against the minimum standards. Standards are set out in 10 domains. A standard is rated compliant, partially compliant or non-compliant. Only compliant standards are counted towards the overall award.

Awards are given as follows:

- Fully compliant – 100% compliant standards
- Substantially compliant – 88 – 99% compliant standards
- Partially compliant – 77 – 88% compliant standards
- Non-Compliant – less than 77% compliant standards

The Trust achieved a rating of 83% (high partially compliant) increasing from last year's Non complaint score of 64%.

The Trust did not receive any inadequate ratings on question sets, and areas of good practice were identified by NHS England, and will be shared with regional and national partners.

Feedback received from NHS England was:

- "NHS England and the ICB have reviewed the evidence of 59 standards and supports the self-assessment position against 49 standards (the organisation's initial self-assessment was 56 fully compliant and 3 partially compliant), a challenge has been raised against 10 standards".
- "3 areas of good practice have been identified, which NHS England is keen to share across the region".
- "Good progress has been made with clear foundations to continue adding more detail into documentation, continue to develop training areas and progress compliance further in upcoming years."

3. Proposed next steps

By 30 November 2025:

- Finalised positions will have been taken to the LHRP for agreement.
- Action plans developed for organisations
- ICB report to region on final position and other factors

By 31 December 2025: submission of Regional Assurance to National EPRR.

4. Recommendation

Following a recommendation from the Quality and Safety Committee, the Board is asked to note the EPRR annual position ahead of the regional assurance submission.

Executive Summary - People Committee

Assurance

Variation	Will consistently pass the target if nothing changes	Will not consistently pass or fail the target if nothing changes	Will consistently fail the target if nothing changes	No Target or Moving Target
Improving varitation (high or low) or 3 months better than target	Vacancy Rate % of Staff on E-Rostering System	Staff Retention		
No significant change or N/A to SPC	E-Rostering Level of Attainment		E-Job Planning Level of Attainment	Sickness Absence Staff Availability Proportion of Temporary Staffing Bank Spend against Plan
Concerning variation (high or low) or 3 months off target	AHPs Vacancy Rate	Personal Development Reviews	% of E-Rosters Approved 6 Weeks Ahead % of Staff with an Active E-Job Plan	Sickness Absence - Short Term HCSW Vacancy Rate

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

Trust Board - People & Workforce
November 2025 – Month 8

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

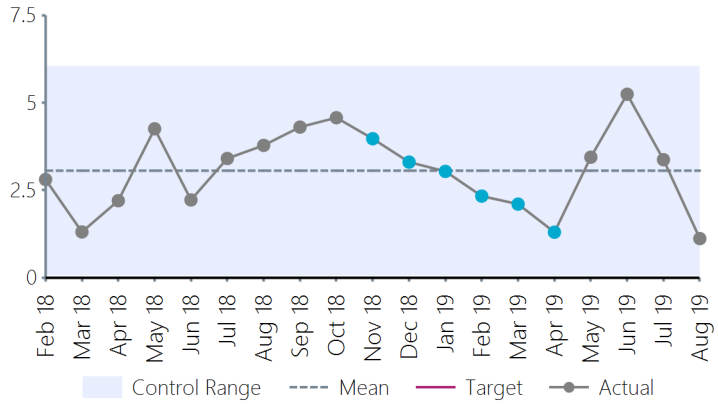
Some examples of these are shown in the images to the right:

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

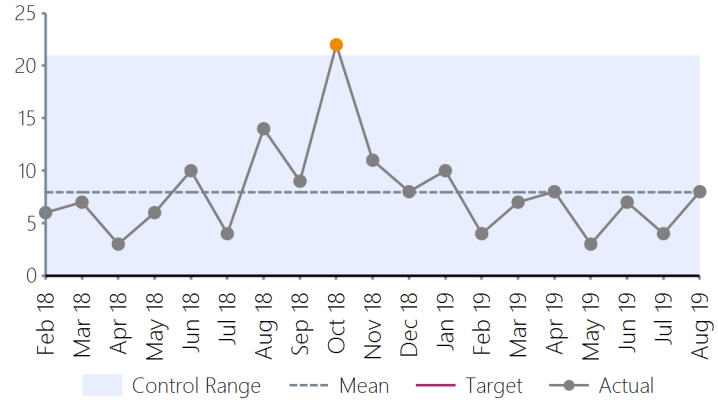
b) shows a point of concern sitting above the control range.

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

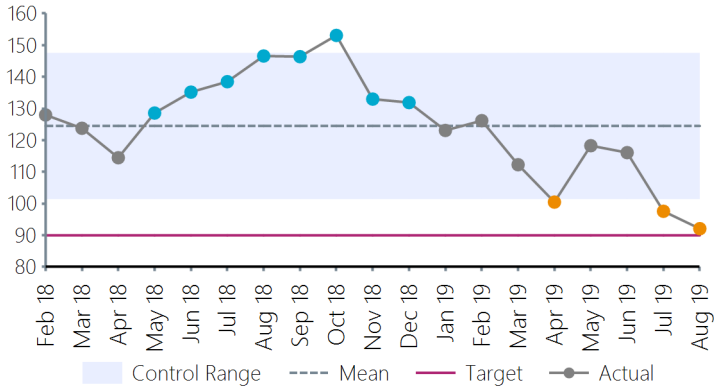
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Staff

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Sickness Absence	5.54%	5.06%			Moving Target	+	
Staff Turnover - FTE	9.98%	9.99%			?		
Leavers per Month	12	15			?		
Vacancy Rate	8.00%	7.04%		H	P	+	15/04/24

Summary - Caring for Finances

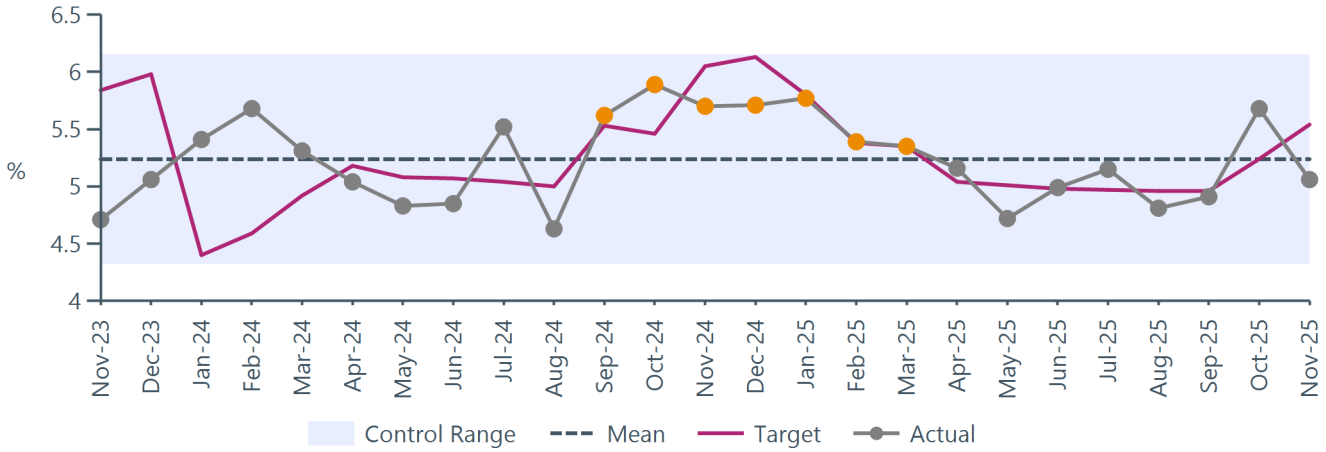
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Agency Spend against Plan	1.30	0.20		N/A to SPC	Moving Target		
Proportion of Temporary Staffing as a % of the Trust Pay Costs	7.10%	8.00%		N/A to SPC	Moving Target	+	
Bank Spend against Plan	5.80	7.60		N/A to SPC	Moving Target	+	

Sickness Absence

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

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
5.54%	5.06%		Moving Target



Trajectory

What these graphs are telling us

Metric is experiencing common cause nature. Metric has a moving target; derived from the Trust's Operational Plan.

Narrative

The Sickness Absence rate for November is reported at 5.06%; below the 5.54% plan. As shows on the SPC graph above, this remains normal variation. The metric has been included as an exception this month in order to reference the updated NOF publication.

The latest NOF Publication relates to Quarter 2 where the NOF score for this metric is 2.66; this relates to the 4.97% sickness absence for the quarter ending June-25 as the methodology used represents a quarter of aggregated monthly figures.

Actions

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
5.70%	5.71%	5.77%	5.39%	5.35%	5.16%	4.72%	4.99%	5.15%	4.81%	4.91%	5.68%	5.06%

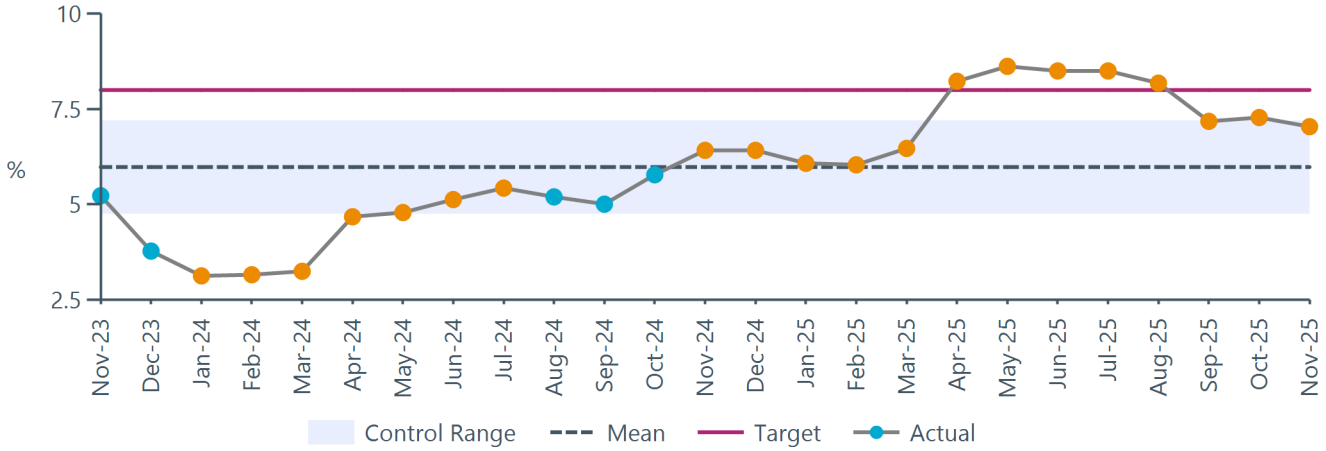
Vacancy Rate

% of Posts Vacant at Month End 211183

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
8.00%	7.04%	H	P

Trajectory



What these graphs are telling us

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

Narrative

The Vacancy Rate reported for the end of November is 7.04%, below the 8% target. The metric is reported as special cause variation of a concerning nature with data points over the last twelve months all above the mean. As shown in the graph above, there was an increase in April attributable to a budget increase in line with financial reconciliation and workforce plan submission.

Actions

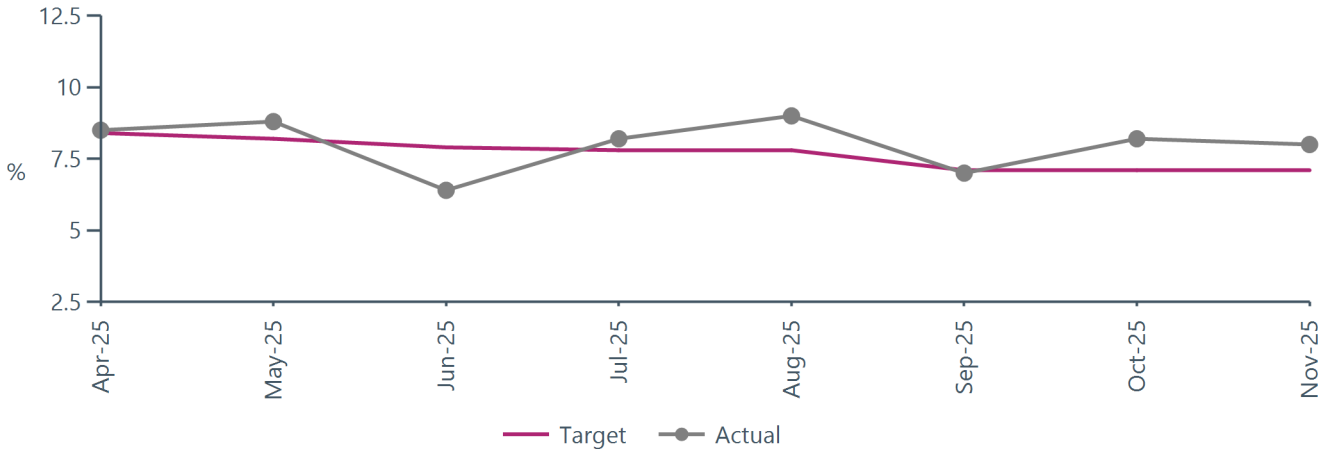
Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
6.42%	6.42%	6.08%	6.04%	6.47%	8.23%	8.62%	8.50%	8.50%	8.18%	7.18%	7.28%	7.04%

Proportion of Temporary Staffing as a % of the Trust Pay Costs

Agency & Bank staff costs as a proportion of total staff costs. 217871

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
7.10%	8.00%	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Proportion of temporary staff 8.0%, which is 0.9% adverse to plan.

Actions

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
					8%	8%	6%	8%	9%	7%	8%	8%

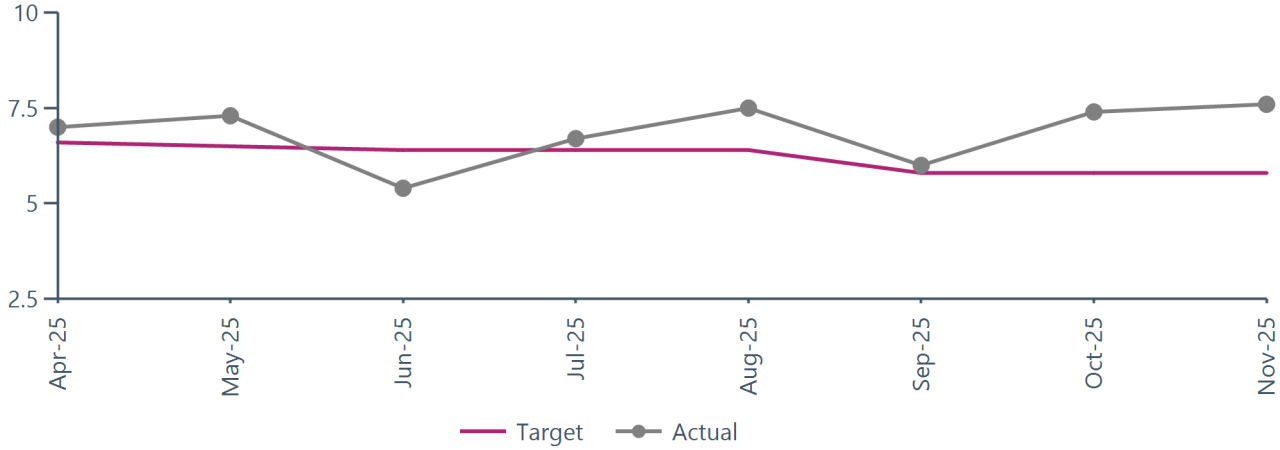
- Staff - Patients - Finances -

Bank Spend against Plan

National planning guidance requires a 15% reduction in agency costs in 25/26 relative to 24/25. The 25/26 agency expenditure plan us set at this level. 217872

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
5.80	7.60	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Bank usage 7.6% of total pay plan in month, 1.8% adverse to plan.

Actions

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
					7	7	5	6	7	6	7	7

- Staff - Patients - Finances -

Chair's Assurance Report
People and Culture Committee

Committee / Group / Meeting, Date	
Board of Directors Meeting, January 2026	
Author:	**Contributors:**
Name: Amber Scott Role/Title: Executive Assistant	
Report sign-off:	
Paul Maubach, Chair of the People and Culture Committee	
Is the report suitable for publication:	
Yes	

1. Key issues and considerations:

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

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

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

This report provides a summary of the items considered at the People and Culture Committee on 20th November 2025 and 18th December 2025. It highlights the key areas the People and Culture Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

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

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

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

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

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

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

3. Assurance Report from People and Culture Committee

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

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

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

There were no issues to escalate to the Board.

3.2 Areas of on-going monitoring with new developments

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

Workforce Reduction Programme – Recurrent Risk
Progress has been made against the workforce reduction target, with just over 20 WTE reduced against a target of 42 WTE. However, the Committee noted that the majority of measures implemented to date are non-recurrent and rely on short-term cost controls (e.g. delayed start dates, restrictions on bank and overtime, and recovery of enhanced payments). There is a material risk that the Trust will enter the next financial year with an underlying recurrent workforce cost pressure. The Committee requests Board oversight to ensure that sustainable recurrent actions are identified and implemented, and that the underlying workforce position for 2025/26 is clearly articulated.

Bank Staffing Overspend
While agency spend is currently favourable and forecast to be within plan, the Committee identified a significant and worsening overspend in bank staffing, forecast at c.£900k year-end. This is largely driven by medical out-of-hours usage and pressures within specific departments, including MCSI. The scale of the overspend presents a financial and operational risk requiring focused executive action and Board visibility.

Agency and Bank Reduction Targets – Risk of Non-Compliance with National Mandates
National mandates require a 30% agency and 15% bank reduction. Although agency spend is below plan, reductions remain at risk, particularly in rheumatology, where milestones underpin delivery of the 2026/27 plan. The methodology for national measurement is not yet fully understood, creating a risk of inaccurate reporting.

Sickness Absence – Short-Term Trends
Overall sickness absence remains within target; however, short-term sickness absence is above target, driven largely by cold, cough and flu. The Committee has requested a forward-looking analysis to identify high-risk departments, assess future trajectory, and triangulate sickness trends with other performance indicators. This will be monitored closely, as persistent short-term sickness could impact service resilience.

Healthcare Support Worker Vacancy Rates
Healthcare support worker vacancy rates remain high at 13.06%. The Committee discussed concerns regarding the persistence and accuracy of the reported figures and the impact of sickness, retention challenges, pay issues, and limited staff mobility across clinical areas. While the proposed Band 2 to Band 3 review may improve retention, vacancy levels remain a workforce risk and will continue to be monitored.

Job Planning Attainment
Level 1 job planning attainment remains below target at 87% against a 90% requirement. The Committee noted the risk of ongoing non-compliance and requested a management deep dive to identify root causes and deliver a clear improvement plan. Progress will be reviewed at the January meeting.

Board Assurance Framework
Current BAF risk framing does not adequately reflect the risk of maintaining safe and appropriate workforce levels for operational delivery. The focus of the workforce objective / risk should be on ensuring a sustainable workforce via an appropriate balance of skills within the workforce to deliver the required level of activity / plans. The focus would need to be on ensuring the workforce was configured to deliver activity efficiently and effectively.

Mandatory Training – Patient Safety and Compliance Risks
Hotspots in BLS, ILS, and safeguarding training present potential patient safety and regulatory risks. The Committee requires a clearer risk-based justification for prioritising training areas; current gaps require Board awareness.

Global Majority Nurse
The committee agreed to implement pay acceleration for overseas nurses from the date the pay grade issue was formally raised, rather than from the start of employment, citing consistency with national guidance and previous organisational practice. The group discussed potential challenges and the need to ensure funding is linked to the Finance and Performance Committee. The Committee approved the approach to pay acceleration of overseas nurses.

3.3 Areas of assurance

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

Sexual Safety Action Plan (Current Position)
The Committee took assurance from the update on staff engagement, self-assessment activity, incident reporting arrangements, and governance oversight through existing casework and Freedom to Speak Up processes.

Workforce Performance Report
The Committee took assurance from the other elements of the report.

Agency Staffing Position
The Committee noted a favourable agency variance and confirmation that actions are in place, including consultant appointments and agency rate negotiations, to sustain this position.

Management of Change Policy
The Committee approved the amended Management of Change Policy, including the addition of reference to voluntary resignation schemes, with no further issues identified.

Case Management and Just Culture
A small increase in disciplinary cases and continued complexity in investigations were noted. Work continues to embed just culture principles, strengthen learning from cases, and triangulate case trends with other organisational metrics.

Freedom to Speak Up – Reporting Trends and System Development
Case volumes have increased, while anonymous reporting has reduced—potentially indicating greater confidence. New reporting tools and refined categorisation (e.g., harassment, discrimination) are being introduced in line with National Guardian Office standards.

Well Led Review Action Plan
The committee reviewed the draft well led action plan in its entirety and emphasised the importance of mapping new actions to existing processes such as the staff survey and case management, to maximise value and avoid duplication. The committee endorsed the action plan.

EDS Domain 3 Annual Report
The report on inclusive leadership, summarised staff engagement efforts, and discussed action plans for improvement, with the committee seeking clarification on ratings and recommendations for board action. The Trust reported on the inclusive leadership domain, noting limited staff engagement at events but improved participation through alternative methods. The committee reviewed the scoring outcomes and associated action plans.

Chair Assurance Reports were received from the following meetings:

- **Education and Training Oversight Group** - The Committee took assurance from the report with no alerts being received.
- **Trust Performance and Operational Improvement Group** - The Committee took assurance from the report with no alerts being received.
- **Local Negotiating Meeting** - The Committee took assurance from the report with no alerts being received.
- **Non Medical Safe Staffing Group** – The following table is shared to ensure timely reporting to the Board.

Ward	Safe Staffing for October 2025	Day				Night				Day		Night			Care Hours Per Patient		
		Registered		Care Staff		Registered		Care Staff		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	At midnight (monthly total)	CHPPD Registered Midwives / Nurses	CHPPD Care Staff	
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
										≥80%	≥80%	≥80%	≥80%				
Alice	110 - TRAUMA & ORTHOPAEDICS	1041.00	976.75	0.00	0.00	696.00	695.75	0.00	0.00	93.8%	-	100.0%	-	134	12.5	0.0	
Clwyd	110 - TRAUMA & ORTHOPAEDICS	1156.00	1126.75	919.50	846.00	744.00	768.00	564.00	585.50	97.5%	92.0%	103.2%	103.8%	443	4.3	3.2	
MCSI Inpatients	400 - NEUROLOGY	2996.00	3226.00	4807.25	4094.83	2249.50	2295.00	1737.00	1888.50	107.7%	85.2%	102.0%	108.7%	1,345	4.1	4.4	
Kenyon	110 - TRAUMA & ORTHOPAEDICS	858.00	830.25	693.50	641.50	672.00	674.50	342.50	372.00	96.8%	92.5%	100.4%	108.6%	358	4.2	2.8	
Oswald	110 - TRAUMA & ORTHOPAEDICS	746.00	745.00	557.00	425.00	744.00	744.00	0.00	0.00	99.9%	76.3%	100.0%	-	183	8.1	2.3	
Ludlow	110 - TRAUMA & ORTHOPAEDICS	1021.50	981.08	664.50	520.33	720.00	751.50	348.00	344.00	96.0%	78.3%	104.4%	98.9%	297	5.8	2.9	
Powys	110 - TRAUMA & ORTHOPAEDICS	1116.50	1125.75	851.00	919.50	756.00	756.00	688.00	784.00	100.8%	108.0%	100.0%	114.0%	368	5.1	4.6	
Sheldon	300 - GENERAL MEDICINE	1283.00	1253.25	1438.50	1442.50	756.00	756.00	1104.00	1164.00	97.7%	100.3%	100.0%	105.4%	515	3.9	5.1	
HDU	110 - TRAUMA & ORTHOPAEDICS	1065.50	983.25	204.00	101.50	1008.00	864.00	0.00	0.00	92.3%	49.8%	85.7%	-	88	21.0	1.2	
Totals		11283.50	11248.08	10135.25	8991.16	8345.50	8304.75	4783.50	5138.00	99.7%	88.7%	99.5%	107.4%	3731	5.2	3.8	
MSK Unit		5217.50	5047.08	3332.50	3028.83	3900.00	3814.00	1942.50	2085.50	96.7%	90.9%	97.8%	107.4%	1554	5.7	3.3	
Specialist Unit		6066.00	6201.004	6802.75	5962.33	4446	4490.75	2841	3052.5	102.2%	87.6%	101.0%	107.4%	2177	4.9	4.1	
	Trust Total		97.5%														

Recommendation

The Board is asked to:

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Freedom to Speak Up Report
Q2, 2025/6: July to September 2025

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 07 January 2026

Author: **Contributors:**

Name: Elizabeth Hammond
Role/Title: Freedom to Speak Up Guardian

Report sign-off:

Name: Dylan Murphy, Trust Secretary

Meeting: People and Culture Committee, November 2025

Is the report suitable for publication?

YES

Key issues and considerations:

This paper is provided as a summary on Freedom to speak Up (FTSU) activity for Q2, 2025/6: July to September 2025.

This report is informed by triangulation of appropriate patient safety and quality and worker safety and wellbeing experience data and themes emerging from speaking up channels to:

1. Identify wider concerns and emerging issues; and
2. Identify and share learning across the Trust.

Key Points:

- This quarter FTSU has received a total of eighteen cases:
  - Of the eighteen cases received, twelve have been closed and six require further follow-up.
  - Of the six cases which remain open, the Guardian is awaiting feedback from managers dealing with the concerns. Four cases are around the same issue where an investigation has been requested.
  - Of the twelve cases closed, an average of eight day was required to close them.

- Of the eighteen cases raised:
  - Two were anonymous.
  - Two related to Patient Safety/Quality.
  - Two related to Worker Safety/Wellbeing.
  - Eleven related to Attitudes and Behaviours.
  - Ten Other concerns were raised.
  - Four were raised to a Champion and then escalated to the Guardian, fourteen were raised directly with the Guardian (three of which followed an initial conversation with the Trust Secretary).
  - Three were treated as advice and fifteen were treated as concerns and escalated to an appropriate Manager.
  - There were no concerns raised around Apollo.

- Cases can have several elements. For example, one case may have elements that relate to patient safety/quality and elements that relate to attitudes and behaviour. The NGO also includes ‘anonymous’ as a reporting category. “Anonymous” is not presented as a category of complaints in its own right in this report.

- All cases raised have been responded to within 48hrs and escalated to the appropriate department when required.

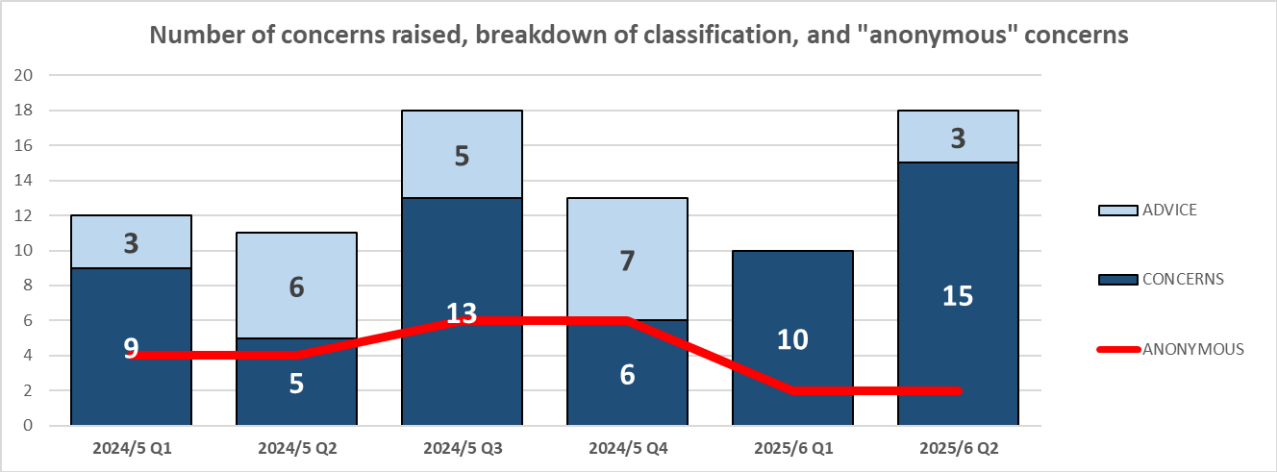
Freedom to Speak Up Report
Q2, 2025/6: July to September 2025

1. Overall number of concerns

Graph 1 shows the total of cases raised, and how many:

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

Graph 1



Commentary

- Overall numbers have fluctuated between 10 and 18 per quarter over the last six quarters. The number of contacts this quarter is at the top end of this range.
- This quarter, two situations / incidents have led to multiple individuals coming forward with concerns. That partly explains the relatively high overall figures.
- It is positive that people have used the Champions to raise concerns, as well as the Guardian.
- A high proportion of contacts were treated as concerns.
- The line in the chart above shows the number of concerns that were raised anonymously. When considered as a percentage, the figures over the last six quarters are:

2024/5, Q1	2024/5, Q2	2024/5, Q3	2024/5, Q4	2025/6, Q1	2025/6, Q2
33.33%	36.36%	33.33%	46.15%	20%	11.11%

There are multiple options for staff to raise concerns anonymously but the last couple of quarters have seen a decrease in the proportion of people choosing to do so. That is regarded as a positive sign. It suggests that people are comfortable raising concerns openly; it enables more detailed investigation of issues raised; and it enables individual feedback to the person raising the concern.

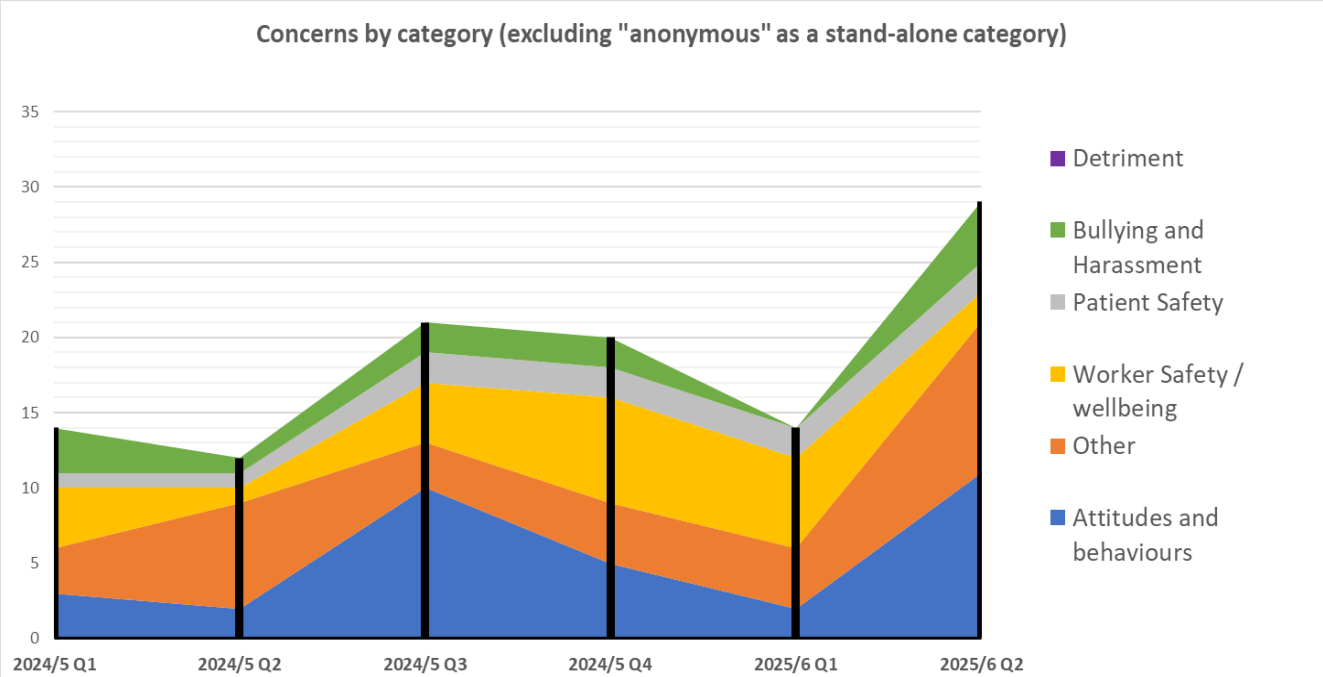
2. Concerns raised broken down by type of concern

Graph 2a shows the concerns raised broken down by the reporting categories required by the NGO (excluding "anonymous" as a category in its own right). These categories are as agreed with the person who raised the concerns, or as recoded directly by the person who raised the concern (dependent on the route the individual took in raising their concerns). This presents the types of concern received over six quarters - up to, and including Q2, 2025/6.

Please note that a concern may cover a number of elements. e.g. A single contact may be reported as a case involving "attitudes and behaviours", "worker safety / wellbeing", and "bullying and harassment". As a result, the number of "concerns by category" (which focuses on the content of concerns) is greater than the number of "concerns raised" (which focuses on the number of individuals who've engaged the FTSU process).

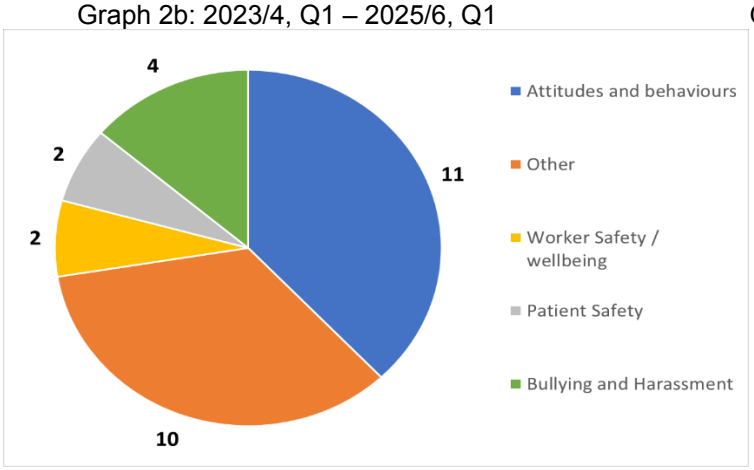
Freedom to Speak Up Report
Q2, 2025/6: July to September 2025

Graph 2a

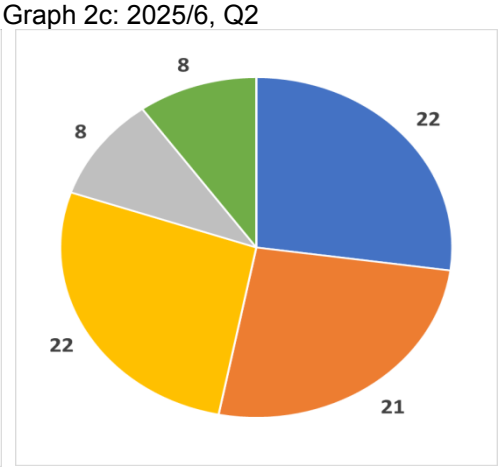


The breakdown of concerns raised by "type" is presented in an alternative format below. The first chart (Graph 2a) shows the breakdown for Q2, 2025/6. The second (Graph 2c), shows the breakdown for the previous five quarters (Q1, 2024/5 to Q1, 2025/6) – this is provided to show how the profile this month reflects the longer-term profile:

Graph 2b: 2023/4, Q1 – 2025/6, Q1



Graph 2c: 2025/6, Q2



The figures that support graphs 2a-c are outlined below:

	2024/5 Q1	2024/5 Q2	2024/5 Q3	2024/5 Q4	2025/6 Q1	2025/6 Q2
Attitudes and behaviours	3	2	10	5	2	**11**
Other	3	7	3	4	4	**10**
Worker Safety / wellbeing	4	1	4	7	6	**2**
Patient Safety	1	1	2	2	2	**2**
Bullying and Harassment	3	1	2	2	0	**4**
Detriment	0	0	0	0	0	**0**

Commentary

When looked at in comparison with the longer-term position, this quarter saw:

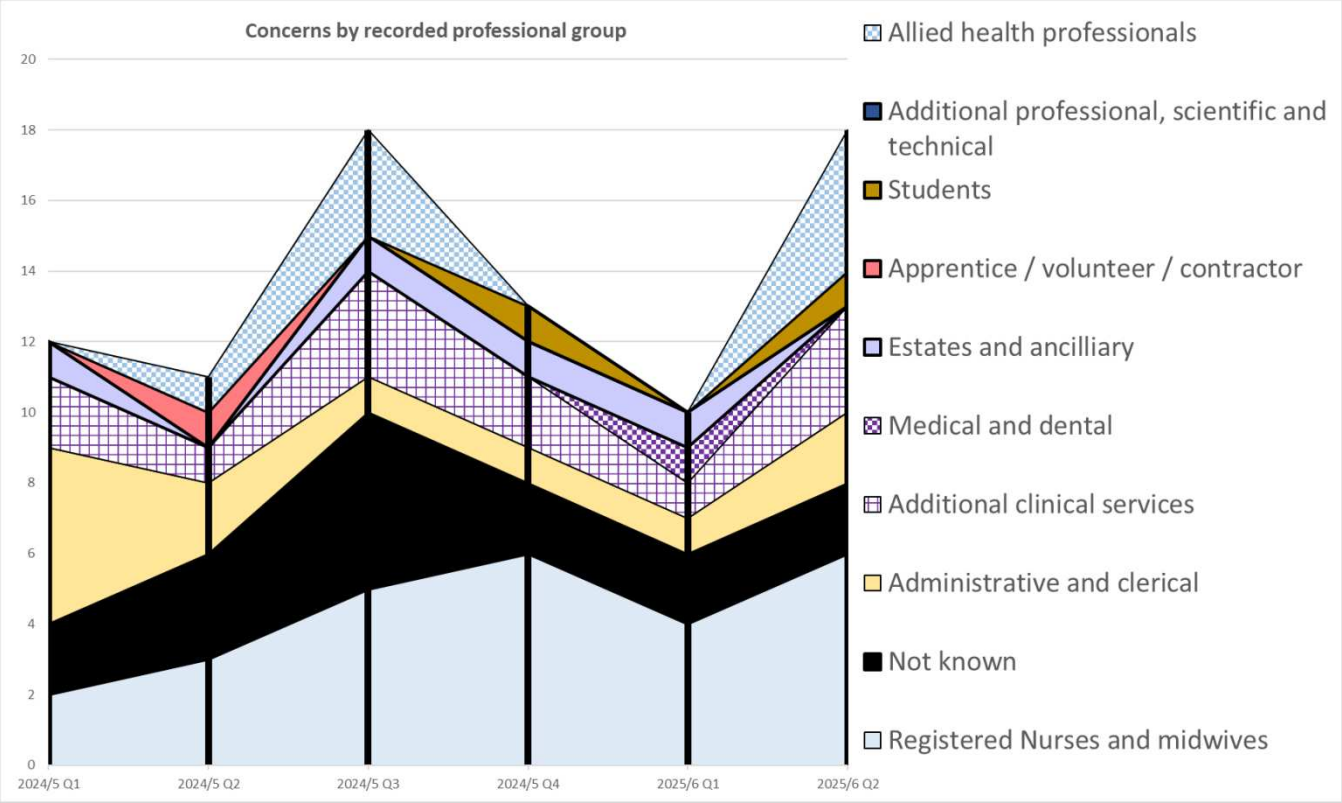
- A relatively high number of cases involving "Attitudes and Behaviours". Over the previous couple of quarters, there had been a marked decline in the number of concerns relating to "attitudes and behaviours", following a spike in Q3, 2025/6. This rose significantly in Q2 of 2025/6.
  As noted at section 1, several cases relate to a common issue. One issue accounted for four concerns and all staff involved cited both "attitudes and behaviours" and "bullying and harassment" as elements of their concerns.
- A relatively high number of cases involving "Bullying and Harassment". That links to the cases referred to above, where multiple concerns related to the same issue. There were no cases this quarter that had any reported element of sexual harassment. That is not a distinct reportable category of concern (to the NGO) but the Trust will start to record cases that have elements of either sexual harassment, a racial element, or some other discriminatory element.
- Relatively few cases involving "Worker safety / wellbeing". This had accounted for the greatest number of concerns in the previous couple of quarters. This was due to the added element of "wellbeing" which meant that cases where staff reported stress, feeling overwhelmed, and other mental health issue are recorded under this category.
- A relatively large number of concerns are not covered by the NGO classification and are therefore reported as "Other". The "Other" concerns this quarter were linked to:
  - course training;
  - contract of employment;
  - lack of equipment; and
  - managers perceived to have not followed policies
- No cases this quarter were related to Apollo. That would suggest that staff are using the other engagement mechanism to raise concerns / issues, rather than FTSU arrangements.

3. Concerns raised by the profession of the person raising them

The graphs in this section present the profession of the individuals who have raised a concern, and compares the figures with previous quarters.

Graph 3a

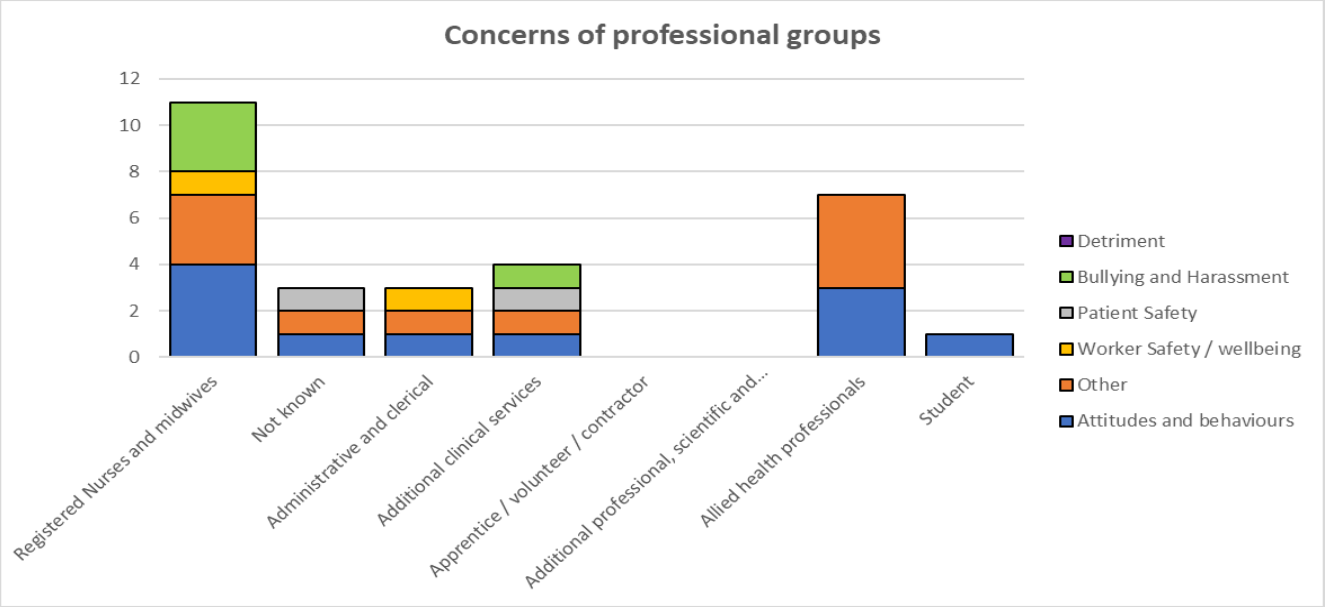
This graph shows the profession of people who have raised concerns over six quarters:



The figures that support graphs 3a and 3b are outlined below:

	2024/5 Q1	2024/5 Q2	2024/5 Q3	2024/5 Q4	2025/6 Q1	2025/6 Q2
Registered Nurses and midwives	2	3	5	6	4	**6**
Not known	2	3	5	2	2	**2**
Administrative and clerical	5	2	1	1	1	**2**
Additional clinical services	2	1	3	2	1	**3**
Medical and dental	0	0	0	0	1	**0**
Estates	1	0	1	1	1	**0**
Apprentice / volunteer / contractor	0	1	0	0	0	**0**
Students	0	0	0	1	0	**1**
Additional professional, scientific and technical	0	0	0	0	0	**0**
Healthcare scientists	0	0	0	0	0	**0**
Allied Health Professionals	0	1	3	0	0	**4**

The types of concern raised by each professional group are shown below, in Graph 3c:



4. Triangulation

Similar Trusts

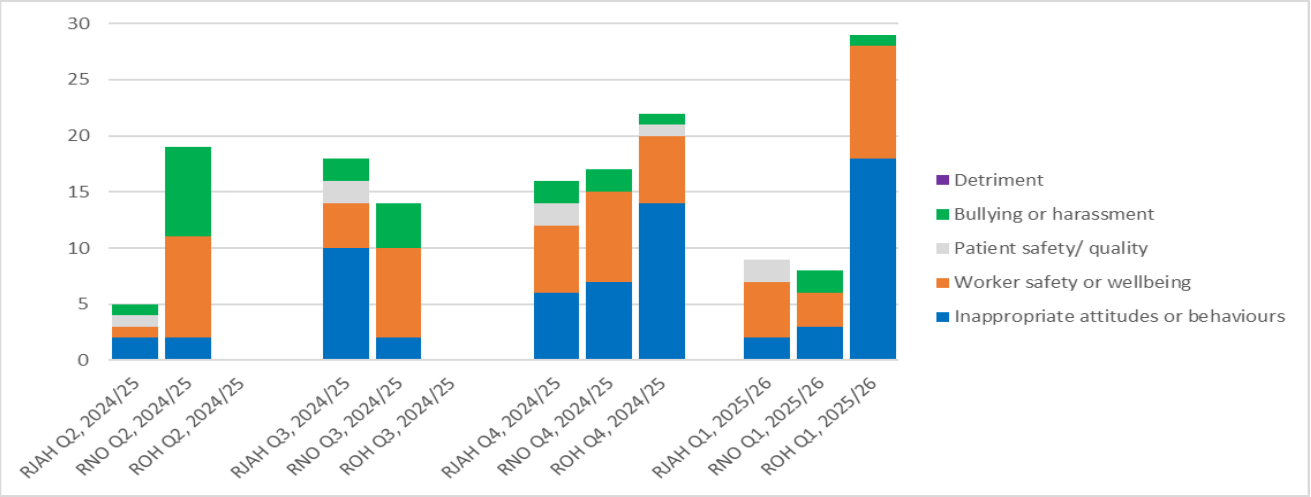
Comparison data for the last four quarters, as reported by the National Guardian's Office, is included below for the three specialist orthopaedic trusts:

- RJAH;
- Royal National Orthopaedic (RNO) Hospital London; and
- The Royal Orthopaedic Hospital (ROH), Birmingham;

The most frequently reported concerns for each of the three Trusts relate to "attitudes and behaviour" and "worker safety and wellbeing". Those two things are often linked, as people who are experiencing inappropriate attitudes and behaviours will report that their wellbeing has suffered as a result.

Freedom to Speak Up Report
Q2, 2025/6: July to September 2025

Graph 4a: The categories of concern reported by the NGO are:



(There are apparent gaps in reporting for ROH in Q2 and Q3 of 2024/25).

The number of cases brought to Freedom to Speak Up Guardians reported by the NGO are:

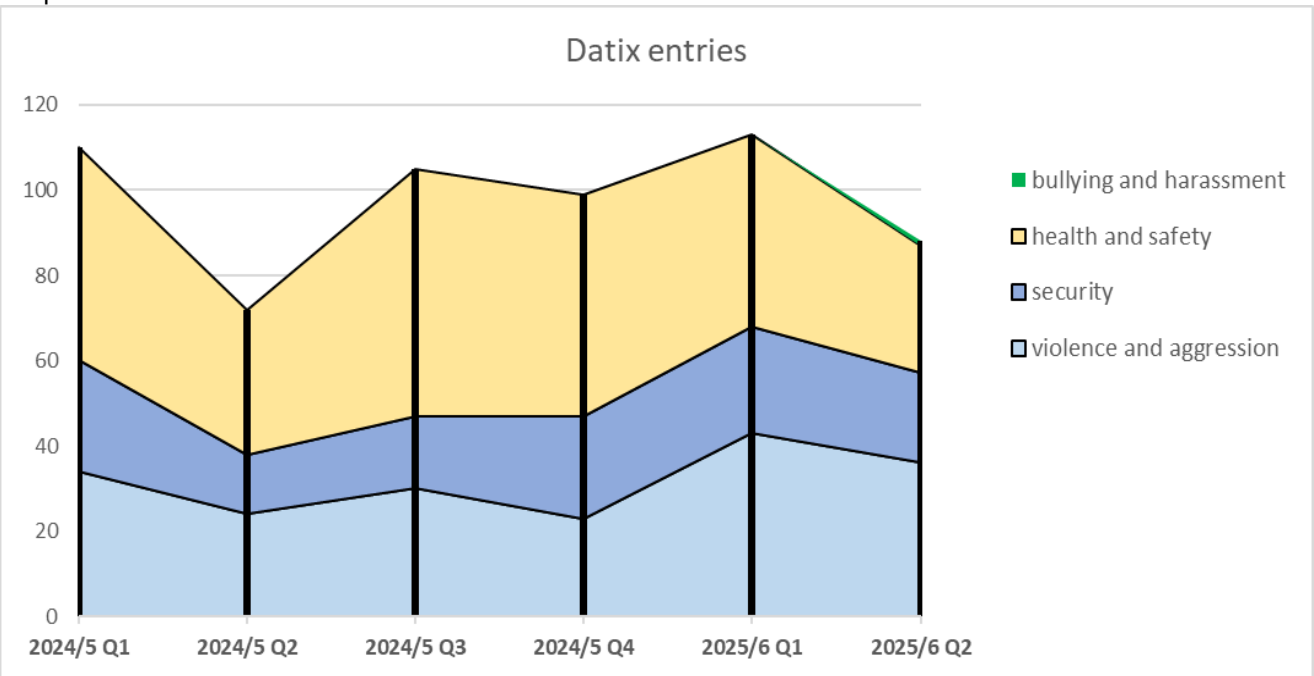
	Q2, 2024/5	Q3, 2024/5	Q4, 2024/5	Q1, 2025/6
RJAH	11	18	13	10
ROH*	-	25	17	26
RNO*	12	12	8	7

*No cases are recorded under the "Anonymous" category for ROH or RNO during this period.

Datix entries

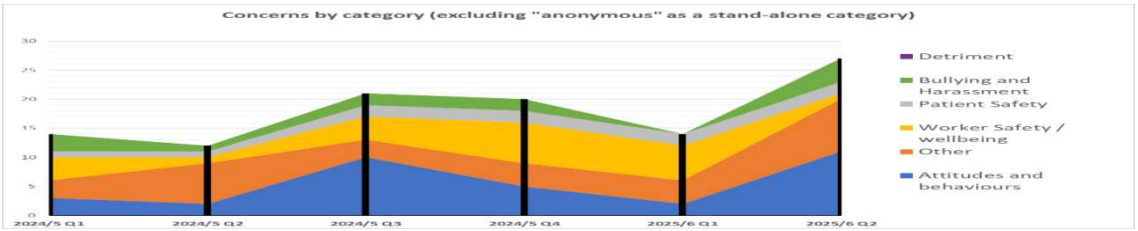
It is not possible to make straightforward, direct comparisons when considering FTSU concerns and Datix entries. When it comes to Violence and Aggression reporting on Datix, for example, these will generally relate to patients' behaviors towards staff. There is no direct equivalent within the FTSU reporting categories and the focus of FTSU concerns generally relates to staff-to-staff behaviors (though they may highlight areas for improvements for patient care). The relationship between the two sets of data is not straightforward, but consideration of both, particularly over time, may help identify any underlying issues.

Graph 4b:



The content of Graph 2a is included again below to provide a broad comparator of the number of concerns

raised (by type) over a six month period, compared to the number of Datix entries for the same period. The scale is an attempt to show the relative number of FTSU concerns (where the y axis is up to 30 in the chart below) and Datix entries (where the y axis is up to 120 in the chart above).



5. Outcomes / Learning

As a result of the concerns raised this quarter:

- The issue / incident that resulted in multiple concerns around “Attitudes and Behaviours” / “Bullying and Harassment” was escalated and resulted in an investigation.
- The other issue that resulted in multiple concerns was escalated to senior management and was addressed to the satisfaction of the people who raised their concerns.
- There has been particular learning for individuals around policy requirements, and one case where a process has been developed to support managers to deliver policy requirements.
- No concerns were raised via FTSU, this quarter, around Apollo.
- Some anonymised information has been shared with department leads so that lessons learned can be shared within the departments and measures can be put in place to avoid repeating the same practice which resulted in the concern been raised.

To improve the level of feedback received from case handlers in FTSU cases, a simple feedback form has been developed. This is included at the Attachment.

6. Feedback

After dealing with a concern, the FTSU Guardian sends a link to a Microsoft feedback form. The forms are anonymous and are sent out in batches, when the concerns are closed, and at the end of each quarter. Out of the nine feedback forms sent out, three forms were completed.

The responses to the multiple-choice questions were:

	YES / Extremely satisfied	NO / Not satisfied	MAYBE / Satisfied	NO RESPONSE
Given your experience, would you use FTSU again?	3	0	0	6
How well do you feel your concern was handled, overall?	2	0	1	6
Did you suffer any detriment?	0	3	0	6

The response to the open-ended question was:

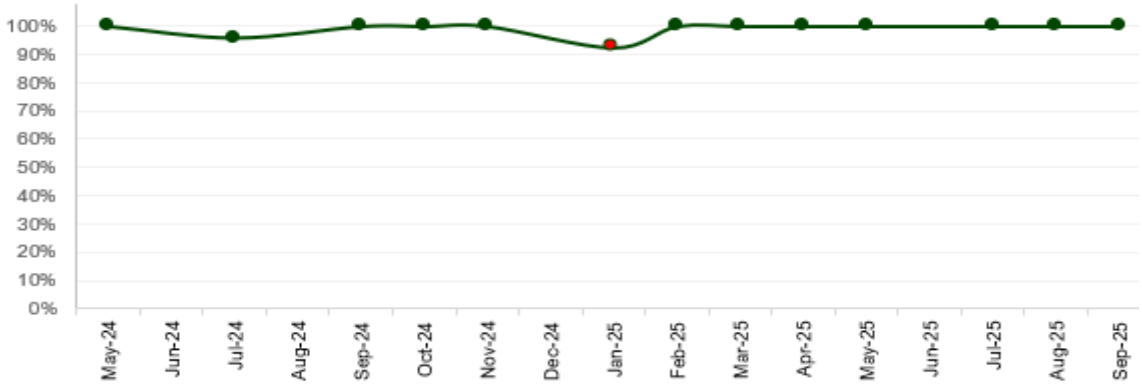
Is there any other feedback you would like to share to help improve the FTSU service?	1. *I think it is a valuable service.* 2. *The FTSU were easy to get in touch with and after leaving a request to speak to them on an answer machine I was seen 1:1 to discuss my concerns* 3. *I only wish that Liz was my union rep as she was super supportive and had a good understanding of employment matters.*

Freedom to Speak Up Report
Q2, 2025/6: July to September 2025

As part of the Quality Accreditation Assessments, ward staff are asked a series of questions that relate to FTSU:

Statement of Compliance		
Freedom to Speak up	1	Do staff know who the Freedom to Speak up guardians are. (Ask 3 staff)
	2	Do staff know how to raise a concern (Ask 3 staff)
	3	Do staff feel confident to raise a concern (Ask 3 staff)
	4	Do staff feel that they will be treated fairly, without predjudice or discrimination following raising a concern (Ask 3 Staff)
	5	Freedom to Speak up posters are displayed on the ward.

The FTSUG is working with the nursing team to access these scores and understand how the results for individual questions are used to calculate the overall compliance score. The Trust-wide, overall scores for those questions were:



The overall scores for individual areas are shown in the table below. In June 2024, Kenyon, Gladstone and Oswald had a score of 85%. By March 2025, all three had improved their score to 100%. In January 2025, Recovery scored 85% (and has not yet been rescored).

Ward	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Alice		100%						100%						100%				
Kenyon			85%							100%								
Wrekin			85%									100%						
Gladstone				92%			100%				100%							
Powys				100%				100%								100%		
Clwyd								100%					100%					
HDU											100%							
Ludlow						100%						100%						
Oswald			85%														100%	
Sheldon						100%												100%
Theatres																		
Recovery										85%								
Baschurch								100%								100%		

These scores will enable the FTSUG to pinpoint areas where the message about FTSU and how to raise a concern is not clear, or where staff may have concerns around speaking up.

- Local leaders on Kenyon, Gladstone and Oswald wards have taken action in response to earlier assessments to improve their scores. Recovery has also had the opportunity to do so but has not yet been rescored.
- During this time period, the FTSU walkabout has taken place; new starters will have attended the induction and /or preceptorship course, which included a FTSU overview, a talk on “courageous conversation”; and a toolkit/ strategy on dealing with difficult conversations has been introduced.
- Though there are no results for Theatres, we have a degree of confidence in the visibility of the service as they have a designated FTSU Champion who is actively promoting FTSU and has already referred several staff members to the FTSU Guardian. The FTSUG has also run several pop-up

sessions where anyone could speak up or make appointments for a confidential meeting.

7. Additional activity during Q2, 2025/6

FTSU Guardian

During Q2, 2025/6 the FTSU Guardian undertook the following activity:

- Attendance at the Regional NGO meetings and FTSU bi-monthly meetings.
- Training completed of two FTSU Champions with protected characteristics.
- Introduction of a learning and improvement tool. This tool is sent to the manager with the initial e-mail escalating a concern. The form has four boxes for the manager to complete and return once the concern has been action and learning has been identified. See appendix 1 for the form. These forms allow the anonymised learning to be shared, where applicable, across the Trust. It also allows the manager to implement their own improvements and promote the education of staff.
- Completion of the mandatory annual NGO annual training.
- FTSU is part of the Violence and Prevention & Reduction Standards Group. When staff raise a concern some of the concerns can come under this standard. FTSU will now be sharing the data of how many concerns are raise around bullying and harassment, attitudes and behaviours and detriment with sub-sections, attached about protected characteristics or racial issues.

Wider "speaking up" developments

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

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

That goes beyond the FTSU function, but FTSU is an important element. That work supports the findings of the **Review of patient safety across the health and care landscape, July 2025 (the "Dash Review")** which notes that:

"There is a need to strengthen the importance of listening to and acting on staff voice, as identified in the recent publication of the National State of Patient Safety 2024, which highlighted the recent NHS Staff Survey results and the need for greater confidence in the system.

Staff should be supported and encouraged to share concerns about quality and safety as part of a data, evidence and learning-led culture that fosters improvement. The currently variable priority and quality of systems when it comes to supporting the freedom to speak up needs to be addressed by organisations through the work of Freedom to Speak Up Guardians."

8. Next steps

During Q3, FTSU will:-

- Provide and promote opportunities to "speak up"; October is FTSU Month. A walk about with Champions has been arranged.
- Capture the information gathered from various existing sources – including the FTSU function, people services, and the clinical governance teams, Violence and Prevention & Reduction Standards Group and also mechanisms such as the Exec "Buddy" visits, Patient Safety Visits, Board visits, etc;
- Identify and learn the lessons from that information and act accordingly.
- Provide feeding back to people who "speak up"; and
- Feed key message and learning back into the wider organisation.

Well-led review

The independent developmental well-led review report noted the following:

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

Freedom to Speak Up Report
Q2, 2025/6: July to September 2025

An action plan in response to the report is in development. There are no recommendations that relate directly to the FTSU function but there are likely to be underpinning actions that support the broader recommendations which the FTSU function can support. Any such actions will be taken forward via the well-led review action plan and will support the actions already underway via the staff survey working group.

Wider "speaking up" developments

In early 2026, the Trust will be implementing a new system to replace the DATIX complaint / incident / risk reporting system, along with a number of other systems currently in use. That provides an opportunity to improve recording through the implementation of consistent categories / tags across a number of channels that staff can use to "raise concerns". That would support more comprehensive analysis and reporting on the topics that staff are reporting via the various channels available to them. Those opportunities are being explored through a working group which is helping configure the new system.

Recommendation:

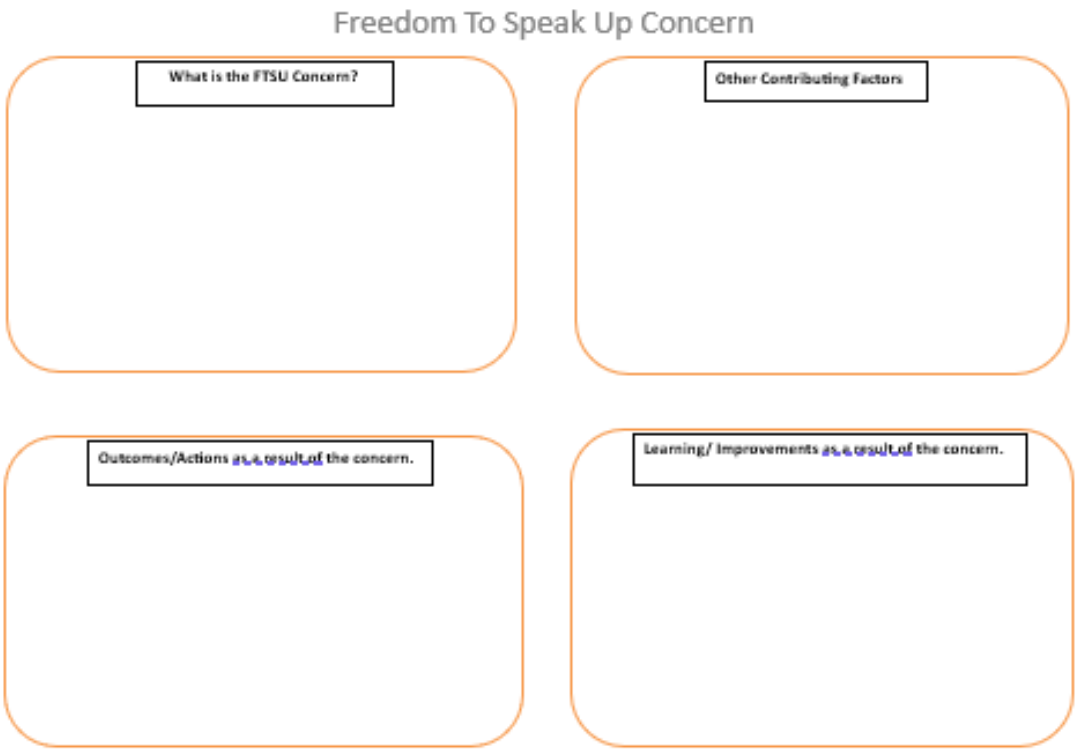
That the Committee:

1. NOTE that appropriate FTSU arrangements are in place and that concerns are:
   - Addressed and concluded in a timely manner, with lessons learned and communicated.
   - Categorized and reported to the NGO as required.
   - Triangulated with other sources of data and reviewed over time to identify potential areas of concern that require attention.
2. NOTE the ongoing and planned actions to further develop the arrangements.
3. CONSIDER the level of assurance received from the report and the planned developments.

Acronyms	
FTSU	Freedom to Speak Up
NGO	National Guardians Office
Attachments	
Attachment 1	Learning and Improvement Tool

Freedom to Speak Up Report
Q2, 2025/6: July to September 2025

Attachment 1



Executive Summary - Finance & Performance Committee

Assurance

Variation	Will consistently pass the target if nothing changes	Will not consistently pass or fail the target if nothing changes	Will consistently fail the target if nothing changes	No Target or Moving Target
Improving variation (high or low) or 3 months better than target	18 Week Performance - Actual v Plan			18 Weeks RTT Open Pathways Time to First Appointment - English Patients 6 Week Wait for Diagnostics - English Total Outpatient Activity - % Moved to PIFU Pathway
No significant change or N/A to SPC		% Combined BADS Performance Variance YTD to Financial Plan	Implied Productivity	Time to First Appointment - Welsh Patients Total Outpatient Activity Against Plan Expenditure Capital Expenditure
Concerning variation (high or low) or 3 months off target		No of Spinal Injury Patients Fit for Admission Report Turnaround Times - % in 28 Days	8 Week Wait for Diagnostics - Welsh Bed Occupancy - All Wards - 2pm	Theatre Cancellations On The Day of Surgery English List Size Welsh List Size % Patients Waiting Over 52 Weeks - English Patients Waiting Over 104 Weeks - Welsh Theatre Cases per Session Touchtime Utilisation Total Theatre Activity Against Plan Elective Activity Against Plan Total Diagnostic Activity Against Plan

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

Trust Board - Performance
November 2025 – Month 8

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

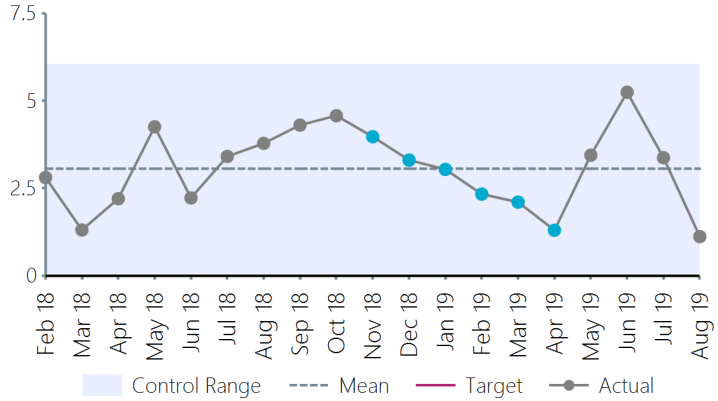
Some examples of these are shown in the images to the right:

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

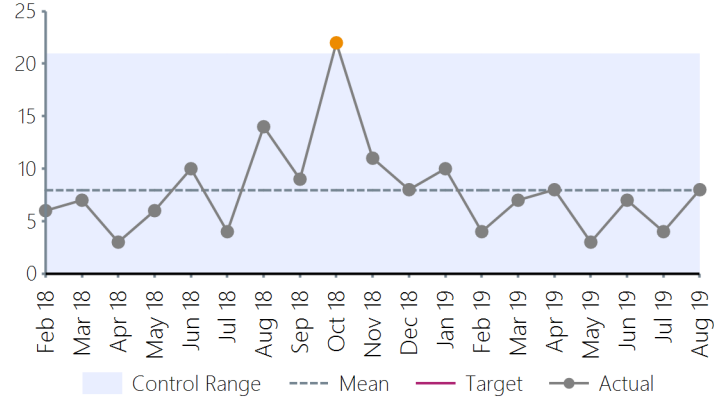
b) shows a point of concern sitting above the control range.

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

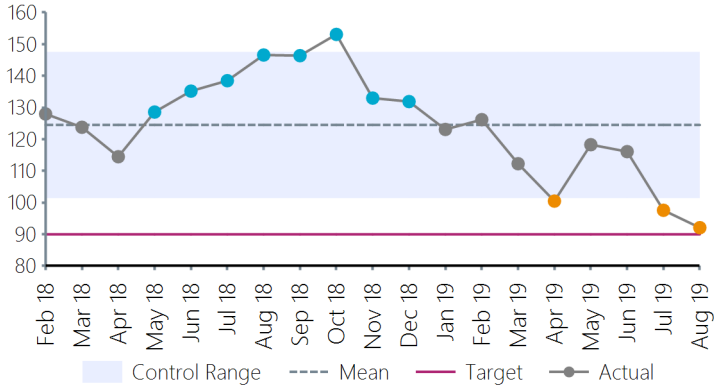
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
31 Day General Treatment Standard*	96.00%	100.00%		H	?		
62 Day General Standard*	85.00%	77.78%	100.00%		?	+	12/09/23
28 Day Faster Diagnosis Standard*	77.00%	69.35%	87.18%		Moving Target	+	12/09/23
18 Weeks RTT Open Pathways	51.08%	57.29%		H	Moving Target	+	24/06/21
18 Week Performance - Difference Between Planned and Actual	0.00%	6.21%		N/A to SPC	P	+	
Time to First Appointment - English Patients	62.80%	74.46%		N/A to SPC	Moving Target	+	
Time to First Appointment - Welsh Patients		43.63%		N/A to SPC	No Target	+	
% of Patients Waiting Over 52 Weeks - English	3.27%	4.51%		L	Moving Target	+	
Patients Waiting Over 104 Weeks - Welsh (Total)		416		H	No Target	+	
6 Week Wait for Diagnostics - English Patients	95.00%	95.93%	85.64%	H	Moving Target	+	04/03/24

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
8 Week Wait for Diagnostics - Welsh Patients	100.00%	98.22%				+	04/03/24

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Elective Activity Against Plan (volumes)	1,188	1,121			Moving Target	+	24/06/21
% Combined BADS Performance	85.00%	32.65%			F	+	
Total Outpatient Activity against Plan (volumes)	13,909	13,712			Moving Target	+	24/06/21
Total Outpatient Activity - % Moved to PIFU Pathway	6.60%	8.28%		H	Moving Target	+	
Total Diagnostics Activity against Plan - Catchment Based	2,904	2,830			Moving Target	+	

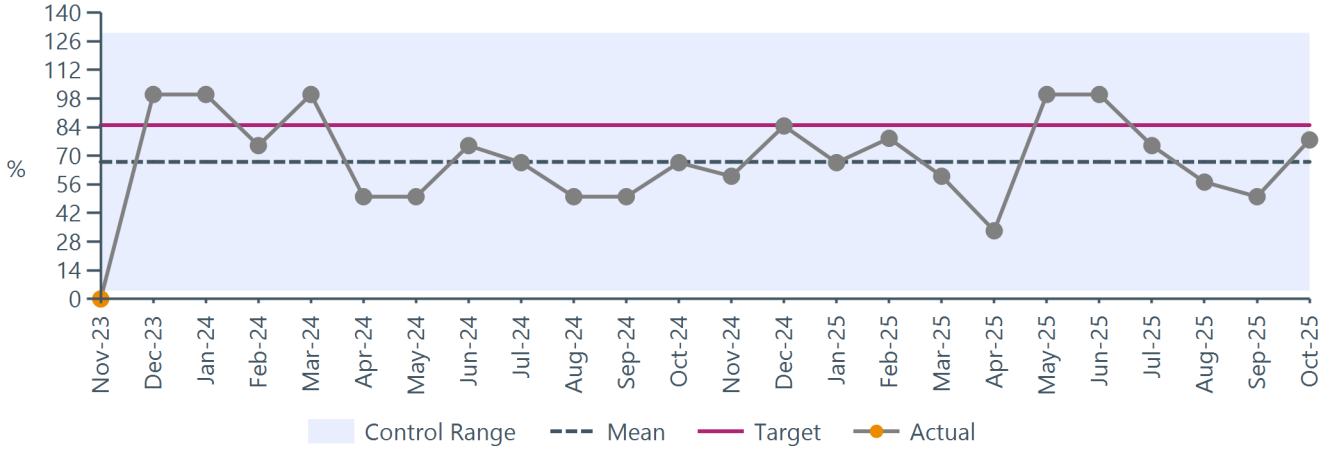
62 Day General Standard*

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

Exec Lead: Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	77.78%		

Trajectory



What these graphs are telling us

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

Narrative

The 62 Day General Standard is reported at 77.78% in October; this is reported in arrears. Of the patients reported against this standard, RJAH was accountable for the following breach:
* 1x full breach - 62 Day Consultant Upgrade - number of delays in pathway due to patient unable to tolerate original MRI due to pain so another required scheduling. MDT discussion required biopsy slides that were performed outside UK. Patient was admitted for pain management and then sustained a fracture.

Actions

As outlined in the narrative to the left, there were a number of factors that contributed to this complex pathway.

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
60.00%	84.62%	66.67%	78.57%	60.00%	33.33%	100.00%	100.00%	75.00%	57.14%	50.00%	77.78%	

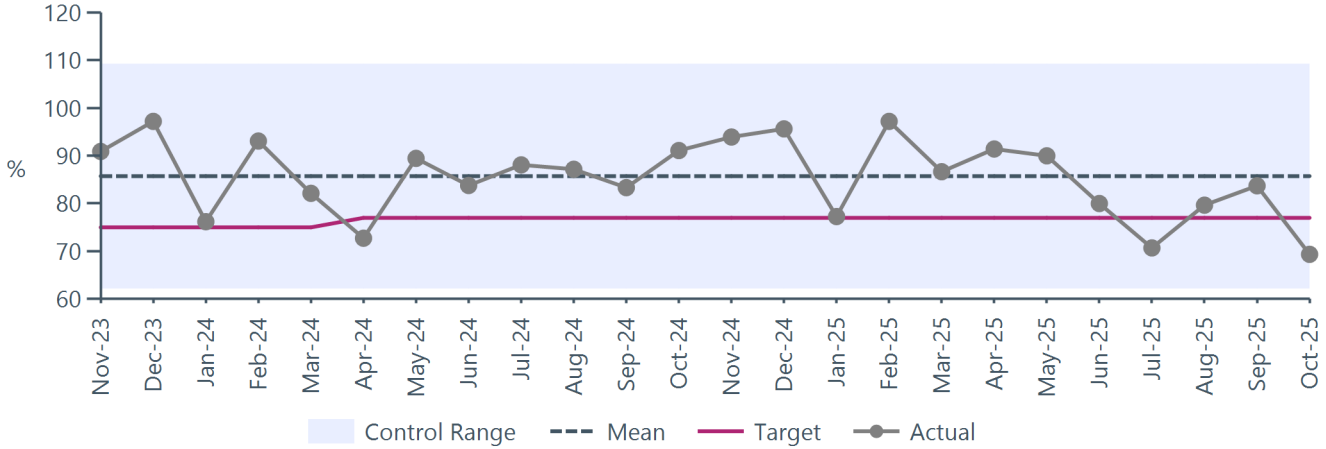
28 Day Faster Diagnosis Standard*

% of patients informed of a diagnosis or ruling out of cancer within 28 days. National Target. Trajectory as per Trust's Operational Plans. 217484

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
77.00%	69.35%		Moving Target

Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. Metric has a moving target; derived from the Trust's Operational Plan.

Narrative

The 28 Day Faster Diagnosis Standard is reported at 69.35% in October; this is reported in arrears. Nineteen patients breached this standard with reasons associated with:
* MRI capacity delays (6)
* Pathways requiring multiple diagnostics/awaiting results (6)
* Patients who wished to delay their MRI appointments (3)
* Late referrals in from referring Trusts (2)
* Paediatrics tumour capacity issue, this was at time of referral, 15 day wait for Outpatient Appointment (1)
* Spinal tumour capacity issue, this was result of how the clinics fell at time of referral (1) – Service Manager working with spines to go over clinic capacity for the spinal tumour service
* Access delay with processing referral, issue with Apollo and this has been reported via governance, datix etc and patient is now off pathway (1)

Actions

Actions in relation to the breaches reported this month include:
* 6x Pathways requiring multiple diagnostics/awaiting results – unable to do anything regarding these as this is work up for diagnosis
* 1x Paediatric tumour capacity issue – discussed with service manager to review template for clinic
* 1x Spinal tumour capacity issue - Tumour Service Manager is working with spines to go over clinic capacity for the spinal tumour service – regular meetings with spines service manager and ASM to look into the spinal tumour capacity and process for dating patients
* 2x late referrals in from referring Trusts – informed relevant trusts to redirect referrals instead of triaging first
* 3x patients delaying their MRI appointments – patient choice unable to mitigate
* 1x access delay with processing referral – this was discussed at spinal directorate and tumour governance to ensure a process is in place for patients referred in with neurogenic tumours
* 6x MRI capacity delays – process now in place to try and uncouple more, to date patients for MRI first and then OPA in tumour

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
93.94%	95.65%	77.27%	97.22%	86.67%	91.43%	90.00%	80.00%	70.69%	79.66%	83.72%	69.35%	

18 Weeks RTT Open Pathways

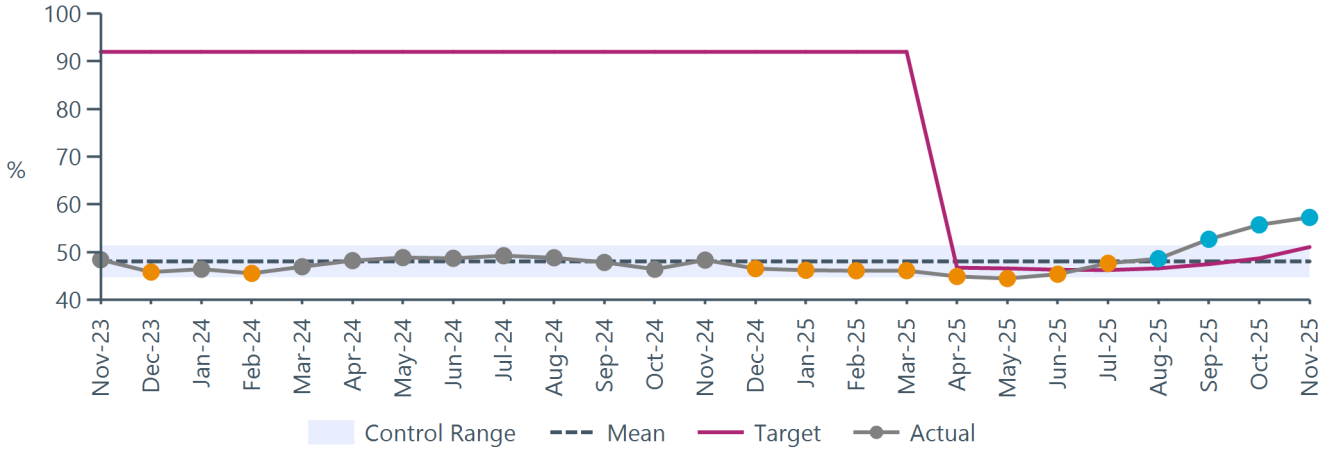
% of English patients on waiting list waiting 18 weeks or less 211021

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
51.08%	57.29%	H	Moving Target

Trajectory

Actual
Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric has a moving target; in line with the Trust's Operational Plan.

Narrative

2025/26 English National Planning Guidance stipulates that every organisation should improve their 18-week performance by 5% as a minimum and all Trusts to achieve 60%. The Trust's Operational Plan forecasts a position of 60% by the end of March 2026 and is visible in the graph above.

Our November performance was 57.29% for patients waiting 18 weeks or less to start their treatment. This was 6.21% better than the position of 51.08% that was planned for the end of November. As shown on the SPC above, this metric remains reported as special cause of an improving nature. There has been a 12.37% improvement from the end of April to this latest position. This metric is included in the NOF where the latest position for September scored the Trust at 3.82.

The performance breakdown by milestone is as follows:
* MS0 - 158 patients of which 5 are breaches
* MS1 - 9251 patients waiting of which 2568 are breaches
* MS2 - 1963 patients waiting of which 1235 are breaches
* MS3 - 5515 patients waiting of which 3405 are breaches

Actions

Ongoing actions includes the following:
* Trust has received GIRFT visits relating to both Inpatients and Outpatients areas throughout quarter three and there are programmes of work associated with both areas. There are three asks of clinical firms:
 - Standardised clinic templates from January
 - Agree and monitor follow up protocols within specialties
 - Increase cases per session within theatres
* Given Spinal Disorders continues to be a significant challenge there is system-wide work underway led by RJAH to review referral criteria. Phase one (amendment to secondary care referral criteria) is due to commence from 5th January. Urgent work required for MRI access for primary care.
* Insourcing work continues for all long waiting patient cohorts. Initial activity levels have been below the expected levels due to specific challenge in key sub-specialities however work has increased in November, as shown in IPR. That level of activity has been forecast forward for remainder of financial year.
* Additional support in place to assist bookings.
* Non-complex acute Pain Service - Lead Consultant now recruited; start date to be confirmed. Anticipated start date for service in quarter two of 26/27.

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
48.35%	46.57%	46.22%	46.12%	46.14%	44.92%	44.49%	45.39%	47.68%	48.64%	52.72%	55.74%	57.29%

18 Week Performance - Difference Between Planned and Actual

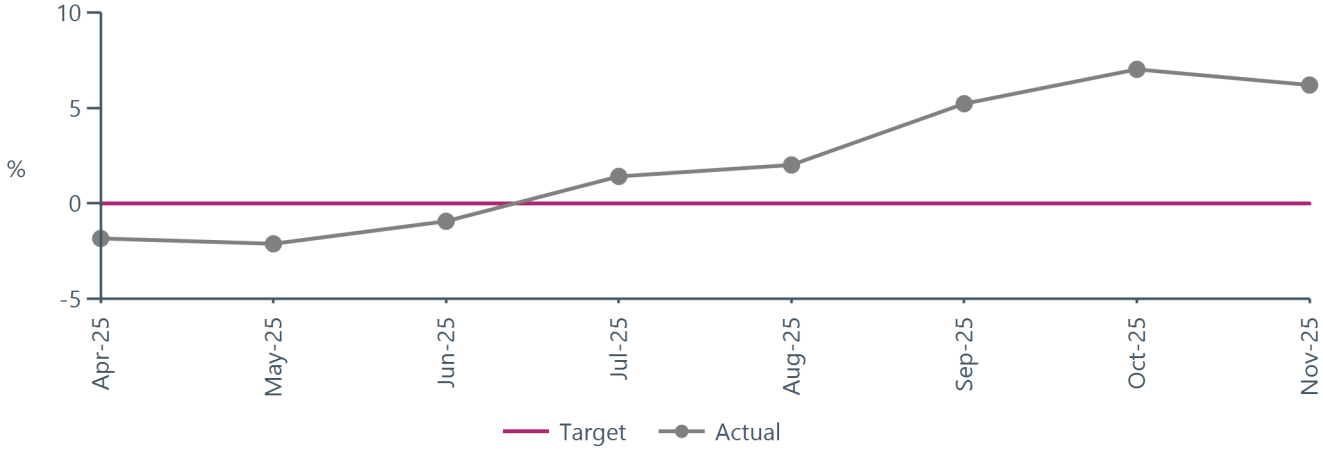
Difference between planned and actual 18 week performance 217889

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0.00%	6.21%	N/A to SPC	P

Trajectory

Actual
Trajectory



What these graphs are telling us

This is currently reported as a line graph until there are sufficient data points to transition it to SPC. Metric is consistently meeting the target.

Narrative

This metric forms part of the IPR to ensure it encompasses all metrics that form part of the National Oversight Framework (NOF).

The latest NOF Publication relates to Quarter 2 where the NOF score for this metric is 1; this reflected the September-25 position where the Trust was 5.23% less than it planned to be.

At the end of November, the position reported for month end is 57.29%; this is 6.21% better than the plan of 51.08%.

Actions

Ongoing actions includes the following:
* Trust has received GIRFT visits relating to both Inpatients and Outpatients areas throughout quarter three and there are programmes of work associated with both areas. There are three asks of clinical firms:
 - Standardised clinic templates from January
 - Agree and monitor follow up protocols within specialties
 - Increase cases per session within theatres
* Given Spinal Disorders continues to be a significant challenge there is system-wide work underway led by RJAH to review referral criteria. Phase one (amendment to secondary care referral criteria) is due to commence from 5th January. Urgent work required for MRI access for primary care.
* Insourcing work continues for all long waiting patient cohorts. Initial activity levels have been below the expected levels due to specific challenge in key sub-specialities however work has increased in November, as shown in IPR. That level of activity has been forecast forward for remainder of financial year.
* Additional support in place to assist bookings.
* Non-complex acute Pain Service - Lead Consultant now recruited; start date to be confirmed. Anticipated start date for service in quarter two of 26/27.

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
					-1.83%	-2.11%	-0.93%	1.42%	2.02%	5.23%	7.03%	6.21%

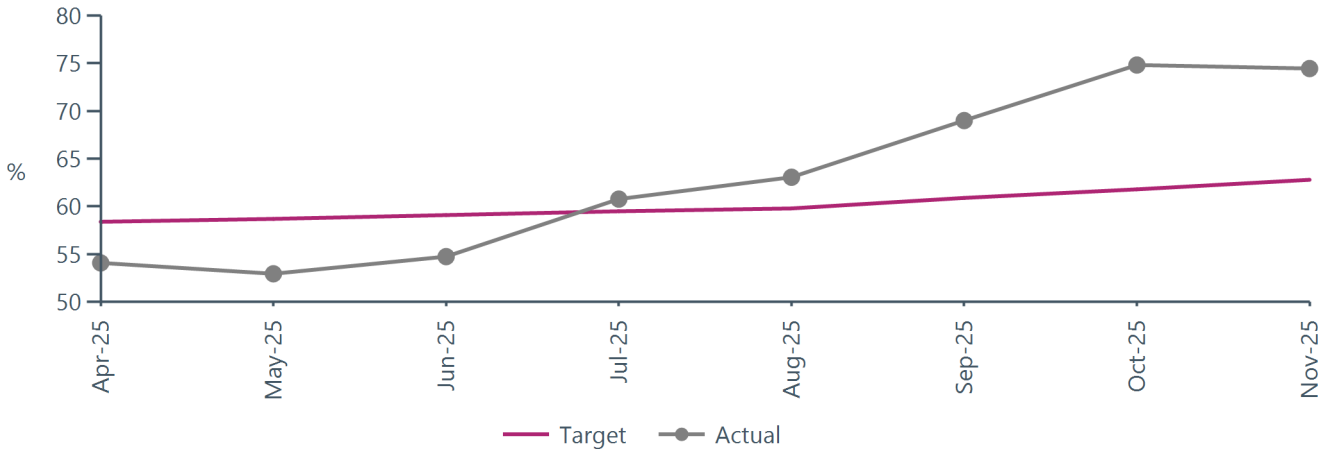
Time to First Appointment - English Patients

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
62.80%	74.46%	N/A to SPC	Moving Target

Trajectory



What these graphs are telling us

This is not applicable to SPC until there are sufficient data points. Metric has a moving target; in line with the Trust's Operational Plan.

Narrative

This metric focuses on the time to first appointment waiting for first event and of those patients, the % waiting less than 18 weeks. The reported position is taken from the Waiting List MDS position for week ending 30th November 2025. NHSE Guidance stipulates the week ending positions we should officially report that fall closest to month end. This is an unvalidated position.

2026/26 English National Planning Guidance stipulates that every organisation should improve their 18-weeks for a first appointment performance by 5% as a minimum and all Trusts to achieve 67%. The Trust's Operational Plan forecasts a position of 67% by the end of March 2026.

For week ending 30th November 74.46% of patients waiting for first appointment were under 18 weeks; 11.66% above the 62.80% plan. As shown on the graph above, we've now been reporting this since April where in that period there has been a 20.74% improvement. The data is reviewed at the weekly Outpatient Activity meeting at sub-speciality level. Performance ranges from 50.57% in Spinal Disorders to 100% in Paediatric Rheumatology, Muscle and Physiotherapy.

Actions

Ongoing actions includes the following:
* Trust has received GIRFT visits relating to both Inpatients and Outpatients areas throughout quarter three and there are programmes of work associated with both areas. There are three asks of clinical firms:
 - Standardised clinic templates from January
 - Agree and monitor follow up protocols within specialties
 - Increase cases per session within theatres
* Given Spinal Disorders continues to be a significant challenge there is system-wide work underway led by RJAH to review referral criteria. Phase one (amendment to secondary care referral criteria) is due to commence from 5th January. Urgent work required for MRI access for primary care.
* Insourcing work continues for all long waiting patient cohorts. Initial activity levels have been below the expected levels due to specific challenge in key sub-specialities however work has increased in November, as shown in IPR. That level of activity has been forecast forward for remainder of financial year.
* Additional support in place to assist bookings.
* Non-complex acute Pain Service - Lead Consultant now recruited; start date to be confirmed. Anticipated start date for service in quarter two of 26/27.

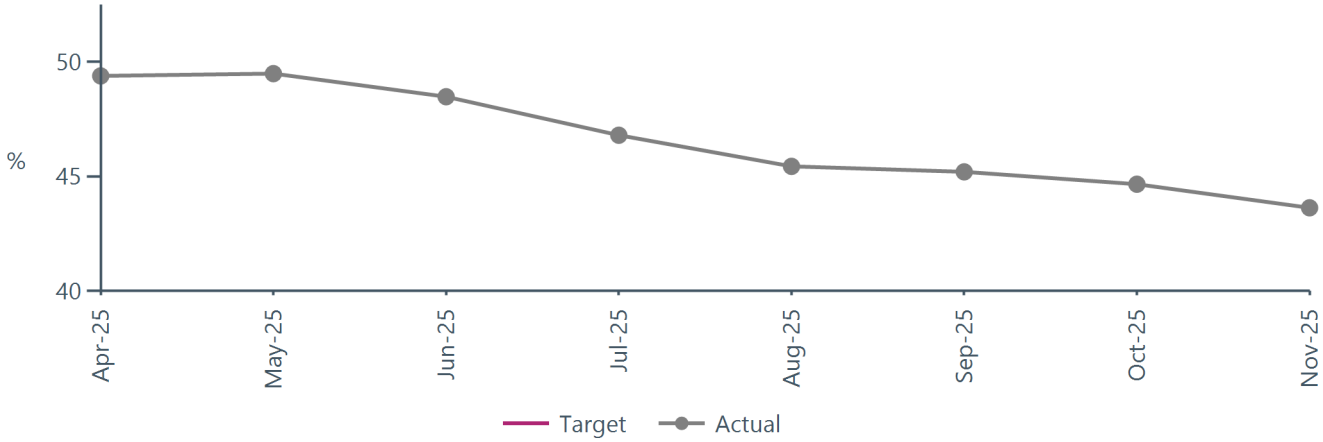
Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
					54.09%	52.95%	54.75%	60.78%	63.07%	69.01%	74.83%	74.46%

Time to First Appointment - Welsh Patients

The denominator is the count of incomplete outpatient pathways waiting for a first appointment at the snapshot date. The numerator is the count of incomplete pathways waiting for a first appointment at the snapshot date that have been waiting less that 1 217880

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	43.63%	N/A to SPC	No Target



Trajectory

Actual
Trajectory

What these graphs are telling us

This is not applicable to SPC until there are sufficient data points. The metric has no target.

Narrative

This metric focuses on the time to first appointment waiting for first event and of those patients, the % waiting less than 18 weeks. The reported position is taken from the Waiting List MDS position for week ending 30th November 2025. NHSE Guidance stipulates the week ending positions we should officially report that fall closest to month end. This is an unvalidated position. This metric forms part of English expectations. For week ending 30th November 43.63% of Welsh patients waiting for first appointment were under 18 weeks; there is no plan for Welsh patients. Performance ranges from 19.57% in Spinal Disorders to 100% in Occupational Therapy, Orthotics & Elderly Medicine.

2025/26 Welsh activity profiles continue to be discussed with Welsh Health Boards, that will impact list size. Since July there are expectations from Powys Health Board to provide first appointment no sooner than 52 weeks that the Trust is not in agreement with due to the potential for clinical risk. Despite Exec to Exec discussions, there is still no agreement on this.

For other Welsh Health Boards, the Trust continues to work with maximum waits standards set out in Welsh Assembly expectations of 52 weeks for Outpatient Activity and 104 weeks for Inpatient Activity.

Actions

Ongoing actions includes the following:
* Welsh long waits patients continue to be addressed through the prioritisation process.
* Trust has received GIRFT visits relating to both Inpatients and Outpatients areas throughout quarter three and there are programmes of work associated with both areas. There are three asks of clinical firms:
 - Standardised clinic templates from January
 - Agree and monitor follow up protocols within specialties
 - Increase cases per session within theatres
* Assessment at sub-speciality level has taken place to understand the pressures for 1st Appointment and TCIs with a focus on dating these patients from November.
* Mutual Aid continues to be utilised with individual consultant in Arthroplasty to begin at Yale and individual consultant in Upper Limb at Nuffield. Will assess if a suitable option for further consultants.
* Validation exercise in November utilising Dr Dr - focus on patients 104+ weeks at end of March.

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
					49.39%	49.49%	48.48%	46.80%	45.44%	45.20%	44.66%	43.63%

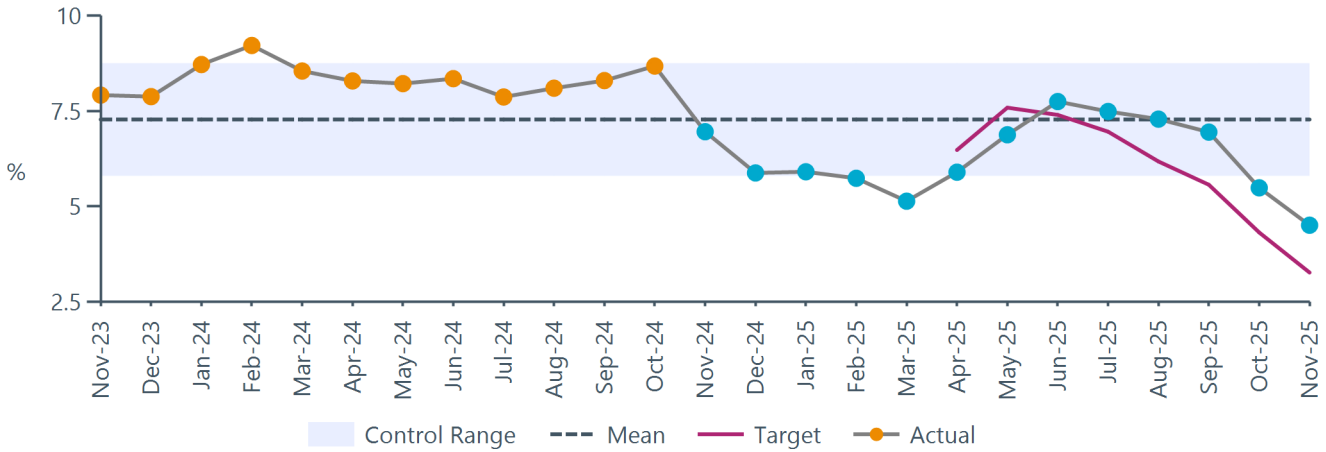
% of Patients Waiting Over 52 Weeks - English

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
3.27%	4.51%	L	Moving Target

Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric has a moving target; in line with the Trust's Operational Plan.

Narrative

2025/26 English National Planning Guidance stipulates that every organisation should reduce the volume of patients waiting over 52 weeks to <1% of their list size. The Trust's Operational Plan forecasts a position of 1% by the end of March 2026. At the end of November, 762 patients were waiting over 52 weeks, this equates to 4.51% of the English list size, a reduction from 5.49% throughout the month. The sub-specialties with the highest volume of patients are; Knee & Sports Injuries (175), Arthroplasty (174) and Spinal Disorders (152). Patients waiting, by weeks brackets is:

* >52 to <=65 weeks - 695 patients
* >65 to <=78 weeks - 56 patients
* >78 weeks - 11 patients
* >104 weeks - 3 patients

This metric is part of the NOF, with the latest score for Quarter 2 reported at 3.94 for the September month end position of 6.95%.

Actions

Ongoing actions includes the following:

* Trust has received GIRFT visits relating to both Inpatients and Outpatients areas throughout quarter three and there are programmes of work associated with both areas. There are three asks of clinical firms:
  - Standardised clinic templates from January
  - Agree and monitor follow up protocols within specialties
  - Increase cases per session within theatres
* Given Spinal Disorders continues to be a significant challenge there is system-wide work underway led by RJAH to review referral criteria. Phase one (amendment to secondary care referral criteria) is due to commence from 5th January. Urgent work required for MRI access for primary care.
* Insourcing work continues for all long waiting patient cohorts. Initial activity levels have been below the expected levels due to specific challenge in key sub-specialities however work has increased in November, as shown in IPR. That level of activity has been forecast forward for remainder of financial year.
* Additional support in place to assist bookings.
* Non-complex acute Pain Service - Lead Consultant now recruited; start date to be confirmed. Anticipated start date for service in quarter two of 26/27.

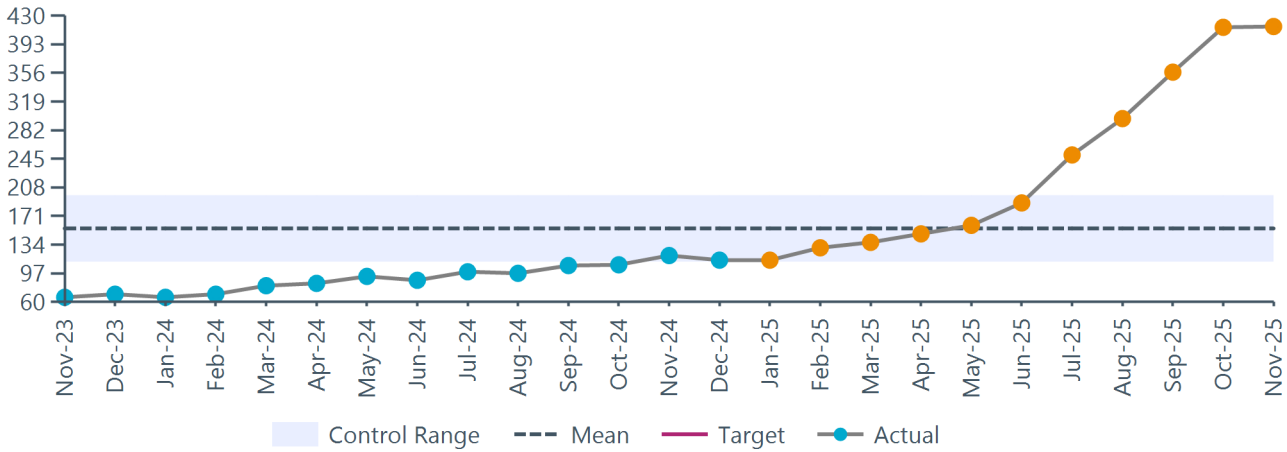
Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
6.96%	5.88%	5.91%	5.74%	5.14%	5.90%	6.88%	7.75%	7.49%	7.29%	6.95%	5.49%	4.51%

Patients Waiting Over 104 Weeks - Welsh (Total)

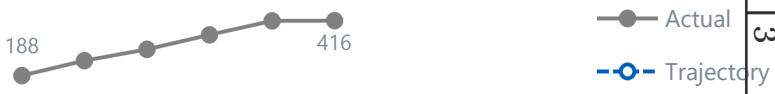
Number of Welsh RTT patients waiting 104 weeks or more at month end 217803

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	416	H	No Target



Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. There is no target for this metric.

Narrative

At the end of November there were 416 Welsh patients waiting over 104 weeks. The patients are under the care of these sub-specialities; Spinal Disorders (286), Knee & Sports Injuries (48), Arthroplasty (43), Foot & Ankle (31), Neurology (4), Hand & Upper Limb (2), ORLAU (1) and Veterans (1).

2025/26 Welsh activity profiles continue to be discussed with Welsh Health Boards, that will impact list size. Since July there are expectations from Powys Health Board to provide first appointment no sooner than 52 weeks that the Trust is not in agreement with due to the potential for clinical risk. Despite Exec to Exec discussions, there is still no agreement on this.

For other Welsh Health Boards, the Trust continues to work with maximum waits standards set out in Welsh Assembly expectations of 52 weeks for Outpatient Activity and 104 weeks for Inpatient Activity.

Actions

Ongoing actions includes the following:
* Welsh long waits patients continue to be addressed through the prioritisation process.
* Trust has received GIRFT visits relating to both Inpatients and Outpatients areas throughout quarter three and there are programmes of work associated with both areas. There are three asks of clinical firms:
 - Standardised clinic templates from January
 - Agree and monitor follow up protocols within specialties
 - Increase cases per session within theatres
* Assessment at sub-speciality level has taken place to understand the pressures for 1st Appointment and TCIs with a focus on dating these patients from November.
* Mutual Aid continues to be utilised with individual consultant in Arthroplasty to begin at Yale and individual consultant in Upper Limb at Nuffield. Will assess if a suitable option for further consultants.
* Validation exercise in November utilising Dr Dr - focus on patients 104+ weeks at end of March.

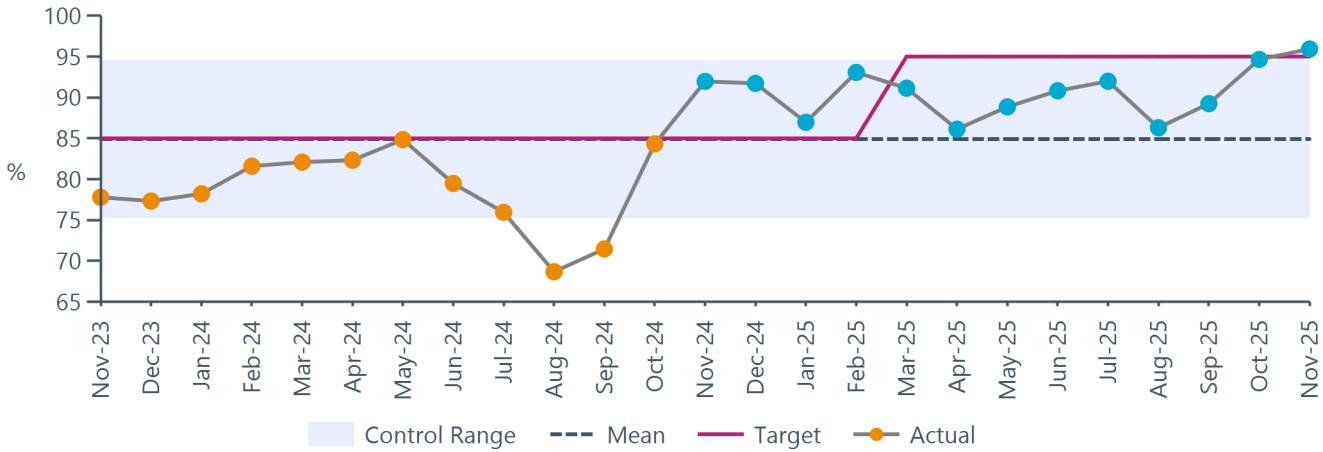
Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
120	114	114	130	137	148	159	188	250	297	357	415	416

6 Week Wait for Diagnostics - English Patients

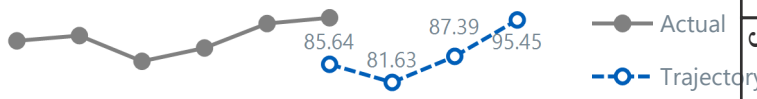
% of English patients currently waiting less than 6 weeks for diagnostics. National Target with Trajectory as per Trust's Operational Plans. 211026

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
95.00%	95.93%	H	Moving Target



Trajectory



What these graphs are telling us

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

Narrative

Performance for November is 95.93% against the 95% target. This position has exceeded the trajectory of 85.64% that was forecast in the Trust's submitted Operational Plans. Reported position relates to 49 patients who waited beyond 6 weeks. Of the 6-week breaches; 5 are over 13 weeks, all within MRI.

Performance and breaches by modality:
* MRI – 94.37% - D2 (Urgent - 0-2 weeks) – 2 with 1 dated, D4 (Routine – 6-12 weeks) – 41 with 19 dated
* CT – 96.72% - D2 (Urgent - 0-2 weeks) – 1 dated, D4 (Routine – 6-12 weeks) – 3 dated
* Ultrasound – 99.33.07% - D4 (Routine - 6-12 weeks) - 2 dated
* DEXA Scans – 100%

Ultrasound activity plan was met in November. National target – 0 patients waiting over 13 weeks by end of September 2024 and 95% against the 6-week standard within all modalities.

Actions

Ultrasound - there has been a significant improvement - no immediate actions required.

MRI - Recruitment commenced and associated training plans. Case for permanent MRI capacity aims to enhance service flexibility. Funding secured for additional mobile MRI activity for the current financial year. Plan to remove backlog of 13 week waits (from MCSI) to a dedicated clinic.

CT – DM01 performance stands at 96.72%, indicating strong compliance – no immediate actions required.

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
91.97%	91.72%	86.97%	93.07%	91.13%	86.13%	88.85%	90.82%	91.98%	86.30%	89.24%	94.65%	95.93%

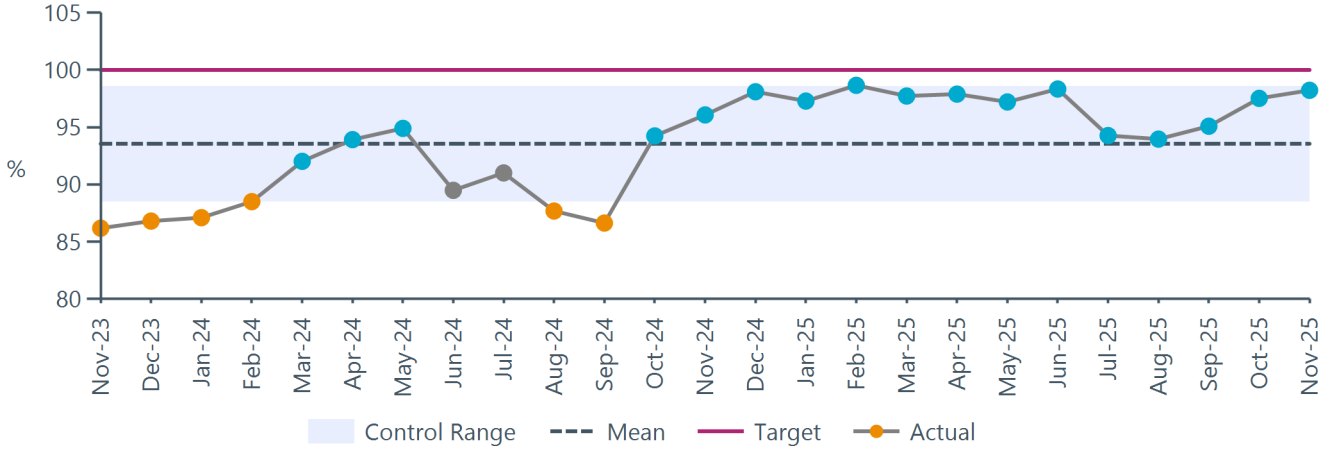
8 Week Wait for Diagnostics - Welsh Patients

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
100.00%	98.22%	H	F

Trajectory



What these graphs are telling us

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

Narrative

The 8-week standard for diagnostics is reported at 98.22%. The reporting position includes 8 patients who waited beyond 8 weeks.

Performance and breaches by modality:
* MRI - 98.12% - D4 (Routine - 6-12 weeks) – 7 with 4 dated
* CT - 96.88% - D4 (Routine - 6-12 weeks) – 1 dated
* Ultrasound - 100%
* DEXA Scans - 100%

Ultrasound activity plan was met in November.

Actions

Ultrasound - there has been a significant improvement - no immediate actions required.

MRI - Recruitment commenced and associated training plans. Case for permanent MRI capacity aims to enhance service flexibility. Funding secured for additional mobile MRI activity for the current financial year. Plan to remove backlog of 13 week waits (from MCSI) to a dedicated clinic.

CT – DM01 performance stands at 100%, indicating strong compliance – no immediate actions required.

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
96.07%	98.10%	97.28%	98.66%	97.72%	97.89%	97.20%	98.33%	94.27%	93.96%	95.09%	97.52%	98.22%

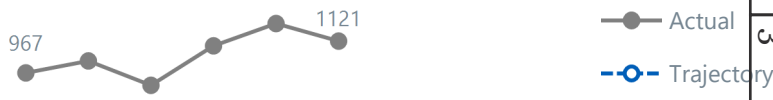
Elective Activity Against Plan (volumes)

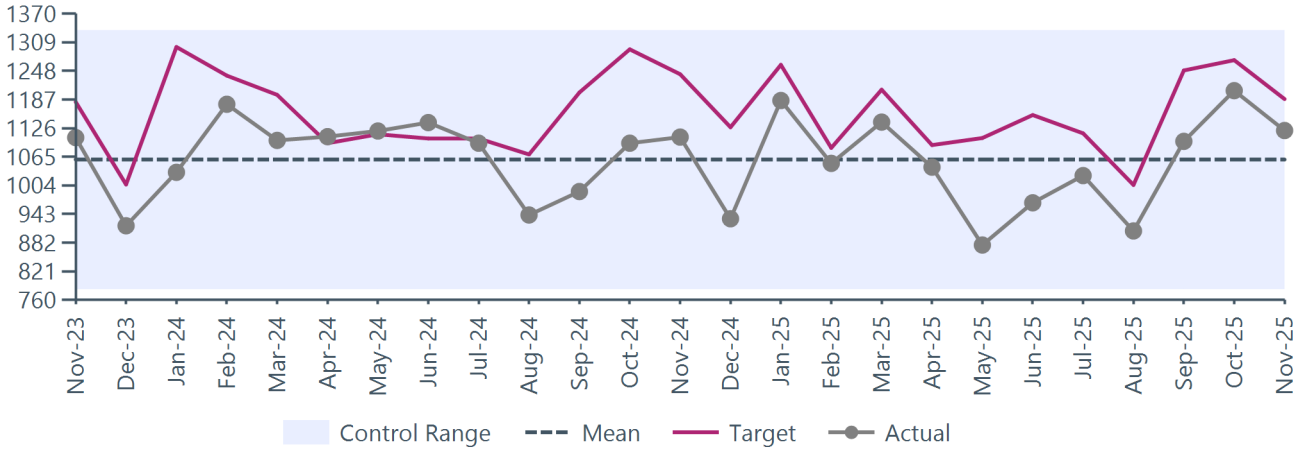
Total elective activity rated against plan. Target as per Trust's Operational Plans. 217796

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
1,188	1,121		Moving Target

Trajectory





What these graphs are telling us

Metric is experiencing common cause variation. Metric has a moving target; in line with the Trust's Operational Plan.

Narrative

Total elective activity is monitored against the 2025/26 elective spells plan set out in the NHSE activity submission.

For November 2025, the Trust planned for 1188 elective spells, achieving 1121 spells, which equates to 94.36% performance, 67 spells below plan.

While some teams exceeded their planned activity levels in November, overall performance was offset by underachievement in some areas:

Spinal Injuries including Neurology – 41.38%
Tumour - 53.13%
Knee & Sports Injuries – 67.92%

November's performance remains above the mean and within statistical control limits. This indicates the presence of common cause variation.

Actions

* Theatre Availability in progress with focus on fixed sessions for weekends and evenings.
* Specific actions in relation to PP activity that will influence overall Theatre Activity.
* Limited levels of activity being undertaken at Independent Sector providers - this is not expected to deliver the levels of activity originally anticipated. Delivered activity in November was Nuffield Shrewsbury -22 patients and Spire Yale - 9 patients. Ongoing usage of Independent Sector is to be reviewed to ensure it aligns with Insourcing arrangements and income.
* Insourcing activity levels increased in November with these levels now forecast for the remainder of the financial year.
* Ongoing work regarding the temporary transfer of Orthopaedic activity from PRH to RJAH; commenced with regular sessions offered through 6-4-2 process.

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
1107	933	1185	1051	1139	1043	877	967	1025	907	1098	1206	1121

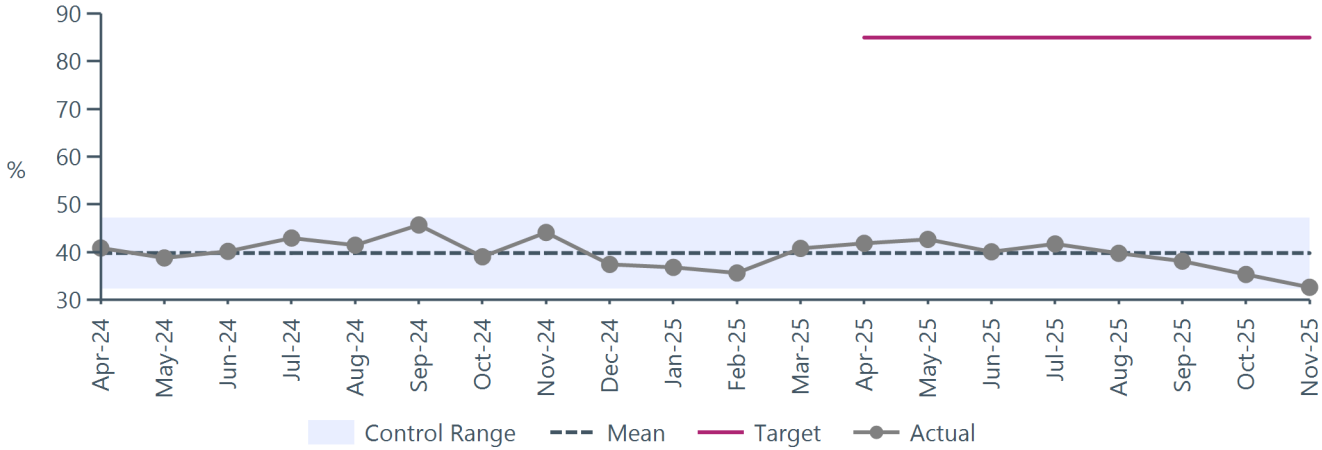
% Combined BADS Performance

Percentage of surgical procedures completed as a day case as a proportion of all procedures aligned with the British Association of Day Surgery (BADS) directory of procedures September 2024 Edition

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	32.65%		F

Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. Assurance indicates metric is consistently failing the target.

Narrative

This is a new metric for the 2025/26 period, using a revised methodology compared to previous reports. Historical data has been recalculated based on this new methodology and presented in the graph above.

The metric measures the percentage of Combined BADS Performance, aligned with the Orthopaedic and Urology sections of the BADS Directory of Procedures (September 2024 Edition). It continues to be monitored against the overall 85% target, set under the 2023/24 elective care NHSE planning guidance, reflecting the Trust's delivery of BADS day cases as a proportion of all BADS procedures undertaken.

In November, BADS performance was reported at 32.65%. If patients discharged on day zero—regardless of their intended management—were included, the metric would have reached 52.72%.

Although this metric consistently fails to meet the target and performance has declined over the last four months, it does report common cause variation.

Actions

Since day-case rates vary significantly across different surgical procedures, it is recognised that, as a Specialist Orthopaedic Trust, the volume of Total Hip, Total Knee, and Uni-Knee arthroplasties performed at RJAH will impact the Trust's ability to achieve the overall 85% target. This makes it more challenging to attain high day-case rates compared to other surgical specialties. This has been raised and discussed with GIRFT and NHSE where it is recognised that this measure is not appropriate for this Trust. Alternative measure to be considered with assessment of what is monitored through the Model Health System.

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

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
44.14%	37.45%	36.83%	35.65%	40.80%	41.86%	42.69%	40.09%	41.74%	39.78%	38.13%	35.34%	32.65%

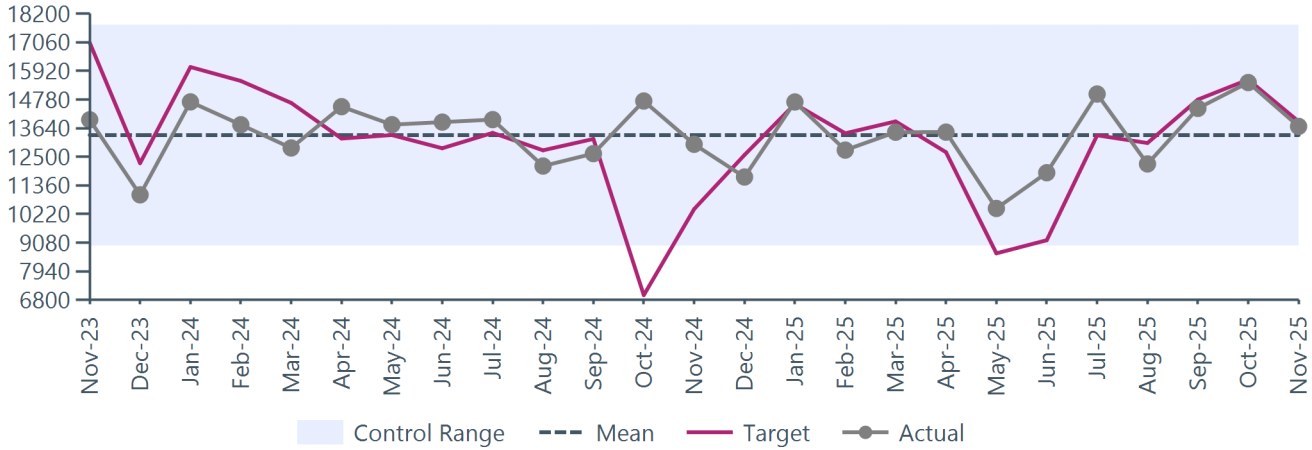
Total Outpatient Activity against Plan (volumes)

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
13,909	13,712		Moving Target

Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. Metric has a moving target; in line with the Trust's Operational Plan.

Narrative

The outpatient activity plan was not met in November and is reported -197 of plan at 98.58%. A breakdown of Outpatient activity below:
* IJP activity was -571 at 95.74%, * OJP activity was +33 at 109.35%, * Insourcing was +341 at 341.84%
Areas/reasons for under-performance includes:
* Some consultants continue to work to reduced clinic templates following implementation of the Apollo system (Arthroplasty & Paediatric Orthopaedics)
* Arthroplasty - Enhanced Recovery activity is not all recorded due to administrative capacity. Two new consultants were assumed in plan from September.
* Metabolic Medicine/DEXA - Staffing issues that has impacted booking team - this will also impact December.
* Orthotics - Continue to have staffing issues with difficulties filling vacancies and sourcing support for capacity.
* Physiotherapy/OT - High volumes of patient cancellations in both areas.

Actions

* Apollo Impact - Some system updates have been made to the Outpatients section of the system - need to review if this has seen transactions less onerous for clinicians who are not yet back to pre Apollo templates
* Arthroplasty - Resource required to log Enhanced Recovery activity being reviewed by Service Manager and discussed with Finance. Two new consultants were assumed in plan from September; these will now be in place in quarter four.
* Orthotics - Use of agency being slowly being progressed.
* Physiotherapy - unlikely to hit plan in December as a result of estates work in the gym that has led to activity cancelled.
* Metabolic Medicine/DEXA - Staffing issues under review by Service Manager/Unit Managing Director.

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
13000	11696	14685	12767	13480	13484	10444	11867	15001	12216	14429	15458	13712

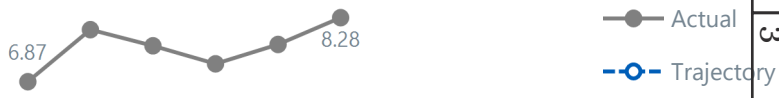
Total Outpatient Activity - % Moved to PIFU Pathway

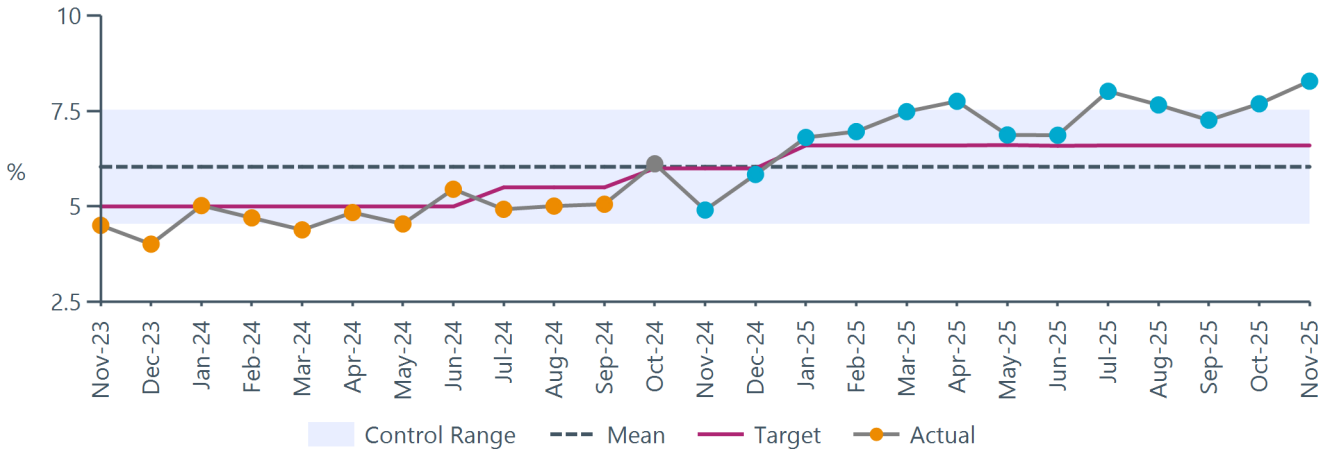
Total Outpatient Activity - % Moved to Patient Initiated Follow Up Pathway against plan. Target as per Trust's Operational Plans. 217715

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
6.60%	8.28%	H	Moving Target

Trajectory





What these graphs are telling us

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

Narrative

The target for the number of episodes moved to a PIFU Pathway is 6.60% of all outpatients attendances. In November this was exceeded with 8.28% of total outpatient activity moved to a PIFU pathway. As demonstrated on the SPC above, this has now been reported as a period of improvement for twelve months.

Since the implementation of our new EPR system on 12th May 2025, we have seen an expected increase in the number of patients discharged to PIFU and an expected decrease in the number of patients moved to PIFU.

Patients reported as moved to PIFU in our submissions May 2025 and previous were due to the limitations of our old PAS system. Our submission now captures all patients who are put on PIFU through their outcome of their last appointment.

As a Trust we have few very patients who are moved to PIFU as opposed to discharged to PIFU. Since go-live there has been some configuration issues with the outcome of attendance but the impact on our reported numbers is minimal.

Actions

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
4.91%	5.84%	6.81%	6.96%	7.49%	7.76%	6.87%	6.87%	8.02%	7.66%	7.26%	7.69%	8.28%

Total Diagnostics Activity against Plan - Catchment Based

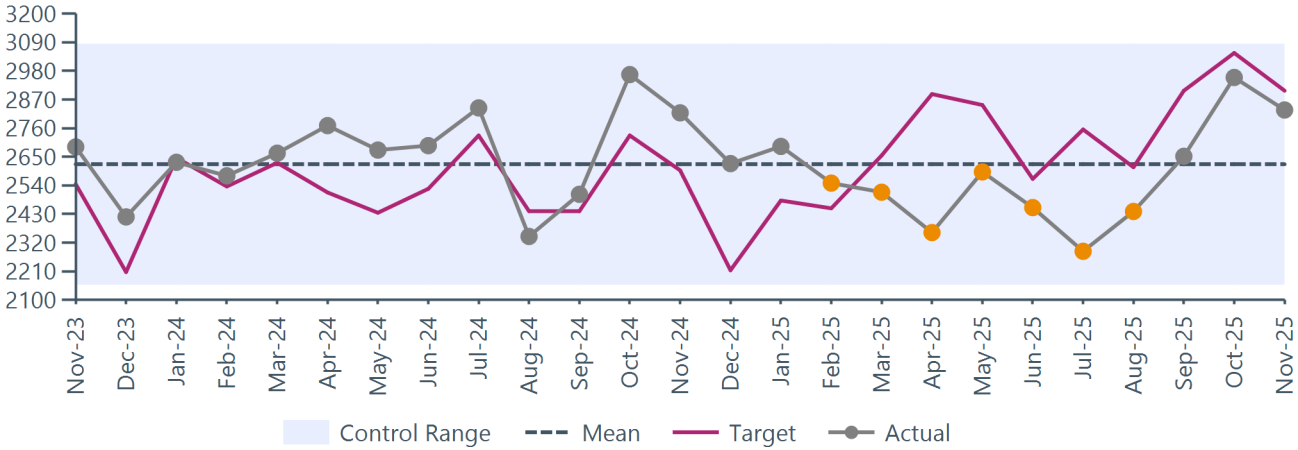
Total Diagnostic Activity against Plan - (MRI, U/S and CT activity) against plan. Target as per Trust's Operational Plans. 217794

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
2,904	2,830		Moving Target

Trajectory

Actual
Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. Metric has a moving target; in line with the Trust's Operational Plan.

Narrative

The Diagnostic activity plan was not met in November. Overall activity is reported at 97.45% with a breakdown as follows:
* U/S – 1008 against 946; equating to 106.55%
* MRI - 1445 against plan of 1503; equating to 96.14%
* CT – 377 against plan of 455; equating to 82.86%

Actions

MRI - Recruitment commenced and associated training plans. Case for permanent MRI capacity aims to enhance service flexibility. Funding secured for additional mobile MRI activity for the current financial year.

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
2819	2624	2690	2549	2514	2359	2592	2455	2287	2440	2652	2955	2830

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

Board Update – Financial Position Month 08, November 2025

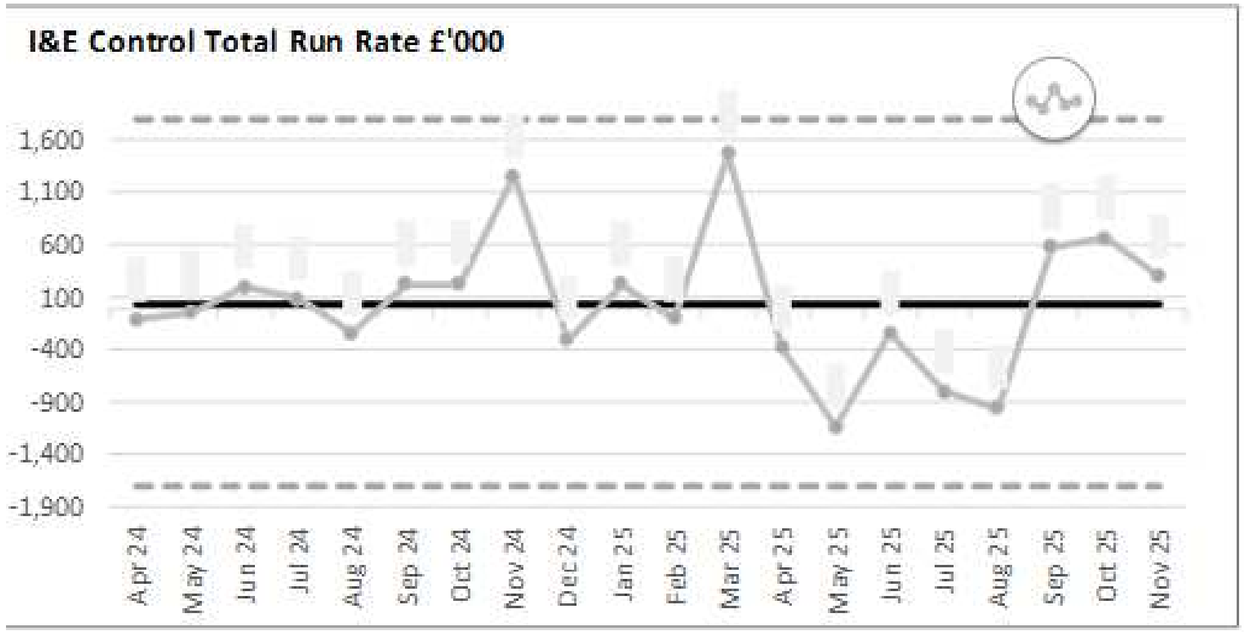
Meeting 7th January 2026

Improving lives through excellent and innovative care

NHS

Income & Expenditure Position November 2025

	Annual Plan	In Month Position			YTD Position		
		Pass through adj Plan	Actual	Variance	Pass through adj Plan	Actual	Variance
Clinical Income	153,952	12,945	13,075	130	100,837	95,691	(5,146)
Private Patient income	11,987	1,089	1,131	42	8,201	7,559	(642)
Other income	6,849	729	722	(7)	5,197	5,440	243
Pay	(107,081)	(9,002)	(8,839)	163	(71,679)	(69,597)	2,082
Non-pay	(57,229)	(4,735)	(5,131)	(396)	(38,727)	(35,867)	2,860
EBITDA	8,478	1,026	958	(68)	3,829	3,226	(603)
Finance Costs	(9,285)	(797)	(729)	68	(6,087)	(5,733)	354
Capital Donations	1,620	108	0	(108)	286	207	(79)
Operational Surplus	813	337	229	(108)	(1,972)	(2,300)	(328)
Remove Capital Donations	(1,620)	(108)	0	108	(286)	(207)	79
Add Back Donated Dep'n	809	67	70	3	534	559	25
Control Total	0	296	301	5	(1,725)	(1,950)	(225)



In month (November 2025): £0.3m surplus, on plan.

- **NHS Clinical Income £0.1m favourable -** driven by £0.3m adverse theatre performance (59 cases), offset by £0.3m favourable on insourcing (48 cases) at increased cost. £0.1m adverse internal outpatient delivery offset by £0.1m favourable insourced outpatient delivery at increased cost. £0.2m favourable YTD correction to Carpel Tunnel best practice tariff and £0.1m favourable uncoded activity from M7 offset by £0.1m adverse outsourcing (pass through) and £0.1m diagnostics.
- **Non-NHS income £0.03m favourable –** driven by favourable private patients pricing and additional dental sessions, offset by adverse research commercial trials.
- **Pay expenditure £0.2m favourable –** driven by £0.2m favourable workforce recruitment slippage, £0.1m enhanced controls and £0.1m favourable agency. Partially offset by £0.2m adverse bank spend (Outpatient clinics and Anaesthetics OJP).
- **Non-Pay £0.4m adverse -** driven by £0.2m adverse insourcing (income offset but pressure to plan), £0.1m implants and consumables case mix (income offset) and £0.1m outpatients/ORLAU/Orthotics.

Year to Date: £1.9m deficit, representing a £0.2m adverse position to plan.

Bridge from Year to Date Plan (£1.7m) versus Actual (£1.9.m)

Plan (£1.7m)

Actual (£1.9m)

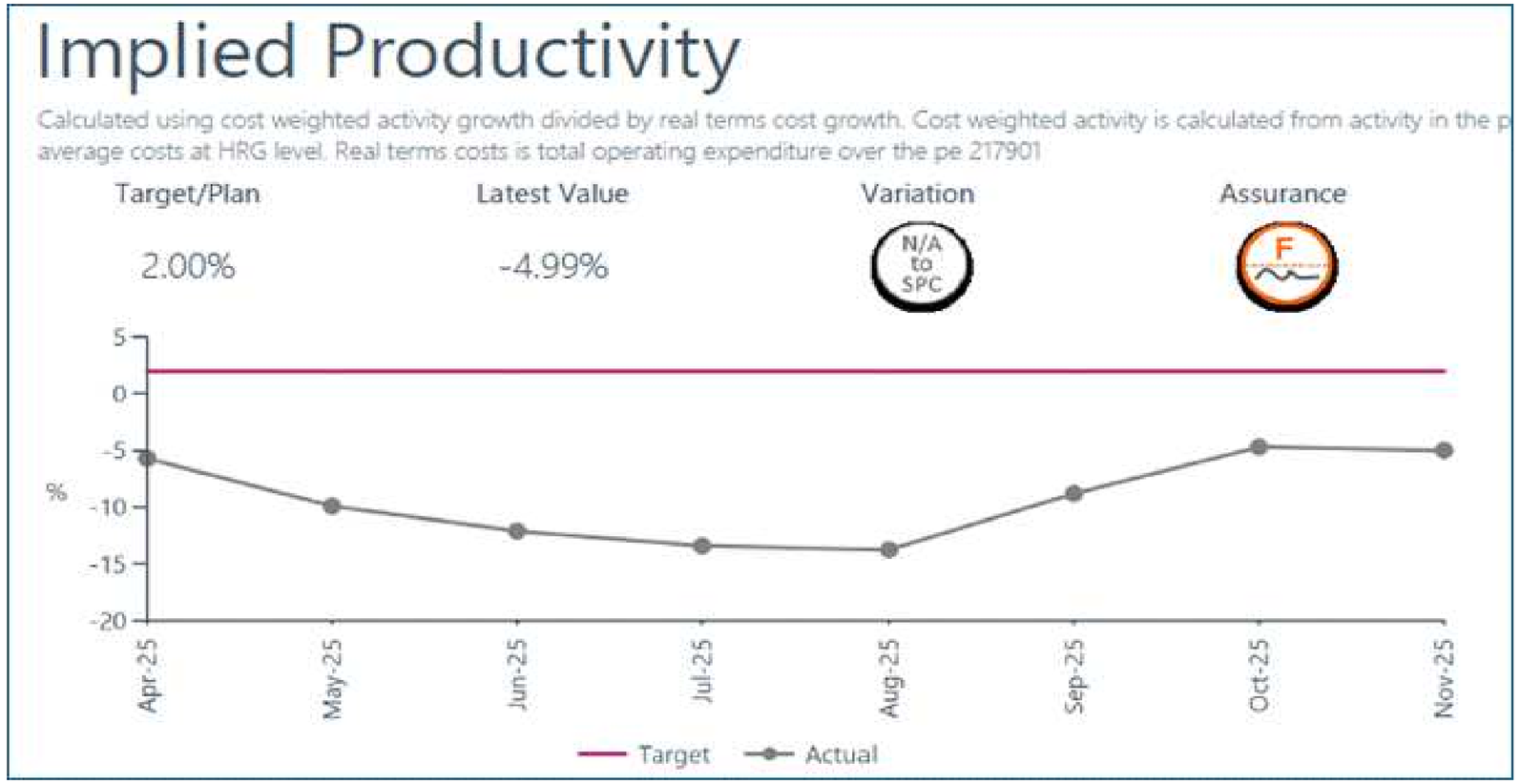
The bridge shows the key drives of the variances to plan YTD of (£0.2m) : Plan (£1.7m) versus Actual (£1.9m)

The primary driver is adverse income performance linked to lower than planned elective theatre activity, outpatients and diagnostics which is largely offset by lower than planned pay & non pay expenditure.

Clinical income elective & daycase is shown net of direct marginal cost reductions.

Further to this £1.1m of balance sheet mitigations and £0.4m of interest receivable are supporting the overall position.

Implied Productivity Update



Implied Productivity

This metric divides cost weighted activity growth by the real terms (inflation adjusted) cost growth of the Trust to demonstrate how efficiently the Trust is delivering its activity against its cost base. The overall NOF score is then calculated relative to the score of all other organisations.

Calculation

Cost weighted activity growth – this takes activity during the two periods 24/25 and 25/26 and applies a national average cost based on data from the National Cost Collection (NCC) then divides the two numbers to give a growth %. Maximising activity increases the numerator and leads to an improved score.

Real terms cost growth – this takes operational expenditure excluding impairments but including Public Dividend Capital (PDC) charges during the two periods 24/25 and 25/26 then divides the two numbers to give a growth %. Spend is adjusted for inflation across periods.

The graph shows the year to date (YTD) trend of implied productivity. National reporting (which informs the NOF score) is 4 months in arrears. An internal model has been developed by the finance team to estimate the implied productivity % per month, this is checked back against the national reporting and the model adjusted, so far this has proved accurate within 1%.

Implied productivity deteriorated during the implementation of the new EPR system and plateaued during **August at –13.8%,** the position has recovered since then due to improvements in activity levels with **November delivering –5%.**

Further improvements to baseline activity levels are required in line with the planned levels of activity to achieve the 2% productivity target set nationally.

Efficiency- Month 8 Performance Summary

25/26 Month 8 Planned Savings	25/26 Month 8 Actual Savings	25/26 Month 8 Savings Variance
£866k	£1,001k	£135k

25/26 Full Year Planned Savings	25/26 Full Year Forecast Savings	25/26 Full Year Savings Variance
£9,594k	£10,596k	£1,002k

Internal Plan & Actuals	Month 8			YTD			Forecast		
	Plan	Actual	Variance	YTD Plan	YTD Actual	Variance	Plan	Forecast	Variance
MSK	432	445	13	2,966	2,766	-199	4,623	4,471	-152
Spec	310	270	-40	1,877	1,686	-190	3,377	3,164	-213
Corporate	124	151	27	1,046	1,311	265	1,594	1,959	365
Total Recurrent	**866**	**866**	**0**	**5,888**	**5,764**	**-124**	**9,594**	**9,594**	**0**
YTD Non-Recurrent	**0**	**134**	**134**	**0**	**931**	**931**	**0**	**1,002**	**1,002**
Total including Mitigations	**866**	**1,001**	**135**	**5,888**	**6,695**	**807**	**9,594**	**10,596**	**1,002**

Unit	Planned £000's	Forecast £000's	Delivered £000's	Low Risk £000's	Medium Risk £000's	High Risk £000's	Unidentified £000's	Risk Adjusted Forecast £000's	Movement £000's
Corporate	1,594	2,751	2,735	16	0	0	0	2,751	0
MSK	4,623	4,584	3,660	752	172	0	0	4,541	-43
SPEC	3,377	3,261	2,420	477	119	245	0	3,048	-213
Total	**9,594**	**10,596**	**8,815**	**1,245**	**291**	**245**	**0**	**10,339**	**-256**

Risk adjusted forecast assumes:
- 100% delivery of Delivered/ Low Risk schemes
- 75% delivery of Medium Risk schemes
- 25% delivery of High Risk schemes

This represents a ‘most likely’ year end position if no further action is taken.

Performance Headlines

Month 8:

- Overall, **£1.001k efficiencies achieved, £135k favourable to plan**.
- Recurrent delivery on plan, with an additional £134k of non recurrent mitigations recognised in month.

Year to Date:
£6,695k efficiencies achieved, £807k favourable to plan.

- Recurrent delivery £124k adverse to plan, offset by £931k non recurrent mitigations.
- Following a review of risk scored the level of red rated schemes stands at £245k, representing just 2.3% of the total forecast value for the year.
- In total 95% of the forecast total is flagged as either delivered or green rated for low risk.

Cash Position

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Actual	19.88	19.75	19.59	19.84	21.65	21.09	21.03	19.33				
Forecast								19.33	21.38	20.21	19.86	19.12
Plan	18.42	17.71	17.66	16.52	16.06	13.77	14.75	15.27	14.99	16.17	16.37	16.80

Cash balances dropped by £1.7m this month linked to capital programme and £0.6m due to STW ICB new ledger implementation resulting in part payment of the mandate in month (now paid in December). The cash balance is now £19.3m which is £4.1m above plan, mainly due to clinical income (underperformance not yet recovered by commissioners and LVA payments received earlier than expected) and generally reduced non-pay expenditure.

The year end forecast is now £2.3m above plan, due to revised assumptions on capital phasing, lease arrangements, and deferral into 26/27 of the majority of the Headley Court income for the Veterans rehabilitation pilot.

Capital Position

Capital Programme Position as at 2526-08									
Project	Annual Plan £000s	In Month Plan £000s	In Month Actual £000s	In Month Variance £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Forecast Outturn £000s	Forecast Variance £000s
Backlog maintenance	500	50	50	0	350	255	95	500	0
Digital investment & replacement	500	82	117	(35)	350	279	71	474	(26)
Capital project management	170	14	14	(0)	113	114	(1)	170	0
Equipment replacement	1,000	100	259	(159)	560	749	(189)	950	(50)
Diagnostic equipment replacement	700	0	257	(257)	700	611	89	635	(65)
Compliance (IPC/health & safety/quality)	360	20	8	12	280	233	47	360	0
Estates reconfiguration	206	20	10	10	150	27	123	206	0
PACS/RIS replacement	200	5	0	5	120	0	120	0	(200)
Invest to save	200	0	0	0	100	0	100	165	(35)
Digital & innovation strategy	500	0	0	0	320	0	320	500	0
Surgical innovations	750	200	0	200	200	725	(525)	725	(25)
EPR implementation	500	0	(12)	12	500	491	9	503	3
Rheumatology hub	500	100	0	100	100	14	86	500	0
Rheumatology hub (donated element)	500	100	0	100	100	0	100	0	(500)
Donated / Granted medical equipment	220	8	3	5	186	210	(24)	220	0
Energy/decarbonisation plan (grant)	900	0	0	0	0	0	0	857	(43)
Critical infrastructure funding (CIR)	500	100	27	73	200	121	79	1,340	840
Solar works (GBE funding)	2,407	0	72	(72)	0	1,011	(1,011)	2,407	0
Leases (IFRS16)	250	0	0	0	180	146	34	300	50
Electric Vehicle Charge Points (PDC)	0	0	0	0	0	0	0	14	14
Cyber risk reduction (PDC)	0	0	0	0	0	0	0	40	40
Contingency	0	0	0	0	0	0	0	348	348
Total Capital Funding	10,863	799	806	(7)	4,509	4,985	(476)	11,214	351
Less donated / grant capital	(1,620)	(108)	(3)	(105)	(286)	(210)	(76)	(1,077)	543
NHS Capital Funding - Charge to CDEL	9,243	691	803	(112)	4,223	4,775	(552)	10,137	894
Less PDC funded schemes	(2,907)	(100)	(99)	(1)	(200)	(1,132)	932	(3,801)	(894)
Charge to System Operational Capital	6,336	591	704	(113)	4,023	3,643	380	6,336	0

Capital expenditure is £476k above plan Year to Date.

This is due to earlier than planned expenditure on surgical innovations (spinal navigation equipment) and solar works, partially offset by slippage on diagnostic equipment and digital investment.

The Full Year forecast is now £351k above plan

This is due to the previously reported additional external Public Dividend Capital (PDC) funding of £894k for Estates Safety Works, Electric Vehicle Charging Points and Cyber Security. This is partially offset by the planned £500k donated expenditure on the Rheumatology Hub being re-phased into 26/27 and the planned grant expenditure for the energy/decarbonisation plan reducing by £43k.

Neither the PDC funding or the donated/grant expenditure are charged against the System Operational Capital, so the forecast remains as breakeven.

Trust Board - Finance
November 2025 – Month 8

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

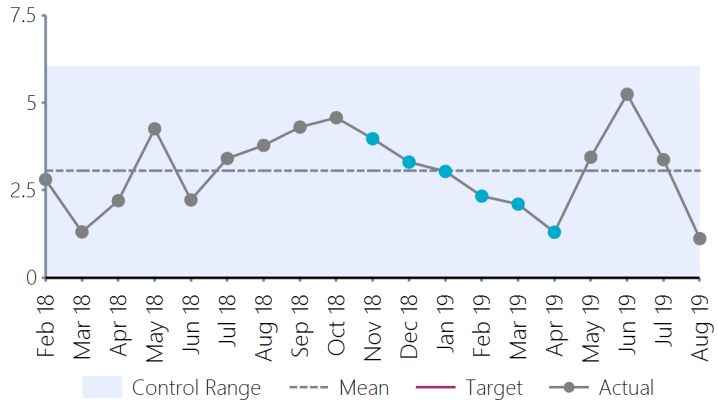
Some examples of these are shown in the images to the right:

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

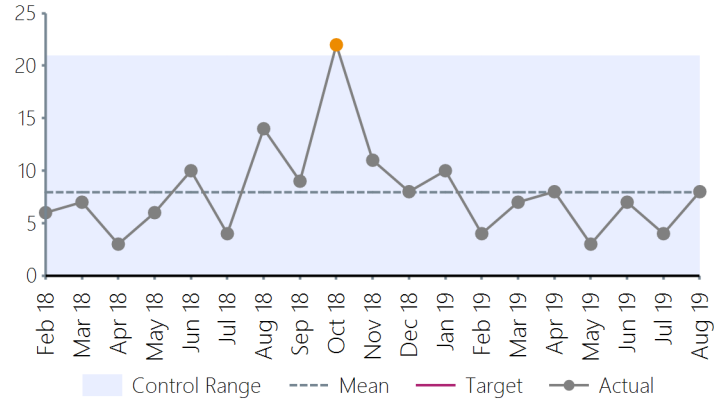
b) shows a point of concern sitting above the control range.

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

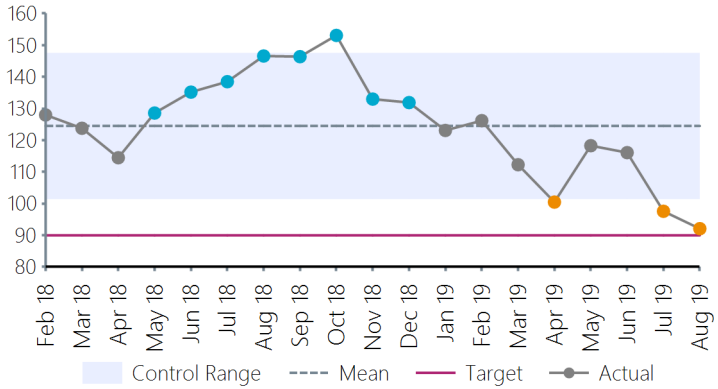
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Finances

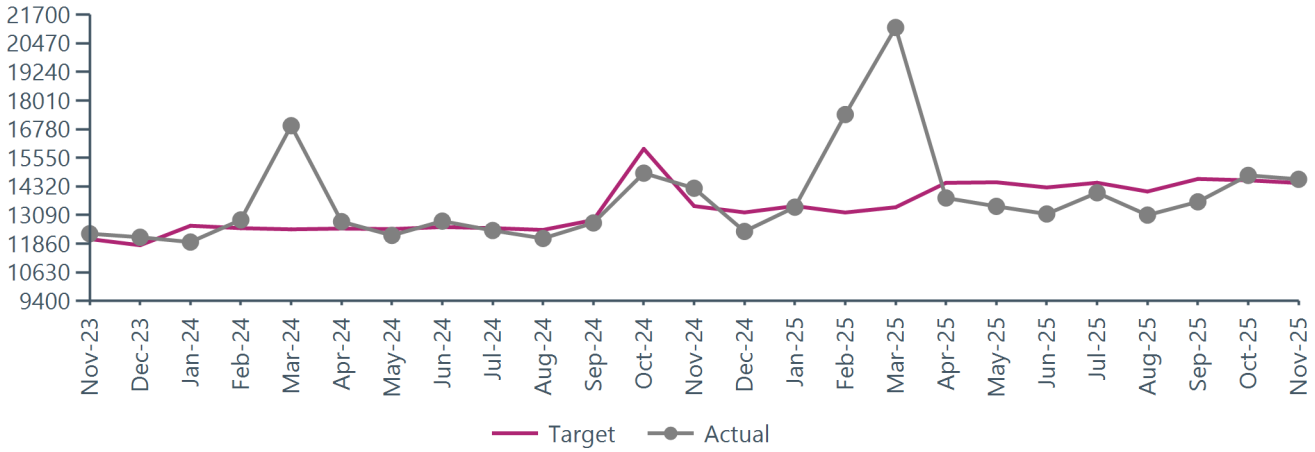
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Financial Control Total	296	301.30		N/A to SPC	Moving Target		
Income	14,763	14,928.50		N/A to SPC	Moving Target		
Expenditure	14,467	14,627.20		N/A to SPC	Moving Target	+	
Efficiency Delivered	865	1,000		N/A to SPC	Moving Target		
Cash Balance	15,266	19,328		H	Moving Target		
Capital Expenditure	799	806		N/A to SPC	Moving Target	+	
Performance (£'000k) against Low Value Agreement Block	67	30		N/A to SPC	Moving Target		
Planned Surplus/Deficit	-1,725.00	-1,950.60		N/A to SPC	Moving Target		
Variance Year-to-Date to Financial Plan	0.00	-225.60		N/A to SPC	?	+	
Implied Productivity	2.00%	-4.99%		N/A to SPC	F	+	

Expenditure

All Trust expenditure including Finance Costs 216334

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
14,467.00	14,627.20	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Overall expenditure £160k adverse to plan.

- Pay position £164k favourable to plan; due to Recruitment slippage, Improvement and Intervention actions (enhanced controls for vacancies, temporary staffing & recruitment), and reduced Agency spend. Offset partially by high bank spend (Outpatient clinics and Anaes OJP).

- Non-Pay £396k adverse; driven by insourcing costs, implants & consumables.

- Finance costs £71k favourable to plan driven by interest receivable.

Actions

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
14242	12387	13429	17409	21149	13823	13463	13136	14047	13087	13657	14795	14627

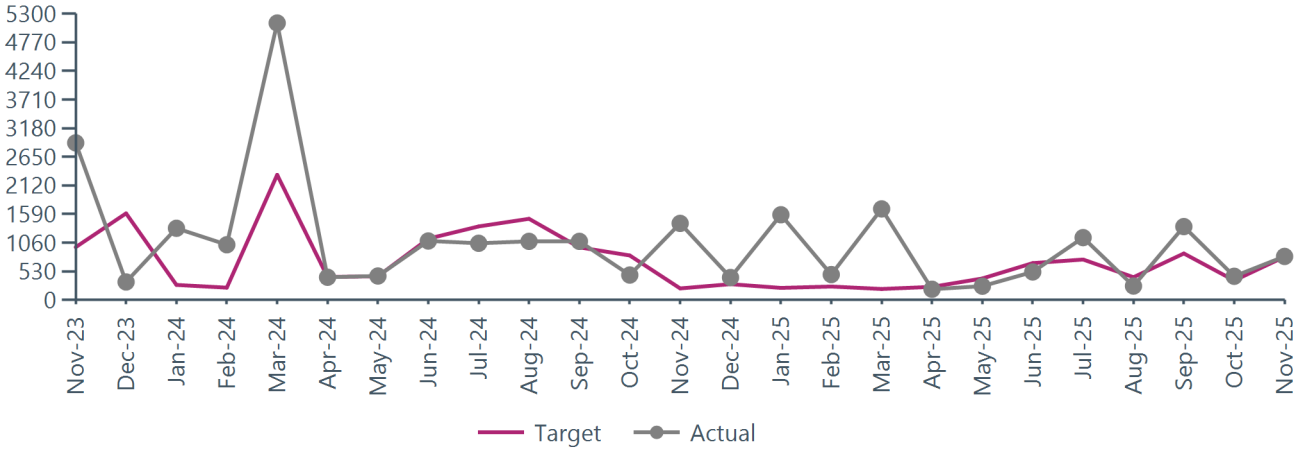
Capital Expenditure

Expenditure against Trust capital programme 215301

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
799	806	N/A to SPC	Moving Target

Trajectory



What these graphs are telling us

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

Narrative

Capital expenditure is £476k above plan YTD. This is due to earlier than planned expenditure on surgical innovations (spinal navigation equipment) and solar works, partially offset by slippage on diagnostic equipment and digital investment.

The forecast is now £351k above plan. This is due to the previously reported additional external PDC funding of £894k for Estates Safety Works, Electric Vehicle Charging Points and Cyber Security, offset by the planned £500k donated expenditure on the Rheumatology Hub slipping into 26/27 and the planned grant expenditure for the energy/decarbonisation plan reducing by £43k. Neither the PDC funding or the donated/grant expenditure are charged against the System Operational Capital. so that is forecast to breakeven.

Actions

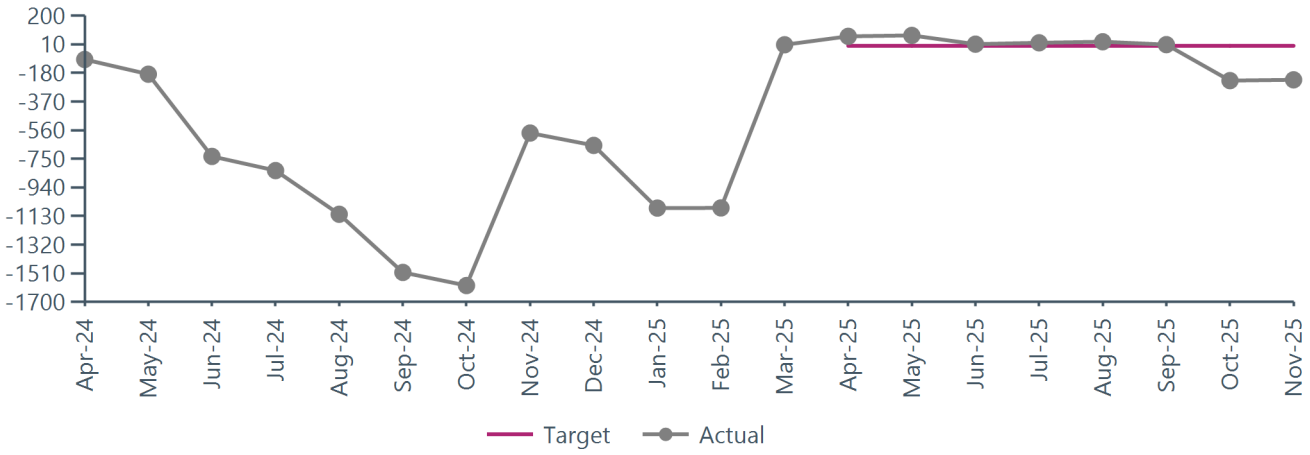
Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
1418	415	1577	469	1686	198	255	518	1154	258	1358	438	806

Variance Year-to-Date to Financial Plan

Determined from the variance to the planned financial position for the year 217900

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
0.00	-225.60	N/A to SPC	?



Trajectory

What these graphs are telling us

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

Narrative

The performance is adverse to plan YTD resulting in a NOF score of 4, this will trigger a NOF override for the Trust of 3 at the end of Q3 unless mitigated.

Actions

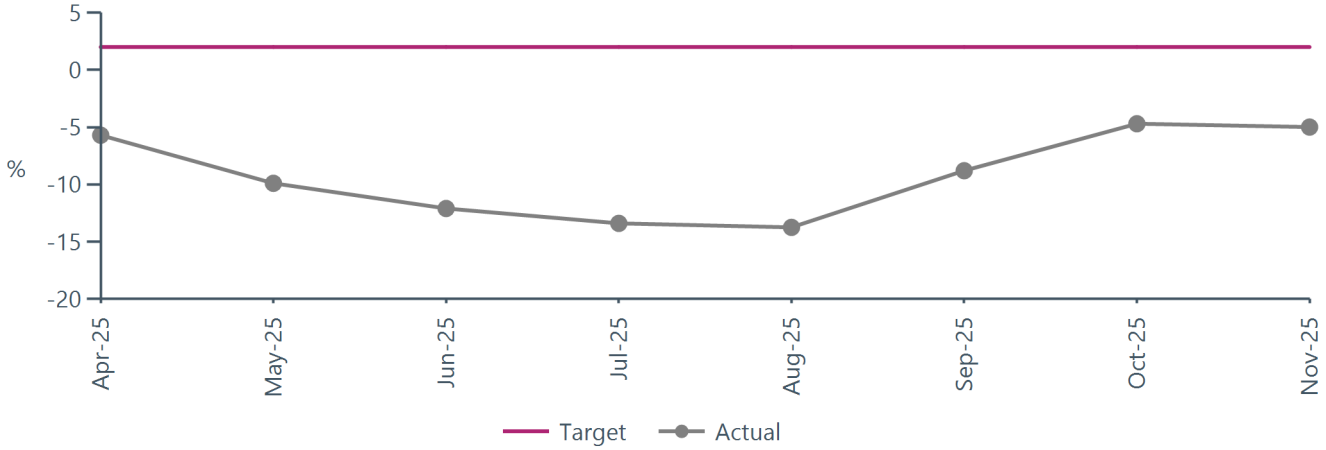
Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
-579	-661	-1077	-1076	7	63	69	11	20	27	8	-230	-225

Implied Productivity

Calculated using cost weighted activity growth divided by real terms cost growth. Cost weighted activity is calculated from activity in the period multiped by national average costs at HRG level. Real terms costs is total operating expenditure over the pe 217901

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
2.00%	-4.99%	N/A to SPC	F



Trajectory

Actual
Trajectory

What these graphs are telling us

This measure is not appropriate to display as SPC. Assurance indicates metric is consistently failing the target.

Narrative

Implied productivity is -4.99% YTD when comparing M8 25/26 with M8 24/25. The main drivers of the reduced performance are activity driven due to the cessation of the LLP contract (which has Q1 activity in 24/25), the impact of the EPR implementation in 25/26 (in particular M2 & 3) partially offset by the increase in in job plan capacity from recruitment.

Actions

Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
					-5.70%	-9.90%	-12.10%	-13.40%	-13.75%	-8.80%	-4.70%	-4.99%

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Finance and Performance Committee

Committee / Group / Meeting, Date

Board of Directors - Public Meeting, 07 January 2026

Author: **Contributors:**

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Report sign-off:

Sarfraz Nawaz, Chair of the Finance and Performance Committee

Is the report suitable for publication?

Yes

1. Key issues and considerations:

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

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

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

2. Strategic objectives and associated risks:

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

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

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

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

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

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

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

3. Assurance Report from Finance and Performance Committee

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

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

Activity Recovery Risks (Chair Report from ARC)

- Performance: Long wait trajectories remain on track, with confidence in achieving key targets by December.
- Activity Risks: Forecasts for insourcing and SaTH activity have been downgraded due to under-delivery, creating concern about a potential activity deficit in the second half of the year.
- Financial Position: Current financial mitigation has relied on balance sheet resources, which are now exhausted, increasing financial risk for the remainder of the year.
- Operational Alignment: Emphasis on aligning operational planning with financial discussions, as reduced activity directly impacts income and overall financial sustainability.

Partial assurance – while progress on long waits is positive, significant risks remain around activity delivery and financial resilience.

Financial Forecast (M7)

The Committee is assured that appropriate mitigations and governance processes are in place, but notes significant financial risk requiring continued monitoring and Board oversight.

- Current Position: The Trust reported a £0.7m surplus for Month 7, improving the year-to-date position but remaining £0.2m behind plan overall.
- Income Drivers: Income was supported by backdated ERF funds; however, ongoing challenges persist due to lower activity levels and the need for tighter control of pay and non-pay expenditure.
- The current activity forecast suggests continued challenge in achieving planned income in future months therefore focus on increasing productivity whilst tightly managing trust operating costs continues, with new mitigations required to de-risk delivery of the full year financial plan.
- Capital Position: A £0.2m contingency slippage has been allocated to the new theatre development, with further scoping underway for potential Q4 reallocations.
- Governance: The theatre business case has been approved at Private Board and will progress through system governance as part of planning assumptions.

Activity and Finance Forecast

The position is being actively managed with mitigations in progress, including insourcing adjustments and capacity optimisation. Financial risk remains, and achieving break-even will require successful delivery of planned activity improvements and cost controls. Ongoing monitoring and escalation of risks are in place, with further updates to be provided as initiatives progress.

- **Activity Forecast:** Theatre activity remains below plan with a shortfall of approximately 500 cases, driven by reduced insourcing, SaTH transfers, and lower cases per session.
  Improvement initiatives are underway, but current forecasts do not reflect potential gains. Recovery of CPS to planned levels is assumed in Q4, which presents a risk.

Outpatient activity shows some positive trends; however, productivity challenges persist and are being closely monitored.
Key risks include delivery of patient activity and achievement of efficiency targets. Without mitigations, NOF score for finance could deteriorate in Q3, potentially impacting the Trust's overall NOF rating to 3. The Executive team and Senior leaders are developing a risk mitigation plan to avoid a deterioration in activity delivery and financial impact.
Private practice activity is performing above plan, providing some assurance.
Enhanced pay controls and non-pay cost reduction measures are being implemented, with further action is required to bridge the gap to break-even.
Activity recovery remains critical, with focus on improving cases per session, IJP utilisation, and maximising insourcing opportunities.

Spinal Disorders Improvement Plan
The Committee received an update on the Spinal Disorders Improvement Plan. Key points noted:

- Operational Oversight: A bi-weekly operational group is in place to drive implementation.
- Phase One: Nearing go-live, pending MSK agreement. Expected to redirect ~42 referrals/month back to MSK, freeing Trust capacity.
- Phase Two: Will address pathway redesign (MRI access, GP engagement). Impact and timelines are still being quantified.
- Collaboration: Work with Powys to strengthen single points of access and validate referrals.
- Workforce & Service Development: Recruitment of additional surgeons and pain service development underway; full recovery will take time.

Partial assurance was confirmed at this stage – the improvement plan is progressing with clear operational leadership, however quantifiable outcomes and timelines including recruitment and services changes is required.

3.2 Areas of on-going monitoring with new developments

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

Board Assurance Framework
During discussion, members noted several points requiring refinement. Minor typographical errors were identified for correction, and it was requested that the confidence levels, particularly those relating to delivery and activity were be reviewed to ensure they accurately represent current progress. It was agreed that the BAF should be updated to reflect the most recent position and ongoing work.

Delivery Model Progress Update
Overall, the Committee took partial assurance, recognising that while important foundations are being established, several core elements remain in development and will require sustained oversight.

- Outsourcing and mutual aid in orthopaedics have not delivered the expected impact, and further work is required to stabilise and improve performance into next year.
- Outpatient transformation benefits have not yet materialised, and the Committee emphasised the need for clearer evidence of impact as work progresses.
- Job planning remains a significant challenge nationally and locally. Members highlighted the need to strengthen the link between individual job plans, team objectives, and Trust-wide activity targets to secure genuine workforce buy-in. The absence of a robust system for job plan delivery was noted, though the Committee welcomed the pilot of a new system as a positive step.
- Ensuring clarity on what is within the Trust's control versus external constraints remains essential to maximising productivity and operational grip.

The Committee noted the progress made and endorsed the direction of travel. While the foundations of the Delivery Model are strengthening, several critical components.

Planning Update
The Committee noted that work is progressing and reiterated the importance of developing a realistic, evidence-based plan. Although the planning process is moving forward appropriately and key risks

have been identified, the current iteration does not yet provide sufficient detail, quantification, or validated mitigations to give full confidence in deliverability.
The Committee was assured that future iterations will include detailed productivity schemes, GIRFT findings, and refined trajectories. Operational and financial plans will also be aligned with ICB requirements and national templates.
The Committee agreed the following next steps:

- Update operational and financial plans in line with Committee feedback.
- Develop detailed productivity schemes and underlying assumptions.
- Include specialty-level trajectories and disaggregated waiting list data in the next iteration.
- Complete financial triangulation and sensitivity analysis.

The draft plan will undergo further scrutiny by the Board at the Extraordinary Board meeting on 15 December, in preparation for the submission deadline of 17 December.

Case of Need: Rheumatology Hub
The Committee received the proposal to develop a hub with consulting rooms, MDT training space, and infusion suites to enhance patient experience, improve flow, and meet national audit standards. The Committee agreed on the case of need in principle, requesting further information on:

- Need clarity on tender outcomes and confirmation of pledged funds.
- Ensure stakeholder engagement (patients, MDT, consultants) is documented.
- Provide clearer articulation of benefits and measurable evaluation methods.
- Final funding confirmation

The final proposal will be re-submitted to the Committee for approval.

Portland Insourcing Contract
The Portland Insourcing Contract requires formal extension and approval for increased outpatient activity. The extension is justified by Portland meeting agreed volumes, and the committee is asked to support continuation. Urgent award justifications and supporting narrative are needed. The contract was previously discussed at November's Private Board Meeting with no objections. The Committee approved the Portland Insourcing Contract Extension.

3.3 Areas of assurance

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

Performance Report
Members acknowledged positive movement in several metrics but highlighted concerns around Welsh long waits, productivity, and theatre utilisation. Assurance was provided that actions are in place to address these areas, with continued monitoring by PFIG and operational teams.

Efficiency Programme
The Committee is assured that efficiency delivery is being actively managed, with recovery plans in place and continued monitoring of performance and cost-saving initiatives.

Service Line Review
The committee is assured that robust review processes are in place, with targeted actions to address financial and operational variances. Further updates will be provided as recovery plans progress.

Well Led Review Action Plan
The committee reviewed the draft well led action plan in its entirety. The committee endorsed the action plan.

The Committee received the following Chairs' Assurance Reports:

- **Trust Performance and Operational Improvement Group** – There were no specific areas escalate to the committee.
- **Performance and Financial Improvement Group** – the Committee noted the report, there were no issues to escalate to the Committee that were no capture separately within the FP agenda.

Chair's Assurance Report
Finance and Performance Committee

- **STW MSK Provider Collaborative Board** – It was agreed that following will be referred to the DERIC Committee for further support: Radiology Tracking Risk (Risk 3285) and Digital Infrastructure Delays – Significant delays in implementing digital solutions, including the Strata pilot. It was noted that most risks associated with the MSK transformation are linked to digital elements, either caused by or potentially mitigated through digital support.

Recommendation

The Board is asked to:

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

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

Committee / Group / Meeting, Date

Board of Directors– Public Meeting, 07 January 2026

Author: **Contributors:**

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Report sign-off:

Martin Evans, Non-Executive Director, Chair of the DERIC Committee

Is the report suitable for publication:

Yes

1. Key issues and considerations:

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

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

This report provides a summary of the items considered at the Committee meeting held on 20 November 2025. It highlights the key areas the Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

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

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

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

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

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

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

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

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

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

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

There were no specific items to escalate to the Board.

3.2 Areas of on-going monitoring with new developments

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

Innovation Story: Opiate Reduction QI Project Presentation

The Committee received and reviewed a detailed presentation on the Trust's Opiate Reduction Quality Improvement Pilot, noting strong clinical rationale, early progress, and areas requiring strengthened oversight.

The Committee took assurance from:

- A clear evidence base demonstrating significant clinical risk associated with pre-operative opioid use, including higher complication, infection and revision rates.
- Alignment of the project with GIRFT recommendations, NICE guidance, and the Trust's strategic objective to enhance services.
- A structured model for a new opioid optimisation pathway, incorporating multidisciplinary working and patient-centred support through the MyRecovery app.
- Positive engagement from early partners including a GP practice, community pharmacists, and research colleagues.
- Clear potential benefits for patients, including improved surgical outcomes, reduced complications, and enhanced pre-operative optimisation.

The Committee noted limited assurance in the following areas:

- Data and evaluation: Robust outcome monitoring is not yet established; a system is in development.
- Capacity and resourcing: Internal time pressures, limited admin support, and the need for system leadership were highlighted as barriers.
- External engagement gaps, particularly inconsistent GP involvement and fragmented service pathways.
- Digital constraints, including ongoing issues with Apollo not displaying complete community records.

The Committee agreed the following actions to strengthen assurance:

- Explore potential alignment with the National Implementation Neighbourhood Health Project.
- ICB-level discussions with Vanessa Whately to support system-wide coordination.

Overall, the Committee recognised the initiative as a promising and strategically aligned programme with clear patient benefit but requiring further development in governance, system engagement, resourcing and data capture to provide full assurance.

Board Assurance Framework

The Committee considered the three risks aligned to its remit:

- BAF 5. Delivering innovation, growth and achieving systemic improvements – the Committee agreed the revisions presented with the report and recommended this is submitted to the Board.
- BAF 7. Responding to a significant disruptive event - the Committee agreed the revisions presented with the report and recommended this is submitted to the Board.
- In relation to BAF 6. Responding to opportunities and challenges in the wider health and care system, the Committee agreed that a current score of 16 compared to other public sector organisations is more suitable.

Chair Report: Research Meeting

The Committee noted a continuing deterioration in research income, with an adverse variance of £25k in-month and £94k year-to-date, despite small positive contributions from several studies. Research opportunities have dropped significantly, resulting in reduced activity and challenges in maintaining income streams. The service is managing cost pressures, with favourable variances in both pay and non-pay, but overall financial performance remains materially off-plan.

There is an increasing reliance on securing external grants, with two applications in progress which, if successful, could stabilise the budget.

The Committee recognised the risk to sustainability if the decline in available studies is not reversed.

Research Progress and Opportunities Discussion

The Committee was assured that proactive work is underway to explore new income-generating opportunities, including: A potential rental model for academic institutions such as Keele University to utilise Trust space. The proposal to establish a Satellite Clinical Trials Unit (CTU), which would strengthen research capability and create additional revenue streams. The Committee noted that appropriate resource planning is being considered, acknowledging that a statistician and expanded research team would be required for the CTU model.

The Committee raised concerns about the need to re-evaluate the existing financial contract with Keele University, highlighting this as a priority action due to changes in leadership and ongoing financial pressures.

The Committee was informed that a meeting is being arranged with the new Vice Chancellor at Keele University, with the aim of reviewing the partnership and agreeing future contractual and research arrangements.

Further exploration of additional support avenues and funding opportunities will continue, ensuring sustainability and growth of the Trust's research portfolio.

Chair Report: Digital Transformation Group

Areas requiring the Committee's attention include:

- Apollo system stability – Three module outages occurred in October. System C has visited the Trust and is preparing an improvement plan. A working group has been formed to address ongoing issues locating clinical documents due to inconsistent titling and storage.
- Radiology PACS Upgrade (Fuji) – Testing is underway on-site with supplier support and a rollback plan in place.
- Digital Portfolio – The Committee recognised the need to reassess project RAG statuses, as several projects require clarification on whether they are in scope-development or delivery phases (e.g., digital literacy, conference facilities, CoPilot rollout, FDP). Updated reporting is expected at the next meeting.
- National NHSE guidance on Co-Pilot is being incorporated into a developing Trust AI policy, supported by two staff members attending national training.

The Committee received assurance in the following areas of progress:

- Finalised Terms of Reference.
- Active functioning of the Clinical Reference Group.
- Bluespier integration working well with positive performance reported.

- Continued developments in the Patient Portal, PACS/RIS procurement, and the Windows 11 transition.
- Good progress across several key digital projects.
- Confirmation that the Radiology PACS upgrade commenced successfully in November, with operational oversight continuing outside the Committee.
- MyRecovery is progressing, with anticipated advancement soon.

Chair Report: EPR Assurance Implementation Meeting
The update focused on the performance and required improvements relating to System C, following concerns previously raised about shared ownership and responsiveness. System C has been on site for several weeks undertaking further review work and has now provided a draft improvement plan structured across delivery timeframes.
The Committee noted that the draft plan requires refinement, and Trust discussions with System C are ongoing to confirm priorities, recommendations, and realistic timescales. The EPR team will continue to lead these negotiations to ensure an adequate and accountable improvement trajectory.
During discussion, the Committee was assured that a full log of existing system issues has already been shared with System C, and the Trust is awaiting a revised response by close of play on 20 November. This demonstrates active oversight and continued scrutiny of supplier performance.
The Committee noted that work is progressing, that the supplier is now more actively engaged, and that a structured improvement plan has been initiated. Assurance is moderated by the need for further refinement of the plan and confirmation that System C will deliver improvements within agreed timelines.

Education and Training Strategy Progress Report
The Committee noted that a key challenge is the lack of adequate training space, which may limit the Trust's ability to meet increasing educational demand. A previous proposal for a dedicated training centre will be revisited**.** Potential funding routes, including via the Orthopaedic Institute, will be explored and an updated has been requested for the next meeting on options and potential funding approaches for a training centre.

Chair Report: Multiprofessional Education Strategy Working Group
The Committee received the Chair's report from the Multiprofessional Education Strategy Working Group and took positive assurance that structured progress continues across key education workstreams. The following points were highlighted:

- A lack of dedicated training space remains a significant constraint on the delivery of education across the Trust.
- Work is underway to standardise training feedback through a single Trust-wide form, replacing multiple existing formats. A pilot is planned to use QR-code-based collection of training needs via the appraisal process. Managers have expressed a preference for block training days to support better operational release and completion of competencies, which will need factoring into future planning.

3.3 Areas of assurance

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

Performance Report
Further work on the metrics and assurance framework will continue, with an updated position to be brought to the January meeting.
The Committee emphasised the importance of aligning all work with DM and ensuring consistent reporting back through the appropriate governance channels.

Well Led Review Action Plan
The committee reviewed the draft well led action plan in its entirety and emphasised the importance of mapping new actions to existing processes to maximise value and avoid duplication. The committee endorsed the action plan. The Committee agreed that it is keen to agree and implement Recommendation 7 in the report as soon as possible.

Digital Security Report

Due to the nature of the report, limited details are shared within the public forum. The Committee reviewed and noted the submitted report and highlighted which considered security compliance, cyber security operations Centre Alerts and future Improvements/Innovation.

Proposal of Exec Leads for Education Streams
The Committee noted the verbal report which is to be discussed further at the Executive Team Meeting.

Recommendation

The Board is asked to:

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Audit and Risk Committee

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 07 January 2026

Author:	**Contributors:**
Name: Mary Bardsley Role/Title: Assistant Trust Secretary	N/A

Report sign-off:

Martin Newsholme, Chair of the Audit and Risk Committee

Is the report suitable for publication:

Yes

1. Key issues and considerations:

The Trust Board has established an Audit and Risk Committee. According to its terms of reference: '*The Board of Directors has delegated responsibility for the oversight of the Trust's system of internal control and risk assurance to the Audit and Risk Committee. This Committee is responsible for seeking assurance that the Trust has adequate and effective controls in place. It sought assurance regarding the Trust's internal and external audit programme, the local counter fraud service and compliance with the law and regulations governing the Trust's activities. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board.'*

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

This report provides a summary of the items considered at the Committee meeting held on 11 November 2025. It highlights the key areas the Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

The Audit and Risk Committee is responsible for seeking assurance that the Trust has adequate and effective controls in place to ensure all objectives and themes supported.

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

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

3. Assurance Report from Activity Recovery Committee

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

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

There were no specific areas of concern to escalate to the Board.

3.2 Areas of on-going monitoring with new developments

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

Chair Report from the Information Governance Meeting: DSPT Compliance

- One incident was reported to the Information Commissioner's Office (ICO) via the Data Security and Protection Toolkit (DSPT) incident reporting tool.
- There was one FOI breach during the reporting period, which occurred due to human error.
- The Committee is assured that incidents have been appropriately managed, FOI and SAR compliance is largely maintained with remedial actions in place, and data quality monitoring is ongoing. Continued oversight will be required to ensure improvements in FOI processes and visibility of data quality reporting.

Finance Governance

- Veterans' non-contract debt has reduced from £0.4m to £0.2m, though the contract requires reassessment and improved management processes.
- The Committee noted the need to set a clear trigger level for veterans' debt escalation to strengthen financial controls

Register of Interests and Hospitality

The Committee noted a decline in response rates for annual Register of Interests and Hospitality returns, with a significant dip in May. This was primarily due to the introduction of a revised process in 2025/26 requiring manager counter-signatures, which has increased turnaround times and administrative workload. Additionally, a large volume of returns became due following a previous review exercise, compounding the backlog. Members suggested introducing an electronic form to simplify completion and reviewing whether all declared interests are relevant to staff roles. They also asked whether alternative approaches could achieve compliance without reducing the integrity of the process.

3.3 Areas of assurance

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

Counter Fraud (MIAA)

The Committee acknowledged the Counter Fraud and MIAA paper and was assured that work is progressing as planned, with no significant concerns raised. There was emphasis on updating the anti-fraud policy and aligning it with the new business conduct policy.

Internal Audit Annual Review (MIAA)

The Committee expressed satisfaction with MIAA's performance. The Trust received reports from the following:

- Data Security Protection Toolkit
- ESR/Payroll Review *(moderate assurance opinion)*
- Fit and Proper Person Test *(substantial assurance opinion)*
- Medicines optimisation and Change of Pharmacy *(substantial assurance opinion)*

Chair's Assurance Report
Audit and Risk Committee

External Audit Progress Report
The Committee noted the progress made and is assured that the external audit is on track, with appropriate planning, resourcing, and independence confirmed.

Business Conduct Paper
The Committee approved the proposal to amalgamate the Standards of Business Conduct (SoBC) Policy, Standards of Business Conduct (BCBM) for Board Members Policy and the Managing Conflicts of Interest (CoI) Policy and is assured that:

- Work is progressing to streamline and clarify policies relating to standards of conduct and conflicts of interest.
- The approach will enhance transparency and reduce duplication.
- Further consolidation will be explored to ensure clarity and ease of reference.

Standards for Financial Instructions and Scheme of Delegation
The revised documents have been circulated for feedback, and the final versions will be presented at the February meeting for approval. Procurement has requested that these documents be standardised.

Risk Management
Trust-wide training compliance remains strong, with governance arrangements for digital risks and Apollo integration maturing appropriately.

Corporate Risk Register – 6 month Review
The Committee is assured that:

- Risks are actively monitored and managed through established governance processes.
- Appropriate actions are being taken to address long-standing and emerging risks.
- Further work is planned to review high risks and strengthen alignment across risk reporting structures.

Recommendation

The Board is asked to:

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