The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Board of Directors | Public Meeting 29.07.2026

MEETING
29 July 2026 09:30 BST

PUBLISHED
28 July 2026

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Agenda

Location
Board Room, Main Entrance

Date
29 Jul 2026

Time
09:30 BST

	Item	Purpose	Owner	Time	Page
1	Welcome			09:30	-
1.1	Apologies	Information	All Attendees		-
1.2	Minutes of the previous meeting (01 July 2026)	Approval	Chair		4
1.3	Action Log / Matters Arising	Discussion	Chair		20
1.4	Declarations of Interest	Information	All Attendees		21
2	Chair and CEO Update	Information	Chair and Chief Executive Officer	09:35	22
3	Risk Managment			09:50	-
3.1	Board Assurance Framework	Assurance	Trust Secretary		26
3.2	Corporate Risk Register	Assurance	Trust Secretary		88
4	Quality and Safety			10:10	-
4.1	IPR Exception Report	Assurance	Interim Chief Nurse Patient Safety Officer		94
4.2	Chair Report from Quality and Safety Committee	Assurance	Non-Executive Director		103
4.2.1	Learning from Deaths - Q1 Report	Assurance	Deputy Chief Medical Officer		107
4.2.2	Fuller Board Assurance Statement	Approval	Interim Chief Nurse Patient Safety Officer		110
	BREAK			10:35	-
5	People and Workforce			10:45	-
5.1	IPR Exception Report	Assurance	Chief People and Culture Officer		116
5.2	Chair Report from People and Culture Committee	Assurance	Non Executive Director		125
5.2.1	Freedom to Speak Up - Q1 Report	Assurance	Non Executive Director		128
5.2.2	Guardian of Safe Working Hours - Q1 Report	Assurance	Deputy Chief Medical Officer		140
6	Performance and Finance			11:10	-
6.1	IPR Exception Report	Assurance	Director of Performance		149
6.2	Finance Performance Report	Assurance	Chief Finance and Commercial Officer		171
6.3	Chair Report from Finance and Performance Committee	Assurance	Non-Executive Director		188
7	DERIC			11:35	-

	Item	Purpose	Owner	Time	Page
7.1	Chair Report from Digital, Education, Research, Innovation and Commercialisation Committee	Assurance	Non-Executive Director		190
8	Questions from the Governors and Public	Discussion	Chair	11:45	-
9	Risk Reflection / Values Reflection	Discussion	Chair	11:50	-
10	Any Other Business	Discussion	All	11:55	-
10.1	Next Meeting: 07 October 2026				-

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

BOARD OF DIRECTORS | PUBLIC MEETING

WEDNESDAY 01 JULY 2026 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	✓
Mike Hallissey (MH)	Non-Executive Director	✓
Stacey Keegan (SK)	Chief Executive Officer	×
Angela Mulholland-Wells (AMW)	Chief Finance and Commercial Officer	✓
Clair Hobbs	Interim 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	✓
John Pepper (JP)	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	✓
Heather Thomas Bache (HTB)	Communications Officer	✓
Colin Chapman (CC)	Governor – observing	✓
Jan Greasley (JG)	Governor – observing	✓
Victoria Sugden (VS)	Governor – observing	✓
Kate Betts (KB)	Governor – observing	✓
Sheila Hughes (SH)	Governor – observing	✓
Gill Pitcher (GP)	Governor – observing	✓

Ref	Discussion and Action Points
1.0	**Welcome and introductions**
	The Chair opened the meeting by welcoming all attendees. A particular welcome was extended to the Governors, Mike Hallissey, newly appointed Non-Executive Director, who attended his first public Board meeting following his appointment in June, Steve Bishton, who joined the meeting to present the Orthotics Manufacturing Service story.
1.1	**Apologies**
	Apologies were noted from Stacey Keegan and Dylan Murphy. 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.

Ref	Discussion and Action Points
1.3	**Minutes of the previous meeting**
	The minutes of the Board of Directors (Public) Meeting held on 06 May 2026 were approved as an accurate reflection of the meeting.
1.4	**Matters Arising and Action Log**
	It was confirmed that there were no outstanding actions to discuss, and the attendees had no further comments. There were no matters arising shared.
2.0	**Service Presentation: Orthotics Manufacturing**
	RL introduced Steve Bishton, Technical Lead for Orthotics Manufacturing, who joined the meeting to provide a spotlight presentation on the Orthotics Manufacturing Service. Steve explained that he has worked at RJAH for over 20 years, having started his career as an Orthotic Technician before progressing to his current role as Technical Lead. He highlighted his passion for developing both people and services. The presentation provided an overview of orthotics manufacturing, including the design and production of external devices that support, protect and improve movement. Examples of products manufactured by the team include insoles, leg braces and spinal jackets. Steve emphasised that each device is individually manufactured to meet a patient's specific needs. The service supports 17 Orthotists and delivers care across RJAH and Shropshire. One of the key areas supported by the team is the diabetic foot care service. Steve spoke positively about workforce development and highlighted a new partnership with the University of Derby. This has led to the creation of the first recognised training pathway for Level 3 Manufacturing Apprenticeships and Level 5 Clinical Apprenticeships within the service. Two apprentices have already successfully completed the programme, with a further two due to commence training in September 2026. In relation to People and Culture, Steve highlighted the team's strong focus on staff wellbeing and mental health. He described the team culture as adaptable, supportive and inclusive, which has been reflected in recent staff survey results. Positive improvements have been seen in responses relating to opportunities for staff to suggest improvements within their team and department. The service also continues to perform strongly in relation to workforce retention, achieving a retention rate of 90.9% against a target of 82%. Regarding Quality and Governance, Steve advised that the team is preparing for MHRA Registration, strengthening governance arrangements, compliance processes and quality assurance systems. This work aims to provide greater confidence to patients and clinicians while also creating future commercial opportunities for the Trust. In respect of Innovation and Improvement, Steve outlined the development of two satellite workshops, which have improved turnaround times by locating manufacturing facilities closer to clinical areas. This has enhanced both patient experience and service responsiveness. He also highlighted the introduction of new 3D printing technology, which has reduced manufacturing production times by approximately one hour per product. The innovation has increased capacity, improved consistency of production and enabled skilled staff to focus on more specialised activities and service improvements. Members noted that a further presentation on this work would be provided to the DERIC Committee to offer greater oversight of this area. In closing, Steve reflected on the many achievements of the service and described RJAH as a great place to work. He thanked his team for their ongoing commitment and the Board for the opportunity to present before inviting questions and comments from members. The Board discussed the following: • **Commercialisation**: Welcomed the presentation and asked whether the commercialisation of orthotics manufacturing could be incorporated into the regular commercial update provided by Mark Salisbury. AMW advised that discussions with Steve and Jane were ongoing regarding registration on the appropriate supply framework and ensuring that all relevant regulatory requirements are in place prior to commercialisation.

Ref	Discussion and Action Points
	It was acknowledged that this represents a positive direction of travel; however, further work is required to formalise the process. • **Culture:** ME reflected on the positive culture demonstrated by the team and highlighted the inspirational impact that individuals within the department are having. She emphasised the importance of sharing these successes both internally and externally, particularly with patients. A discussion took place regarding how patient feedback is currently captured, with feedback generally received through clinical teams and being considered through service management processes. It was recognised that there is an opportunity to strengthen how patient feedback relating specifically to the manufacturing service is gathered and shared across the organisation, ensuring that positive feedback is communicated back to the teams involved. • **Collaborative Working:** JP thanked the team for the presentation and sought an update on the joint working arrangements with Shropshire, Telford and Wrekin NHS Trust (SaTH). It was reported that relationships and collaborative working have improved, although some organisational boundaries remain and continue to be addressed. MC noted that services are delivered across locations at both Princess Royal Hospital (PRH) and Royal Shrewsbury Hospital (RSH), and work is ongoing to optimise service locations and improve pathways, particularly for acute patients. It was also highlighted that there is a significant shortfall in diabetic patient services due to under-commissioning, a challenge that is recognised across the wider healthcare system. • **Sim Lab:** HT highlighted the potential opportunity presented by the Simulation Laboratory (SimLab) and suggested that consideration be given to how the space could be utilised to educate patients about the services provided and the work undertaken by the orthotics manufacturing team. • **Career Opportunities:** MC commented that the service provides an excellent example of how the Trust can offer meaningful career opportunities and attract people into rewarding healthcare careers. Members noted that Steve would be representing the service at an upcoming careers event. • **Improvement Champions:** MC also acknowledged the contribution made by the Improvement Champions and the positive impact of the improvement methodology in supporting service development and staff skills. Particular thanks were extended to Liv, Steph and their teams for their continued commitment and contribution. HT reiterated the Board's commitment to supporting this agenda and thanked Steve again for his contribution.
3.0	**Chair and CEO Update**
	Chair Update At the previous meeting, the Trust had not yet received the National Oversight Framework (NOF) assessment. Over the past year, the Trust has delivered strong performance across a range of areas, including RTT, productivity and capacity, and operational performance, with no significant quality and safety concerns that have not already been reported through our governance processes. Our Amber/Green rating reflected this positive position. HT delighted to report that the Trust has now been placed in Tier 1, the highest tier within the National Oversight Framework. This achievement is welcome confirmation of the significant progress we have made and reflects the collective efforts of staff, leaders and Governors across the organisation. HT thanked everyone for their contribution in helping us reach this important milestone. HT also provided an update on the following: • **Board Development and Regional Collaboration**: As part of the Board's development cycle, there continues to be a strong regional ambition to share learning and best practice across organisations. The Regional Chair has highlighted RJAH's Enhanced Recovery programme as an example of good practice, and the Trust has been invited to present at a regional workshop on 15 July. The event is primarily aimed at Non-Executive Directors; however, all Board members are welcome to attend. Executive and Non-Executive Directors will receive further details and invitations through the Directors' Administration Team as appropriate. • **NHS Modernisation**: The NHS remains in a period of transition as we await further details regarding the proposed NHS Modernisation Bill. As a Trust, will continue to monitor

Ref	Discussion and Action Points
	developments closely and assess any implications for the organisation as further information becomes available. • **Baroness Amos Review of Maternity Services:** The recently published Baroness Amos Review of Maternity Services has prompted national consideration across healthcare organisations. While RJAH does not provide maternity services, many of the themes highlighted in the review remain highly relevant to our organisation, particularly those relating to transparency, listening to the patient voice, organisational culture, and responding effectively when things go wrong. The recommendations and learning points from the review will be considered through the Quality and Safety Committee, with any relevant implications and assurances reported through to the Board. **Deputy Chief Executive Officer Update** MC provided the following updates: • **Corporate Priorities:** We recently launched our 2026/27 Corporate Priorities, aligned to our five-year Trust Strategy. These priorities set out key actions, outcomes, and clear accountability through assigned Senior Responsible Officers, Delivery Leads, and Assurance Committees. The programme is now being rolled out across the organisation to help everyone understand how their role contributes to achieving the Trust's strategic goals and delivering success for patients and staff. • **Mann Review into antisemitism and racism in the NHS:** At RJAH, we are committed to ensuring everyone is treated with dignity, respect and fairness. Racism, discrimination and hatred have no place in our Trust. Every member of staff should feel safe, valued and respected, and every patient should receive compassionate care in an inclusive environment. While we are proud of our culture, we recognise that inclusion requires continuous learning, listening and action. We fully support the recommendations of the Mann Review and the NHS's commitment to strengthening its response to racism and discrimination. • **National patient safety award:** RJAH has been shortlisted as a finalist in the HSJ Patient Safety Awards in the Harnessing a Human Factors Approach to Improve Patient Safety category. The shortlisted project, Blending Human Factors and Improvement Magic, has empowered staff across the organisation with the confidence, skills and support to improve care delivery. By combining Human Factors and quality improvement, the initiative has fostered a culture where staff identify risks, challenge existing practices and test new ideas that benefit patients and colleagues. • **Industrial action:** Industrial action among Resident Doctors, previously postponed following an agreement between the government and the British Medical Association (BMA), has since been rescheduled. While the agreement focused on improving working conditions rather than further pay increases, a new round of industrial action has now been confirmed. The Trust remains focused on maintaining patient safety and minimising disruption to patients throughout this period. • **Marathon runners:** The Trust is incredibly grateful to the 13 runners who took part in this year's London Marathon in support of RJAH Charity, raising an outstanding £29,000. To celebrate their achievement, the Trust hosted a special thank-you event at the hospital. The funds raised will contribute to a wide range of charitable projects that enhance patient care and staff wellbeing. • **Galvanise Ethnic Minority Leadership Programme:** The Trust are pleased to support the rollout of the programme across STW. This programme is designed for clinical and non-clinical staff from ethnic minority backgrounds with leadership aspirations, supporting a more diverse workforce. It focuses on leadership development, self-awareness, networking, relationship building and career planning to help participants prepare for future development and promotion opportunities. • **Freedom to Speak Up Guardian:** We were delighted to welcome Kate Hannah to the Trust in June as our new Freedom to Speak Up Guardian. This important role provides colleagues with a safe and confidential route to raise concerns and supports our culture of openness, learning and patient safety. The Board also thanked Claudette Jones from the Royal Orthopaedic Hospital (ROH) for her support during the transition period. • **RJAH Star Award – April:** Our April winner was Dan Booth, our Clinical Audit Quality Lead, who was recognised for the vital role he has played in guiding teams during the implementation of Radar Healthcare – a system used to support patient safety, patient experience, risk management and clinical and quality audits. Dan was nominated by

Ref	Discussion and Action Points
	Louise Arnold, the Deputy Radiology Services Manager and Quality Lead, who said Dan was always incredibly helpful and supportive whenever she has a query, but his support during the rollout of Radar was particularly outstanding. • **RJAH Star Award – May:** Our May winner was Dylan Murphy, our Trust Secretary, who received his award in recognition of the significant impact he's made in strengthening governance and assurance across the Trust. As Trust Secretary, Dylan's role involves working independently across the Board of Directors, executive team and wider staff as a trusted and impartial advisor. He was nominated by Mary Bardsley, Assistant Trust Secretary, who praised both his leadership and the positive impact he has on colleagues across the Trust. Following the updates from the HT and MC, the Board discussed the following matters: • **Heatwave Response:** The Board expressed its thanks to all staff for their professionalism, adaptability, and commitment during the recent period of extreme heat. Members recognised the challenges associated with working across a diverse estate, including older buildings, and acknowledged the significant efforts made by staff to maintain services. The Board noted that improvements to air conditioning and air handling systems are being considered as part of ongoing estates planning and thanked colleagues for their resilience and flexibility. SN welcomed the progress being made to support staff in the heat and asked whether there was any additional support required from the Board to assist delivery. SN also welcomed the update regarding assurance through the relevant committees on the learning from the Trust's response to recent and anticipated future heatwaves. It was suggested that a future assurance report could be presented outlining improvements made and lessons learned. MC advised that the Trust had activated its Extreme Weather Plan through the Emergency Preparedness, Resilience and Response (EPRR) arrangements, which includes provisions for periods of extreme heat. The impact of the recent heatwave would be reviewed and reflected within relevant policies and plans. **ACTION:** assurance reporting and lessons learnt on how to support staff to be presented to the relevant committees. • **Maternity Services Improvement Plan:** The Board discussed the Trust's 100-day Maternity Improvement Action Plan. It was recognised that there are opportunities to strengthen how concerns and complaints are managed, particularly through consideration of the relationship between complaints, health inequalities, and organisational accountability. Members highlighted the importance of triangulating information from multiple sources, including complaints, audit findings, PROMs, and other patient feedback data, to support continuous improvement and learning. • PV reflected on the maternity services discussion and asked how the Trust could further assess and understand organisational culture. Members agreed this was an important consideration as part of future reviews and improvement work. • DH highlighted the ongoing work in response to the John Mann letter. It was noted that the Executive Team had agreed an approach to relaunching and embedding the Trust values, supported by a dedicated action plan. Members discussed the potential for a communication and engagement approach similar to that used for the Sexual Safety Charter to ensure awareness and engagement across the workforce. • PM spoke in support of the Trust's work to address discrimination and shared reflections from recently attending anti-ageism training. PM noted how valuable the training had been and suggested that the Trust should consider how education and awareness raising could be further facilitated to support staff and strengthen understanding in this area. Members welcomed the suggestion and supported continued development of learning opportunities. The Board noted the updates provided, and HT invited further comments from members. In response to a query, SK confirmed that the Trust's contribution to the wider System work would be presented at a future Board meeting, following the workshop held in May.
3.1	**Board and Committee Reporting Cycle**
	HT referred to the paper, and the Board noted the proposed changes to the Board and Committee meeting schedule, including the introduction of bi-monthly meetings for the Assurance Committees.

Ref	Discussion and Action Points
	Members were advised that full details were contained within the Board papers and were reminded that the dates of public Board meetings remain available on the Trust website. SN noted that oversight arrangements through the Finance and Performance Committee would be considered as part of the planning round, with additional meetings scheduled where necessary to support effective oversight and reporting requirements.
3.2	**National Oversight Farmwork**
	In addition to the Chair's update on the National Oversight Framework, MC referred to the paper and members discussed the collective support being provided across the organisation in response to the NOF. The Board emphasised the importance of maintaining robust oversight and assurance arrangements to ensure continued organisational focus and delivery.
4.0	**Quality and Safety**
4.1	**Performance Report – Quality and Safety Committee**
	The Board received the Quality and Safety Performance Report (by exception) and noted the following key points: • There are no issues requiring escalation. • **Infection Prevention and Control (IPC):** Performance remains positive, with compliance continuing to exceed the agreed tolerance levels. • **Complaints:** The response rate has improved both the timeliness and quality of responses following a review of the complaints process. As part of the acknowledgement stage, teams are now seeking opportunities to meet with patients directly. Waiting times and communication continue to be the most common themes raised in complaints. • **Surgical Site Infections (SSI):** Four cases are reported this month; two relate to procedures undertaken in March and two relate to April. All are being managed through the usual review and investigation processes, with no issues requiring escalation. • **Unexpected Deaths:** One unexpected death has been reported and is being managed in line with the Trust's standard review process. No concerns have been identified that require escalation. The Board noted the performance report.
4.2	**Chair's Assurance Report – Quality and Safety Committee**
	LW presented the key points from the Quality and Safety Committee Chair's Assurance Report. The following matters were highlighted: • **Complaints:** The Committee received an update on the improvements arising from the complaints deep dive. The Committee was encouraged by the positive progress being made and is beginning to see the benefits of the actions implemented. Members discussed the progress made against the Complaints Deep Dive and the associated Waiting Well Task and Finish Group. • **MSCI Loss of Site (LoS):** The Committee received an update on the impact of MSCI LoS on patient outcomes. Members noted the successful multi-agency summit hosted by the Trust and the resulting changes that have been implemented. A further update will be brought back to the Committee in October to review progress and impact. • **Great Ormond Street Hospital (GOSH) Report:** The Committee reflected on the presentation received in May regarding the GOSH report. Shared learning and benchmarking information have since been circulated, and the Clinical Effectiveness Group is actively considering the identified improvement opportunities, with work progressing as planned. • **Enhanced Recovery:** Members welcomed the update on the Enhanced Recovery Programme, which demonstrated positive outcomes and benefits for patients, supporting improved recovery and patient experience. The Board discussed the following: • **Learning from Deaths**: ME highlighted that within the Learning from Deaths was encouraging pleased to hear positive feedback from a patient and their family regarding the early reconciliation process and noted the valuable contribution of the Medical Examiner service in supporting patient and family engagement. • **Quality Account 2025/26:** LW informed the Board that the document was reviewed by the Quality and Safety Committee and subsequently approved by the Board of Directors on 24 June. Appreciation was extended to the Governors for their contribution and support

Ref	Discussion and Action Points
	throughout the process. The approved Quality Account is now available to view on the Trust website. Thank you to everyone involved for their hard work, commitment, and contribution to the development of the Quality Account and its successful approval. The Board confirmed that it was satisfied with the level of assurance provided and acknowledged the Committee's continued focus on key quality and safety risks.
4.3	**Quality and Safety Committee – Self Assessment and Annual Report**
	LW presented the Committee's self-assessment and annual report. Consistent with the findings from the reviews of the other Board committees, no significant issues were identified and, therefore, no changes to the remit of the core committees are proposed. The review did, however, identify opportunities to improve the timeliness and quality of some committee papers. Work is underway across the Trust to strengthen the paper review and approval process to support the timely circulation of high-quality meeting papers. The Committee's revised Terms of Reference were reviewed and recommended to the Board for approval. The Board considered the revised Terms of Reference, raised no comments, and approved.
4.4	**IPC Annual Report**
	CH presented the key highlights from the report, noting that: • The Committee received the IPC Annual Report and recognised the significant achievements delivered by the Infection Prevention and Control (IPC) team over the past year. • Members acknowledged the valuable contribution of Sam Young and expressed their appreciation for her work in supporting and advancing the IPC agenda. • The Committee also commended the dedication of the IPC team and recognised that these achievements had been supported through effective collaboration across clinical and operational teams throughout the Trust. • Looking ahead, the Committee noted the continued focus on strengthening antimicrobial stewardship as a key priority. LW confirmed that the Annual Report had been considered by the Quality and Safety Committee and was recommended to the Board for approval, with no concerns requiring escalation. The Board commended the report, recognising the significant contribution of the IPC team, and approved the IPC Annual Report.
4.5	**Patient Experience and Complaint Annual Report**
	CH presented the Patient Experience and Complaints Annual Report and highlighted the following key points: • .Positive patient experience outcomes were highlighted, including examples of inpatient services performing well and positive feedback from the Care Quality Commission (CQC), with the Trust recognised as one of the organisations achieving strong patient experience results. • Two patient stories had been received and were shared with members. Work is ongoing to develop a forward plan for future patient stories, with a patient also due to attend the next public Board meeting to share their experience directly. • Discussion focused on the importance of continuing to capture and learn from patient feedback to support ongoing improvements in care and experience. HT welcomed the report and commended colleagues across the Trust, noting that the organisation has maintained a high standard of patient experience despite the significant challenges and pressures faced over the past 12 months. HT thanked all teams for their continued dedication and commitment to delivering excellent patient care. LW confirmed that The Patient Experience Annual Report was recommended for approval, with no significant issues to escalate, with the exception of the complaints position The Board approved the Annual Report.

Ref	Discussion and Action Points
4.5	**Health and Safety Annual Report**
	CH presented the Health and Safety Annual Report and highlighted the following key points: • Overall, it had been a positive year for health and safety across the Trust. • Enforcement actions relating to sharps management and dermatitis patients had been addressed, with all required actions completed and learning embedded within practice. • There had been a reduction in both RIDDOR-reportable incidents and wider health and safety issues during the reporting period. • The move to bi-monthly Health and Safety Committee meetings had been well received and working effectively. It was noted that theatre representation has been limited in attendance at the meetings and this will be picked up with the teams. • All Central Alerting System (CAS) alerts had been managed and responded to within the required timescales. The Board discussed the following: • ME highlighted the importance of monitoring incidents of violence and aggression towards staff. CH confirmed that violence and aggression incidents remain a key area of focus. LW added that further detail will be provided in the forthcoming Annual Security Report, which is scheduled to be presented to a future meeting of the Quality and Safety Committee. • PM reported improved attendance and engagement from both Estates and Theatres at Health and Safety Committee meetings. Theatre compliance issues continue to be monitored and supported through CH in their 'buddy' role. In addition, the Head of Facilities, as Chair of the Health and Safety Committee, has attended every meeting throughout the year, providing consistent Estates representation and oversight. LW confirmed the report had been reviewed by the Quality and Safety Committee and was recommended for approval. The Board accepted and approved the Health and Safety Annual Report.
5.0	**People and Workforce**
5.1	**Performance Report**
	The Board received the People and Workforce Performance Report (by exception) and noted the following key points: • Pleased to report continued positive performance against key workforce indicators, including sickness absence, staff turnover, leavers, and vacancy rates, all of which remain within target. • It was also noted that agency expenditure continues to be below plan, reflecting effective workforce management and reduced reliance on temporary staffing, although bank spend remains above plan. • Short-term sickness absence increased slightly during May and June, largely due to seasonal coughs and colds. However, overall sickness levels remain within the Trust's target as a result of proactive management and effective attendance monitoring. The Committee expressed its thanks to managers across the Trust for their continued efforts in maintaining performance against workforce targets and supporting staff wellbeing. The Board noted the report and was assured by the overall performance position. No significant workforce issues or concerns were raised for further Board action.
5.2	**Chair's Assurance Report – People and Culture Committee**
	ME provided an overview of the key matters discussed at the People and Culture Committee for Board assurance. The following points were highlighted: • **Staff Wellbeing**: The Committee agreed to undertake a deep dive into anxiety, stress and depression, recognising these as leading causes of absence across the NHS. This work will commence following implementation of the new Occupational Health contract. • **Workforce Performance**: Continued focus remains on improving compliance with six-week roster approval and job planning requirements. Further work is underway, and trajectories will be presented to future meetings to demonstrate the expected pace of improvement. Overall workforce performance remains positive. The Committee has also introduced specific monitoring of workforce requirements for the new theatres programme to ensure staffing plans remain on track for delivery

Ref	Discussion and Action Points
	• **Equality, Diversity and Inclusion**: Positive progress was noted against the Equality, Diversity and Inclusion agenda, including increased disability declaration rates and ongoing staff network engagement. The Committee received assurance that leadership support for these initiatives will continue. • **Staff Survey**: Updates were received on departmental actions arising from the NHS Staff Survey. The Committee emphasised the importance of demonstrating tangible improvements and staff experience outcomes resulting from this work. • **Absence Management:** The Committee received an excellent presentation from Hannah Rose, Matron for MCSI, highlighting significant improvements in absence management within a challenging clinical area. Members were particularly impressed by her strong and inclusive leadership approach and discussed opportunities to share learning and best practice more widely across the organisation. • **Policy and Assurance Reports**: The Committee approved the Sexual Safety Plan and received assurance that key actions are now embedded within routine business processes, including recruitment and induction arrangements. • **Pay Gap Reports**: The Committee reviewed and approved the Ethnic Diversity Pay Gap Report and Disability Pay Gap Report. No significant concerns were identified, and both reports are due to be published on the Trust website. The Board discussed the following: • **Occupational Health Contract:** LW asked for an update on the Occupational Health contract. It was confirmed that the contract has now been awarded and that a new provider will be in place from September. • **Staff Networks:** PV highlighted the importance of staff networks, drawing on learning from a Well-Led review undertaken last year. It was also noted that the visible involvement and engagement of the Chief Executive and Senior Leadership Team in staff networks is important in demonstrating organisational commitment. MC responded that each staff network has an Executive Lead who provides support and sponsorship in their respective areas. However, it was acknowledged that there is an opportunity to consider how this support and senior leadership engagement could be strengthened further going forward. The Board acknowledged the strong workforce metrics and positive performance reported and expressed its thanks for the continued efforts of staff across the Trust.
4.3	**People and Culture Committee – Self Assessment and Annual Report**
	ME presented the Committee's self-assessment and annual report. Consistent with the findings from the reviews of the other Board committees, no significant issues were identified and, therefore, no changes to the remit of the core committees are proposed. The review did, however, identify opportunities to improve the timeliness and quality of some committee papers. Work is underway across the Trust to strengthen the paper review and approval process to support the timely circulation of high-quality meeting papers. The Committee's revised Terms of Reference were reviewed and recommended to the Board for approval. The Board considered the revised Terms of Reference, raised no comments, and approved.
5.3	**Freedom to Speak Up Annual Report**
	The Board received the Freedom to Speak Up (FTSU) Annual Report and noted the significant progress made over the past 12 months. On behalf of the Board, HT thanked SN and DM for their leadership on the remit. HT thanked SN for his support and commitment to the FTSU agenda as Board representive for 2025/26. It was noted that ME will assume responsibility going forward through his role as Senior Independent Director (SID) and membership of the People and Culture Committee. The Board expressed its appreciation to both SN and DM for their support in driving improvements and strengthening the Trust's FTSU arrangements over the previous year. In discussing the report, members noted that a number of concerns had been categorised under Staff Safety and Wellbeing. Assurance was provided that this largely reflected changes and

Ref	Discussion and Action Points
	improvements in categorisation and reporting processes, rather than indicating any significant increase in concerns within this area. The Board also discussed the evolving role of the Freedom to Speak Up Guardian. Members welcomed the appointment of Kate Hannah as the Trust's new Freedom to Speak Up Guardian and noted the positive initial engagement since her arrival. It was recognised that the role will place a stronger emphasis on organisational learning, alongside staff engagement and supporting cultural development across the Trust. Whilst the number of concerns raised remained relatively low, members agreed that this should not lead to complacency. Assurance was provided that ongoing work is being undertaken to ensure staff feel confident to speak up and raise concerns where necessary. The Board also noted the relatively low number of concerns attributed to registered nurses and discussed the need to explore this further. It was recognised that this may relate to reporting practices, including instances where staff groups are not disclosed, and members agreed that this would be monitored and reviewed going forward. The Board discussed the following points: • SN reflected on the significant development of the Freedom to Speak Up function over the last 18 months under DM portfolio. Members welcomed the increased focus on organisational learning and the identification of broader themes and trends arising from concerns raised. It was noted that benchmarking work with other organisations had been undertaken and was helping to inform future developments. • Members welcomed the appointment of the new Freedom to Speak Up Guardian and noted that a fresh perspective would support the continued evolution of the service, with further opportunities to strengthen learning and organisational improvement. • PV sought clarification regarding the outcomes and learning arising from concerns raised through the Freedom to Speak Up process. It was noted that learning had informed policy and process improvements where required. Members discussed the importance of understanding how staff utilise the Freedom to Speak Up route alongside other mechanisms for raising concerns, feedback, and issues within the Trust. • The Board was assured that the Trust remains committed to promoting a culture where staff feel able to speak up and that learning from concerns continues to be used to drive improvements across the organisation. Overall, the Board was assured by the report and no significant concerns were identified
6.0	**Performance and Finance**
6.1	**IPR Exception Report (inc. Long Waiting Patients)**
	MC presented the Integrated Performance Report (IPR), highlighting current performance against key operational metric noted the positive position across a number of key performance indicators, particularly within cancer access standards and elective recovery. • **Cancer Performance**: Remained strong, with the Trust achieving 100% compliance against the 31-day treatment standard. Performance against the 62-day standard and 28-day Faster Diagnosis Standard remained positive. The single breach of the 62-day target related to a patient who chose to delay their diagnostic pathway in order to receive investigations closer to home. Similar factors contributed to non-compliance against the 28-day target. Due to the relatively small patient numbers involved, performance remains particularly susceptible to individual patient circumstances. • **Elective Access and Waiting Lists**: Referral to Treatment (RTT) performance improved to 64.52%, representing a 1% improvement on the previous month and exceeding plan by 2%. Continued progress was also reported against the Welsh 26-week diagnostic and treatment standards, with performance improving for four consecutive months. A range of actions are in place to support further improvement, including specialty-specific performance targets aligned to available capacity and significant recruitment programmes. Successful recruitment within the Spinal Disorders Service, one of the Trust's most challenged areas, is expected to strengthen outpatient capacity and support further reductions in waiting times later in the year. Recruitment to Sports Surgery has also been particularly successful, with three new surgeons due to join the Trust between August and October.

Ref	Discussion and Action Points
	The Board also noted the recruitment plans associated with the new theatre development, which will bring additional capacity into the organisation. Approximately 37 staff are required to support the new theatre, with recruitment progressing in line with plan. Alongside workforce growth, there remains a continued focus on ensuring robust administrative processes, including timely validation of waiting lists, effective management of clinical outcomes, and maintaining accurate and clean waiting lists. • **Outpatient Waiting Times**: Performance against first outpatient appointment waits remained strong for English patients. Encouraging improvements were also reported for Welsh patients, with a continued focus on reducing inequity in access. Welsh first outpatient waits have improved by 5% over the last four months. • **Performance against the 52-week wait standard**: remained broadly on plan, with the Trust within 2% of its target. However, a slight deterioration was reported within the Welsh four-year wait cohort. An agreed and robust recovery plan is now in place to eliminate these waits during the year, supported by targeted recruitment in key specialties, particularly Spinal Disorders and Sports Surgery, alongside enhanced internal oversight of Welsh long waits. Positive and ongoing discussions continue with Welsh commissioners, particularly Powys Teaching Health Board, regarding future activity levels and contract arrangements to ensure they support both the Trust's ambitions and the Welsh Government's objective of eliminating very long waits. National funding allocations to support long-wait reductions have been announced, and discussions remain ongoing regarding the impact on future contracts. • **Diagnostics**: Diagnostic performance remained strong, achieving 95.64% and 97.64% compliance against the six-week and eight-week standards respectively. No significant concerns were identified and no issues required escalation. • **Elective Activity and Theatre Productivity**: Overall elective activity exceeded plan. However, this masked continued challenges within theatre activity, which remained below planned levels and continues to be a key area of operational focus. • The primary driver of the shortfall was workforce resourcing, alongside slower than anticipated recovery in theatre productivity. A number of unplanned staffing absences also impacted delivery, including extended parental leave, fellowship commitments, long-term sickness absence and other workforce pressures. Operational teams continue to focus on maximising theatre utilisation and recovering lost activity. • **BADS**: Whilst the reported BADS metric appeared unfavourable, management advised that this does not reflect the Trust's overall performance. RJAH continues to be recognised nationally as a leading organisation for length of stay performance and is regarded as an example of best practice in this area. The Trust is therefore working with NHS England, regional partners and national teams to review the appropriateness of the current metric and identify a more meaningful measure of performance. It was noted that the current BADS metric does not align with the Trust's nationally recognised length of stay outcomes, suggesting that an alternative measure may better reflect organisational performance. The Board acknowledged the progress made against key performance standards and reaffirmed the importance of maintaining momentum to ensure delivery of the operational plan, further reduction in long waits, and timely treatment for patients.
6.2	**Finance Performance Report**
	AMW presented the Finance Performance Report and highlighted the following key points: • Month 2 (May), the Trust reported a deficit of approximately £0.9 million, representing a £57,000 favourable variance to plan. • Whilst deficits at this stage of the year can create some concern, it was recognised that the Trust has historically started the financial year in a deficit position before improving performance during the latter part of the year. • The year-to-date deficit stands at £4.4 million, with a number of activity-related income pressures continuing to impact performance. However, these pressures are being partially offset through robust cost control measures, including vacancy management, controls on agency and bank expenditure, careful management of variable pay, and ongoing scrutiny of non-pay expenditure. • Members noted that productivity remains below target; however, performance is improving month-on-month and the trend is expected to continue. It was highlighted that productivity

Ref	Discussion and Action Points
	measures continue to be affected by historic factors, which are gradually unwinding. The key focus remains on increasing activity levels while maintaining tight control over costs. Delivering planned activity levels will be essential to improving productivity performance and moving closer to, or potentially beyond, the NHS England productivity target. • The Board also noted the importance of aligning workforce recruitment, particularly for the new theatres, with activity delivery plans to ensure that additional costs are not incurred ahead of corresponding income generation. • An update was provided on discussions with commissioners. Whilst relationships remain positive and constructive, there are currently approximately £2m of commissioner challenges relating to activity, performance standards and affordability assumptions, particularly with Powys Teaching Health Board. Discussions are ongoing and progress continues to be made through engagement with the appropriate stakeholders. • In relation to cash, the Board was assured that there are no concerns regarding the Trust's cash position. Although cash performance is currently below plan, this largely reflects the timing of forecast submissions and changes that occurred between plan submission in February 2026 and the start of the financial year, including pay-related assumptions, capital funding arrangements and support funding profiles. • Capital expenditure is currently behind planned phasing; however, this reflects the normal challenges associated with profiling a capital programme several months in advance. No significant risks were identified, and delivery of the capital programme remains on track. In summary, the Trust remains financially well controlled, performing slightly ahead of plan despite activity and income pressures. While productivity and contractual challenges remain, these are being actively managed, and the Trust continues to maintain a stable cash position and strong financial oversight.
6.4	**Chair Report from Finance and Performance Committee**
	SN presented the Chair's Assurance Report and highlighted the following key points: • Performance remains mixed and continues to be a key area of focus for the Committee, particularly in relation to long waiters. Members welcomed the increasing availability of more granular performance information, which is helping the Committee gain a deeper understanding of the underlying issues and challenges. • The Committee discussed the efficiency of the Specialist Unit at its June meeting. Members noted a combination of short-term operational pressures and longer-term challenges, as outlined within the current risk and mitigation plans. Work is continuing to strengthen the associated actions and controls. • In relation to the Theatre Improvement Programme, the Committee was assured that the programme remains on track. AMW highlighted the importance of retention as a key factor in supporting the sustainability of improvements alongside recruitment initiatives. • The Committee also received an update on the Four Eyes review. It was noted that learning from the review and actions arising will continue to be progressed through the agreed action plan, with regular monitoring of delivery. The Board discussed the following: • **Theatre Improvement Plan**: PV referred to the Four Eyes report and sought assurance regarding the current position and whether the appropriate operational leads were sufficiently involved in the work. In response, MC advised that the recommendations from the Four Eyes review, CARDOS, GIRFT and other related reviews had been consolidated into a single improvement plan focused on optimising theatre efficiency and productivity. The plan recognises the contribution required from a range of teams, including pre-operative assessment, administration, and clinical services. Clear ownership, actions, and timescales have been established, and the remaining elements of the plan are expected to be finalised shortly. Once complete, the consolidated plan will be presented through the appropriate governance committees, including the Finance and Performance Committee, providing a clear organisational approach to improving theatre productivity and efficiency, supported by a benefits realisation framework. MC acknowledged that further work remains to be undertaken. The consolidated plan incorporates recommendations from the relevant reviews and reports that have been completed to date, ensuring alignment across improvement activities.

Ref	Discussion and Action Points
	PV noted that the Four Eyes report highlighted a number of potential factual inaccuracies and data-related concerns. MC confirmed that these have been reported back to the provider. Subject to the outcome of this work, and the availability of funding, further engagement with Four Eyes may be considered. It was also noted that there are elements of the report with which the Trust does not fully agree, and these have not been incorporated into the transformation plan. • **104 Welsh Patient waiting list** - MN requested further detail regarding the Welsh 104-week position, including the key actions and risks associated with achieving the target. MC advised that a significant proportion of patients have chosen to remain on waiting lists for treatment by specific consultants. Actions being taken include increasing consultant capacity, reviewing insourcing opportunities, undertaking job plan reviews, and progressing recruitment initiatives. The principal risks include managing relationships with NHS England whilst balancing multiple competing priorities, alongside the Trust's commitment to reducing inequalities between English and Welsh patients. A further risk relates to the commissioning envelope provided by Powys Teaching Health Board, which is currently approximately £2m below the level required to support delivery of the 104-week target and the Trust's wider ambitions. Fortnightly meetings have been established to maintain oversight and ensure progress remains on track. The Board noted the Chair's Report and confirmed that it was satisfied with the assurance provided.
6.5	**Finance and Performance Committee – Self Assessment and Annual Report**
	SN presented the Committee's self-assessment and annual report. Consistent with the findings from the reviews of the other Board committees, no significant issues were identified and, therefore, no changes to the remit of the core committees are proposed. The review did, however, identify opportunities to improve the timeliness and quality of some committee papers. Work is underway across the Trust to strengthen the paper review and approval process to support the timely circulation of high-quality meeting papers. The Committee's revised Terms of Reference were reviewed and recommended to the Board for approval noted that additional meeting may be scheduled to support with the planning submission throughout the year. The Board considered the revised Terms of Reference, raised no comments, and approved.
7.0	**Digital, Education, Research, Innovation and Commercialisation**
7.1	**Chair Report from Digital, Education, Research, Innovation and Commercialisation Committee**
	ME presented the Chair's Assurance Report and highlighted the following key points: • **EPR Assurance Meeting:** Whilst no formal meeting was held in June, the Committee received a Senior Responsible Officer (SRO) update. Members noted that progress is being made with the Business Process Review programme, although further detail is required regarding timelines, delivery trajectories and the anticipated impact on associated corporate risks. The Committee has requested a more comprehensive update at its next meeting to enable greater oversight of progress and risk reduction. The Committee received assurance that clinician engagement continues to improve. Feedback has identified a number of key issues that clinicians are encountering within digital systems, and these have now become the focus of targeted improvement activity. It is anticipated that measurable improvements will be seen over the next three months, resulting in tangible benefits for clinical users. • **PACS and Imaging Systems**: An update was provided on the Picture Archiving and Communication System (PACS). The Committee received its strongest level of assurance to date regarding the proposed way forward. Members noted the need for a short-term extension to the current contract whilst work progresses on the emerging West Midlands regional imaging network solution. Assurance was received that the contract extension could be secured appropriately and that discussions with the current provider regarding performance improvements are ongoing. Members welcomed the renewed momentum at regional level and agreed that participation in the wider West Midlands solution remains the preferred option for the Trust.

Ref	Discussion and Action Points
	• **Training Centre Development**: Constructive discussions continue regarding the future development of the Training Centre. A dedicated working group has been established to further develop proposals, and a more detailed update will be presented to the Committee in September. • **Digital Roadmap**: The Committee welcomed the development of a clear Digital Roadmap, setting out priorities over the short, medium and longer term. Members were encouraged by opportunities to secure additional funding to support the Trust's digital ambitions. The Committee requested that future iterations of the roadmap include clearer articulation of the anticipated benefits and timing of improvements to organisational performance, patient experience and staff experience. • **Research and Innovation**: The Committee received two informative presentations showcasing research activity within the Trust, including the ASCOT programme, which has been running successfully for almost two decades. Members discussed opportunities for further commercialisation and welcomed the establishment of organisational structures to support these discussions. The Committee also reflected on the breadth of research activity undertaken in partnership with local universities and recognised the value of continuing to showcase this work through DERIC. • **Education and Training**: The Committee noted the highly positive results from the National Education and Training Survey. The Trust performed above the national average across the majority of assessed domains, with performance in the remaining areas broadly in line with national benchmarks. No domains were identified as areas of significant concern, providing strong assurance regarding the quality of education, training and support provided to learners and resident doctors. The Board noted the Chair's Report and confirmed that it was satisfied with the assurance provided noted the progress on the elements within the portfolio.
7.2	**DERIC Committee – Self Assessment and Annual Report**
	ME presented the Committee's self-assessment and annual report. Consistent with the findings from the reviews of the other Board committees, no significant issues were identified and, therefore, no changes to the remit of the core committees are proposed. ME also outlined proposed changes to the committee structure, with Assurance Committee meetings moving to a six-monthly cycle aligned to the public Board meetings. The remaining meetings will adopt a more strategic, deep-dive format, providing greater opportunity for focused discussion and supporting the delivery of the Trust's vision. Members noted Executive support for this revised approach. The Committee reviewed the revised Terms of Reference and recommended them to the Board for approval. In addition to the annual amendments, the document includes revisions to the Authority section to more accurately reflect the Committee's role in supporting the development of strategies and providing assurance on their delivery, rather than developing and implementing strategies directly. Members welcomed the clarification of the Committee's responsibilities, the strengthened focus on strategic delivery assurance, and the establishment of the Strategy Delivery Group (SDG). The Board considered the revised Terms of Reference, raised no comments, and approved them.
8.0	**Chair Report from Audit and Risk Committee**
	MN presented the Chair's Assurance Report and highlighted the following key points: • The Board received the Chair's Assurance Report from the Audit Committee, highlighting key discussions from the meetings held on 11 May and 24 June. • The Committee received the External Auditor's Audit Findings Report and reviewed the Annual Report and Accounts prior to recommending them to the Board for approval. • Members noted that this was the first year working with the Trust's new external auditors, KPMG, and acknowledged the challenges associated with transition to a new audit provider. KPMG reported no significant issues in relation to the Trust's financial statements or balance sheet. A query was raised regarding the future revaluation of estate assets, which will be considered further going forward. No amendments to the accounts were required as a result of the audit process.

Ref	Discussion and Action Points
	• The Board approved the Annual Report and Accounts, and all relevant submissions have subsequently been completed. The Committee commended Trust colleagues and the external auditors for their pragmatic and collaborative approach throughout the process. • The Committee also received the Internal Audit Annual Report. Individual audit reviews had been completed throughout the year, aligned to the Trust's strategic objectives and risk register. The annual opinion provided substantial assurance, reflecting the effectiveness of the Trust's governance, risk management and control arrangements. Recognition was given to teams across the organisation for addressing audit recommendations promptly and effectively. • The Counter Fraud Annual Report was received, with assurance provided that no significant concerns had been identified regarding the Trust's approach to counter fraud activity. • Finally, the Committee reviewed the revised Risk Management Policy and recommended it to the Board for approval. The updated policy clarified roles and responsibilities and reflected the transition from the DATIX system to the new RADAR risk management system. The Board were content with the assurance report provider and commended the teams for their work on the annual report and annual account results and submission.
8.1	**Risk Management Policy**
	MN confirmed that the Committee endorsed the Risk Management Policy. Members noted that future iterations should further consider the Board's risk appetite and strengthen the reporting of risk management processes to the Board. The Board approved the policy.
9.0	**Questions from the Governors and Public**
	HT welcomed comments and questions from the members of the public: • **Board Governance and Reporting Cycle:** HT reminded Governors and members of the public that the Board schedule of business has been reviewed to ensure committee meetings are aligned to the appropriate reporting months and support the new governance and reporting cycle. Members noted that the next public Board meeting is scheduled for 29 July, supporting the proposed move to a bimonthly Board meeting cycle. • **Presentation Feedback:** Governors commended the presentation and expressed their appreciation for the engaging delivery. Recognition was given Steve Bishton for his enthusiasm and the positive focus on organisational culture. • **Orthotics Manufacturing and Equipment Utilisation:** Commended staff involved in the initiative for commercialisation the orthotics services, particularly the positive developments around manufacturing products in-house. Reflecting on his time at the Trust, CC highlighted historical challenges regarding patients not fully utilising prescribed equipment, often due to comfort, fashion preferences, or a lack of understanding of its importance. It was noted that some equipment was not returned or used as intended, leading to waste. Assurance was sought that patients are supported to understand the benefits of the equipment provided and encouraged to use it appropriately to maximise outcomes • **Staff Sickness and Wellbeing:** A question was raised regarding sickness absence related to stress, anxiety and depression. Specifically, clarification was sought as to whether absence is concentrated within a recurring cohort of staff and what additional support mechanisms are in place, or could be introduced, to better support those individuals and improve wellbeing outcomes. DH confirmed this would be picked up outside of the meeting. • **Powys Commissioning Arrangements and Waiting Times:** welcomed the work being undertaken with Powys to address health inequalities and reduce waiting times from 104 weeks towards 52 weeks. Further information was requested regarding the Trust's ambition and negotiating position within these discussions. It was acknowledged that challenges remain due to differing national policies, particularly the Welsh "first outpatient appointment" measure and the complexities of aligning performance expectations across England and Wales. The Board expressed concern regarding the widening disparity between waiting times for English patients, who are typically treated within 18 weeks, and

Ref	Discussion and Action Points
	Welsh patients, who may wait in excess of 52 weeks. It was noted that teams remain determined to work closely with neighbouring providers to support action to address this inequity.
10.0	**Risk and Value Reflection**
	Reflecting on the meeting there were no specific risks to raise which were not already recorded on either the corporate risk register or the Board Assurance Framework.
11.0	**Any Other Business**
	Board Reporting Cycle: It was agreed that the agenda for the October meeting will be considered and explore opportunities to condense both the public and private Board sessions into the morning in order to accommodate the Board to Board session with ROH. HT thanked the attendees for their contribution to the meeting before brining it to a close.
11.1	**Date and time of next meeting:** Wednesday 29 July 2026 at 9:30am

Board of Directors Meeting

Updated: 27 July 2026

Action Log No.	Original Meeting Date	Minute reference	Action	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
1	01-Jul-2026	**CEO Report - Heatwave**	Assurance reporting and lessons learnt on how to support staff to be presented to the relevant committees.	MC	**02-Sep-2026**	On track - after action review has been scheduled to identify learning from the recent heatwave. Added to the QS workplan.	**ON TRACK**

Member	First Name	Surname	Email	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	Sarfraz	Nawaz		Non Executive Director	Financial Interests	Wakefield Council – Corporate Director of Resources	01/02/2026	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	Husband has also just been appointed as Interim CEO to the Devon, Cornwall and Scilly Isles	19/03/2026	Ongoing
Board	Penny	Venables		Non Executive Director	Non-Financial Personal Interests	Husband is NED at Birmingham and Black Country ICB	01/02/2026	Ongoing
Board	Penny	Venables		Non Executive Director	Non-Financial Personal Interests	Chair Kore Wellness, 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 Chairman 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	Mike	Hallissey		Non Executive Director	Non-Financial Professional Interests	Non-Executive Director of Sandwell and West Birmingham NHS Trust	01/01/2022	Ongoing
Board	Mike	Hallissey		Non Executive Director	Non-Financial Professional Interests	Consultant Surgeon, University Hospitals Birmingham NHS Foundation Trust	01/05/1995	Ongoing
Board	Mike	Hallissey		Non Executive Director	Indirect Interests	Director, Pegasus Classic Car Parts Ltd	01/11/2025	Ongoing
Board	John	Pepper		Associate Non Executive Director	Financial Interests	GP appraiser for NHSE	2012	31/03/2026
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	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	01/04/2023	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	Non-Financial Professional Interests	Member and chair of the Jenner Society at Morton Hall and organiser of the annual MMI evening at RJAH	01/01/2016	Ongoing
Board	Ruth	Longfellow		Chief Medical Officer	Non-Financial Professional Interests	Member of Orthopaedic Institute	01/01/2016	Ongoing
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 completing consultant work at Johnson Fellows Charter House, Birmingham, Ad hoc HR consultancy Johnson Fellows (previously a senior partner)		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	Clair	Hobbs		Interim Chief Nurse and Patient Safety Officer	No interest to declare	N/A	N/A	N/A

Chief Executive Officer Update

Committee / Group / Meeting, Date

Board of Director - Public Meeting, 29 July 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 the Board with an update from the Chief Executive Officer on key activities and developments since the last Board meeting, which are not covered elsewhere on the agenda.

Recommendations:

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

Acronyms	
Acronym	**Definition**
CQC	Care Quality Commission
ICB	Integrated Care Board
MSK	Musculoskeletal
NHS	National Health Service
NHSE	NHS England
RJAH	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
SDG	Strategy Delivery Group

Chief Executive Officer Update

1. Change in Government Leadership

Since the last Board meeting, there has been a significant change in national political leadership, with Andy Burnham becoming Prime Minister and a new Cabinet appointed in July 2026. The refreshed ministerial team includes a number of changes across key departments relevant to the NHS, including Health and Social Care, the Treasury and Business. As the new Government establishes its priorities, further detail is expected on public service reform, NHS performance, workforce and productivity, and the wider devolution agenda. The Trust will continue to monitor national policy developments and assess any implications for RJAH's strategic objectives and operational delivery.

2. National Publications

Several important national publications have been released during the reporting period, which will influence the Trust's strategic and operational priorities over the coming months.

The new National Patient Standards, published in early July, establish a national benchmark for the experience of patients accessing non-urgent (elective) care. The standards place a strong emphasis on communication, information sharing, personalised support and reducing uncertainty throughout the patient journey, from referral through to treatment. A multidisciplinary working group has been established to review current practice and oversee implementation across the Trust.

Shortly afterwards, the National Quality Strategy was published, aligning closely with the Government's wider 10-Year Health Plan. The strategy focuses on delivering consistently high-quality care, reducing unwarranted variation, tackling health inequalities, promoting continuous improvement and increasing transparency in outcomes and performance. The Trust has commenced a review of its existing quality and improvement strategies to ensure alignment with the national direction.

In addition, NHS England has published new National Staff Standards, setting clearer expectations regarding the experience of NHS staff, including wellbeing, inclusion, leadership, development and support. These standards reinforce the importance of creating compassionate, inclusive workplaces where staff are empowered to deliver excellent care.

Alongside this, the new Management and Leadership Framework has been introduced to strengthen leadership capability across the NHS. The framework sets out expectations for managers and leaders at all levels, with a focus on compassionate leadership, accountability, continuous improvement, operational excellence and delivery. The framework provides an opportunity for the Trust to further strengthen leadership development and ensure alignment between organisational culture, leadership behaviours and strategic objectives.

Collectively, these publications provide a coherent national direction centred on improving patient outcomes, enhancing staff experience, strengthening leadership capability and embedding continuous improvement. Work is underway to assess the implications for RJAH and to refresh relevant strategies, policies and programmes to ensure alignment with emerging national expectations.

3. Neighbourhood Health Visit

Last week, we welcomed Dr Claire Fuller for an NHS England/ICB Cluster Neighbourhood Health visit. The visit provided an opportunity to showcase progress across the Cluster, including RJAH's leadership of MSK transformation. Feedback was highly positive, recognising the strong foundations and tangible progress achieved to date. The discussion also brought constructive challenge, encouraging partners to accelerate delivery and strengthen collaborative efforts to realise the full ambition of neighbourhood health and system transformation.

4. NHS Midlands Best Practice Day

We were delighted to be invited to participate in this event, chaired by Russell Hardy, Chair of NHS England Midlands, and to present our Enhanced Recovery Programme as part of the productivity showcase. While the session primarily focused on the programme's impact in reducing length of stay, we also highlighted the wider benefits it has delivered for patients, including improved outcomes, experience, and recovery.

The event was designed for Non-Executive Directors and provided an opportunity to share learning from across the Midlands, celebrating innovation and improvement whilst encouraging constructive challenge through the question: *"If they can do it, why aren't we?"* This created a valuable forum for reflection, learning, and the spread of best practice across the region.

5. Heatwave

June and July have seen record-breaking temperatures. While many of us enjoy the summer weather, prolonged periods of heat can create additional challenges for both our staff and our patients, particularly within a busy healthcare environment.

I would like to place on record my sincere thanks to all our colleagues for their hard work, resilience and can-do attitude throughout this period. Despite the demanding conditions, staff have continued to go above and beyond to ensure patients receive the highest standards of care and support.

As we experience more frequent periods of extreme weather, it is important that we continue to adapt our estate and infrastructure to meet the challenges of the future. We are therefore reviewing our Estates Strategy and cooling plans to ensure they are fit for the future, helping us to create environments that support the wellbeing of patients, visitors and staff, while maintaining the resilience of our services during periods of sustained heat.

6. CQC Engagement visit

During July, we welcomed a team from the Care Quality Commission (CQC) to the Trust. The visit included a series of formal presentations alongside visits to a number of clinical and corporate departments, providing an opportunity to showcase our services, culture, and approach to care.

Throughout the visit, the focus was firmly on learning and improvement, with constructive discussions that enabled us to share our progress, reflect on our experiences, and identify opportunities to further strengthen the quality of services we provide for patients and colleagues.

7. Strategy Delivery Group

We have established a new Strategy Delivery Group (SDG), replacing the former Trust Management Group. The SDG has been created to strengthen oversight and delivery of the Trust's strategic ambitions, with a particular focus on our five-year strategy and associated corporate priorities.

The group met for the first time in early July and is now developing a work programme to support the coordinated delivery of key strategic objectives across the organisation. A core function of the SDG will be to provide oversight, challenge and assurance, with progress being reported through the Board committee structure.

As the group is still in its early stages, we are continuing to refine both its operating arrangements and the format of the assurance reporting that will be provided to committees. This will evolve over time to ensure the Board receives clear and meaningful insight into the delivery of our strategic priorities.

8. Veterans Strategy Session

The development of our Veterans' Orthopaedic Service as a nationally recognised centre of excellence is one of the five core pillars of the Trust's five-year strategy. During 2026/27, we have committed to developing a sustainable future model for veterans' services and to further develop our veterans' rehabilitation pathway to ensure it continues to meet the needs of those who have served.

As part of this work, we held a dedicated strategy session in July, bringing together a range of key internal and external stakeholders to help shape the future direction of the service. The session provided a valuable opportunity to explore opportunities, challenges and ambitions for the programme, ensuring that future developments are informed by a broad range of expertise and perspectives.

The outputs from the session will support the development of a clear strategic framework for veterans' services, helping to ensure that the Trust remains at the forefront of specialist orthopaedic and rehabilitation care for the veteran community.

9. Inappropriate Accessing of Patient Records

You may have seen recent national messaging regarding the inappropriate access of patient records. This follows a number of cases across the NHS where records have been accessed without a legitimate work-related reason, resulting in serious consequences for both patients, families and staff, including disciplinary action and dismissal.

In busy healthcare environments, access to patient information is often essential to delivering care, however it is vital that records are only accessed when there is a clear and lawful reason to do so. Unauthorised access is a breach of patient confidentiality, undermines trust, and may result in significant personal and professional consequences.

In line with national guidance, we will be launching a staff awareness campaign to reinforce the importance of appropriate access to patient information and to ensure colleagues fully understand

their responsibilities when handling patient records. The campaign will highlight both the legal and ethical obligations associated with accessing confidential information, as well as the potential consequences of failing to adhere to these standards.

10. Digital Inclusion and Patient Access Survey

The Trust has launched a Digital Inclusion and Patient Access Survey to help us better understand how confident patients feel when using digital services, including appointment text reminders, email communications, online information and other digital tools. As digital technology continues to play an increasingly important role in healthcare delivery, it is essential that we understand the needs and experiences of all our patients.

The feedback gathered through the survey will help inform future developments and ensure that, as more services become available digitally, no patient is unintentionally excluded or disadvantaged. The findings will provide valuable insight into the barriers some patients may face, whether related to access to technology, digital skills, confidence or connectivity.

This work forms part of our wider commitment to reducing health inequalities and improving access to care for all patients, regardless of age, location, background, or digital capability. By understanding our patients' experiences, we can ensure that digital innovation continues to enhance care while remaining inclusive, accessible and responsive to the needs of the communities we serve.

11. Digital improvements

We have further enhanced the way we communicate with patients through the rollout of a new appointment reminder service in partnership with our digital provider, DrDoctor. Patients with upcoming appointments now receive automated text message reminders, with the ability to confirm their attendance or request to rearrange their appointment if required. This improvement supports a more convenient patient experience, helps reduce missed appointments, and enables more efficient management of clinic capacity.

The introduction of the new DrDoctor Patient Portal is another important milestone in our digital transformation programme, providing patients with greater access, choice and control over their care. The portal represents a significant step forward in how we engage with patients and support them throughout their treatment journey.

Alongside these developments, we continue to invest in the enhancement of Apollo and associated digital applications as part of our commitment to delivering safer, more efficient and user-friendly systems for both patients and staff. A number of upgrades and improvements are planned over the coming months, with further functionality being introduced between now and September.

Engagement sessions will take place during August to provide colleagues with an early opportunity to view and test a range of planned developments. These include Workspace V2, which will deliver an enhanced clinical portal experience, improving navigation, increasing visibility of key documents, and providing more intuitive access to patient information. Feedback from these sessions will help shape the final implementation and ensure the changes meet the needs of clinical and operational teams.

Collectively, these developments represent significant progress, supporting improved patient and staff experience, enhanced clinical workflows and the delivery of high-quality, efficient care.

12. 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 July winner was **Ellie Moore**, a Nursing Associate on Ludlow Ward, who was recognised for going above and beyond to support a patient. Ellie was nominated by the patient herself, who said she was only able to get through a traumatic period thanks to Ellie's compassion, kindness and reassurance. She described her as "an absolute angel in human form".
- Our June winner was **Dan Booth**, our Clinical Audit Quality Lead, who was recognised for the vital role he has played in guiding teams during the implementation of Radar Healthcare – a system used to support patient safety, patient experience, risk management and clinical and quality audits.

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

13. Conclusion

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

Board Assurance Framework

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

(Part 1) Covering paper

Committee / Group / Meeting, Date

Board of Directors, July 2026

Author:

Name: Dylan Murphy
Role/Title: Trust Secretary

Contributors:

Executive Team members

Report sign-off:

n/a

Is the report suitable for publication?:

YES

Executive Summary:

The Board Assurance Framework (BAF) outlines the key risks to delivery of the Trust's objectives and the mitigations in place to address those risks. The BAF identifies a number of themes and associated strategic risks. The following BAF themes have been agreed for 2026/7:

BAF Theme		Risk Score
1	**Continued focus on excellence in quality, safety and patient experience.**	**C5 X L2 = 10**
2	**Focus on equity of service and addressing health inequalities**	**C5 X L4 = 20**
3	**Effective workforce engagement, capability and culture to enable sustainable, digitally enabled service transformation**	**C5 X L2 = 10**
4	**Delivering financial sustainability**	**C5 X L3 = 15**
5	**Delivering the required levels of productivity, performance and activity**	**C5 X L3 = 15**
6	**Delivering innovation, improvement and growth**	**C4 X L4 = 16**
7	**The challenges of operating in both the Welsh and English health systems**	**C4 X L5 = 20**
8	**Responding to a significant disruptive event**	**C5 X L3 = 15**
9	**Security of digital, data and AI systems and ability to respond to cyber threats**	**C4 X L4 = 16**

The scores are as presented to the committees at the July round of meetings and are subject to revision, pending committee discussions. Any proposed changes will be identified in the appropriate Chair's assurance report.

Previous discussions have focussed on the broad themes and strategic risks reflected in the BAF titles and associated descriptors. This paper now includes the initial detail around those BAF entries, including the risk score, the rational for that score, the target score, the controls in place to mitigate the risk (and the associated sources of assurance).

Most of the BAF themes and associated risks are broadly reflective of those considered in 2025/6. The exceptions, where a new theme has been agreed, are:
BAF 7 – re. the challenges of operating in both the Welsh and English health systems
BAF 9 – re. the security of digital, data and AI systems and ability to respond to cyber threats

Recommendations:

That the Board:

- NOTE the first full iteration of the BAF for 2026/7;

- CONSIDER any required revisions, including any revisions proposed by the Board committees (to be identified via the Chair's assurance reports);
- CONSIDER the level of assurance provided by the report.

(Part 2) Strategic alignment and supporting detail

Strategic objectives and associated risks:

The following strategic objectives, developed in light of national and system priorities, 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	✓
The BAF reflects the key themes covered by the Trust's strategic objectives, the risks to delivering them, and the actions in place (or planned) to mitigate those risks. The revised draft BAF has been considered alongside the updated corporate objectives for 2026/7.		

Trust values:

The content of this report reflects / supports the following Trust values:

Trust Values		
1	Professional	✓
2	Excellence	✓
3	Respect	✓
4	Friendly	✓
5	Inclusive	✓
6	Caring	✓
The Trust's objectives should align with, and support the Trust's values. The BAF provides assurance that the objectives are being delivered.		

Report development and engagement:

The 2025/6 BAF has been used as the starting point for an updated BAF for 2026/7. Broad themes for inclusion / reflection from 2026/7 onwards have been considered by the Board, the Board committees and the executive team in a number of sessions from November 2025 onwards.

At the Executive team session on 10 March 2026, the draft BAF descriptors and themes were considered alongside the emerging corporate objectives for 2026/7 (and beyond). The draft BAF was subsequently considered at the March round of committees and the April Board meeting.

As the BAF reflects strategic, relatively long-term risks, much of the supporting detail from the 2025/6 BAF remains relevant (and has provided the starting point for the 2026/7 BAF).

The BAF themes and strategic risks were agreed at the May 2026 Board meeting, after consideration at the April 2026 committee meetings.

The new sequence of reporting was considered by the Board in May 2026, and formally agreed at the June 2026 Board meeting.

Next steps:

The Board will receive an overarching BAF paper at its meeting on 29 July 2026.

As agreed at the public Board meeting in June, the BAF will move to a cycle of review at every other full committee meeting (i.e. November '26, March '27, July '27) to inform every other public Board meeting (i.e. December '26, April '27, August '27).

Executive owners will continue to review and update the BAF prior to consideration at the Board Committees.

Acronyms

BAF	Board Assurance Framework
CFCO	Chief Finance and Commercial Officer
CMO	Chief Medical Officer
CNO	Chief Nursing and Patient Safety Officer
COO	Chief Operating Officer
CPO	Chief People and Culture Officer
DERIC	Digital, Education, Research, Innovation and Commercialisation Committee
F&P	Finance and Performance Committee
P&C	People and Culture Committee
Q&S	Quality and Safety Committee

Attachments

Attachment 1	Summary of BAF themes and strategic risks
Attachment 2	Detailed BAF entries

BAF Theme		Strategic Risk	Oversight Committee	Executive Owner
1	Continued focus on excellence in quality, safety and patient experience.	• IF the Trust does not have robust policies, procedures and practices in place to monitor and deliver compliance with statutory requirements, regulations and good practice, promote the quality and safety of services, and effectively communicate with patients • THEN there is a risk that the Trust fails to meet required, or expected, standards and insufficient organisational focus is placed on the quality and safety of services • RESULTING IN increased incidence of avoidable harm, reduction in patient satisfaction, failure to deliver excellent standards of care, reputational damage, and regulatory action against the Trust.	Q&S	CNO / CMO
2	Focus on equity of service and addressing health inequalities	• IF the Trust does not address systemic issues / structural barriers that affect people's ability to access services • THEN it will be unable to deliver equitable services to all of its patients • RESULTING IN persisting health inequalities - potential variation in outcomes, increases in avoidable harm, and reputational damage.	F&P / Q&S	COO
3	Effective workforce engagement, capability and culture to enable sustainable, digitally enabled service transformation	• IF the Trust is unable to effectively engage, develop and support its workforce through a positive, inclusive culture that promotes continuous learning, embraces lessons learned, and adapts to changing roles, workforce models and digital ways of working — alongside delivering a sustainable long-term workforce plan • THEN it may be unable to attract, retain and develop a workforce of the right size, skills and behaviours, and will face challenges in embedding innovation, service transformation and digitally enabled care, limiting productivity and the ability to respond to changing population and service needs, • RESULTING IN reduced staff experience and wellbeing; increased reliance on temporary staffing; constrained service capacity and operational performance; inequitable access to services; poorer patient outcomes and experience; failure to fully realise the benefits of digital investment; non-compliance with regulatory standards; and reputational damage, negatively impacting the Trust's ability to be an employer of choice.	P&C	CPO / CNO
4	Delivering financial sustainability	• IF the Trust is unable to deliver financial sustainability in the medium to long-term • THEN it will lead to regulatory intervention and impact on future investment • RESULTING IN the Trust being unable to deliver its objectives, which will have an adverse impact on patient care / patient experience etc	F&P	CFCO
5	Delivering the required levels of productivity, performance and activity	• IF the Trust is not configured to deliver services in the most efficient / effective way (adopting new ways of working and new technologies as required to achieve that), and does not have sufficient capacity / resilience to consistently deliver those services • THEN it will be unable to improve productivity, address waiting list targets and will face a shortfall in income (resulting in failure to deliver the financial plan)	F&P	COO

BAF Theme		Strategic Risk	Oversight Committee	Executive Owner
		• RESULTING IN inability to reduce waiting times at the required rate; an adverse impact on patient experience, potentially resulting in patient harm; increased scrutiny from regulators (leading to burdensome reporting requirements and/or enforcement action which reduce capacity and place constraints on the Trust's ability to act independently in pursuit of its objectives).		
6	Delivering innovation, improvement and growth	• IF the Trust does not have the required infrastructure / capacity / expertise / culture to support innovation and growth, particularly the adoption of digital technologies; or governance processes / funding regimes place constraints on the Trust's ability to act • THEN it will not be able to identify / pursue opportunities to innovate, deliver improvements for patients and staff, or develop commercial opportunities • RESULTING IN a failure to maximise opportunities to improve staff experience, clinical outcomes, patient satisfaction and increase income (which could be reinvested in services). In the longer-term, failure to innovate could affect the Trust's ability to operate effectively (in relation to more innovate organisations).	DERIC	CMO
7	The challenges of operating in both the Welsh and English health systems	• IF The Trust is unable to effectively manage key relationships and the operational and financial challenges of delivering the differing expectations of commissioners in both the English and Welsh systems • THEN there is a risk to: the efficient delivery of services (due to the need for separate arrangements to satisfy differential targets); delivery of the financial plan; the Trust's ability to reduce waiting times for Welsh patients in line with its intentions; the Trust's ability to deliver the required level of performance for English patients • RESULTING IN Persisting inequity in the timelines of services offered to patients which may adversely affect patient experience and outcomes; reputational damage to the Trust; and an adverse impact on the Trust's National Oversight Framework rating.	F&P / Q&S	COO
8	Responding to a significant disruptive event	• IF the Trust does not have adequate plans in place to respond to a significant disruptive event beyond the control of the Trust, such as a major incident • THEN it will be unable to provide an adequate response to the immediate need and/or maintain other key services due to unavailability of the required resources / staff • RESULTING IN potential patient harm, increased waiting times etc	Q&S	COO
9	Security of digital, data and AI systems and ability to respond to cyber threats	• IF the Trust does not have adequate plans, systems, processes, and culture in place to protect digital, data and AI systems and/or prevent, or respond to cyber attacks • THEN it will be unable to provide an adequate response to the immediate need and/or maintain other key services due to unavailability of the required systems / resources • RESULTING IN an inability to perform essential functions, potentially leading to patient harm, increased waiting times, financial losses etc	DERIC	CFCO

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 1)

Continued focus on excellence in quality, safety and patient experience.	BAF 1
IF…	the Trust does not have robust policies, procedures and practices in place to monitor and deliver compliance with statutory requirements, regulations and good practice, promote the quality and safety of services, and effectively communicate with patients
THEN…	there is a risk that the Trust fails to meet required, or expected, standards and insufficient organisational focus is placed on the quality and safety of services
RESULTING IN…	increased incidence of avoidable harm, reduction in patient satisfaction, failure to deliver excellent standards of care, reputational damage, and regulatory action against the Trust.

Related corporate objectives:		
1	Deliver high quality clinical services	✓
2	Develop our Veterans service as a nationally recognised centre	
3	Integrate MSK pathways within and across STW	
4	Grow our services and workforce sustainably	
5	Innovation, education and research at the heart of what we do	

Risk Appetite and tolerance:		Quality – Cautious: 6	
Assurance Committee:		Quality and Safety Committee	
Executive Owner (strategic lead):		Chief Nurse / Chief Medical Officer	
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	~~December 2025~~May 2026
		Date Last Reviewed by the assurance Committee:	~~November 2025~~April 2026

SECTION 1: Scoring

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	5	5	**< >**	5	**< >**	5	5
Likelihood	4	2	**< >**	2	**< >**	2	1
Total	**20**	**10**	**< >**	**10**	**< >**	**10**	**5**

< > = no change V = a positive downward change ^ = a negative upward change

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 1)

Rationale for the current score, including an explanation of any movement:
The Trust has robust arrangements in place but must continue to be vigilant and ensure policies and procedures are adhered to, there is effective engagement with service users, and safety remains the primary consideration when any developments / innovations are considered. The recent positive CQC inspection outcome provides assurance that robust arrangements are generally in place and provides clarity on areas to develop further.
Rationale for the target score and the plan to reduce the risk:
The Trust is able to reduce the likelihood of this risk through: 1. Having a culture that emphasises the primary importance of patient safety; 2. Implementing appropriate policies, procedures and working practices that ensure quality and safety; and 3. Monitoring outcomes through reports, KPIs etc.

SECTION 2: ~~Contributory f~~Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
1	Clinical staffing – compliance with safe staffing requirements and delivery of the clinical strategy	• Reporting on safer staffing / Guardian of Safe Working Hours • IPR reporting on: ➢ Safe Staffing • MIAA Substantial Assurance rating • Nursing Safer Staffing Establishment reviews conducted in line with Safer Nursing Care Tool and NICE guidance. • Reporting on delivery of the approved Clinical Strategy	Reduce risks through compliance with national safe staffing requirements. This control would have a SIGNIFICANT impact	~~Strong~~High
2	Maintenance of robust quality / clinical governance arrangements – development and implementation of quality strategy	• Quality Strategy / quality priorities considered and approved by the Committee. • Implementation of Good Governance Institute report recommendations. • Reporting on quality priorities (to Q&S quarterly) • Quality Accreditation Programme and associated delivery plan in place. • Assurance reporting from the Strategy Delivery Group	Maintaining and promoting quality through an agreed strategy. This control would have a SIGNIFICANT impact	~~Strong~~High
3	Maintenance of robust quality / clinical governance arrangements – learning from feedback / patient safety walkabouts	• Regular Board visits, involving non-executive directors • "~~Sit and see~~Go See" visits • Reporting on patient safety walkabouts; patient stories.	Maintaining and promoting quality and safety through a culture of openness and learning.	~~Strong~~ High

SECTION 2: ~~Contributory f~~Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
		• Assurance reports from Patient Safety Meeting, • Executive 'buddy' visit reports	This control would have a SIGNIFICANT impact	
4	Maintenance of robust quality / clinical governance arrangements – learning from quality spot checks, incidents / complaints / legal claims etc..	• Reporting on legal claims, harms reviews, PSIRF, Duty of Candour. • IPR reporting on: ➢ Patient Safety Incident Investigations ➢ Number of Patient Safety Reviews ➢ Number of Complaints ➢ Standard Complaints Response Rate Within 30 Days ➢ Complex Complaints Response Rate Within 45 Days ➢ Complaints Reopened ➢ Number of Compliments • Assurance reports from Patient Safety Meeting, • Reporting from Multi-Disciplinary Clinical Audit Meeting. • Extraordinary thematic reviews periodically as required/deemed appropriate	Maintaining and promoting quality and safety through continuous review / learning. This control would have a SIGNIFICANT impact	~~Strong~~High
5	Maintenance of robust quality / clinical governance arrangements – learning from deaths	• Regular reporting on learning from deaths. • IPR reporting on: ➢ Total deaths • Assurance reports from Patient Safety Meeting • Reporting via MDCAM	Maintaining and promoting quality and safety through continuous review / learning. This control would have a SIGNIFICANT impact	~~Strong~~ High
6	Maintenance of robust quality / clinical governance arrangements – quality and safety measures	• IPR reporting on: ➢ Patient Safety Alerts Not Completed by Deadline ➢ Medication Errors with Harm ➢ Number of Deteriorating Patients ➢ RJAH Acquired VTE (DVT or PE) ➢ VTE Assessments Undertaken ➢ 28 days Emergency Readmissions ➢ WHO Quality Audit - % Compliance against NatSSIPs 2 ➢ Total Patient Falls	Maintaining and promoting quality and safety through continuous review / learning. This control would have a SIGNIFICANT impact	Medium (To reflect continued improvements relating to ROM, the Drugs and Therapeutics Meeting).

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 1)

SECTION 2: ~~Contributory f~~Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
		➢ Inpatient Ward Falls per 1,000 Bed Days ➢ RJAH Acquired Pressure Ulcers ➢ RJAH Acquired Tissue Viability Incidents ➢ Pressure Ulcer Assessments ➢ MCSI Admissions – Average Waiting Time • Assurance reports from: ➢ Patient Safety Meeting ➢ Drugs and Therapeutics Meeting –including reporting on antimicrobial stewardship. • Peer reviews / external reviews: ➢ Muscular Dystrophy UK centre of excellence award (following audit) / DMD accreditation review ➢ GIRFT accreditation ➢ MCSI peer review ➢ Paeds peer review ➢ HTA (via ROM) ➢ MHRA (via ROM)		
7	Maintenance of robust quality / clinical governance arrangements - Clinical Effectiveness monitoring and reporting arrangements	• Reporting on clinical audit forward plan / clinical audit outcomes. • NICE compliance • Enhanced governance arrangements to strengthen reporting from the Clinical Effectiveness Meeting, including outcome data – GIRFT, National Joint Reg, Brit Assoc of Day Surg; PROMS, NCIP data; Brit Spine Register etc.	Maintaining and promoting quality and safety through continuous review / learning. This control would have a SIGNIFICANT impact	~~Strong~~ High
8	Maintenance of robust quality / clinical governance arrangements – patient engagement and learning from patient experience	• Quarterly and annual reporting on Patient Experience. • Assurance reports from Patient Experience Meeting. • Implementation of a Patient Experience Strategy to incorporate the “experience of care improvement framework” and associated reporting to the Patient Experience Meeting. • CQC inpatient survey results • Picker survey results	Maintaining and promoting quality and safety through continuous review / learning. This control would have a SIGNIFICANT impact	~~Strong~~High
9	Maintenance of robust quality / clinical governance arrangements – patient experience measures	• IPR reporting on: ➢ Theatre Cancellations on the Day of Surgery ➢ 31 Day General Treatment Standard	Maintaining and promoting quality and safety through continuous review / learning.	~~Strong~~ High

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 1)

SECTION 2: ~~Contributory f~~Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
		➢ 62 Day General Standard ➢ 28 Day Faster Diagnosis Standard ➢ Overdue Follow Up Backlog ➢ Mixed Sex Accommodation % Delayed Discharge Rate Note: This will remain for one more month and proposal going to Q&S this month to amend to metric reporting on NCTRs	This control would have a SIGNIFICANT impact	
10	Maintenance of robust infection prevention and control (IPC) governance arrangements / training programme	• Reporting on IPC BAF and CNO/DIPC Reports. • IPR reporting on: ➢ RJAH Acquired C.Difficile ➢ RJAH Acquired E. Coli Bacteraemia ➢ RJAH Acquired MRSA Bacteraemia ➢ RJAH Acquired MSSA Bacteraemia ➢ RJAH Acquired Klebsiella spp ➢ RJAH Acquired Pseudomonas ➢ Surgical Site Infections ➢ Outbreaks • Assurance reports from via IPC Meeting	Reduce risks by development of and adherence to robust IPC policies and procedures. This control would have a SIGNIFICANT impact	~~Strong~~ High
11	Maintenance of appropriate, up-to-date policies and procedures	• Reporting on policy status • Assurance reporting / ratification of relevant policies	Maintaining and promoting quality and safety through appropriate policies and procedures. This control would have a SIGNIFICANT impact	~~Strong~~High
12	Successful implementation of the EPR	• EPR Implementation assurance meeting, reporting into DERIC Committee • Reporting from Digital Transformation Meeting and the Clinical Reference Group • Posts in place, including: ➢ CCIO ➢ CNIO ➢ Digital Pharmacist ➢ Clinical Safety Officer	Reduce risks through more effective communication of patient information. This control would have a SIGNIFICANT impact (in maintaining quality and safety standards)	Medium (reflecting the successful implementation but relatively early stage of deployment, with issues to be addressed)

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 1)

SECTION 2: ~~Contributory f~~Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
13	Maintenance of robust governance arrangements in relation to regulatory compliance	• Enhanced governance arrangements to strengthen reporting from: ➢ The Regulatory Oversight Meeting (informed by the Regulatory Oversight Dashboard), to include reporting on delivery of any action plans following external inspections / reviews. ➢ The Drugs and Therapeutics Meeting. • Engagement with, and learning from, external agencies such as: ➢ EPIC ➢ MHRA ➢ HSE	Maintaining and promoting quality and safety through continuous review / learning that supports compliance with required standards. This control would have a SIGNIFICANT impact	Medium (arrangements are in place. Some external feedback awaited from regulators / supporting bodies)

SECTION 3: Factors that could negatively affect the Trust's ability to deliver this theme, and adversely affect efforts to address the strategic risk			
Ref.	**Description of inhibiting factors –** *what additional factors may adversely affect delivery and add to this risk?*	**Potential impact –** *how will this affect the consequence or likelihood?*	**Potential mitigations –** *how might this be avoided / mitigated?*
1	Capacity / capability – including the potential impact of burdensome reporting requirements and/or regulatory intervention, including recruitment "freeze" or constraints on spending.	If resources are constrained, there is a risk that quality / patient safety could be compromised.	Demonstrating delivery / capability through: • Compliance with NOF requirements (and any quality-related performance criteria agreed with NHSE). • Self-assessment against the CQC quality statements.

SECTION 4: Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
1	Supporting infrastructure for six day working / increased activity. including: a) Insourcing arrangements; b) Pharmacy; c) Therapy; and d) Radiography	Improve the capacity of the organisation to continue to focus on excellence in quality and safety by delivering more efficient and effective ways of working and addressing inequity in patient pathways.	~~MC~~COO	~~Timelines tbc for the constituent 5 year strategies for the supporting services. This agenda is managed as business as usual through the Executive Team.~~	AMBER (as elements, including strategy for pharmacy in development).

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 1)

SECTION 4: Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
				Appointment of an insourcing provider is expected within Q2 2026/27, which will support delivery of the planned activity for the year. A further review of the workforce areas will be completed in 2027/28.	
2	Delivery of actions identified during the critical care review to demonstrate compliance with the GPIC Standards and prioritisation of those actions to make the greatest impact.	Improve the capacity of the organisation to continue to focus on excellence in quality and safety.	~~RL / MC~~CMO / COO	Internal reviews undertaken. External ~~review to be undertaken~~peer review completed and the Trust is working through the associated actions. There were no immediate safety risks however the Trust does not meet the requirements of a Level 2 Critical Care Unit. ~~w/c 20 April 2025. Deadline for subsequent actions tbc (dependent on review outcome).~~ There is a deadline to respond by 20 July 2026 to the letter received.	AMBER (~~awaiting outcome of external review~~pending the response to RJAH's response~~)~~
3	Gap analysis of nursing workforce standards compliance to be undertaken (and development / implementation of any actions required to achieve compliance).	Improve the capacity of the organisation to continue to focus on excellence in quality and safety.	~~CH~~CNO	Review ~~to be~~ undertaken in Q1, 2026/7. Subsequent	AMBER(awaiting outcome of gap analysis)

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 1)

SECTION 4: Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
				action tbc following the analysis. Review completed, awaiting discussion and actions due to team annual leave.	
4	Delivery of CQC Critical Care action plan following 2025 inspection to ensure implementation and sustained delivery of requirements	Support delivery of quality of care and patient safety	CNO	~~April 26~~ This is being monitored through the Regulatory Oversight Meeting.	AMBER
5	Development and implementation of arrangements, including appropriate training, to promote the operational ownership of digital solutions to support the patient experience strategy (e.g. through development and implementation of My Recovery; Doctor Doctor etc).	Improve the ability of the organisation to engage patients and improve quality and safety. Support a strategic approach to the development and implementation of digital solutions to enhance patient experience	~~KDF / MCAMW~~CNIO / CFCO	Roll-out included in Digital roadmap during 2026/7	AMBER
6	Build on the work of the Regulatory Oversight Meeting by developing a programme of external / peer reviews of regulated services to assess compliance and increase awareness of regulatory requirements / responsibilities.	Support delivery of regulatory compliance	~~RL~~ CMO	Tbc – to be informed by the findings of external reviews / reports. ROM members asked to identify opportunities for peer review at June meeting.	AMBER
~~7~~	~~The need to assess and respond to national and regional developments, including those reflected in the NHS 10 Year Plan, which affect organisational functionals / structures, longer-term strategy / policy, and immediate operational priorities.~~ ~~This will include:~~ ~~• a review / refresh of strategic and corporate objectives;~~ ~~• the development / revision of plans to deliver those objectives;~~	~~Improve the ability of the organisation to deliver national strategic and operational priorities, improving the efficiency and quality of services.~~	~~SK / HT (leading the wider Board)~~	~~Q1, 2026/7~~	~~AMBER (as work in development)~~

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 1)

SECTION 4: Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
	• ~~revision of the BAF to capture those objectives and the risks to their delivery.~~				

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 2)

Focus on equity of service and addressing health inequalities	BAF 2
IF…	the Trust does not address systemic issues / structural barriers that affect people's ability to access services
THEN…	it will be unable to deliver equitable services to all of its patients
RESULTING IN…	persisting health inequalities - potential variation in outcomes, increases in avoidable harm, and reputational damage.

Related corporate objectives:		
1	Deliver high quality clinical services	✓
2	Develop our Veterans service as a nationally recognised centre	
3	Integrate MSK pathways within and across STW	
4	Grow our services and workforce sustainably	
5	Innovation, education and research at the heart of what we do	

Risk Appetite and tolerance:	Quality – Cautious: 6		
Assurance Committee:	Finance and Performance Committee / Quality and Safety Committee		
Executive Owner (strategic lead):	Chief Operation Officer (COO)		
Risk Owner (overall managerial lead):			
Date Opened:	06/05/2026	**Date Last Reviewed by the Board:**	May 2026
		Date Last Reviewed by the assurance Committee:	April 2026

SECTION 1: Scoring

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	5	5		n/a		5	5
Likelihood	5	4		n/a		4	2
Total	**25**	**20**		**n/a**		**20**	**10**

< **>** = no change **V** = a positive downward change **^** = a negative upward change

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 2)

Rationale for the current score, including an explanation of any movement:
It is known that people's access to services and their clinical outcomes are affected by socio-economic factors. This is an existing, large-scale issue that needs further work to address. As such, both the consequence and the likelihood are scored highly at this point. The differing expectations of commissioning bodies in Wales and England is driving inequity in the length of waits for Welsh and English patients. Longer waiting times result in a poorer patient experience and increase the likelihood of patient harm. This is covered in more detail in BAF 7.
Rationale for the target score and the plan to reduce the risk:
Work is underway to address the issue but the scale and structural nature of the problems mean that thought will need to be given to a realistic target score.

SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
1	Arrangements with Welsh commissioners that deliver a level of service that is acceptable to the Trust.	Reporting on commissioning arrangements with Welsh commissioners Performance reporting on Welsh patients.	Ensuring timely access to services for patients, irrespective of the commissioning body. This control would have a SIGNIFICANT impact.	Low
2	Services designed to meet the needs of particular communities which deliver timely access to services	Reporting on: • Waiting times by relevant socio-economic factors; • DNA and "was not brought" performance; • The development of outreach services and other initiatives.	Ensuring timely access to services for patients, irrespective of their socio-economic circumstances. This control would have a SIGNIFICANT impact.	Medium
3	Maintenance of robust quality / clinical governance arrangements – learning from quality spot checks, incidents / complaints / legal claims etc..	• Reporting on legal claims, harms reviews, PSIRF, Duty of Candour. • IPR reporting on: ➢ Patient Safety Incident Investigations ➢ Number of Patient Safety Reviews ➢ Number of Complaints ➢ Standard Complaints Response Rate Within 30 Days ➢ Complex Complaints Response Rate Within 45 Days ➢ Complaints Reopened	Maintaining and promoting quality and safety through continuous review / learning. This control would have a SIGNIFICANT impact	High

SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
		➢ 4Number of Compliments • Assurance reports from Patient Safety Meeting, • Reporting from Multi-Disciplinary Clinical Audit Meeting. • Extraordinary thematic reviews periodically as required/deemed appropriate		
4	Maintenance of robust quality / clinical governance arrangements – patient engagement and learning from patient experience	• Quarterly and annual reporting on Patient Experience. • Assurance reports from Patient Experience Meeting. • Implementation of a Patient Experience Strategy to incorporate the "experience of care improvement framework" and associated reporting to the Patient Experience Meeting. • CQC inpatient survey results • Picker survey results	Maintaining and promoting quality and safety through continuous review / learning. This control would have a SIGNIFICANT impact	High
5	Maintenance of robust quality / clinical governance arrangements – patient experience measures	• IPR reporting on: ➢ Theatre Cancellations on the Day of Surgery ➢ 31 Day General Treatment Standard ➢ 62 Day General Standard ➢ 28 Day Faster Diagnosis Standard ➢ Overdue Follow Up Backlog	Maintaining and promoting quality and safety through continuous review / learning. This control would have a SIGNIFICANT impact	High
6	Maintenance of structures to focus on health inequalities	Reporting from the Trust's health inequalities group	Maintaining and promoting a focus on addressing health inequalities. This control would have a MODERATE impact	Medium
7	Engagement in national / regional arrangements to address health inequalities	CMO involvement in Clinical Leadership network / NHSE's Health Inequalities Improvement Programme, leading a project on digital inclusion / exclusion (supported by the and CNIO improvement team). This is a 12 month programme running to June 2027.	Developing strategies / plans to address health inequalities, based on local and national research / best practice. This control would have a SIGNIFICANT impact	Medium (as in early days of development)

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 2)

SECTION 3: Factors that could negatively affect the Trust's ability to deliver this theme, and adversely affect efforts to address the strategic risk			
Ref.	**Description of inhibiting factors –** *what additional factors may adversely affect delivery and add to this risk?*	**Potential impact –** *how will this affect the consequence or likelihood?*	**Potential mitigations –** *how might this be avoided / mitigated?*
1	Capacity / capability – including constraints on spending / services imposed by commissioners.	If resources are constrained, there is a risk that access to services could be compromised (resulting in differential access to / quality of service).	• Maintain regular reporting within the governance cycle, with routine assurance reporting embedded. •
2	Regulatory – including differing performance targets / funding regimes.	Differing performance targets in the English and Welsh systems, and the associated funding regimes / potential regulatory interventions could drive differential access to / quality of services.	• Continue dual reporting of both English and Welsh performance standards, including demographic breakdowns of key performance metrics.

SECTION 4: Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
1	Supporting infrastructure for six day working / increased activity. including: a) Insourcing arrangements; b) Pharmacy; c) Therapy; and d) Radiography	Improve the capacity of the organisation to continue to focus on excellence in quality and safety by delivering more efficient and effective ways of working and addressing inequity in patient pathways.	COO	Appointment of an insourcing provider is expected within Q2 2026/27, which will support delivery of the planned activity for the year. A further review of the workforce areas will be completed in 2027/28	AMBER (as elements, including strategy for pharmacy in development).
2	Development and implementation of arrangements, including appropriate training, to promote the operational ownership of digital solutions to support the patient experience strategy (e.g. through development and implementation of My Recovery; Doctor Doctor etc).	Improve the ability of the organisation to engage patients and improve quality and safety. Support a strategic approach to the development and implementation of digital solutions to enhance patient experience	CMO / CFCO	This will be picked up via the delivery plans for the associated strategies.	AMBER
3	Implementation of the minimum standards of patient experience as part of the elective reform plan.	Improve the ability of the organisation to engage patients and improve their understanding / experience	COO	December 2026	AMBER (as work in development)

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 2)

BAF Risks, controls and assurances – 2026/27 (BAF 3)

Effective workforce engagement, capability and culture to enable sustainable, digitally enabled service transformation.	**BAF 3**
IF…	the Trust is unable to effectively engage, develop and support its workforce through a positive, inclusive culture that promotes continuous learning, embraces lessons learned, and adapts to changing roles, workforce models and digital ways of working — alongside delivering a sustainable long-term workforce plan
THEN…	it may be unable to attract, retain and develop a workforce of the right size, skills and behaviours, and will face challenges in embedding innovation, service transformation and digitally enabled care, limiting productivity and the ability to respond to changing population and service needs,
RESULTING IN…	reduced staff experience and wellbeing; increased reliance on temporary staffing; constrained service capacity and operational performance; inequitable access to services; poorer patient outcomes and experience; failure to fully realise the benefits of digital investment; non-compliance with regulatory standards; and reputational damage, negatively impacting the Trust's ability to be an employer of choice.

Related corporate objectives:		
1	Deliver high quality clinical services	✓
2	Develop our Veterans service as a nationally recognised centre	✓
3	Integrate MSK pathways within and across STW	✓
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	✓

Risk Appetite and tolerance:		Workforce – Seek (risk tolerance at 12)	
Assurance Committee:		People & Culture Committee	
Executive Owner (strategic lead):		Chief People Officer (CPO) / Chief Nursing Officer (CNO)	
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	~~December 2025~~ May 2026 (in previous form)
		Date Last Reviewed by the assurance Committee:	April 2026 (in previous form)

SECTION 1: Scoring

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE*	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	5	5	**< >**	5	**< >**	5	5
Likelihood	4	3	**V**	2	**< >**	2	2
Total	**20**	**15**	**V**	**10***	**< >**	**10**	**10**

**Reduced to (5x2) 10 in August 2024.*

< > = no change **V** = a positive downward change **^** = a negative upward change

Rationale for the current score, including an explanation of any movement:

The **consequence remains at 5 (catastrophic)** as failure in this risk area would have a fundamental impact on the Trust's ability to deliver safe, effective and sustainable services. This includes risks to patient outcomes, workforce wellbeing, regulatory compliance, financial sustainability (including agency reliance), and the Trust's reputation as an employer of choice. The increasing reliance on workforce transformation, new roles, and digital enablement further elevates the potential impact if this risk materialises.

The **likelihood remains at 2 (low)**, reflecting the sustained progress made by the Trust in strengthening its workforce position. This includes successful recruitment initiatives, the development of alternative workforce pipelines, and continued investment in staff experience, wellbeing, and leadership.

In addition, the Trust has:

- Strengthened its focus on **retention and career development**, supporting workforce sustainability over the longer term
- Continued to embed a more **inclusive and supportive culture**, aligned to staff engagement and improvement ambitions
- Made early progress in **adapting roles and ways of working**, including the introduction of new roles and service models
- Begun to advance **digitally enabled ways of working**, although this remains an area of ongoing maturity

However, the likelihood has **not reduced further** due to a number of ongoing and emerging challenges:

- Persistent **national workforce shortages** in key specialties
- Increasing demand for services and **system-wide workforce pressures**
- The scale of change required to fully embed **new workforce models and digital capability**
- The need to consistently translate **lessons learned and continuous improvement** into sustained practice

Overall, while controls are operating effectively and improvement has been demonstrated (reflected in the earlier reduction from 15 to 10), these external and transformational pressures mean the risk remains **present but controlled**, rather than minimal.

Rationale for the target score and the plan to reduce the risk:

The **target score remains at 10 (5 x 2)**, recognising that while the Trust can reduce the likelihood of the risk occurring, it **cannot eliminate it entirely** due to factors outside of its direct control, including national workforce supply constraints and broader NHS financial pressures.

The Trust will seek to **maintain likelihood at 2** through continued strengthening of its control framework, with a particular focus on:

- **Workforce sustainability and planning**
  Delivering a robust, long-term workforce plan aligned to service transformation, including pipeline development, succession planning, and alignment to system priorities
- **Retention, wellbeing and staff experience**
  Enhancing flexible working, career development pathways, and leadership capability to improve retention and engagement
- **Workforce transformation and new roles**
  Expanding and embedding new roles and skill mix models to improve capacity, productivity and resilience

BAF Risks, controls and assurances – 2026/27 (BAF 3)

- **Digitally enabled workforce capability**
  Building digital confidence and capability across the workforce to support new models of care and improve efficiency and patient outcomes
- **Continuous improvement and learning culture**
  Strengthening mechanisms to capture and embed lessons learned, support innovation, and enable staff to contribute to service improvement
- **System working**
  Aligning workforce actions with system partners (linked to BAF 06) to address shared workforce challenges and maximise collective impact

Given the scale and complexity of workforce and transformation challenges, the Trust's ambition is to **sustain this risk at a controlled level**, rather than reduce it further, ensuring resilience while continuing to deliver improvement.

~~Contributory factors and associated controls~~SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls* –** *what control measures are in place to address this risk? *links to NHS People Plan objectives*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
1	"Growing for the future": Effective, targeted recruitment – Trust-wide recruitment strategy / plan	• Reporting on: ➢ Workforce strategy / plans (including workforce profile); ➢ Recruitment trajectories. ➢ Local 5 Year People Plan ➢ International recruitment plan ➢ Medical Workforce Plan • IPR reporting on: ➢ Staff Turnover - FTE– Rolling/cumulative 12-month figure using latest full calendar month's data, calculated using FTE. Includes all substantive staff (permanent & fixed term), except junior doctors ➢ Leavers per Month - Number of leavers per month - excluding non-voluntary reasons, retire & return, and rotational doctors ➢ Staff Retention ➢ Sickness Absence • Assurance reporting from NSSG • Evidence of embedding: ➢ System retention plan People Promise Exemplar ➢ NHSE EDI High Impact Plan • Assurance reporting from the Strategy Delivery Group	Ensure plans are in place to inform recruitment of the required staff to deliver the trust's objectives / statutory duties This control would have a SIGNIFICANT impact	~~Strong~~ High
2	"Growing for the future": Effective, targeted recruitment - recruitment and	• Reporting on: ➢ Responsible Officer revalidation	Ensure plans are in place to recruit and effectively utilise	Medium

BAF Risks, controls and assurances – 2026/27 (BAF 3)

~~Contributory factors and associated controls~~SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls* –** *what control measures are in place to address this risk? *links to NHS People Plan objectives*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
	retention of clinical staff to ensure appropriate skills mix	➢ Safe Staffing Establishment reviews • IPR reporting on: ➢ Vacancy Rate ➢ Nursing Vacancy Rate (Trust) ➢ Healthcare Support Worker Vacancy Rate ➢ Allied Health Professionals Vacancy Rate ➢ Time to Hire - Recruitment • Evidence of embedding: ➢ System retention Plan ➢ People Promise Exemplar Cohort 2	staff to support delivery (as well as quality and safety), reducing the reliance on temporary staffing (particularly in key areas). This control would have a SIGNIFICANT impact	
3	"Growing for the future": Effective, targeted recruitment - Efficient recruitment process	• Reporting on: ➢ EDI support • IPR reporting on: ➢ Time to Hire - Recruitment	Ensure recruitment of the required staff with minimum delay This control would have a SIGNIFICANT impact	~~Strong~~ High
4	"Growing for the future" / "New ways of working and delivering care": Effective, targeted recruitment - focus on key roles / "pressure points" that drive activity	• Reporting on: ➢ International recruitment; ➢ "Local" recruitment; ➢ Recruitment plans for Theatres; ➢ Recruitment trajectories; ➢ Operational risk profile for staffing; ➢ Vacancy rates – with variable targets, dependent on the criticality of the role ➢ Robust agency approval process with escalation • IPR reporting on: ➢ % Staff Availability ➢ Agency Spend against Plan ➢ Proportion of Temporary Staffing as a % of the Trust Pay Costs ➢ E-Rostering Level of Attainment ➢ Percentage of Staff on the E-Rostering System ➢ % of E-Rosters Approved Six Weeks Before E-Roster ➢ % of System-Generated E-Roster (Auto-Rostering) ➢ E-Job Planning Level of Attainment	Ensure recruitment of the required staff to support delivery This control would have a SIGNIFICANT impact	~~Strong~~ High / Medium

BAF Risks, controls and assurances – 2026/27 (BAF 3)

~~Contributory factors and associated controls~~SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls* –** *what control measures are in place to address this risk? *links to NHS People Plan objectives*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
		➢ Percentage of Staff with an Active E-Job Plan • Assurance Reporting from: ➢ System Retention working group ➢ Agency reduction working group (in line with capping rules) ➢ Confirm and challenge meetings ➢ System vacancy panel control • Agency staffing policy revision to reflect the shift to a substantive workforce		
5	"Looking after our people" – staff support arrangements	• Reporting on: ➢ Staff survey results. ➢ Staff networks. ➢ Support initiatives such as "cost of living" support ➢ Staff recognition schemes • IPR reporting on: ➢ Sickness Absence ➢ Sickness Absence - Short Term ➢ Sickness Absence - Long Term • Improved workforce dashboard	Maintain / improve retention of staff through improved staff wellbeing This control would have a SIGNIFICANT impact	~~Strong~~High
6	"Looking after our people" - Support to international recruits	• Reporting on: ➢ support arrangements. ➢ Staff induction revision and improved information sharing ➢ Coaching all managers – evidence of attendance and reduction in F2SU and complaints ➢ EDI High impact Plan ➢ Staff-led Networks	Maintain / improve the retention of international recruits through offering the required support This control would have a SIGNIFICANT impact	Medium
7	"New ways of working and delivering care": Staff development - Effective "onboarding" / induction process	• Reporting on improved onboarding / induction arrangements. • Assurance reporting from: ➢ Learning and Development Meeting ➢ Education and Training Strategy and working group	Maintain / improve the retention of staff This control would have a SIGNIFICANT impact	Medium

BAF Risks, controls and assurances – 2026/27 (BAF 3)

~~Contributory factors and associated controls~~SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls* –** *what control measures are in place to address this risk? *links to NHS People Plan objectives*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
8	"New ways of working and delivering care": Staff development - Robust PDR process	• IPR reporting on: ➢ Personal Development Reviews	Maintain / improve the retention of staff and promote development This control would have a SIGNIFICANT impact	Medium / Low
9	"New ways of working and delivering care" / "Belonging in the NHS": Staff engagement / communication	• Reporting on: ➢ Freedom to Speak Up ➢ Staff engagement / communication channels / initiatives ➢ Senior leaders as advocates of People Promise Exemplar program ➢ Flexible working ➢ Toolkits for managers around new ways of working • Assurance reporting from: ➢ Joint Consultancy Group Meeting; ➢ Local Negotiating Meeting	Maintain / improve retention of staff and through improved wellbeing and more effective communication This control would have a SIGNIFICANT impact	Medium
10	"Belonging in the NHS" - EDI initiatives / training programmes	• Reporting on: ➢ EDS2 compliance including PSED. ➢ WRES/WDES compliance ➢ Gender Pay Gap ➢ Policies / Training programmes / initiatives, including: ○ Oliver McGowan training; ○ Menopause awareness; • IPR reporting on: ➢ Statutory & Mandatory Training • Assurance reporting from EDI Meeting. • Civility and respect toolkit and action plan	Maintain / improve retention of staff through improved staff wellbeing This control would have a SIGNIFICANT impact	Medium
11	"Growing for the future" / "New ways of working and delivering care": Retention / staff development initiatives	• Reporting on: ➢ Staff retention initiatives; ➢ Leadership development programme • Evidence of embedding: system Retention High Impact Plan ➢ People Promise approved objectives	Ensure plans are in place to maintain / improve the retention of staff and promote development This control would have a MODERATE impact	Medium

BAF Risks, controls and assurances – 2026/27 (BAF 3)

~~Contributory factors and associated controls~~SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls* –** *what control measures are in place to address this risk? *links to NHS People Plan objectives*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
12	"New ways of working and delivering care": Effective clinical leadership / engagement	• Reporting on delivery of the Clinical Strategy and associated implementation plans around the associated workforce elements	To implement effective structures and plans to enhance engagement This control would have a SIGNIFICANT impact	Medium
13	"New ways of working and delivering care": Staff development – programmes and support arrangements, including: ➢ Career Days/focus on recruitment and niche roles ➢ Leadership Development Programme; ➢ Apprenticeships etc. ➢ Advanced Practice model in development	Reporting on: ➢ Delivery / development of staff / leadership development programmes (and other initiatives), including staff feedback; ➢ Implementation of an Apprenticeships Policy. ➢ Early, mid and late career platform training modules ➢ Retire and return roles ➢ Legacy mentoring ➢ Embedding scope for growth principles in career conversations ➢ Itchy feet conversations(stay) ➢ Advanced Practice Strategy/Plan milestones on delivery	Maintain / improve retention of staff and promote development This control would have a MODERATE impact	Medium / Low
14	Consideration of shared services / potential efficiencies through joint working	Reporting on: ➢ System "shared services" programme and associated working groups. ➢ The development of the Alliance with ROH and opportunities for joint working.	Support workforce sustainability and contribute to delivery of growth reduction targets	Medium (Programme established but proposals / potential impact tbc)

BAF Risks, controls and assurances – 2026/27 (BAF 3)

SECTION 3: Factors that could negatively affect the Trust's ability to deliver this theme, and adversely affect efforts to address the strategic risk			
Ref.	**Description of inhibiting factors –** *what additional factors may adversely affect delivery and add to this risk?*	**Potential impact –** *how will this affect the consequence or likelihood?*	**Potential mitigations –** *how might this be avoided / mitigated?*
1	Capacity / capability – including the potential impact of burdensome reporting requirements and/or regulatory intervention, including recruitment "freeze" or constraints on spending.	If resources are constrained, there is a risk that the Trust will not be able to recruit as planned.	Demonstrating delivery / capability through: • Compliance with NOF requirements (and any performance criteria agreed with NHSE). • Self-assessment against the CQC quality statements. Development / implementation of "new ways of working".
2	Capacity / capability – the potential impact of the headcount reduction target.	There is a risk that the Trust will not be able to maintain the workforce required to deliver its plans.	Delivery of a revised operating model which improves efficiency and enables headcount reductions without adversely affecting services. Completion of impact assessments for any posts that remain unfilled, or are removed.
3	Capacity / capability – reliance on temporary staffing.	Areas that are more reliant on temporary staffing are less resilient. This also affects the Trust's ability to effectively plan and manage activity reliant on those staff.	Identification of key roles / "fragile services" and targeted recruitment to address that.

SECTION 4: **Additional actions to address gaps in controls**					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
1	"New ways of working and delivering care": Including: Delivery of the Clinical Strategy via plans for critical workforce elements, including medical, nursing, AHPs etc. Those workforce plans are to be triangulated with the activity and financial plans to provide assurance around the deliverability of both elements.	The workforce will be supported to deliver innovation in their areas of work and the Trust can make best use of its resources. This will support delivery of multiple BAF themes	~~RL~~ CMO / CNO, supported by executive colleagues.	The Clinical Strategy was agreed in May 2025. Delivery of the Strategy and supporting workforce plans to be considered at the Board sub-committees as appropriate. The Strategy Development Group will monitor strategies and associated actions.	AMBER
2	Delivery of actions identified during the critical care review to demonstrate compliance with	Improve the capacity of the organisation to continue to focus on excellence in quality and safety.	~~RL~~ CMO / COO~~MC~~	Internal reviews undertaken. External ~~review to be~~	AMBER (~~awaiting outcome of~~

BAF Risks, controls and assurances – 2026/27 (BAF 3)

SECTION 4: Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
	the GPIC Standards and prioritisation of those actions to make the greatest impact.			~~undertaken w/c 20 April 2026. Deadline for subsequent actions tbc (dependent on review outcome).~~peer review completed and the Trust is working through the associated actions. There were no immediate safety concerns however the Trust does not meet the requirements of a Critical Care Unit. There is a deadline to respond by 20 July 2026 to the letter received.	~~external review)~~pending the response to the Trust's submission)
3	Gap analysis of nursing workforce standards compliance to be undertaken (and development / implementation of any actions required to achieve compliance).	Improve the capacity of the organisation to continue to focus on excellence in quality and safety.	~~CH~~CNO	Review to be undertaken Q1, 2026/7. Subsequent action tbc following the analysis. Review completed, awaiting discussion and actions due to team annual leave.	AMBER (awaiting outcome of gap analysis)
4	Opportunities for collaboration / shared services across the system and/or wider partnerships	Increased resilience of teams and services	CEO / ~~AMW~~CFCO	STW shared services workstream underway. To be delivered in line with agreed system plans. Strategic alliance agreed with ROH. Arrangements to be delivered as agreed	AMBER (as work underway / in development)

BAF Risks, controls and assurances – 2026/27 (BAF 3)

SECTION 4: Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
				via the alliance governance arrangements (tbc).	
~~5~~	~~The need to assess and respond to national and regional developments, including those reflected in the NHS 10 Year Plan, which affect organisational functionals / structures, longer-term strategy / policy, and immediate operational priorities. This will include a) a review / refresh of strategic and corporate objectives; b) the development / revision of plans to deliver those objectives; c) revision of the BAF to capture those objectives and the risks to their delivery.~~	~~Improve the ability of the organisation to deliver national strategic and operational priorities, improving the efficiency and quality of services.~~	~~SK / HT (leading the wider Board)~~	~~Q3, 2025/6~~	~~AMBER (as work in development)~~
5	The CNO and CMO are to review the existing Clinical / Nursing and AHP, Quality and Patient Experience strategies.	To review and potentially consolidate linked strategies to ensure a consistent, clear approach.	CNO / CMO	Q3, 2026/7	AMBER (as work in development)

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 4)

Delivering financial sustainability	BAF 4
IF…	the Trust is unable to deliver financial sustainability in the medium to long-term
THEN…	it will lead to regulatory intervention and impact on future investment
RESULTING IN…	the Trust being unable to deliver its objectives, which will have an adverse impact on patient care / patient experience etc

Related corporate objectives:		
1	Deliver high quality clinical services	✓
2	Develop our Veterans service as a nationally recognised centre	✓
3	Integrate MSK pathways within and across STW	
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	

Risk Appetite and tolerance:	Finance – Open: 9		
Assurance Committee:	Finance and Performance		
Executive Owner (strategic lead):	Chief Finance and Commercial Officer (CFCO)		
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	~~December 2025~~ May 2026
		Date Last Reviewed by the assurance Committee:	~~November 2025~~ April 2026

SECTION 1: Scoring

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE*	Direction of travel to…	PROPOSED CURRENT SCORE	TARGET
Consequence	5	5	**< >**	4	^	5	5
Likelihood	4	3	^	5	V	3	2
Total	**20**	**15**	^	**20***	V	**15**	**10**

** Increased to (5x4) 20 in August 2024; amended to (4x5) 20 in March 2025*

< > = no change V = a positive downward change ^ = a negative upward change

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 4)

Rationale for the current score, including an explanation of any movement:
The Trust has set a breakeven plan for the medium-term planning timeframe which is for three years from 26/27 to 28/29. This is underpinned by the following planning assumptions: • Delivery of efficiency and productivity improvements of c5% year on year that requires material levels of service transformation • Change in culture and increase capacity and capability required to delivery an ambitious multi-year service re-design and transformation programmes • Cost planning assumptions diverge materially e.g. inflationary pressures not recognised in cost uplift, industrial action, pay awards impacts • Uncertain future commissioning intentions - nationally, locally and in Wales. Changing NHS payment regime that is yet to be defined. • Block contract deconstruction and fixed LVA where commissioners do not recognise the cost of delivering specialist and core elective services, whilst also not recognising the pressure in current elective tariffs that have not been reviewed for years. The consequence remains high as delivery of the financial plan is a key element of the current oversight framework.–.
Rationale for the target score and the plan to reduce the risk:
The financial settlement for the system, the changing nature of reimbursements, tariffs and commissioning intentions are all uncertain -with NHS payment regimes beyond the control of the Trust. The Trust has the ability to reduce the likelihood of this risk through: • Accurate planning, delivering core activity, productively • Delivery of major developments designed to increase capacity and throughput e.g. new theatre expansion • Delivery of transformation programmes and service transformation designed to increase productivity and drive efficiencies • Engagement with commissioners in both England and Wales, promoting of the specialist nature of our services and advocating for appropriate reimbursement, including working with NHSE finance teams, NOA and FSH • Unlocking diversified income through other non-NHS or commercial opportunities

~~Contributory factors and associated controls~~ SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk

Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
1	In Job / out of job plan – reduction to no more than 20% of total activity outside IJP	• Reporting on: ➢ OJP / IJP • IPR reporting on: ➢ IJP Activity - against Plan ➢ OJP Activity - against Plan	Reduce costs and improve productivity. This control would have a SIGNIFICANT impact.	~~Medium~~ High
2	Delivery of activity plans for NHS and private patients (PP)	• IPR reporting on: ➢ Total Activity against Plan (volumes) – inpatients, daycases; outpatients; PP; Insourcing • Assurance Reporting from:	Maximise income and improve productivity This control would have a SIGNIFICANT impact.	Medium

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 4)

~~Contributory factors and associated controls~~ SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
		➢ Trust Performance and Operational Improvement Group (TPOIG) (to F&P) ➢ Improvement Group (to F&P) – if in escalation ~~➢ Theatre Development Group (to F&P)~~ ~~➢ MSK Transformation Programme Board (to F&P)~~		
3	Income recovery under, LVA, NCA	• Reporting to: ➢ F&P ➢ Improvement Group – if in escalation	Delivery of income plan. This control would have a SIGNIFICANT impact.	Medium
4	Delivery of efficiency plans / cost improvement programmes.	• Reporting on: ➢ Financial Performance ➢ Efficiency programme risk through Improvement Group – if in escalation ➢ Financial Plan Development / Delivery ➢ Monthly progress reviews at TPOIG ➢ Deep dives at F&P as required • IPR reporting • Assurance Reporting from: ➢ TPOIG (to F&P) ➢ Improvement Group (to F&P) – if in escalation ➢ Procurement Steering Group (to F&P) ➢ Finance & Performance Committee (to the Board) ➢ MIAA "Significant Assurance" rating on Efficiency Programme review (reported to A&R Committee in July 2024)	Full delivery of efficiency plan. This control would have a MODERATE impact.	High
5	Productivity gains, including improved theatre productivity.	• Reporting on: ➢ Productivity Dashboard ➢ Operational plan delivery ➢ Efficiency programme productivity schemes ➢ NHSE productivity reports (implied efficiency) • Assurance Reporting from: ➢ Improvement Group (to F&P) – if in escalation ➢ Theatre Development Group (to F&P) ➢ Finance & Performance Committee (to the Board)	Deliver productivity stretch included in the plan. This control would have a MODERATE impact.	Medium / low

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 4)

~~Contributory factors and associated controls~~ SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
6	Temporary staffing controls, including bank and agency	• Temporary staffing cost report (to P&C) • IPR reporting on: ➢ Agency Spend against Plan ➢ Proportion of Temporary Staffing as a % of Trust Pay Costs • Assurance reporting: ➢ NSSG (to P&C) ➢ Finance & Performance Committee (to the Board)	Reduce costs and improve productivity. This control would have a MODERATE impact.	High

SECTION 3: Factors that could negatively affect the Trust's ability to deliver this theme, and adversely affect efforts to address the strategic risk			
Ref.	**Description of inhibiting factors –** *what additional factors may adversely affect delivery and add to this risk?*	**Potential impact –** *how will this affect the consequence or likelihood?*	**Potential mitigations –** *how might this be avoided / mitigated?*
1	Efficiency programme slippage	Leading to increased cost or reduced income versus plan	Continued identification and pipeline of schemes developed above plan for contingency Regular oversight through IG, TPOIG and F&P
2	Excess Inflation	Increased cost above funded plan assumptions	Over delivery of efficiency programme
3	Veterans growth for out of area patients not funded, aligned to increased consultant capacity	Reduced income	Development of Veterans Strategy to include local, national NHSE commissioning clarity and Non-NHSE Also, continue: Lobbying support from NHSE Support from STW ICB as host commissioner Regular dialogue and communication with out of area ICB's Agreed and issued transparent billing method for NCA Veterans activity, for inclusion within new IAP / AMPs (Indicative Activity Plan and Activity Management Plans)
4	Apollo EPR not fully optimised causing financial impact	Increase cost of optimisation period, post go-live Reduced income through DQ issues or process change to activity capture	Enhance EPR development team to deliver improvements and optimisation of Apollo, unlocking and enabling productivity gains Robust and enhanced level of activity information gained through new systems to track and monitor activity levels *Ncraesd* Robust leadership and management and delivery of Apollo improvement roadmap; recruitment of senior leadership role CDIO

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 4)

5	Non delivery of activity linked to consultant capacity levels	Reduced income	Operational Delivery meeting overseeing activity forecasts on weekly basis Oversight of recruitment plans through P&CC Insourcing arrangements to provide additional capacity out of core hours
6	Delay in opening the new theatre	Reduced income	Regular oversight by the Board will monitor construction progress and staffing developments.

SECTION 4: **Additional actions to address gaps in controls**					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
1	Development and delivery of a commercial strategy for the Trust…	Increase income	Chief Finance & Commercial Officer		
2	Continually review activity levels for NHS and private patient delivery	Achieve Income plan	Chief Operating Officer	Ongoing	AMBER
3	Continually review efficiency plan delivery and risk	Achieve efficiency plan recurrently	Chief Finance & Commercial Officer	Ongoing	AMBER
4	~~The need to assess and respond to national and regional developments, including those reflected in the NHS 10 Year Plan, which affect organisational functionals / structures, longer-term strategy / policy, and immediate operational priorities.~~ ~~This will include:~~ • ~~a review / refresh of strategic and corporate objectives;~~ • ~~the development / revision of plans to deliver those objectives;~~ • ~~revision of the BAF to capture those objectives and the risks to their delivery.~~	~~Improve the ability of the organisation to deliver national strategic and operational priorities, improving the efficiency and quality of services.~~	~~SK / HT (leading the wider Board)~~	~~Q1, 2026/7~~	~~AMBER (as work in development)~~

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 5)

Delivering the required levels of productivity, performance and activity.	BAF 5
IF…	the Trust is not configured to deliver services in the most efficient / effective way (adopting new ways of working and new technologies as required to achieve that), and does not have sufficient capacity / resilience to consistently deliver those services
THEN…	it will be unable to improve productivity, address waiting list targets and will face a shortfall in income (resulting in failure to deliver the financial plan)
RESULTING IN…	inability to reduce waiting times at the required rate; an adverse impact on patient experience, potentially resulting in patient harm; increased scrutiny from regulators (leading to burdensome reporting requirements and/or enforcement action which reduce capacity and place constraints on the Trust's ability to act independently in pursuit of its objectives).

Related corporate objectives:		
1	Deliver high quality clinical services	✓
2	Develop our Veterans service as a nationally recognised centre	
3	Integrate MSK pathways within and across STW	✓
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	

Risk Appetite and tolerance:		Quality - Cautious: 6; Finance - Open: 9	
Assurance Committee:		Finance and Performance (primarily)	
Executive Owner (strategic lead):		Chief Operating Officer (COO)	
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	~~December 2025~~ May 2026
		Date Last Reviewed by the assurance Committee:	~~November 2025~~ April 2026

SECTION 1: Scoring

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	4	4	**< >**	5	**< >**	5	5
Likelihood	4	3	^	4	V	3	2
Total	**16**	**12**	^	**20***	V	**15**	**10**

** raised to (4x5) 20 in November 2024*

< > = no change V = a positive downward change ^ = a negative upward change

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 5)

Rationale for the current score, including an explanation of any movement:
Good progress has been made in: • Addressing RTT targets; • Reducing patient list sizes; • Increasing capacity, through theatre development and recruitment (reducing reliance on OJP activity) These developments will need to be sustained in delivering a challenging plan. This will require further recruitment and a shift in practices which represent a significant cultural change within the organisation. Failure to achieve this will have significant consequences for the Trust, so the consequence score has been retained at the highest level.
Rationale for the target score and the plan to reduce the risk:
The Trust has limited ability to affect the wider demand for services. It can however reduce the likelihood of this risk through: 1. Ensuring its plans are as accurate as possible; 2. Ensuring its activity is delivered as efficiently as possible; 3. Developing / maintaining the necessary infrastructure / workforce to deliver the activity. 4. Continuing to reduce reliance on OJP. This target relates to the end of the 2023-28 strategic plan period but there is significant pressure to address performance in the short term.

~~**Contributory factors and associated controls**~~ **SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk**

Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
1	Development and delivery of a revised operating model	• Reporting on: ➢ Increased IJP activity ➢ Substantive recruitment ➢ Activity levels	This control would have a SIGNIFICANT impact	Medium in the short-to-medium term High in the longer-term
2	Delivery of activity in theatres	• Reporting on: ➢ Progress of the theatre build and bringing the new theatre on-line. ➢ The Four Eyes Insight work on theatre optimisation • IPR Reporting on: ➢ Total Theatre Activity Against Plan • Assurance Reports from: ➢ Theatre Development Group ➢ TPOIG	Increase capacity and the volume of activity delivered. This control would have a SIGNIFICANT impact	High

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 5)

~~Contributory factors and associated controls~~ SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
3	Effective clinical leadership / engagement	• IPR Reporting on: ➢ Total Theatre Activity Against Plan • Assurance Reports from: ➢ Joint Consultancy Group Meeting; ➢ Local Negotiating Meeting • Reporting (via the People and Culture Committee) on the development of effective arrangements to engage and involve the clinical / medical workforce via: ➢ A medical engagement strategy ➢ An updated delivery model	To develop effective structures and plans to enhance engagement and drive delivery This control would have a SIGNIFICANT impact	Medium
4	Recruitment & retention, including focus on key roles / "pressure points" that drive activity	• Reporting on: ➢ Workforce strategy / plans (to P&C); ➢ Recruitment plans for Theatres; ➢ Recruitment trajectories. • IPR Reporting (to P&C) on: ➢ Safe Staffing	Increase capacity and the volume of activity delivered. This control would have a SIGNIFICANT impact	~~Strong~~ High
5	Development of system-wide MSK service	• Reporting on: ➢ MSK Programme Board; ➢ Development of the provider collaborative; ➢ NHS Oversight Framework exit criteria.	Increase efficiency / productivity / capacity This control would have a SIGNIFICANT impact	Medium
6	Effective processes and pathways to maximise efficiency / productivity	• IPR and additional reporting on: ➢ Theatre Cases per Session against plan ➢ Touchtime Utilisation ➢ % Combined BADS Performance ➢ Average Length of Stay - Elective & Non Elective ➢ Bed Occupancy – All Wards – 2pm ➢ Outpatient DNA Rate (Consultant Led and Non Consultant Led Activity) ➢ New to Follow Up Ratio (Consultant Led and Non Consultant Led Activity) ➢ Total Outpatient Activity - % Virtual ➢ Total Outpatient Activity - % Moved to PIFU Pathway • Assurance Reports from:	Increase efficiency / productivity This control would have a SIGNIFICANT impact	~~Medium~~Low

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 5)

~~Contributory factors and associated controls~~ SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
		➢ Theatre Development Group		
7	Intensive waiting-list management processes, including effective validation.	• IPR and additional reporting on: ➢ Theatre Cancellations on the Day of Surgery ➢ % of waiting lists validated Note: This is not an IPR metric but does form part of the sign off pack for weekly Waiting List MDS submission that goes to NHSE	Increase efficiency / productivity This control would have a SIGNIFICANT impact	~~Medium~~High
8	Implementation and consistent application of e-job planning and e-rostering	• IPR Reporting (to P&C) on: ➢ % of E-Rosters Approved Six Weeks Before E-Roster ➢ % of System-Generated E-Roster (Auto-Rostering) ➢ E-Job Planning Level of Attainment ➢ Percentage of Staff with an Active E-Job Plan	Increase efficiency / productivity This control would have a MODERATE impact	~~Strong~~ ~~High~~ Medium
9	Accurate planning assumptions	• Reporting on: ➢ Development and delivery of the plan • IPR Reporting on: ➢ MCSI Admissions – Average Waiting Time ➢ Theatre Cancellations on the Day of Surgery ➢ 18 Weeks RTT Open Pathways ➢ English List Size ➢ Welsh List Size ➢ Combined List Size ➢ Time to first appointment – English Patients ➢ Time to first appointment – Welsh Patients ➢ % 52+ weeks of English waiting size ➢ Patients waiting over 104 weeks (Welsh) ➢ Overdue Follow Up Backlog ➢ 6 Week Wait for Diagnostics - English Patients ➢ 8 Week Wait for Diagnostics - Welsh Patients ➢ Note: Not an IPR metric Elective Activity Against Plan (volumes) ➢ Total Outpatient Activity against Plan (volumes) ➢ Total Diagnostics Activity against Plan - Catchment Based	To support delivery and enable early identification of issues that require addressing. This control would have a MODERATE impact	Medium

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 5)

~~Contributory factors and associated controls~~ SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
		➢ Note: Not an IPR metric –in development for Q3Referrals Received for Consultant Led Services • Assurance Reports from: ➢ TPOIG		
10	Continued optimisation of the EPR	• Reporting on: ➢ the initial and longer-term impact of EPR implementation (as factored into activity plans) • Assurance Reports (to DERIC) from: ➢ EPR Implementation Assurance Meeting	Increase efficiency / productivity This control would have a MODERATE / LOW impact	Medium ~~(reflecting successful launch of system but ongoing need to optimise)~~
~~**11**~~	~~Mutual aid / utilisation of the independent sector~~	~~Reporting into F&P / Activity Recovery Committee on mutual aid numbers~~	~~To increase capacity and the volume of activity delivered~~ ~~This control would have a MODERATE impact~~	~~Low~~
~~**12**~~	~~Short to medium term plan to increase activity, including on-payroll OJP, TOIL, insourcing etc.~~	~~Reporting into the Activity Recovery Committee.~~	~~To increase capacity and the volume of activity delivered~~ ~~This control would have a MODERATE Impact~~	~~Medium~~
~~**13**~~	~~Increased scrutiny and performance management to ensure appropriate application of patient access policy~~	~~Reporting into the Activity Recovery Committee on the actions in response to the NHSE letter~~	~~To reduce the number of reportable long waiters~~ ~~This control would have a MODERATE Impact~~	~~High~~HIGH
11	Appointment of new surgical insourcing contract	• Assurance Reports from: ➢ FP committee	This control would have a SIGNIFICANT impact	Medium

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 5)

SECTION 3: Factors that could negatively affect the Trust's ability to deliver this theme, and adversely affect efforts to address the strategic risk			
Ref.	**Description of inhibiting factors –** *what additional factors may adversely affect delivery and add to this risk?*	**Potential impact –** *how will this affect the consequence or likelihood?*	**Potential mitigations –** *how might this be avoided / mitigated?*
1	Capacity / capability – including the potential impact of burdensome reporting requirements and/or regulatory intervention, including recruitment "freeze" or constraints on spending.	If resources are constrained, there is a risk that the Trust will not be able to recruit, or deliver activity, as planned.	Demonstrating delivery / capability through: • Compliance with NOF requirements (and any performance criteria agreed with NHSE).
2	Capacity of existing workforce – including capacity issues due to unavailability of theatre workforce.	If resources are constrained, there is a risk that the Trust will not be able to deliver activity as planned.	Addressing availability issues through: • Competitive rates of pay • Collaboration with partner organisations
3	Potential industrial action.	Reduction in staff availability would reduce the amount of activity (reducing income) and/or increase agency costs.	The likelihood of industrial action is outside the control of the Trust. The impact can be reduced through effective contingency planning.
4	Impact of mitigations less than hoped for, due to a low take-up of bank activity / other alternative working arrangements (developed to comply with framework requirements).	There is a risk that the Trust will not be able to recruit, or deliver activity, as planned.	As 2, above, plus ongoing engagement with staff (in the short term) and the development and delivery of an updated operating model.
5	Differing expectations / requirements of English and Welsh commissioners (and the response of regulators).	Differing expectations will create inequity of treatment times for Welsh and English patients.	Ongoing communication with Welsh commissioners to clarify requirements / better understand future demand.
6	The complexity of operational management of delivery (in balancing resources, planned activity, patient flows etc.)	If plans are not sufficiently aligned, there is a risk that inadequate resource will be available to deliver the required activity and/or there will be insufficient activity to deliver the financial plan.	Alignment of workforce, financial and activity plans, including clarity on trajectories for future months. Operational oversight of performance against plans.

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 5)

SECTION 4: Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
1	Effective communication with staff to promote / support the cultural change required to deliver the revised operating model (as reflected in BAF 2)	Increase the success of the controls, reducing the likelihood score.	See BAF 2	See BAF 2	See BAF 2
~~**2**~~	~~The need to assess and respond to national and regional developments, including those reflected in the NHS 10 Year Plan, which affect organisational functionals / structures, longer-term strategy / policy, and immediate operational priorities.~~ ~~This will include:~~ ~~• a review / refresh of strategic and corporate objectives;~~ ~~• the development / revision of plans to deliver those objectives;~~ • ~~revision of the BAF to capture those objectives and the risks to their delivery.~~	~~Improve the ability of the organisation to deliver national strategic and operational priorities, improving the efficiency and quality of services.~~	~~SK CEO / Chair HT (leading the wider Board)~~	~~Q1, 2026/7~~	~~AMBER~~ ~~(as work in development)~~
~~**3**~~**2**	Establish medium-to-long-term insourcing arrangements and maximise the delivery of the current, short-term arrangement.	Increase the level of activity delivered through the insourcing arrangements	~~SK~~ CEO / ~~MC~~COO	~~Q1~~Q2, 2026/7 (for longer-term arrangements)	AMBER

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 6)

Delivering innovation, improvement and growth	BAF 6
IF…	the Trust does not have the required infrastructure / capacity / expertise / culture to support innovation and growth, particularly the adoption of digital technologies; or governance processes / funding regimes place constraints on the Trust's ability to act
THEN…	it will not be able to identify / pursue opportunities to innovate, deliver improvements for patients and staff, or develop commercial opportunities
RESULTING IN…	a failure to maximise opportunities to improve staff experience, clinical outcomes, patient satisfaction and increase income (which could be reinvested in services). In the longer-term, failure to innovate could affect the Trust's ability to operate effectively (in relation to more innovate organisations).

Related corporate objectives:		
1	Deliver high quality clinical services	✓
2	Develop our Veterans service as a nationally recognised centre	
3	Integrate MSK pathways within and across STW	
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	✓

Risk Appetite and tolerance:		Quality - Cautious: 6; ~~-~~Finance - Open: 9; Reputational / Regulatory - Open: 9	
Assurance Committee:		Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee	
Executive Owner (strategic lead):		Chief Medical Officer	
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	~~December 2025~~May 2026
		Date Last Reviewed by the assurance Committee:	April 2026

SECTION 1: Scoring:

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	4	4	**< >**	4	**< >**	4	4
Likelihood	4	3	**^**	4	**< >**	4	2
Total	**16**	**12**	**^**	**16**	**< >**	**16**	**8**

< > = no change **V** = a positive downward change **^** = a negative upward change

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 6)

Rationale for the current score, including an explanation of any movement:
Work and investment will be required to develop the required infrastructure / capacity / expertise to deliver this strategic theme, particularly in relation to the digital agenda and the adoption of new technologies. A Chief Digital and Information Officer (CDIO) has been appointed. They will assess the position and future requirements on appointment. Failure to deliver it will result not only in missed opportunities, but could lead the Trust to fall behind other, more innovative organisations. As such, there is a significant risk to the long-term success / viability of the organisation, if it fails to innovate.
Rationale for the target score and the plan to reduce the risk:
This risk is within the control of the Trust to mitigate. There will however be capacity / financial constraints affecting the Trust's ability to pursue these goals. There may also be challenges in attracting the required expertise to drive elements of this agenda.

~~Contributory factors and associated controls~~ SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk

Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
1	Workforce development / engagement to support and encourage innovation	• Appointment of a Commercial Director • Reporting via People and Culture Committee (See BAF 2). • Development / engagement elements of strategies relevant to the DERIC agenda (as referenced in "additional actions" section).	See BAF 2 for general measures to - Maintain / improve retention of staff through improved wellbeing and more effective communication. Improved engagement of staff in the innovation / growth agenda. This control would have a SIGNIFICANT impact	Medium
2	Effective clinical engagement / leadership	• Reporting from Chief Executive / executive team on clinical engagement / leadership. • Medical Director reporting on medical engagement / leadership. • Self-assessment against The King's Fund's "*Medical Engagement Checklist*". • Outputs from improvement activity~~the innovation club~~ (as reported to DERIC) • Clinical engagement / presentation at DERIC… • Outputs from the SDG…	To develop effective plans and drive delivery of the innovation~~ / ~~, improvement and growth agenda. This control would have a SIGNIFICANT impact	Medium / High
3	Effective operational engagement / leadership	• Outputs from the innovation club (as reported to DERIC)	To develop effective plans and drive delivery of the innovation / growth agenda.	Medium

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 6)

~~Contributory factors and associated controls~~ SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
		• Reporting on ~~development of new operating model and~~ development of new roles to support commercialisation etc.	This control would have a SIGNIFICANT impact	
4	Effective plans to support recruitment / retention / skills mix.	• Reporting on plans to develop infrastructure to support growth / "commercial development". • Reporting on development opportunities and experiences of staff in delivering innovation. • Staffing / skills elements of strategies relevant to the DERIC agenda (as referenced in "additional actions" section). • Reporting via People and Culture Committee (see BAF 2)	See BAF 2 for general measures to - Ensure recruitment of the required staff to support delivery; Ensure plans are in place to maintain / improve the retention of staff and promote development etc. This control would have a SIGNIFICANT impact	Medium
5	Effective co-operation with partners, such as ROH, to identify opportunities to innovate and improve	• Reporting on the development of the strategic alliance with ROH. • Reporting on the development of other partnership arrangements.	To develop effective plans and drive delivery of the innovation / growth agenda. This control would have a SIGNIFICANT impact	Medium (as the work is in progress)

SECTION 3: Factors that could negatively affect the Trust's ability to deliver this theme, and adversely affect efforts to address the strategic risk			
Ref.	**Description of inhibiting factors –** *what additional factors may adversely affect delivery and add to this risk?*	**Potential impact –** *how will this affect the consequence or likelihood?*	**Potential mitigations –** *how might this be avoided / mitigated?*
1	Capacity / capability – including the potential impact of burdensome reporting requirements and/or regulatory intervention, including recruitment ~~"freeze" or~~ constraints on spending. The current focus on addressing the performance issues with long-waiters is impacting on the Trust's capacity to progress other areas of work.	If resources are constrained, there is a risk that the Trust will not be able to recruit / develop as planned.	Demonstrating delivery / capability through: • Compliance with NOF requirements (and any performance criteria agreed with NHSE). • A reduction in the number of long-waiting patients.

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 6)

2	Delivery of finance and activity plans / reduction in waiting lists.	See BAF 3 - Growth into new markets / innovation will be difficult to achieve / prioritise until core services are being delivered in line with NHSE expectations.	Controls / mitigations are contained in BAF 3 and BAF 4, as considered by the Finance and Performance Committee.
3	Capacity / capability – a lack of expertise to drive the innovation / growth agenda (including the adoption of digital and other technologies)	Without the required capacity / capability in place, the Trust will be unable to deliver its ambitions.	Increased capacity / capability through the recruitment of key individuals A clear plan for the delivery of the Trust's objectives in this arena.
4	Capacity / capability – The effect of "change fatigue" …	Too much change in too short a period of time will adversely affect people's enthusiasm / capacity to adapt and deliver change.	Effective training / communication and clear prioritisation to avoid overload.

Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
1	Approval and delivery of a digital / data strategy. ~~Committee consideration of the Strategy deferred to January as a more focussed agenda has been agreed for the November meeting.~~ A Strategy Delivery Group has been developed to drive / monitor delivery and provide upward assurance reporting.	Will increase the ability of the Trust to identify and pursue opportunities / establish the required infrastructure, thereby reducing the likelihood of the risk.	CDIO ~~/~~ CFCO ~~/ RL~~	Digital strategy was agreed by the DERIC Committee in April 2025.	AMBER (Strategy approved but moving into delivery stage)
2	Approval and delivery of an income growth / commercialisation strategy (including private patients). ~~This will inform / be informed by the research and digital strategies, and the appointment of a Chief Finance and Commercial Officer~~ A Strategy Delivery Group has been developed to drive / monitor delivery and provide upward assurance reporting.	Will increase the ability of the Trust to identify and pursue opportunities / establish the required infrastructure, thereby reducing the likelihood of the risk.	~~RL~~ CFCO ~~/ MC~~	Elements were picked up as part of the revised research strategy agreed in March 2025. CFO and Commercialisation Officer now appointed and in post.	AMBER (as work is in early stages of development)
3	Approval and delivery of a research strategy. ~~An open space event to engage staff in the development of the strategy has been arranged for 3 December 2024.~~ A Strategy Delivery Group has been developed to drive / monitor delivery and provide upward assurance reporting.	Will increase the ability of the Trust to identify and pursue opportunities / establish the required infrastructure, thereby reducing the likelihood of the risk.	~~Andrew Roberts / RL~~CMO	The Research Strategy was agreed by the DERIC Committee in March 2025.	AMBER (as strategy now agreed but more work needed to deliver it)

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 6)

Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
4	~~Approval and d~~Delivery of an innovation and improvement strategy. A Strategy Delivery Group has been developed to drive / monitor delivery and provide upward assurance reporting.	Will increase the ability of the Trust to identify and pursue opportunities / establish the required infrastructure, thereby reducing the likelihood of the risk. Assurance reporting from the Strategy Delivery Group	~~RL / MC~~ CMO / COO	A draft Innovation and Improvement Strategy was considered by the DERIC Committee in April 2025. The Strategy Development Group will monitor strategies and associated actions.	AMBER
5	~~Approval and D~~delivery of an education strategy. A Strategy Delivery Group has been developed to drive / monitor delivery and provide upward assurance reporting.	Will increase the ability of the Trust to identify and pursue opportunities / establish the required infrastructure, thereby reducing the likelihood of the risk. Assurance reporting from the Strategy Delivery Group	~~DH / RL~~ CPO / CMO	The Strategy was approved by the Committee in September. The first working groups have been held. The project to build an education centre has been reinitiated. Meetings have been held around the steps required to become a University Teaching Hospital. Clinical education group being established…	AMBER (as strategy now agreed but more work needed to deliver it)
6	~~Development of a~~ Delivery of the Clinical Strategy, to include medical, nursing, AHPs etc. This is being developed by the Executive Team, engaging with colleagues as appropriate.	The workforce will be supported to deliver innovation in their areas of work and the Trust can make best use of its resources. This will support delivery of multiple BAF themes	~~RL~~ CMO / CNO	A draft Clinical Strategy was considered at P&C / Q&S in December 2024. The 2024-29 Clinical Strategy was	AMBER (as strategy now agreed but more work needed to deliver it)

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 6)

Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
	A Strategy Delivery Group has been developed to drive / monitor delivery and provide upward assurance reporting.	Assurance reporting from the Strategy Delivery Group		subsequently published. The Strategy Development Group will monitor strategies and associated actions.	
7	The need to assess and respond to national and regional developments, including those reflected in the NHS 10 Year Plan, which affect organisational functionals / structures, longer-term strategy / policy, and immediate operational priorities. This will include: • a review / refresh of strategic and corporate objectives; • the development / revision of plans to deliver those objectives; • revision of the BAF to capture those objectives and the risks to their delivery.	Improve the ability of the organisation to deliver national strategic and operational priorities, improving the efficiency and quality of services.	~~SK~~ CEO / Chair ~~HT~~ (leading the wider Board)	Q1, 2026/7	AMBER (as work in development)
8	Review of the role and operation of DERIC to ensure continued focus on delivery of the "DERIC" agenda.	Will support the ability of the Trust to identify and pursue opportunities / establish the required infrastructure, thereby reducing the likelihood of the risk.	Exec Owners / Ctte Chair	Q3 2026/7 - ~~I~~in line with the developmental well-led review action plan. ToR recently reviewed and approved	GREEN

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 7)

The challenges of operating in both the Welsh and English health systems	BAF 7
IF…	The Trust is unable to effectively manage key relationships and the operational and financial challenges of delivering the differing expectations of commissioners in both the English and Welsh systems
THEN…	There is a risk to: the efficient delivery of services (due to the need for separate arrangements to satisfy differential targets); delivery of the financial plan; the Trust's ability to reduce waiting times for Welsh patients in line with its intentions; the Trust's ability to deliver the required level of performance for English patients
RESULTING IN…	Persisting inequity in the timelines of services offered to patients which may adversely affect patient experience and outcomes; reputational damage to the Trust; and an adverse impact on the Trust's National Oversight Framework rating.

Related corporate objectives:		
1	Deliver high quality clinical services	✓
2	Develop our Veterans service as a nationally recognised centre	✓
3	Integrate MSK pathways within and across STW	✓
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	✓

Risk Appetite and tolerance:	Reputational / Regulatory - Open: 9		
Assurance Committee:	Board of Directors		
Executive Owner (strategic lead):	Chief Executive Officer		
Risk Owner (overall managerial lead):	Nia Jones, Managing Director of Planning and Strategy		
Date Opened:	May 2026	**Date Last Reviewed by the Board:**	n/a
		Date Last Reviewed by the assurance Committee:	n/a

SECTION 1: Scoring

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	5	5		n/a		5	3
Likelihood	5	4		n/a		4	4
Total	**25**	**20**		**n/a**		**20**	**12**

< > = no change **V** = a positive downward change **^** = a negative upward change

Rationale for the current score, including an explanation of any movement:

There is a significant differential between English and Welsh long waits, with a higher number of Welsh patients waiting for extended periods. This remains a complex and evolving situation. Key factors include:
• Differing commissioning arrangements / expectations result in:
  ➢ Operational challenges, as teams are required to work to multiple sets of externally set "rules", requiring different processes and operational targets;
  ➢ Differences in the timeliness of services provided to patients, resulting in differences in the quality of patients' experiences.
  ➢ Difference in community service provision
• The Trust is subject to NHSE's oversight framework, but that framework takes no account of performance in relation to Welsh patients, despite the significant volume of Welsh activity delivered by the Trust.
• There is a risk to Trust performance if Welsh long waiters transfer to English lists to expedite their treatment (resulting in deteriorating performance against English waiting list targets).
• There is a risk to Trust performance if Welsh government targets changed, increasing the pressure on services (and potentially affecting the Trust's capacity to deliver against the NHSE targets).

Rationale for the target score and the plan to reduce the risk:
This is an initial suggested target that will be further considered by the executive team and Board.

SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
1	Implementation of effective provider collaborative arrangements within STW, primarily through MSK lead role.	Assurance reporting to Board, via the Finance and Performance Committee, on the operation of the MSK Provider Collaborative.	Improved working within STW partners to improve services / deliver efficiencies etc. This control would have a SIGNIFICANT impact	Low
2	Strategic alliances with specialist orthopaedic providers.	Reporting to Board on relationship with the National Orthopaedic Alliance, ROH, Federation of Specialist Trusts etc.	Improved working within specialist partners to improve services / deliver efficiencies etc. This control would have a MODERATE impact	Medium (Agreement in place and existing areas of collaboration to continue. Further opportunities for collaboration to be developed).

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 7)

SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
3	Plans for building upon the elective surgery hub / paediatric hub status.	Reporting to Board and Finance and Performance Committee	Improve services and increase income, providing greater resilience to the Trust (and by extension, the STW system) This control would have a SIGNIFICANT impact	High / Medium
4	Developing services with Welsh providers.	Reporting to Board on development of arrangements with Welsh commissioners / providers	Improved working within Welsh partners to improve services / increase income, providing greater resilience to the Trust (and by extension, the STW system) This control would have a SIGNIFICANT impact	Medium
5	Workforce strategy and associated plans.	Reporting via People and Culture Committee (See BAF 2)	To support development of the required workforce to deliver the objectives This control would have a SIGNIFICANT impact	High
6	Estates strategy and associated plans.	Reporting via Finance and Performance Committee	To support provision of the necessary infrastructure to deliver the objectives This control would have a SIGNIFICANT impact	Medium
7	Constructive engagement with STW / Other partners (as BAF 4)	Reporting and assurance via F&P Committee and Board	To develop effective plans and drive delivery This control would have a MODERATE impact	Low
8	Constructive engagement with regulators, including via CQC keep-in-touch meetings etc.	Reporting and assurance via F&P Committee and Board	To provide assurance to regulators and minimise the risk of intervention This control would have a SIGNIFICANT impact	Medium
9	Agreeing an appointments activity plan with Welsh commissioners	Reporting and assurance via F&P Committee and Board		

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 7)

SECTION 3: Factors that could negatively affect the Trust's ability to deliver this theme, and adversely affect efforts to address the strategic risk			
Ref.	**Description of inhibiting factors –** *what additional factors may adversely affect delivery and add to this risk?*	**Potential impact –** *how will this affect the consequence or likelihood?*	**Potential mitigations –** *how might this be avoided / mitigated?*
1	Capacity / capability – including the potential impact of burdensome reporting requirements and/or regulatory intervention, including recruitment "freeze" or constraints on spending.	If resources are constrained, there is a risk that the Trust will not be able to act as planned.	Demonstrating delivery / capability through: • Compliance with NOF requirements (and any performance criteria agreed with NHSE).
2	Failure to deliver finance and activity plans / reduce waiting lists.	Growth into new markets / innovation will be difficult to achieve / prioritise until core services are being delivered in line with NHSE expectations.	Demonstrating delivery / capability through: • Compliance with NOF requirements (and any performance criteria agreed with NHSE).

SECTION 4: Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
1	Work with Welsh providers to develop arrangements – quarterly workshops established with BCUHB (to identify key opportunities – with a priority on winter planning) and Powys Health Board (in relation to clinical leadership). Two workshops to date with Powys, one with BCUHB.	Improved arrangements with partners to improve services / deliver efficiencies, and increase income	MD P&S	Completed for establishment of workshops – deadline for specific agreements in discussion.	AMBER
2	Ongoing work with system partners to consider shared services etc.	Improved arrangements within STW to improve services / deliver efficiencies etc.	CFCO	Quarter 4 2025/26	AMBER
3	Further collaboration with Royal Orthopaedic Hospital – Chair and CEO meeting held (and to continue); Board to Board meeting took place in April 2026; Exec to Exec meetings have taken place to consider opportunities for collaboration in line with the Memorandum of Understanding	Improved working within specialist partners to improve services / deliver efficiencies	CEO	October 2026 (for second B2B meeting)	AMBER (as still relatively early days of the collaboraton)

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 8)

Responding to a significant disruptive event.	BAF 8
IF…	If the Trust does not have adequate plans in place to respond to a significant disruptive event beyond the control of the Trust, such as a major incident
THEN…	Then it will be unable to provide an adequate response to the immediate need and/or maintain other key services due to unavailability of the required resources / staff
RESULTING IN…	Resulting in potential patient harm, increased waiting times etc

Related corporate objectives:		
1	Deliver high quality clinical services	✓
2	Develop our Veterans service as a nationally recognised centre	
3	Integrate MSK pathways within and across STW	
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	

Risk Appetite and tolerance:		Quality - Cautious: 7	
Assurance Committee:		Quality and Safety Committee	
Executive Owner (strategic lead):		Chief Operating Officer (COO)	
Risk Owner (overall managerial lead):			
Date Opened:	23/04/2026	**Date Last Reviewed by the Board:**	~~December 2025~~ May 2026 (in previous form, including "cyber")
		Date Last Reviewed by the assurance Committee:	April 2026

SECTION 1: Scoring

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	5	5		n/a		5	5
Likelihood	5	3		n/a		3	2
Total	**25**	**15***		**n/a**		**15**	**10**

**Scored as a new risk, following the change of scope.*

< > = no change **V** = a positive downward change **^** = a negative upward change

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 8)

Rationale for the current score, including an explanation of any movement:
The described risk relates to a lack of adequate plans to respond to potentially disruptive external events. The Trust cannot reduce the likelihood of those external events taking place. It can however reduce the likelihood that such events, should they occur, would result in significant disruption. Technically, having adequate plans in place would reduce the "likelihood" of the risk. The Trust has improved its EPRR assessment rating and has a number of tried and tested continuity plans. That results in a reduction in the likelihood score. The external events could be catastrophic in nature. As such, the consequence has been recorded at the highest level. As there is now a dedicated "cyber" BAF entry, that entry focusses on preventing a cyber attack / loss of information. This entry focusses on the Trust's ability to continue to operate following such an event. The relationship between those two elements – prevention and response - may not always be clear cut and thought will need to be given to appropriate assurance reporting arrangements between the Q&S, F&P and DERIC committees.
Rationale for the target score and the plan to reduce the risk:
The Trust is not able to influence external events that could have a significant impact on the Trust. The Trust does however have the ability to reduce the impact such events have on the Trust's ability to operate, whether through protective measures, or through robust plans and procedures to react to such events.

~~Contributory factors and associated controls~~ SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk

Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
1	Critical incident / EPRR / business continuity plans	Annual external assessment of EPRR, as reported to Q&S Assurance reporting to Q&S from Health & Safety Meeting Internal Audit review of arrangements in Q2 2026/7.	Reduce the impact of a potentially disruptive event through an effective response. This control would have a SIGNIFICANT impact	Medium
2	Robust critical incident / EPRR / business continuity procedures	Annual external assessment of EPRR, as reported to Q&S (including update in Nov 2025) Assurance reporting to Q&S from Health & Safety Meeting Exercise / simulation of a major incident – exercise undertaken on 20 May 2025.	Reduce the impact of a potentially disruptive event through an effective response. This control would have a SIGNIFICANT impact	Medium

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 8)

~~Contributory factors and associated controls~~ SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
3	Robust testing / auditing of arrangements for EPRR	Annual external assessment of EPRR, as reported to Q&S Assurance reporting to Q&S from Health & Safety Meeting	Reduce the impact of a potentially disruptive event through strengthening policies / procedures. This control would have a SIGNIFICANT impact	Medium
4	IPC policy / practice / training	Reporting to Q&S - See BAF 1, factor 10.	Reduce the likelihood / impact of a potentially disruptive event through strengthening systems / procedures / practices. This control would have a SIGNIFICANT impact	~~Strong~~High
5	Strong links with system plans, including mutual aid arrangements	Annual external assessment of EPRR, as reported to Q&S *System / partner simulations and exercises…*	Reduce the impact of a potentially disruptive event through collective learning / provision of mutual aid etc. This control would have a MODERATE impact	Medium

SECTION 3: Factors that could negatively affect the Trust's ability to deliver this theme, and adversely affect efforts to address the strategic risk			
Ref.	**Description of inhibiting factors –** *what additional factors may adversely affect delivery and add to this risk?*	**Potential impact –** *how will this affect the consequence or likelihood?*	**Potential mitigations –** *how might this be avoided / mitigated?*
1	Disruption to supply chains beyond the control of the Trust	Inability to deliver activity, or perform certain functions due a lack of available resource.	Liaison with procurement team to identify areas of particular vulnerability for the Trust (in support of business continuity plans at a regional / national level).

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 8)

SECTION 4: Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
1	Exercise / simulation of a major incident – including testing of local response procedures.	Improve the Trust's preparedness for an incident.	~~MC~~COO	~~Tbc. Last exercise undertaken in May 2025. Further exercises to be held.~~Internal and external exercise is undertaken. EPRR testing is undertaken as part of a rolling programme and forms part of the annual assurance process.	AMBER
2	Engagement in system-wide learning from live events	Improve the Trust's preparedness for an incident.	~~MC / SA~~COO	Ongoing	GREEN
3	An EPRR improvement plan has been developed to improve the Trust's compliance with the requirements.	Improve the Trust's preparedness for an incident through improved training etc.	~~MC~~COO	~~Quarterly~~ Bi-annually reporting into Q&S	AMBER (assessment score improved but more actions to be delivered)
4	A business continuity plan auditing exercise is underway to confirm the existence / appropriateness of local business continuity plans.	Improve the Trust's ability to respond to an incident through effective planning and staff familiarity with local plans.	~~MC~~COO	~~Quarterly~~ Bi-annual reporting into Q&S	GREEN
~~**5**~~	~~The development of an STW EPRR function.~~	~~Improve the system's preparedness for an incident through increasing capability and capacity across system partners.~~	~~MC~~	~~Q3 2025/6~~	~~AMBER~~
~~**5**~~**6**	~~The need to assess and respond to national and regional developments, including those reflected in the NHS 10 Year Plan, which affect organisational functionals / structures, longer-term strategy / policy, and immediate operational priorities.~~ ~~This will include:~~ ~~• a review / refresh of strategic and corporate objectives;~~ ~~• the development / revision of plans to deliver those objectives;~~	~~Improve the ability of the organisation to deliver national strategic and operational priorities, improving the efficiency and quality of services.~~	~~SK CEO/Chair/ HT (leading the wider Board)~~	~~Q1, 2026/7~~	~~AMBER (as work in development)~~

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 8)

SECTION 4: Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
	• ~~revision of the BAF to capture those objectives and the risks to their delivery.~~				

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 9)

Security of digital, data, and AI systems and ability to respond to cyber threats	BAF 9
IF…	the Trust does not have adequate plans, systems, processes, and culture in place to protect digital, data and AI systems and/or prevent, or respond to cyber attacks
THEN…	it will be unable to provide an adequate response to the immediate need and/or maintain other key services due to unavailability of the required systems / resources
RESULTING IN…	an inability to perform essential functions, potentially leading to patient harm, increased waiting times, financial losses etc

Related corporate objectives:		
1	Deliver high quality clinical services	✓
2	Develop our Veterans service as a nationally recognised centre	
3	Integrate MSK pathways within and across STW	
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	

Risk Appetite and tolerance:	Quality - Cautious: 7		
Assurance Committee:	Digital, Education, Research, Innovation and Commercialisation Committee		
Executive Owner (strategic lead):	Chief Finance and Commercial Officer (CFCO)		
Risk Owner (overall managerial lead):	Chief Digital and Information Officer (CDIO)		
Date Opened:	23/04/2026	**Date Last Reviewed by the Board:**	n/a
		Date Last Reviewed by the assurance Committee:	n/a

SECTION 1: Scoring

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE*	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	5	4		n/a		4	3
Likelihood	4	4		n/a		4	4
Total	**20**	**16**		**n/a**		**16**	**12**

< > = no change **V** = a positive downward change **^** = a negative upward change

Rationale for the current score, including an explanation of any movement:
The current national / international threat of a cyber-attack, and the experience of organisations that have been subject to an attack, suggest that this is (and will remain) a significant risk. The adoption of AI and new digital technologies presents opportunities but requires robust governance to prevent the unauthorised, or inappropriate use of such tools which could lead to the loss of data, impaired decision-making, or increased vulnerability to cyber attacks.

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 9)

Rationale for the target score and the plan to reduce the risk:
The Trust is not able to prevent external actors attempting to infiltrate the Trust's systems but it can have policies and procedures in place to make them less likely to succeed. It also has the ability to: • Reduce the impact such events have on the Trust's ability to operate, whether through protective measures, or through robust plans and procedures to react to such events; and • Reduce the likelihood of data / information loss through robust systems and practices. The current national / international threat of a cyber-attack, and the experience of organisations that have been subject to an attack, suggest that this is (and will remain) a significant risk.

SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
1	Robust policies and procedures governing the use of digital systems / tools…	Assurance reporting from the Digital Operational Meeting, incorporating escalation from the: • Information Governance Group • Data Management Group • Design Safety Authority • Prioritisation and Innovation Group DERIC review of: • Digital / information risks. • Relevant key policies. • Relevant Audit, or other external assessments.	Reduce the likelihood of a cyber attack or other unauthorised / accidental loss of data through effective controls. Reduce the likelihood / impact of a potentially disruptive event through strengthening systems / procedures. This control would have a SIGNIFICANT impact	Medium
2	Robust policies and procedures governing the use of data / information...	Assurance reporting from the Digital Operational Meeting, incorporating escalation from the: • Information Governance Group • Data Management Group • Design Safety Authority • Prioritisation and Innovation Group DERIC review of: • Digital / information risks. • Relevant key policies. • Relevant Audit, or other external assessments.	This control would have a SIGNIFICANT impact	High

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 9)

SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
3	Effective training / education / communication of good practice and threats …	Assurance reporting from the Digital Operational Meeting, incorporating escalation from the: • Information Governance Group • Data Management Group • Design Safety Authority • Prioritisation and Innovation Group DERIC review of: • Digital / information risks. • Relevant key policies. • Relevant Audit, or other external assessments. • Training compliance and the outcome of test exercises.	Reduce the likelihood of a cyber attack or other unauthorised / accidental loss of data through effective controls. This control would have a SIGNIFICANT impact	High
4	Regular testing of compliance with policy / procedures…	Assurance reporting from the Digital Operational Meeting, incorporating escalation from the: • Information Governance Group • Data Management Group • Design Safety Authority • Prioritisation and Innovation Group DERIC review of: • Digital / information risks. • Relevant key policies. • Relevant Audit, or other external assessments. Training compliance and the outcome of test exercises.	Reduce the likelihood of a cyber attack or other unauthorised / accidental loss of data through effective controls. This control would have a SIGNIFICANT impact	High
5	Maintenance of infrastructure…	Assurance reporting from the Digital Operational Meeting, incorporating escalation from the: • Information Governance Group • Data Management Group • Design Safety Authority • Prioritisation and Innovation Group DERIC review of:	Reduce the likelihood / impact of a potentially disruptive event through strengthening systems / procedures. This control would have a SIGNIFICANT impact	Medium

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 9)

SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
		• Digital / information risks. • Relevant key policies. • Relevant Audit, or other external assessments. Training compliance and the outcome of test exercises.		
6	Regular testing of systems etc…	Assurance reporting from the Digital Operational Meeting, incorporating escalation from the: • Information Governance Group • Data Management Group • Design Safety Authority • Prioritisation and Innovation Group DERIC review of: • Digital / information risks. • Relevant key policies. • Relevant Audit, or other external assessments. Training compliance and the outcome of test exercises.	Reduce the likelihood / impact of a potentially disruptive event through strengthening systems / procedures. Reduce the likelihood / impact of a potentially disruptive event through strengthening systems / procedures. This control would have a SIGNIFICANT impact	High
7	Robust critical incident / EPRR / business continuity procedures	Annual external assessment of EPRR, as reported to Q&S (including update in Nov 2025) Assurance reporting to Q&S from Health & Safety Meeting Exercise / simulation of a major incident –exercise undertaken on 20 May 2025. MIAA internal audit scheduled for Q2 2026/7	Reduce the impact of a potentially disruptive event through an effective response. This control would have a SIGNIFICANT impact	Medium
8	Robust testing / auditing of arrangements for EPRR	Annual external assessment of EPRR, as reported to Q&S Assurance reporting to Q&S from Health & Safety Meeting	Reduce the impact of a potentially disruptive event through strengthening policies / procedures. This control would have a SIGNIFICANT impact	Medium

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 9)

SECTION 2: Factors that impact upon delivery of this theme, and the associated controls to address the strategic risk				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of confidence –** *what is the current level of confidence that this control is in place, and is effective?*
9	Strong links with system plans, including mutual aid arrangements	Annual external assessment of EPRR, as reported to Q&S *System / partner simulations and exercises…*	Reduce the impact of a potentially disruptive event through collective learning / provision of mutual aid etc. This control would have a MODERATE impact	Medium
10	Additional software and system support which effectively reduce Cyber exposure	Assurance reporting from the Digital Operational Meeting, incorporating escalation from the: • Information Governance Group • Data Management Group • Design Safety Authority • Prioritisation and Innovation Group DERIC review of: • Digital / information risks. • Relevant key policies. • Relevant Audit, or other external assessments.	Reduce likelihood of Cyber-attack by deploying additional defences	High

SECTION 3: Factors that could negatively affect the Trust's ability to deliver this theme, and adversely affect efforts to address the strategic risk			
Ref.	**Description of inhibiting factors –** *what additional factors may adversely affect delivery and add to this risk?*	**Potential impact –** *how will this affect the consequence or likelihood?*	**Potential mitigations –** *how might this be avoided / mitigated?*
1	A lack of funding for Cyber initiatives, particularly those prescribed by the new directive approach from NHS England on Cyber.	Inability to add new software to reduce Cyber risk, potentially exposing the Trust to external attack.	Additional funding has been requested from NHS England for Cyber Initiatives. Existing funding envelope is being redeployed as appropriate to support new systems with stronger controls being implemented. Existing capital funding available if appropriate (but a lot of this funding is revenue)

BAF – Strategic Risks, controls and assurances – 2026/27 (BAF 9)

SECTION 4: Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
1	Exercise / simulation of a major incident – including testing of local response procedures.	Improve the Trust's preparedness for an incident.	AEO	. Internal and external exercise is undertaken. EPRR testing is undertaken as part of a rolling programme and forms part of the annual assurance process.	AMBER
2	Engagement in system-wide learning from live events (e.g. global IT outage)	Improve the Trust's preparedness for an incident.	AEO / CDIO	Ongoing	GREEN
3	An EPRR improvement plan has been developed to improve the Trust's compliance with the requirements.	Improve the Trust's preparedness for an incident through improved training etc.	AEO	Bi-annual reporting into Q&S	AMBER (assessment score improved but more actions to be delivered)
4	A business continuity plan auditing exercise is underway to confirm the existence / appropriateness of local business continuity plans.	Improve the Trust's ability to respond to an incident through effective planning and staff familiarity with local plans.	AEO	Bi-annual reporting into Q&S	GREEN

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Corporate Risk Summary

(Part 1) Covering paper

Committee / Group / Meeting, Date	
Board of Directors, 29 July 2026	
Author:	**Contributors:**
Name: Dylan Murphy Role/Title: Trust Secretary	-
Report sign-off:	
N/A	
Is the report suitable for publication:	
Yes	

Exec Summary:

26 individual risks currently rated at 15 or above on the Trust's risk register were considered by the Board committees during the July round of meetings. Each of the risks was allocated to at least one Board committee for oversight. A high-level summary of the risks is attached.

The committees received more detailed summaries of the relevant risks that outlined:

- The risk score;
- A full description of the risk, including the key implications;
- An update on the current position;
- A summary of the existing controls;
- A confidence rating on the effectiveness of the existing and planned controls; and
- A projected date at which the risk could be reduced, or closed.

Following feedback from the committees, future reports will be condensed further to concentrate on key elements of assurance.

Each Committee was asked to:

1. NOTE the extracts from the high-rated risks relevant to the remit of the Committee;
2. COMMENT on the revised format, to inform future reports; and
3. IDENTIFY any risk-related issues it wishes to raise with the Board via the Chair's assurance report.

As noted by the committees, this year has seen a couple of significant developments that have affected the Trust's risk management arrangements:

1. The transfer of risks from the Apollo implementation programme into the Trust's broader risk management processes; and
2. The implementation of Radar Healthcare as the system used by staff to record and manage risks (replacing the previous Datix system).

Both developments have presented practical challenges, and there is an ongoing process to review and refine risks that have transferred from the Apollo Programme, and optimise the use of Radar Healthcare (to accurately capture risk and their existing mitigations, and to support effective assurance reporting).

Recommendations:

That the Board:

1. NOTE the risks rated at 15 or above, and the movement in any such risks, as considered by the Board Committees during July 2026;
2. CONSIDER any risk-related escalations from the July round of Committee meetings; and
3. CONSIDER the level of assurance provided by the risk management arrangements, as reflected in the corporate risk register and Chairs' assurance reports.

(Part 2) Strategic alignment and supporting detail

Strategic objectives and associated risks:

The following strategic objectives, developed in light of national and system priorities, 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	✓
Corporate risks could relate to delivery of any of the Trust's strategic objectives.		

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	✓
Strategic risks are outlined in the Board Assurance Framework. The risks included on the Trust's corporate risk register may contribute to those wider strategic risks.		

Trust values:

The content of this report reflects / supports the following Trust values:

Trust Values		
1	Professional	
2	Excellence	✓
3	Respect	
4	Friendly	
5	Inclusive	
6	Caring	
The effective management of risk contributes to the continued drive for excellence (though individual risks could have elements that relate to multiple other Trust values).		

Report development and engagement:

This report presents a summary of the risks presented to the Board sub-committees in July 2026. Those reports are based on: content drawn from the Datix, and latterly, Radar Healthcare risk management systems (as added by the relevant risk owners); discussion at the Risk Management Group; comments from executive leads; and committee discussions.

Prior to consideration at the committees, the risks were considered by:

- The executive team, collectively, on 7 July; and
- The Risk Management Group (RMG) meeting on 9 July.

Accountable executives have also subsequently met with risk owners to review and update their risks. Those conversations will inform the next round of corporate risk reports.

Supporting detail:

Strategic versus operational risk

Strategic Risks relate to delivery of the strategic objectives of the Trust. They can be affected by factors such as capital availability; political, legal and regulatory changes; reputational issues etc. These will usually be identified at Board, or Executive level, and are generated "from the top down'. These strategic risks are captured in the Board Assurance Framework.

Corporate Risk Summary

Operational risks concern the day-to-day running of the Trust. These are usually identified by departments or business units and are captured on local risk registers. As such, these are usually generated "from the bottom up". Where these risks become sufficiently serious they are escalated to the corporate risk register. Each entry on the corporate risk register is reviewed on a monthly basis, has an identified executive lead, and is overseen by a committee of the Board. The benchmark for consideration for inclusion on the corporate risk register has been set at 15 or above.

Risk Management Group and risk review process

In accordance with the Risk Management Policy, a Risk Management Group has been established. This Group meets monthly and is chaired by the Chief Nurse and Patient Safety Officer, and reports into the Audit and Risk Committee.

As part of the Trust's wider risk management process:

- staff across the organisation continue to manage operational risk;
- the risk management training programme continues – the next steps include targeted support to individuals who are responsible for managing a large number of risks (particularly high scoring risks) that have not yet attended a session;
- the Trust Performance and Operational Improvement Group, chaired by the Chief Operating Officer, continues to monitor high-level risks and associated mitigating actions;
- Risks with a digital component are considered through the revised Digital and Information governance structure; and
- the Risk Management Group and clinical governance team continue to review and develop the processes and procedures necessary to implement risk management arrangements.

Next steps

- The Risk Management Group will continue to meet monthly.
- Risk Management training will continue, including targeted support to key individuals / teams.
- Work will continue with operational risk owners to support the recording of risks in a way that optimizes the assurance reporting (providing the necessary focus on controls, confidence in the effectiveness of the controls / planned controls, and a clearer view on the timetable for implementing the controls and reducing / eliminating the risk).

Attachment: "Corporate risks" considered by Board committees in July 2026:

Attachment: “Corporate risks” considered by Board committees in July 2026:

Risk ref.	Headline risk	Ctte	July 26 Score	Notes
044	**Document Scanning solution post Apollo go-live**	DERIC	**C4 x L4 = 16**	The key mitigation—the introduction of an automated and robotic scanning/upload process—is currently planned for implementation by 30 September 2026. Meaningful risk reduction is expected once the solution is deployed, adopted by users and able to deliver the anticipated efficiency benefits.
057	**Fragmented and Non-Sequential Clinical Documentation in CareFlow**	DERIC	**C4 x L4 = 16**	The first significant milestone is the implementation and testing of the Timeline/Journal View scheduled for 17 July 2026, followed by training materials due 21 August 2026 and delivery of the consolidated documentation dashboard and consultant-linked documentation functionality by 4 September 2026. These improvements are expected to provide clinicians with a more structured and accessible view of patient records and support reduction of the residual risk score to the target level.
071	**Orthotics Service Risk**	Q&S / F&P	**C5 x L4 = 20**	Some workforce initiatives, including apprenticeship development proposals, are expected to progress during 2026. However, meaningful risk reduction is unlikely until additional sustainable workforce capacity is secured and appointment waiting times begin to reduce. The current target is to reduce the risk score to 10 by 31 March 2027.
098	**Traceability of Orthoses**	Q&S	**C4 x L4 = 16**	The principal mitigation is the implementation of a digital information management and traceability system, currently planned for delivery by 28 August 2026. Meaningful risk reduction is expected once the system is operational and capable of supporting traceability of orthotic products supplied to patients. The current target is to reduce the risk score from 16 to 8 following successful implementation.
140	**Radiology Safety and Inefficiencies Due to Underutilisation of Digital Order Communications**	Q&S	**C5 x L4 = 20**	The key mitigation is the full adoption of digital order communications and electronic acknowledgement processes across all clinical teams, supported by workflow redesign, training and removal of paper-based reporting. The target risk score is expected to be achieved by 29 September 2026, when the Trust anticipates that digital processes will be sufficiently embedded to reduce reliance on manual controls and improve patient safety assurance.
149	**Non compliance with AHP and pharmacy standards for Critical Care Patients**	Q&S	**C4 x L4 = 16**	The key mitigation is the establishment of suitable physiotherapy resource with advanced respiratory skills capable of supporting critically ill patients and addressing GPICS compliance gaps. This control is currently planned for implementation by 30 September 2026, which aligns with the target date for reducing the residual risk score from 16 to 12.
152	**Missing Outpatient Follow-Up Waiting List Review Dates**	F&P	**C4 x L5 = 20**	All identified controls are currently implemented. The target risk score of 4 was scheduled for 31 July 2026, but the most recent review confirms that data-quality issues continue to exist and that mitigation work remains ongoing. Meaningful risk reduction will depend on resolution of the outstanding EPR review-date issues and establishment of an agreed process ensuring all planned review dates are recorded consistently. Risk to be reduced and new risk added, focussed on inappropriate review dates being added.
161	**Insufficient blood monitoring system relating to Rheumatology DAWN system**	Q&S	**C4 x L4 = 16**	The principal mitigations are the implementation of an effective digital blood monitoring solution and the appointment of additional pharmacy support resource. The Pharmacy Technician post is planned for implementation by 31 August 2026, which aligns with the target date for reducing the residual risk score from 16 to 4. Meaningful risk reduction is expected once a sustainable digital monitoring process is operational and embedded within routine Rheumatology prescribing pathways.
162	**Homecare Prescription Backlog**	Q&S / P&C	**C4 x L5 = 20**	The principal mitigations are the introduction of additional prescribing support and the recruitment of a Pharmacy Technician to support monitoring and recall activities. Recent reviews indicate that additional clinicians are expected to begin assisting prescription processing from mid-July 2026, whilst the Pharmacy Technician control remains overdue. Meaningful risk reduction is expected once prescribing capacity is sufficient to sustainably eliminate the backlog and maintain timely processing of homecare prescriptions.

Risk ref.	Headline risk	Ctte	July 26 Score	Notes
176	**Electrical Infrastructure Capacity**	Q&S	C5 X L3 = 15	The principal mitigation is the planned upgrade of the site's electrical infrastructure and consideration of additional electrical supply arrangements. The current control action is due by 4 September 2026, while the overall target risk score is planned to be achieved by 31 March 2027. Meaningful risk reduction is expected once additional electrical capacity is available and able to support future operational and estate development requirements.
182	**Risk to not delivering against the Harms Review Policy**	Q&S	C4 x L4 = 16	Existing controls are already in place and operating. Current actions focus on resolving outstanding RTT and overdue follow-up cohorts, improving review-date accuracy and providing assurance through reporting to governance committees. The current target is to reduce the risk score from 16 to 8 by 31 August 2026, with meaningful improvement expected once outstanding cohorts have been completed and harms review processes are consistently operating within the required timescales.
185	**Compromise to patient data due to cyber attack (Malware)**	DERIC	C5 x L4 = 20	The principal controls are already implemented and operating. Current work focuses on reviewing the outcomes of the June 2026 external penetration test undertaken by Dionach and identifying any additional controls required through the Digital Risk Committee. The long-term target is to reduce the residual score from 20 to 12 by 1 January 2030 through continued strengthening of cyber resilience, security monitoring, medical device protection and risk management arrangements.
194	**Data loss due to use of deprecated encryption protocols**	DERIC	C4 x L3 = 15	The key mitigation is the full decommissioning of Graphnet EPR and migration of users to CareFlow and Bridgehead. This action is currently planned for completion by 31 August 2026. Once the legacy system is no longer required, the Trust should be able to remove reliance on the deprecated encryption protocols that create the current risk exposure.
197	**Poor system integration across RIO, Lorenzo and imaging leading to delays in service delivery**	DERIC / Q&S	C4 x L4 = 16	The main mitigations identified are the introduction of a single electronic patient record across all participating provider organisations and implementation of system-wide order communications for investigations. However, the available risk record does not specify approved implementation dates for these measures. The existing control action was due on 2 February 2026 and is recorded as overdue. Therefore, meaningful risk reduction remains dependent upon future approval and delivery of these system integration programmes. Amalgamation of 197 and 221 being considered. Will probably remain a high-rated risk.
202	**Occupational Health surveillance**	P&C / Q&S	C4 x L4 = 16	Most controls are already in place, including data review processes, weekly contract meetings and governance oversight. A planned control relating to occupational health surveillance assurance is due for completion by 31 July 2026. Further improvement is expected through completion of procurement activity and establishment of sustainable occupational health service arrangements once contract discussions conclude.
221	**Absence of investigation tracking**	Q&S	C4 x L4 = 16	The principal mitigation is the implementation of a formal investigation tracking solution, potentially including order communications functionality for MSST referrers into Radiology and other diagnostic services. The current control action is due for completion by 28 October 2026, and the wider risk target date remains 30 March 2027. Meaningful risk reduction is expected once a fully auditable tracking solution is operational and embedded within routine clinical workflows Amalgamation of 197 and 221 being considered. Will probably remain a high-rated risk.
234	**Consultant Anaesthetist vacancies and recruitment impacting on operational plan**	F&P / P&C	C4 x L4 = 16	Most controls are already in place and operating. Recruitment activity has resulted in recent substantive appointments and continues to support workforce resilience. However, the risk record currently shows no planned reduction in score before 31 December 2026, with the target score remaining at 16. Further improvement is therefore dependent on continued successful recruitment and retention of consultant anaesthetists.
240	**Loss of previous Bluespier function**	DERIC / Q&S	C4 x L4 = 16	The key mitigation is the planned upgrade to Bluespier Version 9.12.4, which is expected to introduce stock management functionality through the interoperability process. This control is scheduled for completion by 10 September 2026, which aligns with the target date for reducing the risk score from 16 to 4. Meaningful risk reduction is expected once stock and resource requirements can again be managed effectively at the point of listing.
268	**Increased demand to Rheumatology due to primary**	Q&S / P&C / F&P	C4 x L4 = 16	The principal planned mitigation is recruitment of a dedicated Pharmacy Technician to support prescribing and blood monitoring activity, with implementation targeted for 31 July 2026. Additional benefit is also expected from recently increased Rheumatology nursing capacity. Meaningful risk reduction is anticipated once backlog pressures reduce

Risk ref.	Headline risk	Ctte	July 26 Score	Notes
	care not adopting shared care agreements			and primary care adoption of shared care agreements improves, supporting achievement of the target risk score by 31 August 2026.
298	**The Orthotics IT System**	DERIC / F&P	**C4 x L4 = 16**	The key mitigation is the implementation of the new digital Orthotics system, currently scheduled for completion by 30 September 2026. Reviews indicate that procurement activity and implementation planning are progressing. Meaningful risk reduction is expected once the new system is operational and capable of providing digital prescribing, ordering, traceability and service management functionality previously delivered through the legacy Access database. A business case in development and some roles recruited to. Anticipate reduction as a result.
327	**Orthotics accommodation on SATH sites**	Q&S	**C4 x L4 = 16**	The target score was set for 24 June 2026, but the available risk record continues to show a current score of 16. The most recent review indicates that further assessment of alternative accommodation is still required, including a second viewing, before a viable solution can be confirmed. Meaningful risk reduction is therefore dependent on securing accommodation that addresses the IPC, health and safety and environmental concerns identified in the risk record.
343	**Clinical Adoption of Apollo EPR due to limitations in ease access to modules from key screens**	DERIC	**C4 x L4 = 16**	The first significant mitigation is the planned introduction of Workspace V2 and Timeline/Journal View capability within CareFlow, due by 11 September 2026. The longer-term solution, enabling clinicians to launch CareFlow processes directly from Workspace, is scheduled for 31 March 2027. Meaningful risk reduction is expected as these developments improve workflow integration, reduce duplicate processes and support greater clinical adoption of Apollo. Accountable executive to be reviewed to reflect the focus on clinical engagement.
347	**Non delivery of planned elective activity growth leading to income loss 26/27**	F&P	**C5 X L4 = 20**	All identified controls are currently implemented and operating. The principal focus is ongoing performance management throughout 2026/27 to ensure delivery of the planned 10% elective activity growth. The target risk score of 10 is expected to be achieved by 31 March 2027, in line with the end of the financial planning period.
350	**Efficiency Programme Slippage leading to increased cost 26/27**	F&P	**C5 X L3 = 15**	The identified controls are already implemented and operational. Monthly performance reviews through TPOIB and Finance & Performance assurance arrangements will continue throughout 2026/27. The Trust aims to reduce the risk score from 15 to 10 by 31 March 2027, alongside delivery of the Efficiency Programme and associated savings plans.
353	**Welsh commissioning - overperformance against contract 26/27 leading to non payment of activity**	F&P	**C4 x L4 = 16**	The principal controls are already underway through contract monitoring and commissioner engagement. Planned negotiations with Welsh Health Boards were due by 31 July 2026, whilst the development of long-waiter trajectories remains overdue. The Trust aims to reduce the residual risk score from 16 to 8 by 31 March 2027, through continued commissioner engagement, robust activity forecasting and agreement of sustainable commissioning arrangements.
356	**Workforce Review of Pharmacy sustainability**	Q&S / P&C	**C4 x L4 = 16**	A business case is in development. That will address the risk but will take time to develop, approve and implement.

Trust Board - Quality & Safety

June 2026 – Month 3

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

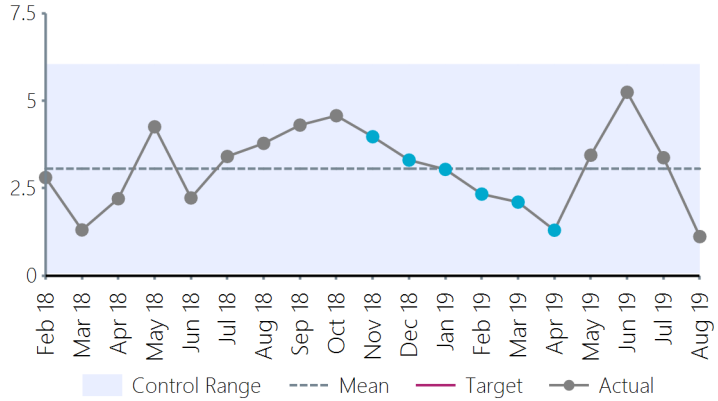
Some examples of these are shown in the images to the right:

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

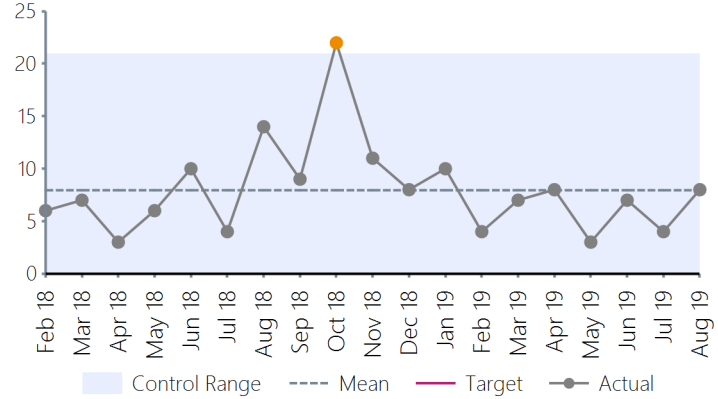
b) shows a point of concern sitting above the control range.

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.

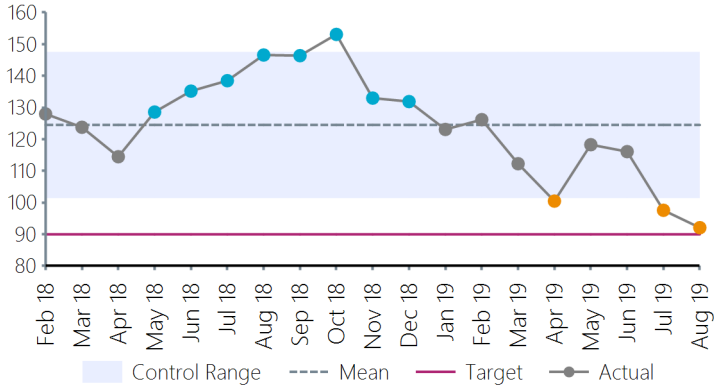
a)



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	NOF
Patient Safety Incident Investigations		0		N/A to SPC	No Target		06/07/26	
Number of Complaints	14	7			Moving Target	+		
Discharge Ready Date to Actual Discharge Date	0.61	0.77		N/A to SPC	?			+
RJAH Acquired C.Difficile	0	0		N/A to SPC	P		06/07/26	+
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	?		06/07/26	+
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		06/07/26	+
RJAH Acquired MSSA Bacteraemia	0	0		N/A to SPC	P		06/07/26	
RJAH Acquired Klebsiella spp	0	0		N/A to SPC	?		06/07/26	
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		06/07/26	
Surgical Site Infections	0	0			?			

Summary - Caring for Patients

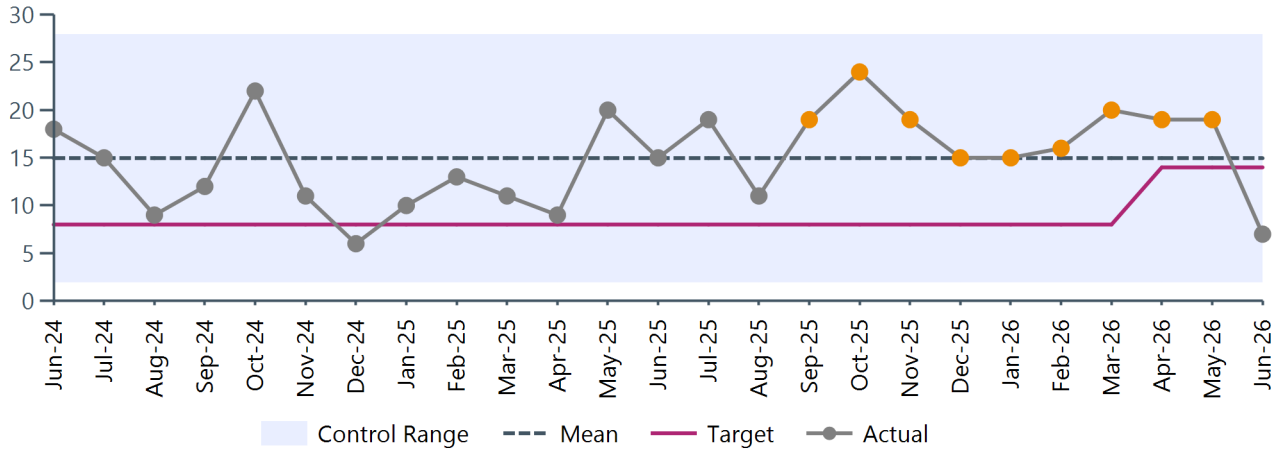
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
Outbreaks	0	0		N/A to SPC	?		04/03/24	
Number of Deteriorating Patients	5	4			?			
Total Deaths	0	1		N/A to SPC	?	+	12/09/23	
WHO Quality Audit - % Compliance against NatSSIPs 2	95%	100%		N/A to SPC	P			

Number of Complaints

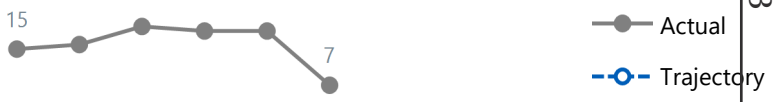
Number of complaints received in month 211105

Exec Lead
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
14	7		Moving Target	



Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. Following the target change, the assurance icon indicates a moving target.

Narrative

There were seven complaints received in July. This KPI has been included as an exception to draw attention to this position reported the first time below target since December-24. There were recent changes made to the process whereby this could be a contributory factor whereby PALS concerns have not turned into formal complaints.

The following provides a breakdown of the reasons for complaints:
* Patient Care including Nutrition / Hydration (2)
* Values and Behaviours - Staff (2)
* Trust Administration (1)
* Communications (1)
* Waiting Times (1)

Actions

Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
15	19	11	19	24	19	15	15	16	20	19	19	7

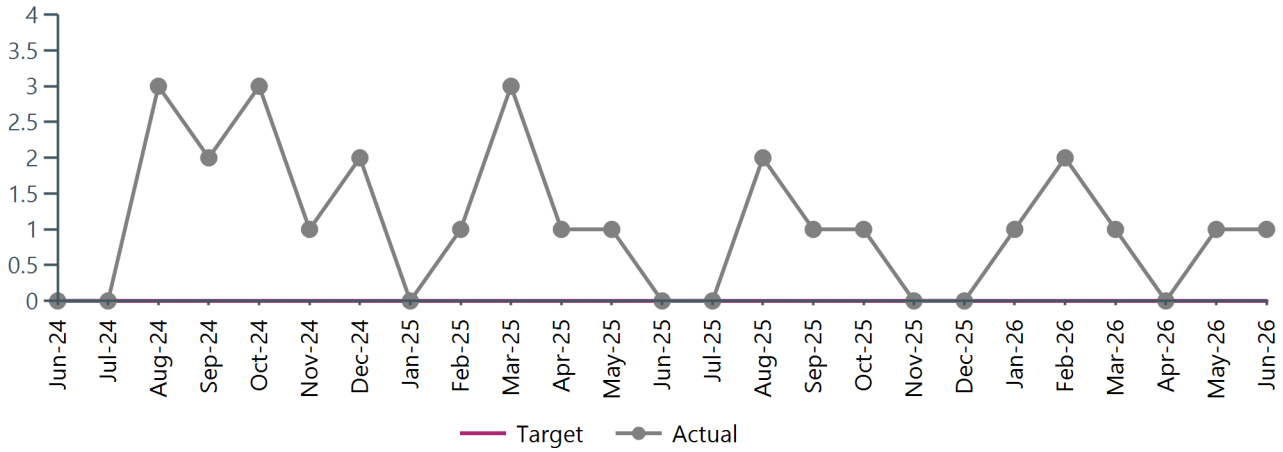
- Staff - Patients - Finances -

Total Deaths

Number of Deaths in Month 211172

Exec Lead
Chief Medical Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
0	1	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

There was one death throughout the Trust in June; this has been classified as an Expected death.

Actions

Learning from Deaths Reviews are completed by the Trust Lead.

Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
0	0	2	1	1	0	0	1	2	1	0	1	1

1	2	3	4	5	6	7	8	9	10

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 – Public Meeting, 29 July 2026

Author: **Contributors:**

Name: Sophie Donnelly
Role/Title: Executive Assistant

Report sign-off:

Lindsey Webb, Non-Executive Director – Chair of the Quality and Safety 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."

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 16 July 2026. 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, developed in light of national and system priorities, 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, safety and patient experience.	✓
2	Focus on equity of service and addressing health inequalities	✓
3	Effective engagement with the workforce to support a positive staff experience and a culture of continuous improvement	
4	Delivering financial sustainability	
5	Delivering the required levels of productivity, performance and activity	
6	Delivering innovation, improvement and growth	✓
7	The challenges of operating in both the Welsh and English health systems	✓
8	Responding to a significant disruptive event	✓

9	Security of digital, data and AI systems and ability to respond to cyber threats	

Trust values:

The content of this report reflects / supports the following Trust values:

Trust Values		
1	Professional	✓
2	Excellence	✓
3	Respect	✓
4	Friendly	✓
5	Inclusive	✓
6	Caring	✓

3. Assurance Report from Quality and Safety Committee

3.1 Areas of non-compliance/risk, matters to be addressed urgently, or other significant developments

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;

Represent significant developments / improvements that will help the Trust deliver its objectives; AND / OR

Require the approval of the Board for work to progress.

Chair Report from Patient Safety Meeting: noted a follow-up process failure in Radiology was escalated, linked to patients being removed from waiting lists following cancellations or DNAs without notification. A retrospective review is underway, affected patients are being identified and harm reviewed, and mitigations have been introduced following Apollo implementation, including additional staffing support and strengthened documentation.

Complaints Deep Dive: noted improvements in complaint response quality and that the backlog had reduced to fewer than 10 cases. Further work is underway to simplify the process, strengthen service ownership, improve early resolution and develop better reporting of reopened complaints, resolution meetings and local performance. The deep dive will remain a monthly agenda item to support continued oversight.

Chair Report from Regulatory Oversight Meeting: noted DBS compliance remains under review, with 17 members of staff outstanding and the matter escalated to ETM alongside Occupational Health compliance. Occupational Health data access and potential historic data gaps remain subject to further work, with executive support to drive progress welcomed.

Amos Review Board Assurance Statement: The Committee was advised that the submission is due by 31 July 2026 and will be presented to the Board. A meeting between the Interim Chief Nurse and Chair of the Quality and Safety Committee has been arranged to support Quality and Safety oversight and ensure any associated risks or implications are considered before Board review.

Board Assurance Framework: reviewed the revised Board Assurance Framework and received assurance that the risk ratings and associated controls remained appropriate. Particular consideration was given to the risks relating to health inequalities and emergency preparedness, with members agreeing that the current scores remained appropriate pending further progress against planned actions and assurance activities.

Corporate Risk Register: reviewed the Corporate Risk Register and received assurance that risk management arrangements remain effective. Members welcomed improvements to the reporting format, including clearer articulation of controls, timescales and risk trajectories, and noted that a wider review of corporate risks is underway with accountable officers to ensure scores remain appropriate

and that the register remains focused on the Trust's most significant strategic risks. The Committee requested continued refinement of reporting to support assurance and oversight.

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:

Waiting Well / Communication Working Group: reviewed progress against the Trust's patient communication improvement programme, including plans to strengthen communication with patients waiting for treatment through the implementation of Dr Doctor and the Waiting Well module. Members noted that a self-assessment will be undertaken against recent national requirements and requested a further update on compliance, patient engagement and future developments at a subsequent meeting.

Integrated Performance Report: noted improvements in complaints performance and medication incidents; however, theatre cancellations on the day of surgery, MCSI patients fit for admission and discharge delays remain areas of focus. A new Pre-Operative Fit to Proceed metric has been introduced to strengthen oversight of patients ready for surgery.

Consultant Ballot: noted the recent consultant ballot and received assurance that previous industrial action had minimal impact on Trust services, although the position will continue to be monitored as further information becomes available.

3.3 Areas of assurance

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

PSIRF Report: noted no PSIIs were commissioned in June. 4 patient safety reviews were commissioned, 5 new actions were added to the Patient Safety Improvement Plan, and no incidents met the Duty of Candour threshold. Assurance was provided that overdue actions are expected to be completed before the next meeting.

Learning from Deaths Q1 Report: received assurance regarding 2 deaths during the reporting period, including 1 sudden but not unexpected death where the Coroner raised no concerns. 1 post-operative death within 30 days of surgery remains subject to a Coroner's inquest, with learning to be reported once available. The appointment of an End-of-Life Practitioner is expected to support improvements in completion of ResPECT forms.

Legal Claims Q1 Report: noted 27 open CNST claims with no new claims in Q1, 4 CNST claims settled, 11 open ELPL claims with 2 new claims, 1 open LTPS claim and 2 open coronial requests. The Committee requested future reports focus more clearly on themes, trends, learning and triangulation with incidents and complaints.

Approvals: The Committee reviewed and approved:

- Business Continuity Management System Policy
- Trust Business Impact Assessment
- Corporate Business Continuity Plan
- Incident Communication Plan
- Security Annual Report

Chair Reports were received from the following Meetings and Groups:

Patient Experience Meeting: noted the improvement plan is being reviewed to ensure SMART actions, and the Transport SOP pilot within the Veterans Café remains under review with additional support in place to ensure safe implementation.

IPC&C Meeting: noted NHS England correspondence regarding fit testing records and ongoing work to ensure compliance. HCID training has been secured for relevant staff in August and MCSI audit compliance has improved to 90%.

Chair's Assurance Report
Quality and Safety Committee

Health and Safety Meeting: noted manual handling training is under review due to non-attendance rates, the independent Health and Safety report has been received and members welcomed triangulation with employer liability claims to support understanding of emerging themes, risks and learning.

Trust Performance and Operational Improvement Group: noted high DNA rates within Therapy Services remain under review, with Dr Doctor text reminders now live. Members also noted that 20% of GP practices have not yet signed up to shared care agreement, creating pressure for Rheumatology and Pharmacy services, and that work continues to improve patient access to administrative teams.

EPR Assurance Meeting: noted access to shared care records is now in place and has been positively received by clinical teams. Several Apollo developments have re-entered the development cycle following testing issues, with significant updates anticipated in September and expected to reduce or close a number of the highest-rated risks. A revised Apollo roadmap and communications plan are now available.

Drugs and Therapeutics Meeting: noted the delayed implementation of CMM Service Pack 4 from June to August and reviewed actions following the theft of 7 nitrous oxide cylinders. The matter had been reported to the Police, no CCTV was available, and work with Estates has strengthened security arrangements with a new SOP awaiting ratification.

Strategy Delivery Group: noted the newly established group has met and will strengthen oversight of Trust strategies, corporate objectives and strategic delivery. Terms of Reference will be circulated, and updates will be reported through all Committees to support organisational oversight.

NSSG Meeting: took assurance from the report.

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.

Learning From Deaths Quarterly Report

(Part 1) Covering paper

Committee / Group / Meeting, Date	
Quality and Safety Committee, 16 July	
Author:	**Contributors:**
Name: Dr James Neil Role/Title: Mortality Lead	Name: N/A Role/Title: N/A
Report sign-off:	
Name: Dr Ruth Longfeloow Role/Title: Chief Medical Officer	
Is the report suitable for publication?:	
YES	

Executive Summary:

A summary report on Learning from Deaths is presented to the Quality and Safety Committee. After a death is reported on Radar, it is then reviewed at the Patient Safety Working Group, using PSIRF methodology and a decision is made as to whether a Patient Safety Incident Investigation (PSII) is required.

A Structured Judgement Review (SJR) is then completed in a timely manner using the SJR Plus methodology developed by NHS England.

All deaths are reported to the Board of Directors. They are also reviewed and discussed at the Multi-disciplinary Clinical Audit Meeting. A more detailed discussion takes place at the Mortality Steering Group, which meets quarterly, and the Governance Team continues to support the bereavement process with the family throughout.

The Mortality Steering Group report is subsequently presented and discussed at the Patient Safety Committee.

There have been 2 deaths in total during Q1 2026/27 — one classified as *expected and one as sudden but not unexpected.

**"Expected", "sudden but not unexpected", and "unexpected" are NHSE-defined categories that describe whether a death is predictable in relation to an individual's underlying medical condition.*

Recommendations:

The Committee is asked to:

- CONSIDER the content of the report
- CONFIRM the level of assurance provided following presentation of the paper

Learning From Deaths Quarterly Report

(Part 2) Strategic alignment and supporting detail

Strategic objectives and associated risks:

The following strategic objectives, developed in light of national and system priorities, 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	
The Learning from Deaths report supports the Trust objective to deliver high quality clinical services by ensuring all inpatient deaths are systematically reviewed, providing assurance that care is safe, effective, and not compromised by avoidable failures. Where learning is identified, it is acted upon through service improvements, strengthened clinical governance, and enhanced end-of-life care, embedding continuous quality improvement into everyday clinical practice.		

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	
The Learning from Deaths report supports BAF theme to Continued focus on excellence in quality and safety by ensuring all inpatient deaths are systematically reviewed, providing assurance that care is safe, effective, and not compromised by avoidable failures. Where learning is identified, it is acted upon through service improvements, strengthened clinical governance, and enhanced end-of-life care, embedding continuous quality improvement into everyday clinical practice		

Trust values:

The content of this report reflects / supports the following Trust values:

Trust Values		
1	Professional	✓
2	Excellence	✓
3	Respect	✓
4	Friendly	
5	Inclusive	
6	Caring	✓
All inpatient deaths are systematically reviewed, providing assurance that care is safe, effective, and not compromised by avoidable failures. Where learning is identified, it is acted upon through service improvements.		

Report development and engagement:

The report is presented to the Quality and Safety Committee ahead of the Board meeting for assurance.

Supporting detail:

To provide an update on the current position and emerging trends for In-Patient Learning from Deaths (LFD) for Q1 2026/27. NHS England requires a quarterly report to the Board outlining the status of LFD investigations, including current numbers, progress against actions, and key themes identified

Learning From Deaths Quarterly Report

Date	Total In-patient Deaths	Number for case record (SJR) review	Death likely due to problems with care	ME review/Family feedback.	Coroner review.
April 26	0	0	0	N/A	N/A
May 26	1 (Sudden but not unexpected)	1	0	RJAH was very good – 'they did everything they could' and kept daughter informed throughout the medical emergency.	D/w Coroner due to sudden death. Happy with COD, CN1A.
June 26	1 (Expected)	1	0	No family concerns or learning from ME.	N/A

**"Expected", "sudden but not unexpected", and "unexpected" are NHSE-defined categories that describe whether a death is predictable in relation to an individual's underlying medical condition.*

Deaths within 30 days of surgery:

One patient died in April, 10 days after infected hip revision, in SATH ICU. Inquest to take place in late August 2026.

Learning from Structured Judgment Reviews:

- RESPECT form not completed which may have avoided futile CPR.
- Good to excellent overall care of complex patient with at times distressing symptoms. Good planning in place in case of deterioration. Excellent EOL care and family liaison.

All learning outcomes have been disseminated to the relevant consultant teams. These findings are scheduled for review at the 2026 Mortality Steering Group and MDCAM meetings.

The SJR will be incorporated into the April 2026 RADAR submission.

Acronyms

LFD	Learning from Deaths
SJR	Structure Judgement Review
MSG	Mortality Steering Group
PSIRF	Patient Safety Incident Response Framework
PSII	Patient Safety Incident Investigation

Fuller Board Assurance Statement

(Part 1) Covering paper

Committee / Group / Meeting, Date	
Board of Directors, 29 July 2026	
Author:	**Contributors:**
Name: Sophie Donnelly Role/Title: Executive Assistant	
Report sign-off:	
Clair Hobbs, Interim Chief Nurse and Patient Safety Officer	
Is the report suitable for publication?:	
YES	
Executive Summary:	
This report presents the Board Assurance Statement prepared in response to the Fuller Inquiry recommendations relevant to NHS organisations. The statement provides assurance on the Trust's current arrangements for the care of people after death, including safeguarding oversight, estates-related assurance, governance of any relevant facilities, and review of the recommendations immediately relevant to the NHS. The Board is asked to approve the statement prior to submission to NHS England by 31 July 2026, noting the assurance position set out in Appendix A.	
Recommendations:	
The Board is asked to approve the statement, prior to NHSE submission on 31 July 2026.	

(Part 2) Strategic alignment and supporting detail

Strategic objectives and associated risks:

The following strategic objectives, developed in light of national and system priorities, 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	

The report supports the Trust objective to deliver high quality clinical services by providing Board-level assurance that arrangements relating to care after death, safeguarding oversight, estates assurance and relevant governance arrangements have been reviewed in line with national requirements.

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	

The report relates to the BAF theme of continued focus on excellence in quality and safety, as it provides assurance on governance, safeguarding oversight and arrangements for the safe and respectful care of people after death.

Trust values:

Please delete the "✓"s as appropriate and add brief supporting narrative in the section below

The content of this report reflects / supports the following Trust values:

Trust Values		
1	Professional	✓
2	Excellence	✓
3	Respect	✓
4	Friendly	✓
5	Inclusive	✓
6	Caring	✓

The report reflects the Trust values by demonstrating a professional and caring approach to governance, safeguarding and the respectful management of arrangements following death. It supports excellence through review against national recommendations, respect through ensuring appropriate oversight of care after death, and inclusivity by recognising the importance of clear processes, roles and responsibilities across the relevant teams involved.

Report development and engagement:

The Statement has been developed with input from relevant Trust leads and teams, including Estates and Facilities, Safeguarding, the End-of-Life Practitioner, and the Chair of Quality and Safety Committee. This engagement has informed the assurance position presented to the Board.

Supporting detail:

Following publication of the Fuller Inquiry recommendations, NHS organisations are required to review the recommendations immediately relevant to the NHS and provide assurance that appropriate

governance and oversight arrangements are in place. The attached Board Assurance Statement summarises the Trust's current position against the relevant assurance statements. Rather than duplicate the content of the statement, this covering report confirms the purpose of the submission, the governance route through which the statement has been developed, and the approval required from the Board prior to submission to NHS England by 31 July 2026.

Acronyms

BAF	Board Assurance Framework
PAM	Premises Assurance Model

Appendices

Appendix A	*Fuller Board Assurance Statement*

Assurance Statement	Confirmed (yes/no)	Additional Comments or Qualifications
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.	Yes	The Trust no longer has a Mortuary onsite. There is a Trust Standard Operational Procedure for the off-site Mortuary which is in date and describes Trust and contractor responsibilities. A yearly audit is planned in Summer 2026 for further assurance.
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.	Yes	The Trust commissioned an external Security Consultant to undertake a security audit in line with Fuller recommendations; the findings of which generated an action plan, including the requirement of additional CCTV and door access control. Assurance obtained at Patient Safety meeting, Quality and Safety Committee then to Trust Board via chair's report – 26 of the 29 recommendations are applicable to the Trust with only 2 actions outstanding which continues to be monitored until completion – planned date of September 2026 for both.
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.	Yes	Executive oversight of Safeguarding is provided by the Chief Nurse and Patient Safety Officer through the Trust's Safeguarding governance structure, with Board assurance through established governance arrangements.

		In line with the NHS Safeguarding Accountability and Assurance Framework, oversight includes safeguarding arrangements for people after death. Relevant Trust policies and safeguarding training have been reviewed to reflect learning from the Fuller Inquiry where applicable. An End of Life Practitioner has also recently been appointed to compliment existing care practices and policies.
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries (or wider facilities) where the deceased are cared for including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency.	Yes	The Trust no longer has a Mortuary onsite. There is an agreed contract with a private local Funeral Director. The agreement specifies that the deceased will be collected from the ward environment within a 4-hour window following contact. An identified action is in place to review contract monitoring and KPIs to provide further assurance to the Quality & Safety Committee. The Anatomy lab is regulated and inspected under the HTA licence. The last inspection CAPA's have all been addressed and closed by the HTA under the anatomical licence.

		All HTA Act requirements continue to be monitored through the Regulatory Oversight Meeting and to Quality & Safety Committee.
For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.	Yes	PAM is reviewed annually; Estates and Facilities are on schedule to review PAM 2026 before the September deadline with Executive and Board sign off. Previous PAM have been completed by the Head of Estates & Facilities, this has now been further strengthened by the appointment of a PAM Manager.

Trust Board - People & Workforce
June 2026 – Month 3

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

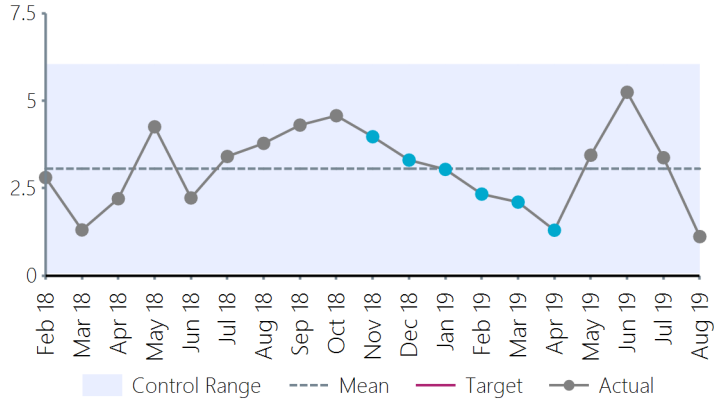
Some examples of these are shown in the images to the right:

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

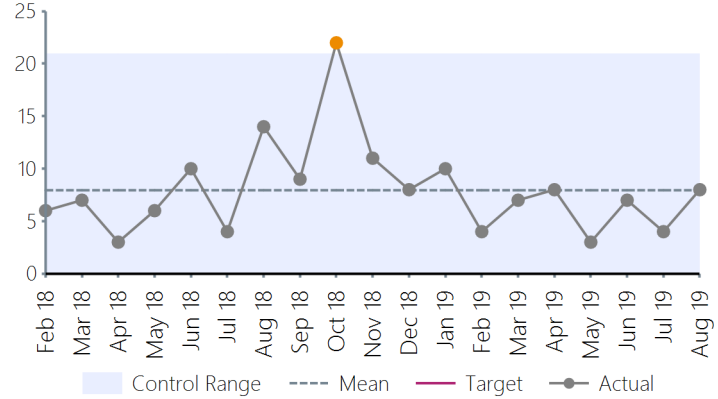
b) shows a point of concern sitting above the control range.

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.

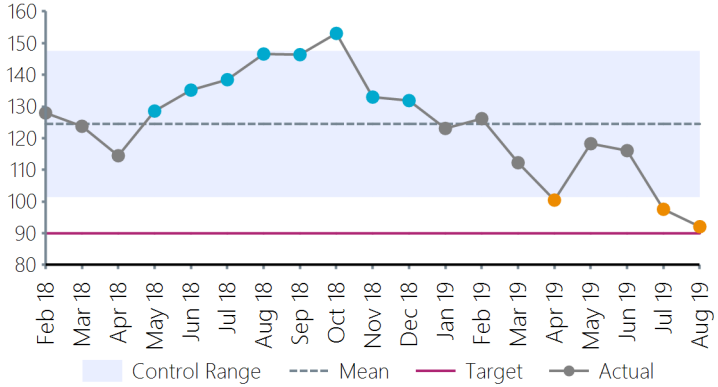
a)



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	NOF
Sickness Absence	4.75%	4.52%			Moving Target			+
Staff Turnover - FTE	9.77%	9.69%			Moving Target			
Leavers per Month	12	12			?			
Vacancy Rate	8.00%	6.88%			P			

Summary - Caring for Finances

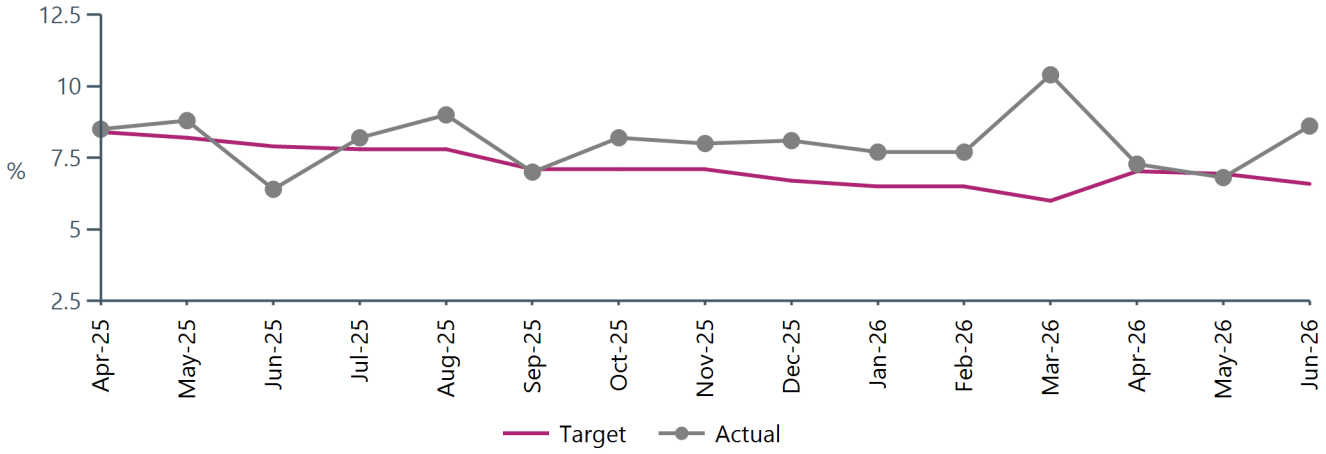
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
Agency Spend against Plan	86	61		N/A to SPC	Moving Target			
Proportion of Temporary Staffing as a % of the Trust Pay Costs	6.59%	8.61%		N/A to SPC	Moving Target	+		
Bank Spend against Plan	553	748		N/A to SPC	Moving Target	+		

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 & Commercial Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
6.59%	8.61%	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 8.61%, which is 2.02% adverse to plan driven by Medical out of job plan usage and Non medical Clinical staff.

Actions

Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
6%	8%	9%	7%	8%	8%	8%	7%	7%	10%	7%	6%	8%

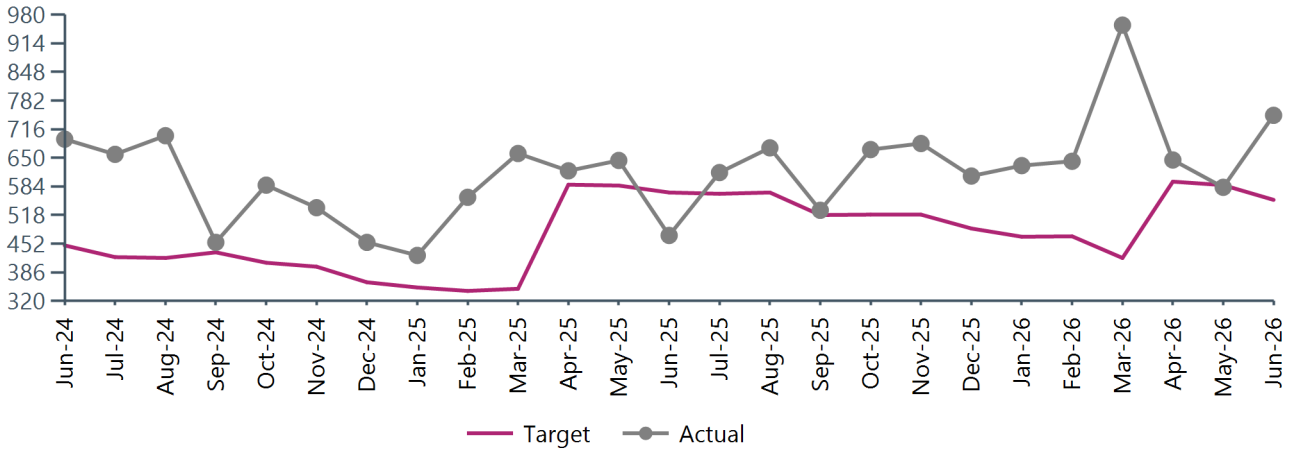
- Staff - Patients - Finances -

Bank Spend against Plan

National planning guidance requires a 15% reduction in bank costs in 26/27 relative to 25/26, plan calculated nationally based on M6 25/26 FOT 217872

Exec Lead
Chief Finance & Commercial Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
553	748	N/A to SPC	Moving Target	



Trajectory

Actual
Trajectory

What these graphs are telling us

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

Narrative

Bank spend £195k adverse to plan in month , £240k adverse ytd.
- £118k adverse Medical out of job plan usage.
-£ 81k adverse Non Medical clinical staff (Nursing, AHP & CSS)
-£2k favourable Non Clinical staff

Actions

Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
471	616	673	529	669	683	608	632	642	956	645	582	748

1	2	3	4	5	6	7	8	9	10

Chair's Assurance Report
People and Culture Committee

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Committee / Group / Meeting, Date	
Board of Directors Meeting, July 2026	
Author:	**Contributors:**
Name: Emma Jones 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 receive 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 23rd July 2026. 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	

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, safety and patient experience.	✓
2	Focus on equity of service and addressing health inequalities	
3	Effective engagement with the workforce to support a positive staff experience and a culture of continuous improvement	✓
4	Delivering financial sustainability	✓
5	Delivering the required levels of productivity, performance and activity	
6	Delivering innovation, improvement and growth	✓
7	The challenges of operating in both the Welsh and English health systems	✓
8	Responding to a significant disruptive event	
9	Security of digital, data and AI systems and ability to respond to cyber threats	

The primary BAF theme considered by this Committee is BAF 03 but elements of its work relate to multiple BAF themes.

Trust values:

The content of this report reflects / supports the following Trust values:

Trust Values		
1	Professional	✓
2	Excellence	✓
3	Respect	✓
4	Friendly	✓
5	Inclusive	✓
6	Caring	✓
The Committee seeks to promote and operate in accordance with the staff values.		

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 wish 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.

Corporate Risks / Workforce Immunisation Data

The Committee wishes to draw the Board's attention to risk 202 around occupational health surveillance.

The Committee discussed the risk associated with the current incumbent provider who hold the Trusts immunisation and vaccination data. The Trust is unable to access this data for all staff. Members expressed concern regarding the impact this could have on workforce contingency planning, outbreak management and assurance of staff immunisation status. The risk is being actively managed and will continue to be monitored and escalated as required.

Mandatory Training Compliance

The Committee raised concerns regarding continued levels of mandatory training non-compliance and DNA rates, particularly in relation to high priority clinical training. Members requested additional reporting to identify staff remaining non-compliant beyond the three-month grace period and sought assurance that risks to patient safety and service delivery are being appropriately managed. Consideration may need to be given as to how line managers are held to account for compliance; but also to ensure relevant training is fully accessible for all staff.

3.2 Areas of on-going monitoring with new developments

ADVISE - The People and Culture Committee wish 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 Triangulation Dashboard

The Committee welcomed development of the workforce triangulation dashboard and advised that future iterations should include benchmarking, comparison data and clearer alignment with organisational culture and values to strengthen assurance and performance oversight.

The Committee received updates on a number of national developments / communications received by the Trust in recent weeks:

- **NHS England Staff Standards Framework**
  NHSE letter on preventing unlawful access to patient records
- **Lord Mann review**

The Committee was advised that further work is required to assess the implications for the Trust, and align with existing programmes of work to develop an appropriate response.

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.

The Committee wishes to assure the Board of the following:

Staff Values
The Committee noted, and supported, the proposal for a staff values award scheme through which staff could recognise their colleagues.

Communications Re-set
The Committee noted, and supported, the proposed approach to staff engagement and communications, noting the importance of using different channels for different audiences.

Band 5 Nursing Evaluation
The Committee noted the update and received assurance that the Trust was on target to complete the exercise by the required deadline.

Board Assurance Framework
The committee considered the BAF report and took assurance but noted that thought should be given to reconciliation of the sources of assurance in the BAF with the various metrics reported to the Committee.

Corporate Risk Reporting
The Committee reviewed the revised Corporate Risk Register and took assurance from the report but noted that further development was underway to improve clarity regarding risk movement, target dates, mitigation actions and assurance levels, enabling more effective scrutiny and oversight.

Equality Delivery System (EDS)
The Committee received assurance regarding progress against EDS objectives, including improvements in workforce wellbeing measures and staff engagement in the assessment process.

Freedom to Speak Up
The Committee considered the Quarter 1 report, noting progress in service development, increased focus on visibility and accessibility, and plans to strengthen data triangulation and intelligence-led reporting. Assurance was received regarding the actions being taken.

Guardian of Safe Working Hours
The Committee considered and took assurance from the Quarter 1 report.

Recommendation

The Board is asked to:

- 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.

Attachments:
Freedom to Speak Up Guardian's Q1 Report
Guardian of Safe Working Hours' Q1 Report

Freedom To Speak Up Report
Q1 2026/27 Apr-Jun 2026

(Part 1) Covering paper

Committee / Group / Meeting, Date	
People and Culture Committee – July 2026	
Author:	**Contributors:**
Name: Kate Hannah Role/Title: Freedom to Speak Up Guardian	Name: Role/Title:
Report sign-off:	
Name: Dylan Murphy Role/Title: Trust Secretary	
Is the report suitable for publication?	
YES	

Executive Summary:

This paper provides an update on Freedom to Speak Up (FTSU) activity for Quarter 1, 2026/27 and seeks to provide assurance regarding the effectiveness of the Trust's speaking up arrangements.

During Quarter 1, the FTSU service received five contacts. Two concerns required escalation through Trust processes, whilst three contacts provided feedback and intelligence which did not require formal escalation but have been captured to support organisational learning and identification of emerging themes. All contacts received a response within established timescales.

Whilst activity levels are lower than those reported during 2025/26, the Committee is asked to interpret this data with caution given the transition between substantive Freedom to Speak Up Guardians during this period. Interim arrangements were in place through support from an experienced Guardian from another NHS Trust, however reduced local visibility may have influenced reporting levels.

This quarter has also marked the commencement of the new substantive Freedom to Speak Up Guardian. Alongside case management activity, significant time has been invested in meeting staff, leaders, champions and key stakeholders to develop an understanding of current speaking up arrangements, organisational culture and identify opportunities for improvement.

Initial engagement has identified several strengths, including a committed champion network, strong support from senior leaders for speaking up, and established governance and reporting mechanisms. Opportunities have also been identified to further strengthen awareness and visibility of the service, improve understanding of the different routes available for raising concerns, enhance feedback and learning arrangements, and continue developing a culture in which colleagues feel confident to speak up and trust that concerns will be acted upon.

Early themes emerging through engagement activity include:

- Communication and the importance of timely, consistent feedback.
- Staff understanding of Freedom to Speak Up and alternative routes for raising concerns.
- Visibility and accessibility of the FTSU service.
- Perceptions of fairness and equity in some workforce processes, particularly recruitment, promotion and access to opportunities.
- Opportunities to strengthen organisational learning and the sharing of outcomes following concerns raised.
- Opportunities to strengthen the triangulation of intelligence from Freedom to Speak Up, Staff survey results, People Services, Patient Safety, Sexual Safety and other staff feedback mechanisms to identify emerging themes, areas of good practice and opportunities for improvement.

An initial development programme and action plan has been established for 2026/27 focused on increasing visibility of the service, supporting the Champion network, improving organisational

learning and feedback mechanisms, and embedding a culture of speaking up, listening up and acting up across the organisation.
Recommendations:
The Committee is asked to: 1. Note the report and activity undertaken during Quarter 1 2026/27. 2. Take assurance regarding the operation of the current Freedom to Speak Up service. 3. Support the proposed programme of development for 2026/27. 4. Note the planned review of the RADAR Concerns Module as a mechanism to strengthen Freedom to Speak Up governance, reporting and organisational learning

Freedom To Speak Up Report
Q1 2026/27 Apr-Jun 2026

(Part 2) Strategic alignment and supporting detail

Strategic objectives and associated risks:

The following strategic objectives, developed in light of national and system priorities, 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	
The Freedom to Speak Up service supports delivery of high-quality clinical services by providing staff with a safe route to raise concerns regarding patient care, quality and workplace culture. It also supports the Trust's workforce ambitions by promoting psychological safety, staff wellbeing, organisational learning and continuous improvement.		

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, safety and patient experience.	✓
2	Focus on equity of service and addressing health inequalities	
3	Effective engagement with the workforce to support a positive staff experience and a culture of continuous improvement	
4	Delivering financial sustainability	
5	Delivering the required levels of productivity, performance and activity	
6	Delivering innovation, improvement and growth	
7	The challenges of operating in both the Welsh and English health systems	
8	Responding to a significant disruptive event	
9	Security of digital, data and AI systems and ability to respond to cyber threats	
Effective Freedom to Speak Up arrangements support the Trust's ability to identify and respond to quality, safety and workforce concerns at an early stage. The service contributes to organisational learning, staff experience, patient safety and continuous improvement by providing intelligence regarding cultural themes, emerging risks and opportunities for intervention.		

Trust values:

The content of this report reflects / supports the following Trust values:

Trust Values		
1	Professional	✓
2	Excellence	✓
3	Respect	✓
4	Friendly	✓
5	Inclusive	✓
6	Caring	✓
The Freedom to Speak Up service supports all Trust values by promoting a culture where colleagues are treated with respect, feel included, act professionally and are encouraged to raise concerns that support excellence in patient care and staff experience.		

Report development and engagement:

The issues presented within this report have been informed through discussions with:

- Executive and non-executive leads for Freedom to Speak Up;
- Freedom to Speak Up Champions;
- People Services colleagues;
- Governance and Patient Safety colleagues;
- Equality, Diversity and Inclusion leads;
- Leads for Raising Concerns and Sexual Safety workstreams.

Feedback from stakeholders has been supportive of the proposed development priorities. Common themes included increasing visibility of the Freedom to Speak Up service, strengthening feedback and organisational learning arrangements, improving staff understanding of routes for raising concerns and making better use of organisational intelligence to identify emerging themes and areas for improvement.

The proposed priorities will continue to be aligned with wider Trust workstreams, including Staff Survey improvement planning, Raising Concerns and Sexual Safety programmes.

Next steps:

The next phase of development will focus on:

- Increasing the visibility and accessibility of the Freedom to Speak Up service through staff engagement, communications and departmental visits.
- Reviewing and strengthening the Freedom to Speak Up Champion network, including creating opportunities for champions to share learning, ideas and good practice.
- Improving staff awareness of the different routes available for raising concerns and clarifying the role of the Freedom to Speak Up Guardian.
- Developing approaches to feedback and organisational learning, including exploring mechanisms to demonstrate actions taken in response to concerns raised.
- Strengthening the triangulation of intelligence from Freedom to Speak Up contacts, Staff Survey findings, People Services, Patient Safety, Sexual Safety and other staff feedback mechanisms to identify recurring, emerging or previously unidentified themes.
- Developing and implementing an action plan in response to Trust Staff Survey findings relating to speaking up and raising concerns.

Themes identified through Freedom to Speak Up activity and wider staff engagement will be considered through several existing Trust workstreams, including:

- Raising Concerns workstream.
- Sexual Safety programme.
- Staff survey action planning.
- People and Culture governance structures.
- Patient Safety and workforce culture discussions, where appropriate.
- Regular meetings with key stakeholders including People Services, Governance, Patient Safety and Equality, Diversity and Inclusion leads.

This will support a coordinated organisational approach to responding to staff feedback and promoting a positive speaking-up culture.

The People and Culture Committee will receive the next quarterly Freedom to Speak Up report for Quarter 2, 2026/27, in accordance with the Trust's established reporting cycle.

The next report will provide a further update on the development of the service, including progress against the priorities outlined above, emerging themes from triangulated organisational intelligence, and any early indicators of impact.

Supporting detail (if required):

1. Overall number of contacts – Q1

Table 1: Contact types

Contact Type	Number
Escalated Concerns	2
Feedback / Intelligence Contacts	3
Advice / Signposting	0
Total Contacts	5

Commentary

During Quarter 1, the Freedom to Speak Up service received a total of five contacts.
Of these:

- Two contacts were raised as concerns and were escalated through the appropriate management and governance processes.
- Three contacts did not require formal escalation but provided information, observations or feedback which have been recorded and considered as part of wider organisational intelligence and learning.

All contacts received a response within established timescales and have/are being managed in accordance with Trust processes.

Activity levels during Quarter 1 were lower than those reported in previous quarters. However, caution should be exercised when interpreting this data as the quarter coincided with a transition period between substantive Freedom to Speak Up Guardians. Whilst interim arrangements ensured continuity of service, local visibility and awareness may have influenced reporting levels. Activity and themes will continue to be monitored over subsequent quarters.

2. Contacts raised by type of concern

Table 2: Contacts by concern themes

Theme	Frequency raised
Worker Safety / Wellbeing	5
Racial Element	1
Attitudes & Behaviours	1

Commentary

During Quarter 1, the Freedom to Speak Up service received five contacts. Analysis of these contacts identified several themes. As individual contacts may involve more than one issue, the total number of themes recorded may exceed the total number of contacts received.

The most frequently identified theme was Worker Safety and Wellbeing, which was present in all five contacts. In line with national Freedom to Speak Up reporting guidance, this category extends beyond physical safety concerns and may include matters affecting staff wellbeing, confidence, workplace experience and psychological safety. One contact included a reported racial element. This has been recorded in line with the Trust's approach to capturing concerns relating to discrimination, equality and inclusion, enabling themes to be monitored and understood alongside wider workforce intelligence.

Themes relating to workplace attitudes and behaviours were also identified, reflecting the importance of respectful and inclusive working environments in supporting positive staff experience and a culture where colleagues feel able to speak up. The volume of concerns received during Quarter 1 is too small

to draw firm conclusions regarding trends. However, the themes raised continue to reflect issues commonly encountered within speaking up arrangements and align with feedback received through wider staff engagement activities.

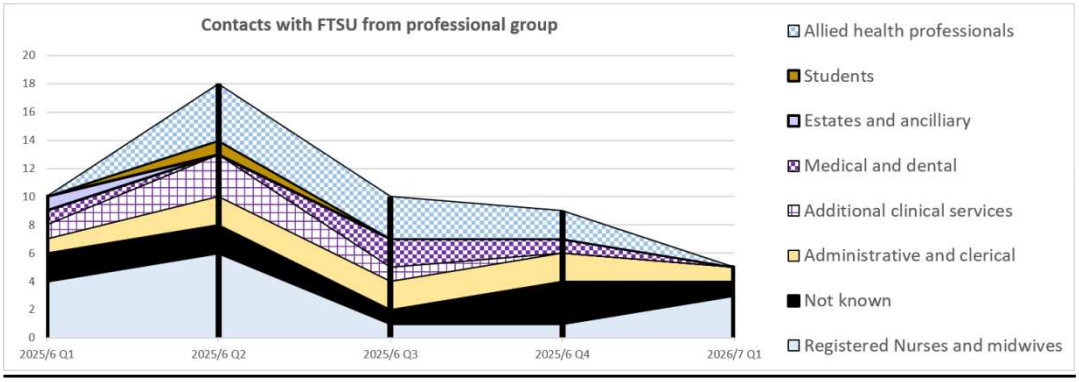
Key themes identified through Freedom to Speak Up contacts included:

- Communication and information sharing.
- Workplace experience, attitudes and behaviours
- Staff well-being and psychological safety
- Perceptions of fairness and equity.
- Feedback and organisational learning.

As part of the ongoing development of the service, these themes will be considered alongside intelligence gathered from other sources, including Staff Survey results, People Services information, Patient Safety intelligence, Sexual Safety workstreams and informal staff feedback. This triangulated approach will support identification of recurring, emerging or previously unidentified themes requiring targeted intervention.

3. Nature of contacts by professional group

Graph 1: Contacts by Professional Group



Commentary

Due to the small number of contacts received during Quarter 1, detailed analysis by professional group should be interpreted with caution. Whilst the data continues to be reviewed, no significant patterns can currently be identified. Future reports will monitor whether specific staff groups are underrepresented within speaking up activity and whether targeted engagement may be required.

As part of the service development programme, efforts will be made to increase engagement and awareness across all staff groups to ensure colleagues feel confident in accessing support when required.

4. Outcomes and Learning

Whilst the number of escalated concerns was low during Quarter 1, the concerns and feedback received have contributed to organisational learning and provided valuable insight into staff experience.

Learning emerging during the quarter has reinforced the importance of:

- Clear and consistent communication.

- Accessible routes for raising concerns.
- Timely feedback following concerns raised.
- Understanding staff perceptions regarding fairness and equity.
-

Promoting an inclusive culture where colleagues feel safe to raise concerns relating to equality, diversity and inclusion, and where feedback informs organisational improvement.
One contact included a reported racial element. The concern was responded to appropriately and discussed with senior People and Culture colleagues. The individual has subsequently agreed to support the Trust's ongoing Equality, Diversity and Inclusion work, helping to shape the development of anti-racism initiatives and future staff engagement activity. Whilst maintaining confidentiality, this represents a positive example of how concerns raised through speaking up arrangements can contribute to wider organisational learning and cultural improvement.

The feedback and intelligence received during the quarter have been incorporated into the service development priorities for 2026/27 and will continue to inform wider organisational improvement initiatives.

A key focus moving forward will be ensuring that learning from concerns is more clearly communicated back to staff through strengthened feedback mechanisms and sharing of improvement activity.

5. National Reporting

From 1 July 2026, responsibility for Freedom to Speak Up functions transferred from the National Guardian's Office (NGO) to NHS England, following recommendations arising from the Dash Review. These changes include responsibility for national data collection, provision of guardian support and training, and the ongoing development of national Freedom to Speak Up policy and guidance.
As national reporting arrangements continue to evolve, there is currently limited clarity regarding the future format and mechanism for the submission, analysis and publication of Freedom to Speak Up data at national level. Whilst further guidance from NHS England is awaited, the FTSU service will continue to maintain robust local monitoring and reporting arrangements to ensure oversight of Freedom to Speak Up activity, emerging themes, organisational learning and areas of potential risk.

As such, a key priority during 2026/27 is to strengthen local governance, case management and reporting arrangements. As part of this work, the Freedom to Speak Up Guardian is working collaboratively with governance colleagues to review how the Trust's RADAR concerns module may be utilised to support the management of Freedom to Speak Up concerns.

The aim of this review is to explore whether RADAR could provide a more systematic and integrated approach to:

- Recording and tracking Freedom to Speak Up contacts and concerns
- Supporting consistent case management and documentation
- Improving oversight of actions, outcomes and feedback
- Enhancing thematic analysis and identification of recurring concerns
- Strengthening organisational learning
- Supporting the triangulation of information from Freedom to Speak Up, Staff Survey findings, People Services, Patient Safety, Sexual Safety and other workforce intelligence sources
- Providing enhanced assurance reporting to the Trust's governance committees and Board

This work supports the wider ambition to develop a more intelligence-led Freedom to Speak Up function that not only responds effectively to individual concerns but also uses staff voice and organisational intelligence to identify emerging themes, support cultural improvement and inform targeted interventions across the Trust.

Progress against this priority, together with any recommendations arising from the RADAR review, will be reported through future Freedom to Speak Up updates.

6. Freedom to Speak Up Guardian Induction and Engagement Activity

Kate Hannah commenced in post as the Trust's substantive Freedom to Speak Up (FTSU) Guardian at the end of June 2026, following a period of interim cover arrangements. Kate`s primary focus has been on induction, relationship building and developing an understanding of the Trust's current speaking up arrangements, culture and priorities.

Activity undertaken to date has included:

- Completion of the NHS England Freedom to Speak Up Guardian Foundation Training.
- Meetings with key stakeholders across the Trust, including Executive and Non-Executive leads, People Services, Governance, Patient Safety and Equality, Diversity and Inclusion colleagues.
- Engagement with Freedom to Speak Up Champions to understand their experiences, aspirations and opportunities for further development of the Champion network.
- Review of existing FTSU policies, reporting arrangements, communications and governance structures.
- Engagement with wider Trust workstreams relating to Raising Concerns, Sexual Safety and staff experience.
- Initial review of Staff Survey findings has already identified several areas where targeted engagement, immediate improvements ("quick wins") and longer-term cultural development activity may be beneficial. This work will be incorporated into the developing Freedom to Speak Up action plan and wider organisational improvement activity

The initial approach has been one of listening and learning to ensure that future development priorities are informed by staff experiences, organisational intelligence and wider Trust priorities.

7. Initial observations and emerging themes

As part of the induction process, engagement has taken place with staff, champions, leaders and key stakeholders across the Trust. Whilst it is too early to draw firm conclusions, several recurring themes and opportunities for development have emerged. These observations outlined in Table 3 will continue to be tested and explored through engagement activity, staff survey analysis and wider organisational intelligence.

Table 3: Initial Observations

Observation	What I've Heard / Seen	Proposed Response
Visibility of FTSU	Staff and champions would like the service to have a more visible presence across the Trust.	Increase Guardian visibility through departmental visits, engagement activity and communications.
Understanding of FTSU	Some colleagues are unclear about the role of FTSU and how it differs from other routes for raising concerns.	Refresh communications and improve signposting to help staff access the most appropriate support.
Champion Network	Champions are committed and keen to develop a more connected network that supports staff and shares ideas and learning.	Review and strengthen the Champion network, establish regular forums and increase opportunities for involvement.
Communication and Feedback	Staff value opportunities to raise concerns but would like clearer feedback and visibility of outcomes.	Develop a "You Said, We Did" approach and strengthen organisational feedback mechanisms.
Equity and Fairness	Some staff have highlighted perceptions of unfairness relating to recruitment, promotion and access to opportunities.	Explore themes further through triangulation with workforce data, Staff Survey findings and other intelligence sources.
Organisational Learning	Information exists across several systems and workstreams, but opportunities exist to strengthen organisational learning.	Develop a more intelligence-led approach through triangulation of FTSU, Staff Survey, People Services, Patient Safety and Sexual Safety data.
Staff Survey Findings	Initial review suggests some hotspots where targeted support and quick wins may be beneficial, alongside longer-term cultural development.	Incorporate findings into the FTSU development plan and support local action planning.

These observations suggest that there are strong foundations on which to build. The focus for the coming months will be to increase visibility, strengthen understanding of speaking up arrangements, improve organisational learning and ensure staff voices are used to inform meaningful improvement across the Trust.

8. Next steps and development priorities

Based on the engagement and learning undertaken during Quarter 1, an initial programme of development has been established to strengthen speaking up arrangements across the Trust.
Key priorities include:

- Increasing the visibility and accessibility of the Freedom to Speak Up service through enhanced staff engagement and communication.
- Refreshing communications to improve understanding of the Freedom to Speak Up role and other available routes for raising concerns.
- Strengthening and developing the Freedom to Speak Up Champion network.
- Improving organisational feedback and learning mechanisms, including development of a "You Said, We Did" approach.
- Continuing review of Staff Survey findings to identify areas where targeted support, quick wins and longer-term cultural improvements may be required.
- Strengthening links with the Raising Concerns and Sexual Safety workstreams to support a coordinated approach to staff voice and organisational learning.
- Developing a more intelligence-led approach through triangulation of data and intelligence from multiple sources.
- Working alongside Governance colleagues to review how the RADAR Concerns Module may support Freedom to Speak Up case management, reporting, thematic analysis and organisational learning.

The overarching aim is to build on the strong foundations already in place and further develop a visible, responsive and learning-focused speaking up culture across the organisation.

9. Development Roadmap

To support delivery of these priorities, a detailed action plan and development roadmap has been established for the next quarter. Several actions are already underway, including stakeholder

engagement, FTSU Champion engagement, review of Staff Survey findings and exploration of opportunities to strengthen organisational intelligence and learning through data triangulation.

The roadmap is structured around three phases:

Understand

- Complete stakeholder engagement.
- Review current arrangements and available intelligence sources.
- Analyse Staff Survey findings and identify hotspots.
- Establish baseline themes and opportunities.

Strengthen

- Increase visibility and awareness of the service.
- Further develop the Champion network.
- Improve communications and staff understanding of speaking up routes.
- Introduce improved feedback and learning mechanisms.
- Begin regular triangulation of organisational intelligence.

Embed

- Develop a more integrated and intelligence-led approach to speaking up.
- Strengthen organisational learning and thematic reporting.
- Inform targeted interventions through triangulated data and staff feedback.
- Monitor impact through future reporting, workforce indicators and staff feedback.

Progress against the roadmap will be reported through future quarterly Freedom to Speak Up updates.

Having joined the organisation during this quarter, my initial priority as FTSUG has been to listen, learn and understand the experiences of colleagues across the Trust. My assessment is that there are strong foundations on which to build. Over the coming months, the focus will be on increasing visibility, strengthening feedback and organisational learning, developing the Champion network and ensuring that staff voices continue to inform meaningful improvement across the organisation

Acronyms

Acronym A	**FTSU/G – Freedom to Speak Up/Guardian**

Attachments

Attachment A	**Freedom to Speak Up Service development Road Map 26/27**

Attachment A provides further detail regarding the Freedom to Speak Up Service Development Roadmap for 2026/27 and should be read alongside this report.

Freedom to Speak Up Report Q1 2026/67: Attachment A – Service Development Roadmap

Purpose

This roadmap sets out the key priorities for developing the Freedom to Speak Up service during 2026/27. It focuses on increasing visibility and accessibility of the service, strengthening organisational learning and intelligence, developing the Champion network, and embedding robust governance arrangements to support a positive speaking up culture.

Phase 1: Understand (July – September 2026)
The initial phase focuses on building relationships, understanding current arrangements and establishing a baseline view of organisational culture and speaking up activity.
Key actions include:

- Introducing the new FTSU Guardian and increasing visibility through staff engagement.
- Meeting Freedom to Speak Up Champions and reviewing network coverage.
- Engaging with People Services, Governance, Patient Safety and EDI colleagues.
- Mapping available intelligence sources and reviewing Staff Survey findings.
- Reviewing current communications, feedback mechanisms and governance arrangements, including the RADAR concerns module.

Outcome:
Improved understanding of current speaking up arrangements, staff experience, organisational intelligence and development opportunities.

Phase 2: Strengthen (October -December 2026)
This phase focuses on implementing improvements identified during the review period and strengthening support for staff who wish to speak up.
Key actions include:

- Refreshing communications and awareness materials.
- Developing regular "Meet Your Guardian" opportunities.
- Establishing the Champion Forum and communication network.
- Introducing intelligence-sharing arrangements and thematic reporting.
- Developing a "You Said, We Did" approach to organisational learning and feedback.
- Strengthening links with the Raising Concerns and Sexual Safety workstreams.

Outcome:
Increased visibility of the service, stronger organisational learning arrangements and improved engagement across the Trust.

Phase 3: Embed (January 2027 – Ongoing)
This phase moves into embedding sustainable processes that support continuous learning and improvement.
Key actions include:

- Routine triangulation of Freedom to Speak Up intelligence with workforce, patient safety and staff experience data.
- Embedding of thematic dashboards and enhanced reporting.
- Embedding feedback and learning communications.
- Evaluating the effectiveness of service developments and identifying future priorities.
- Implementing recommendations arising from the RADAR review where appropriate.

Outcome:
Fully embedded intelligence-led Freedom to Speak Up service that supports organisational learning, staff confidence and a culture of speaking up, listening up and acting up

Freedom to Speak Up Report Q1 2026/67: Attachment A – Service Development Roadmap

Key Milestones

Milestone	Target Date
Completion of stakeholder engagement and baseline review	Sep-26
Champion Forum established	Oct-26
Refreshed communications and visibility programme launched	Oct-26
"You Said, We Did" framework agreed	Nov-26
RADAR review completed	Dec-26
Intelligence-sharing and thematic review arrangements embedded	Jan-27
Enhanced reporting and dashboard development	Feb-27
Evaluation and priorities for 2027/28 agreed	Mar-27

Delivery Plan

The roadmap will be delivered through the detailed implementation plan below, which sets out the key workstreams, actions, timescales and success measures for the period July–September 2026.

Workstream / Action	Jul 2026	Aug 2026	Sep 2026	Success Measure
VISIBILITY & AWARENESS				
New Guardian introduction & communications	■			Communication issued
Department/ward engagement visits	■	■	■	Minimum 10 engagement sessions
Review FTSU communications & materials	■	■		Materials refreshed
Review intranet resources		■		Resources updated
Launch Meet Your Guardian sessions		■	■	Sessions established
CHAMPION NETWORK				
Meet current Champions	■	■		100% engagement
Establish Champion Forum		■		Forum established
Develop Champion TOR		■		TOR agreed
Champion communication network		■	■	Network operating
Review Champion coverage			■	Gap analysis completed
ORGANISATIONAL INTELLIGENCE				
Meet HR, Governance, Patient Safety & EDI leads	■			Stakeholder map completed
Map intelligence/data sources	■	■		Data sources identified
Establish intelligence-sharing meetings		■		Meetings scheduled
Begin data triangulation		■	■	Thematic review produced
Develop thematic dashboard			■	Prototype developed
Review Staff Survey hotspots and quick wins	■	■	■	Actions identified
LEARNING & FEEDBACK				
Review current feedback mechanisms	■			Review completed
Develop You Said We Did framework		■		Framework agreed
Pilot learning communications			■	First communication issued
GOVERNANCE & RADAR				
Review RADAR concerns module for FTSU use	■	■	■	Options appraisal completed
Link FTSU with Raising Concerns workstream		■	■	Governance link established
Link FTSU with Sexual Safety workstream		■	■	Reporting arrangements established

Progress against the development plan will be monitored through the success measures identified and reported through future quarterly Freedom to Speak Up assurance reports.

Safe Working Hours: Doctors in Training

0. Reference Information

Author:	Chris Marquis, Guardian of Safe Working	Paper date:	09/07/2026
Executive Sponsor:	Ruth Longfellow, Chief Medical Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	People and Culture Committee	Paper Ref:	To be inserted by the person collating the agenda
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

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

2.2 Summary

The Trust has in place a Guardian of Safe Working and this paper presents the July 2026 report from the Guardian. It outlines the work that has been undertaken to date and highlights some of the issues being faced. The report provides the data currently available in relation to rota vacancies and agency and locum usage. Format has been updated to reflect updated National standards.

2.3. Conclusion

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

3. The Main Report

3.1. Introduction

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

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

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

The Guardian will:

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

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

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

Other new features of the 2016 contract include:

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

Exception reporting – enabling doctors to raise exception reports where their work schedules do not reflect their work, and to ensure that a work schedule remains fit for purpose, this is beneficial to employers as it will give real-time information and be able to identify key issues as they arise. It also benefits doctors, as issues over safe working or missed educational opportunities can be raised and addressed early on in a placement, resulting in safer working and a better educational experience.

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

3.2 Guardian of Safe Working Report

3.2.1 High level data

For the period January 2026

Specialty	Contract	Headcount
Orthopaedics	Training posts	18
	Of which Doctors in training on 2016 contract	16
Rehabilitation/Spinal Injuries	Training posts	2
	Of which Doctors in training on 2016 contract	2

3.2.2 Number of exception reports submitted

Number of exception reports submitted over the last quarter	**0**

3.2.3 Categories of exception report submitted

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start					
Additional hours an unscheduled late finish					
Breaches of non-resident on-call patterns					
The inability to take contractual breaks					
Inadequacy of clinical support					
Inadequacy of rostered skills mix					
Raising concerns of a suspected non-compliant rota pattern					
Detriment or threat of detriment related to exception reporting					
Information breach					
Access and completion resolved in time					

Access and completion breaches					
Access and completion test					
Other: optional free text box					
Total					

3.2.3 Experiences of actual or threatened detriment

One of the guiding principles of the exception reporting reforms is to prevent doctors experiencing, either threatened or actual, detriment because of exception reporting or indicating intent to exception report. Detriment in an employment context is when an employer, or colleagues, treats an individual unfairly or subjects them to a disadvantage for the sole or main reason that they asserted an employment right.

Quarterly survey response rate	5 responses
Doctors experiencing actual detriment as a result of exception reporting	0
Doctors feeling that they are not discouraged from exception reporting	4

3.2.4 Withdrawals

A doctor can choose to withdraw an exception report that they have submitted at any point in the process following submission. All exception reporting data, including those which have been withdrawn, will be retained for the GoSWH to allow them to perform their role in checking for potential safety implications.

Number of exception reports withdrawn over the last quarter	0

3.2.5 Access to individual doctors' exception reporting data

Personally identifiable data related to exception reporting must not be shared without the doctors' specific consent, except where a senior manager or member of the board of directors is presented with an overriding public interest or has a legal obligation.

The affected doctor should be notified of this action as soon as practically possible, and the number of such disclosures must be presented in a manner that preserves a doctors' anonymity.

Number of exception reports disclosures over the last quarter	0

3.2.6 Work schedule reviews

The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose. A work schedule review can be triggered by one or more exception reports, or by a request from either the doctor or the employer.

Number work schedules reviews related to exception reporting patterns or instances	0

3.2.7 Resident Doctor Agency and Locum usage and Rota Vacancy Report

Trauma and Orthopaedics

Number of vacancies

Apr 26	0
May 26	0
Jun 26	0

Vacant shifts

Apr 26	5
May 26	5
Jun 26	3

Total cost - £12900

Medicine

Number of Vacancies

Apr 26	0
May 26	0
Jun 26	0

Vacant shifts

Apr 26	12
May 26	14
Jun 26	0

Total Cost £22140

MCSI - **Data outstanding**

Number of Vacancies

Apr 26	0
May 26	0
Jun 26	0

Vacant Shifts

Apr 26	6
May 26	0
Jun 26	1

Total cost - £3975

3.2.5 Fines

None

3.3 Challenges

3.3.1 Adapting to new resident doctor roles

Oversight of all resident doctor positions in the Trust with clear points of contact and

communication lack clarity. This is a continued piece of work.

3.3.2 Weekend work and cover

Increased volume of weekend work, combined with new IT systems is leading to concern regarding volume of work and duplication of effort. Work is ongoing with involved parties.

3.3.3 RDF

RDF format is being updated to reflect national trends. Format and TOC have been updated.

Next Steps

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

3.4. Conclusion

The Trust has had no exception reports.

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

Christopher Marquis

Guardian of Safe Working

Appendix 1: Junior Doctor Agency and Locum usage and Rota Vacancy Report

Trust Board - Performance

June 2026 – Month 3

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

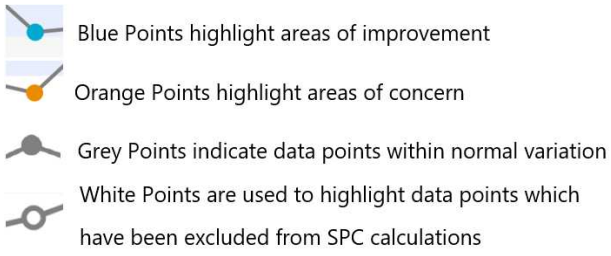
There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

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

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

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



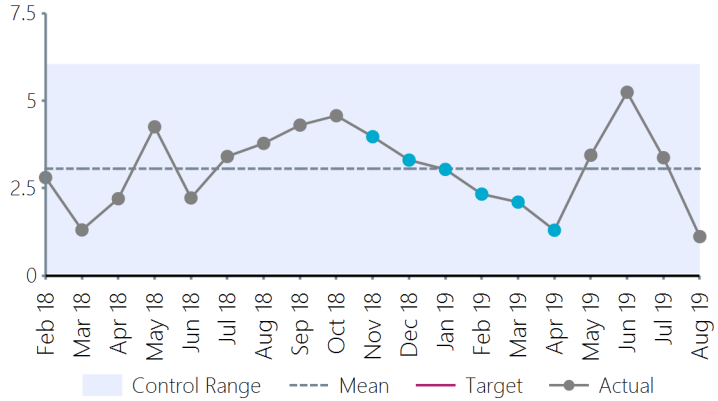
Some examples of these are shown in the images to the right:

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

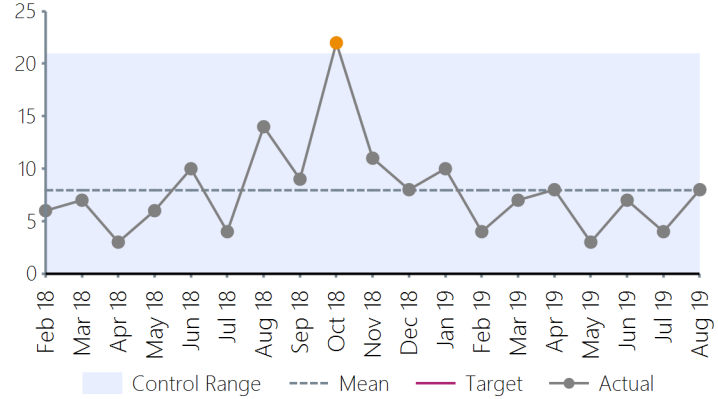
b) shows a point of concern sitting above the control range.

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

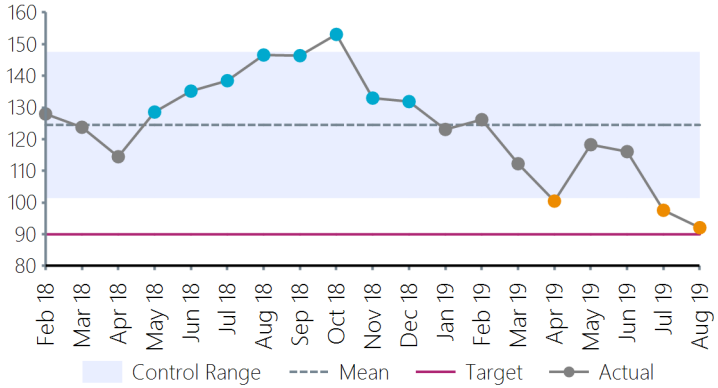
a)



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	NOF
31 Day General Treatment Standard*	96.00%	100.00%	100.00%	H	?			
62 Day General Standard*	85.00%	100.00%	100.00%		?		12/09/23	
28 Day Faster Diagnosis Standard*	77.00%	81.82%	83.78%	L	?			
18 Weeks RTT Open Pathways	62.82%	65.05%		H	Moving Target	+	24/06/21	+
18 Week Performance - Difference Between Planned and Actual	0.00%	2.23%			?	+		+
26 Weeks RTT Open Pathways		52.18%		L	No Target	+		
Time to First Appointment - English Patients (18 Weeks)	81.81%	79.98%		H	Moving Target	+		
Time to First Appointment - Welsh Patients (26 Weeks)		62.11%		H	No Target	+		
% of Patients Waiting Over 52 Weeks - English	1.15%	1.46%		L	Moving Target	+		+
Patients Waiting Over 104 Weeks - Welsh (Total)		366		H	No Target	+		

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
6 Week Wait for Diagnostics - English Patients	95.00%	92.53%	95.31%			+		
8 Week Wait for Diagnostics - Welsh Patients	100.00%	96.54%				+	04/03/24	

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
Elective Activity Against Plan (volumes)	1,228	1,273			Moving Target	+	24/06/21	
% Combined BADS Performance	85.00%	36.33%			F	+		
Total Outpatient Activity against Plan (volumes)	15,070	15,075			Moving Target	+	24/06/21	
Total Outpatient Activity - % Moved to PIFU Pathway	7.50%	8.49%		H	Moving Target	+		
Total Diagnostics Activity against Plan - Catchment Based	2,733	2,471			Moving Target	+		

18 Weeks RTT Open Pathways

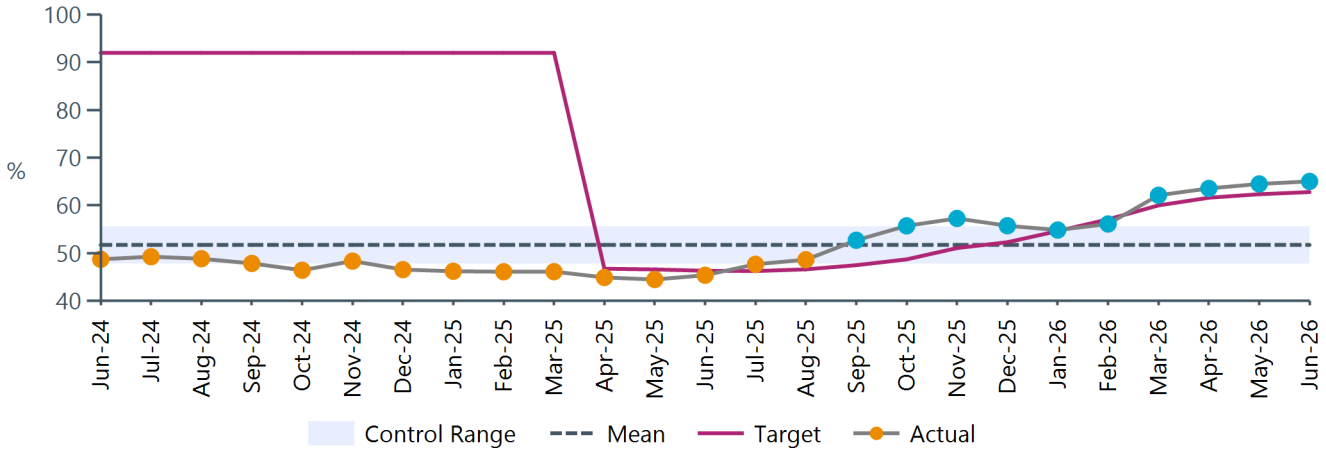
% of English patients on waiting list waiting 18 weeks or less 211021

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
62.82%	65.05%	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

The NHS England Medium-Term Planning Framework stipulates that in 2026/27 Trusts should improve the % of patients waiting no longer than 18 weeks for treatment by 7% or reach 65% (whichever is greater). The 2028/29 expectation is to reach 92%. The Trust's Operational Plan forecasts a position of 67% by the end of March 2027.

The June month-end position is 65.05% for patients waiting 18 weeks or less to start their treatment. As shown on the SPC above, this metric remains reported as special cause of an improving nature and continues to improve month on month. This metric is included in the NOF where the latest position for March scored the Trust at 3.19.

The performance breakdown by milestone is as follows:
* MS0 - 81 patients of which 0 are breaches
* MS1 - 7528 patients waiting of which 1575 are breaches
* MS2 - 1270 patients waiting of which 740 are breaches
* MS3 - 4547 patients waiting of which 2378 are breaches

Actions

For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
* Work towards internal ambitions where sub-speciality level targets have been set
* Improve clinical oversight and engagement
* Reducing 1st Outpatient Waits below 18/26 weeks
* Prioritisation of Welsh 104+ and English 52+ waits
* Exploring the inclusion of a Health Inequalities lens within the Trust's waiting list recovery
* Applying productivity improvements from recent reviews
* Head of Business Intelligence has remodelled our RTT data based on the latest available to provide an updated trajectory. Further work is underway with Service Managers to look at the impact of improving time to Outpatient 1st Appointments and the potential deterioration this will have on 18 weeks % performance.
* Increased capacity coming on board throughout remainder of the year as a result of additional theatre and clinical recruitment
* Currently reviewing tenders for surgical insourcing contract to commence in August

Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
45.39%	47.68%	48.64%	52.72%	55.74%	57.29%	55.76%	54.86%	56.13%	62.15%	63.58%	64.52%	65.05%

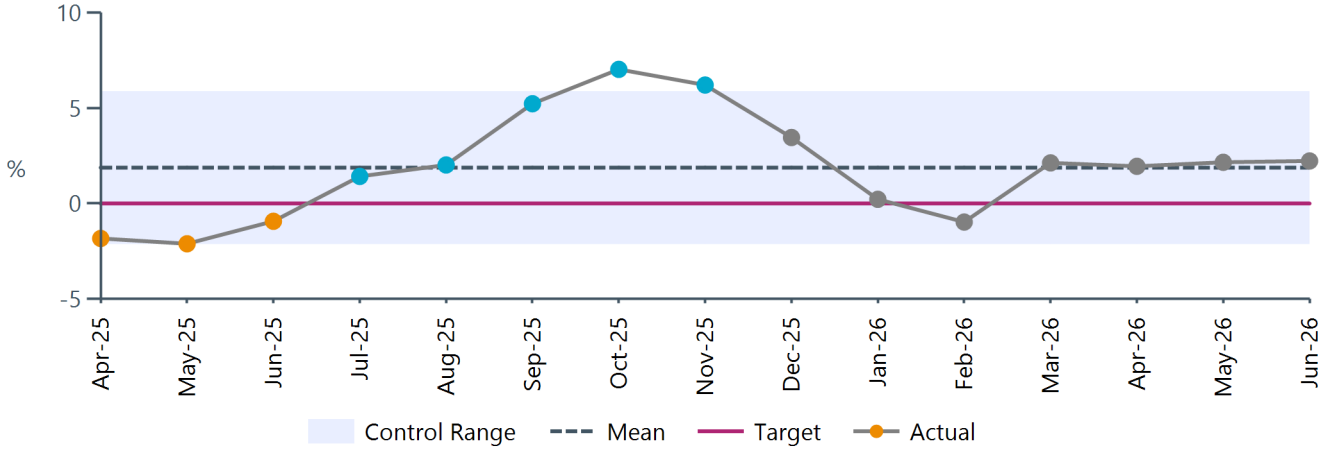
18 Week Performance - Difference Between Planned and Actual

Difference between planned and actual 18 week performance 217889

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
0.00%	2.23%			+

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

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 4 where the NOF score for this metric is 1; this reflected the March-26 position where the Trust was 2.13% better than it planned to be.

At the end of June, the position reported for month end is 65.05%; above the plan of 62.82% by 2.23%.

Actions

For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
* Work towards internal ambitions where sub-speciality level targets have been set
* Improve clinical oversight and engagement
* Reducing 1st Outpatient Waits below 18/26 weeks
* Prioritisation of Welsh 104+ and English 52+ waits
* Exploring the inclusion of a Health Inequalities lens within the Trust's waiting list recovery
* Applying productivity improvements from recent reviews
* Head of Business Intelligence has remodelled our RTT data based on the latest available to provide an updated trajectory. Further work is underway with Service Managers to look at the impact of improving time to Outpatient 1st Appointments and the potential deterioration this will have on 18 weeks % performance.
* Increased capacity coming on board throughout remainder of the year as a result of additional theatre and clinical recruitment
* Currently reviewing tenders for surgical insourcing contract to commence in August

Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
-0.93%	1.42%	2.02%	5.23%	7.03%	6.21%	3.46%	0.22%	-0.97%	2.13%	1.95%	2.16%	2.23%

26 Weeks RTT Open Pathways

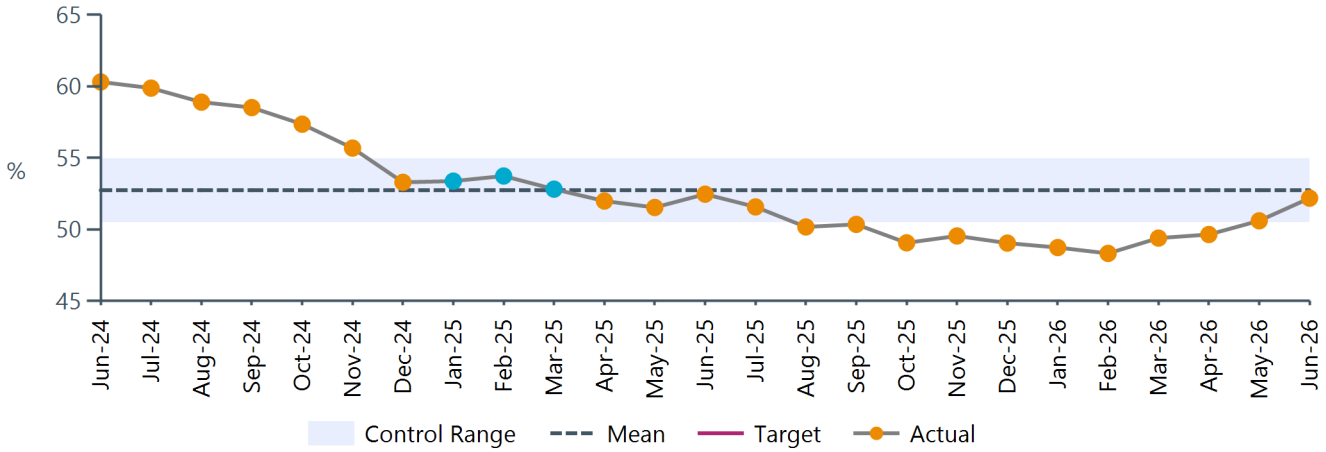
% of Welsh patients on waiting list waiting 26 weeks or less 217917

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
-	52.18%	L	No Target	

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

The June month-end position is 52.18% for Welsh patients waiting 26 weeks or less to start their treatment. As shown on the SPC above, this metric is a reported as special cause variation of a concerning nature but the latest position is back towards the mean after some consistent improvement since February.

The performance breakdown by milestone is as follows:
* MS0 - 5 patients of which 2 are breaches
* MS1 - 6303 patients waiting of which 2361 are breaches
* MS2 - 794 patients waiting of which 468 are breaches
* MS3 - 2860 patients waiting of which 1933 are breaches

Actions

For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
* Work towards internal ambitions where sub-speciality level targets have been set
* Improve clinical oversight and engagement
* Reducing 1st Outpatient Waits below 18/26 weeks
* Prioritisation of Welsh 104+ and English 52+ waits
* Applying productivity improvements from recent reviews
* Increased capacity coming on board throughout remainder of the year as a result of additional theatre and clinical recruitment
* Currently reviewing tenders for surgical insourcing contract to commence in August

Specifically for our Welsh patients:
* Dedicated focus on patients waiting for DEXA following an improved position for English patients
* Increased oversight of Welsh RTT performance through Senior Operational Delivery Group
* Health Inequalities Working Group will be monitoring the rate of improvement for Welsh patients, alongside that of English patients

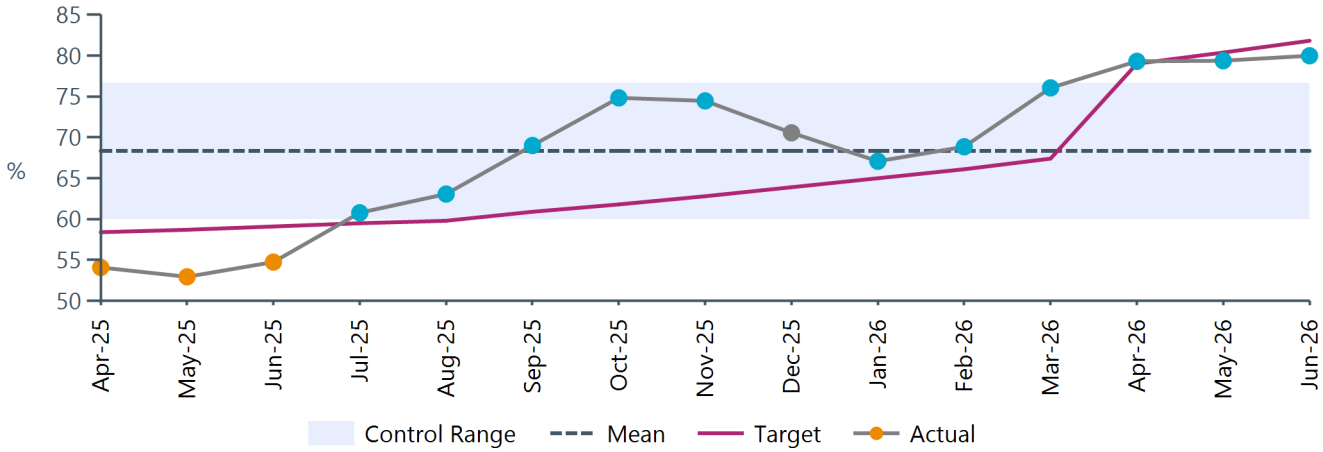
Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
52.46%	51.57%	50.17%	50.35%	49.06%	49.54%	49.04%	48.73%	48.32%	49.39%	49.64%	50.60%	52.18%

Time to First Appointment - English Patients (18 Weeks)

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	NOF
81.81%	79.98%	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; 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 28th June 2026. NHSE Guidance stipulates the week ending positions we should officially report that fall closest to month end. This is an unvalidated position.

For week ending 28th June 79.98% of patients waiting for first appointment were under 18 weeks; below the 81.81% plan. Performance ranges from 44.19% in Spinal Disorders to 100% in Elderly Medicine, Muscle, Neurophysiology, Physiotherapy and Occupational Therapy.

Actions

For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
* Work towards internal ambitions where sub-speciality level targets have been set
* Improve clinical oversight and engagement
* Reducing 1st Outpatient Waits below 18/26 weeks
* Prioritisation of Welsh 104+ and English 52+ waits
* Exploring the inclusion of a Health Inequalities lens within the Trust's waiting list recovery
* Applying productivity improvements from recent reviews
* Increased capacity coming on board throughout remainder of the year as a result of additional theatre and clinical recruitment
* Currently reviewing tenders for surgical insourcing contract to commence in August

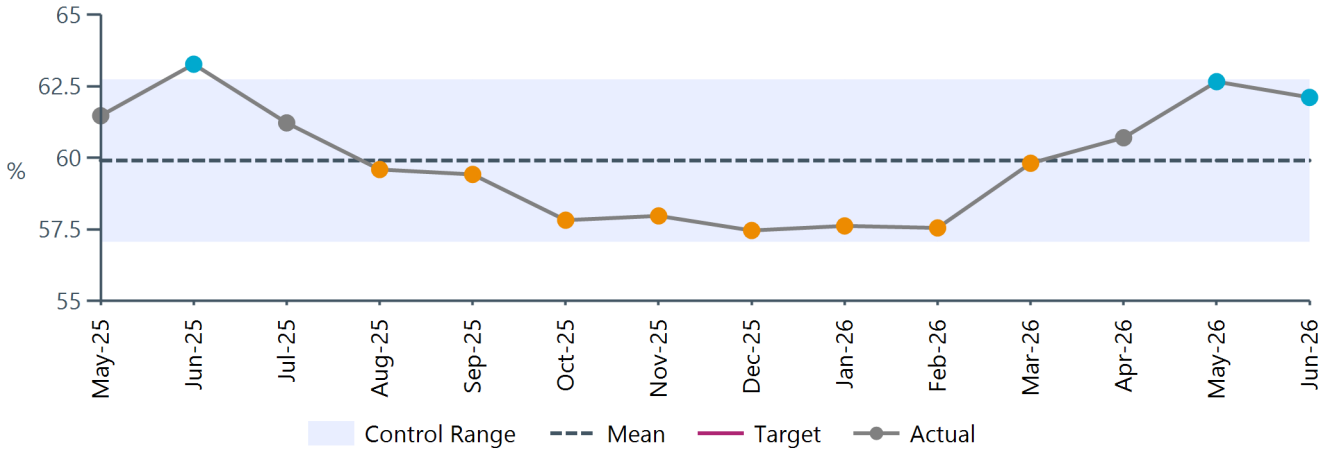
Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
54.75%	60.78%	63.07%	69.01%	74.83%	74.46%	70.56%	67.08%	68.85%	76.05%	79.30%	79.37%	79.98%

Time to First Appointment - Welsh Patients (26 Weeks)

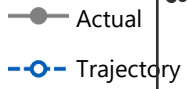
The denominator is the count of incomplete outpatient pathways waiting for a first appointment at the snapshot date. The numerator is the count of incomplete pathways waiting for a first appointment at the snapshot date that have been waiting less than 2 217916

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
-	62.11%	H	No Target	



Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature.

Narrative

The NHS Wales Performance Framework for 2026/27 has been published where it expects no patients to be waiting more than 26 weeks for a new outpatient appointment.

For week ending 28th June 62.11% of patients waiting for first appointment were under 26 weeks. Performance ranges from 37.32% in Spinal Disorders to 100% in Muscle, Occupational Therapy, Paediatric Medicine and Rheumatology. There has been dedicated focus on patients waiting for DEXA where performance at this snapshot date was 76.86%.

Actions

For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
* Work towards internal ambitions where sub-speciality level targets have been set
* Improve clinical oversight and engagement
* Reducing 1st Outpatient Waits below 18/26 weeks
* Prioritisation of Welsh 104+ and English 52+ waits
* Applying productivity improvements from recent reviews
* Increased capacity coming on board throughout remainder of the year as a result of additional theatre and clinical recruitment
* Currently reviewing tenders for surgical insourcing contract to commence in August

Specifically for our Welsh patients:
* Dedicated focus on patients waiting for DEXA following an improved position for English patients
* Increased oversight of Welsh RTT performance through Senior Operational Delivery Group
* Health Inequalities Working Group will be monitoring the rate of improvement for Welsh patients, alongside that of English patients

Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
63.27%	61.22%	59.59%	59.42%	57.82%	57.97%	57.46%	57.62%	57.55%	59.81%	60.70%	62.66%	62.11%

% of Patients Waiting Over 52 Weeks - English

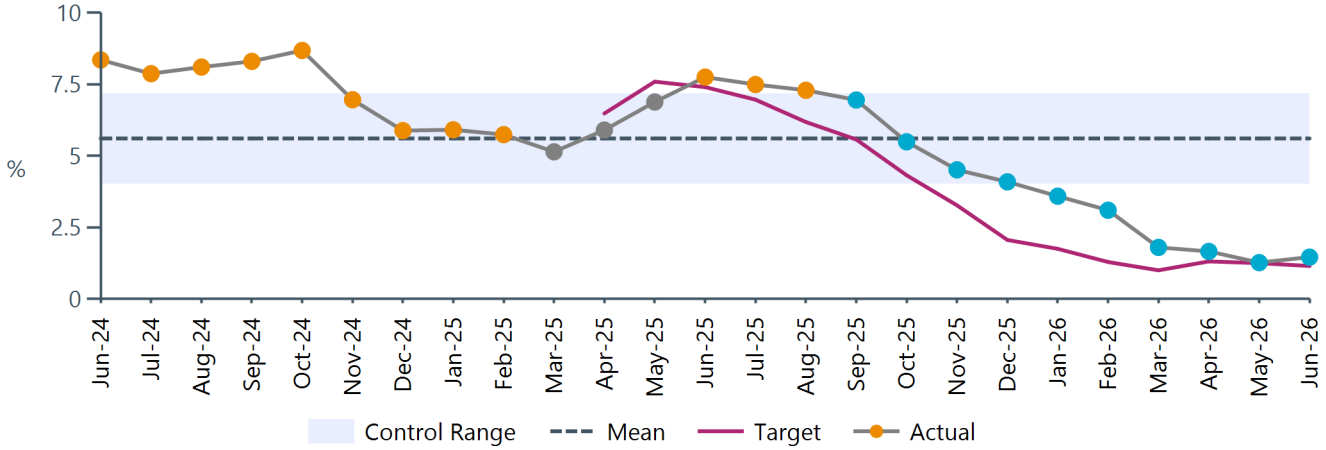
The number of English patients waiting over 52 weeks as a proportion of the English List Size. 217874

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
1.15%	1.46%	L	Moving Target	+

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

At the end of June, 196 patients were waiting over 52 weeks, this equates to 1.46% of the English list size. As shown on the SPC above, there has been a period of sustained improvement since August.

Patients waiting, by weeks brackets is:
* >52 to <=65 weeks - 176 patients
* >65 to <=78 weeks - 17 patients
* >78 weeks - 3 patients
* No patients waiting greater than 104 weeks

This metric is part of the NOF, with the latest score for Quarter 4 reported at 3.13 for the March month end position of 1.80%.

Actions

For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
* Work towards internal ambitions where sub-speciality level targets have been set
* Improve clinical oversight and engagement
* Reducing 1st Outpatient Waits below 18/26 weeks
* Prioritisation of Welsh 104+ and English 52+ waits
* Exploring the inclusion of a Health Inequalities lens within the Trust's waiting list recovery
* Applying productivity improvements from recent reviews
* Increased capacity coming on board throughout remainder of the year as a result of additional theatre and clinical recruitment
* Currently reviewing tenders for surgical insourcing contract to commence in August

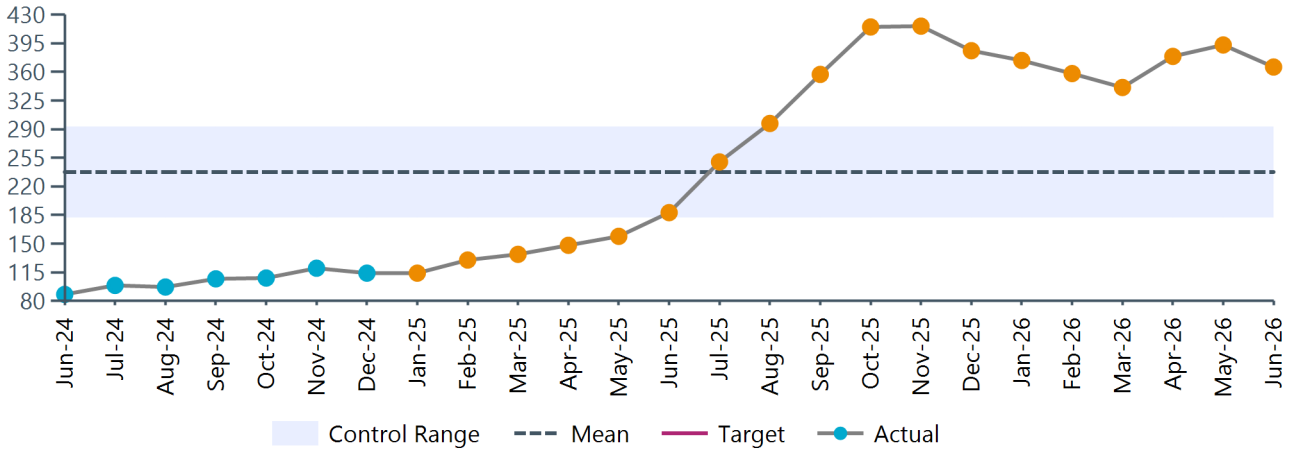
Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
7.75%	7.49%	7.29%	6.95%	5.49%	4.51%	4.09%	3.59%	3.10%	1.80%	1.66%	1.27%	1.46%

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	NOF
-	366	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 June there were 366 Welsh patients waiting over 104 weeks. The patients are under the care of these sub-specialities; Spinal Disorders (173), Foot & Ankle (60), Knee & Sports Injuries (53), Arthroplasty (39), Hand & Upper Limb (37), Metabolic Medicine (2), Paediatric Orthopaedics (1) and Veterans (1).

An internal trajectory is now in place to get to a position of zero Welsh patients waiting over 104 weeks by the end of 2026/27. This aligns with the Welsh framework.

Actions

For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
* Work towards internal ambitions where sub-speciality level targets have been set
* Improve clinical oversight and engagement
* Reducing 1st Outpatient Waits below 18/26 weeks
* Prioritisation of Welsh 104+ and English 52+ waits
* Applying productivity improvements from recent reviews
* Increased capacity coming on board throughout remainder of the year as a result of additional theatre and clinical recruitment
* Currently reviewing tenders for surgical insourcing contract to commence in August

Specifically for our Welsh patients:
* Dedicated focus on patients waiting for DEXA following an improved position for English patients
* Increased oversight of Welsh RTT performance through Senior Operational Delivery Group
* Health Inequalities Working Group will be monitoring the rate of improvement for Welsh patients, alongside that of English patients

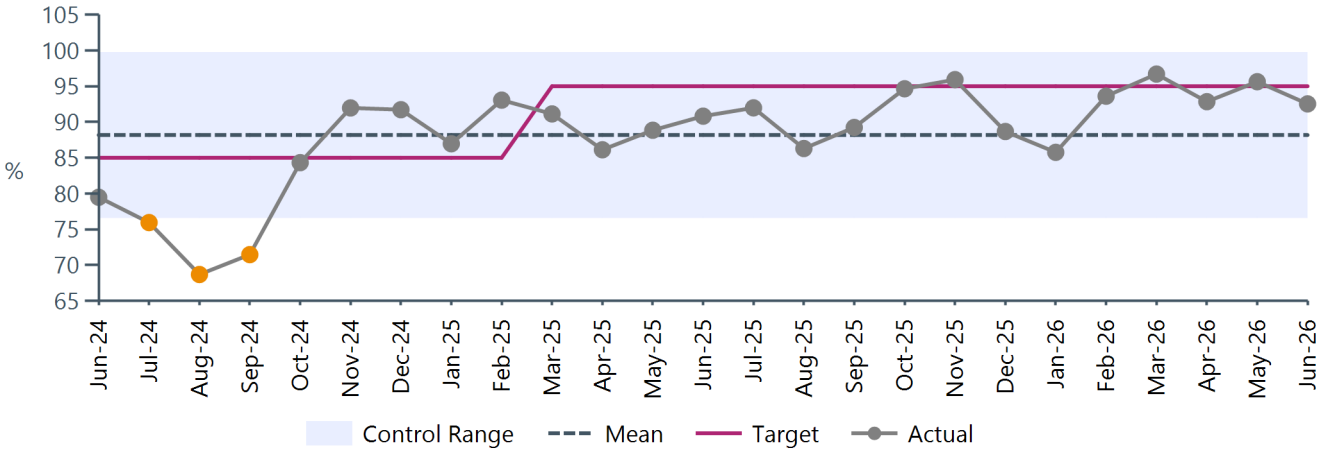
Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
188	250	297	357	415	416	386	374	358	341	379	393	366

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	NOF
95.00%	92.53%		Moving Target	



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 NHS England Medium-Term Planning Framework stipulates that in 2026/27 all Trusts should deliver a 3% improvement, or 20% overall performance (whichever is greater). The 2028/29 target is to reach less than 1% waiting beyond 6 weeks.
Performance for June is 92.53% against the 95% target. The trajectory for June month end was 95.31%; this reflects the Trust's submitted Operational Plans. Reported position relates to 104 patients who waited beyond 6 weeks. Of the 6-week breaches; 4 are over 13, all in MRI.
Performance and breaches by modality:
* MRI – 89.15% - D2 (Urgent - 0-2 weeks) – 2 dated, D4 (Routine – 6-12 weeks) – 95 with 78 dated
* CT – 97.28% - D2 (Urgent - 0-2 weeks) – 2 dated, D4 (Routine - 6-12 weeks) – 2 with 1 dated
* Ultrasound – 99.13% - D2 (Urgent - 0-2 weeks) – 1 dated, D4 (Routine - 6-12 weeks) – 2 dated
* DEXA – 100%
The underperformance against both the national standard and planned trajectory is primarily attributable to MRI waiting times. June activity plan included 223 examinations to be carried out in the mobile MRI scanner, however the mobile scanner was not utilised during the month.

Actions

Actions include:
* Midlands Centre for Spinal Injuries (MCSI) patient transfer breaches — The Trust is investigating discharge lounge space to help avoid long waiting times to support spinal injuries patients for MRI.
* Booking delays — This will be addressed as vacancies are recruited to through the phased pipeline.
* Significant downtime - Due to heat and location of cooling units for both static scanners, MRI have experienced downtime on recommendation from supplier. Working with Siemens and Estates to investigate longer term climate resilience for extreme temperatures.
* The Radiology Service is working with the Information Team to set up routine forecasting information for Imaging Services.

Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
90.82%	91.98%	86.30%	89.24%	94.65%	95.93%	88.67%	85.77%	93.61%	96.70%	92.84%	95.64%	92.53%

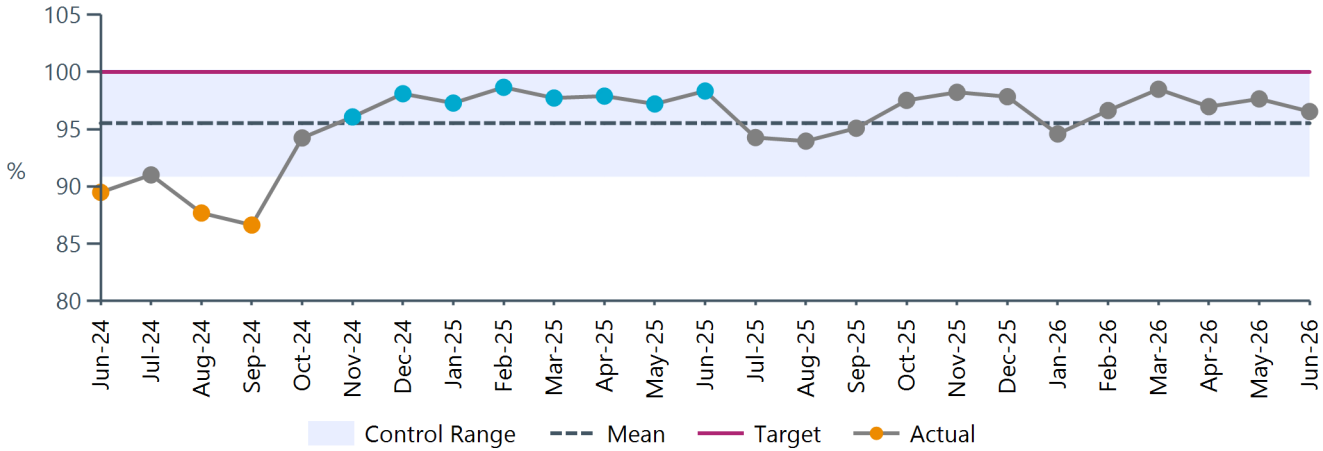
8 Week Wait for Diagnostics - Welsh Patients

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
100.00%	96.54%			

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 NHS Wales Performance Framework for 2026/27 outlines the expectation that no patients should wait more than 8 weeks for a specified diagnostic.

The 8-week standard for diagnostics is reported at 96.54%. The reporting position includes 20 patients who waited beyond 8 weeks.
Performance and breaches by modality:
* MRI – 95.93% - D2 (Urgent - 0-2 weeks) – 1 undated, D4 (Routine - 6-12 weeks) – 19 with 18 dated
* CT – 100%
* Ultrasound – 100%
* DEXA Scans - 100%

The underperformance against the Performance Framework is primarily attributable to MRI waiting times. June activity plan included 223 examinations to be carried out in the mobile MRI scanner, however the mobile scanner was not utilised during the month.

Actions

Actions include:
* Midlands Centre for Spinal Injuries (MCSI) patient transfer breaches — The Trust is investigating discharge lounge space to help avoid long waiting times to support spinal injuries patients for MRI.
* Booking delays — This will be addressed as vacancies are recruited to through the phased pipeline.
* Significant downtime - Due to heat and location of cooling units for both static scanners, MRI have experienced downtime on recommendation from supplier. Working with Siemens and Estates to investigate longer term climate resilience for extreme temperatures.
* The Radiology Service is working with the Information Team to set up routine forecasting information for Imaging Services.

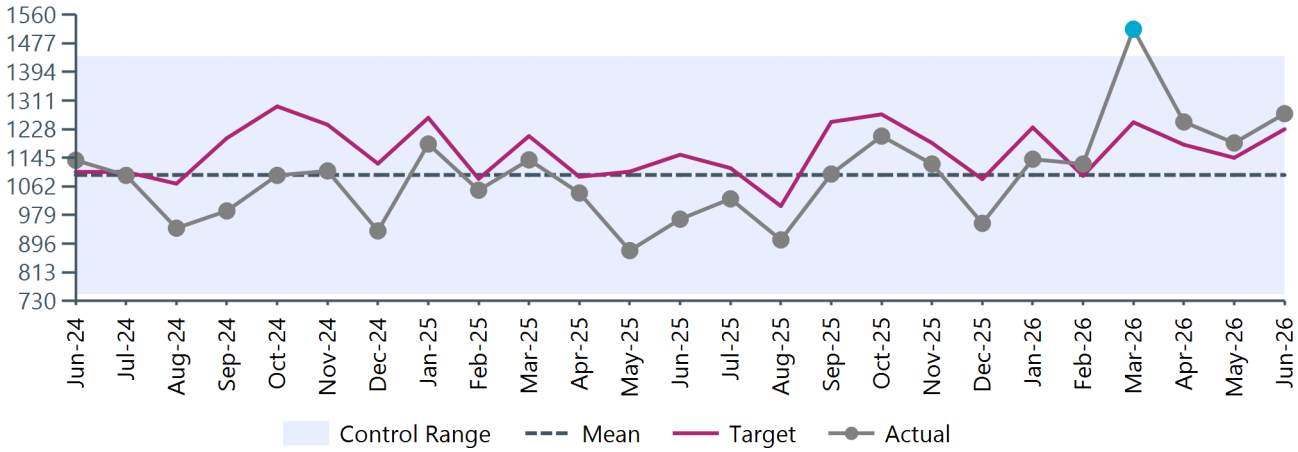
Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
98.33%	94.27%	93.96%	95.09%	97.52%	98.22%	97.84%	94.58%	96.63%	98.49%	96.97%	97.64%	96.54%

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	NOF
1,228	1,273		Moving Target	



Trajectory

Actual
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

Total elective activity is monitored against the 2026/27 elective spells plan as set out in the Trust's Operational Plan submitted to NHSE.

In June, the Trust planned for 1,228 elective spells and delivered 1273 spells, achieving 103.66% of plan and delivering 45 spells above target. This includes 33 patients who were treated by other providers on behalf of RJAH.

June's performance sits above the mean and within the statistical control limits, indicating the presence of common cause variation.

Actions

Increased capacity coming on board throughout remainder of the year as a result of additional theatre and clinical recruitment

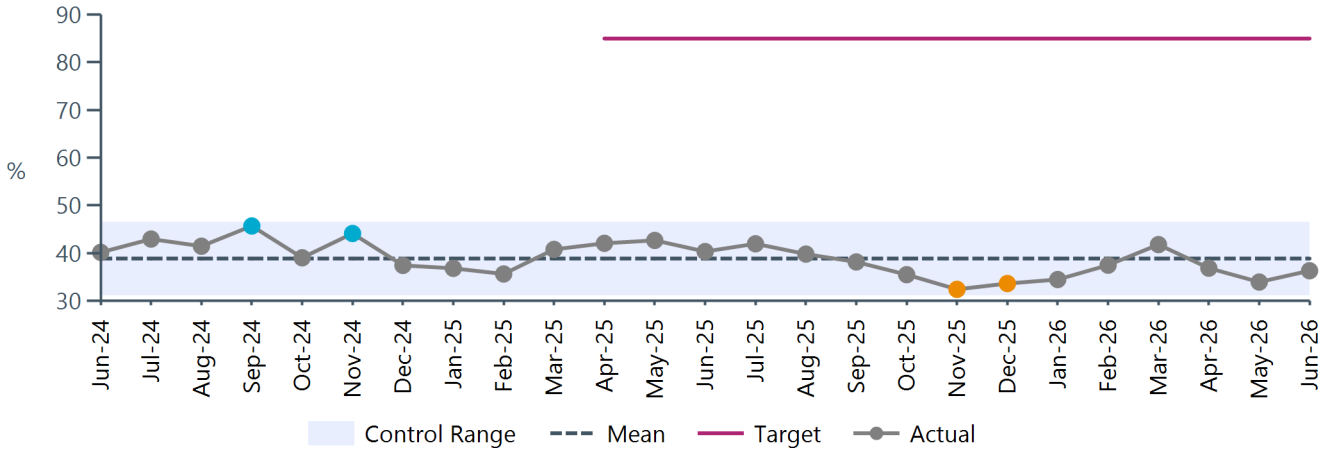
Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
967	1026	907	1098	1208	1127	955	1141	1127	1518	1249	1188	1273

% 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	NOF
85.00%	36.33%		F	



Trajectory

What these graphs are telling us

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

Narrative

The metric measures Combined BADS Performance against the Orthopaedic and Urology procedures within the BADS Directory of Procedures (January 2026 Edition) and continues to be monitored against the NHSE target of 85%.

June performance was 36.23%. Including all patients discharged on day zero, regardless of intended management, would increase performance to 51.35%.

June performance remains below the mean and within common cause variation. The narrow control limits suggest that material improvement is unlikely without targeted intervention.

As the metric is dependent on fully coded activity, the reported position may be subject to further change.

Actions

The Trust has an established clinically led day case working group. This group reviews current day case practices and performance.

Other actions include educating the Bookings team on BADS day-case-by-default procedures, supported by a reference guide and the inclusion of these procedures within Patient Tracking Lists. This supports accurate intended management selection and enables proactive identification of patients whose waiting list intended management does not align with BADS guidance.

Collectively, these actions are expected to reduce data quality errors and improve reporting accuracy.

Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
40.35%	41.98%	39.82%	38.17%	35.51%	32.43%	33.65%	34.49%	37.50%	41.81%	36.87%	33.96%	36.33%

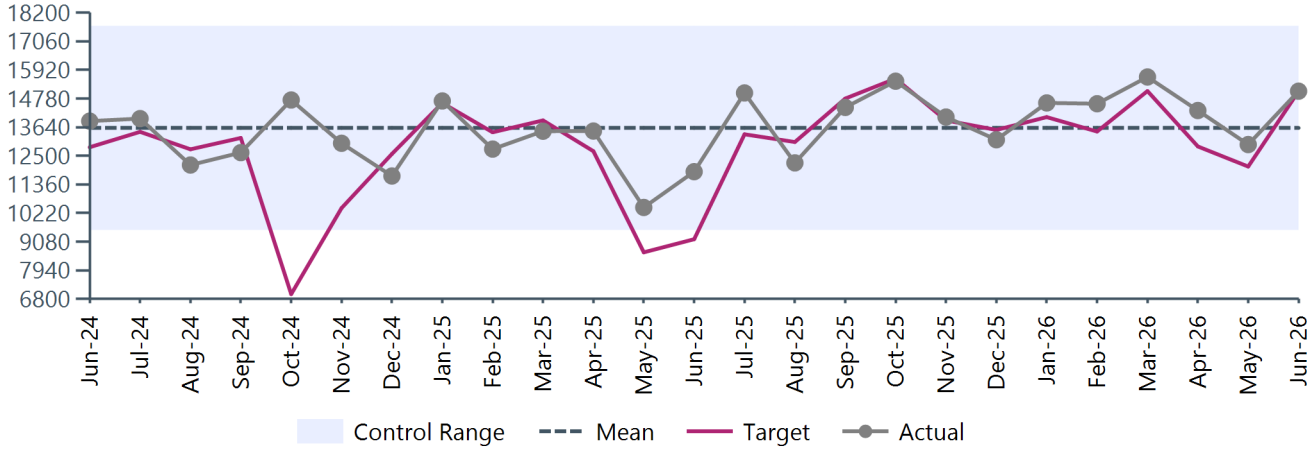
Total Outpatient Activity against Plan (volumes)

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	NOF
15,070	15,075		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 met in June with +5 attendances over plan and the position reported at 100.03%. It must also be noted, at the point of IPR production and when this data was extracted on 5th working day, there still remained outcomes to be processed on Careflow so this position will continue to increase as they are transacted.

A breakdown of Outpatient activity below:
* IJP activity was 282 at 97.84%, * OJP activity was +191 at 154.26%, * Insourcing activity was +67 at 151.54% * 61 appointments were delivered via Outsourcing that had no plan
* New activity 98.22%, * Follow Up activity 100.79%

Actions

Some areas fell behind plan in June with reasons outlined below:
* Foot & Ankle - Consultant availability in month
* Paediatric Medicine - new paediatrician has commenced but referral management centre was not aware so flow of referrals was not coming through to the Trust. Operational Lead has addressed this and referrals are now being received. Unplanned leave in this area throughout June also contributed.
* Paediatric Orthopaedics - Higher levels of leave than anticipated.
* Spinal Disorders - 3 new AHP roles were part of planning assumptions from April but not in post yet.
* Physiotherapy - this area continues to see high levels of late cancellations and DNAs. Lost activity in gym and hydro classes due to hot weather. Increased levels of absence due to leave, sickness and bereavement.

Monitoring of delivered activity against plan remains under focus at weekly activity meeting with close scrutiny of the various elements that form the overall plan, i.e. IJP/OJP/Insourcing and First/Follow-Up.

Increased capacity coming on board throughout remainder of the year as a result of additional theatre and clinical recruitment.

Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
11869	15004	12218	14427	15472	14044	13140	14606	14574	15640	14305	12948	15075

Total Outpatient Activity - % Moved to PIFU Pathway

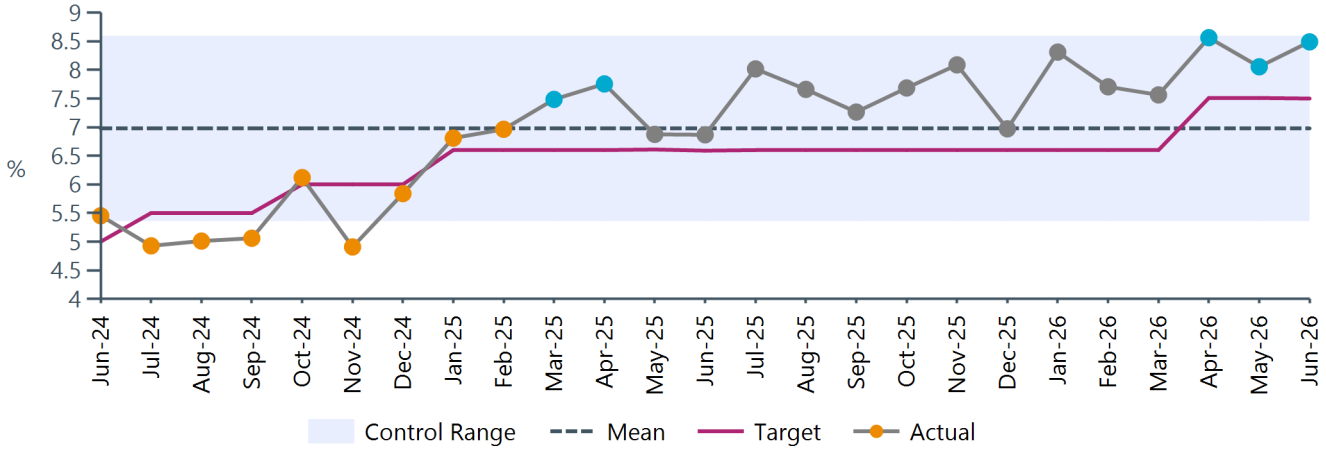
Total Outpatient Activity - % Moved to Patient Initiated Follow Up Pathway against plan. Target as per Trust's Operational Plans. 217715

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
7.50%	8.49%	H	Moving Target	

Trajectory

Actual
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 7.50% of all outpatients attendances. In June this was exceeded with 8.49% of total outpatient activity moved to a PIFU pathway. As demonstrated on the SPC above, this has now been reported as sustained improvement since January-25.

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.

Actions

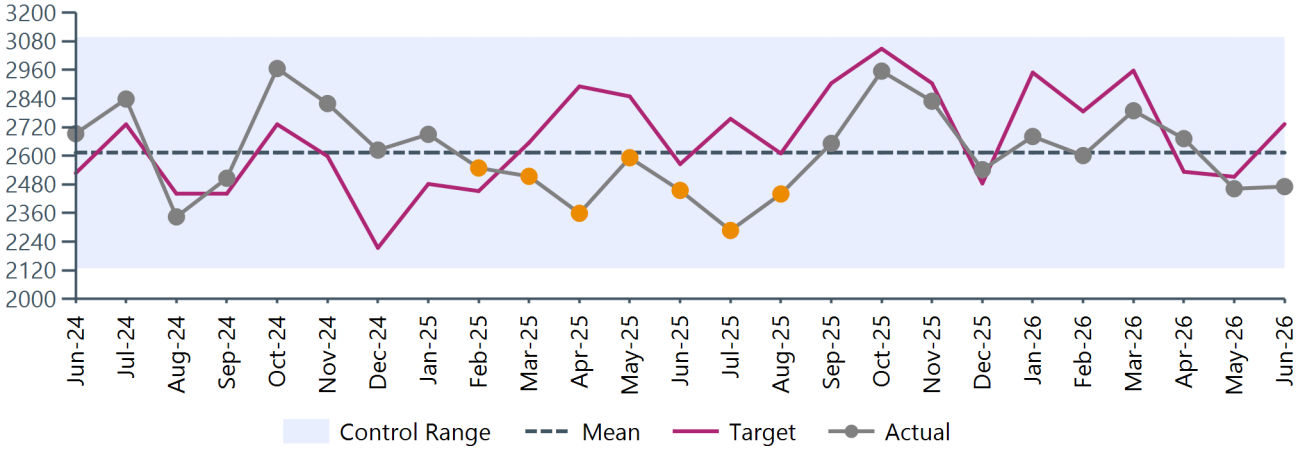
Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
6.87%	8.02%	7.66%	7.26%	7.68%	8.09%	6.97%	8.31%	7.71%	7.56%	8.56%	8.06%	8.49%

Total Diagnostics Activity against Plan - Catchment Based

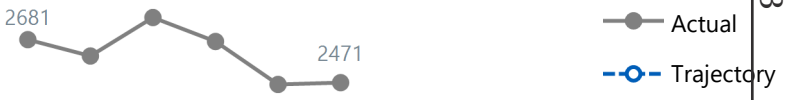
Total Diagnostic Activity against Plan - (MRI, U/S and CT activity) against plan. Target as per Trust's Operational Plans. 217794

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
2,733	2,471		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 Diagnostic activity plan was not met in June. Overall activity is reported at 90.41% with a breakdown as follows:
- MRI - 1150 against plan of 1408; equating to 81.68%
- U/S – 930 against 946; equating to 98.31%
- CT – 391 against plan of 379; equating to 103.17%

The overall variance to plan was primarily attributable to MRI activity. The June plan included an assumption that the mobile MRI scanner would contribute 223 examinations during the month. As the mobile MRI unit was not utilised in June, this planned activity was not delivered, significantly impacting overall MRI performance.

Actions

* Newly recruited staff within the booking team are now in post and undergoing initial training to improve booking turnaround times, increase activity and enhance capacity utilisation.
* The Radiology Service is working with the Information Team to set up routine forecasting information for Imaging Services.
* Mobile MRI scanner planned for July

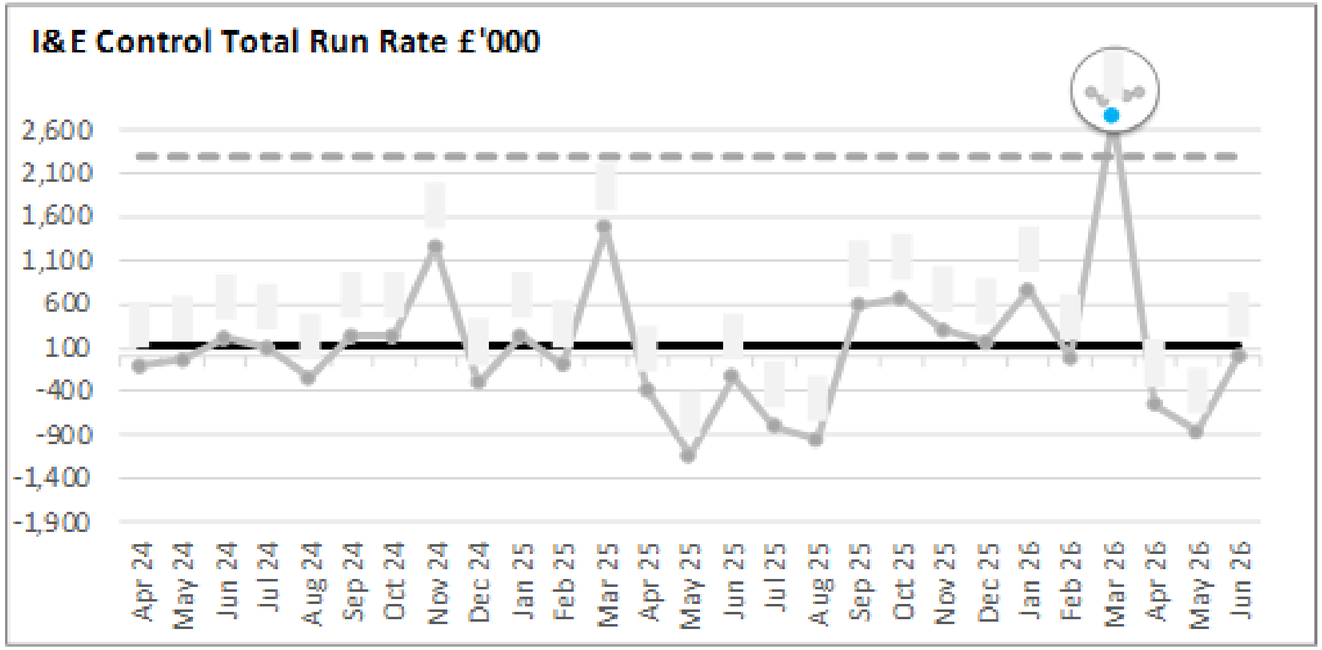
Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
2455	2287	2440	2652	2955	2829	2542	2681	2601	2789	2672	2462	2471

1	2	3	4	5	6	7	8	9	10


NHS
The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust
M3 Financial
Position
Update
Improving lives through excellent and innovative care
NHS

Income & Expenditure Position June 2026

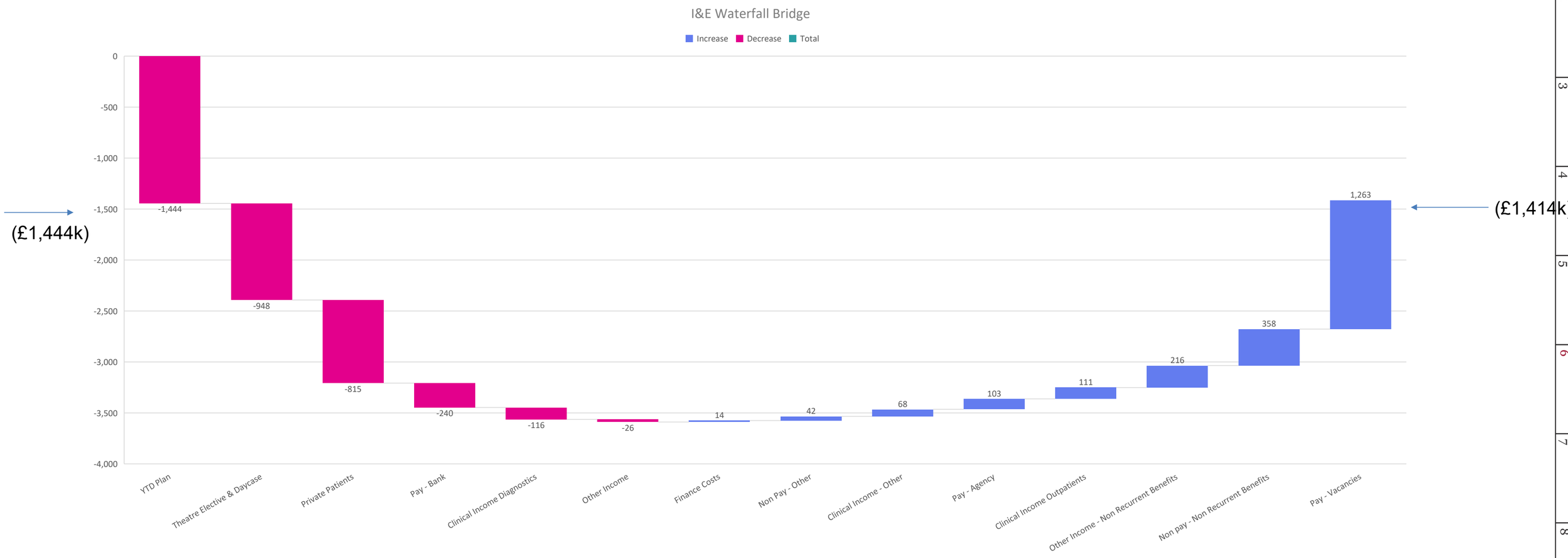
	Annual Plan	In Month Position			YTD Position		
		Pass through adj Plan	Actual	Variance	Pass through adj Plan	Actual	Variance
Clinical Income	168,015	13,880	13,354	(526)	39,621	38,559	(1,062)
Private Patient income	12,343	1,165	721	(444)	3,310	2,339	(971)
Other income	7,783	683	873	190	2,009	2,069	60
Pay	(116,834)	(9,745)	(9,371)	374	(29,189)	(28,063)	1,126
Non-pay	(62,267)	(5,199)	(4,828)	371	(14,956)	(14,092)	864
EBITDA	9,040	784	749	(35)	795	812	17
Finance Costs	(9,904)	(819)	(810)	9	(2,453)	(2,437)	16
Capital Donations	3,350	388	310	(78)	1,156	444	(712)
Operational Surplus	2,486	353	249	(104)	(502)	(1,181)	(679)
Remove Capital Donations	(3,350)	(388)	(310)	78	(1,156)	(444)	712
Add Back Donated Dep'n	865	69	71	2	215	213	(2)
Control Total	0	34	10	(24)	(1,444)	(1,414)	30



In month: £0.01m surplus, £0.02m adverse to plan. Year to Date: £1.4m deficit which is a £0.03m favourable variance to plan

- **NHS Clinical Income £0.53m adverse -** driven by £0.39m adverse theatres internal delivery (94 cases adverse to plan), £0.09m adverse deconstructing the block impact, £0.07m adverse diagnostics partially offset by £0.1m favourable non theatre delivery , £0.08m favourable theatre insourcing (4 cases favourable to plan).
- **Non-NHS income £0.25m adverse –** driven by £0.44m adverse private patient income, 2/3rds of which results from volume (33 patients adverse to plan) and 1/3rd case mix, partially offset by £0.22m of non recurrent RTA income.
- **Pay expenditure £0.37m favourable –** driven by £0.27m favourable workforce recruitment slippage, £0.2m favourable enhanced controls (vacancy and temporary staffing) and £0.02m favourable agency partially offset by £0.2m adverse bank (OJP and Non Medical Nursing, AHP & CSS)
- **Non-Pay £0.38m favourable -** driven by £0.2m favourable of non recurrent benefits, £0.15m favourable implants and consumables (PP & NHS volumes)

Bridge: YTD plan £1,444k deficit versus actual £1,414k deficit



The bridge shows the key drives of the variances to plan YTD in delivery of the £1,414k deficit

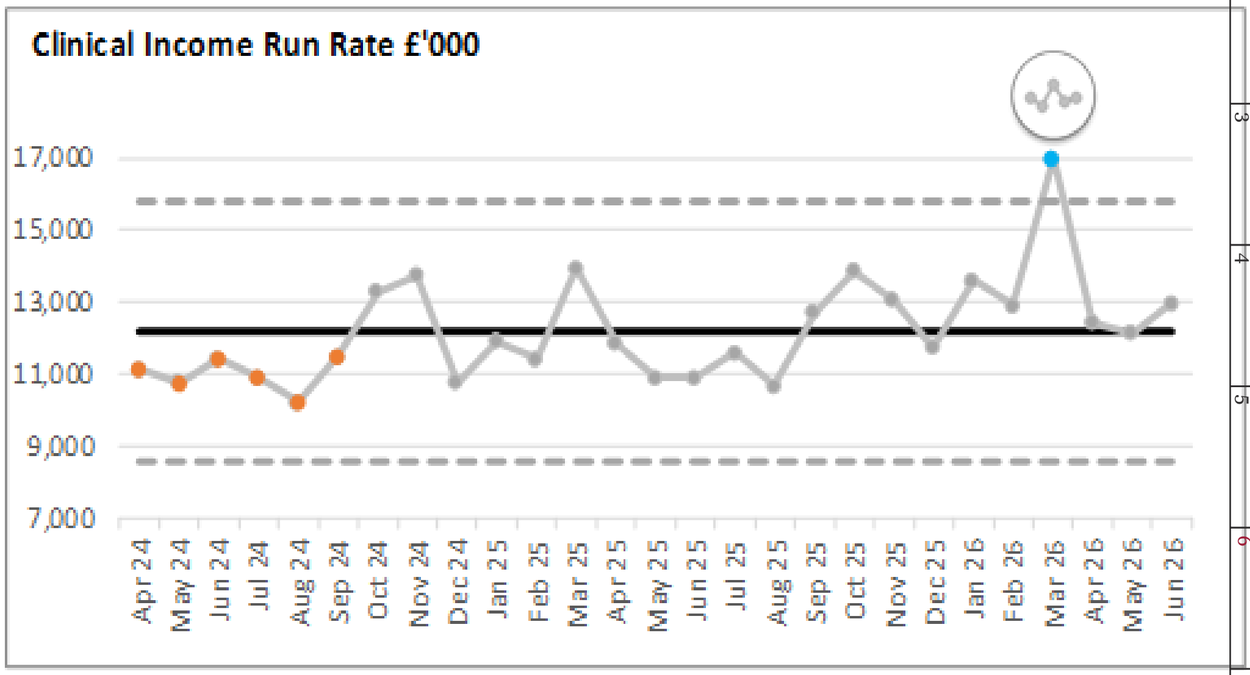
Adverse income performance linked to lower than planned elective theatre activity and private patients is offset by improved outpatient performance (partially offset in cost) along with lower than planned pay due to vacancies & enhanced controls and non-pay expenditure (marginal costs and non-recurrent).

Non recurrent items include in year mitigations - purchase order closure review, balance sheet review, RTA income and VAT rebate

Note: clinical income elective & daycase, and private patients are shown net of direct marginal costs.

Clinical Income Run Rate

Summary Income Position		2026-27 Month 3 YTD Plan Activity	Actual Activity	Difference Activity	Plan income £m	Actual Income £m	Fixed Adjustment £m	Variance Income £m
Variable Contract Income								
Elective Day case	Theatres	1,243	964	(279)	3.63	2.86	0.00	(0.77)
Elective Inpatient	Theatres	1,583	1,456	(127)	11.77	11.54	(0.09)	(0.32)
Elective Inpatient & Day case	Non Theatres	708	1,298	590	0.56	0.77	(0.00)	0.21
Outpatient First Attendance		12,813	11,805	(1,008)	3.01	2.99	(0.00)	(0.03)
Outpatient Procedures		2,100	2,540	440	0.61	0.76	(0.01)	0.14
Diagnostics		10,924	10,493	(431)	1.12	1.00	0.01	(0.12)
High Cost Drugs/Devices					2.54	2.37	0.00	(0.17)
Other Allocations					1.34	1.10	0.00	(0.24)
Total Variable Contract Income		29,372	28,556	(816)	24.58	23.38	(0.10)	(1.29)
Fixed Contract Income								
Non Elective Inpatients		146	188	42	1.17	1.83	(0.66)	(0.00)
Regular Day case		513	333	(180)	0.48	0.31	0.17	0.00
Critical Care					0.55	0.38	0.17	0.00
Outpatient Follow Ups		26,575	28,570	1,995	2.83	3.21	(0.38)	(0.00)
Other Fixed Income					10.25	8.58	1.67	0.01
Total Fixed Contract Income		27,234	29,091	1,857	15.27	14.30	0.97	0.00
Total Clinical Income from Contracts		56,606	57,647	1,041	39.85	37.68	0.88	(1.29)



Clinical Income by Point of Delivery (POD)

Clinical income is £1.29m adverse to plan YTD

- Elective inpatient and day case theatre performance is £1.09m adverse to plan driven by adverse theatre activity delivery.
- Other elective inpatient and day case performance is £0.21m favourable to plan driven by overperformance against metabolic medicine & rheumatology day cases.
- Outpatient first attendances and procedures performance is £0.11m favourable to plan driven by outpatient procedure volumes above plan.
- Diagnostics assessments are £0.12m adverse to plan due to lower than planned unbundled scans.
- Other Allocations Actual performance includes £44k of RTT sprint funding and £28k of Prior year income

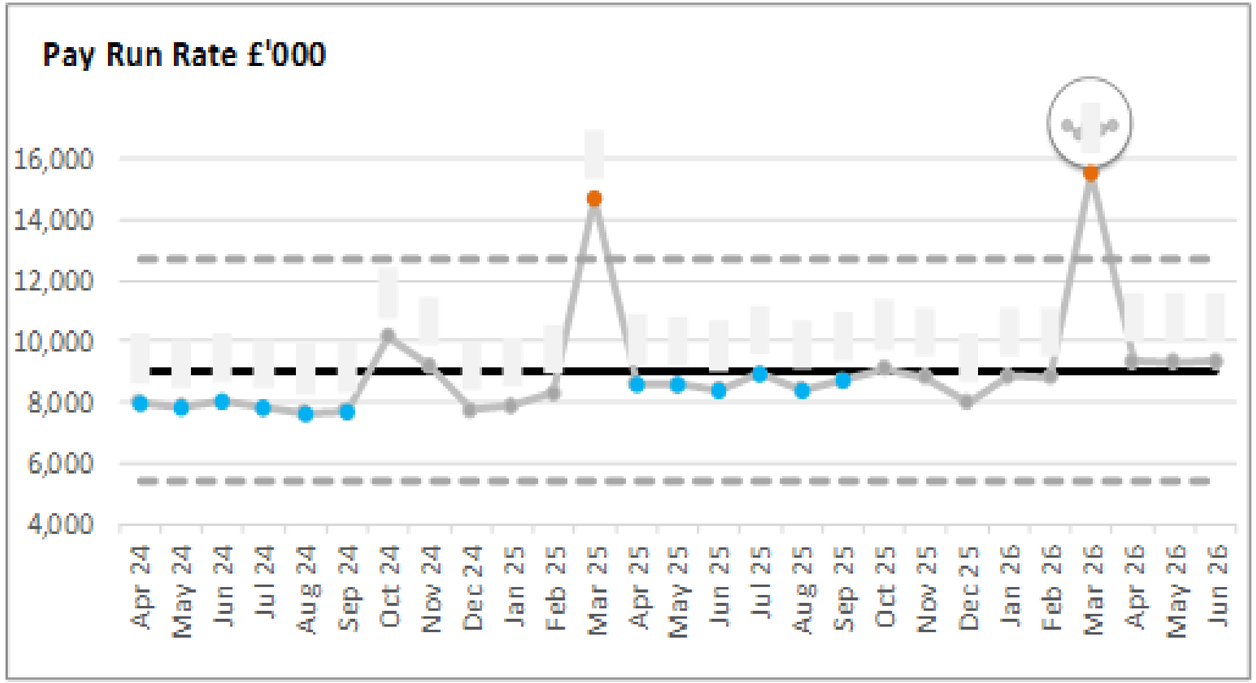
Clinical Income Run Rate

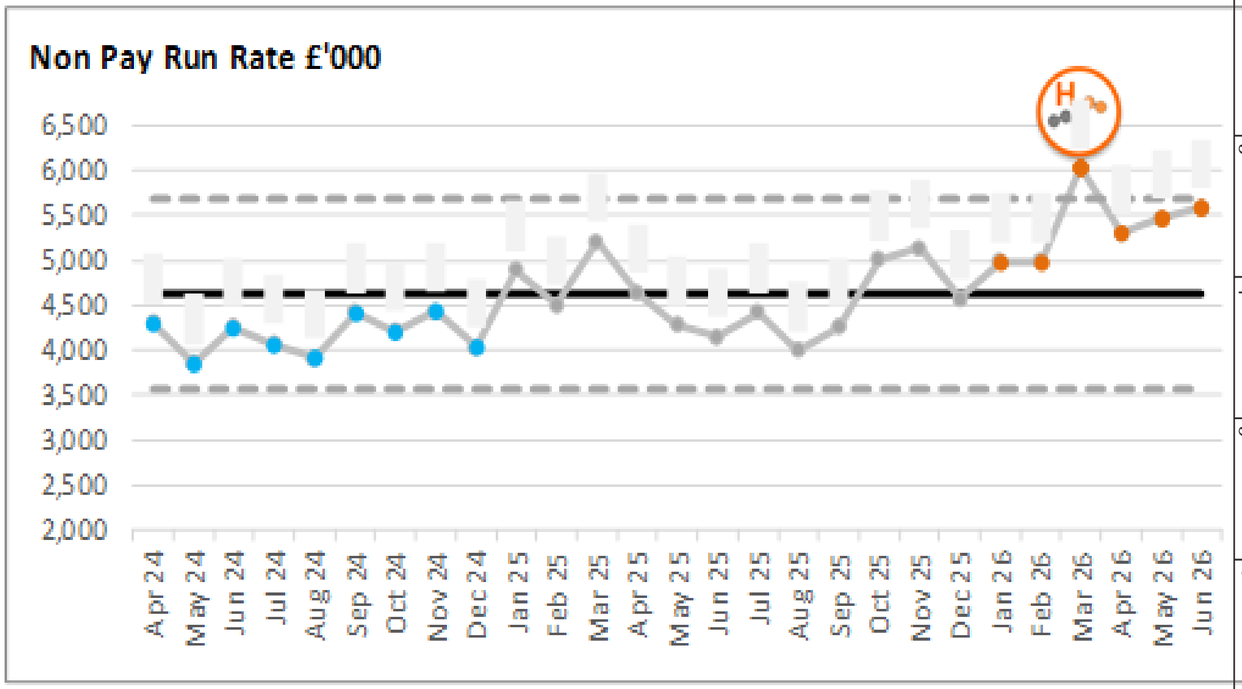
The clinical income run rate is driven by elective activity delivery in month.

The 24/25 assigned cause variation is linked to the cessation of the LLP insourcing contract in 2024.

The March 2026 spike in income is in relation to additional sprint funding and redistributed deficit support funding recognised at the end of the year.

Expenditure Run Rate





Pay Run Rate

The upwards spike in M12 of both years relates to the central pension contribution reported in the Trust accounts.

Enhanced pay controls are in place :

- Vacancies are all agreed through the Vacancies and Temporary Staff Panel
- Clinical and non-clinical overtime, bank and agency are subject to approval by the Vacancies and Temporary Staff Panel
- Agency must operate within the agency caps set by NHSE unless authorised by the CEO

Non-Pay Run Rate

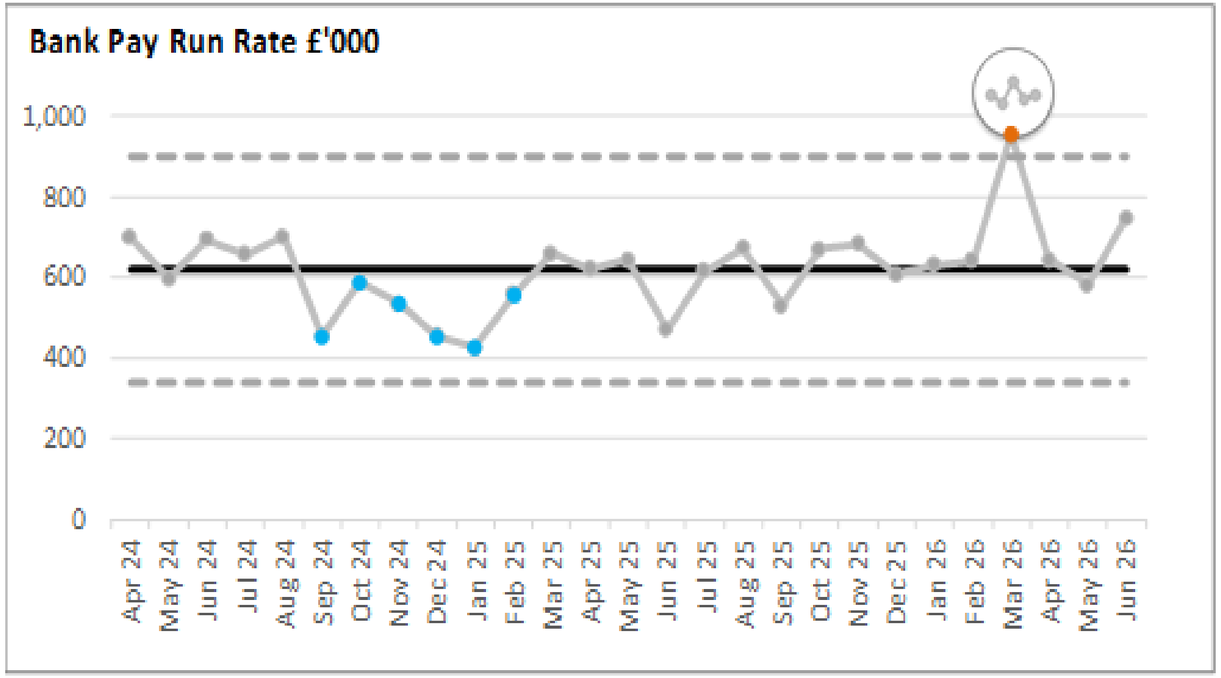
The non pay run rate is showing common cause variation despite the lower than planned levels of marginal cost spend.

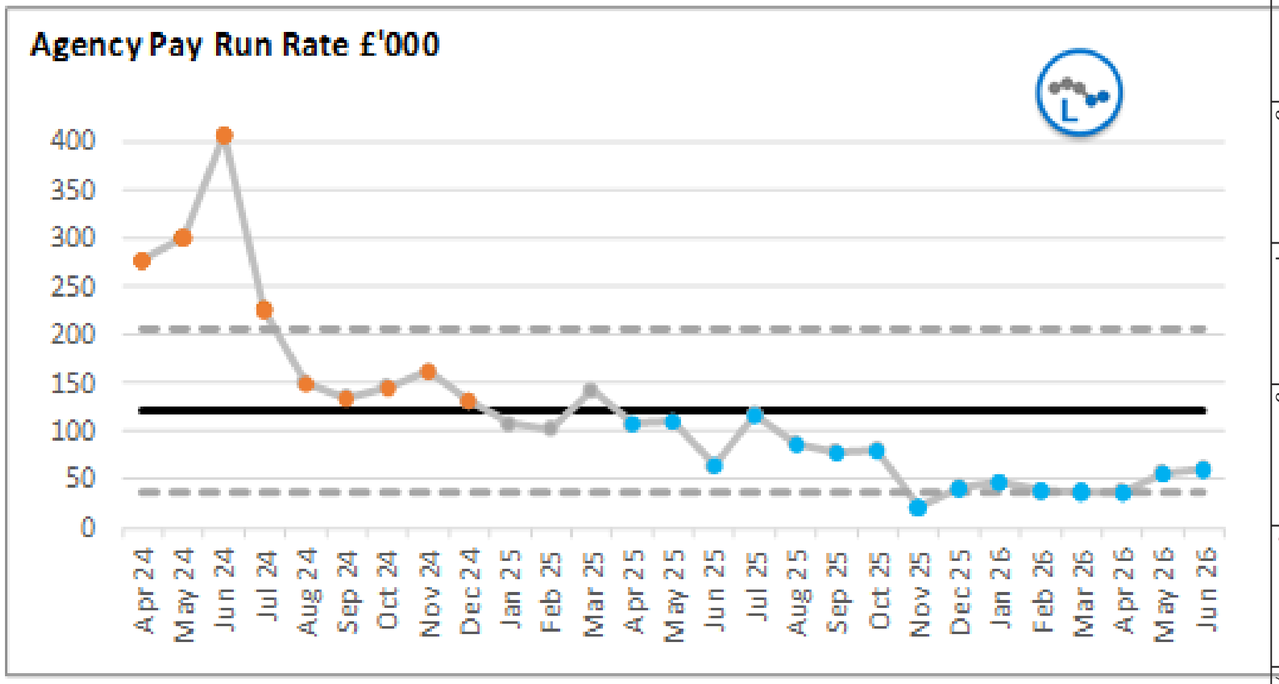
October 25 onwards shows a more normalised run rate driven by the increased activity levels, utilities (linked to phasing in the plan) and award of new insourcing contract. March 26 spike relates to validation sprint, insourcing, consumables and year-end adjustments.

Enhanced controls are in place :

- Non-clinical orders >£10k must be approved by the CFO
- Discretionary non-clinical orders are reviewed by finance before proceeding

Bank & Agency Run Rate





Bank Run Rate

Bank run rate showed assignable cause variation in 24/25 linked to the reduction in bank rates and implementation of enhanced controls. 25/26 shows common cause variation. June 26 spike is linked to high OJP usage and clinical bank supporting the Q4 sprint activity.

Enhanced controls are in place :

- Clinical staff bank is managed through e-roster, shifts are approved by senior members of the clinical nursing team
- Bank shifts are presented to Vacancy and Temporary Staffing Panel weekly as part of the agency request process

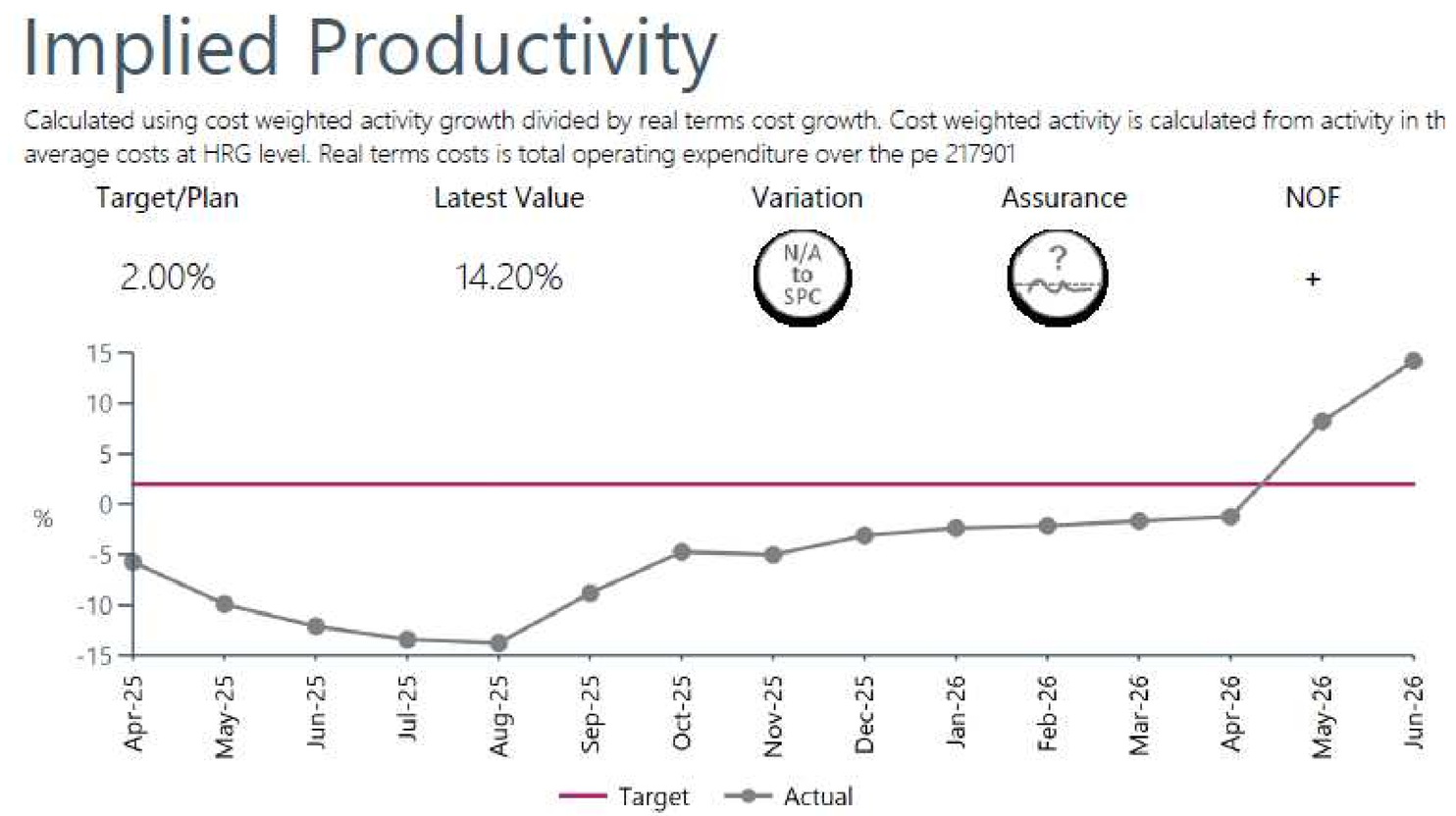
Agency Run Rate

Agency run rate shows assignable cause variation for end of 24/25 and 25/26 due to reduction in usage linked to hourly cap compliance, recruitment, onboarding long term agency and enhanced sign off.

Enhanced controls are in place :

- The engagement of off-framework agency providers is banned as per NHSE guidelines.
- The process of requesting agency staff engagement is set out in the Trust's Agency and Temporary Staffing Policy. 1) Framework suppliers within price cap if no take up of the shift through the bank; 2) Framework suppliers escalated rates for short notice bookings (24-72 hours before shift);
- Sign off arrangements are as follows: If shift is above £100 hour (to be signed off by CEO), If framework shifts exceeds price cap by more than 50% (to be signed off by relevant Exec Director)

Implied Productivity



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 25/26 and 26/27 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 25/26 and 26/27 then divides the two numbers to give a growth %. Spend is adjusted for inflation across periods.

The graph shows the 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 for **June is 14.21%** against the minimum target set by NHSE of 2%. The implied productivity metric indicates that year-to-date activity has increased more quickly than expenditure. However, the measure is sensitive to the comparison period and to changes in activity recording and methodology. The current improvement is influenced by comparison against a prior year period, and the previous year was affected by the Apollo implementation. For this reason, it is more important to look at trends over several months rather than interpreting any single month's result as evidence of a sustained change in productivity.

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

Commissioner Performance

NHS Clinical Income - by Contract									
Contracts	Contract Type	Month 3 - June 2026				2026/27 Month 3 YTD			
		Plan £'000	Actual Exc Pass Through £'000	Pass Through £'000	Variance £'000	Plan £'000	Actual Exc Pass Through £'000	Pass Through £'000	Variance £'000
Shropshire, Telford & Wrekin ICB	API	6,651	6,732	2	82	19,086	19,132	544	590
NHS England Contract (Including Delegated)	API	1,620	1,422	57	-141	4,619	4,072	568	21
Cheshire & Merseyside ICB	API	1,014	1,047	0	33	2,928	3,011	24	107
Staffordshire & Stoke-on-Trent ICB	API	355	305	0	-50	1,017	901	3	-113
Herefordshire & Worcestershire ICB	API	357	369	0	12	1,032	1,068	0	36
Black Country ICB	API	147	127	0	-20	417	431	2	16
Betsi Cadwaladr UHB	API	1,479	1,552	31	104	4,209	4,181	169	141
Powys TLHB	API	993	1,064	6	77	2,812	2,491	115	-206
Hywel Dda UHB	API	58	89	0	31	169	173	10	15
API Contracts Total		12,673	12,706	96	129	36,290	35,460	1,436	606
Low Value Activity (LVA)	Block	394	394		0	1,151	1,151		0
Joint Commissioning Wales (JCW)	Block / NCA	154	154		0	461	461		0
Fixed Contracts Total		548	548	0	0	1,612	1,612	0	0
Other Non Commissioned Activity (NCA)	NCA	13	3	0	-10	39	22	0	-17
Overperformance Reserve / DtB Plan Reduction		559	0	0	-559	1,907	0	0	-1,907
Other		0	0	0	0	0	28	0	28
Other Subtotal		572	3	0	-569	1,945	50	0	-1,896
Total		13,793	13,257	96	-440	39,847	37,122	1,436	-1,290

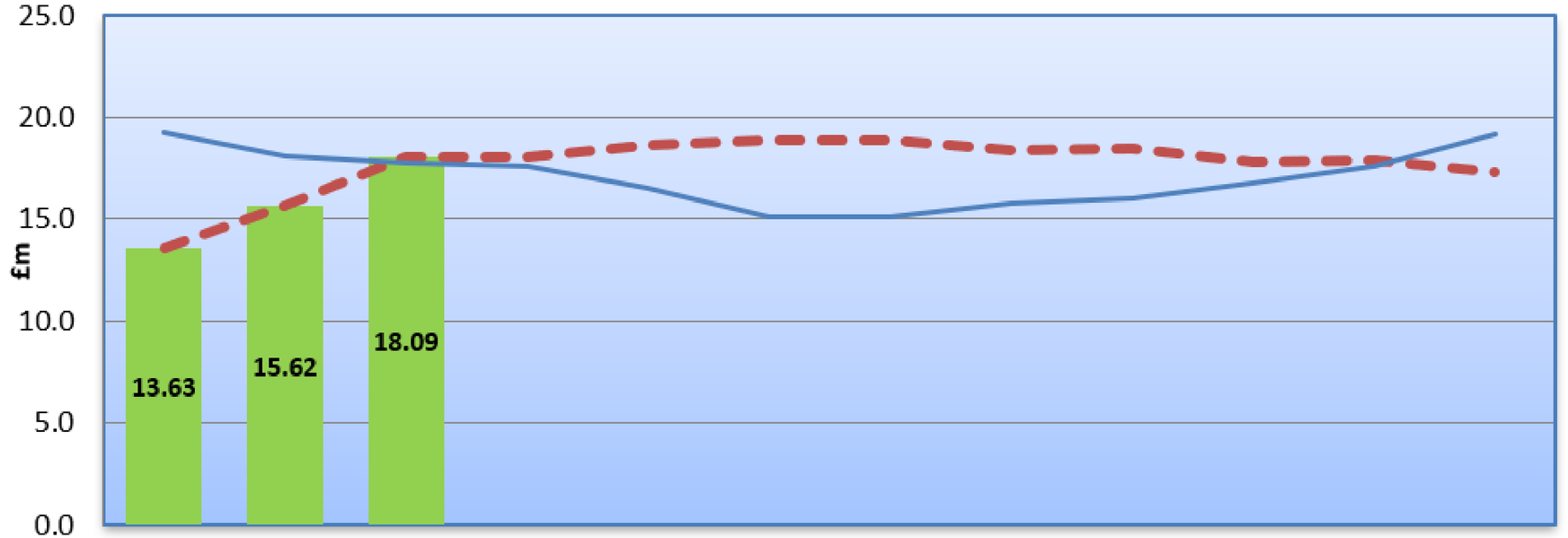
M3 YTD performance £1.29m adverse to plan: £0.23m adverse pass through variance and £1.06m adverse clinical income versus plan

- Largest underperformance is with Powys TLHB £0.21m driven by levels of activity delivery. A revised 2026/27 contract offer was issued to Powys on 16th July with the intention of being presented to Welsh Parliament for access to additional funding which is available to support the health system in Wales. An update will be provided verbally on this if available.

- Overperformance for Shropshire Telford & Wrekin ICB is £0.6m driven by activity mix and the recognition of a £44k allocation for RTT sprint funding in Month 1.

The overperformance reserve represents the planned level of activity within the operational plan which commissioners have not included in contracts. Most commissioners have set up RTT reserves to fund variable activity up to the constitutional standards, this will closely monitored and reported through regular contract meetings with those commissioners.

Cash Position



	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Actual	13.63	15.62	18.09									
Forecast	13.63	15.62	18.09	18.06	18.67	18.86	18.89	18.35	18.47	17.84	17.86	17.30
Plan	19.22	18.11	17.73	17.56	16.52	15.09	15.14	15.78	16.00	16.80	17.59	19.21

- Cash balances increased by £2.2m to £18.1m at the end of June due to performance related payments and LVA income received. This was lower than previously expected and is a payment timing issue on behalf of the commissioners rather than a change or increase in overall income due.

- The year end forecast has been increased by £0.5m to £17.3m following revised commissioner monthly contracts. Some commissioners have already updated their payments in line with national planning guidance (Cost Uplift Factor 26/27). We are waiting for confirmation the final publication of this guidance which will give more certainty to contract uplifts for the year.

Capital Position

Capital Programme Position as at 2627-03								
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
Backlog maintenance	300	30	19	11	60	19	41	400
Digital investment & replacement	400	0	-15	15	100	6	94	400
Capital project management	180	15	17	-2	45	49	-4	180
Equipment replacement	900	60	73	-13	60	97	-37	1,000
Diagnostic equipment replacement	500	210	0	210	210	0	210	500
Compliance (IPC/health & safety/quality)	200	20	11	9	20	11	9	200
Estates reconfiguration	150	20	0	20	40	0	40	150
Developments subject to business cases	1,180	0	8	-8	0	11	-11	1,310
Theatre replacement strategy	2,950	400	165	235	1,200	165	1,035	2,300
Energy/decarbonisation plan (internal)	100	20	0	20	20	0	20	100
Apollo EPR improvement programme	0	0	23	-23	0	68	-68	320
Charitable donations to support capital	150	8	7	1	16	41	-25	150
Rheumatology hub (charitable elements)	800	180	2	178	540	3	537	690
Energy/decarbonisation plan (grant)	2,400	200	300	-100	600	400	200	2,415
Critical infrastructure funding (CIR)	1,304	120	1	119	240	8	232	1,304
Menzies lease	833	0	0	0	0	0	0	833
Leased vehicles & equipment	117	0	0	0	0	0	0	117
Total Capital Funding	**12,464**	**1,283**	**610**	**673**	**3,151**	**878**	**2,273**	**12,369**
Less donated / grant capital	-3,350	-388	-309	-79	-1,156	-444	-712	-3,255
NHS Capital Funding - Charge to CDEL	**9,114**	**895**	**301**	**594**	**1,995**	**434**	**1,561**	**9,114**
Less PDC funded schemes	-1,304	-120	-1	-119	-240	-8	-232	-1,304
Charge to Operational Capital	**7,810**	**775**	**301**	**474**	**1,755**	**426**	**1,329**	**7,810**

Capital expenditure whilst still behind plan increased compared to previous months. £0.6m was spent in month of which £0.3m was on the decarbonisation scheme and £0.2m for the Theatre replacement scheme. A further £0.1m was spend on equipment replacement.

The capital position is currently £2.2m behind plan YTD mainly due to phasing changes on the big construction schemes – theatres and rheumatology.

A revised capital forecast outturn is due to be presented to Capital Management Group in July taking into account potential changes relating to the Menzies lease, and schemes approved through the Capital Prioritisation Group, releasing the centrally held capital provision.

Trust Board - Finance

June 2026 – Month 3

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

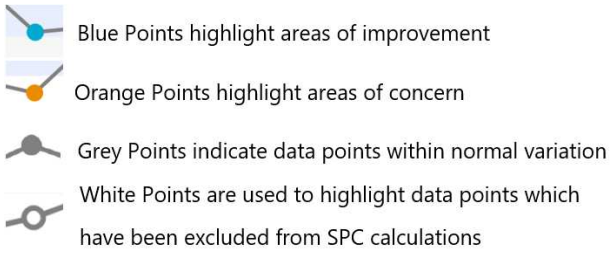
There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

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

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

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



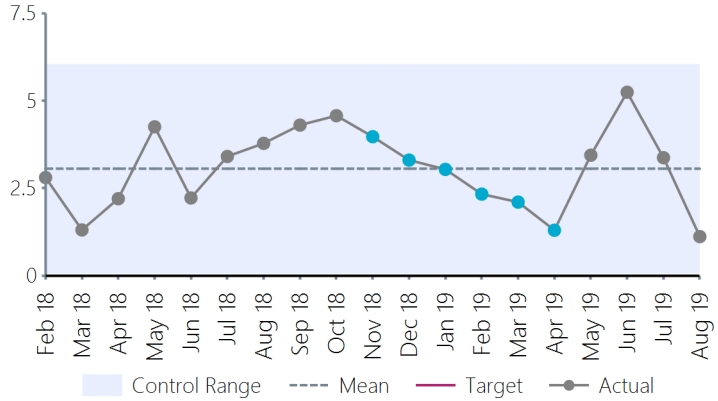
Some examples of these are shown in the images to the right:

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

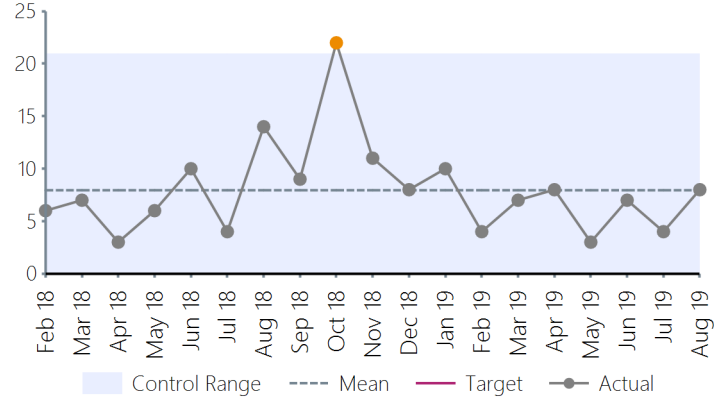
b) shows a point of concern sitting above the control range.

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

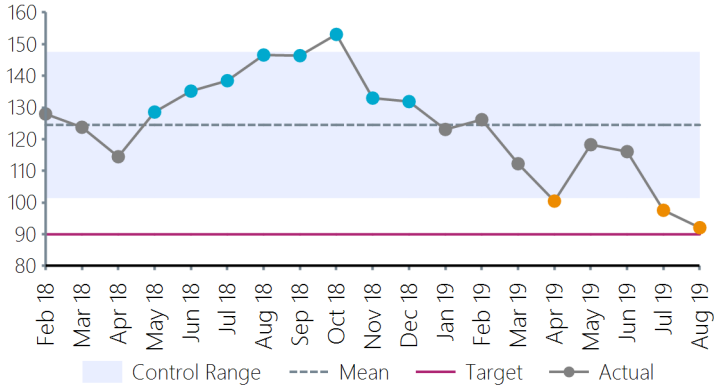
a)



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

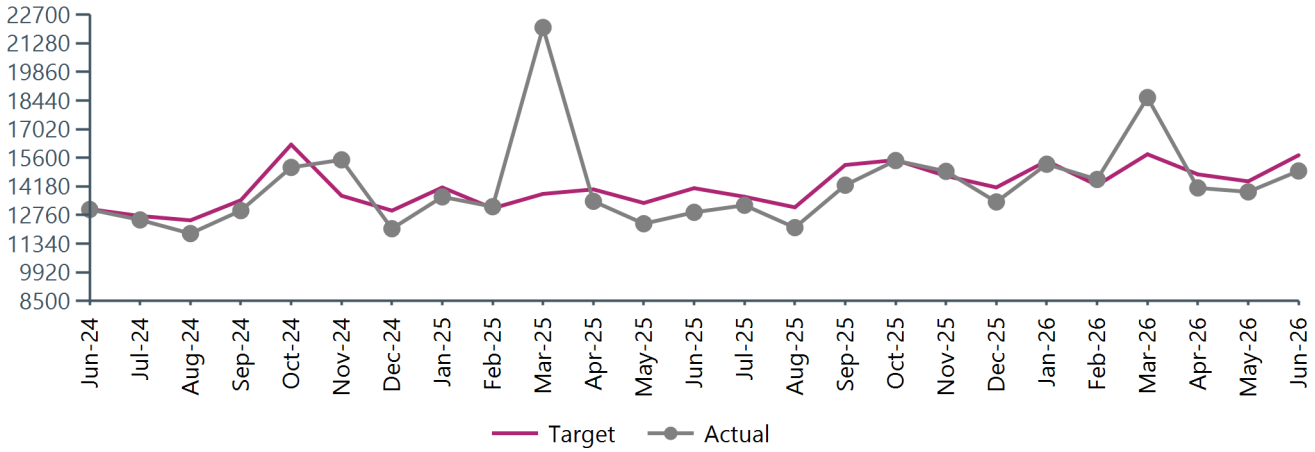
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
Financial Control Total	33.97	8		N/A to SPC	Moving Target			
Income	15,728	14,948		N/A to SPC	Moving Target	+		
Expenditure	15,694	14,938		N/A to SPC	Moving Target			
Efficiency Delivered	641	685		N/A to SPC	Moving Target			
Cash Balance	17,728	18,093			Moving Target			
Capital Expenditure	1,283	610		N/A to SPC	Moving Target			
Performance (£'000k) against Low Value Agreement Block	0.00	12.98		N/A to SPC	Moving Target			
Planned Surplus/Deficit	-1,444.47	-1,414.00		N/A to SPC	Moving Target			+
Variance Year-to-Date to Financial Plan	0	30		N/A to SPC	P			+
Implied Productivity	2.00%	14.20%		N/A to SPC	?			+

Income

All Trust Income, Clinical and Non-Clinical 216333

Exec Lead
Chief Finance & Commercial Officer

Target/Plan	Latest Value	Variation	Assurance	NOF
15,728	14,948	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 income £780k adverse to plan:

NHS Clinical income £526k adverse to plan:
- Theatre performance £312k adverse (94 cases adverse internally & 4 cases favourable insourcing)
- Outpatients and radiology procedures delivery £10k favourable
- Non theatre procedures and stays £101k favourable (driven by metabolic medicine)
- Theatres outsourcing £58k adverse

Non NHS income £254k adverse to plan: driven by shortfalls on private patient delivery partially offset by non recurrent benefit RTA income.

Actions

Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
12895	13246	12137	14242	15463	14928	13410	15282	14527	18589	14106	13910	14948

1	2	3	4	5	6	7	8	9	10

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, 29 July 2026

Author: **Contributors:**

Name: Henrietta Hensher
Role/Title: Executive Assistant

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 Committee meeting held on 24 July 2026. 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, developed in light of national and system priorities, 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, safety and patient experience.	
2	Focus on equity of service and addressing health inequalities	✓
3	Effective engagement with the workforce to support a positive staff experience and a culture of continuous improvement	
4	Delivering financial sustainability	✓
5	Delivering the required levels of productivity, performance and activity	✓
6	Delivering innovation, improvement and growth	
7	The challenges of operating in both the Welsh and English health systems	✓
8	Responding to a significant disruptive event	✓
9	Security of digital, data and AI systems and ability to respond to cyber threats	

Chair's Assurance Report
Finance and Performance Committee

Trust values:

The content of this report reflects / supports the following Trust values:

Trust Values		
1	Professional	✓
2	Excellence	✓
3	Respect	✓
4	Friendly	✓
5	Inclusive	✓
6	Caring	✓

3. Assurance Report from Finance and Performance Committee

3.1 Areas of non-compliance/risk, matters to be addressed urgently, or other significant developments

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;
Represent significant developments / improvements that will help the Trust deliver its objectives; AND / OR
Require the approval of the Board for work to progress.

- **Orthotics:** The Committee discussed the continuing orthotics risk, particularly in relation to diabetic foot patients, and questioned whether the potential for patient harm and service impact now warranted further Board oversight. Members requested further assurance regarding the management of this high-risk cohort and the appropriate governance arrangements for the risk.
- **Operational Performance:** Remains under close review, particularly theatre activity, cancellations, spinal performance and private patient activity. Members requested continued oversight of the improvement programmes already in place and agreed to review progress following the Quarter 2 reforecast.

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:

- **Finance:** Whilst the Trust remains broadly on plan at Month 3, delivery of the efficiency programme requires continued close monitoring. Members recognised that a number of schemes remained high risk and requested that the Quarter 2 reforecast include clearer mitigation and contingency planning to support delivery of the full-year financial plan.

3.3 Areas of assurance

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

- **Board Assurance Framework and Corporate Risk Register:** Continue to be strengthened, including improvements to the presentation of strategic risks and ongoing work to improve the quality of risk reporting and assurance.
- **Capital Management:** The capital programme remains on track and within the approved capital allocation, including the Rheumatology development.

Recommendation

The Board is asked to:
1. CONSIDER the content of section 3.1 and agree any action required;
2. NOTE the content of section 3.2 and CONSIDER whether any further action is required; and
3. NOTE the content of section 3.3.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
DERIC Committee

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 29 July 2026

Author: **Contributors:**

Name: Henrietta Hensher
Role/Title: Executive Assistant

Report sign-off:

Martin Evans, 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 Commercial (DERIC) 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 23 July 2026. 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, developed in light of national and system priorities, 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, safety and patient experience.	
2	Focus on equity of service and addressing health inequalities	
3	Effective engagement with the workforce to support a positive staff experience and a culture of continuous improvement	✓
4	Delivering financial sustainability	
5	Delivering the required levels of productivity, performance and activity	
6	Delivering innovation, improvement and growth	✓
7	The challenges of operating in both the Welsh and English health systems	
8	Responding to a significant disruptive event	
9	Security of digital, data and AI systems and ability to respond to cyber threats	✓

Chair's Assurance Report
DERIC Committee

Trust values:

The content of this report reflects / supports the following Trust values:

Trust Values		
1	Professional	✓
2	Excellence	✓
3	Respect	✓
4	Friendly	✓
5	Inclusive	✓
6	Caring	✓

3. Assurance Report from DERIC Committee

3.1 Areas of non-compliance/risk, matters to be addressed urgently, or other significant developments

ALERT - The 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;
Represent significant developments / improvements that will help the Trust deliver its objectives; AND / OR
Require the approval of the Board for work to progress.

Electronic Patient Record (EPR): September is an important milestone for the EPR programme, with implementation of planned system changes expected to significantly reduce the current high-scoring EPR risks. Whilst confidence in delivery has increased, the Committee recognised that successful implementation and demonstration of improved clinical performance remain essential before assurance can be reduced. The Committee therefore agreed that the EPR Assurance Group should continue until the impact of these changes has been evidenced

Commercialisation Strategy: The Committee reviewed the Trust's Commercialisation Strategy and approved its submission to the Board for consideration on 29th July, subject to a small number of agreed amendments. These are:

- Refining the introductory narrative to better reflect the Trust's wider strategic ambitions rather than focusing primarily on financial pressures.
- Amending the governance diagram to include the Executive Team reporting relationship.
- Reviewing the commercial risk prioritisation matrix to ensure it better reflects the Trust's agreed risk appetite.

Subject to these minor amendments, the Committee recommends the Strategy to Board for approval.

3.2 Areas of on-going monitoring with new developments

ADVISE - The 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:

Research, Capability and Culture Survey for nurses and Allied Health Professionals: The findings of the Research Capability and Culture Survey undertaken across nursing and Allied Health Professional staff were reviewed. Whilst the survey provides an important baseline for future development, it identified opportunities to further strengthen research capability and engagement across these professional groups. A programme of work is being developed to address the findings and progress will continue to be monitored by the Committee.

Integrated Performance Report: The Committee agreed that the current IPR does not sufficiently capture and report on the key areas of performance for the 5 areas of business reported to DERIC and it was requested that further work be carried out, led by Executive leads and to report back in 3 months.

3.3 Areas of assurance

Chair's Assurance Report
DERIC Committee

ASSURE - The DERIC Committee considered the following items and did not identify any issues that required escalation to the Board.
The Innovation and Improvement Strategy: Progress against the strategy was reviewed and the committee was assured of progress being made – highlights included the development of the Innovation Fund, the ongoing work of and support for Improvement Champions and plans for the Improvement Week (14th to 18th September) all of which is helping to embed continuous improvement across the Trust. **Cyber Security**: There are continued improvements in Microsoft Defender security, positive phishing exercise results and ongoing staff awareness training to strengthen organisational resilience. **Board Assurance Framework:** The Committee reviewed BAF 6 and BAF 9 and suggested a review of the rationale for the scoring of BAF 6 and an update of the controls / actions relating to the various strategies overseen by DERIC. **Corporate Risk Register:** The revised format provides clearer alignment between strategic risks, committee oversight and organisational priorities and future reports would be condensed further (to concentrate on key elements of assurance). There were no proposed score changes. **Research update:** Research capacity continues to strengthen through the appointment of an Academic Clinical Lecturer, Professor Geraint Thomas and continued development of the Trust's academic partnerships and research programme.

Appendices: Commercialisation Strategy (private board)

Recommendation

The Board is asked to:

1. CONSIDER the content of section 3.1, approve the Commercialisation Strategy, and agree any further action required;
2. NOTE the content of section 3.2 and CONSIDER whether any further action is required; and
3. NOTE the content of section 3.3.