The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors | Public Meeting

MEETING

3 September 2025 09:30 BST

PUBLISHED

2 September 2025

Agenda

Location	Date	Time
Meeting Room 1, Main Entrance	3 Sep 2025	09:30 BST

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1.4	Action Log / Matters Arising	All Attendees		-
2	Patient Story	Chief Medical Officer	09:35	-
3	Risk Management		09:50	-
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10	Questions from the Governors and Public	Chair	12:15	-
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Member	First Name	Surname	Position	Type of Interest	Description of Interest (including for indirect interests, details of the relationship with the person who has the interest)	Date interest relates From	Date interest relates To	Comments, including action taken to mitigate any potential conflict of interest.
Board	Harry	Turner	Chairman	Non-Financial Personal Interests	Presiding Justice West Mercia judiciary	01/10/2026	Ongoing	
Board	Harry	Turner	Chairman	Financial Interests	In Form Solutions Management Consultancy	01/02/2024	Ongoing	
Board	Sarfraz	Nawaz	Non Executive Director / SID	Financial Interests	Executive Director of Finance at National Citizens Trust	18/09/2023	n/a	No conflict between role at NCS and RJAH
Board	Sarfraz	Nawaz	Non Executive Director / SID	Financial Interests	Wakefield Council – Chief Finance Officer	01/09/2025	Ongoing	
Board	Sarfraz	Nawaz	Non Executive Director / SID	Non-Financial Professional Interests	Member of CIPFA	01/01/2021	Ongoing	
Board	Martin	Evans	Non Executive Director	Financial Interests	Non-Executive Director at North Staffordshire Combined Healthcare NHS Trust	28/08/2024	Ongoing	
Board	Martin	Evans	Non Executive Director	Financial Interests	Director at MJE Associates Ltd.	01/04/2020	Ongoing	
Board	Martin	Evans	Non Executive Director	Financial Interests	Coach for the National Neighbourhood Health Implementation Programme	01/09/2025	Ongoing	
Board	Penny	Venables	Non Executive Director	Financial Interests	Consultant – In-Form Solutions Ltd, Lichfield Business Hub, Lichfield Council House, 20 Frog Lane, Lichfield, Staffordshire, WS13 6YY. Work as a management consultant via this business.	01/01/2021	Ongoing	
Board	Penny	Venables	Non Executive Director	Financial Interests	Trustee Board of Birmingham University Guild of Students	01/01/2025	Ongoing	
Board	Penny	Venables	Non Executive Director	Financial Interests	Member of the Members Council of the West Bromwich Building Society	01/10/2024	Ongoing	
Board	Penny	Venables	Non Executive Director	Non-Financial Professional Interests	Non-Executive Director – British Dietetic Association, 3rd Floor Interchange Place, 151 – 165 Edmund Street, Birmingham B3 2TA. Sit on the Board of Directors of the BDA.	01/06/2020	01/10/2024	
Board	Penny	Venables	Non Executive Director	Non-Financial Personal Interests	Chair Sandwell Leisure Trust, Tipton Sports Acadamy, Wednesbury Oak Road, Tipton, West Midlands DY4 0BS.	01/11/2023	Ongoing	
Board	Martin	Newsholme	Non Executive Director	Financial Interests	Non executive director of Shropshire Doctors Co-operative Limited	01/08/2019	Ongoing	To my knowledge Shropdoc and RJAH do not trade with each other
Board	Martin	Newsholme	Non Executive Director	Financial Interests	Non executive director at Warrington Housing Association	01/09/2018	Ongoing	Warrington Housing is not in the healthcare section and doesn't trade with RJAH
Board	Lindsey	Webb	Non Executive Director	Indirect Interests	Husband is a NED at Birmingham and Solihull ICB		Ongoing	
Board	Darius	Mirza	Non Executive Director	Financial Interests	Chair, SPLIT Charity – Supporting Paediatric Liver and Intestinal Transplantation, Birmingham	02/02/2016	Ongoing	No Conflict
Board	Darius	Mirza	Non Executive Director	Financial Interests	Trustee – THTPF (Transplants Help the Poor Foundation, Mumbai, India)	01/04/2016	Ongoing	No Conflict
Board	Darius	Mirza	Non Executive Director	Financial Interests	Vice Chair, George Eliot School Board of Governors, Nuneaton	01/04/2023	01/04/2026	No Conflict
Board	Darius	Mirza	Non Executive Director	Financial Interests	Shareholder, Organox Ltd, Oxford (Machine Perfusion Device Manufacturer, Oxford)	01/09/2018	Ongoing	No Conflict
Board	Paul	Maubach	Associate Non Executive Director	Non-Financial Professional Interests	Member of CIPFA	01/03/2023	Ongoing	
Board	Paul	Maubach	Associate Non Executive Director	Financial Interests	Senior Advisor for Primary Care (Department of Health	01/03/2023	31/07/2024	
Board	Paul	Maubach	Associate Non Executive Director	Financial Interests	Senior Advisor for Neighbourhood Health (Department of Health	01/08/2024	Ongoing	
Board	Paul	Maubach	Associate Non Executive Director	Financial Interests	Director and Owner of Maubach Consulting Ltd – through which I provide management consulting and advisory services to different organisations.If it transpires either at a committee or Board meeting of the Trust, the meeting is either discussing or engaging with an organisation that my company is also engaged with, then I will declare a potential conflict of interest to the Chair.	01/03/2023	Ongoing	
Board	Atif	Ishaq	Associate Non Executive Director	Financial Interests	Data Product Director at Haleon Plc	01/01/2022	01/01/2025	
Board	Atif	Ishaq	Associate Non Executive Director	Financial Interests	Enterprise AI & Advanced Analytics Director at Mars Inc	04/2025	Ongoing	
Board	Atif	Ishaq	Associate Non Executive Director	Financial Interests	Owner of Digital Clinician Ltd	01/01/2018	Ongoing	
Board	Atif	Ishaq	Associate Non Executive Director	Financial Interests	Digital Advisor and Webmaster to Pharmacy Care Matters LTD	01/01/2011	17/07/2025	
Board	Atif	Ishaq	Associate Non Executive Director	Financial Interests	Digital Advisor and Webmaster to Quest Legal Advocates LTD	01/01/2011	Ongoing	
Board	Atif	Ishaq	Associate Non Executive Director	Financial Interests	Webmaster for Shrawley, North Claines and Hanbury Parish Councils	01/01/2011	Ongoing	
Board	Atif	Ishaq	Associate Non Executive Director	Financial Interests	Self-employed webhosting provider	01/01/2011	Ongoing	
Board	Atif	Ishaq	Associate Non Executive Director	Non-Financial Personal Interests	Justice of the Peace for West Mercia Judiciary	01/01/2017	Ongoing	
Board	Stacey	Keegan	Chief Executive Officer	Non-Financial Professional Interests	STW ICB Partner Member	01/07/2022	Ongoing	
Board	Stacey	Keegan	Chief Executive Officer	Non-Financial Professional Interests	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	Withdraw from discussions as appropriate.
Board	Ruth	Longfellow	Chief Medical Officer	Financial Interests	Member of GAS (Gobowen Anaesthetic Services)	01/11/2019	01/06/2025	GAS was set up as an LLP, but no longer functions as an LLP since the recent pension rule changes
Board	Mike	Carr	Chief Operating Officer	Indirect Interests	Parent is Chief Executive of Midlands Partnership NHS Trust.	01/05/2022	Ongoing	Withdraw from discussions as appropriate.
Board	Mike	Carr	Chief Operating Officer	Non-Financial Personal Interests	Member of the Labour party.	01/01/2017	Ongoing	Withdraw from discussions as appropriate
Board	Mike	Carr	Chief Operating Officer	Non-Financial Personal Interests	Trustee at Stay Charity	01/02/2025	Ongoing	Withdraw from discussions as appropriate
Board	Denise	Harnin	Chief People and Culture Officer	Non-Financial Personal Interests	Spouse is a senior partner at Johnson Fellows Charter House, Birmingham, Ad hoc HR consultancy Johnson Fellows		Ongoing	
Board	Angela	Mulholland-Wells	Chief Finance and Commerical Officer	Non-Financial Professional Interests	Board Trustee and chair of the Audit, Finance and Risk Committee for Mines Advisory Group.	01/10/2023	Ongoing	
Board	Paul	Kavanagh-Fields	Chief Nurse and Patient Safety Officer	Non-Financial Professional Interests	Chair of the NOA workforce network	01/06/2024	Ongoing	
Board	Paul	Kavanagh-Fields	Chief Nurse and Patient Safety Officer	Non-Financial Professional Interests	Member of the Cavell Advisory Panel, supporting a UK charity that assists nurses, midwives, and maternity support staff facing financial hardship.	01/10/2024	Ongoing	

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING
WEDNESDAY 02 JULY 2025 AT 09:30AM IN BOARD ROOM AT RJAH
MINUTES OF MEETING

Voting Members in Attendance

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

Others in Attendance

Name	Role	Attending
Paul Maubach	Associate Non-Executive Director	✓
Atif Ishaq	Associate Non-Executive Director	✓
Denise Harnin	Chief People and Culture Officer	✓
Kirsty Foskett	Assistant Chief Nurse and Patient Safety Officer	✓
Dylan Murphy	Trust Secretary	✓
Mary Bardsley	Assistant Trust Secretary (minute secretary)	✓
Chris Hudson	Head of Communications	✓
Colin Chapman	Governor (observing)	✓
Kate Betts	Governor (observing)	✓
Jan Greasley	Governor (observing)	✓
Karina Wright	Governor (observing)	✓

Ref	Discussion and Action Points
1.0	**Welcome and introductions**
	The Chair welcomed all attendees to the meeting. HT encouraged the Board to take a moment to acknowledge the profound loss the Trusts has experienced with the passing of our Interim Chief Nurse, Sam Young. Sam was not only a dedicated and compassionate leader, but also a driving force behind several key initiatives that have left a lasting impact on patient care and staff wellbeing across the Trust. Her commitment to improvement work, especially around clinical safety and nursing development, was both visionary and deeply rooted in her values. Sam's presence, leadership, and warmth will be greatly missed by all of us. HT invited invite all the members of the meeting to joining in a one-minute silence to reflect on Sam's memory and the legacy. It was confirmed that the staff across the Trust have also been invited to share in this moment.
1.1	**Apologies**
	Apologies for absence were received from Lindsey Webb and Paul Kavanagh-Fields. On behalf of the Board, HT extended a warm welcome to KF, who joined the meeting as the representative for the nursing portfolio. HT also welcomed Mr Nigel Kiely who joined to present a service story. It was formally confirmed that the Board was quorate, enabling the meeting to proceed with full decision-making authority.

Ref	Discussion and Action Points
1.2	**Declarations of Interest**
	The Chair reminded attendees of their obligation to declare any interest which may be perceived as a potential conflict of interest with their Trust role and their role on this Board. There were no conflicts of interest identified in relation to the items for discussion which required members to withdraw from discussion or decision-making.
1.3	**Minutes of the previous meeting**
	The minutes of the Board of Directors (Public) Meeting held in May 2025 were approved as an accurate record subject to the following amendments: • Attendance table – include AMW and MS • Attendance table – remove Craig Macbeth
1.4	**Matters Arising and Action Log**
	There were no further matters to raise. The Board agreed to close the action as it was confirmed this was presented through to the Quality and Safety Committee.
2.0	**Staff Story**
	RL introduced Nigel to the Board, who joined the meeting to share his experience on a Mercy Ship. The following key points were noted: **Motivation and Background** • Inspired by stories from Mercy Ships and people working abroad. • Felt personal skills (e.g., accounting) could be useful in charitable work. • Motivated by wife's involvement in refugee charity work and public recognition. • Decided to volunteer with Mercy Ships, a large hospital ship organization. **Journey to the Ship** • Travel involved multiple flights and a boat journey to reach the ship near Freetown. • First impressions of the ship: large, modern, 12 decks, well-equipped. • Welcomed warmly with personalized touches (e.g., welcome pack). • Expected rough accommodations but found it civilised and comfortable. **Life in Freetown** • City described as squalid but full of character and friendly people. • Beaches and tourist attractions exist but are often littered. • Social life includes pizza nights, running clubs, and Liverpool FC-themed restaurants. • Security and safety were well-managed. **Mercy Ships Operations** • Large international team from various countries (USA, Netherlands, Nigeria, Malaysia). • Patients selected from countryside and brought to the ship for treatment. • Ship equipped with 6 wards, ICU, CT scanner, Rehabilitation unit and clinics for nutrition, malaria, HIV testing • Pre-op assessment is thorough; physical ability to climb gangway is essential. **Surgical Work** • Focus on treating children with severe lower limb deformities. • Operations often simple but life-changing. • One-shot surgery approach due to lack of follow-up opportunities. • Post-op care includes therapy and rehabilitation onboard. • Example: a girl with a long-standing stiff knee was successfully treated. **Teamwork and Environment** • Strong emphasis on teamwork and flexibility. • Everyone focused on one task—helping patients. • No cancellations; operations proceeded smoothly. • Leadership and coordination were effective and respectful. • Weekly safety training and emergency drills. **Challenges and Reflections** • Application process was complex and demanding. • Cultural and lifestyle adjustments required. • Ship life was rigorous with many rules. • Mercy Ships is a religious (evangelical) organization, which felt unfamiliar. • Despite challenges, the experience was deeply rewarding.

Ref	Discussion and Action Points
	• Expressed desire to return and encouraged others to consider volunteering. Following the presentation, the Board discussed the lessons learnt. It was noted to be a very different environment compared to working at the Trust and the members of the meeting discussed the lessons learnt which could be considered or adapted by the organisation. There was a focus on getting patients into theatre quickly and the action for running two theatres simultaneously along with minimising distractions. Along with the efficient pre-operative system in place, with cancellations being swiftly replaced. Overall, a strong team ethos was noted, with emphasis on leadership and shared goals. The Board also discussed team familiarity, noting that some surgeons at RJAH often work with changing teams. It was confirmed that at the Trust a morning introduction is completed as part of the safety huddle this was also a similar approach used on the Mercy Ships. The Board expressed their gratitude to Nigel for taking the time to share his insights before also extended their best wishes for his upcoming return to Mercy Ships in January.
3.0	**Chair and CEO Update**
	Chair Update HT provided the Board with the following updates: • **CQC -** thank you to all the teams who hosted the recent CQC visit in May. The Trust have received positive feedback on the day, which has since been confirmed in the follow-up letter. We are currently awaiting the final report. The Well-Led Review was originally scheduled for 8–10 July. However, in light of Sam's passing, this has been postponed. In May, the Board was also observed by the Value Circle, who supported us with a mock CQC inspection. An action plan will be developed based on the feedback received and will be progressed accordingly. • **NHS Confed -** HT attended the NHS Confederation meeting, including the Chair's Lunch, where key themes around system transformation were discussed. The message from Jim Mackey remained consistent with his previous communications, reinforcing the need for agility and responsiveness as the NHS continues to evolve. A significant point of discussion was the shift in system accountability, with Trusts now directly accountable to NHS England. One of the central messages from the meeting was the reinvention of outpatient services, highlighting the importance of using data to support and drive organisational change. • **National Operational Framework -** has been published and was circulated last week. It outlines approximately 28 metrics, and the team is actively working to develop an oversight dashboard to ensure alignment with relevant committees and governance structures. This work is ongoing and will continue to evolve as the framework is embedded. • **John Pepper –** HT informed the Board that Associate Non-Executive Director John Pepper's term has now concluded, and he is no longer a member of the Board. The Board extended its sincere thanks to John for his valuable contributions during his tenure and wishes him all the very best for the future. • **NED recruitment** - An offer has been approved by the Council of Governors, with the intention for the candidate to join the Board by the end of July, subject to the completion of the required checks. HT has confirmed that further information will be provided once these checks are complete There were no specific questions raised following the update. **CEO Update** SK commenced her report by acknowledging the passing of Sam and sharing the following words: *'We are deeply saddened by the recent passing of our Interim Chief Nurse, Sam Young, following a tragic accident. Sam had served the Trust for many years in senior nursing roles, and her sudden loss has come as a profound shock to colleagues across the organisation. Sam was an exceptional and supportive colleague, valued by fellow Board members and respected by staff at every level of the Trust. She was held in the highest regard, not only for her outstanding clinical expertise and unwavering commitment to patient care, but most of all for the warmth and integrity of her character. Sam was kind, compassionate, and brought a sense of joy and humanity to every interaction. Sam's absence will be felt deeply. In the days and weeks ahead, we will find meaningful ways to honour Sam's legacy and celebrate the life of someone who made such a lasting impact on us all.'*

Ref	Discussion and Action Points

	SK continued to highlight the following from the report:
	• **Performance** – The Trust continues to work diligently to mitigate long waiting times. Further updates and progress will be shared throughout today's meeting
	• **NHS 10 year plan** – The Trust welcomes the anticipated release of the new NHS 10-Year Plan, expected tomorrow. A CEO briefing has been scheduled for this evening to provide early insights.
	• **NHS operating model** – The dissolution of NHS England remains scheduled for October 2026. In the interim, NHSE and DHSC teams are working more closely together, although progress is occurring at a potentially slower pace than initially anticipated. Cluster arrangements within the system are still under consideration, with future structures yet to be confirmed
	• **National Oversight Framework** - Some of our team members have early access to NOF data and are supporting efforts to ensure data accuracy. The Trust are currently reviewing the data sign-off process to improve its robustness and reliability.
	• **National Orthopaedic Alliance** – In May, SK attended the NOA Annual Conference, where orthopaedic colleagues from across the UK came together to share insights, best practices, and challenges. The event highlighted opportunities for collaboration to enhance orthopaedic care and outcomes. Congratulations to all colleagues who were shortlisted for awards and showcased their exceptional work.
	• **Federation of Specialist Trust** – The report titled *"The Power of Specialism"*, produced by members of the Federation of Specialist Hospitals, is currently under discussion within NHSE. The report aims to inform the forthcoming NHS 10-Year Plan. As a member of the Federation, our Trust has contributed to both the report and a series of supporting case studies that provide evidence and context for further dialogue.
	• **CQC** – Thank you to all teams for their resilience during the launch of Apollo. Despite the pressures, we welcomed guests and visitors, using the opportunity to showcase our work. We now await the full CQC report.
	• **Apollo** - The Trust is now in the seventh week since the launch of our Apollo Electronic Patient Record system. While the transition has presented challenges, I recently wrote to staff acknowledging the stress and difficulties experienced. Apollo offers significant opportunities, and the Apollo Team is actively working to address issues and improve the user experience.
	• **Freedom to Speak Up (FTSU)** – The Trust is pleased to announce the appointment of Dylan Murphy, Trust Secretary, as the new Executive Lead for Freedom to Speak Up. Dylan will work closely with Liz Hammond (FTSU Guardian), Sarfraz Nawaz (FTSU Non-Executive Lead), and our network of FTSU Champions to continue fostering a culture of openness and support.
	• **Supporting Patients on their Pathway Award** - Congratulations to our Paediatric Team for winning the *Supporting Patients on Their Pathway Award* at the prestigious NOA Excellence in Orthopaedics Awards. Their work in enhancing the pre-admission and procedural experience for children has significantly transformed pre-operative care for young patients and their families.
	• **New diabetic foot service** – The Trust has launched a new minor diabetic foot service in partnership with The Shrewsbury and Telford Hospital NHS Trust (SaTH). This service provides essential surgical interventions, such as toe tenotomies, for diabetic patients with tendon-related foot conditions, helping to prevent complications such as ulcers and infections.
	• **STAR Award** - Each month, SK has the pleasure of presenting the RJAH Stars Award to an individual or team in recognition of exceptional achievement or performance. Since our last public Board meeting, we've celebrated two outstanding winners:
	  • June Winner: Louise Naylor, Ward Manager, Baschurch Day Unit Louise received an incredible 13 nominations from her team, all highlighting her exceptional support during the rollout of our Apollo Electronic Patient Record. Her colleagues praised her unwavering dedication—often arriving early, staying late, and working additional hours to ensure the ward was fully prepared for the transition.
	  • May Winner: Kirsty Sperring, Healthcare Assistant, Main Outpatients Kirsty was recognised for her compassion and professionalism after going above and beyond to support a patient with complex safeguarding needs. During an evening

Ref	Discussion and Action Points
	clinic, she identified concerns when an unaccompanied patient arrived and took immediate action to escalate the situation. Congratulations to both Louise and Kirsty—your dedication and care truly embody the spirit of the RJAH Stars Award. The Board discussed the following: • **ICB restructure** – A query was raised regarding the extent to which stakeholders have a voice in the ongoing ICB restructure, and whether there are formal mechanisms in place to share views. It was noted that private Board sessions have taken place, during which preliminary discussions have occurred. PwC has been engaged to support a comprehensive review within the Integrated Care System (ICS). While there is a stated commitment from the system to engage and secure support from provider organisations, this is anticipated to take place following the formal confirmation of cluster arrangements • **Apollo** – the communication issued to staff regarding the Apollo programme was positively received and commended. The letter was recognised for its clarity and tone, reflecting a thoughtful approach to staff engagement. • **Diabetic foot service** – Chris Marquis and Cat Heaver attended the DERIC meeting to deliver a presentation on the diabetic foot service. The presentation highlighted the need for robust data collection in health inequalities. The Board noted the updates from both the Chair and CEO.
5.2	**System Integrated Improvement Plan**
	DM presented the paper to the Board, highlighting the following key points Executives from RJAH were invited to attend a session hosted by NHS England (NHSE) and the Integrated Care Board (ICB) on 3 October 2024. The purpose of the session was to discuss RJAH's contribution to the "system transition plan." This transition involves moving the ICB and SaTH from Level 4 to Level 3 of the NHS Oversight Framework (NOF), making it a system-wide initiative. The transition plan focuses on five key areas: finance, workforce, urgent and emergency care (UEC), governance, and leadership. This plan has been regularly reviewed at both the Board and committee levels. A summary of the plan is included within the associated action plan, which is considered a working document that reflects a specific point in time. Progress within the plan is color-coded: • Blue indicates actions that are completed and supported by evidence. • Green shows actions that are on track for completion but are still awaiting evidence. • Red highlights issues within the UEC section, where actions are dependent on SaTH and therefore outside RJAH's direct control. • Amber relates to the development of a system-wide risk governance policy. While providers are aligned in principle, overarching documentation is still required. The Board discussed the following: • Where actions fall within RJAH's remit, the Trust is making good progress against the plan. However, challenges within the wider system have been noted, and there is uncertainty regarding how long the current transition requirements will remain in place • On page 89 of the pack, the engagement strategy is referenced. It is noted that RJAH's engagement strategy needs to align with the system-wide plan, although a separate engagement strategy currently exists. This strategy outlines how RJAH connects with providers and partners, and whether a working group would be beneficial. The Trust agreed to consider this outside of meeting. The Board acknowledged the progress.
3.2	**ROH Memorandum of Understanding with ROH**
	The proposed MoU establishes a strategic alliance between The Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH) and The Royal Orthopaedic Hospital (ROH) to provide a framework for collaboration on specific joint projects. Both organisations have a history of successful cooperation, and staff across both trusts already maintain strong, positive working relationships. This framework is designed to formalise and support these existing connections.

Ref	Discussion and Action Points
	SK informed the Board of the following: • The proposed objectives and benefits of this alliance are currently in development and will be refined collaboratively. These will guide our shared efforts and ensure alignment with both trusts' strategic priorities. • Initial governance arrangements have been suggested; however, further work is required before these can be finalised. • The MoU was approved at ROH's recent public Board meeting. • RJAH is now asked to consider and approve the MoU, noting the proposed next steps. • A joint communications plan has been drafted by RJAH and ROH highlighting the requirement to ensure aligned to the NHS long-term plan which is expected to be circulated by Monday. The Board discussed the following: • Noted that the initiative is supported by NHS England (NHSE) • Acknowledged the strong working relationships exist at both Board and operational levels. • Proposed for 12 months review of the MoU is completed from the date of approval, subject to agreement with both partners. The Board approved the MOU and welcomed the collaborative working.
3.3	**Corporate Objectives 2024/25 End of Year report**
	The Trust has reviewed progress against the 2024/5 objectives and summarised within the attached Corporate Objectives – End of Year Report. The report is an opportunity to reflect on the achievements that the Trust has made against all 5 strategic objectives. Key areas to highlight included: • The Trust has taken an increasingly proactive leadership role in the development of MSK services across Shropshire, Telford and Wrekin and will we moving to a shadow MSK lead provider role in 2025/26. • The Trust has reviewed and approved supporting strategies across multiple domains, ensuring alignment to the overarching trust strategy. • The Trust opened a new operating theatre in November 2024 increasing the Trust's surgical capacity. • The Trust has re-signed the Armed Forces Covenant pledging its support to people who are serving in, or who have served in the Armed Forces • Organisational structure changes agreed to strengthen Commercial arm of the organisation through appointment of a Chief Finance and Commercial Officer and approval to recruit to a new commercial post. **Draft Corporate Objectives 2025/26** The 2025/26 draft Corporate Objectives are being presented to the Board for approval. The Corporate Objectives being presented to the board reflect the feedback from Board members, Senior Managers and Senior Clinicians following the Board Strategy Development workshop held in February 2025. Key points to note included: • The objectives have been informed by multiple sessions, including the Board meeting, Executive Governance meeting, and Executive Team meeting. Efforts were made to consolidate and streamline input from these discussions. • A strong emphasis has been placed on performance-related elements, reflecting the organisation's commitment to performance recovery and improvement. • The objectives represent a balance between maintaining core business operations and driving forward strategic progress. • There is a recognised need to align delivery leads with the appraisal process to ensure accountability and integration. • Consideration should be given to the governance and oversight mechanisms that will support the delivery of these objectives. The Board is asked to: • Note the year-end report.

Ref	Discussion and Action Points
	• Approve the Corporate Objectives for 2025/26. The Board discussed the following: • Concerns were raised in relation to how the corporate objectives can be effectively embedded into individual personal objectives, acknowledging that the approval of the revised objectives today may not allow sufficient time for to achieve. However, it was acknowledged that certain elements, such as performance, are already integrated into staff appraisals and are being actively progressed. The Board agreed to reflect further on this point. • The Board welcomed the inclusion of specific objectives related to performance and highlighted that the forthcoming 10-year plan will incorporate these elements, potentially aligning with neighbourhood delivery strategies. A period of reflection is anticipated in the coming weeks as the 10-year plan is circulated, with the possibility of additional objectives being included. • The Board expressed appreciation for the corporate objectives and emphasised the importance of deliverables. Greater insight into departmental clinical strategies was requested and suggested that the board hold a dedicated session to review and understand the strategic development process, particularly in relation to business case approvals. • It was noted that should be reference within the objectives an enabling platform, is not currently included. It was agreed that this would be considered, with further reflection to take place in the context of the Board Assurance Framework (BAF), where Apollo will be addressed. • The Trust acknowledged the title, and names were to be revisited. The Board approved the corporate objectives 2025/25 subject to further reflection on the 10-year plan.
4.0	**Quality and Safety**
4.1	**Performance Report – Quality and Safety Committee**
	The following points were highlighted from the Quality and Safety performance report (by exception only): • **Complaints** - The Board received an update on patient complaints for the reporting period, with a total of 20 complaints formally logged. 9 complaints were related to concerns about the quality of care or issues with planned care pathways. 6 complaints pertained to appointment cancellations, which have been flagged as a recurring theme. The Board acknowledged the impact of these issues on patient experience and emphasised the importance of timely resolution and communication. It was confirmed that learning has been identified from the complaints received, and this is being actively fed into service improvement initiatives. The Quality and Safety Committee is currently awaiting a comprehensive review, including a deep dive analysis, to better understand the underlying causes and to inform targeted interventions. This work is aligned with the Trust's commitment to continuous improvement and patient-centred care. • **Surgical Site Infections (SSI)** – there has been a notable increase in Surgical Site Infections was reported in May, with cases traced back to procedures conducted in March and April. All affected cases have undergone detailed clinical review. No breaches in decontamination protocols were identified, and the Trust's infection prevention and control measures were found to be compliant. . • **Unexpected Patient Death** – there has been one unexpected patient death was reported during the period. The incident has been escalated and is currently under review in line with the Trust's Framework. The Board expressed condolences and reaffirmed its commitment to transparency and learning from adverse events.
4.2	**Chair's Assurance Report – Quality and Safety Committee**
	PV highlighted the following key points from the Quality and Safety Committee Chairs Assurance report: • **Apollo Programme** - the Committee received assurance regarding the clinical safety case for the Apollo programme, which remains a live document. It will be re-presented to the Committee in due course. The technology log and mitigation plans are being

Ref	Discussion and Action Points
	continuously updated. The Committee will continue to request relevant information at future meetings. The significant amount of work being undertaken was acknowledged, and the importance of clear and effective communication was noted. • **Orthopaedic Tissue Samples - a**n audit of orthopaedic tissue samples is currently underway, led by the Research Manager. Assurance reporting is being channelled through DERIC. Pending the outcome of the review, the service has been temporarily suspended. • **Quality Accounts 2024/25**– the Committee endorsed the Quality Accounts which is recommended to the Board for approval • **Complaints Deep Dive – the Committee requested a** thematic deep dive has been requested for the July meeting to explore complaint in greater detail. • **Annual Reports** – the Committee consider a number of annual reports have been reviewed and subsequently passed on to the Board for further consideration. • **Chair Report from Safeguarding Meeting – the committee requested** An update on safeguarding training is scheduled to be presented at the August meeting due to the lack of compliance reported at the People and Culture Committee. • **Psychological Support Action Plan** –the Committee has requested a broader, Trust-wide action plan in response to the review of the tumour bone action plan, with a particular focus on psychological support. • **JC Laboratory Business Case - t**he business case for the JC Laboratory is being prepared and will be presented to DERIC for consideration. The Board discussed the following: • There has been a noticeable increase in complaints and emphasised the importance of actively listening to patients. A specific update has been requested for the next public Board meeting via the Committee Chair Report. The Board thanked PV for the update.
4.2.1	**Quality and Safety Committee Annual Report (inc. Terms of Reference)**
	The Committee conducted its standard annual review and confirmed that there were no issues to raise. The Terms of Reference (TOR) were endorsed by the members of the Committee. The Board subsequently reviewed and approved the Terms of Reference.
4.2.2	**Quality Accounts 2024/25**
	The Quality Accounts were presented to the Quality and Safety Committee for endorsement prior to submission to the Board for final approval. The document provides a comprehensive overview of key quality-related activities and outcomes for the 2024/25 period. The Board discussed the following: • Members of the committee confirmed that the draft Quality Accounts had been received and were supported at the previous meeting. • The Board commended the document, particularly the introduction of the Martha Law and the identification of causes for concern. ME requested feedback on the frequency of use and the impact of this initiative. As this is an ongoing project, an update will be provided in due course. The Board approved the Quality Accounts.
4.2.3	**EPRR Policy**
	MC presented the document, highlighting the following. • Last year, the Trusts' EPRR assessment outcome was below expectations. Since then, significant work has been undertaken to address the identified gaps. The updated EPRR Policy and Business Continuity Plan now require formal approval by the Board. • These documents were reviewed and approved in May at the Quality and Safety Committee. The documents outline the roles and responsibilities of individual staff members and reflect engagement with the Trust, the wider system, and external partners in their development. • The Trust is currently working towards achieving a rating of "Substantial Assurance" in the next assessment cycle. • The Quality and Safety Committee has recommended the documents for Board approval. The Board discussed the following:

Ref	Discussion and Action Points
	• During the review, PV raised a point regarding the clarity of the BCP: specifically, whether it is clear which policy should be followed in different scenarios. There is a need to distinguish between the Corporate Business Continuity Plan and the Major Incident Plan. The definition of a major incident is a key component, and it is essential that on-call staff are familiar with both documents. This will support appropriate categorisation and response in the event of an incident. • It was noted that as part of the Quality Accreditation process, there is an expectation that staff members are aware of the Business Continuity Plan and understand their roles within it. The Board approved the EPRR Policy and Corporate Business Continuity Plan.
4.2.4	**Corporate Business Continuity Plan**
	The corporate business continuity plan discussion was taken within the EPRR Policy discussion.
4.2.5	**IPC Annual Report**
	The annual report for Infection Prevention and Control (IPC) was presented. The following key points were noted: • The report was formally recommended to the Board for approval following a review at the Quality and Safety Committee. • It was noted that during a recent regional meeting, the Trust was highlighted as an exemplar organisation for its response to IPC challenges over the past two years. The Board approved the annual report and commended the on working work within the organisation in relation to IPC.
4.2.6	**Patient Experience Annual Report**
	The annual report for the patient experience was presented. The following key points were noted: • The report was also recommended for onward approval, with a particular focus on ongoing work to explore and address patient complaints. • Findings from the latest Care Quality Commission (CQC) survey were featured, reinforcing the importance of IPC in patient care and organisational performance. • The report emphasised the need to continue raising awareness of the importance of IPC across the Trust. The Board approve the annual report and commended the ongoing work within the organisation relation to patient experience.
4.2.7	**Health and Safety Annual Report**
	The annual report for Health and Safety was presented. It was noted that conversation at the Quality and Safety Committee were in relation to the areas for focus and improvement for the financial year in relation to COSHH assessments. The Board approved the annual report and commended the on working work within the organisation in relation to Health and Safety.
5.0	**People and Workforce**
5.1	**Performance Report**
	The following points were highlighted from the People and Workforce performance report (by exception only): • Overall, the Trust are ahead of target in achieving the key performance indicators. • A particular focus has been placed on Healthcare Support Worker (HCSW) recruitment, which is expected to positively impact bank and agency staffing costs. • In relation to agency staffing, the Trust is currently on target. The work undertaken by PKF and SY has been commended for its effectiveness and contribution to this progress.
5.2	**Chair's Assurance Report – People and Culture Committee**
	ME highlighted the following key points from the People and Culture Committee Chairs Assurance report: • **Medical Training and Contractual Arrangements** - The Committee reviewed issues relating to medical training provision under current contractual arrangements. Short-term mitigation measures are in place; however, this situation exemplifies a broader which is to be addressed. It was noted that reliance on external organisations can lead to service gaps and potential impacts on quality and safety. The Trust highlighted the importance of

Ref	Discussion and Action Points
	reviewing external contacts and considering how service gaps are acknowledged and addressed. • **Occupational Health Service** - The Committee noted ongoing underperformance against contractual expectations. The contract has been extended until August 2026 and is currently under review to ensure future service delivery meets required standards. • **Equality, Diversity and Inclusion (EDI) Annual Report** - The Committee commended the significant work undertaken in preparing the EDI Annual Report and recommended it for Board approval. • **Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Action Plans** - Both action plans were reviewed and are recommended for approval by the Board. • **Freedom to Speak Up (FTSU) Update** - An update was provided on FTSU activities and were assured. • **Apollo Programme** - Staff-related issues arising from the Apollo programme are being actively considered by the Committee. • **Job Planning** - The Committee requested a job planning trajectory to be presented at the next meeting to support workforce planning and assurance. • **Ethnicity Pay Gap Report** - these documents were reviewed and are recommended for Board approval. The Board thanked ME for the update.
5.2.1	**People and Culture Committee Annual Report (inc. Terms of Reference)**
	The Committee conducted its standard annual review and confirmed that there were no issues to raise. The Terms of Reference (TOR) were endorsed by the members of the Committee. The Board subsequently reviewed and approved the Terms of Reference.
5.2.2	**Freedom to Speak Up Annual Report**
	The Freedom to Speak Up Annual Report was considered at the People Committee and included Quarter 4 data. The self-reflection tool was reviewed, which led to several actions and recommendations. These have now been completed, and it was confirmed that diverse Freedom to Speak Up Champions have been appointed. A further review is planned, which will include consideration of the Memorandum of Understanding (MoU) and collaboration with the Royal Orthopaedic Hospital (ROH) to identify shared learning opportunities. Feedback from the Well-Led Review will also be welcomed and incorporated. DM highlighted the revised presentation of the data has been noted and will continue to be developed. There is also ongoing work aligned to the staff survey will be broadened to better understand how staff feel about speaking up and to reinforce its importance. The Board discussed the following: • SN provided assurance regarding the self-reflection work and welcomed fresh support from DM. • SN also confirmed that the report was discussed at the People Committee highlighted that Quarter 1 will serve as a baseline to assess whether issues are being raised through the Freedom to Speak Up process, particularly in relation to Apollo. • Concerns were raised in relation to ensuring that Champions have protected time to carry out their roles effectively and engage meaningfully. This will be addressed as part of the next steps, ensuring appropriate resources are in place. • The report provides assurance that robust policies and structures are in place. Efforts have been made to improve the culture and encourage staff to speak up. However, there is a need to ensure that issues raised, particularly the six related to workplace safety. • It was noted that the National Guardian's Office is being dissolved and consideration of the implications is required, and a response will be formulated. The Board approved the annual report.
5.2.3	**Ethnicity Pay Gap Report**
	The report outlined the ongoing work being undertaken to address the ethnicity pay gap within the Trust. It was noted that key performance indicators (KPIs) are currently being developed to support the monitoring and tracking of progress in this area.

Ref	Discussion and Action Points
	The Board discussed the following • Noted the importance of further developing and expanding the staff network to support this area of work. • The data table requires a key for clarity, and a thorough sense check of the document is recommended. • The staff portal should be updated to reflect the latest information. The Board approved for publication.
5.2.4	**EDI Annual Report**
	Following a recommendation from the People and Culture Committee, the Board approved the annual report and commended the on working work within the organisation in relation to EDI.
6.0	**Performance and Finance**
6.1	**IPR Exception Report**

	MC presented performance report, highlighted the following key points:
	• **RTT and longest waits** - RTT performance remains a key focus for the Trust. April activity levels met planned targets; however, performance fell short due to assumptions made during validation. Month 1 was behind plan, with further deterioration reported in May. It was noted that the key driver for a rection in activity was temporarily reduced to support the Apollo implementation.
	• **Recovery and Performance Improvement** – the Trust are actively focusing on recovery, both in the immediate and medium term. Some of the key mitigations include:
	  ○ Milestone 1 is centred on outpatient improvements, supported by additional capital investment and initiatives such as "Super Saturday." A new DEXA scanner has been delivered, enabling increased activity.
	  ○ Insourcing has been introduced in neurophysiology and rheumatology.
	  ○ Clinical and patient validation processes are underway.
	• **External Engagement and Support** – the Trust had visits from NHS England and the GIRFT team, who continue to support the Trust. The Executive team have requested support in showcasing areas of positive performance, such as our pre-operative process, which has been highlighted as best practice.
	• **Commitment to RTT Improvement** – the organisation remains committed to improving RTT performance and the Board have some protected time dedicated to this during tomorrow's development session. Actions are being monitored daily, with the goal of returning to target by the end of July.
	• **Medium-Term Planning and Sustainability** - sustainability efforts are progressing, including more flexible job plans that have supported increased capacity—particularly in pain services and MDT spine clinics within the community. Further work is being completed to refine the data analysis and forecasting methods to align metrics with national requirements.
	• **Welsh Patient List and Powys Commissioning** - Powys Health Board commissioning decisions are impacting waiting times, primarily to support financial constraints. This will be reflected in performance metrics when the Welsh patient list goes live on 1 July. A footnote will be added to public papers to clarify that these delays are commissioner-led decisions. Powys Health Board has relaxed the maximum outpatient wait of 52 weeks, which presents a significant risk. For 100 and 104-week waits, exceptions are being made for urgent, cancer, and paediatric cases. It was confirmed that Betsi Cadwaladr University Health Board is not pursuing minimum waiting times or capping activity.
	
	The Board noted the report and welcomed the dedicated time has been set aside tomorrow to explore these issues in detail.

6.1.1	**Long Waiters Presentation**
	The long waiters discussion has been captured within the IPR performance report agenda item as a key performance indicator for the Trust.
6.2	**Finance Performance Report**
	The Trust continues to deliver in line with its financial plan for Month 2, with a planned deficit of £1.5m. The financial plan remains flexible to accommodate fluctuations in activity levels and fixed costs throughout the year. The control total has been met, although the contributing factors differ from initial expectations. This has been achieved through variances in both pay and non-pay expenditure.

Ref	Discussion and Action Points
	Operational units are actively managing underspends, and vacancy controls are in place to support financial stability. Inflationary pressures have been lower than anticipated in some areas, and the Trust hopes to continue benefiting from this trend. Agency staffing costs remain within capped limits. Bank staffing has experienced overspend due to the Apollo Programme, which is a short-term initiative supporting system implementation and is expected. Efficiency targets are being met, with £1.3 million delivered against a £1.2 million target, placing the Trust slightly ahead of plan. The overall financial risk profile remains balanced. Workforce challenges persist and are recognised as a key area of risk. To support improvement, the Trust has established the Workforce Improvement Group (WIG), which reports to both the Financial Improvement Group (FIG) and the Finance and Performance Committee. The Trust maintains a positive cash position. Financial reporting and recording processes are aligned with best practice standards. Finally, the Trust continues to engage with the Financial Shared Services Programme and is actively exploring opportunities for collaboration.
6.3	**Chair Report from Finance and Performance Committee**
	SN presented the Chairs report, highlighting the following: • **Spinal Services** - the current approach to spinal services is unsustainable and requires urgent review. Feedback has been provided on the business case, which includes a proposal to cease new referrals and explore alternative models of care. An Equality Impact Assessment (EQIA) is needed, alongside clear modelling of potential breaches and a trajectory for service delivery if new referrals are paused for 12 months. This matter will be escalated to the Board in due course. • **Financial Position** - the Trust has achieved its financial target; however, concerns remain regarding the suitability of income offsets and opportunity costs, particularly in relation to contribution income from activity. Further analysis is required to ensure financial sustainability. • **Efficiency Programme** – the Committee commended the team for a strong start to the year. A £6m efficiency has already been delivered, exceeding the total achieved in the previous year. This is a significant accomplishment. • **Private Patient (PP) Plan** - while the target has not yet been met, the plan was ambitious and has resulted in substantial growth. A further deep dive is planned to explore opportunities and challenges in more detail. • **Veterans Programme** - progress has been made on the veterans block contract. Confidence is growing, and system-wide support has been secured. Letters have been circulated to all Integrated Care Boards (ICBs), and a fixed block contract has been approved. National NHS England support is now required. The Trust will issue formal communications following Q1, outlining the recommendations. The Board discussed the following: • **Efficiency Savings** - the £6m efficiency delivered initiatives is commendable. However, there are reservations about the sustainability of similar savings in future years. The pipeline for the coming year is under development, and a medium-term plan has been received from the system. While this year's targets are aligned with previous efficiency goals, uncertainty remains around funding. There are further opportunities yet to be shared. The Board noted the update.
6.3.1	**Finance and Performance Committee Annual Report (inc. Terms of Reference)**
	The Committee conducted its standard annual review and confirmed that there were no issues to raise. The Terms of Reference (TOR) were endorsed by the members of the Committee. The Board subsequently reviewed and approved the Terms of Reference
7.0	**Chair Report from Digital, Education, Research, Innovation and Commercialisation Committee**

Ref	Discussion and Action Points
	ME presented the Chair's Report, highlighting the following key updates: • **Apollo Programme** - the Clinical Reference Group has now been formally established to support the Apollo Programme. • **EPR Governance** - governance arrangements have been implemented to ensure appropriate oversight of the Electronic Patient Record (EPR), including how it is monitored and reported. • **Apollo Risk Management** - it was noted that risks associated with the EPR implementation must be effectively transitioned into the Business-As-Usual (BAU) Corporate Risk Register (CRR). • **Cyber Security** - significant progress has been made, particularly with enhanced testing of the Patient Administration System (PAS). • **PACS Update** - the Trust has exited the West Midlands Imaging Network and is now collaborating with SaTH. A Business Case will be presented by the team in due course. While the Trust is pursuing a longer-term contract with WM Imaging (as confirmed by NHSE), a separate procurement process is being undertaken due to urgency. • **Diabetic Services** - the clinical team delivered a presentation on the launch of the new diabetic service, as referenced in the CEO's report. • **Institute of Orthopaedics** - an update was provided on the Institute, and Eric Evans reaffirmed his commitment to continued collaboration with the Trust moving forward. The Board noted the report.
7.1	**DERIC Committee Annual Report (inc. Terms of Reference)**
	The Committee conducted its standard annual review and confirmed that there were no issues to raise. The Terms of Reference (TOR) were endorsed by the members of the Committee. The Board subsequently reviewed and approved the Terms of Reference.
7.2	**Digital Strategy**
	The Digital Strategy was presented at the DERIC meeting in April, marking a significant shift from a transactional approach to a transformational one. This evolution is being driven by strong engagement and leadership from clinical teams, reflecting a shared commitment to harnessing digital innovation to improve patient care and operational efficiency. It was acknowledged that the strategy may require refinement to align with the forthcoming 10-Year Plan, ensuring it remains resilient, forward-looking, and adaptable to future developments. The next steps include: • Development of detailed implementation plans. • Identification of the resources necessary for successful delivery. • Integration of these elements into the Trust's Corporate Objectives The Board: • Emphasised the importance of keeping the strategy under regular review, recognising that digital initiatives can quickly become outdated in a fast-evolving landscape. • Noted a delivery plan will be formulated and progress reported back to DERIC on a regular basis, with close monitoring to ensure accountability and momentum. • Requested a focus on identifying any quick wins or priority areas that may require immediate attention to maximise early impact. The Board approved the Digital Strategy.
8.0	**Chair Report from Audit and Risk Committee**
	MN presented the Chair's Report, outlining the following key updates: • **Counter Fraud Annual Report** - the report received a satisfactory rating, reflecting effective performance and compliance with relevant standards. • **Head of Internal Audit Report** - a substantial assurance rating was provided. On behalf of the Board, MN extended sincere thanks to all team members for their continued support and valuable contributions throughout the year. • **External Audit Report** - the financial statements were found to be consistent with the management accounts reviewed during the year. The evaluation of the new theatre project identified an adjustment requirement of approximately £2.1m. Attention was also drawn to

Ref	Discussion and Action Points
	the Healthcare Support Worker (HCSW) provision, which will be monitored over the next 12 months. A variance of £250k was noted in the audit report, acknowledged by the Board and will be addressed accordingly. • **Annual Report and Accounts** - collectively, the reports reflect a robust governance framework. While overall performance is strong, the reports also highlight clear areas for improvement and the need for continued oversight The Board noted the update.
9.0	**Questions from the Governors and Public**
	HT encouraged questions and comments from the members of the governors: **RJAH and ROH MoU** – queried whether the MoU would allow for mutually agreed secondments between RJAH and ROH to support staff development and promote cross-organisational learning. The Trust welcomed this suggestion and confirmed it would be considered as part of ongoing collaboration. It was also noted that Keele University is a partner of ROH, and the triangulation between RJAH, ROH, and Keele University presents valuable opportunities for joint initiatives and shared learning. **Clinical Strategy Day** – queried whether attendance of the Governors could be considered as part of the session. **Apollo** – expressed appreciation for the open letter addressing the Apollo programme, recognising the challenges staff have faced and the importance of acknowledging their efforts. **10-year planning** –discussed the Trust's 10-year strategic plan and its implications for current operations. The Trust confirmed that a dedicated session has been organised for staff to explore the long-term strategy, its impact on the organisation, and its alignment with corporate objectives. It was noted that while the plan spans a decade, there will be a particular focus on the immediate two-year period to ensure short-term priorities are addressed effectively.
10.0	**Any Other Business**
	There were no further items of business for discussion HT thanked all attendees for their time and contribution to the discussion before closing the meeting.
10.1	**Date and time of next meeting:** Wednesday 03 September 2025 at 9:30am

Committee / Group / Meeting, Date

Board of Directors, September 2025

Author:

Name: Dylan Murphy
Role/Title: Trust Secretary

Contributors:

Mary Bardsley, Assistant Trust Secretary

Executive Owners

Report sign-off:

n/a

Is the report suitable for publication?:

YES

Key issues and considerations:

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. Unless it has been retained by the Board for direct oversight, each of these has been allocated to a committee of the Board, for oversight. As the DERIC Committee did not meet in August, the DERIC-overseen entries will be considered at the September Committee meeting:

Themes / Lead "Committee"	Strategic Risk
1. Continued focus on excellence in quality and safety. Quality and Safety Committee	• If the Trust does not have robust policies, procedures and practices in place to promote the quality and safety of services • Then there is a risk that insufficient organisational focus is placed on the quality and safety of services • Resulting in increased incidence of avoidable harm, reduction in patient satisfaction and failure to deliver excellent standards of care
2. Creating a sustainable workforce. People and Culture Committee	• If the Trust does not attract and retain staff with the appropriate skills and values, embrace equality, diversity and inclusion, and be regarded as an employer of choice • Then it will be unable to deliver planned activity and/or promote an inclusive, supportive culture for staff • Resulting in reduced patient satisfaction; an inability to address inequality of service provision; reputational damage, adversely affecting efforts to retain/recruit staff
3. Delivering the financial plan. Finance and Performance Committee	• If the Trust is unable to deliver its financial plan • Then it will lead to regulatory intervention and impact on future investment • Resulting in the Trust being unable to deliver its objectives, which will have an adverse impact on patient care / patient experience etc
4. Delivering the required levels of productivity, performance and activity. Finance and Performance Committee	• If the Trust does not have sufficient capacity to deliver the activity plan within agreed resourcing levels • Then it will be unable to address waiting list targets and will face a shortfall in income / fail to deliver the financial plan • Resulting in increased waiting times; an adverse impact on patient experience, potentially resulting in patient harm; increased scrutiny from system partners / regulators (leading to burdensome reporting requirements and/or enforcement action which reduce capacity and place constraints on the Trust's ability to act independently in pursuit of its objectives).
5. Delivering innovation, growth and achieving systemic improvements. Digital, Education, Research, Innovation and Commercialisation Committee	• If the Trust does not have the required infrastructure / capacity / expertise to support innovation / growth; or governance processes / funding regimes place constraints on the Trust's ability to act • Then it will not be able to identify / pursue opportunities to innovate, develop commercial opportunities and deliver systemic improvements • Resulting in a failure to maximise opportunities to improve staff experience, clinical outcomes, patient satisfaction and increase income (which could be reinvested in services).

Themes / Lead "Committee"	Strategic Risk
6. Responding to opportunities and challenges in the wider health and care system. Board of Directors	• If the Trust does not strengthen its joint-working arrangements with partners governance processes / funding regimes place constraints on the Trust's ability to implement such arrangements • Then it will not maximise opportunities to address health inequalities; improve outcomes / services for patients; support national and system priorities; enhance staff experience; or deliver efficiencies • Resulting in lost opportunities to contribute to the delivery of national and local objectives; potential loss of accreditation status; and potential failure to achieve NHS oversight framework targets (leading to burdensome reporting requirements and/or enforcement action / constraints on the Trust's ability to act independently in pursuit of its objectives).
7. Responding to a significant disruptive event. Quality and Safety Committee / Digital, Education, Research, Innovation and Commercialisation Committee	• If the Trust does not have adequate plans in place to respond to a significant disruptive event beyond the control of the Trust, such as a pandemic, or cyber-attack • Then it will be unable to provide an adequate response to the immediate need and/or maintain other key services due to unavailability of the required resources / staff • Resulting in potential patient harm, increased waiting times etc

Heatmap

There have been no changes to the heatmap since the BAF was last considered by the Board:

Likelihood	Consequence: (1) Insignificant	(2) Minor	(3) Moderate	(4) Major	(5) Catastrophic
(5) Almost certain				**BAF 03 (20)** (financial plan delivery)	
(4) Likely				**BAF 07 (16)** (disruptive event)	**BAF 04 (16)** (productivity/perf.)
(3) Occasionally / Possible				**BAF 05 (12)** (innovation and growth) **BAF 06 (12)** (system working)	
(2) Unlikely					**BAF 02 (10)** (sustainable workforce) **BAF 01 (10)** (quality and safety)
(1) Rare					

Need for review and revision

It is good practice to regularly review the Board Assurance Framework. There are a number of factors that support the need for review at this point:

- Recently announced changes to the wider NHS – including the abolition of NHS England; reductions in the size of the ICB / possible structural changes; revisions to the remit of ICBs; changes to the "oversight framework" / "performance assessment framework"; and the resultant change in the relationship between providers and the Department for Health and Social Care – will have significant implications for the Trust. There is still significant uncertainty around these changes and the Trust will need to be agile in responding to risks and opportunities that these changes present.
- The Trust needs to review "Fit for the Future", the 10 Year Plan for the NHS (published in July 2025) and consider its implications for the Trust's strategic and corporate objectives. There will need to be alignment between those objectives and the BAF.
- The differing expectations / requirements of English and Welsh commissioners could lead to increasing inequity in waiting times between English and Welsh patients. This is a significant risk that needs to feature in the revised BAF.
- The implementation of Apollo is a significant operational change. The implementation of the revised operating model will also present significant operational, and wider cultural change.
- The existing BAF 3 is focussed on "delivering the financial plan". Thought will be given to reframing the risk to be a strategic one, focussing not only on delivery of the in-year financial plan but more broadly on financial sustainability into the medium term, and the underlying recurrent position of the Trust. This aligns to the NHSE plan to extend planning to a 1+4 year period (hopefully accompanied by longer term financial allocations that match this timeframe). This position will become clearer as we enter Q3 planning.
- The existing BAF 4 is based on "capacity". Thought will be given to reframing the risk to reflect an emphasis on the efficient and effective configuration / delivery of services.
- More thought will be given to the opportunities / risks associated with technological developments and artificial intelligence.

Corporate objectives and risk appetite:

Each of the BAF strategic risks are aligned to the Trust and system objectives. Each also refers to the relevant risk appetite target score(s).

Recommendations:

The Board is asked to:

1. REVIEW the detailed extract for BAF 06, Responding to opportunities and challenges in the wider health and care system;
2. NOTE the extracts of the other BAF themes / risks and CONSIDER any issues escalated by the Board committees (as featured in the associated Chairs' assurance reports).
3. CONSIDER the next steps in the development of the BAF and the key factors that should be reflected in an updated BAF.

Report development and engagement history:

At the May 2024 public meeting, the Board approved the current BAF. Since then, the BAF has been considered on a quarterly basis. The proposed draft revisions have been considered by the executive team.

Next steps:

The content will be updated to reflect the committee's recommendations before presentation to the Board.

The BAF is now in a quarterly review cycle. The sequence of reporting will be:

1. September DERIC Committee, reporting to Board via Chair's assurance report;
2. November committees, followed by December (private) Board;
3. February committees, followed by March (public) Board;
4. June committees, followed by July (private) Board.

The November round of committee meetings will include a broader review of the BAF. This will be informed by sessions considering the implications of the 10 Year Plan for the NHS and how these should be reflected in the Trust's strategic and corporate objectives. The BAF will then need to be recast to reflect those objectives / priorities and the risks to delivering them.

Attachment A:	Board Assurance Framework

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 1)

Continued focus on excellence in quality and safety.	BAF 1
IF…	the Trust does not have robust policies, procedures and practices in place to promote the quality and safety of services
THEN…	there is a risk that insufficient organisational focus is placed on the quality and safety of services
RESULTING IN…	increased incidence of avoidable harm and reduction in patient satisfaction

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	

Related system objectives:	
Improve outcomes in population health and healthcare	✓
Tackle inequalities in outcomes, experience and access	✓
Support broader social and economic development	
Enhance productivity and value for money	

Risk Appetite and tolerance:	Quality – Cautious: 6		
Assurance Committee:	Quality and Safety Committee		
Executive Owner (strategic lead):	Chief Nurse, Paul Kavanagh-Fields / Chief Medical Officer, Ruth Longfellow		
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	~~05/03/25~~ 04/06/2025
		Date Last Reviewed by the assurance Committee:	~~22/05/2025~~ 21/08/25

	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 – 2024/25 (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, and safety remains the primary consideration when any developments / innovations are considered. A reducing proposed to reflect enhanced governance and oversight arrangements in recent months.
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..

Contributory factors and associated controls				
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
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.	Maintaining and promoting quality through an agreed strategy. This control would have a SIGNIFICANT impact	Strong
3	Maintenance of robust quality / clinical governance arrangements – learning from feedback / patient safety walkabouts	• Regular Board visits, involving non-executive directors • "Sit and see" visits • Reporting on patient safety walkabouts; patient stories. • Assurance reports from Patient Safety Meeting, • Executive 'buddy' visit reports	Maintaining and promoting quality and safety through a culture of openness and learning. This control would have a SIGNIFICANT impact	Strong

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 1)

Contributory factors and associated controls				
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?*
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 ~~➢ PALs contacts~~ Note: an IPR KPI • 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
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
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 ➢ Inpatient Ward Falls per 1,000 Bed Days ➢ RJAH Acquired Pressure Ulcers	Maintaining and promoting quality and safety through continuous review / learning. This control would have a SIGNIFICANT impact	Medium (To reflect review and planned improvements relating to ROM and the Drugs and Therapeutics Meeting).

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 1)

Contributory factors and associated controls				
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?*
		➢ RJAH Acquired Tissue Viability Incidents ➢ Pressure Ulcer Assessments ➢ ~~Average number of weeks waiting for Spinal Injury admission~~ MCSI Admissions – Average Waiting Time • Assurance reports from: ➢ Patient Safety Meeting ➢ Drugs and Therapeutics Meeting – reporting and assurance arrangements under review and to be strengthened. • 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 ~~Assurance reports 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
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

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 1)

Contributory factors and associated controls				
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	Maintenance of robust quality / clinical governance arrangements – patient experience measures	• IPR reporting on: ➢ ~~Volume of Theatre Cancellations~~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 ➢ 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	Maintaining and promoting quality and safety through continuous review / learning. This control would have a SIGNIFICANT impact	Strong
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
11	Successful implementation of the EPR	• EPR Implementation assurance meeting, reporting into DERIC Committee • Posts in place, including: ➢ 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 ~~/ Low~~ (reflecting the ~~most recent NHSE review outcome~~successful implementation but relatively early stage of deployment, with issues to be addressed) ~~That rating relates to the successful implementation of the~~

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 1)

Contributory factors and associated controls				
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?*
				~~system – If there are any safety concerns, the system will not be implemented.~~
12	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)

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.

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 ~~etc…~~. including: a) Insourcing arrangements; b) ~~Benchmarking on p~~Pharmacy; ~~/~~ c) ~~t~~Therapy; and d) ~~/ R~~radiography ~~etc…~~	Improve the capacity of the organisation to continue to focus on excellence in quality and safety by delivering more efficient and effective ways of	MC	Ongoing throughout 2024/5 – timelines tbc for the constituent 5 year strategies for the supporting services. This agenda is managed	AMBER (as elements, including strategy for

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 1)

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**
		working and addressing inequity in patient pathways.		as business as usual through the Executive Team ~~on an as required basis~~.	pharmacy in development).
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	~~We are awaiting the results of Safer Staffing Establishment reviews due June 2025.~~ The additional specialist nursing roles required as part of GPICS form part of the Trust wide advanced practice review currently underway with full plan expected August 2025.	AMBER (~~with a view to upgrade following an update on progress~~Initial safer staffing review completed, second to be undertaken)
3	CQC Critical Care rating action plan review to prioritise actions to make the greatest impact, ensure implementation and sustained delivery of requirements	Support delivery of quality of care and patient safety	CNO	Aug 2025	AMBER
~~**4**~~	~~Further development of the Clinical Effectiveness Meeting.~~	~~Develop the approach to clinical excellence which will support delivery of quality and safety~~	~~RL~~	~~Completed but will keep under review~~	~~GREEN~~
~~**5**~~	~~Development and implementation of a Patient Experience Strategy to incorporate the "experience of care improvement framework":~~	~~Improve the ability of the organisation to engage patients and improve quality and safety~~	~~CNO~~	~~Aug 2025~~	~~AMBER~~ GREEN
~~6~~4	Development and implementation of arrangements to promote the operational ownership of ~~Implementation of methods~~digital solutions to support the patient experience strategy ~~better engage patients~~ (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	RL / AWM (~~following EPR implementation)~~	~~May~~ December 2025	AMBER

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 1)

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**
~~7~~	~~Development of a Clinical Strategy, to include medical staff, nursing staff, AHPs etc.~~	~~Develop the strategic approach to clinical excellence and innovation which will support delivery of quality and safety~~	~~RL / PKF~~	~~A draft Clinical Strategy was considered at P&C / Q&S in December 2024. It was subsequently published in May 2025.~~ ~~Implementation of the revised delivery model is being overseen by a dedicated sub-group, reporting into the Finance and Performance Committee.~~	~~AMBER~~ GREEN
~~8~~	~~Review of arrangements relating to the Regulatory Oversight Meeting and the Drugs and Therapeutics Meetings undertaken and identified improvements to be implemented.~~	~~Enhance the assurance arrangements around compliance with the required standards.~~	~~RL (supported by DM) / Fiona Bevan~~	~~Some actions already implemented. Revised arrangements to be embedded by April 2025~~	~~AMBER~~ GREEN ~~(as some elements still to be implemented).~~
~~9~~	~~Critical care review completed against GPIC Standards.~~	~~Ongoing monitoring~~ ~~Improve the capacity of the organisation to continue to focus on excellence in quality and safety~~	~~RL~~	~~Review complete. Currently moving through the review / approval process. The report was noted at Q&S in November (with updates on the action plan to be considered via the patient Safety Meeting).~~	~~AMBER~~ ~~(with a view to upgrade following an update on progress)~~
5	Appropriate staff training and education to increase awareness of regulatory requirements / responsibilities.	Support delivery of regulatory compliance	RL	Tbc – to be informed by the findings of external reviews / reports.	AMBER
6	The need to assess and respond to national and regional developments, including those reflected in the	Improve the ability of the organisation to deliver national	SK / HT (leading the wider Board)	Q3, 2025/6	AMBER

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 1)

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**
	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.	strategic and operational priorities, improving the efficiency and quality of services.			(as work in development)

BAF Risks, controls and assurances – 2024/25 (BAF 2)

Creating a sustainable workforce.	BAF 2
IF…	the Trust does not engage and retain staff with the appropriate skills and values, embrace equality, diversity and inclusion, and be regarded as an employer of choice
THEN…	it will be unable to deliver planned activity and/or promote an inclusive, supportive culture for staff, or strengthen employees' skills
RESULTING IN…	reduced patient satisfaction; an inability to address inequality of service provision; reputational damage, adversely affecting efforts to retain/recruit staff, poorer employee experience resulting in an increased workforce turnover and absence.

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	✓

Related system objectives:	
Improve outcomes in population health and healthcare	✓
Tackle inequalities in outcomes, experience and access	✓
Support broader social and economic development	✓
Enhance productivity and value for money	✓

Risk Appetite and tolerance:	Workforce – Seek (risk tolerance at 12)		
Assurance Committee:	People & Culture Committee		
Executive Owner (strategic lead):	Denise Harnin, Chief People Officer / Paul Kavanagh-Fields, Chief Nursing Officer		
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	~~05/03/2025~~ 04/06/2025
		Date Last Reviewed by the assurance Committee:	~~22/05/2025~~ 21/08/2025

	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

BAF Risks, controls and assurances – 2024/25 (BAF 2)

Rationale for the current score, including an explanation of any movement:
The Trust has made good progress in recruiting staff, exploring all options and alternative routes into professional roles. There will need to be a continued focus on retention, development and innovative utilisation of staff to maximise the benefits of that progress. This will include better supporting people throughout their careers, boosting the flexibilities we offer our staff and improving the culture and leadership to support this approach. People & Culture Committee note: The controls and additional actions for the Trust in relation to its own workforce / workforce challenges need to be reviewed in light of the workforce planning requirements. The system-wide controls / actions relating to workforce also need to be considered as part of BAF 06, **Responding to opportunities and challenges in the wider health and care system.**
Rationale for the target score and the plan to reduce the risk:
The Trust is unable to affect the national shortage in certain specialties or the wider financial pressures on the NHS. It can however reduce the likelihood of this risk through having effective plans and processes in place to: 1. Support the development and wellbeing of the workforce; 2. Attract and retain the required workforce; 3. Make best use of its workforce

Contributory factors and associated controls				
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 ~~➢ Rolling/cumulative 12 month figure using FTE, all substantive staff (minus resident doctors)~~ ➢ ~~In Month Leavers (excluding medical rotation and "retire and return").~~Leavers per Month - Number of leavers per month - excluding non-voluntary reasons, retire & return, and rotational doctors ➢ Staff Retention ➢ Sickness Absence	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

BAF Risks, controls and assurances – 2024/25 (BAF 2)

Contributory factors and associated controls				
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?*
		• Assurance reporting from NSSG • Evidence of embedding: ➢ System retention plan People Promise Exemplar ➢ NHSE EDI High Impact Plan		
2	"Growing for the future": Effective, targeted recruitment - recruitment and retention of clinical staff to ensure appropriate skills mix	• Reporting on: ➢ Responsible Officer revalidation ➢ Safe Staffing Establishment reviews • IPR reporting on: ➢ Vacancy Rate ➢ Nursing Vacancy Rate (Trust) ➢ Healthcare Support Worker Vacancy Rate ➢ Allied Health Professionals Vacancy Rate ➢ ~~Advertising Start Date to Conditional Offer~~Time to Hire - Recruitment • Evidence of embedding: ➢ System retention Plan ➢ People Promise Exemplar Cohort 2	Ensure plans are in place to recruit and effectively utilise 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	Medium
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
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 ➢ Robust agency approval process with escalation • IPR reporting on: ➢ % Staff Availability ➢ ~~Agency - On Framework~~ ➢ ~~Agency - Off Framework~~ ➢ ~~Agency - Insourcing~~ ➢ ~~Proportion of Temporary Staffing~~	Ensure recruitment of the required staff to support delivery This control would have a SIGNIFICANT impact	Strong / Medium

BAF Risks, controls and assurances – 2024/25 (BAF 2)

Contributory factors and associated controls				
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?*
		➢ 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 ➢ 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 ~~by staff groups~~ ➢ 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
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

BAF Risks, controls and assurances – 2024/25 (BAF 2)

Contributory factors and associated controls				
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?*
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
8	"New ways of working and delivering care": Staff development - Robust PDR process	• IPR reporting on: ➢ Personal Development Reviews ~~(and revision of process to improve compliance)~~	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":	• Reporting on: ➢ Staff retention initiatives;	Ensure plans are in place to maintain / improve the retention	Medium

BAF Risks, controls and assurances – 2024/25 (BAF 2)

Contributory factors and associated controls				
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 / staff development initiatives	➢ Leadership development programme • Evidence of embedding: system Retention High Impact Plan ➢ People Promise approved objectives	of staff and promote development This control would have a MODERATE impact	
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 ~~• Reporting 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~~ 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

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".

BAF Risks, controls and assurances – 2024/25 (BAF 2)

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.

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: ~~Development~~ Delivery of ~~of a~~the Clinical Strategy via ~~, to include~~ 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 ~~and delivery of a revised operating model (taking account of the results of the "medical engagement" survey).~~ ~~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, including: • BAF 2 - Creating a sustainable workforce • BAF 3 – Delivering the financial plan • BAF 4 - Delivering the required levels of productivity, performance and activity • BAF 5 - Delivering innovation, growth and achieving systemic improvements	RL / PKF, supported by executive colleagues.	~~A draft Clinical Strategy was considered at P&C / Q&S in December 2024. It was subsequently~~ The Clinical Strategy was agreed ~~published~~ in May 2025. Delivery of the Strategy and supporting workforce plans to be considered at the Board sub-committees as appropriate. ~~Implementation of the revised delivery model is being overseen by a dedicated sub-group, reporting into the Finance and~~	AMBER

BAF Risks, controls and assurances – 2024/25 (BAF 2)

				~~Performance Committee.~~	
2	Safer staffing establishment tool to be implemented (for nursing) and an equivalent methodology to be developed and implemented for other clinical / support staff .	Provide an updated set of recommendations for staffing establishment, providing more assurance and increase quality and patient safety. Support required staffing numbers to deliver services.	CNO / DH	Safer Staffing Report ~~due~~ considered in July 2025. A second review to be completed in December / January. Thought to be given to appropriate measures for other staffing groups – e.g. AHPs, theatre and pharmacy. Date tbc	AMBER (as work underway)
3	Opportunities for collaboration / shared services across the system and/or wider partnerships	Increased resilience of teams and services	CEO / AMW	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 via the alliance governance arrangements (tbc).	AMBER (as work underway / in development)
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;	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)

	• revision of the BAF to capture those objectives and the risks to their delivery.				

BAF – Strategic Risks, controls and assurances – 2025/26 (BAF 3)

Delivering the financial plan	BAF 3
IF…	the Trust is unable to deliver its financial plan
THEN…	it will lead to regulatory intervention and impact on future investment
RESULTING IN…	the Trust being unable to deliver its objectives, which will have an adverse impact on patient care / patient experience etc

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	

Related system objectives:	
Improve outcomes in population health and healthcare	
Tackle inequalities in outcomes, experience and access	
Support broader social and economic development	
Enhance productivity and value for money	✓

Risk Appetite and tolerance:	Finance – Open: 9		
Assurance Committee:	Finance and Performance		
Executive Owner (strategic lead):	Chief Finance and Commercial Officer, Angela Mullholland-Wells		
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	~~05/03/2025~~ 04/06/2025
		Date Last Reviewed by the assurance Committee:	~~02/06/2025~~ 18/08/2025

	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	< >	4	5
Likelihood	4	3	^	5	< >	5	2
Total	**20**	**15**	^	**20***	< >	**20**	**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 – 2025/26 (BAF 3)

Rationale for the current score, including an explanation of any movement:
The Trust has set a breakeven plan for 2025/26, this is underpinned by : • Delivery of a 6% efficiency/productivity improvement target valued at £9.6m requiring a considerable level of cost saving and transformation of service delivery • The continued implementation of sustainable levels of theatre and outpatient capacity following the cessation of insourcing capacity in 24/25 which drives variable income levels • Non recurrent stretched levels of private patient income delivery • Recovery of non contract income from out of area commissioners for Veterans service growth A Financial Improvement Group continues to oversee the delivery of key risks including the forecasts & actions around activity delivery of the operational plan and oversight of the efficiency programme risk, forecast and actions. The consequence remains high as delivery of the financial plan is a key element of the revised oversight framework. Plans / arrangements are in place to support delivery and reduce the likelihood of failing to meet the plan. This will need to be kept under review throughout the year.
Rationale for the target score and the plan to reduce the risk:
The financial settlement for the system and the operation of NHS payment regimes are beyond the control of the Trust. The Trust has the ability to reduce the likelihood of this risk through accurate planning, the delivery of efficiencies and potential income growth (though there are resource and regulatory constraints on its ability to achieve those).

Contributory factors and associated controls				
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% than total activity	• Reporting on: ➢ OJP / IJP • IPR reporting on: ➢ IJP Activity - against Plan ➢ OJP Activity - against Plan ➢ Going to be removed the IJP/OJP separate metrics this month but the graphs and supporting data will remain in the F&P covering paper that accompanies the IPR	Reduce costs and improve productivity. This control would have a SIGNIFICANT impact.	~~High~~ Medium
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 – 2025/26 (BAF 3)

Contributory factors and associated controls				
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) ➢ Financial Improvement Group (to F&P) ➢ Theatre Development Group (to F&P) ➢ MSK Transformation Programme Board (to F&P)		
3	Income recovery under, LVA, NCA	• Reporting to: ➢ F&P ➢ Financial Improvement Group	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 FIG ➢ 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) ➢ Financial Improvement Group (to F&P) ➢ 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: ➢ Financial Improvement Group (to F&P) ➢ 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
6	Temporary staffing controls, including bank and agency	• Temporary staffing cost report (to P&C) • IPR reporting on:	Reduce costs and improve productivity.	High

BAF – Strategic Risks, controls and assurances – 2025/26 (BAF 3)

Contributory factors and associated controls				
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?*
		➢ ~~Agency Agency usage against cap~~ ➢ ~~Bank usage against cap~~ ➢ 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)	This control would have a MODERATE impact.	

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 FIG, TPOIG and F&P
2	Excess Inflation	Increased cost above funded plan assumptions	Over delivery of efficiency programme ~~Additional funding from NHSE~~
3	Veterans growth for out of area patients not funded	Reduced income	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 implementation causing financial impact	Increase cost of project delivery or unforeseen costs once implemented Reduced income through DQ issues or process change to activity capture	Robust testing of activity data through new systems Monitoring of historical vs new activity levels Robust project management and forecasting
5	Non delivery of activity linked to consultant capacity levels	Reduced income	FIG overseeing activity forecasts on weekly basis Oversight of recruitment plans through P&CC Insourcing arrangements to provide additional capacity out of core hours

BAF – Strategic Risks, controls and assurances – 2025/26 (BAF 3)

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	Continually review activity levels for NHS and private patient delivery	Achieve Income plan	Chief Operating Officer	Ongoing	AMBER
2	Continually review efficiency plan delivery and risk	Achieve efficiency plan recurrently	Chief Finance & Commercial Officer	Ongoing	AMBER
~~**3**~~	~~Agree and issue transparent billing method for NCA Veterans activity, for inclusion within new IAP / AMPs (Indicative Activity Plan and Activity Management Plans)~~	~~Achieve Income Plan~~	~~Deputy Chief Finance Officer~~	~~End June~~	~~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)	Q3, 2025/6	AMBER (as work in development)

BAF – Strategic Risks, controls and assurances – 2025/26 (BAF 4)

Delivering the required levels of productivity, performance and activity.	BAF 4
IF…	the Trust does not have sufficient capacity to deliver the activity plan
THEN…	it will be unable to address waiting list targets and will face a shortfall in income
RESULTING IN…	increased waiting times; an adverse impact on patient experience, potentially resulting in patient harm; increased scrutiny from system partners / regulators (leading to burdensome reporting requirements and/or enforcement action which reduce capacity and place constraints on the Trust's ability to act independently in pursuit of its objectives).

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	

Related system objectives:	
Improve outcomes in population health and healthcare	✓
Tackle inequalities in outcomes, experience and access	✓
Support broader social and economic development	
Enhance productivity and value for money	✓

Risk Appetite and tolerance:		Quality - Cautious: 6; Finance - Open: 9	
Assurance Committee:		Finance and Performance (primarily)	
Executive Owner (strategic lead):		Chief Operating Officer, Mike Carr	
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	~~05/03/2025~~ 04/06/2025
		Date Last Reviewed by the assurance Committee:	~~02/06/2025~~ 18/08/2025

	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	~~4~~5
Likelihood	4	3	**^**	4	**< >**	4	2
Total	**16**	**12**	**^**	**20***	**< >**	**20**	~~8~~10

** raised to (4x4) 16 in August; raised to (4x5) 20 in November 2024*

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

BAF – Strategic Risks, controls and assurances – 2025/26 (BAF 4)

Rationale for the current score, including an explanation of any movement:
Improvements have been made but demand is increasing and the Trust has submitted a very challenging plan. Delivery will be dependent on successful implementation of the revised operational model and that is dependent on further recruitment and a shift in practices which represent a significant cultural shift within the organisation. This will need to be done during a period of operational change, including the implementation of the Apollo EPR system, and a shifting relationship with the regulators / commissioners. Good progress has been made in addressing RTT targets. This will need to be sustained. Failure to achieve this will have significant consequences for the Trust.
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. Revising the Trust operational model to reduce 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				
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	Low in immediate-term; Medium/ 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. • IPR Reporting on: ➢ Total Theatre Activity Against Plan ~~➢ IJP Activity - Theatres - against Plan~~ ~~➢ OJP Activity - Theatres - against Plan~~ ~~➢ PP Activity - Theatres - against Plan~~ Note: These separate metrics are going to be removed this month but the graphs and supporting analysis will remain in the F&P covering paper that accompanies the IPR – Insourcing will also be included • Assurance Reports from:	Increase capacity and the volume of activity delivered. This control would have a SIGNIFICANT impact	High

BAF – Strategic Risks, controls and assurances – 2025/26 (BAF 4)

Contributory factors and associated controls				
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 ➢ TPOIG		
3	Effective clinical leadership / engagement	• IPR Reporting on: ➢ Total Theatre Activity Against Plan ➢ ~~IJP Activity - Theatres - against Plan~~ ➢ ~~OJP Activity - Theatres - against Plan~~ ➢ ~~PP Activity - Theatres - against Plan~~ Note: These separate metrics are going to be removed this month but the graphs and supporting analysis will remain in the F&P covering paper that accompanies the IPR – Insourcing will also be included • 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 ➢ ~~Establishment reviews~~	Increase capacity and the volume of activity delivered. This control would have a SIGNIFICANT impact	Strong
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	Increase efficiency / productivity	Medium

BAF – Strategic Risks, controls and assurances – 2025/26 (BAF 4)

Contributory factors and associated controls				
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?*
		➢ ~~Overall BADS %~~% 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: ➢ Theatre Development Group	This control would have a SIGNIFICANT impact	
7	Intensive waiting-list management processes, including effective validation.	• IPR and additional reporting on: ➢ ~~Volume of Theatre Cancellations on the day (to Q&S)~~Theatre Cancellations on the Day of Surgery ➢ % of waiting lists validated Note: This is not an IPR metric but ~~– it~~ 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
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
9	Accurate planning assumptions	• Reporting on: ➢ Development and delivery of the plan • IPR Reporting on: ➢ ~~Average number of weeks waiting for Spinal Injury admission~~ MCSI Admissions – Average Waiting Time ➢ Theatre Cancellations on the Day of Surgery ➢ ~~Volume of Theatre Cancellations (on the day)~~ ➢ 18 Weeks RTT Open Pathways	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 – 2025/26 (BAF 4)

Contributory factors and associated controls				
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?*
		➢ 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 ➢ ~~Diagnostic Report turnaround time~~ Note: Not an IPR metric ➢ Elective Activity Against Plan (volumes) ➢ Total Outpatient Activity against Plan (volumes) ➢ Total Diagnostics Activity against Plan - Catchment Based ➢ ~~Outpatient clinic utilisation~~ Note: Not an IPR metric – in development for Q3 ➢ Referrals Received for Consultant Led Services • Assurance Reports from: ➢ TPOIG		
10	Successful implementation 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 issues)
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	~~Medium~~ 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	Medium

BAF – Strategic Risks, controls and assurances – 2025/26 (BAF 4)

Contributory factors and associated controls				
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?*
			This control would have a MODERATE Impact	
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
14	Creation of a dedicated sub-group to oversee implementation of the revised operating model..	Assurance reporting from the operating model oversight group.	To provide assurance on progress in implementing the revised operating model (which is a critical driver of activity and financial performance) This control would have a MODERATE Impact	HIGH

BAF – Strategic Risks, controls and assurances – 2025/26 (BAF 4)

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 – 2025/26 (BAF 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 NOTE: to be re-cast / further developed in the updated BAF	Increase the success of the controls, reducing the likelihood score.	Tbc	Tbc	tbc
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 / HT (leading the wider Board)	Q3, 2025/6	AMBER (as work in development)
~~2~~					
3					

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 5)

Delivering innovation, growth and achieving systemic improvements.	BAF 5
IF…	the Trust does not have the required infrastructure / capacity / expertise to support innovation / growth; or governance processes / funding regimes place constraints on the Trust's ability to act
THEN…	it will not be able to identify / pursue opportunities to innovate, develop commercial opportunities and deliver systemic improvements
RESULTING IN…	a failure to maximise opportunities to improve staff experience, clinical outcomes, patient satisfaction and increase income (which could be reinvested in services).

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	✓

Related system objectives:	
Improve outcomes in population health and healthcare	✓
Tackle inequalities in outcomes, experience and access	✓
Support broader social and economic development	✓
Enhance productivity and value for money	✓

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 – Ruth Longfellow	
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	~~05/03/2025~~ 04/06/2025
		Date Last Reviewed by the assurance Committee:	22/05/2025

	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	**< >**	3	**< >**	3	2
Total	**16**	**12**	**< >**	**12**	**< >**	**12**	**8**

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

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 5)

Rationale for the current score, including an explanation of any movement:
Work is required to develop the required infrastructure / capacity / expertise to deliver this strategic theme. Failure to deliver it will result in missed opportunities but will have limited impact on the Trust's ability to deliver its current, core service. Note: The DERIC Committee noted that the likelihood score would need to be reviewed in light of the Trust's ability to resource its ambitions around the "D.E.R.I.C." agenda.
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.

Contributory factors and associated controls				
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	• 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 the innovation club (as reported to DERIC)	To develop effective plans and drive delivery of the innovation / growth agenda. This control would have a SIGNIFICANT impact	Medium
3	Effective operational engagement / leadership	• Outputs from the innovation club (as reported to DERIC) • Reporting on development of new operating model and development of new roles to support commercialisation etc.	To develop effective plans and drive delivery of the innovation / growth agenda. This control would have a SIGNIFICANT impact	Medium

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 5)

Contributory factors and associated controls				
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?*
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
NOTE: The growth element is primarily covered in BAF 06 – responding to opportunities and challenges in the wider health and care system – and are not repeated here.				

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.
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	Delay to the implementation of the EPR system	There are cost and reputational implications to the delay. This also results in delays in achieving the benefits of the system.	The programme timetable is under review. Delays provide opportunity for further development / detailed training etc. to improve functionality and improve staff readiness…

		There are resource implications due to the need for staff retraining etc. to support the revised roll-out.	

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.	Will increase the ability of the Trust to identify and pursue opportunities / establish the required infrastructure, thereby reducing the likelihood of the risk.	Simon Adams / RL	Digital strategy was agreed by the DERIC Committee in April 2025.	RED
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	Will increase the ability of the Trust to identify and pursue opportunities / establish the required infrastructure, thereby reducing the likelihood of the risk.	RL / 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.	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	The Research Strategy was agreed by the DERIC Committee in March 2025.	AMBER (as strategy now agreed but more work needed to deliver it)
4	Approval and delivery of an innovation strategy.	Will increase the ability of the Trust to identify and pursue opportunities / establish the required infrastructure, thereby reducing the likelihood of the risk.	RL / MC	A draft Innovation and Improvement Strategy was considered by the DERIC Committee in April 2025.	AMBER
5	Approval and delivery of an education strategy.	Will increase the ability of the Trust to identify and pursue opportunities / establish the required infrastructure, thereby reducing the likelihood of the risk.	DH / RL	The Strategy was approved by the Committee in September.	GREEN

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 5)

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 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.	
6	Development of a 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, including: • BAF 2 - Creating a sustainable workforce • BAF 3 – Delivering the financial plan • BAF 4 - Delivering the required levels of productivity, performance and activity • BAF 5 - Delivering innovation, growth and achieving systemic improvements	RL / PKF	A draft Clinical Strategy was considered at P&C / Q&S in December 2024. The 2024-29 Clinical Strategy was subsequently published.	AMBER (as strategy now agreed but more work needed to deliver it)
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)	Q3, 2025/6	AMBER (as work in development)

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 5)

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 – 2024/25 (BAF 6)

Responding to opportunities and challenges in the wider health and care system.	BAF 6
IF…	the Trust does not strengthen its joint-working arrangements with partners, or governance processes / funding regimes place constraints on the Trust's ability to implement arrangements
THEN…	it will not maximise opportunities to address health inequalities; improve outcomes / services for patients; support national and system priorities; enhance staff experience; or deliver efficiencies
RESULTING IN…	lost opportunities to contribute to the delivery of national and local objectives; potential loss of accreditation status; and potential failure to achieve NHS oversight framework targets.

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	✓

Related system objectives:	
Improve outcomes in population health and healthcare	✓
Tackle inequalities in outcomes, experience and access	✓
Support broader social and economic development	✓
Enhance productivity and value for money	✓

Risk Appetite and tolerance:		Reputational / Regulatory - Open: 9	
Assurance Committee:		Board of Directors	
Executive Owner (strategic lead):		Chief Executive, Stacey Keegan	
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	~~04/12/24~~ 05/03/25
		Date Last Reviewed by the assurance Committee:	n/a

	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	**< >**	3	**< >**	3	2
Total	**16**	**12**	**< >**	**12**	**< >**	**12**	**8**

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

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 6)

Rationale for the current score, including an explanation of any movement:
This risk is partly within the control of the Trust to mitigate. It is however dependent on the cooperation of partners and may be affected by capacity / financial constraints (on the Trust itself, or on partner organisations). Recently announced changes to the wider NHS – including the abolition of NHS England; reductions in the size of the ICB / possible structural changes; revisions to the remit of ICBs; changes to the "oversight framework" / "performance assessment framework"; and the resultant change in the relationship between providers and the Department for Health and Social Care – will have significant implications for the Trust. There is still significant uncertainty around these changes and the Trust will need to be agile in responding to risks and opportunities that these changes present.
Rationale for the target score and the plan to reduce the risk:
The Trust is developing relationships within and beyond STW. As noted above, progress is dependent on the cooperation of partners and may be affected by capacity / financial constraints (on the Trust itself, or on partner organisations).

Contributory factors and associated controls				
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.	Reporting to Board on development of the provider collaborative / system leadership on MSK services	Improved working within STW partners to improve services / deliver efficiencies etc. This control would have a SIGNIFICANT impact	Medium / High
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
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)	Low / Medium

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 6)

Contributory factors and associated controls				
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?*
			This control would have a SIGNIFICANT impact	
5	Developing veterans / military support services, including rehab services.	Reporting to Board on development of veteran / rehab services.	Improved working within 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
6	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
7	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
8	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
9	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

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 6)

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).

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	Nia Jones	Completed for establishment of workshops – deadline for specific agreements in ~~2025~~discussion.	~~AMBER~~ RED
2	MOD bid in development – the MOD tender specification was issued in September. There was an expectation that the service would cover specific multiple locations. Following further clarification on possible options, it became clear we would not meet the specification.	Improved arrangements with partners to improve services / deliver efficiencies, and increase income	Nia Jones	Closed	RED
3	Elective Orthopaedic configuration options appraisal in development – discussion continues and there is agreement with SaTH on joint recruitment of surgeons. There is also agreement that initial focus will be on trauma reconfiguration (which would result in additional capacity for elective service). Formal reconfiguration of MSK will follow.	Improved arrangements within STW to improve services / deliver efficiencies etc.	Mike Carr	Quarter 1 2025/26	AMBER
4	Ongoing work with system partners to consider shared services etc.	Improved arrangements within STW to improve services / deliver efficiencies etc.	Angela Mulholland-Wells~~Owner is under review~~	~~January 2025~~Quarter 4 2025/26	AMBER

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 6)

5	Further collaboration with Royal Orthopaedic Hospital – Exec to Exec meeting being planned to ~~progress~~ consider opportunities for collaboration in line with the Memorandum of Understanding	Improved working within specialist partners to improve services / deliver efficiencies	Stacey Keegan	~~January~~ September 2025	AMBER
6	Revised System MSK governance structure - Establishment of MSK collaborative board and associated sub-meetings	Improved collaboration with partners and a strategic planning	Mike Carr	April 2025 - Completed	~~AMBER~~ GREEN

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 7)

Responding to a significant disruptive event.	BAF 7
IF…	the Trust does not have adequate plans in place to respond to a significant disruptive event beyond the control of the Trust, such as a pandemic, or cyber-attack
THEN…	it will be unable to provide an adequate response to the immediate need and/or maintain other key services due to unavailability of the required resources / staff
RESULTING IN…	potential patient harm, increased waiting times etc

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	

Related system objectives:	
Improve outcomes in population health and healthcare	✓
Tackle inequalities in outcomes, experience and access	✓
Support broader social and economic development	
Enhance productivity and value for money	

Risk Appetite and tolerance:	Quality - Cautious: 7		
Assurance Committee:	Quality and Safety Committee / Digital, Education, Research, Innovation and Commercialisation Committee		
Executive Owner (strategic lead):	Mike Carr, Chief Operating Officer		
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	~~05/03/2025~~ 04/06/2025
		Date Last Reviewed by the assurance Committee:	22/05/2025 (for DERIC) 21/08/2025 ~~and~~ for Q&S~~)~~

	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	3	^	4	< >	4	3
Likelihood	4	4	< >	4	< >	4	4
Total	**20**	**12**	^	**16***	< >	**16**	**12**

**Increased to (4x4) 16 in June 2024*

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

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 7)

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. As the aim of the plans is to mitigate the impact of potentially disruptive events, it is easier to understand the controls as affecting the "consequence" of the risk. To reflect national messaging on the likelihood of a cyber-attack, and the potential consequences, the Board agreed (on 05/06/24) that the risk score should be increased.
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 (particularly in relation to IT threats), or through robust plans and procedures to react to such events. The current national / international threat of a cyber-attack, and the experience of organisations that have been subject to an attack, suggest that reducing the risk to an 8 may be unrealistic. The Trust will continue to develop its arrangements but a consequence rating of 3 feels a more realistic target.

Contributory factors and associated controls				
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	Reduce the impact of a potentially disruptive event through an effective response. This control would have a SIGNIFICANT impact	LOW
2	Robust critical incident / EPRR / business continuity procedures	Annual external assessment of EPRR, as reported to Q&S 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	LOW
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.	Medium

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 7)

Contributory factors and associated controls				
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?*
			This control would have a SIGNIFICANT impact	
4	IT security policy / practices / staff education	Regular IG reporting to DERIC Committee Assurance reporting to DERIC from Information Governance Meeting DPST reporting… Report and associated actions following dummy phishing attack exercise.	Reduce the likelihood of a cyber attack or other unauthorised / accidental loss of data through effective controls. This control would have a SIGNIFICANT impact	Medium
5	IT system testing / auditing programme	Regular reporting to DERIC Committee Assurance reporting to DERIC from Information Governance Meeting Report and associated actions following dummy phishing attack exercise.	Reduce the likelihood / impact of a potentially disruptive event through strengthening systems / procedures. This control would have a SIGNIFICANT impact	Medium
6	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
7	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

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 7)

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	Completion of fit mask testing to ensure staff have competently fitted FFP3 face masks (Risk ID 3056).	Improve the Trust's preparedness for another pandemic / outbreak.	PKF	As reported in the corporate risk update in April, this risk has been reduced as an external provider had been procured and fit testing had commenced.	GREEN
~~**2**~~	~~Exercise / simulation of incident, focussing on a cyber attack (relates to risk ID 1511) – dummy phishing attack undertaken . Report on staff response to be completed to assess effectiveness of response, with follow-up actions to be identified and implemented as required.~~	~~Improve the Trust's preparedness for a cyber-attack.~~	~~MC / SA~~	~~Completed~~	~~GREEN~~
3	Exercise / simulation of a major incident~~ – exercise undertaken on 20 may 2025~~.	Improve the Trust's preparedness for an incident.	MC	~~Completed~~tbc NOTE: last exercise undertaken in May 2025. Further exercises to be held.	~~GREEN~~AMBER
4	Engagement in system-wide learning from live events (e.g. global IT outage)	Improve the Trust's preparedness for an incident.	MC / SA	Ongoing	GREEN
5	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	Quarterly reporting into Q&S	AMBER
6	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	Quarterly reporting into Q&S	GREEN
7	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
8	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:	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)

	• 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.				

Corporate Risk Summary

Committee / Group / Meeting, Date

Board of Directors, 03 September 2025

Author:		**Contributors:**
Name:	Dylan Murphy	-
Role/Title:	Trust Secretary	

Report sign-off:

N/A

Is the report suitable for publication:

Yes

Key issues and considerations:

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.

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 as 15 or above.

Risk Management Group

In accordance with the revised 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. The Group has considered the process for reviewing and escalating risk within the Trust to clarify the various checkpoints through which a risk should pass before agreed "corporate risks" are presented to the Board Committees.

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

- staff across the organisation continue to manage operational risk;
- there is a dedicated Governance Manager for each of the two Units - Specialist and MSK - as well as "Corporate services" (for functions that do not fall in either Unit).
- 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;
- the Risk Management Group continues to oversee high-level risks as well as the overall risk profile of the Trust.

A summary of the risks considered at the August round of Board sub-Committees*, following review at the August Risk Management Group meeting, is included in **Table 1**. Points of escalation are raised in individual Committee Chair's Assurance Reports but the following tables include some notes to reflect the discussion.

**DERIC did not meet during August so did not review the risks it oversees / jointly oversees.*

"Corporate risks" previously considered by Board committees that remained live in August 2025:

Risk ref.	Headline risk	Ctte	Inherent Risk	June 24	Aug 24	Oct 24	Dec 24 / Jan 25	Mar 25	May 25	Aug 25	Notes
1511	Compromise to patient data due to cyber attack (Malware)	DERIC	C4 x L5 = 20	C4 x L4 = 16	-	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	Reflects elements of the BAF entry around responding to a major, unforeseen event.
2281	Impact of potential failure of the Orthotics System (and resultant lack of historical data)	DERIC / F&P	C4 x L4 = 16	n/a	n/a	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	Orthotics risks to be further reviewed to potentially consolidate into one relating to the IT system (and its capabilities), and another around the demand / capacity challenge and its impact on waiting times.
3007	Ability of orthotics team to respond to increasing diabetic demand into the service	F&P / P&C / Q&S	C4 X L5 = 20	C4 x L4 = 16*	-	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	
3181	Implications of the lifetime advisory on a particular suppliers' Orthoses (which requires review / potential replacements)	Q&S	C4 x L5 = 20	n/a	n/a	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	
3096	There is a risk that the current Picture Archive and Communication system (PACs) and Radiology information system (RIS) servers will not be replaced within the required timeframe due to delays in the procurement.	DERIC / F&P / Q&S	C4 x L5 = 20	C4 x L5 = 20	-	C4 x L5 = 20	C4 x L5 = 20	C4 x L5 = 20	C4 x L5 = 20	C4 x L5 = 20	Progress has been made. Servers have been purchased. Technical support is now required to bring them on stream (and reduce the risk).
3150	Inadequate general paediatric cover	P&C / Q&S	C4 x L5 = 20	C4 x L4 = 16*	-	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	An agreement in principle with Betsi to share a role with Wrexham. Will need to see how that develops but a potential candidate has been identified. Risk to be re-cast as it relates to a safe service that lacks resilience.

Risk ref.	Headline risk	Ctte	Inherent Risk	June 24	Aug 24	Oct 24	Dec 24 / Jan 25	Mar 25	May 25	Aug 25	Notes
3186	Medicines Supply shortages - lack of resilience to national supply chain issues	Q&S	C4 x L5 = 20	C4 x L5 = 20	-	C4 x L5 = 20	C4 x L5 = 20	C4 X L4 =16	C4 X L4 =16	C4 x L4 = 16	This remains an issue. Progress being made with on-site storage but national issues are beyond the Trust's control.
3203	There is a risk that deteriorating patients at the weekend will receive sub optimal management	Q&S	C5 X L4 = 20	n/a	n/a	C5 X L3 = 15	C5 X L3 = 15	C5 X L3 = 15	C5 X L3 = 15	C5 X L3 = 15	Middle grade anaesthetist cover being put in place. Foundation doctor cover being put in place at weekends. Risk to be re-cast to capture the need to have a plan to keep pace with increased activity / insourcing / six-day working.
3238	Occupational Health surveillance insufficient to provide assurance that employees are having their occupation health surveillance needs assessed against the agreed health and safety matrix	P&C / Q&S	C4 X L4 = 16	n/a	n/a	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	Will be updated following the HSE inspection Report but there are immediate and longer-term risks relating to OH provision that need to be addressed.
3265	Absence of robust system to provide assurance that requested radiology images are tracked and the results are viewed, acted upon and recorded accordingly.	Q&S	C4 X L5 = 20	n/a	n/a	C4 x L4 = 16	C4 X L4 = 16	C4 X L4 = 16	C4 X L4 = 16	C4 x L4 = 16	The system solution will not address the issue. The requirements are being audited to produce a gap analysis.

"Corporate risks" considered by Committees for the first time in August 2025:

Risk ref.	Headline risk	Ctte	Inherent Risk	June 24	Aug 24	Oct 24	Dec 24 / Jan 25	Mar 25	May 25	Aug 25	Comments
3343	Failure to deliver planned activity increase linked to consultant capacity leading to income loss	F&P	C4 X L5 = 20	n/a	n/a	n/a	n/a	n/a	n/a	C4 X L4 = 16	Financial risk developed since the last report.

"Corporate risks" previously considered by Board committees reported as REDUCED, CLOSED, or subject to further review in August 2025:

Risk ref.	Headline risk	Ctte	Inherent Risk	June 24	Aug 24	Oct 24	Dec 24 / Jan 25	Mar 25	May 25	Aug 25	Comments
3228	Inability to recruit consultant rheumatologist adversely affecting waiting lists and resilience of the service.	P&C	C4 x L5 = 20	n/a	n/a	n/a	n/a	C4 X L4 = 16	C4 X L4 = 16	CLOSED	Closed following successful recruitment into the service.
3282	Suspension of MHRA licence, inability to manufacture autologous chondrocytes and treat patients	Q&S	C4 X L5 = 20	n/a	n/a	n/a	C4 X L5 = 20	C4 X L5 = 20	C4 X L5 = 20	CLOSED	Closed as Trust not seeking to reinstate the licence at this point. Mitigations are in place to enable the lab to function and options for future operations are being explored.

Strategic objectives and associated risks:

This work supports all of the Trust's objectives and feeds the Board Assurance Framework.

Recommendations:

That the Board NOTE the risks rated at 15 or above, and the movement in risks rated at 15 or above, as considered by the Board Committees during August 2025.

Report development and engagement history:

The Risk Management Group is in operation to ensure appropriate check and challenge of high rated risks.

The Board sub-committees considered the detail of each risk they oversee during the October round of meetings. This report provides a summary of the content considered in more detail at the committee meetings.

Next steps:

The Risk Management Group will continue to meet on a monthly basis and work with staff to implement the revised risk management arrangements. The Board sub-committees will continue to review risks rated at 15 or above that align with their remit.

Risk Management training will continue, including targeted support to key individuals / teams.

Chief Executive Officer Report

Committee / Group / Meeting, Date

Board of Director, Public Meeting, 03 September 2025

Author:

Name: Stacey Keegan
Role/Title: Chief Executive Officer

Contributors:

Chris Hudson,
Head of Communications

Report sign-off:

Stacey Keegan, Chief Executive Officer

Is the report suitable for publication:

Yes

Key issues and considerations:

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

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

Recommendations:

The update is shared with the Board for oversight and discussion on the contents of the report.

Acronyms	
AGM	Annual General Meeting
ICB	Integrated Care Board
LoF	League of Friends
MARs	Mutually Agreed Resignation Scheme
MCSI	Midland Centre for Spinal Injuries
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust
SaTH	The Shrewsbury and Telford Hospital NHS Trust
STW	Shropshire Telford and Wrekin
UK	United Kingdom

Chief Executive Officer Report

1. RJAH Strategic Objectives for 2025/26

Earlier this month, we proudly launched our strategic objectives for the year across the organisation, marking a significant milestone in our journey. These objectives are rooted in our bold and ambitious five-year strategy, which sets out our overarching vision for the future. While we can't achieve everything at once, our annual strategic objectives help us take purposeful steps toward that long-term ambition.

Now that they've been launched, our focus shifts to bringing them to life, ensuring that every colleague understands and can articulate how their individual role contributes to our collective goals.

2. Launch of our Mutually Agreed Resignation Scheme (MARS)

Board members will be aware that the Trust is currently operating a Mutually Agreed Resignation Scheme (MARS). This initiative forms part of our broader response to the financial pressures facing the NHS and the expectation that we reduce headcount and cost across the organisation. We are actively exploring a range of approaches to achieve this, including:

- Rigorous vacancy reviews to assess whether roles are essential or could be delivered differently
- Redeployment opportunities
- Promoting more flexible ways of working

MARS is an additional tool we are using to support this effort. It is important to note that MARS is not a redundancy programme. Instead, it offers staff, primarily those in non-patient-facing roles, the opportunity to voluntarily resign from their post, by mutual agreement with the Trust, in return for a severance payment. The scheme remains open for applications until Thursday, 11 September.

Important to note that whilst this is a priority for us, so is the safety and quality of our services, access and our people, all decisions are viewed and taken with these at the forefront.

3. Insourcing contract with Portland Clinical

A key priority for 2025/26 is to increase clinical activity and continue making meaningful progress in reducing our waiting lists. To help achieve this, we're pleased to announce that Portland Clinical has been awarded an insourcing contract to support orthopaedic services.

In alignment with NHS England's insourcing guidelines, the service will be delivered outside of core hours, including evenings and weekends whilst ensuring patients receive timely care while maximising use of available capacity. This arrangement, which began in early August, provides a valuable boost to service continuity and complements the Trust's longer-term strategy to address capacity challenges through sustainable workforce recruitment, workforce redesign, pathways improvements and targeted infrastructure investment.

We're confident that this partnership will make a positive impact for both patients and staff, as we continue working towards a more resilient and responsive service.

4. NHS Staff Survey 2025 – Let's Make Every Voice Count

In the coming weeks, we'll be formally launching the NHS Staff Survey 2025. This survey is one of our most important tools for listening to our people, understanding their experiences, and shaping improvements that matter.

Last year, our response rate was 47%, a figure which we're keen to improve. Every response helps us build a clearer picture of what's working well and where we need to do better. That's why we're asking for everyone's support in taking part this year.

As part of the launch, we've developed a range of communication tools encouraging participation, and we've prepared an information pack that highlights key insights from last year's survey and the actions we've taken in response. We want to show that our people's feedback leads to real change.

5. Togetherness Week is Back – Starting Monday 8 September!

We're excited to announce that our annual Togetherness Week returns next week, beginning Monday 8 September. This special week is all about recognising and celebrating our incredible colleagues, and embracing the idea that we're at our best when we work well together.

The celebrations are kindly coordinated by our wonderful League of Friends (LoF) team, who have been busy planning a week full of fun and appreciation. To help shape this year's events, the LoF recently

ran a staff survey to gather feedback on last year's Togetherness Week, what people enjoyed most, and what could be improved. Your insights have played a key role in shaping what's to come.
We can't wait to celebrate with you!

6. Annual General Meeting

September is shaping up to be a busy month, and I'd like to draw your attention to a key date in our calendar, the Trust's Annual General Meeting, which will take place on Monday 29 September.
This important event offers us the opportunity to reflect on the achievements and challenges of the past financial year, while also sharing our plans and priorities for the months ahead. We're keen to encourage wider participation, not only from our staff, but also from patients and members of the public.
To make the AGM as accessible as possible, we'll be hosting it in a hybrid format this year. Attendees are welcome to join us in person or virtually via Microsoft Teams.

7. Ian Green OBE, Chair, NHS Shropshire, Telford and Wrekin Integrated Care Board

We were delighted to host Mr Ian Green, newly appointed NHS STW ICB Chair at RJAH in August. An opportunity for some of the senior team to share the positive work, future developments and challenges, through a round table conversation and site visit.

8. Innovative new hip treatment

I'm always pleased to see us enhancing and expanding our services here at RJAH, and I'm especially delighted to share news of a significant advancement in patient care. Individuals living with hip bursitis, also known as Greater Trochanteric Pain Syndrome, a common and often painful condition, are now benefitting from a new, cutting-edge treatment: focused shockwave therapy.
This non-invasive procedure has demonstrated remarkable results, offering relief to many who previously struggled with persistent pain. The treatment was introduced following a research study led by Mr Robin Banerjee, one of our Consultant Orthopaedic Surgeons. Over the course of two years, the study involved more than 100 patients and compared the effectiveness of standard steroid injections with focused shockwave therapy.
The findings were compelling: up to 80% of patients treated with shockwave therapy reported significant improvement, compared to just 15% of those who received steroid injections. These results were first presented to the British Hip Society and published in 2021. Following further evaluation by the NHS and NICE, the therapy was recognised as a valid and effective treatment option.
Thanks to generous funding from the League of Friends, RJAH is proud to be the first NHS hospital in the UK to offer this innovative therapy; another example of our commitment to delivering world-class care to our patients.

9. New Covered Seating Pods Enhance the Path of Positivity

Patients, staff, and visitors can now enjoy the outdoors in greater comfort and accessibility, thanks to the installation of two brand-new covered seating pods along the hospital's Path of Positivity.
Funded by NHS Charities Together, these thoughtfully designed pods offer a sheltered and inclusive space for rest, reflection, and social connection. Positioned along the popular wellness path at the rear of the hospital, the pods provide weather-resistant seating that encourages year-round use and supports wellbeing for all.
Whether taking a quiet moment alone or enjoying a chat with a colleague or loved one, the new pods make the Path of Positivity even more inviting.

10. Celebrating 60 Years of Excellence at the Midland Centre for Spinal Injuries (MCSI)

This year marks a significant milestone for the Midland Centre for Spinal Injuries (MCSI), as we proudly celebrate 60 years of pioneering care, rehabilitation, and innovation. Established in 1965 in response to the growing demand for a dedicated spinal injury service in the Midlands, MCSI quickly became one of the first specialist centres of its kind in the UK.
Over the past six decades, MCSI has evolved into a nationally recognised centre of excellence, supporting the rehabilitation of more than 4,000 patients and shaping the future of spinal cord injury care.
To commemorate this remarkable anniversary, staff, patients, families, and volunteers gathered in Horatio's Garden on the unit for a special celebration. The event honoured the service's rich history and provided an inspiring opportunity to look forward to the future of spinal injury care.

11. National award for Spinal Injury Sister

I was delighted to see one of our outstanding nurse leaders receive national recognition for her dedication and compassionate care. Cath Roberts, Sister at the Midland Centre for Spinal Injuries, was recently honoured with a prestigious Cavell Star Award.

Cath was nominated by her colleague, Sophie Podmore, Student Nurse Associate, in recognition of the exceptional support she provided to a patient with learning difficulties who had become a high tetraplegic following a neck injury.

The Cavell Star Awards, run by the charity Cavell, celebrate nurses, midwives, and healthcare support workers across the UK who go above and beyond in delivering outstanding care. Cath's award is a testament to her professionalism, empathy, and unwavering commitment to her patients.

12. RJAH Stars Award

Each month, I have the privilege of presenting the RJAH Stars Award to an individual or team whose exceptional performance or achievements have made a meaningful impact across our Trust.

Our most recent recipient is Steve Humphreys, a dedicated Scrub Nurse, recognised for his outstanding contribution to improving efficiency and outcomes in hip arthroscopy procedures. Steve was nominated by Mr Rajpal Nandra, Consultant Orthopaedic Surgeon, who commended his initiative, innovation, and leadership.

Congratulations, Steve — your commitment and care truly reflect the values we celebrate through the RJAH Stars Award. Thank you for making a difference.

13. Conclusion

The update is shared with the Board for oversight and discussion on the contents of the report.

System Integrated Improvement Plan

Committee / Group / Meeting, Date

Board of Directors, 03 September 2025

Author:		Contributors:
Name:	Dylan Murphy	Action Plan "Task" owners.
Role/Title:	Trust Secretary	

Report sign-off:

n/a

Is the report suitable for publication:

No – this reflects work in progress to develop a position.

Key issues and considerations:

RJAH executives were invited to an NHSE / ICB session on 3 October 2024 to discuss RJAH's contribution to the "system transition plan".

The "transition" relates to the ICB / SaTH transition from Level 4 of the NHS Oversight Framework (NOF) to Level 3 of the Framework. Though the "transition" only technically applies to organisations rated at NOF 4, the associated plan recognises that individual organisations may have limited ability to deliver sustained improvement in isolation - that improvement will be dependent on wider system working. The plan is therefore a system-wide plan. It has five areas of focus:

1. Finance;
2. Workforce;
3. Urgent and Emergency Care (U&EC);
4. Governance; and
5. Leadership.

Whilst the deliverables in the plan represent exit-criteria for the organisations in NOF 4, that is not true for RJAH (or the other contributors that are not rated at Level 4). Each provider in the system is however expected to demonstrate its commitment to supporting the plan. Each organisation therefore has its own deliverables, based on the particular contribution it can make to the wider plan.

Following the session on 3 October, the ICB circulated a more detailed template for all providers to complete and return. This was referred to as the "System Integrated Improvement Plan" (or SIIP). The SIIP template has a "***Plan***" for each of the five areas, with organisation-specific deliverables..

A request was received from the System that each provider was to confirm the monitoring arrangements against the SIIP. The Finance and Performance Committee and People and Culture Committee received elements of the Plan at their August meetings. For visibility, the full plan (as at the 11 August submission deadline) is attached.

Strategic objectives and associated risks:

This work supports all of the Trust's objectives and feeds the Board Assurance Framework.

Recommendations:

That the Board notes the progress updated in relation to the RJAH contribution to the System Integrated Improvement Plan.

Attachment: RJAH Contributions to SIIP

Metric ID	Deliverable(s) *The outputs that you need to produce to demonstrate delivery of exit criteria*	Deliverable Owner	Task ID	Task(s) *The tasks you need to complete to produce the deliverables* (please add / remove lines as necessary)	Task Owner	Start Date	End Date	RAG	Revised Deadline Date Requested	Notes
1.1	The Trust has an agreed medium term 3-5 year financial plan (MTFP) in place that has been signed off by the Board and agreed with the ICS and NHS England Triangulation exercise - financial plan to workforce, activity and performance plans; with evidence of testing and review against the HTP model. To be included with the MTFP for sign off.	Angela Mulholland-Wells	RJAH 1.1.1	MTFP planning assumptions base case modelled and updated in the system MTFP	Mark Salisbury	Complete	Complete	Complete; Evidence received		MTFP agreed as system and taken through committee. This is avaialble on the sharepoint drive for all system partners.
			RJAH 1.1.2	Annual refresh of MTFP and 5 year high level financial plan (including triangulation)	Mark Salisbury	Annual	31st Dec	Complete; Evidence received	27th March. Delay due to confirmation of final plan position.	MTFP and finance strategy completed - for approval with provider finance committees and ICS finance committee in April.
			RJAH 1.1.3	Ongoing monitoring of underlying position against MTFP assumptions	Mark Salisbury	Annual	31st March	Complete; Evidence received		MTFP is used as the basis for the recurrent underlying position for financial planning, we update this regularly throughout the year along with system partners.
			RJAH 1.1.4	RJAH Demand and capacity model aligned to system model - 1 year model	Nia Jones	Started	31/10/2024	On Track	30/06/25	**RJAH demand and capacity** - re-fresh undertaken to inform the 2025/26 operational plan. All 2024/25 input information to inform thesystem D&C model provided end of October 2025. **System D&C model**: Workshop taking place with PA in attendance on the 23rd April 2025 to support achievements of fit for purpose outputs from the D&C model. **Timeline for completion received from ICB following discussions with PA which will lead to completion of this excercise by 5th June 2025.**
			RJAH 1.1.5	RJAH Demand and capacity model aligned to system model 3-5 years	Nia Jones	Started	31/03/2025	On Track	30/06/25	All 2024/25 input information to inform thesystem D&C model provided end of October 2024. System D&C model: Workshop taking place with PA in attendance on the 23rd April 2025 to support achievements of fit for purpose outputs from the D&C model. The inputs for 2025/26 and future years to be refreshed following confirmation that the model outputs are fit for purpose which is anticipated 30th April 2025. **Timeline for completion received from ICB following discussions with PA which will lead to completion of this excercise by 5th June 2025.**
			RJAH 1.1.6	Ongoing monitoring of activity plans and underlying position against longer term planning assumptions	Nia Jones	Annual	31st Dec	Complete; Evidence received		**Activity is monitored monthly with regular bridge summaries provided on variance against plan and changes in future plans as part of the system planning rounds setting out key interventions that provide step changes in anticipate and actual activity. Bridge accompanies activity plan subbmisions to the ICB.**
			RJAH 1.1.7	Triangulation to activity, workforce and performance and updated for 25/26 operational planning guidance	Mark Salisbury / Nia Jones	Started	31/01/2025	Complete; Evidence received	27th March. Delay due to confirmation of final plan position.	Financial, workforce and operational plan triangulation completed. Files saved down as evidence along with feedback from NHSE.
			RJAH 1.1.8	Recovery plan trajectory based on Strategic Transformation Programmes and Benchmarking opportunities updated in RJAH and system MTFP model.	Mark Salisbury	Started	31/03/2025	Complete; Evidence received		MTFP is used as the basis for the recurrent underlying position for financial planning, we update this regularly throughout the year along with system partners. Includes assumptions on efficiency and transformation to deliver deficit reduction target over three years.
			RJAH 1.1.9	10-Year first draft capital plan developed	Mark Salisbury	Complete	Complete	Complete; Evidence received		10 year capital programme developed and updated. This is avaialble on the sharepoint drive for all system partners.
			RJAH 1.1.10	Capital MTFP update following capital allocations and guidance	Mark Salisbury	Started	31/01/2025	Complete; Evidence received		10 year capital programme updated aligned to final plan submission. Updated on the consolidated system 10 year capital plan which is on sharepoint for all organisations.
			RJAH 1.1.11	Long-Term financial plan model - capital and revenue updated to match the system LTFP	Victoria Brownrigg	Complete	Complete	Complete; Evidence received		Updated as per LTFP. Available on sharepoint. Paper saved down as evidence.
			RJAH 1.1.12	Long term financial plan model - updated to match the system LTFP	Victoria Brownrigg	Started	31/03/2025	Complete; Evidence received	30/06/25	Completed - MTFP agreed with all organisations along with finance strategy. The backing files are held as central models in the share drive and updated at key points in the planning process.
1.2	24/25 and 25/26 financial plans agreed and signed off by RJAH aligned to the ICS plans and NHS England Plans to include a fully developed Financial Improvement Plan (i.e. CIPs) with supporting PIDs linked to the benchmarking opportunities	Angela Mulholland-Wells	RJAH 1.2.1	24/25 Revenue Plan agreed by RJAH, ICS and NHSE and fully identified CIP plan	Mark Salisbury	Complete	Complete	Complete; Evidence received		24/25 plan and delivery. Final plan slides included as evidence.
			RJAH 1.2.2	25/26 Revenue Plan agreed by RJAH, ICS and NHSE	Mark Salisbury	Started	31/03/2025	Complete; Evidence received		Financial, workforce and operational plan triangulation completed. Files saved down as evidence along with feedback from NHSE.
			RJAH 1.2.3	25/26 Draft efficiency schemes high level	Victoria Brownrigg	Started	30/11/2025	Complete; Evidence received		Draft efficiencies to be presented to FIP on 23rd Jan. Draft plan slides for check & challenge included as evidence.
			RJAH 1.2.4	25/26 Draft effiiency schemes detail	Victoria Brownrigg	Started	31/01/2025	Complete; Evidence received		Draft efficiencies to be presented to FIP on 23rd Jan. Draft plan slides for check & challenge included as evidence.
			RJAH 1.2.5	25/26 Draft efficiency confirm & Challenge with executive team	Victoria Brownrigg	Started	28/02/2025	Complete; Evidence received	Evidence will be part of the detailed FIP pack for efficiencies by end March	Draft efficiencies reviewed by Financial Improvement Group in February
			RJAH 1.2.6	25/26 Efficiency plan identified	Victoria Brownrigg	Started	31/03/2025	Complete; Evidence received		Efficiency programme identified - further work to de-risk schemes
			RJAH 1.2.7	25/26 Efficiency plan PID's signed off by scheme leads and directors	Victoria Brownrigg	Started	31/03/2025	Complete; Evidence received		High level PID documentation shared as part of efficiency programme oversight.
			RJAH 1.2.8	25/26 Efficiency plan QIA's developed by clinical leads	Ian Maclennan / Lisa Newton	01/01/2025	28/02/2025	Complete; Evidence received	tbc	PIDS and QIAS completed by delivery units and signed off.
			RJAH 1.2.9	25/26 Efficiency plan QIA's signed off by CNO / CMO	Ian Maclennan / Lisa Newton	28/02/2025	31/03/2025	Complete; Evidence received	tbc	PIDS and QIAS signed by Chief Nurse. Sign off by CMO in progress
			RJAH 1.2.10	25/26 draft operational activity plan based on D&C work	Nia Jones	Started	28/11/2025	Complete; Evidence received		D&C models refresh in D&C file on sharepoint - linked feed through to the Operational Activity plan 2025/26.
			RJAH 1.2.11	25/26 monthly review of activity plan aligned to performance and financial requirements based on development of D&C model and interventions	Nia Jones	Started	31/01/2025	Complete; Evidence received	29th April 2025 - final plan submission d	Operational plan includes D&C model and interventions. F&P committee presentations provide a breakdown of interventions for elective activit, new patients and outpatients
			RJAH 1.2.12	25/26 sign off operational activity plan	Nia Jones	Started	31/03/2025	Complete; Evidence received	29th April 2025 - final plan submission d	Operational Plan sign off and submission, signed off through F&P committee and Board.
			RJAH 1.2.13	25/26 sign offworkforce plan aligned to activity delivery	Andrea Martin	Started	31/03/2025	Complete; Evidence received	29th April 2025 - final plan submission d	Workforce plan sign off F&P 19th March 2025 and submission on the 27th March 2025.
			RJAH 1.2.14	25/26 Triangulation of finance, activity and workforce	Mark Salisbury / Nia Jones	Started	31/03/2025	Complete; Evidence received		Financial, workforce and operational plan triangulation completed. Files saved down as evidence along with feedback from NHSE.
			RJAH 1.2.15	25/26 draft cost pressures	Victoria Brownrigg	Started	30/10/2025	Complete; Evidence received		Draft plan slides for check & challenge included as evidence.
			RJAH 1.2.16	25/26 cost pressures prioritisation	Victoria Brownrigg	Started	30/11/2025	Complete; Evidence received		Draft plan slides for check & challenge included as evidence.
			RJAH 1.2.17	25/26 cost pressures internal confirm and challenge	Victoria Brownrigg	Started	31/12/2025	Complete; Evidence received		Draft plan slides for check & challenge included as evidence.

Metric ID	Deliverable(s) *The outputs that you need to produce to demonstrate delivery of exit criteria*	Deliverable Owner	Task ID	Task(s) *The tasks you need to complete to produce the deliverables* (please add / remove lines as necessary)	Task Owner	Start Date	End Date	RAG	Revised Deadline Date Requested	Notes
			RJAH 1.2.18	25/26 cost pressures system confirm and challenge	Victoria Brownrigg	Started	31/01/2025	Complete; Evidence received		Draft plan slides for check & challenge included as evidence.
			RJAH 1.2.19	25/26 organisational sign off draft plan submission	Mark Salisbury	Started	28/02/2025	Complete; Evidence received		Headline plan slides from finance committee saved down in folder
			RJAH 1.2.20	25/26 organisational sign off final plan submission	Mark Salisbury	Started	31/03/2025	Complete; Evidence received		Board approved final plan for submission
			RJAH 1.2.21	25/26 budget setting - pay / non pay completed	Victoria Brownrigg	Started	31/01/2025	Complete; Evidence received		Budget sign off completed confirms budget setting
			RJAH 1.2.22	25/26 budget sign off	Victoria Brownrigg	Started	31/03/2025	Complete; Evidence received		Budget sign off completed
			RJAH 1.2.23	In year monitoring of financial performance against plan assumptions identifying escalation actions where needed (oversight through FIG and F&P Committee)	Mark Salisbury	Ongoing	Ongoing	On Track		Monthly finance committee meetings Monthly Performance and Improvement Oversight Meetings Weekly system FIP meetings
			RJAH 1.2.24	Monitor ongoing demand & capacity actuals against plan assumptions identifying escalation actions where needed (oversight through FIG and F&P Committee)	Nia Jones	Ongoing	Ongoing	On Track		
1.3	Capital plans for 24/25 and 25/26 signed off by RJAH aligned to system plans and NHS England	Angela Mulholland-Wells	RJAH 1.3.1	24/25 Capital Plan agreed June 24 System Finance Committee, agreed by all STW organisations and NHSE (Complete).	Mark Salisbury	Complete	Complete	Complete; Evidence received		RJAH final plan saved as evidence
			RJAH 1.3.2	24/25 Secure remedy for EPR overspend c£3.0m	Mark Salisbury	Started	31/03/2025	Complete; Evidence received		Additional PDC funding confirmed. MOU recieved confirming value.
			RJAH 1.3.3	Support system delivery of 24/25 CDEL - application of the Capital prioritisation framework in action in year. Performance monitoring through CPOG - Capital report Prioritisation Oversight Group, application of the Capital Prioritisation Framework as required. (Monthly).	Mark Salisbury	01/04/2024	31/03/2025	Complete; Evidence received		Plan delivered within CDEL envelope
			RJAH 1.3.4	Support System Capital Strategy & Capital Prioritisation Framework developed with system partners and approved at System Finance Committee June 2024. (Complete).	Mark Salisbury	Complete	Complete	Complete; Evidence received		Agreed as system partners
			RJAH 1.3.5	Draft System Infrastructure strategy developed and submitted to NHSE July 24 for review	Nick Huband	Complete	Complete	Complete; Evidence received		Several enagement meetings took place to inform document
			RJAH 1.3.6	Initial capital plan 25/26 populated in July 24	Mark Salisbury	Complete	Complete	Complete; Evidence received		Agreed as system partners
			RJAH 1.3.7	Capital prioritisation within available resource for 25/26 once funding limits following guidance is confirmed.	Mark Salisbury	01/11/2024	31/03/2025	Complete; Evidence received		Final capital programme agreed within the reduced system envelope and submitted in final FPR
			RJAH 1.3.8	Update the 25/26 Capital plan following the release of national capital guidance and sign-off by individual organisation and system governance and NHSE.	Mark Salisbury	01/11/2024	31/03/2025	Complete; Evidence received		Final capital programme agreed within the reduced system envelope and submitted in final FPR
			RJAH 1.3.9	Submission of agreed 25/26 capital plan into technical planning forms	Diana Owen	01/02/2025	31/03/2025	Complete; Evidence received		Final capital programme agreed within the reduced system envelope and submitted in final FPR
			RJAH 1.3.10	Delivery of 25/26 CDEL - application of the Capital prioritisation framework in action in year. Performance monitoring through CPOG - Capital report Prioritisation Oversight Group, application of the Capital Prioritisation Framework as required. (Monthly).	Mark Salisbury	01/04/2025	31/03/2026	On Track		RJAH Capital Management Group meet monthly to oversee capital delivery, Finance Committee oversight of the workplan Monthly meetings of the capital oversight prioritisation group. These papers are avaiable on the share drive under ICS reporting / CPOG.
1.4	Independent review of 'grip & control' - identifying RJAH's gaps (I&I phase 1 work) resulting in a plan to address gaps Follow up re-assessment review of 'grip & control'	Angela Mulholland-Wells	RJAH 1.4.1	organisational self-assessment of NHSE grip and control checklist &	Mark Salisbury	Complete	Complete	Complete; Evidence received		Grip & control actions implemented. Full tracker shared regularly.
			RJAH 1.4.2	Delivery against Phase 1 I&I organisation specific intervention action plans (No PO No Pay, efficacy of vacancy and temporary staffing controls and de-risking cost efficiency schemes). Key outputs reported in finance report to finance committee monthly.	Mark Salisbury	15/08/2024	30/11/2024	Complete; Evidence received		Grip & control actions implemented. Full tracker shared regularly.
			RJAH 1.4.3	Delivery of Phase 2 I&I scope in relation to efficacy of controls (run-rate improvements) for Workforce, UEC and System PMO (high risk CIPs) - delivery of interventions post PWC Phase 2 completion by March 25.	Mark Salisbury	15/09/2024	31/03/2025	Complete; Evidence received		I&I work forms part of the delivery of the 24/25 financial plan, this is a significant mitigation to lost income throughout the year. A continuation of the expenditure controls is built into the 25/26 financial plan to support delivery of the break even control total.
			RJAH 1.4.4	Follow up review of I&I actions to ensure continued delivery	Mark Salisbury	01/08/2025	01/10/2025	On Track		HFMA Sutainability Assessment Completed - saved in folder NHSE Grip & Control checklist completed - saved in folder Internal audit to review for assurance as part of financial controls audit
			RJAH 1.4.5	External review of Individual organisation assessment against NHSE grip and control checklist & HFMA Financial Sustainability checklist and efficacy of controls.	Mark Salisbury	Complete	Complete	Complete; Evidence received		PWC action tracker saved down along with HFMA sustainability checklist.
			RJAH 1.4.6	Delivery of individual organisational internal audit report recommendations from prior years and pro-active management in year	Mark Salisbury	01/04/2024	31/03/2026	On Track		Head of internal audit opinion saved down. Substantial assurance. See section D in particular.
			RJAH 1.4.7	Individual organisational tracking of timely completion of internal audit actions	Mark Salisbury	01/04/2024	31/03/2026	On Track		
			RJAH 1.4.8	Delivery of individual organisational external audit report recommendations	Mark Salisbury	01/04/2024	31/03/2026	On Track		Part of audit report 1.4.11
			RJAH 1.4.9	Individual organisational tracking of timely completion of external audit actions	Mark Salisbury	01/04/2024	31/03/2026	On Track		Part of audit report 1.4.11
			RJAH 1.4.10	Internal Audit findings for all finance related audits to be rated moderate or substantial	Mark Salisbury	01/04/2024	31/03/2026	On Track		Financial audit saved down. High assurance.
			RJAH 1.4.11	External audit including VFM to be rated moderate or substantial	Mark Salisbury	01/04/2024	31/03/2026	On Track		VFM and audit report saved down.

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2.1	Workforce delivery plans for 24/25 and 25/26 aligned to overall system plans and signed off by Board	Denise Harnin	RJAH 2.1.1	Set up and deliver workshop with all planning stakeholders (People team, Workforce, Finance and Ops leads etc), across the Trust to identify the priority areas needed that support delivery of our OPERATIONAL workforce plan.	Nia Jones	started	30/11/2024	Complete; Evidence received		Completed - 3 workshops held during November.
			RJAH 2.1.2	Develop actions and milestones that support each priority area with time frame and actions owners.	Nia Jones	started	30/11/2024	Complete; Evidence received		Future Delivery Model Action plan identifying key programmes of work to support delivery. Action plan and February 2025 progress update included as evidence
			RJAH 2.1.3	Finalise plan with fully supported narrative describing the impact and benefit of delivering the plan.	Nia jones	started	31/12/2024	Complete; Evidence received		2nd draft submission to the system on the 31st January. Next Headline submission to be presented to the system on the 19th February2025. This includes the D&C requirements to achieve 60% against 18 week RTT target.
			RJAH 2.1.4	Capture risks to delivery of plan and any mitigations to reduce risk.	Nia Jones	started	31/12/2024	Complete; Evidence received		Completed. Risks included in the system risk register. Additional risks to be updated as operational planning round for 2025/26 continued.
			RJAH 2.1.5	Ensure actions and milestones is reported at workforce planning and assurance group and Agency reduction group. Plan agreed with system and feeds into system process.	Nia Jones	started	31/01/2025	Complete; Evidence received		Completed 17/1/25
			RJAH 2.1.6	Identify baseline and outturn forecast for NUMERICAL WORKFORCE PLAN. Plan agreed with system and feeds into system process	Tina Powell	started	30/11/2024	Complete; Evidence received		1st draft submitted. 31/1/25 – 2nd draft submission
			RJAH 2.1.7	Review known changes, service changes needed, and business cases approved within 24/25. Outline any assumptions in terms of workforce metrics, turnover absence levels etc.	Tina Powell	started	31/12/2024	Complete; Evidence received		Completed for 2024/25
			RJAH 2.1.8	Populate Workforce Planning Template . ongoing monitoring against plan (during 25/26) through governance and escalating actions if off plan	Tina Powell	started	31/01/2025	Complete; Evidence received		AWFP Functional Template shared as evidence.
			RJAH 2.1.9	Calculate the % Change by Staff Group	Tina Powell	started	31/01/2025	Complete; Evidence received		AWFP Functional Template shared as evidence.
			RJAH 2.1.11	Review Budget with Stakeholders/Budget holders	Tina Powell	started	28/02/2025	Complete; Evidence received		Completed as part of budgeted establishment reconciliation
			RJAH 2.1.12	Challenge / Sense Check Data (February 25)	Tina Powell	Feb-25	28/02/2025	Complete; Evidence received		Confirm and challenge meeting held on 7th March and actions completed. Actions attached.
2.2	RJAH People and OD strategy aligned to system strategy	Denise Harnin	RJAH 2.2.1	Review system feedback and refresh RJAH Strategy	Tina Powell	started	31/03/2025	Complete; Evidence received		People Plan aligned to System priorities
			RJAH 2.2.2	Ensure alignment with the new 10-year NHS strategy	Tina Powell	started	31/03/2025	Complete; Evidence received		
			RJAH 2.2.3	Develop RJAH Engagement Strategy to support People and OD Strategy	Caroline Nokes Lawrence	started	31/03/2025	On Track		
			RJAH 2.2.4	Maintain NHS staff survey results in 24/25 and completion rate in 25/26. Through: 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; and Itchy feet conversations	Caroline Nokes Lawrence	started	31/03/2025	Complete; Evidence received		CNL Query - take off reference to 25/26 results as some way off into the future.
			RJAH 2.2.5	Translate NHS Staff Survey results to inform RJAH Strategy	Caroline Nokes Lawrence	when results available	31/03/2025	Complete; Evidence received	Results going to People Committee March 25	Results went to People Committee March 25
			RJAH 2.2.6	Board approved People & OD Strategy including recruitment and retention	Andrea Martin	when results available	31/03/2025	Complete; Evidence received	Plan approved through People Committee	Plan approved through People Committee
			RJAH 2.2.7	Monthly IPR reports, focusing on workforce actual vs plan for absence and retention	Tina Powell / Andrea Martin	when results available	31/03/2025	Complete; Evidence received	Ongoing, provided monthly	Ongoing, provided monthly
			RJAH 2.2.8	Outcome of National staff survey results.	Caroline Nokes Lawrence	when results available	31/03/2025	Complete; Evidence received		CNL Query - appears to be a duplicate. Requested removal.
			RJAH 2.2.9	Benchmark delivery of strategy vs peers	Nia Jones	when results available	31/03/2025	On Track		CNL: Requested removal as unclear how it differs from / adds to the existing tasks.
			RJAH 2.2.10	Take through RJAH People Committee.	Denise Harnin	when results available	31/03/2025	Complete; Evidence received		CNL: As above - Requested removal as unclear how it differs from / adds to the existing tasks.
			RJAH 2.2.11	Take through System People and OD Collaborative for assurance	Denise Harnin	when results available	31/03/2026	On Track		CNL: As above - Requested removal as unclear how it differs from / adds to the existing tasks.

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3.1.5	Working with system partners to deliver the System Discharge Alliance Plan to reduce No Criteria to Reside, and thus reduce escalation inpatient acute capacity (linking to reduced bed occupancy)	Mike Carr	RJAH 3.1.5.1	Continue to provide access to Sath Consultants at RJAH (to support the delivery of Orthopaedic inpatient activity at RJAH on behalf of all providers).	Mike Carr	01/01/2024	Ongoing	On Track		IS UNDERWAY AND ONGOING.
			RJAH 3.1.5.2	Work collaboratively with the system discharge hub to expedite discharge delays (to reduce NCTR levels on Sheldon Ward to a maximum of 3 patients).	Mike Carr	01/01/2024	01/12/2024	Complete; Evidence received		ONGOING. A SPIKE IN NUMBERS IN JAN / DEC AS OPENED AN ADDITIONAL CARE OF ELDERLY WARD. The position has subsequently improved.
			RJAH 3.1.5.3	Work collaboratively with the system discharge hub to expedite discharge delays (to reduce LoS on Sheldon Ward to 21 days initially, then scope a further reduction phase 2.)	Mike Carr	01/01/2024	Phase 1 by 01/12/24	On Track		AS ABOVE. WORK IN PROGRESS FOR FUTURE FOR PHASE 2. LoS position continues to improve.
3.1.3	Work with system partners to deliver alternatives to ED attendances/ admissions and Care Coordination system plan	Mike Carr	RJAH 3.1.3.1	Reduction in MSK ED attendances, Metrics to be developed and target established by 01.12.24	Richard Fallows	Ongoing	01/12/24 to establish baseline target	At Risk	See 3.1.3.4 Note: Q2, 2025/6.	Using pre SATH new EPR data a simple baseline was described for Spinal related pain and ED for 5 years. There are DQ issues. Closed 11/09/24. Our focus was between the spinal pain burden in ED and CES detection. New data to start after GIRFT cMSK Recovery and launch of CES pathway - see 3.1.3.4 below. Targets to be set pending above being implemented. As of April 25 awaiting launch of CES pathway with 24/7 MRI. STW wide end-end spinal pathway meeting 9/5/25. Post Careflow SaTH ED spinal data collection being re-established for monitoring going forwards - 1st draft complete. Still awaiting 24/7 MRI. Still open however new data collection based on new access to the ED data from Careflow SaTH is being refined and will arrive quarterly. Can we suggest a new target date of end of September 2025 to delivery on this, with an amber rating?
			RJAH 3.1.3.2	Sheldon Ward engagement with the Care Transfer Hub	Mike Carr	Ongoing	N/A			
			RJAH 3.1.3.3	Utilise available inpatient capacity where possible (Holiday Period, Weekends)	Mike Carr		In place, with winter ward due to commence 23/12/24	Complete; Evidence received		
			RJAH 3.1.3.4	Rollout of GCA and CES pathways.	Mike Carr	01/04/2024	Nov 24 for GCA and CES	At Risk	See Note: Is it possible to split the two elements?	GCA Phase 1 ready to launch awaiting ICB approval. CES Phase 1 core pathway awaiting SaTH recruitment/Management of Change to staff 24/7 MRI. Was originally meant to go live in July 2024. Unknown launch date. Dependent on SaTH so cannot confirm, but an estimated launch date of Q2 2025/6. April 25 GCA Phase 1 signed off by ICB, preparing for immient launch. GCA Phase 1 & 2 Launch set for 4th July 2025. GCA pathway launched 04/07/25. This line is for CES pathway only now still awaiting 24/7 MRI for potential CES. The GCA pathway is now live so should be completed (BLUE). However the CES pathway is challenegd by SaTH MRI provision (RED). Can we split these out? Rated Amber to reflect the progress in the RJAH-owned element.
			RJAH 3.1.3.5	Develop waiting list prioritisation tool to prioritise patients at high risk of non-elective admission	Mike Carr	01/01/2025	01/04/2025	On Track		The tool has been designed and agreed. Data is required from the ICB before it can be implemented.
			RJAH 3.1.3.6	Enact a robust system escalation framework underpinned by dynamic risk assessment.	Mike Carr		As per system action			
			RJAH 3.1.3.7	Monitor internal metrics via the Trust IPR	Mike Carr	Ongoing	N/A			
			RJAH 3.1.3.8	System level evaluation of MSK programmes of work.	Mike Carr	Ongoing	Dec 25 update on MSST effectiveness Audit	Complete; Evidence received		Clinical Effectiveness Review undertaken and audit reported to MSK Board.
3.2	Effective, regular attendance from RJAH at UEC Delivery Group	Mike Carr	RJAH 3.2.1	Attendance at UEC Delivery Group (Mike Carr, COO)	Mike Carr	started	N/A	On Track		MC continued attendance at UEC Board, UEC Ops Group as well as regular engagement in other system meetings (including with the local authority).

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4.1	Individual RJAH governance structure (Level 2) for Finance, UEC and Workforce re-designed, implemented and functioning (balancing finance, quality & safety, performance and workforce)	Stacey Keegan	RJAH 4.1.1	Review current RJAH structure at Level 2 for UEC, Finance and workforce + interface with system governance structures	All leads	started	31/12/2024	Complete; Evidence received		SIIP action plan aligned to relevant Board committees (which received the plan during the December round of meetings).
			RJAH 4.1.2	Committee agendas – including Finance & Performance Ctte - to be reviewed to ensure continued / increased focus on key areas	All leads	started	31/12/2024	Complete; Evidence received		Activity recovery committee established.
			RJAH 4.1.3	Proposals for change made to RJAH Board taking into account development of provider collaborative(s).	Stacey Keegan	started	31/03/2025	Complete; Evidence received		No change to structures required - actions aligned and Activity Recovery Committee created.
			RJAH 4.1.4	Integrated Performance Reports (IPRs) to be reviewed to ensure continued focus on key performance measures for 2024/5.	Mike Carr	31/12/2024	31/03/2025	Complete; Evidence receive	Complete for 2024/5. Now being updated for 2025/6.	IPRs continue to be reviewed and will be updated to reflect the revised NOF.
			RJAH 4.1.5	Regular reporting in place to provide assurance to the Board, in line with the agreed arrangements.	Stacey Keegan / Dylan Murphy	01/04/2025	31/03/2026	Complete; Evidence received		Committees receiving reports (and have an escalation route through chairs' assurance reports).
4.2	RJAH elements of the system performance & accountability framework - developed and implemented	Stacey Keegan	RJAH 4.2.1	Agreement of SIIP approval and ongoing assurance arrangements within RJAH.	Stacey Keegan / Dylan Murphy	completed	06/11/2024	Complete; Evidence received		
			RJAH 4.2.2	RJAH elements of system performance & accountability framework documented and signed off by RJAH board	Stacey Keegan / Dylan Murphy	started	01/04/2025	Complete; Evidence received		A draft framework has been developed by the ICB and shared with providers for comment. The updated draft has been considered by system Chief Executives. The Framework was considered by the RJAH Board **on 2 April 2025.**
			RJAH 4.2.3	Development of governance arrangements to deliver MSK / elective orthopaedics on a system level, via a provider collaborative arrangement	Mike Carr	started	01/04/2025	Complete; Evidence received		ICB commissioning intentions include RJAH as the lead provider. The Board has agreed the scope of works to be undertaken to establish a formal collaborative. A draft governance structure, TOR etc have been developed and were considered by the System Transformation and Digital Committee in March 2025. The newly created MSK Operational Performance and Governance Group met on 14 April 2025. The Provider Collaborative Board is to meet, in shadow form, on 16 April 2025 .
			RJAH 4.2.4	Board to consider and approve TOR / MOU / appropriate delegations to enable the creation and operation of provider collaborative arrangements	Stacey Keegan / Dylan Murphy	started	01/04/2025	Complete; Evidence receive	Shadow arrangements from April 2025, moving towards formal arrangements by April 2026.	As 4.1.3 above. Scope of the collaborative and the next steps in creation of a formal collaborative (via shadow arrangements from April 2025 onwards) agreed.
			RJAH 4.2.5	Regular reporting in place to provide assurance to the Board, in line with the agreed arrangements.	Stacey Keegan / Dylan Murphy	01/04/2025	31/03/2026	Complete; Evidence received		MSK Board reporting into the Finance and Performance Committee (and upward reporting to the Board via the Chair's Assurance Report).
4.3	An agreed RJAH and all STW provider wide risk management approach (including consistent policies and risk assessment tools) that is then adopted as the system and ICB approach that is implemented and functioning.	Stacey Keegan	RJAH 4.3.1	Engage with programme / governance leads to develop consistent risk management policies - to include risk scoring, risk reporting/escalation, risk management procedures.	Dylan Murphy	started	01/04/2025	On Track		A series of meetings have been held with governance leads to review existing arrangements and develop proposals for a consistent approach. Finance-specific risk rating scheme agreed and in operation. Principles and general approach are already consistent. Individual risks are raised at the appropriate system fora but there is no system-agreed escalation process.
			RJAH 4.3.2	Approve the system-agreed risk management policies - to include risk scoring, risk reporting/escalation, risk management procedures - via RJAH governance structure.	Dylan Murphy	started	01/04/2025	At Risk	Rated "amber" as certain, key elements already in place.	Principles broadly agreed. Proposals to be confirmed by ICB-lead and considered collectively by chief execs before formal adoption / implementation. Finance-specific risk approach agreed and in operation.
			RJAH 4.3.3	Engage with programme / governance leads to co-ordinate the implementation of agreed, system-wide arrangements.	Dylan Murphy	started	01/04/2025	At Risk	Rated "amber" as certain, key elements already in place.	Dependent on actions above. Broad approach to risk management is already consistent . Finance-related risk approach agreed and in operation.
			RJAH 4.3.4	Implement the approved, system-wide risk management policies - to include risk scoring, risk reporting/escalation, risk management procedures.	Dylan Murphy	01/04/2025	01/04/2025	At Risk	Rated "amber" as certain, key elements already in place.	Dependent on actions above. Broad approach to risk management is already consistent. Finance-related risk approach agreed and in operation.
			RJAH 4.3.5	Maintaining the regular review of risk management via the Board and committee structure and undertake an annual review of the wider process at the Audit and Risk Committee.	Dylan Murphy	01/04/2025	31/03/2026	On Track		Requires formal implementation of a system-wide process. RJAH risk process in place and is regularly reviewed.
4.4	RJAH elements of the System PMO designed, implemented and functioning	Stacey Keegan	RJAH 4.4.1	Engage with programme / governance leads to develop and implement proposals	Craig Macbeth	01/10/2024	01/04/2025	Complete; Evidence received		System PMO established
			RJAH 4.4.2	RJAH elements of system PMO structure & approach documented and signed off by RJAH board and ICB	Craig Macbeth	01/10/2024	01/04/2025	Complete; Evidence received		Agreed by Board-level executive lead
			RJAH 4.4.3	Continue to drive the delivery of a system PMO with all partners	Craig Macbeth	01/10/2024	01/04/2025	Complete; Evidence received		Arrangements in operation.

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5.1	Individual RJAH elements of the functioning Provider Collaborative (aligned to the priorities within the Strategic Commissioning Plan approved by IC Board) where open and honest conversations are brokered.	Stacey Keegan	RJAH 5.1.1	Continue to lead workforce programme as SRO	Stacey Keegan	started	N/A	Complete; Evidence received		
			RJAH 5.1.2	Continue to lead planned care programme as SRO	Stacey Keegan	started	N/A	Complete; Evidence received		
			RJAH 5.1.3	Continue to lead MSK Transformation Group (working towards MSK collaborative arrangements)	Stacey Keegan / Mike Carr	started	N/A	Complete; Evidence received		
			RJAH 5.1.4	Act as 'waiting well' lead under the health inequalities workstream which will have links to UEC / exit criteria	Mike Carr	started	N/A	On Track		
			RJAH 5.1.5	As with the Governance deliverable: Agree and approve the scope of the provider collaborative and the necessary arrangements (including delegations) via RJAH governance arrangements, i.e. Audit and Risk Committee and Board of Directors	Stacey Keegan / Mike Carr	started	01/04/2025	Complete; Evidence received		See Goverance task 4.2.3. Proposals agreed at Board meeting on 2 April, shadow Provider Collaborative Board met on 16 April.
			RJAH 5.1.6	Ensure individual RJAH contribution to delivery of Options appraisal (governance and scope) for Shared services as part of wider Provider Collaborative	Mike Carr	started	01/04/2025	On Track		A representative has been identified and the Trust continues to engage in the discussion. The formal group meeting has yet to be arranged but the Trust is ready to engage as and when that happens.
			RJAH 5.1.7	Consider the findings of any external assessments and monitor progress of any associated actions, in line with 5.3.2 and 5.3.3	Stacey Keegan / Dylan Murphy	as and when undertaken	TBC, in accordance with review timetable and subsequent action plan			
5.3	Demonstrate collaborative decision-making through the co-development and co-delivery of an System Integrated Improvement Plan that supports delivery of all the RSP exit criteria at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions for the whole population served by the system.	Stacey Keegan	RJAH 5.3.1	Contribution to system improvement process through developing and delivering an RJAH action plan.	all deliverable owners	started	31/03/2026	On Track		
			RJAH 5.3.2	Initial external assessment of collaborative decision-making monitored through the Board and relevant sub-committees (as appropriate, dependent on findings).	Stacey Keegan / Dylan Murphy	as and when undertaken	TBC, in accordance with action plan			
			RJAH 5.3.3	Action plan following initial and any follow-up assessments to be monitored via the Board and relevant sub-committees (as appropriate, dependent on findings).	Stacey Keegan / Dylan Murphy	as and when undertaken	TBC, in accordance with action plan			
			RJAH 5.3.4	Board sign-off of RJAH elements of the SIIP and ongoing assurance arrangements on delivery	Stacey Keegan / Dylan Murphy	completed	06/11/2024	Complete; Evidence received		
			RJAH 5.3.5	Board committees / Board monitoring of SIIP extracts relevant to the Board / Committee remit, i.e.: F&P for finance and UEC; P&C for workforce and elements of Leadership; Audit and Risk for Governance; The Board for aspects of Leadership and overall progress.	Stacey Keegan / Dylan Murphy	started	31/03/2026	Complete; Evidence received		
5.4	RJAH's contribution to a clear system culture and leadership improvement programme and evidence of a positive shift in staff experience through pulse survey/NHS staff survey.	Stacey Keegan	RJAH 5.4.1	Proactively participate in and contribute to System CEO OD Programme	Stacey Keegan	01/11/2024	31/03/2026	On Track		
			RJAH 5.4.2	Ensure Executive participation in the Executive Directors Development programme	Stacey Keegan	29/01/2025	31/03/2026	On Track		
			RJAH 5.4.3	Developed an action plan with key outcomes from the 2023 survey – shared with staff	Caroline Nokes Lawrence	started	completed	Complete; Evidence received		
			RJAH 5.4.4	A Staff Survey Task and Finish Group established, made up of people from across the Trust and will meet every four to six weeks to take actions forward.	Caroline Nokes Lawrence	started	completed - resuming in March 2025 for 2024 results	Complete; Evidence received		
			RJAH 5.4.5	Set up 'it's ok to ask' sessions for staff to drop in – myth busting	Caroline Nokes Lawrence	started	completed	Complete; Evidence received		
			RJAH 5.4.6	Included Bank staff for 2024 survey	Caroline Nokes Lawrence	started	review in March 2025	Complete; Evidence received		
			RJAH 5.4.7	Shared the 'you said, we did' actions	Caroline Nokes Lawrence	started	completed	Complete; Evidence received		
			RJAH 5.4.8	Linked actions to WRES/WDES action plans	Caroline Nokes Lawrence	started	completed and new plans for 2024 ongoing	On Track		

NHS Oversight Framework – capability assessment

Committee / Group / Meeting, Date

Board of Directors, 3rd September 2025

Author: **Contributors:**

Name: Dylan Murphy
Role/Title: Trust Secretary

Report sign-off:

Name: Stacey Keegan
Role/Title: Chief Executive Officer

Is the report suitable for publication?:

YES

Key issues and considerations:

Assessing provider capability: Guidance for NHS trust boards was published by NHS England on 26th August 2025. The outcome of the assessment will be published alongside (and may ultimately affect) the Trust's segmentation rating under the NHS Oversight Framework.

The introduction to the guidance explains that:
"As part of the NHS Oversight and Assessment Framework, NHS England will assess NHS trusts' capability, using this alongside providers' NOF segments to judge what actions or support are appropriate at each trust. As a key element of this, NHS boards will be asked to assess their organisation's capability against a range of expectations across six areas derived from The Insightful Provider Board, namely:

- Strategy, leadership and planning
- Quality of Care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

These will inform a self-assessment which is intended to strengthen board assurance and help oversight teams take a view of NHS trust capability based on boards' awareness of the challenges their organisations face and subsequent actions to address them. The purpose of this is to focus trust boards' attention on a set of key expectations related to their core functions as well as encourage an open culture of 'no surprises' between trusts and oversight teams. NHS England regional teams will then use the assessment and evidence behind it, along with other information, to derive a view of the organisation's capability."

The Guidance goes on to describe the three stages to the assessment process:

"1. NHS trust boards carry out an annual self-assessment against the 6 domains in the *Insightful Provider Board* and:

- highlight any areas for which they consider they do not meet the criteria, the reasons why and the actions being taken or planned then, within two months,
- submit the completed self-assessment template to their regional oversight team with supporting evidence.

2. Oversight teams review the self-assessment and:

- triangulate this with other information including the trust's recent operational history and track record of delivery and third-party intelligence (see below) as necessary to develop a holistic view of capability
- assign a capability rating to the trust.

Oversight teams will discuss the capability rating with the NHS trust and consider, in the round, the principal challenges the organisation faces, prioritising issues and the actions needed – for

example, monitor something more closely, request follow-up action(s) and/or refresh the capability rating to reflect concerns if necessary.

3. **Oversight teams** will, across the financial year, use the capability assessment to inform oversight, for example where:
   - risks flagged in the self-assessment are a concern (e.g. inability to make 1 or more certifications), or
   - annual self-assessments do not tally with oversight team's views or information from third parties, or
   - subsequent performance/events at the trust or third-party information are a cause for concern such that elements of the self-assessment are no longer valid and, in order to assess 'grip', teams may wish trusts to review the basis on which they made the initial assessment."

The six domains are broken down into sixteen "self-assessment criteria". For each of the criteria, the guidance suggests multiple examples of "indicative evidence or lines of enquiry".

By **22nd October 2025** Boards are asked to certify that the criteria under each domain have been met (partially met, or not met). Trusts are expected to provide supporting evidence

Having considered the self-assessment and having taken account of "a range of considerations, including the historical track record of the trust, its recent regulatory history and any relevant third-party information, the oversight team will decide the trust's capability rating and share this with it, including the rationale for the rating." The rating scheme will be:

- **Green**: High confidence in management
- **Amber–green**: Some concerns or areas that need addressing
- **Amber–red**: Material issue needs addressing or failure to address major issues over time
- **Red:** Significant concerns arising from poor delivery, governance and other issues

The guidance states that "third-party information relating to the organisation's governance and risk profile, staff morale and quality of care provided may inform NHS England's view of NHS trust capability. We expect that where trusts receive information that impacts on their self-assessment they should share this with NHS England". The "third-parties" listed in the guidance are:

- NHS England
- Care Quality Commission
- Medicines and Healthcare products Regulatory Agency
- Human Tissue Authority
- The Human Fertilisation and Embryology Authority
- The Health & Safety Executive
- The Information Commissioner's Office
- NHS Counter Fraud Authority
- Professional regulators:
  - General Medical Council
  - Nursing and Midwifery Council
  - General Chiropractic Council
  - General Dental Council
  - General Optical Council
  - General Osteopathic Council
  - General Pharmaceutical Council
  - Health and Care Professionals Council
  - Social Work England
- Local Government and Social Care Ombudsman
- Parliamentary and Health Service Ombudsman
- Health Service Safety Investigations Body
- Healthwatch
- Ofsted
- Coroners
- Royal Colleges

- Local authorities

Strategic objectives and associated risks:

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

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

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

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

Recommendations:

That the Board:

1. NOTE the publication of the capability assessment for NHS organisations; and
2. AGREE the sign-off process for the capability self-assessment and Board certification.

Report development and engagement history:

Following a period of engagement, NHSE published the revised NHS Oversight Framework on 26th June 2025.

The revised Oversight Framework indicated that NHSE would use a "capability assessment" to determine its oversight arrangements with organisations. NHSE indicated that, in exceptional circumstances, where NHS England identifies concerns about a provider's capability, it can place an organisation in segment 5 (regardless of its segmentation rating based on the performance and finance elements of the Framework).

The "capability assessment" was published on 26th August 2025.

Next steps:

The executive team will lead the completion of the self-assessment. An update on progress will be reported to the Board at a private session on 1st October 2025.

Options for review and approval of the Board certification by 22nd October could include:

OPTION A: After executive review of the supporting evidence and agreement on the outcome, the proposed Board certification document will be considered and approved directly by the Board (either by correspondence, or at a virtual meeting).

OPTION B: After executive review of the supporting evidence and agreement on the outcome, the proposed Board certification document will be considered by the Chair of the Board and the Chief Executive Officer to approve on behalf of the Board.*

OPTION C: The Board appoints a sub-group of members to review the supporting evidence and approve the self-assessment outcome on behalf of the Board (following executive review and agreement).*

*Under any such arrangement, the self-assessment outcome would be shared with the Board following approval. Should any concerns be raised during the review process, those would be raised with the Board before approval / submission.

ATTACHMENT 1: Board certification of self-assessment outcome template
ATTACHMENT 2: Self-assessment criteria and "indicative evidence or lines of enquiry"

Attachment 1: Board certification of self-assessment outcome template

Provider Capability - Self-Assessment Template

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	*If the Board cannot make this certification, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*

Signed on behalf of the board of directors

Signature

Name

Date

Attachment 2: Self-assessment criteria and "indicative evidence or lines of enquiry"

I. Strategy, leadership and planning

Self-assessment criteria	Indicative evidence or lines of enquiry
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	• Are the trust's financial plans linked to and consistent with those of its commissioning ICB or ICBs, in particular regarding capital expenditure? • Are the trust's digital plans linked to and consistent with those of local and national partners as necessary? • Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy? • Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level?
2. The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	• Is the trust currently complying with the conditions of its licence? • Is the trust meeting requirements placed on it by regulatory instruments – for example, discretionary requirements and statutory undertakings – or is it co-operating with the requirements of the national Performance Improvement Programme (PIP)?
3. The board has the skills, capacity and experience to lead the organisation	• Are all board positions filled and, if not, are there plans in place to address vacancies? • What proportion of board members are in interim/acting roles? • Is an appropriate board succession plan in place? • Are there clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance?
4. The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served	• Is the trust contributing to and benefiting from its NHS trust collaborative? • Does the board regularly meet system partners, and does it consider there is an open and transparent review of challenges across the system? • Can the board evidence that it is making a positive impact on the wider system, not just the organisation itself – for example, in terms of sharing resources and supporting wider service reconfiguration and shifts to community care where appropriate and agreed?

II. Quality of care

Self-assessment criteria	Indicative evidence or lines of enquiry

5. Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	• The trust can demonstrate and assure itself that internal procedures:
	  ○ ensure required standards are achieved (internal and external)
	  ○ investigate and develop strategies to address substandard performance
	  ○ plan and manage continuous improvement
	  ○ identify, share and ensure delivery of best practice
	  ○ identify and manage risks to quality of care
	• There is board-level engagement on improving quality of care across the organisation
	• Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients
	• Board assesses whether resources are being channelled effectively to provide care and whether packages of care can be better provided in the community

Self-assessment criteria	Indicative evidence or lines of enquiry
	• Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust’s internal governance arrangements are robust • Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement
6. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	• Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself that it has a comprehensive picture of patient experience? • Does the board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the trust’s communities? • Is the board satisfied that it receives timely information on quality that is focused on the right matters? • Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real-time measures, and explore whether staff effectively respond to this? • How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance? • Is the board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns? • Is the board satisfied that the trust has a clear system to both receive complaints from patients and escalate serious and/or re-occurring complaints to the relevant executive decision-makers?

III. People and culture

Self-assessment criteria	Indicative evidence or lines of enquiry
7. Staff feedback is used to improve the quality of care provided by the trust	• Does the board look at the diversity of its staff and staff experience survey data across different teams (including trainees) to identify where there is scope for improvement? • Does the board engage with staff forums to continually consider how care can be improved? • Can the board evidence action taken in response to staff feedback?
8. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels	• Does the trust regularly review skills at all levels across the organisation? • Does the board see and, if necessary, act on levels of compliance with mandatory training?
9. Staff can express concerns in an open and constructive environment	• Does the board engage effectively with information received via Freedom To Speak Up (FTSU) channels, using it to improve quality of care and staff experience? • Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required? • Is there a clear and streamlined FTSU process for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns? • Is there a safe reporting culture throughout the organisation? How does the board know? • Is the trust an outlier on staff surveys across peers?

IV. Access and delivery of services

Self-assessment criteria	Indicative evidence or lines of enquiry
10. Plans are in place to improve performance against the relevant access and waiting times standards	• Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving system partners as necessary? • Where waiting time standards are not being met or will not be met in the financial year, is the board aware of the factors behind this? • Is there a plan to deliver improvement?
11. The trust can identify and address inequalities in access/waiting times to NHS services across its patients	• The board can track and minimise any unwarranted variations in access to and delivery of services across the trust's patients/population and plans to address variation are in place
12. Appropriate population health targets have been agreed with the ICB	• Is there a clear link between specific population health measures and the internal operations of the trust? • Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system?

V. Productivity and value for money

Self-assessment criteria	Indicative evidence or lines of enquiry

13. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	• Board uses all available and relevant benchmarking data, as updated from time to time by NHS England, to:
	  ○ review its performance against peers
	  ○ identify and understand any unwarranted variations
	  ○ put programmes in place to reduce unwarranted negative variation
	• The trust's track record of delivery of planned productivity rates

VI. Financial performance and oversight

Self-assessment criteria	Indicative evidence or lines of enquiry
14. The trust has a robust financial governance framework and appropriate contract management arrangements	• Trust has a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data • Have there been any contract disputes over the past 12 months and, if so, have these been addressed? • [Potentially more appropriate for acute trusts] Are the trust's staffing and financial systems aligned and show a consistent story regarding operational costs and activity carried out? Has the trust had to rely on more agency/bank staff than planned?
15. Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	• Does the board stress-test the impact of financial efficiency plans on resources available to underpin quality of care? • Are there sufficient safeguards in place to monitor the impact of financial efficiency plans on, for example, quality of care, access and staff wellbeing? • Does the board track performance against planned surplus/deficit and where performance is lagging it understands the underlying drivers?

Attachment 2: Self-assessment criteria and “indicative evidence or lines of enquiry”

Self-assessment criteria	Indicative evidence or lines of enquiry
16. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	• Is the board contributing to system-wide discussions on allocation of resources? • Does the trust’s financial plan align with those of its partner organisations and the joint forward plan for the system? • Would system partners agree the trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS?

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	The Trust Winter Plan has been presented at Trust Board on 3rd September 2025.
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	The QEIA has been previously approved for the Trust's 2025/26 Operational Plan with no changes as part of winter preparedness and planning.
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	The Trust Winter Plan reflects the requirements of the Trust within the system Winter Plan 2025/26 and has been shared with the ICB for assurance purposes.
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	An NHSE Regional winter planning stress test exercise is planned for September 2025 to meet this requirement.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Mr Mike Carr, Chief Operating Officer.
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	The Trust is demonstrating no changes to the operational plan as a result of system winter planning and preparedness.
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for	Yes	RJAH does not form part of the surge capacity solution

Provider:	The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

base, moderate, and extreme escalations of winter pressures.		in the 2025/26 STW Winter plan
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	Yes	There are no adjustments required to the Trust's Operational Plan as a result of winter planning and preparedness.

Provider CEO name	Date	Provider Chair name	Date
Stacey-Lea Keegan		Harry Turner	

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	Flu delivery plan is currently progressing, with commencement of the vaccination programme on 6th October 2025.
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	RJAH does not form part of the non-elective surge capacity solution in the 2025/26 system winter plan. The Trust will be supporting SATH with additional elective capacity through the provision of ward and theatre facilities for SATH consultants to undertake orthopaedic activity at RJAH September 2025 to February 2026.
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to	Yes	RTT trajectories submitted are not impacted by the winter pressures with any risks

	mitigate the impacts of likely winter demand – including on diagnostic services.		associated with winter pressures mitigated.
Infection Prevention and Control (IPC)			
6.	IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	No changes to current operational practices as a result of winter planning with no surge capacity being provided by RJAH.
7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	No changes to existing Trust cohorting practices being planned for 2025/26.
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.		
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.		


NHS
The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust
Winter Planning 2025/26
Mike Carr, Chief Operating Officer
Improving lives through excellent and innovative care
NHS

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

NHSE Winter Planning priorities 2025/26

Prevention – Achieve at least a 5% improvement on last year's flu vaccination rate for frontline staff by the start of flu season. Staff sickness trajectories aligned to seasonality with sufficient workforce to meet capacity requirements.

Capacity - Ensure that the demand profile for elective and non-elective patients is understood with appropriate capacity in place to meet demand. Confirm that the RTT and cancer trajectories signed off and returned to NHSE in April 2025 are not impacted by winter pressures and winter preparedness plans with any risks associated with winter pressures mitigated.

Infection Prevention and Control (IPC) – All systems should test their winter virus resilience plans against the IPC mechanisms available both in and out of hospital. This includes making sure they have identified cohorting spaces ready to be actioned, explored the direct admission of flu patients into community bedded capacity and followed appropriate policies and procedures.

Prevention

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

- **20205/26 Vaccination programme**

The Trust's Flu Vaccination campaign will commence on the 6th October 2025 with additional initiatives planned in 2025/26 to improve uptake in excess of the 5% minimum improvement requirement set by NHSE.

- **Staff Sickness profiling**

Sickness seasonality was factored into the Operational Plan for 2025/26 with no profile change required.

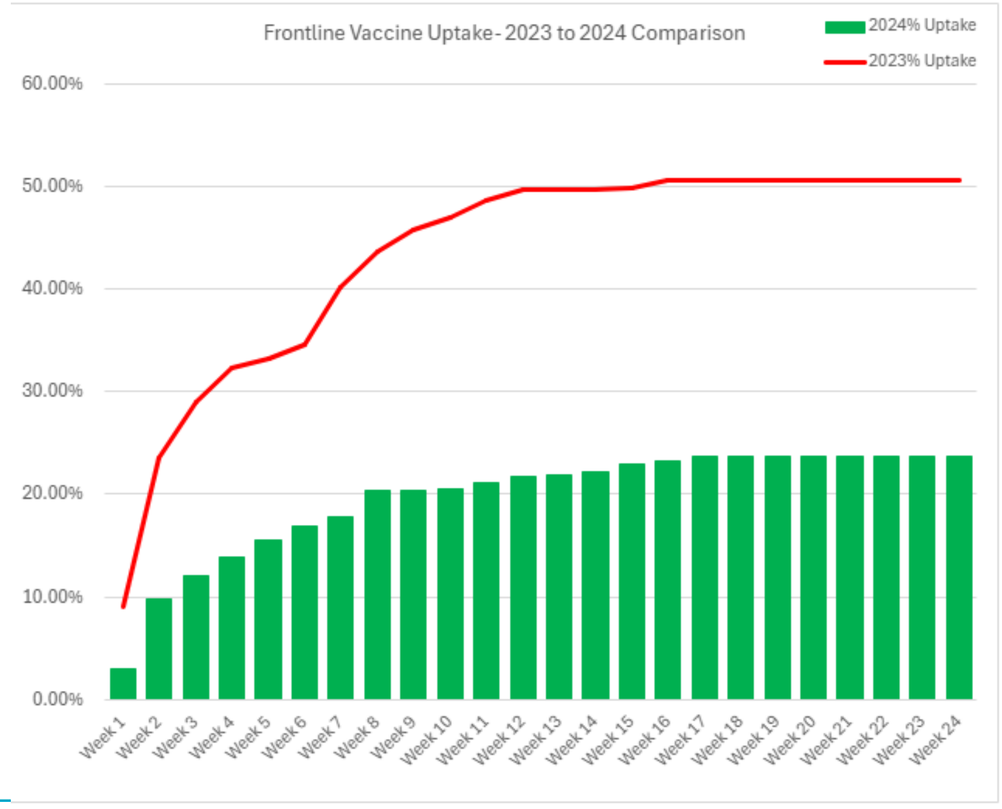
- **Staff workforce trajectories**

There are no additional initiatives that are required in terms of surge capacity requirements for RJAH and therefore no winter plan related changes required to the operational plan profile submitted in April 2025.

Vaccination Programme – Year on Year uptake

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

- The Trust's frontline workforce vaccine uptake in 2024/25 was 23.66% setting an expectation for a minimum of 28.66% in 2025/26.
- The Trust will be working towards returning to 2023/24 uptake levels at 50.56%



FRONTLINE

			2023			2024		
	Start	End	Total given	Cumulative	2023% Uptake	Total given	Cumulative	2024% Uptake
Week 1	9/30/2024	10/6/2024	120	120	9.00%	41	41	2.92%
Week 2	10/7/2024	10/13/2024	193	313	23.48%	96	137	9.76%
Week 3	10/14/2024	10/20/2024	74	387	29.03%	32	169	12.05%
Week 4	10/21/2024	10/27/2024	43	430	32.26%	26	195	13.90%
Week 5	10/28/2024	11/3/2024	12	442	33.16%	23	218	15.54%
Week 6	11/4/2024	11/10/2024	19	461	34.58%	19	237	16.89%
Week 7	11/11/2024	11/17/2024	74	535	40.14%	12	249	17.75%
Week 8	11/18/2024	11/24/2024	48	583	43.74%	36	285	20.31%
Week 9	11/25/2024	12/1/2024	27	610	45.76%	1	286	20.38%
Week 10	12/2/2024	12/8/2024	16	626	46.96%	2	288	20.53%
Week 11	12/9/2024	12/15/2024	22	648	48.61%	8	296	21.10%
Week 12	12/16/2024	12/22/2024	15	663	49.74%	10	306	21.81%
Week 13	12/23/2024	12/29/2024	0	663	49.74%	2	308	21.95%
Week 14	12/30/2024	1/5/2025	0	663	49.74%	3	311	22.17%
Week 15	1/6/2025	1/12/2025	2	665	49.89%	11	322	22.95%
Week 16	1/13/2025	1/19/2025	9	674	50.56%	5	327	23.31%
Week 17	1/20/2025	1/26/2025	0	674	50.56%	5	332	23.66%
Week 18	1/27/2025	2/2/2025	0	674	50.56%	0	332	23.66%
Week 19	2/3/2025	2/9/2025	0	674	50.56%	0	332	23.66%
Week 20	2/10/2025	2/16/2025	0	674	50.56%	0	332	23.66%
Week 21	2/17/2025	2/23/2025	0	674	50.56%	0	332	23.66%
Week 22	2/24/2025	3/2/2025	0	674	50.56%	0	332	23.66%
Week 23	3/3/2025	3/9/2025	0	674	50.56%	0	332	23.66%
Week 24	3/10/2025	3/16/2025	0	674	50.56%	0	332	23.66%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Vaccination Programme – Key Initiatives

- The vaccination programme for 2025/26 will be led by Rachel Flood and Zoe Day.
- Campaign communication plans will be mobilised in September 2025.
- Vaccination programme will commence on Monday 6th October 2025.
- Baschurch will be the main location for staff drop-in sessions.
- Occupational Health will be undertaking departmental walkaround to increase uptake.
- Outreach and CSMN will be supporting vaccination programme for staff working night and weekend shifts
- Incentivisation schemes are currently being sought to support with uptake.

Demand and Capacity Review

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Demand :

- **Non elective demand**: The Non elective demand profiled has been reviewed at system level with no requirement for additional RJAH non elective capacity in 2025/26. This means that, as compared to previous years, an additional ward over the 2 week Christmas and New Year period will not be required. The Trust will review all opportunities associated with this capacity being released to deliver additional elective activity above planned levels.

Capacity:

- Non Elective – No additional capacity requirements
- Elective: The Trust will be supporting SATH with additional elective capacity through the provision of ward and theatre facilities for SATH consultants to undertake orthopaedic activity at RJAH September 2025 to February 2026. This has been factored into the Trust's elective activity forecast and will be tracked as part of delivery of the operational plan.

RTT

- RTT trajectories submitted are not impacted by system winter preparedness plans.

Cancer trajectories

- The cancer trajectories submitted are not impacted by system winter preparedness plans.

Infection Prevention and Control

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

All systems should test their winter virus resilience plans against the IPC mechanisms available both in and out of hospital. This includes making sure they have identified cohorting spaces ready to be actioned, explored the direct admission of flu patients into community bedded capacity and followed appropriate policies and procedures.

RJAH IPC adjustments

- There are no changes to current operational practices as a result of winter planning with no surge capacity being provided by RJAH.
- There are no changes to existing Trust cohorting practices being planned for 2025/26.

Recommendations and Next steps

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

- The Board is asked to review and approve the Board Assurance Statements based in the winter planning update provided.
- The Trust will share the Winter preparedness update and board assurance statements with the ICB to support their winter plan assurance via the ICB Board on the 24th September 2025.
- The Trust is required to submit the Board Assurance Statements to NHSE on the 30th September 2025.

Executive Summary - Quality & Safety Committee

Assurance

Variation

	Will consistently pass the target if nothing changes	Will not consistently pass or fail the target if nothing changes	Will consistently fail the target if nothing changes	No Target or Moving Target
Improving variation (high or low) or 3 months better than target				
No significant change or N/A to SPC		Number of Deteriorating Patients		Number of Patient Safety Reviews Number of Compliments MCSI Admissions - Average Waiting Time Medication Errors Theatre Cancellations On Day of Surgery
Concerning variation (high or low) or 3 months off target		Number of Complaints Standard Complaints Response Rate - 30 Days Complex Complaints Respone Rate - 45 Days No of Spinal Injury Patients Fit for Admission		Complaints Re-opened % Delayed Discharge Rate

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

Trust Board - Quality & Safety

July 2025 – Month 4

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

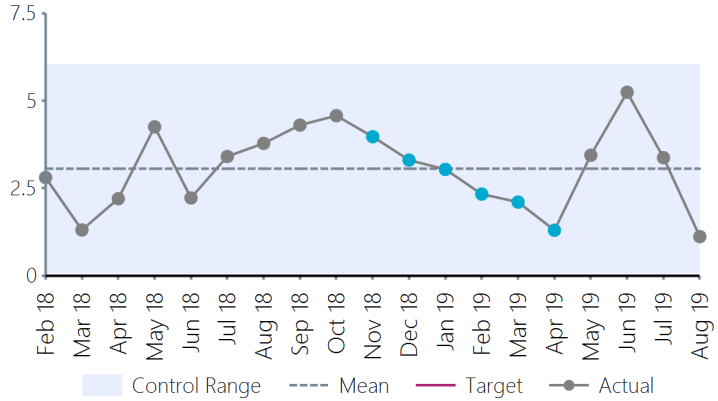
Some examples of these are shown in the images to the right:

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

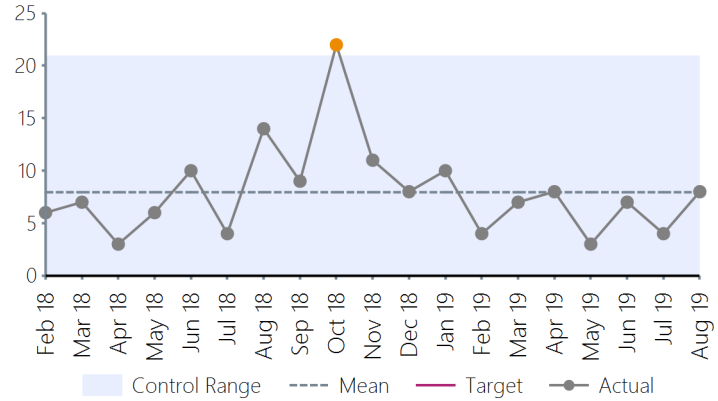
b) shows a point of concern sitting above the control range.

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

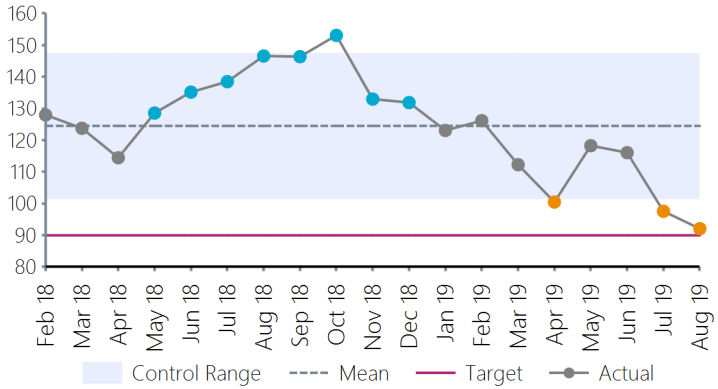
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Patient Safety Incident Investigations		0		N/A to SPC	No Target		
Number of Complaints	8	19			?	+	
RJAH Acquired C.Difficile	0	0		N/A to SPC	P		04/03/24
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	P		04/03/24
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		04/03/24
RJAH Acquired MSSA Bacteraemia	0	0		N/A to SPC	P		04/03/24
RJAH Acquired Klebsiella spp	0	0		N/A to SPC	P		04/03/24
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		04/03/24
Surgical Site Infections	0	0			?		04/03/24
Outbreaks	0	0		N/A to SPC	P		04/03/24

Summary - Caring for Patients

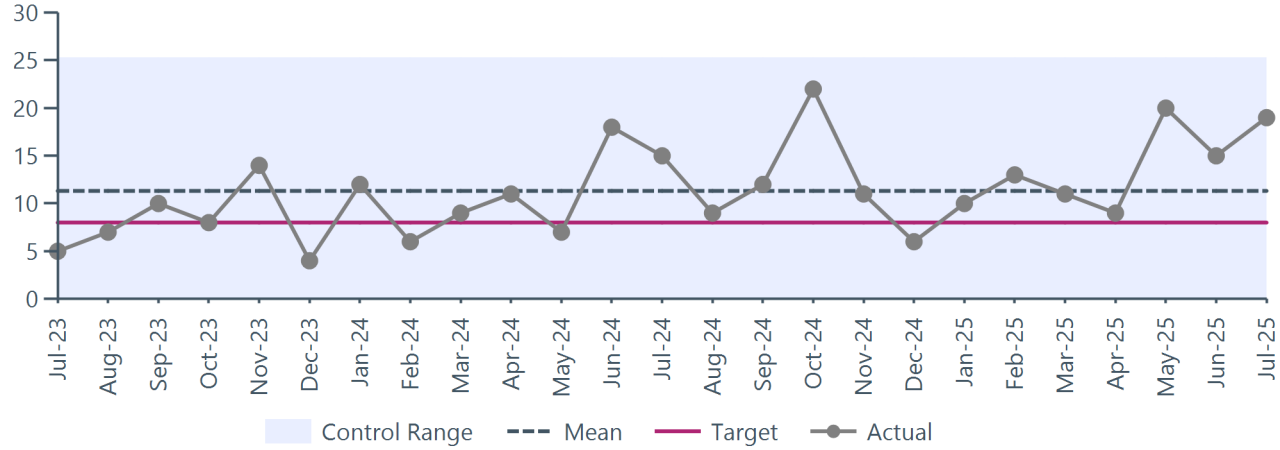
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Number of Deteriorating Patients	5	10				+	
Total Deaths	0	0		N/A to SPC			12/09/23
WHO Quality Audit - % Compliance against NatSSIPs 2							

Number of Complaints

Number of complaints received in month 211105

Exec Lead
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
8	19		



Trajectory

What these graphs are telling us

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

Narrative

There were nineteen complaints received throughout July and the volume has now exceeded the tolerance of eight since January. A breakdown of reasons for July complaints is:

* Care provided (10)
* Cancelled appointments (3)
* Cancelled surgery (3)
* Waiting times (2)
* Correspondence not received (1)

Actions

An increase in the volume of complaints has been seen throughout the past year. A deep dive was presented to the Quality & Safety Committee in July. Output actions will be monitored through Patient Experience Committee.

Learning is identified for each complaint as part of the complaints response. Any themes are shared at Unit level and through Patient Experience Committee.

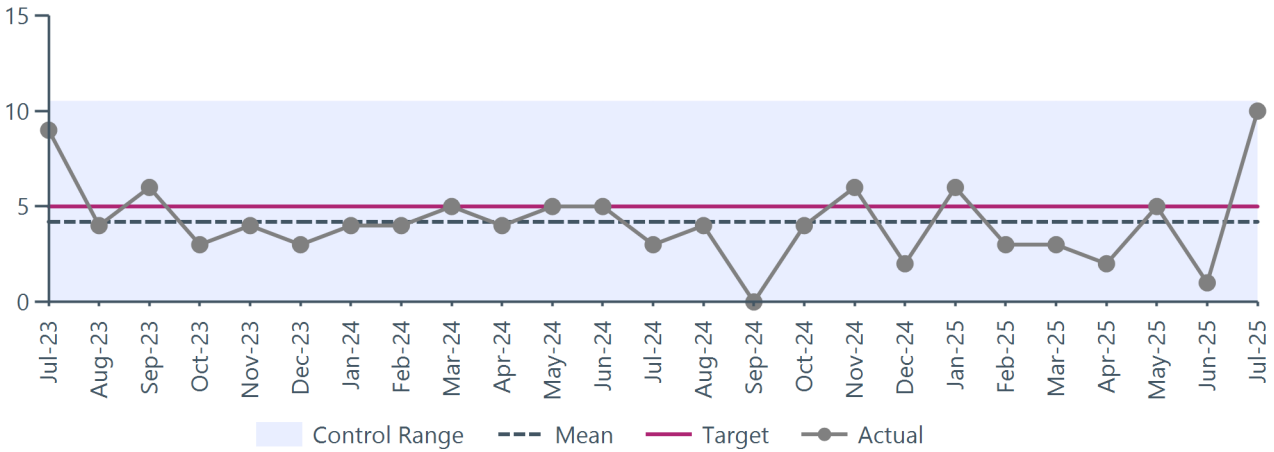
Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
15	9	12	22	11	6	10	13	11	9	20	15	19

Number of Deteriorating Patients

Number of Deteriorating Patients transferred to HDU in month 217826

Exec Lead:
Chief Medical Officer

Target/Plan	Latest Value	Variation	Assurance
5	10		



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

Throughout July there are ten deteriorating patients reported. As demonstrated on the SPC above, this does still remain within normal variation but has been included as an exception to provide context to the increase. Of the ten incidents reported, five relate to one MCSI patient who deteriorated a number of times and required transfer to HDU for stabilisation. Good collaboration was demonstrated between MCSI and HDU areas to manage the care for this patient.

Actions

Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
3	4	0	4	6	2	6	3	3	2	5	1	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 Meeting, 03 September 2025

Author: **Contributors:**

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Report sign-off:

Lindsey Webb, Non-Executive Director

Is the report suitable for publication:

Yes

1. Key issues and considerations:

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

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

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

This report provides a summary of the items considered at the Quality and Safety Committee on 24 July 2025 and 21 August 2025. It highlights the key areas the Quality and Safety Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

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

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

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

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

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

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

3. Assurance Report from Quality and Safety Committee

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

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

Powys Commissioning Restrictions
Powys Teaching Health Board is again considering restrictions on both elective and outpatient activity due to financial pressures. Specifically, a cap on outpatient appointments (first appointments restricted to 52 weeks) and inpatient admissions limited to those waiting 100–104 weeks.
These restrictions are not aligned with NHS England targets and pose a direct risk to patient safety, particularly for new patients who may present with undiagnosed or deteriorating conditions.
The Trust has taken a principled decision not to implement these restrictions and to continue to prioritise based on clinical need. Partner medical directors across the region share our concerns.
The Committee recommends the Board formally support and endorse the Trust's position to resist the imposition of a 52-week cap, to provide organisational clarity and keep patient safe.

Apollo Digital Transformation Risks
While Apollo has delivered benefits, the Committee remains concerned about unresolved risks:

- Data migration, prescription workflows, and microbiology result filing.
- Lack of visibility of patient review dates, creating risks of missed follow-up appointments.
- Dependence on a small number of trained Clinical Safety Officers (though additional staff are now in training).

The transfer of Apollo risks to the corporate risk register has not yet been completed with sufficient assurance around mitigations. Risks rated 15+ remain live and require clear oversight as Apollo transitions from project to business-as-usual.

HSE Improvement Notice
Following a two-day Health and Safety Executive inspection, the Trust has received an improvement notice primarily related to occupational health provision and data reporting. The full written report is awaited. The notice will be published on the HSE website and requires compliance within defined timescales. Progress will be monitored closely, with clear visibility of compliance deadlines and actions being monitored by the Health and Safety Committee and assurance reporting to the Committee.

MHRA / OsCell Laboratory
The Trust has commenced the process of revoking its MHRA licence for the OsCell laboratory. A formal closure report is expected next month once the process has been completed.

Board Assurance Framework

The current BAF includes tracked changes and proposed risk score adjustments. A suggestion to lower the likelihood score for BAF 1 (governance-related risk) was deferred pending further assurance on Apollo risks, the HSE inspection, and the MHRA closure report.

Corporate Risk Register
The Committee considered and reviewed the risks aligned to the Committee and recommended the amendments to the Board for approval. The Committee discussed:

- **Paediatric Cover Risk:** Interim cover is being provided via costly agency staff, but this is unsustainable. A shared post is being developed. Risk remains high due to limited resilience; the risk register will be updated accordingly.
- **Medicine Supply Shortages** (Risk 3186): Positive progress noted; plans are in place to manage the risk.
- **Radiology** (Risk 3096): Discussed at Finance and Performance Committee; timeline for mitigation is being developed.
- **Weekend Working** (Risk 3203): Concerns about increased activity from insourcing affecting pharmacy and critical care. A working group will review weekend procedures and safety implications.
- **Occupational Health** (Risk 3238): Surveillance and contracting issues persist; awaiting HSE inspection report. Progress will be monitored via the People Committee.
- **Tracking Investigations** (Risk 3265): Collaborative efforts with Shropshire Community Health Trust (SCHT) and SaTH are underway to address the risk.
- **Neurological Assessments on MCSI**: Audit findings presented; concerns about timeliness of re-audits. Improvement work is ongoing, with a deep dive planned for the next Quality and Safety meeting.
- **DTPB Clinical Risks** (Rated 15+): Transitioning from Apollo to standard risk register. Committee requested more detail on mitigations and impacts before full integration.

Modern Slavery Report
The Modern Slavery Report was endorsed at the Committee and is recommended to the Board for approval.

Committee Terms of Reference
The revised terms of reference are recommended to the Board for approval following the agreement for the Director of Estates and Facilities to become a member of the meeting.

3.2 Areas of on-going monitoring with new developments

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

Orthotics Service Pressures
The Committee received a deep dive on orthotics. Demand continues to rise sharply, particularly for diabetic foot care, against a backdrop of national workforce shortages and slow system-level progress on a business case first submitted in 2022. A new digital system is funded, but integration challenges with SATH and inpatient workflows remain unresolved. The risk of inadequate orthotics provision is system-wide and may affect patient safety and outcomes, particularly for diabetic patients at risk of amputation. Locally, the Trust is exploring workforce modernisation and university partnerships, but these will not deliver in the short term.

Safe Staffing and Workforce Flexibility
Monthly reviews confirm safe staffing levels; however, patient throughput (rather than bed occupancy) is increasingly the key driver of demand. Concerns remain about medication handling during busy discharge periods and the capacity to staff weekends as insourcing increases activity. December's repeat safer nursing care audit will provide a more complete picture of workforce resilience.

Complaints and Patient Experience
Complaint volumes are increasing, with response times slipping. A new process and standard letter template aim to strengthen clinical ownership and communication with patients. A deep dive showed

many complaints arise not from waiting times themselves, but from inefficiencies, repeated rescheduling, and confusing communication. Improvements are planned through digital solutions for clinic letters and call handling.

Training Compliance
Compliance remains below target in safeguarding, BLS, and fire safety. While no direct patient safety impact has been identified, the Committee requested a focused update via the Patient Safety report. ESR tracking limitations and safeguarding requirements for bank staff remain problematic. A risk has been placed on the register.

Performance Report

- MCSI audits continue to highlight inconsistent neurological assessments; a deep dive is planned for a future meeting.
- Deteriorating patient incidents spiked in July, largely due to one complex case, but require monitoring.
- DNAs and on-the-day cancellations remain a concern; a thematic review is planned.
- Discharges – increasing delays; reporting has shifted to "No Criteria to Reside" for greater accuracy.

Annual Reports
The Committee received and considered the following annual reports for 2024/5 and are presented to the Board for consideration and oversight:

- Controlled Drugs and Accountable Officer
- Security
- Safeguarding

3.3 Areas of assurance

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

PSIRF Reports and Patient Safety Reviews
The Committee were assured with the report and review which have been undertaken. Actions are being monitored and there are no systemic failures identified.

GIRFT Pre-op Pathway
The Committee acknowledged the significant improvement in same-day cancellations, with external recognition as best practice.

Quality Strategy, Priorities, and Accreditation
All aspects were reported as on track, with strong ward engagement and positive inspection ratings.

IPC Report
Overall, the Committee were assured with the report which have received, there are no reportable HCAIs in Q1 and the improved audit compliance was acknowledged.

Learning from Deaths
There were no concerns raised in relation to learning from deaths. The report is presented to the Board of Directors for oversight.

Legal Claims
There were no concerns raised in relation to legal claims and there are no emerging quality or safety themes identified. The report is presented to the Board of Directors for oversight.

Policies / Plans
The Committee considered and approved the following policies and plans:

- Business Continuity Policy
- Emergency Critical Incident Mutal Aid
- Countermeasures Plan

- CBRN/HAZMAT plan
- Situation Report Plan
- Incident Control Plan
- Incident Response Plan
- Evacuation and Shelter Plan
- Trust Adverse Weather and Health Plan

Chair Assurance Reports:
The Committee received the following Chairs assurance reports:

- **Patient Experience:** Actions in response to concerns raised through patient stories continue to be monitored and learning addressed. Complaints deep dive reports provided assurance that lessons are being embedded, with oversight retained through the Patient Experience Meeting.
- **Health Inequalities:** Positive cross-organisational work with local authorities, community services, and primary care is strengthening service integration and improving the use of data to inform planning.
- **Drugs and Therapeutics**: Annual controlled drugs and medicines storage audits were completed and reviewed, meeting CQC requirements. Updated policies, including non-medical prescribing, were noted to be aligned with national standards.
- **Infection Prevention and Control:** The Tuberculosis Policy was approved, and a two-year IPC improvement plan was set, with ambitions focusing on education, integration, innovation, collaboration, and digital support.
- **Clinical Effectiveness:** Positive assurance was received
- **Safeguarding**: Annual safeguarding and restrictive practice reports were approved.
- **Regulatory Oversight:** NRFit Needles and Syringes the transition to safer devices is ongoing but there are practical issues for surgeons. Comparisons with other Trusts and further discussion are scheduled.
- **Patient Safety:** Consideration is being given to standing down the Theatre Safety Culture Review Group, with responsibilities likely to transfer into the Perioperative Service User Group to avoid duplication.
  In relation to Martha's Rule, there has been minimal use has been noted to date, with queries raised only regarding outpatient services. Monitoring will continue with reporting incorporated into this report.

Recommendation

The Board is asked to:

1. CONSIDER the overall assurance level listed at section 2 and;
   - **Powys Restrictions** – SUPPORT AND ENDORSE the Trust's position to resist the imposition of a 52-week cap, to provide organisational clarity and keep patient safe.
   - **Modern Slavery Statement** – APPROVE the Modern Slavery Statement which were endorsed at the Committee.
   - **Committee Terms of Reference** – APPROVE the revised Terms of Reference which were endorsed by the Committee
2. CONSIDER the remaining content of section 3.1 and agree any action required.
3. NOTE the content of section 3.2 and CONSIDER whether any further action is required; and
4. NOTE the content of section 3.3.

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Quality and Safety Committee. The Committee is a Non-Executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Membership and Quorum

The Committee shall be appointed by the Board from the Non-Executive Directors (including the Associate Non-Executive Directors) and the Executive Directors of the Trust and shall consist of:

- Up to four Non-Executive members
- Chief Medical Officer
- Chief Nurse and Patient Safety Officer
- Chief Operating Officer/Deputy CEO

Non-Executive members may be drawn from the Non-Executive Director membership of the Board or the Associated Non-Executive Directors.

In exceptional circumstances a deputy may attend in place of an Executive Director. The nominated deputy can act on behalf of the absent Executive Director. This is to be noted at the beginning of the meeting.

The Board of Directors will appoint a Committee Chair from the Non-Executive Director members of the Committee. In the absence of the appointed Chair, the Committee will appoint another Non-Executive member to chair the meeting.

A quorum will be two Non-Executive members and two Executive members. Deputies representing Executive members will count towards the quorum but at least one of the Executive members must be drawn from the listed membership.

3. Attendance

The Trust Secretary, Deputy Chief Nurse and DPIC, Assistant Chief Nurse and Patient Safety Officer, Chief Pharmacist and the Director of Estates and Facilities will be expected to attend each meeting.

The Chair of the Trust may attend at the invitation of the Chair of the Committee.

The Chief Executive Officer will receive a standing invitation to attend.

The ICB will receive a standing invitation to send a representative of the ICB Quality Team.

Senior Managers and Unit Representative will be required to attend the meeting when presenting a paper.

The Trusts governors are invited to observe the meetings.

4. Frequency of meetings and meeting administration

The Committee will meet at least 10 times a year for regular business. The Chair of the Committee may call additional meetings.

The Chief Nurse and Patient Safety Officer shall agree the agenda with the Chair of the Committee and other attendees. The Assistant Trust Secretary will organise the collation and distribution of the papers and keep a record of matters arising and issues to be carried forward.

5. Authority

The Committee is authorised by the Board to investigate any activity and is expected to make recommendations to the full board, within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise if it considers this necessary.

6. Reporting

A written Chair's Assurance Report will be presented to the Board no later than the Board meeting the following month (or the soonest available meeting if a Board meeting does not fall that month). The Chair's Report shall:

1. Alert the Board to any issues that:
   - 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.
2. Advise the Board of any areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives.
3. Assure the Board on other items considered where the Committee did not identify any issues that required escalation to the Board.

The Committee will undertake an Annual self-assessment, which will be presented to the Trust board, along with an Annual Report.

7. Key responsibilities

- Promote excellence in patient care in all aspects of quality and safety, and monitor and review the "Quality Improvement Strategy".

- 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 Committee 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 ensure the Trust is meeting core standards and is compliant with national guidelines to include (but not be limited to) prevention and control of infection and effective and efficient use of resources through evidence based clinical practice.

- To consider NHSE Quality Governance Framework in the delivery of its key responsibilities

- To receive an agreed level of clinical data and trend analysis from clinical forums and working groups, which provides adequate clinical matrix to inform and analyse the clinical services provided at the Trust.

- To ensure that the Committee has adequate information on which to advise and assure the Board on standards of care provision.

- To receive reports from the following assurance meetings:
  - Adult and Children Safeguarding Meeting
  - Infection Prevention and Control Meeting
  - Clinical Effectiveness Meeting
  - Patient Safety Meeting
  - Patient Experience Meeting
  - Health and Safety Meeting
  - Drugs and Therapeutics Meeting
  - Health and Inequalities Meeting
  - MRHA Meeting
  - Regulatory Oversight Meeting

- The Quality and Safety Committee shall review the draft Quality Accounts before submission to the Trust Board

- The Committee shall ratify such policies as the Board has not reserved to itself and as required by the Trust's Policy Approval Framework.

- Clinical outcomes
  - Monitoring the effectiveness of the Trust's arrangements for the systematic monitoring of mortality and other patient outcomes.
  - Receiving and commenting on action plans and progress reports proposed by management in response to monitoring data on patient outcomes.

- Incident reporting and investigation

- Monitoring the effectiveness of the Trust's compliance with the requirements of the Patient Safety Incident Response Framework.
- Reviewing the outcomes of investigations, ensuring that the information is presented in sufficient detail to enable systemic failings in patient care to be identified; receiving and commenting on action plans and progress reports proposed by management in response to SIs, near misses and other incidents.

- Patient Experience
  - Monitoring the effectiveness of the Trust's systems for complaints handling and reviewing complaints for trends and themes.
  - Monitoring the effectiveness of the Trusts systems for advocacy and the encouragement of feedback from patients and relatives.

- Review of compliance with statutory and regulatory requirements relevant to the remit of the Committee, including CQUIN and CQC requirements.

- Patient Information Governance
  - Monitoring the arrangements to ensure the security of personally identifiable data.

0. Reference Information

Author:	Dr James Neil	Paper date:	24-7-2025
Executive Sponsor:	Dr Ruth Longfellow	Paper Category:	Governance and Quality
Paper Reviewed by:	Mortality Steering Group	Paper Ref:	To be inserted by the person collating the agenda
Forum submitted to:	Quality and Safety	Paper FOIA Status:	Full / Partial / Non-disclosure Delete as appropriate

1. Purpose of Paper

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

Learning from Deaths summary report to Q and S.

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

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

Deaths are reported through the Board of Directors.

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

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

MSG report discussed at Patient Safety committee.

2. Executive Summary

2.1. Context

To report the current numbers and trends in Q1 25 for In-patient Learning from Deaths (LFD).

2.2. Summary

See Numbers Below.

2.3. Conclusion

No trends identified.

Learning from deaths identified (see below).

3. The Main Report

3.1. Introduction

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

3.2. Learning From Deaths Summary.

Date	Total In-patient Deaths	Number for case record (SJR) review	Death likely due to problems with care	ME review/Family feedback.	Coroner review.
April 25	1(Expected)	1	0	No concerns	N/a
May 25	1 (Expected)	1	0	No concerns	N/a
June 25	0	0	0	N/a	N/a

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

Both patients at end of life on SWAN pathway.

3.3. Associated Risks.

None.

3.4. Next Steps

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

LFD lead now working as a Medical Examiner at SATH.

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

3.5. Learning from SJR's.

Good assessment of rapid deterioration. Appropriate plans put in place when clear now EOL. Good EOL care and family communication.
Good end of life care. Early discussions allowing appropriate treatment plan. Good EOL care, responsive to changing patient status. Good record of family discussions.

All learning passed on to consultant teams.

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

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

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

Appendix 1: Acronyms

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

Controlled Drugs Annual Report July 2025

Committee / Group / Meeting, Date

Quality and Safety Committee July 24th, 2025

Author:

Name: Fiona Bevan
Role/Title: **Chief Pharmacist, Controlled Drug Accountable Officer**

Contributors:

Name: Maryse Mackenzie
Role/Title: Trust Medication Safety Officer

Report sign-off:

Name: Dr Ruth Longfellow
Role/Title: Chief Medical Officer

Is the report suitable for publication?:

YES

Key issues and considerations:

The Trust is legally required to appoint a Controlled Drugs Accountable Officer (CDAO) who is responsible for overseeing all aspects of use of Controlled Drugs at the Trust.

This report is written by the CDAO to provide assurance to the board around the governance and usage of CDs in 2024 – 2025. The report gives an oversight of the patterns of usage of CDs, the mechanisms in place to measure compliance with the governance requirements, highlights current gaps in assurance and provides a detailed action plan for improvement.

The report provides assurance that controlled drugs are being used safely at RJAH, in accordance with legislative requirements. Audit data indicates over 90% compliance with required standards with the main theme for improvement around documentation and second signatures for destruction of unused contents of vials in theatres.

The gaps in assurance relate primarily to the need to update policies and procedures now that the Trust has successfully implemented EPMA. It is hoped that the new system will support the ability to access more accurate usage data for controlled drugs but the reporting tools are still in their infancy. In addition there is increasing volume of CDs being dispensed to support early discharge of patients on enhanced recovery pathways. The doses and quantities issued to patients were agreed at the beginning of the project but it is essential to establish if this is appropriate.

Strategic objectives and associated risks:

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

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

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

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

7	Responding to a significant disruptive event	

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

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

Recommendations:

Report development and engagement history:

N/A

Acronyms

CD Controlled Drug
CDAO Controlled Drug Accountable Officer
CQC Care Quality Commission
CDLIN Controlled Drug Local Intelligence Network
RJAH Robert Jones and Agnes Hunt Orthopaedic Hospital
SOP Standard Operating Procedure

1. Background / context

1.1 The purpose of Report

- To provide assurance to the Board on the governance arrangements around the management of Controlled Drugs at RJAH.
- To provide assurance that use of controlled drugs at RJAH is in line with the regulatory and legislative requirements relating to controlled drugs.
- To highlight any areas of concern relating to management of controlled drugs
- To raise awareness of quality improvement and best practice relating to controlled drugs
- To update on actions from the report of 2023 – 2024 and propose a new action plan for management of controlled drugs for 2024 - 25

1.2 Background

The Trust is required to work under two main areas of legislation: The Misuse of Drugs Act 1971 and supporting regulations (Home Office legislation) [(1)] and The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (Department of Health legislation)[(2)] .

The main purpose of the Misuse of Drugs Act is to prevent the misuse of Controlled Drugs by imposing restrictions on their possession, supply, manufacture, import and export. The Department of Health regulations set out strengthened governance arrangements for Controlled Drugs used as medicines. The Misuse of Drugs Act divides controlled drugs into five schedules each specifying the requirements governing activities such as supply, possession, prescribing (handwriting requirements), storage and record keeping. See below for summary of the schedules and required restrictions:

Schedule 1	includes drugs not used medicinally such as hallucinogenic drugs (e.g. LSD), ecstasy-type substances, raw opium, and cannabis. A Home Office licence is generally required for their production, possession, or supply.	NA at RJAH
Schedule 2	Includes strong opiates, cocaine, ketamine, and cannabis-based products for medicinal use in humans. Full CD requirements relating to prescriptions, safe custody and documentation.	Applicable at RJAH
Schedule 3	includes the barbiturates, buprenorphine, gabapentin, midazolam, pregabalin, temazepam, and tramadol. There is variation for each drug with regard to handwriting/storage and documentation which makes it confusing for staff with the potential to miss a necessary requirement. Therefore, under RJAH Trust Policy POL002, Controlled Drug Policy, all schedule 3 drugs are treated the same as schedule 2 for assurance and best practice.	Applicable at RJAH
Schedule 4	Includes benzodiazepines, non-benzodiazepine hypnotics (zolpidem tartrate, and zopiclone). Controlled drug prescription requirements do not apply, and Schedule 4 Controlled Drugs are not subject to safe custody requirements. Records in registers do not need to be kept	Applicable at RJAH
Schedule 5	Includes low strength codeine and morphine, which due to their low strength, are exempt from virtually all Controlled Drug requirements. Note nitrous oxide is included in this schedule	Applicable at RJAH

The Controlled Drug Regulations 2013 require healthcare organisations to appoint a Controlled Drugs Accountable Officer (CDAO) who has responsibility for: -

- All aspects of Controlled Drugs management within their organisation
- Ensuring standard operating procedures are up to date and followed in practice.
- The procurement and storage arrangements of CDs
- That safe practices are in place for prescribing and administration of CDs.
- That CDs are used appropriately.
- Relevant individuals are trained.
- There are effective routes for reporting controlled drug related concerns.
- CDAOs are required to submit a quarterly occurrence report of controlled drug incidents from within their organisation so that the Area Team CDAO can identify trends of concern. Each area has a Local Intelligence Network (LIN) where trends and intelligence across the area can be shared.

The Gosport Report[3], published in 2018, highlighted patient deaths linked to inappropriate prescribing and administration of CDs. Following the publication of this report several recommendations were made for all healthcare organisations to put in place:

- Regular monitoring of prescribing patterns to ensure unusual prescribing or unusually high doses are identified.
- Ensure staff have ability and confidence to escalate concerns around usage of CDs.
- Mortality review with reference to medication/prescribing

1.3 Assurance of Governance Processes for Controlled Drugs

The CDAO for RJAH is the Chief Pharmacist who took over the role from the Chief Nurse in March 2024. The CDAO is supported in their role by the Trust Medicines Safety Officer and the Assistant Chief Nurse, Patient Safety Officer.

The following arrangements/processes are in place within the Trust in accordance with legislation:

Legally Required Action/Process	Assurance for RJAH	Gaps in Assurance
Ensuring standard operating procedures are up to date and followed in practice.	• The Trust has a policy for Controlled Drugs (POL022) with a suite of SOPs controlling prescribing, administration, storage and all other aspects of CD management outside Pharmacy. The policy was issued in May 2022 and due for review May 2025. • Pharmacy Department has a suite of SOPs covering all aspects of CD management. Note the CD SOPs relating to dispensing/checking and record storage are awaiting updating following implementation of Electronic prescribing in May 25 and impending implementation of a new Omnicell electronic storage cabinet – delayed due to Apollo project • Audits of standards undertaken quarterly	• The CD policy has had minor updates in line with change of practice but this has resulted in the review date for the whole policy being incorrectly updated – the CD policy needs a full review • The Pharmacy CD sops require updating since EPMA go-live May 2025
The procurement and storage arrangements of CDs.	• Pharmacy ordering processes follow agreed SOPs using Pharmacy computer system. Full audit trail of ordering. • Storage of CDs in wards and Pharmacy in line with Trust policy and legal requirements – quarterly audits.	• Should have external audit of CDs in Pharmacy. Will arrange in 25/26 in collaboration with West Midlands Chief Pharmacists.
Safe practices are in place for prescribing and administration of CDs.	• Policy and SOPs in place for prescribing and administering CDs. • Pre-printed prescriptions developed and approved for enhanced recovery, discharge prescriptions and end of life discharge prescriptions. This is in line with Trust prescribing guidance and ensures that CDs prescribed are at the recommended dose and written legally. • Pharmacists clinically check majority of prescriptions at admission and at least once a week if in-patient for longer. Doses and appropriateness of CDs form part of this clinical check. • New electronic prescription system introduced so only authorised staff have a password to prescribe and administer medicines. In addition protocols have been built for certain common pathways using CDs and the discharge prescription is automatically printed to meet prescription writing regulations	• Please see above re policy review • Doses and quantities supplied of morphine on enhanced recovery discharge currently being audited for assurance that the quantity is appropriate for majority of patients.
That CDs are used appropriately	• Audits of CD usage quarterly. • Clinical check of prescriptions by pharmacists. • The CD audits now reported in Trust audit report template and reported through Drug and Therapeutics	Due to unprecedented sickness in Pharmacy and implementation of EPMA there have been occasional delays to CD audits but all have been completed and reported – albeit late.

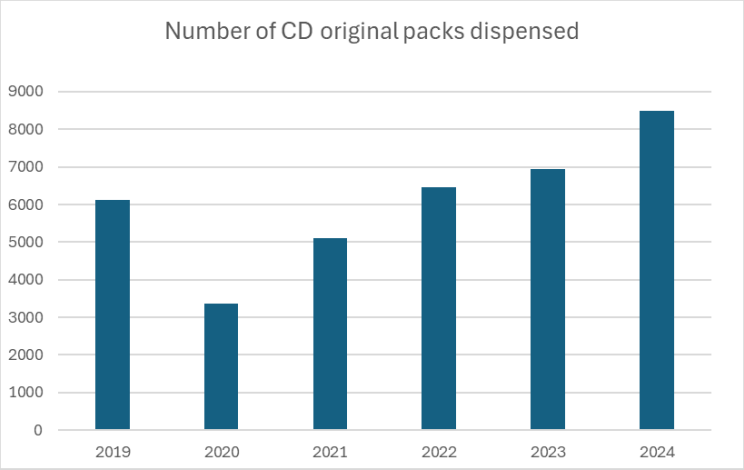
Relevant individuals are trained.	• Mandatory training package on controlled drugs – training compliance monitored currently	
There are effective routes for reporting and escalating controlled drug related concerns.	• The Trust encourages staff to report all CD related incidents on the Datix system. • Importance of escalation/reporting included in training.	Needs more oversight for any unaccounted for losses – new process established for gaining assurance on any unaccounted for loss. New documentation introduced for ward managers to follow for investigation to ensure investigations are robust. New panel established with Chief Pharmacist (CDAO), Medicines Safety Officer and Head of Governance with relevant matron/ACN with ward manager to present investigation.
CDAOs required to submit quarterly occurrence report of controlled drug incidents from within their organisation to the CDLIN.	In 2025, quarterly report submitted to the West Midlands CD Local Intelligence Network – note an extension requested for Q4 due to long term absence of Medicines Safety Officer. Report shared with Trust D&T for oversight.	There was a gap identified with regard to pulling reports for CD incidents from Datix. The MSO had developed a bespoke process for tracking CD incidents but this was not accessible to other staff. There has now been a "flag" added to the Datix incident report so that all CD incidents can be identified and reports pulled by any member of staff with appropriate permissions.
Regular monitoring of prescribing patterns to ensure unusual prescribing or unusually high doses are identified.	• Usage of CDs issued from Pharmacy are reviewed regularly to detect any unusual ordering patterns. • Prescriptions clinically checked by pharmacists. • Electronic prescribing implemented in May 25	• While Trust was still using paper-based prescribing it was difficult to track and monitor prescribing at a patient/doctor level. With new EPMA system need to explore what reports are now possible.
Mortality review with reference to medication/prescribing	In the event of an expected death, RJAH governance team complete a mortality review which includes a review of medication.	

1.4 Controlled Drug Use at RJAH

The number of doses of Controlled drugs issued from Pharmacy can be monitored using the Pharmacy electronic stock control system (CMM). The system was introduced to RJAH in 2016 but reporting capability has not been fully utilised to date and reports are limited. A new Pharmacy Digital team was recruited in summer 2024 and, alongside implementing EPMA, they have been improving understanding of how reports can be pulled from the system. It is hoped that improved, regular quarterly reports on CD usage can be provided and monitored through the quarterly update report.

Controlled Drugs Annual Report July 2025

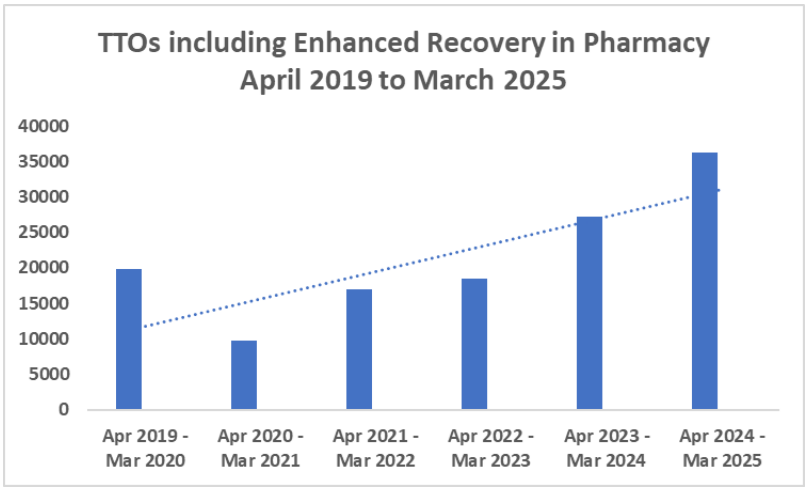
Usage of controlled drugs has continued to rise in recent years with volume dispensed in 2022, 2023 and 2024 greater than 2019 pre-pandemic with a 39% increase in number of packs of controlled drugs dispensed in 2024 compared to 2019:



Year	No CD OPs
2019	6114
2020	3374
2021	5109
2022	6468
2023	6945
2024	8486

Note usage not displayed in financial year as unable to report from CMM.

This increase in use of controlled drugs can be explained by increased dispensing activity, predominantly linked to the introduction of enhanced recovery in August 2023. Even though patient activity may not have grown significantly in 2023/24 and 24/25 the impact on Pharmacy activity has been significant – see graph below.



Prior to the introduction of Enhanced recovery, patients would have received post op opiate based analgesia on the ward on an as required basis – i.e. may not always need opiate analgesia. As enhanced recovery patients are discharged within 24 hours of surgery there is the need to supply them with a small quantity of when required oral morphine to control post-op pain. This has led to a 40% increase in activity for the Pharmacy. Each enhanced recovery prescription will include a supply of oral morphine.

During 23/24 the Trust moved from prescribing morphine liquid 10mg/5ml for discharge to using the immediate release morphine tablet (Actimorph). This followed a local agreement in Shropshire Telford and Wrekin ICS to look at reducing the actual amount of morphine that patients are discharged with. In 2019 STW was identified as an outlier regarding prescribing

of high dose opiates and RJAH Pharmacy and clinicians worked with ICS colleagues to reduce the potential for patients to take long term, high dose opiates. Using Actimorph, not modified release preparations or large volumes of liquid allows for shorter courses of opiates on discharge and prevents prescribing of long-term opioid treatments. Instructions on the discharge summary are clear that the immediate release medication provided is for a short course for acute pain only.

In December 2024 the Pharmacy team introduced a new CD delivery receipt form to replace the existing "books" of triplicate prescriptions. This was to support the introduction of EPMA when CDs would no longer be prescribed on these books, to improve patient flow by not requiring to wait for the book to be on the ward before CDs could be prescribed and improve information governance as patients information was held on these books for some time. Note the new delivery receipt forms have been identified as good practice by the Home Office and CQC during inspections at other Trusts.

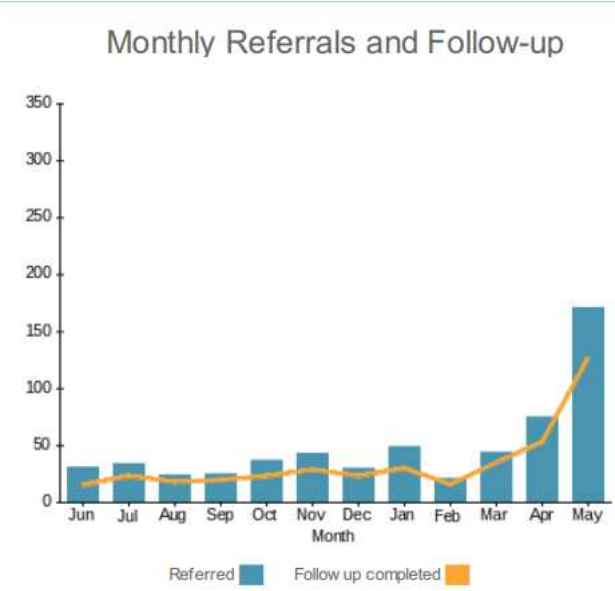
In early 2025 an audit project was started to review the appropriateness of the dosing and quantities of opiates dispensed for enhanced recovery patients. This audit involves speaking with patients after their surgery to establish if they have used the morphine provided, how much they needed and ensure they know how to dispose of safely by taking to community pharmacy. This audit is ongoing and will report later in 2025.

In March 2025 the MHRA published a safety report entitled Modified Release Opioids and Treatment of Post-operative Pain, Public Assessment Report [4]. The report highlighted the risk of modified release opioid medicines used in the treatment of pain following an operation may increase the risk of breathing difficulties and persistent use or dependence on these medications. The Commission on Human Medicines (CHM) considered that these risks when used for the treatment of pain following an operation exceeded the benefits, and therefore the indication for post-operative pain relief has been removed from morphine and oxycodone modified release products. It is assuring that RJAH had already moved to use immediate release morphine. Use of modified release opiates is rare at RJAH and only prescribed for patients who are legitimately prescribed for long term use – e.g. cancer patients.

1.5 Improving Patient Safety with Controlled Drugs

Controlled drugs can cause serious harm if prescribed or administered inappropriately. Historically, many patients would continue opiates post discharge as the opiate formed part of the discharge prescription and it was simply added to the repeat prescription. The Discharge Medicines Service (DMS) has been established across England to support patient safety with medicines post discharge and help to prevent re-admission. Hospital pharmacists send a copy of the discharge letter to the patient's nominated community pharmacy via a secure portal. The community pharmacist will be aware of the discharge medicines and will contact the patient within a week of discharge to ensure that they know what they are taking. Through referring all patients discharged on opiates to community pharmacy colleagues via DMS, patients are being supported to only take opiates for a short period of time post-discharge and community pharmacy colleagues ensure that long term opiates are not continued.

DMS referrals to community pharmacy for review have increased significantly in the past year going from less than 50 per month in the year 23/24 to triple that rate (>150 per month) in 24/25. This has been achieved by allocating dedicated Pharmacy assistant hours to the Discharge Medicines Service. Note in May 25 figures were lower due to the EPMA implementation.



Jun – May 23/24

Jun – May 24/25

As part of the pre-op Pharmacy service, pharmacists and pharmacy technicians undertake a comprehensive medicines reconciliation of patients' regular medicines and counsel patients on how to take their medicines, including post op pain relief post discharge. Pharmacists will always review doses of opiates to ensure that they are safe. There has been a new initiative started in 2024/25 with the Pharmacy team working closely with RJAH Pain Team to support patients on long term opiates to reduce their opiate use before and after surgery. While this is still at the early stages of this initiative the Pain Team nurses have reported some success in weaning some patients from dependency on long term opiates. Funding is being sought to develop this initiative further with GPs being able to refer patients to the service prior to being admitted for surgery.

1.6 Safe and Legal Prescribing of Controlled Drugs

Prescribing of controlled drugs is controlled by the Misuse of Drugs Act and it is an offence for a pharmacist to dispense a prescription for a controlled drug that does not meet legal requirements. This often leads to delays for patients at discharge as, inevitably, prescribers can inadvertently omit one aspect of the legal requirements. To support more efficient prescribing and to promote best practice in choice and dose of opiate, the Pharmacy team have introduced two pre-populated prescriptions for discharge. Enhanced recovery and end of life prescriptions have been developed with prepopulated opiates and doses in accordance with Trust guidelines.

With the introduction of electronic prescribing the doctors have questioned the need for ongoing "wet" signatures for a prescription generated in the electronic prescribing system. Unfortunately under current UK legislation prescribing CDs in hospitals with electronic prescribing there is still a requirement for a "wet" signature for all schedule 2 and 3 CDs prescribed to be taken away from the hospital i.e. outpatients and discharge prescriptions. In primary care, the need for a wet signature on a prescription has been replaced with an electronic version of prescription authorisation and Community pharmacies can dispense CDs via the Electronic Prescription Service (EPS). Note this system has been set up so that there is ONE unique CD prescription that is sent electronically to a nominated community

pharmacy and cannot be re-printed for further dispensing. This system is not yet approved by the Home Office in any UK hospital pharmacy.

1.6 Controlled Drug Audits

There is formal audit of all clinical areas every quarter looking at the: -

- Ordering process.
- Receipt documentation.
- Entry into the clinical area register.
- Maintenance of the clinical area register.
- Scrutiny of the administration records.
- Ensuring balance is correct and stock is suitable for use.
- Storage.
- Review of the documentation of part used CDs.
- Destruction process as documented in the register.

Audits are completed by the Pharmacy team using the Tendable® platform. The CD policy specifies that the audits should be completed a minimum of every six months with theatres and any areas scoring less than 90% being audited every three months so that increased focus can be put on addressing non compliance and risks.

Controlled Drug Audit Data as of April 2025

% Compliance by Area	Audit % Compliance
Alice	91%
Sheldon	91%
Kenyon	91%
Gladstone	91%
Wrekin	91%
Powys	91%
Clwyd	100%
Anaesthetic room 1	90%
Anaesthetic room 2	90%
Anaesthetic room 3	95%
Anaesthetic room 4	95%
Anaesthetic room 5	90%
Anaesthetic room 6	95%
Anaesthetic room 7	95%
Anaesthetic room 8	90%
Anaesthetic room 9	90%
Anaesthetic room 10	95%
Anaesthetic room 11	95%
Anaesthetic room 12	95%
Radiology	95%
HDU	100%
Recovery	95%
Menzies Recovery	95%
Oswald	95%
Baschurch	91%
Ludlow	81%

The main areas of non-compliance are: -

- In three ward areas it was identified that a second signature was missing from an administration of a CD.
- In theatres it was identified that staff are not consistently signing for all three aspects of supply administration and destruction (SAD) of CDs. The SAD criteria is set to provide assurance of safe custody and accountability for safe disposal of waste controlled drugs. The missing elements identified are crucial and require change in practice to be supported.
- In one area patient own medicines had not been signed out of the patient own CD register.

There has been a policy change to reflect the allowance of a single line through an entry in a CD register regarding maintenance of record keeping.

Following audit, the findings are fed back to the clinical area and any immediate actions completed.

1.7 Controlled Drug Training

CD training compliance across the Trust is at 93% an increase from the previous compliance data of 87.6% this time 12 months ago for substantive staff across the Trust. Full training compliance can be seen in the table below.

Job Related CD Training Compliance

	Not Including Bank Staff			Including Bank Staff		
Quater	Number of Staff Required to Complete	Number of Staff Completed	Compliance Percentage	Number of Staff Required to Complete	Number of Staff Completed	Compliance Percentage
Q4	356	334	94%	397	365	91.9%
Q3	352	329	93%	395	361	91.4%
Q2	356	332	93%	394	362	91.9%
Q1	349	323	92%	392	357	91%

1.8 Controlled Drug Incidents

When anomalies or errors occur at any stage in the management of controlled drugs, staff are trained and encouraged to report via the Trust's reporting system (Datix). Each incident is investigated by the Medicines Safety Officer and the senior nurse for the relevant area (all shared with the CDAO at time of reporting) and subsequently compiled into a report for submission to the CD Local Intelligence Network (LIN). There have been several changes to reporting of CD incidents to the LIN and at present, we are required to submit incidents relating to all schedules. The quarterly report is shared at Patient Safety Meeting and Drug and Therapeutics. See Table below for numbers of CD related incidents reported 2024-2025.

Incident by CD Lin Category for 2024-25	Incidents Q1	Incidents Q2	Incidents Q3	Incidents Q4
Accounted for Losses	3	1	1	3

Governance	5	9	4	20
Unaccounted for Losses	3	1	2	4
Patient Involved	16	18	14	16
Patient or member of the Public of concern	0	0	0	0
Professional/Individuals of Concern	0	1	0	0
Other	0	0	0	1

It should be noted that in quarter 2 an attempt of diversion of a schedule 4 controlled drug was identified by a healthcare professional. This was quickly identified and intercepted and the individual managed appropriately. This was escalated to the appropriate CD LIN accountable officer and within the Trust.

Investigation following a report of an unaccounted loss of a CD has not been as robust as it should have been. New documentation has been introduced for ward managers to follow a consistent process for investigation of a CD that has been reported missing. A panel consisting of the Trust Governance Lead, the Medicines Safety Officer and the CDAO will meet every two months so that ward managers can present the findings of the investigation. Matrons and Associate Chief Nurse for the speciality will also be invited to the panel. This panel will be an opportunity to gain assurance that unaccounted losses have been appropriately investigated and establish if there are any potential concerns of diversion or abuse of CDs. Outcomes and learning from these reviews will be included in the quarterly CD LIN report.

2.Action Plan

2.1 Progress on Action Plan for 2024/25

Action	Responsibility	Update	Date completed/expected
Review CD policy and associated SOPS to include new registered staff roles and review frequency of CD audits in line with risks.	Chief Pharmacist (CDAO)/Medicines Safety Officer with Senior nurses.	Amendments approved at Drug & Therapeutics Sept 24 and update saved - CD policy on Percy has not been changed – urgent update on Percy required	July 25
Implement a robust process for investigating and accountability following an unaccounted-for loss of a controlled drug.	Chief Pharmacist (CDAO)/Medicines Safety Officer, Chief Nurse with Senior nurses.	Document for investigation developed. Piloted by MCSI. First panel meeting July 25. Comms to all wards needed	July/august 2025
Improve timeliness of CD stock destruction in Pharmacy • Add into Policy, the acceptable time of stock holding before destruction occurs. • Add into Policy the maximum wait time for collection of CDs for destruction from clinical areas.	Pharmacy Dispensary Manager.	SOP for destruction of CDs in Pharmacy updated in line with legislation requirements. CDAO has identified named, senior, individuals to destroy stock CDs and rota set up. Report on destruction to Pharmacy governance	Complete
Improve reporting on usage of CDs via CMM data: -	Digital Lead Pharmacist, Senior Technician for Digital	EPMA system implementation delayed to May 25 – improved reporting expected for Q3	October 2025

		25/26 when the Digital team are familiar with the reporting tools	
Install CD Omnicell unit into Pharmacy to support with increased workload as will no longer require paper registers and storage is safer.	Pharmacy Dispensary Manager, Digital Lead Pharmacist.	Capital bid approved and Omnicell purchased. Installation delayed due to delay of EPMA and EPR system	November 2025
Implement EPMA reporting on CD usage post go-live.	Pharmacy Digital Team.	As above	
Develop a plan for the Trust to incrementally install electronic medicine storage cabinets into ward areas to improve safe storage and accountability of use of schedule 4 and 5 controlled drugs.	CDAO, Medicines Safety Officer, Chief Nurse and deputies.	Delays in EPMA/EPR go-live has delayed all digital projects	October 26
Introduce West Midlands theatre CD audit tool to improve assurance around CD use in theatres (in line with recent intelligence shared by LIN) particularly looking at documentation and destruction of unused part vials.	CDAO & MSO Chief Nurse and deputies	Added to audit template. One review has been completed – see Q4 audit report Template added to Tendable for future audits.	Complete
Written CD audit reports need to be presented at Trust D&T committee for appropriate oversight.	MSO	Delay in formally presenting audit data due to long term sickness in Pharmacy but audit report now completed and presented to D&T July 25	Complete
Should have external audit of CDs in Pharmacy. To be arranged in 24/25 year	CDAO	Needs to be further explored with partners across the West Midlands region	

2.2 Action Plan for Assurance of Controlled Drugs 2025/2026

Action	Lead Person	Anticipated Completion Date
Review Trust CD policy and associated SOPs	CDAO and MSO	April 2026
Review Pharmacy CD SOPs following EPMA implementation	Pharmacy Governance Lead Pharmacist and Pharmacy Dispensary Manager	October 2025
Include learning from CD incident investigation panel in quarterly reports	MSO/Senior Technician	September 2025
Establish a suite of reports on CD usage to be included in quarterly report and reviewed at D&T for assurance	Digital Pharmacy Team/CDAO/MSO	October 2025
Install and implement Omnicell electronic CD cabinet in Pharmacy	Digital Pharmacy team, Dispensary Manager, Chief Pharmacist	December 2025
Consider having external audit of CD processes by system partner	CDAO	March 2026

Build a case for capital investment for electronic medicine storage cabinets in areas of high CD usage – Theatres and MCSI	CDAO/Pharmacy Governance Lead/MSO	March 2026
Work with theatre staff and anaesthetists to improve accountability/signatures for destruction of unused remains of CDs in theatres	Anaesthetic Lead Consultant, Theatre Manager, MSO, CDAO	December 2025
Improve Accountability and assurance with ward areas not consistently completing CD documentation correctly	MSO/Senior Pharmacy Technician/Matrons/ACNs	December 2025

References:

1. Learning from Gosport, The Government response to the report of the Gosport, Independent Panel. 21 November 2018
2. 2. The Misuse of Drugs Regulations 2001. legislation.gov.uk. 2001.https://www.legislation.gov.uk/uksi/2001/3998/
3. The Human Medicines Regulations 2012. legislation.gov.uk. 2012.https://www.legislation.gov.uk/uksi/2012/1916/regulation
4. The Controlled Drugs (Supervision of Management and Use) Regulations 2013 https://www.legislation.gov.uk/uksi/2013/373/

Committee / Group / Meeting, Date

Quality and Safety committee, 21 August 2025

Author:

Name: Martine Williams
Role/Title: **Facilities operational manager**

Contributors:

Name:
Role/Title:

Report sign-off:

Name: Nick Huband
Role/Title: Director of Estates and Facilities

Is the report suitable for publication:

YES

Key issues and considerations:

This paper presents an annual report on security management activities for the financial year of 24/25

Strategic objectives and associated risks:

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

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

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

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

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

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

Recommendations:

The Committee is asked to NOTE the contents of the report

Acronyms

LSMS	Local Security Management Specialist
SMD	Security Management Director
PAM	Premises Assurance Model
ARA	Acknowledgement of Responsibilities Agreement
TRiM	Trauma Risk Management

0. Reference Information

Author:	Martine Williams	Paper date:	04/04/2025
Executive Sponsor:	Chief Nursing Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	Health & Safety Meeting	Paper Ref:	
Forum submitted to:		Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Quality & Safety Committee and what input is required?

The paper provides the annual report on security management activities for the financial year ended 31st March 2025.

2. Executive Summary

2.1. Context

The Trust is required to have in place and maintain adequate security management arrangements to ensure that staff and patients are in a safe and secure environment.

The attached annual security report provides information on reported security incidents, and other security management work across the Trust in 2024-25

2.2. Summary

An increased number of incidents have been reported based on previous years data, however the number of reported non- physical assaults has significantly decreased. Most of the non-physical assaults were related to patients with challenging behaviours on M.C.S.I.

It is noted that investigation of incidents by individual departments has improved, and areas have begun to take a proactive approach to security management and identify potential issues prior to escalation; a testament to the prevention and reduction culture promoted by the Trust.

Progress was made against Fuller Inquiry outcomes and there are currently no recorded security risks scoring 12 or more (High).

Year	Total Security Incidents	Physical Assaults on Staff	Non-physical Assaults on Staff	Hate Crime	Race Crime
22/23	69	9	9	3	3
23/24	167	8	36	0	1
24/25	172	23	27	1	2

2.3. Conclusion

The Committee is asked to **NOTE** the contents of the report.

3. The Main Report

Introduction

Security affects everyone who uses, or works within, the NHS.

The security and safety of staff, patients, visitors, and property must be a priority within the delivery and development of health services.

All of those working within the NHS have a responsibility to be aware of these issues and to assist in preventing security related incidents and losses.

Reductions over time in losses or incidents, through the consequences of violence, theft or damage will lead to more resources being freed up for the delivery of better patient care and contribute to creating and maintaining an environment where staff, patients and visitors feel, and are, more secure.

Aside from publishing this Annual Report, the Trust will also adopt three key principles designed to minimise the incidence of crime, and to deal effectively with those who commit crimes against the NHS.

The report provides insight on progress with managing violence and aggression by service users (clinical as well as intentional/inexcusable aggression) including reports on sanction and redress and support to staff affected.

The three key principles are:

'Inform and Involve' those who work for or use the NHS about crime and how to tackle it. NHS staff and the public should be informed and involved with a view to increasing understanding of the impact of crime against the NHS. This can take place through communications and promotion such as public awareness campaigns and media management. Working relationships with stakeholders will be strengthened and maintained through active engagement.

'Prevent and Deter' crime in the NHS to take away the opportunity for crime to occur or to re-occur and discourage those individuals who may be tempted to commit crime. Successes will be publicised so that the risk and consequences of detection are clear to potential offenders. Those individuals who are not deterred should be prevented from committing crime by robust systems, which will be put in place in line with Trust policy.

'Hold to Account' those who have committed crime against the NHS. Crimes must be detected and investigated, suspects prosecuted where appropriate, and redress sought where possible. In relation to crimes against NHS staff, criminal damage or theft of NHS property, investigation and prosecution should be undertaken in liaison with the police and Crown prosecution service.

Strategic Governance

Security Management

The Chief Finance Officer is the Board nominated Security Management Director (SMD) with responsibility for security management and ensuring that security issues are considered at the highest level and where necessary brought to the attention of the Board.

Local Security Management Specialist (LSMS)

The ongoing role of LSMS is embedded within the Trust and as a consequence advice and guidance are requested when there is an incident or issue that affects security.

The LSMS is responsible for reviewing and investigating all security-related incidents and ensuring post incident reviews are conducted. This includes police liaison, supporting and keeping witnesses informed and giving crime prevention advice where appropriate.

Investigating security incidents or breaches in a fair, objective, and professional manner to ensure those responsible for such incidents can be held to account for their actions is a vital aspect of the security management role.

Due to the relatively low level of incidents; the Trust combines the role of LSMS with the responsibilities of the Facilities Operational Manager.

A quarterly security report is presented to the Trust Fire, Security and Electrical Systems Group which forms part of the Chair Report for Health & Safety Meeting. The Group is attended by staff side Chairs/representatives, Union representatives and has senior management representation.

3.1 Inform and Involve

The LSMS has ensured that RJAH staff and the public were informed and involved with a view to increasing understanding of the impact of crime against the NHS. This took place through communications, department visits and specific advice in relation to reported incidents.

Working relationships with stakeholders were strengthened and maintained through active engagement. Work was undertaken to change the culture and perceptions of crime so that it was not tolerated at any level.

Information and intelligence were provided via targeted alerts and from colleagues in the police which allowed the LSMS to optimise the security management of the Trust.

Activities related to this standard include:

The Fire, Security and Electrical Systems Group met on a regular basis to discuss current fire and security matters and concerns. The group reported directly to the Health and Safety Meeting which in turn reported to the Quality and Safety Committee.

The LSMS also worked closely with Governance and Estates personnel to ensure all security incidents were reported through the correct channels within the Trust and that all relevant personnel were notified.

The LSMS and Local Counter Fraud Specialist have worked closely together throughout the year promoting a united approach to the management of both security and fraud within the Trust.

Prevent and Deter

Activities related to this standard include:

The LSMS has been proactively promoting a Trust-wide pro security culture, engaging clinical staff to raise awareness of the options available to them to prevent and deter incidents of violence and aggression. This has led to improved incident investigation on a departmental level, promoting a learning ethos to security within the Trust.

The LSMS has proactively engaged with the Estates team to recommend security options for the capital projects. Close working relationships with West Mercia Police and Counter Terrorism Officers were maintained.

The Trust used the in-house communications as well as the Trust Facebook page to publicise security initiatives.

Hold to Account

The use of Sanctions including Acknowledgement of Responsibilities Agreement (ARA) and warning letters was considered in all cases of violence and aggression to deter potential repeat offenders. There were no incidents that required criminal behaviour orders or the use of ARA's however a number of warning letters were sent to patients who exhibited unacceptable behaviours.

A partnership working agreement continues to be used to reinforce acceptable behaviours where required.

The LSMS had access to the DATIX incident management system and was automatically notified of all security incidents. A post-incident review was conducted where appropriate to

ensure where possible new procedures, initiatives or physical security measures were introduced to reduce or prevent the incident from occurring again.

RJAH worked hard to reduce the risk of violence and aggression towards staff by a combination of preventative measures, training, investigation, learning from experience and actively pursuing the application of sanctions and redress.

3.2 Security Incident Data

Security incident reporting remains key to the maintenance of a pro-security culture. Figures below demonstrate good awareness by staff on how to report and the need for doing so. Staff are also supported by the LSMS were required to complete accurate and appropriate reports.

Detailed below are the categorised Security Incident Statistics Trust wide for period 1st April 2024 to 31st March 2025 compared with the previous two years.

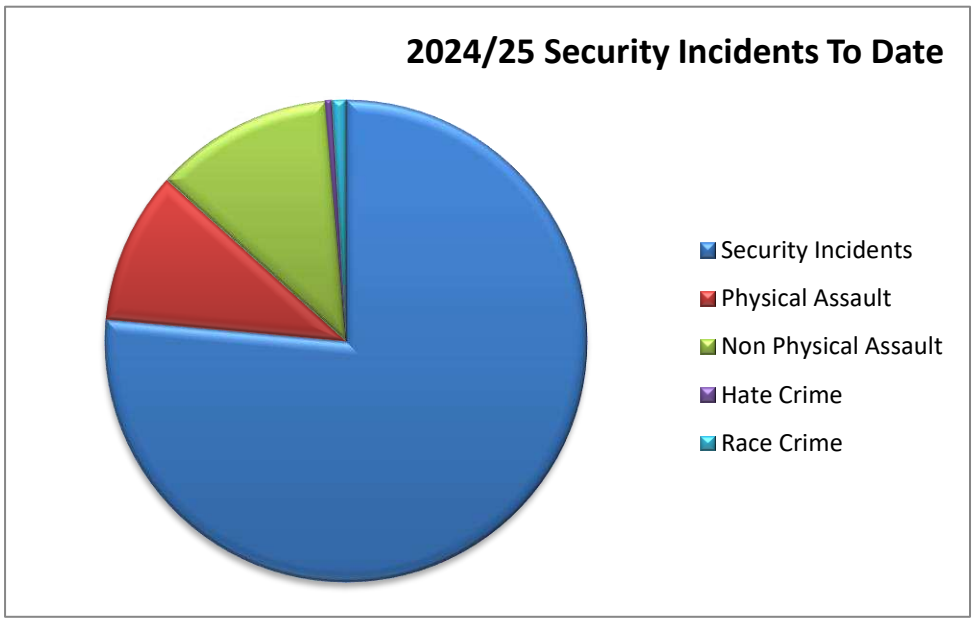
The number of incidents reported via Datix has signifantly increased as a result of the high level of incidents on M.C.S.I involving a small number of patients.The ward matron initiated the below steps to support the staff:

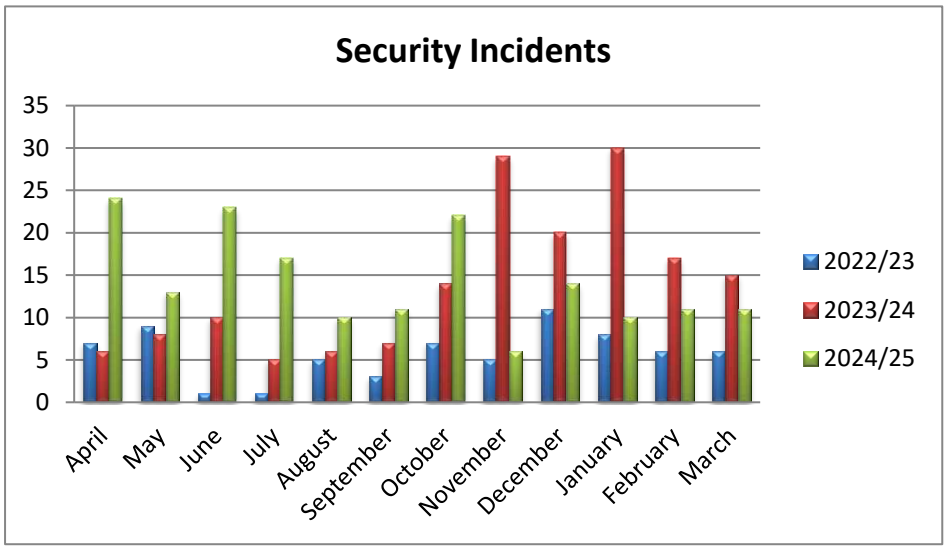
- TRiM(Trauma Risk Management) is a structured training program designed to help organisations and individuals manage the psychological impact of traumatic events. It's a peer-delivered system focused on proactive risk assessment and support for those exposed to potentially traumatic incidents. TRiM emphasise early intervention and peer support to foster a culture of psychological well-being and resilience.

Twice weekly sessions for a period of 8 weeks - this is to allow staff to discuss situations to which they have felt vulnerable and unable to manage due to violence and aggression. It also allows them to consider different managing techniques for complex patients and hopefully rebuild some resilience.

- Neurodiversity training delivered. Neurodiversity Awareness Training is an equalities, diversity and inclusion training designed to help participants understand and appreciate the differences in cognitive processing and neurodevelopmental conditions.

All incidents are summarised on a quarterly basis to the Fire, Security and Electrical Systems Group and trends analysed to promote directed training/support where required.





During the current reporting period, a total of **23 physical assaults** were reported across the Trust. Of these, **8 incidents** were reported specifically from **Sheldon Ward**.

All incidents have been reviewed and categorised as having **clinical reasons**, with no malicious intent identified. These assaults were primarily associated with patients experiencing cognitive impairments. Staff have reported that the physical assaults typically occur during personal care routines or when patients are disoriented or confused, which is consistent with behaviour associated with progressive cognitive decline.

8 physical assaults were reported from **M.C.S.I**

While all incidents were clinically driven, preventive measures focused on behavioural health, training, and personalised care are recommended to reduce future occurrences and support both patients and staff.

Both wards Conduct regular multidisciplinary reviews to proactively address patient behaviours and needs.

A total of seven physical assaults were recorded and are categorised as follows:

Powys Ward: 2 incidents

Both incidents were categorised as having clinical reasons.

Clwyd Ward: 2 incidents

Both incidents were also classed as having clinical reasons.

Alice Ward: 2 incidents

These incidents were caused by children under the age of 4.

Orthotics Department (Outpatient): 1 incident

This was also caused by a child under the age of 4.

Themes identified within the ‘other’ category of reporting in 2024-25 included:

Lost ID or door access cards – the LSMS has worked with the communications team to reiterate the potentially serious implications of a lost ID card, each lost card must be fully investigated and reported via Datix. Following work undertaken in 22/23, the has been a reduction in the number of cards lost by the theatre team.

There has been a noticeable increase in the number of incidents involving patients vaping on the wards. This behaviour is raising concerns related to health, safety, and ward compliance with smoke-free policies.

Over recent months, staff have reported a rise in the frequency of patients vaping in both communal and private areas within the wards. In several cases, patients were found vaping in their rooms, bathrooms, or even in shared ward spaces, creating discomfort for others.

Key concerns include:

Health and Safety Risks: Vaping poses potential respiratory risks, particularly in enclosed environments or around vulnerable patients. There are also concerns about fire safety due to improper charging or storage of vaping devices.

Impact on Other Patients: The smell and presence of vapor can be distressing or triggering, particularly for patients with respiratory conditions or histories of substance misuse.

Following the Fuller Report

In November 2021, the Secretary of State for Health and Social Care announced an independent inquiry into the issues raised by the actions of David Fuller, an electrical maintenance supervisor. Over the course of 15 years, Fuller committed sexual offences against at least 100 deceased women and girls in the mortuaries of the Kent and Sussex Hospital and the Tunbridge Wells Hospital. His victims ranged in age from nine to 100.

Key Recommendations: The inquiry made 17 recommendations to improve practices and policies around mortuary security and the handling of deceased individuals **Enhanced Security Measures**: Implementing stricter security protocols in hospital mortuaries, including controlled access and surveillance systems.

	Recommendation	Evidence of Assurance	Actions	RAG
3.	Trusts must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The Trust should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements.	External contractors from Estates and Facilities do not carry out any lone working and are always accompanied by a member of staff from the Trust and this requirement to not lone work is reflected in the contractor's induction.	The people services team are currently in the process of reviewing and updating individual DBS checks.	In progress
8.	Trust should treat security as a corporate not a local departmental responsibility	Trust security LSMS in place and is managed through corporate services.	No further action required.	Complete
9.	Trust must install CCTV cameras in the mortuary, including the post-mortem rooms, to monitor the security of the deceased and safeguard their privacy and dignity.	CCTV in place and reviewed as per recommendation 7.	No further action required.	Complete
10.	Trust must ensure that footage from the CCTV is reviewed on a regular basis by appropriately trained staff and examined in conjunction with swipe card data to identify trends that might be of concern.	As per recommendation 7.	No further action required.	Complete
11.	Trust must proactively share Human Tissue Authority reports with organisations that rely on Human Tissue Authority licensing for assurance of the service provided by the mortuary.	Mortuary at RJAH limited to storage and not pathology services	No further action required.	Complete
12.	We have illustrated throughout this Report how Maidstone and Tunbridge Wells NHS Trust relied on reassurance rather than assurance in monitoring its processes. The Board must review its governance structures and function in light of this.	Terms of Reference are in place for the HTA Meeting which takes place bi-monthly. The group reports to the Regulatory Oversight Group (ROG) via a Chairs Report, where HTA updates are also a	Estates and Facilities to be invited to ROG.	Complete

		standing agenda item on the agenda. At present estates and facilities who oversee the management of the mortuary do not currently attend.		
15.	Trust should treat compliance with Human Tissue Authority standards as a statutory responsibility for the Trust, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the Designated Individual. The Act will be subject to review in Phase 2 of the Inquiry's work.	As per recommendation 12.	Estates and Facilities to be invited to ROG.	Complete

These recommendations ensure that mortuary facilities are secure and respectful environments, preventing any future occurrences of such egregious violations. The goal is to honour the dignity of the deceased and provide peace of mind to their families.

However, due to the decommissioning of the mortuary at RJAH Hospital, the number of recommendations applicable to the Trust has been reduced from 17 to 7. The closure of this facility effectively removes certain site-specific obligations, though the broader responsibilities related to security and safeguarding remain in place.

Associated Risks

All security risks are managed in accordance with the Trust Risk Management Policy. All risks which have been scored and evaluated as requiring to be placed on the Trust Risk register, are entered on to the Datix system where they, and accompanying action plans, are regularly reviewed. The requirement to regularly review and record progress is initiated by a system generated electronic alert to the risk owner.

There are currently no recorded security risks scoring 12 or more (High).

Looking Forward to 2025-26

In 2025/26 the Trust will be required to meet a new statutory obligation known as the Prevent Duty. Also known as Martyn's Law, the Prevent Duty is forthcoming legislation that will place a statutory requirement on those responsible for certain publicly accessible locations to consider the threat from terrorism and implement appropriate and proportionate mitigation measures.

In preparation for its arrival and in addition to maintaining existing security arrangements and measures already outlined in this report, the following proposal will be made to further strengthen the organisations security profile and mitigate relevant threats:

3 yearly security awareness training for all staff in the form of Action Counters Terrorism (ACT) awareness eLearning. This is a free 60 minute online counter terrorism awareness training course for all UK based companies, organisations, and individuals. ACT Awareness eLearning provides nationally recognised corporate counter terrorism guidance to help people better understand, and mitigate against, current terrorist methodology.

Next Steps

The Health and Safety Meeting is asked to **NOTE** the contents of the report.

Conclusion

RJAH has worked hard to reduce the risk of violence and aggression towards staff with a combination of preventative measures, improved training, investigation, learning from experience and actively pursuing the application of sanctions.

This year, the Trust has operated a consistent risk-based approach to escalation of security measures, by ensuring the LSMS is embedded in the multi-disciplinary team to offer timely advice when considering changes to services operated by the Trust.

Through the Premises Assurance Model (PAM), the Trusts SLA with its security contractor is reviewed and updated annually to ensure it is fit for purpose. This model challenges the Trust to provide evidence of its robust procedures across all Estates and Facilities services, including security management.

Appendix 1: Acronyms

LSMS	Local Security Management Specialist
SMD	Security Management Director
DH	Department of Health
SLA	Service Level Agreement
PAM	Premises Assurance Model

Safeguarding Annual Report 2024/2025

Committee / Group / Meeting, Date

Board of Directors, 03 September 2025

Author:

Helen Harris
Named Nurse Safeguarding Adults
Edyta Szpila
Named Nurse Safeguarding Children

Contributors:

Bethan Mallen, Adult Safeguarding Practitioner
Rebecca Wright-Powell, Adult Safeguarding Practitioner

Report sign-off:

Kirsty Foskett, Assistant Chief Nurse and Patient Safety Officer

Quality & Safety Committee, 21st August 2025

Is the report suitable for publication?:

YES

Key issues and considerations:

The report provides assurance in regard to the safeguarding agenda and position over the reporting period 2024/2025.

Strategic objectives and associated risks:

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

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

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

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

Recommendations:

The meeting is asked to agree the Trust Safeguarding Annual Report for 2024/2025.

Report development and engagement history:

The Safeguarding Annual Report was considered at Safeguarding Committee in July 2025 and has been updated with minor amendments.

Next steps:

If approved the Safeguarding Annual Report will be published.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Safeguarding Annual Report 2024 / 2025

Authors:

Helen Harris - Named Nurse Safeguarding Adults

Edyta Szpila - Named Nurse Safeguarding Children and Young People

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Introduction

The Safeguarding Annual Report provides assurance to the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) Board regarding safeguarding activity for the reporting period 1st April 2024 – 31st March 2025.

RJAH is committed to ensuring that all staff are aware of their safeguarding responsibilities in relation to children, young people and adults at risk. The report demonstrates continued organisational compliance with statutory requirements and national and local safeguarding frameworks.

The Trust has made significant investment in the Safeguarding Team, recruiting dedicated Named Nurses for Adults and Children, and a Domestic Abuse and Sexual Safety Lead, to enhance and support the organisational safeguarding agenda.

The team are committed to the promotion of safeguarding best practice and ensures that all statutory functions are fulfilled, responding proactively to the needs of staff members, patients and their support mechanisms. The vision of the team is to truly embed safeguarding practices within the Trust, making it visible within everyday core business.

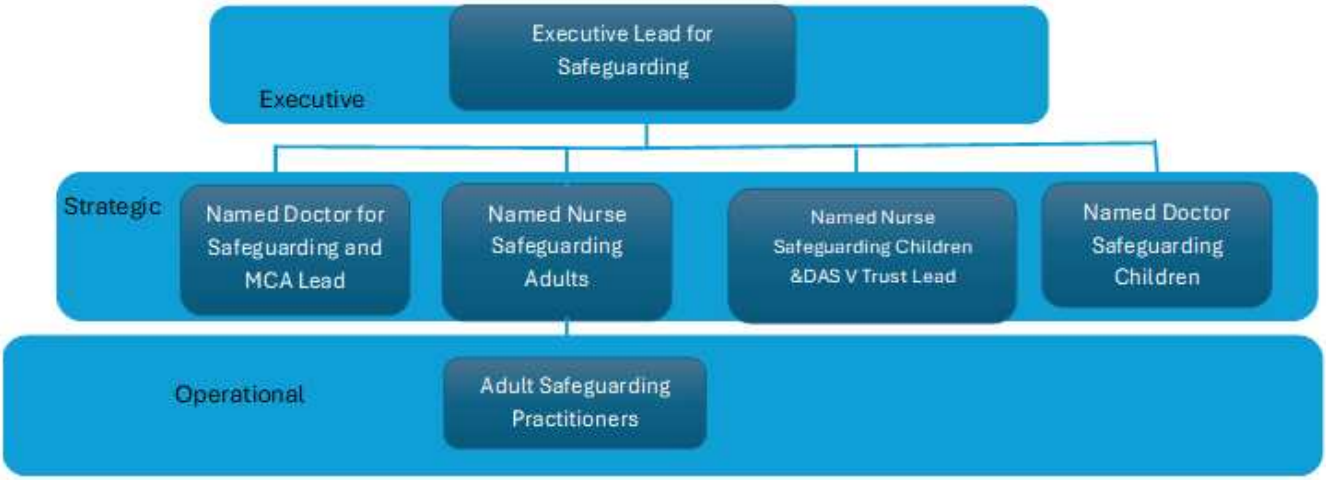
Safeguarding governance contributes to a wide range of performance and quality measures both internally and externally, in accordance with the Care Quality Commission (CQC), Shropshire Safeguarding Community Partnership (SSCP), Telford & Wrekin Safeguarding Partnership and our local Integrated Care Board (ICB). This includes:

- Mandatory Training
- Deprivation of Liberty Safeguards (DoLS) Applications.
- Referrals to Adult and Children's Social Care
- Section 42 Enquiries
- SARs / CSPR / DHRs
- PREVENT / Channel Pannel requests.
- Domestic Abuse Stalking and Harassment (DASH) Risk Assessments.
- Safeguarding activity for children, young people and adults
- Safeguarding supervision
- Advice and support to all staff
- Staff allegations
- LADO and PIPOT
- Was Not Brought (WNB) rates

Safeguarding Structure

NHS organisations are required to identify specific statutory individuals to provide expert safeguarding advice and support to all employees, whilst promoting best practice. These individuals, Named Doctor and Named Nurse for Safeguarding Children and Young People, Named Nurse Safeguarding Adults ensure that the safeguarding agenda is supported and adhered to throughout the organisation in accordance with statutory guidance and legislation.

The Executive Lead for provides strategic leadership throughout the Trust, ensuring that the safeguarding agenda is a key and fundamental strategy within the organisation, embedding principles in all areas of service provision. A Non-Executive Lead is identified to ensure board scrutiny, challenge and accountability in relation to the safeguarding agenda.



Executive Lead for Safeguarding	Paul Kavanagh-Fields Chief Nurse and Patient Safety Officer
Non-Executive Lead for Safeguarding	John Pepper
Named Doctor for Safeguarding Children & Young People	Dr Richa Kulshrestha Consultant Paediatric Neurodisability
Named Nurse Safeguarding Children & Young People and DASV Lead	Edyta Szpila Named Nurse Safeguarding Children (15hrs) Domestic Abuse & Sexual Violence Lead (18.75hrs)
Named Doctor for Safeguarding Adults and MCA Lead	Mr Srinivasa Budithi Consultant Surgeon in Spinal Injuries
Named Nurse Safeguarding Adults	Helen Harris (1WTE) Post includes Trust Lead for Prevent, Dementia, Mental Health and Learning Disabilities & Autism
Adult Safeguarding Practitioners	Bethan Mallen (17hrs) Rebecca Wright-Powell (26hrs)

Key Achievements

- Improvements observed across the organisation regarding the safeguarding priorities for 2024/2025, with a steady increase in mandatory training safeguarding children throughout the year.
- There is evidenced growth in awareness and confidence across the Trust in recognising and reporting potential safeguarding concerns, including domestic abuse.
- Group supervision has been established for children's practitioners across three staff groups, and face-to-face safeguarding children training has been delivered in-house, receiving positive feedback.
- The 0-19 specialist community public health teams safeguarding liaison form is embedded in practice when following up missed appointments or professional concerns, contributing to a decrease in WNB paediatric rates, with this success shared with external partners.
- Patient-facing Trust website with Learning Disability resources set up with support of the Trust's Communication Team.
- The Assessing Mental Capacity Policy together with the Mental Capacity and Best Interest Toolkit launched and received positive feedback.
- The Safeguarding Adults and Children's flag/alerts have been approved for use in the new electronic patient system (EPR), Apollo.

- Additional Training
  - ✓ Mental Capacity Training.
  - ✓ Dementia Training for Health Care Assistants.
  - ✓ Butterfly Scheme Re-Launch.
  - ✓ Dementia Communication Training.
  - ✓ Conflict Resolution Training and De-escalation Training delivered by Innovation Team.
  - ✓ Communication in Dementia Care and Management of a Patient Requiring Enhanced Supervision.
  - ✓ Consent and Legal Responsibility co-delivered by Trust Solicitors.
  - ✓ Mental Capacity and Best Interests Toolkit Lunch and Learn.
  - ✓ Study day on Alice Ward on Children as stand-alone victims of Domestic Abuse.
  - ✓ Safeguarding and Parental Responsibility Lunch and Learn.
  - ✓ Child and Young Person Neglect Training.
  - ✓ Mental Health Grab Pack Training.

- Updated Policies and Procedures:
  - ✓ Mental Health Policies.
  - ✓ Mental Health Grab Pack.
  - ✓ Assessing Mental Capacity Policy Mental Capacity and Best Interest Toolkit.
  - ✓ Safeguarding Children and Young People Policy.
  - ✓ Safeguarding Supervision Policy.
  - ✓ Carers' Policy.
  - ✓ Paediatric Clinical Holding Policy.

- In review at time of report
  - ✓ Restrictive Practice Policy.
  - ✓ Managing Allegations Against Staff Policy.
  - ✓ Domestic Abuse Procedure.

- Assurance audits
  - ✓ Mental Capacity Act (MCA) Documentation.
  - ✓ PREVENT Audit.
  - ✓ FGM Audit.
  - ✓ Child Victims of Domestic Abuse.

Section 1: Statutory Frameworks and National Policy Drivers

Whilst there are significant differences in the laws and policies that shape how we safeguard children, young people and adults at risk, the objective of all legislation is to ensure that all individuals are protected to life free from harm, abuse and neglect.

This report provides a summary of RJAH discharges its statutory duties in relation to:

- Mental Capacity Act (2005) / Deprivation of Liberty Safeguards Amendments (2009)
- Care Act (2014)
- Counter Terrorism and Security Act (2015)
- Learning from Lives and Deaths (LeDeR) (2021)
- Children Act (1984, 2023)
- Working Together to Safeguard Children (2018, 2023)
- Domestic Abuse Act (2021)
- NHS Sexual Safety Charter (2023)
- SSCP / Telford & Wrekin Safeguarding Partnership

The Mental Capacity Act (2005) / Deprivation of Liberty Safeguards (DoLS) Amendments (2009)

The Mental Capacity Act 2005 protects and empowers individuals who are, or may be, unable to make decisions for themselves. It applies to everyone working in health and social care providing support, care and treatment to people aged 16 and over who live in England and Wales.

The five fundamental principles of the MCA ensure that all individuals are provided with an opportunity to engage in the decision-making process, even where it is identified that they lack the mental capacity to make their own decisions.

The act allows restraint and restrictions to be used, but only where it is identified that they are in the best interests of the individual and utilising extra safeguards, which are Deprivation of Liberty Safeguards (DoLS). DoLS was due to be replaced by Liberty Protection Safeguards (LPS) however HM Government announced in 2023 that implementation is delayed, with no further update.

The Care Act (2014)

Adult safeguarding is established as a core function of every local authority's care and support system. The Care Act sets out the statutory framework for safeguarding adults. The Act requires local authorities to have a Safeguarding Adult Board (SAB); one key function of which is to ensure that policies and procedures governing adult safeguarding are fit for purpose and can be translated into effective adult safeguarding practice.

The Counterterrorism and Security Act (2015)

The overall aim of HM Government's counter-terrorism strategy, CONTEST, is to reduce the risk from terrorism to the UK population, ensuring that citizens can go about their lives freely and with confidence. PREVENT remains one of the four key pillars of the CONTEST framework; Prevent, Pursue, Protect and Prepare.

Whilst RJAH remains a non-priority site, all healthcare and other regulated bodies have a statutory duty to engage with the framework to ensure early identification and intervention of individuals who are susceptible to radicalisation.

Learning from Lives and Deaths (LeDeR) 2021

LeDeR was introduced in 2017, developed and designed to improve the care of individuals with a learning disability and/or autism. Individuals within these groups are likely to die 25 years earlier than others. The aim of LeDeR is to reduce health inequalities and prevent individuals from dying sooner than they should. In 2021, the NHS Long Term Plan made a commitment to continue LeDeR and a new LeDeR policy was produced, providing for the first time core aims and values of the programme and the expectations placed on the health and social care system.

The RJAH Safeguarding Team attended local LeDeR governance and steering groups reviewing deaths and taking actions to improve services within the local areas, ensuring compliance with the LeDeR policy. The Learning Disability Improvement Standards (LDIS) were developed in conjunction with experts with experience with the Listen, Act, Do framework being fundamental.

The Reasonable Adjustments Digital Flag (RADF) has been discussed within the ICS, ensuring that moving forward there will be interface with the GP Spine; this is an ongoing conversation with the Apollo Team. Until full implementation, local reasonable adjustment flags are active within the Apollo system to ensure Phase I of the RADF is underway and compliant.

The team has been instrumental in the creation and launch of the patient facing RJAH Learning Disabilities and Autism website. Once the ICB LD&A website is developed and live, the plan is for both to link to support patients across the system. The website has been promoted within the Trust via the Patient Engagement Group, Healthcare Professionals Network (previously SNAHP) and the Quality and Safety Group.

The Learning Disability Service Evaluation questionnaire has been approved identifying patient and carer feedback; however, this has been deferred to Q1 2025 / 2026.

The Children Act (1984, 2004) / Working Together to Safeguard Children (2018, 2023)

The Children Act (1989) and Section 11 of the Children Act (2004) placed a statutory duty on all NHS Trusts to plan to ensure that it has regard for the need to safeguard and promote the welfare of children when exercising its functions. The new arrangements are led by three statutory partners, The Shropshire Safeguarding Community Partnership, the Local Authority, West Mecia Police and ICB.

Domestic Abuse Act (2021)

Domestic abuse is a public health epidemic and health services have to be part of the solution. The government's strategy for tackling domestic abuse is based on prevention, protection, justice, and support. Evidence has shown many survivors of domestic abuse desperately wanted someone to ask them what was happening at home when in contact with a health professional and thus the government believes that the NHS has a particular contribution to make. The Domestic Abuse Act 2021 provides a more comprehensive definition of domestic abuse, recognizing not only physical violence but also emotional, coercive, and controlling behavior. This expanded definition ensures that various forms of abuse are addressed.

Training on domestic abuse is part of the Safeguarding Adults L3 training package. The topic of children as standalone victims of domestic abuse, as well as emotional abuse resulting from domestic abuse, is also addressed in the L3 Safeguarding Children Training.

NHS Sexual Safety Charter (2023)

NHS England launched the sexual safety charter in 2023, ensuring that NHS Trusts and partner organisations work collaboratively to ensure and enforce a zero-tolerance approach to unwanted, inappropriate and/or harmful sexual behaviours within the workplace. The charter has 10 core principles underpinning the actions that all agencies are expected to undertake to achieve. At the time of publication, 349 NHS Trusts and partner organisations have signed up to the organisational charter. Sexual Safety Training has been sourced and will be delivered from Q1 2025-2026.

Safeguarding Partnerships

SSCP and Telford & Wrekin Safeguarding Partnership are they statutory bodies for coordinating and ensuring effectiveness of arrangements to safeguard and promote the welfare of children, young people and adults at risk within Shropshire, Telford & Wrekin. All Trust Safeguarding policies, procedures and training are aligned with ICB Safeguarding policies and guidance.

RJAH attend:

- Children Quality Assurance and Performance Group
- JTAI Preparation meetings
- Adult Safeguarding & Protection Practice Oversight Group
- Children's Safeguarding & Protection Practice Oversight Group
- Children's Oversight Group
- Statutory Case Review Group
- Training Pool
- Adult Statutory Case Review Group
- Child Sexual Abuse Task and Finish Group
- Domestic Abuse Forum
- Neglect Sub-Group
- MCA Midlands Forum
- Telford Safeguarding Partnership Panel Meetings
- Telford Child Sexual Exploitation (CSE) Sub-Group

Safeguarding Assurance Audits

Audits provide an opportunity to assess and evaluate safeguarding knowledge, skills and confidence, in conjunction with evaluating processes and procedures throughout the organisation. Fundamentally, this provides assurance against regulatory standards and systemically enables benchmarking within the Trust, locally and nationally, ensuring that NHS providers are compliant with robust regulatory standards are in place.

Within the reporting period there have been 4 assurance audits completed and reported, as identified above.

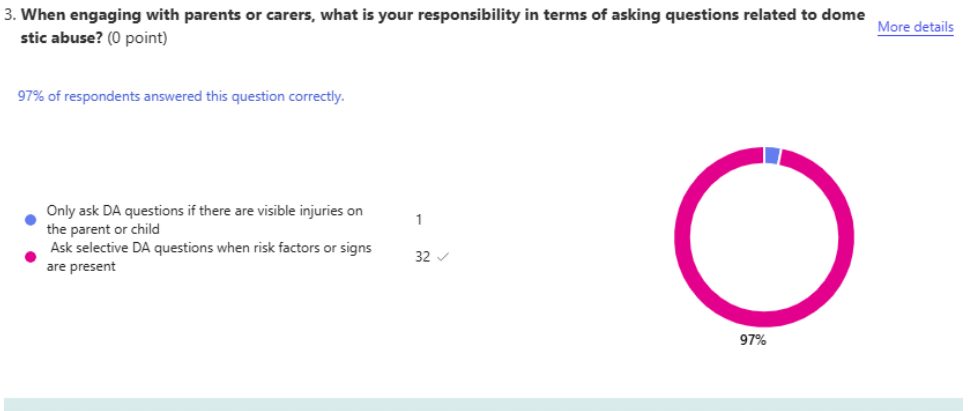
- **FGM**
  An FGM Take 10 audit was completed within Q1 provided assurance of staff knowledge and confidence when acknowledging and reporting incidents of FGM, but also identification of risk to other female family members. The audit provided assurance that the vast majority of staff were confident in how to raise concerns as well as who to contact.

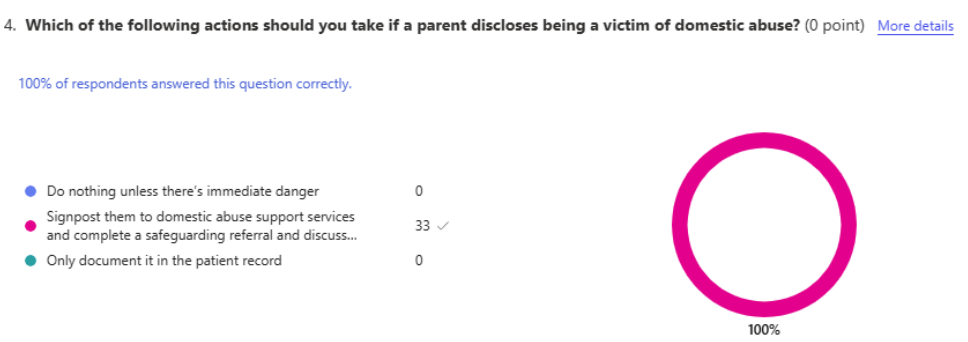
- **MCA Documentation**
  The team completed a deep dive audit within Q2, in relation to assessments of mental capacity undertaken within the Trust. A total of 6 records were chosen at random, with 5 of the forms capturing the correct decision information in the capacity assessment. The small sample did not provide an overall picture of the Trust position, therefore an additional audit was complete in Q3 for assurance purposes. The sample size was increased to 13; the stage one diagnostic criteria was 77% compliant and stage two functional criteria being 92% compliant.

  Ongoing advice and support continues to be provided by the team throughout the Trust, with ad hoc and bespoke training, as well as MCA / DoLS being incorporated into L3 Safeguarding Adult training. Additional, lunch and learn sessions have been provided inline with the implmentation of the MCA / BI toolkit and amended forms. Feedback is also given directly to staff on completion of MCA forms identified.

- **Prevent**
  Within Q4, an audit was undertaken in relation to Prevent following a request from the ICB system. The aim was to identify the level of confidence amongst staff within the system in relation to the Prevent / Channel agenda. The results were positive, showing that staff were aware of how to raise concerns related to Prevent, exploitation and radicalisation. The results were shared internally with the appropriate committee and externally with the ICB Designated Lead.

- **Children as Stand-Alone Victims of Domestic Abuse**
  - The Domestic Abuse Act 2021 introduced important changes, recognising children as stand-alone victims of domestic abuse.
  - The Domestic Abuse Statutory Guidance 2023 further emphasizes this shift in approach.
  - In response to these legislative updates, staff working with children were surveyed to assess their understanding of the changes.
  - The survey results demonstrated a good level of understanding among staff regarding the new legislation and the importance of viewing children as independent victims of domestic abuse.





Key insights from the aggregated responses:

- Nearly all respondents recognise their responsibility to ask selective domestic abuse questions when risk factors or signs are present, and to assess, signpost, and refer as appropriate if a child may be affected.
- The majority feel 'somewhat confident' in their understanding of their role in addressing domestic abuse concerns, with a smaller group feeling 'very confident.'
- Almost all are aware of relevant local and national services, and most acknowledge that children are recognized as standalone victims under the Domestic Abuse Act. The most common actions taken are to signpost to support services and make safeguarding referrals for both the child and the parent, with most also referring perpetrators to support services when safe to do so.

Section 2: Mandatory Training

Whilst there are significant differences in the laws and policies that shape how we safeguard children, young people and adults at risk, the objective of all legislation is to ensure that all individuals are protected to live free from harm, abuse and neglect.

Safeguarding training is mandated for all staff working within the NHS and is dependent upon the role that the individual undertakes within the organisation. All safeguarding training is delivered in line with the safeguarding intercollegiate documents; Safeguarding Children and Young People: Roles and Competences for Health Care Staff. Intercollegiate Document (2014) and Safeguarding Adults: Roles and competencies for Health and Care staff Intercollegiate Document (2018)

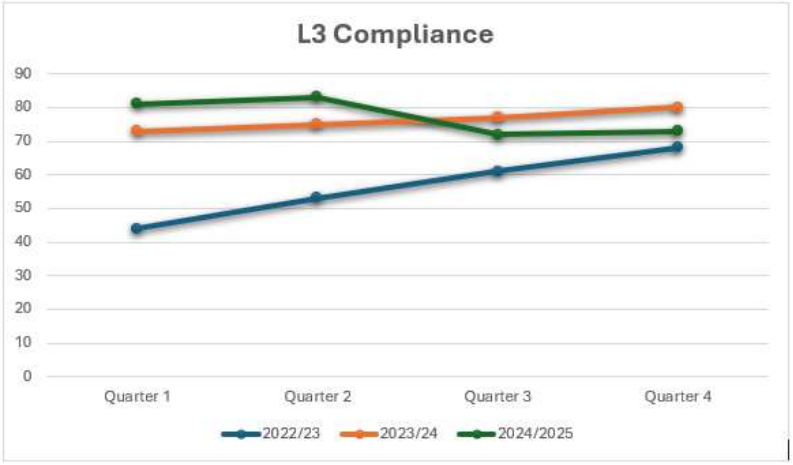
Training is based around a 3-yearly training cycle, with the level and hours dictated via the intercollegiate document. Training compliance is included within the ICB quarterly SAF quality schedule. The NHSE Digital Data Collection Framework is also required to be completed from Q4.

Safeguarding Adults

- **Level 1 training**
  Staff members complete this training online via ESR, with this metric persistently outperforming all of the other adult categories; with a consistent above measure above the Trust target of 92%.

- **Level 2 training**
  The last two quarters of the year saw this compliance rate fall below 92%, with Q3 at 90% and Q4 at 89%.

- **Level 3 training**
  All quarters saw low compliance across the year; significantly lower than Trust compliance of 92%, with Q1 81%, Q2 83%, Q3 72% and Q4 73%. Overall, L3 training has consistently improved compared to previous years. A persistent area of challenge is, and continues to be, bank staff compliance, despite remedial actions being taken.



- **Level 4 training**
  Training at Level 4 for Named Nurses, MCA and Paediatric Leads continues to be consistently at 100%.

Themes / Trends
Discussions have been ongoing with the Learning & Development Team identifying that the decline in compliance was significantly impacted by:

- Staff sickness during winter months.
- Winter pressures lead to low attendance.
- Training cancellation by the external provider in Q4.

Remedial actions have been identified and include:

- Additional training dates
- Extended classroom capacity.
- Improved communication with Matrons / Service Leads / Ward Managers.
- Liaison with Comms to promote training sessions / additional dates.

Safeguarding Children & Young People

- **Level 1 Safeguarding Children Training**

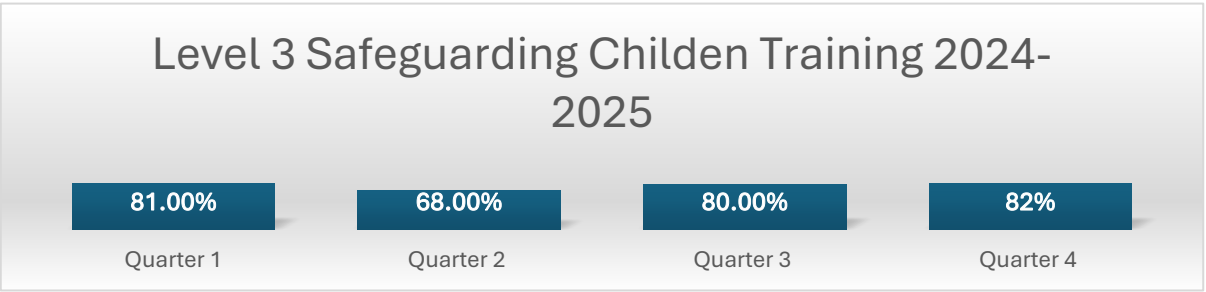
Staff have been complaint with level 1 training in all quarters.

- **Level 2 Safeguarding Children Training**

Staff have been complaint with level 1 training in all quarters.

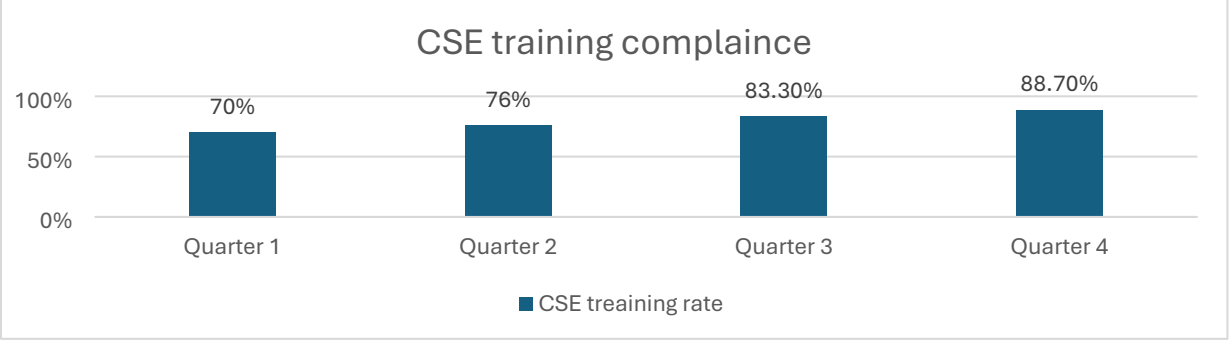
- **Level 3 Safeguarding Children Training**

There has been a steady increase in mandatory safeguarding children training throughout the year following an initial compliance decrease in quarter 2.



CSE

Training
Online training has been set up on the ESR in July 2024 and has been meeting its training trajectory at expected level of 88.7% in quarter 4.



Additional Safeguarding Training and Development in 2024-2025

- ✓ Mental Capacity Training
- ✓ Dementia Training for Health Care Assistant
- ✓ Butterly Scheme Re- Launch
- ✓ Dementia Communication Training
- ✓ Conflict Resolution Training and De-escalation training delivered by the Innovation Team
- ✓ Communication in Dementia Care and Management of a patient who requires Enhanced Supervision
- ✓ Consent and Legal Responsibility co-delivered by the Safeguarding Team and the Trust Solicitors
- ✓ Mental Capacity and Best Interest Toolkit Lunch and Learn
- ✓ Study day on Alice Ward on Children as stand-alone victims of Domestic Abuse
- ✓ Lunch and Learn sessions or Safeguarding and Parental Responsibility
- ✓ Child and young person neglect training (half day)

Dementia

Dementia is an umbrella term for several diseases that affect memory, thinking and the ability to perform daily activities. The illness is progressive and mainly affects older people as they age. Every year there are nearly 10 million new cases of dementia, which is currently the seventh leading cause of death.

Training in relation to dementia care is completed via an online module and sits within the staff ESR matrix; current compliance is 94%, exceeding the Trust target of 92%.

Dementia care and re-launch of the Butterfly scheme was identified as a safeguarding priority for 2024 / 2025. The Safeguarding Team have liaised with the Innovation Team and Comms Team in the re-launch of the Butterfly scheme, providing additional training, resources and knowledge for specific staff working with patients experiencing dementia.

The Acute Confusional State (Delirium) in Older People SOP has been reviewed and presented to the senior nurse and ward teams as a teaching package sharing knowledge of the delirium pathway, supporting staff with interventions to manage patients who are unwell.

Learning Disability and Autism

All NHS providers have a requirement to ensure all staff complete mandatory training in respect of learning disability and autism. The Oliver McGowan training is the preferred mechanism within the ICB, which is delivered in two parts. Part 1 is an e-learning module that all members of staff must complete. Part 2 is delivered as Tier 1 (a 60-minute webinar), or Tier 2 (a full day face to face session); both sessions have lived experience experts in attendance. Initially OMMT was commissioned via NHSE, accelerating to Trusts sourcing training independently within the system. The RJAH board took the decision to commission an external provider to facilitate training.

A training needs analysis was completed with 30% of staff (600) to undertake Tier 1 and 70% of staff (1500) identified as having to undertake Tier 2 competence. Since the inception uptake has been excellent at RJAH with the training being very well received. The NHSE expectation of compliance is 30% with all rates of training exceeding this metric. Currently training compliance stands at 90% for Part 1 and 41% for Tier 1 and 37% for Tier 2.

Mental Health

Mental health training is completed via an online module which is dictated within ESR for all relevant staff members; current compliance for this module is 96%, well above the target KPI.

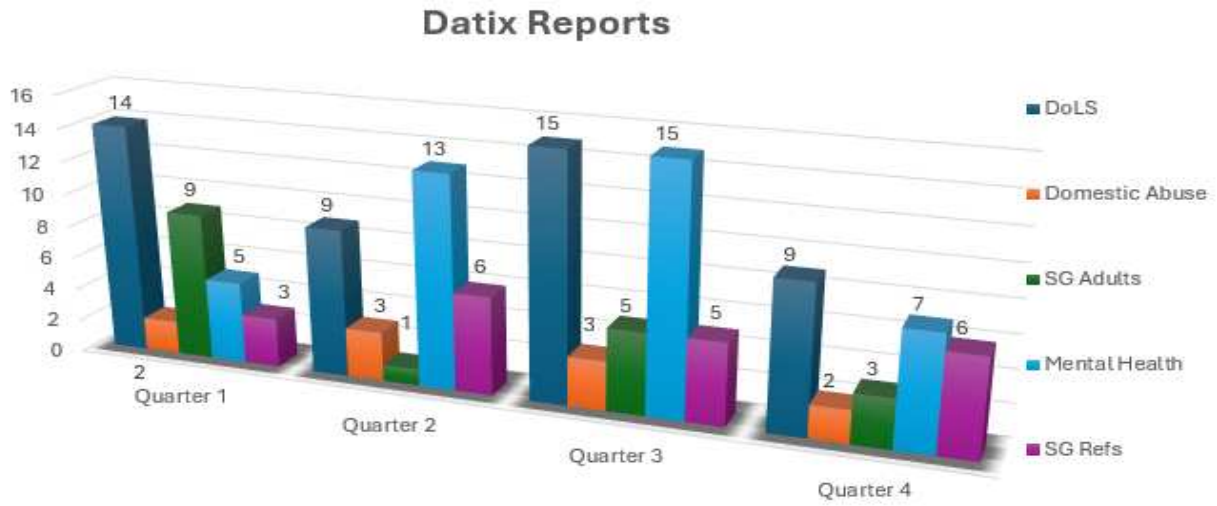
Additional training has been sourced, specifically for MCSI staff, when supporting patients who have a mental health condition or a neurodivergence. This de-escalation and management training was sourced, commissioned and commenced in conjunction with MPFT colleagues and the Psychology Team, ensuring that staff have the tools and knowledge to support patients with communication, active listening and where necessary, conflict resolution. The training has been well received and remains ongoing.

PREVENT

Prevent training continues to be provided as part of the RJAH onboarding mandatory training matrix. This is a metric within the ICB SAAF and is now also reportable quarterly via the NHS Digital Data Collection Framework. All staff at RJAH complete Level 3 Prevent Training and have consistently outperformed this well above the required 85% KPI, with the compliance not dropping below 95%.

Section 3: Safeguarding Adult Activity

Safeguarding Adult Activity

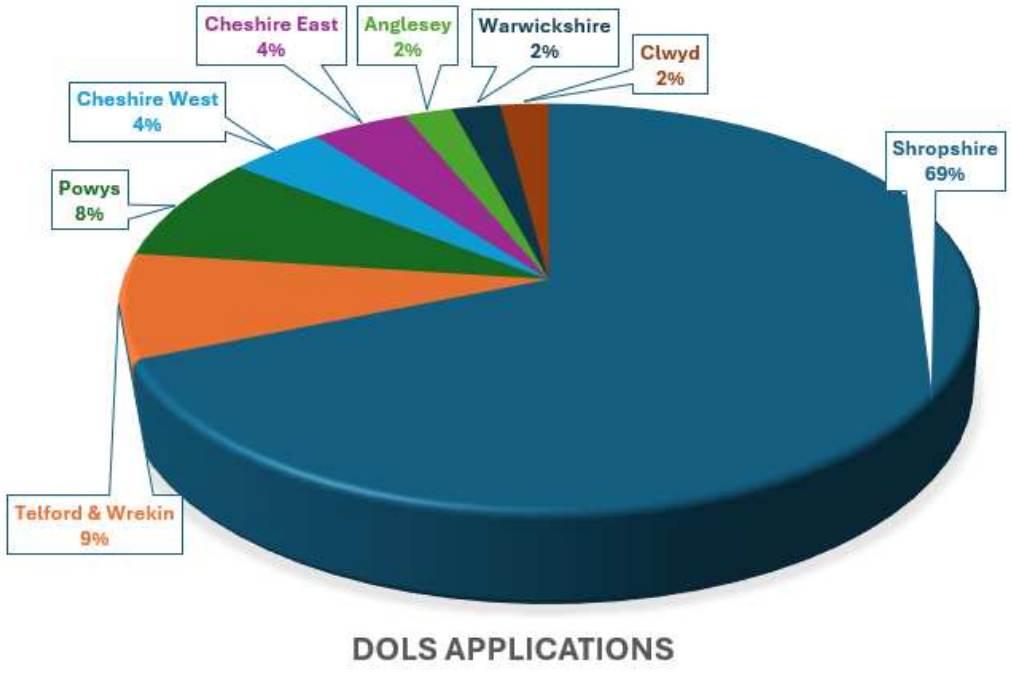


Datix Reporting

A total of 135 Datix reports were completed by staff over the four quarters: a decrease of 14% (from previous year end). Within the categories, DoLS was again the dominant category with 35% (47), a decrease of 16%. The second placed category, 30% (40), was identified as mental health concerns, up a significant 58%. Datix's in relation to safeguarding adults was the next category, with 17% (23); a decrease of 32%; followed by referrals to local authority 11% (15), a decrease of 36%. Lasty, 7.5% (10) reports were made in relation to domestic abuse, consistent with the previous year.

DoLS Applications

Within the reporting period there were a total of 49 DoLS***** applications made by staff at RJAH, with a relatively steady split across the quarters, and beginning and end of year (Q1 = 16, Q2 = 9, Q3 = 15 & Q4 = 9).



This reflects an overall reduction of 25% from the previous year, with 65 DoLS applications being made, across 13 different local authority sites. The reduction is primarily due to a decrease in overall patient activity during the time frame.

*Discrepancy noted against Datix reporting, which identified 47 DoLS applications made. This was due to staff not always completing a Datix in relation to DoLS applications; however, following discussion, no further occurrence since Q1.

Patients were subject to DoLS applications for a total of 912 days, with the overall average day number being 19.

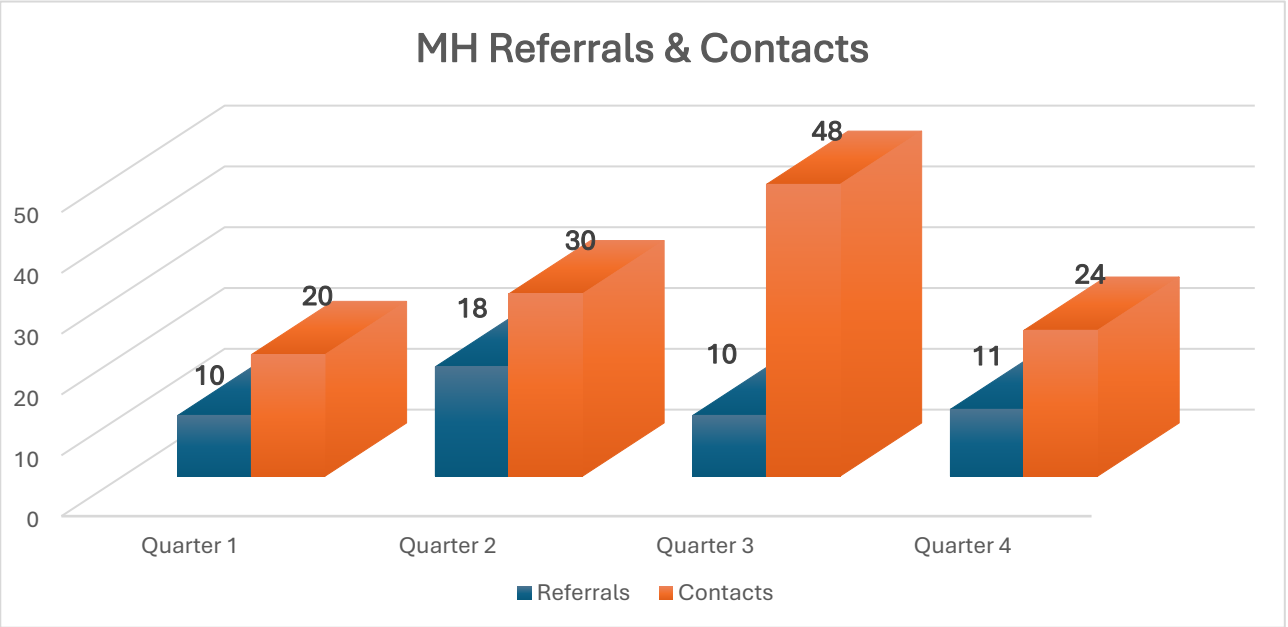
The majority of DoLS were made to Shropshire (33), remaining were made to Telford & Wrekin (4), Powys (4), Cheshire West (2), Cheshire East (2), Anglesey (1), Warwickshire (1), Clwyd (1), and Staffordshire (1). Patients from 9 local authoritites were accommodated at RJAH; a reduction from the previous year which identified 13 local authorities.

Mental Health

Mental health issues continue to be a significant, and ongoing, issue at RJAH and was one of the identified safeguarding priorities for 2024 / 2025. Concerns under this category range from waiting list patients experiencing levels of pain; to inpatients who have significant and enduring mental health illnesses and require additional support for patients and staff.

RJAH commissions a Mental Health Liaison Service from MPFT colleagues, who provide advice and support to both patients and staff on the wards, utilising a weekly face to face service, together with telephone contact available on a 24 / 7 basis.

Referrals made to MHLT total 49 this year, with the team reviewing these individuals a total of 122 times (contacts).



Additionally, a psychology service is also commissioned from MPFT, for patients within MCSI. Patients waiting for internal transfer to an MCSI bed are currently unable to access this service, however, this provision is due to be reviewed.

Themes / Trends

- Patients requiring MHLT support should consent to a referral (or have been deemed to lack the ability to consent to a referral due to lacking mental capacity, and therefore one is completed following a best interest decision being made and documented accordingly).
- Patients awaiting internal transfer to MCSI requiring psychological support are unable to access this service provision.
- Non-clinical staff, such as Patient Access Team, Medical Secretaries and PALS Team, continue

to receive contacts from patients who are experiencing high levels of pain, who are unhappy with the waiting times, and some of whom state that they are unable to cope with this anymore; and on occasion identifying suicidal ideation. A Standard Operation Procedure (SOP) was therefore created to support non-clinical staff in having such conversations, identifying next steps and remedial actions. Whilst training has previously been provided for non-clinical staff, further sessions are planned.

Mental Health First Aiders

There have been increasing incidents throughout the Trust where staff members have required additional support with mental health issues, due to a variety of reasons. The Safeguarding Team have, and will continue to, support line managers and members of the People Services Team (HR) with these types of concerns.

The Trust has supported the training of 33 staff members to complete the Mental Health First Aider Course, in order to provide additional listening support for staff members who are experiencing a mental health related issue. These Mental Health First Aiders (MHFA) provide signposting guidance towards specialist support services. Contact information is identified within the Trust wellbeing portal OurSpace; as well as via posters throughout the organisation. Peer support and supervision sessions are undertaken quarterly for the MHFA's and moving forward this will be undertaken by the Safeguarding Team providing guidance and governance.

Safeguarding Advice & Support

Within the reporting period 177 instances of advice, support or supervision to staff members have occurred across the organisation in relation to adult and children safeguarding concerns. Eleven of these were in relation to adults, 57 were related to children, additionally 65 staff accessed children safeguarding supervision.

Pre-Op / Ward Alerts

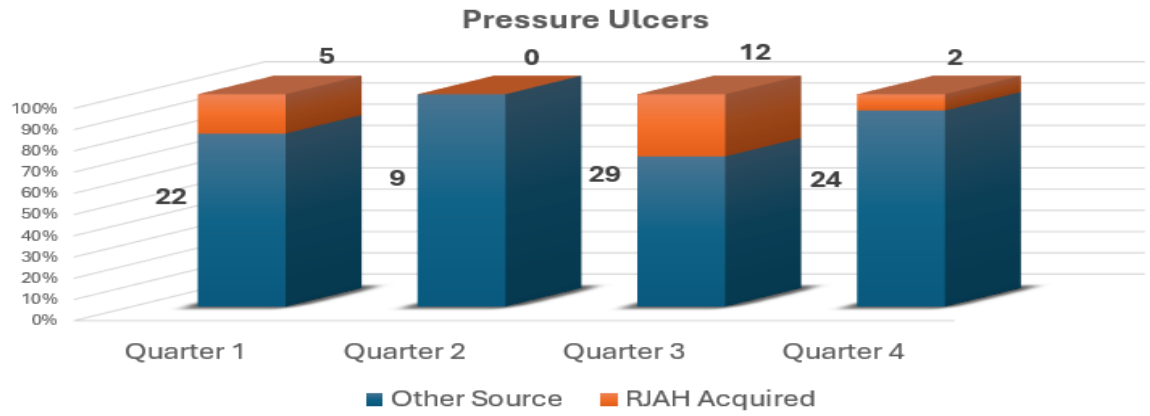
Patients who attend RHAH for a pre-operative assessment and who require, or may require, reasonable adjustments, or have a safeguarding concern identified, will have a pre-operative alert form completed. These are subsequently emailed to the Patient Access Team and Safeguarding Team in order to highlight to teams that some additional support is, or may be, required. Within this reporting period a total of 147 pre-operative alerts were received by the Safeguarding Team; with an average of 37 per quarter. The implementation of the Apollo digital system will require this process to be reviewed and reconsidered.

Pressure Ulcers

The Safeguarding Adults Protocol: Pressure Ulcers and the Interface with a Safeguarding Enquiry Process is national guidance for staff dealing with individuals who have, or may have, pressure damage of category 2 or above. Where multiple category 2 damage has occurred, or category 3 or above, the protocol should be accessed and scored against the decision guide and provides staff considerations for next steps.

Of the 103 reports of skin / pressure damage, 19 were felt to be acquired whilst a patient at RJAH, with 2 of these being reported to the local authority via a safeguarding referral.

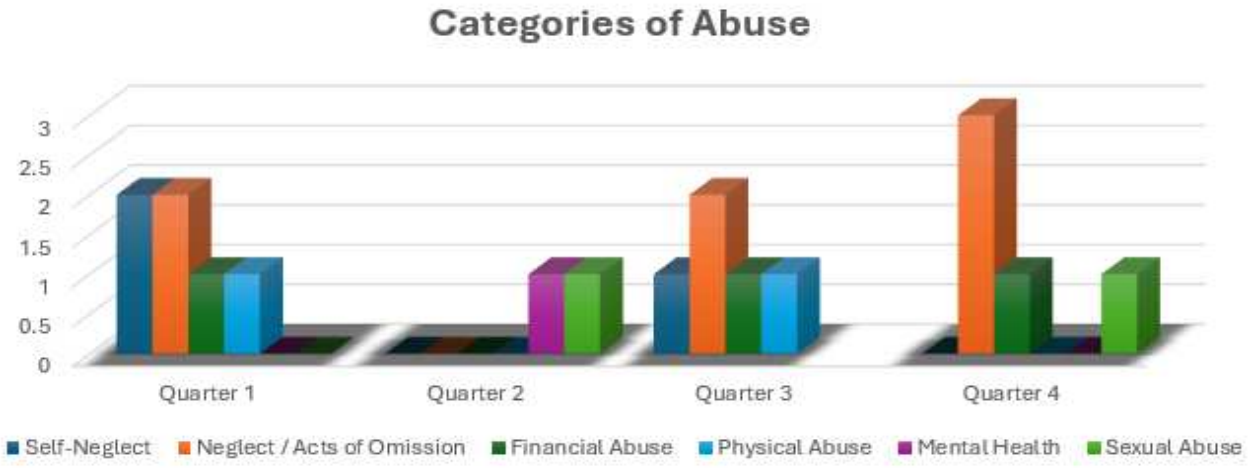
17 of the



reports were complex cases (multiple 2 and above), with 15 reports falling within the criteria for utilising the protocol, however only 2 had the protocol completed; evidence that staff are not recognising the importance of this mechanism. A new reporting system is currently due to be adopted, and the Safeguarding Team are working closely with colleagues in Information Governance to ensure the new mechanism is sustainable in terms of safeguarding and pressure damage reporting.

Safeguarding Referrals

This reporting period there were a total of 19 safeguarding referrals made to the relevant local authority regarding adults at risk. Of the above referrals, 1 was in respect of care undertaken within the Trust and as a potential source of harm, however the case was closed by the local authority with no further action required or learning identified.



Themes / Trends

The following categories were identified as the primary category of abuse within the rereferrals:

- Neglect / Acts of Omission 8
- Self-Neglect 3
- Financial Abuse 3
- Physical Abuse 2
- Sexual Abuse 2
- Mental Health 1

Section 42 Enquiries

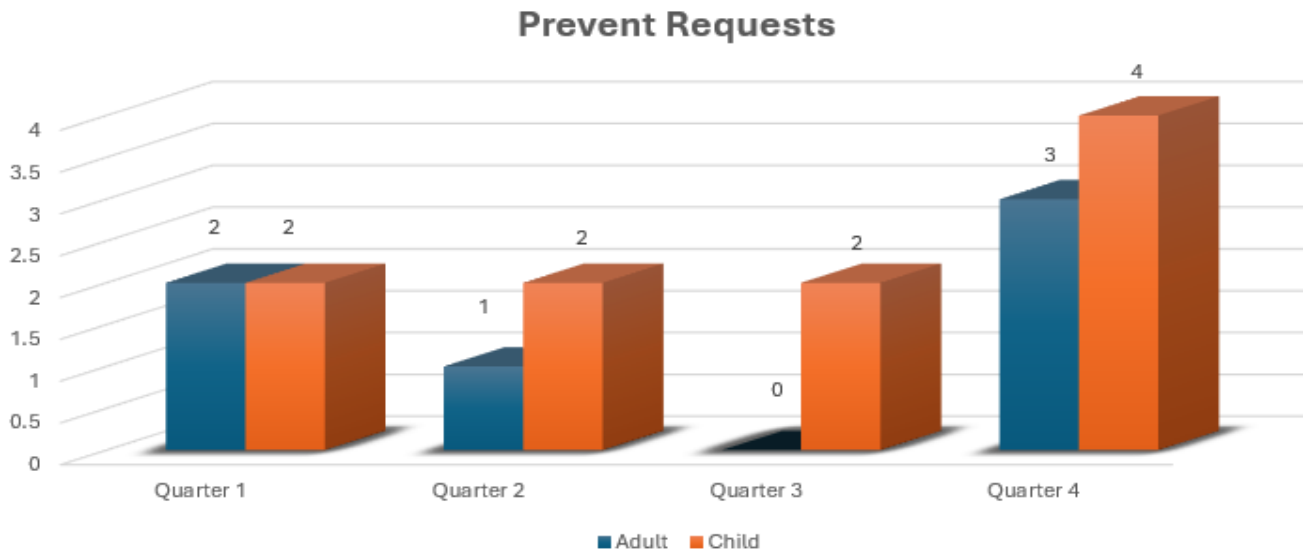
As per the Care Act (2015), Section 42, all agencies have a statutory requirement to engage with social care and respond to allegations or concerns made in relation to adults at risk.

Following referrals made to local authority there were no Section 42 (S42) enquiries progressed during the reporting period. RJAH made two referrals to the local authority in respect of care undertaken within the Trust; both cases were responded to within the agreed timescales, and both were closed with no further action required.

PREVENT Requests

In accordance with Section 26 of the Counter Terrorism and Security Act 2015, RJAH has a responsibility to share relevant and proportionate information with other professional bodies about individuals who are susceptible to radicalisation. Within the reporting period, 16 requests were made to RJAH for health information; all of whom were male. 6 were in relation to adults and 10 to children; of these only 4 were historically known to RJAH services. No Prevent / Channel referrals were made during the reporting period, which is in line with previous reporting.

Attendance at Channel Panel was not requested and therefore no representative from RJAH was required. Channel Panel training was undertaken in Q3, with the RJAH Safeguarding Practitioner attending finding it helpful, especially in terms of the multi-disciplinary nature of the training, enabling a valuable insight.



In Q4 information was disseminated from the Home Office, via NHS England and the ICS, in response to a statement by the Home Secretary (in January 2025 after the conviction of Axel Rudakubana following the Southport attack) outlining the next steps:

> *'Whilst longer term improvements are considered, measures are being introduced to clarify the policy position and strengthen assurance on this significant issue 'referrals categorized as '**fascination with extreme violence or mass casualty attacks**.' Until more long-term approaches are developed the relevant guidance has been adapted and these types of cases can be considered and supported by the existing Channel programme.*
>
> *While there may be times when the precise ideological driver is not clear, referrals should proceed if there is a concern that someone may be susceptible to radicalisation. Therefore, please consider making a referral if the issue of an exact ideology is uncertain, but it is believed the individual may be susceptible to radicalisation.'*

The above was communicated via RJAH Comms Team and intranet page was set up with all the relevant information including emoji language and Incel ideology, this information is also shared within L3 Safeguarding Adults mandatory training package.

Staff Allegations / PiPoT / LADO Referrals

There was a total of 8 staff allegations made during this reporting period; with 2 referrals being made in accordance with People in Positions of Trust (PiPoT) guidance and 2 referrals made to the Local Authority Designated Officer (LADO). Two cases were referred to the individuals' respective professional body, with 1 case remaining ongoing with continued police involvement. All staff allegations are dealt with in line with local and national guidance.

Safeguarding Adult Review (SAR)

Where the SSCP receive a referral for a SAR within the local system, all partner agencies, including RJAH, are asked to complete initial scoping reports in order to review and analyse best practice, and identify learning. Where appropriate, representatives from partner agencies who were engaged with the individual attend decision making meetings to summarise practice and share learning across the system. During this reporting period 3 scoping reports have been completed in relation to SAR's, with several common persistent themes being identified, including:

- Self-Neglect.
- Communication.
- Engagement.
- Mental Health.
- Mental Capacity Act.
- Information sharing.
- Professional curiosity.

Section 4: Safeguarding Children and Young People

During the reporting period, the Trust made a total of five referrals to Children's Social Care and three referrals to the Early Help service.

Safeguarding Children Activity

The Trust participated in the following multi-agency safeguarding meetings:

- Three Child in Need (CIN) meetings following cases where children were not brought to healthcare appointments.
- One Pre-discharge planning meeting for a toddler who was an inpatient following a surgery and was on the Child Protection (CP) Plan in quarter 4.
- Three CIN meetings and Pre discharge Planning meetings were attended for a complex inpatient in quarter 2.

Child Safeguarding Practice Reviews (CSPR)s

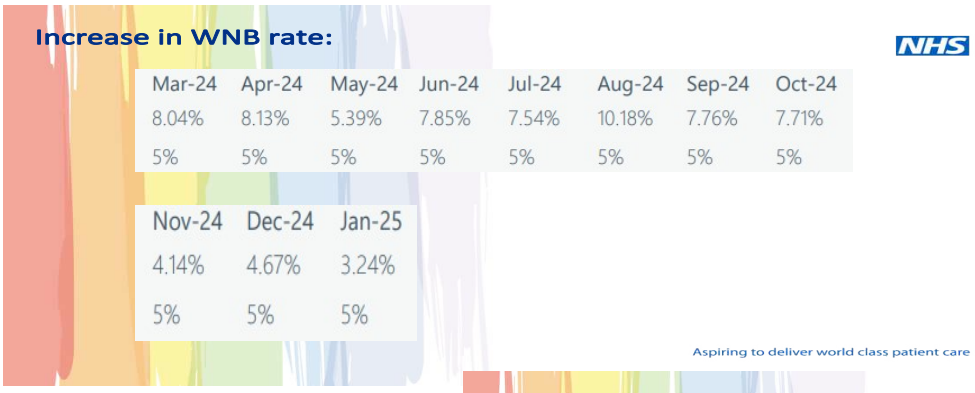
There has been one Rapid Review attended in 2024-2025 which progressed to Child Practice Review however the author has not been appointed yet.

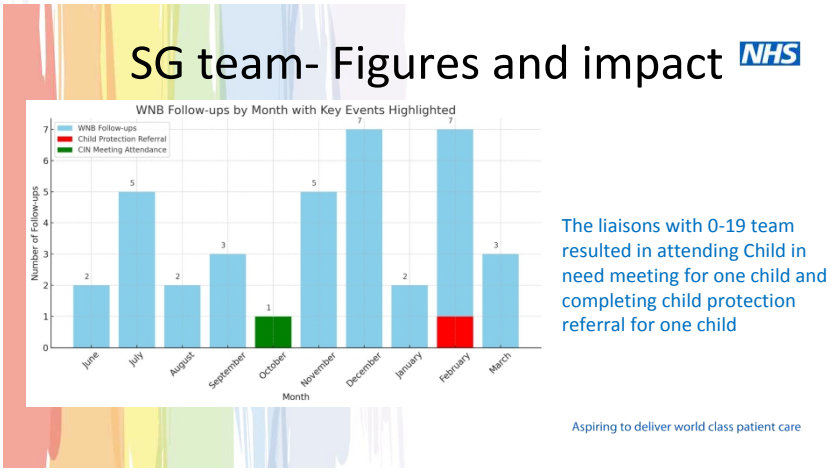
Safeguarding children 0-19 Liaison Forms

The liaison forms were created to follow up children with two or more Was Not Brought (WNB), patterns of WNB or any other safeguarding concerns and from June to March 2025- in 37 liaisons which resulted in one referral to children social care for one child and attending Child in Need (CIN) meeting for one child.

Children who were not brought to their appointment (WNB)

The WNB figures remained around 5.7%, there has been excellent work undertaken in the health inequality workstream to reduce the WNB rate and update from colleagues was requested to be shared with the Safeguarding Committee Meeting.

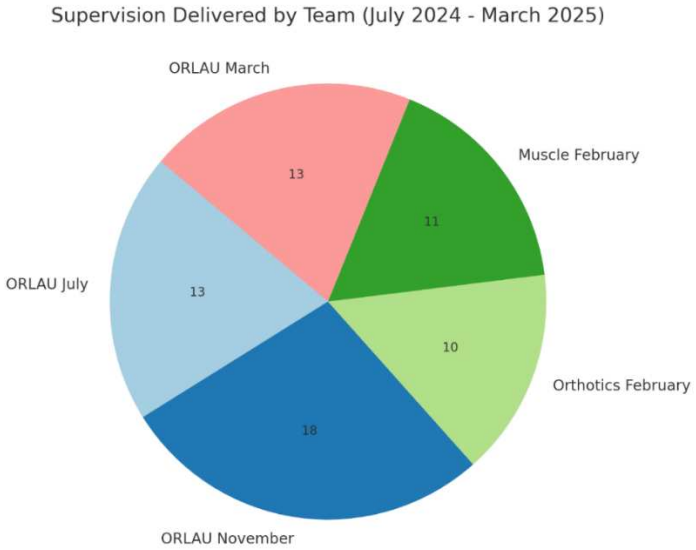




Supervision Summary (July 2024 - March 2025)

The Safeguarding Supervision Policy has been reviewed, resulting in significant updates to the delivery of children's safeguarding supervision. A key change was the introduction of structured group safeguarding supervision sessions for staff working directly with children on a one-to-one basis.
The rollout began with the ORLAU team and has since expanded to include all relevant paediatric staff groups.

Safeguarding supervision policy has been updated and face to face safeguarding children supervision has been rolled out to three staff groups, available to all clinical, registered staff across the organisation and is aligned to national guidance.
The Named Nurse for Safeguarding Children delivered a total of 5 group supervision sessions, reaching 65 staff members across the Trust.



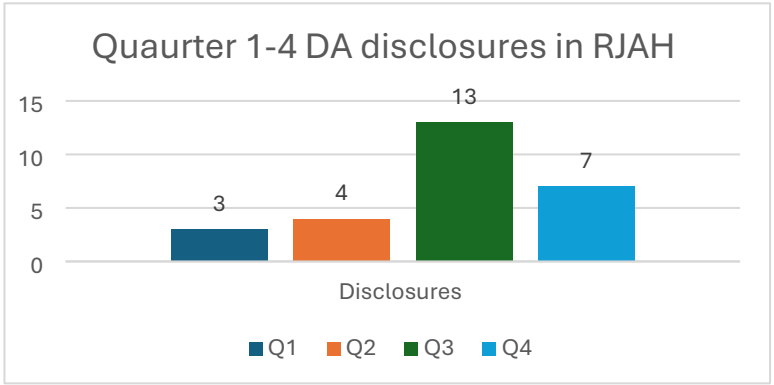
Breakdown of Supervision Sessions Delivered**:**

- ORLAU – July 2024: 13 staff
- ORLAU – November 2024: 18 staff
- Orthotics – February 2025: 10 staff
- Muscle Team – February 2025: 11 staff
- ORLAU – March 2025: 13 staff

Section 5: Domestic Abuse and Sexual Safety Activity

Domestic Abuse

There has been a significant increase in completion of CAADA DASH risk assessments completed in quarter 3 following disclosures of DA.



There were 27 disclosures of domestic abuse made by service users and staff. Of these, 10 CAADA DASH Risk Assessment were completed.

MARAC referrals

There were three MARAC referrals completed for service users.

Harmful Practices / Gender Based Abuse (FGM / Forced Marriage / Honour Based Abuse)

During the reporting period there were no identified cases of FGM, Forced Marriage or Honour Based Abuse.

Domestic Homicide Review (DHR)

In accordance with the Domestic Abuse Act 2021, a Domestic Homicide Review (DHR) is undertaken by partner agencies, within the local system, when serious harm or death has occurred. Within the reporting period there have been 6 DHR scoping requests; the outcomes of which remain pending with one meeting the threshold for DHR which is ongoing.

Section 6: Priorities 2025 / 2026

Whilst there have been challenges during 2024-2025 across the safeguarding agenda, the 2023-2024 priorities have been broadly achieved whilst others were removed as found less relevant. The Trust is now in a stronger position moving forward into the coming year following significant investment.

The Safeguarding Team has identified nine key priorities for 2025/26 to improve safeguarding standards across the Trust for both adults and children. These priorities focus on policy updates, training compliance, digital improvements, and strengthening internal frameworks:

Improving Training Compliance

A revised Level 3 Adult Safeguarding training package has been developed to meet national standards, incorporating topics like MCA, DoLS, domestic abuse, and modern slavery. Compliance is being actively monitored and promoted, with the Children's L3 compliance nearing 90%.

Was Not Brought (WNB) Policy

The WNB policy is under review to align with statutory requirements and now includes Adults at Risk. CPIS checks are being incorporated into the process, supported by newly developed guides.

Safeguarding Champions Programme

A competency-based framework for Safeguarding Champions is in development, with plans to embed this in the Band 6 development programme and forum. Workshops will include mental health, LD&A, dementia, and children's safeguarding topics.

Domestic Abuse & Sexual Violence Policy

The Domestic Abuse policy is being updated to reflect statutory duties and digital system changes (Apollo). A combined policy for Domestic Abuse and Sexual Violence is in draft and will be shared with People Services.

Restrictive Practices Policy Review

A revised policy is pending approval, with a focus on compliance and promotion across the Trust. Training is being sourced, and data collection on chemical restraint is in planning with Pharmacy.

Pressure Ulcer Policy and Safeguarding Integration

The safeguarding element within the Pressure Ulcer Policy is being reviewed in partnership with Tissue Viability. Safeguarding content will be included in the training from January 2026.

PREVENT Policy

The PREVENT policy is being reviewed to ensure alignment with updated statutory guidance, including definitions of extremism. Training will also be revised if required.

CPIS Phase Two Rollout

CPIS access is being expanded and streamlined across all children's services. A narrated guide and new SOP are being introduced, alongside updates to policies and procedures to reflect digital system changes. CP-IS phase two implementation is ongoing with a meeting arranged with NHS England digital and system C and the database of staff needing additional roles on their smart card has been collected. The SOP for CP-IS checks will be shared when appropriate with staff and training will be provided by the safeguarding team.

Complex Care Pathway Development

Safeguarding is embedded in the Trust's Complex Care Pathway to ensure reasonable adjustments under the Equality Act. A redesigned safeguarding checklist supports this integration.

Conclusion

The Safeguarding Annual Report 2024 / 2025 demonstrates the Trust's ongoing commitment to ensuring the safety and wellbeing of children, young people, and adults at risk. Despite the challenges experienced across the health and care system during this period, RJAH has maintained a strong safeguarding culture, supported by a dedicated team, robust governance, and collaborative working with system partners.

The expansion of the safeguarding team, development of specialist roles, and the introduction of structured safeguarding supervision and additional training have strengthened safeguarding processes and staff confidence across the Trust. Improvements in data reporting, engagement in statutory reviews, and contributions to multi-agency learning all reflect the Team's proactive approach and its ambition to continually improve outcomes for service users.

Looking ahead to 2025 / 2026, the safeguarding agenda remains ambitious and aligned with national priorities. The identified priorities will ensure ongoing development of digital systems, improvements in training compliance, and further integration of safeguarding into all areas of care delivery. Through strong leadership, accountability, and an unwavering focus on safeguarding as core business, the Trust is well-positioned to build upon these foundations and deliver excellence in protecting the most vulnerable.

Abbreviations

CAADA	Coordinated Action Against Domestic Abuse
CQC	Care Quality Commission
CIN	Child in Need
CP	Child Protection
CPIS	Child Protection Information System
CSE	Child Sexual Exploitation
CSPR	Child Safeguarding Practice Review
DASH	Domestic Abuse Stalking & Harassment
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
EPR	Electronic Patient Record
ESR	Electronic Staff Record
FGM	Female Genital Mutilation
ICB	Integrated Care Board
ICS	Integrated Care System

LADO	Local Area Designated Officer
LD&A	Learning Disability and/or Autism
LeDeR	Learning Disability Mortality Review
LPS	Liberty Protection Safeguards
MARAC	Multi-Agency Risk Assessment Conference
MCA	Mental Capacity Act
MCSI	Midlands Centre for Spinal Cord Injury
MPFT	Midlands Partnership Foundation Trust
NHSE	NHS England
PiPoT	People in Positions of Trust
RADF	Reasonable Adjustment Digital Flag
RJAH	Robert Jones & Agnes Hunt Orthopaedic Hospital
SAB	Safeguarding Adult Board
SAR	Safeguarding Adult Review
SCPR	Safeguarding Children Practice Review
SSCP	Shropshire Safeguarding Community Partnership
WNB	Was Not Brought

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Adult and Children's Safeguarding Meeting

Committee / Group / Meeting, Date

Board of Directors, 03 September 2025

Author: **Contributors:**

Sophie Donnelly, Executive Assistant

Report sign-off:

Kirsty Foskett, Assistant Chief Nurse and Patient Safety Officer (Chair)
Quality and Safety Committee, Thursday 21st August 2025

Is the report suitable for publication?

YES

1. Key issues and considerations:

The Quality and Safety Committee has established an Adult and Children's Safeguarding Meeting. According to its terms of reference: *"The Meeting will aim to assure that all statutory requirements are met and Healthcare Standards (Care Quality Commission) relating to safeguarding children and adults with Care and Support needs are performance monitored and appropriate action taken to ensure compliance."*

In order to fulfil its responsibilities, the Meeting has established a number of "Groups" which focus on particular areas of the Meeting's remit. The Adult and Children's Safeguarding Meeting held on 31st July 2025 considered the Modern Slavery statement before endorsement at the Quality and Safety Committee.

The statement is attached as an appendix for the Committee's recommendation for approval by the Board.

2. Strategic objectives and associated risks:

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

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

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

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

The following strategic themes, as outlined in the Board Assurance Framework, are relevant to the content of this report:

	Assurance framework themes	Relevant
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.	✓

4.0 Conclusion / Recommendation

The Board is asked to:

- CONSIDER and APPROVE the content of revised Modern Slavery Statement which is recommended by the Quality and Safety Committee

TRUST RESPONSE TO THE REQUIREMENTS OF THE MODERN SLAVERY ACT 2015

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust ("the Trust") fully supports the Government's objective to eradicate Modern Slavery and human trafficking and recognises the significant role the NHS has to play in both combatting it and supporting victims.

Information on the Trust's governance structure, which underpins delivery of this agenda, can be found at Trust Documents - RJAH

Information on particular policies and procedures which support the delivery of this agenda are outlined in this Statement.

The Modern Slavery Act 2015, including the definitions of slavery, servitude and forced or compulsory labour, human trafficking and exploitation covered by the Act can be viewed at: https://www.legislation.gov.uk/ukpga/2015/30/pdfs/ukpga_20150030_en.pdf

PROCUREMENT

The Trust operates in accordance with **Procurement Policy Note – Tackling Modern Slavery in Government Supply Chains - PPN 02/23**

ACTIONS / AWARENESS

Section 54 of The Modern Slavery Act requires suppliers with an annual turnover in excess of £36M and carrying out a business, or part of a business, in the UK, to develop a Modern Slavery Statement.

- Further to the publication of the subject PPN and new guidelines, from 1st April 2023 In-Scope Organisations must use the guidance 'Tackling Modern Slavery in Government Supply Chains' to identify and manage risks in both ***'new'*** procurement activity and **'existing'** contracts.
- In support of the above, Procurement need to use the designated GOV table (Page 6 onwards in below link) to assess any risk of modern slavery, which has now been updated to include current global modern slavery risks in key sectors of concern such as cotton, PPE and polysilicon. We also need to note that there is a new requirement for supply chain information to now be provided at the selection stage of new procurements deemed as high risk of modern slavery (applies to new and existing contracts where applicable)
  PPN_02_23_-_Update_to_Tackling_Modern_Slavery_in_Government_Supply_Chains_2023_-_Guidance.pdf (publishing.service.gov.uk)
- We also note that there is additional guidance on enhanced due diligence activities and on using existing exclusion grounds more effectively.

ACTIONS FOR EXISTING CONTRACTS

- Carry out a Modern Slavery risk assessment on our existing contracts where applicable.
- Conduct supply chain mapping exercise(s) where applicable and then invite suppliers to complete the Modern Slavery Assessment Tool (if appropriate)
- Continue to work in collaboration with existing suppliers to address modern slavery risks and monitor progress. Put action plans in place to mitigate the risks identified.
- Work with the suppliers on high and medium risk contracts to mitigate the risks through strengthened contract management (NCP)
- Repeat this exercise at least annually for high-risk contracts and at reasonable intervals for medium risk contracts.

ACTIONS FOR NEW CONTRACTS

- Assess modern slavery risks in new procurements.
- Identify which contracts are at high or medium risk of modern slavery based on industry type, complexity of supply chain, the nature of the workforce, context in which the supplier operates, type of commodity and supplier location.

- Pre-procurement & Specification: Design new procurements in line with the associated risk level including (if appropriate) application of the Social Value Model.
- Selection Stage: Consider the mandatory and discretionary exclusion grounds as set out in the Standard Selection Questionnaire. For high-risk procurements, Part 1 and 2 declarations should be submitted for supply chain members.
- Award Stage: Apply tender response questions relating to modern slavery where they link to the specification, taking a proportionate approach.
- Contract Conditions: Consider including specific terms and conditions to strengthen contractual protection.

MSAT TOOL Modern Slavery Assessment Tool - Supplier Registration Service (cabinetoffice.gov.uk)

THE POLICIES IN RELATION TO SLAVERY AND HUMAN TRAFFICKING

Human Trafficking and Modern slavery guidance is included in the Trust's Safeguarding of Vulnerable Adult and Safeguarding Children and Young People Policy, for further advice and guidance please refer the West midlands Adult and child protection procedures. Welcome | West Midlands Safeguarding Children Group (procedures.org.uk) WM Adult Docs (safeguardingwarwickshire.co.uk)

The response to Human Trafficking and Modern Slavery is coordinated under the safeguarding adult and/or safeguarding children process. The police are the lead agency and staff are directed to the appropriate Home Office website for further information.

THE DUE DILIGENCE PROCESSES IN RELATION TO SLAVERY AND HUMAN TRAFFICKING IN ITS BUSINESS AND SUPPLY CHAINS.

The Trust is committed to ensuring that there is no Modern Slavery or Human Trafficking in our supply chains or in any part of our business.

The Trust adheres to the National NHS Employment Checks / Standards. This includes employees' identity, right to work in the UK and compliant references.

The Trust has in place systems to encourage the reporting of concerns and the protection of whistle blowers. Where possible we build long standing relationships with our suppliers and make clear our expectations of business behaviour. With regards to national or international supply chains, we expect these entities to have suitable anti-slavery and human trafficking policies and processes.

THE PARTS OF ITS BUSINESS AND SUPPLY CHAINS WHERE THERE IS A RISK OF SLAVERY AND HUMAN TRAFFICKING TAKING PLACE, AND THE STEPS IT HAS TAKEN TO ASSESS AND MANAGE THAT RISK.

The Trust is committed to social and environmental responsibility and has zero tolerance for Modern Slavery and Human Trafficking. Any identified concerns regarding Modern Slavery and Human Trafficking would be escalated as part of the organizational safeguarding process and in conjunction with partner agencies; such as the Local Authority and Police.

THE EFFECTIVENESS IN ENSURING THAT SLAVERY AND HUMAN TRAFFICKING IS NOT TAKING PLACE IN ITS BUSINESS OR SUPPLY CHAINS, MEASURED AGAINST SUCH PERFORMANCE INDICATORS AS IT CONSIDERS APPROPRIATE.

The Trust aim to be as effective as possible in ensuring that modern slavery and Human Trafficking is not taking place in any part of our business or supply chains:

I. Audit of all safeguarding referrals.

I. NHS employment checks and payroll systems.

II. Level of communication with next link in the supply chain and their understanding of, and compliance with, our expectations in relation to the NHS terms and conditions. These conditions relate to issues such as bribery, slavery and other ethical considerations.

TRAINING ABOUT SLAVERY AND HUMAN TRAFFICKING IS AVAILABLE TO ITS STAFF.

Reference is currently made to Slavery and Human Trafficking within the organisation's Mandatory Safeguarding Children training programme, induction, eLearning and training updates.

This statement is made pursuant to Section 54(1) of the Modern Slavery Act 2015 and constitutes our organisation's modern slavery and human trafficking statement for the current financial year.

Approved by the Board of Directors on XXXX

Executive Summary - People Committee

Assurance

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

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

Trust Board - People & Workforce
July 2025 – Month 4

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

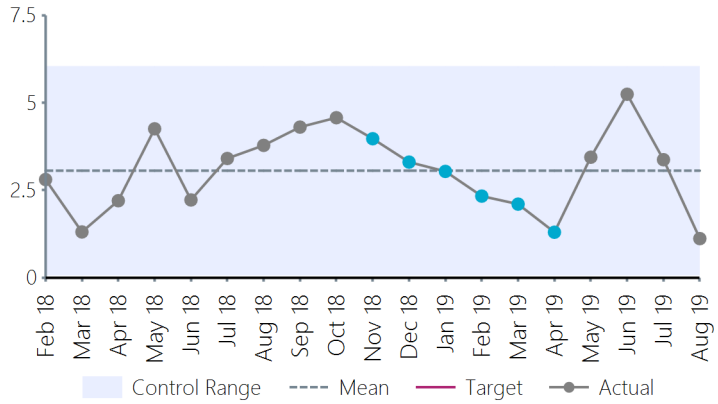
Some examples of these are shown in the images to the right:

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

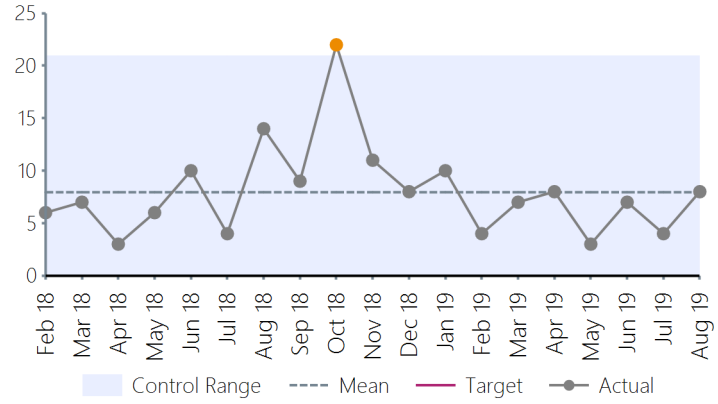
b) shows a point of concern sitting above the control range.

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

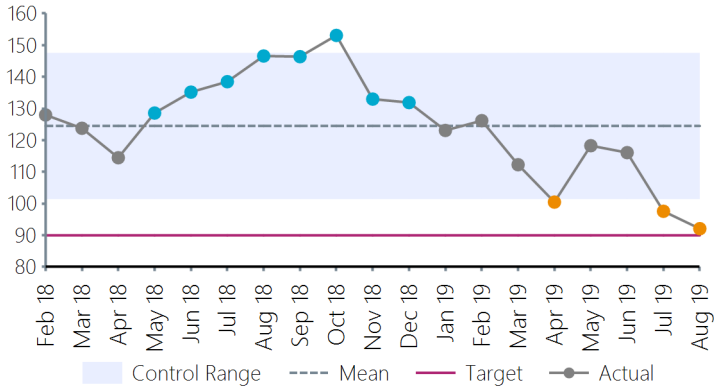
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Staff

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Sickness Absence	4.97%	5.15%			Moving Target		
Staff Turnover - FTE	9.98%	9.82%			?		
Leavers per Month	12	13			?		
Vacancy Rate	8.00%	8.50%		H	P	+	15/04/24

Summary - Caring for Finances

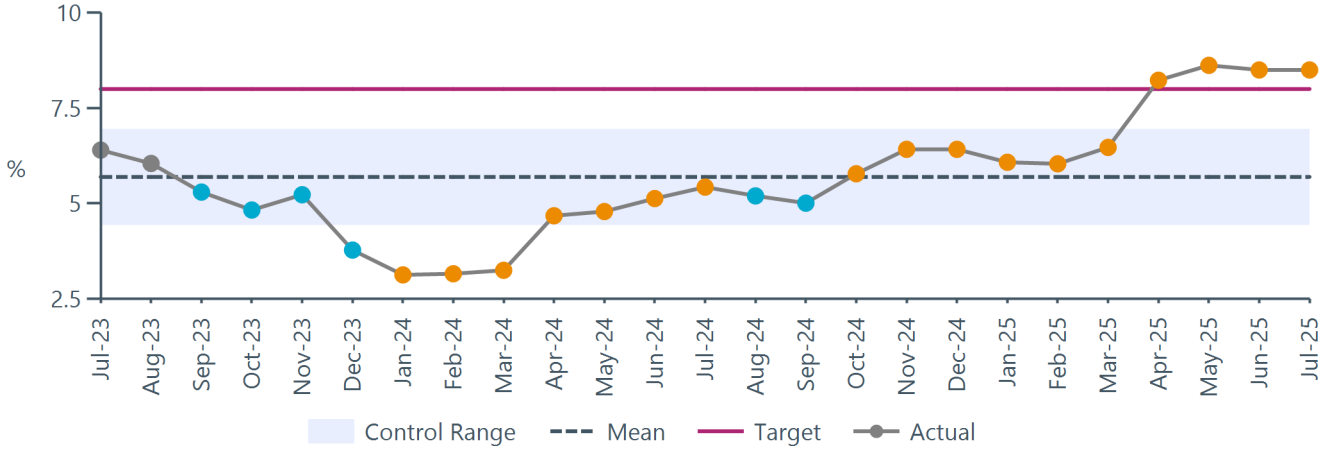
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Agency Spend against Plan	1.40	1.30		N/A to SPC	Moving Target		
Proportion of Temporary Staffing as a % of the Trust Pay Costs	7.80%	8.20%		N/A to SPC	Moving Target	+	
Bank Spend against Plan	6.40	6.70		N/A to SPC	Moving Target	+	

Vacancy Rate

% of Posts Vacant at Month End 211183

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
8.00%	8.50%	H	P



Trajectory

What these graphs are telling us

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

Narrative

The Vacancy Rate reported for the end of July is 8.50%; above the 8% target. As shown in the SPC graph above, there was an increase in April attributable to a budget increase in line with financial reconciliation and workforce plan submission.

In line with workforce plan, there was a reduction in budgeted establishment in July due to completion of Apollo implementation. Additional 5.66 WTE Budget reduction agreed at Workforce Improvement Group for NHS Infrastructure roles.

Actions

The vacancy rate is expected to reduce as recruitment to new posts forms part of the Workforce Plan.

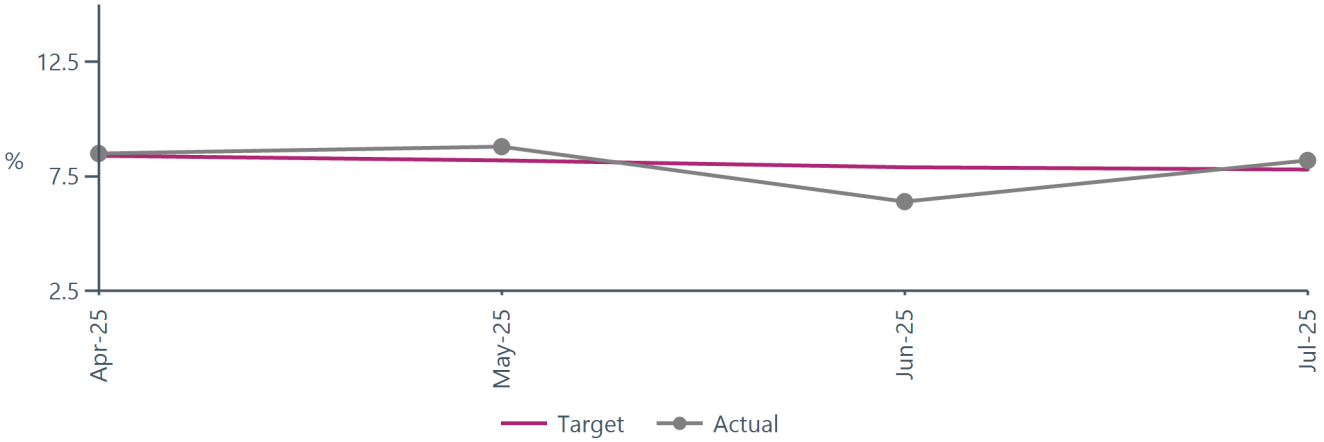
Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
5.43%	5.20%	5.01%	5.78%	6.42%	6.42%	6.08%	6.04%	6.47%	8.23%	8.62%	8.50%	8.50%

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

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

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
7.80%	8.20%	N/A to SPC	Moving Target



Trajectory

Actual
Trajectory

What these graphs are telling us

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

Narrative

Proportion of temporary staff 8.2%, which is 0.4% adverse to plan.

Actions

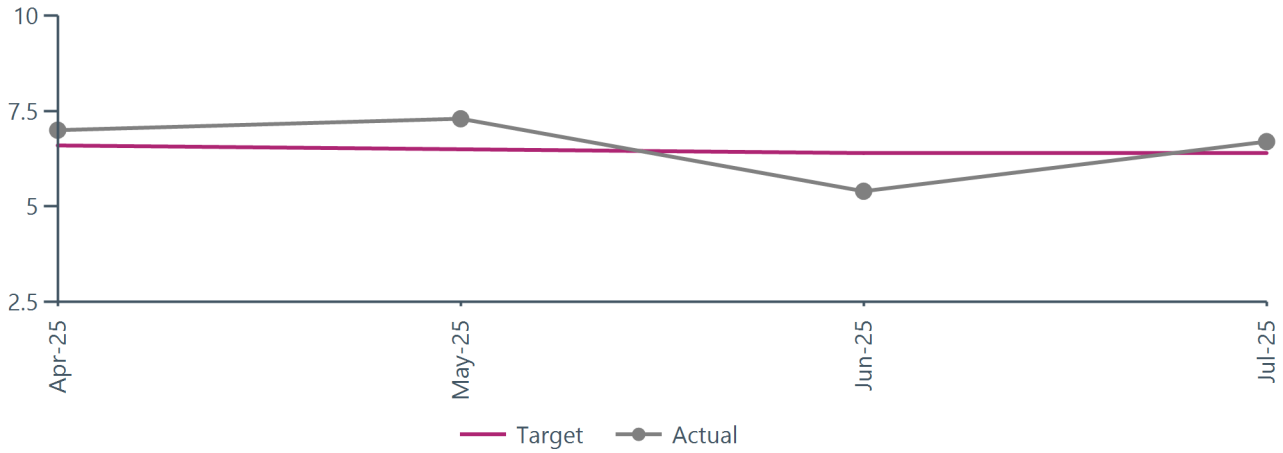
Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
									8.50%	8.80%	6.40%	8.20%

Bank Spend against Plan

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

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
6.40	6.70	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Bank usage 6.7% of total pay plan in month, 0.3% adverse to plan.

Actions

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

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, Sept 2025

Author:	**Contributors:**
Name: Felicity Kipling Role/Title: Executive Assistant	

Report sign-off:

Paul Maubach, Deputy Chair of the People and Culture Committee

Is the report suitable for publication:

Yes

1. Key issues and considerations:

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

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

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

This report provides a summary of the items considered at the People and Culture Committee on 21st July 2025 and 21st August 2025. It highlights the key areas the People and Culture Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

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

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

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

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

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

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

3. Assurance Report from People and Culture Committee

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

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

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

- **Job Planning**
  - July: Target to reach Level 4 by June was missed; Trust remains at Level 1. Committee was not assured, noting the need for clearer trajectory.
  - August: Progress reported (60% attainment, 76.1% in month) showing some movement in the right direction. However, assurance not yet achieved; Committee awaits the detailed September report with staff group breakdowns and next steps.
- **Healthcare Support Worker Vacancies (July)**
  Vacancy rate remains high (16.1 WTE). Recruitment activity is ongoing, though Committee noted that a credible trajectory to substantially lower rates before winter is still required.
- **National Exception Reporting Framework- Medical Workforce (July)**
  Implementation due September. Risk of additional costs and reliance on IT supplier flagged, though internal support is being mobilised to strengthen delivery. Committee noted this as a significant risk but welcomed proactive mitigation steps.
- **Occupational Health Contract- Optima (August)**
  Committee expressed strong concern regarding resilience of current service provision. Risks include HSE involvement and gaps in surveillance data. Contract has been extended to Aug 2026, with tendering to begin Nov 2025. Active monitoring and contingency planning are underway.
- **Employee Relations Case Management (August)**
  Committee not assured due to data gaps (e.g. performance management cases, protected characteristics). Work is required to ensure full visibility and equity of approach; Committee looks forward to improvements in reporting.

3.2 Areas of on-going monitoring with new developments

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

- **Mandatory/Statutory Training & Compliance**
  - July: Overall compliance at 92.4%, close to target. Committee noted variation across staff groups and high DNA rates, requesting further analysis of relative risk of training elements.
  - August: Positive update received with appointment of a medical devices trainer to reduce backlog. CPD accreditation for the leadership programme continues to progress.

- **Agency Medical Posts & Workforce Models**
  - July: Continued reliance in rheumatology and histopathology acknowledged, but alternative recruitment models (CESR route, Keele University joint posts) are being pursued.
  - August: Committee welcomed updates on national reviews of Physician Associates/Anaesthetic Associates and nursing job evaluation, noting importance of clear staff communication and role clarity.
- **Apollo (Electronic Patient Record, July)**
  User concerns noted; Committee emphasised value of a human factors review to inform optimisation.
- **10-Year NHS Workforce Plan (July)**
  Committee reflected on national implications for skill mix, technology, and community-based care. Local workforce strategy will adapt accordingly.
- **Freedom to Speak Up (July)**
  Seven cases reported, consistent with peers. Committee requested stronger evidence of impact, but noted the value of this channel in surfacing Apollo-related concerns.
- **Accessible Access Guides (August)**
  Committee welcomed this three-year project to improve accessibility for patients and staff. Launch scheduled for early 2026, with surveyors starting Sept 2025. Importance of strong internal communications was highlighted.
- **Workforce & Financial Triangulation (August)**
  Committee noted misalignment in workforce and financial reporting and welcomed the agreed action to reconcile data for greater clarity.
- **Staff Survey & Cultural Initiatives (August)**
  Committee supported the focus on burnout, civility, bullying/harassment, and raising concerns. Strong linkages with psychological safety work were noted.
- **EDS Domain Two (August)**
  Staff engagement in the recent session was low. Committee encouraged more innovative methods for future domains to drive greater participation.

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.

- **Agency & Bank Spend**
  - July: Spend favourable to plan (£61k in month, £156k YTD). Committee took positive assurance, with frameworks fully maintained.
  - August: Agency spend continues to track favourably; most posts remain within price caps. Some overspend in bank/overtime noted but attributed to planned waiting list initiatives.
- **Sickness, Turnover & Vacancy Pipelines**
  - July: Sickness recorded at 4.99%, in line with plan. Improved exit data noted.
  - August: Slightly above target due to short-term absences. Nursing and HCSW vacancies expected to reduce through pipeline recruitment and rolling adverts, offering a positive trajectory.
- **Leadership Development**
  - July: Programme fully subscribed and well evaluated. CPD accreditation and curriculum refresh underway. Committee suggested future board visibility of feedback.
  - August: Progress continues, with additional training resource (medical devices trainer) further strengthening capability.
- **System Improvement Plan (ICB)**
  - July: Report received; no further action required.
  - August: Actions ongoing with evidence requests being met. Committee took assurance of progress.
- **Guardian of Safe Working**
  - July: No exception reports received; positive assurance given.
  - August: Transition to electronic reporting (RL Datix) on track for Sept 2025, with governance and confidentiality safeguards in place.

- **Anti-Racism Strategy (August)**
  Draft strategy progressing, aligned to RES and ICS campaigns. Committee assured of commitment to delivery.
- **Core Training Compliance Financial Impact (July)**
  Initial DNA costing completed, with further refinement underway to strengthen understanding of financial implications.

Recommendation

The Board is asked to:

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

Freedom to Speak Up Report
Q1, 2025/6: April - June 2025

Committee / Group / Meeting, Date

Board of Directors, 03 September 2025

Author: Contributors:

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

Report sign-off:

Name; Dylan Murphy, Trust Secretary
People and Culture Committee, July 2025

Is the report suitable for publication?

YES

Key issues and considerations:

This paper is provided as a summary on Freedom to speak Up(FTSU) activity for Q1 April-June 2025.

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

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

Key Points:

- This quarter FTSU has received a total of ten cases:
  - Of the ten cases received seven have been closed and three require further follow-up.
  - Of the three cases which remain open, the Guardian is awaiting feedback from managers dealing with the concerns.
  - Of the seven cases closed, an average of eight day was required to close them.

- Of the ten cases raised:
  - Two were raised anonymously,
  - Two related to Patient Safety/Quality,
  - Five related to Worker Safety/Wellbeing,
  - Two related to Attitudes and Behaviours,
  - Five Other concerns were raised,
  - Two were raised to a Champion and seven were raised with the Guardian, and one with the Executive Lead.
  - All ten were treated as concerns and escalated to appropriate managers.

- Cases can have several elements. For example, one case may have elements that relate to patient safety/quality and elements that relate to attitudes and behaviour. The NGO also includes 'anonymous' as a reporting category.

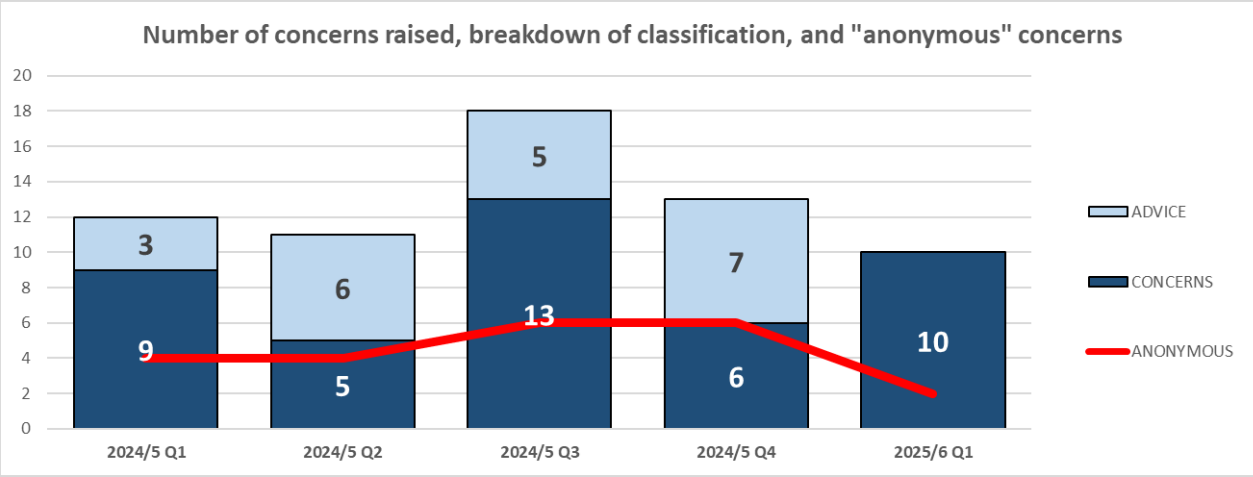
- All cases raised have been responded to within 48hrs and escalated to the appropriate department.

1. Overall number of cases

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

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

Graph 1



Commentary

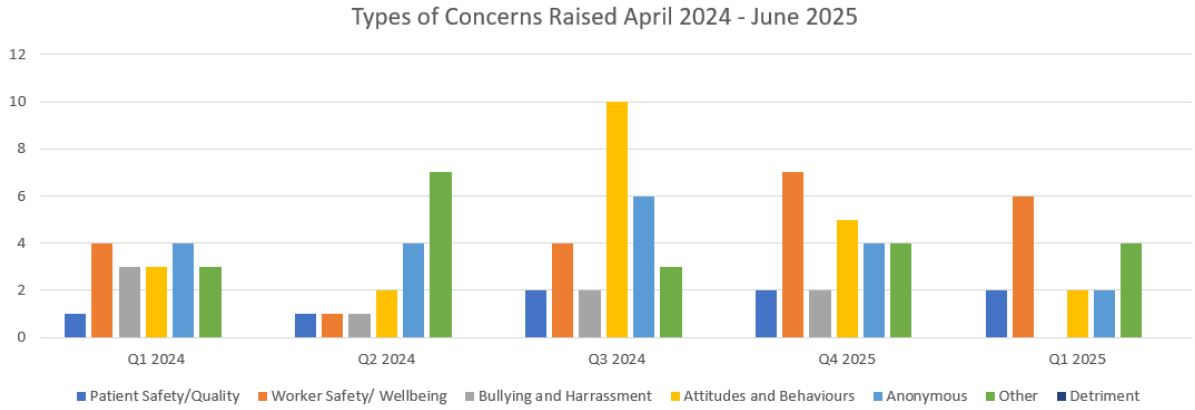
Overall numbers have fluctuated between 10 and 18 per quarter over the last five quarters. The number of contacts this quarter is at the low end of this range but:

- It is positive that people have used the Champions to raise concerns, as well as the Guardian.
- A high proportion of those were treated as concerns. In fact, every contact received in quarter 1 was processed as a concern and was escalated for action.
- A high proportion of the contacts were from individuals who were happy to disclose their identity. The percentage of anonymous concerns was just 20%. That compares with 33% in Q1 of last year, 36% in Q2, 33% in Q3 and 46% in Q4. There are a number of ways to interpret that. There are multiple options for staff to raise concerns anonymously but ideally, they would feel comfortable doing so openly.

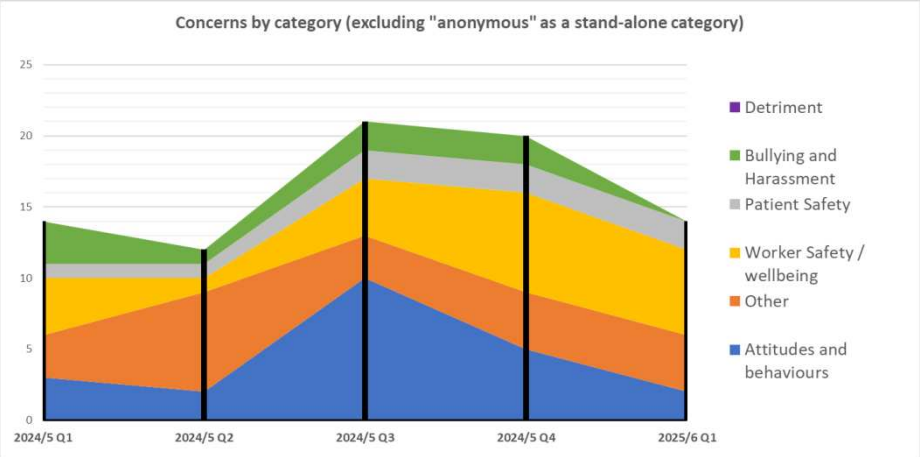
2. Concerns raised broken down by type of concern

Graph 2a presents data on the Types of concerns raised, in the categories required by the NGO. This compares the types of concern with the previous four quarters.

Graph 2a

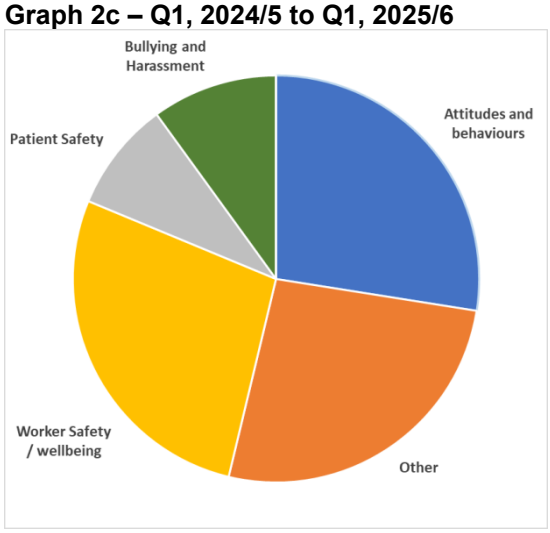


Graph 2b presents the same figures, over the same time period, in a different format but excludes "anonymous" as a category of concern in its own right.

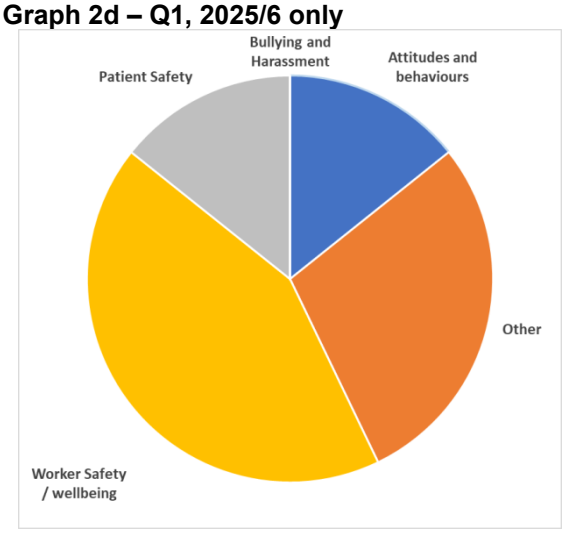


The breakdown of concerns raised by "type" is presented in an alternative format below:

Graph 2c – Q1, 2024/5 to Q1, 2025/6



Graph 2d – Q1, 2025/6 only



The figures that support the graphs in section 2 are outlined in **Table 1** below:

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

Commentary

Over the last couple of quarters, there has been a marked decline in the number of concerns relating to "attitudes and behaviours", following a spike in Q3, 2025/6. In 2024 Q3 there were six cases of attitudes and behaviours and one bullying and harassment.

The "Worker safety / wellbeing" category has accounted for the greatest number of concerns in the last couple of quarters. This is due to the added element of "wellbeing". Cases where staff have reported

stress, feeling overwhelmed and other mental health issue are now recorded under Worker safety/wellbeing.

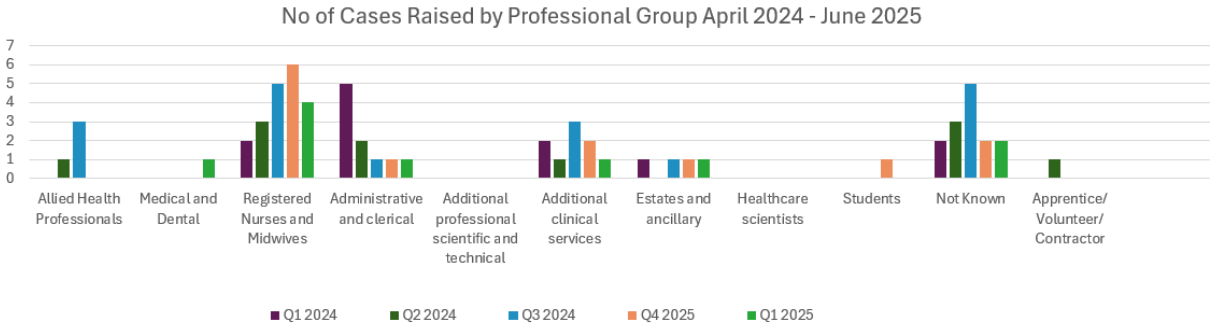
'Other' concerns relate to any other concerns not covered by the NGO classification. Examples of this include policy issues, recruitment and fraud.

Two of the cases this quarter were related to Apollo. Due to the small number, staff were clearly using the support available from the Apollo programme to raise their concerns, rather than FTSU arrangements.

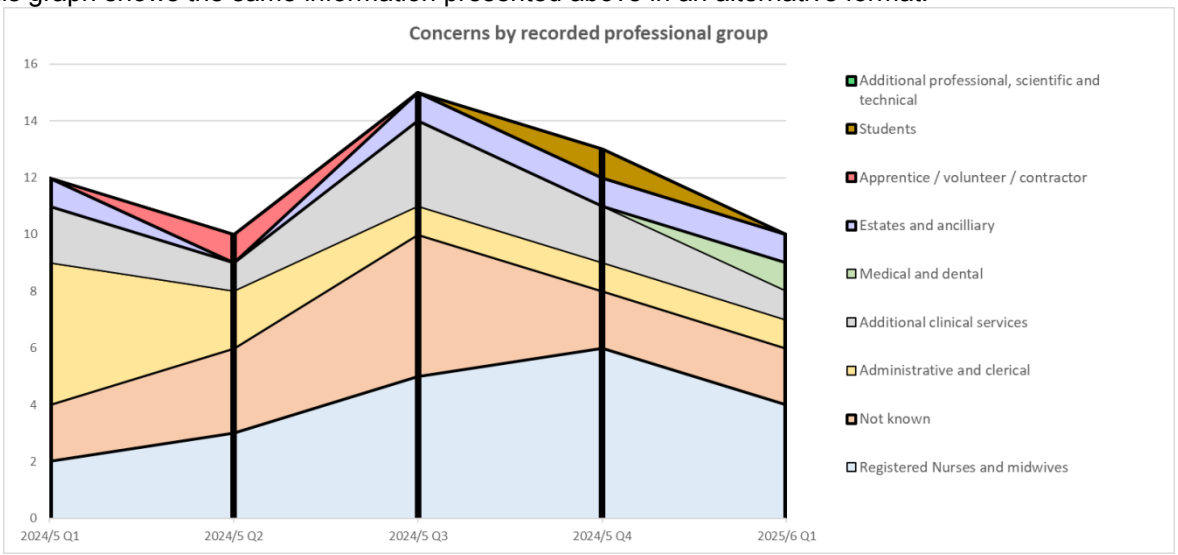
3. Concerns raised by the profession of the person raising them

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

Graph 3a
This graph shows the profession of people who have raised concerns over the five quarters since the fourth quarter of 2023/4:



Graph 3b
This graph shows the same information presented above in an alternative format:

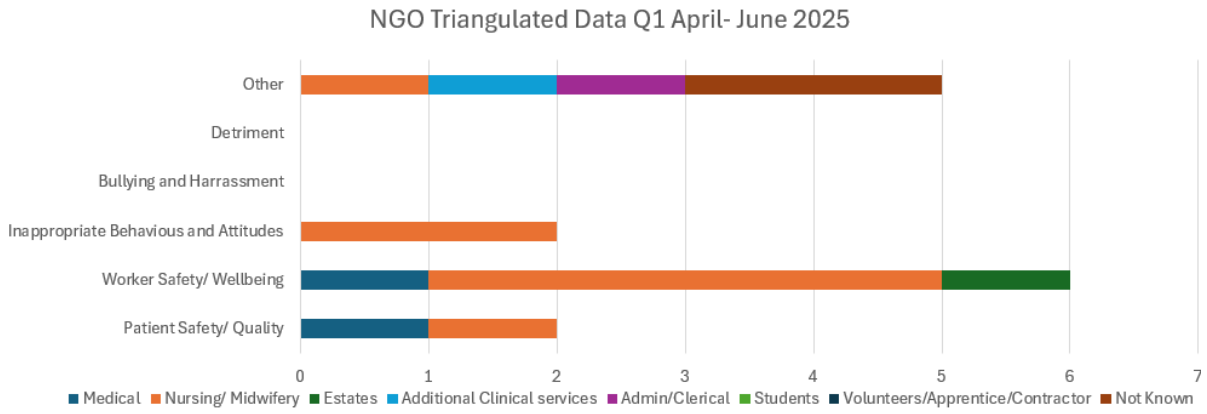


The figures that support graphs 3a and 3b are outlined in **Table 2 – number of cases raised by professional group:**

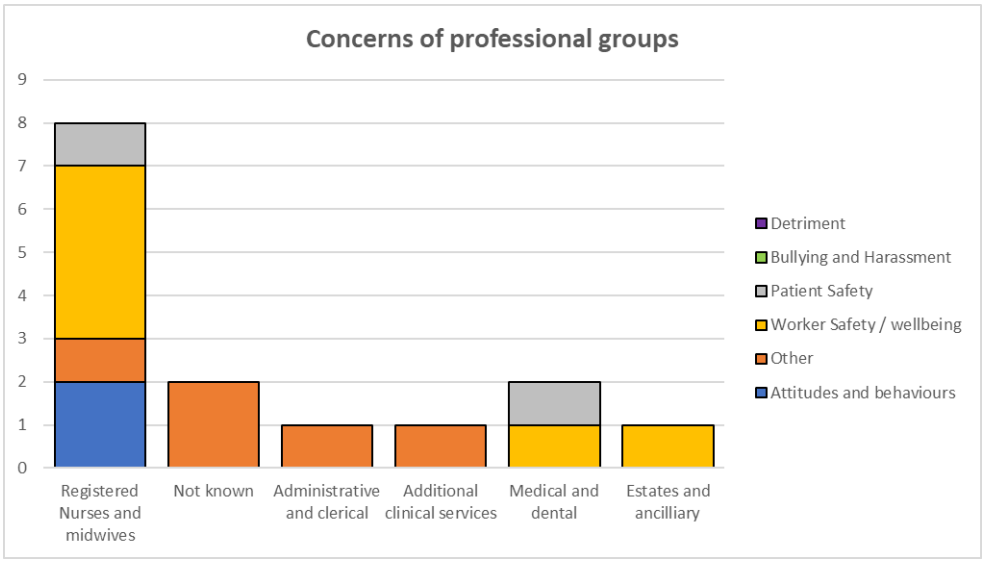
	2024/5 Q1	2024/5 Q2	2024/5 Q3	2024/5 Q4	2025/6 Q1
Registered Nurses and midwives	2	3	5	6	4
Not known	2	3	5	2	2
Administrative and clerical	5	2	1	1	1
Additional clinical services	2	1	3	2	1
Medical and dental	0	0	0	0	1
Estates	1	0	1	1	1
Apprentice / volunteer / contractor	0	1	0	0	0
Students	0	0	0	1	0
Additional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

The following graphs shows the type of concerns raised by each professional group.

Graph 3c



Graph 3d



Commentary
Nurses continue to be the professional group most likely to use the FTSU service. It is relatively unusual to receive a concern from the "medical and dental" group. This quarter's concern from that group related to the impact of the Apollo implementation.

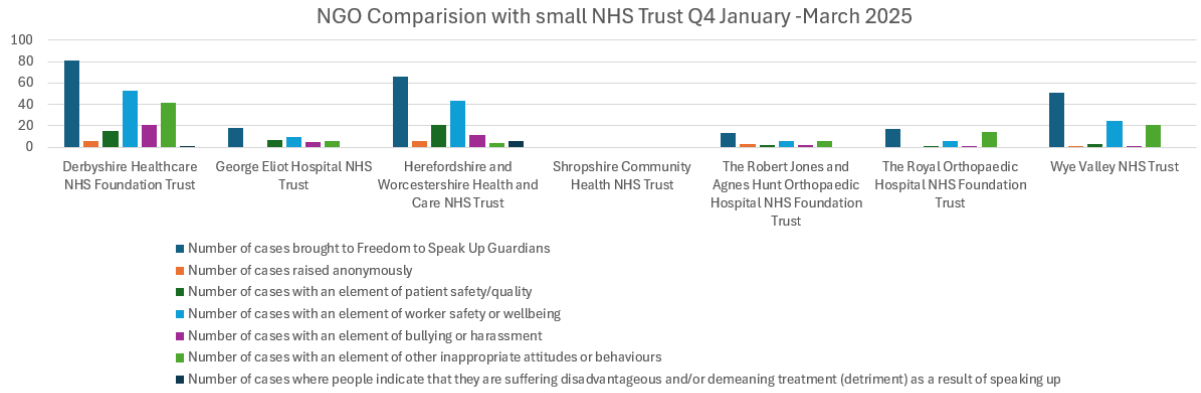
This is the first time that FTSU data has been presented this way. We will continue to monitor the nature of the concerns raised by each group to discern any patterns.

4. Comparison with other providers

Graph 5 compares small, Midlands-based NHS Trusts with RJAH. The NGO's definition of small is under 5,000 staff members. The Royal Orthopaedic Hospital (ROH) Birmingham is similar in size and nature so is the most obvious comparator.

Due to the national reporting timetable, these figures relate to Q4 2024/5: January to March 2025.

Graph 4a



Commentary
The most obvious comparator in this group is the Royal Orthopaedic Hospital (ROH), Birmingham. The number of cases at RJAH and ROH appear broadly comparable during the quarter. There were slightly more cases at ROH but the profile looks similar – with "behaviours and attitudes" and "worker safety and wellbeing" being the two categories that appear most often. These are the top two categories in five of the six organisations included in the graph above.

The proportion of concerns raised anonymously during Q4 appears relatively high at RJAH (but that dropped significantly in Q1, 2025/6).

As mentioned elsewhere in this report, we will be doing some more work with ROH to better understand their arrangements and learning from the FTSU process. To provide a more meaningful set of comparisons, we will also look to compare the published figures for RJAH, ROH, and the Royal National Orthopaedic Hospital in future reports.

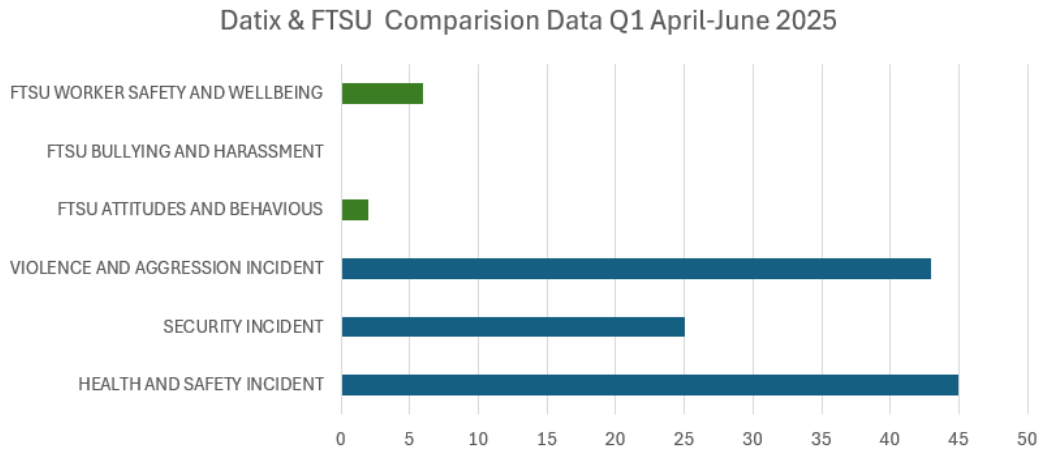
5. Triangulation with incidents reported on Datix

Graph 5a is a comparison of RJAH Datix data and RJAH FTSU data for Q1, April-June 2025. Graph 5b presents the Datix figures for five quarters, from quarter 1 of 2024/5.

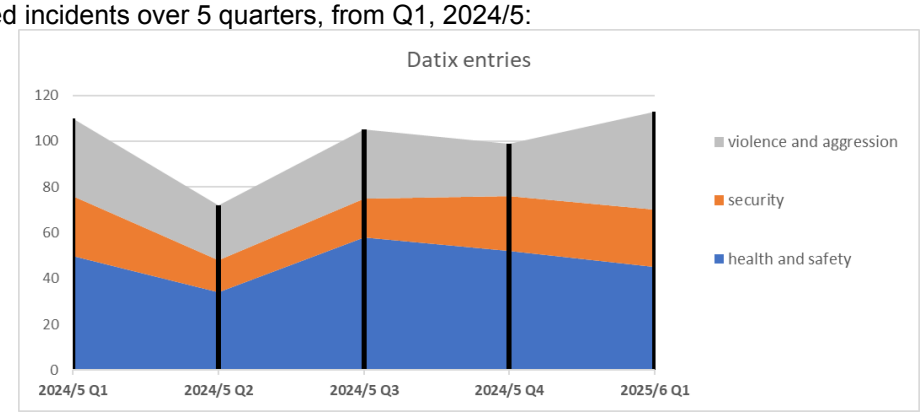
It is not possible to make straightforward, direct comparisons when considering FTSU concerns and Datix entries. When it comes to the Violence and Aggression reporting on Datix, for example, these will generally relate to patients' behaviors towards staff. There is no direct equivalent within the FTSU reporting categories and the focus of FTSU concerns generally relates to staff-to-staff behaviors

(though they may highlight areas for improvements for patient care). The relationship between the two sets of data is not straightforward, but consideration of both, particularly over time, may help identify any underlying issues.

Graph 5a



Graph 5b
Datix reported incidents over 5 quarters, from Q1, 2024/5:



6. Learning

As a result of the concerns raised this quarter:

- There has been particular learning for individuals and their managers on specific practice / policy / procedure.
- Messages have been fed back into the Apollo programme to alert them to concerns.
- Some cases have been anonymously shared with department leads so that lessons learned can be shared within the departments and measures can be put in place to avoid repeating the same practice which resulted in the concern been raised.
- Following concerns raised about policies, in the 'Other' concerns category, all staff communications have been issued to alert staff to the existence and application of particular policies.

7. Feedback

The FTSU Guardian sends a link to a Microsoft feedback form to all people who raise a concern. The forms are anonymous and are sent out in batches when the concerns are closed, and at the end of each quarter (to help preserve anonymity). Out of the eight feedback forms sent out during the quarter, only one was returned. The four questions, and the responses received were:

- Given your experience, would you use FTSU again? *Maybe*
- How well do you feel your concern was handled, overall? *No answer*
- Did you suffer any detriment? *No answer*
- Is there any other feedback you would like to share to help improve the FTSU service? *No*

answer.

People have not engaged with this process so thought will be given to other ways of gaining feedback.

8. Other Actions undertaken this quarter

Completion of the mandatory annual NGO annual training by the Guardian.

Attendance at the Regional NGO meetings and FTSU bi-monthly meetings. During this meeting there was an update on the dissolution of the NGO Office, how this would affect FTSUGs, Staff survey results and the impact on FTSU, the launch of the new NGO data system and the inability to upload Q1 2025 data and possible new data collection for other hospitals.

Recruitment of two FTSU Champions with protected characteristics.

The *Freedom to Speak Up Development Guide*, which can be found on the NGO website, recommends that the Guardian review the service via a SMART analysis every two years to help drive continuous improvement. This has been completed and a number of themes have been identified for consideration:

- The importance of visible support from senior executives and the best way of promoting that, including a visible presence during 'Speak Up October'.
- Continued development and implementation of the Quality Management system for FTSU.
- Improving resilience, as there is a single point of failure with one FTSUG for the organisation.
- Developing closer links with Mental Health First aiders and the Guardian for Safe Working Hours.
- Establishing a dedicated budget for promotion of the FTSU service.

9. Next steps

During Q2, as part of the staff survey action plan, a working group will meet to consider how the Trust can best:

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

That goes beyond the FTSU function, but FTSU will have a key part to play. The findings of the *Freedom to Speak Up Development Guide* SMART analysis will be used to inform that work.

That work, which is already in train, supports the findings of the **Review of patient safety across the health and care landscape, July 2025 (the "Dash Review")** which notes that:
"There is a need to strengthen the importance of listening to and acting on staff voice, as identified in the recent publication of the National State of Patient Safety 2024, which highlighted the recent NHS Staff Survey results and the need for greater confidence in the system.

Staff should be supported and encouraged to share concerns about quality and safety as part of a data, evidence and learning-led culture that fosters improvement. The currently variable priority and quality of systems when it comes to supporting the freedom to speak up[80] needs to be addressed by organisations through the work of Freedom to Speak Up Guardians."

We will consider any findings of the independent developmental well-led review. This included a focus on arrangements to support speaking up. The draft, headline findings (which are subject to review following engagement with a wider staffing group) included the following:

- *"There has been a positive shift towards creating an engaging and open culture."*
- *"The Trust has focused on strengthening risk management, the Board Assurance Framework, transitioning to two business units, and developing the freedom to speak up function".*

- *"The culture has evolved positively, shifting away from past issues and becoming more open, transparent, and constructive. There was consistent messaging from interviews that the Trust focuses on its people and culture, led from the top down, creating a friendly, welcoming, supportive, and caring organisation that values patient care."*

In line with the recently agreed Memorandum of Understanding with the Royal Orthopaedic Hospital NHS Foundation Trust, we will undertake some joint work to learn from one another's experiences and consider how we best take forward the FTSU elements of the 10 Year Plan and Dash Review recommendations.

Recommendation:
That the Board:

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

Acronyms

FTSU	***Freedom to Speak Up***
NGO	***National Guardian's Office***

Safe Working Hours: Doctors in Training Q1 Report 2025/26

0. Reference Information

Author:	Chris Marquis, Guardian of Safe Working	Paper date:	17/07/2025
Executive Sponsor:	Chief Medical Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	People and Culture Committee 17 July 2025	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Board of Directors is asked to ***consider*** 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 2025 annual summary report from the Guardian. It outlines the work that has been undertaken to date and highlights some of the issues being faced. The report provides the data currently available in relation to rota vacancies and agency and locum usage.

2.3. Conclusion

The Board is asked to ***consider*** 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 July 2025

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

3.2.2 Exception reports (regarding working hours)

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

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

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

During the financial year we have received an exception report from a trainee in a Welsh placement, on a centralised contract with RJAH. We have engaged with the trainee, responsible department and HR to ensure the issue raised is being addressed. TOIL was provided and a diary exercise instigated.

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

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

3.2.3 Work schedule reviews

Please see above.

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

3.2.4 Resident Doctor Agency and Locum usage and Rota Vacancy Report

Trauma and Orthopaedics

Number of Vacancies (28 posts)

Apr 25	3
May 25	3
Jun 25	3

Vacant shifts

Apr 25	11
May 25	8
Jun 25	10

Total cost - £21900

Medicine

Number of Vacancies (12 posts)

Apr 25	1
May 25	1
Jun 25	1

Vacant shifts

Apr 25	6
May 25	10
Jun 25	1

Total Cost £11370

MCSI

Number of Vacancies (9 posts)

Apr 25	13
May 25	8
Jun 25	7

Vacant Shifts

Apr 25	2
May 25	3
Jun 25	3

Total cost - £ 8840

Long Term Vacant Shifts

- One in Medicine (no GP trainee)
- One in MCSI (empty post as successful candidate declined position)
- Three in T&O

3.2.5 Fines

None – please see exceptions report section 3.2.2

3.3 Challenges

3.3.1 New Framework Agreement for Exception Reporting

There are significant concerns nationally with the Guardian role regarding the planned go live for the new framework. Consensus is there needs to be a delay in implementation to allow appropriate systems to be put in place to manage the process. Despite this pressure, this does not seem to be the current position.

Possible estimated predict costs to the Trust are in the region of £100 -160 000 annually.

3.3.2 Software System

Progress has been made in establishing an electronic ER system.

Associated Risk

There is an ongoing, dynamic position with the various stake holders with the go live of the new ER framework. As an organisation, our size is an advantage but concerns around appropriate support to manage the new system are significant.

Next Steps

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

3.4. Conclusion

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

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

Christopher Marquis, Guardian of Safe Working

Executive Summary - Finance & Performance Committee

Assurance

Variation	Will consistently pass the target if nothing changes	Will not consistently pass or fail the target if nothing changes	Will consistently fail the target if nothing changes	No Target or Moving Target
Improving variation (high or low) or 3 months better than target			8 Week Wait for Diagnostics - Welsh	6 Week Wait for Diagnostics - English Total Outpatient Activity - % Moved to PIFU Pathway
No significant change or N/A to SPC				18 Weeks RTT Open Pathways Time to First Appointment - English Patients Time to First Appointment - Welsh Patients % of Patients Waiting Over 52 Weeks - English Total Theatre Activity Against Plan Total Outpatient Activity Against Plan Outpatient DNA Rate Income Captial Expenditure Proportion of Temporary Staffing Bank Spend against Plan
Concerning variation (high or low) or 3 months off target			% Combined BADS Performance Bed Occupancy - All Wards - 2pm	English List Size Welsh List Size Patients Waiting Over 104 Weeks - Welsh Theatre Cases per Session Touchtime Utilisation Elective Activity Against Plan Outpatient Procedures - ERF Scope Total Outpatient Activity - % Virtual Total Diagnostic Activity Against Plan

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

Trust Board - Performance

July 2025 – Month 4

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

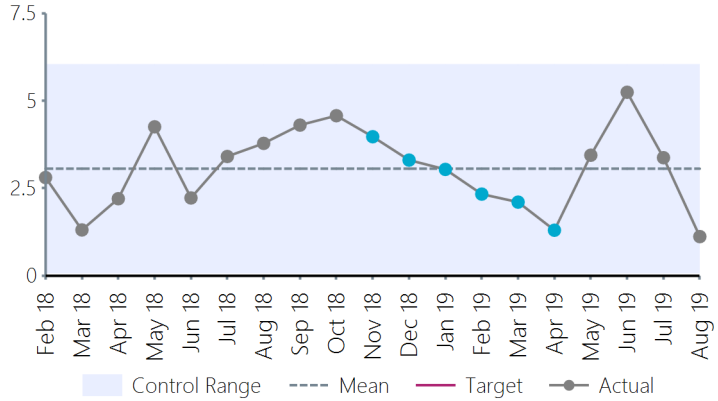
Some examples of these are shown in the images to the right:

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

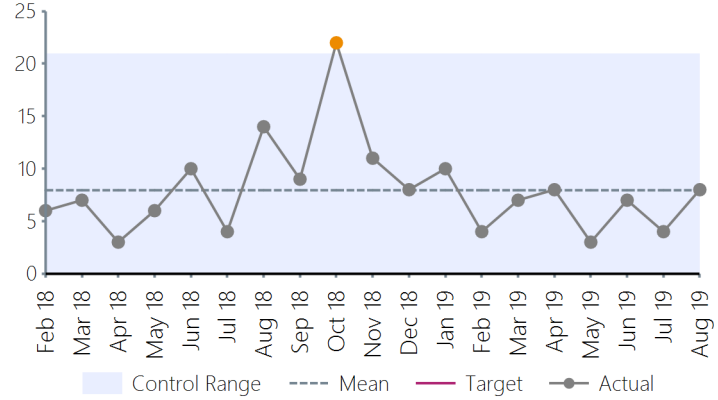
b) shows a point of concern sitting above the control range.

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

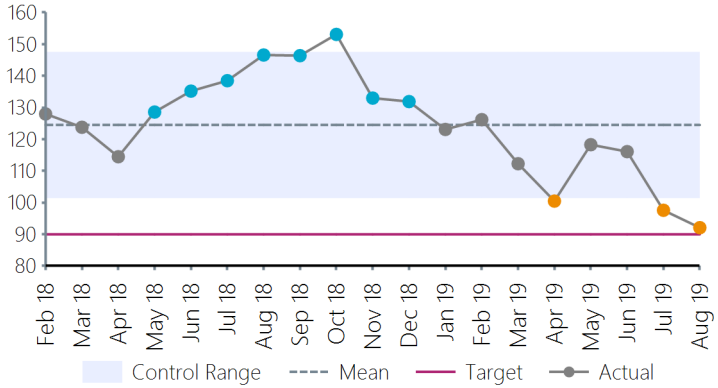
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
31 Day General Treatment Standard*	96.00%	100.00%		H	?		
62 Day General Standard*	85.00%	100.00%	100.00%		?		12/09/23
28 Day Faster Diagnosis Standard*	77.00%	80.00%	88.10%		Moving Target		12/09/23
18 Weeks RTT Open Pathways	46.26%	47.68%			Moving Target	+	24/06/21
Time to First Appointment - English Patients	59.50%	60.78%		N/A to SPC	Moving Target	+	
Time to First Appointment - Welsh Patients		46.80%		N/A to SPC	No Target	+	
% of Patients Waiting Over 52 Weeks - English	6.96%	7.49%			Moving Target	+	
Patients Waiting Over 104 Weeks - Welsh (Total)		250		H	No Target	+	
6 Week Wait for Diagnostics - English Patients	95.00%	91.98%	87.07%	H	Moving Target	+	04/03/24
8 Week Wait for Diagnostics - Welsh Patients	100.00%	94.27%		H	F	+	04/03/24

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Elective Activity Against Plan (volumes)	1,115	1,020			Moving Target	+	24/06/21
% Combined BADS Performance	85.00%	40.69%			F	+	
Total Outpatient Activity against Plan (volumes)	13,356	14,534			Moving Target	+	24/06/21
Total Outpatient Activity - % Moved to PIFU Pathway	6.60%	8.22%		H	Moving Target	+	
Total Diagnostics Activity against Plan - Catchment Based	2,755	2,282			Moving Target	+	

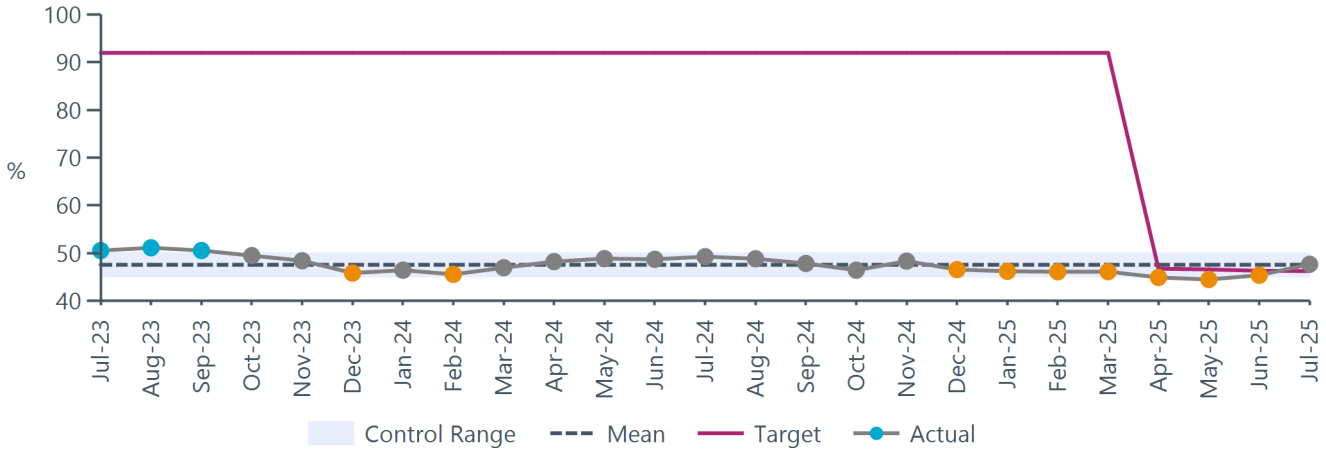
18 Weeks RTT Open Pathways

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
46.26%	47.68%		Moving Target

Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. This metric has a moving target - as per Trust's Operational Plan.

Narrative

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

Our July performance was 47.68% against the 92% open pathway performance for patients waiting 18 weeks or less to start their treatment. The Trust planned to be at 46.26% at the end of July. The performance breakdown by milestone is as follows:
* MS0 - 84 patients of which 13 are breaches
* MS1 - 9802 patients waiting of which 3908 are breaches
* MS2 - 1887 patients waiting of which 1291 are breaches
* MS3 - 5525 patients waiting of which 3838 are breaches

Month-end position is inclusive of patients being progressed at mutual aid providers.

Actions

The performance for the trust is significantly challenged, in particular Waiting List metrics. In order to address this we continue to work on both the long term changes required but also short term mitigating actions with a particular focus on that since early June.

Long term focus includes the following:
* Further Clinical recruitment; 3 Arthroplasty Surgeons appointed 1st August. Business case approved for further Advanced Practitioners in Spinal Disorders. Advert to be launched for Spinal Disorders Surgeon and Complex Pain Physician.
* Close working with GIRFT regarding pathway optimisation with significant focus on Spinal Disorders.
* Introduction of additional DEXA scanner from 16th June.
* Award of Insourcing Contract to provide additional capacity with a specific focus on the long wait cohorts (52+ waits)

Key mitigation actions have focused on additional MS1 capacity alongside patient and clinical validation and insourcing contracts for Rheumatology and Neurology have commenced.

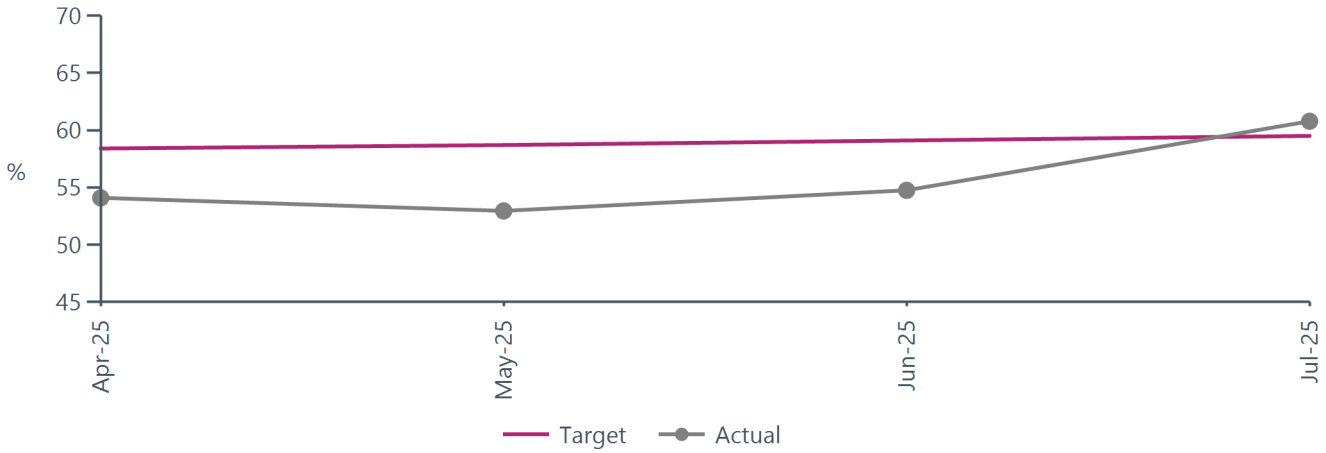
Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
49.27%	48.84%	47.86%	46.44%	48.35%	46.57%	46.22%	46.12%	46.14%	44.92%	44.49%	45.39%	47.68%

Time to First Appointment - English Patients

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
59.50%	60.78%	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

This is not applicable to SPC until there are sufficient data points. The metric has a moving target.

Narrative

This metric focuses on the time to first appointment waiting for first event and of those patients, the % waiting less than 18 weeks. The reported position is taken from the Waiting List MDS position for week ending 3rd August. NHSE Guidance stipulates the week ending positions we should officially report that fall closest to month end. This is an unvalidated position.

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

For week ending 3rd August 60.78% of patients waiting for first appointment were under 18 weeks; above the 59.50% plan. As shown on the SPC graph above, we've now been reporting this for four months where in that period there has been a 6.69% improvement. The data is reviewed at the weekly Outpatient Activity meeting at sub-speciality level. Performance ranges from 43.37% in Spinal Disorders to 100% in Occupational Therapy.

Actions

The performance for the trust is significantly challenged, in particular Waiting List metrics. In order to address this we continue to work on both the long term changes required but also short term mitigating actions with a particular focus on that since early June.

Long term focus includes the following:
* Further Clinical recruitment; 3 Arthroplasty Surgeons appointed 1st August. Business case approved for further Advanced Practitioners in Spinal Disorders. Advert to be launched for Spinal Disorders Surgeon and Complex Pain Physician.
* Close working with GIRFT regarding pathway optimisation with significant focus on Spinal Disorders.
* Introduction of additional DEXA scanner from 16th June.
* Award of Insourcing Contract to provide additional capacity with a specific focus on the long wait cohorts (52+ waits)

Key mitigation actions have focused on additional MS1 capacity alongside patient and clinical validation and insourcing contracts for Rheumatology and Neurology have commenced.

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

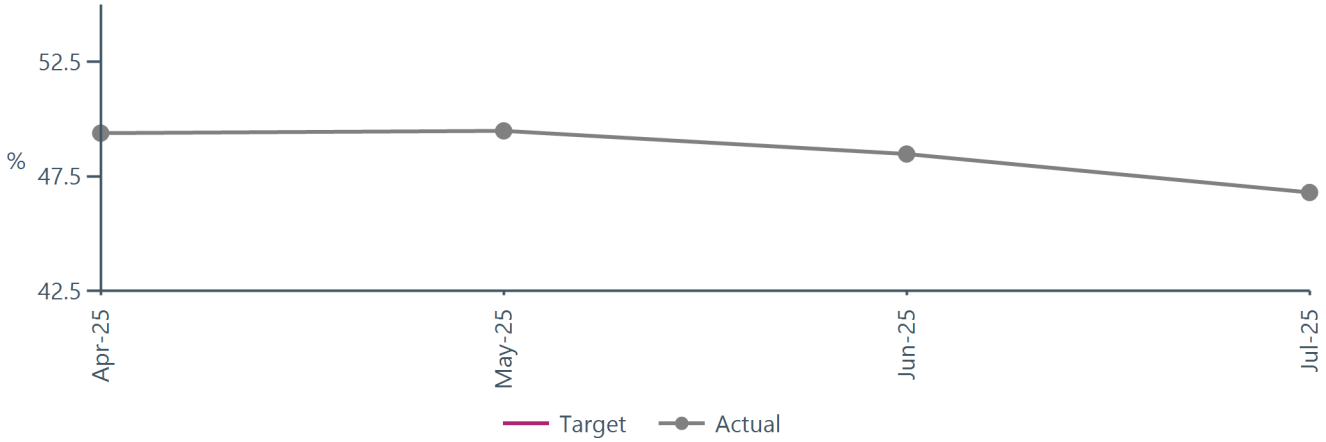
Time to First Appointment - Welsh Patients

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	46.80%	N/A to SPC	No Target

Trajectory



What these graphs are telling us

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

Narrative

This metric focuses on the time to first appointment waiting for first event and of those patients, the % waiting less than 18 weeks. The reported position is taken from the Waiting List MDS position for week ending 3rd August. NHSE Guidance stipulates the week ending positions we should officially report that fall closest to month end. This is an unvalidated position. This metric forms part of English expectations. For week ending 3rd August 46.80% of patients waiting for first appointment were under 18 weeks; there is no plan for Welsh patients. Performance ranges from 26.13% in Spinal Disorders to 100% in Physiotherapy.

2025/26 Welsh activity profiles continue to be discussed with Welsh Health Boards, that will impact list size. Since July there are expectations from Powys Health Board to provide first appointment no sooner than 52 weeks. This will have significant impact on our waiting list. Conversations are ongoing with Powys.

For other Welsh Health Boards, the Trust continues to work with maximum waits standards set out in Welsh Assembly expectations of 52 weeks for Outpatient Activity and 104 weeks for Inpatient Activity. The Trust recognises the disparity with English expectations with a proposal to redress balance between English and Welsh standards to be taken through committees in September.

Actions

The performance for the trust is significantly challenged, in particular Waiting List metrics. In order to address this we continue to work on both the long term changes required but also short term mitigating actions with a particular focus on that since early June.

Long term focus includes the following:
* Further Clinical recruitment; 3 Arthroplasty Surgeons appointed 1st August. Business case approved for further Advanced Practitioners in Spinal Disorders. Advert to be launched for Spinal Disorders Surgeon and Complex Pain Physician.
* Close working with GIRFT regarding pathway optimisation with significant focus on Spinal Disorders.
* Introduction of additional DEXA scanner from 16th June.

Key mitigation actions have focused on additional MS1 capacity alongside patient and clinical validation and insourcing contracts for Rheumatology and Neurology have commenced.

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

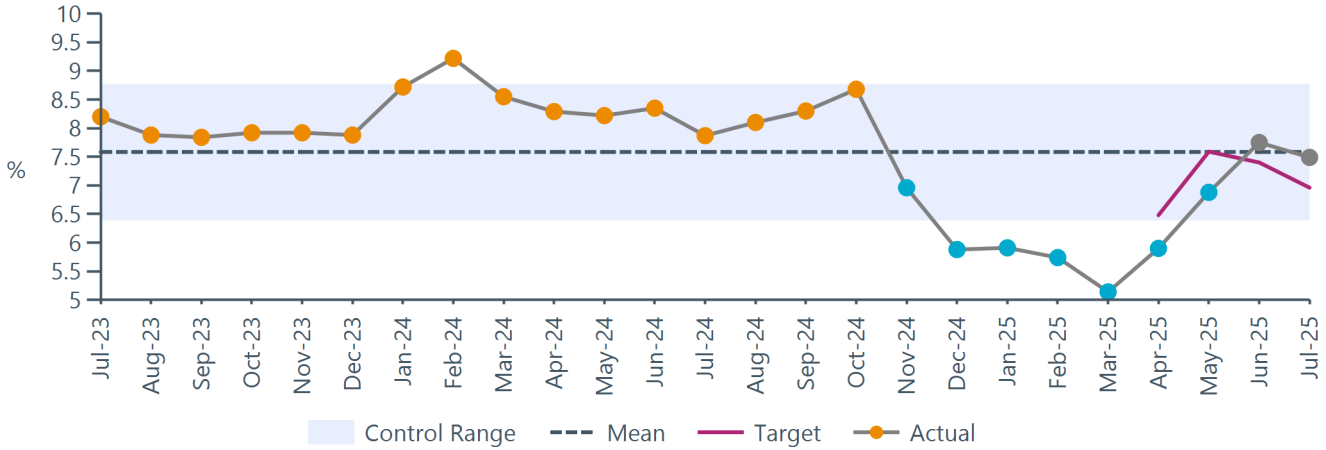
% of Patients Waiting Over 52 Weeks - English

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
6.96%	7.49%		Moving Target

Trajectory



What these graphs are telling us

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

Narrative

2025/26 English National Planning Guidance stipulates that every organisation should reduce the volume of patients waiting over 52 weeks to <1% of their list size. The Trust's Operational Plan forecasts a position of 1% by the end of March 2026.

Although this is a new metric introduced to the IPR for 25/26, the historic data has been added to the graph above. As the graph shows, there was substantial reduction at the end of last year but that has gradually increased between April and July. At the end of July 7.49% of the English list size is patients waiting over 52 weeks, this is above our plan of 6.96% (negative).

The volume of patients waiting over 52 weeks equates to 1295, a reduction of 48 from the end of June. The sub-specialties with the highest volume of patients are; Spinal Disorders (401), Arthroplasty (305) and Knee & Sports Injuries (189). Patients waiting, by weeks brackets is:

* >52 to <=65 weeks - 1130 patients
* >65 to <=78 weeks - 160 patients
* >78 weeks - 5 patients

Actions

The performance for the trust is significantly challenged, in particular Waiting List metrics. In order to address this we continue to work on both the long term changes required but also short term mitigating actions with a particular focus on that since early June.

Long term focus includes the following:

* Further Clinical recruitment; 3 Arthroplasty Surgeons appointed 1st August. Business case approved for further Advanced Practitioners in Spinal Disorders. Advert to be launched for Spinal Disorders Surgeon and Complex Pain Physician.
* Close working with GIRFT regarding pathway optimisation with significant focus on Spinal Disorders.
* Introduction of additional DEXA scanner from 16th June.
* Award of Insourcing Contract to provide additional capacity with a specific focus on the long wait cohorts (52+ waits)

Key mitigation actions have focused on additional MS1 capacity alongside patient and clinical validation and insourcing contracts for Rheumatology and Neurology have commenced.

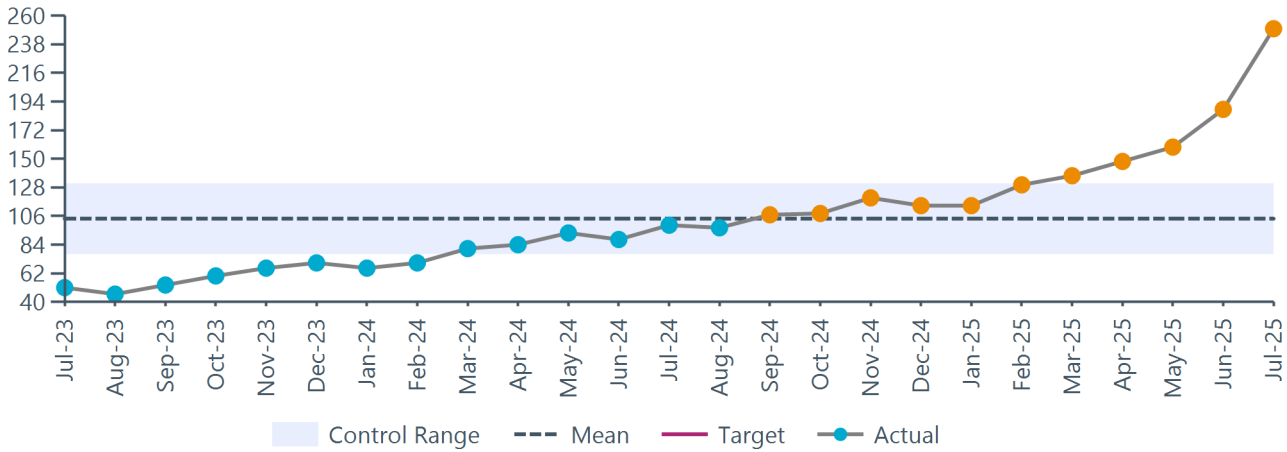
Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
7.87%	8.10%	8.30%	8.68%	6.96%	5.88%	5.91%	5.74%	5.14%	5.90%	6.88%	7.75%	7.49%

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
-	250	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 July there were 250 Welsh patients waiting over 104 weeks. The patients are under the care of these sub-specialities; Spinal Disorders (153), Knee & Sports Injuries (39), Arthroplasty (29), Foot & Ankle (26), Veterans (2) and Hand & Upper Limb (1).

2025/26 Welsh activity profiles continue to be discussed with Welsh Health Boards, that will impact list size. Since July there are expectations from Powys Health Board to provide first appointment no sooner than 52 weeks. This will have significant impact on our waiting list. Conversations are ongoing with Powys.

For other Welsh Health Boards, the Trust continues to work with maximum waits standards set out in Welsh Assembly expectations of 52 weeks for Outpatient Activity and 104 weeks for Inpatient Activity. The Trust recognises the disparity with English expectations with a proposal to redress balance between English and Welsh standards to be taken through committees in September.

Actions

The performance for the trust is significantly challenged, in particular Waiting List metrics. In order to address this we continue to work on both the long term changes required but also short term mitigating actions with a particular focus on that since early June.

Long term focus includes the following:
* Further Clinical recruitment; 3 Arthroplasty Surgeons appointed 1st August. Business case approved for further Advanced Practitioners in Spinal Disorders. Advert to be launched for Spinal Disorders Surgeon and Complex Pain Physician.
* Close working with GIRFT regarding pathway optimisation with significant focus on Spinal Disorders.
* Introduction of additional DEXA scanner from 16th June.

Key mitigation actions have focused on additional MS1 capacity alongside patient and clinical validation and insourcing contracts for Rheumatology and Neurology have commenced.

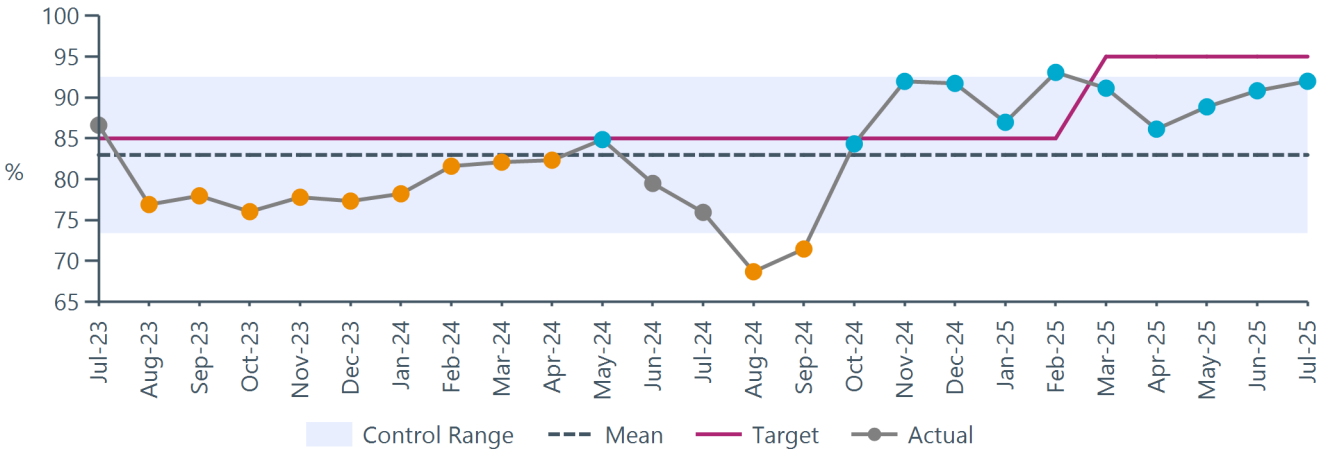
Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
99	97	107	108	120	114	114	130	137	148	159	188	250

6 Week Wait for Diagnostics - English Patients

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
95.00%	91.98%	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.

Narrative

Performance for July is 91.98% against the 95% target. The trajectory for July month end was 87.07%; this reflects the Trust's submitted Operational Plans. Reported position relates to 122 patients who waited beyond 6 weeks. Of the 6-week breaches; 5 are over 13 weeks, all within MRI.
Performance against trajectory and breaches by modality:
* MRI – 89.72% against trajectory of 80.31%
D2 (Urgent - 0-2 weeks) - 9 with 5 dated, D3 (Routine - 4-6 weeks) - 3 with 2 dated, D4 (Routine – 6-12 weeks) – 94 with 80 dated
* CT – 95.96% against trajectory of 100%
D2 (Urgent - 0-2 weeks) -1 dated, D4 (Routine - 6-12 weeks) – 3 dated
* Ultrasound – 96.77% against trajectory of 100%
- D2 (Urgent - 0-2 weeks) -1 dated, D4 (Routine - 6-12 weeks) - 11 dated
* DEXA Scans – 100% against trajectory of 100%
None of the diagnostic activity plans were met in July. National target – 0 patients waiting over 13 weeks by end of September 2024 and 95% against the 6-week standard within all modalities.

Actions

Ultrasound – U/S clinic templates reviewed to increase the number of appointments per session. Templates increased week commencing 21st July to accommodate 2 further patients per session. Additional weekend clinics are also being offered.

MRI – Recruitment to Business case. MRI staffing case of need in progress with a view to adopt acceleration software (up to 20% increase in productivity). Case for permanent MRI capacity to add flexibility to service. MRI mobile scanner activity rephased as planned full delivery anticipated.

CT – Demand for CT impacted by under-performance in surgical specialty activity, current DM01 performance 96% therefore no applicable actions at this time.

Skill-mix within modalities to maximise efficiency and productivity.

Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
75.95%	68.69%	71.47%	84.33%	91.97%	91.72%	86.97%	93.07%	91.13%	86.13%	88.85%	90.82%	91.98%

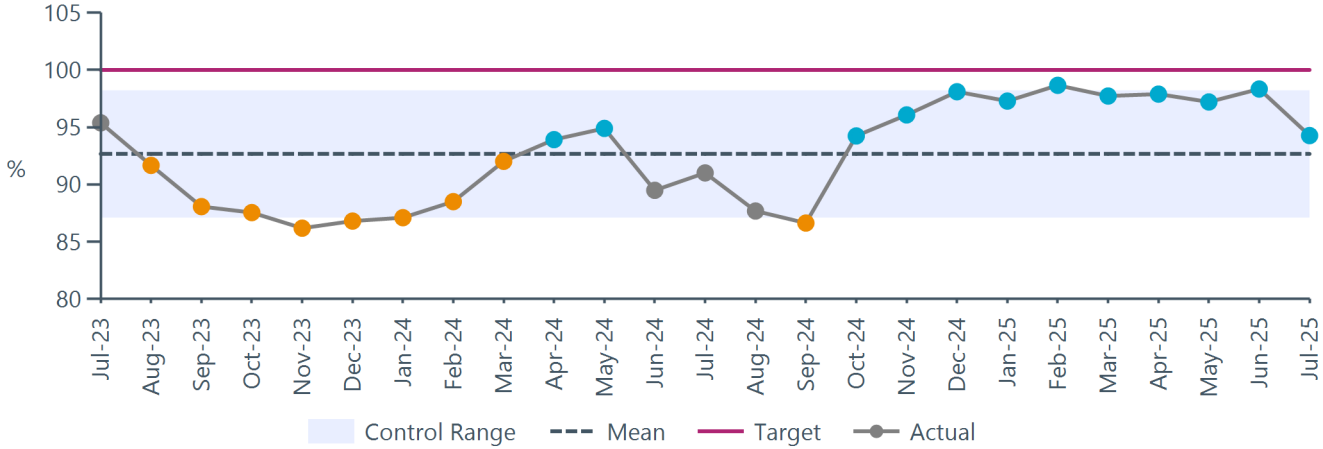
8 Week Wait for Diagnostics - Welsh Patients

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
100.00%	94.27%	H	F

Trajectory



What these graphs are telling us

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

Narrative

The 8-week standard for diagnostics is reported at 94.27%. The reporting position includes 27 patients who waited beyond 8 weeks.
Performance and breaches by modality:
* MRI – 93.69% - D2 (Urgent - 0-2 weeks) - 1 undated, D4 (Routine - 6-12 weeks) - 24 with 19 dated
* CT – 100%
* Ultrasound – 96% - D2 (Urgent - 0-2 weeks) - 1 dated, D4 (Routine - 6-12 weeks) - 1 dated
* DEXA Scans - 100%

None of the diagnostic activity plans were met in July.

Actions

Ultrasound – U/S clinic templates reviewed to increase the number of appointments per session. Templates increased week commencing 21st July to accommodate 2 further patients per session. Additional weekend clinics are also being offered.

MRI – Recruitment to Business case. MRI staffing case of need in progress with a view to adopt acceleration software (up to 20% increase in productivity). Case for permanent MRI capacity to add flexibility to service. MRI mobile scanner activity rephased as planned full delivery anticipated.

CT – Demand for CT impacted by under-performance in surgical specialty activity, current DM01 performance 96% therefore no applicable actions at this time.

Skill-mix within modalities to maximise efficiency and productivity.

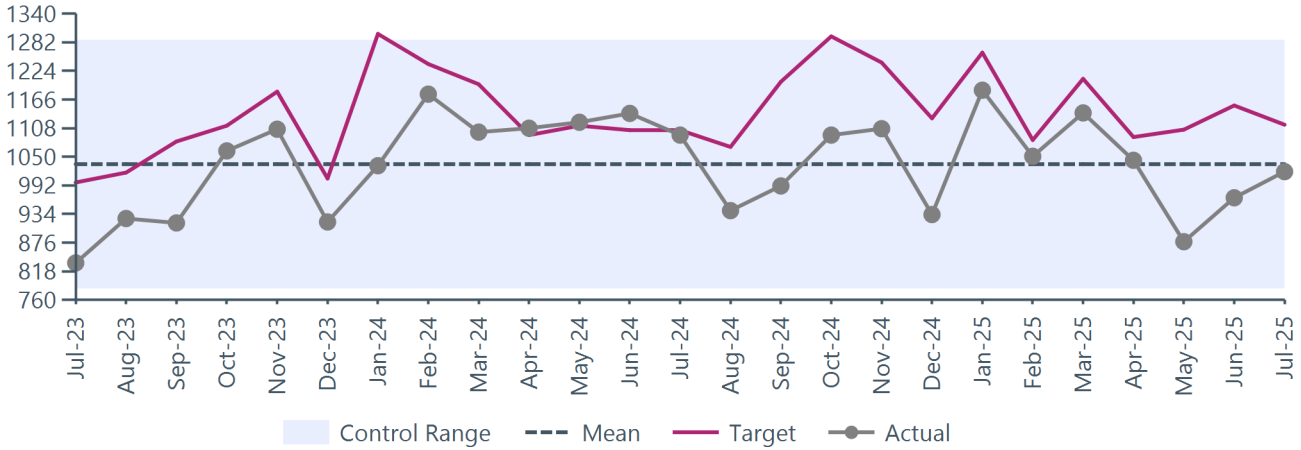
Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
91.01%	87.68%	86.63%	94.24%	96.07%	98.10%	97.28%	98.66%	97.72%	97.89%	97.20%	98.33%	94.27%

Elective Activity Against Plan (volumes)

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
1,115	1,020		Moving Target



Trajectory

What these graphs are telling us

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

Narrative

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

For July 2025, the Trust planned for 1,115 elective spells, achieving 1020 spells, which equates to 91.48% performance — 95 spells below plan.

Performance shortfalls which were primarily driven by the ongoing implementation of the Apollo PAS system are now showing signs of stabilisation as processes are becoming more embedded.

July marks the 2nd consecutive month of improvement since Apollo implementation. The latest data point is now approaching the mean and remains within statistical control limits—suggesting common cause variation rather than any special cause.

Actions

* Implementation of Apollo brought challenges to patient flow with issues in Baschurch impacting volume of Theatre Activity. Process and capacity on Baschurch have been reviewed to address this with staff from Recovery continuing to supporting Baschurch in mornings to ensure adequate staffing resource for admissions.
* Theatre Availability under review with focus on fixed sessions for weekends and evenings.
* Specific actions in relation to PP activity that will influence overall Theatre Activity.
* Continuation of mutual aid by RJAH Consultants being undertaken at Independent Sector providers and logged back to RJAH systems. Plan was 45 cases; 9 delivered:
- Nuffield Shrewsbury: 8 patients treated in July
- Spire Yale: 1 patient treated in July

Ongoing usage of Independent Sector is to be reviewed to ensure it aligns with Insourcing arrangements and income.
* Insourcing with Portland Clinical is due to commence 23rd August for additional Theatre Activity.
* Ongoing work regarding the temporary transfer of Orthopaedic activity from PRH to RJAH; proposed start date is end of September.

Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
1094	941	991	1094	1107	933	1185	1051	1139	1043	878	967	1020

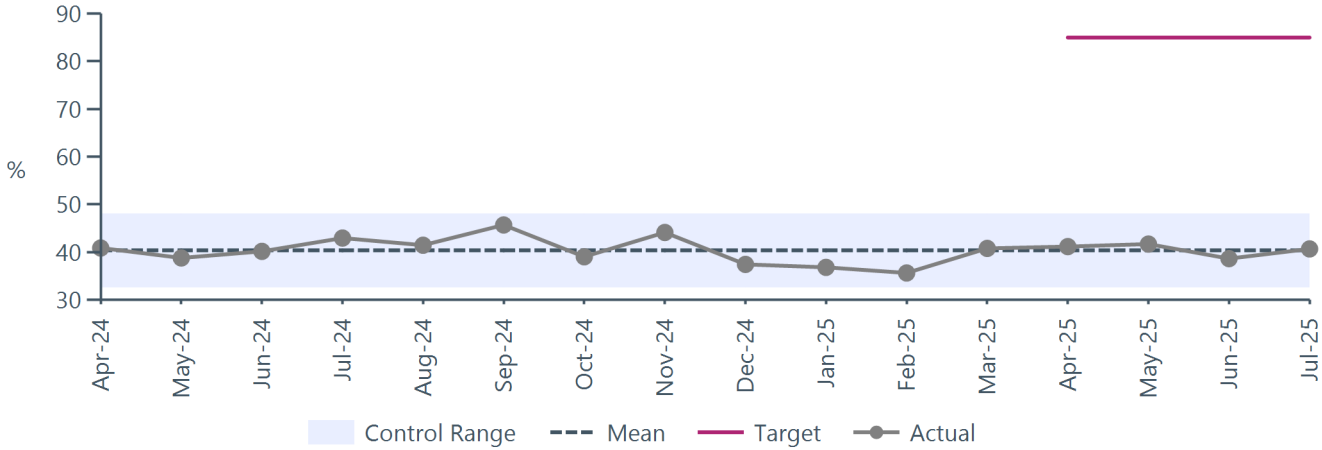
% Combined BADS Performance

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	40.69%		F

Trajectory



What these graphs are telling us

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

Narrative

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

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

In July, BADS performance was reported at 40.69%. If patients discharged on day zero—regardless of their intended management—were included, the metric would have reached 57.58%.

Actions

Since day-case rates vary significantly across different surgical procedures, it is recognised that, as a Specialist Orthopaedic Trust, the volume of Total Hip, Total Knee, and Uni-Knee arthroplasties performed at RJAH will impact the Trust's ability to achieve the overall 85% target. This makes it more challenging to attain high day-case rates compared to other surgical specialties.

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

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

Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
42.97%	41.47%	45.71%	39.05%	44.14%	37.45%	36.83%	35.65%	40.80%	41.18%	41.71%	38.66%	40.69%

Total Outpatient Activity against Plan (volumes)

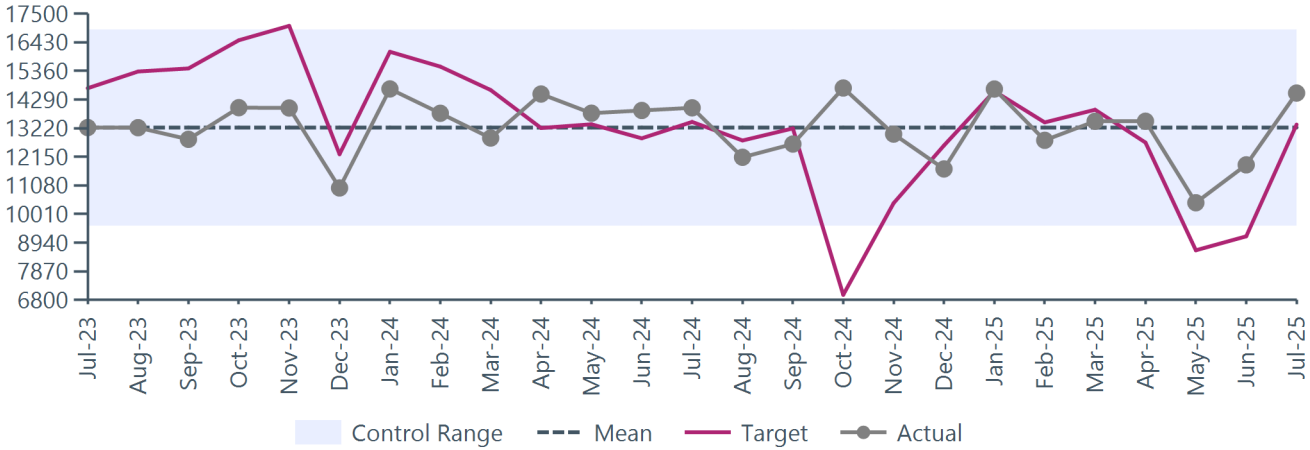
Total outpatient activity (consultant led and non-consultant led) against plan. Target as per Trust's Operational Plans. 217795

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
13,356	14,534		Moving Target

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

The outpatient activity plan was met in July and is reported +1178 of plan at 108.82%. The plan for July assumed no impact from Apollo, whereas the plan in initial months of Apollo implementation had been adjusted. A number of services were able to return to business as usual levels of activity sooner than anticipated. A breakdown of Outpatient activity below:
* IJP activity was +653 at 105%
* OJP activity was +637 at 305% - increased clinics undertaken on Saturdays by some consultants as part of RTT improvement initiative to address delivery of New Outpatient Appointments
* Insourcing was -114 at 70%

Within Neurology, the Insourcing plan was 0 this month as it was anticipated that the Insourcing contract in this area would run from April to June, however there were delays in it commencing so activity is still ongoing with 98 reported in July.

Within Rheumatology, the Insourcing plan was 380 with actual activity at 168 as there was not the requirement for all planned follow ups.

Actions

Outpatient Activity levels remain an area of focus and are reviewed weekly at sub-speciality level via meeting chaired by Specialist Unit Managing Director. As at 11th August, forecast for August indicates performance against plan at 74%, with IJP at 70%, OJP at 112% and Insourcing at 60%.

Weekly meeting also reviews the volume of activity undertaken as New and Follow Up against their specific plans.

Further transformation focus in Outpatients is also ongoing. The Trust has worked with the national GIRFT Team to identify further opportunities in this area.

Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
13982	12133	12628	14723	13000	11696	14685	12767	13480	13481	10433	11849	14534

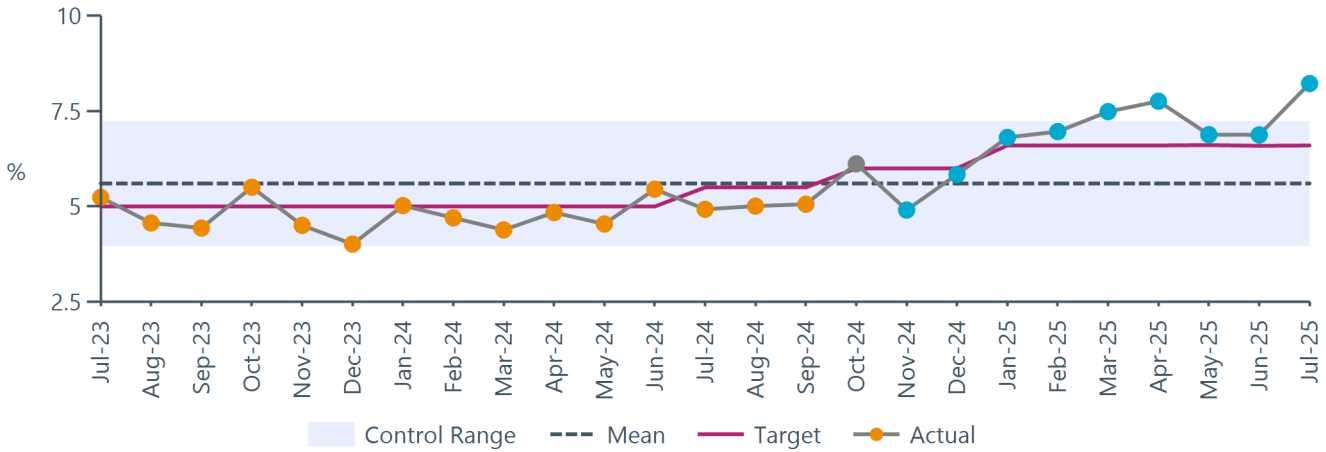
Total Outpatient Activity - % Moved to PIFU Pathway

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
6.60%	8.22%	H	Moving Target

Trajectory



What these graphs are telling us

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

Narrative

The target for the number of episodes moved to a PIFU Pathway is 6.60% of all outpatients attendances. In July this was exceeded with 8.22% of total outpatient activity moved to a PIFU pathway. As demonstrated on the SPC above, this is the 7th month above target and displayed as special cause variation of an improving nature.

Following the implementation of the new EPR system on 12th May 2025 issues following go live continue to be addressed. May position is also impacted. A corresponding increase in patients discharged to PIFU has been seen. May, June and July positions are also expected to be underreported due to exclusions currently being made whilst issues are resolved. Once these have been resolved May, June and July's data will be updated accordingly.

Actions

Close review of this metric as the mechanism of recording is different in Apollo.

Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
4.93%	5.01%	5.06%	6.12%	4.91%	5.84%	6.81%	6.96%	7.49%	7.76%	6.88%	6.88%	8.22%

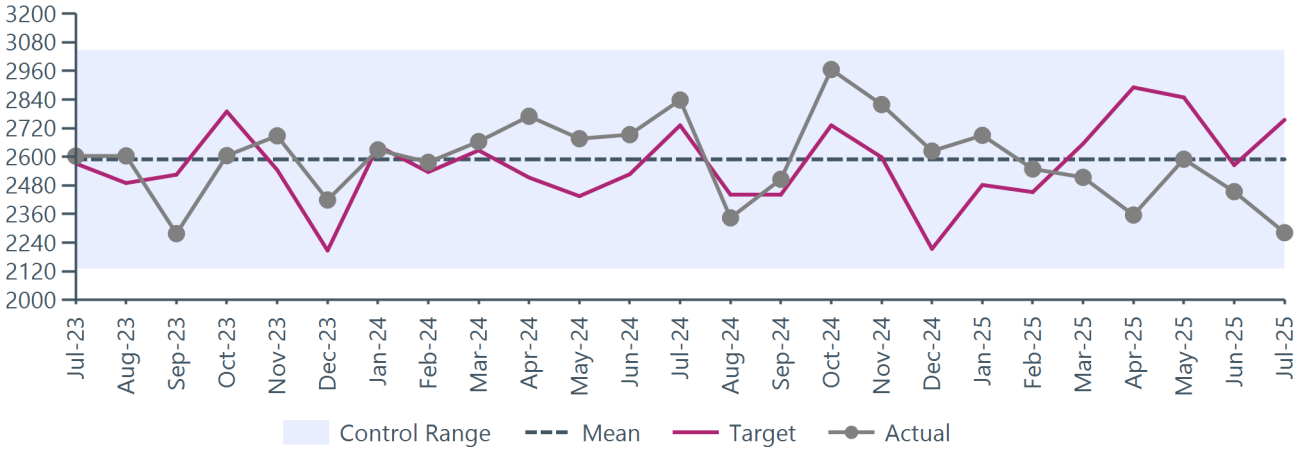
Total Diagnostics Activity against Plan - Catchment Based

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
2,755	2,282		Moving Target

Trajectory



What these graphs are telling us

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

Narrative

The Diagnostic activity plan was not met in July. Overall activity is reported at 82.83% with a breakdown as follows:
- CT – 352 against plan of 470; equating to 74.89%
- MRI - 1203 against plan of 1249; equating to 96.32%
- U/S – 727 against 1036; equating to 70.17%

The combination of leave and study in July exceeded last year's levels, which impacted activity - particularly ultrasound. It is anticipated that this will continue to impact activity delivery in August.

Actions

* Ultrasound – U/S clinic templates reviewed to increase the number of appointments per session. Templates increased week commencing 21st July to accommodate 2 further patients per session. Additional weekend clinics are also being offered.
* MRI – Recruitment to Business case. MRI staffing case of need in progress with a view to adopt acceleration software (up to 20% increase in productivity). Case for permanent MRI capacity to add flexibility to service.
* CT – No applicable actions at this time as waiting list for this modality is low and DM01 performance for CT at 96%.
* Skill-mix within modalities to maximise efficiency and productivity. Agreed for replacement of lost slots due to equipment breakdown.
* Delivery of Diagnostics Activity is being monitored through FIG with an Actions Mitigation Plan to address activity levels and associated recover measures.
* The approval process for annual/study leave is under-review by Clinical Lead and Service Manager.

Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
2838	2344	2506	2966	2819	2624	2690	2549	2514	2356	2590	2454	2282

NHS
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M04 Financial Position Update

Improving lives through excellent and innovative care

NHS

I&E Position

The Robert Jones and Agnes Hunt Orthopaedic Hospital
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Performance Against Plan £'000s							
Category	Annual Plan	In Month Position			YTD Position		
		Pass through adj Plan	Actual	Variance	Pass through adj Plan	Actual	Variance
Clinical Income	153,781	12,229	11,613	(616)	48,823	45,331	(3,492)
Private Patient income	11,987	928	993	65	4,117	3,585	(532)
Other income	7,020	654	640	(14)	2,702	3,003	301
Pay	(107,364)	(9,230)	(8,945)	285	(35,799)	(34,539)	1,260
Non-pay	(56,947)	(4,668)	(4,417)	251	(19,795)	(17,479)	2,316
EBITDA	8,477	(87)	(116)	(29)	48	(99)	(147)
Finance Costs	(9,285)	(787)	(753)	34	(2,891)	(2,731)	160
Capital Donations	1,620	8	0	(8)	32	129	97
Operational Surplus	812	(866)	(869)	(3)	(2,811)	(2,701)	110
Remove Capital Donations	(1,620)	(8)	0	8	(32)	(129)	(97)
Add Back Donated Dep'n	809	66	69	3	266	277	11
							0
Control Total	0	(809)	(800)	9	(2,575)	(2,555)	20

- **£801k deficit in month, £9k favourable to plan**
- NHS Clinical Income £616k adverse:
  - £444k adverse theatres – activity on plan, driven by casemix
  - £197k adverse insourcing / outsourcing (offset in cost)
  - £112k adverse diagnostics
  - £135k favourable outpatients (driven by premium cost clinics in rheumatology, Arthroplasty & spinal disorders and overperformance in orthotics non consultant led)
- Non NHS income £51k favourable:
  - £65k favourable private patients 5 cases favourable
  - £19k adverse research (reduced commercial trials)
- Pay £285k favourable :
  - £201k favourable improvement & intervention actions (vacancy control, temporary staffing, recruitment)
  - £187k favourable workforce recruitment slippage (offset by activity)
  - £67k favourable revenue to capital transfer Apollo
  - £54k adverse Bank – driven by outpatients and anaesthetics out of job plan premiums
  - £116k adverse estimated pay award impact M1-4 as per guidance
- Non-Pay £251k favourable:
  - £197k favourable Insourcing/outsourcing (offset in income)
  - £94k favourable inflation to date lower than plan and slippage on cost pressures
  - £53k favourable implants/consumables
  - £51k adverse Wards – non capital equipment, bed hire
  - £42k Estates & Facilities – utilities, materials and cleaning
- Finance Costs £37k favourable driven by interest receivable
- **YTD £2,555k deficit, £20k favourable to plan.**

Month 4 Efficiency Performance

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Internal Plan & Actuals	Month 4			YTD			Forecast		
	Plan	Actual	Variance	YTD Plan	YTD Actual	Variance	Plan	Forecast	Variance
MSK	365	326	-39	1,328	1,265	-62	4,611	4,617	6
Spec	256	229	-27	792	658	-134	3,395	3,024	-371
Corporate	151	220	69	507	678	171	1,588	1,953	365
Total Recurrent	**772**	**775**	**3**	**2,627**	**2,602**	**-25**	**9,594**	**9,594**	**-0**
YTD Non-Recurrent	**0**	**49**	**49**	**0**	**399**	**399**	**0**	**399**	**399**
Total including Mitigations	**772**	**823**	**51**	**2,627**	**3,001**	**374**	**9,594**	**9,993**	**399**

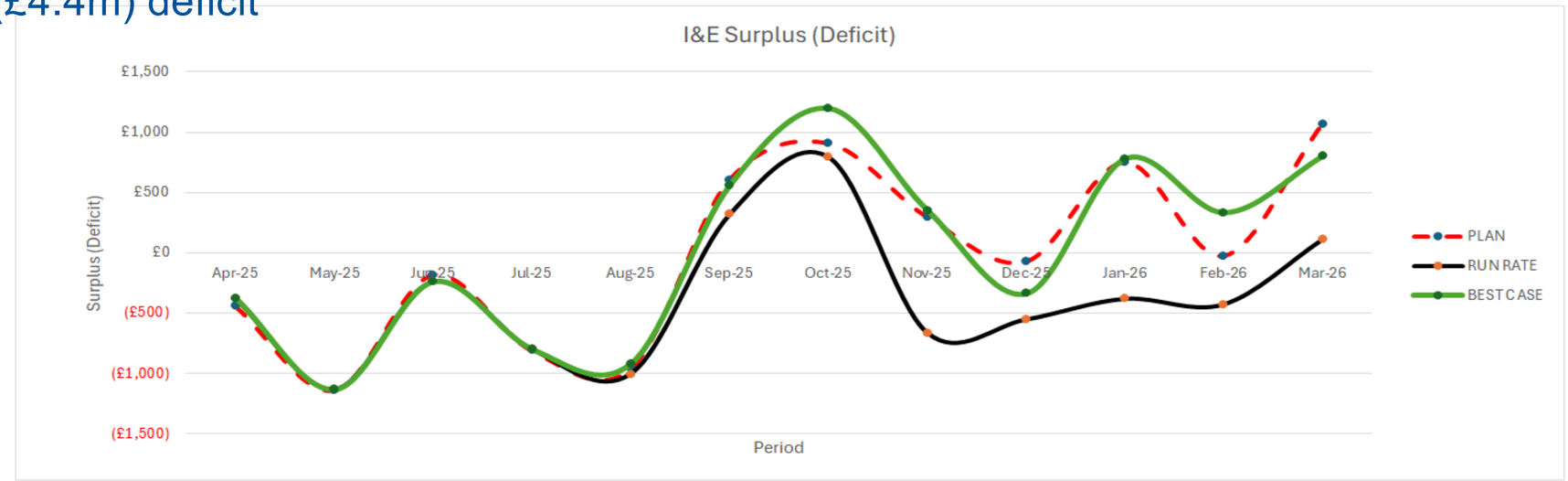
Performance

- Overall £823k efficiencies achieved, £51k favourable to plan. Recurrent delivery £3k favourable to plan, with a further £49k of non recurrent mitigations recognised in month (interest receivable and procurement).
- YTD £3,001k efficiencies achieved, £374k favourable to plan. Recurrent delivery £25k adverse to plan, offset by £399k non recurrent mitigations.
- The level of red rated schemes is low at £68k, however there remains £1.6m of amber rated schemes which require further de-risking. This is reflected in the Trust financial risks at £459k remaining for the year based on delivery risk of 100% of red schemes and 25% of amber.

Financial Forecast FY52-26

Best Case £0.2m surplus
Run Rate (£4.4m) deficit

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust



I/E Surplus (Deficit)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	I/E Surplus (Deficit)
PLAN	(£442)	(£1,140)	(£183)	(£810)	(£957)	£604	£907	£296	(£71)	£750	(£24)	£1,070	**£0**
RUN RATE	(£379)	(£1,135)	(£241)	(£801)	(£1,005)	£319	£797	(£664)	(£554)	(£382)	(£428)	£112	**(£4,361)**
BEST CASE	(£379)	(£1,135)	(£241)	(£801)	(£918)	£561	£1,196	£349	(£339)	£779	£332	£801	**£204**
Variance to Plan													
RUN RATE	*£63*	*£5*	*(£58)*	*£9*	*(£48)*	*(£285)*	*(£110)*	*(£960)*	*(£483)*	*(£1,132)*	*(£404)*	*(£958)*	*(£4,361)*
BEST CASE	*£63*	*£5*	*(£58)*	*£9*	*£39*	*(£43)*	*£289*	*£53*	*(£268)*	*£29*	*£356*	*(£269)*	*£204*

- The above shows the monthly forecast Net Operating Surplus/Deficit for both the Best Case and Run Rate, versus Plan
- The Best Case scenario £0.2M favourable includes current identified operational recovery actions with associated Income and Costs, alongside other financial impacts assumed in Q2-4 e.g. known cost increases and efficiency plan delivery assumption.
- The Run Rate scenario is (£4.4M) adverse to plan. It should be noted this does not represent a realistic or accepted forecast but purely provides a view assuming no improvement on the Q1 performance, using underlying run rates and without future mitigation.

Financial Forecast Methodology

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

UL = underlying

		APPROACH TO FORECAST	INCOME	EXPENDITURE
1	RUN RATE FORECAST	• Assessment of M1-4 YTD Activity, Income and Expenditure, removing one off non-recurring benefits and pressures to give underlying run rates. • M1-4 underlying position extrapolated for M5-12	**Clinical Activity Income** = Income run rate per day extrapolation **Private Patient Activity** = Plan **Non-Clinical Other Income** = UL run rate	**Pay** = UL run rate Substantive, Variable Bank & Agency flexed according to rate per calendar day **Non-Pay** = UL run rate flexed according to Cost per Unit, per Working or Calendar day
2	BEST CASE	• Operational Recovery Plan and Other Known movements M5-12 • Other Financial Risks and Opportunities overlay	**Clinical Activity Income** = Operational Activity Plan x Unit Income per Activity **Private Patient Activity** = Operational Activity Plan x Unit Income per Activity **Non-Clinical Other Income** = UL run rate	**Pay** = UL run rate, plus future planned movements, plus cost of recovery actions **Non-Pay** = Operational Activity Plan x Unit Cost for Prosthesis & Consumables. Unit cost per day for Other Non-Pay expenditure. Plus, cost of recovery actions

Scenario Assessment – Best, Most Likely, Worst Cases

The Robert Jones and Agnes Hunt Orthopaedic Hospital
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The below table shares a risk adjusted view of the Best Case £0.2m above plan, moving through the Likely (£1.2m) and Worst case (£2.6m) scenarios, based on flexed assumptions.

This is the first iteration of the financial forecast based on the initial activity performance improvement plan, with additional plans to be developed.

Interventions & Efficiency Most Likely Model		
RAG		
R	A	G
25%	75%	100%

Interventions & Efficiency Worst Case Model		
RAG		
R	A	G
0%	50%	100%

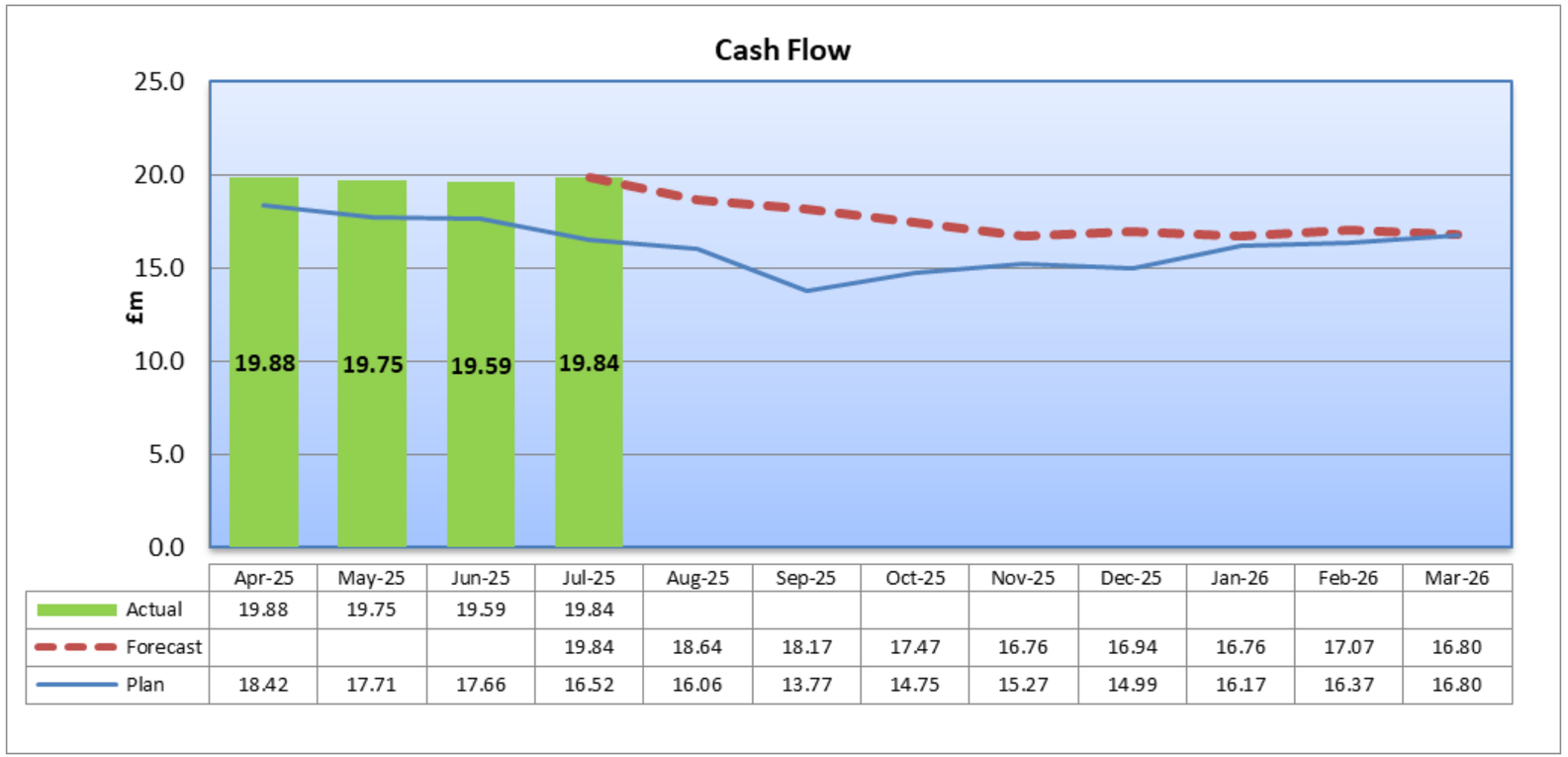
		BEST CASE	MOST LIKELY	WORST CASE
Surplus (Deficit) £'000		**£204**	**£204**	**£204**
Risks				
Private Patient Delivery		£0	(£420)	(£839)
Efficiency delivery		£0	(£459)	(£851)
Recovery and Operational Interventions	**Area**			
Insourcing	Theatres	£0	(£297)	(£396)
Visiting Consultant - Spinal Disorders	Theatres	£0	£0	£0
Upper limb fellow	Theatres	£0	£0	£0
Extended sessions spinal	Theatres	£0	(£6)	(£12)
Additional Rheumatology activity - News	Outpatients	£0	£0	£0
Recruitment - Visiting Consultant - Spinal Disorders - News	Outpatients	£0	£0	£0
Recruitment - 2xCNS Spinal Disorders	Outpatients	£0	(£10)	(£14)
OJP - Additional clinics	Outpatients	£0	£0	£0
100 paediatrics. 200 spinal disorders	Outpatients	£0	(£4)	(£9)
MRI Scanner - total contract to be deliverd in full year with lost activity in Q1 rephased	Diagnostics	£0	(£5)	(£6)
Radiologist delivering additional ultrasound as compared to plan	Diagnostics	£0	(£1)	(£5)
Veterans Service Activity/Income recovery > commissioned block		£0	(£200)	(£667)
Adjusted Surplus (Deficit)		**£204**	**(£1,198)**	**(£2,594)**

Private Patients: Best case is delivery of plan M5-12 based on activity forecast. Worst case assumes Q1 run rate continues, Likely assumes 50% of stretch plan delivered M5-12

Worst case assumes no payment for delivery > block. Most Likely 80% recovery of invoices

Cash Position

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Actual	19.88	19.75	19.59	19.84								
Forecast				19.84	18.64	18.17	17.47	16.76	16.94	16.76	17.07	16.80
Plan	18.42	17.71	17.66	16.52	16.06	13.77	14.75	15.27	14.99	16.17	16.37	16.80

- The cash balance of £19.8m is £3.3m above plan, mainly due to significant levels of 24/25 under performance on contract income not yet recovered by commissioners.
- Recovery is expected during the next couple of months, along with other 24/25 performance adjustments.

Capital

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Position as at	2526-04	Capital Programme 2025/26						
Project	**Annual Plan £000s**	**In Month Plan £000s**	**In Month Completed £000s**	**In Month Variance £000s**	**YTD Plan £000s**	**YTD Completed £000s**	**YTD Variance £000s**	**Forecast Outturn £000s**
Backlog maintenance	500	50	85	-35	150	112	38	500
Digital investment & replacement	500	22	3	19	82	3	79	500
Capital project management	170	14	14	0	56	56	0	170
Equipment replacement	1,000	80	201	-121	160	316	-156	1,000
Diagnostic equipment replacement	700	154	0	154	404	0	404	630
Compliance (IPC/health & safety/quality)	360	180	7	173	200	154	46	360
Estates reconfiguration	206	30	0	30	90	0	90	206
PACS/RIS replacement	200	5	-6	11	60	0	60	200
Invest to save	200	0	0	0	50	0	50	200
Digital & innovation strategy	500	80	0	80	160	0	160	500
Surgical innovations	750	0	733	-733	0	733	-733	750
EPR implementation	500	0	117	-117	500	497	3	500
Rheumatology hub	500	0	0	0	0	0	0	500
Rheumatology hub (donated element)	500	0	0	0	0	0	0	500
Donated / Granted medical equipment	220	8	0	8	32	129	-97	220
Energy/decarbonisation plan (grant)	900	0	0	0	0	0	0	900
Critical infrastructure funding (CIR)	500	0	0	0	0	0	0	500
Solar works (GBE funding)	2,407	0	0	0	0	0	0	2,407
Leases (IFRS16)	250	125	0	125	125	125	-0	250
Contingency	0	0	0	0	0	0	0	70
Total Capital Funding	10,863	748	1,153	-405	2,069	2,125	-56	10,863
Less donated / grant capital	-1,620	-8	0	-8	-32	-129	97	-1,620
NHS Capital Funding - Charge to CDEL	9,243	740	1,153	-413	2,037	1,996	42	9,243
Less PDC funded schemes	-2,907	0	0	0	0	0	0	-2,907
Charge to System Operational Capital	6,336	740	1,153	-413	2,037	1,996	42	6,336

- The capital plan for 25/26 is £10.9m, made up of £6.3m internally funded schemes, £2.9m from external funding (PDC) and £1.6m from grants and donations.
- Capital expenditure is £56k over plan YTD. This is due to earlier than planned expenditure on Spinal Navigation Equipment un der the surgical innovations budget, which is offset by slippage on other schemes, particularly the diagnostic equipment replacement.
- Forecast delivery of plan in full.

Financial Risk

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Risk Type	Category	Risk name	Risk Description	Estimated Value Methodology	Risk ID	Pro Rata Remaining Risk £'000	Mitigations £'000	Residual Risk £'000	Residual Risk Rating	Mitigations / actions	SRO
Income	Internally Driven	Failure to deliver planned activity increase linked to consultant capacity leading to income loss	The plan is based on a number of assumptions that will increase consultant capacity to deliver activity, if these do not deliver the delivery of the activity and therefore income will be at risk.	Based on contribution from additional cases	3343	£ 2,000	£ 704	£ 1,296	16	Financial Improvement group overseeing activity delivery weekly Extend the recovery action plan for theatre recovery plan to mitigate the forecast shortfall for the full year 173 cases Development of an action plan to mitigate the net £70k per month for diagnostics for MRI, CT, Unbundled procedures	Mike Carr - Chief Operating Officer
Expenditure	Internally Driven	Efficiency Programme Slippage leading to increased cost	The efficiency programme is set at a highly challenging 6% target, slippage or non delivery of schemes will result in a deterioration in the Trust financial position.	Risk based on red schemes at 100% and amber schemes at 25% aligned to ICS methodology from PwC	3341	£ 459	£ -	£ 459	12	Financial Improvement Group review of efficiency plans including executive oversight and identification of 20% contingency Monthly review of performance through TPOIB. Monthly assurance through F&P. System Financial Improvement Programme oversight of efficiency progress. Continue to de-risk schemes from red and amber to green and identify mitigating opportunities in year WIG oversight of corporate infrastructure reductions	Angela Mulholland-Wells, Chief Finance and Commercial Officer
Income	Externally Driven	Veterans growth for out of area patients not funded through Low Value Agreement (LVA) block.	The LVA block has been updated but still includes 19/20 year and does not include 24/25, planned growth in veterans activity will exceed the LVA values leading to income recovery risk.	Estimated overperformance on LVA block.	3342	£ 667	£ 467	£ 200	12	Formal correspondence issued to all ICB's on billing methodology for 25/26, this is signed by RJAH and STW ICB as host commissioner and supported by regional NHSE Continue to chase debt and monitor individual commissioner performance Clarify that future billing should not be required once the LVA baseline is updated to more current performance levels (removal of 19/20 and inclusion of 24/25)	Angela Mulholland-Wells, Chief Finance and Commercial Officer

Financial Risk

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Risk Type	Category	Risk name	Risk Description	Estimated Value Methodology	Risk ID	Pro Rata Remaining Risk £'000	Mitigations £'000	Residual Risk £'000	Likelihood	Consequence	Residual Risk Rating	Mitigations / actions	SRO
Income / Expenditure	Internally Driven	Apollo EPR project team costs	Risk that continued development and support of the system from the project team leads to increased unfunded revenue costs.	Based on cost of extending partial project resource for 3 months	3250, 3147	£ 300	£ 300	£ -	2	4	8	Project overseen by EPR Programme Board with escalation through Digital Committee. Financial forecast regularly updated with latest project milestones and workforce, risk register is maintained for project. Review of project costs to ensure as efficient as possible.	Mike Carr - Chief Operating Officer
Income	Externally Driven	English associate commissioning contract differences leading to non payment of activity	English associate ICB's and NHSE have been set a fixed allocation for variable elective activity based on m7 24/25 forecast outturn. This causes a variance to RJAH operational plan assumptions which are based on delivering 60% RTT performance requirement and 24/25 performance is understated due to insourcing contract ceasing and c42% starting RTT.	Based on differences in variable contract values		£ 4,800	£ 4,800	£ -	2	4	8	Activity is required to deliver mandatory performance standards - guidance supports this Clauses included in contracts for activity payments to support RTT plan delivery Close contract monitoring and forecast with commissioners Escalation to NHSE as required	Angela Mulholland-Wells, Chief Finance and Commercial Officer
Expenditure	Externally Driven	Inflationary Environment leading to increased costs	Planning inflation is set at 3.5% - the Trust is at risk of higher than planned inflation in key areas such as food, energy, implants and drugs.	Risk based on inflation running at 4% for the year	3344	£ 300	£ 300	£ -	2	3	6	Procurement steering group monthly review of inflation pressures. Robust management of inflation proposals from supplies and strategic use of inflation reserve. Robust negotiation of controllable costs under contracts and pricing challenges.	Angela Mulholland-Wells, Chief Finance and Commercial Officer
					Total	£ 8,526	£ 6,571	£ 1,955					

- £8.5m of remaining risk has been identified along with £6.6m of mitigations leaving a residual risk of £2.0m. These represent potential risks that are not included in the financial forecast.

- The risk rating for LVA billing has reduced to 12 due to YTD performance lower than plan and recovery of income through invoicing the residual risk is reducing.
- The efficiency scheme delivery risk has been reduced to 12 due to YTD delivery on plan acknowledging there is further de-risking required

- There is one risk >15 risk rating

1. Failure to delivery planned activity levels

Trust Board - Finance

July 2025 – Month 4

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

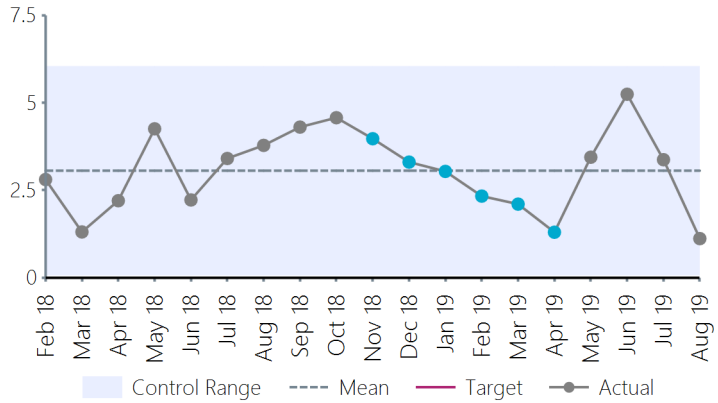
Some examples of these are shown in the images to the right:

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

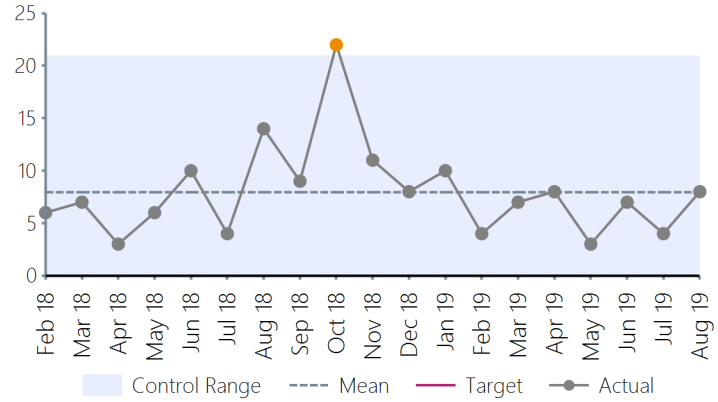
b) shows a point of concern sitting above the control range.

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

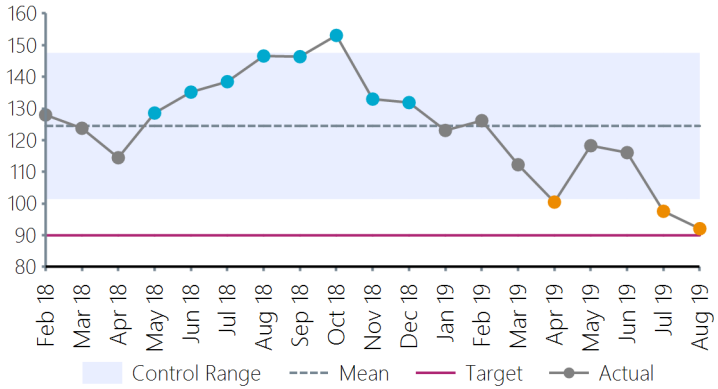
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Finances

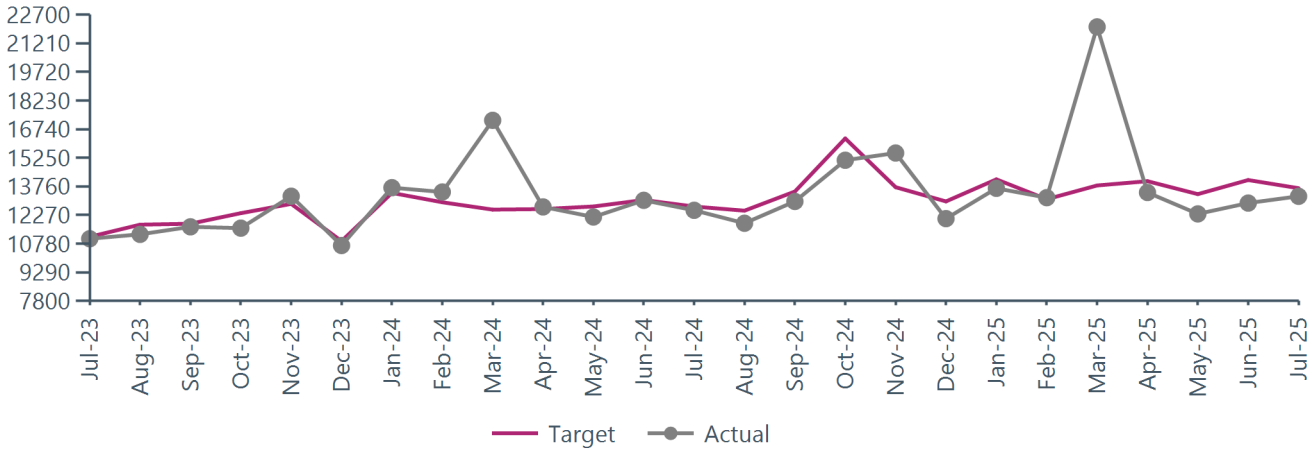
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Financial Control Total	-810	-800.70		N/A to SPC	Moving Target		
Income	13,667.10	13,246.90		N/A to SPC	Moving Target	+	
Expenditure	14,477.10	14,047.60		N/A to SPC	Moving Target		
Efficiency Delivered	772	823		N/A to SPC	Moving Target		
Cash Balance	16,523	19,835.42		L	Moving Target		
Capital Expenditure	748	1,154		N/A to SPC	Moving Target	+	
Performance (£'000k) against Low Value Agreement Block	57,923	8,527		N/A to SPC	Moving Target		

Income

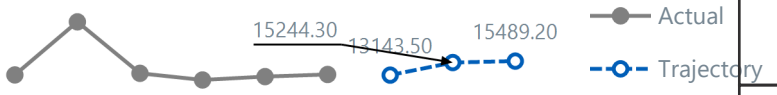
All Trust Income, Clinical and Non-Clinical 216333

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
13,667.10	13,246.90	N/A to SPC	Moving Target



Trajectory



What these graphs are telling us

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

Narrative

Overall income £420k adverse to plan:

NHS Clinical income £616k adverse to plan:
- Internal capacity delivery £421k adverse to plan driven by Theatre casemix (£444k adverse), Diagnostics unbundled MRI (£112k adverse); partially offset by Outpatients (£135k favourable)
- External insourcing/outsourcing delivery £197k adverse to plan (offset in expenditure)

Non NHS income £50k favourable to plan: Private Patients income £65k favourable (5 cases), Research £19k adverse (reduced Commercial trials).

Actions

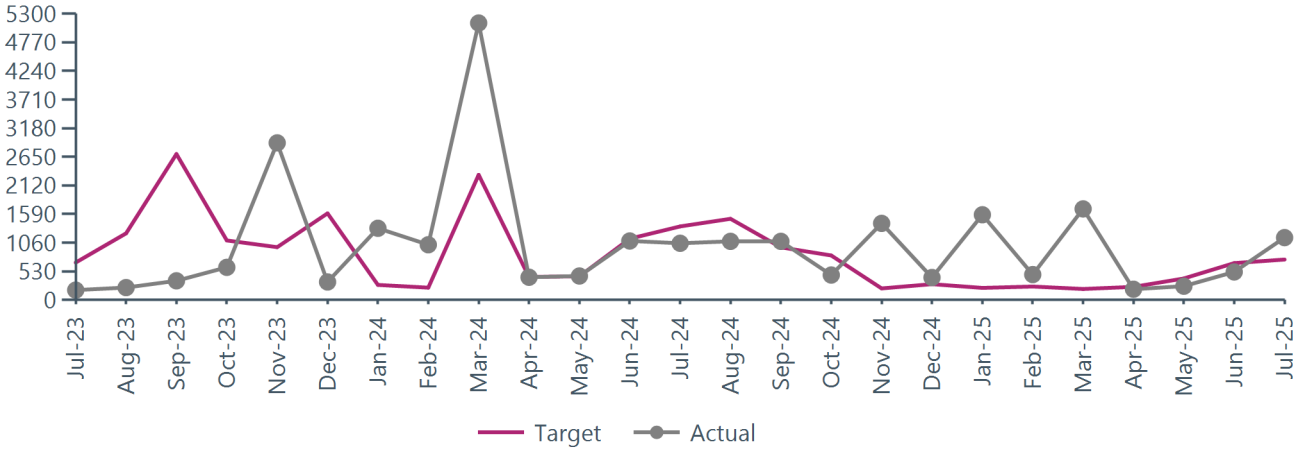
Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
12518	11843	12980	15124	15498	12083	13662	13175	22066	13444	12330	12895	13246

Capital Expenditure

Expenditure against Trust capital programme 215301

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
748	1,154	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Capital expenditure is £56k over plan YTD. This is due to earlier than planned expenditure Spinal Navigation Equipment (£0.7m) which is offset by slippage on other schemes, particularly the diagnostic equipment replacement. Forecast remains on plan.

Actions

Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
1049	1085	1085	461	1418	415	1577	469	1686	198	255	518	1154

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, 03 September 2025

Author: **Contributors:**

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Report sign-off:

Sarfraz Nawaz, Chair of the Finance and Performance Committee

Is the report suitable for publication?

Yes

1. Key issues and considerations:

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

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

This report provides a summary of the items considered at the Finance and Performance Committee on 28 July and 18 August 2025. It highlights the key areas the Finance and Performance Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

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

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

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

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

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

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

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

3. Assurance Report from Finance and Performance Committee

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

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

Financial Position and Underlying Risk
While Month 4 (July) results are broadly in line with plan (YTD £2.5m deficit, £20k favourable), delivery has been underpinned by non-recurrent mitigations. Activity shortfalls (notably diagnostics and theatre activity) remain the primary driver of financial risk. The Committee highlighted that recurrent vs non-recurrent positions need clearer separation in reporting and that the underlying adverse variance of up to £4.4m (worst case forecast) requires continued Board oversight.

Spinal Disorders Pathways
Long waits and increasing referrals present a significant system-wide risk. Regional engagement has not yet secured effective shared solutions. Internal mitigations are underway (insourcing, pathway redesign, recruitment of locum and substantive consultants, sciatica and pain clinics), but demand management at system level is still unresolved. The Committee agreed to monitor monthly and escalates the issue for Board consideration of strategic next steps with commissioners and regional partners.

Board Assurance Framework
The current BAF includes tracked changes and proposed risk score adjustments.

- BAF 3 has been updated, including changes to IPR provisions and reclassifying Veterans initiatives from an action to a mitigation. A risk score reduction to 16 was proposed, pending ongoing review.
  Emphasis is shifting from short-term financial delivery to long-term sustainability, with broader strategic cost/resource planning. Further updates are expected, especially around activity and treatment themes discussed in the Activity Recovery Committee.
- BAF 4, a new inhibiting factor and mitigation were added to better reflect operational challenges and team performance.
  Planning discussions stress the need to align activity with capacity and refine language for service efficiency. A score increase to Consequence 5 and Likelihood 2 was suggested due to ongoing performance challenges.

Corporate Risk Register
The Committee considered and reviewed the risks aligned to the Committee and recommended the amendments to the Board for approval. The Committee discussed:

- New Risk 3343 approved - concerning financial consequences of not meeting planned activity targets.
- Noted that only one financial risk rated 15+ included in the report and other financial risks exist but fall below the reporting threshold.

- Concerns raised about risks within Apollo. A separate report from the Digital Transformation Programme Board has been submitted to the Quality and Safety Committee detailing these risks and their inclusion in the risk register.
- Requested a review of the radiology system risk as servers reach end of life in September 2026 and although there is ongoing work to mitigate the System the timeline for replacement is unclear

Committee Terms of Reference
The revised terms of reference are recommended to the Board for approval following the agreement for the Director of Estates and Facilities to become a member of the meeting

3.2 Areas of on-going monitoring with new developments

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

Performance

- RTT performance improved by 2% from June to July and is currently ~2 months ahead of plan; weekly first appointment waits are improving by c.1% per week. However, assurance is not consistent across all specialties, rheumatology shows strong improvement (11% waiting list reduction since February), but paediatrics and spinal remain under pressure.
- DNA rates and on-day cancellations continue to impact productivity. A DNA "deep dive" is underway, and further communication strategies (including information on the cost/impact of missed appointments) are being trialled.
- Welsh waiting lists remain a concern, with a deteriorating equity position for patients compared to English lists. Timing for rebalancing access remains unresolved and requires further strategic discussion.

Children and Young People (CYP) RTT Trajectories
A revised trajectory has been produced following clarification of the baseline position (confirmed at 61.7% vs. the 75.9% previously submitted to NHSE). The revised likely case target is 68.4% with improvement steps in September (paediatric insourcing) and March (recruitment of additional consultant). The Q4 step-up is dependent on a consultant business case not yet approved. The Committee highlighted the associated risk of non-delivery.

Efficiency Delivery

- The Trust is on track year to date with £2.6m achieved against the £9.6m plan; forecast delivery remains achievable but carries c.£1.6m red-rated risk.
- Workforce schemes remain the most significant area of risk, particularly delays in closing fixed-term posts and limited delivery from digital and access programmes. Mitigations are in progress, and escalation to the People and Culture Committee has been agreed.
- Unit-level efficiency delivery shows variation (e.g. Specialist Unit £370k adverse offset by Corporate), with alternating monthly reporting agreed to ensure transparency and early escalation of risks.

Financial Risks and Forecasting

- While Q1 delivered plan through mitigations, the Committee emphasised the need for clearer monthly tracking of activity, recurrent/non-recurrent contributions, and specialty-level performance.
- A new risk (3343) has been added to the Corporate Risk Register regarding financial consequences of failing to meet planned activity targets.
- Humber ICB historic debt remains unpaid despite escalation; write-off is being considered alongside NHSE engagement.

MCSI Inpatient Length of Stay

- High bed occupancy continues. Efforts to reduce length of stay for pressure ulcers are showing results, but acute and urology pathways remain challenged.

- Workforce gaps, particularly in therapy provision, are delaying rehabilitation. A workforce paper has been submitted to NHSE, and a new clinical lead is in place.
- Committee requested Quality and Safety oversight of the 6-week bed rest pathway following patient concerns.

Apollo Implementation

- Outpatient activity remains below pre-go-live levels but is improving. A post-implementation review of benefits is scheduled for September via the EPR Assurance Group.
- Risks related to Apollo's financial and operational impact are being separately captured on the risk register.

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.

Rheumatology Service
Significant improvements in waiting list reduction through insourcing, new triage guides, and follow-up pathways. Strong evidence of sustainable improvement and good patient feedback.

Grip and Control Review
Annual self-assessment confirmed strong internal controls; three outstanding actions remain but are being managed.

The Committee received the following Chairs Assurance reports for consideration:

- **Capital Management Group** -capital programme progressing with no risks to overall delivery. Contingency for Apollo remains protected.
- **Procurement Steering Group** - oversight maintained, no risks escalated.
- **Financial Improvement Group** - strengthened focus on linking finance, activity and recovery actions; Terms of Reference under review to ensure alignment with Committee oversight.
- **STW MSK Provider Collaborative Board** - ongoing work noted; alignment with Trust recovery ambitions being progressed.
- **Activity Recovery Committee**: Forecasting methodology developing, triangulation of activity and finance improving, with full-year forecast due by end August. Early assurance gained from Portland mobilisation though further evidence required before extension.

System Improvement Plan
Trust elements progressing, with further work underway to separate completed from system-dependent actions.

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.

Terms of Reference (~~April~~ July 2025)
Finance and Performance Committee

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Finance and Performance Committee. The Committee is a Non-Executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Membership and Quorum

The Committee shall be appointed by the Board from the Non-Executive Directors (including the Associate Non-Executive Directors) and the Executive Directors of the Trust and shall consist of:

- Up to four Non-Executive members
- Chief Finance and Commercial Officer
- Chief Operating Officer

Non-Executive members may be drawn from the Non-Executive Director membership of the Board or the Associated Non-Executive Directors.

In exceptional circumstances a deputy may attend in place of an Executive Director. The nominated deputy can act on behalf of the absent Executive Director. This is to be noted at the beginning of the meeting.

The Board of Directors will appoint a Committee Chair from the Non-Executive members of the Committee In the absence of the appointed Chair, the Committee will appoint another Non-Executive member to chair the meeting.

A quorum will be two Non-Executive members and two Executive Directors. Deputies representing Executive members will count towards the quorum but at least one of the Executive members must be drawn from the listed membership.

3. Attendance

Other Executive Directors and Managing Directors will be required to attend when appropriate.

The Trust Secretary, Managing Director for Planning and Strategy, Performance Insight and Improvement Manager ~~and Operational Director of Finance~~ , Deputy Chief Finance Officer and Director of Estates and Facilities will attend each meeting.

An open invitation is extended to the Council of Governors, who are invited to attend as an observer only. The Governors will have the opportunity to feed back any comments under the Any Other Business agenda item.

The Chair of the Trust may attend at the invitation of the Chair of the Committee.

The Chief Executive Officer will receive a standing invitation to attend.

4. Frequency of Meetings and meeting administration

The Committee will meet at least ten times a year for regular business. The Chair of the Committee may call additional meetings when required.

When appropriate Committee meetings will take place virtually, in line with the virtual board good governance guidance.

The Chief Finance and Planning Officer shall agree the agenda with the Chair of the Committee. The Assistant Trust Secretary will organise the collation and distribution of the papers, record the proceedings of the Committee and keep a record of matters arising and issues to be carried forward.

5. Authority

The Committee is authorised by the Board to provide an objective view of the financial and performance position of the Trust and will act to oversee the delivery of achieving financial, activity and operational performance targets, making any decisions delegated to it and if appropriate, report and make recommendations to the Board, within its terms of reference.

The Committee is distinct and separate from the Audit and Risk Committee and will act to minimise any possible areas of overlap between these two Committees.

It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise if it considers this necessary.

6. Reporting

A written Chair's Assurance Report will be presented to the Board no later than the next public Board meeting (with verbal reports by exception to private Board meetings). The Chair's Report shall:

1. Alert the Board to any issues that:
   - 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.
1. Advise the Board of any areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives.
2. Assure the Board on other items considered where the Committee did not identify any issues that required escalation to the Board.

The Committee will undertake an Annual self-assessment, which will be presented to the Trust Board, along with an Annual Report.

7. Key Responsibilities

The Finance and Performance Committee supports and advises the Board on all aspects of the Trust's Annual and Long-Term Financial Plans and recommends adoption of the plans to the Board of Directors.

<u>Strategy</u>

- To consider and approve the key planning and financial assumptions to be used in the five-year strategy and annual operational plan.
- Oversight of strategic issues related to income e.g., changes to tariff, commissioning intentions, tendering for new services, risks from competition and market share.
- To consider recommendations of investment and disinvestment of Trust sub-specialty / service reviews ensuring strategic steer in keeping with the Trust strategy and objectives.
- Capital planning oversight, ensuring forward planning, regular review and recommendations including acquisitions and disposal of assets, in line with the Trust strategy and objectives.
- To consider, evaluate and if appropriate recommend for Board approval commercial developments and partnerships opportunities in keeping with the Trust strategy and objectives.
- To consider and recommend Board approval of material business cases as defined by the Trust SFI's (currently investments above c£250k)

- Consider post project evaluation reports on significant capital investments. This will include all schemes over £250k and other schemes which are considered to represent a significant risk to the Trust.

Oversight and Scrutiny

- Receive regular reports on financial performance including the overall financial performance against plan and associated risk rating, performance of Capital programme and the performance of activity against contract.
- To review corporate risks and Board Assurance Framework risks relevant to the committee's remit on behalf of the Board.
- To evaluate progress and recommend further actions from the review of in year financial, CIP, activity, RTT and productivity performance information, including SLR review.
- Review the Trust's investment register of cash investment as required.
- To evaluate progress of service transformation and investment plans, ensuring establishment of models of best practice in line with the Trust strategy.
- Promoting sustainability and receiving sustainability KPIs.
- To receive routine Chairs' Assurance Reports from meetings that report into the Committee, as appropriate.
- Receive relevant internal audit reports.
- To provide oversight in respect of all aspects of business planning, partnerships, and development.
- To provide oversight of the Trust annual plan and its subsequent delivery.
- To receive deep dives for scrutiny and further assurance into key performance areas. At the time of the meeting, the Committee will decide which deep dive will be presented at the following meeting.

Policies/Strategies

- The Committee shall ratify such policies as the Board has not reserved to itself and as required by the Trust's Policy Approval Framework.
- Review progress made in delivering key enabling strategies such as (but not limited to) Estates~~,~~ and Procurement raising any significant risks regarding their delivery to the Board.

July 2025 - Finance and Performance Committee
September 2025 – Board of Directors

Terms of Reference
Activity Recovery Committee (2025/6)

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Activity Recovery Committee (ARC). The Committee is a Non-Executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference. Due to the close links with the work of the Finance and Performance Committee, the ARC will operate as if a sub-group of the Finance and Performance Committee and will report into that Committee (rather than into the Board directly).

2. Membership and Quorum

The Committee shall be appointed by the Board from the Non-Executive Directors and Executive Directors of the Trust and shall consist of;

- Three Non-Executive Directors (including associates)
- Chief Executive Officer – invited to attend as required
- Chief Operating Officer
- Chief Nurse and Patient Safety Officer or Chief Medical Officer
- Chief Finance and Commercial Officer

In exceptional circumstances a deputy may attend in place of an Executive Director.

The Board of Directors will appoint a Committee Chair from the Non-Executive members of the Committee and a Non-Executive Director will be nominated to Chair meetings in the absence of the Chair.

A quorum will be two Non-Executive member and two Executive members.

3. Attendance

The Trust Secretary, Managing Director(s) and Head of Improvement and Business Insights will be expected to attend each meeting.

The Chair of the Board has open invitation to attend.

The Chief Operating Officer shall agree the agenda with the Chair of the Committee and other attendees. The Assistant Trust Secretary will organise the collation and distribution of the papers and keep a record of matters arising and issues to be carried forward.

4. Frequency of meetings

The Committee will meet monthly. The Committee will continue to meet until such time as the activity position has recovered sufficiently to return to routine assurance arrangements.

The Chair of the Committee may call additional meetings.

5. Authority

The Committee is authorised by the Board to investigate any activity and is expected to make recommendations within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise if it considers this necessary.

6. Reporting

A written Chair's Assurance Report will be presented to the Finance and Performance Committee no later than the next meeting (with verbal reports by exception). The Chair's Report shall:

1. Alert the Committee to any issues that:

- 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.

2. Advise the Finance and Performance Committee of any areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives.
3. Assure the Finance and Performance Committee on other items considered where the Committee did not identify any issues that required escalation to the Finance and Performance Committee.

The Board will receive assurance on matters relating to the remit of the ARC via the Chair's Assurance Report from the Finance and Performance Committee.

7. Key responsibilities

The purpose of the Activity Recovery Committee is to assist the Board in obtaining assurance that there are adequate plans in place to achieve the activity levels set out in the operational plan.* The Committee will do this by:

- Reviewing the development and progress of actions / initiatives to improve performance and drive delivery of the activity plan.
- Overseeing implementation of short, medium and longer-term plans to improve productivity and increase activity. This will include, but not be limited to, work focussing on:
  - Improving RTT performance;
  - Reducing the number of long waiters;
  - Managing demand;
  - Implementing GIRFT recommendations (as they relate to activity recovery);
  - Recruitment / workforce (as they relate to activity recovery).
- Considering "deep dives" for further assurance on issues relating to its remit, including progress in reducing waits for the very longest waiting patients.
- Receiving Assurance Reports from groups that support the work of the Committee, including those relating to:
  - Mutual aid arrangements
  - Waiting list management / initiatives
  - Theatre staffing / productivity
  - Insourcing arrangements
- Providing assurance to the Finance and Performance Committee / Board on matters relating to the Committee's remit, escalating any areas of concern.

* The Finance and Performance Committee will oversee overall delivery of the operational / activity plan. The ARC will oversee the implementation and delivery of actions / initiatives that support recovery and delivery of the plan. The Quality and Safety Committee will consider the impact of actions / initiatives / performance on quality, safety, and health inequalities.

ARC agreed in July 2025
FPC agreed in July 2025
Board of Directors – September 2025 (TBC)

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

Committee / Group / Meeting, Date

Board of Directors Meeting, 03 September 2025

Author: **Contributors:**

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Report sign-off:

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

Is the report suitable for publication:

Yes

1. Key issues and considerations:

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

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

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

2. Strategic objectives and associated risks:

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

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

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

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

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

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

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

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

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

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

Chair Report from Electronic Patient Record (EPR) Implementation Meeting

- Concerns remain around the responsiveness of the supplier (System C) to resolving issues in a timely manner.
- The current reliance on a single Clinical Safety Officer, coupled with limited dedicated clinical input to the optimisation programme, poses a risk to safe and effective delivery. Plans are in place to provide additional resilience.
- While governance structures are in place, there is evidence that awareness across the organisation is variable.
- The Committee has requested further assurance around clinical engagement, resilience around the Clinical Safety Officer role and data around supplier performance.

PACS/RIS Procurement Project

- Significant delays in the regional procurement have created risk to service continuity, given the expiry of existing contracts.
- The Trust is now progressing a local procurement approach, with clinical engagement prioritised to ensure system suitability.
- Implementation is unlikely before August 2026, with uncertainties around costings until options appraisal is complete.
- Without timely delivery, there is potential disruption to imaging services and patient pathways.
- The committee is supportive and understand the need to progress procurement outside of the Regional framework but are keen to see this as a joint procurement with SATH or any other Trust if at all possible and feasible.

3.2 Areas of on-going monitoring with new developments

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

Chair Report from Digital Transformation Programme Board

- Preparations for Windows 11 upgrade are progressing with contingency planning in place.
- Proposal for enhanced 24/7 on-call digital cover is being developed.
- Alignment with the NHS 10-Year Plan noted, with opportunities in digital patient portals and AI.

- Committee emphasised the importance of a clear staff training and engagement plan to accompany technical rollouts and to take learning as appropriate from the EPR implementation.

Cyber Security Report

- Development of a unified cyber strategy across system partners underway, with shared policies and products to strengthen resilience.
- Pilot of Microsoft 365 virtual desktops commenced; expected to deliver cost and efficiency benefits.
- Monitoring of unpatched devices continues, with mandatory retraining implemented for staff following security breaches.

Digital Strategy Progress Update

- Year-one delivery plan now defined, with projects linked to strategic objectives.
- Committee requested greater transparency in project prioritisation, particularly for safety-critical initiatives and those that would provide the greatest positive impact on Trust performance.

Digital Metrics for IPR

- The draft metrics are being developed (system uptime, service desk performance, transactional data).
- The Committee highlighted the need for further work to establish clear distinction between operational metrics and board-level strategic performance indicators that will be overseen by the committee.
- Inclusion of digital maturity, staff experience, and patient access indicators will strengthen assurance.

Innovation and Improvement Strategy

- The Committee approved the Strategy subject to Equality, Diversity and Inclusion (EDI) review and refinement of deliverables.
- Committee emphasised the need for clearer differentiation between "improvement" and "innovation," and stronger engagement of corporate teams.

Research Financial Pressures

- National reduction in commercial research activity continues to impact income was acknowledged.
- The department is pursuing mitigations but financial sustainability remains a concern.
- The Committee requested a further update at the next meeting.

Research Audit – Tissue Samples

- The audit confirmed that there were no breaches in relation to patient consent, but minor process deviations were identified in relation to staff roles.
- Duty of candour implications are currently under review.
- Processes are to be clarified and refined and the Committee requested the outcome is reported back to the meeting in due course.
- This item had been referred to DERIC by both the Quality and Safety Committee and the Council of Governors.

3.3 Areas of assurance

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

Apollo Update
No separate concerns to raise.

Education and Training Oversight
The Committee was assured by the routine reporting and there were no items of escalation noted.

Research Strategy Progress
The Committee were content that the Strategy was nearing completion with minor refinements underway to align with NHS Long-Term Plan.

Quality Improvement Audits
The Committee commended the evidence of measurable improvements across multiple areas within the organisation including clinical observations recording, pressure ulcer prevention, and post-operative blood testing. The Committee noted these as strong examples of clinical audit driving practice change.

Recommendation

The Board is asked to:

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Audit and Risk Committee

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 03 September

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

Report sign-off:

Martin Newsholme, Chair of the Audit and Risk Committee

Is the report suitable for publication:

Yes

1. Key issues and considerations:

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

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

This report provides a summary of the items considered at the Committee meeting held on 15 July 2025. It highlights the key areas the Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

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

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

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

3. Assurance Report from Activity Recovery Committee

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

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

Committee Annual Report

The Committee completed the annual report and the terms of reference have been updated. There were no areas of concerns to raise to the Board as the Committee is operating effectively. The Board is asked to formally review and approve the Terms of Reference.

Chair Report from the Information Governance Meeting: DSPT Compliance

- The Trust's self-assessment against the 2025 Data Security and Protection Toolkit (DSPT) indicates two areas of non-compliance.
- In addition, MIAA has challenged the Trust's evidence in a further two areas judged compliant by management, requiring supplementary assurance.
- Discussions with NHSE are ongoing to resolve a definitional dispute regarding "critical systems", which materially affects compliance ratings.
- An improvement plan for non-compliant areas is required by the end of the month, and subject to NHSE review, ratings may be adjusted to "Approaching Standards".
- Risks remain heightened by the absence of a dedicated Records Manager, with recruitment constrained by system-wide freezes.
- Collaborative solutions are being pursued with partners but a sustainable resolution has yet to be secured.

Finance Governance: Aged Debt and ICB Payments

- The Trust is carrying £1.4m of aged debt, including £0.4m from Veterans' non-contract invoices and multiple unpaid ICB invoices.
- While progress has been made, the Committee concluded that this matter cannot be resolved solely within Audit & Risk and requires escalation to the Finance and Performance Committee.

3.2 Areas of on-going monitoring with new developments

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

System Integrated Improvement Plan (SIIP)

- RJAH has progressed all elements within its control; however, delivery remains hampered by unresolved system-level dependencies.
- The Trust is awaiting further information on the NHS Oversight Framework (2025/26). The Trust will continue to collaborate where relevant, but progress is contingent on factors outside its direct control.

Risk Management: Waiting Times

- Long-waiting patient risks are under review, with concerns raised regarding potential impacts on safety, equity and reputation.
- The Committee sought assurance that Equality Impact Assessments (EQIAs) are consistently completed, visible to the Board, and embedded into recovery decision-making.

Chair's Assurance Report
Audit and Risk Committee

Policy Governance
Whilst revised templates, central tracking and a more disciplined process are now in place, the Committee remains concerned about lack of consistency with timely review and renewal.

3.3 Areas of assurance

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

Counter Fraud (MIAA)
The Trust achieved a 'green' rating across all 12 standards in the Counter Fraud Return, submitted on time. Preparations are underway for new "failure to prevent fraud" legislation (effective September), including a gap analysis, awareness raising, and strengthened supplier standards

Internal Audit Annual Review (MIAA)
The Committee expressed satisfaction with MIAA's performance. Despite some delays, the 2025/26 programme is progressing, and follow-up recommendations are being closed in a timely manner. A more targeted approach to post-audit feedback will improve engagement.

Finance Governance
Beyond the aged debt issues flagged above, the Committee took assurance from:

- A healthy cash balance of £19.8m, £2m above plan.
- High compliance (96%) with "No Purchase Order, No Payment" policy.
- Low levels of theatre wastage, demonstrating effective operational control.

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

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.

Committee Annual Review

Committee / Group / Meeting, Date

Board of Directors, 03 September 2025

Author: Contributors:

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Report sign-off:

Name: Dylan Murphy, Trust Secretary
Audit and Risk Committee, 15 July 2025

Is the report suitable for publication?:

YES

Key issues and considerations:

The Committees of the Board have been established in accordance with the Trust's constitution and each committee is required to produce a self-assessment and annual report. Elements considered at the Audit and Risk Committee meeting in May 2025 included:

- The membership, attendance, role and responsibilities of the Committee as set out in the TOR;
- The meetings held during the year and the attendance at those meetings;
- A review of the business considered during the year;
- Options for conducting a self-assessment; and
- The Terms of reference.

Following the May meeting:

- The Chair considered the Health Care Financial Management Association (HFMA) Self-Assessment checklist. The completed assessment is included at Appendix A.
- An HFMA committee members' survey was circulated to (non-executive) members of the Committee. A blank copy of the survey is included at Appendix B.

Strategic objectives and associated risks:

The work of the Committee supports delivery of all of the Trust's strategic objectives:

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

The work of the Committee is relevant to all of the Board Assurance Framework (BAF) themes and associated strategic risks:

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

System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system. The work of the Committee is relevant to all of these:

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

Recommendations:

That the Board:

1. CONSIDER and ENDORSE the HFMA self-assessment outcome (or propose any revisions, if appropriate);
2. CONSIDER the draft Terms of Reference for 2025/26 and AGREE any revisions which have been recommended by the Audit and Risk Committee.

Report development and engagement history:

This report has been produced using the content of existing documentation.

Next steps:

The HFMA survey has been re-circulated to committee members for completion in advance of the next regular meeting of the Committee.

The Terms of Reference is presented to the Board for consideration and approval.

Appendices

Appendix A HFMA Committee Self-Assessment – checklist completed by the Committee Chair

Appendix B HFMA Committee members' survey – circulated to Committee members.

Appendix C Audit and Risk Committee Terms of Reference

HFMA *NHS audit committee handbook*

Appendix B: Self-assessment checklists

There are a number of sources for audit committees to assess their own effectiveness, although where they have been developed for central government, non-NHS public sector bodies and the third sector, or the private sector, they should be used carefully.

Most of the large accountancy practices will have their own checklists, while many organisations may have their own templates for assessing the effectiveness of their board and sub-committees, using a standard template.

The National Audit Office checklist covers both the basic requirements of an audit and risk assurance committee, in line with HM Treasury guidance, but also aspects of good practice.Error! Bookmark not defined.

The checklists offered below are designed to be specific to NHS bodies (both trusts and ICBs), although they will still require some tailoring, depending on how the organisation has decided to set up its audit committee (for instance, how much of a 'risk assurance' role it has taken with regard to other board sub-committees.)

Processes checklist

This checklist can be completed by the secretary to the committee, along with the chair of the committee, and the results shared with the whole committee. The value of this checklist is that it should be a simple (yes /no) check against the standard requirement. Where the answer is 'no' then the committee should consider whether it should comply (or explain why not).

Area/ Question	Yes	No	Comments/Action
1.0 Composition, establishment and duties			
1.1 Does the audit committee have written terms of reference and have they been approved by the governing body?	✓		YES. The TOR are reviewed annually by the Committee and are then presented to the Board of Directors for approval.
1.2 Are the terms of reference reviewed annually?	✓		YES. The TOR are reviewed annually by the Committee and are then presented to the Board of Directors for approval.
1.3 Has the committee formally considered how it integrates with other committees that are reviewing risk?	✓		YES. The committee considers the arrangements in place to manage risk while other Board sub-committees consider particular risks relevant to their remit.

Area/ Question	Yes	No	Comments/Action
1.4 Are committee members independent of the management team?	✓		YES. Committee membership consists of Non-executive Directors of the Board.
1.5 Does at least one committee member have a financial background?	✓		YES. The Chair has appropriate experience to serve as Chair of an Audit Committee.
1.6 Are all executive officers that you would expect to attend present at meetings?	✓		YES.
1.7 Are the outcomes of each meeting and any internal control issues reported to the next governing body meeting?	✓		YES. A Chair's Assurance Report is produced after each committee meeting. This report is produced in a "Triple A" format to identify areas the committee wishes to "Alert", "Advise" and "Assure". This is presented to the Boad of Directors and the Council of Governors.
1.8 Does the committee prepare an annual report on its work and performance for the governing body?	✓		YES. This self-assessment exercise forms part of that annual report.
1.9 Has the committee established a plan of matters to be dealt with across the year?	✓		YES. The Committee agrees a workplan at the start of the year which it keeps under review, to help manage its business.
1.10 Are committee papers distributed in sufficient time for members to give them due consideration?	✓		YES, ordinarily. If there are occasions when that is not the case, items will be deferred,
1.11 Has the committee been quorate for each meeting this year?	✓		YES.

Area/ Question	Yes	No	Comments/Action
1.12 Is there a succession plan in place for the chair of the audit committee?			The Chair of the Committee has been appointed for a second 3 year term to May 28.
1.13 Are there clear arrangements in place in terms of how the committee works within the integrated care system?		✓	System-wide arrangements are not well-developed. There is no defined reporting route from the committee into any system-wider structures.
2.0 Internal control and risk management			
2.1 Has the committee reviewed the effectiveness of the organisation's risk management framework?	✓		YES. There are regular reports on risk management arrangements. Internal audit conducts an annual review of the assurance framework and risk management core controls.
2.2 Has the committee reviewed the effectiveness of the organisation's assurance framework?	✓		YES. There are regular reports on the operation of the BAF. Internal audit conducts an annual review of the assurance framework and risk management core controls.
2.3 Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements - for example, as set by the Care Quality Commission?	✓		Internal Audit conducted a review of arrangements for oversight and assurance regarding regulatory compliance during the final quarter of 2024/5. The Trust's Regulatory Oversight Meeting routinely reports into the Quality and Safety Committee.
2.4 Has the committee reviewed the accuracy of the draft annual governance statement?	✓		YES. The Committee reviews the draft Annual Governance Statement.
2.5 Has the committee reviewed key data against the data quality dimensions?	✓		Data quality is reported via assurance reports from the Trust's Information Governance Meeting (which reports into the Committee).

Area/ Question	Yes	No	Comments/Action
3.0 Annual report and accounts and disclosure statements			
3.1 Does the committee receive and review a draft of the organisation's annual report and accounts?	✓		YES. The Committee reviews the draft Annual Report and Accounts.
3.2 Does the committee specifically review: • changes in accounting policies • changes in accounting practice due to changes in accounting standards • changes in estimation techniques • significant judgements made in preparing the accounts • the going concern assessment • significant adjustments resulting from the audit • explanations for any significant variances?	✓		YES. These are reported when the accounts are presented to the Committee.
3.3 Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?	✓		The draft accounts are presented to the Committee for consideration, as is the draft Annual Report. The "final" Annual Report and accounts are also presented for consideration / recommendation to the Board (highlighting any changes since consideration of the draft versions).
3.4 Does the committee ensure that it receives explanations for any unadjusted errors in the accounts found by the external auditors?	✓		YES. These are reported when the accounts are presented to the Committee.
4.0 Internal audit			
4.1 Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?	✓		YES. The Committee considers the internal audit charter at the start of the year.

Area/ Question	Yes	No	Comments/Action
4.2 Does the committee review and approve the internal audit plan, and any changes to the plan?	✓		YES. The Committee reviews and approves the annual audit plan.
4.3 Is the committee confident that the audit plan is derived from a clear risk assessment process?	✓		YES. The audit plan is developed with reference to the Board Assurance Framework and associated strategic risks. There is flexibility in the plan to respond to emerging risks.
4.4 Does the committee receive periodic progress reports from the head of internal audit?	✓		YES. Each meeting includes a progress report from internal audit.
4.5 Does the committee effectively monitor the implementation of management actions arising from internal audit reports?	✓		YES. Each meeting includes an action completion follow-up report from internal audit
4.6 Does the head of internal audit have a right of access to the committee and its chair at any time?	✓		YES.
4.7 Does the committee hold periodic private discussions with the internal auditors?	✓		YES.
4.8 Does the committee assess the performance of internal audit?	✓		YES. There is an annual review of the performance of internal audit.
4.9 Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?	✓		YES. That is considered within the internal audit charter report each year.
4.10 Has the committee evaluated whether internal audit complies with the *Public sector internal audit standards*?	✓		YES. That is considered within the internal audit charter report each year.
4.11 Does the committee receive and review the head of internal audit's annual opinion?	✓		YES.

5.0 External audit			
5.1 Are appropriate external audit procurement arrangements in place?	✓		YES. The Trust has appointed an external auditor.
5.2 Do the external auditors present their audit plan to the committee for agreement and approval?	✓		YES.
5.3 Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?	✓		YES. The Committee reviews this before making a recommendation to the Board on approval of the Annual Report and Accounts.
5.4 Does the committee review the external auditor's value for money conclusion?	✓		YES. The Committee reviews this before making a recommendation to the Board on approval of the Annual Report and Accounts.
5.5 Does the external audit representative have a right of access to the committee and its chair at any time?	✓		YES.
5.6 Does the committee hold periodic private discussions with the external auditors?	✓		YES. The Committee meets in private with the external auditors annually as deemed necessary. The Chair of the Committee has periodic conversations with the lead auditor to discuss any significant matters arising.
5.7 Does the committee assess the performance of external audit?	✓		YES. There is an annual review of the performance of external audit.
5.8 Does the committee require assurance from external audit about its policies for ensuring independence?	✓		YES. The External Auditors set out their independence procedures in their audit planning document which is submitted to the Committee.
5.9 Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?	✓		YES. That Policy was last reviewed and approved in July 2023.

6.0 Clinical audit [Note: this section is only relevant for providers]			
6.1 If the committee is not responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant committee?			Clinical audit reports into the Quality and Safety Committee and upwards to the Board. An annual report on the governance arrangements around clinical audit will be added to the Committee work plan.
7.0 Counter fraud			
7.1 Does the committee review and approve the counter fraud work plans and any changes to the plans?	✓		YES. The Committee reviews and approves the annual counter-fraud plan.
7.2 Is the committee satisfied that the work plan is derived from an appropriate risk assessment and that coverage is adequate?	✓		YES. The plan is informed by a risk assessment conducted in line with Government Counter Fraud Profession's (GCFP) methodology.
7.3 Does the audit committee receive periodic reports about counter fraud activity?	✓		YES. Each meeting includes a progress report from the counter-fraud specialist.
7.4 Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?	✓		YES. The Committee receives regular reports from the counter-fraud specialist.
7.5 Do those working on counter fraud activity have a right of direct access to the committee and its chair?	✓		YES.
7.6 Does the committee receive and review an annual report on counter fraud activity?	✓		YES.
7.7 Does the committee receive and discuss reports arising from quality inspections by NHSCFA?	✓		YES. The Committee receives regular reports from the counter-fraud specialist.

Effectiveness checklist

This checklist should be completed by all members and regular attenders of the committee, with an encouragement for them to use the comments column for suggestions for improvement. The secretary and chair should review the results and, with the committee members, agree an action plan for improvement.

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to Answer	Comments/ Action
Theme 1 – committee focus						
1.1 The committee has set itself a series of objectives for the year.						
1.2 The committee has made a conscious decision about the information it would like to receive.						
1.3 Committee members contribute regularly to the issues discussed.						
1.4 The committee is aware of the key sources of assurance and who provides them.						
1.5 The committee receives assurances from third parties who deliver key functions to the organisation - for example, NHS Shared Business Services or private contractors.						

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to Answer	Comments/ Action
1.6 Equal prominence is given to both quality and financial assurance.						
Theme 2 – committee team working						
2.1 The committee has the right balance of experience, knowledge and skills to fulfill its role.						
2.2 The committee has structured its agenda to cover quality, data quality, performance targets and financial control.						
2.3 The committee ensures that the relevant executive director attends meetings to enable it to understand the reports and information it receives.						
2.4 Management fully briefs the committee on key risks and any gaps in control.						
2.5 Other committees provide timely and clear information in support of the audit committee.						
2.6 The committee environment enables people to express their views, doubts and opinions.						

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to Answer	Comments/ Action
2.7 Committee members understand the messages being given by external audit, internal audit and counter fraud specialists.						
2.8 Internal audit contributes to the debate across the range of the agenda.						
2.9 Members hold their assurance providers to account for late or missing assurances.						
2.10 Decisions and actions are implemented in line with the timescale set down.						
Theme 3 – committee impact						
3.1 The quality of committee papers received allows committee members to perform their roles effectively.						
3.2 Members provide real and genuine challenge – they do not just seek clarification and/ or reassurance.						
3.3 Debate is allowed to flow, and conclusions reached without being cut short or stifled.						

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to Answer	Comments/ Action
3.4 Each agenda item is 'closed off' appropriately so that the committee is clear on the conclusion; who is doing what, when and how, and how it is being monitored.						
3.5 At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well, not so well and so on.						
3.6 The committee provides a written summary report of its meetings to the governing body.						
3.7 The governing body challenges and understands the reporting from this committee.						
3.8 There is a formal appraisal of the committee's effectiveness each year.						
Theme 4 – committee engagement						
4.1 The committee challenges management and other assurance providers to gain a clear understanding of their findings.						

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to Answer	Comments/ Action
4.2 The committee is clear about its role in relationship to other committees that play a role in relation to clinical governance, quality and risk management.						
4.3 The committee receives clear and timely reports from other governing body committees which set out the assurances they have received and their impact (either positive or not) on the organisation's assurance framework.						
4.4 We can provide two examples of where we as a committee have focused on improvements to the system of internal control as a result of assurance gaps identified.						
Theme 5 – committee leadership						
5.1 The committee chair has a positive impact on the performance of the committee.						
5.2 Committee meetings are chaired effectively.						

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to Answer	Comments/ Action
5.3 The committee chair is visible within the organisation and is considered approachable.						
5.4 The committee chair allows debate to flow freely and does not assert his/ her own views too strongly.						
5.5 The committee chair provides clear and concise information to the governing body on committee activities and gaps in control.						

Audit and Risk Committee - Terms of Reference (~~October 2024~~ May 2025)

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Audit and Risk Committee. The Committee is a Non-Executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Membership and Quorum

The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of no less than three members. At least one of the members should have recent relevant financial experience. A quorum shall be two members. The Board will appoint a Committee Chair and Deputy Chair from the Committee members.

3. Attendance

The Chief Finance and ~~Planning~~ Commercial Officer, Trust Secretary and Head of Financial Accounting, as well as appropriate Internal and External audit representatives will be expected to attend the meeting.

The counter fraud specialist or representative will attend a minimum of two committee meetings a year.

The Chief Executive Officer should be invited to attend meetings that should discuss at least annually with the Audit and Risk Committee the process for assurance that supports the governance statement. The Chief Executive Officer should also attend when the Committee considers the draft annual governance statement, annual report, and annual accounts.

Other Executive Directors may be invited to attend, particularly when the Committee is discussing areas of risk or operations that are the responsibility of that director.

Representatives from other organisations and other individuals may be invited to attend on occasion.

~~The Trust Secretary~~ A member of the Directors Admin Function shall be the secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

At least once a year the Committee will meet privately with the Internal and External Auditors.

4. Access

The head of internal audit, representative of external audit and counter fraud specialist have a right of direct access to the Chair of the Committee.

5. Frequency

The Committee must consider the frequency and timing of the meeting needed to allow it to discharge all its responsibilities. A benchmark of five meetings per annum at the appropriate times for the reporting and audit cycle is suggested. The Trust, Chief Executive Officer, external auditors to head of internal audit may request an additional meeting if they consider it to be necessary.

6. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7. Responsibilities

The Committee's duties/responsibilities can be categorised as follows:

Integrated governance, risk management and internal control
The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisations (clinical and non-clinical) that supports the achievement the organisations objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- All control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission (CQC) regulations), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
- The Trust's polices, processes and procedures to manage organisational risk and the internal control framework, including the design, implementation and effectiveness of those systems. That shall include the processes and procedures to develop, review and scrutinise the strategic risks presented in the Board Assurance Framework and the significant operational risks presented in the Trust's corporate risk register.
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives and the appropriateness of the above disclosure statements.
- The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.
- The policies and procedures for all work related to fraud and corruption as required by NHS Protect and best practice.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key Committees so that it understands processes and linkages. However, these other Committee must not usurp the Committee's role.

Internal Audit
The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2017 and provide appropriate independent assurance to the Committee, Chief Executive Officer, and the Board of Directors. This will be achieved by:

- Considering the provision of the internal audit service and costs involved.
- Reviewing and approve the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the assurance framework.
- Considering the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise the use of audit resources.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust.
- Monitoring the effectiveness of Internal Audit and carrying out an annual review.

External Audit
The Committee shall review and monitor the external audits' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment of the external audit service, the audit fee and any questions of resignation and dismissal, in accordance with the procedures governing NHS Foundation Trusts as appropriate

- Discussing and agreeing with the External Auditor, before the audit commences, the nature and scope of the audit as set out in the annual plan.
- Discussing with the External Auditors their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Reviewing all External Audit reports, including the report to those charges with governance and any work undertaken outside the annual audit plan, together with appropriateness of management responses.
- Ensuring that there is in place a clear policy for engagement of external auditors to supply non-audit services.
- Monitoring the effectiveness of External Audit and carrying out an annual review.

Other assurance functions
The Committee shall review the findings of other assurance function, both internal and external to the organisation, and consider the implications for the governance of the organisation.

In addition, the Committee will review the work for other Committees within the organisations, whose work can provide relevant assurance to the audit's committees own areas of responsibility. This will include any clinical governance, risk management or quality committees that are established.

In reviewing the work of a clinical governance committee, and issues around clinical risk management, the audit committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

Counter Fraud Service
The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcome of work in these areas.

With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

The Committee will refer any suspicion of fraud, bribery, and corruption to the NHSCFA.

Management
The Committee shall request and review, as appropriate, reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control. That shall include reports on the risk profile of the Trust and the operation of the Trust's processes for monitoring and managing risk, including staff training on risk management.

They may also request specific reports from individual functions within the Trust (e.g., clinical audit) as they may be appropriate to the overall arrangements.

The Committee will receive regular reports on the development and maintenance of the Board Assurance Framework. The Committee will consider the review process to provide assurance on the adequacy of that process to the Board of Directors.

Financial Reporting
The Committee will monitor the integrity of the financial statements of the origination and any formal announcements relating to its financial performance.

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

The Committee shall review the annual report and before submission to the Board, focusing particularly on:
- The wording in the annual governance statement and other disclosures relevant to the relevant to the terms of reference of the Committee
- Changes in, and compliance with, accounting policies, practices, and estimation techniques
- Unadjusted misstatements in financial statements

- Significant judgments in preparation of the financial statement
- Significant adjustment resulting from the audit
- Letters of representation
- Explanation for significant variances

8. Reporting

The Committee shall report to the Board of Directors on how it discharges its responsibilities.

A Chairs Assurance Report of the main issues of the discussion, drawing attention to any issues that require full Board or Executive action, will be presented at the next Board of Directors meeting. In addition to this the approved minutes of the meeting will also be submitted to the private session of the Board. This is in line with the committee reporting process agreed by the Board.

The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness and embeddedness of risk management in the Trust
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning meeting
- The robustness of the processes behind the quality accounts

The annual report should also describe how the Committee has fulfilled its terms of reference and give details on any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

9. Administrative Support

The Committee shall be supported administratively by its secretary (the Assistant Trust Secretary) – duties will include:

- Agreement of agendas with the Chair and attendees
- Preparation, collation and circulation of the papers in good time
- Ensuring that those included to each meeting attend
- Taking the minutes and helping the chair to prepare reports to the Board
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the chair – for example, with the internal/external auditors or LCFS
- Maintaining records of member's appointments and renewal dates
- Advising the Committee on pertinent issues/areas of interest/policy development
- Ensuring the action points are taken forward between meetings
- Ensuring the Committee members received the development and training requited

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