

Infection Prevention & Control and Cleanliness Annual Report 2024/25

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 02 July 2025

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Report sign-off:

Samantha Young, Interim Chief Nurse and Director of IPC
Quality and Safety Committee, 19 June 2025

Is the report suitable for publication:

YES

Key issues and considerations:

The IPC Annual Report demonstrates the activities of RJAHS relating to infection prevention and control from April 2024 to March 2025, including progress made against the work plan and targets identified in the Infection Prevention and Control Annual Programme. It also includes performance against key areas in Infection Prevention and Control. Ward specific audits are reported monthly through Trust wide Key Performance Indicators (KPIs).

Strategic objectives and associated risks:

The report fulfils its statutory requirements under the Health and Social Care Act 2008: Code of Practice on the prevention and control of infection and related guidance, which sets out ten criteria of which a registered provider must be compliant. The prevention and management of infection is the responsibility of all staff working within RJAHS and is integral to patient safety. The Infection Prevention and Control Team maintains organisational focus and works collaboratively to deliver the IPC strategy to ensure continued compliance with IPC practices.

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

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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	✓

	What providers will need to show evidence of
Criterion 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
Criterion 3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
Criterion 4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion
Criterion 5	Ensure that people who have or at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.
Criterion 6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
Criterion 7	Provide or secure adequate isolation facilities.
Criterion 8	Secure adequate access to laboratory support as appropriate
Criterion 9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
Criterion 10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Recommendations:

The Board is asked to review the report and approve as an accurate record of IPC services for 2024-2025 ready for publication on RJAH external internet site.

Report development and engagement history:

This report is produced annually and offers an overview of compliance and quality specific to The Health and Social Care Act 2008: Code of Practice on the prevention and control of infection.

Infection Prevention & Control and Cleanliness Report 2024/25

Forward by the Director of Infection Prevention and Control



As the Interim Chief Nurse and Director of Infection Prevention and Control (DIPC), it gives me great pleasure to introduce the Trust’s Infection Prevention and Control annual report for the year 2024/25. It describes the achievements of the Trust under the specialist advice, guidance and support of our Infection Prevention and Control (IPC) Team.

This year, we have focussed on embedding solid foundations of IPC practice across the Trust, with a particular focus on the prevention of healthcare associated infections. The report includes highlights of how the IPC Team have delivered on the IPC Strategy and how all staff across the Trust are engaged in effective IPC practices, ensuring we continue to provide safe, effective, and caring services.

They have increased clinical capacity within the team to improve visibility to advise, guide and educate staff, patients, and visitors in all IPC matters. In addition, they have developed new systems and revised our policies to align with the NHS Patient Safety Strategy and National Infection Prevention and Control Manual. This includes how the Trust investigates infection events and monitors Surgical Site Infections, sharing improvements and learning with colleagues, not only locally, but across the Country with the Royal Orthopaedic Hospital in Birmingham.

Auditing is an important practice to monitor compliance with standards and legislation. We updated our audit suite last year and have continued to make improvements with feedback from our teams to make it easier for them to demonstrate high standards of IPC practice, as well as the cleanliness of our facilities and improvements to our estate.

This report demonstrates that infection prevention and control is taken very seriously here at the Trust, and we are committed to providing excellent and innovative care in a safe and clean environment.

Sam Young

Interim Chief Nurse, Director of Infection Prevention & Control

Glossary of terms

Bacteraemia	The presence of bacteria in the blood without clinical signs or symptoms of infection
CDI	Clostridioides difficile infection. It is a bacterium found in the intestines of around 1 in 30 adults, and usually causes no harm. An overgrowth of this bacteria can produce toxins which cause inflammation and can be difficult to treat.
E. coli	Escherichia Coli is a bacterium found in the intestines. It can cause infections and can prove difficult to treat.
HAI	Healthcare Associated Infection. An infection either as a direct result of healthcare intervention such as medical or surgical treatment, or from being in contact with a healthcare setting.
MRSA	Methicillin Resistant Staphylococcus Aureus is a highly resistant strain of the common bacteria
MSSA	Methicillin Sensitive Staphylococcus Aureus is the more common sensitive strain of Staphylococcus Aureus.

Acronyms

AE (D)	Authorised Engineer (D)
AMS	Antimicrobial Stewardship
ANTT	Aseptic Non-Touch Technique
CAUTI	Catheter-Associated Urinary Tract Infection
CQC	Care Quality Commission
DIPC	Director of Infection Prevention & Control
E. coli	Escherichia coli
Gram -ve BSIPWG	Gram Negative Bloodstream Infection Prevention Working Group
HAI	Healthcare Associated Infection
HPV	Hydrogen Peroxide Vapour
HTM	Health Technical Memorandum
IPC	Infection Prevention & Control
IPCM	Infection Prevention & Control Meeting
IPCT	Infection Prevention & Control Team
ICD	Infection Control Doctor
ICS	Integrated Care System
KPIs	Key Performance Indicators
MDT	Multi-Disciplinary Team
MHRA	Medicines and Healthcare products Regulatory Agency
PIR	Post Infection Review
PLACE	Patient Led Assessment of the Care Environment
SATH	Shrewsbury and Telford Hospitals
SSI	Surgical Site Surveillance
SNAHP	Senior Nurse and Allied Health Professionals
SOP	Standard Operating Procedure
STW	Shropshire, Telford and Wrekin
TSSU	Theatre Sterile Services Unit

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UKHSA	UK Health Security Agency
WTE	Whole Time Equivalent

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Introduction

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) is a specialist orthopaedic centre. We provide specialist and routine orthopaedic care to our local catchment area, as well as specialist services both regionally and nationally.

Our organisation is a single site hospital based in Oswestry, Shropshire, close to the border with Wales. We serve the people of England and Wales, as well as acting as a national healthcare provider. We also host some local services which support the communities in and around Oswestry. The hospital is a specialist centre for the treatment of spinal injuries and disorders and provides specialist treatment for children with musculoskeletal disorders. Additionally, the Trust works with partner organisations to provide specialist treatment for bone tumours and community-based rheumatology services.

The Trust is part of the National Orthopaedic Alliance (NOA), an acute care collaboration vanguard designed to improve orthopaedic care quality across England.

We are proud to be a Veteran Aware hospital aiming to provide the best care for veterans in the NHS.

Veteran Aware hospitals are leading the way in improving veterans' care within the NHS.

We are part of the Veterans Covenant Hospital Alliance (VCHA) which means we share and drive best practice in NHS care for people who serve or have served in the UK Armed Forces in line with the Armed Forces Covenant.

We support the health commitments of the Armed Forces Covenant and are committed to ensuring no disadvantage and giving special consideration where appropriate.

As a member of Shropshire, Telford and Wrekin Integrated Care System, we strive to deliver world class care by working in partnership to continuously improve and meet the needs of those we serve.

Health and Social Care Act 2008: code of practice on the prevention and control of infections

The Health and Social Care Act (revised 2022), sets out the code of practice on the prevention and control of infections and applies to registered providers of all health and adult social care in England. This act sets out the overall framework for the regulation of health and adult social care activities by the Care Quality Commission (CQC).

	What providers will need to show evidence of
Criterion 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
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Criterion 9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
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Key Achievements 2024/25

- We are delighted that the Trust has maintained under the national thresholds set by NHS England for healthcare associated infections this year. This is a big improvement from last year and shows the increased engagement and ownership of IPC practice across all staff groups.
- NHS England have stood down routine monitoring at the Trust, because of positive improvements and the sustained change observed throughout the organisation. A follow up visit to the Therapies department in March was an opportunity for the teams to showcase the extensive improvements made to the department, which showed that previous issues had been addressed. This could not have been achieved without the engagement and ownership of the Therapies teams. We would like to extend our thanks to the Therapies Leads, who were instrumental in ensuring prompt completion of actions and for sharing their improvement journey at a The Allied Healthcare Professional celebration event.
- This year we saw changes in the structure of the IPC team, which have enabled us to extend the clinical capacity within the team. This means that we have been able to adopt a more proactive approach to IPC across the Trust and that staff have more access to advice and support. The new structure also includes the addition of the Tissue Viability service, which has enabled a more collaborative approach to prevention of surgical site infections.
- We have led on a working group to agree actions to prevent the occurrence of bloodstream infections in our patients. This collaboration between other wards has improved the quality of care around urinary catheterisation.
- The IPC Team have worked hard to revise all IPC related policies to ensure that are aligned with national IPC guidance, providing a standardised approach to IPC across the Trust.
- Our continued collaboration through the IPC and Cleanliness Working Group has been the driving force behind improvements to the estate, including works to walls, floors, bathrooms, and the refurbishment of the Therapies department. This work means that it is now easier to keep areas clean and has also had a positive impact on patient experience.
- In May, the IPC Team hosted the annual IPC Fayre which was well attended by staff across the Trust. Continued collaboration with the Estates & Facilities teams enabled a combined approach to infection prevention and control, which included practical demonstrations on how to perform effective cleaning of patient equipment, IPC games, and a fun interactive education session in our simulation lab which was supported by our Training Team.



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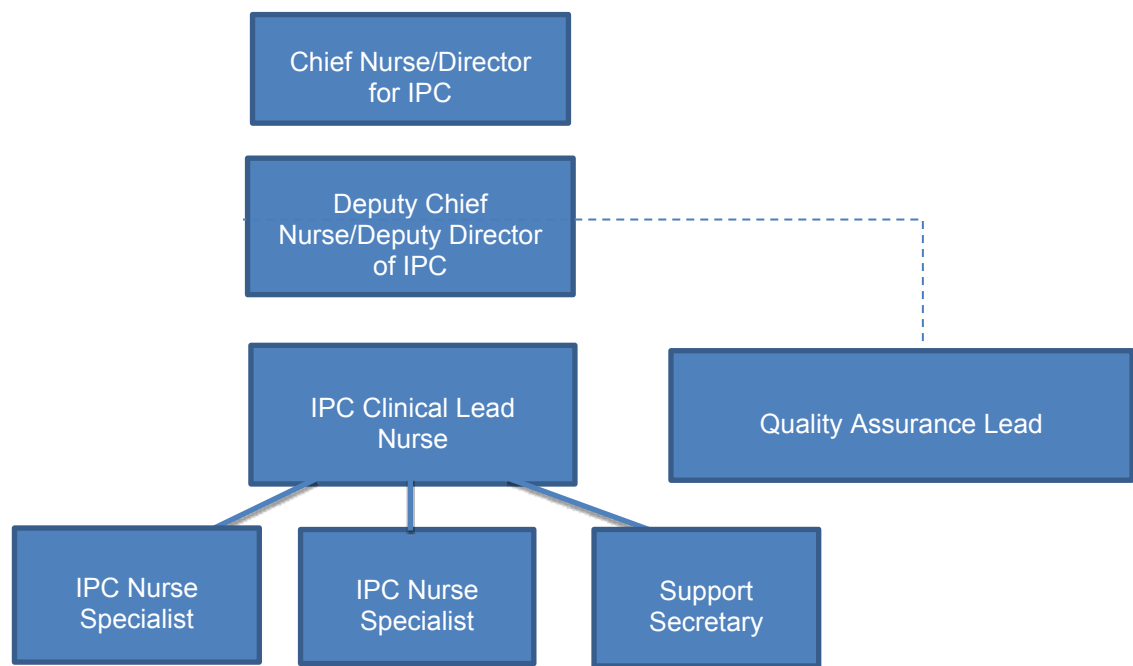
- In September, the IPC Team took part in the World Patient Safety Day. This was an opportunity to raise awareness to staff about the work being undertaken by the Gram -ve Bloodstream Infection Prevention Group. Sr Genevieve created an information board to show staff the importance of practising standard IPC precautions to prevention infections related to invasive devices.



IPC Nurse Specialist Genevieve Chavez

Criterion 1: Systems to manage and monitor the prevention and control of infection.

Team Structure



The **Chief Executive Officer** has overall responsibility to ensure that systems and resources are available to implement and monitor compliance with infection prevention and control at RJAH.

The **Director of Infection Prevention & Control (DIPC)** is the Executive Lead for IPC and oversees the implementation of the IPC programme of work through their role as Chair of the Trust Infection Prevention and Control and Cleanliness Meeting (IPCCM). The DIPC delegates the responsibility and management of IPC for the Trust to the Deputy Director for Infection Prevention and Control (DDIPC). The DDIPC reports directly to the DIPC and on to the Chief Executive and the Board on all IPC matters.

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The Trust employs an Infection Control Doctor who is employed by SaTH and has a contract to deliver services for RJAH in the in and out of hours period. This includes clinical microbiology advice and reporting, virtual, microbiology ward rounds, antimicrobial stewardship and infection prevention and control advice.

The ICD:

- Advises and supports the DIPC
- Oversees local IPC policies and their implementation by ensuring that adequate laboratory support is in place
- Attends the Water Safety Group and Decontamination Group
- Provides expert clinical advice on infection management
- Attends Infection MDT meetings and provides expert advice on complex/infected cases
- Has the authority to challenge clinical practice including inappropriate antibiotic prescribing

The Infection Prevention and Control Team (IPCT)

The Infection Prevention and Control Team (IPCT) are the medical and nursing infection prevention and control specialists responsible for providing a proactive IPC service to the Trust aligned to the National Infection Prevention and Control Manual, the IPC Strategy, and their programme of works.

RJAH Orthopaedic Hospital NHS Foundation Trust (RJAH) IPCT currently consists of:

- Deputy Director of IPC (1.0 WTE)
- Infection Prevention and Control Lead Nurse: Band 7 (1 WTE)
- Infection Prevention & Control Nurse Specialist: Band 6 (2.0 WTE)
- IPC Administrator/Support Secretary Band 2 (1.0 WTE)

The Antimicrobial Pharmacist

The Trust has a designated Antimicrobial Pharmacist. They work with the ICD and other members of the IPC team. The role of the antimicrobial pharmacist includes:

- Supporting antimicrobial stewardship initiatives
- Lead for the Trust antimicrobial CQUINs
- Maintaining a programme of audits in line with national guidance

Infection Prevention Control & Cleanliness Meeting

The RJAH Infection Prevention & Control Meeting (IPCCM) is a multidisciplinary Trust Meeting with stakeholder representation from UKHSA and the ICB. The IPCCM oversees the activity of the IPCT and observes the implementation of the infection control programme of work.

The IPC Programme of Work/Workplan

The IPC Programme of Work 2024-25 was designed to focus on achieving full compliance with the standards identified in the Health and Social Care Act, and to monitor compliance with national and local infection related thresholds. To ensure consistent momentum with improvements, the team adopted an annual workplan to meet deadlines assigned to works sited on the IPC Quality Improvement plan.

Quality Management System

We continue to use a quality management system to capture all data in relation to IPC. The system holds a data warehouse that consolidates all IPC related data and provides a central space for correlation of themes and trends. The system incorporates a dashboard providing a live position for IPC governance position.

This year, the system has evolved to include:

- Live Unit level dashboards for real-time data
- Policy matrix and review tracker
- IPC unit reports linked to the system for auto-population of data. Unit reports are presented at Infection Control & Cleanliness Meeting.
- Reports to monitor and track actions relating to IPC generated from many sources.
- Rolling audit plan to include IPC Assurance audits
- Live reporting to surgical site infections and statistical process charts.

Infection Prevention and Control Working Group

The purpose of the Infection Prevention and Control, and Cleanliness Working Group (IPCCWG) this group is to ensure that the Trust is fully engaged and proactive in delivering the IPC agenda aligned to the statutory requirements of The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections (Revised December 2022) Care Quality Commission Standards and other national, regional or professional bodies. This involves oversight of leadership and ownership of IPC and cleanliness at a service and operational level.

The group provides a forum for discussion, review and approval of IPC, cleanliness, and estates related activity, policy, procedure and guidance, and monitors the progress of actions against the Infection Prevention and Control Quality Improvement Plan and IPC Quality Management System.

The Infection Prevention and Control Working Group met monthly throughout 2024. The meetings were well attended with the IPC Quality Improvement plan as a standing item on the agenda to maintain oversight of actions. This group reports to the Infection Prevention & Control and Cleanliness Meeting. The Working Group provides effective communication between the IPC team, operational areas, and Estates & Facilities by identifying and resolving issues in line with Trust priorities.

IPC Link Staff System

The IPC Link Staff system enables the IPC Team to deliver key information, education, and advice that is shared to the wards and departments in a cascade system. IPC Link Staff form part of a group that meets bi-monthly. The IPC Team and the link staff ward/department managers agree to roles and responsibilities which clearly define the expectations of the link staff role. Attendance at meetings has been mixed this year, so the IPC team have provided a central hub of information for link staff to ensure that up to date information is shared. With the support from the Trust's Library services, the IPC team were provided with IPC related board games as a fun way to learn around importance of isolation, management of CDI, and the importance of antimicrobial stewardship.

Health & Social Care Act 2008 (HSCA) & Board Assurance Framework IPC BAF

Annual Statement – HSCA and IPC Board Assurance Framework Compliance

Throughout the year, compliance with the Health and Social Care Act and the IPC Board Assurance Framework (BAF) has been closely monitored via the monthly IPC&C Meeting and reported through the Quality Management System's Assurance Dashboard.

In Quarter 2, NHS England released an updated IPC BAF with revisions to Criteria 1, 3, and 10, prompting a comprehensive review to ensure Trust alignment. Actions to address partial compliance with Criteria 1.7 (tailored IPC training), 3.2 (AMR Annual Plan reporting), and immunisation standards under Criterion 10 were embedded into the IPC Quality Improvement Plan.

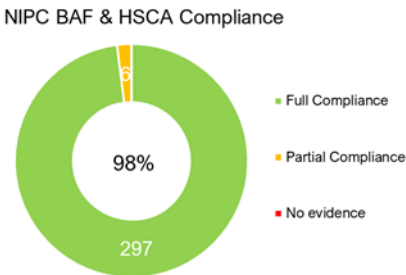
The Trust maintained a 97% regulatory compliance rate in Quarter 3 and 4, with continued efforts to strengthen performance against Criteria 1, 4, 6, and 9. Notably, IPC policy alignment with the National IPC Manual was finalised by the March 2025 deadline, while the development of role-specific IPC training packages continues as part of the 2025–2027 IPC Strategy.

We close the year reporting 6 open actions and a compliance of 98% to our regulatory compliance. All improvement efforts continue to be tracked and evidenced through the IPC Quality Improvement Plan, as detailed in Section 7.

Compliance to both frameworks are monitored by the IPC Team and reported through the IPC&CC Meeting for oversight.

Mandatory Surveillance

All organisms of significance are monitored by the IPC team via a database supported by the SaTH laboratory so that timely action can be taken to support the clinical teams in the management of patients, including safe patient placement and advice on isolation requirements to prevent cross infection risks.



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Healthcare Associated Infections (HAIs)

HAIs can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being on contact with a healthcare setting. There is overwhelming evidence that the implementation of IPC best practices leads to significant reductions in HAIs and patient harm. All healthcare workers are responsible for the prevention of HAIs by ensuring they practice standard infection control precautions at every patient interaction.

Reportable infections are categorised either as avoidable or unavoidable:

An **avoidable** HAI is an infection that could have been prevented by following correct IPC precautions. For example, a patient could develop a urinary tract infection from a catheterisation performed in a healthcare setting where the practitioner did not follow correct precautions.

An **unavoidable** HAI is an infection that could not have been prevented, despite following best practice. For example, a patient with a history of CDI who has had a prolonged stay in hospital, and receives antibiotics to treat an infection, which disrupts the microbiome of the intestines and allows CD to germinate and produce toxins that can cause watery diarrhoea.

The IPC Team follow a post-infection review process for every RJAH acquired reportable infection. This system allows the organisation to identify how the case occurred and identify how the Trust can learn and improve.

Reducing healthcare associated infections (HAIs) remains high priority. Challenges in the management of infections have been experienced nationally with not only an increase in resistant micro-organisms, but also the number of patients experiencing infections. We are delighted that the Trust has maintained under the national thresholds set by NHS England for healthcare associated infections this year. This is an improvement from last year and shows the increased engagement and ownership of IPC practice across all staff groups. The chart below shows the distribution of 14 HAIs across this year:

Organism	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	RJAH Total	Threshold
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	2	1	0	1	0	0	4	N/A
C Diff	1	0	0	0	0	0	0	2	0	0	0	0	3	4
E.coli	0	0	1	3	1	0	2	0	0	0	0	0	7	10
Klebsiella	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Pseudomonas	0	0	0	0	0	0	0	0	0	0	0	0	0	N/A

Clostridioides difficile infection (CDI)

Clostridioides difficile is a type of bacteria that can cause diarrhoea and other symptoms. It is found in peoples' intestines and affects around 3% of the population where is causes no symptoms. If Clostridioides difficile is present in the bowel, it can grow to unusually high levels (usually after taking antibiotics for another infection) and can produce toxins that attack the intestines and cause mild to severe infection.

The Trust reported 3 cases of RJAH acquired CDI this year, with all cases deemed as unavoidable as there were multiple risk factors that contributed to the infection, such as multiple courses of antibiotics.

A rise of hospital onset CDI has been observed nationally following the COVID-19 pandemic, whereas prior to this, rates were generally declining with some fluctuations. The IPC Team updated the CDI policy this year, and provided guides for staff around the management of patients with unexplained loose stools. There has been an improvement in the management of isolation for patient who experience unexplained loose stools, with improvements on the timeliness of sending stool samples for testing. Prompt action and enhanced cleaning in these instances plays a key role in the prevention of spread.

Multi-drug resistant organisms (MSSA, E.Coli, Klebsiella)

There were 4 cases of MSSA and 7 cases of E.Coli bloodstream infections this year. Bloodstream infections occur when microorganisms enter the bloodstream, sometimes through medical devices such as urinary catheters and cannulas. Out of these cases, there were 3 case that were deemed as avoidable, and learning has taken place to prevent recurrence. The reamining 8 cases that were deemed as unavoidable due to other patient risk factors such as antibiotic use and other comorbidities.

Commitment to Reducing Healthcare-Acquired Infections: Establishment of the Gram-Negative Bloodstream Infection Prevention Working Group

A Gram-negative infection is caused by Gram-negative bacteria, which are known for their resistance to many antibiotics and can lead to serious health issues. In June 2024, the Trust established a Gram-Negative Bloodstream Infection Prevention Working Group as part of its commitment to reducing healthcare-acquired infections. This initiative, responding to the national rise in infections in 2023, focused on improving infection prevention practices, implementing targeted actions, and monitoring infection rates to ensure patient safety and contribute to the wider effort to reduce healthcare-acquired infections. After extensive work, the group was stepped down in March 2025, with all Trust wide open actions transferred to the IPC Quality Improvement Plan for ongoing completion and broader monitoring. Improvement works included:

- Development and implementation of a urinary catheterisation policy to standardise practice across the Trust
- Review of patient and staff education around urinary catheterisation
- Revised blood culture policy
- Worked collaboratively with the Shropshire Continence Group to standardise catheter products within the System
- Completed an audit of cannula insertion practice
- Review patient education around hydration and implemented improvements

Infection Prevention & Control Ward/Department Audits

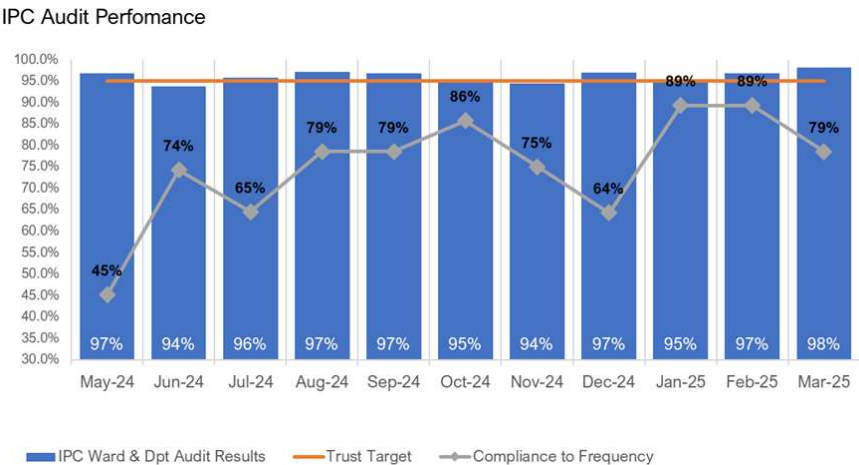
The IPC Team began the year with a targeted effort to enhance the quality and effectiveness of audits. In April 2024, a review of the IPC audit programme saw the integration of the Hand Hygiene and Bare Below the Elbows (BBE) audits into the IPC General Inspection Audit, effectively consolidating three separate audits into a single, streamlined process.

This was in response to feedback regarding the volume of audits expected from clinical areas, staffing constraints, and confusion around audit scheduling. The aim was to reduce duplication, ease operational demands, and bring greater clarity and efficiency to the audit process.

The electronic audit software retains the ability to analyse individual components enabling the team to identify recurring themes and take targeted action. Scores from the audits continue to feed into the IPC Quality Management System (QMS), where data is triangulated to support reporting and assurance.

A peer audit model was also introduced, with a collaborative plan developed and shared via Microsoft Teams to ensure coordinated and accessible scheduling.

The graph below shows Trust-wide audit scores and frequency compliance from April 2024. Overall, scores consistently met or exceeded the 95% target, with a slight dip in November due to missed audits. It also highlights a strong upward trajectory from the starting baseline of 45% at the beginning of the year.



The IPC Team continue to support departments in delivering the peer-to-peer audit model, offering flexibility and guidance as needed. Pairing similar areas for audits has improved quality and relevance.

Any gaps in audit frequency are addressed at working group meetings, with ongoing support to strengthen assurance.

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Real-time tracking via the IPC QMS Unit Dashboard allows teams to monitor compliance and provide feedback.

For system issues, paper audits and a scoring toolkit are available on the IPC intranet to maintain continuity.

IPC Quality Assurance Walks

The IPC Team continued to undertake Quality Assurance Walks across the Trust to seek assurance on standards of infection prevention across the Trust.

At the start of the year, the schedule was revised to align audit frequencies with Functional Risk (FR) categories, ensuring a targeted and risk-based approach, as outlined below:

FR1: Monthly (Theatres, Recovery, HDU and TSSU)

FR2: Bi Monthly (Wards)

FR4: Quarterly (Outpatient areas, Radiology and Therapies)

Walks continue to be scored using a RAG (Red, Amber, Green) rating. However, the scores for 'Green' were uplifted to the Trust target of 95% to better reflect an improvement in standards.

This year a total of 195 walks were undertaken that identified common themes such as condition of walls and floors in clinical areas. Quality assurance walks are documented using an electronic programme that enables actions to be identified to the responsible ward/dept manager straight away. All actions are monitored through the Infection Prevention and Control & Cleanliness Working Group to ensure that actions are dealt with in a timely manner.

This year, the IPC team are pleased to report 100% compliance to the IPC QA walk plan.

Hand Hygiene Surveys

Patient hand hygiene surveys were introduced in April 2024 to gather patient feedback on handwashing facilities and staff hygiene practices in wards and clinical areas. Integrated into the electronic audit system, these surveys ensured consistent data collection. Over the year, patients shared valuable insights, including concerns about bed space clutter from hand wipes before meals and suggestions to move hand hygiene signs in shared areas. These surveys will continue to be an important tool for identifying areas needing extra IPC support. In 2024/25, training data was used to guide where to conduct the surveys, focusing on areas with low compliance. By combining survey data with handwashing competency training, the Trust identified areas requiring additional training to improve staff handwashing practices. Positive feedback was also received from patients who participated, praising staff for their friendliness, professionalism, and the cleanliness of the environment.

Criterion 2: Provide and maintain a clean and appropriate environment.

The Trust understands the importance of a clean, appropriate environment and focuses on providing excellent outcomes.

Cleanliness

Environmental cleaning was provided by the Trust's in-house team of cleaners and deep cleaners; the internal team was supported by external window cleaners and pest control operatives. Cleaning staff are allocated to their own area, giving them ownership of the standard; the number of hours for each area is determined by the Credits for Cleaning information system, with further input from local stakeholders, on a risk adjusted basis.

In 2024/25, the in-house team was further supported by contracted cleaners providing cleaning services within the Theatre department. Contractor teams are trained and supported by Trust staff to ensure consistency of service delivery.

Cleaning responsibilities are defined, reviewed annually and displayed prominently across clinical departments, promoting accountability regardless of the staff group responsible for cleaning.

Outcomes for cleaning continued to be monitored internally throughout the year. External and patient led monitoring, including Patient Led Assessments of the Care Environment (PLACE) assessments were completed in line with our workplan.

Cleanliness – Enhanced Cleaning

Whilst routine cleaning is completed in all areas daily, staff in high-risk areas are supported with extra staff to complete an enhanced clean on a weekly basis. In the very high-risk area of Theatres there is a rolling deep clean

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programme that runs alongside the routine clean; cleaning in these areas is completed over night, when the theatres are not in use, to provide the most effective service.

The Trust recognises the potential need to employ the use of technologies such as hydrogen peroxide vapour for the fogging of facilities and equipment in certain circumstances, as specified by the Cleaning Policy, room cleaning is completed as below:

- **Green** – Standard daily clean using detergent.
- **Amber** – Terminal clean using 1000 ppm Chlorine Based Agent
- **Red** – Terminal clean using 1000 ppm Chlorine Based Agent followed by HPV fogging.

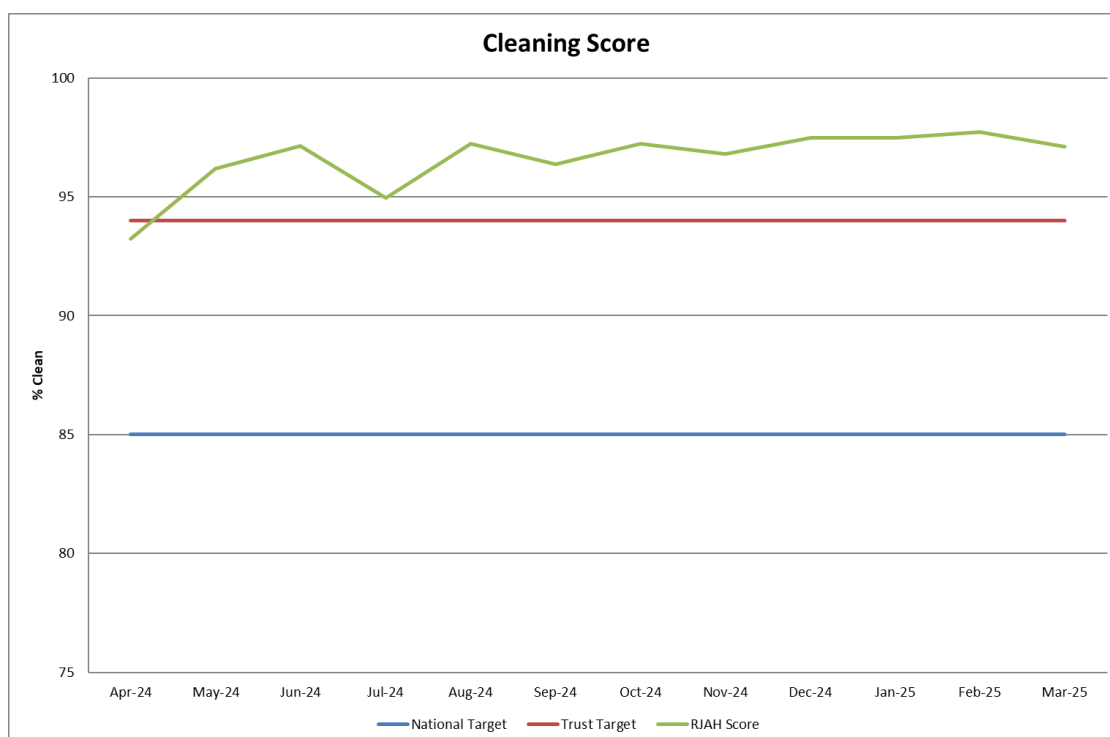
This protocol has ensured that there are no delays in the provision of enhanced cleaning whilst clinical sign off is sought.

The Trust employed an external contractor to complete HPV fogging; responses to date have been quick, effective, and professional.

38 individual rooms and 5 complete bays have required a red terminal clean in 2024/25; in each case a stringent process of isolation is undertaken by the estates team alongside a physical clean of the environment and equipment prior to completion.

Cleanliness – Internal Monitoring

The Housekeeping Department has devised an effective sign-off sheet that allows staff to easily demonstrate the work they have completed and alert the next person on shift to any outstanding requirements. Evidence of cleaning is retained by the department and is validated by supervisor monitoring and managerial spot checks. The department has continued to work collaboratively with clinical teams to share expertise in robust cleaning documentation, focused this year on theatres and therapies departments.



Internal monitoring is carried out every day, visiting all areas on a rolling programme according to their risk. All cleanliness matters are issued within 24 hours to the relevant team, assurance is provided in relation to resolution through signed off completion. All required improvements identified by the audits are acted upon by the internal team and the results are reported to the Infection Prevention, Control & Cleanliness Meeting on a quarterly basis, with specific action plans or failure themes managed through the Infection Prevention, Control & Cleanliness Working Group.

The Trust has a risk based national cleanliness target of 85%, internally the Trust has set a 94% target, for the year 2024/25 the Trust achieved an average score of 96.57%. Noting that in early 2024, the average score fell below Trust (internal) target, a programme of improvement was enacted, with oversight of the Infection Prevention, Control and Cleanliness Working Group and Meeting. The group monitored both the initial impact of actions which included

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improved supervision, changes to work patterns, training and awareness sessions with both cleanliness technicians and clinical team, as well as gaining assurance that these actions provided sustained improvement in overall score.

National Standards of Cleanliness

The Trust fully complies with the requirements of The National Standards of Healthcare Cleanliness. In 2024, the Trust successfully gained NHS England Exemplar Site Status, following a robust accreditation process which included evidence package submission and review, and an on-site visit, with a focus on demonstrating full compliance with the National Standards, an innovative approach to delivering cleaning services, and collaboration and ownership of cleaning across the multi-disciplinary team. The Trust will hold this status for 2 years, when a reaccreditation process will begin.



Infection Prevention & Control and Cleanliness - Collaborative Working

The Estates, Facilities and Infection Prevention and Control teams work collaboratively throughout the year, formally through the Infection Prevention, Control and Cleanliness Working group, documented sign off following refurbishment works and quarterly reports. Again, this year, the team has joined to facilitate an IPC fayre, where awareness and education relating to waste segregation, cleaning standards and cleaning techniques were shared.

Cleanliness and Environment - Kitchen

The Trust kitchen retained its 5-star food hygiene rating at last inspection in June 2024, which in particular, highlighted the high standards of cleanliness within the Trust kitchens and maintenance of assurance records in line with Hazard Analysis Critical Control Point (HACCP) principles.

The inspector noted that recommendations highlighted as part of the 2022 inspections had been completed.

The on-site nursery is registered with Shropshire Council environmental health and retained its 5-star food hygiene rating in November 2023.

Compliance with the National Standards for Healthcare Food and Drink, published in 2022 and requiring specific standards for food safety within a healthcare setting, is monitored by the Nutrition & Hydration Steering Group, with Food Safety also specifically discussed through Health and Safety Working Group. In 2024, the Trust bolstered its food safety assurance, in line with recommendations made in the standard, by securing the services of an external Food Safety Specialist, who along with completing bi-annual audits, supports with specialist advice and guidance.

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CQC Inpatient Survey

The CQC Inpatient Survey 2023 results were published in August 2024, with the Trust scoring top in the country under the metric 'how clean was the hospital room or ward that you were in' with an average score of 9.83. The consistently excellent results achieved through this survey are a testament to the dedication and exacting standards maintained by the entire housekeeping team.



PLACE – Patient Led Assessment of the Care Environment

The National PLACE assessment was completed and submitted in October 2024.

PLACE captures responses to questions on cleanliness; food; privacy, dignity and wellbeing; condition, appearance and maintenance; dementia and disability. Each year questions are updated/added to reflect what is deemed as best practice – therefore careful consideration must be given when making any comparison to previous years responses, however this patient led assessment provides vital insight into the patient's perspective of the environment.

This year, we welcomed students from The Marches School 6th Form to take part in the assessment, gaining valuable insight from their perspective alongside patient panel and volunteer representation.

Domain	2024 score
Cleanliness	100%
Food	94.82%
Privacy, Dignity & Wellbeing	87.97%
Condition, Appearance & Maintenance	98.71%
Dementia	76.76%
Disability	78.35%

Actions arising from the PLACE assessment, along with commentary and feedback outside of the scoring criteria, are collated to form an action plan overseen by the Patient Experience Meeting. Where appropriate, actions are linked to and inform development of the Patient Experience Strategy.

Linen

Quarterly review meetings were held to ensure standards relating to the provision of linen were monitored.

Linen services are provided by an alternative external supplier, who continues to provide assurance to the infection control working group through monthly compliance reporting against National Guidance standards (HTM 01 04). The Trust alongside other consortium partners undertook an on-site visit to the contractor, validating assurances in August 2024.

Clinical Waste

Quarterly review meetings continued to ensure standards relating to the provision of clinical waste were monitored.

Clinical waste services are provided by an alternative external supplier. Assurance this waste is being managed, both at Trust level and by the external contractor, in line with National Guidance is provided to the infection control working group through annual pre acceptance audits.

The NHS England Clinical Waste strategy, alongside relevant guidance (HTM 07 01) sets out a clear direction of travel for the management of clinical waste, including a waste segregation target of 20% incineration (yellow bag) waste, 20% infectious (orange bag) and 60% offensive waste. Compliance with this guidance is monitored through the Health and Safety working Group, in close the collaboration with Infection Prevention and Control team. The Trust continues to report segregation metrics above those specified by the strategy.

In February 2025, reusable sharps containers were implemented across the Trusts, replacing in all appropriate areas single use models – in line with further recommendations within the strategy. Roll out of this system was complimented with comprehensive on-site training, visual aids and a robust assurance and auditing process.

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Estates Department Contribution to the Clean and Appropriate Work Environment

Estates department activity is essential in delivering the IPC agenda, it is delivered under the principles outlined in National Guidance, which covers the importance of a clean, safe environment for all aspects of healthcare.

Matters of Estate that impact the clean environment are escalated through the IPC working group for prioritisation and oversight. This year, projects have included:

- Refurbishment of Hydrotherapy Pool
- Refurbishment of Kenyon Ward
- Toilet refurbishment scheme across site
- Flooring replacement scheme across site

Water

The control of water is a legal requirement; the Estates Department work to National Guidance to mitigate risks from exposure to Waterborne Pathogens

The Estates department continues to employ a third-party contractor to provide technical advice for water services and undertake water risk assessments on Trust properties every two years or where required following incidents or significant infrastructure changes.

There is a written site-specific scheme of control within the Water Safety Plan. Eurofins provide the Trust an internet-based water testing database storage and reporting for statutory test results. There is also a three-monthly review of test results, control measures and procedures at the Water Safety Group to ensure compliance with current legislation and these results are published at the Infection Prevention Control Working Group.

In line with National Guidance. The Trust has an Authorising Engineer for Water AE (W), appointed in writing. The AE(W) is a 'independent advisor,' who offers technical advice to the Estates Engineers, auditing the management of water safety and increasing the Trust's resilience and bolsters the management of water hygiene.

The Estates Department continually undertake water tests throughout the Trust estate. This water testing is carried out in line with legislation and guidance. Testing is standard practice at RJA to ensure robust control of waterborne infections such as legionellosis; it is a method of using qualitative data to measure that our planned maintenance is successfully controlling growth of microorganisms in the potable water supply. The Trust conducts Water sample tests, at a greater frequency than required by guidance; the purpose of which is to identify potential issues sooner so that corrective actions can be implemented at the earliest possible time.

In response to out of parameter results, the mechanical team within the Estates department continue to employ an effective method of thermal disinfection. This process increases efficacy and reduces costs because of the in-house delivery of such works. Disinfection is often employed to manage domestic water hygiene.

The Trust is therefore assured that the Water Safety of the site is compliant in-line with current Legislations and guidance.

Ventilation

It is a legal requirement to provide adequate Ventilation in enclosed areas of a workplace.

Ventilation is led and monitored by the Estates Department, supported by an Authorising Engineer for Ventilation AE(V), appointed in writing. The AE(V) is a 'independent advisor,' a requirement of National Guidance and offers technical advice to the Trust, auditing the Specialised Ventilation and increasing the Trust's resilience.

The Trust conducts monthly air velocity tests, at a greater frequency than required by guidance; the purpose of which is to identify potential issues sooner so that corrective actions can be implemented at the earliest possible time.

The RJA Estates team conduct Quarterly PPMs on all Air Handling units (AHUs) to ensure they are clean, fully functional, and proactively manage any issues that should arise.

Accredited third party contractors revalidates theatres on an annual basis, providing an inspection and reverification report. These reports are then reviewed by the Trust's Authorising Person (AP(V)) and the AE(V)

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The Trust is therefore assured that the sites Ventilation Systems are compliant in-line with current Legislations and guidance.

Decontamination Group

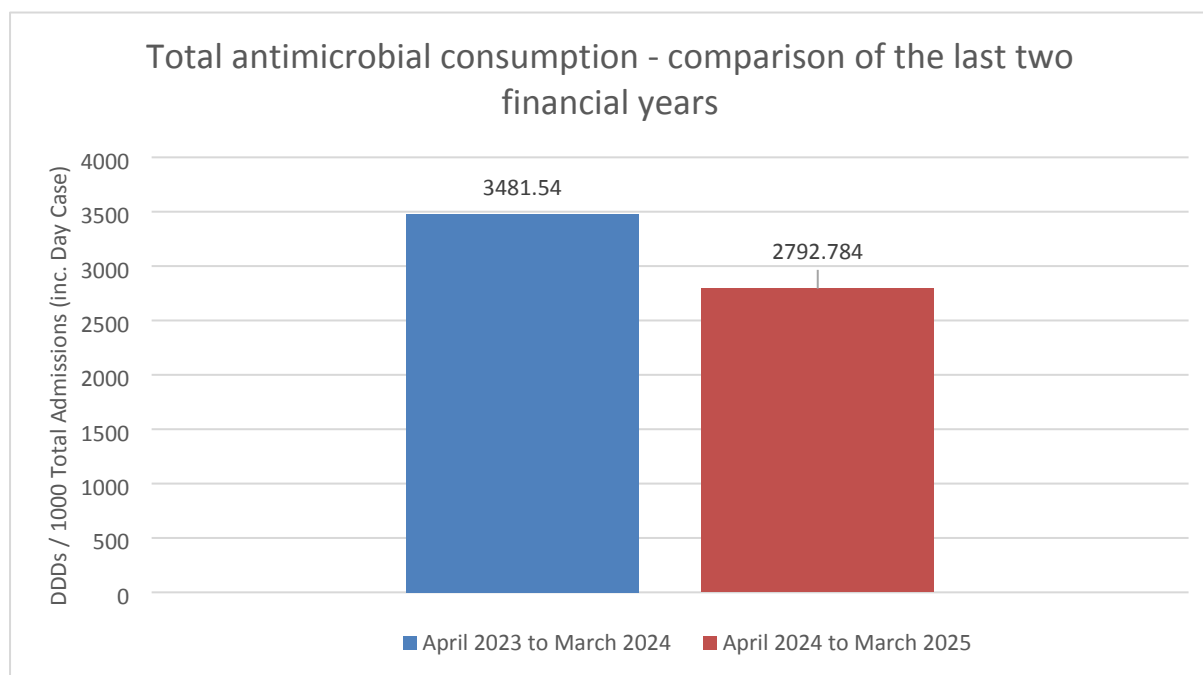
Decontamination, which covers the theatre and sterile services environment, is led and monitored by the Estates department supported by their third party accredited Authorising Engineer for Decontamination AE(D), who is appointed in writing. The AE(D) is a 'independent advisor,' a requirement of National Guidance who offers technical advice to the Trust, auditing the Decontamination equipment and increasing the Trust's resilience.

The RJAH Estates team maintain a local testing regime of Decontamination equipment on a weekly basis and proactively manage any issues that should arise. Reports are produced for Quarterly and Annual Testing. These reports are then reviewed by the Trusts Authorising Person (AP(D)) and the AE(D)

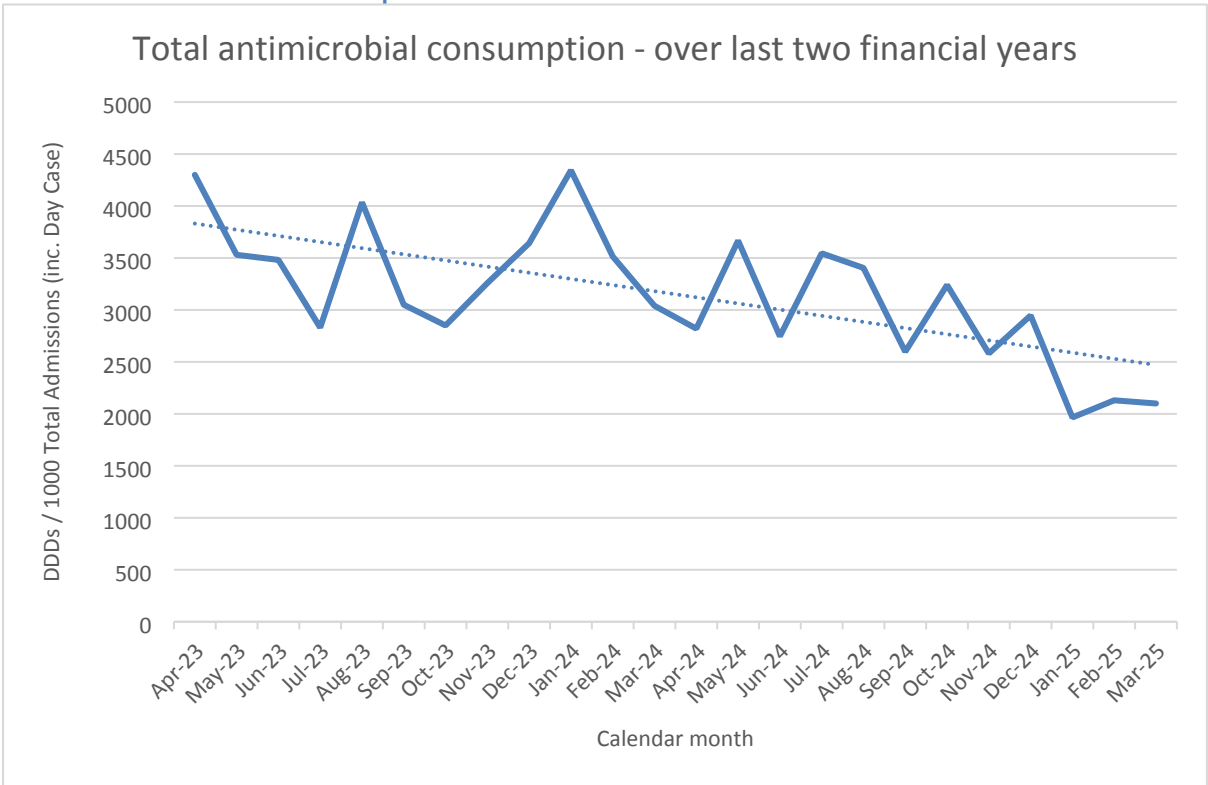
The Trust is therefore assured that the Decontamination of Theatre Surgical equipment is compliant in-line with current Legislations and guidance.

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

The graph below shows that when comparing the total antimicrobial consumption between April 2023 to March 2024 and April 2024 to March 2025 the usage has reduced by around 20%. The second graph also displays that there has been a downward trend in the overall usage of antimicrobials even though there have been peaks and troughs throughout the last two financial years. This is when looking at DDDs/1000 total admissions.

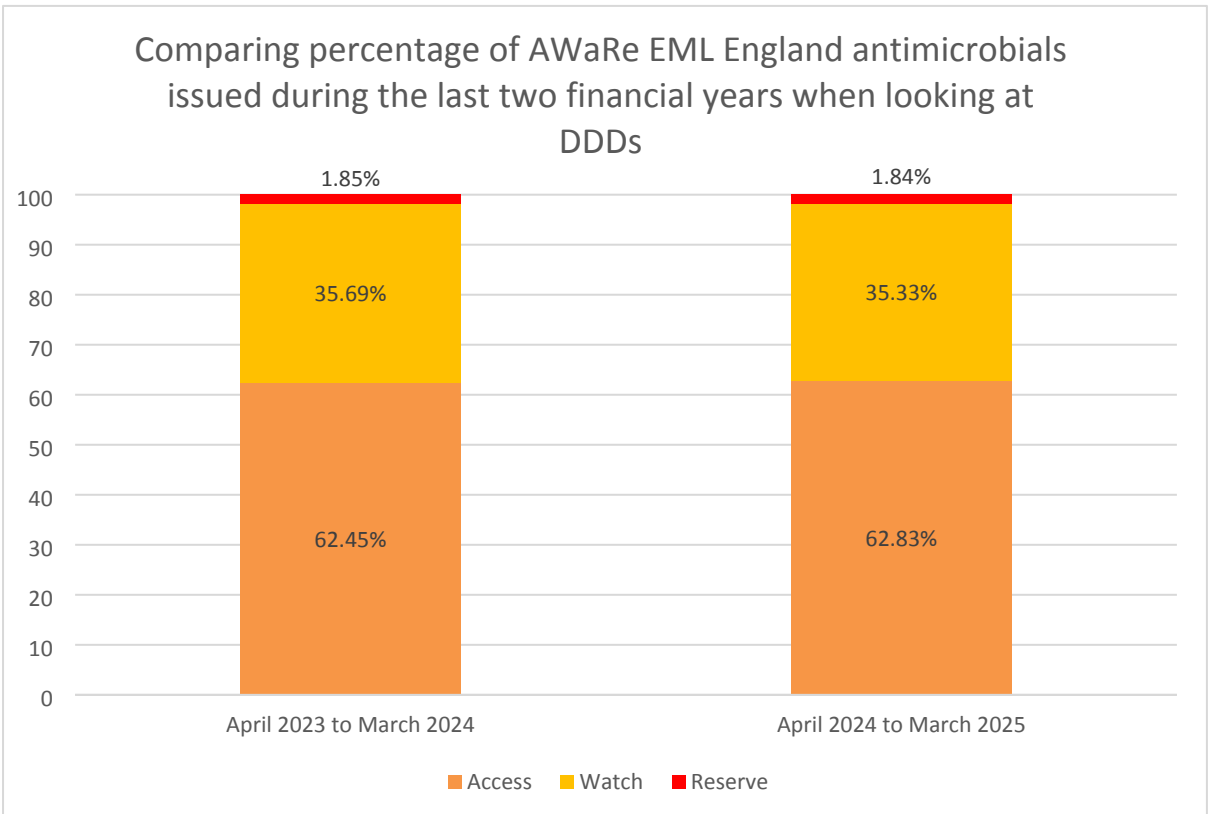


DDD (Defined Daily Dose) – 'The assumed average maintenance dose per day for a drug used for its main indication in adults'. It is defined by the World Health Organisation (WHO).



AWaRe antimicrobials review

The graph below shows the percentage of access, watch and reserve antibiotics that have been issued over the last 24 months when looking at DDDs. There is little to no difference in the percentage of AWaRe antimicrobials issued when comparing the last two financial years. Ideally the use of watch and reserve antibiotics should be kept to a minimum as these are preserved for more serious infections and those microorganisms that have multiple resistances. Clear documentation about why an antimicrobial has been started and who has recommended it is sometimes lacking. The implementation of electronic prescribing will ensure that an indication must be entered before an antibiotic can be prescribed.



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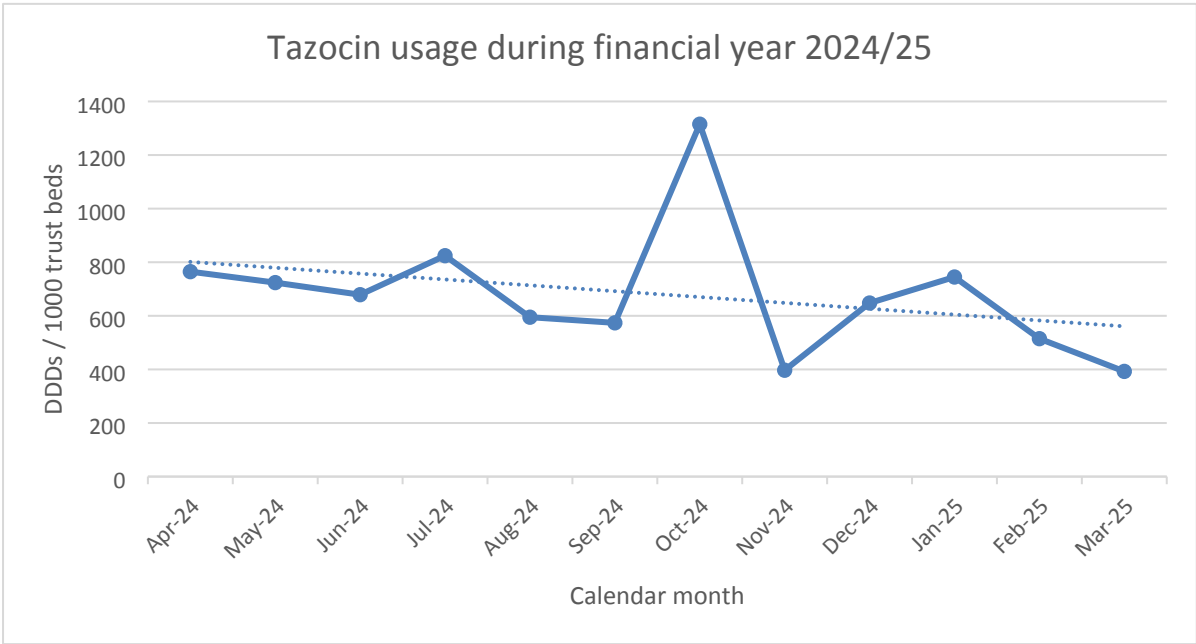
EML – List of Essential Medicines

AWaRe – This is a WHO classification for antimicrobials which is split into Access, Watch and Reserve:

- **Access** antibiotics e.g. amoxicillin – first or second choice antibiotics which are used empirically for common infections while minimising the potential for resistance. They usually have a narrow spectrum of activity, fewer side effects and are lower cost.
- **Watch** antibiotics e.g. meropenem – first or second choice antibiotics which are used for more specific limited number of infections. They need to be closely monitored to avoid overuse as they are more prone to be a target of antibiotic resistance.
- **Reserve** antibiotics e.g. linezolid – these are ‘last resort’ antibiotics used for severe infections usually associated with multi-drug-resistant bacteria. They need to be closely monitored to ensure their continued effectiveness.

When looking at the WHO AWaRe classification, carbapenems and Tazocin are ‘watch’ antibiotics, however, according to the modified England AWaRe index carbapenems are ‘reserve’ antibiotics. The updated list was published in 2019, and the changes were made due to several factors such as recommendations in national guidelines, to reduce the risk of C. difficile infection, due to AMR and the need to preserve some antibiotics for multi-drug-resistant infections. The graphs below indicate the usage of both during the last financial year as they are often prescribed within the Trust.

This graph shows the overall usage of Tazocin during the last financial year 2024/25 when looking at DDDs/1000 Trust beds. There was a peak in usage in October 2024, but usage has since declined, and the overall trend is downwards. An audit was conducted on Tazocin usage in Q3 (October to December) 2024/25 which showed that most of the time, Tazocin is being used appropriately but is often the chosen antibiotic when a patient spikes a temperature. Clearer documentation is required as to why Tazocin is being prescribed, and the antibiotic policy should be used or microbiology advice sought.

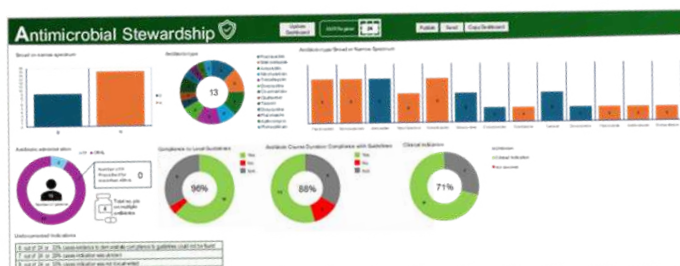


This graph shows the overall usage of carbapenems (ertapenem and meropenem) during the last financial year 2024/25 when looking at DDDs/1000 trust beds. There are peaks and troughs in usage and the overall trend is upwards, however, those patients prescribed carbapenems during the peaks in July and November 2024 were all appropriate and prescribed according to guidelines or as per microbiology advice.



- ## Antimicrobial Stewardship (AMS) Toolkit Development

The toolkit was trialled on Sheldon Ward over six weeks from February to March 2025. It includes a dynamic dashboard to analyse prescribing data and will soon be rolled out Trust-wide as a ready-to-use tool to strengthen antimicrobial stewardship efforts.



Once analysed data and insights captured throughout the trial will play a key role in shaping the Trust's antimicrobial stewardship strategy for 2025/2026, ensuring a data-driven approach to improving prescribing practices and reducing the risk of antimicrobial resistance.

Criterion 4: Provide suitable accurate information on infections to service users.

Patients who are identified to be carrying or infected with alert organisms are visited by the IPC Team to ensure that patients are well informed about their condition and how they will be managed during their admission. This is a fundamental element of the role of the IPC team. During the visit, patients and families can discuss any queries or concerns, and the IPC Team take opportunities to educate patients on how they can manage infections once they are discharged.

Patient Information

All patient information leaflets are stored on the Trust website and in paper format.

Patient leaflets are reviewed every year, with improvements made to align the content with current guidance, to enhance accessibility of information for patients, and to avoid information overload.

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In addition to the Trust website, the IPC team have an intranet page which is managed locally by the IPC Team. This page has proven to be an effective information hub for staff and serves as a central source for all IPC related information.

IPC Bulletin

In April 2024, the IPC bulletin was replaced by the Trust-wide Quality & Safety Bulletin as part of the Trust's effort to streamline communication and promote a collaborative approach to safety culture and learning.

The Quality & Safety Bulletin is distributed monthly and facilitated by the Trust Communications Team, with IPC invited to contribute. The IPC Team continues to utilise this important resource to update staff on reviewed and revised policies, as well as share critical information about changes in both national and local IPC guidance.

Medical Illustration Team

The IPC team maintains strong collaboration with the Medical Illustration team, who have continued to offer invaluable support throughout the year, helping us deliver key information to both staff and patients. Examples of their contributions include:

- Posters for IPC Fayres and exhibitions
- Patient Information Leaflets

The Team continues to benefit from their prompt and efficient service, which allows us to communicate information in a professional and timely manner.

Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection.

The IPC team perform several activities that minimise the risk of infection to patients, staff and visitors including advice on all aspects of infection prevention and control; education and training; audit; formulating policies and procedures; interpreting and implementing national guidance at a local level; alert organism surveillance and managing outbreaks of infection.

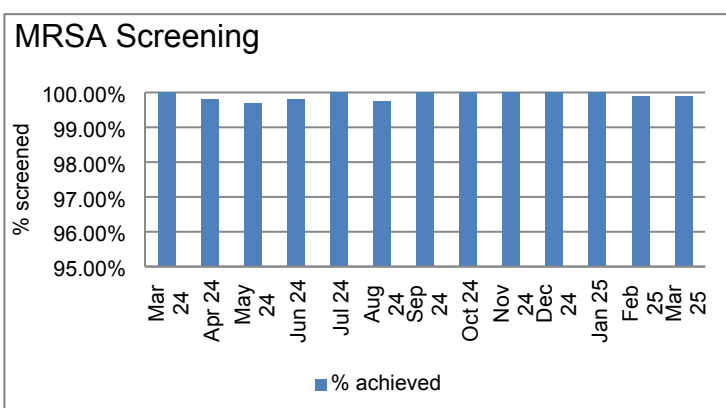
Oswestry Infection Control (OIC)

The IPC Team receive a daily report (between Mon-Fri) which identifies all positive samples sent to the laboratory as part of the OIC reporting system. This system enables the IPC team to advise and support on the management of patients' infections, including patient placement, to reduce risk of cross-infection.

MRSA screening

Meticillin-Resistant Staphylococcus Aureus (MRSA) is a type of bacteria that has become resistant to many of the antibiotics used in hospitals. It usually lives harmlessly on the skin, but if it enters the body, it can cause serious infection.

All elective surgical patients undergo screening for MRSA, and positive results are alerted to the IPC Team daily as part of the OIC reporting system. This enables prompt recognition of MRSA so that decolonisation treatment can be offered to the patient, preventing potential delays or complications of surgery.



The graph and table below demonstrate the MRSA screening compliance, which is consistently above 99%.

	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Eligible patients	991	1010	989	1007	972	796	813	958	978	840	1046	890	992
Screened for MRSA	991	1008	986	1005	972	794	813	958	978	840	1046	889	991
% achieved	100.00%	99.80%	99.70%	99.80%	100.00%	99.75%	100.00%	100.00%	100.00%	100.00%	100.00%	99.89%	99.90%
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Surgical Site Infection Surveillance Service (SSISS)

Surgical site infection (SSI) is a type of healthcare associated infection in which a surgical incision site becomes infected after a surgical procedure. SSI are associated with increased morbidity and mortality in surgical patients and risk can be minimised with appropriate care before, during and after surgery. The management of an SSI can involve prolonged hospitalisation, readmission, and reoperation, can be associated with increased diagnostic and treatment costs affecting patient safety and care.

Surveillance of SSI with appropriate and timely feedback of data to clinicians is crucial in supporting strategies to reduce the burden of infection within the health system. The importance of monitoring and reducing rates of surgical site infection is widely acknowledged and the IPC Team at RJAH follow policy and process to support early SSI recognition and actions to minimise risk and preserve patient safety.

Pathogens that cause SSI may originate from:

- the patient's own microbial flora presents on skin and in the body
- the skin or mucous membranes of operating personnel
- the operating room environment
- instruments and equipment used during the procedure

There are several activities undertaken at the Trust to prevent SSIs from occurring:

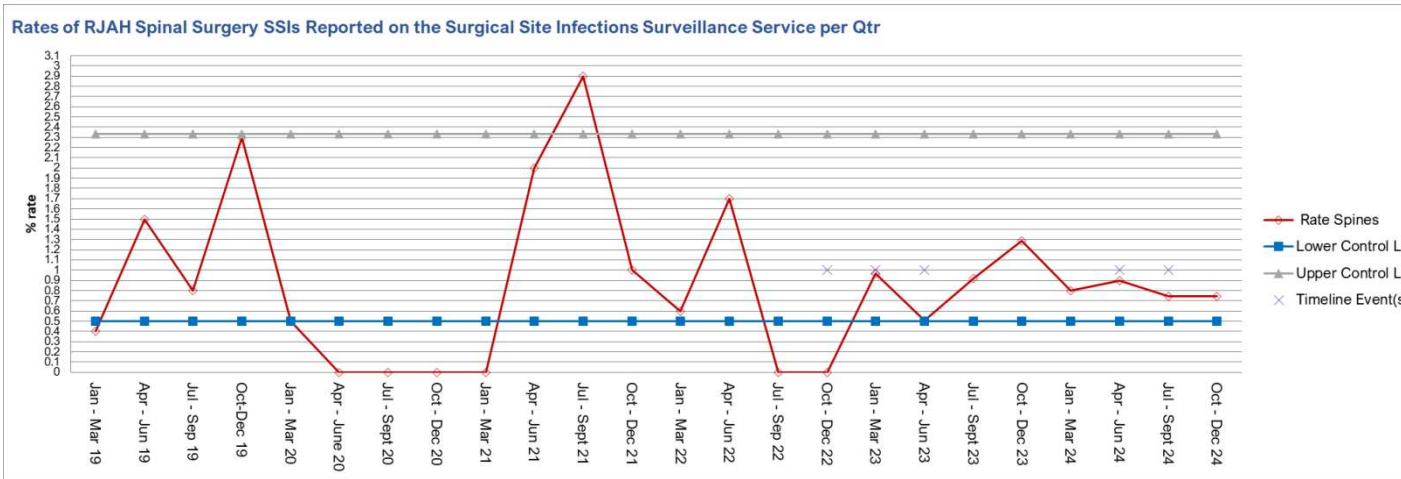
- Minimising the number of microorganisms introduced into the incision site, for example removing microorganisms that normally colonise the skin of patient, maintaining asepsis and managing air quality.
- Enhancing the patients' defences against infection, for example by minimising tissue damage and maintaining normal body temperature during the procedure.
- Preventing the multiplication of microorganisms at the incision site, for example using prophylactic antibiotics.
- Preventing access of microorganisms into the incision site, for example postoperatively by use of a wound dressing.

In April 2004, surveillance of surgical site infections (SSIs) in orthopaedic surgery became mandatory for all English NHS Trusts. RJAH submits surgical site infection data to the UK Health Security Agency (UKHSA) database on a quarterly basis.

The UK Health Security Agency (UKHSA) analyses the submitted data at quarterly intervals to identify hospitals whose SSI incidence may be high or low, enabling the Trust to benchmark against the national rate of infection.

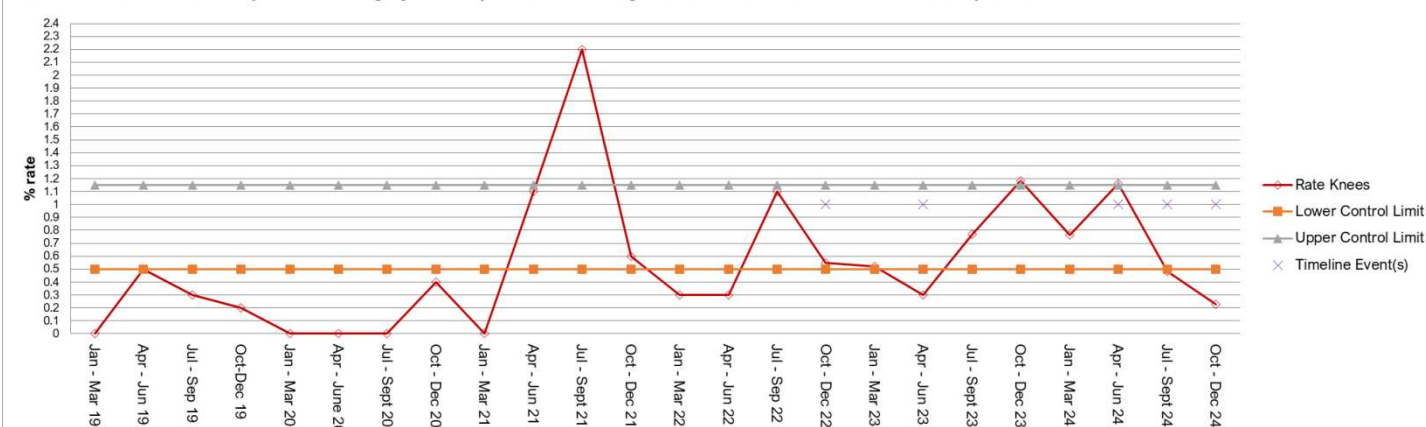
From April 2024 – October 2024, RJAH submitted data to SSISS on total of 3241 operations – 1248 Total Hip Replacements (THR), 1370 Total Knee Replacements (TKR) and 623 Spinal surgeries was collected by the RJAH surgical site surveillance team. During this period, there have been a total of 22 reported, with 8 THR, 10 TKR, and 4 spinal surgeries.

The following graphs show the breakdown in RJAH rate of surgical site infections reported to UKHSA between January 2024 and December 2024. At the time of writing this report, UKHSA have not yet reconciled SSI data for Jan-March which is why it is not shown below.

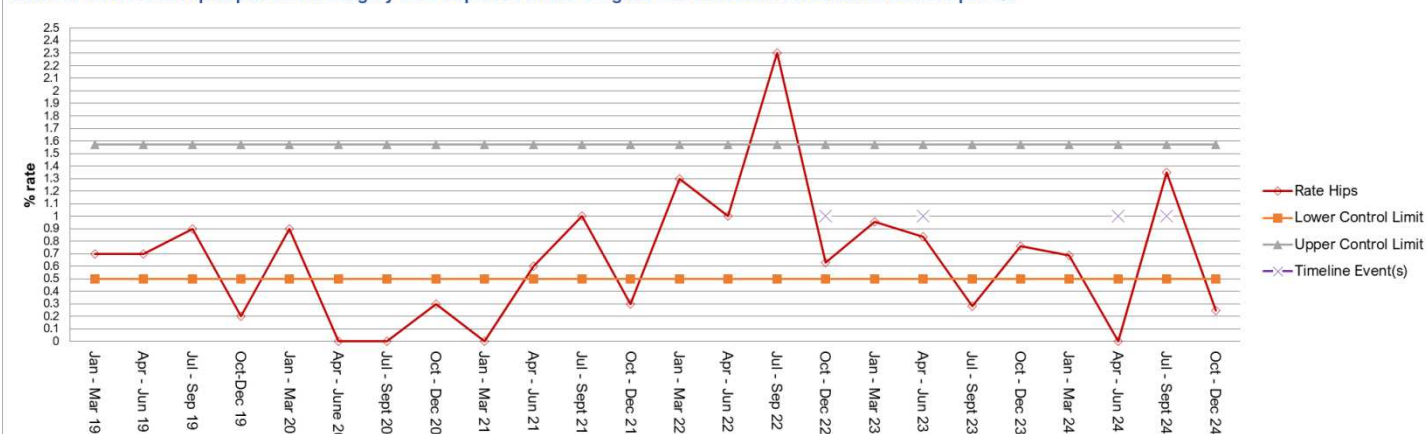


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Rates of RJAH Total Knee Replacement Surgery SSIs Reported on the Surgical Site Infections Surveillance Service per Qtr



Rates of RJAH Total Hip Replacement Surgery SSIs Reported on the Surgical Site Infections Surveillance Service per Qtr



The Trust continues to assess the standards across the surgical pathway using the OneTogether Assessment.

OneTogether is a partnership between leading professional organisations with an interest in the prevention of surgical site infection (SSI). The partnership has been initiated as a quality improvement collaborative with the aim of promoting and supporting the adoption of best practice to prevent SSI throughout the patient's surgical pathway.

The OneTogether assessment tool has been designed to demonstrate compliance across the surgical pathway and is set out in 7 standards:

1. Skin preparation
2. Prophylactic antibiotics
3. Patient warming
4. Maintaining asepsis
5. Surgical environment
6. Wound management
7. Surveillance of surgical site infection

The Trust extended the MSSA decolonisation programme this year to include all patients undergoing joint replacement surgery. All patients having joint replacement surgery receive a 5-day decolonisation regime to prevent increased skin colonisation and to reduce the risk of developing a surgical site infection.

The IPC Clinical Lead Nurse held an education session for Theatre staff around their role in the prevention of SSIs. A patient story was shared which showed the reality of living with the complications from SSI and how this impacted the patient's life. This was a poignant reminder about how infection prevention and control is everyone's responsibility. The Theatres teams have worked towards improving knowledge around SSI prevention and link staff have attended IPC conferences to expand their knowledge and share their learning with their teams.

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We welcomed IPC colleagues from the Royal Orthopaedic Hospital in Birmingham to provide a peer review of our facilities and practice within the Theatres environment which gleaned positive feedback; and we continue to work together around SSI prevention and are included in working group meetings to share ideas.

Infection Multi-Disciplinary Team (MDT)

The Infection MDT meet weekly to discuss infections and make recommendations for treatment. The Infection MDT is attended by Consultant Surgeons, a Consultant Microbiologist, an antimicrobial Pharmacist, the Infection Prevention & Control Team, and a Consultant Radiologist.

UKHSA Surgical Site Surveillance System requirements are to report hip, knee, and spinal surgery, however the Infection MDT reviews patients from all orthopaedic specialities, including upper limb, lower limb, sports & spinal injuries.

Outbreaks

An outbreak of infection is described as two or more people (this could be patients and staff) with the same disease or symptoms or the same organism and are linked through a common exposure, personal characteristics, time, or location. The Trust follows the recently updated Infection Event and Outbreak Management Policy to ensure a standardised response to outbreak management that includes external reporting.

There was 1 outbreak of diarrhoea and vomiting reported this year on Sheldon ward. This was expected due to the prevalence of Norovirus at the time. The IPC Team commended the ward staff for their prompt actions to prevent transmission of the infection to other patients, and they managed to contain the outbreak to one side of the ward. This meant that the ward was able to stay open to admission in the unaffected areas.

An 'after action review' was conducted once the outbreak was closed to identify areas of good practice and opportunities for learning.

The review was led by the IPC Team in collaboration with the Matron and Ward/Departmental Manager. Feedback takes the form of a poster for areas to display and are included in all reports through the IPC&CWG.

Infection Event

There was one infection event in December relating to an acquisition of MRSA (colonisation, not infection) in one patient. The IPC team instigated the Infection Event and Outbreak Management policy to ensure all correct actions were taken. It should be noted that this case did not meet outbreak criteria, however, due to the patient having no previous history of MRSA, it was important to investigate if a transmission event had occurred. There were some key learning points from the investigation which included some gaps in MRSA swabbing techniques. The IPC Team have since provided 'hands on' support to the teams to ensure that MRSA swabbing is performed correctly, including follow up ward-based teaching sessions.

Serious Incidents

There were no serious incidents related to IPC to report in 2024/25.

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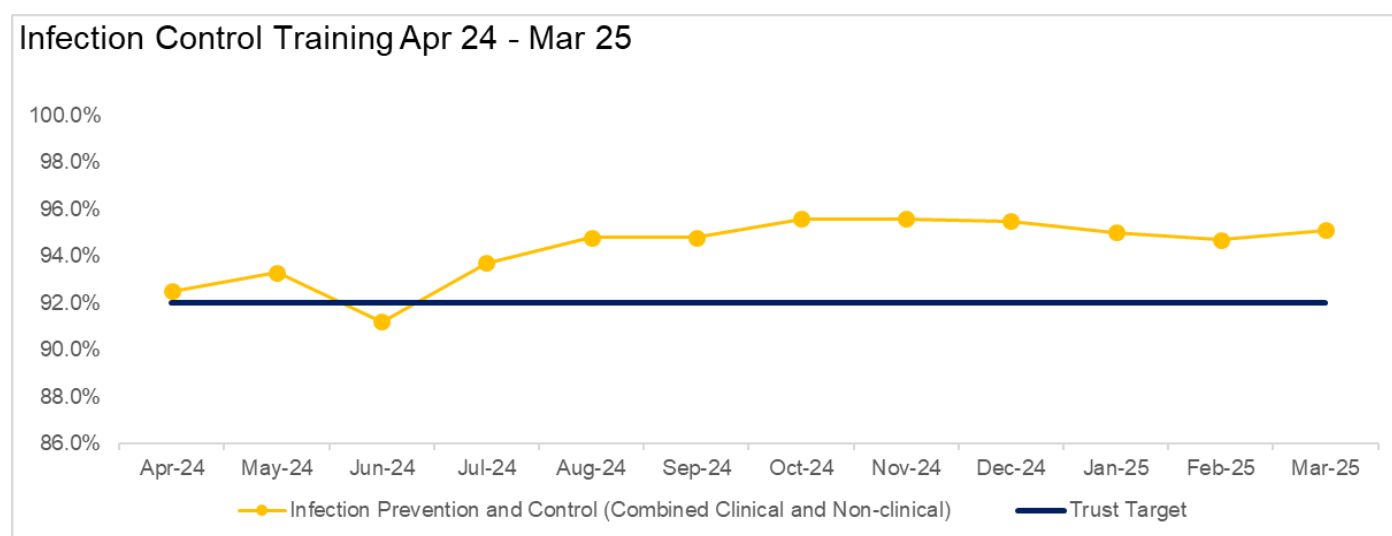
Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

Our IPC Arrangements and Responsibilities policy reflects the management and reporting structure of RJAH outlining its collective responsibility for IPC from Board to floor, demonstrating that responsibility is disseminated to all staff in the organisation.

The following IPC modules are monitored via ESR and mandatory for staff to completed:

- Infection Control Training Clinical & Non-Clinical
- Hand Hygiene
- Aseptic Non-Touch Technique

The chart below shows that the Trust has maintained good compliance to infection prevention and control training and has met the required Trust target of 92%:



Additional to the mandatory suite of IPC modules managed via ESR, the following training is delivered by the IPC Team:

- Induction training for all clinical and non-clinical staff and rotational doctors
- Hand washing assessments to clinical staff to ensure staff obtain full hand hygiene competency.
- All volunteers receive a training presentation and hand hygiene education.

The IPC Team have provided a number additional of education sessions throughout the year as part of the IPC strategy, including:

- MRSA Decolonisation
- Handwashing
- Catheter specimen urine sampling
- Standard IPC precautions
- Transmission-based precautions
- CDI management including a practical Sim-lab session
- Surgical site infection prevention
- Care Certificate: IPC
- Ad-hoc sessions in ward/departmental areas

Criterion 7: Provide or secure adequate isolation facilities.

The Trust has isolation policies in place and has single side room accommodation with en-suite facilities to isolate patients when required.

The Trust Isolation Policy includes a risk assessment tool which allows staff to consider individual requirements for isolation to ensure patients are managed on a case-by-case basis. In rare cases where there has been no side room

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available; the IPC team have assisted the ward area with mitigations dependent upon the organism – this is documented in a risk assessment template and kept in the patient's notes.

Cleaning and management of our isolation facilities is conducted by our facilities team in accordance with our policy, the National Cleaning Standards, and the National IPC Manual.

Criterion 8: Secure adequate access to laboratory support as appropriate.

The contract for laboratory services is with Shropshire and Telford Hospitals NHS Trust (SaTH) which is fully UKAS (United Kingdom Accreditation Service) compliant under ISO 15189. The ICD is a Consultant Microbiologist at SaTH who is contracted to work at RJAH as a specialist. Medical microbiology support is provided 24 hours a day, 365 days a year. In addition, we have a service level agreement with Sheffield laboratory who provide advice and guidance specific to samples from theatres and radiology.

Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

Following the introduction of the National IPC Manual in early 2023, the IPC Team initiated a review of all policies and procedures to ensure full alignment with its requirements. This work continued into 2024/25 and was completed by the end of March 2025. A policy tracker was implemented to monitor progress, feeding real-time compliance data into the IPC Quality Management System. The following table shows the policies that were updated and ratified as part of this work:

Policy/Procedure	Date ratified at monitoring committee
Standard Infection Control Precautions Policy POL271	May 24
Respiratory Infection Policy POL272	May 24
HCAI Reporting SOP166	May 24
Surgical Site Infection Surveillance Policy SOP046	Jun 24
Transmissible Spongiform Encephalopathy (TSE) Including all Forms of Creutzfeldt-Jakob Disease (CJD) POL275	Jun 24
Clostridioides difficile	Aug 24
Measles Policy POL279	Feb 25
MRSA	Mar 25

The IPC Team shares updates on policy changes, reviews, and ratifications through the Trust-wide Quality & Safety Bulletin to keep staff informed.

Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Optima Health Occupational Health

As a Trust, we are committed to supporting our colleagues, recognising that their wellbeing is fundamental to the smooth running of the hospital, having a positive impact on patient care, and supporting morale. We have a service level agreement with Optima Health along with our partner providers in STW and a suite of wellbeing support services accessible to all staff. In line with the Health and Social Care Act, Optima Health are required to provide risk-based screening and assessment of immunity to infection is completed for all new starters via a pre-placement questionnaire, and if required, blood testing. Immunisations are offered in accordance with the Green Book, and a recall system is in place to follow up on outstanding or booster vaccines. Records of immunisation and clearance are maintained, including for staff undertaking exposure prone procedures (EPPs). Staff can access OH services here on site or at the OH facility at SaTH.

Blood Borne Virus Exposure

Blood borne virus exposure incidents or injuries may represent a significant risk to staff working in healthcare environments. Under Health and Safety Legislation, Optima Health work collaboratively with the Trust's Health and Safety and IPC teams in preventing, reducing, and controlling the risks of healthcare-associated infection. They provide a full assessment and follow-up service for all blood borne virus exposure incidents, including sharps injuries,

Infection Prevention & Control and Cleanliness Annual Report 2024/25

and ensure timely access to post-exposure prophylaxis (PEP) in line with national guidance. For incidents occurring out of hours, emergency departments provide initial treatment, with Optima Health completing all required follow-up assessments and blood tests.

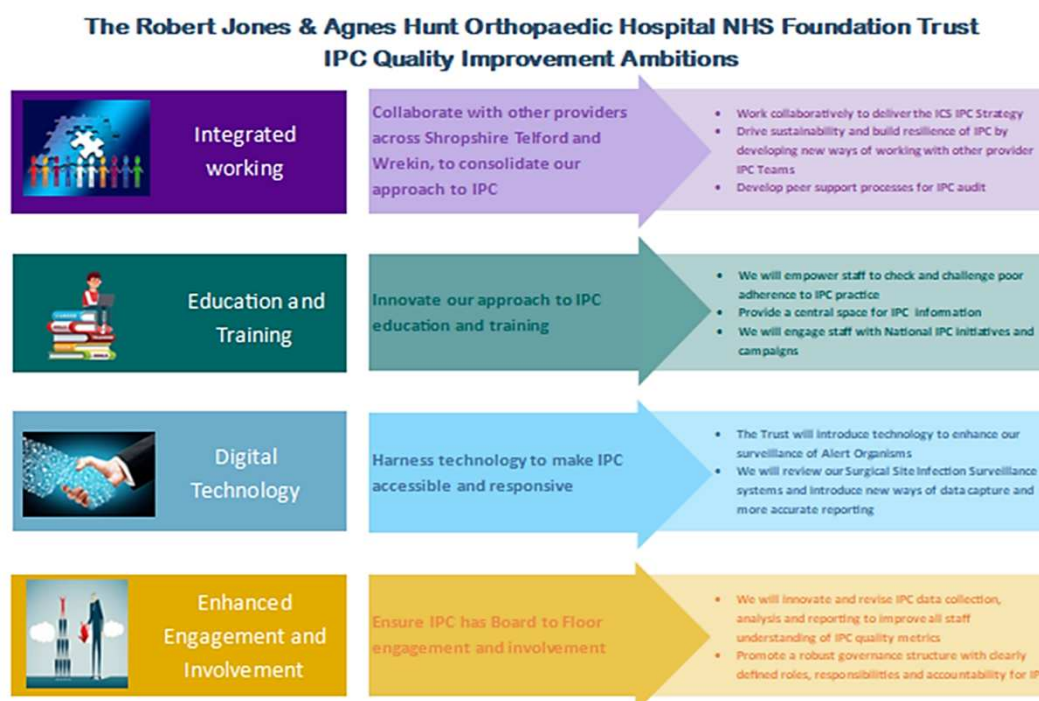
Safer sharps

The Trust has maintained compliance with the Health and Safety (Sharp Instruments in Healthcare Regulations) 2013.

Sharps (including needlestick) injuries remained at a low level with 18 incidents reported this year. This is a downward trend since last year. Work is ongoing to ensure that safer sharps become the default devices of choice wherever reasonably practicable.

Our progress to our IPC Ambitions

We have made good progress with our 2-year IPC strategy and look forward to focussing the next year on revised ambitions and sustaining the levels of IPC across the Trust.



Our success against our strategy is summarised below:

Integrated Working

- The RJAH IPC Team provide representation at the ICS IPC and AMS monthly meetings and deliver a provider report on local IPC metrics.
- The Deputy DIPC has worked collaboratively with colleagues from STW to deliver the Clostridioides Difficile Action Plan; this is regularly reviewed through the ICS IPC monthly meetings to ensure oversight and delivery of actions.
- Since Jan 2025 The IPC Clinical Lead has supported an ICB Task & Finish Group around CDI focussing on primary care.
- The RJAH IPC Team have worked together with the Royal Orthopaedic Hospital in Birmingham and now have shared information streams for surgical site infection. The RJAH IPC Clinical Lead is included in the ROH PSSI prevention working groups. The ROH IPC Team visited RJAH in August 2024 and performed a peer review in theatre practices, with positive feedback.
- The IPC Team have embedded the peer-to-peer programme audit programme which provides objective feedback on IPC performance in wards and departments. Audit results are shared through IPC governance systems with increase ownership from ward and departmental managers to rectify matters relating to IPC in a

Infection Prevention & Control and Cleanliness Annual Report 2024/25

timely manner.

- The IPC Team support ward and departmental staff to carry out IPC audits to ensure a standardised approach by offering shadowing sessions to allow for teaching of fundamental aspects of IPC in relation to the environment and practices.

Education and Training

- The IPC Team continues to support the Care Certificate programme. The content of the session has been aligned to the National Infection Prevention & Control Manual for England (NIPCM)
- We have continued to empower staff through education. This will give them the confidence to check and challenge IPC practice. The IPC team have developed several education tools which cover topics such as CDI, Microbiology, MRSA screening and urine sampling.
- We continue to monitor progress and improvements against the IPC Quality Metrics through our QMS.
- We continue to deliver 'back to basics' IPC education session which includes information on SICPs
- The IPC Clinical Lead continues to hold a weekly team meeting to ensure traction on the IPC Workplan.
- The IPC Link Practitioner Teams Channel is maintained by the IPC Support Secretary where key documents and articles of interest are shared. The IPC link for the Library provides excellent support to the team and has purchased IPC board games to make learning more engaging and fun.
- All IPC related policies have been updated in line with the National IPC Manual for England to ensure staff are informed to the most up to date practice and terminology.
- We continue to schedule bi-annual IPC fayres and lead on improvement cycles. We held an IPC Fayre in May 2024 which was well received.
- We took part in a Patient Safety Fayre in 2024 with a focus on Gram-ve bacteraemia prevention

Digital Technology

- An IPC tagging system is under development within Apollo to ensure that we capture IPC data and display this to clinical teams at all aspects of the patient journey. This will ensure IPC management is a priority, reducing the risk of acquisition and HAI.
- The IPC team have met with the Apollo team to ensure that we capture IPC data and display this to clinical teams at all aspects of the patient journey.
- All IPC staff have completed Apollo training to ensure readiness for the 'go live' date in May 2025
- The SSI surveillance policy has been updated to reflect the revised SSI process in line with PSIRF.
- The IPC Clinical Lead continues to hold bi-annual MDT reviews of all SSIs to identify themes and form actions. This has led to increased engagement and ownership around SSI prevention from the Theatres teams.
- The QA walks questions for Theatres now include a question set around SSI prevention to ensure monthly oversight as opposed to a twice-yearly check. Results are reported through the monthly IPC Quality reports that are delivered to the IPCCM.

Enhanced Engagement and Involvement

- The IPC team continue to include ward/dept representation at all Quality Assurance walks so that immediate actions can be taken to remedy IPC related issues. The Facilities team are given feedback around issues related to their responsibilities within the Cleaning Charter.
- We continue to share IPC data through the IPCCM governance reporting structures and provide support the Matrons who are responsibility for providing monthly Unit reports.
- SSI activity is monitored through the IMDT meeting for engagement and oversight from the surgical body.
- In line with PSIRF, SSI MDT reviews take place bi-annually (or sooner if the upper control limit is reached) to explore contributory factors and agree recommendations and actions.

Infection Prevention & Control and Cleanliness Annual Report 2024/25

Conclusion

This year the IPC team have focussed supporting sustained standards of IPC across the Trust. We have updated all IPC policies to reflect evidence-based practice. We have seen improvements across all clinical areas around ownership and engagement of IPC, and integrated working is embedded across the Trust. We continue to work collaboratively and have unique working relationships with our Estates & Facilities Team to ensure that required works are completed in a timely and safe way.

We have expanded the IPC Team which has increased the ability to provide hands on support in all areas, with a more proactive approach to supporting and advising the Trust on all IPC matters.

Over the next few weeks, the team are working on a new strategy with new ambitions that support best practice, and are excited to be planning on working alongside the Training and Development Team to provide new ways of learning through simulation, and 'serious gaming'. The move away from traditional teaching methods is welcomed by staff and will aid knowledge retention, resulting in even better patient care.

The team are very close to moving towards digital transformation and going live with the Apollo System which will go live in May 2025.

We are delighted to say that we have seen a sustained approach to IPC across the Trust and, this has shown in a reduction of healthcare-associated infections despite the challenges faced nationally.

The IPC Team would like to thank the staff at RJAH for their commitment and dedication to their roles, and for immersing into all aspects of IPC improvement which has contributed to better patient outcomes. We look forward to working alongside you all again this year.

Samantha Young	Interim Chief Nurse and Director of Infection Prevention and Control (DIPC)
Anna Morris	Clinical Lead for Infection Prevention & Control
Hayley Gingell	Quality Assurance Lead

May 2025

Patient Experience Annual Report

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 02 July 2025

Author:

Name: Alison Harper
Role/Title: MSK, Clinical Governance Manager

Contributors:

Matthew Hughes, Clinical Governance Assistant

Report sign-off:

Sam Young, Interim Chief Nurse and Patient Safety officer
Quality and Safety Committee, 19 June 2025

Is the report suitable for publication:

Yes

Key issues and considerations:

The purpose of this report is to provide insight into what patients think about their experience of care received at the RJAH between April 2024 - March 2025

The Trusts collects patient experience data as an active part of monitoring the quality of care which provides an important “health check” of the services we provide as well as promoting a strong culture of listening to patients and improving services.

The overall evidence collected in this report provides assurance that the hospital is delivering services that are truly patient centred and identified actions to improve the patient experience with the timely resolution of complaints and PALS concerns.

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:

Following a consideration at the Quality and Safety Committee, it is recommended that the Board approved the annual report.

Patient Experience Annual Report

Next Steps:

Progress with actions being taken outlined below:

Acronyms

PALS	Patient Advice and Liaison Service (PALS)
FFT	Friends and Family Test questions
EDI	Equality, Diversity, and Inclusion
CQC	Care Quality Commission
IQVIA	IQVIA patient feedback system

#Caring for Patients
Patient Experience Annual Report
April 2024 - March 2025

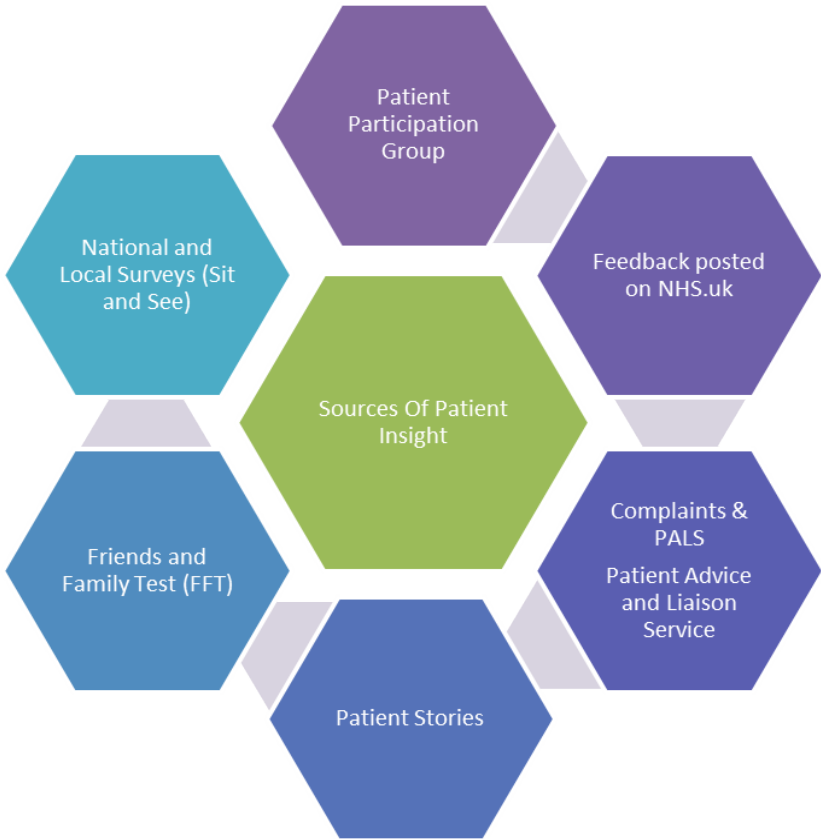
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Patient Experience Annual Report

Summary

Collecting patient experience data is an important part of monitoring the quality of care provided at the RJAH and provides an important insight into areas where we need to improve from the patient perspective.

This report provides an overview on patient experience feedback collected during 2024-2025 from a number of sources. This includes PALS concerns, Complaints, Friends and Family (FFT) surveys, Patient Stories, Patient Engagement, and Shropshire Healthwatch.



The table below shows overall patient feedback in 2024/2025 compared to 2023/2024:

Feedback	2023/24	2024/25	Diff from 2023/24 to 2024/25	% Change
Complaints	98	144	46	47%
Local Resolution	44	51	7	16%
PALS concerns	424	618	194	46%
Trust enquiries (via RJAH emails, PALS email, PALS telephone and website). Not PALS concerns	4979	6211	1232	25%
Compliments	13189	13207	18	0%
FFT result	98%	98%	-	-

Patient Experience Annual Report

Key highlights April 2024 to March 2025

- During 2024/2025, the Trust has continued to work towards completing the commitments identified in our Patient Experience Strategy (2021-2024) with 50 actions being completed.
- Results from the National Inpatient Survey 2023 were highly recognised by the CQC with RJAHH being one of the top nine performing Trusts across England. The Trust once again scored 1st in the country for overall patient experience, for the sixth consecutive year.
- Monthly patient feedback collected over 2024/2025 continues to also be positive; with 13207 compliments being received and 98% of patients (25,035), said their experience was good or very good.
- Four Patient Engagement meetings were held in 2024/2025 with an active work plan and agenda items.
- The Trust works in partnership with Shropshire Healthwatch, who attend the Trusts Patient Experience Meeting, PLACE inspections and the Patient Engagement Group
- The Trust uses patient stories as a source of patient insight and the Trust Board often starts with a patient story. 3 patient stories were shared at the Trust Board
- 144 formal complaints were received in 2024/25, an increase from last year by 46, 47%.
- The main theme for complaints is waiting times for treatment, management of future care, values and behaviours, and communications.
- 95% of standard complaints were closed within timescales and 66% of complex complaints. In 2024/25 complaints received have been more complex in nature.
- 23 complaints were re-opened, no trends identified as separate issues raised in each.
- The Trust recognises that complaints resolution provides an opportunity to learn and helps drive quality improvement. 49 complaints closed had 89 actions identified.
- 618 PALS reported in 2024/25 an increase of 46%. The top reasons for a patient contacting PALS were: Waiting times (206), Appointment delays and cancellations (75).
- The Trust received 6211 enquiries dealt with by PALS (from RJAHH emails, PALS email enquiries, PALS telephone and website), this is a 25% increase compared to the previous year. These are not PALS concerns. These relate to treatment dates; GP expedite letters and emails for consultants.
- Results from monthly IQVIA feedback survey were all positive across the questions asked

Patient Experience Annual Report

Heat Map Summary April 2024 – March 2025

	target	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	24/25 total
Total Complaints received in month	8	11	7	18	15	9	12	22	11	6	9	13	11	144
Standard complaints		8	6	16	10	9	11	17	11	6	5	11	9	119
complex complaints		3	1	3	5	0	1	5	0	0	4	2	2	26
% Standard Complaints Response Rate Within 25 Days due in month (from KPI)	100%	100%	100%	100%	87.50%	81.25%	100%	100%	91.67%	100%	100%	80%	100%	95%
% Complex Complaints Response Rate Within 40 Days due in month (from KPI)	100%	100%	75%	75%	0%	50%	80%	100%	100%	0%		100%	50%	66%
Standard complaints responded to in 25 working days target	no target	6	3	6	14	13	13	14	11	10	11	4	5	110
Standard complaints due to be responded to in 25 working days target	n/a	6	3	6	16	16	13	14	12	10	11	5	5	117
Complex complaints responded to in 40 working days target	n/a	1	3	3	0	1	4	1	1	0	0	2	1	17
Complex complaints due to be responded to in 40 working days target	n/a	1	4	4	1	2	5	1	1	3	0	2	2	26
PALS converted to complaint - Initiated by Patient	n/a	1	1	4	3	2	1	2	1	1	0	1	0	17
PALS converted to complaint - Initiated by Trust	n/a	1	1	0	0	2	1	0	0	0	0	0	1	6
% Complaints progressed from PALS	no target	18%	29%	22%	20%	44%	17%	9%	9%	14%	0%	8%	9%	1.99
Complaint FULLY upheld	no target	2	1	3		1	1	1	3	1			2	15
Complaint NOT upheld	no target	4	1	5	3	1	1	8	5	1	4	4	3	40
Complaint PARTIALLY upheld	no target	5	5	10	12	7	10	13	3	4	5	9	6	89
re-opened complaint	0	1	1	1	4	2	2	3	2	1	2	2	2	23
Complaints with action plan closed	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Complaints referred to the Ombudsman	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PALS concerns	no target	40	28	54	53	52	47	73	58	37	69	60	47	618
Trust enquiries (via RJAH emails, PALS email, PALS telephone and website). Not PALS concerns		460	484	536	482	485	545	552	565	468	575	493	566	6211
FFT	95%	97.80%	98.40%	98.40%	98.28%	98.61%	98.38%	98.36%	97.63%	98.69%	98.63%	97.85%	98.16%	98%
negative FFT scores (not Good or very good)	no target	48	23	35	40	27	32	38	52	23	33	46	40	437
Compliments	no target	1157	789	1170	1239	1120	1079	1146	1115	937	1257	1071	1127	13207
Key														
green is used where targets have been met														
red where targets have not been met														

Patient Experience Annual Report

Patient Experience Strategy 2021-2024

Aligned to the Trust Quality Strategy (2024 to 2027), during 2024/2025 the Trust has continued to work towards completing the commitments identified in our Patient Experience Strategy (2021-2024).

The Patient Experience improvements commitments aspired to provide patients, carers, and their relatives with world class care. To provide the best patient experience of care at each phase of the patient pathway and interaction with our staff to put patient experience at the heart of everything we do.

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

The Patient Experience improvements commitments were:

1. We will work in partnership with our patients and actively involve them in decisions about their care.

2. We will communicate to our patients in a manner that is accessible and appropriate to their own individual needs whilst listening to our patients about their priority of care and what matters most to them.

3. We will involve our patients and services users and the public generally in decisions regarding the way we deliver services and any future developments.

4. We will engage with our patients to facilitate patients to manage their own health conditions and get the best out of their wellbeing.

5. We will further develop the role of volunteers to ensure we maximise their input to enhance patient experience

During 2024/2025, progress towards these commitments have been tracked through the Patient Experience Improvement plan with 50 actions being completed.

The current Patient Experience Strategy is being refreshed in 2025 taking on board the principles from the Experience of Care Improvement Framework released by NHS England in February 2025. This set out guidance on ensuring NHS services have a whole system approach to listening, collecting, analysing, learning and using feedback for continuous improvement as well as an effective leadership and a receptive culture

National Adult Inpatient Survey 2023 results

The NHS Adult Inpatient Survey runs every year, and all NHS Trusts in England are required to conduct the survey to provide a measure on what our patient think about their experience.

Results of the Inpatient Survey 2023 were publicised in July 2024. A total of 162,492 patients were invited to participate in the survey across 131 acute and specialist NHS trusts.

- The results from the National Inpatient Survey 2023 were highly positive. The Care Quality Commission (CQC) recognised the RJAH as one of the top nine performing Trusts across England.



Patient Experience Annual Report

- The Trust once again scored 1st in the country for overall patient experience, for the sixth consecutive year.
- The quality of the Trust food provided has been rated No 1 in the country for the 18th time in the last 19 years.

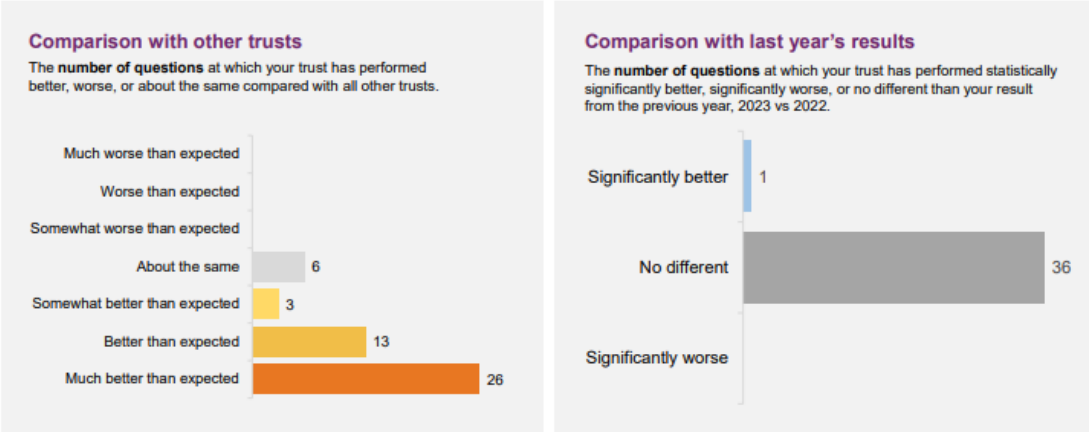
Results compare to previous years with national, highest and lowest results for the question on overall patient experience.

	2018	2019	2020	2021	2022	2023	2024
National Average	8.1	8.1	8.4	8.1	8.1	8.1	
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS TRUST	9.1	9.2	9.5	9.4	9.4	9.3	Data not published until July 25
Highest	9.1	9.2	9.5	9.4	9.4	9.3	
Lowest	7.3	7.4	7.5	7.4	7.4	7.5	

Areas performing well and for improving

- The Trust is performing better than most Trusts across 42 questions and the 2024 results are aligned to the RJAH’s previous year results with no worse results for a question.

Summary of findings for your trust



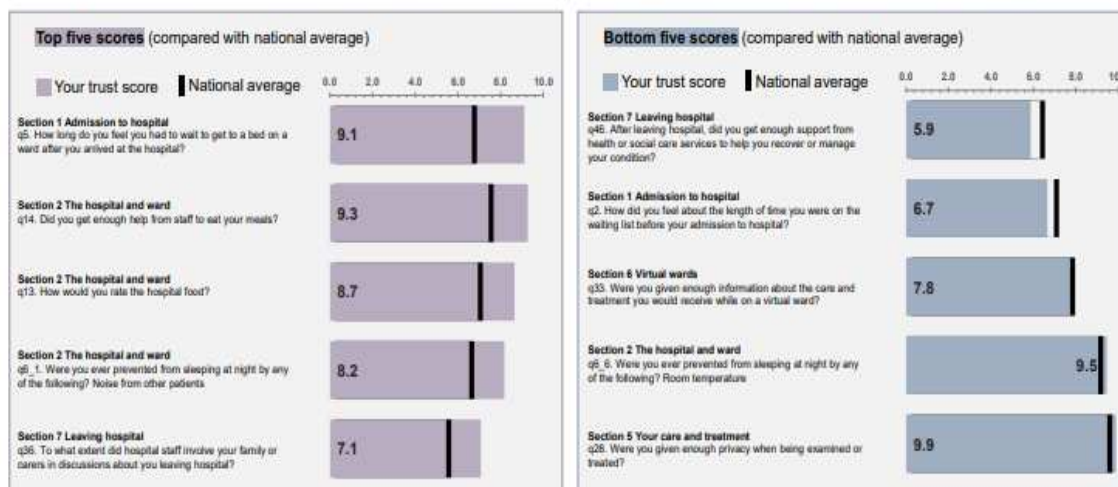
- The chart below shows the RJAH top and bottom results compared to the national average.

Patient Experience Annual Report

Best and worst performance relative to the national average

These five questions are calculated by comparing your trust's results to the national average (the average trust score across England).

- **Top five scores:** These are the five results for your trust that are highest compared with the national average. If none of the results for your trust are above the national average, then the results that are closest to the national average have been chosen, meaning a trust's best performance may be worse than the national average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the national average. If none of the results for your trust are below the national average, then the results that are closest to the national average have been chosen, meaning a trust's worst performance may be better than the national average.



Areas identified for Improvement

- Question 7 : Leaving Hospital
Support from health or social care services: Patients getting enough support to recover/manage condition after leaving hospital
- Question 2 : Admission to Hospital
Waiting list: Length of time on waiting list before hospital admission

These two themes will be taken forward in the refreshed Patient Experience Strategy in 2025 and how patient can be supported prior to admission and after discharge.

Patient Engagement

The Trust has a Patient Engagement Group that works in partnership with patients, staff, and stakeholders to help ensure services are patient centered and meets quarterly.

Patient Engagement group membership includes:

Current and previous patients, Shropshire Healthwatch, Oswestry Rheumatology Association, Shropshire Patients Group, Shropshire Carer's, Spinal Injuries Association, League of Friends and staff representatives from Patient Safety, Governance, Multi-faith Lead, Quality Improvement, Estate and Facilities, and Matrons.

Four Patient Engagement meetings were held during 2024/2025, (April 24, July 24 October 24 and February 2025) with an active work plan covering the following agenda items:

- Patient Experience Improvement Plan
- Quality Accreditation
- GIRFT diabetic passport
- Trust Strategy
- Health Inequalities and Weight Management
- Nutrition and Hydration
- Inpatient Survey results 2023
- Patient Safety Incident Response Framework (PSIRF)
- PLACE inspections
- Estates Sustainability and the Green Plan
- Learning Disabilities and Autism

Patient Experience Annual Report

- Enhanced Recovery
- Digital and Apollo implementation EPR system
- End of Life project
- Martha's Rule
- Volunteers Update
- Patient Information Leaflets for approval

Patient representatives involved in Trust activities.

- Members of the Patient Engagement group have also been actively involved in attending the Patient Experience Meeting, Nutrition and Hydration Group, presenting patient stories to Trust Board, PLACE inspections, staff stakeholder interview panels and reviewing patient information leaflets.
- Patient Safety Partners have been recruited as part of the implementation of the Patient Safety Incident Response Framework (PSIRF) and invited to attend the Patient Safety Working Group and Patient Safety Meeting.

Patient Stories and Compliments

The Trust uses patient stories as a source of patient insight and the Trust Board often starts with a patient story. 3 patient stories were shared at the Trust Board, which are detailed below.

• Trust Board May 24

An ex-RAF veteran patient shared their experience at the May 2024 Board meeting about the treatment for an ankle replacement and the wait time anticipating being seen quicker as a veteran. The patients feedback was complimentary, however suggested improvements were on the improved communication and staff training for the Veterans policy, and improved communication on waiting times whilst waiting for surgery.

Outcome:

Patient story followed up as a formal complaint and Trust reply provided. Service Manager to provide training to operational management teams across the Trust to ensure staff are aware on how patients are prioritised and how the Veterans covenant is applied to the treatment of patients.

• Trust Board September 2024

A patient story was shared at the September 2024 Trust Board highlight their patient pathway from GP referral in 2019 to see a hip consultant for an opinion in 2024. Referral went via the Referral Assessment Service NHS Shropshire, Telford and Wrekin (RAS), Musculoskeletal Services Shropshire and Telford (MSST) and patient spent 3 weeks chasing referrals that appeared to be routinely mislaid. Patient angry frustrated and confused as to why after 15 months since referral, there was no date for an appointment with the consultant.

Outcome:

Patient story followed up as a formal complaint and Trust reply provided. Learning identified for improvement in the MSST Orthopaedic referral pathways and for improved communication between Shropshire partner organisation including RJA Patient Access team, MSST and Referral Assessment Service (RAS and TRAQ's).

• Trust Board meeting January 2025

A patient story was shared at the January 2025 Trust Board meeting by a patient who was a retired police officer and has sustained a number of injuries which resulted in problem with back and hip pain and also suffered with PTSD. Patient had hip replacement and appointment with spinal consultant.

Patient Experience Annual Report

Patient very complementary with consultant, clinical staff in Theatres, Recovery and Clwyd ward, and reported "there is no Hospital matching ours and our standards are incredible".

Outcome:

No improvement identified and compliments share with the relevant staff.

There were 13207 compliments received across departments recorded in the IQVIA system which has increased by 18 from last year. These are share with staff



NHS Website comments

There was a total of 6 compliments and 1 suggestion to improve, posted on the NHS website during 2024/2025.

- The positive comments received were positive highlighted the excellent care provided by the consultant and staff. Patients expressed their gratitude and described their experiences as wonderful.
- There was one negative comment about waiting over a month to get their Xray results.

Healthwatch

The Trust works in partnership with Shropshire Healthwatch, who attend the Trusts Patient Experience Meeting, PLACE inspections and the Patient Engagement Group.

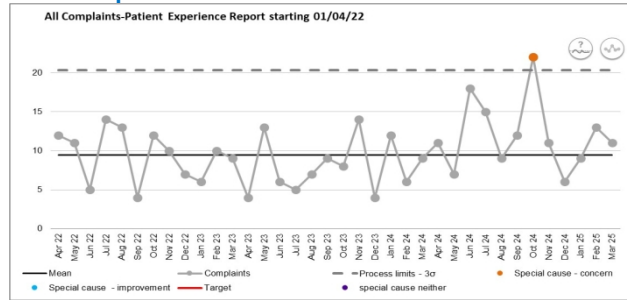
Healthwatch only shared one feedback report from the feedback data collected for period May 2024 - August 2024. 54 comments, 55 were positive, 24 had a negative aspect and 4 were neutral. The negative comments were across several themes, but highest theme was noted related to be parking (8) and waiting times (3).



Formal Complaints

- There were 144 formal complaints received in 2024/25, an increase from last year by 46, 47%.(98 were received in 2023/24)
- There has been 119 standard complaints (83%) and 26 (17%) complex complaints.
- In 2024/25 the concerns raised are more complex in nature compared to 2023/2024, with 12 complex complaints (12%).
- No specific theme was identified for the increase seen in October in the below SPC chart (main reason for complaints in October 24 was wait times or appointment delays).

Patient Experience Annual Report



Top themes of Complaints:

The table below compares complaints themes by year with the complaint category of complaint.

- The main theme for complaints is waiting times for treatment (40), management of future care (25), values and behaviours (21).
- Complaints have decreased for admission and discharge, and privacy and dignity perspectives.

	2023/2024	2024/2025	Diff
Waiting Times & Appt	18	40	22
Management of Future Care	19	25	6
Values & Behaviours (Staff)	15	21	6
Communications	8	17	9
Patient Care including Nutrition / Hydration	15	16	1
Admissions, discharge and transfers excluding delayed	11	8	-3
Facilities Services	2	4	2
Prescribing Errors	0	4	4
Access to treatment or drugs (including decisions made)	0	3	3
Other	3	2	-1
Trust Administration	1	2	1
Consent to treatment	1	1	0
Privacy, dignity and wellbeing	4	1	-3
Total	97	144	47

- Themes from Waiting times for surgery or appointment (40):**
Top specialties are

Breakdown of complaint subject	Complaints on waiting times
Spinal Surgery	13
Arthroplasty	8
MSST	5
Foot & Ankle	2
Hand & Upper Limb	2
MSK - Veterans Services	2
Radiology	2
Sports Injuries	2
Ludlow - Private Patient	1
Metabolic Medicine - DXA	1
Rheumatology - Outpatient	1
Therapies - Physiotherapy	1
Grand Total	40

- Themes from Management of Care (25):**

Patient Experience Annual Report

Breakdown of complaint subject	Complaints mangement of care
Post operative complications	5
Unhappy with MSST pathways	5
Outcome of clinic appt	5
Comunication between staff	2
Unhappy with diagnosis	2
Delays to getting appointment, care whilst he was an inpatient	1
Pateint attended SATH with no nurse escort	1
Patient care including issues with OT,Physio, Psychology, and facilities	1
Patient has concerns about prolonged inpatient status	1
Refusal by MCSI to accept referral for patient's care	1
Unhappy that under three Trusts and not one care plan	1
Grand Total	25

• Staff behaviour by profession (21):

- Consultant Surgeon (15)
- Secretary/Administration/Clerical staff (2)
- Nursing staff (2)
- AHP staff (2)

Complaints by Department :

- The MSK Unit received the highest number of complaints (MSK 83 (58%), Specialist 57(40%), Corporate 4, (3%).
- The highest department was in the Spinal Surgery and Arthroplasty Specialties (these complaints primarily relate to waiting times)

Improvement Action:

Given the notable increase in the number of complaints received across the year, a deep dive into complaints has been requested. The output will be shared with members of the Patient Experience Meeting.

Complaint Performance

The Trust is required to acknowledge all responses within three working days; this target was met.

From April 24-March 25, the Trust internal target to resolve standard complaints was within 25 working days and complex complaints within 40 working days.

- **95% of standard** complaints were closed within timescales and **66% of complex** complaints.
- 7 standard complaints did not close on time 9 complex complaints. Reasons for breach include delay in receiving comments, complex nature of complaints and queries at final signoff.

The Trusts Complaints Policy was updated in March 2025 to align with the Parliamentary Health Service Ombudsman (PHSO) NHS complaints standards. As part of this exercise, we benchmarked our complaints response times against members of the National Orthopaedic Alliance and have reflected our response times accordingly. The new response times for standard complaints is 30 working days and complex complaints within 45 working days.

Complaints re-opened.

- 23 complaints were re-opened with a further reply provided. No trends identified as separate issues raised in each. This is increased from 2023/24 with 16 complaints were re-opened.

Patient Experience Annual Report Complaints Upheld

For 24/25, 15 complaints were fully upheld complaints, 89 partially upheld and 40 not upheld.

Definition of upheld complaints

If a complaint is received which relates to one specific issue, and substantive evidence is found to support the complaint, then the complaint should be recorded as upheld.
Where there is no evidence to support any aspects of a complaint made, the complaint should be recorded as not upheld.
If a complaint is made regarding more than one issue, and one or more of these issues (but not all) are upheld, the complaint should be recorded as partially upheld.

Learning from Complaints

The Trust recognises that complaints resolution provides an opportunity to learn and helps drive quality improvement. Actions plans are produced when service improvements are identified as part of the complaint investigation.

- For complaints closed during 2024/25, 49 complaints had 89 actions identified.
- Any actions or learning from complaints is being logged in a complaint action tracker to provide robust evidence that actions identified are being implemented and closed.
- Learning and actions from complaints are shared via the Monthly Unit reports, Specialty reports and at the Patient Experience Meeting.

Learning identified by category of complaint.

	MSK Unit	Specialist Unit	Grand Total
Integrated Care	4	4	8
Values & Behaviours (Staff)	4	3	7
Appointments including delays and cancellations	5	1	6
Communications	3	3	6
Patient Care including Nutrition / Hydration	6		6
Waiting Times	4	2	6
Facilities Services	2	1	3
Access to treatment or drugs (including delays)	1	1	2
Prescribing Errors	2		2
admissions, discharge and transfers excluded	1		1
Privacy, dignity and wellbeing		1	1
Trust Administration	1		1

Examples of learning from closed complaints

CRP 1024-12 Powys Ward.

Patient raised concerns about nursing staff on ward, with the complaint centring around staff communication skills, handling of mental health conditions and sharing of personal information.

Learning: Ward manager has arranged for staff to participate in targeted mental health training to ensure that staff are better equipped to understand patients with mental health issues in the future

CRP 0924-12 MRI

Patient shared concerns following visit to MRI dept surrounding issues with privacy and dignity and staff attitude.

Learning: The Radiology department are introducing pyjama-style gowns with support from the charitable funds to ensure patients feel more comfortable and dignified during their MRI appointment. Staff also reminded to remain in line with trust values and behaviours.

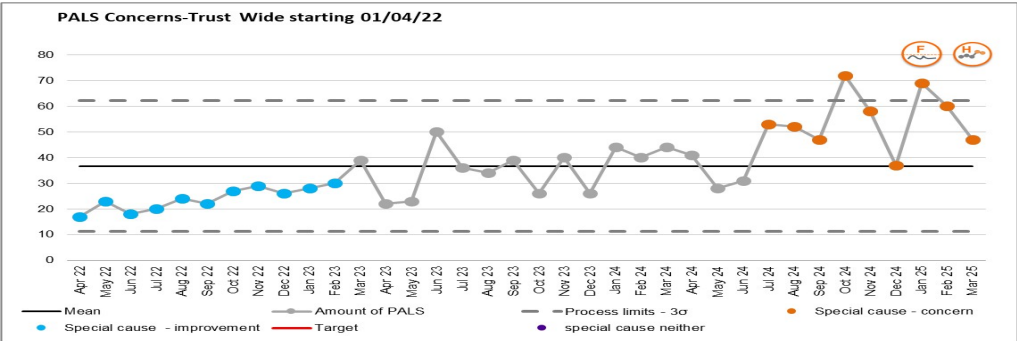
morphine sulphate at 08:00am, however the patient was given 60mg of oramorph instead.

Learning: For a period of eight weeks on commencing in post, all new nursing staff will be required to undertake a two person check when administering Oramorph.

Patient Experience Annual Report

PALS concerns

In 2024-25, there were 618 PALS concerns received, 194 more than in the previous year, an increase by 46%



Top theme of PALS concerns:

- The top reasons for a patient contacting PALS were:
 - Waiting times (206)
 - Appointment delays and cancellations (75)
 - Management of future care (79)
 - Communications (74)

The top five reasons for PALS concerns in 2024/25

	2023/2024	2024/25	Diff
Waiting Times	92	206	114
Management of Future Care	66	79	13
Appointments including delays	63	75	12
Communications	42	74	32
Values & Behaviours (Staff)	33	50	17
Admissions, discharge and canc	35	27	-8
Patient Care	24	23	-1

For waiting times and appointment delays (206) the highest specialties are shown below (above 10):

Patient Experience Annual Report

Speciality	PALS concerns waiting times
Specialist - SPINAL DISORDERS	86
MSK - ARTHROPLASTY	70
MSK - SPORTS INJURIES	19
Specialist - RHEUMATOLOGY	19
MSK - FOOT & ANKLE	18
MSK - SOOS MSST	12
MSK - UPPER LIMB	11
Specialist - METABOLIC SERVICES	9

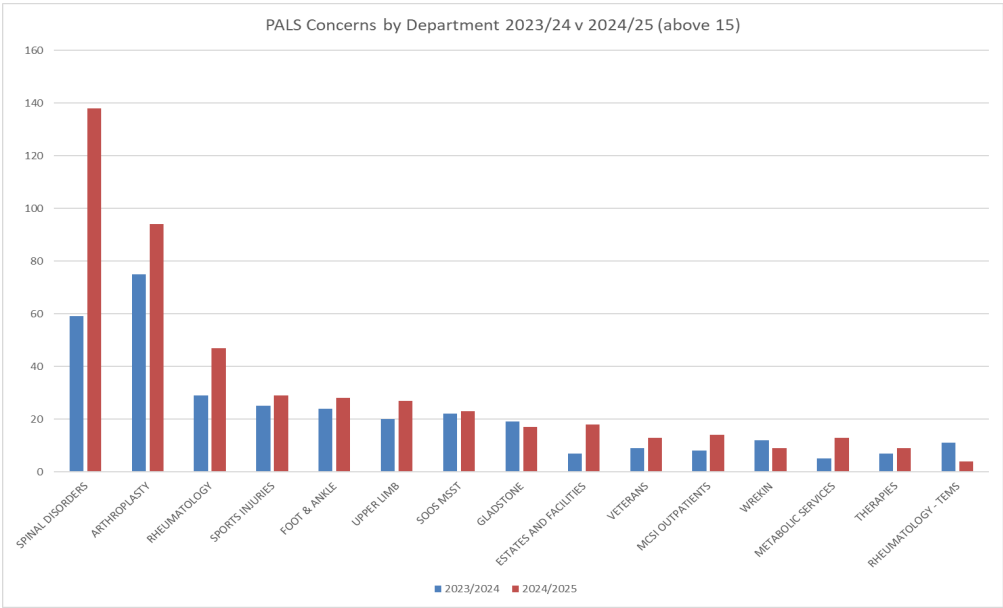
For management of care (79) the highest specialties are shown below

Speciality	PALS concerns mangement of care
Specialist - SPINAL DISORDERS	17
MSK - ARTHROPLASTY	7
MSK - SOOS MSST	6
Specialist - MCSI OUTPATIENTS	6
MSK - UPPER LIMB	5
Specialist - GLADSTONE	4
Specialist - WREKIN	4
Specialist - RHEUMATOLOGY	4
Radiology	4

PALS concerns by Department :

- In 2024/25 MSK Unit received 291 PALS concerns, Specialist received 304 and corporate services received 23 PALS concerns.

The graphs below show PALS concerns received by department for 2024/25 (above 15)

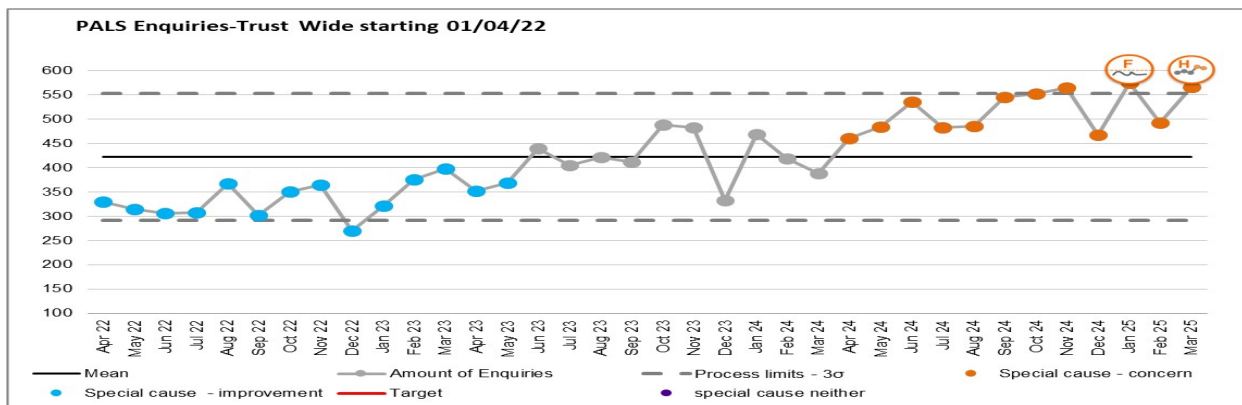


Trust Enquiries (requests for information or passing on emails/information) dealt with by PALS

Patient Experience Annual Report

The Trust received 6211 Trust enquiries dealt with by PALS (from RJAH emails, PALS email enquiries, PALS telephone and website), this is a 25% increase compared to the previous year. These are not PALS concerns. The main theme of enquiries relates to treatment dates, GP expedite letters and emails for consultants.

	2023/2024	2024/2025	diff
Enq Email	3258	4205	947
PALS Email (not PALS concerns)	494	536	42
Telephone	729	926	197
web enquiries	498	544	46
total	4979	6211	1232



Locally resolved issues.

There were 54 local resolutions reported from the ward/department. These are concerns resolved on the spot by ward or department staff. The main concerns resolved locally are on MCSI Inpatient Ward (27) then Ludlow Ward (8).

Row Labels	Local resolutions
Specialist - GLADSTONE	16
Specialist - WREKIN	11
MSK - LUDLOW	8
Specialist - MCSI OUTPATIENTS	5
Specialist - MONTGOMERY	2
Specialist - ORLAU	2
Specialist - POWYS	2
Specialist - SHELDON	2
MSK - MRI	1
MSK - PRE-OPERATIVE ASSESSMENT UN	1
Specialist - CHILDREN'S OUTPATIENTS	1
Specialist - MEDICAL SECRETARIES	1
Specialist - OUTPATIENTS DEPARTMENT	1
Specialist - SPINAL DISORDERS	1
Grand Total	54

Cases referred to the Parliamentary & Health Service Ombudsman (PHSO)

No cases referred to the PHSO throughout 2024/25

Friends and Family Test (FFT)

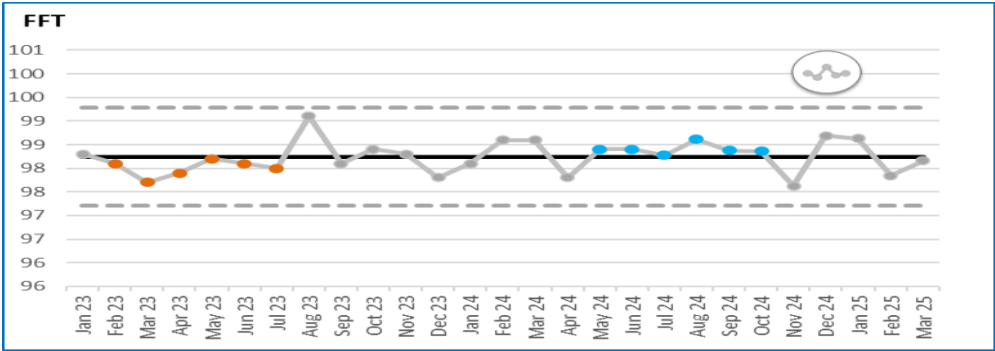
The NHS Friends and Family Test (FFT) "Overall, how was your experience of our service" provides patient feedback to assess if patients are happy with the service provided, and suggestions for how to improve.

Patient Experience Annual Report

FFT data is collected in real time using the IQVIA patient feedback system and patients are sent a text to invite them to complete a FFT survey electronically (after discharge or clinic appointment). Paper cards are also on display in wards/departments, as well as poster with QR codes.

- For 2024/2025, 25,035 patients completed a FFT feedback survey.
- 98.3% of patients (24,599) said they would rate their experience as good or very good.

The chart below shows the average FFT score per month.



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

	2020/ 21	2021/ 22	2022/ 23	2023/ 24	2024/ 25
National Average	94%	94%	94% *	94%*	94% *
Highest Score	100%	100%	100% *	100%*	100% *
Lowest Score	65%	64%	73% *	75%*	69% *
The Robert Jones and Agnes Hunt	98%	98%	98%	98%	99%

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

The top themes of the negative comments from FFT scores are shown below for 2024/25. FFT results are shared in Unit, department, and Speciality level Governance Quality reports with trends of low scores monitored monthly.

Patient Experience Annual Report

	Q1	Q2	Q3	Q4	Grand Total
waiting times	31	28	30	42	131
poor communication	19	13	15	17	64
unhappy with outcome of appt	13	19	17	13	62
staff attitude	13	12	9	9	43
no comment	7	10	13	10	40
compliment	4	6	8	10	28
cancelled surgery	1	4	3	6	14
admin error	4	1	1	1	7
accessibility	4	1	1		6
cancelled appointment		1	5		6
equipment issues		1		5	6
staffing issues			3	3	6
dignity and privacy	2		2		4
Nursing care		2	2		4
car parking	1	1			2
catering			1	1	2
estates & facilities				2	2
lost property				2	2
cleanliness		1			1
GP issues			1		1
Grand Total	99	100	111	121	433

IQVIA Patient feedback surveys:

As well as being asked the FFT question, patients are asked several other questions about their visit for inpatients and outpatients.

The results for 2024/25 for the IQVIA inpatient and outpatient surveys are shown below with all questions receiving high scores:

Question text	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Total
1. Overall, how was your experience of our service? Please can you tell us why you gave your answer.	99	98	98	98	98	99	97	98	99	98	97	98	98
Total	99	98	98	98	98	99	97	98	99	98	97	98	98

About your care

Question text	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Total
7. Were staff caring and compassionate?	99	98	98	99	99	99	98	99	99	99	98	99	99
8. Did you like the food provided, if you were offered any? (If not please leave blank)	90	88	91	90	90	92	89	91	91	90	89	89	90
9. Did you feel the ward was clean?	99	99	99	99	99	99	99	100	99	99	99	99	99
10. Did you find the staff welcoming and friendly?	99	99	99	99	99	99	99	99	99	99	98	99	99
11. Did you feel that the noise levels were acceptable at night?	88	89	88	90	86	88	87	86	89	85	86	90	88
12. Did the staff practice good hand hygiene?	99	99	98	98	99	99	98	99	99	98	98	99	99
13. Was your privacy/ dignity & comfort respected?	99	98	99	99	99	100	98	99	99	99	99	99	99
14. Was your admission date changed by the hospital?	89	91	88	90	90	89	86	86	89	90	89	91	89
15. After leaving hospital, did you get enough support from staff?	91	89	91	92	92	92	87	94	93	95	94	91	92
16. Were you involved as much as you wanted to be in decisions about your care and treatment?	97	94	95	94	94	96	94	96	96	96	93	94	95
Total	95	95	95	95	95	96	94	95	96	95	95	95	95
Overall	95	95	95	96	95	96	94	95	96	96	95	96	95
Total number of surveys	328	282	323	420	298	271	308	342	273	383	327	344	3,899

Patient Experience Annual Report

Question text	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Total
1. Overall, how was your experience of our service? Please can you tell us why you gave your answer:	96	97	97	97	98	97	97	97	97	97	97	97	97
Total	96	97	97	97	98	97	97	97	97	97	97	97	97

About your care

Question text	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Total
3. Did you feel that the department was clean?	99	99	99	99	99	99	99	99	99	99	99	99	99
4. Were you informed about waiting times?	86	90	87	86	88	88	88	87	88	87	88	88	88
5. Did you find the staff welcoming and friendly?	98	98	99	99	99	99	98	99	98	99	99	99	99
6. Was your privacy/ dignity & comfort respected?	99	99	99	99	99	99	99	99	99	99	99	99	99
7. Did the Health Care Professional explain the procedure satisfactorily? (if you had one - if not please leave blank)	98	99	98	98	99	98	99	98	98	98	98	98	98
8. Were staff caring and compassionate?	98	98	99	98	99	99	99	99	98	98	99	99	99
9. Did the Healthcare Professional introduce themselves?	98	98	98	98	98	98	99	98	98	98	99	98	98
10. Did the Health Care Professional listen to you?	98	99	99	99	99	99	100	99	98	99	99	100	99
Total	97	98	97	97	98	97	98	97	97	97	97	97	97
Overall	97	97	97	97	98	97	98	97	97	97	97	97	97
Total number of surveys	870	912	992	973	869	868	917	970	777	1,053	904	989	11,094

Sharing Patient monthly feedback in the Radiology department:

Patient Experience Annual Report

Radiology Feedback Posters



Health and Safety Annual Report 2024/25

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 02 July 2025

Author:

Name: Ian Gingell
Role/Title: Health and Safety Manager

Contributors:

Report sign-off:

Name: Nick Huband, Director of Estates and Facilities
Quality and Safety Committee, 19 June 2025

Is the report suitable for publication?:

Yes

Key issues and considerations:

Annual report of health and safety activities for financial year 2024/25

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:

Following a recommendation from the Quality and Safety Committee, the Board is asked to consider and approve the annual report.

Health and Safety Annual Report 2024/25

1. Health and Safety Annual Report

1.1 Introduction

The Health & Safety Executive (HSE) has memoranda of understanding with other regulatory bodies including the Care Quality Commission, General Medical Council and the Nursing and Midwifery Council, which set out roles and responsibilities and clarifies which regulator is likely to act in the event of a patient or member of staff suffering serious harm/death.

The HSE focus their investigations on systemic failure of management systems, which may include:

- Systemic failures to comply with statutory health and safety duties.
- The absence of or wholly inadequate arrangements for assessing risks to health and safety.
- Lack of suitable controls and inadequate monitoring and maintenance of the procedures or equipment needed to control the risks, resulting in serious harm or death.

The HSE may, dependant on the circumstances, investigate RIDDOR reportable incidents which include some needlestick injuries, work related injuries and serious injuries or ill-health caused by hazardous substances.

1.2 Health and Safety Arrangements

The Trust had a clearly defined structure for health and safety reporting:



The Chief Finance Officer retained Board-level responsibility for health and safety. The Trust employed a health and safety team comprising of a manager and an advisor to comply with the requirement to appoint a competent person under section 7(1) of the Management of Health and Safety Regulations 1999.

In addition to general health and safety management, the team also undertook the roles of Medical Devices Safety Officer, Central Alerting System Liaison Officer, Emergency Preparedness, Resilience and Response Lead, Premises Assurance Model Compliance Lead, and Violence Prevention & Reduction Lead.

The team also provided health and safety, security management, and medical devices management support to Shropshire Community Health NHS Trust via a service level agreement.

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

Health and Safety Annual Report 2024/25

1.3 Fee for Intervention (FFI)

A fee for intervention is charged if the HSE identify a material breach of health and safety law. A material breach is something which an inspector considers serious enough that they need to formally write to the Trust requiring action to be taken to rectify the breach.

The fee is currently £174 an hour (increasing to £183 in 2025/26) and the total charge would include the costs covering the HSE inspector's time during inspections, preparing reports, obtaining specialist advice and any costs associated with formal enforcement or prosecutions.

The Trust did not incur any fee for intervention costs in 2024/25.

1.4 Health and Safety Management Systems

Organisations have a legal duty to put in place suitable arrangements to manage for health and safety.

The Health and Safety Executive provide a framework in the form of the document 'Managing for Health and Safety' (HSG65). This framework outlines the management arrangements and systems that organisations should have in place to manage their health and safety risks in a proactive manner. It also treats health and safety management as an integral part of good management generally, rather than as a stand-alone system.

The limited health and safety resource led to a mostly reactive approach leading to challenges in adhering to the HSG65 'Plan, Do, Check, Act' model, however a summary of the activities related to the model are detailed below.

PLAN

The Health and Safety Committee met bi-monthly throughout the year, via Microsoft Teams, and included health and safety representatives from staffside unions in compliance with the Safety Representatives and Safety Committees Regulations, 1977.

The Health and Safety Working Group, chaired by the Health and Safety Advisor, also met bi-monthly and provided an invaluable forum for the management of operational level safety issues.

The Trust employed a Health and Safety Manager, supported by a Health and Safety Advisor, to undertake the role of Competent Person as required by the Management of Health and Safety Regulations 1999, supported by a Health and Safety Advisor.

DO

The Health and Safety Committee met bi-monthly during 2024/25 and monitored health and safety incidents, RIDDOR reported incidents, safety alerts and legislation changes.

The overarching Health and Safety policy set out the organisational duties of Trust employees and detailed the arrangements required to comply with the Health and Safety at Work, etc Act and the Management of Health and Safety at Work Regulations.

Health and safety risk assessments were recorded in DATIX risk module and monitored in accordance with the Trust's Risk Management Strategy.

The Health and Safety Working Group led on resolving operational level health and safety issues.

CHECK

A programme of health and safety spot checks continued, with unannounced safety checks being carried out by the Trust's Health and Safety Advisor.

The Trust had a comprehensive incident reporting system in operation. The DATIX database was utilised to record all staff, patient and visitor health and safety related incidents. Fire, security, and violence and aggression incidents were reported to the Health and Safety Meeting via a Chair report from the Fire, Security and Electrical Systems Group.

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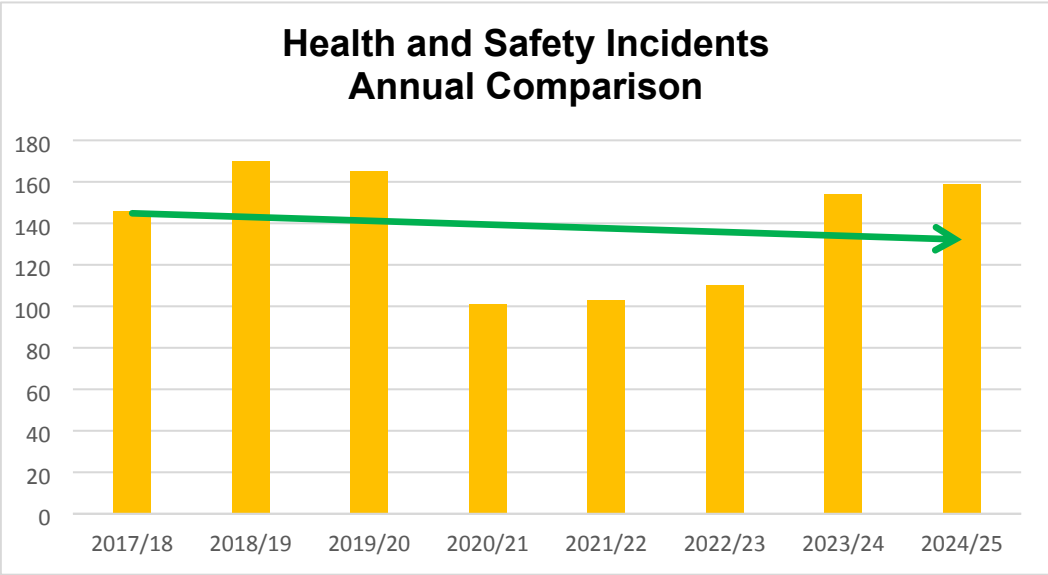
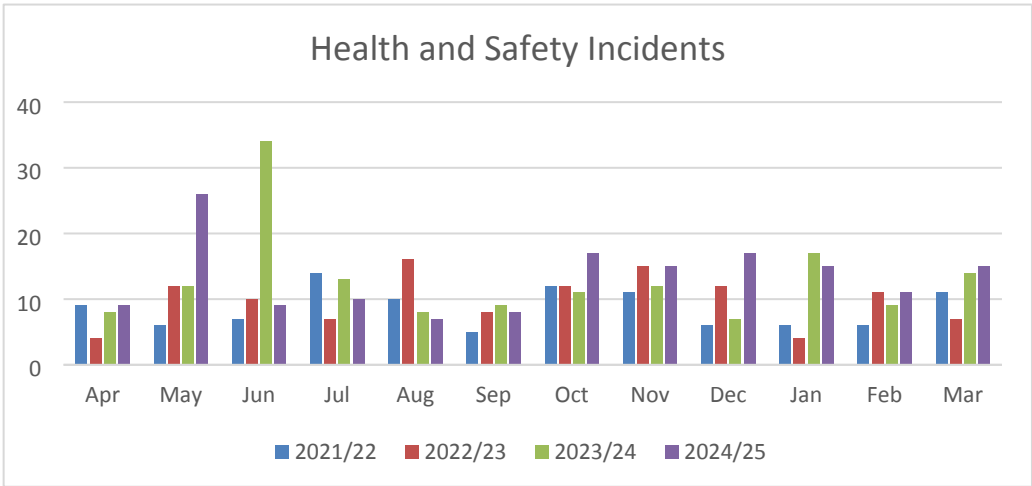
Health and Safety Annual Report
2024/25

Any safety issues noted during unannounced safety spot checks were communicated to the relevant service manager. Immediate remedial actions were taken where appropriate, and a number of capital bids were approved to address concerns with aging equipment that did not comply with current safety standards.

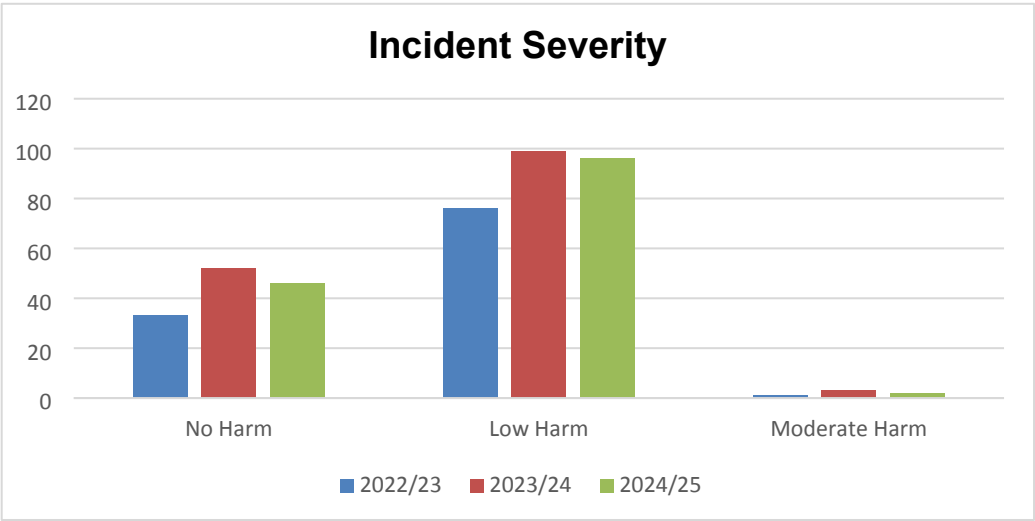
Incidents reported to the Health and Safety Executive as required by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) were jointly investigated by the Health and Safety Manager/Advisor and Staffside Union Safety Representatives.

1.5 DATIX Incident Reporting (Trends and Analysis)

A total of 159 health and safety incidents were reported during the 2024/25 financial year, a slight increase over the previous year's total of 154.



Health and Safety Annual Report
2024/25
Severity of incidents



1.6 Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)

The Health and Safety Manager/Advisor ensured that incidents involving specified injuries, occupational disease, or resulting in a member of staff taking more than seven days off work as a result of a work-related accident, were also reported to the Health and Safety Executive (HSE) under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

During 2024/25 there were six incidents reported to the HSE under the requirements of the RIDDOR regulations. No regulatory action or sanction was received in respect of the reported incidents.

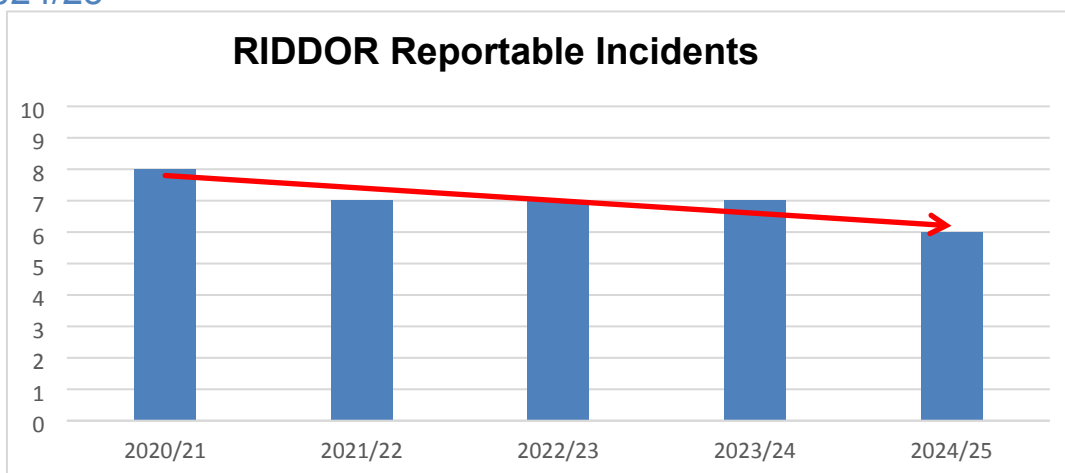
RIDDOR Description	2023/24	2024/25
Occupational Disease	4	0
Slips, Trips and Falls	2	1
Lifting and handling injuries	1	5

1.6.1 RIDDOR Trend Analysis

There remained a relatively low number of RIDDOR reportable incidents in the Trust, and there is an indication that an upward trend previously reported is flattening out.

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Health and Safety Annual Report 2024/25

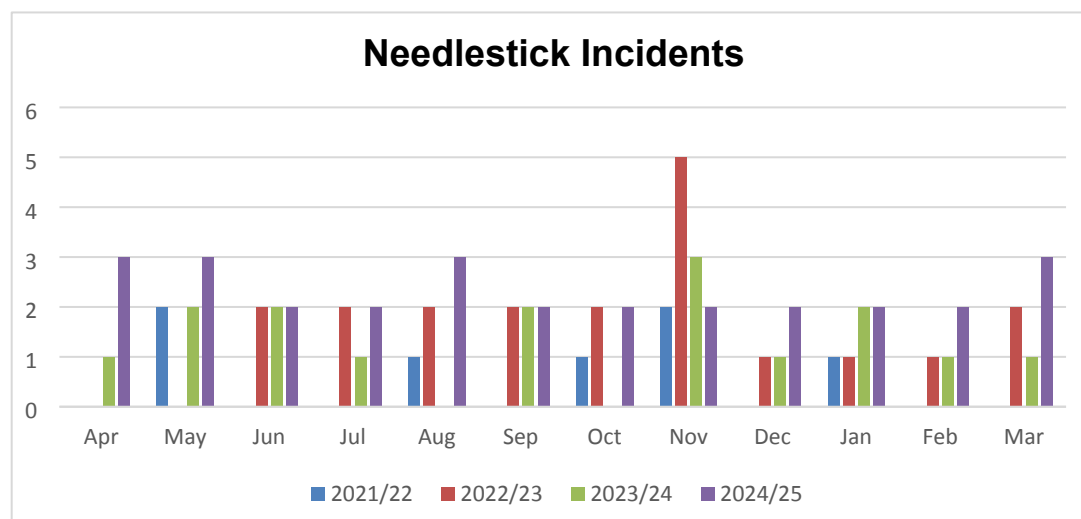


All incidents have involved members of staff, no patients, visitors or other site users sustained reportable injuries. The incidents were recorded on DATIX and investigated by ward or department managers in accordance with Trust policy. The Health and Safety team ensured all RIDDOR reportable incidents were notified to Staffside Safety Representatives in accordance with the Safety Representatives and Safety Committees Regulations 1977.

1.7 Safer sharps

The Trust maintained compliance with the Health and Safety (Sharp Instruments in Healthcare Regulations) 2013.

Sharps (including needlestick) injuries remained at a low level with no incident meeting the criteria for reporting to the HSE. Work is ongoing to ensure that safer sharps become the default devices of choice wherever reasonably practicable.



1.8 Health and Safety Meeting

The Health and Safety Committee met bi-monthly and included health and safety representatives from staffside unions in compliance with the Safety Representatives and Safety Committees Regulations, 1977.

The Terms of Reference were reviewed, and the Committee renamed to 'Meeting' to reflect changes to the Corporate assurance and escalation requirements.

Health and Safety Annual Report 2024/25

Health and Safety Committee Attendance 2024/25						
	April 2024	June 2024	Aug 2024	Oct 2024	Dec 2024	Feb 2025
Chair	✓	✓	✓	X	X	X
Head of Estates and Facilities (Deputy Chair)	X	✓	✓	✓	✓	✓
Health and Safety Manager / Advisor	✓	✓	✓	✓	✓	✓
Governance Representation	✓	✓	✓	✓	✓	✓
Theatre Representation	✓	✓	X	✓	✓	X
Clinical Representation	✓	✓	✓	✓	✓	✓
People Services Business Partner	✓	✓	✓	✓	✓	✓
Training and Development Lead	X	X	✓		X	X
Staffside Representation	✓	✓	✓	✓	X	✓
Manual Handling Coordinator	✓	✓	X	X	X	✓
Occupational Health Representative	X	✓	X	✓	✓	✓
Quorate	✓	✓	✓	✓	X	✓

1.9 Central Alerting System Safety Alerts

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Alerts that are distributed include Estates Safety Alerts, Chief Medical Officer Messages, MHRA Drug Alerts, and Medical Device Alerts.

The Health and Safety Advisor undertook the role of CAS Liaison Officer and was responsible for operational management of the CAS process. The Health and Safety Manager had overall responsibility for ensuring compliance with the process.

Progress towards completion of alert actions was monitored by relevant Meetings and Committees, with overall progress monitored by the Health and Safety Meeting. Executive approval was sought before the Health and Safety Advisor formally signed alerts off via the web portal.

The Trust received a total of 13 Safety Alerts through CAS in 2024/25, of which 11 were formal National Patient Safety Alerts, all of which were actioned (where required) and completed within their respective deadlines.

One National Patient Safety Alert received in the previous financial year has breached its completion deadline. NatPSA/2024/002/NHSPS, 'Transition to NRRfit connectors for intrathecal and epidural procedures, and delivery of regional blocks'. Works are ongoing to achieve compliance by the end of June 2025.

Health and Safety Annual Report
2024/25

2.0 Conclusion

The Board is asked to consider and approve the content of the annual report.

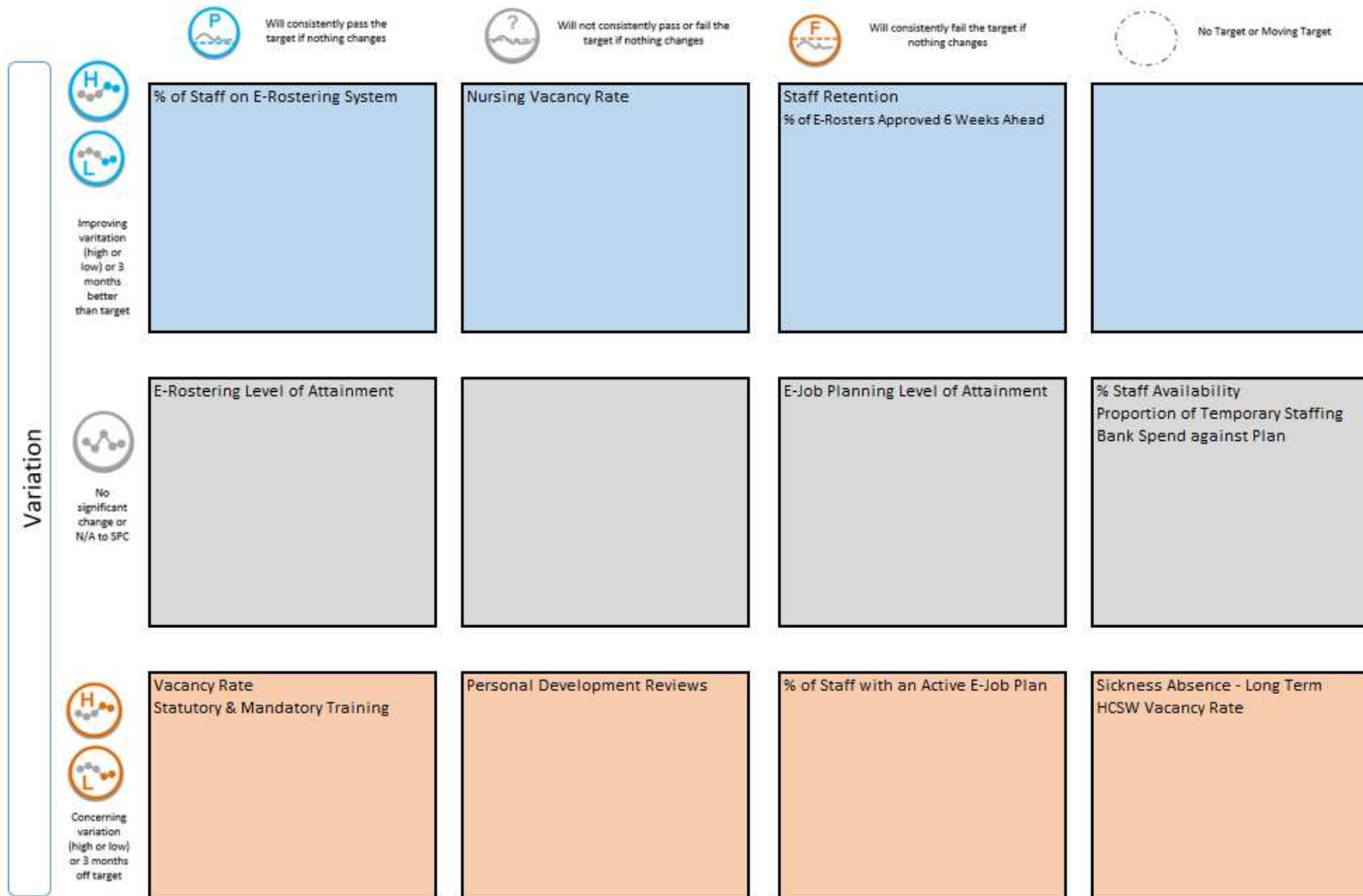
Appendix 1: Acronyms

CAS	Central Alerting System
HSE	Health and Safety Executive
PAM	Premises Assurance Model
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

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Executive Summary - People Committee

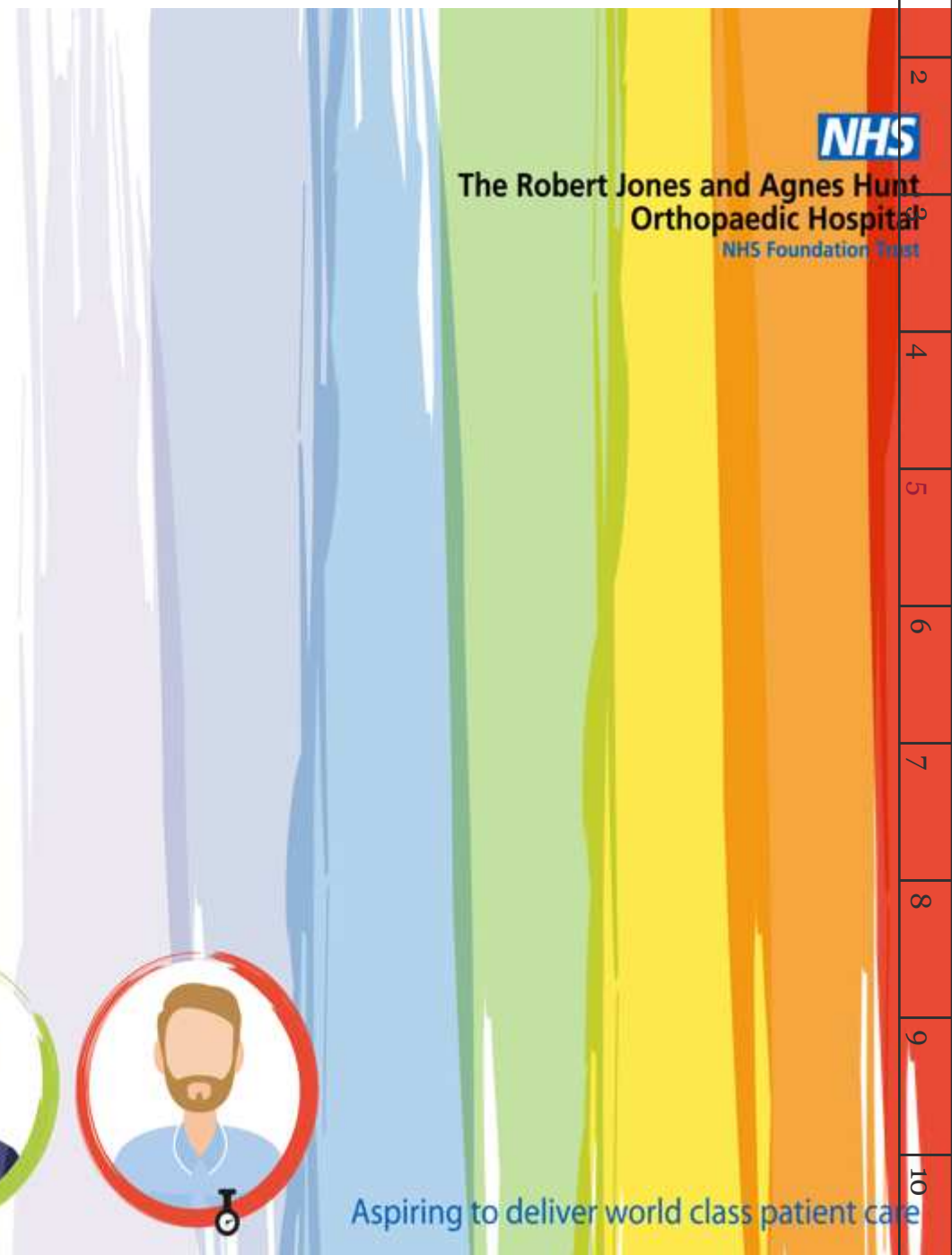
Assurance



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

May 2025 – Month 2



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:

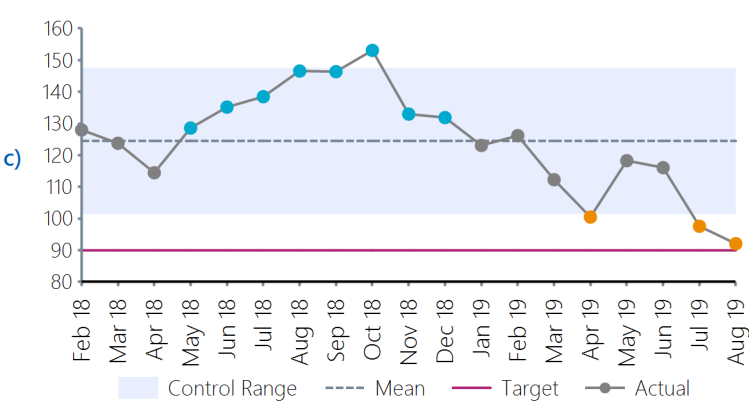
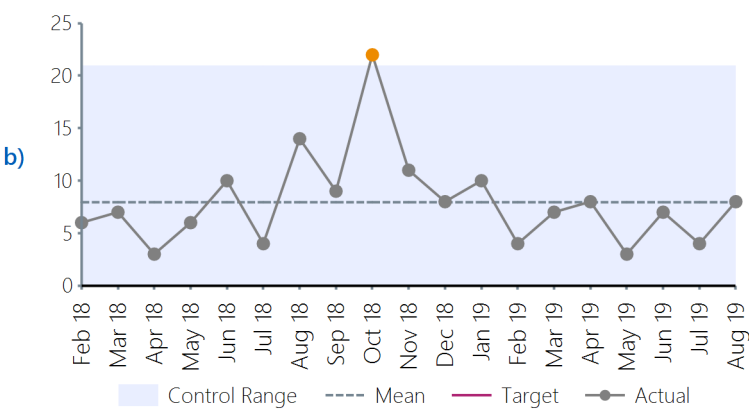
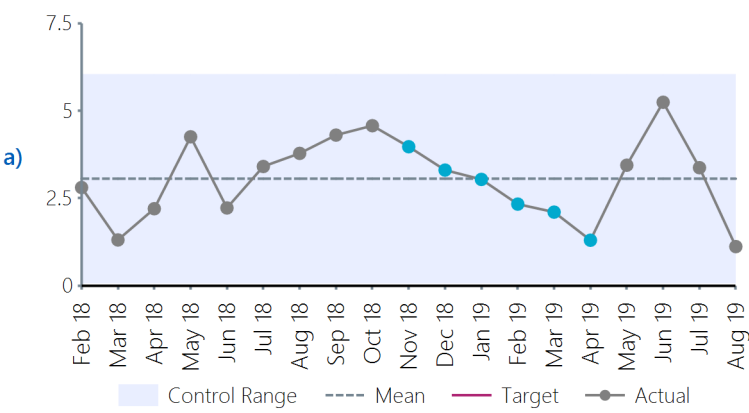
- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of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



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 exception 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.

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 or falling short.

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.

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

No improvement required to comply with the dimensions of data quality

Green

Satisfactory - minor issues only

Amber

Requires improvement

Red

Significant improvement required

Dates

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

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Summary - Caring for Staff

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Sickness Absence	5.01%	4.72%					
Staff Turnover - FTE	9.98%	9.55%					
Leavers per Month	12	12					
Vacancy Rate	8.00%	8.62%				+	15/04/24

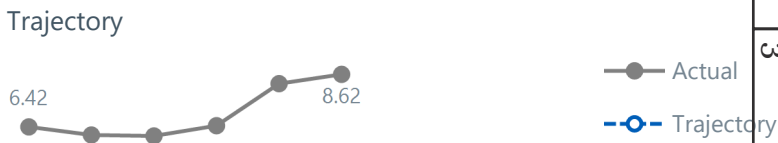
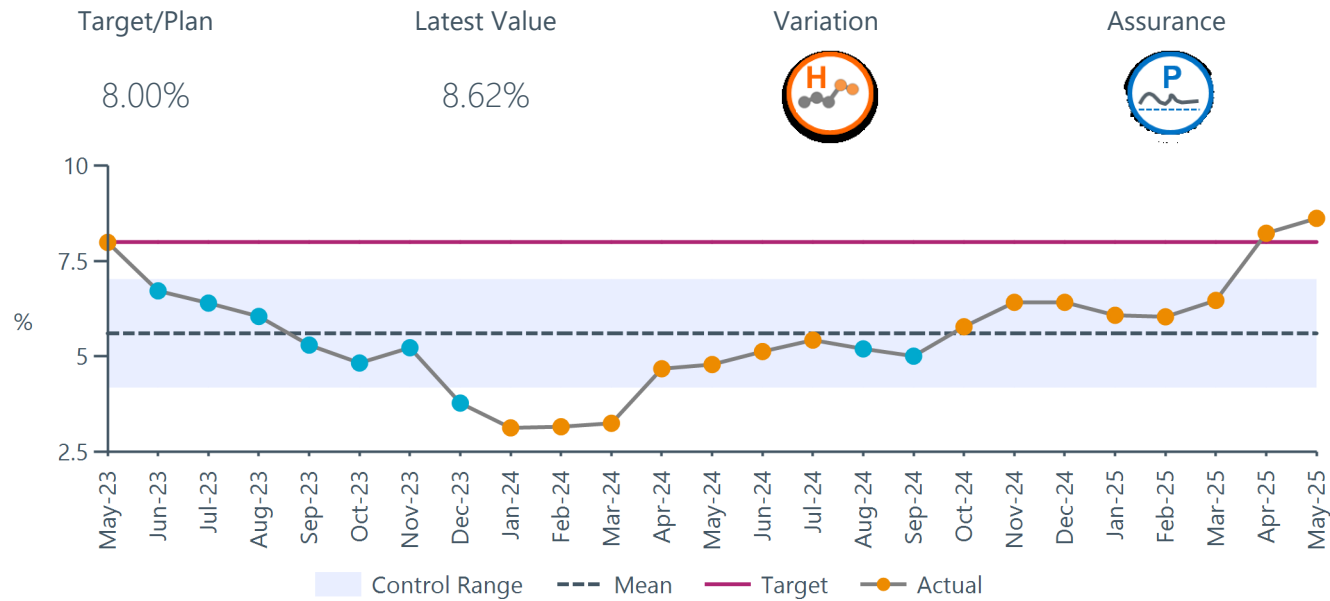


Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Agency Spend against Plan	1.70	1.30		N/A to SPC	Moving Target		
Proportion of Temporary Staffing as a % of the Trust Pay Costs	8.20%	8.80%		N/A to SPC	Moving Target	+	
Bank Spend against Plan	6.50	7.30		N/A to SPC	Moving Target	+	

Vacancy Rate

% of Posts Vacant at Month End 211183



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 May is 8.62%; above the 8% target. As shown in the SPC graph above, this has increased from April and above the control range. This is partly due to an increase in establishment following financial reconciliation for year-end and alignment with the new 2025/26 Trust Workforce Plan. We expect to see the vacancy rate reduce as recruitment to new posts forms part of the Workforce Plan. May has seen a reduction in the staff in post for WTE by 6.7 that has also contributed to the vacancy rate reported.

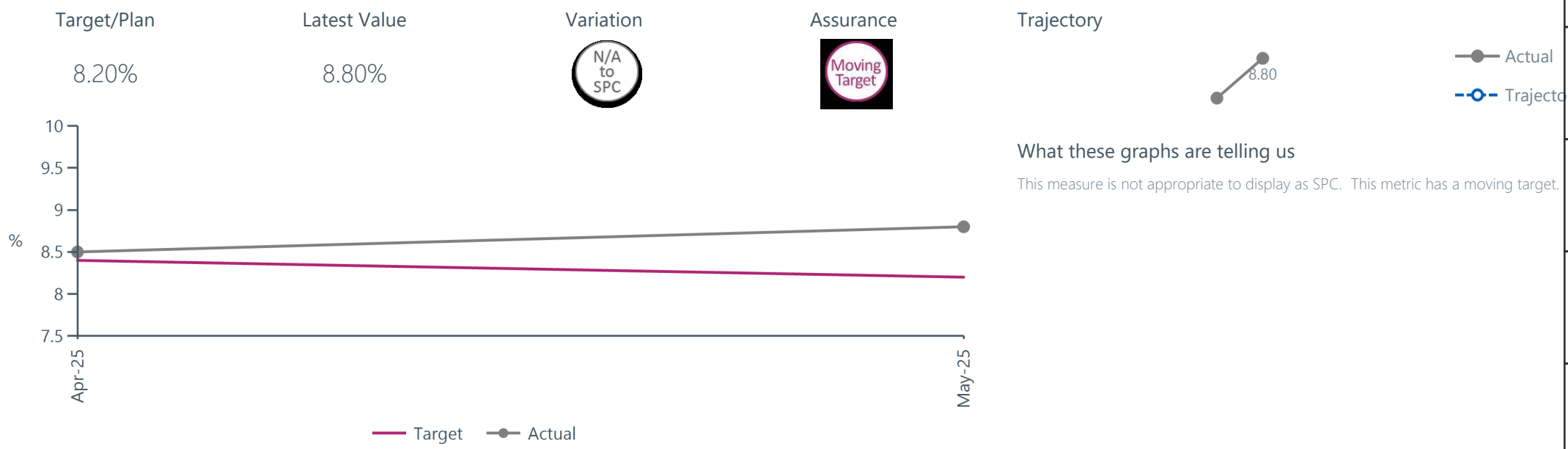
Actions

May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
4.79%	5.13%	5.43%	5.20%	5.01%	5.78%	6.42%	6.42%	6.08%	6.04%	6.47%	8.23%	8.62%

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



Narrative
Proportion of temporary staff 8.8%, which is 0.6% adverse to plan driven by additional bank hours to support EPR Apollo implementation

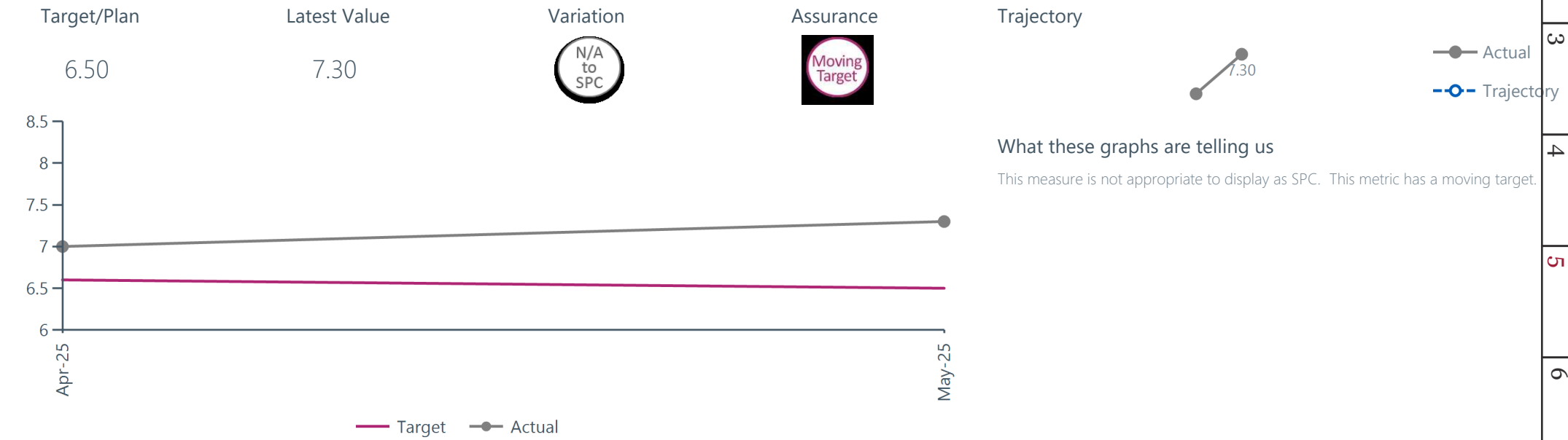
Actions

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



What these graphs are telling us

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

Narrative

Bank usage 7.3% of total pay plan in month, 0.8% adverse to plan driven by additional bank hours to support EPR Apollo implementation

Actions

Committee / Group / Meeting, Date

Board of Directors Meeting, 02 July 2025

Author:

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Contributors:

Report sign-off:

Martin Evans, 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 22 May 2025 and 19 June 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:

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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.

Medical Device Training – Contractual Compliance and Risk to Safety

Significant concerns were raised regarding the delivery and governance of medical device training. The current provider has not delivered any sessions since April, resulting in unacceptable delays. A short-term mitigation has been implemented through internal facilitation. A full options appraisal is underway to determine whether to bring this training in-house or procure an alternative provider. Patient safety and staff competence are at risk if a sustainable solution is not rapidly identified.

Occupational Health Service – Underperformance and Contractual Risk

The Trust's current Occupational Health provider, Optima, continues to fall short of agreed KPIs, prompting escalating dissatisfaction among staff and managers. While the contract has been extended to August 2026, the Committee noted this is subject to stringent management and oversight. A formal tender process has been initiated to identify a potential new provider, with support from procurement and finance teams. The risk of continued suboptimal service provision is high and requires ongoing committee oversight.

Apollo Implementation – Operational and Workforce Pressures

Six weeks post-implementation, the Apollo system continues to generate considerable pressure across the workforce. Feedback indicates issues with cognitive overload, user fatigue, and ongoing adaptation challenges. While several mitigating actions are in place—including clinical reference groups, increased staff support, and digital optimisation—the Committee stresses that this remains a significant workforce wellbeing and cultural risk. A "lessons learned" report is being developed, and people-related risks will remain a standing oversight item.

Equality, Diversity and Inclusion (EDI) Reports [\(recommended to the Board for approval\)](#)

The Committee approved the Annual EDI Report, WRES/WDES action plans, and the Trust's first Ethnicity Pay Gap Report (which shows a positive median differential for ethnically diverse staff). The reports reflect meaningful progress in embedding an inclusive culture.

Freedom to Speak Up Reports [\(recommended to the Board for approval\)](#)

Quarterly and annual data demonstrate a healthy reporting culture. Focus remains on awareness, accessibility, and system-level learning from concerns raised.

3.2 Areas of on-going monitoring with new developments

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

Workforce Performance – Sickness Absence, Turnover, and Recruitment Pressures

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While there has been a notable reduction in long-term sickness (down to 3.3%, the lowest in 12 months), this remains above target and is driven by mental health and musculoskeletal conditions. Targeted interventions are underway. Recruitment of healthcare support workers shows encouraging signs, with 15.5 WTE in the pipeline. However, the overall vacancy rate and attrition—particularly citing work-life balance—require continued focus. An effectiveness review of current interventions has been requested for the next meeting.

Freedom to Speak Up (FTSU) – Capacity and Culture

The Committee continues to support the work of the FTSU Guardian. However, concerns were raised around the lack of protected time for Champions, limiting their ability to embed cultural change. Themes of bullying, attitudes, and behaviours remain disproportionately represented in concerns raised, warranting deeper cultural diagnostics. An updated action plan is under development and will be monitored for impact.

Workforce Resourcing – Agency, Bank and Overtime Trends

Agency spend remains under plan and medical agency compliance is improving. However, bank and overtime usage—largely attributed to Apollo—exceeds forecasts. A clearer trajectory and plan have been requested. Three high-cost agency posts (in rheumatology, spinal surgery and paediatrics) remain off-cap and are being reviewed monthly with system partners. Exit strategies are being developed, alongside recruitment efforts.

Job Planning Compliance

Job planning compliance has improved from 29.6% to 37.2. The Committee has requested a formal trajectory and assurance on improvement plans to achieve the 90% target.

Workforce Reduction Targets

To meet NHS infrastructure expectations, a reduction of 42 WTE must be achieved by year-end. A weekly Workforce Improvement Group has been established and a private joint session with Finance and Performance colleagues is scheduled to assess progress. The Committee will continue to scrutinise workforce impact and delivery risk.

Fixed-Term Contracts – Employment Law Risk

The Committee discussed legal risks related to how breaks in service are applied to fixed-term contracts. Current Trust practice may risk unfair treatment. Policy guidance is under urgent review, with legal advice being sought.

3.3 Areas of assurance

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

Sexual Safety Training

The Trust's sexual safety training, delivered by Freedom Personal Safety, was highly commended by the Committee. Recorded sessions are being developed to widen access. An increase in disclosures is anticipated, seen as a positive sign of growing trust in internal reporting mechanisms.

Corporate Risk Register & Board Assurance Framework (BAF)

Committee oversight has ensured that current and emerging risks—especially in workforce and digital transformation—are reflected within the BAF. Amendments to capture recent developments (e.g., Apollo, recruitment constraints, and cross-border commissioning risks) are in progress.

National Education and Training Survey

The Committee celebrated the Trust's outstanding results—ranking first in the Midlands and second nationally. A press release is pending and will be circulated in due course.

System Integrated Improvement Plan

The Committee noted that the Trust continues to meet its contribution expectations under the system-wide plan coordinated by NHSE/ICB.

Job Evaluation – National Profiles

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Chair's Assurance Report People and Culture Committee

Preparation is underway for the release of updated national profiles for Bands 5–9. Early scoping suggests minimal financial risk, with only a small number of roles likely to require additional training. A detailed summary will be brought to the Board in September.

Chairs Assurance Reports

- **Education and Training Oversight Group** – issues noted in relation to the medical devices training have been escalated.
- **Trust Performance and Operational Improvement Group** - job planning attainment compliance levels are being monitored through the group. The improvement champions training has been CPD accredited.
- **EDI meeting** - the committee noted the report, there were no areas of concern noted.
- **Non-medical staffing subgroup** - the Trust continues to address the national recruitment challenges for orthotics and have been exploring a training hub in collaboration with Keele university.
- **Local negotiation committee** - the Committee noted the report there were no areas of concern to raise.
- **Joint consultation group** - there are three management of change consultations ongoing.
- **Multidisciplinary re-education strategy meeting** - the committee noted the report.

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.

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People and Culture Committee Annual Report 2024/25

Committee / Group / Meeting, Date

Board of Directors, 02 July 2025

Author:**Contributors:**

Name: Mary Bardsley / Dylan Murphy
Role/Title: Assistant Trust Secretary / Trust Secretary

Report sign-off:

Name: Dylan Murphy, Trust Secretary
People and Culture Committee, 24 April 2024

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.

The purpose of the People and Culture Committee is to assist the Board in obtaining assurance that the Trust's workforce strategies and policies are aligned with the Trust's strategic aims and support a patient-focused, performance culture where staff engagement, development and innovation are supported. Its particular responsibilities are set out at section 1 of the following report.

In line with good practice, the committees of the Board undertake an annual review of their operation and effectiveness. This involves:

- Reviewing the role of the committee, its key responsibilities, membership and business considered during the year.
- A questionnaire on the effectiveness of the operation of the committee (completed by individual members / core attendees).
- A self-assessment against key governance questions (for collective consideration).
- Review of the terms of reference to ensure the focus of the Committee remains relevant in 2025/26.

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 note that, at the April meeting, the Committee:

1. **Noted** the report;
2. **Considered** the outcome of the committee effectiveness survey and did not identify any required actions;
3. **Considered and agreed** the draft self-assessment document (as included at section 8);

People and Culture Committee Annual Report 2024/25

4. **Noted** the 2024/25 Decision / activity log (as included at attachment A).
5. **Considered** the draft Terms of Reference for 2025/26 (as included at attachment B) and recommended that the Board approve them.

The Board is therefore asked to consider and approve the proposed terms of reference for 2025/6.

Report development and engagement history:

This report has been produced from existing documentation. The self-assessment and TOR are initial drafts for consideration – they have not been considered or approved by any other forum or individual.

Next steps:

The committee-approved report will be presented to the Board meeting in May, to provide assurance that the Committee has fulfilled its role and responsibilities during the year.

Any issues of concern, or apparent gaps in the governance arrangements, that are identified will be reported to the Board and the Audit and Risk Committee for consideration.

Appendices

Attachment A Committee Decision / Activity Log 2024/25

Attachment B Terms of Reference 2025/26

People and Culture Committee Annual Report 2024/25

1. Committee Roles and Responsibilities (2024/25)

The key responsibilities of the Committee are as follows:

- To ensure the Trust is meeting its statutory and regulatory requirements in relation to workforce management.
- To oversee the development and implementation of the People Plan and any related workforce plans.
- To monitor and develop the Trust's plans for talent management, succession planning, staff engagement, performance, reward and recognition strategies and policies.
- To receive an agreed level of workforce data and trend analysis to inform and analyse workforce issues.
- To ensure that the Committee has adequate information on which to advise and assure the Board on 'Caring for Staff'.
- To receive reports from meetings that report into the Committee assurance on operational matters.
- To receive reports as provided by the ICS People Committee
- 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 workforce strategies raising any significant risks regarding their delivery to the Board.
- To assure and provide advice to the Board on any arising People Services issues of significance.

2. Membership (2024/25)

The membership section of the current terms of reference is:

- Up to four Non-Executive members
- Chief People and Culture Officer
- Chief Nurse and Patient Safety Officer
- Chief Operating Officer/Deputy Chief Executive Officer
- Chief Finance and Planning Officer

3. Meetings (2023/24)

During 2024/25, the committee met on 12 occasions (monthly). It was noted that all meetings were quorate.

4. Committee Attendance (2024/25)

Overall, good attendance has been noted from all core members of the meeting.

Name	Title	Attendance
Core Membership		
Paul Maubach	Associate Non-Executive Director (Chair)	11 / 12
Sarfraz Nawaz	Non-Executive Director	08 / 09
Atif Ishaq	Associate Non-Executive Director	10 / 12
John Pepper	Associate Non-Executive Director	10 / 12
Martin Evans	Non-Executive Director	09 / 12
Denise Harnin	Chief People and Culture Officer	11 / 12
Mike Carr	Chief Operating Officer	09 / 12
Craig Macbeth	Chief Finance and Planning Officer	11 / 12
Paul Kavanagh-Fields	Chief Nurse and Patient Safety Officer	06 / 10
*Stacey Keegan	Chief Executive Officer	03 / 12
In Attendance		
Dylan Murphy	Trust Secretary	09 / 12
Andrea Martin	Deputy Chief People and Culture Officer	11 / 12
Caroline Nokes Lawrence	Associate Chief People and Culture Officer	10 / 12

*The Chief Executive Officer has an open invitation to the meeting and is not required to attend the

People and Culture Committee Annual Report 2024/25

meetings.

5. Committee Activity and Decision Log (2024/25)

The business considered by the Committee during the year is included at attachment A.

6. Conduct of Meetings (2024/25)

The Committee conducted its business in accordance with the provisions of the Trust's constitution and terms of reference.

Formal minutes of the meeting were produced which included a record of the attendees present at the meeting. The Committee provided an update to the Board via the Chair's Assurance Report to the Board of Directors following each meeting.

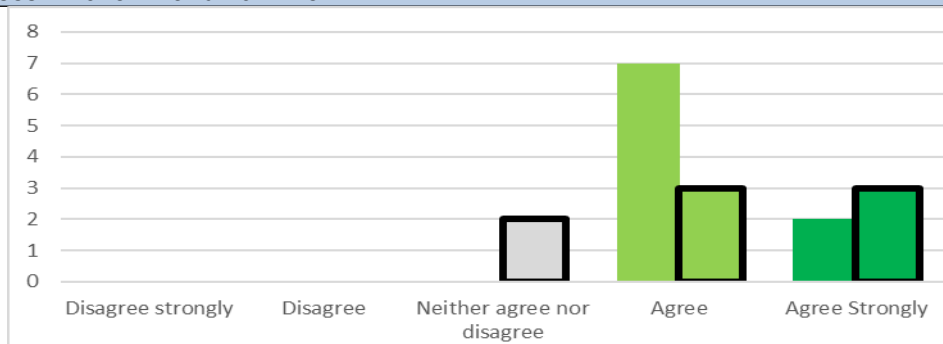
7. Committee Effectiveness Survey (2024/25)

The Committee effectiveness survey was circulated to a total of 11 people (core members and frequent attendees of the meeting). There was a total of 8 responses received.

The 2024/25 results (the second of the two columns, with the black outline) are displayed alongside the 2023/24 results (based on the 9 returns received last year).

Q1 The work plan gives appropriate coverage to the areas which I consider that it should be covering

Responses – 2023/24 and 2024/25

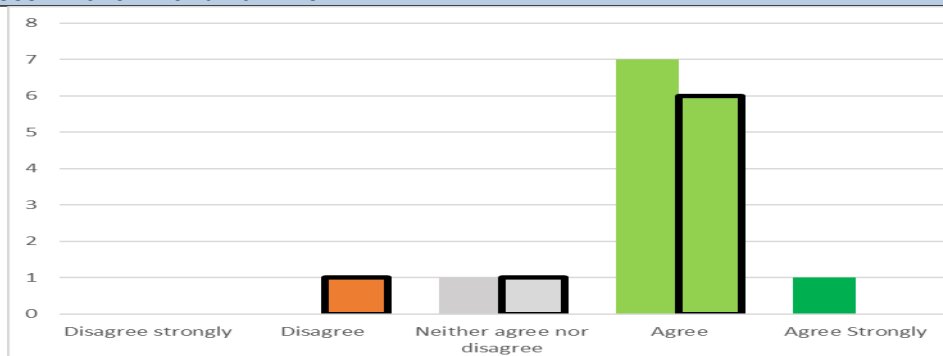


Comments

- Could benefit from more oversight of delivery of planning assumption

Q2 Current workload facilitates adequate scrutiny of areas delegated to the Committee

Responses – 2023/24 and 2024/25



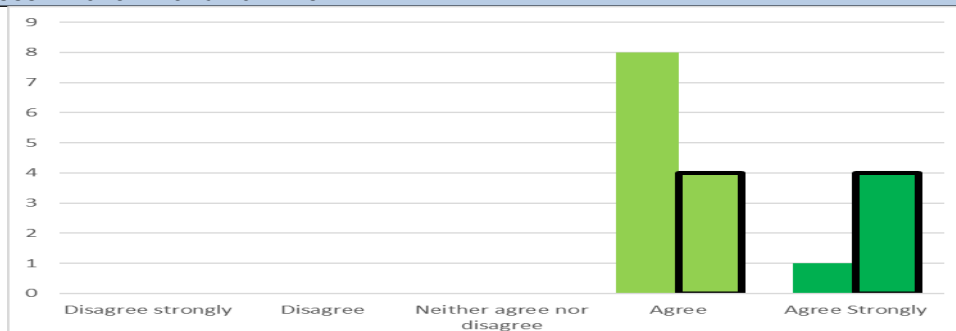
Comments

- Often find that we have to work at pace to get through all of the committee items

People and Culture Committee Annual Report 2024/25

Q3 I have the appropriate skills and training to provide valuable input into the Committee

Responses – 2023/24 and 2024/25

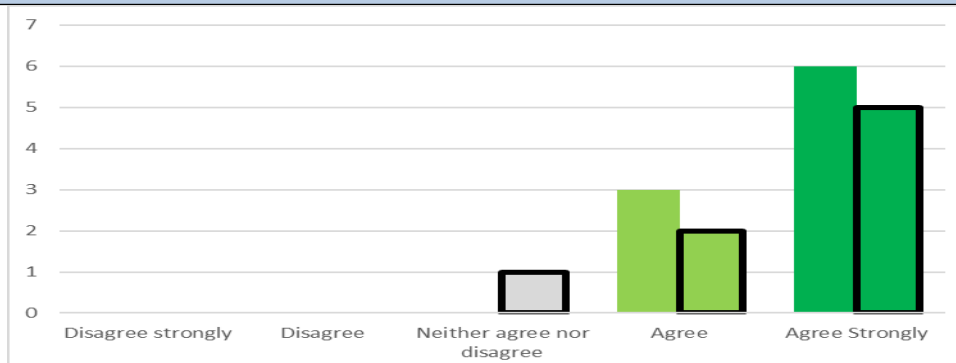


Comments

- There are no responses.

Q4 I consider that the meetings are well chaired and that members are given sufficient opportunity to contribute

Responses – 2023/24 and 2024/25

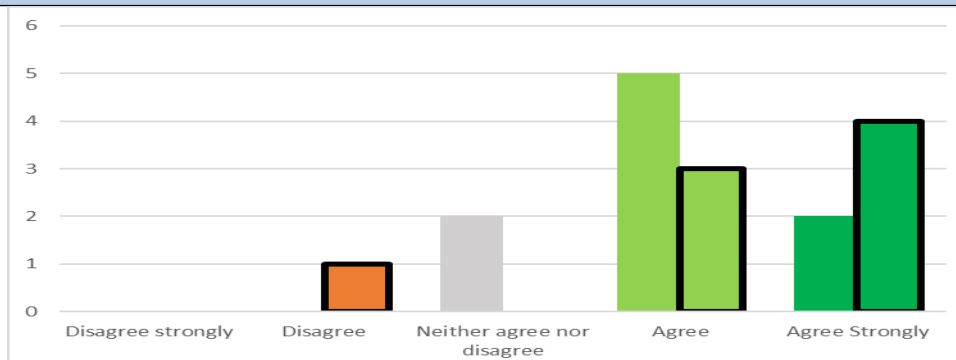


Comments

- Contribution - I believe this has been strengthened by targeting 2-3 key areas of focus per committee therefore allowing further opportunities for discussion and debate.
- Need to ensure the agenda is not overloaded and give time to big pieces of work that may need more attention

Q5 I consider that the time spent on each agenda item is appropriate and sufficient for scrutiny and challenge as required

Responses – 2023/24 and 2024/25



Comments

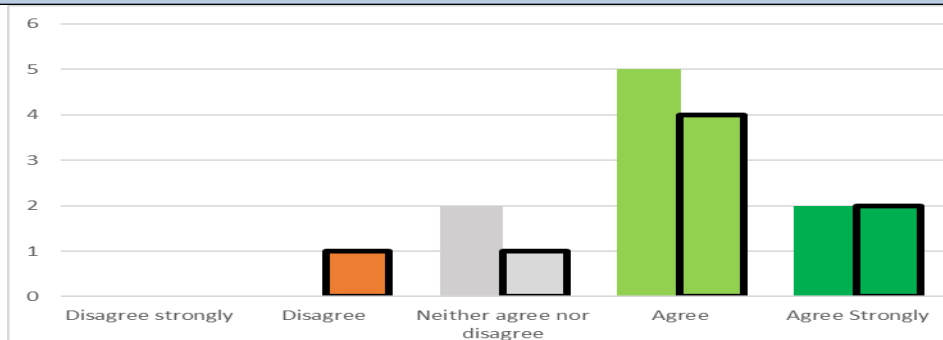
- We give more time to items that warrant a significant amount of discussion and the meeting is flexed to allow important conversations to continue when /if they arise.

People and Culture Committee Annual Report 2024/25

- sometimes agenda items get bumped, which can be deflating when you have prepared a report or update

Q6 I have received the information which I require to consider the Trust's people risks and their mitigations

Responses – 2023/24 and 2024/25

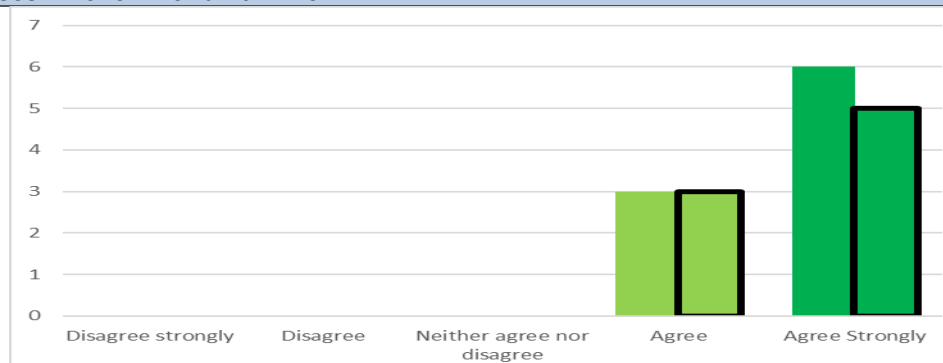


Comments

- More needed on treatment and tolerance

Q7 The Committee has added value to the Trust's workforce matters

Responses – 2023/24 and 2024/25

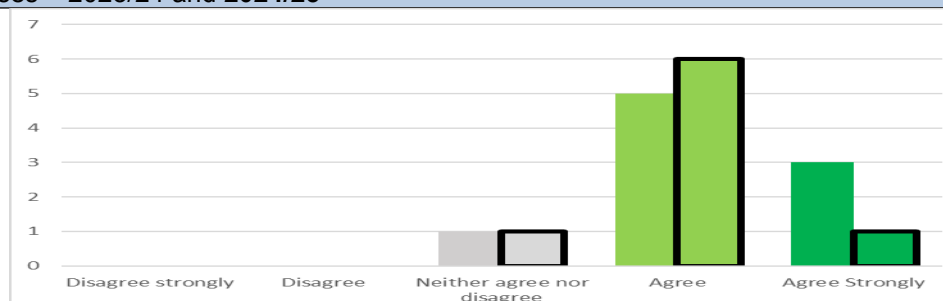


Comments

- There are no responses.

Q8 The Committee has had sufficient time/information to consider workforce matters

Responses – 2023/24 and 2024/25



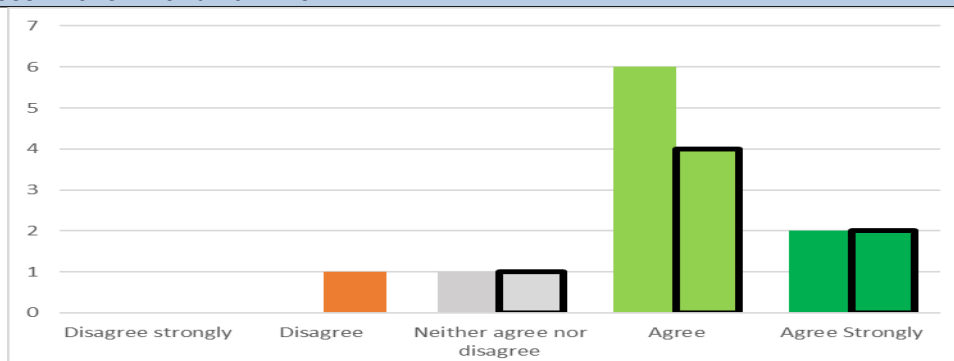
Comments

- There are no responses.

People and Culture Committee Annual Report 2024/25

Q9 The quality of the papers and presentations ensure the Committee can add value and rigour to workforce governance

Responses - 2023/24 and 2024/25

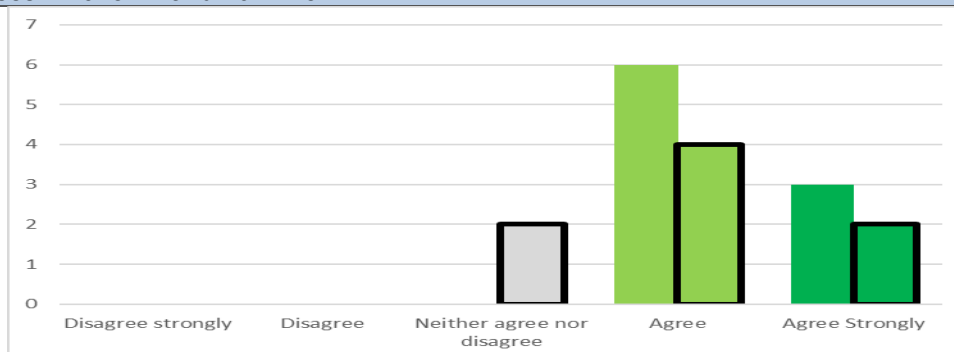


Comments

- Papers can be more concise

Q10 I consider that the Committee receives sufficient information on the people KPIs to gain assurance on the Trust's performance in these areas

Responses - 2023/24 and 2024/25



Comments

- Papers can be more concise

People and Culture Committee Annual Report 2024/25

8. Committee Self-Assessment (2024/25)

Area / Question	Response	Comments / Action
Composition, Establishment and Duties		
Does the committee have written terms of reference that adequately and realistically define the Committees role?	Yes	Approved by the Trust Board and incorporated into the Board Governance Pack.
Have the terms of reference been adopted by the Board?	Yes	As above.
Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?	Yes	Yes annual review is included in the work plan with ad hoc changes made as and when required throughout the year.
Are committee members independent of the management team?	Yes	The committee is chaired by a Non-Executive and has another 3 Non-Executives within its membership.
Are members, particularly those new to the committee provided with relevant training?	N/A	There is no formal training for this Committee but the Chief People Officer/Chair of the Committee would be available as required to talk through the role of the committee, the nature of the discussion etc for any new attendees. A discussion is also held as part of the NED induction meetings.
Has the committee established a plan for the conduct of its own work across the year?	Yes	This is set for the financial year ahead and reviewed on a monthly basis as a standard agenda item for the meeting.
Are changes to the current and future workload discussed and approved at Board level?	Yes	The remit is set by the Board through approval of the terms of reference and the workplans are reviewed at each committee meeting with an overview of any changes presented to the Board via the Chair's Report.
Does the committee report to the Board regularly?	Yes	The chair of the committee presents an assurance report to the Board on a monthly basis.
Does the committee assess its own effectiveness periodically?	Yes	This is undertaken annually as part of the committee annual report.
Does the committee prepare an annual report on its work and performance in the preceding year?	Yes	It is presented to the Committee and considered alongside the self-assessment.
Has the committee been quorate for each meeting this year?	Yes	This is confirmed by the minutes of the meeting and reported to the Board as part of the assurance report.
Compliance with the Law and Regulations Governing the NHS		
Does the committee review assurance and regulatory compliance reporting processes?	Yes	This is undertaken by the committee in relation to workforce issues and assurance is provided to the Board via the Chair's report.

People and Culture Committee Annual Report 2024/25

Does the committee have a mechanism to keep it aware of topical, legal and regulatory issues?	Yes	These would be escalated through the Trust's governance framework. The Trust's Executive Team provide updates as required.
Internal Control		
Has the committee formally considered how it integrates with other committees?	Yes	All committee work plans have been reviewed simultaneously to ensure timely flow of information from one to another. Through the Chair's report and the Executive Lead, matters can be escalated up, down or sideways to appropriate committees.
Has the Committee formally considered how its work integrates with the wider performance management and standards compliance?	Yes	The Committee receives an update on the KPIs from the Integrated Performance Report and commissions deep dives as required for assurance purposes.
Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?	Yes	The Trust launched the Corporate Stands Manual in 2023/24 which supports with the correct format and content of the reports. There are occasions where papers are marked to follow due to the reporting timelines.
Administrative Arrangements		
Does the committee have a plan of matters to be dealt with over the coming year?	Yes	This is set for the financial year ahead and reviewed on a monthly basis as a standard agenda item for the meeting.
Are papers circulated in good time and are minutes received as soon as possible after the meetings?	Yes	There are occasions when papers need to be delayed but the packs are circulated with good time and updated with papers that have been delayed for genuine reasons. If papers have been delayed to such an extent that the committee would not have sufficient time to consider them, they are deferred to the next meeting.
Does the committee meet the appropriate number of times a year?	Yes	The committee meets on a monthly basis.
Other Issues		
Does the Annual Report include a description of the committee's establishment and activities?	Yes	This is included in the Annual Governance Statement

9. Forward look into 2025/26

To support with continuous improvement of the People and Culture Committee, members are asked to review the Terms of Reference and consider any required revisions for 2025/26.

People and Culture Committee Annual Report 2024/25

10. Recommendation

That the Board note that, at the April meeting, the Committee:

1. **Noted** the report;
2. **Considered** the outcome of the committee effectiveness survey and did not identify any required actions;
3. **Considered and agreed** the draft self-assessment document (as included at section 8);
4. **Noted** the 2024/25 Decision / activity log (as included at attachment A).
5. **Considered** the draft Terms of Reference for 2025/26 (as included at attachment B) and recommended that the Board approve them.

The Board is therefore asked to consider and approve the proposed terms of reference for 2025/6.

People and Culture Committee - ACTIVITY / DECISION LOG

Updated: 20 March 2025

Decision Ref No.	Meeting Date	Topic/Agenda item	Conflicts of interest considered and agreed treatment of the conflict	Conclusion/Decision (e.g. Approved, Noted, Recommended ... etc. SEE "Decision" Types tab for guidance)	If applicable - results of vote and/or dissenting views	If Recommendation - destination for onward submission?
1	18-Apr-2024	Minutes of the Previous Meeting	None	Approved - Minutes were approved from the previous meeting.		
2	18-Apr-2024	Action Log / Matters Arising	None	Noted - Actions and matters arising noted by Committee.		
3	18-Apr-2024	Declarations of Interest	None	Agreed - Update to Declartions of Interest agreed.		
4	18-Apr-2024	Corporate Risk Register	None	Noted - Corporate Risk Register updates noted.		
5	18-Apr-2024	Workforce Performance Report	None	Noted - Workforce Performance Report updates noted.		
5	18-Apr-2024	Agency Update	None	Noted - Agency Update noted.		
6	18-Apr-2024	Theatre Approach Update	None	Noted - Theatre Approach updates noted.		
7	18-Apr-2024	Continuing Professional Development	None	Noted - Continuing Professional Development updates noted.		
8	18-Apr-2024	Staff Establishment Reviews	None	Noted - Staff Establishment Reviews updates noted.		
9	18-Apr-2024	Vacancy Approval Process	None	Noted - Vacancy Approval Process noted.		
10	18-Apr-2024	EDI Update	None	Noted - EDI Update noted.		
11	18-Apr-2024	Freedom to Speak Up Report Q4	None	Noted - FTSU Q4 report noted.		
12	18-Apr-2024	Guardian of Safe Working Hours Annual Report Q4	None	Noted - Annual report and Q4 updated noted.		
13	18-Apr-2024	Civility & Compassion Briefing	None	Noted - Civility and Compassion update noted.		
14	18-Apr-2024	Staff Survey / Engagement	None	Noted - Staff engagement survey noted by Committee.		
15	18-Apr-2024	Chair Report: JCG	None	Noted - Chair Report: JCG noted.		
16	18-Apr-2024	Chair Report: EDI Meeting	None	Noted - Chair Report: EDI noted.		
17	18-Apr-2024	Chair Report: Non-Medical Staffing Sub-Group	None	Noted - Chair Report: NMSSG noted.		
18	18-Apr-2024	Chair Report: ICS People Committee	None	Noted - Update under agenda item 7.1 noted.		
19	18-Apr-2024	Committee Effectiveness Annual Report	None	Agreed - Draft Annual Report agreed by Committee.		
20	18-Apr-2024	ICS People Support	None	Noted - ICS People Support updates noted.		
21	23-May-2024	Minutes of the Previous Meeting	None	Noted - Minutes were approved.		
22	23-May-2024	Action Log / Matters Arising	None	Noted - Actions and matters arising noted by Committee.		
23	23-May-2024	Declarations of Interest	None	Noted - No declarations of interest were noted.		
24	23-May-2024	Work Experience Presentation	None	Noted - Work Experience Presentation noted.		
25	23-May-2024	Board Assurance Framework	None	Noted - BAF noted.		
26	23-May-2024	Workforce Performance Report	None	Noted - Workforce Performance Report updates noted.		
27	23-May-2024	Agency Report	None	Noted - The agency report was noted by the Committee.		
28	23-May-2024	Personal Development Review Deep Dive	None	Noted - The PDR report was noted.		
29	23-May-2024	Workforce Plan Submission	None	Noted - The Workforce plan submission was noted.		
30	23-May-2024	Rising National Living Wage	None	Noted - The update was noted.		
31	23-May-2024	Employment Law Tracker	None	Noted - The tracker was noted.		
32	23-May-2024	Staff Survey / Engagement	None	Noted - The update was noted.		
33	23-May-2024	Civility & Compassion Briefing	None	Noted - The update was noted.		
34	23-May-2024	EDI Update	None	Noted - The update was noted.		
35	23-May-2024	Core Training Compliance	None	Noted - The update was noted.		
36	23-May-2024	Chair Report: LNM	None	Noted: The Chair report was noted.		
37	23-May-2024	Medical Job Planning Policy	None	Approved: The policy was approved by the Committee.		
38	23-May-2024	Chair Report: EDI Meeting	None	Noted: Updated noted through previous agenda item.		
39	23-May-2024	WDES and WRES Action Plans	None	Noted - The action plans were noted.		
40	23-May-2024	Chair Report: Non-Medical Staffing Sub-Group	None	Noted: The Chair report was noted.		
41	23-May-2024	Chair Report: JCG	None	Noted: The Chair report was noted.		
42	23-May-2024	Chair Report: ICS People Committee	None	Noted - Update noted.		
43	23-May-2024	Formal Review of Committee Effectiveness	None	Approved - The review was approved.		
44	23-May-2024	Committee Terms of Reference	None	Approved - ToR were approved.		
45	23-May-2024	Review of Workplan and Attendance Matrix	None	Approved - The workplan and the matrix were approved.		
46	23-May-2024	Chair Report: TPOIG	None	Noted - The Chair report was noted.		
47	19-Jun-2024	Minutes of the Previous Meeting	None	Approved - The minutes of the meeting were approved.		
48	19-Jun-2024	Action Log / Matters Arising	None	Approved - / action log were approved.		
49	19-Jun-2024	Declarations of Interest	None	Noted - No declarations of interest were noted.		
50	19-Jun-2024	Corporate Risk Register	None	Noted - Risk register noted.		

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Decision Ref No.	Meeting Date	Topic/Agenda item	Conflicts of interest considered and agreed treatment of the conflict	Conclusion/Decision (e.g. Approved, Noted, Recommended ... etc. SEE <i>"Decision" Types</i> tab for guidance)	If applicable - results of vote and/or dissenting views	If Recommendation - destination for onward submission?	2
51	19-Jun-2024	Workforce Performance Report	None	Noted - Performance report noted.			
52	19-Jun-2024	Agency Report	None	Noted - Agency Update noted.			
53	19-Jun-2024	Staffing Establishment Review	None	Noted - Establishment review noted.			
54	19-Jun-2024	Staff Survey Focus Update	None	Noted - Staff Survey update noted.			3
55	19-Jun-2024	Retain & Engage	None	Noted - Retain and Engage progress and report noted.			
56	19-Jun-2024	Chair Report: Non-Medical Staffing Sub-Group	None	Noted - Chair Report noted.			
57	19-Jun-2024	Chair Report: ICS People Committee	None	Noted - Update noted.			
58	19-Jun-2024	Review of Workplan and Attendance Matrix	None	Approved - Workplan approved and martix noted.			
59	19-Jun-2024	Risk Reflection	None	Noted - Risk Update noted.			
60	19-Jun-2024	National Oversight Framework Dashboard	None	Noted - National Oversight dashboard noted.			4
61	25-Jul-2024	Minutes from Previous Meeting	None	Approved - The minutes of the meeting were approved.			
62	25-Jul-2024	Action Log/Matters Arising	None	Approved - / action log were approved.			
63	25-Jul-2024	Declarations of Interest	None	Noted - No declarations of interest were noted.			
64	25-Jul-2024	Workforce Performance Report	None	Noted - Performance report noted.			
65	25-Jul-2024	Establishment Review Summary	None	Noted - Establishment review noted.			
66	25-Jul-2024	EDS2 Domain 2 Report	None	Approved- The Committee approved the report and its publication subject to the suggestions made by the Committee			5
67	25-Jul-2024	5 Year People Plan Action	None	Noted- 5 Year People Plan Action noted.			
68	25-Jul-2024	Training Compliance Report	None	The Committee noted the report recognising the follow-up work on PDRs and the review of training arrangements should provide further assurance.			
69	25-Jul-2024	Leadership Programme (with Ande Joseph)	None	Noted- Leadership Programme was noted.			
70	25-Jul-2024	Clinical Engagement	None	Noted- Clinical Engagement was noted.			
71	25-Jul-2024	Chair Report Non-Medical Staffing Sub-Group	None	Noted- Chair Report Non-Medical Staffing Sub-Group was noted			
72	25-Jul-2024	Chair Report EDI	None	Noted- Chair Report EDI was noted			6
73	25-Jul-2024	Chair Report JCG	None	Noted- Chair Report JCG was noted.			
74	25-Jul-2024	ICS People Committee	None	Noted- ICS People Committee verbal update was noted.			
75	25-Jul-2024	Career Grade Medical Staff Leave Policy	None	Approved- Career Grade Medical Staff Leave Policy was approved.			
76	25-Jul-2024	Apprenticeship Policy	None	Approved- Apprenticeship Policy was approved.			
77	25-Jul-2024	Work Experience Policy	None	Approved- Work Experience Policy was approved.			
78	25-Jul-2024	Review of Workplan and Attendance Matrix	None	Noted- Review of Workplan and Attendance Matrix was noted.			7
79	22-Aug-2024	Declarations of Interest	None	Noted - No declarations of interest were noted.			
80	22-Aug-2024	Minutes of the Previous Meeting	None	Approved - The minutes of the meeting were approved.			
81	22-Aug-2024	Action Log/ Matters Arising	None	Approved - / action log were approved.			
82	22-Aug-2024	Chief People and Culture Update	None	Noted- Chief People and Culture Update was noted.			
83	22-Aug-2024	Board Assurance Framework	None	Noted- Board Assurance Framework was noted.			
84	22-Aug-2024	Workforce Performance Report	None	Noted- Workforce Performance Report was noted.			8
85	22-Aug-2024	Agency Report	None	Noted- Agency Report was noted.			
86	22-Aug-2024	TIF2 Workforce Update	None	Noted- TIF2 Workforce Update was noted.			
87	22-Aug-2024	Guardian of Safe Working Hours Report (Q1)	None	Noted- Guardian of Safe Working Hours Report (Q1) was noted.			
88	22-Aug-2024	Freedom to Speak Up Report (Q1)	None	Noted- Freedom to Speak Up Report (Q1) was noted.			
89	22-Aug-2024	People Services Report on Disciplinary Cases and Policy	None	Noted- People Services Report on Disciplinary Cases and Policy was noted.			
90	22-Aug-2024	Employment Law Changes Action Plan	None	Noted- Employment Law Changes Action Plan was noted.			9
91	22-Aug-2024	Chair Reports/update	None	Noted- The following Chair Reports were noted: Chair Report Non- Medical Staffing Sub-Group, Chair Report JCG, ICS People Committee Update.			
92	22-Aug-2024	Review of the Workplan and Attendance Matrix	None	Noted- Review of the Workplan and Attendance Matrix was noted.			
93	19-Sep-2024	Minutes of the Previous Meeting- August 24	None	Approved - The minutes of the meeting were approved.			
94	19-Sep-2024	Action Log/ Matters Arising	None	Approved - action log was approved.No Matters arising.			
95	19-Sep-2024	Chief People and Culture Update	None	Noted- Chief People and Culture Update was noted.			
96	19-Sep-2024	Performance Report	None	Noted- Workforce Performance Report was noted.			10
97	19-Sep-2024	Guardian of Safe Working Hours Report (Q1)	None	Noted- Guardian of Safe Working Hours Report (Q1) was noted.			
98	19-Sep-2024	EDI Update	None	Noted- EDI Update was noted.			
99	19-Sep-2024	International Nurses Survey	None	Noted- International Nurses Survey was noted.			
100	19-Sep-2024	Establishment Reviews	None	Noted- Establishment Reviews was noted, further assurance requested.			

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Decision Ref No.	Meeting Date	Topic/Agenda item	Conflicts of interest considered and agreed treatment of the conflict	Conclusion/Decision (e.g. Approved, Noted, Recommended ... etc. SEE <i>"Decision" Types</i> tab for guidance)	If applicable - results of vote and/or dissenting views	If Recommendation - destination for onward submission?	2
101	19-Sep-2024	Medical Engagement	None	Noted- Medical Engagement was noted.			3
102	19-Sep-2024	Staff Survey	None	Noted- Staff Survey was noted.			
103	19-Sep-2024	Regular Assurance Reports	None	Noted- The following Chair Reports were noted: Chair Report Non- Medical Staffing Sub-Group, ICS People Committee Update.			
104	19-Sep-2024	Review of the Workplan and Attendance Matrix	None	Noted- Review of the Workplan and Attendance Matrix was noted.			4
105	19-Sep-2024	Risk Reflection	None	Noted- No specific risks to raise.			
106	24-Oct-2024	Chief People and Culture Update	None	Noted- Chief People and Culture Update was noted.			
107	24-Oct-2024	Corporate Risk Register	None	Noted- The Corporate Risk Register was noted.			5
108	24-Oct-2024	Workforce Performance Report	None	Noted- Workforce Performance Report was noted.			
109	24-Oct-2024	Agency Report	None	Noted- The agency report was noted.			
110	24-Oct-2024	Personal Development Deep Dive	None	Noted- The Personal Development Deep Dive was noted.			6
111	24-Oct-2024	Core Training Compliance Report	None	Noted- The Core Training Compliance Report was noted.			
112	24-Oct-2024	Global Majority Staff Engagement	None	Noted- The Global Majority Staff Engagement Update was noted.			
113	24-Oct-2024	Guardian of Safe Working Hours Report (Q2)	None	Noted- Guardian of Safe Working Hours Report Q2 was noted.			7
114	24-Oct-2024	Freedom to Speak Up Report (Q2)	None	Noted- Freedom to Speak Up Q2 Report was noted.			
115	24-Oct-2024	People Promise Update	None	This agenda item was deferred.			
116	24-Oct-2024	Education and Training Strategy	None	Noted- The strategy was noted.			8
117	24-Oct-2024	Draft Anti Racism Strategy	None	Noted- The strategy was noted with a request for further review at the next meeting			
118	24-Oct-2024	Regular Assurance Reports	None	Noted- The following Chair Reports were noted: Non Medical Staffing Sub Group, LNM Meeting, JCG, EDI, ICS People Committee Update, Safe Nurse and ODP Staffinh Escalation Policy, TPOIG.			
119	24-Oct-2024	Policies	None	The following policies were deferred and a front sheet with key changes made was requested- Flexible working policy & Subsistence Policy			9
120	24-Oct-2024	Review of the Workplan and Attendance Matrix	None	Noted- review of the workplan and attendance matrix was noted.			
121	24-Oct-2024	Risk Reflection	None	Noted- No specific risks to raise.			
122	21-Nov-2024	Board Assurance Framework	None	Recommend to the Board for Approval		Board of Directors	10
123	21-Nov-2024	Chief People and Culture Update	None	Noted- the Committee noted the update.			
124	21-Nov-2024	Workforce Performance Report/ Time to Hire Deep Dive	None	Noted- The Committee noted the reports.			
125	21-Nov-2024	WRES/WDES Reports	None	Noted- The Committee noted the reports.			11
126	21-Nov-2024	Personal Development Review/ Draft Appraisal and Development Guidance	None	Noted-the Committee noted the update and guidance			
127	21-Nov-2024	Medical Engagement	None	Noted- the Committee noted the update.			
128	21-Nov-2024	Responsible Officer and Revalidation Annual Report	None	Noted-the Committee noted the update.			12
129	21-Nov-2024	Anti-Racism Strategy	None	Noted-the Committee noted the update			
130	21-Nov-2024	Policy Ratification	None	Approved- The Flexible Working Policy and Subsistence Policy were approved.			
131	21-Nov-2024	Review of the Workplan and Attendance Matrix	None	Noted-The Committee noted the Workplan and Attendance Matrix.			13
132	19-Dec-2024	Chief People and Culture Update	None	Noted- The Committee noted the update.			
133	19-Dec-2024	Corporate Risk Register	None	Noted and Recommended to the Board of Directors.		Board of Directors	
134	19-Dec-2024	Theatre Recruitment Deep Dive	None	Noted- The Committee noted the Theatre Recruitment Deep Dive.			14
135	19-Dec-2024	Workforce Performance Report	None	Noted- The Committee noted the Workforce Performance Report.			
136	19-Dec-2024	Premium Workforce (M8) Report	None	Noted- The Committee noted the report.			
137	19-Dec-2024	System Integrated Improvement Plan (SIIP)	None	Noted- The Committee noted the report.			15
138	19-Dec-2024	WRES & WDES Report	None	Noted & Approved the reports for publication.			
139	19-Dec-2024	Statutory and Mandatory Training Review	None	Noted- The Committee noted the update			
140	19-Dec-2024	Leadership and Development Programme Review	None	Noted- The Committee noted the Leader and Development Programme review and expressed full support for the ongoing work.			16
141	19-Dec-2024	Pay Escalations	None	Noted- The Committee noted the Pay Escalations update.			
142	19-Dec-2024	Draft Clinical Strategy	None	Noted- The Committee noted the draft clinical strategy.			
143	19-Dec-2024	Regular Assurance Reports	None	Noted- The following Chair Reports were noted: Non Medical Staffing Sub Group, JCG, EDI, ICS People Committee Update.			17
144	19-Dec-2024	Review of the Workplan and Attendance Matrix	None	Noted- The Committee noted the Workplan and Attendance Matrix.			
145	19-Dec-2024	Risk Reflection	None	No specific risks to raise.			
146	23-Jan-2025	Medical Engagement Progress	None	Noted- The Committee noted the update.			18

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Decision Ref No.	Meeting Date	Topic/Agenda item	Conflicts of interest considered and agreed treatment of the conflict	Conclusion/Decision (e.g. Approved, Noted, Recommended ... etc. SEE <i>"Decision" Types</i> tab for guidance)	If applicable - results of vote and/or dissenting views	If Recommendation - destination for onward submission?	2
147	23-Jan-2025	Job Planning	None	Noted- The Committee noted the update.			3
148	23-Jan-2025	Workforce Performance Report	None	noted- The Committee took significant assurance from the report.			
149	23-Jan-2025	Premium Workforce (M9) Report	None	Noted- The Committee noted the update.			
150	23-Jan-2025	People Promise Update	None	noted- The Committee took significant assurance from the report.			4
151	23-Jan-2025	Gender Pay Gap Report	None	Aproved- The Committee approved the report.			
152	23-Jan-2025	Disciplinary Case Management Summary (Verbal Presentation)	None	Noted- The Committee noted the update.			
153	23-Jan-2025	Freedom to Speak Up Q3 Report	None	noted- The Committee took significant assurance from the report.			5
154	23-Jan-2025	Chair Report Non-Medical Staffing Subgroup	None	Noted- The Committee noted the chair report.			
155	23-Jan-2025	ICS People Committee Update	None	Noted- The Committee noted the update.			
156	23-Jan-2025	Development of Plans 2025/26	None	Noted- The Committee noted the update.			6
157	23-Jan-2025	Review of Workplan and Attendance Matrix	None	Noted- The Committee noted the Workplan and Attendance Matrix.			
158	23-Jan-2025	Risk Reflection	None	No specific risks to raise.			
159	23-Jan-2025	Chair Report Trust Performance and Operational Improvement Group	None	Noted- The Committee noted the chair report.			7
160	23-Jan-2025	Planning Timetable	None	Noted- The Committee noted the Planning Timetable.			
161	27-Feb-2025	Board Assurance Framework	None	Noted- The Committee noted the update.			
162	27-Feb-2025	Workforce Performance Report	None	Noted- The Committee noted the update.			8
163	27-Feb-2025	Premium Workforce (M10) Report	None	Noted- The Committee noted the update.			
164	27-Feb-2025	Job Planning Attainment	None	Noted- The Committee noted the update.			
165	27-Feb-2025	Statutory Training Compliance Report	None	Noted- The Committee noted the update.			9
166	27-Feb-2025	System Integrated Improvement Plan	None	Noted- The Committee noted the update.			
167	27-Feb-2025	Guardian of Safe Working Hours Q3 Report	None	Noted- The Committee noted the update.			
168	27-Feb-2025	Improvewell Presentation	None	Noted- The Committee noted the update.			10
169	27-Feb-2025	Review of Staff Networks Presentation	None	Noted- The Committee noted the update.			
170	27-Feb-2025	Trans Equality Policy	None	Approved- The Committee approved the policy subject to the comments made.			
171	27-Feb-2025	Policy Statement in the Recruitment of Ex Offenders	None	Approved- The Committee approved the policy.			11
172	27-Feb-2025	Professional Registration Policy	None	Approved- The Committee approved the policy.			
173	27-Feb-2025	Regular Assurance Reports	None	Noted- The Committee noted the following: Chair Report Non-Medical Staffing Subgroup, Chair Report Education and Training Oversight Meeting , Chair Report- EDI Meeting, Chair Report- JCG, ICS People Committee Update.			
174	27-Feb-2025	Review of Workplan and Attendance Matrix	None	Noted- The Committee noted the Workplan and Attendance Matrix.			12
175	20-Mar-2025	Corporate Risk Register	None	Noted- The Committee noted the Corporate Risk Register.			
176	20-Mar-2025	Workforce Performance Report	None	Noted- The Committee noted the Workforce Performance Report.			
177	20-Mar-2025	Absence Management Report	None	Noted- The Committee noted the Absence Management Report			13
178	20-Mar-2025	Premium Workforce (M11) Report	None	Noted- The Committee noted the Premium Workforce Report			
179	20-Mar-2025	2025/26 Workforce Plan	None	Noted- The Committee noted the 2025/26 Workforce Plan			
180	20-Mar-2025	Staff Survey Overview	None	Noted- The Committee noted the Staff Survey Overview			14
181	20-Mar-2025	People Promise Update (verbal)	None	Noted- The Committee noted the People Promise Update			
182	20-Mar-2025	Personal Development Proposal	None	Noted- The Committee noted the Personal Development Proposal			
183	20-Mar-2025	Retain Workstream SRO Update	None	Noted- The Committee noted the Retain Workstream SRO Update			15
184	20-Mar-2025	STW HR System Review	None	Noted- The Committee noted the STW HR System Review			
185	20-Mar-2025	Regular Assurance Reports	None	Noted- The Committee noted the Non-Medical Staffing Subgroup and Multi Professional Education Strategy Meeting Chair Reports.			
186	20-Mar-2025	National Pregnancy and Baby Loss People Policy Framework	None	The Committee approved the National Pregnancy and Baby Loss People Policy Framework.			16
187	20-Mar-2025	Fixed Term Contracts Policy	None	The Committee considered the policy and suggested amendments prior to bring back for further discussion- Noted.			
188	20-Mar-2025	Review of Workplan and Attendance Matrix	None	The Committee noted the Review of Workplan and Attendance Matrix			
189	20-Mar-2025	System Integrated Improvement Plan	None	The Committee noted the System Integrated Improvement Plan			17
190	20-Mar-2025	Risk Reflection	None	There were no specific risks to raise. The Committee were content that the current risks are reflected within the Board Assurance Framework or the corporate risk register.			
191	20-Mar-2025	Workforce Plan 2025/25	None	The Committee noted the Workforce Plan 2025/25			

People and Culture Committee

Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the People and Culture 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 People and Culture Officer
- Chief Nurse and Patient Safety Officer
- Chief Operating Officer
- Chief Finance and Planning 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. A Director will be nominated to chair meetings in the absence of the Chair.

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, ~~and~~ Deputy Chief People and Culture Officer ~~and~~ Associate Chief People and Culture Officer 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.

Service managers, unit representative and subject matter experts will only be expected to attend when a relevant paper is being presented. A time slot will be allocated to those individuals to support the logistics of the meeting.

An invitation is extended to the Council of Governors to observe the meeting.

4. Frequency of meetings and meeting administration

The Committee will meet monthly for regular business. The Chair~~man~~ of the Committee may call additional meetings.

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The Chief People and Culture Officer shall agree the agenda with the Chair of the Committee. A member of the Executive office secretariat 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

- 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
- To ensure the Trust is meeting its statutory and regulatory requirements in relation to workforce management.
- To oversee the development and implementation of the People Plan and any related workforce plans
- To monitor and develop the Trust's plans for talent management, succession planning, staff engagement, performance, reward and recognition strategies and policies
- To receive an agreed level of workforce data and trend analysis to inform and analyse workforce issues
- To ensure that the Committee has adequate information on which to advise and assure the Board on 'Caring for Staff'
- To receive reports from meetings that report into the Committee, currently including:
 - Equality Diversity and Inclusion Meeting

~~○ Learning and Development Meeting~~

- Joint Consultancy Group Meeting
- Local Negotiating Meeting
- Trust Performance and Operational Improvement Group
- Non-medical staffing sub-group
- Education and Training Oversight Group

- To receive reports as provided by the ICS People Committee
- 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 workforce strategies raising any significant risks regarding their delivery to the Board.
- To assure and provide advice to the Board on any arising People Services issues of significance

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Freedom to Speak Up Report: Q4, 2024/5: January to March 2025

Committee / Group / Meeting, Date

Board of Directors, July 2025

Author:

Name: Elizabeth Hammond
Role/Title: Freedom To Speak up Guardian (FTSUG)

Contributors:

Name: Dylan Murphy
Role/Title: Trust Secretary

Report sign-off:

Name: Dylan Murphy
Role/Title: Trust Secretary

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 Q4, 2024/5 - January to March 2025. This paper is as presented to the People and Culture Committee, which was asked to note the content and agree any subsequent recommendations / actions.

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

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

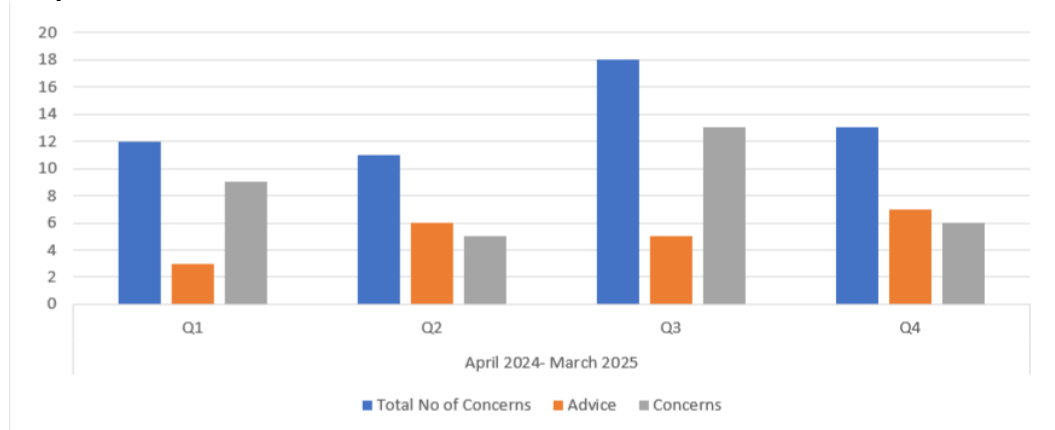
Key Points:

- This quarter, FTSU has received a total of thirteen cases:
 - Of the thirteen cases received, eleven have been closed and two remain open.
 - Of the two cases remaining open, one has just been received and actioned. The other has been escalated as a concern, and the Guardian is awaiting feedback from the person dealing with it.
 - The 11 cases took an average of 6 days to close.
- Of the thirteen cases raised:
 - Six were anonymous,
 - Two related to patient safety,
 - Six related to worker safety,
 - Two had an element of bullying and harassment;
 - Six related to attitudes and behaviors;
 - Three 'other' concerns were raised;
 - All were raised with the Guardian; and
 - Seven required advice and were redirected.
- Cases can have a number of elements. For example, one case may have elements that relate to "patient safety" and elements that relate to "attitudes and behavior". The NGO also includes "anonymous" as a reporting category in its own right. If the example case was raised "anonymously", it would feature as three concerns in the reported data.
- All cases raised have been responded to within 48hrs and escalated if required, or signposted to the appropriate department.

Assessment of cases

Graph 1a shows the total number of cases raised, and how they were treated. The total number of cases raised this quarter is thirteen. An alternative presentation of these figures is included as Graph 1b in the appendix.

Graph 1a



The total number of cases raised in 2024-25 was 54, compared with 46 cases in 2023/24. This is a 20% increase on last year.

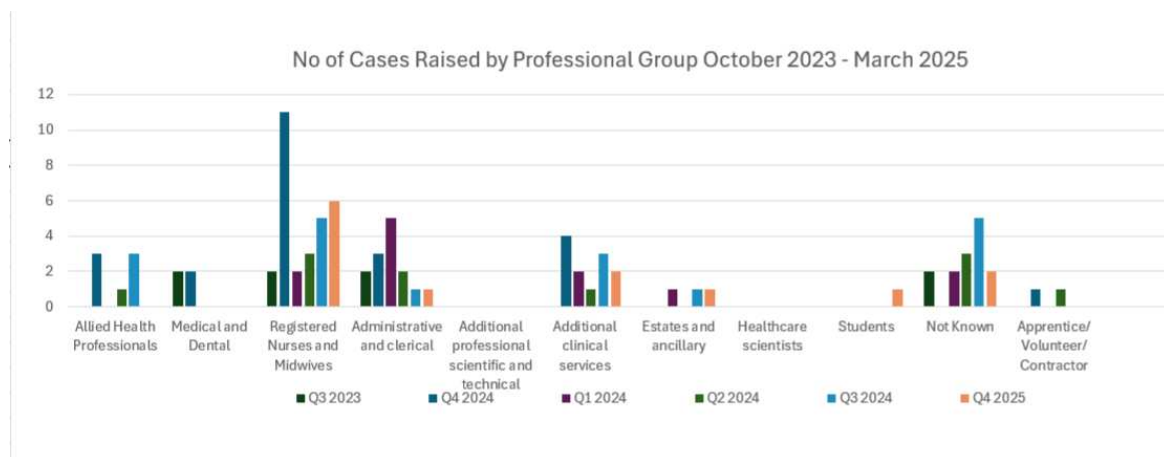
To provide some context, the FTSUG has broken cases down into two categories:

- “Advice” refers to cases where contact was made with the FTSU Guardian which resulted in redirection and general advice (i.e. no further follow up or feedback was required).
- “Concerns” refer to cases which resulted in further follow up and escalation.

Both will be counted when reporting “concerns” to the NGO. The cases noted as resulting in “Advice” would fall under the “Other” category of reporting into the NGO.

Graph 2a shows the Professional groups who have raised concerns during Quarter 4 (as required / reported to the NGO). An alternative presentation of these figures is included as Graph 2b in the appendix.

Graph 2a



The FTSU team have received cases from a broad range of professional groups across the Trust. Registered Nurses raised the most, with 29.63% over the last year, followed by Administration and Clerical with 16.66%, and then Additional Clinical Services with 14.81%. Twenty-two percent of this year's cases did not record a profession, or were anonymous concerns.

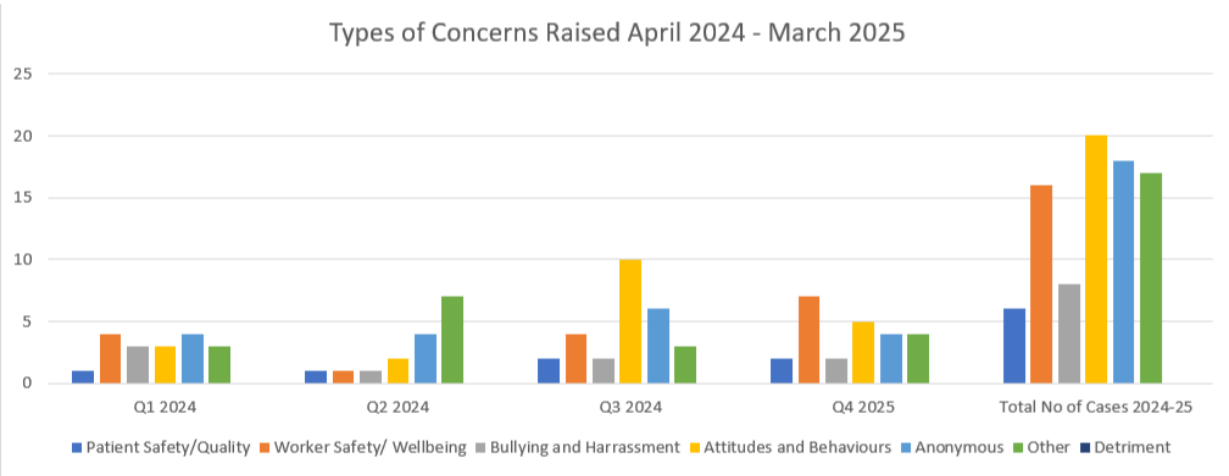
Graph 3a presents the data required by the NGO on the 'Types of concerns' raised. Graph 3b in the appendix presents this in an alternative format (excluding "anonymous" as a category in its own right).

The categories that must be reported are:

- Patient Safety/Quality;
- Attitudes and Behaviours;
- Worker Safety and Wellbeing;
- Bullying and Harassment;
- Other (procedures, policies, fraud etc); and
- Anonymous concerns.

When staff raise a concern, it can have more than one element. If that is the case, the concern would be reported under multiple categories.

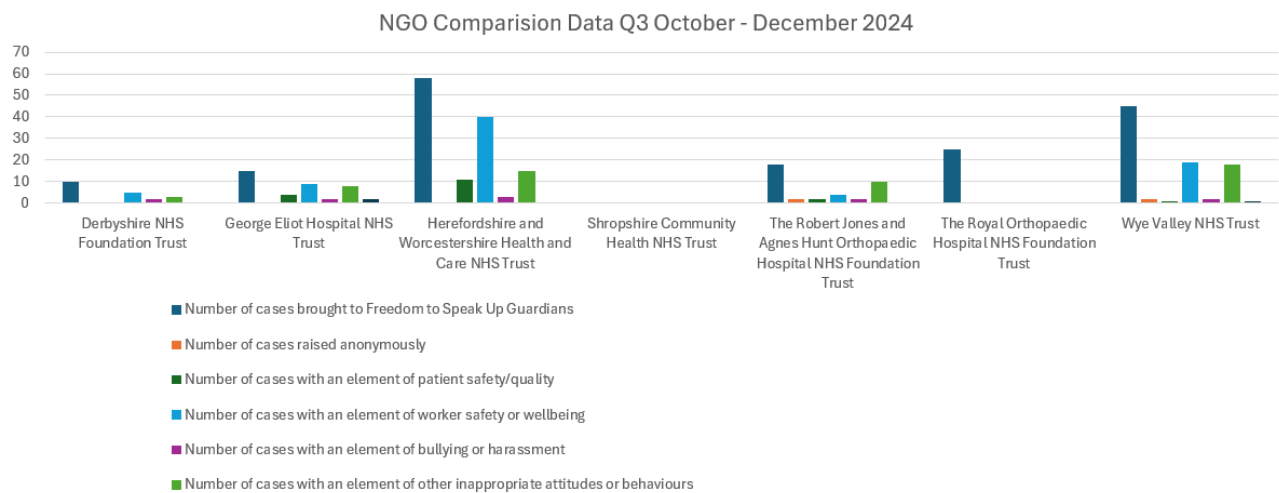
Graph 3a



The final cluster in this chart shows the totals for 2024-25. Graph 3c in the appendix presents this in an alternative format (excluding "anonymous" as a category in its own right).

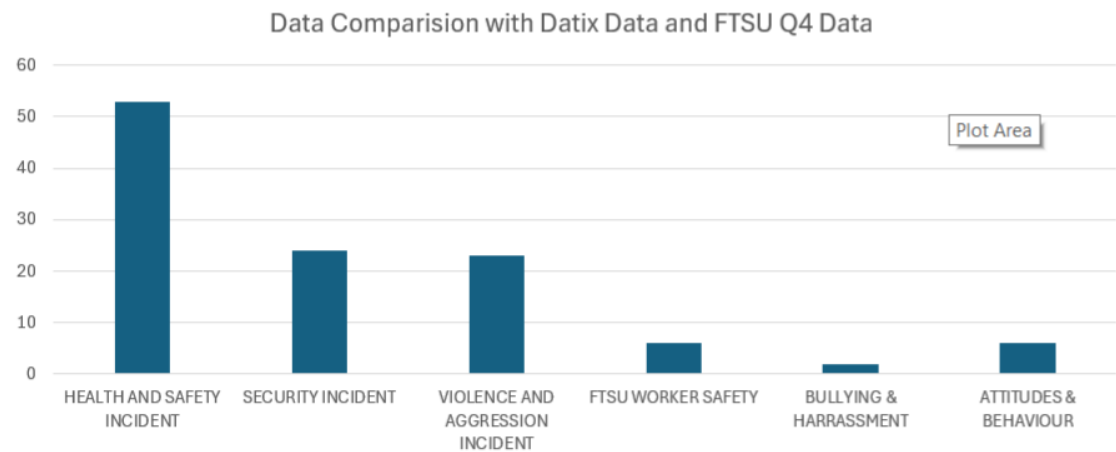
Graph 4 compares small, Midlands-based NHS Foundation Trusts with RJAH. The NGO definition of small is under 5,000 staff members. The Royal Orthopedic Hospital (ROH) Birmingham is the most similar Trust to RJAH. The data below is for Q3 January – March 2025. No data was submitted for Shropshire community.

Graph 4



Graph 5a is a comparison with the RJAH Datix data to the RJAH FTSU data for Q4, January to March 2025. 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 5a compares the moderate to severe Datix incidents (in the first three columns), against the number of concerns raised to FTSU (in the second three columns).

Quarterly Datix figures are obtained from RJAH Clinical Governance. An alternative format for showing the Datix figures, which can then be compared with the FTSU case figures is included in the appendix at Graph 5b.

Learning and improvement

In 2024/25 the FTSU RJAH have promoted FTSU across the Trust by:

- Updating posters of the Champions and Non-exec, Executive lead and Guardian for FTSU.
- In October, the Champions and Guardians promoted FTSU by having a walk about, explaining about FTSU and explaining how they can raise a concern.

Mandatory FTSU e-learning was introduced last year. This included three modules and is a one-off training session. Speaking Up is for every member of staff, Listening Up is an additional module for Managers and the Follow Up module is for senior manager/ executive managers as well as the other two modules. FTSU Champions are also asked to complete all three modules. This Year:

- 92.2% of staff have completed the Speaking Up module,
- 83.4% have completed the Listening Up module and
- 81.6% have completed the Follow up module.

The introduction of a QR code for a Microsoft FTSU raising concerns form has been completed. This form enables anyone wishing to raise a concern either anonymously or by name can do so by scanning the code. Once the person has submitted the form this is sent directly to the Guardian, computer identification is not traceable, therefore if someone wishes to stay anonymous they can. If contact details are added, then the Guardian can contact the person to discuss the concern, signpost them as appropriate, and give feedback as necessary.

Completed actions for 2024-25 include:

1. Completion of the National Guardian Office Reflection and planning tool.
2. The additional appointment of three global majority FTSU champions, bringing the total of champions up to twelve. The Champion's role is to raise the profile of FTSU in their department and signpost staff to an appropriate person for advice or escalation.
3. The Guardian has introduced a closed, information portal, for the Champions. The Guardian can share updates from the National Guardian Office. There is also a separate digital chat room and What's App group, so Champions can ask questions and gain support from each other. Bi-monthly face to face meetings is also available.
4. A Microsoft form for Champions to record concerns raised to them has been developed. This enables accurate data to be collected and shared with the Guardian in real time.
5. Ensuring face to face presentations on FTSU at Trust induction and development days, and Preceptorship programme.
6. The implementation of a feedback survey form of staff who have raised concern. The surveys are issued in batches at the end of every quarter to those whose cases have been closed. The feedback form is anonymous so that staff can give honest feedback about the FTSU service.
7. With the implementation of a new bespoke database, additional data is going to be collected around protected characteristics to measure if staff with protected characteristics are raising more concerns than other members of staff.

Results of feedback to date

Of the 10 feedback forms sent out, four were completed. The questions, and responses received were:

- *Given your experience would you use FTSU again?*
Three responded Yes and one responded Maybe.

- *How well, do you feel your concern was handled, overall?*
Three responded they were satisfied, and one said they were extremely satisfied.
- *Did you suffer any detriment as a result of raising your concern?*
Three responded No. One left a comment saying that “I worry about my future with the Trust. I feel the complaint/concern did not land well with the senior management and they may no longer be supportive of my progression, despite the hard work that I have put in”.
- *Is there any other feedback you would like to share to help improve the FTSU service?*
“It’s a great service to have in the workplace and is something I would use again if needed”.
“Immediate offer of a meeting and good advice given”.

Anyone who raises a concern and shares their identity is given frequent updates by the FTSUG.

Managers who are assigned concerns to respond to are also required to provide feedback to the person who raised the concern,. The FTSUG checks that the person has received feedback.

Correspondence is also sent to the person dealing with the concern (the “manager”), to ask for an update on the feedback given to a staff member, actions undertaken, and any lessons learned. This is to ensure that Speaking Up results in wider learning and improvement. At the present time, the feedback about changes made, as a direct result of a concern, is proving challenging.

Ongoing actions

1. Updates to the Healthcare Professionals and Clinical Network meetings on feedback, learning and improvement.
2. Securing ring-fenced time for Champions. Although managers supported the Champions to attend bi- monthly meetings and FTSU Promotion days, the Champions are finding that they cannot attend due to service needs.
3. Attendance at the Regional NGO meetings, national NGO Conference and ICB FTSU meetings.

Developments planned for 2025/6

The FTSU function will transfer into the Trust Secretary’s portfolio. The FTSUG and Trust Secretary will work together, engaging the FTSU NED lead, to agree objectives to support and promote the function.

In terms of future reporting, work has begun to review and further develop:

- The presentation of FTSU data, to aid understanding and provide assurance. Some initial examples of alternative formats are attached for review / comment at Appendix A.
- The arrangements for triangulating information to identify underlying themes / emerging issues.
- The collection, sharing, and presentation of lessons learned as a result of concerns having been raised.
- A data management system to support the capture, triangulation, presentation and analysis of information.

Recommendation:

That the Board note the content of the FTSU report and consider the People and Culture Committee response to the recommendations (as noted in the Chair's Assurance Report from the People and Culture Committee), that the Committee:

1. NOTE that appropriate FTSU arrangements are in place and that concerns are:
 - Addressed and concluded in a timely manner, with lessons learned and communicated.
 - Categorized and reported to the NGO as required.
 - Triangulated with other sources of data and reviewed over time to identify potential areas of concern that require attention.
2. NOTE the ongoing and planned actions to further develop the arrangements; and
3. CONSIDER and comment on the potential alternative / additional presentation of data provided at Appendix A.

Acronyms

FTSU = Freedom to Speak Up
FTSUG = Freedom to Speak up Guardian
NGO = National Guardian's Office
NHS = National Health Service

Attachments

Appendix A – Alternative / additional presentation of data

- The following graphs present existing FTSU reporting alongside potential alternatives which may aid understanding / analysis and provide greater assurance.
- The first few **graphs** provide an alternative way of presenting information that has previously been included in FTSU reports. These present information on categories of concern and the professional group raising concerns separately.
- The National Guardian's Office (NGO) require reporting on "anonymous" concerns as a category of concern in their own right. That is potentially confusing, so for our own assurance purposes, we could present that in a different way.
- The proposed Graphs 1b, 2b, 3b and 5b can be presented directly above / below one another to enable general comparison up and down the "quarter" lines.
- The **tables** towards the end propose a new way of recording and presenting information on FTSU cases. Tables 1a and 1b attempt to combine the information on the categories of concern and the professional groups raising them. This would also enable the creation of graphs showing concerns raised by different professional groups over time. Hopefully, the work with Hayley will support that.
- Table 2a is illustrative and represents the sort of information recorded on individual cases, including information on the outcome / lessons-learned (as well as the constituent elements of the concern and which professional groups raised them). To protect anonymity, it is not proposed that this level of detail will be reported / shared beyond the FTSU function but it will support appropriate analysis and reporting to the Committee.

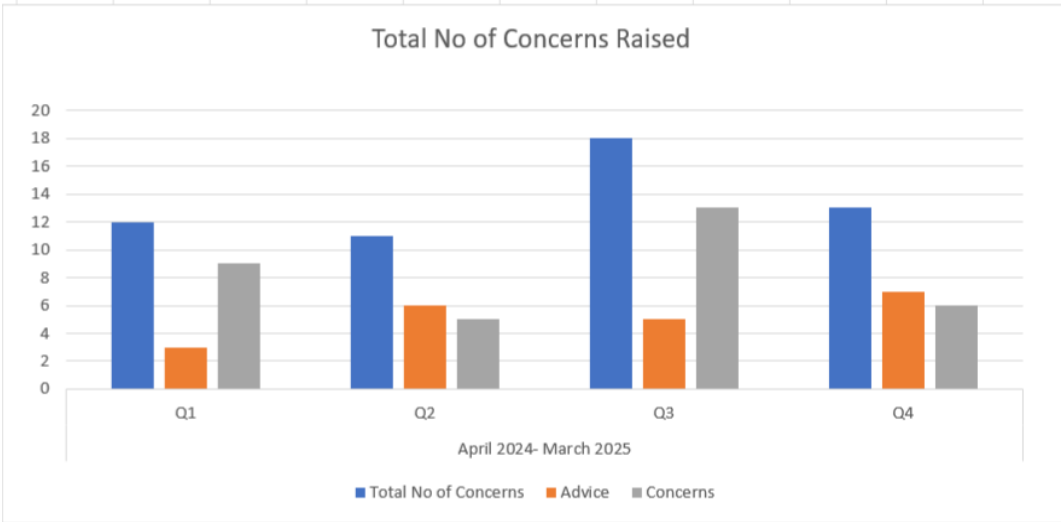
Example graphs / tables included:

Graphs 1a and 1b:	The number of concerns raised and the breakdown of "advice" versus "concerns"
Graphs 2a and 2b:	Concerns received from particular professional groups
Graphs 3a, 3b and 3c:	Categories of concern raised
Graphs 5a and 5b:	Datix comparison
Tables 1a and 1b:	Table showing categories of concern raised by professional groups
Table 2:	Table summarising the detail and outcome of individual cases – NOT TO BE REPORTED DIRECTLY.

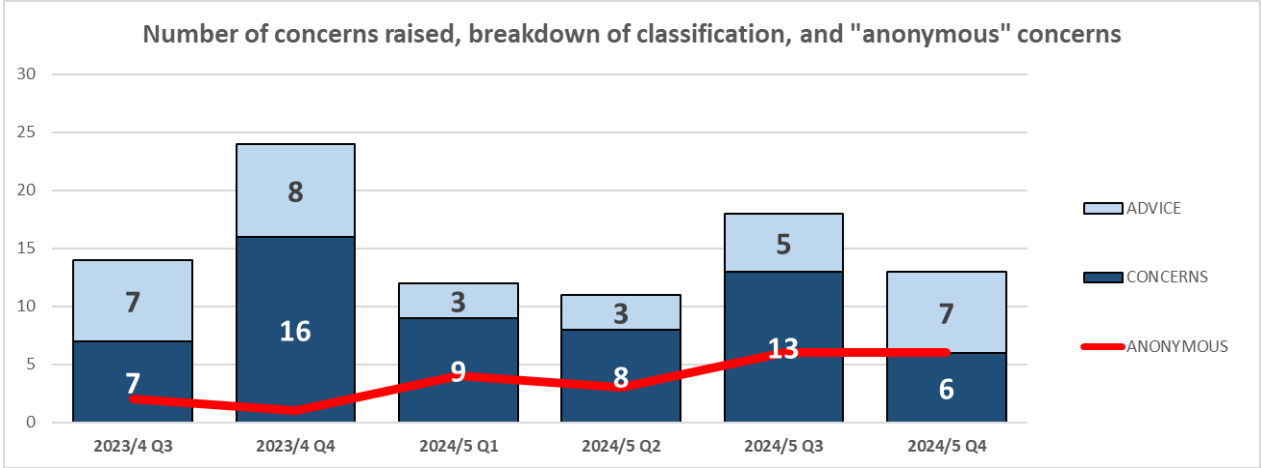
Appendix A – alternative / additional presentation of data

These graphs show the number of concerns raised and how many of these were treated as “concerns”, and how many were considered for “advice” only.

Existing - Graph 1a (current presentation, covering four quarters)



Proposed alternative / addition - Graph 1b (covering six consecutive quarters)



This version consolidates the current three columns into one. It also superimposes the number of “anonymous” concerns received – this line shows the number of contacts that were received “anonymously”.

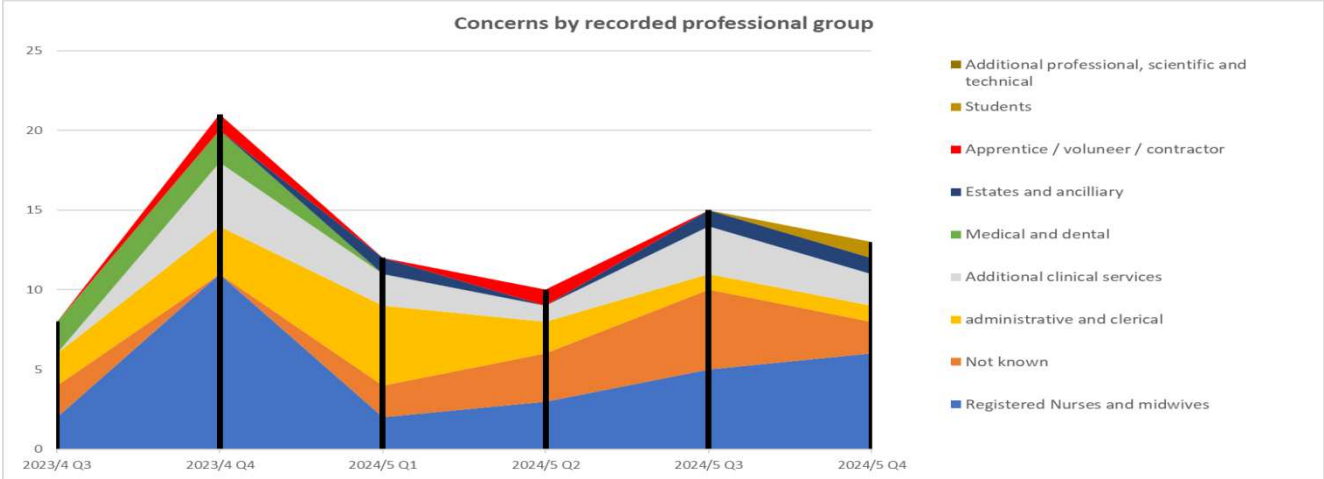
Appendix A – alternative / additional presentation of data

These graphs show the concerns received from particular professional groups.

Existing - Graph 2a (covering six consecutive quarters)



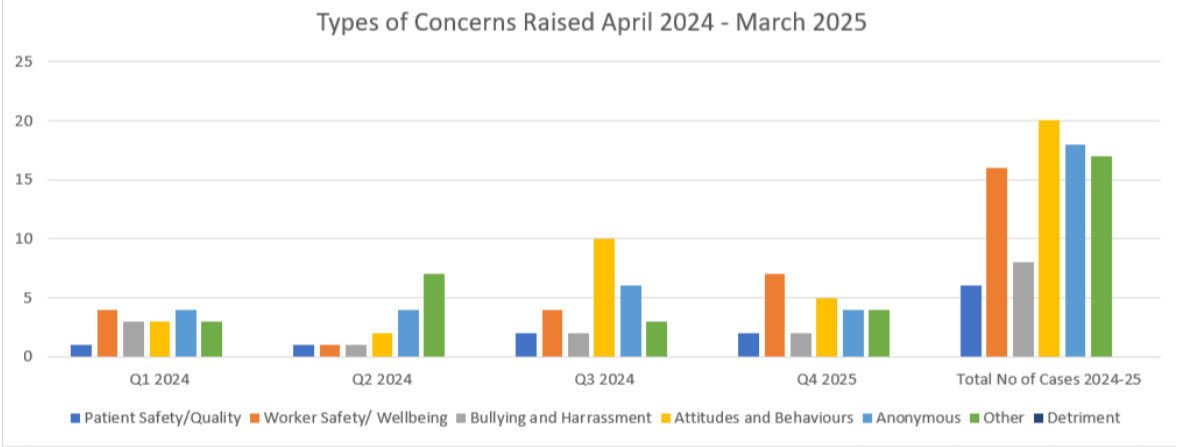
Proposed alternative / addition - Graph 2b (covering six consecutive quarters)



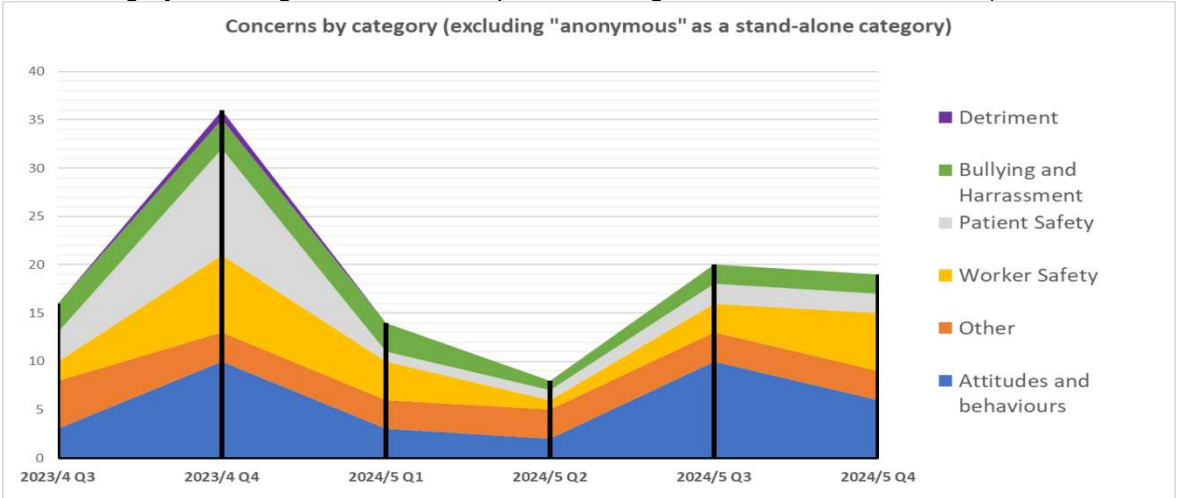
This version may make it easier to discern changes in the absolute, and relative, number of concerns raised by particular professional groups over time.

NOTE: A table including the figures can be provided, alongside the graphic representation, so it is easier to interpret.

Existing - Graph 3a (categories as reported to NGO, covering four quarters, plus annual figures)



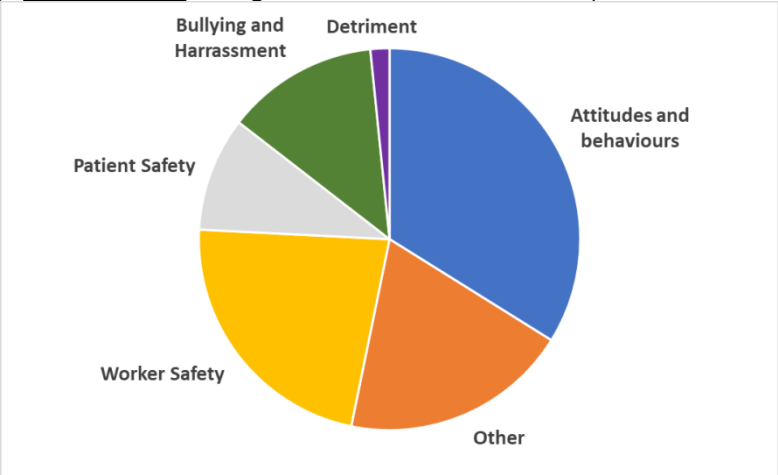
Proposed alternative / addition - Graph 3b (categories reported to NGO excluding “anonymous” as a stand-alone category, covering six consecutive quarters, using same colour scheme as 3c)



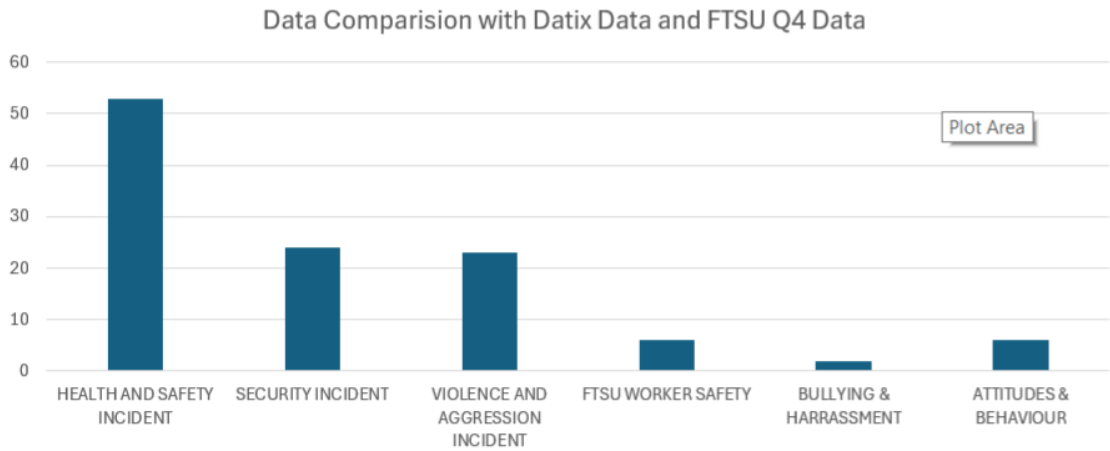
This version may make it easier to discern changes in the absolute, and relative, numbers of particular types of concern over time.

NOTE: A table including the figures can be provided, alongside the graphic representation, so it is easier to interpret. The graphs could then have supporting narrative to explain what may be behind any increases / decreases.

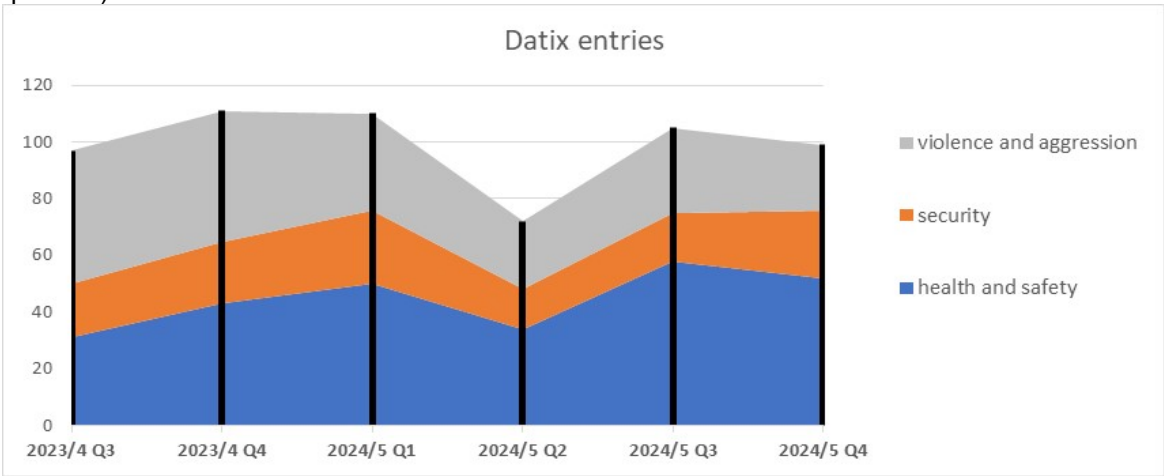
Proposed alternative / addition - Graph 3c (cases by category reported to NGO, excluding “anonymous” as a stand-alone category, during 2024/5, using same colour scheme as 3b)



Existing - Graph 5a (current presentation of Datix “moderate” to “severe” cases and selection of FTSU concerns, by current quarter)



Proposed alternative / addition - Graph 5b (Datix “moderate” to “severe” incidents over six consecutive quarters)



NOTE: Additional sources of “HR” data / other intelligence are being considered for comparison, to develop a broader picture.

Tables 1a and 1b: Summary of concerns by both category and professional group. This could be completed quarterly and annually.

NAME PROVIDED (BY CATEGORY)	Registered Nurses and midwives	Not known	Administrative and clerical	Additional clinical services	Medical and dental	Estates and ancillary	Apprentice / volunteer / contractor	Students	Additional professional, scientific and technical	Healthcare scientists	
Attitudes and behaviours											TOTAL
Other											TOTAL
Worker Safety											TOTAL
Patient Safety											TOTAL
Bullying and Harrassment											TOTAL
Detriment											TOTAL
	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	
ANONYMOUS (BY CATEGORY)	Registered Nurses and midwives	Not known	Administrative and clerical	Additional clinical services	Medical and dental	Estates and ancillary	Apprentice / volunteer / contractor	Students	Additional professional, scientific and technical	Healthcare scientists	
Attitudes and behaviours											TOTAL
Other											TOTAL
Worker Safety											TOTAL
Patient Safety											TOTAL
Bullying and Harrassment											TOTAL
Detriment											TOTAL
	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	

NOTE: IF WE CAPTURE THE FIGURES THIS WAY, WE CAN CREATE GRAPHS TO SHOW CONCERN CATEGORIES BY PROFESSIONAL GROUP OVER TIME (IN A SIMILAR FORMAT TO 1B, 2B, OR SOME OTHER WAY).

Table 2a: Summary of each case – **Not proposed for sharing, but provides a platform to support wider analysis / reporting.**

COMBINED (BY CASE)	Professional Group	Concern or Advice?	ANONYMOUS?	Category of concern included:						Comment / action taken	Case closed?	Outcome / learning	Feedback provided?
				Attitudes and behaviours	Other	Worker Safety	Patient Safety	Bullying and Harrassment	Detriment				
CASE 1													
CASE 2													
CASE 3													
CASE 4													
CASE 5													
CASE 6													
CASE 7													
CASE 8													
CASE 9													
CASE 10													



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



The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust

RJAH Ethnicity Pay Gap Report 2024



➔ *Improving lives through excellent and innovative care*



INTRODUCTION

Data Snapshot as at 31st March 2024:

Ethnic Origin Grouping Summary	Mean Hourly Rate	Median Hourly Rate	Total Full Pay Relevant Employees
BME	28.5859	19.5927	161
Not Known	25.6972	19.8198	55
White	18.4853	14.6395	1,665
% Diff White - BME	-54.6418	-33.8339	90
% Diff White - Not Known	-39.0142	-35.3855	97

Ethnic Origin Grouping	Mean Hourly Rate	Median Hourly Rate	Total Full Pay Relevant Employees
Asian	30.6703	21.1030	103
Black	21.3496	18.6824	30
Mixed	25.0781	17.0072	13
NULL	12.4455	12.4455	2
Not Stated	26.1972	21.7950	53
Other	31.7861	24.5763	15
White British	17.9496	14.5275	1,567
White Other	27.0497	18.5462	98
% Diff White British - White Other	-50.6979	-27.6627	94
% Diff White British - Asian	-70.8686	-45.2630	93
% Diff White British - Black	-18.9419	-28.6007	98
% Diff White British - Mixed	-39.7135	-17.0694	99
% Diff White British - Other	-77.0849	-69.1711	99
% Diff White British - Not Stated	-45.9484	-50.0264	97
% Diff White British - NULL	30.6642	14.3310	100

Employers are not required to collect, analyse or publish information on ethnicity pay. As part of our journey towards becoming an inclusive employer of choice we are reporting our ethnicity pay gap for the first time in 2025 based on a snapshot of our workforce on 31 March 2024.

The report is based on the government’s guidance for calculating differences in ethnicity pay and is based on a similar methodology as that used for gender pay gap reporting using electronic staff record (ESR) data. Information on ethnicity is not completed for all employee records, on 31 March 2024.

Employees can update this information and there has been some improvement in recorded information in 2023/2024.

It is important to note that a pay gap differs from equal pay for equal work.

‘Equal pay’ means being paid equally for the same/similar work.

‘Pay gap’ is the difference in the average pay between groups.

The ethnicity pay gap shows the difference in the average hourly rates of pay for Global Majority employees (recorded in ESR as black, Asian, mixed race or other) and White employees across our organisation.

As of 31 March 2024, Total staff numbers: 1,881. 161 employees, 8.56% Global Majority and 88.52 % per cent White. (2.92% reporting as “not stated/unknown”)

Our median ethnicity pay gap was – 33.83% and mean pay gap is – 54.64%

A median pay gap of -33.83% , means that on average global majority employees get paid 34p more per hour for every £1 earned by a white employee

In the Trust, Global Majority employees earn £4.95 per hour more when comparing the median hourly rate and £10.10 more when looking at the average hourly rate.

Within this, we have a pay gap of -28.60% for black staff, -17.07% for mixed race staff, -45.26% per cent for Asian staff (data only provided for groups of over 10 employees)

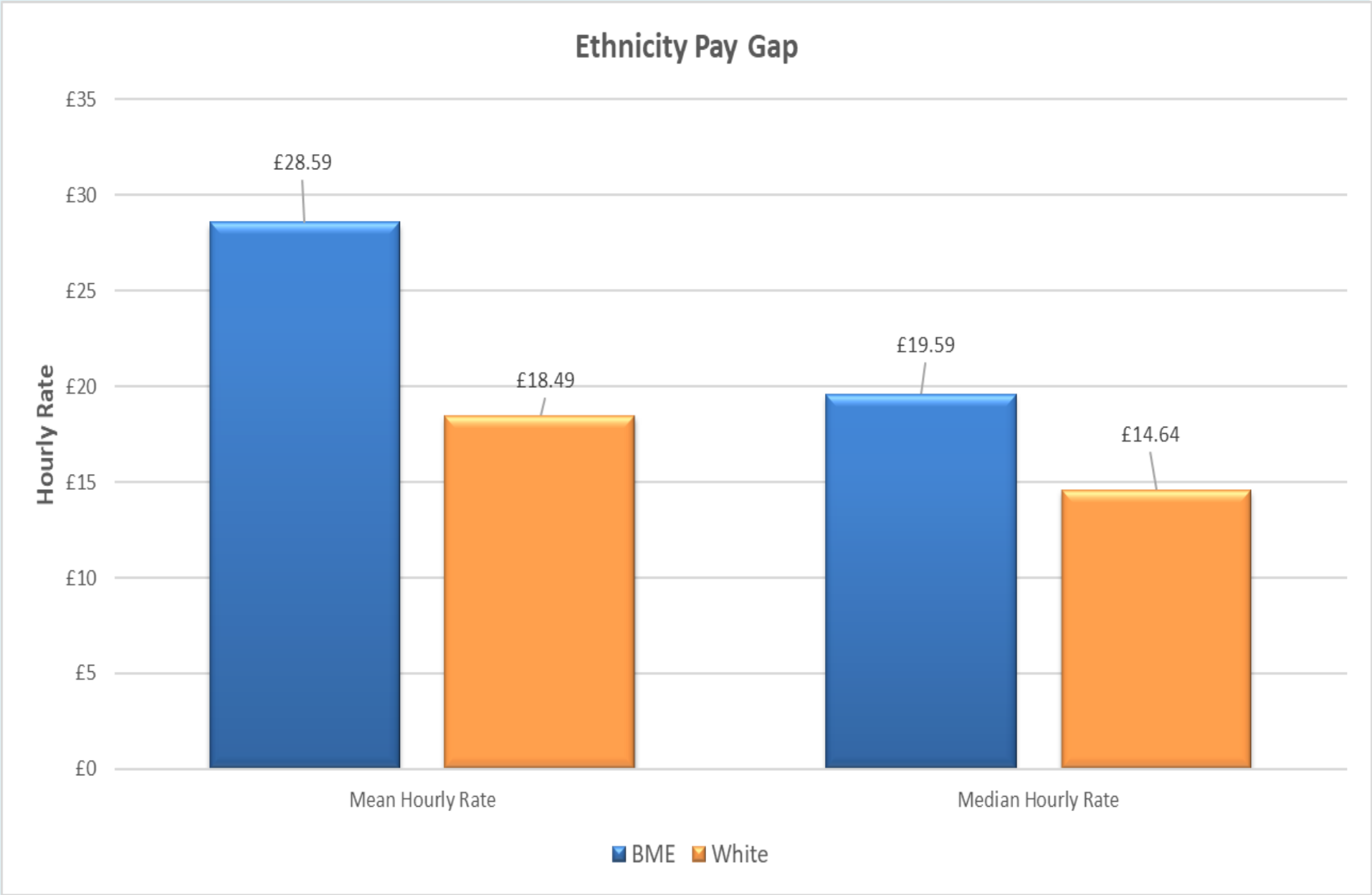


Table below shows that 74% of global majority staff are in roles that require professional registration (*Breakdown of professional registration identified below e.g. GMC/NMC/CIPD/HCPC/AAT etc*)

					Qualified Role
Count of Staff Group/Staff Group	1	2	3	4	Grand Total
Add Prof Scientific and Technical			1	2	3
Additional Clinical Services	14	5	6		25
Administrative and Clerical	5	7	2		14
Allied Health Professionals		3	7	5	15
Estates and Ancillary	2	1			3
Medical and Dental				64	64
Nursing and Midwifery Registered		8	27	2	37
Grand Total	21	24	43	73	161
Headcount in qualified role					119
% in qualified role					74%

What are we doing?

This year we will take the following steps to promote diversity and understanding barriers to promotion and recruitment for global majority colleagues:

- creating an evidence base: To identify barriers to equality and to help us make priorities for action, we have introduced diversity monitoring to understand:
 - the race of those applying for jobs and being recruited;
 - the race of those applying for and getting promotions;
 - the race of those leaving our organisation and their reasons for leaving;
 - the race of those in each role and pay band; and
 - the race of those formally involved in disciplinary, grievance and capability matters.
- reviewing our disciplinary and grievance processes: to support a move towards a just and learning culture.
- discuss the findings from our ethnicity pay gap alongside our equality's workforce analysis with our Ethnic Diverse Staff Network to get qualitative feedback on our organisation and the experience of our global majority employees, and to work collaboratively to develop initiatives to address issues identified.

What is our focus?

Inclusive Recruitment: Explore sharing interview questions in advance and expand interview question to improve standards of hire around inequality and anti-racism competence and experience.

Learning and Development: Develop a leadership programme embedding inclusion

Culture and Engagement: Share ethnicity pay gap reports and action plans with staff networks (pending action).

Ways of Working: Launched an Anti-Racism workstream to address recruitment, progression, retention, and conditions. Anti-racism Policy in progress (pending action).

Background/Key issues and considerations.

Background The UK government in 2017 published the first report to examine the barriers people from global majority face in employment, named Race in the workplace. Their report highlighted the need to first be able to measure the disadvantage some ethnic groups face in order to address the barriers to earning as much as their white colleagues.

In 2018, the Race Disparity Unit and CIPD led the call for the introduction of ethnicity pay gap reporting in “Our Manifesto for Work”. This led to the government consultation on whether to introduce mandatory ethnicity pay gap reporting, which ran from October 2018 to January 2019. The Women and Equalities Committee published a report calling for the Government to implement mandatory reporting of ethnicity pay by April 2023. The Government confirmed no mandatory ethnicity pay gap reporting. The Trust will report on it’s ethnicity pay gap as part of its anti-racist approach.

In the absence of a mandatory framework for ethnic pay gap reporting, Trusts who do take the steps to report their ethnicity pay gaps have to select their own reporting measures.

We have chosen to replicate the measure used in gender pay gap reporting with some changes, to account for the different data sets. The gender pay gap report compares two distinct groups – male and female – whereas ethnicity recorded on ESR can fall into one of four broad categories: white, Black, Asian and global majority, blank (not recorded) and unspecified (chose not to answer). The way that gender is recorded on ESR means that there can be no blank or unspecified records. In calculating the mean and median differences, we have chosen to focus on those who have specified their ethnicity to give the most precise view of the ethnicity pay gap in the Trust, as people with blank or undeclared ethnicities could either be Black, Asian and global majority or white. The blank and unspecified records are included in the Trust average.



As the CIPD observed, use of a single category for Black, Asian and minority ethnic people masks the variations in labour and pay market outcomes between global majority groups. Therefore, we have presented a further data breakdown using the ONS Census's five ethnicity categories.

This report includes:

- The mean and median ethnicity pay gaps
- The mean and median ethnicity bonus pay gap
- The proportion of Black, Asian and global majority and white employees who received a bonus
- The proportions of Black, Asian and minority ethnic and white employees in each pay quartile.

The ethnicity pay gap report shows the difference in the average pay between Black, Asian and global majority staff in our workforce. Where there is a positive percentage, this mean that the pay of white staff is higher than the pay of Black, Asian and global majority employees; the higher the percentage, the greater the ethnicity pay gap.

The ethnicity pay gap is different to equal pay. Ethnic pay disparities are not primarily about those from a white background and other global majority groups being paid differently for the same job. The Equality Act 2010 make it unlawful to discriminate (both directly and indirectly) against employees (and people seeking work) because of their race. Therefore, unless there is a failure to comply with existing law, pay disparities between global majority groups are likely to be due other factors to that impose disadvantage on people from global majority groups.



Recommendations:

While there is currently no legal requirement to publish ethnicity pay gap data in the UK, in line with our commitment to monitoring workplace inequalities between our global majority staff and white staff, and as an example of good practice, we are reviewing this data alongside our mandated Gender Pay Gap data and we ask that the Committee approves the 2023/2024 EPG metrics for two purposes:

- submission of summary figures to central government via a reporting portal.
- publication of the accompanying EPG report on the Trust’s public-facing website.

It is advised that we share our EPG report before the end of financial year,

Report development and engagement history:

The EDI and OD team have met with the Workforce information team to review and understand the data collated, to allow an accurate report to be produced.

Next steps:

The Committee are asked to review the content of the report and approve for publication on the Trust website.



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Acronyms and Definitions:

Mean

The mean hourly rate is the average hourly wage across the entire organisation so the mean ethnicity pay gap is a measure of the difference between women's mean hourly wage and men's mean hourly wage.

Median

The median hourly rate is calculated by ranking all employees from the highest paid to the lowest paid, and taking the hourly wage of the person in the middle; so the median ethnicity pay gap is the difference between women's median hourly wage (the middle paid woman) and men's median hourly wage (the middle paid man)

Pay Gap

Difference in the average pay between two groups.

Mean Gap

Difference between the mean hourly rate for female and male employees. Mean is the sum of the values divided by the number of values.

Median Gap

Difference between the median hourly rate of pay for female and male employees. Median is the middle value in a sorted list of values. It is the middle value of the pay distribution, such that 50% of employees earn more than the median and 50% earn less than the median.

Mean bonus Gap

Difference between the mean bonus paid to female and male employees. Mean is the sum of the values divided by the number of values.

Median Bonus gap

Difference between the median bonus pay paid to female and male employees. Median is the middle value in a sorted list of values. It is the middle value of the bonus pay distribution, such that 50% of employees earn more than the median and 50% earn less than the median.

Bonus Proportions

Proportions of female employees who were paid a bonus, and the proportions of male employees who were paid a bonus.

Quartile Pay Bands

Proportions of female and male employees in the lower, lower middle, upper middle and upper quartile pay bands. Quartile is the value that divides a list of numbers into quartiles.

Equal Pay

Being paid equally for the same/similar work.

Ethnicity Pay

Ethnicity pay gap shows the differences in the average pay between ethnicity

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INTRODUCTION



This report reflects the equality programme of work for staff and patients at, The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, during this reporting period and how, as a Trust, we have considered and evidenced our Equality Act and Public Sector Equality Duty (PSED) responsibilities. We will continue to advance EDI through a range of initiatives, activities and collaborations, which this report will highlight.

The data covers the period 1st April 2024 to 31st March 2025. As part of the Trust's Public Sector Equality Duty (PSED), equality data for staff and patients must be made available to the public via the website, following review and sign off by Trust Board members.

The information is linked to the nine protected characteristics themes under the Equality Act 2010. These nine protected characteristics are:

- Age
- Gender
- Religious belief
- Ethnicity
- Disability
- Marital and Civil partnership
- Pregnancy and Maternity
- Sexual orientation
- Gender Reassignment

Any exceptions have been noted, and this information will be included in the annual Equality and Diversity report.

PRIMARY LEGISLATION



The Robert Jones and Agnes Hunt
Orthopaedic Hospital
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Equality Act 2010 and its Public Sector Equality Duty (PSED)

The Public Sector Equality Duty ([The Equality Act 2010 \(Specific Duties\) Regulations 2011 \(legislation.gov.uk\)](#)) came in to force in April 2011 (s.149 of the Equality Act 2010) and public authorities like the NHS are now required, in carrying out their functions, to have due regard to the need to achieve the objectives set out under s149 of the Equality Act 2010 to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The Equality Act 2010 (Specific Duties) Regulations 2011 require the Trust to:

- Publish information to show compliance with the PSED, at least once a year.
- Produce Equality Objectives at least every four years.

Human Rights Act 1998

The Human Rights Act 1998 sets out universal standards to make sure that an individual's basic needs as a human being are recognised and met. Public authorities have a mandated duty to ensure they have arrangements in place to comply with the Act. It is unlawful for a healthcare organisation to act in any way that is incompatible with the Act. In practice, this means we must treat individuals with Fairness, Respect, Equality, Dignity and Autonomy – known as the FREDa principles.

Read more about [The Human Rights Act | EHRC \(equalityhumanrights.com\)](#).



Associated Legislation

Health and Social Care Act 2022

Statutory obligations on Organisations under the NHS Act 2006 (as amended by the Health and Care Act 2022)

Section 14Z35 of the 2006 Act (as added by section 25(2) of the 2022 Act) imposes the general inequality duty on an Organisation that it: must, in the exercise of its functions, have regard to the need to:

- Reduce inequalities between persons with respect to their ability to access health services.
- Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services (including the outcomes described in section 14Z34(3)).

Modern Slavery Act 2015

The Modern Slavery Act 2015 applies to all organisations in the United Kingdom with a turnover of £36 million or above. A key element of the Act is the 'Transparency in Supply Chains' provision, which requires businesses above a certain threshold to produce a 'Slavery and Human Trafficking Statement' outlining what steps they have

taken in their supply chain to ensure slavery and human trafficking is not taking place.

[Trust Response to the Requirements of the Modern Slavery Act 2015.docx \(rjah.nhs.uk\).](#)

RJAH EDI Objectives 2022-2026



Our progress and achievements so far

- Received 52% response for our Staff Survey
- Published WRES, WDES, Workforce Report and Gender Pay Gap report
- Developed EDI mandatory training on e-learning modules
- Used feedback from staff induction to launch a development session in relation to LGBTQ+
- Held Staff listening events to help shape this strategy and a platform for staff to share experiences

Equality Objectives

We will achieve our ambition to be an inclusive organisation (in line with the NHS People Plan) through a clear set of strategic objectives and an action plan which will work across all areas of the Trust.

The objectives will build on us creating an exceptional inclusive environment at the RJAH which will continue to improve everyone's experience.

Objectives to enable our Trust to:

- Tackle and remove all forms of discrimination in our workplace and for our patients
- Create an inclusive and healthy RJAH culture through our values
- Give the workforce a voice to speak up through Staff Network Groups
- Ensure all our leaders, managers and colleagues can role model in a compassionate and inclusive way
- Ensure the Equality and Diversity Action Plan delivers on the objectives and outcomes

How we can grow in this space

- › Develop an RJAH EDI pledge
- › Develop communication channels for training offers and networking
- › Support the SAND project (Safe Ageing No Discrimination)
- › Commit to align resources of staff to support the inclusion objectives and actions
- › Create an EDI newsletter
- › Develop and grow Trust Staff Network Groups
- › Involvement in reverse mentoring
- › Review the EDI elements of our induction process & leadership programme
- › Board Development Sessions

EDS2 Domain

As a Trust we will continue to work to the regulatory NHS measures as required. These are provided in summary below and we will review these against our action plan for the greatest effect on Inclusion at our Trust.

National NHS staff survey

All Trusts are required to undertake the staff survey which is completed during October and November on an annual basis. Feedback can highlight and provide key issues and opportunities, across different teams but also in diverse groups. The staff survey information is used across the Trust in many different ways.

National NHS Frameworks

The Trust is required to work under the Public Sector Equality Duty (PSED) of the Equality Act 2010. One of these requirements is for the Trust to share the content of this report with the public through our ROH website. This information includes: Workforce Race Equality standards (WRES)
Workforce Disability Equality standards (WDES) standards
Gender Pay gap
EDS 2 framework

Meeting our public sector equality duty

Under the Equality Act 2010 as a public body we have a general public sector equality duty to:

- Eliminate unlawful discrimination
- Promote equality of opportunity
- Foster good relations between people with different backgrounds

Workforce Race Equality Standard (WRES)

Since 2015, all NHS Trusts have been required to collect and publish data on their progress around delivering race equality for staff.

Workforce Disability Equality Standard (WDES)

Since 2017, all NHS Trusts have similarly been required to collect and publish data on their progress around delivering equality for staff with disabilities and long-term health conditions.

Gender Pay Gap

The mandatory gender pay gap analysis requires us to report workforce data across gender and pay bands and develop an action plan to address any gaps or over/under representation.

Equality Delivery System

The Trust utilises the Equality Delivery System 2 as a performance improvement framework to deliver and monitor our progress against our statutory requirements. NHS providers are expected to use EDS2 to help them improve their equality performance for patients, communities and staff, as well as helping them to meet the Public Sector Equality Duty.

The EDS2 has four goals which are:

- Better health outcomes
- Improved patient access and experience
- A representative and supportive workforce
- Inclusive leadership

EDS FY2023/2024 - Summary Scores				
Domain		Description	2023/2024 Rating	2023/2024 Score
Domain One - Service Line.				
Outcome	1A	Patients & Service Users have access to the Service.	Developing	1
	1B	Individual Patients/service users health needs are met.	Achieving	2
	1C	Patient/service users are free from harm.	Achieving	2
	1D	Patients/service users report positive experience of the service.	Achieving	2
Sub Score D1				7
Domain Two - Health and Wellbeing of Staff.				
Outcome	2A	When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions.	Developing	1
	2B	When at work, staff are free from abuse, harassment, bullying and physical violence from any source.	Developing	1
	2C	Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment and physical violence from any source.	Developing	1
	2D	Staff recommend the organisation as a place of work and receive treatment.	Achieving	2
Sub Score D2				5
Domain Three - Inclusive Leadership.				
Outcome	3A	Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.	Developing	1
	3B	Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and ow they will be mitigated and managed.	Achieving	2
	3C	Board members, system and senior leaders (band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients.	Developing	1
Sub Total D3				4
Total Score				16
				Developing



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RJAH Objectives

In December 2023, the Board of Directors agreed a set of strategic objectives for the period to 31 March 2028. These are summarised below. In January 2024, the Board also agreed a revised risk appetite statement.

The Board Assurance Framework (BAF) – as the expression of risk to the delivery of the Trust’s strategic objectives and statutory obligations is continuously reviewed against the revised objectives, taking account of the updated risk appetite.

The Trust agreed the following strategic objectives:

RJAH Objective	
1	Deliver high quality clinical services
2	Develop our Veterans service as a nationally recognised centre of excellence
3	Integrate 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:

STW System Objective	
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



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Statutory and Mandated Requirements

The following key reporting tools and mechanisms were used in an annual reporting period:

- NHS Accessible Information Standard
- NHS Equality Delivery System 2023
- Workforce Disability Equality Standard
- Workforce Diversity Profile Report
- Race Disparity Ratio
- RJAH Annual Equality Action Plan
- RJAH Equality Strategy and Objectives
- Gender Pay Gap
- Workforce Race Equality Standard
- PSED Equality Diversity and Inclusion Annual Report
- NHSE EDI Improvement Plan

Throughout this reporting period, we have published legal and mandated information about equality on our dedicated equality webpages and staff intranet pages. We will refresh these webpages and intranet pages as required and review them annually.





Commissioning and Procurement

The Trust procures from a variety of sources and wherever possible it uses Nationally Agreed Framework Agreements. These Frameworks will have been subject to robust procurement processes, including the nationally agreed supplier selection questionnaire, which takes account things such as Modern Slavery, Equality, Diversity & Inclusion in terms of any legislative breaches which may result in the bidder being marked down or rejected. Social Value is also a mandatory requirement in Public Sector Procurement and specific questions will have been included in all Frameworks and can be tailored dependent upon the requirement, based on a set of nationally agreed themes. The Trusts largest contracts are for Orthopaedics which are procured under an NHS Supply Chain Framework.

In a wider context the Equality and Health Inequalities Impact Assessment applies more so to Healthcare Contracting agreements, where the Trust is procuring (or being commissioned) services, none have been required within this reporting period.

Equality Health Inequality Impact and Risk Assessments (EHIIRA)

Equality and Health Inequalities Impact and Risk Assessments (EHIIRAs) are a well- established and embedded tool in the Trust. Using EHIIRAs helps ensure that services, policies and day-to-day functions are fair, accessible and inclusive. Through a process of questions and data analysis, EHIIRAs help to identify gaps and potential risks and highlight opportunities to improve staff and patient, access, experience and outcomes.

EHIIRAs are evidence-based tools, requiring stakeholder engagement. A Stakeholder is an individual or group that has an interest and a say in any decision or activity of an organisation and can include staff, patients, the public, support groups or business partners.

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Improving Patient Experience and Health Outcomes



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The NHSI Learning Disability Standards for NHS Trusts provide a benchmark against which all trusts can measure their performance in delivering services to people with learning disabilities and autistic people, which in turn drives quality improvement. This is a three-pronged approach:

- Organisational level collection.
- Staff Survey.
- Service User Survey.

This provides a holistic view of the workforce, activity, service models and quality of services provided to people with learning disabilities and autistic people.

The four LD standards are:

- Respecting and protecting rights.
- Inclusion and engagement.
- Workforce.
- Specialist Learning Disability Services.



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Improving Patient Experience and Health Outcomes ... continues

Quality Statement	Evidence Prompts	Evidence
21. Care provision, integration and continuity	We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.	21.1 How does the service make sure that a person's care plan fully reflects their physical, mental, emotional and social needs, including on the grounds of protected characteristics under the Equality Act? These should include their personal history, individual preferences, interests and aspirations, and should be understood by staff so people have as much choice and control as possible. *(Confirmed duplication with the above prompts)*
		Our services cover the complete MSK pathway (physical, mental and social wellbeing) of prevention, assessment, self-care, intervention, treatment and rehabilitation to enable patient independence and an active healthy lifestyle. Patients individual needs are assessed and adjustments are made on the basis of that assessment throughout their pathway. For example; About Me passport (uploaded evidence). The Trust builds facilities in line with the latest guidance, Health Technical Memorandums and Health Building Notes plus Approved Codes of Practice. As an example, the Trust has installed the 'Changing Places' facility in the main entrance (see link: - https://www.changing-places.org/find?toilet=1950). PLACE covers accessibility for the patient and site user, and regularly includes input from wheelchair users, in line with a high proportion of patients. The Quality Accreditation scheme assess estate and environment and the Trust is also due to launch the 'observe and act' improvement approach using patients and volunteers. The Trust has transport arrangements in place where appropriate. A non-emergency transport service is provided for patients, both adults and children, who have a medical condition which prevents them from using other forms of transport to travel to and from healthcare appointments. Information is also available via our Trust website: - Non-Emergency Patient Transport - RJAH To support our patients further there is accessible gym equipment on the Path of Positivity. Evidence: Path of Positivity video Hospital Passport NEPTS Service Non Emergency Patient Transport
		21.2 Where the service is responsible, how are people supported to follow their interests and take part in activities that are socially and culturally relevant and appropriate to them, including in the wider community, and where appropriate, have access to education and work opportunities? The Trust has dedicated Activity Coordinators for Sheldon (medical rehab ward) and MCSI (Spinal Injuries ward), recognising the longer stays of these patients. Sheldon Ward uses the Poppy Lounge, and MCSI has a patient entertainment area. A Play Specialist supports children with a play area, while the Tumour ward (Oswald) has Kates Cabin. These spaces are designed for patients and families to interact. Activity Coordinators and Play Specialists tailor activities to individual needs, and the Trust offers retraining opportunities for spinal injury patients through a Heavy Workshop for rehabilitation and education. The Trust also collaborates with the local community to offer patient activities, such as canal boat trips for MCSI patients, and events like film nights, BBQs, and quizzes. There is a multi-faith room on-site for patients and staff, and access to support services like Macmillan and the Arthritis Research Campaign. The "This Is Me" passport enhances the patient experience. Additionally, the Trust partners with the 'Stepping Into Work' programme through Telford College, leading to successful employment opportunities within the estates and facilities team.
		21.3 Where the service is responsible, how are people encouraged and supported to develop and maintain relationships with people that matter to them, both within the service and the wider community, and to avoid social isolation? Visiting changed to open visiting across site, MCSI have tablets in each bedspace for patient use. School in place on Alice ward and evidence of excellent patient education from classes such as joint school. All enable patients to be connected to other patients staff and family/friends. Dining champions exist to support service users so that they do not eat alone. Relatives and carers are encouraged with the consent of the patient to assist with their care for example supportive meal times. The Trust has invested in environments that replicate and support rehabilitation back into outside environments such as Horatio's garden and activities take place within this area too. Bespoke Sunday worship place for Christian's exists on site. The Trust has employed a Trust chaplaincy and patients have access to other religious and spiritual leaders. Path of positivity is an outside space - accessible gym equipment. The Trust is a member of the Armed Forces Covenant and has a Veterans centre with a support group for both patients and staff.

Improving Patient Experience and Health Outcomes ... continues



Next steps for the Trust are to encourage the uptake amongst staff to partake in current data collection.

A task and finish group will be reinvigorated with clear objectives to improve current practices against the three core standards.

The Trust will continue communicating with Apollo team regarding efficacy of alert system Due to the maturity of the current PAS system the Trust have in place, there is no element to allow recording of patients admitted with learning disabilities or autism. There is an upgrade of the system due to be launched in **July 2024**, called Apollo, which will allow for such data to be captured and this will be included in future reporting, to note the number of:

- Adult patients admitted with learning disabilities or autism.
- Children and Young People admitted with learning disabilities or autism.
- Ethnic Minority background patients admitted with learning disabilities or autism.



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Latest CQC toolkit

"We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support, and treatment in response to this."



The evidence statement applied within the toolkit is as follows:
"The Trust has completed the EDS2 assessment Domain 1, which has identified areas for improvement regarding inclusivity through the health inequalities working group. The Trust is also exploring whether the socio-demographic profile of patient experience feedback matches that of the health population we serve to understand if there are targeted efforts the Trust needs to undertake."

EDS2 Domain 1 - Commissioned or Provided Services.

EDS FY2023/2024 - Summary Scores				
Domain		Description	2023/2024 Rating	2023/2024 Score
Domain One - Service Line.				
Outcome	1A	Patients & Service Users have access to the Service.	Developing	1
	1B	Individual Patients/service users health needs are met.	Achieving	2
	1C	Patient/service users are free from harm.	Achieving	2
	1D	Patients/service users report positive experience of the service.	Achieving	2
Sub Score D1				7

Workforce Diversity Profile and Reporting

We aim to employ a diverse workforce that is representative of our local communities, as we believe this will improve our decision making in the development of health and care services.

This section of the report illustrates the demographics of the Trust' workforce as of 31st March 2025. The Trust will use this data as a baseline to measure the diversity of our staff across the full range of NHS pay grades and in future workforce planning. The table below provides a summary of the key findings.

Protected Characteristic	Narrative
Age	Our highest % age range is between 30 and 65 years, with below 20 years and age 66 - >71 years being our lowest represented age groups.
Sex	Males are considerable underrepresented within our Trust with just 24% of our workforce being male and 76% being female.
Race	The Trust are currently working on declarations of ethnicity through ESR to offer a more accurate reflection of our workforce. 84% of staff are declared as White British with 2% not stating their ethnicity.
Disability	81% of the Trust workforce have declared no disability with 10% unspecified. There is an ongoing project to support staff in declaring disabilities through ESR to enable the Trust to support individuals.
Marriage / Civil Partnership	2% of staff have chosen not to specify their marital status, with 53% being married and 3% being single.
Sexual Orientation	A total of 87% of staff identified as heterosexual or straight. 4% of staff preferred not to state their sexual orientation. With 7% unspecified this makes it difficult to establish if the workforce is representative of the national estimated LGBTQIA+ figure of 3.1% of the population over 16 years of age.



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Protected Characteristic	Narrative
Gender Re-Assignment	This data is not currently captured within the Trust.
Maternity / Pregnancy	A total of 1.69% of the workforce were absent due to maternity leave in March 2025, the position for April 2024 was 2.10%
Religion / Belief	The percentage of staff who identify as Christian is 52%. Non-disclosure among staff is 7% overall. Atheism is at 16% with other religions and beliefs being low in representation. 11% of staff declared they did not wish to declare their religion/belief.
Part Time and Full Time Working Arrangements	Age, disability, religion and belief, race, pregnancy and maternity are all determining factors to consider in better understanding the dynamics of full and part-time working arrangements. While ensuring organisational day to day functions are being met. 55% of the Trust workforce are part-time and equality of opportunity should be given to ensure that these staff are afforded the same opportunities as their full-time counterparts.

Recruitment Process Data by Protected Characteristics

Going forward recruitment data will be analysed by protected characteristics on a quarterly basis by the EDI Team. The information provides a breakdown of applicants by protected characteristics and how they fared in the recruitment process. Due to the record retention policy of our current recruitment system Trac, it is only possible to provide data from Quarter 3.

As this is the first time the Trust has produced and published this information, no clear messaging, analysis or comparisons can be drawn from this first set of data. It should be used as a baseline for identifying any future trends where potential disparities between certain protected groups may exist during the recruitment process, where any such disparities might be mitigated or rationalised.

Although we have recruited 25 international nurses since March 2023, the recruitment process has been completed via an agency and therefore data is unable to be captured via our internal program.

*Maternity / Pregnancy data is not currently collated using our current system.

Protected Characteristic	Category	Applicants	Number Shortlist	Number Appointed	% Appointed
Gender	Male	2172	340	75	24%
	Female	3984	844	237	76%
	Not Stated	10	3	0	0%
Ethnicity	White	1432	798	228	73%
	BME	4634	342	52	17%
	Ethnicity Unknown	100	47	32	10%
Disability	Disabled staff	205	95	16	5%
	Non-disabled staff	5874	1044	264	85%
	Disability Unknown or Null	87	48	32	10%
TOTAL		6166	1187	312	



Workforce Race Equality Standards 2024 (WRES)

The WRES requires NHS trusts to self-assess against nine indicators of workplace experience and opportunity for organisations to compare the workplace and career experiences of ethnic diverse and white staff.

Four indicators relate specifically to workforce data, four are based on data from the national NHS staff survey questions, and one considers ethnic diversity representation on boards.

As a Trust, we are using the term ethnically diverse rather than Black and Minority Ethnic (BME).

[PowerPoint Presentation](#) NHS Workforce Race Equality Standard (WRES) Annual Report 2024

[PowerPoint Presentation](#) - NHS Workforce Race Equality Standard (WDES) Action Plan 2024

Workforce Disability Equality Standards 2024 (WDES)

The data for indicators 1 to 3 and 10 are from the Trust's workforce data as of 31 March 2023. This includes information on disability-related demographics, workforce representation, and disability declaration rates. Indicators 4 to 9 have been obtained from the Trust's National Staff Survey results for the year 2023. These measures cover aspects such as workplace adjustments, perceived discrimination, bullying and harassment, career development opportunities, and satisfaction levels among disabled staff.

The data presented provides a better understanding of the experiences of our disabled workforce and highlights areas of success and areas requiring further attention. The Action Plan will include specific objectives, initiatives, and review of policies to further support disabled staff, promote inclusivity, and further develop a positive work environment.

The WDES Annual Report 2024 demonstrates the Trust's commitment to disability equality and improving the work experience of disabled staff. We will aim to create an environment that promotes equal opportunities and positive change for all staff.

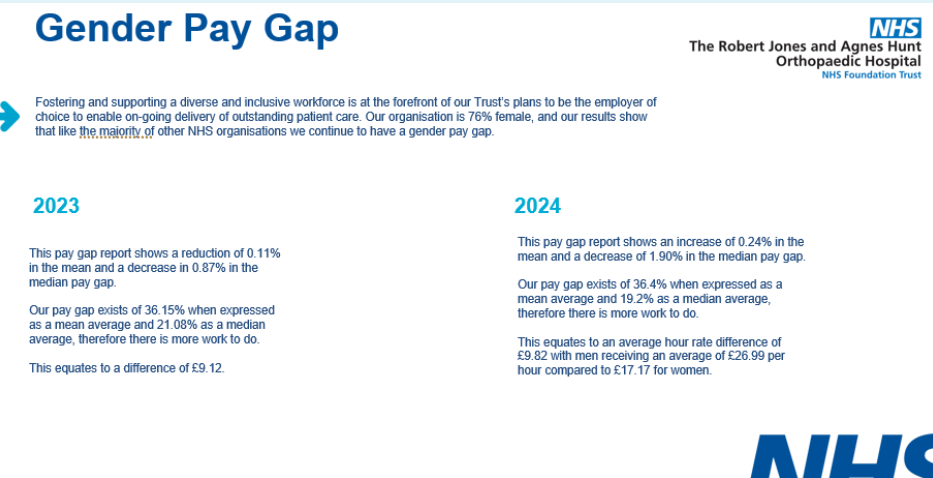
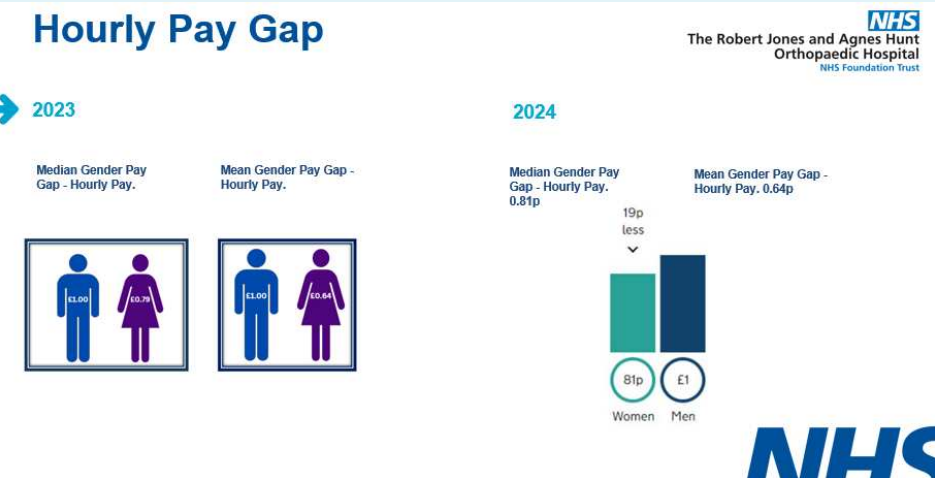
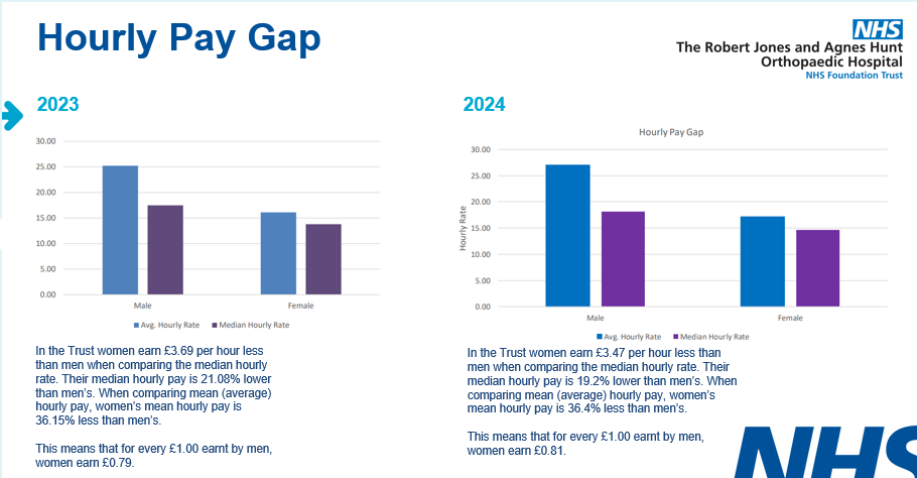
[PowerPoint Presentation](#) NHS Workforce Disability Equality Standard (WDES) Annual Report 2024

[PowerPoint Presentation](#) - NHS Workforce Disability Equality Standard (WDES) Action Plan 2024

Gender Pay Gap Report 2024



The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust



We can use the results of this Gender Pay Gap report to assess

- The levels of gender equality in our workplace.
- The balance of male and female employees at difference levels.
- How effectively talent is being maximised and rewarded.

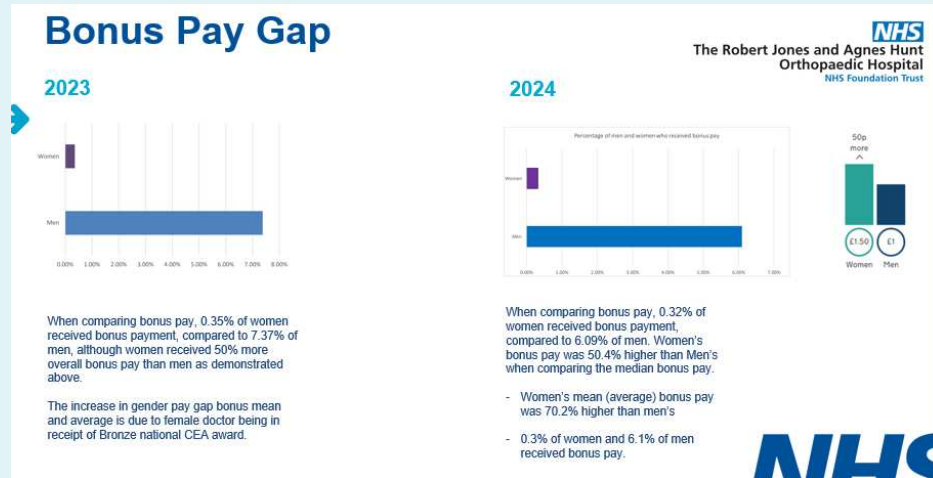
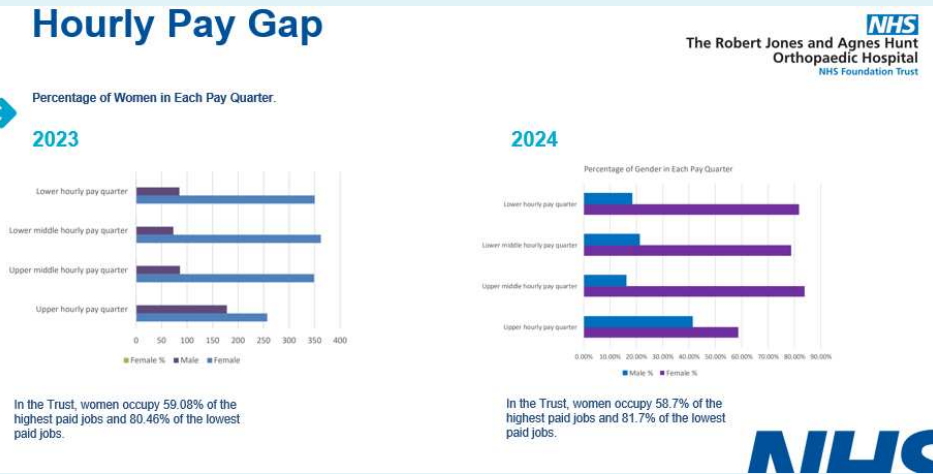
Through analysis of the report's findings the requirement from NHSE is to reduce any gender pay gap. However, the gender pay gap should not be confused with equal pay. Equal pay deals with the pay difference between male and females who carry out the same jobs, similar jobs, or work of equal value

It is unlawful to pay people unequally because of their gender. The Roberts Jones and Agnes Hunt Hospital NHS Foundation Trust supports the fair treatment and reward of all staff irrespective of gender or any other protected characteristics

The gender pay gap shows the difference between the average (mean and median) earnings of men and women. This is expressed as a percentage of men's earning.

Used to its full potential, gender pay gap reporting is valuable tool for assessing levels of equality in the workplace, female, and male participation, and how effectively talent is being maximized

If a workplace has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those areas are. In some cases, the gender pay gap may include unlawful inequality in pay, but this is not necessarily the case.



Ethnicity Pay Gap Report 2025

Employers are not required to collect, analyse or publish information on ethnicity pay. As part of our journey towards becoming an inclusive employer of choice we are reporting our ethnicity pay gap for the first time in 2025 based on a snapshot of our workforce on 31 March 2024.

The report is based on the government's guidance for calculating differences in ethnicity pay and is based on a similar methodology as that used for gender pay gap reporting using electronic staff record (ESR) data. Information on ethnicity is not completed for all employee records, on 31 March 2024.

Employees can update this information and there has been some improvement in recorded information in 2023/2024.

It is important to note that a pay gap differs from equal pay for equal work.

'Equal pay' means being paid equally for the same/similar work.

'Pay gap' is the difference in the average pay between groups.

The ethnicity pay gap shows the difference in the average hourly rates of pay for Global Majority employees (recorded in ESR as black, Asian, mixed race or other) and White employees across our organisation.

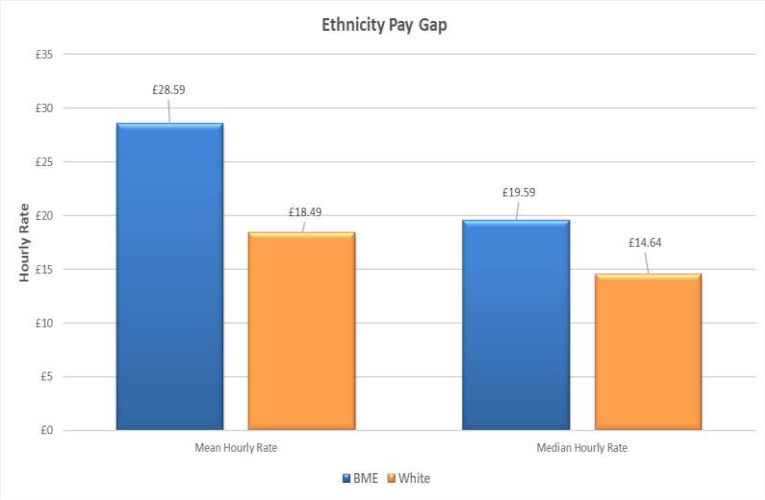
As of 31 March 2024, Total staff numbers: 1,881. 161 employees, 8.56% Global Majority and 88.52 % per cent White. (2.92% reporting as "not stated/unknown")

Our median ethnicity pay gap was – 33.83% and mean pay gap is – 54.64%

A median pay gap of -33.83% , means that on average global majority employees get paid 34p more per hour for every £1 earned by a white employee

In the Trust, Global Majority employees earn £4.95 per hour more when comparing the median hourly rate and £10.10 more when looking at the average hourly rate.

Within this, we have a pay gap of -28.60% for black staff, -17.07% for mixed race staff, -45.26% per cent for Asian staff (data only provided for groups of over 10 employees)



What are we doing?

This year we will take the following steps to promote diversity and understanding barriers to promotion and recruitment for global majority colleagues:

- creating an evidence base: To identify barriers to equality and to help us make priorities for action, we have introduced diversity monitoring to understand:
 - the race of those applying for jobs and being recruited;
 - the race of those applying for and getting promotions;
 - the race of those leaving our organisation and their reasons for leaving;
 - the race of those in each role and pay band; and
 - the race of those formally involved in disciplinary, grievance and capability matters.
- reviewing our disciplinary and grievance processes: to support a move towards a just and learning culture.
- discuss the findings from our ethnicity pay gap alongside our equality's workforce analysis with our Ethnic Diverse Staff Network to get qualitative feedback on our organisation and the experience of our global majority employees, and to work collaboratively to develop initiatives to address issues identified.

What is our focus?

Inclusive Recruitment: Explore sharing interview questions in advance and expand interview question to improve standards of hire around inequality and anti-racism competence and experience.

Learning and Development: Develop a leadership programme embedding inclusion

Culture and Engagement: Share ethnicity pay gap reports and action plans with staff networks (pending action).

Ways of Working: Launched an Anti-Racism workstream to address recruitment, progression, retention, and conditions. Anti-racism Policy in progress (pending action).



The Robert Jones and Agnes Hunt
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Table below shows that
74% of ethnic diverse staff
are in roles that require
professional registration

					Quali fied Role
Count of Staff Group	Quartile				Grand Total
Staff Group	1	2	3	4	
Add Prof Scientific and Technic			1	2	3
Additional Clinical Services	14	5	6		25
Administrative and Clerical	5	7	2		14
Allied Health Professionals		3	7	5	15
Estates and Ancillary	2	1			3
Medical and Dental				64	64
Nursing and Midwifery Registered		8	27	2	37
Grand Total	21	24	43	73	161
				Headcount in qualified role	119
				% in qualified role	74%

Grievance, Disciplinary & Capability Issues

The data below shares the formal cases from April 2024 to March 2025, only the protected characteristics identified within each case have been presented for ease of review. The Human Resources team within People Services continue to monitor the cases received and review any anomalies or areas of concern, ensuring continuous support is offered to those involved.

Please note for the purpose of condensing the table below, only categories relating to the individuals engaged in processes are included (e.g. lesbian/gay not included in sexuality because none involved have stated this category)

Protected Characteristic	Category	Case Type		
		Disciplinary	Grievance	Capability/Performance (not including ill health capability)
Gender	Male	4	3	0
	Female	13	4	1
Ethnicity	White British	11	6	1
	Black or black British - African	2	0	0
	Black or black British - Caribbean	1	0	0
	H Asian or Asian British - Indian	2	1	0
Age Band	Under 20	1	0	0
	26-40	8	1	0
	41-55	5	2	0
	56-65	2	4	1
Religion	Christian	10	5	1
	Atheist	2	0	0
	Unspecified	3	2	0
Sexuality	Heterosexual/straight	13	5	1
	Unspecified	3	2	0
Disability	Yes	2	0	0
	No	11	6	1
	Unspecified	2	1	0

Leavers and the reason for departure

The Trust continually review leavers data to analyse any patterns or trends, and to put additional processes in place to support staff in alternatives to leaving. PDR compliance is monitored monthly by Committee to ensure that staff are in communication with their managers and to support in any areas of concern or any areas of learning and development. Regular catch-up meetings between managers and their teams are also encouraged on a regular basis ensuring that motivating the workforce continues to be a focus with particular emphasis on stay conversations to explore development and motivation of our people as a priority of the HR and wider People Services team.

Leaving Reason (April 2024 to March 2025)	Headcount
Death in Service	1
Dismissal - Capability/Conduct	5
End of Fixed Term Contract	24
Flexi Retirement	40
Retirement - Ill Health	1
Retirement Age	28
Voluntary Resignation - Adult Dependants	1
Voluntary resignation - Pay and Reward Related	5
Voluntary Resignation - Child Dependants	3
Voluntary Resignation - Health	6
Voluntary Resignation - Incompatible Working Relationships	1
Voluntary Resignation - Lack of Opportunities	4
Voluntary Resignation - Other/Not Known	24
Voluntary Resignation - Promotion	9
Voluntary Resignation - Relocation	9
Voluntary Resignation - To undertake further education or training	7
Voluntary Resignation - Work Life Balance	24
Total	192



The Robert Jones and Agnes Hunt
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The data should be seen in the context of the continued return to a more ‘normal’ labour market after the disruption of Covid in 2020-2022.

The data reflects that since April 2023 there has been more resource, and more focus on absence and performance management, likely to have had a push effect on staff leaving, and voluntarily resigning, as alternatives to participating in formal management processes.

The national staff turnover rate for the NHS was 8.1% in August 2023. Staff turnover in RJAH in March 2025 was 8.81%, an increase from the previous year which was 8.08%

This in turn has mirrored a reduction in vacancy rates.

The vacancy rate was 6.47% at year-end 2024/25, an increase from 4.69% in April 24.

Renewed focus on recruitment, and increased resource, allied to actions from the People Services team has supported progress in this area.

Managers are continually encouraged to be flexible with staff retiring and returning, supporting implementation of aspects of the NHS’s People Plan.

As of 31st March 25, the Trust has 109 staff on fixed term contracts, this is a reduction from 134 staff on fixed term contracts at year end 2023/24.

Where the data is opaquer is the number of voluntary resignations for the category ‘other/not known’ which will be the focus of further review and refresh around exit interview process.

RJAH Equality Policy



The Equality, Diversity and Inclusion Policy and its impact on equality have been reviewed in consultation with the trade union and other employee representatives in line with an Equality Impact Assessment. The purpose of the assessment is to minimise and, if possible, remove any disproportionate impact on employees on the grounds of race, sex, disability, age, pregnancy and maternity, marriage and civil partnership, gender reassignment, sexual orientation, religious or other belief.

The Trust is committed to embedding equality, diversity, and inclusion across the organisation rather than it being viewed as an isolated agenda. Ensuring that fair treatment and social inclusion is at the heart of what we do and how we do it.

[edi-policy.pdf](#)

Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense. Inclusion is about an individual’s experience within the workplace and in wider society and, the extent to which they feel valued and included.

The Trust is committed to providing a working environment that is welcoming, inclusive, respectful and is free from unlawful discrimination. We have implemented our Equality Strategy and Action Plan to support with this and to making positive changes within the Trust.



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RJAH STAFF NETWORKS

During 2023/24, staff networks were established to provide a platform for staff and continue to support, express and voice a range of experiences. Information and feedback from these network groups progress through the governance process with the aim of influencing Trust policies, procedures and day-to-day functions. Each network has an Executive Sponsor, and a small budget for the year. All the network groups welcome allies to attend the meetings.

Disability Staff Network



Bio of the Staff Network Chair “We wish to inform all staff that effective help is available and ensure it is provided. Awareness is key.”

“Hello I’m Ellie.

I am an apprentice Health Care Assistant and the chair of the new Staff Disability Network. I have a huge passion regarding equality and diversity and especially when it comes to visible and invisible disabilities.

I love my job, it has always been my dream to help others, provide support and learn new skills.

Despite there being principles regarding equality and diversity, there are often gaps that can lead to personal and professional limits.

I have epilepsy, and through experience I have faced discrimination, generalisation, and stereotyping when it comes to my own and other people’s disabilities. Having epilepsy is not a definition of who I am, in fact, I live with my lovely wife and will never turn down a mocha! It can however influence how others see me.

I want to work with other staff members to patch up those missing gaps, minimise limits and promote equality of opportunity for all staff with conditions and disabilities. Everyone is different.”

The network has been successful in encouraging more staff to attend the meetings and to communicate outside of the meetings, building support networks and safe spaces to gain advice or somebody to listen.

During the short time the network has been established, funding was sought to run an Event called ‘This is Me’, to encourage staff to have the confidence to be who they are and to speak up if reasonable adjustments are required or additional support is needed. The event saw 3 guest speakers attend on the day and several charities offering advice and support. The aim of the event was to build confidence in staff, to raise awareness and to raise the disability declaration rates of the Trust.

Additionally, to this, many actions have been progressed, to implement the following.

- One Page Profiles.
- Sound eliminating Headphones available to all staff.
- Wellbeing portal to be established.
- Support network and safe space to be open.
- Funding for the network to attend training or events to develop.
- Health Passport – trialed for Trust.
- Key Stakeholders giving valued comments and advice on Trust Policies.

In the future the network wish to continue expanding and offering support to as many staff as possible. A parent network has been suggested as a separate space to offer advice and support to parents with disabled and neuro-divergent children.



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Staff Network Group Chair:
Ellie Baldwin

Executive Sponsor:
Mike Carr

RJAH STAFF NETWORKS



The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust

Ethnic Diverse Staff Network



Guest Speakers

The Ethnic Diverse Staff Network Group would like to Welcome:

Staff Network Ally & Guest Speaker: Robert Bound

Recent family Trip to China and culture learning

Thursday 17th October 2024

11:30am to 12:30pm (15 minute talk) Followed by Staff Network Group meeting.

Conference Room 1, Main Entrance, First Floor

ALL Staff Welcome

Guest Speaker : Shashank Chitgopkar
Staff Chair for
Ethnic Diverse Staff Network Group
The Indian Diaspora: Perspectives after a recent visit to India."

Please join us as Shashank discusses his recent visit to India to include:

- How migration of people over millennia has shaped the world we live in. The rich Indian culture, as an example of global migration, has been brought about by integration of many cultures which migrated to the Golden Bird of the East.
- In our time, the journey is now to the west. Studying India may help in integrating the various cultures migrating to the western world.
- An overview on the history of India; a country shaped by millions of years of migration of various cultures and some observations from recent visit.

Thursday 16th January 2025

The Board Room or via MS Teams Link. Please email rjah.edi.od@nhs.net for the MS Teams link

12noon until 1:00pm

All Staff Welcome

Staff Network Group Chair:
Vacant as at March 2025

Executive Sponsor:
Paul Kavanagh-Fields



RJAH STAFF NETWORKS



The Pride Staff Network Group meet month; first Wednesday of the lunch. Lunch and Learn sessions





Staff Network Group

Wednesday 4th September 2024
Venue: The Boardroom, Main Entrance, RJAH
from 12:30pm until 1:30pm

We would like to welcome Pat Aldred, the new SaTH PRIDE Network Chair to RJAH as "guest speaker" at the PRIDE Staff Network group on Wednesday 4th September 2024.



Pat has lots of plans for the future at SaTH and wants to get involved in what is happening in our community.

Pat is the lead chaplain at SaTH and started in the NHS after 25 years in the army where he was the LGBTQ+ Champion for several years.

Pat lives in Shrewsbury with his partner and two sprocker spaniels - Charles and Camilla.

Pat looks forward to networking opportunities and flying the flag wherever he can.

ALL WELCOME

Networking





LGBTQIA+ History Month 1st - 28th February 2025

LGBT + History Month is an annual event, founded by Schools Out, which takes place every February and celebrates the history of LGBTQIA+ communities and the progress made.

Schools Out is an LGBT+ education charity who, through education and advocacy, empower people to create environments where all LGBT+ people feel safe, seen and supported.

INVITE: Pride Network – learn more about pronouns

As part of the Trust’s Pride Network, Alice Amyes, Simulation Technician and Pride Network Chair, held a dedicated session to help staff understand the importance of pronouns and how to use them respectfully in everyday life.

The session covered:

- What are pronouns
- Why pronouns matter
- Types of pronouns
- Using pronouns in practice
- Creating inclusive spaces

The session was a safe space, where staff could ask any questions they may be too worried to ask.

Pride Network – Coffee and Catch-up

The Trust’s Pride Network – previously known as the LGBTQIA+ Network – organised a casual coffee and catch-up session on 16th October an informal space, where members of the network and members of staff can get together. If you have any questions, please contact EDI Team on rjah.edi.od@nhs.net or rjah.pridenetwork@nhs.net

Staff Network Group
Chair:
Vacant

Executive Sponsor:
Ruth Longfellow



RJAH STAFF NETWORKS

Menopause Staff Network

Group meet monthly and as from May 2025 – bi-monthly.



The RJAH Menopause Staff Network Chair continues to link in fortnightly, with the regional **Menopause Task and Finish Group** (North Shropshire, Telford & Wrekin) for best practice sharing.



OurSpace has a designated page for Menopause guidance and signposting

Joint Staff Network Group Chair:
Clare McNeil
Executive Sponsor:
Denise Harnin



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Orthopaedic Hospital
NHS Foundation Trust



National Day for Staff
Networks
Wednesday 14th May
2025
#ReadyForChange

This special day was dedicated to recognising the efforts and achievements of our staff networks.

It was a day to connect, share, and celebrate the diversity and inclusivity that our networks foster.

Whether you are already part of a network or looking to join one staff meet with fellow staff members, to learn about the various networks, and discover how they can be involved.



Human Resources, Organisational Development and Inclusion



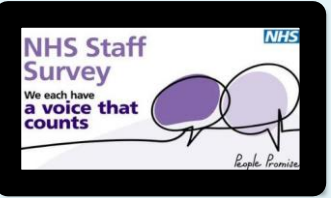
In March 2023 the Trust held Listening Events to gain insight to what our staff wanted to form part of our EDI strategy, the interactive sessions allowed our staff to have a voice and feel included in the decision making of the Trust. Alongside this staff have had access to various support and communication mechanisms including:

- Sexual Safety Charter - Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace and to take appropriate actions.
- Freedom to Speak Up Guardian. More information on how staff are being supported in the Trust.
- SAND Training – Safe Ageing No Discrimination, LGBTQIA+
- Oliver McGowan Training
- Manager’s Briefings – Held hybrid with the Chief Executive Officer and Exec Team to update senior management on any changes or information required to share with staff further.
- Question Time – Held hybrid with the Chief Executive Officer and Exec Team to update all staff on any changes or information required to share with staff further.
- Chat with Harry – Meetings held face-to-face with the Chair to discuss any issues or concerns.
- PDR Training – To raise awareness of the importance of having regular conversations and catch-ups with your team and to support in any further training or changes required to support in their work.



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NHS STAFF SURVEY 2024



The Robert Jones and Agnes Hunt
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Staff Survey 2024 Overall, Most Improved results across all Department.



We are safe and Healthy		
	2023	2024
No data		6.47%

We are always Learning		
	2023	2024
	5.67%	5.74%

We work Flexibly		
	2023	2024
	6.43%	6.61%



Staff Survey 2024 Overall, More work to do areas across all Department.



1 We are Compassionate & Inclusive		
	2023	2024
	7.68%	7.67%

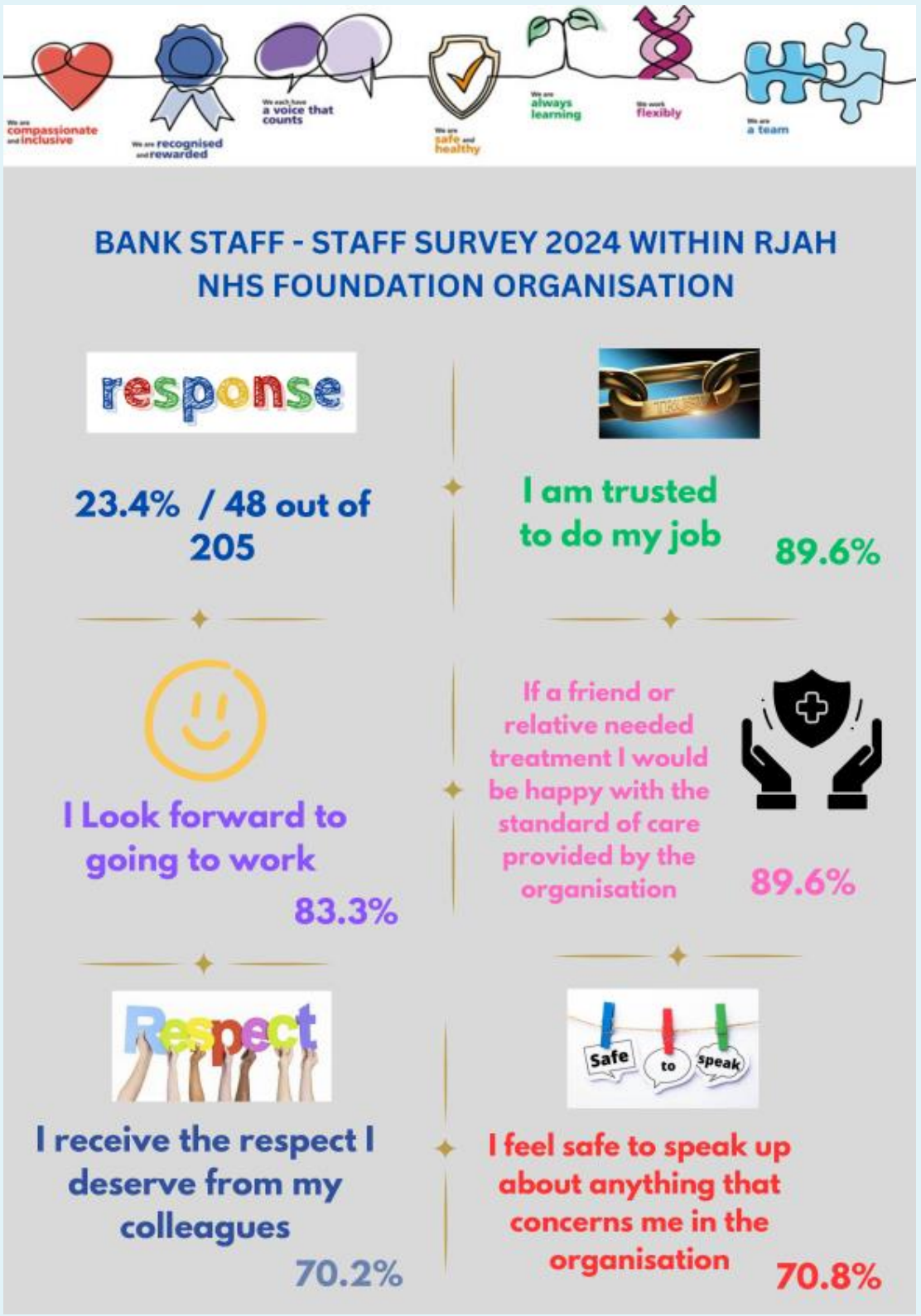
2 We are recognised and Rewarded		
	2023	2024
	6.26%	6.16%

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

4 We are a Team		
	2023	2024
	7.03%	6.99%

5 Staff Engagement		
	2023	2024
	7.35%	7.31%

6 Morale		
	2023	2024
	6.33%	6.31%



EDI Team Learning – 2024.


The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust

EDI Team Learning Update

Caroline, Amber & Gina attended the final on-site Module 4 - Diversity in Health and Care Partners Programme in Leeds on the 2nd July 2024. This event topic discussed Equality, diversity and Inclusion as an improvement tool; exploring and identifying best practice, methodologies and strategies for Organisations to become a more inclusive workplace.





Attending Organisations were presented with a personalised glass shield and framed certificate (and cupcake) for their completion of the programme.



Final Masterclass attended virtually on Tuesday 23rd July which discussed Inclusive recruitment and talent management.

ACCREDITATIONS



SAND Covenant - RJAHH signed a covenant with the charity, committing to understand and respond to the needs of older LGBTQIA+ people in Shropshire, Telford and Wrekin.

The covenant consists of five pledges, which we have committed to at RJAHH.

The pledges are:

- Providing the best possible quality services for older and old LGBTQIA+ people;
- Learning what life can be – and has been – like for different LGBTQIA+ people;
- Vocally and visually supporting groups working with and for older and old LGBTQIA+ people;
- Creating meaningful opportunities for LGBTQIA people and groups to influence;
- Assessing and evidencing change, including work carried out to engage with LGBTQIA+ people.



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ACCREDITATIONS



Data Quality Provider - The Trust celebrated after being named as a National Joint Registry (NJR) Quality Data Provider, after successfully completing a national programme of local data audits.

This is the 6th year running that The Robert Jones and Agnes Hunt Orthopaedic Hospital has been awarded as a Quality Data Provider, which was introduced to offer hospitals a blueprint for reaching high-quality standards relating to patient safety.



NHS Exemplar Trusts Programme for Catering - following a national independent review of hospital food, where the team was recognised as one 21 NHS Trusts in the country to be hailed as exemplar. The Catering Team at the Trust are responsible for providing and serving meals to inpatients, as well as the day to day running of the onsite restaurant, Denbigh's.

ACCREDITATIONS



NHS Pastoral Care Quality Award - International recruitment efforts and commitment to providing gold tandard quality pastoral care at Shropshire’s specialist orthopaedic hospital was recognised by a prestigious national award from NHS England.

Launched in March 2022, the NHS Pastoral Care Quality Award – which aims to standardise the quality and delivery of pastoral care internationally educated nurses and midwives across England – was presented to the team at The Robert Jones and Agnes Hunt Orthopaedic Hospital.



Neuromuscular Team Centre of Excellence Award from MDUK - Our Neuromuscular Centre received a prestigious Centre of Excellence award from leading national charity Muscular Dystrophy UK.

The charity who supports more than 110,000 children and adults in the UK living with one of over 60 muscle wasting and weakening conditions awarded the team for providing outstanding care, promoting best practice locally and nationally and demonstrating their commitment to improving health and care for people living with muscle wasting and weakening conditions.



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ACCREDITATIONS



Veteran Aware - We're a member of the Veterans Covenant Hospital Alliance (VCHA) - a network of over 20 NHS hospitals that have volunteered to share and drive the implementation of best practice for those who service or have served in the UK Armed Forces, and their families, in line with the Armed Forces Covenant.

- We are committed to applying the Armed Forces Covenant and giving special consideration where appropriate.
- Staff should be able to explain the health commitments of the Covenant.
- All relevant staff will be trained and educated in veteran needs.
- Staff will ask patients if they or a close family member serve or have served in the UK Armed Forces, so we can best support their care needs



GIRFT - GIRFT aims to supports systems nationally to ring-fence elective capacity through this hub model and increase capacity nationally by 30% by the end of 2024/25.

Being accredited as an Elective Surgical Hub is seen as a visible marker of high standards and excellent quality. We know we already deliver outstanding care – gaining this accreditation is another positive confirmation of that. It is endorsed by the Royal College of Surgeons, which is another marker of its value and importance.



**The Robert Jones and Agnes Hunt
Orthopaedic Hospital**
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Initiatives

- Free Sanitary Products for all staff
- Free breakfast for all staff
- Denbigh's Lunch Deal
- Money Matters financial education session
- Money Matters financial education 121 sessions
- Free tea, coffee, milk, and sugar to all departments (ceased 31st March 2025)
- Free staff car parking continues
- Bank that bonus (although now ended)
- Bank weekly pay

Equality Statement

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHSFT embraces diversity, equality and inclusion and our aim is to be diverse in age, gender identity, race, sexual orientation, physical or mental ability and ethnicity.

We are committed to ensuring disabled workers aren't disadvantaged when applying for and doing their jobs and offer an interview to all applicants with a disability who meet the minimum criteria for the advertised post. Reasonable adjustments under the Equality Act 2010 will be considered upon request.

Training opportunities for staff

Leadership Programme

The course is made up of three modules as set out below. Each is designed to focus on a different aspect of your leadership journey. Between each module, you will be given a workbook which should take no more than three-to-four hours to do. Successful completion of each module and workbook will see you graduate from the programme, with a formal presentation to take place with some of our very senior leaders

•**Module 1 (Releasing Your Potential)** is all about helping you to be the best version of yourself. You will look at compassionate leadership and the NHS People Promise. You will also focus on employee engagement, and why that is so essential.

•**Module 2 (Essential Management Skills)** will have a focus on communication and support you in mastering being able to hold difficult conversations. You will also explore the importance of getting off to a good start in the way you onboard new recruits, and how you help people to transition into a new role.

•**Module 3 (Looking After Yourself To Lead Effectively)** will encourage you to make sure you are also looking after yourself, something which is essential if you are to function as an effective leader.
What are our senior leaders saying about this?

Stacey Keegan, our Chief Executive, said: “There is a broad combination of fundamental skills that effective leaders need to acquire and develop; from setting objectives to motivating, delegating, coaching, and giving feedback.

“Supporting our leaders is one of our top priorities as we continue on our mission of making RJAH a truly outstanding place to work, and I encourage everyone to sign up for this programme and take advantage of this opportunity.

“The best leaders expand their thinking beyond what’s visible and obvious and can also capitalise on the hidden drivers of organisational success: inclusion, agility, flexibility, and the engagement and wellbeing of the people who work with and for you.

“As you work through this programme, I am sure you will be challenged and stretched. I hope you will also build that toolkit to be the best leader you can be – both here at RJAH and for the NHS as a whole.”



NHS England Midlands Developing Aspirant Leaders (DAL)

NHS England Midlands Developing Aspirant Leaders (DAL) Programme supports ethnic minority nurses and midwives aspiring towards a senior leadership role. DAL was created by ethnic minority nurses and midwives for ethnic minority nurses and midwives and provides academic learning, sponsorship and the ability to safely stretch, delivering a sustainable positive action scheme for progression.

The e-book celebrates the achievements of the second cohort of DAL participants, who all have completed the programme with exceptional results. The book showcases each of the participants, their leadership stretch assignments and the overall success of the programme, which has already led to improvements in patient and staff experience.



EDI Staff-related Training and Development Opportunities

- ➔
- RJAH Leadership Programme
 - Improvement Advocates
 - Access to Oliver McGowan Training
 - Partner on the Diversity in Healthcare Programme 2023/24
 - Freedom to Speak Up Training
 - PDR Awareness
 - Holistic Skills Academy
 - Human Factors Training
 - Sexual Safety Training (commencing in May 2025)
- Following the recent successful award from NHSE in relation to WDES innovation funding, we have set-up 3 training sessions to be run during Neuro-Diversity Celebration week.
- Neuro-Diversity Awareness Training – A webinar open to up to 100 participants, to support in raising awareness and understanding, aimed for all staff.
 - Disability Awareness Training – A 3-hour session open to up to 20 participants, aimed at senior managers to support their teams and the overall workforce.
- Neurodiversity and Autism Awareness Training – A 3-hour session open to up to 20 participants, aimed at senior managers to support their teams and the overall workforce.

Staff group	Successful	Unsuccessful	Total number of applications
Study Leave (non- medical staff)	40	1	43 (2 Pending)
CPD (Registered health care professionals)	869	5	864
Medical study Leave (Consultants and Medical Doctors)	637	0	637
Total Number of applications	1,276	6	1,274 (2 pending as noted above)

Communications and Involvement

Patients and the Public

RJAH communicates regularly with patients and the public in a variety of ways:

- Social media
- Website
- Patient Participation Group
- Surveys

RJAH has social media profiles on the following platforms:

- Facebook: @RJAH.NHS
- X (formally Twitter): @RJAH_NHS
- Instagram: @rjah_nhs
- LinkedIn: The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- YouTube: The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- RJAH EDI Facebook page.



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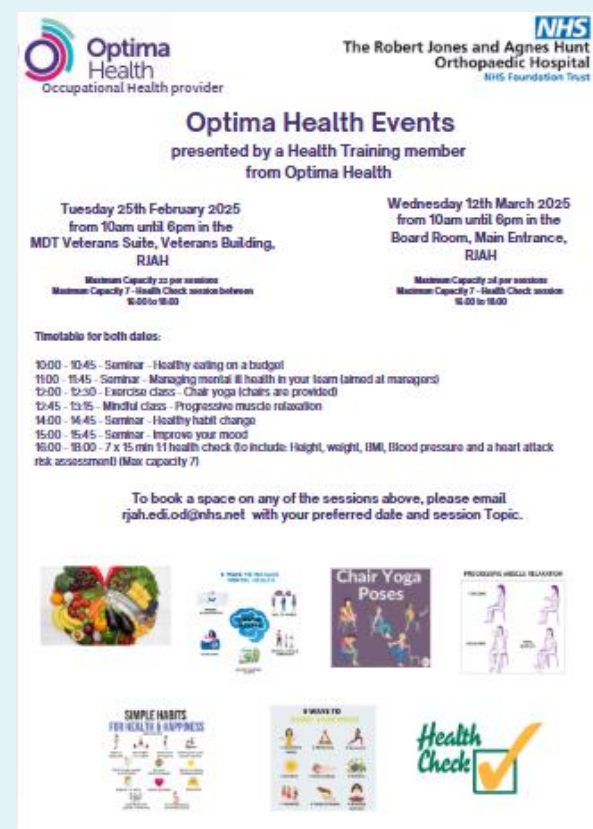


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NHS Foundation Trust

[OurSpace - Useful Resources to help you look after number one](#)

Health and Wellbeing

A staff platform for a whole host of resources and information around wellbeing – mental, physical and financial – can be found on OurSpace – our dedicated wellbeing portal.



Health & Well-being Event for Staff Feb 2025/March 2025.

Access Able – patient and Staff re: Signage

Sian Langford, Facilities Compliance &
Sustainability Manager/
Accredited Counter Fraud Specialist (ACFS)
confirms that funding for Access-Able has
gone through Charitable Funds request and
reviewed at the Charitable Fund Committee.

Outcome below:-

3 years funded, full accessibility guides, 20% of
site reviewed each year.



Neurofriends Support Network.



STAFF

SAND Covenant



RJAH signed Safe Ageing No Discrimination’s (SAND) covenant, committing to understand and respond to the needs of older LGBTQIA+ people in Shropshire, Telford and Wrekin.

SAND are a community organisation who aim to improve the experiences and lives of the ageing LGBTQIA+ community across the county.

Following signing the covenant, RJAH launched dedicated training for staff to open their hearts and minds to the issues the ageing LGBTQIA+ community face. The training included appropriate questions, how best to phrase language and pronoun use. Following the training, staff felt like they can effectively signpost and support colleagues to the relevant resources, and also help colleagues embrace more supportive language and questions.

Sexual Safety Charter

As a Trust, we committed our support to the Sexual Safety Charter launched by NHS England. This means we commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace and to take appropriate actions

Regular Staff Messaging

Email messages are sent out from the Communications Team, on average three times a week, to keep staff updated on news and topics from across the Trust. These messages are also shared with staff via the closed Staff Facebook group, intranet and through briefings known as Question Time (for all staff) and Managers’ Briefing (for managers).



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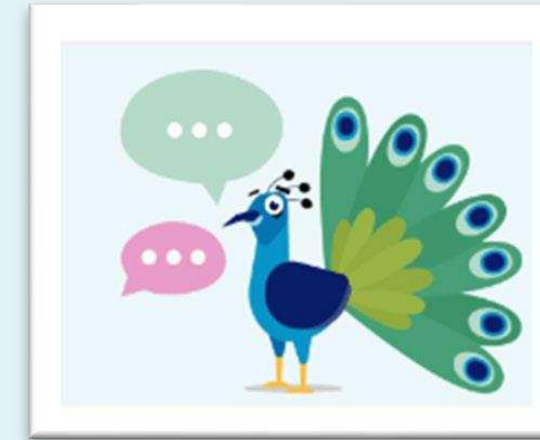
STAFF



Some of the EDI events and themes the Trust has shared information with staff includes (but not limited to):-

- Easter
- Nutrition & Hydration Week
- Armed Forces and Reservices Day
- Freedom to Speak Up Month
- Time to Talk Day
- Race Equality Week
- A series of religious festivals such as Bodhi, Diwali, Hanukkah and more

Intranet



The RJAH staff intranet – Percy – is a digital resource which holds a wealth of information, including articles, events and useful resources, on topics such as health and wellbeing and equality diversity and inclusion.

Trust values /Our signature behaviours



The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust

Value 1: Friendly

We will...	We will not...
1) Look for the positives in someone's ideas before the negatives	1) Take advantage of other's kindness or skills
2) Seek to work with others to deliver better outcomes	2) Be quick to dismiss others' contributions
3) Listen with an open mind	3) Behave in a discourteous manner - verbally or physically
4) Be honest in a considerate manner	4) Bully or undermine people
5) Speak up when we have a gap in our knowledge or understanding	5) Ignore other members of staff if they are felt to be beneath us

make the difference

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Orthopaedic Hospital
NHS Foundation Trust

Value 2: Caring

We will...	We will not...
1) Consider the impact of our decisions on others before acting	1) Abuse our position over others by showing favouritism, or discrimination in any way
2) Do what we say we are going to do (or provide an explanation if we are delayed/no longer able to)	2) Allow our personal moods to affect others
3) Support others personally and professionally - especially when they are struggling or managing a stressful situation	3) Ignore changes in normal behaviours when we see them
4) Acknowledge good will and performance or behaviours as it happens	4) Expect others to work 'above and beyond' when we are not prepared to do so ourselves or because we are staying later
5) Consider others' needs as well as our own	5) Make others feel foolish for admitting a gap in their knowledge or understanding

make the difference

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NHS Foundation Trust

Value 3: Excellence

We will...	We will not...
1) Encourage each other to express ideas on improvements and to share best practices	1) Allow processes to undermine or detract from meeting patient service needs
2) Speak up if we can see a safer, more efficient or cost-effective way of doing things	2) Discourage someone from trying or sharing a better way of doing things
3) Look for the positives, not the negatives, when others express ideas and views	3) Reject opportunities to improve the way we work
4) Provide only constructive feedback - that will help others to develop or improve	4) Leave things to others that we can fix ourselves
5) Act on feedback to improve our personal performance	5) Apportion blame for an unknowing/unintended error

make the difference

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Value 4: Professional

We will...	We will not...
1) Fulfill our roles and responsibilities to the best of our ability	1) Be satisfied with mediocre or worse
2) Encourage our colleagues to do the best job possible	2) Do the bare minimum
3) Openly share ideas and best practice with colleagues	3) Engage in negative gossip
4) Actively participate in personal and professional learning and development	4) Speak in a manner that is intended to upset or intimidate other staff members to get what we want
5) Fully contribute to the team's performance	5) Deliberately avoid or ignore problems or difficult situations which we can help resolve

make the difference

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NHS Foundation Trust

Value 5: Respect

We will...	We will not...
1) Learn from our mistakes by taking appropriate action to prevent recurrence	1) Complain about situations without suggesting solutions
2) Take responsibility for resolving problems within our influence	2) Disregard others' feelings
3) Challenge inappropriate behaviour, or poor working practices	3) Patronise others
4) Politely engage with people, even at times of disagreement	4) Escalate issues we have with a person without first speaking to that individual to resolve
5) We will respect the skillsets of all staff irrespective of position	5) Be disproportionate in our responses to situations

make the difference

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NHS Foundation Trust



WDES ACTION PLAN 2024/25

Area and Objective	Action	Indicator	Lead	Outcome and impact
Inclusive Culture	Increase Board representation Introducing Disability passport	10	EDI Team	➤ Continue to ensure that the recruitment process for <u>Non Executive</u> Board members and Governors is inclusive
Belonging	Increase and encourage staff disability declaration on ESR Promote Staff Network Group and <u>NeuroDiverse</u> Friends	1	EDI Team Staff Network Groups	➤ Host a range of campaigns aimed at updating personal details on ESR, to ensure the Trust's workforce profile is as accurate as it can be and reflects the true picture of our workforce
Eliminating Discrimination	Disability pay gap Identification and promotion of relevant awareness events	7	EDI Team	➤ Improved staff survey scores relating to violence, bullying and harassment from colleagues and managers
Diverse Workforce	Debiasing recruitment processes Opportunities to understand, engage, develop and progress our differently abled talent	2	EDI Team	➤ improvement on key workforce metrics relating to EDI ➤ Improvement and culture of allyship at events

WRES ACTION PLAN 2024/25

Area and Objective	Action	Indicator	Lead	Outcome and impact
Inclusive Culture	Reverse Mentoring Appointment of FTSU champions Promotion of Developing Aspirant Ethnic Minority Nursing and Midwifery Leadership Programme	6 9	EDI Team	➤ Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur ➤ improvement in staff survey results
Belonging	Staff Network Groups Culture/compassionate training Global majority staff listening events	4	EDI team Staff Network Groups	➤ Improvement in access to CPD and non-mandatory training: collect demographic data on applicants
Eliminating Discrimination	Implement Anti Racist Strategy Zero tolerance posters Ethnicity pay gap	8	EDI team	➤ Create zero tolerance through an Anti-Racism statement and guidance ➤ EDI Objectives for board members set by the Chair as part of the annual appraisal process
Diverse Workforce	Recruitment open days/interviews Equal opportunities for career progression	7	Recruitment team EDI team	➤ Undertake a review of talent management programmes and identify opportunities to support the development of ethnic minority leaders of the future

Executive Summary - Finance & Performance Committee

Assurance

	 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
Variation  Improving variation (high or low) or 3 months better than target   No significant change or N/A to SPC  Concerning variation (high or low) or 3 months off target 				% of Patients Waiting Over 52 Weeks - English PP Activity - Theatres Total Outpatient Activity - % Moved to PIFU Pathway
		Theatre Cancellations On The Day of Surgery	% Combined BADS Performance	MCSI Admissions - Average Waiting Time IJP Activity - Theatres Total Theatre Activity Against Plan IJP Activity - Theatres Total Outpatient Activity against Plan Insourcing Activity - Outpatients Income Proportion of Temporary Staffing as % of Pay Costs Bank Spend Against Plan
		No of Spinal Injury Patients Fit for Admission	Bed Occupancy - All Wards - 2pm	18 Weeks RTT Open Pathways English List Size Welsh List Size Patient Waiting Over 104 Weeks - Welsh Overdue Follow Up Backlog 6 Week Wait for Diagnostics - English 8 Week Wait for Diagnostics - Welsh Theatre Cases per Session Touchtime Utilisation OJP Activity - Theatres Elective Activity Against Plan Outpatient Procedures - ERF Scope Outpatient DNA Rate 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

May 2025 – Month 2



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:

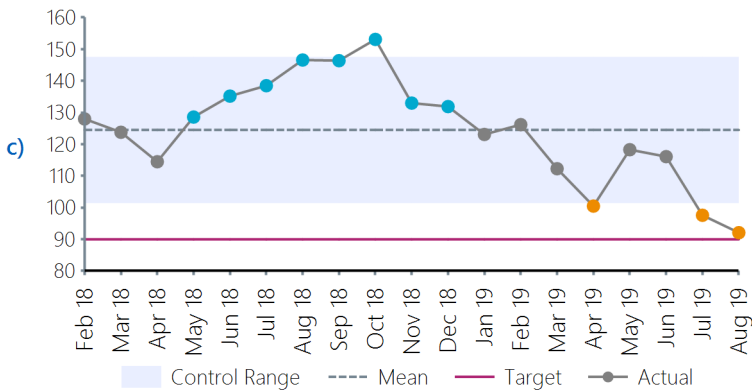
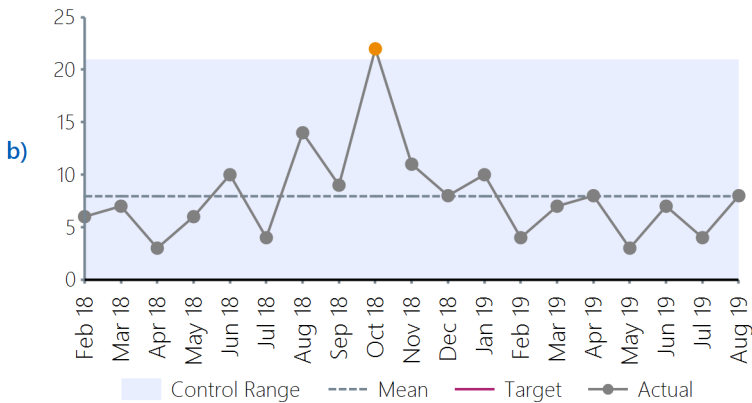
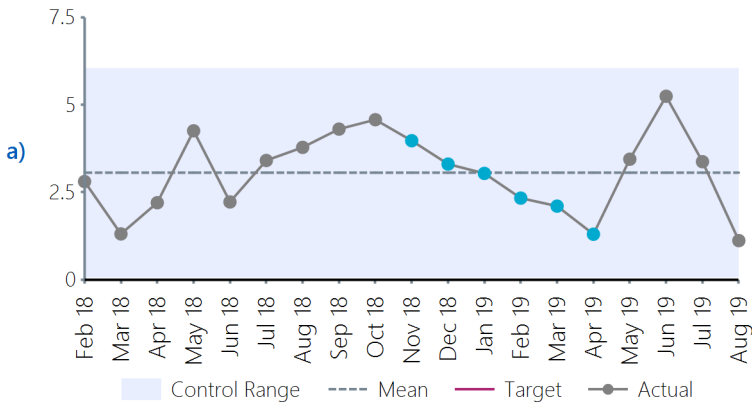
- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of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

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.

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



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 exception 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 or 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



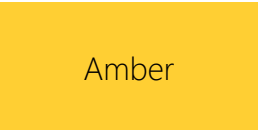
Blue

No improvement required to comply with the dimensions of data quality



Green

Satisfactory - minor issues only



Amber

Requires improvement



Red

Significant improvement required

Dates

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

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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%					
62 Day General Standard*	85.00%	33.33%	50.00%			+	12/09/23
28 Day Faster Diagnosis Standard*	77.00%	91.43%	89.47%				12/09/23
18 Weeks RTT Open Pathways	46.60%	44.49%				+	24/06/21
Time to First Appointment	58.70%	52.95%				+	
% of Patients Waiting Over 52 Weeks - English	7.59%	6.88%				+	
Patients Waiting Over 104 Weeks - Welsh (Total)		159				+	
Overdue Follow Up Backlog	15,379	14,270				+	
6 Week Wait for Diagnostics - English Patients	95.00%	88.85%	94.49%			+	04/03/24
8 Week Wait for Diagnostics - Welsh Patients	100.00%	97.20%				+	04/03/24



Summary - Caring for Finances

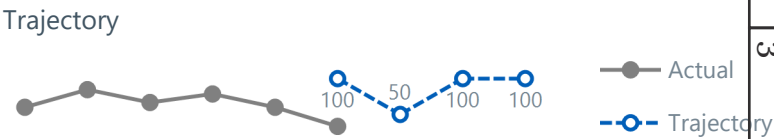
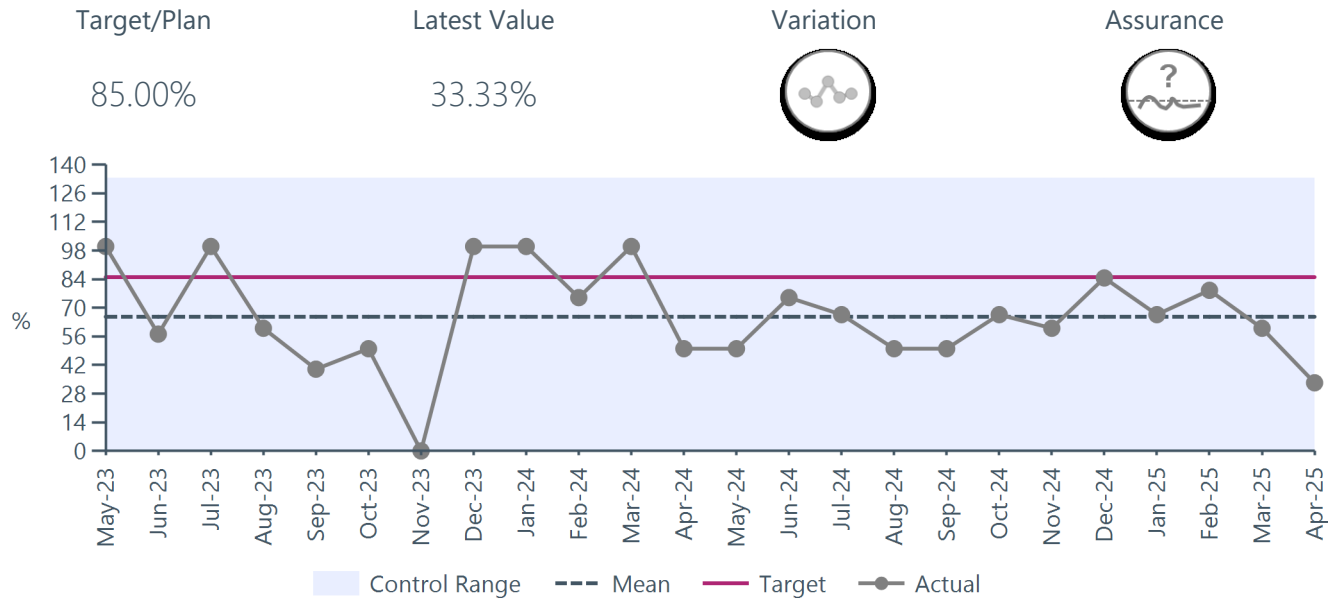
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Elective Activity Against Plan (volumes)	1,105	877				+	24/06/21
% Combined BADS Performance	85.00%	41.69%				+	
Total Outpatient Activity against Plan (volumes)	8,655	9,960				+	24/06/21
Total Outpatient Activity - % Moved to PIFU Pathway	6.61%	7.25%				+	
Total Diagnostics Activity against Plan - Catchment Based	2,849	2,593				+	

62 Day General Standard*

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

Exec Lead

Chief Operating Officer



What these graphs are telling us

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

Narrative

The 62 Day General Standard is reported at 33.33% in April; this is reported in arrears. Of the patients reported, there was one full breach attributable to RJAH due to delay in availability of radiology nurses that impacted scheduling of USS biopsy as decision on medication required to proceed.

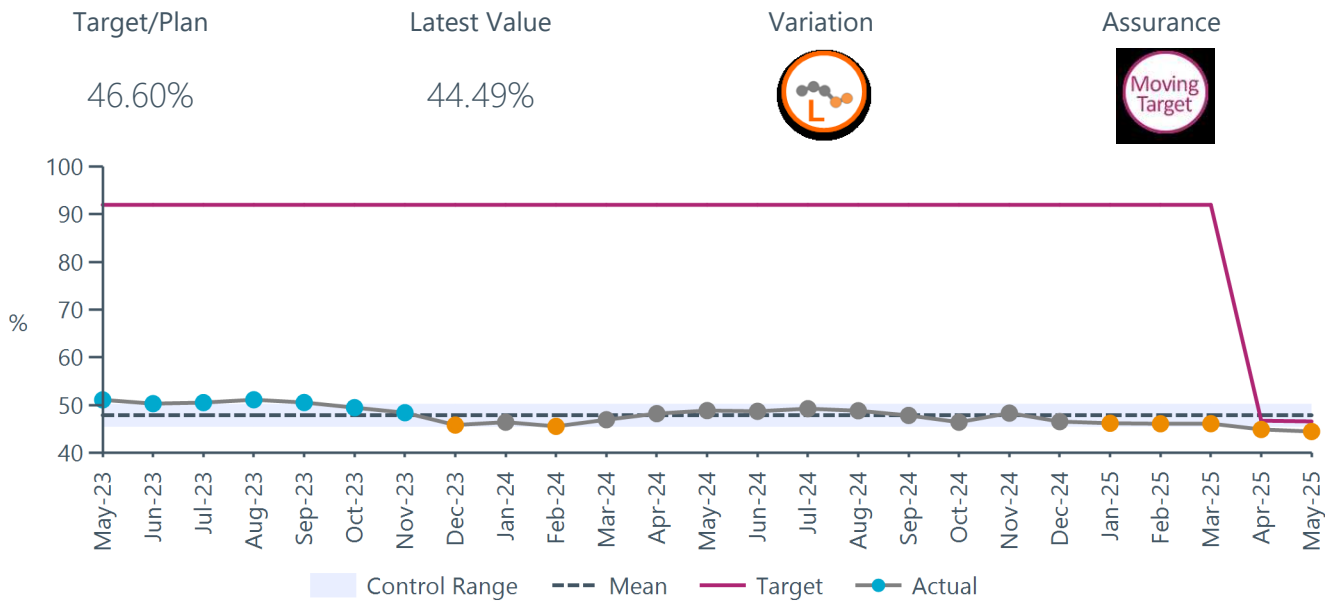
Actions

A new SOP is being implemented to prevent the circumstances happening again and to ensure a clear escalation process is in place if there are no radiology nurses available.

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

18 Weeks RTT Open Pathways

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



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 May performance was 44.49% against the 92% open pathway performance for patients waiting 18 weeks or less to start their treatment. The performance breakdown by milestone is as follows:

- * MS1 - 10703 patients waiting of which 4958 are breaches
- * MS2 - 1408 patients waiting of which 1036 are breaches
- * MS3 - 5169 patients waiting of which 3598 are breaches

Reduced activity levels since July-24 has impacted services with long waits. Month-end position is inclusive of patients being progressed at mutual aid providers.

There has been limited return from technical validation exercise.

Actions

Extraordinary Board session held in June that was focussed on RTT Recovery. In the short term, key area is Milestone 1 recovery where actions include:

- * 'Super Saturday' activity sessions
- * Additional locum appointments
- * DEXA scanner go live from 16th June

In addition:

- * IP activity through extended operating day
- * Additional consultant capacity
- * To further support Outpatient Transformation, the Trust is working with GIRFT Team in an Elective Improvement Offer

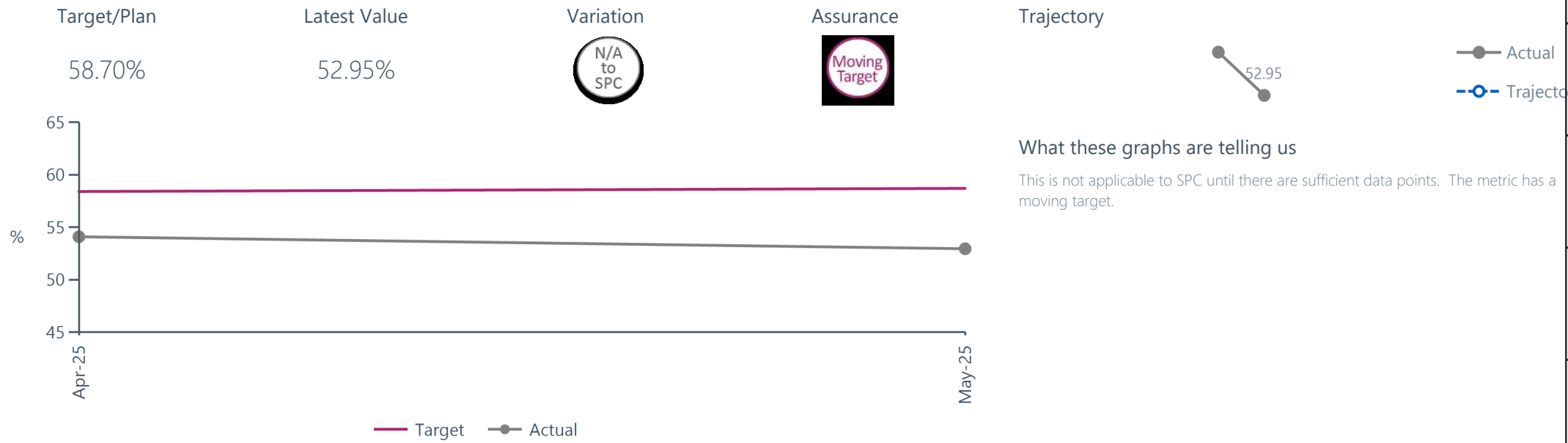
For the medium term, action plan to focus on additional physical and staffing capacity; this will be monitored through FIG.

May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
48.88%	48.73%	49.27%	48.84%	47.86%	46.44%	48.35%	46.57%	46.22%	46.12%	46.14%	44.92%	44.49%

Time to First Appointment

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



Narrative

This is a new metric for 2025/26 and formed part of the Trust's Operational Plan. It 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 1st June. 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 1st June 52.95% of patients waiting for first appointment were under 18 weeks; below the 58.70% plan. The data is reviewed at the weekly Outpatient Activity meeting at sub-speciality level. Performance ranges from 32.09% in Metabolic Medicine to 100% in Occupational Therapy.

There has been limited return from technical validation exercise.

Actions

Extraordinary Board session held in June that was focussed on RTT Recovery. In the short term, key area is Milestone 1 recovery where actions include:

- * 'Super Saturday' activity sessions
- * Additional locum appointments
- * DEXA scanner go live from 16th June

In addition:

- * IP activity through extended operating day
- * Additional consultant capacity
- * To further support Outpatient Transformation, the Trust is working with GIRFT Team in an Elective Improvement Offer

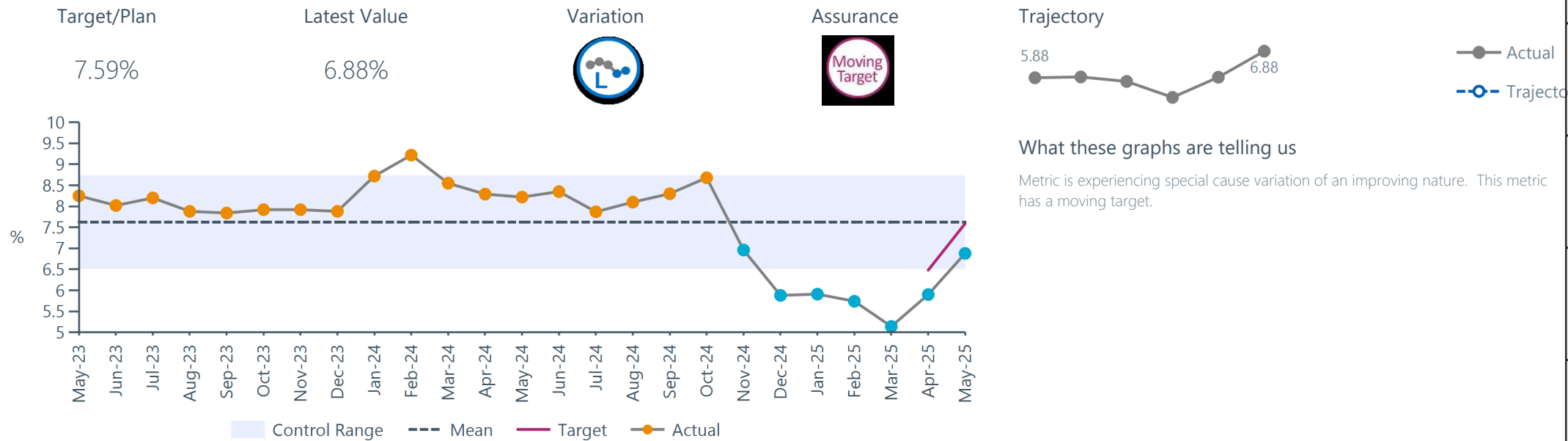
For the medium term, action plan to focus on additional physical and staffing capacity; this will be monitored through FIG.

May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
											54.09%	52.95%

% 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



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 has been a substantial reduction at the end of last year that has been sustained since December however there has been an increase seen over the last two months. At the end of May 6.88% of the English list size is patients waiting over 52 weeks, this is below our plan of 7.59% (positive).

The volume of patients waiting over 52 weeks equates to 1188. The sub-specialties with the highest volume of patients are; Spinal Disorders (426), Arthroplasty (244) and Knee & Sports Injuries (151). Patients waiting, by weeks brackets is:

- * >52 to <=65 weeks - 1110 patients
- * >65 to <=78 weeks - 71 patients
- * >78 weeks - 7 patients

Actions

- Extraordinary Board session held in June that was focussed on RTT Recovery. In the short term, key area is Milestone 1 recovery where actions include:
- * 'Super Saturday' activity sessions
 - * Additional locum appointments
 - * DEXA scanner go live from 16th June

- In addition:
- * IP activity through extended operating day
 - * Additional consultant capacity
 - * To further support Outpatient Transformation, the Trust is working with GIRFT Team in an Elective Improvement Offer

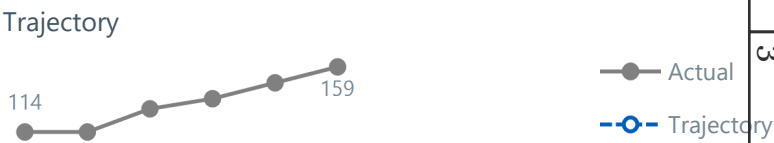
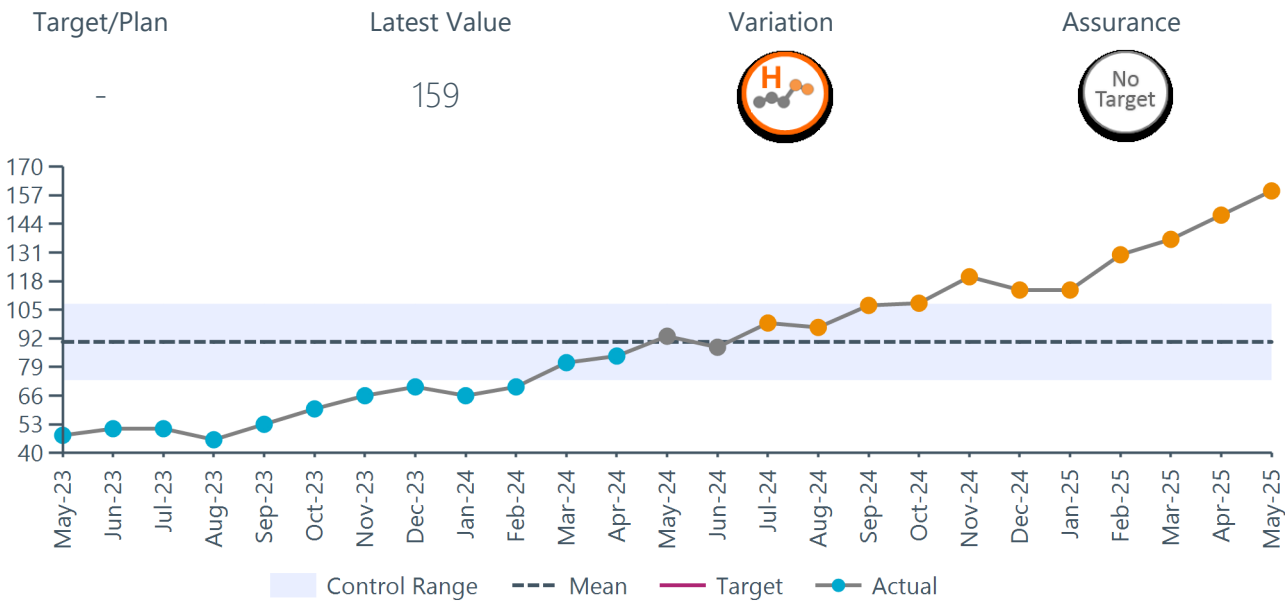
For the medium term, action plan to focus on additional physical and staffing capacity; this will be monitored through FIG.

May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
8.22%	8.35%	7.87%	8.10%	8.30%	8.68%	6.96%	5.88%	5.91%	5.74%	5.14%	5.90%	6.88%

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



What these graphs are telling us

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

Narrative

2025/26 Welsh activity profiles continue to be discussed with Welsh Health Boards, that will impact list size.

At the end of May there were 159 Welsh patients waiting over 104 weeks. The patients are under the care of these sub-specialities; Spinal Disorders (74), Knee & Sports Injuries (39), Arthroplasty (31), Foot & Ankle (13), Hand & Upper Limb (1) and Veterans (1).

2025/26 Welsh activity profiles continue to be discussed with Welsh Health Boards. Powys Health Board has asked the Trust to operationalise from 1st July a minimum wait of 100 weeks for Inpatient Activity. 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.

Actions

- Extra-ordinary Board session held in June that was focussed on RTT Recovery. In the short term, key area is Milestone 1 recovery where actions include:
- * Additional locum appointments
 - * DEXA scanner go live from 16th June
- In addition:
- * IP activity through extended operating day
 - * Additional consultant capacity
 - * To further support Outpatient Transformation, the Trust is working with GIRFT Team in an Elective Improvement Offer
- For the medium term, action plan to focus on additional physical and staffing capacity; this will be monitored through FIG.
- There has been limited return from technical validation exercise.

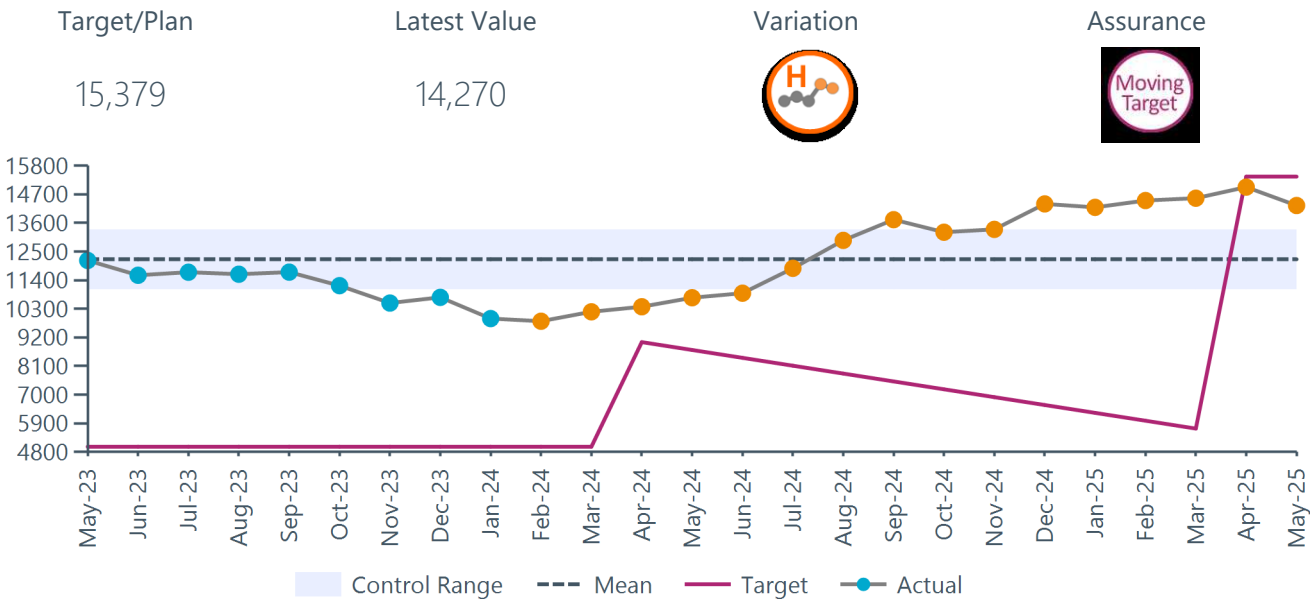
May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
93	88	99	97	107	108	120	114	114	130	137	148	159

Overdue Follow Up Backlog

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

Exec Lead

Chief Operating Officer



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. This metric has a moving target, but this will stabilise with a static target throughout 2025/26.

Narrative

At the end of May, there were 14270 patients overdue their follow up appointment. A new target has been added that formed part of the Trust's Operational Plans and the latest position is reported below that, however the increasing position remains flagged as special cause variation of a concerning nature. In recent months the Trust has focused on it's RTT long waits.

Actions

Please note, there is an issue that impacts the reporting of this metric for May since the Apollo implementation. The functionality of recording review dates is different in Careflow than in the old PAS system. Following Go Live the Information Department identified an issue whereby review dates were missing in the new Careflow system for some patients.

Following investigations and discussion with System C, part of the issue is how the new Careflow system handles review dates for booked patients. System C have offered a potential solution for this cohort of patients which the Information team are investigating. Once fully investigated then the Information team will be able to produce a new summary of genuine missing review dates for the Access teams to work through.

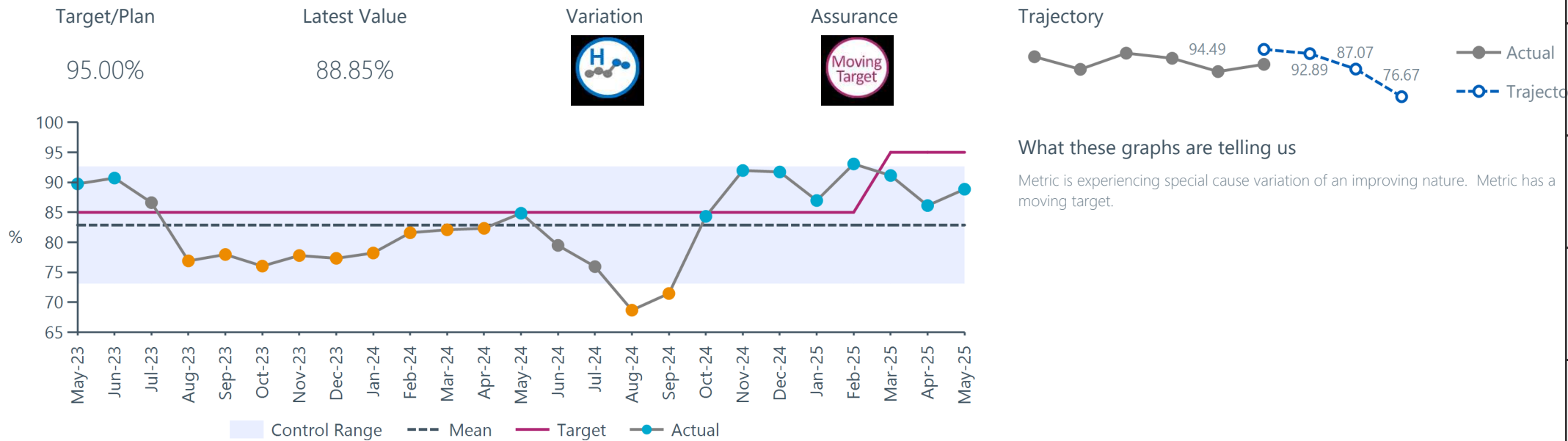
The Trust has commenced a validation exercise with a company that has been used by other Providers within the System to cleanse the waiting list. This began week commencing 14th April with an initial focus on RTT long waits and part of the exercise will include a focus on overdue follow up patients.

May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
10726	10900	11856	12930	13726	13244	13353	14331	14199	14461	14551	14978	14270

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



Narrative

Performance for May is 88.85% against the 95% target. The trajectory for May month end was 94.49%; this reflects the Trust's submitted Operational Plans. Reported position relates to 142 patients who waited beyond 6 weeks. Of the 6-week breaches; 1 is over 13 weeks (Ultrasound).

Performance and breaches by modality:

- * MRI – 92.73% - D2 (Urgent - 0-2 weeks) - 5 dated, D3 (Routine - 4-6 weeks) - 1 undated, D4 (Routine – 6-12 weeks) – 49 with 44 dated
- * CT – 98.90% - D4 (Routine - 6-12 weeks) - 1 dated
- * Ultrasound – 79.33% - D2 (Urgent - 0-2 weeks) – 1 dated, D4 (Routine - 6-12 weeks) - 85 with 81 dated
- * DEXA Scans – 100%

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

Actions

Ultrasound – weekend clinics being utilised to increase activity levels. Additional capacity from new consultant commenced 12th May.

MRI – Continued Increase in demand across ICS. Recruitment to Business Case to increase skill mix and MRI activity. Mobile scanner contract extended.

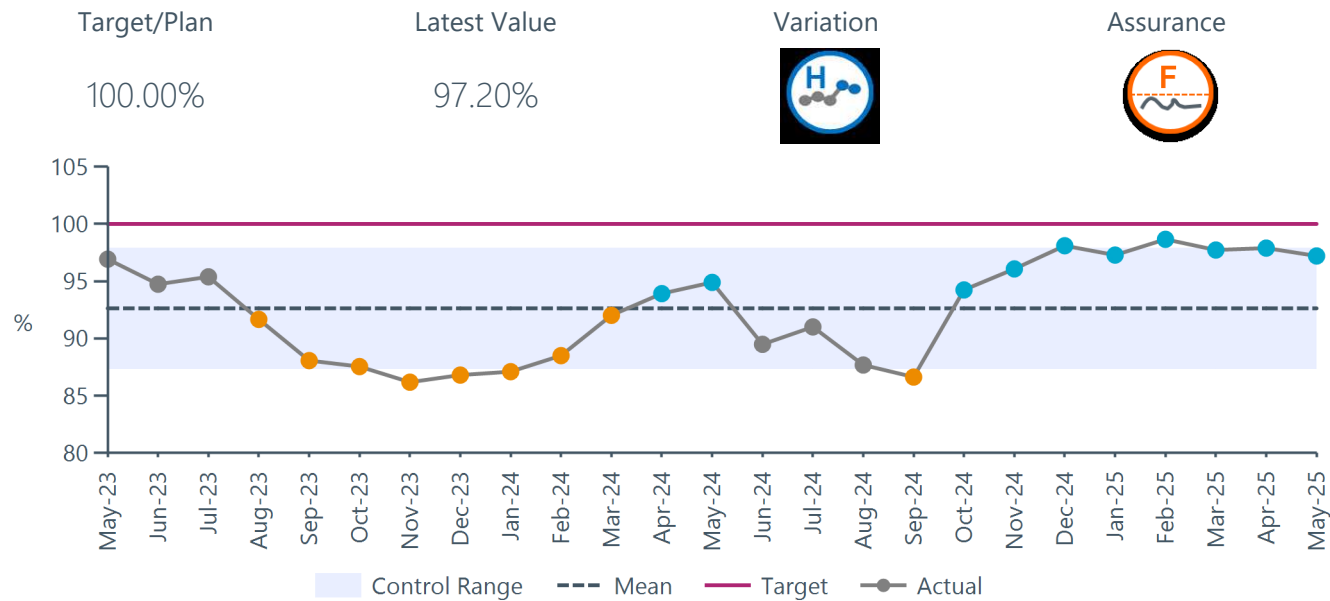
CT- Established process in place to escalate and prioritise RTT breaches where possible.

May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
84.85%	79.49%	75.95%	68.69%	71.47%	84.33%	91.97%	91.72%	86.97%	93.07%	91.13%	86.13%	88.85%

8 Week Wait for Diagnostics - Welsh Patients

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

Exec Lead
Chief Operating Officer



What these graphs are telling us

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

Narrative

The 8-week standard for diagnostics is reported at 97.20%. The reporting position includes 12 patients who waited beyond 8 weeks.

Performance and breaches by modality:

- * MRI – 97.61% - D2 (Urgent - 0-2 weeks) - 1 dated, D4 (Routine - 6-12 weeks) - 7 dated
- * CT – 100%
- * Ultrasound – 94.03% - D4 (Routing - 6-12 weeks) – 4 dated
- * DEXA Scans - 100%

None of the modality activity plans were met in May.

Actions

Ultrasound – weekend clinics being utilised to increase activity levels. Additional capacity from new consultant commenced 12th May.

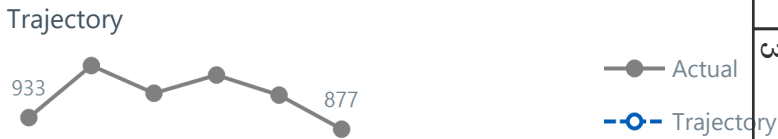
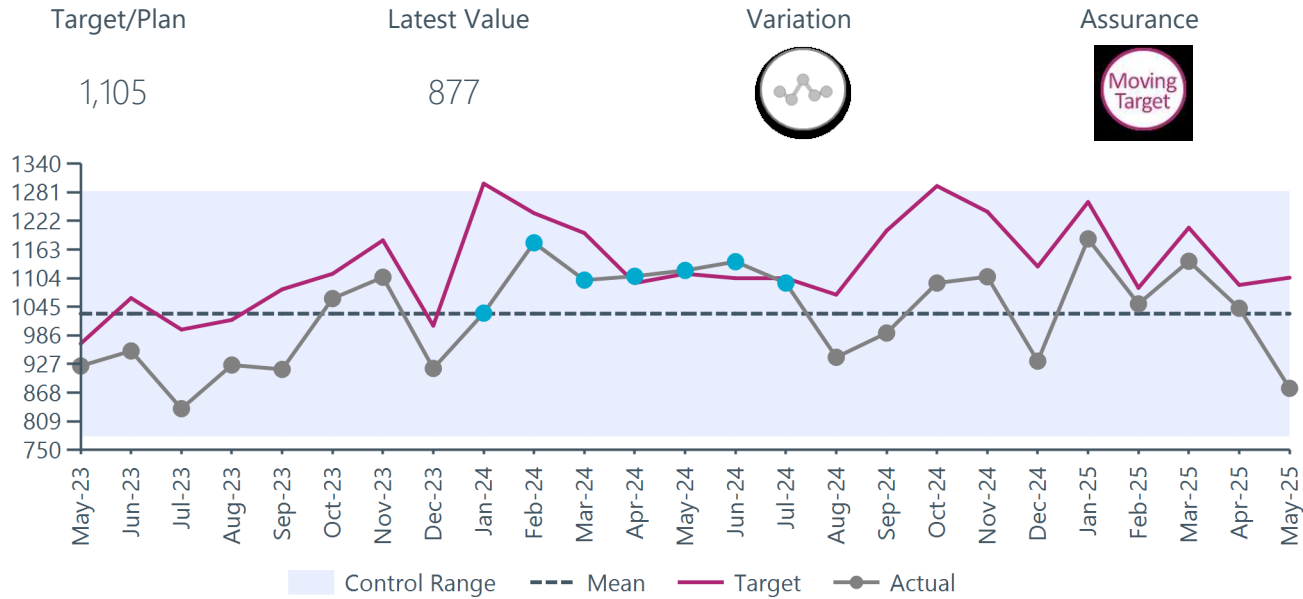
MRI – Continued Increase in demand across ICS. Recruitment to Business Case to increase skill mix and MRI activity. Mobile scanner contract extended.

CT- Established process in place to escalate and prioritise RTT breaches where possible.

May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
94.90%	89.48%	91.01%	87.68%	86.63%	94.24%	96.07%	98.10%	97.28%	98.66%	97.72%	97.89%	97.20%

Elective Activity Against Plan (volumes)

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



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 of the NHSE activity submission.

The plan for May was 1105 elective spells of which the Trust achieved 877 equating to 79.37% (228 cases below plan).

The Apollo PAS implementation affected performance in May, particularly in meeting the Theatre Activity target elective spell target with an increased level of cancellations than anticipated. All Teams except for Foot & Ankle fell short of the monthly target due to multiple factors including challenges in adapting to new workflows, system integration issues, and unforeseen disruptions.

May position fell significantly below the mean however it remains within control range and indicates normal variation.

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 supporting Baschurch in mornings to ensure adequate staffing resource for admissions. Some impacts continued at beginning of June but anticipate no impact throughout July.

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.

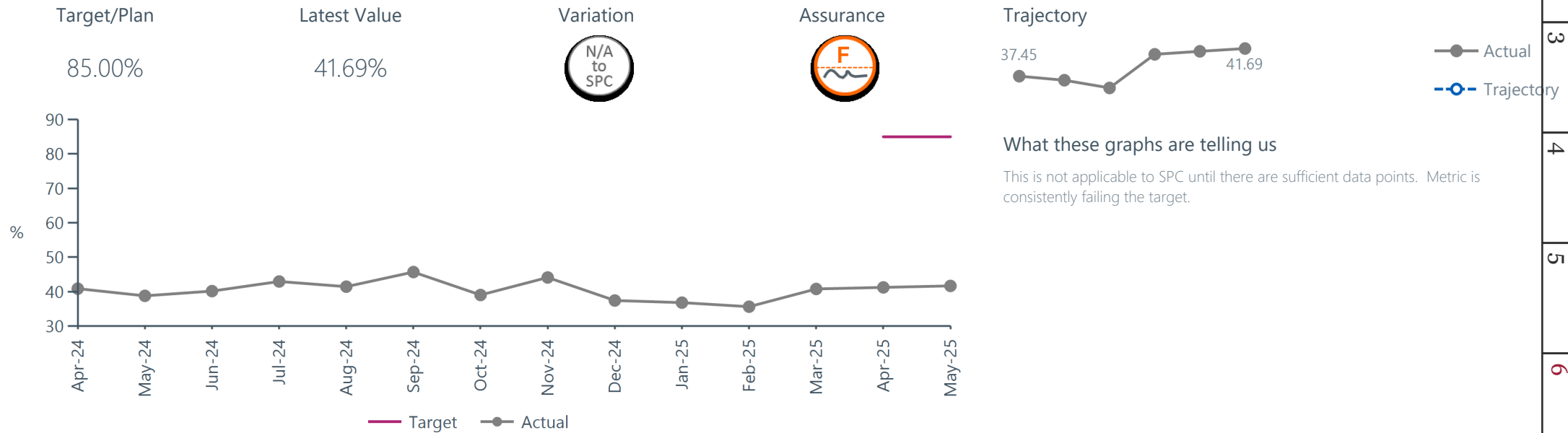
Plan was 40 cases; 35 delivered:

- Nuffield Shrewsbury: 32 patients treated in May
- Spire Yale: 3 patients treated May

May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
1120	1138	1094	941	991	1094	1107	933	1185	1051	1139	1042	877

% 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



Narrative

This is a new metric for the 2025/26 period, using a revised methodology compared to previous reports. Historical data has been recalculated based on this new methodology and presented in the graph above. The metric will transition to Statistical Process Control (SPC) once sufficient data points are available.

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 May, BADS performance was reported at 41.69%. If patients discharged on day zero—regardless of their intended management—were included, the metric would have reached 55.87%.

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. carpal 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.

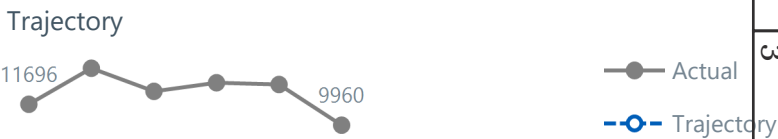
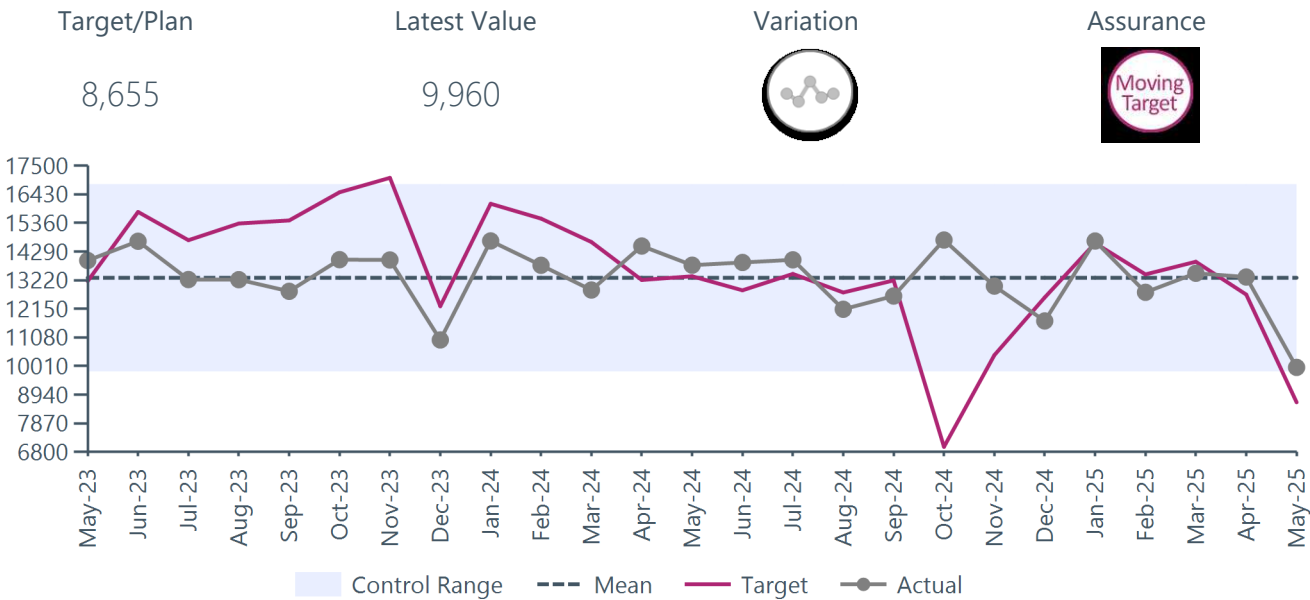
Actions also align to, and support with, the GIRFT recommendation following accreditation as a surgical hub for "A plan and review of clinical pathways that will support the Trust ambition to increase day case rates."

May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
38.80%	40.18%	42.97%	41.47%	45.71%	39.05%	44.14%	37.45%	36.83%	35.65%	40.80%	41.26%	41.69%
- Staff - Patients - Finances -												

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

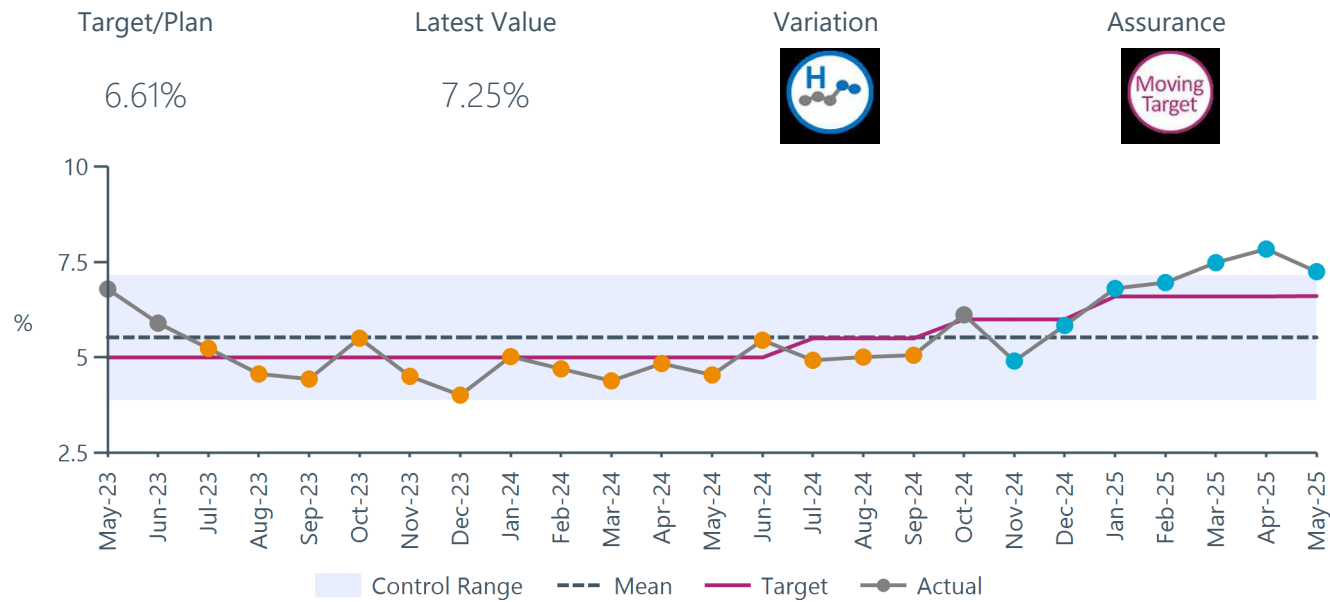
Exec Lead
Chief Operating Officer



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



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 6.61% of all outpatients attendances. In May this was exceeded with 7.25% of total outpatient activity moved to a PIFU pathway. As demonstrated on the SPC above, this is now the highest reported position and displayed as special cause variation of an improving nature.

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

Actions

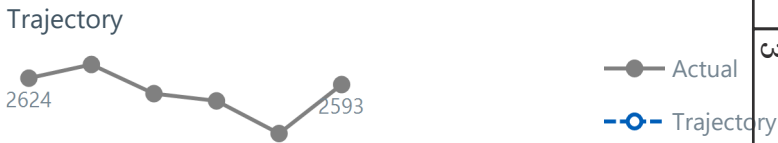
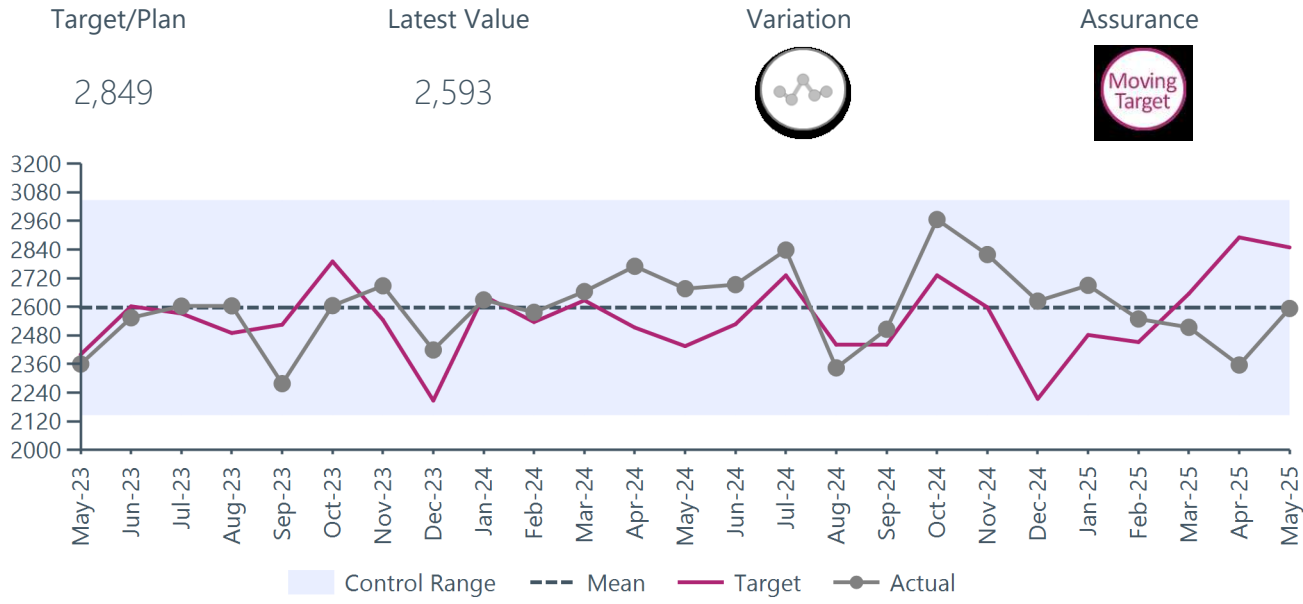
Close review of this metric as the mechanism of recording is different in Apollo.

May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
4.54%	5.45%	4.93%	5.01%	5.06%	6.12%	4.91%	5.84%	6.81%	6.96%	7.49%	7.84%	7.25%
- Staff - Patients - Finances -												

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



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 May, with all three modalities behind plan. Overall activity is reported at 90.94% with a breakdown as follows:

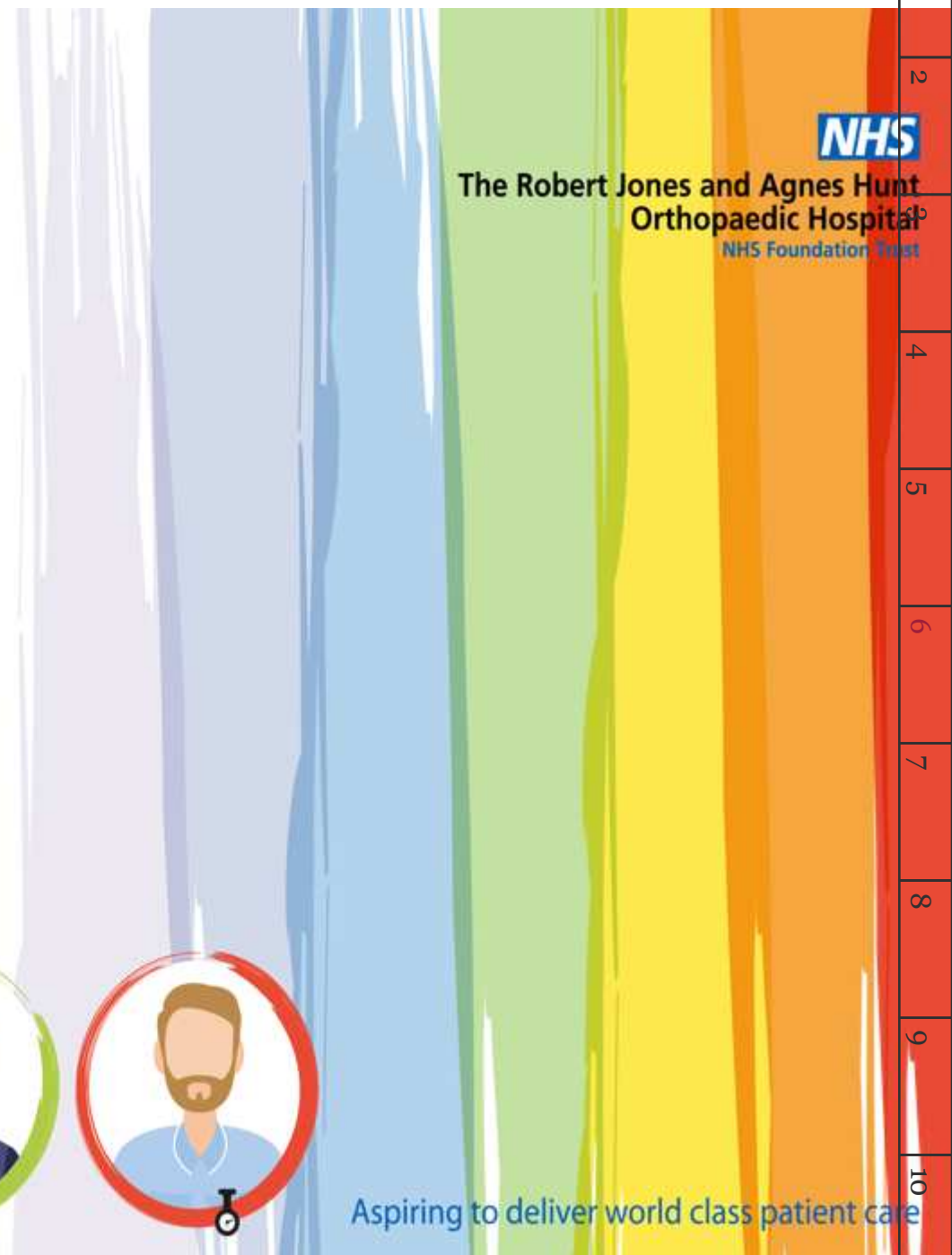
- CT – 344 against plan of 440; equating to 78.18%
- MRI - 1343 against plan of 1463; equating to 91.80%
- U/S – 904 against 946; equating to 95.56%

- Actions**
- Ultrasound – weekend clinics being utilised to increase activity levels. Additional capacity from new consultant commenced 12th May.
 - MRI – Continued Increase in demand across ICS. Recruitment to Business Case to increase skill mix and MRI activity. Mobile scanner contract extended.
 - CT- Established process in place to escalate and prioritise RTT breaches where possible.

May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
2676	2693	2838	2344	2506	2966	2819	2624	2690	2549	2514	2356	2593

Trust Board - Finance

May 2025 – Month 2



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:

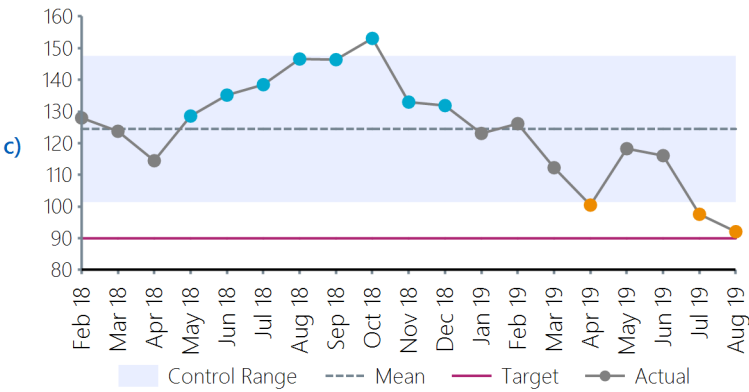
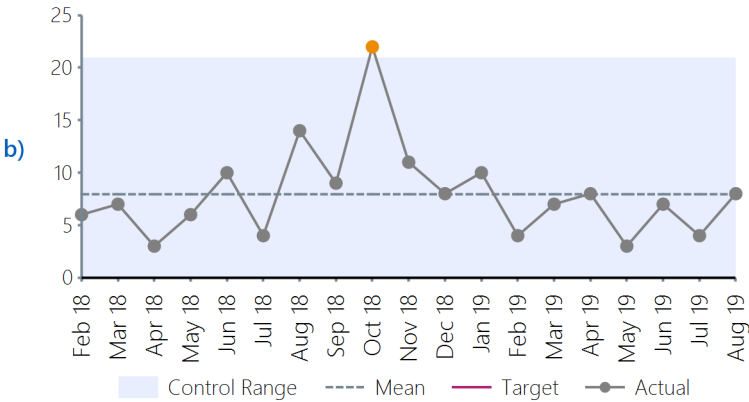
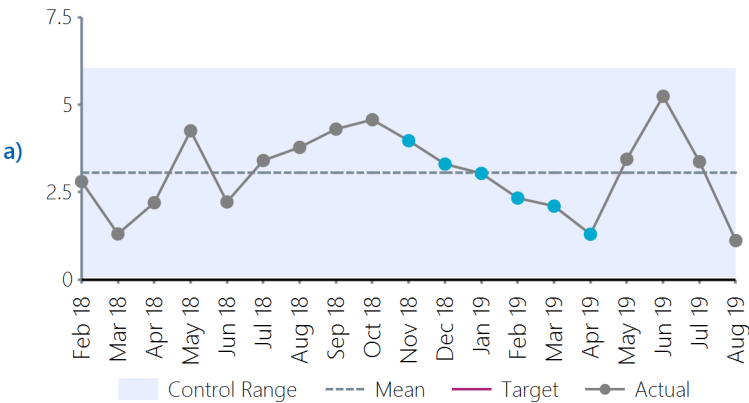
- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of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

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.

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



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 exception 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 or 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

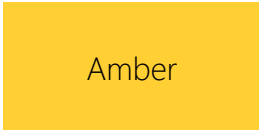
When rated, each KPI will display colour indicating the overall rating of the KPI



No improvement required to comply with the dimensions of data quality



Satisfactory - minor issues only



Requires improvement



Significant improvement required

Dates

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

1
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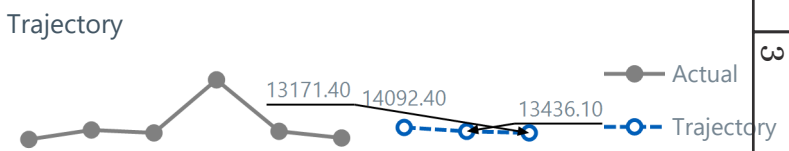
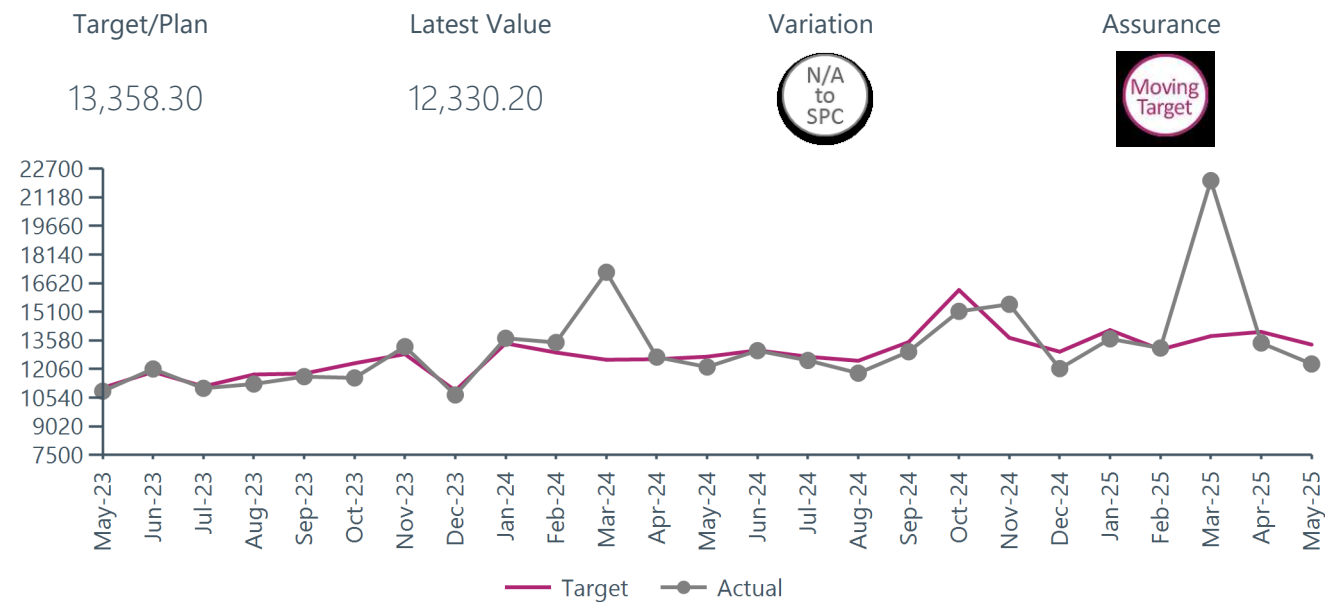


Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Financial Control Total	-1,140	-1,133.50					3
Income	13,358.30	12,330.20				+	4
Expenditure	14,498.30	13,463.70					5
Efficiency Delivered	598	685					
Cash Balance	17,708	19,750					6
Capital Expenditure	397	255					7
Performance (£'000k) against Low Value Agreement Block	62,166	-2				+	8
							9
							10

Income

All Trust Income, Clinical and Non-Clinical 216333



What these graphs are telling us

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

Narrative

Actions

Overall income £1,028k adverse to plan;

NHS Clinical income £774k adverse to plan;

- Internal capacity delivery £491k adverse to plan driven by 135 theatre cases shortfall and underperformance in diagnostics
- External insourcing/outsourcing delivery £144k adverse to plan (offset in expenditure)

Private Patients income £194k adverse (19 cases shortfall to stretch plan)

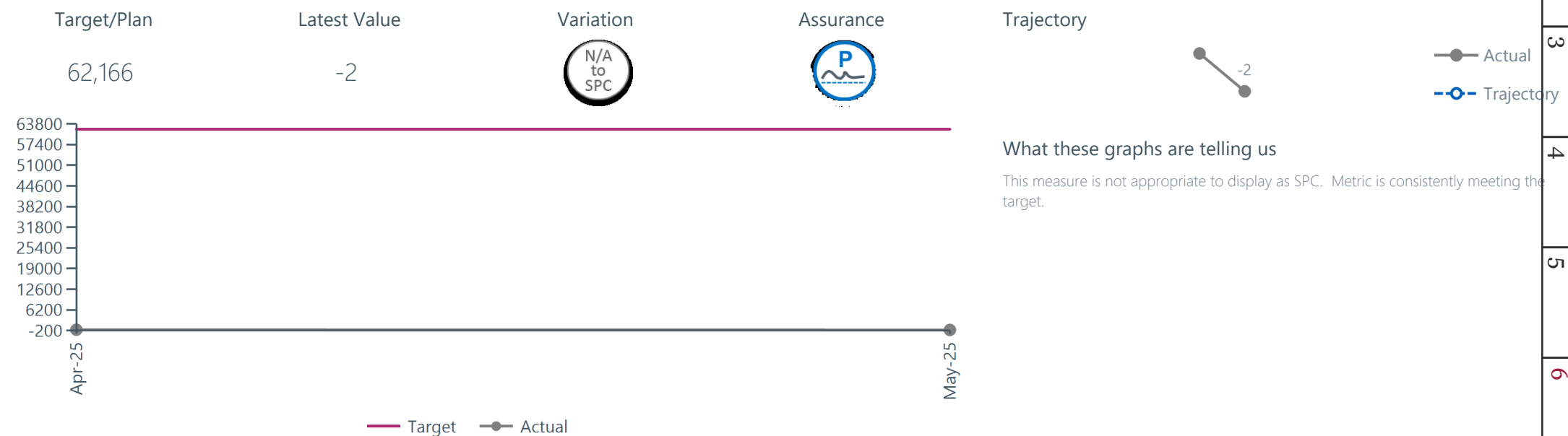
May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
12169	13037	12518	11843	12980	15124	15498	12083	13662	13175	22066	13444	12330

Performance (£'000k) against Low Value Agreement Block

Veterans growth is driving overperformance against the LVA block which must be recovered through NCA billing to out of area commissioners. 217873

Exec Lead

Chief Finance and Planning Officer



Narrative

The amount of Veterans activity did not exceed the baseline within the LVA block in Month 2. This was driven by the theatre activity underperformance caused by the Apollo go-live.

Actions



The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust

M02 Financial Position Update

→ *Improving lives through excellent and innovative care*



1
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I&E Position



The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust

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	153,765	11,694	10,920	(774)	24,043	22,801	(1,242)
Private Patient income	11,987	1,023	829	(194)	2,080	1,694	(386)
Other income	7,020	632	581	(51)	1,329	1,281	(48)
Pay	(106,340)	(8,842)	(8,597)	245	(17,724)	(17,200)	524
Non-pay	(57,955)	(5,013)	(4,279)	734	(10,040)	(8,914)	1,126
EBITDA	8,477	(506)	(546)	(40)	(312)	(338)	(26)
Finance Costs	(9,285)	(700)	(657)	43	(1,402)	(1,315)	87
Capital Donations	1,620	8	81	73	16	81	65
Operational Surplus	812	(1,198)	(1,122)	76	(1,698)	(1,572)	126
Remove Capital Donations	(1,620)	(8)	(81)	(73)	(16)	(81)	(65)
Add Back Donated Dep'n	809	67	69	2	133	139	6
						0	
Control Total	0	(1,140)	(1,134)	6	(1,582)	(1,513)	69

- £1,134k deficit in month, £6k favourable to plan
- NHS Clinical Income £774k adverse:
 - £519k adverse theatres – 135 case shortfall, favourable casemix
 - £144k adverse insourcing / outsourcing (offset in cost)
 - £51k adverse unbundled & diagnostic procedures
 - £51k favourable outpatients (plan reduced to 50% due to EPR)
- Private Patient Income £194k adverse private patients – 19 case shortfall
- Other Income £51k adverse driven by Apollo (cost offset) & Research
- Pay £245k favourable :
 - £269k favourable I&I interventions (vacancy control, temp staffing, recruitment)
 - £148k favourable workforce recruitment slippage (offset by activity)
 - £137k adverse Apollo overtime/OJP/bank
 - £35k adverse wards – driven by bank & agency
- Non-Pay £734k favourable:
 - £319k favourable implants/consumables (NHS & PP)
 - £256k favourable inflation to date lower than plan & slippage on cost pressures
 - £158k favourable Insourcing/outsourcing (offset in income)
- Finance Costs £43k favourable driven by interest receivable
- YTD £1,513k deficit, £69k favourable to plan.



Month 2 Performance



The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust

Internal Plan & Actuals	Month 2			YTD			Forecast		
	Plan	Actual	Variance	YTD Plan	YTD Actual	Variance	Plan	Forecast	Variance
MSK	297	302	5	588	569	-19	4,584	4,466	-118
Spec	151	126	-25	287	247	-40	3,395	3,163	-231
Corporate	150	166	16	291	301	10	1,615	1,964	349
Total Recurrent	598	594	-4	1,166	1,117	-49	9,594	9,594	-0
YTD Non-Recurrent	0	90	90	0	161	161	0	161	161
Total including Mitigations	598	684	86	1,166	1,278	112	9,594	9,755	161

Performance

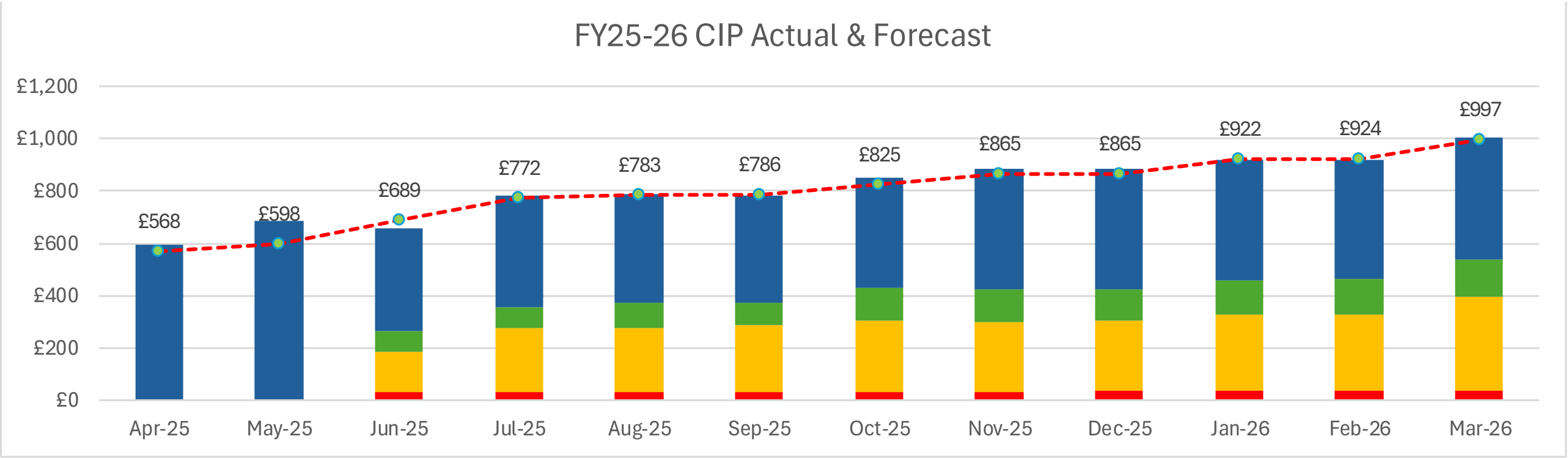
- Overall £684k efficiencies achieved, £86k favourable to plan. Recurrent delivery £4k adverse to plan, offset by £90k non recurrent mitigations (recruitment slippage/vacancies and procurement).
- YTD £1,278k efficiencies achieved, £161k favourable to plan. Recurrent delivery £49k adverse to plan, offset by £161k non recurrent mitigations.



Full Year impact of schemes delivered in Month 2, and RAG rating of future months



The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust



Risk Profile of Plan

Delivered £5.7m / 59%
Green (low) risk £1.1m / 12%
Amber (medium) risk £2.6m / 28%
Red (high) risk £334k / 3%

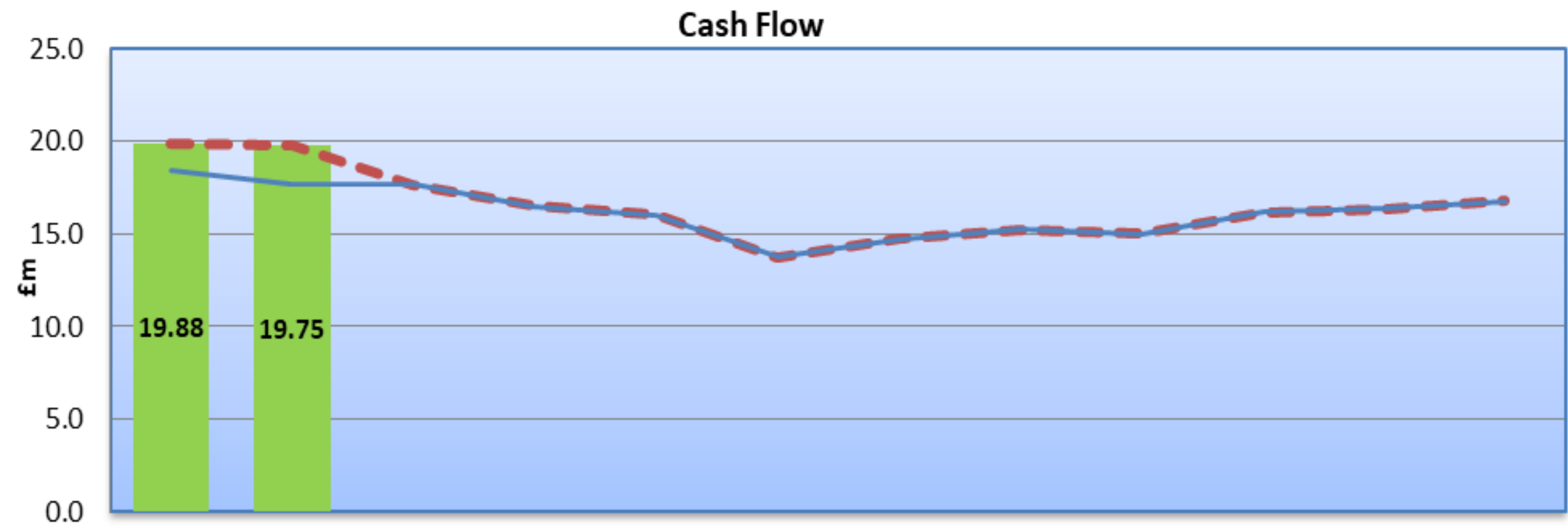
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	FY25-26
Target (£000)	£568	£598	£689	£772	£783	£786	£825	£865	£865	£922	£924	£997	£9,594
% of total plan	6%	6%	7%	8%	8%	8%	9%	9%	9%	10%	10%	10%	
Forecast													
Red			£33	£33	£33	£33	£33	£33	£34	£34	£34	£34	£334
Amber			£154	£245	£241	£254	£272	£267	£270	£291	£293	£362	£2,648
Green			£79	£77	£97	£83	£124	£123	£122	£131	£134	£141	£1,112
Delivered	£593	£684	£389	£428	£420	£413	£423	£463	£460	£462	£460	£465	£5,661
TOTAL	£593	£684	£655	£783	£791	£783	£852	£886	£886	£918	£921	£1,003	£9,755



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										
Forecast	19.88	19.75	17.66	16.52	16.06	13.77	14.75	15.27	14.99	16.17	16.37	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 is £2m above plan mainly due to 24/25 underperformance not yet being 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 2526-02 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	33	8	25	66	17	49	500
Digital investment & replacement	500	0	0	0	0	0	0	500
Capital project management	170	14	14	0	28	28	-0	170
Equipment replacement	1,000	0	0	0	0	25	-25	1,000
Diagnostic equipment replacement	700	125	0	125	125	0	125	700
Compliance (IPC/health & safety/quality)	360	0	0	0	0	0	0	360
Estates reconfiguration	206	30	0	30	30	0	30	206
PACS/RIS replacement	200	5	0	5	10	0	10	200
Invest to save	200	0	0	0	0	0	0	200
Digital & innovation strategy	500	0	0	0	0	0	0	500
Surgical innovations	750	0	0	0	0	0	0	750
EPR implementation	500	182	153	29	364	303	61	500
Rheumatology hub	500	0	0	0	0	0	0	500
Rheumatology hub (donated element)	500	0	0	0	0	0	0	500
Donated medical equipment	220	8	81	-73	16	81	-65	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	0	0	0	0	0	0	250
Total Capital Funding	10,863	397	256	141	639	453	186	10,863
Less donated / grant capital	-1,620	-8	-81	73	-16	-81	65	-1,620
NHS Capital Funding - Charge to CDEL	9,243	389	175	214	623	373	251	9,243
Less PDC funded schemes	-2,907	0	0	0	0	0	0	-2,907
Charge to System Operational Capital	6,336	389	175	214	623	373	251	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 £186k behind plan year to date. £125k of this is due to slippage on the diagnostic equipment replacement scheme.



Financial Risk

Risk Type	Category	Risk name	Risk Description	Estimated Value Methodology	Risk ID	Annual Risk at 1st April 2024 £'000	Risk Rating	Mitigations / actions	SRO
Income	Externally Driven	Veterans growth for out of area patients not funded through LVA.	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 block.	3342	£ 1,000	16	Secure support from NHSE pricing team on continued approach to NCA billing Secure counter signature from STW ICB in support of approach to NCA billing Issue formal correspondence outlining the background to the Veterans service and billing approach along with a clearer approach to overperformance using the methodology outlined above. 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
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	£ 3,000	16	Financial Improvement group overseeing activity delivery weekly	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	£ 1,700	16	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.	Angela Mulholland-Wells, Chief Finance and Commercial Officer
Income	Externally Driven	Powys THB contract cap leading to either non payment of income or long wait breaches	Contract negotiations are ongoing with Powys THB who have proposed a capped contract value of £9.5m with expectation that inpatients are treated to 104 weeks and outpatients to 52 weeks. Internal modelling shows a £1.2m difference in contract value assumptions on this basis so either the offer needs to increase or the health board accepts the consequence of 104 week breaches c220	Based on internal modelling of 104 week and 52 week demand against the contract cap set by Powys		£ 1,200	12	Negotiation with commissioner, contract sign off, escalation Compromise on balance of affordability versus performance requirements Joint understanding of activity & financial modelling and consequences Internal capacity redirected to other commissioners (this is also a risk)	Angela Mulholland-Wells, Chief Finance and Commercial Officer



Financial Risk

Risk Type	Category	Risk name	Risk Description	Estimated Value Methodology	Risk ID	Annual Risk at 1st April 2024 £'000	Risk Rating	Mitigations / actions	SRO
Income / Expenditure	Internally Driven	Apollo EPR - Slippage leading to further cost - Data issues leading to income loss - More disruption to activity levels than planned	Risk that the implementation is more disruptive to activity than planned leading to reduction in pbr income. The EPR implementation will affect all areas of activity recording in the Trust, there is a risk that unforeseen consequences occur in the reporting of activity through the national systems and commissioners leading to a loss of ERF income. Risk that the implementation is more disruptive to activity than planned leading to reduction in pbr income.	Based on cost of extending partial project resource for 3 months and potential income DQ issues	3250, 3147	£ 600	12	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 have been set a fixed allocation for varialbe 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 performacne is understated due to insourcing contract ceasing.	Based on differences in variable contract values		£ 1,400	12	Negotiation with commissioner, contract sign off, escalation Activity is required to deliver mandatory performance standards - guidance supports this Close contract monitoring and forecast with commissioners	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	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						£ 9,200			

- £9.2m of risk has been identified. These risks are monitored and managed through the Trust governance structures.
- There are three risks >15 risk rating
 - Efficiency programme due to the size of the efficiency requirement – this risk has decreased significantly due to updated risk assessments and performance to date
 - Veterans growth income due to the risk of non payment, further action required to secure agreement from ICB’s
 - Failure to delivery planned activity levels due to theatre activity forecast positions for June adverse to plan
- Two new risks have been added relating to commissioner affordability 1) Powys THB commissioning intentions 2) English associate commissioners variable activity



Chair's Assurance Report Finance and Performance Committee

Committee / Group / Meeting, Date

Board of Directors, 02 July 2025

Author:

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Contributors:

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 02 June 2025 and 23 June 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.		

Chair's Assurance Report Finance and Performance Committee

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

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.

Spinal Disorders Service – Strategic and Operational Challenges

The Trust continues to experience unsustainable pressure within its spinal disorders service, with a backlog exceeding 1,800 patients, compounded by weekly referral volumes that consistently outstrip available capacity. Despite the initiation of mutual aid and outsourcing efforts, the current trajectory risks patient harm, breaches to access standards, and reputational impact.

A suite of management options was presented to the Committee; however, a preferred approach could not be endorsed without:

- Robust EQIA assessments.
- Clear modelling of 52-week+ breach trajectories.
- System-wide alignment with NHS England and the ICB.

Given the implications for equity of access, workforce sustainability, and patient safety, the Committee seeks urgent Board-level oversight and strategic steer. Input from the Quality and Safety Committee may also be appropriate.

Inadequacy of Current Performance Reporting and Forecasting

The Committee remains unable to take assurance from the Integrated Performance Report (IPR) as currently constituted. Of particular concern:

- Absence of forward-looking trajectories on key metrics.
- Lack of visibility between intervention delivery and performance improvement.
- Unexplained data classifications (e.g., RTT "Other" categories).
- Inability to assess the effectiveness of recovery actions (e.g., Saturday sessions, insourcing).

This presents a critical gap in assurance for both operational delivery and financial planning. The Committee recommends immediate enhancement of IPRs across all forums, incorporating full-year trajectories and sub-specialty-level data.

The Committee were pleased to note that the long waiters trajectories have been included within the IPR to support a trend analysis and breakdown.

Theatre Activity and Income

The Trust has entered a third consecutive month of underperformance against planned theatre activity, with a forecast of 180 cases below plan in Month 3. This under-activity has directly contributed to a clinical income shortfall of ~£1 million per month.

While mitigated to date by favorable non-pay variances, this trend is not financially sustainable. The Committee recommends that the operational plan and financial forecast be urgently re-aligned and presented to the Board with a clear recovery trajectory.

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:

Chair's Assurance Report Finance and Performance Committee

Medium-Term Financial Plan (MTFP) and System Finance Strategy

The three-year ICS break-even plan remains underpinned by ambitious efficiency assumptions and sustained ERF funding. Key risks identified include:

- Over-dependence on Welsh income (~30% of Trust revenue).
- National tariff distortions based on outdated 2018/19 pricing.
- Volatility of non-recurrent income streams.

The plan is robust but must remain iterative, particularly in light of the upcoming comprehensive spending review. Ongoing triangulation with commissioning and operational assumptions is essential.

Efficiency Programme – Positive Progress, Heightened Risk

Delivery against the £9.6m efficiency target is ahead of plan in months 1 and 2. However, a significant proportion of savings remain in amber/red categories, and:

- Stretch delivery may be needed to offset activity underperformance.
- Pipeline development and reserve schemes are crucial.

Rolling monthly reporting and unit-level presentations have now been embedded. The Committee supports the approach and recommends aiming for 120% of planned savings to build resilience.

Private Practice vs NHS Activity – Need for Assurance

Private practice is delivering c30% growth, though concerns were raised about:

- NHS RTT delivery versus private activity levels.
- Consultant time allocation and productivity variation.

The Committee has commissioned a consultant- and specialty-level breakdown of private vs NHS activity and associated RTT outcomes. The Delivery Model Implementation Oversight Group will oversee triangulation of these datasets.

Apollo Implementation and Bank Staff Usage

A recent increase in non-medical bank usage may be linked to Apollo go-live support. While mitigated to date, the risk of embedded cost escalation exists. A formal impact analysis will be incorporated into forecast assumptions going forward.

3.3 Areas of assurance

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

Board Assurance Framework (BAF) & Corporate Risk Register (CRR)

- BAF is being refreshed to reflect changes in strategic objectives and governance structures (e.g., transition from ARC to Delivery Model Implementation Oversight Group).
- A new risk has been created for long Welsh waits, and scoring is being revised.
- CRR updates were noted, including alignment of operational and financial risks.

System Finance Strategy

The finalised strategy articulates a clear system-wide transformation ambition and is appropriately aligned with NHS England expectations. Future spending profiles are now embedded and reflect the prevention and community care shift.

TIF2 Closure

The Committee reviewed the TIF2 closure report and confirmed that:

- All remedial actions and lessons learned have been recorded.
- The final version has been resubmitted in the national format.
- A follow-up business case is anticipated for a further phase of theatre expansion.

MSK Unit Efficiency

A strong performance was noted, with delivery of £569K vs a target of £588K at M2. Issues such as consultant leave, patient cancellations, and pre-op processes are being actively managed. A deep dive is scheduled for September to assess stretch potential and unmet opportunity.

Chair Reports from Subcommittees

- **Capital Management Group** – Positive update on solar energy funding.

Chair's Assurance Report

Finance and Performance Committee

- **Financial Improvement Group** – TOR under review to better reflect performance alignment.
- **Delivery Model Oversight Group** – Strong focus on 25/26 priorities; data tracking under review.
- **Trust Performance and Operational Improvement Group** – consideration being given to the myrecovery app and whether this has been included within the plan. The Rheumatology proforma is yet to be agreed.
- **STW MSK Provider Collaborative Board** – noted the positive conversations ongoing and informed the committee that the current key challenge is gathering community MSK data and accessing the information to support driver the programme forward.
- **Procurement Steering Group** – Good progress; minor supply chain delays being escalated.

Chair's Assurance Report Finance and Performance Committee

Recommendation

The Board is asked to:

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

Finance and Performance Committee Annual Report 2024/25

Committee / Group / Meeting, Date

Board of Directors, 02 July 2025

Author:

Name: Mary Bardsley / Dylan Murphy
Role/Title: Assistant Trust Secretary / Trust
Secretary

Contributors:

Report sign-off:

Name: Dylan Murphy, Trust Secretary
Finance and Performance Committee, 28 April 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.

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 line with good practice, the committees of the Board undertake an annual review of their operation and effectiveness. This involves:

- Reviewing the role of the committee, its key responsibilities, membership and business considered during the year.
- A questionnaire on the effectiveness of the operation of the committee (completed by individual members / core attendees).
- A self-assessment against key governance questions (for collective consideration).
- Review of the terms of reference to ensure the focus of the Committee remains relevant in 2025/26

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	✓

Finance and Performance Committee Annual Report 2024/25

Recommendations

That the Board note that, at the April meeting, the Committee:

1. **Noted** the report;
2. **Considered** the outcome of the committee effectiveness survey and did not identify any required actions;
3. **Considered and agreed** the draft self-assessment document (as included at section 8);
4. **Noted** the 2024/25 Decision / activity log (as included at attachment A).
5. **Considered** the draft Terms of Reference for 2025/26 (as included at attachment B) and recommended that the Board approve them.

The Board is therefore asked to consider and approve the proposed terms of reference for 2025/6.

Report development and engagement history:

This report has been produced from existing documentation. The self-assessment and TOR are initial drafts for consideration – they have not been considered or approved by any other forum or individual.

Next steps:

The committee-approved report will be presented to the Board meeting in May, to provide assurance that the Committee has fulfilled its role and responsibilities during the year.

Any issues of concern, or apparent gaps in the governance arrangements, that are identified will be reported to the Audit and Risk Committee for consideration.

Appendices

Appendix A Committee Activity/Decision Log 2024/25

Appendix B Terms of Reference 2025/26

Finance and Performance Committee Annual Report 2024/25

1. Committee Roles and Responsibilities (2024/25)

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.

- 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.
- 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 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 to 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.
- 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.

2. Membership (2024/25)

The membership section of the current terms of reference is:

- Up to four Non-Executive members
- Chief Operating Officer/Deputy Chief Executive Officer
- Chief Finance and Planning Officer

3. Meetings (2024/25)

During 2024/25, the committee met on 12 occasions (monthly). It was noted that all meetings were quorate. In addition, there were 1 extraordinary meetings held (with reduced attendees) to consider the operational and financial plans.

Finance and Performance Committee Annual Report 2024/25

4. Committee Attendance (2024/25)

Overall, good attendance has been noted from all core members of the meeting.

Name	Title	Attendance
Core Membership		
Sarfraz Nawaz	Non-Executive Director (Chair)	10 / 10
Martin Newsholme	Non-Executive Director	11 / 13
Paul Maubach	Associate Non-Executive Director	11 / 13
Lindsey Webb	Non-Executive Director	10 / 13
Mike Carr	Chief Operating Officer	11 / 13
Craig Macbeth	Chief Finance and Planning Officer	12 / 13
*Stacey Keegan	Chief Executive Officer	12 / 13
In Attendance		
Dylan Murphy	Trust Secretary	10 / 13
Mark Salisbury	Deputy Operational Director of Finance	12 / 13
Steph Wilson	Performance and Business Insight Manager	10 / 12
Nia Jones	Managing Director for Planning and Strategy	10 / 13

*The Chief Executive Officer has an open invitation to the meeting.

5. Committee Activity and Decision Log (2024/25)

The business considered by the Committee during the year is included at appendix A.

6. Conduct of Meetings (2024/25)

The Committee conducted its business in accordance with the provisions of the Trust's constitution and terms of reference.

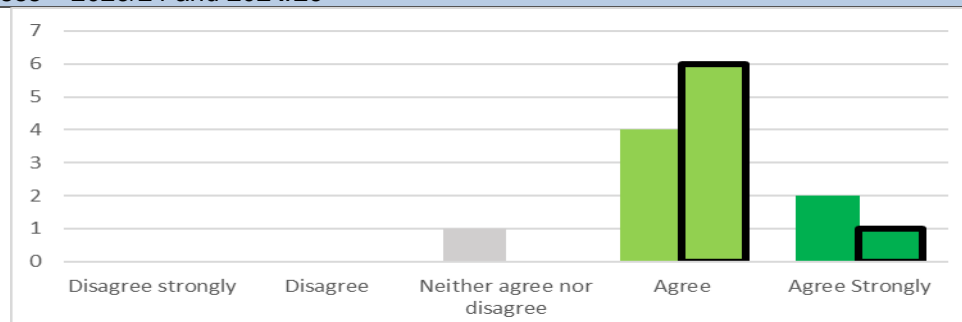
Formal minutes of the meeting were produced which included a record of the attendees present at the meeting. The Committee provided an update to the Board via the Chair's Assurance Report to the Board of Directors following each meeting.

7. Committee Effectiveness Questionnaire (2024/25)

The Committee effectiveness questionnaire was circulated to a total of 11 people (core members and frequent attendees of the meeting). There was a total of 7 responses received. The 2024/25 results (the second of the two columns, with the black outline) are displayed alongside the 2023/24 results (based on the 7 returns received last year).

Q1 The work plan gives appropriate coverage to the areas which I consider that it should be covering

Responses – 2023/24 and 2024/25



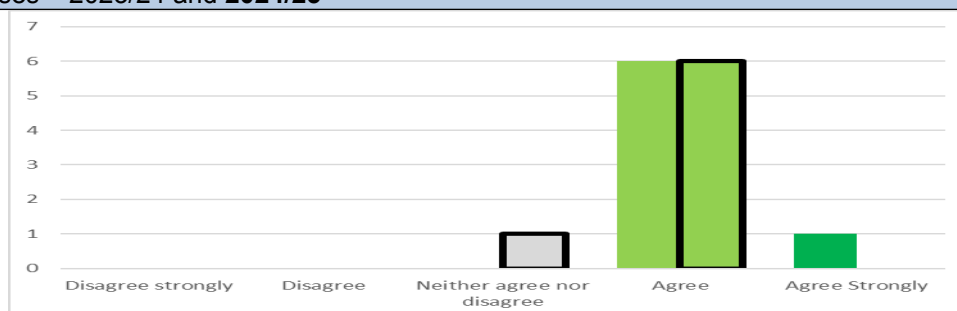
Comments

- There are no responses

Finance and Performance Committee Annual Report 2024/25

Q2 Current workload facilitates adequate scrutiny of areas delegated to the Committee

Responses – 2023/24 and 2024/25

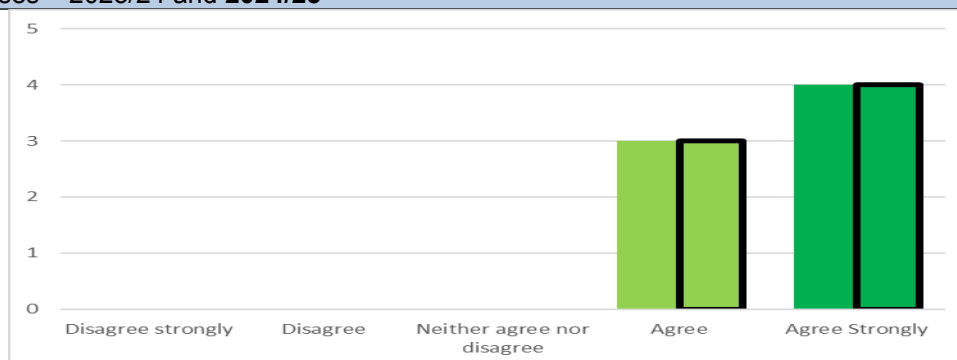


Comments

- Improved since the start of the Activity Recovery Committee

Q3 I have the appropriate skills and training to provide valuable input into the Committee

Responses – 2023/24 and 2024/25

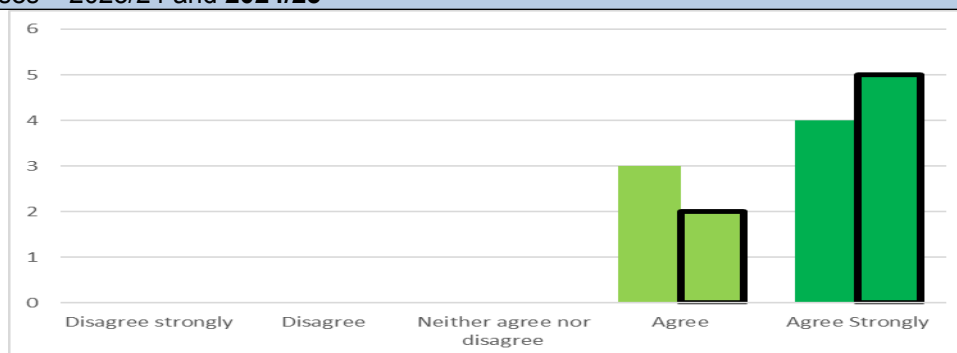


Comments

- There are no responses

Q4 I consider that the meetings are well chaired and that members are given sufficient opportunity to contribute

Responses – 2023/24 and 2024/25



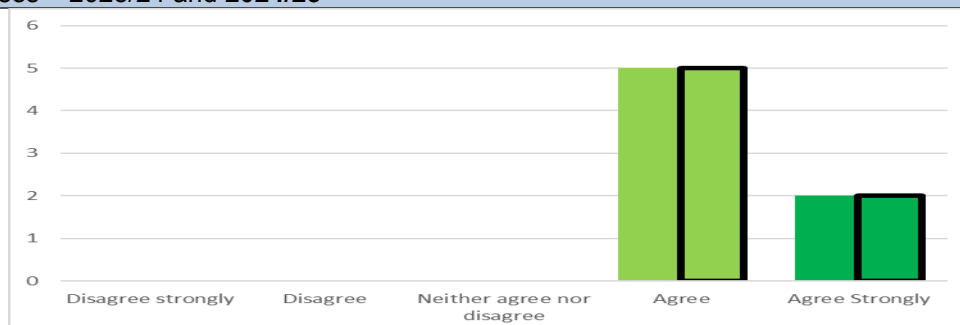
Comments

- There are no responses

Finance and Performance Committee Annual Report 2024/25

Q5 I consider that the time spent on each agenda item is appropriate and sufficient for scrutiny and challenge as required

Responses – 2023/24 and 2024/25

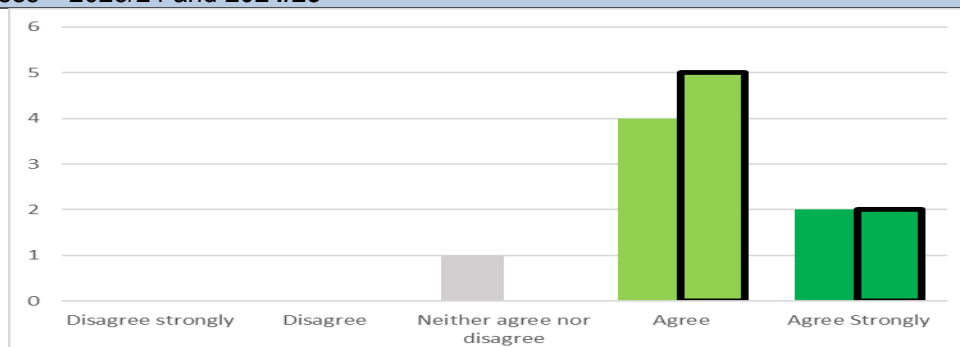


Comments

- As per previous comment.
- I think sometimes we could do with spending a little more time on the underlying position that affects the recurrent forecast (excluding non-recurrent adjustments) so we better understand the underlying health of the Trust's position.

Q6 I have received the information which I require to consider the Trust's financial/activity delivery risks and their mitigations

Responses – 2023/24 and 2024/25

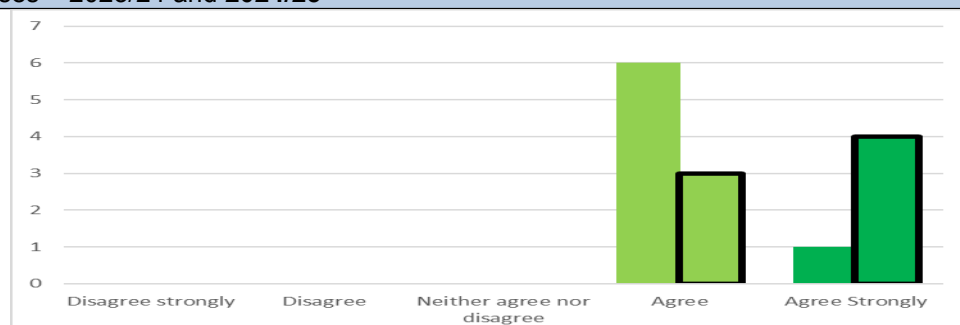


Comments

- There are no responses.

Q7 The Committee has added value to the Trust's assurance processes

Responses – 2023/24 and 2024/25



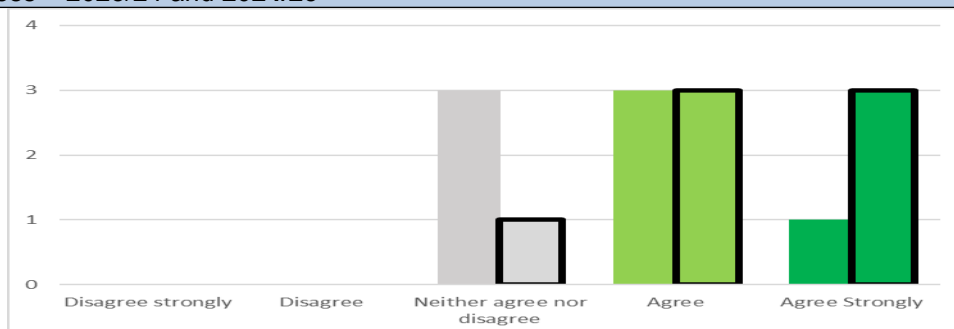
Comments

- There are no responses.

Finance and Performance Committee Annual Report 2024/25

Q8 The Committee has had sufficient time/information to consider major investments

Responses – 2023/24 and 2024/25



Comments

- Time is flexed to make sure we cover key issues

9.The quality of the papers and presentations ensure the Committee can add value and rigour to governance*

Responses – 2023/24 and 2024/25



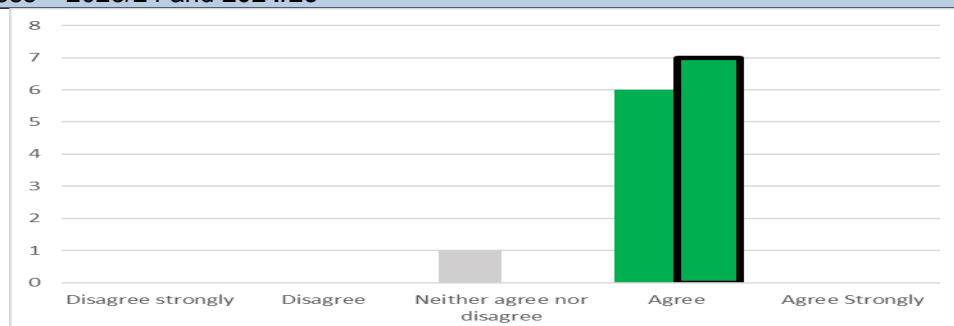
Comments

- There are no responses

*This is a new question, as included in other committee surveys. This replaces a question on the Digital agenda, which is no longer relevant to this committee.

Q10 I consider that the Committee receives sufficient information on the finance/activity KPIs to gain assurance on the Trust's performance in these areas

Responses – 2023/24 and 2024/25



Comments

- As per my earlier point - greater clarity on the underlying position would be advisable

Finance and Performance Committee Annual Report 2024/25

8. Committee Self-Assessment (2024/25)

Area / Question	Response	Comments / Action
Composition, Establishment and Duties		
Does the committee have written terms of reference that adequately and realistically define the Committees role?	Yes	Approved by the Board and incorporated into the Board Governance Pack.
Have the terms of reference been adopted by the Board?	Yes	As above.
Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?	Yes	Yes annual review is included in the work plan with ad hoc changes made as and when required throughout the year.
Are committee members independent of the management team?	Yes	The committee is chaired by a Non-Executive and has another 3 Non-Executives within its membership.
Are members, particularly those new to the committee provided with relevant training?	N/A	There is no formal training for this Committee but the Chief Operating Officer/Chief Finance and Planning Officer/Chair of the Committee would be available as required to talk through the role of the committee, the nature of the discussion etc for any new attendees. A discussion is also held as part of the NED induction meetings.
Has the committee established a plan for the conduct of its own work across the year?	Yes	This is set for the financial year ahead and reviewed on a monthly basis as a standard agenda item for the meeting.
Are changes to the current and future workload discussed and approved at Board level?	Yes	The remit is set by the Board through approval of the terms of reference and the workplans are reviewed at each committee meeting with an overview of any changes presented to the Board via the Chair's Report.
Does the committee report to the Board regularly?	Yes	The chair of the committee presents an assurance report to the Board on a monthly basis.
Does the committee assess its own effectiveness periodically?	Yes	This is undertaken annually as part of the committee annual report.
Does the committee prepare an annual report on its work and performance in the preceding year?	Yes	It is presented to the Committee and considered alongside the self-assessment.
Has the committee been quorate for each meeting this year?	Yes	This is confirmed by the minutes of the meeting and reported to the Board as part of the assurance report.
Compliance with the Law and Regulations Governing the NHS		
Does the committee review assurance and regulatory compliance reporting processes?	Yes	This is undertaken by the committee in relation to issues of finance and performance and assurance is provided to the Board via the Chair's report.

Finance and Performance Committee Annual Report 2024/25

Area / Question	Response	Comments / Action
Does the committee have a mechanism to keep it aware of topical, legal and regulatory issues?	Yes	These would be escalated through the Trust's governance framework. The Trust's Executive Team provide updates as required.
Internal Control		
Has the committee formally considered how it integrates with other committees?	Yes	All committee work plans have been reviewed simultaneously to ensure timely flow of information from one to another. Through the Chair's report and the Executive Lead, matters can be escalated up, down or sideways to appropriate committees.
Has the Committee formally considered how its work integrates with the wider performance management and standards compliance?	Yes	The Committee receives an update on the KPIs from the Integrated Performance Report and commissions deep dives as required for assurance purposes.
Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?	Yes	The Trust launched the Corporate Stands Manual in 2023/24 which supports with the correct format and content of the reports. There are occasions where papers are marked to follow due to the reporting timelines.
Administrative Arrangements		
Does the committee have a plan of matters to be dealt with over the coming year?	Yes	This is set for the financial year ahead and reviewed on a monthly basis as a standard agenda item for the meeting.
Are papers circulated in good time and are minutes received as soon as possible after the meetings?	Yes	There are occasions when papers need to be delayed but the packs are circulated with good time and updated with papers that have been delayed for genuine reasons. If papers have been delayed to such an extent that the committee would not have sufficient time to consider them, they are deferred to the next meeting.
Does the committee meet the appropriate number of times a year?	Yes	The committee meets on a monthly basis.
Other Issues		
Does the Annual Report include a description of the committee's establishment and activities?	Yes	This is included in the Annual Governance Statement

Finance and Performance Committee Annual Report 2024/25

9. Forward look into 2025/26

To support with continuous improvement of the Finance and Performance Committee, members are asked to review the Terms of Reference and consider any required revisions for 2025/26.

10. Recommendation

That the Board note that, at the April meeting, the Committee:

1. **Noted** the report;
2. **Considered** the outcome of the committee effectiveness survey and did not identify any required actions;
3. **Considered and agreed** the draft self-assessment document (as included at section 8);
4. **Noted** the 2024/25 Decision / activity log (as included at attachment A).
5. **Considered** the draft Terms of Reference for 2025/26 (as included at attachment B) and recommended that the Board approve them.

The Board is therefore asked to consider and approve the proposed terms of reference for 2025/6.

Finance and Performance Committee - ACTIVITY / DECISION LOG

Updated: 22 April 2025

Decision Ref No.	Meeting Date	Topic/Agenda item	Conflicts of interest considered and agreed treatment of the conflict	Conclusion/Decision (e.g. Approved, Noted, Recommended ... etc. SEE "Decision" Types tab for guidance)	If applicable - results of vote and/or dissenting views	If Recommendation - destination for onward submission?
1	26-Apr-2024	Corporate Risk Register	None Noted	The Committee noted the Corporate Risk Register.	N/A	
2	26-Apr-2024	Update on ICB/LLP Plans	None Noted	The Committee noted the update on ICB/LLP Plans.	N/A	
3	26-Apr-2024	Final Operational and Financial Plan 2024/25	None Noted	The Committee approved the Final Operational and Financial Plan 2024/25, recommending final sign-off at Board before final submission.	N/A	
4	26-Apr-2024	Performance Report (OPOD)	None Noted	The Committee noted the Performance Report (OPOD).	N/A	
5	26-Apr-2024	KPI Proposal 2024/25	None Noted	The Committee noted the KPI Proposal 2024/25.	N/A	
6	26-Apr-2024	Long Waiters Presentation	None Noted	The Committee noted the Long Waiters Presentation.	N/A	
7	26-Apr-2024	RJAH Financial Performance Report	None Noted	The Committee noted the Finance report.	N/A	
8	26-Apr-2024	EPR Project Financial Forecast Update	None Noted	The Committee noted the EPR Project Financial Forecast Update.	N/A	
9	26-Apr-2024	Productivity Dashboard	None Noted	The Committee noted the Productivity Dashboard.	N/A	
10	26-Apr-2024	NHSE Productivity Template	None Noted	The Committee noted the NHSE Productivity Template.	N/A	
11	26-Apr-2024	Chair's Reports	None Noted	The Committee noted the following Chair's reports: Theatre Development Group, Trust Performance and Operational Improvement Group, MSK Transformation Programme Board, Procurement Steering Group .	N/A	
12	26-Apr-2024	Financial Improvement Group- Terms of Reference	None Noted	The Committee approved the Financial Improvement Group terms of reference.	N/A	
13	26-Apr-2024	Committee Effectiveness Annual Report (interim)	None Noted	The Committee noted the Committee Effectiveness Annual Report.	N/A	
14	26-Apr-2024	Review of Workplan	None Noted	The Committee noted the Workplan.	N/A	
15	24-May-2024	Board Assurance Framework	None Noted	The Committee noted the Board Assurance Framework.	N/A	
16	24-May-2024	2024/25 Planning Update	None Noted	The Committee noted the update on 2024/25 Planning Update.	N/A	
17	24-May-2024	Performance Report (OPOD)	None Noted	The Committee noted the Performance Report (OPOD).	N/A	
18	24-May-2024	Long Waiters Presentation	None Noted	The Committee noted the Long Waiters Presentation.	N/A	
19	24-May-2024	RJAH Financial Performance Report	None Noted	The Committee noted the RJAH Financial report.	N/A	
20	24-May-2024	MSK Unit Efficiency Delivery Report	None Noted	The Committee noted the MSK Unit Efficiency Delivery Report.	N/A	
21	24-May-2024	Medical Devices Internal Audit	None Noted	The Committee noted the Medical Devices Internal Audit.	N/A	
22	24-May-2024	ZLC Appointment Paper	None Noted	The Committee noted the ZLC Appointment Paper.	N/A	
23	24-May-2024	Chair's Reports	None Noted	The Committee noted the following Chair's reports: Trust Performance and Operational Improvement Group, MSK Transformation Programme Board, Capital Management Group, Theatre Development Group, Financial Improvement Group.	N/A	
24	24-May-2024	Committee Effectiveness Annual Report (interim)	None Noted	The Committee noted the Committee Effectiveness Annual Report.	N/A	
25	24-May-2024	Review of Workplan and Attendance Matrix	None Noted	The Committee noted the Workplan and Attendance Matrix.	N/A	
26	24-Jun-2024	Corporate Risk Register	None Noted	The Committee noted the Corporate Risk Register.	N/A	
27	24-Jun-2024	2024/25 Planning Update	None Noted	The Committee noted the update on 2024/25 Planning Update.	N/A	
28	24-Jun-2024	Performance Report (OPOD)	None Noted	The Committee noted the Performance Report (OPOD).	N/A	
29	24-Jun-2024	Long Waiters Presentation	None Noted	The Committee noted the Long Waiters Presentation.	N/A	
30	24-Jun-2024	Productivity Incentivisation	None Noted	The Committee noted the Productivity Incentivisation update.	N/A	
31	24-Jun-2024	RJAH Financial Performance Report	None Noted	The Committee noted the RJAH Financial report.	N/A	
32	24-Jun-2024	Chair's Reports	None Noted	The Committee noted the following Chair's reports: Veterans Oversight Group, Capital Management Group, Procurement Group, MSK Transformation Programme Board (verbal), Theatre Development Group, Financial Improvement Group.	N/A	
33	24-Jun-2024	Review of Workplan and Attendance Matrix	None Noted	The Committee noted the Workplan and Attendance Matrix	N/A	
34	24-Jun-2024	NOF Dashboard	None Noted	The Committee noted the NOF Dashboard.	N/A	
35	29-Jul-2024	PwC Support Update	None Noted	The Committee noted the PwC Support Update.	N/A	
36	29-Jul-2024	Pay Deep Dive	None Noted	The Committee noted the Pay Deep Dive update.	N/A	
37	29-Jul-2024	Financial Position and Mitigations	None Noted	The Committee noted the Financial Position and Mitigations update.	N/A	
38	29-Jul-2024	LVA Update	None Noted	The Committee noted the LVA Update.	N/A	
39	29-Jul-2024	Activity Mitigation Plan	None Noted	The Committee noted the Activity Mitigation Plan.	N/A	
40	29-Jul-2024	Medium Term Financial Plan	None Noted	The Committee noted the Medium-Term Financial Plan.	N/A	
41	29-Jul-2024	Chair's Reports	None Noted	The Committee noted the following Chair's reports: Trust Performance and Operational Improvement Group, Capital Management Group, Theatre Development Group.	N/A	
42	29-Jul-2024	Review of Workplan and Attendance Matrix	None Noted	The Committee noted the Workplan and Attendance Matrix.	N/A	
43	19-Aug-2024	Board Assurance Framework	None Noted	The Committee noted the Board Assurance Framework.	N/A	
44	19-Aug-2024	PWC Update	None Noted	The Committee noted the PWC Update.	N/A	
45	19-Aug-2024	Long Waiters Presentation	None Noted	The Committee noted the Long Waiters Presentation.	N/A	
46	19-Aug-2024	Financial Position and Mitigations	None Noted	The Committee noted the Financial Position and Mitigations update.	N/A	

Finance and Performance Committee - ACTIVITY / DECISION LOG

Updated: 22 April 2025

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47	19-Aug-2024	LLP Mitigations	None Noted	The Committee noted the LLP Mitigations Update.	N/A	
48	19-Aug-2024	Productivity Report	None Noted	The Committee noted the Productivity Report.	N/A	
49	19-Aug-2024	Service Line Reporting	None Noted	The Committee noted the Service Line Reporting update.	N/A	
50	19-Aug-2024	Trust Performance and Operational Improvement Meeting Chair Report	None Noted	The Committee noted the Trust Performance and Operational Improvement Meeting Chair Report.	N/A	
51	19-Aug-2024	Capital Management Group Chair Report	None Noted	The Committee noted the Capital Management Group Chair Report.	N/A	
52	19-Aug-2024	Theatre Development Group Chair Report	None Noted	The Committee noted the Theatre Development Group Chair Report.	N/A	
53	19-Aug-2024	Review of Workplan and Attendance Matrix	None Noted	The Committee noted the Workplan and Attendance Matrix.	N/A	
54	23-Sep-2024	Operating Model	None Noted	The Committee noted the Operating Model paper.	N/A	
55	23-Sep-2024	Long Waiters Deep Dive	None Noted	The Committee noted the Long Waiters Deep Dive paper.	N/A	
56	23-Sep-2024	Financial Performance Report	None Noted	The Committee noted the Financial Performance Report.	N/A	
57	23-Sep-2024	Activity Mitigation Plan	None Noted	The Committee noted the Activity Mitigation Plan.	N/A	
58	23-Sep-2024	Medium Term Financial Plan	None Noted	The Committee noted the Medium-Term Financial Plan.	N/A	
59	23-Sep-2024	Trust Performance and Operational Improvement Meeting Chair Report	None Noted	The Committee noted the Trust Performance and Operational Improvement Meeting Chair Report.	N/A	
60	23-Sep-2024	Procurement Steering Group Chair Report	None Noted	The Committee noted the Procurement Steering Group Chair Report.	N/A	
61	23-Sep-2024	Capital Management Group Chair Report	None Noted	The Committee noted the Capital Management Group Chair Report.	N/A	
62	23-Sep-2024	Theatre Development Group Chair Report	None Noted	The Committee noted the Theatre Development Group Chair Report.	N/A	
63	23-Sep-2024	Review of Workplan and Attendance Matrix	None Noted	The Committee noted the Review of Workplan and Attendance Matrix.	N/A	
64	23-Sep-2024	Proposed process for managing patient choice and unfit patients	None Noted	The Committee noted the process for managing patient choice and unfit patients.	N/A	
65	25-Oct-2024	Corporate Risk Register	None Noted	The Committee noted the update.	N/A	
66	25-Oct-2024	Performance Report	None Noted	The Committee noted the update.	N/A	
67	25-Oct-2024	Long Waiters Presentation	None Noted	The Committee noted the update.	N/A	
68	25-Oct-2024	Activity Forecast and Mitigations	None Noted	The Committee noted the update.	N/A	
69	25-Oct-2024	Financial Report and Forecast	None Noted	The Committee noted the update.	N/A	
70	25-Oct-2024	Pay Review Q2 Report	None Noted	The Committee noted the update.	N/A	
71	25-Oct-2024	Productivity Report	None Noted	The Committee noted the update.	N/A	
72	25-Oct-2024	Specialist Efficiency Report	None Noted	The Committee noted the update.	N/A	
73	25-Oct-2024	PwC Action Plan	None Noted	The Committee noted the update.	N/A	
74	25-Oct-2024	ICS Finance Strategy	None Noted	The Committee noted the update.	N/A	
75	25-Oct-2024	Chair Report Trust Performance and Operational Improvement Group	None Noted	The Committee noted the update.	N/A	
76	25-Oct-2024	Chair Report Capital Management Group	None Noted	The Committee noted the update.	N/A	
77	25-Oct-2024	Chair Report Theatre Development Group	None Noted	The Committee noted the update.	N/A	
78	25-Oct-2024	Chair Report STW MSK Board	None Noted	The Committee noted the update.	N/A	
79	25-Nov-2024	Board Assurance Framework	None Noted	The Committee noted the update.	N/A	
80	25-Nov-2024	RJAH Financial Performance and Forecast	None Noted	The Committee noted the update.	N/A	
81	25-Nov-2024	Activity Forecast (2024/25)	None Noted	The Committee noted the update.	N/A	
82	25-Nov-2024	Productivity Dashboard	None Noted	The Committee noted the update.	N/A	
83	25-Nov-2024	Review of Theatres Estates Strategy (SOC)	None Noted	The Committee noted the update.	N/A	
84	25-Nov-2024	Specialist Unit Efficiency Delivery Update	None Noted	The Committee noted the update.	N/A	
85	25-Nov-2024	Veterans Business Case post implementation review	None Noted	The Committee noted the update.	N/A	

Finance and Performance Committee - ACTIVITY / DECISION LOG

Updated: 22 April 2025

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86	25-Nov-2024	EPR Delay Assessment	None Noted	The Committee noted the update.	N/A	
87	25-Nov-2024	Efficiency Programme -Standard Operating Procedure	None Noted	The Committee noted the update.	N/A	
88	25-Nov-2024	PwC Tracker	None Noted	The Committee noted the update.	N/A	
89	25-Nov-2024	Trust Performance and Operational Improvement Group Chair Report	None Noted	The Committee noted the update.	N/A	
90	25-Nov-2024	Veterans Strategy Oversight Group Chair Report	None Noted	The Committee noted the update.	N/A	
91	25-Nov-2024	Financial Improvement Group Chair Report	None Noted	The Committee noted the update.	N/A	
92	25-Nov-2024	STW MSK Board Chair Report	None Noted	The Committee noted the update.	N/A	
93	25-Nov-2024	Review of Workplan and Attendance Matrix	None Noted	The Committee noted the update.	N/A	
94	30-Dec-2024	Corporate Risk Register	None Noted	The Committee noted the update.	N/A	
95	30-Dec-2024	Performance Report	None Noted	The Committee noted the update.	N/A	
96	30-Dec-2024	Discretionary Spend NHSE Letter	None Noted	The Committee noted the update.	N/A	
97	30-Dec-2024	Pay Escalation Paper	None Noted	The Committee noted the update.	N/A	
98	30-Dec-2024	Financial Report and Forecast	None Noted	The Committee noted the update.	N/A	
99	30-Dec-2024	Activity Mitigation Plan	None Noted	The Committee noted the update.	N/A	
100	30-Dec-2024	Delivery Model Action Plan	None Noted	The Committee noted the update.	N/A	
101	30-Dec-2024	Productivity Waterfall	None Noted	The Committee noted the update.	N/A	
102	30-Dec-2024	Specialist Efficiency Report	None Noted	The Committee noted the update.	N/A	
103	30-Dec-2024	PWC Action Plan	None Noted	The Committee noted the update.	N/A	
104	30-Dec-2024	Service Line Reporting	None Noted	The Committee noted the update.	N/A	
105	30-Dec-2024	EPR Costing Deep Dive	None Noted	The Committee noted the update.	N/A	
106	30-Dec-2024	Planning Timetable 2025/26	None Noted	The Committee noted the update.	N/A	
107	30-Dec-2024	Trust Performance and Operational Improvement Group Chair Report	None Noted	The Committee noted the update.	N/A	
108	30-Dec-2024	Capital Management Group Chair Report	None Noted	The Committee noted the update.	N/A	
109	30-Dec-2024	Theatre Development Group Chair Report	None Noted	The Committee noted the update.	N/A	
110	30-Dec-2024	Financial Improvement Group Chair Report	None Noted	The Committee noted the update.	N/A	
111	30-Dec-2024	Procurement Steering Group Chair Report	None Noted	The Committee noted the update.	N/A	
112	30-Dec-2024	Review of Workplan and Attendance Matrix	None Noted	The Committee noted the update.	N/A	
113	30-Dec-2024	System Integrated Improvement Plan (SIIP)	None Noted	The Committee noted the update.	N/A	
114	30-Dec-2024	Risk Reflection	None Noted	The Committee noted the update.	N/A	
115	27-Jan-2025	Performance Report including Long Waiters	None Noted	The Committee noted the update.	N/A	
116	27-Jan-2025	Financial Report and Forecast	None Noted	The Committee noted the update.	N/A	
117	27-Jan-2025	Theatre Activity Mitigations Presentation	None Noted	The Committee noted the update.	N/A	
118	27-Jan-2025	EPR Costing Deep Dive	None Noted	The Committee noted the update.	N/A	
119	27-Jan-2025	Development of 2025/26 Plans	None Noted	The Committee noted the update.	N/A	
120	27-Jan-2025	Capital Management Group Chair Report	None Noted	The Committee noted the update.	N/A	
121	27-Jan-2025	Financial Improvement Group Chair Report	None Noted	The Committee noted the update.	N/A	
122	27-Jan-2025	Sustainability Group Chair Report	None Noted	The Committee noted the update.	N/A	
123	27-Jan-2025	Trust Performance and Operational Improvement Group Chair Report	None Noted	The Committee noted the update.	N/A	
124	27-Jan-2025	STW MSK Board Chair Report	None Noted	The Committee noted the update.	N/A	
125	27-Jan-2025	Review of Workplan and Attendance Matrix	None Noted	The Committee noted the update.	N/A	

Finance and Performance Committee - ACTIVITY / DECISION LOG

Updated: 22 April 2025

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126	13-Jan-2025 (Extraordinary)	Revised M10 Financial Report and Forecast	None Noted	The Committee approved the revised M10 Financial Report and Forecast.	N/A	
127	24-Jan-2025	Board Assurance Framework	None Noted	The Committee noted the update.	N/A	
128	24-Jan-2025	Business Case – Middle Grade Anaesthetists	None Noted	The Committee approved the Business Case - Middle Grade Anaesthetists.	N/A	
129	24-Jan-2025	NHSE Productivity Planning	None Noted	The Committee noted the update.	N/A	
130	24-Jan-2025	Operational Plan 2025/26	None Noted	The Committee noted the update.	N/A	
131	24-Jan-2025	Financial Plan 2025/26	None Noted	The Committee approved the draft headline financial plan 2025/26.	N/A	
132	24-Jan-2025	Workforce Plan 2025/26	None Noted	The Committee approved the draft headline workforce plan 2025/26.	N/A	
133	24-Jan-2025	Performance Report Including Long Waiters	None Noted	The Committee noted the update.	N/A	
134	24-Jan-2025	Theatre Activity Forecast including mitigations	None Noted	The Committee noted the update.	N/A	
135	24-Jan-2025	Financial Report and Forecast	None Noted	The Committee noted the update.	N/A	
136	24-Jan-2025	Capital Management Group Chair Report	None Noted	The Committee noted the update.	N/A	
137	24-Jan-2025	Financial Improvement Group Chair Report	None Noted	The Committee noted the update.	N/A	
138	24-Jan-2025	Procurement Group Chair Report	None Noted	The Committee noted the update.	N/A	
139	24-Jan-2025	System Integrated Improvement Plan	None Noted	The Committee noted the update.	N/A	
140	24-Jan-2025	Trust Performance and Operational Improvement Group Chair Report	None Noted	The Committee noted the update.	N/A	
141	24-Jan-2025	STW MSK Board Chair Report	None Noted	The Committee noted the update.	N/A	
142	24-Jan-2025	Review of Workplan and Attendance Matrix	None Noted	The Committee noted the update.	N/A	
143	24-Mar-2025	Salix Decarbonisation Bid	None Noted	The Committee approved the Salix Decarbonisation Bid.	N/A	
144	24-Mar-2025	Corporate Risk Register	None Noted	The Committee noted the update.	N/A	
145	24-Mar-2025	System Integrated Improvement Plan	None Noted	The Committee noted the update.	N/A	
146	24-Mar-2025	Performance Report including Long Waiters	None Noted	The Committee noted the update.	N/A	
147	24-Mar-2025	Theatre Activity Forecast Including Mitigations	None Noted	The Committee noted the update.	N/A	
148	24-Mar-2025	Financial Report and Forecast	None Noted	The Committee noted the update.	N/A	
149	24-Mar-2025	Capital Plan 2025/26	None Noted	The Committee approved the Capital Plan 2025/26.	N/A	
150	24-Mar-2025	Operational Plan Update	None Noted	The Committee noted the update.	N/A	
151	24-Mar-2025	Financial Plan Update	None Noted	The Committee noted the update.	N/A	
152	24-Mar-2025	Business Case and Investment Policy	None Noted	The Committee approved the Business Case and Investment Policy	N/A	
153	24-Mar-2025	Capital Management Group Chair Report	None Noted	The Committee noted the update.	N/A	
154	24-Mar-2025	Financial Improvement Group Chair Report	None Noted	The Committee noted the update.	N/A	
155	24-Mar-2025	Sustainability Group Chair Report	None Noted	The Committee noted the update.	N/A	
156	24-Mar-2025	Trust Performance and Operational Improvement Group Chair Report	None Noted	The Committee noted the update.	N/A	
157	24-Mar-2025	STW MSK Board Chair Report	None Noted	The Committee noted the update.	N/A	
158	24-Mar-2025	Review of Workplan and Attendance Matrix	None Noted	The Committee noted the update.	N/A	

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 ~~Planning~~ 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 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.

Strategy

- 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.

~~May 2024 — Finance and Performance Committee supported~~

~~June 2024 — Board of Directors approved~~

April 2025 - Finance and Performance Committee

May 2025 - Board of Directors

Chair's Assurance Report

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

Committee / Group / Meeting, Date

Board of Directors Meeting, 2nd July 2025

Author:

Name: Felicity Kipling
Role/Title: Executive Assistant

Contributors:

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 22nd May and 19th June 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.

Chair's Assurance Report

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

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.

EPR Implementation- Escalation of Clinical and Productivity Risks

May: Following initial post-implementation feedback, DERIC noted early operational gains and no reported patient harm. Positive signs of operational efficiencies post-launch, with plans to embed lessons learned. Nursing feedback indicated reduced medication errors, and pre-operative safety processes improved.

June: A series of formal letters from the consultant body have now flagged more substantial concerns. These relate primarily to medicines management functionality, validation list usability, and workflow disruption, with potential implications for patient safety and clinical productivity. As a result, a Clinical Reference Group has been convened with senior clinical representation across professions. Daily triage meetings, a live Clinical Safety Case, and a structured governance flow are now in place. The system has entered a formal risk transition phase, moving from programme delivery to embedded operational oversight. A governance diagram is being developed to clarify issue identification, escalation, and resolution pathways. Issues are also being categorised to inform future rollouts (e.g., known/unknown/cognitive). Corporate Risk Register integration is now underway. No patient harm has been reported. Although the situation remains within the expected post-go-live turbulence window (as advised by NHS England), the committee urges continued close scrutiny.

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:

Cyber Security

May: Routine reporting of phishing test outcomes indicated no cause for concern.

June: The committee was alerted to a rise in unpatched devices and repeat offenders in patching failures. There is also growing concern around the effectiveness and engagement level of current cyber training programmes. The committee welcomed creative ideas to improve engagement, such as simulation-lab escape rooms, but requires further assurance that current mitigation strategies are proportionate to threat level.

PACS Procurement

May: The Trust's decision to pursue an independent PACS procurement, rather than remain aligned with the West Midlands Imaging Network (WMIN), was supported in principle.

June: The Trust has now formally exited WMIN, with user dissatisfaction with the current provider escalating. A lack of defined governance structure and unclear timelines risk delaying strategic

Chair's Assurance Report

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

decisions. Collaboration with SaTH/UHNM is being explored, and DERIC will play a strategic advisory role. A business case will require cross-committee oversight, including Finance & Performance.

Medical Education Engagement and Strategic Alignment

May: While operational engagement from medical staff is strong, involvement in strategic education planning remains inconsistent. A review is underway to clarify expectations and improve alignment with leadership responsibilities.

June: This item is now explicitly incorporated into the DERIC workplan for visibility and action.

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.

Commercialisation Strategy Development

May: High levels of interest and a healthy idea pipeline have prompted the formation of a Commercialisation Review Group.

June: Work is ongoing to align innovation and commercialisation agendas, with monthly reporting and stakeholder engagement being established.

Innovation Story: Minor Diabetic Foot Service Pilot

June: The Committee welcomed a presentation from Chris Marquis and noted positive clinical outcomes and significant economic benefit from the newly launched (Jan 2025) Minor Diabetic Foot Service. The pilot is already showing promising impact in reducing diabetic foot complications, an area of particular concern locally, as Shropshire has historically been an outlier in national amputation rate data. A case for expansion is being explored, with support across the system.

Orthopaedic Institute Update

June: The Committee welcomed a presentation from Eric Evans in which it was noted the Institute has made a strong post-pandemic recovery in course delivery and research activity. Strategic improvements to fundraising have already generated a high volume of bid submissions. The Committee expressed continued support and welcomed further collaboration.

Education Strategy Delivery and Outcomes

May: Strong progress noted, with six accredited CPD courses launched, multidisciplinary working groups established, and plans for University Hospital status initiated. AI and digital skills training has been integrated into library strategy. The Committee praised the ambition and alignment to wider digital priorities.

June: Interim arrangements for medical device training have been implemented.

Research Governance and Financial Performance

May: A strong year-end position (deficit reduced from £65k to £15k) with robust national benchmarking. Audit recommendations largely addressed.

June: Concerns were raised that current financial reporting may misrepresent position; review underway to ensure clarity and accuracy.

Innovation & Improvement Update

May: Finalised strategy and delivery plan approved, including KPIs, staff upskilling, and visual design enhancements.

June: Improvement programmes (e.g. Improvement Advocates) have achieved CPD certification. Progress was reported in improvement self-assessment, though one area showed a drop due, likely due to more realistic scoring. The Committee endorsed the cultural shift toward greater transparency.

Corporate Risk Register Oversight

May: Significant progress on longstanding risks (e.g., radiology and orthotics systems), with confirmed funding and implementation underway.

June: A number of EPR risks are now being formally recorded as operational issues.

Chair's Assurance Report

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

Committee Governance:

The annual report, self-assessment, work plan, and attendance matrix were reviewed. No concerns identified.

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.

Digital, Education, Research, Innovation and Commercialisation Committee Annual Report 2024/25

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 02 July 2025

Author:

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Contributors:

Report sign-off:

Name: Dylan Murphy, Trust Secretary
Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee, 19 June 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.

In line with good practice, the committees of the Board undertake an annual review of their operation and effectiveness. This involves:

- Reviewing the role of the committee, its key responsibilities, membership and business considered during the year.
- A questionnaire on the effectiveness of the operation of the committee (completed by individual members / core attendees).
- A self-assessment against key governance questions (for collective consideration).
- Review of the terms of reference to ensure the focus of the Committee remains relevant in 2025/26

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

Recommendation:

That the Board note that, at the June meeting, the Committee:

1. **Noted** the report;
2. **Considered** the outcome of the committee effectiveness survey and did not identify any required actions;
3. **Considered and agreed** the draft self-assessment document (as included at section 8);
4. **Noted** the 2024/25 Decision / activity log (as included at attachment A).
5. **Considered** the draft Terms of Reference for 2025/26 (as included at attachment B) and recommended that the Board approve them.

Digital, Education, Research, Innovation and Commercialisation Committee Annual Report 2024/25

The Board is therefore asked to consider and approve the proposed terms of reference for 2025/6.

Report development and engagement history:

This report has been produced from existing documentation. The self-assessment and TOR are initial drafts for consideration – they have not been considered or approved by any other forum or individual.

Next steps:

Any issues of concern, or apparent gaps in the governance arrangements, that are identified will be reported to the Audit and Risk Committee for consideration.

Appendices

Attachment A Committee Activity/Decision Log 2024/25

Attachment B Terms of Reference 2025/26

Digital, Education, Research, Innovation and Commercialisation Committee Annual Report 2024/25

1. Committee Roles and Responsibilities (2024/25)

The key responsibilities of the Committee are as follows:

Digital

- Consider the Trust's digital and data strategy and make a recommendation to the Board on its approval.
- Oversee the delivery of the Trust's digital and data strategy.
- Consider the underpinning governance arrangements that support delivery of the Trust's digital and data strategy / agenda.
- Receive Chair's Assurance reports from relevant meetings that support delivery of this strategy / agenda.

Research

- Consider the Trust's research strategy and make a recommendation to the Board on its approval.
- Oversee the delivery of the Trust's research strategy.
- Consider the underpinning governance arrangements that support delivery of the Trust's research strategy / agenda.
- Receive Chair's Assurance reports from relevant meetings that support delivery of this strategy / agenda.

Education

- Consider the Trust's education strategy and make a recommendation to the Board on its approval.
- Oversee the delivery of the Trust's education strategy.
- Consider the underpinning governance arrangements that support delivery of the Trust's education strategy / agenda.
- Receive Chair's Assurance reports from relevant meetings that support delivery of this strategy / agenda.

Innovation

- Consider the Trust's innovation strategy and make a recommendation to the Board on its approval.
- Oversee the delivery of the Trust's innovation strategy.
- Consider the underpinning governance arrangements that support delivery of the Trust's innovation strategy / agenda.
- Receive Chair's Assurance reports from relevant meetings that support delivery of this strategy / agenda.

Commercialisation

- Consider the Trust's commercialisation opportunities and make appropriate recommendations to the Board.
- Oversee the delivery of any of the Trust's commercial / business development activities.
- Consider the underpinning governance arrangements that support delivery of the Trust's business development strategy / agenda.
- Receive Chair's Assurance reports from relevant meetings that support delivery of this strategy / agenda.

2. Membership (2024/25)

The membership section of the current terms of reference is:

- Up to 4 Non-Executive Directors
- Chief Medical Officer (Executive Lead)
- Chief People and Culture Officer

Digital, Education, Research, Innovation and Commercialisation Committee Annual Report 2024/25

3. Meetings (2024/25)

During 2024/25, the committee met on 10 occasions. It was noted that all meetings were quorate.

4. Committee Attendance (2024/25)

Overall, good attendance has been noted from all core members of the meeting.

Name	Title	Attendance
Core Membership		
Martin Evans	Non-Executive Director (Chair)	09 / 10 90%
Penny Venables	Non-Executive Director	07 / 08 88%
Atif Ishaq	Associate Non-Executive Director	09 / 10 90%
John Pepper	Associate Non-Executive Director	09 / 10 90%
Ruth Longfellow	Chief Medical Officer	09 / 10 90%
Denise Harnin	Chief People and Culture Officer	05 / 10 50%
In Attendance		
Dylan Murphy	Trust Secretary	09 / 10 90%
Mike Carr	Chief Operating Officer	06 / 10 60%
Paul Kavanagh-Fields	Chief Nurse and Patient Safety Officer	03 / 08 38%
Simon Adams	Director of Digital	07 / 10 70%
Sam Young	Deputy Chief Nurse and DIPC (CNIO)	07 / 10 70%
Lis Edwards	Head of Learning and Development	07 / 10 70%
Andrew Roberts	Director of Research, Audit, Outcomes and Innovation	08 / 10 80%
Sammy Davies	Outcomes Manager	08 / 10 80%

5. Committee Activity and Decision Log (2024/25)

The business considered by the Committee during the year is included at attachment A.

6. Conduct of Meetings (2024/25)

The Committee conducted its business in accordance with the provisions of the Trust's constitution and terms of reference.

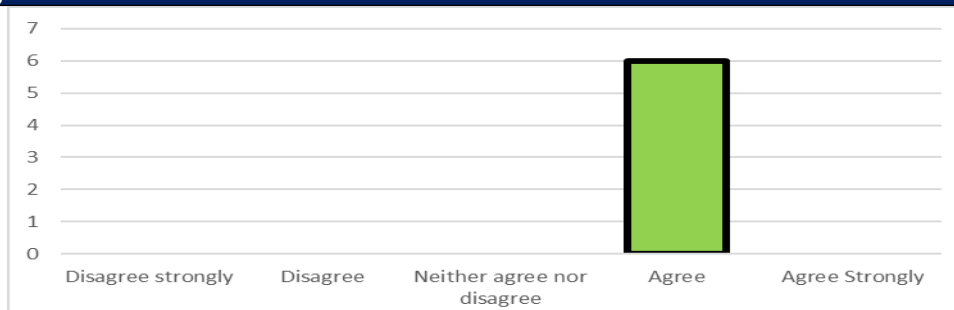
Formal minutes of the meeting were produced which included a record of the attendees present at the meeting. The Committee provided an update to the Board via the Chair's Assurance Report to the Board of Directors following each meeting.

Digital, Education, Research, Innovation and Commercialisation Committee Annual Report 2024/25

7. Committee Effectiveness Survey (2024/25)

The Committee effectiveness survey was circulated to a total of 10 people (core members and frequent attendees of the meeting). There was a total of 6 responses received.

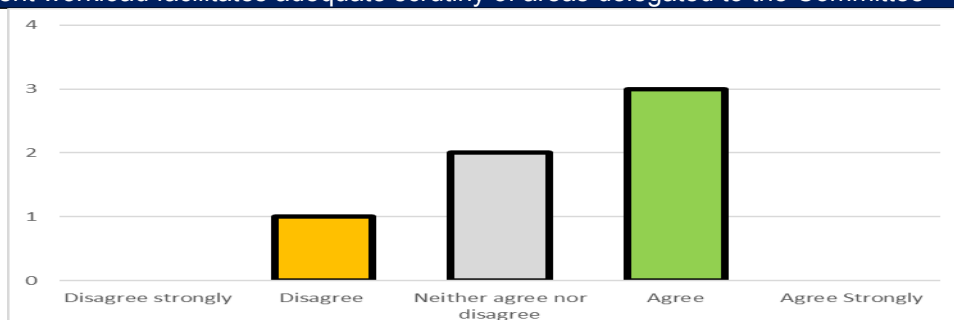
Q1 The work plan gives appropriate coverage to the areas which I consider that it should be covering



Comments

- I think there is overlap of topics into other Committee's and Meetings which would be relevant for DERICC.
- A lot of areas to cover for one committee so work plan is heavy right now

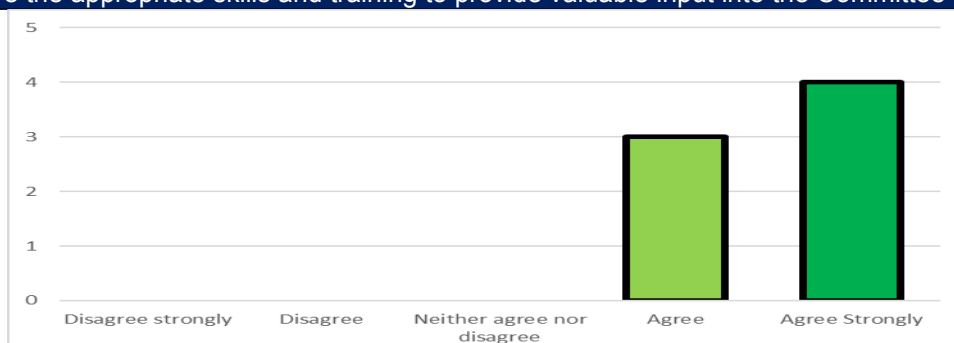
Q2 Current workload facilitates adequate scrutiny of areas delegated to the Committee



Comments

- I think the meeting and agenda is continuing to develop - the fact are of business now has a strategy and delivery plan or soon will have will also help to develop the content and scrutiny of key areas by the committee.

Q3 I have the appropriate skills and training to provide valuable input into the Committee

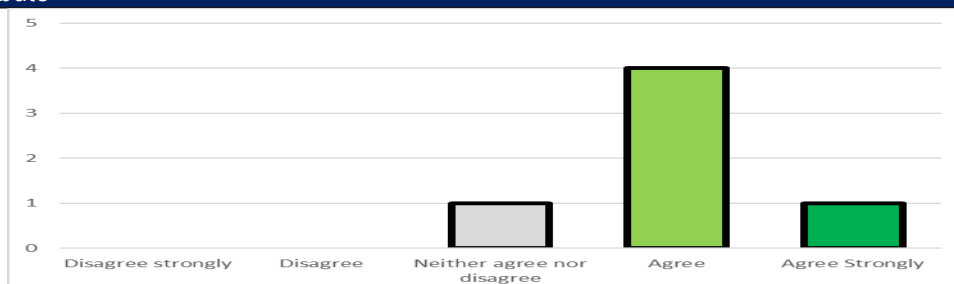


Comments

- There are no responses.

Digital, Education, Research, Innovation and Commercialisation Committee Annual Report 2024/25

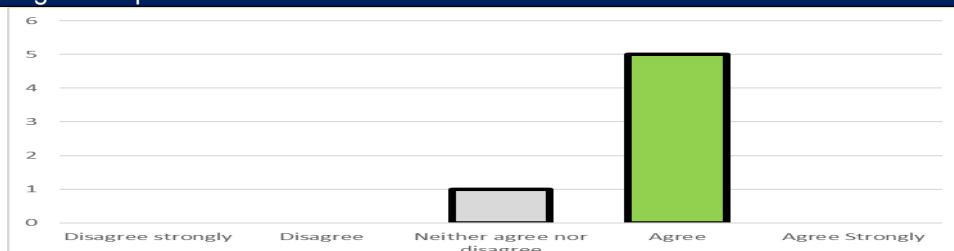
Q4 I consider that the meetings are well chaired and that members are given sufficient opportunity to contribute



Comments

- I believe that it is important to recognise that this meeting has, quite rightly, a different feel to other assurance committees where more time is spent talking about opportunities moving forward as well as to overseeing delivery of business.

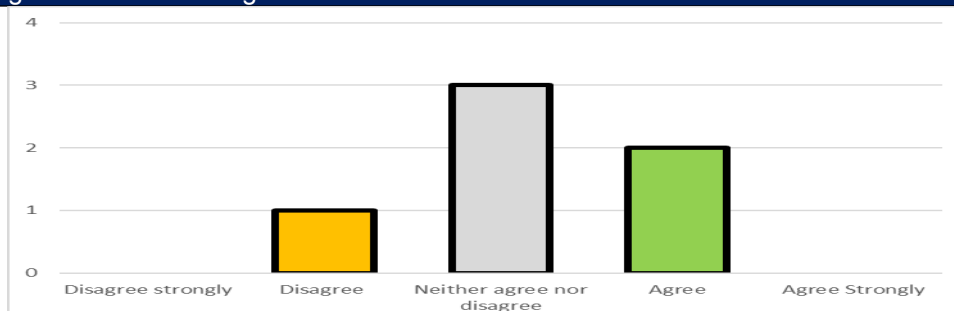
Q5 I consider that the time spent on each agenda item is appropriate and sufficient for scrutiny and challenge as required



Comments

- There are no responses.

Q6 I have received the information which I require to consider the Trust's risks to delivery of the DERIC agenda and their mitigations

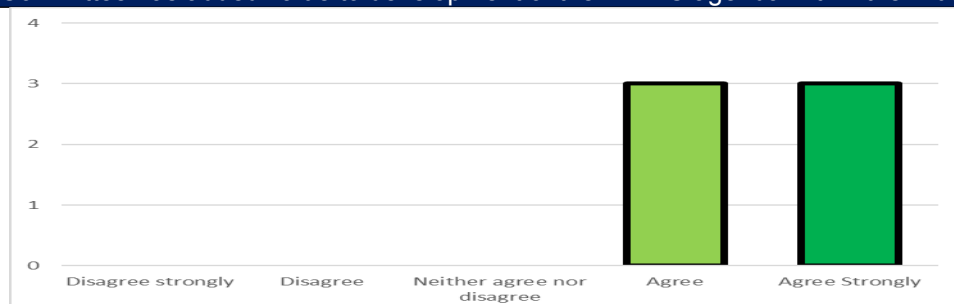


Comments

- Work in progress as this committee matures
- KPIs still being developed

Digital, Education, Research, Innovation and Commercialisation Committee Annual Report 2024/25

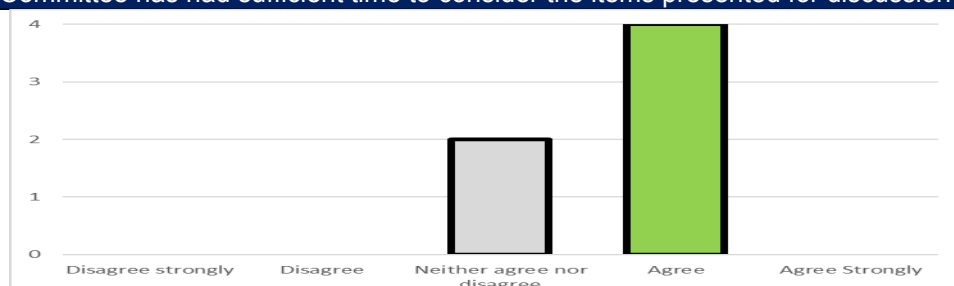
Q7 The Committee has added value to development of the DERIC agenda within the Trust



Comments

- Although still developing as a committee I believe that it has already added value to some key areas of business within the Trust and provided some individuals and areas of business a forum to oversee important areas of business which was previously not there.

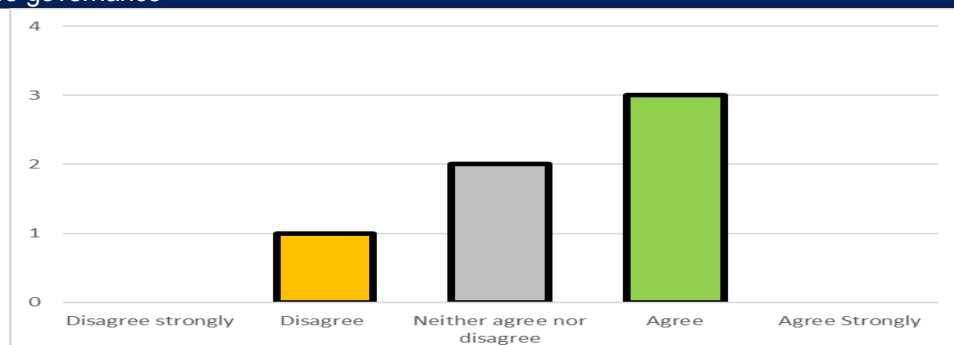
Q8 The Committee has had sufficient time to consider the items presented for discussion



Comments

- Not always received on time

Q9 The quality of the papers and presentations ensure the Committee can add value and rigour to workforce governance



Comments

- This is improving
- Lack of detail in some cases, items regularly postponed, ownership of actions not always present.
- Still some work required on refining information for a Board Sub-Committee.

Digital, Education, Research, Innovation and
Commercialisation Committee Annual Report 2024/25

8. Committee Self-Assessment (2024/25)

Area / Question	Response	Comments / Action
Composition, Establishment and Duties		
Does the committee have written terms of reference that adequately and realistically define the Committees role?	Yes	Approved by the Board of Directors and incorporated into the Board Governance Pack.
Have the terms of reference been adopted by the Board?	Yes	As above.
Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?	Yes	Yes annual review is included in the work plan with ad hoc changes made as and when required throughout the year.
Are committee members independent of the management team?	Yes	The committee is chaired by a Non-Executive and has other Non-Executives within its membership.
Are members, particularly those new to the committee provided with relevant training?	N/A	There is no formal training for this Committee but executives are available as required to talk through the role of the committee, the nature of the discussion etc.
Has the committee established a plan for the conduct of its own work across the year?	Yes	This is set for the financial year ahead and reviewed on a monthly basis as a standard agenda item for the meeting.
Are changes to the current and future workload discussed and approved at Board level?	Yes	The remit is set by the Board through approval of the terms of reference and the workplans are reviewed at each committee meeting with an overview of any changes presented to the Board via the Chair's Report.
Does the committee report to the Board regularly?	Yes	The chair of the committee presents an assurance report to the Board on a bi-monthly basis.
Does the committee assess its own effectiveness periodically?	Yes	This is undertaken annually as part of the committee annual report.
Does the committee prepare an annual report on its work and performance in the preceding year?	Yes	It is presented to the Committee and considered alongside the self-assessment.
Has the committee been quorate for each meeting this year?	Yes	This is confirmed by the minutes of the meeting and reported to the Board as part of the assurance report.
Compliance with the Law and Regulations Governing the NHS		
Does the committee review assurance and regulatory compliance reporting processes?	Partially	This is undertaken by the committee in relation to issues within its remit and assurance is provided to the Board via the Chair's report. The Committee does not perform a standard assurance function (other than Digital) however and its outlook is more developmental / forward-looking.

Digital, Education, Research, Innovation and Commercialisation Committee Annual Report 2024/25

Does the committee have a mechanism to keep it aware of topical, legal and regulatory issues?	Yes	These would be escalated through the Trust's governance framework. The Trust's Executive Team provide updates as required.
Internal Control		
Has the committee formally considered how it integrates with other committees?	Yes	Committee TOR have been reviewed simultaneously to ensure appropriate coverage across the Board committees. Matters can be escalated up to the Board, or sideways to appropriate committees, as appropriate. Work on going with People & Culture committee to ensure clarity on which elements of the Education strategy report into which assurance committee.
Has the Committee formally considered how its work integrates with the wider performance management and standards compliance?	Partially	The Committee KPIs and Integrated Performance Report are in development. As noted above, the primary focus of the committee is developmental / forward-looking, rather than providing a traditional assurance function.
Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?	Yes	This was considered during the committee survey. It was acknowledged that the nature of reports to the committee was still developing.
Administrative Arrangements		
Does the committee have a plan of matters to be dealt with over the coming year?	Yes	This is set for the financial year ahead and reviewed on a monthly basis as a standard agenda item for the meeting.
Are papers circulated in good time and are minutes received as soon as possible after the meetings?	Yes	There are occasions when papers need to be delayed but the packs are circulated with good time and updated with papers that have been delayed for genuine reasons. If papers have been delayed to such an extent that the committee would not have sufficient time to consider them, they are deferred to the next meeting.
Does the committee meet the appropriate number of times a year?	Yes	The committee meets on a monthly basis.
Other Issues		
Does the Annual Report include a description of the committee's establishment and activities?	Yes	This is included in the Annual Governance Statement

Digital, Education, Research, Innovation and Commercialisation Committee Annual Report 2024/25

9. Forward look into 2025/26

To support with continuous improvement of the DERIC Committee, members are asked to review the Terms of Reference and consider any required revisions for 2025/26.

10. Recommendation

That the Board note that, at the April meeting, the Committee:

1. **Noted** the report;
2. **Considered** the outcome of the committee effectiveness survey and did not identify any required actions;
3. **Considered and agreed** the draft self-assessment document (as included at section 8);
4. **Noted** the 2024/25 Decision / activity log (as included at attachment A).
5. **Considered** the draft Terms of Reference for 2025/26 (as included at attachment B) and recommended that the Board approve them.

The Board is therefore asked to consider and approve the proposed terms of reference for 2025/6.

DERIC Committee - ACTIVITY / DECISION LOG
Updated: March 2025

Decision Ref No.	Meeting Date	Topic/Agenda item	Conflicts of interest considered and agreed treatment of the conflict	Conclusion/Decision (e.g. Approved, Noted, Recommended ... etc. SEE <i>"Decision" Types</i> tab for guidance)	If applicable - results of vote and/or dissenting views	If Recommendation - destination for onward submission?
1	24 April 2024	Corporate Risk Register	None noted	The Committee considered and subsequently noted the report.		
2	24 April 2024	Research Update	None noted	The Committee considered and subsequently noted the report.		
3	24 April 2024	Education Update	None noted	The Committee considered and subsequently noted the report.		
4	24 April 2024	Innovation	None noted	The Committee considered and subsequently noted the report.		
5	24 April 2024	Digital	None noted	The Committee considered and subsequently noted the report.		
6	24 April 2024	Review of the workplan	None noted	The Committee considered and subsequently noted the report.		
7	23 May 2024	DERIC Infographic for Trust Strategy	None noted	The Committee discussed and subsequently noted the report.		
8	23 May 2024	Innovation	None noted	The Committee discussed and subsequently noted the report.		
9	23 May 2024	Improvement Champions	None noted	The Committee discussed and subsequently noted the report.		
10	23 May 2024	Board Assurance Framework	None noted	The Committee considered and subsequently noted the report.		
11	23 May 2024	Chair's Report	None noted	The Committee noted the following Chair Reports: Research meeting, EPR Implementation Assurance Meeting		
12	23 May 2024	Annual Research Update	None noted	The Committee considered and subsequently noted the report.		
13	23 May 2024	Cyber Security Report	None noted	The Committee considered and subsequently noted the report.		
14	23 May 2024	MFA Progress Update	None noted	The Committee considered and subsequently noted the report.		
15	23 May 2024	Education Strategy Update	None noted	The Committee considered and subsequently noted the report.		
16	23 May 2024	Library Annual Report	None noted	The Committee considered and subsequently noted the report.		
17	23 May 2024	Review of workplan/attendance matrix	None noted	The Committee considered and subsequently noted the report.		
18	26 June 2024	Ascot Trial Presentation	None noted	The Committee discussed and subsequently noted the report.		
19	26 June 2024	Chair's Report	None noted	The Committee noted the following Chair Reports: Research meeting and EPR Implementation Assurance Meeting		
20	26 June 2024	MyRecovery	None noted	The Committee discussed and subsequently noted the report.		
21	26 June 2024	Corporate Risk Register	None noted	The Committee considered and subsequently noted the report.		
22	26 June 2024	Cyber Security Report	None noted	The Committee discussed and subsequently noted the report.		
23	26 June 2024	Working Group for nurses and AHPs	None noted	The Committee considered and subsequently noted the report.		
24	26 June 2024	Review of workplan/attendance matrix	None noted	The Committee considered and subsequently noted the report.		
25	22 July 2024	Innovation Story: GTPS Shockwave Therapy	None noted	The Committee discussed and subsequently noted the report.		
26	22 July 2024	Delivery of Innovation	None noted	The Committee discussed and subsequently noted the report.		
27	22 July 2024	Research Annual Report	None noted	The Committee approved the report.		
28	22 July 2024	Chair's Report: EPR Implementation Assurance Meeting	None noted	The Committee discussed and subsequently noted the report.		
29	22 July 2024	Cyber Security Report	None noted	The Committee considered and subsequently noted the report.		

DERIC Committee - ACTIVITY / DECISION LOG
Updated: March 2025

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30	22 July 2024	Education and Training Strategy	None noted	The Committee discussed and subsequently noted the report.		
31	22 July 2024	Library and Knowledge Strategy	None noted	The Committee approved the strategy		
32	22 July 2024	Update on Commercialisation Role	None noted	The Committee considered and subsequently noted the report.		
33	22 July 2024	Attendance Matrix	None noted	The Committee noted the attendance matrix		
34	19 September 2024	Board Assurance Framework	None noted	The Committee discussed and subsequently noted the report.		
35	19 September 2024	Innovation Story: Empowering Metabolic Bone Care Through Research and Digital Evolution	None noted	The Committee discussed and subsequently noted the report.		
36	19 September 2024	Chair's Report	None noted	The Committee noted the following Chair Reports: Research meeting and EPR Implementation Assurance Meeting		
37	19 September 2024	Research Manager Overview	None noted	The Committee considered and subsequently noted the report.		
38	19 September 2024	Digital Security Report	None noted	The Committee considered and subsequently noted the report.		
39	19 September 2024	Education and Training Strategy- medical engagement update	None noted	The Committee considered and subsequently noted the report.		
40	19 September 2024	Update on Commercialisation role	None noted	The Committee considered and subsequently noted the report.		
41	19 September 2024	Workplan and Attendance Matrix	None noted	The Committee noted the Workplan and Attendance Matrix		
42	24 October 2024	Innovation Story: Medical Device QR videos	None noted	The Committee considered and subsequently noted the report.		
43	24 October 2024	Delivery of Innovation Strategy and Quality Improvement Training	None noted	The Committee discussed and subsequently noted the report.		
44	24 October 2024	Corporate Risk Register	None noted	The Committee considered and subsequently noted the report.		
45	24 October 2024	Chair's Report	None noted	The Committee noted the following Chair Reports: Research meeting, Nursing and AHP Research Working Group, MDT Education Strategy Working Group and EPR Implementation Assurance Meeting		
46	24 October 2024	Digital Security Report	None noted	The Committee discussed and subsequently noted the report.		
47	24 October 2024	Update on development of commercialisation capability	None noted	The Committee considered and subsequently noted the report.		
48	24 October 2024	Review of Committee Effectiveness	None noted	The Committee considered and subsequently noted the report.		
49	24 October 2024	Workplan and Attendance Matrix	None noted	The Committee noted the Workplan and Attendance Matrix		
50	20 November 2024	EPR Implementation	None noted	The Committee discussed and subsequently noted the report.		
51	20 November 2024	PACS/RIS Update	None noted	The Committee discussed and subsequently noted the report.		
52	20 November 2024	Performance Challenges	None noted	The Committee discussed and subsequently noted the report.		
53	20 November 2024	Board Assurance Framework	None noted	The Committee considered and subsequently noted the report.		
54	20 November 2024	Workplan and Attendance Matrix	None noted	The Committee noted the Workplan and Attendance Matrix		
55	23 January 2025	Innovation Story: Human Factors Workshop	None noted	The Committee considered and subsequently noted the report.		
56	23 January 2025	Corporate Risk Register	None noted	The Committee considered and subsequently noted the report.		

DERIC Committee - ACTIVITY / DECISION LOG
Updated: March 2025

Decision Ref No.	Meeting Date	Topic/Agenda item	Conflicts of interest considered and agreed treatment of the conflict	Conclusion/Decision (e.g. Approved, Noted, Recommended ... etc. SEE <i>"Decision" Types</i> tab for guidance)	If applicable - results of vote and/or dissenting views	If Recommendation - destination for onward submission?
57	23 January 2025	Chair's Report	None noted	The Committee noted the following Chair Reports: Research meeting, Multidisciplinary Education Working group, Education and Training Oversight Meeting. EPR Implementation Assurance		
58	23 January 2025	Delivery of the Research Strategy and associated plans & programmes	None noted	The Committee considered and subsequently noted the report.		
59	23 January 2025	Ambient Voice for Productivity	None noted	The Committee considered and subsequently noted the report.		
60	23 January 2025	Digital Security Report	None noted	The Committee considered and subsequently noted the report.		
61	23 January 2025	Digital/Cyber Strategy Update	None noted	The Committee discussed and subsequently noted the report.		
62	23 January 2025	PACS Update	None noted	The Committee considered and subsequently noted the report.		
63	23 January 2025	Workplan and Attendance Matrix	None noted	The Committee noted the Workplan and Attendance Matrix		
64	27 February 2025	Innovation Story: Research	None noted	The Committee discussed and subsequently noted the report.		
65	27 February 2025	Board Assurance Framework	None noted	The Committee considered and subsequently noted the report.		
66	27 February 2025	Chair's Report	None noted	The Committee noted the following Chair Reports: EPR Implementation Assurance Meeting and Research Meeting		
67	27 February 2025	Digital Security Report	None noted	The Committee discussed and subsequently noted the report.		
68	27 February 2025	Digital Innovation Support	None noted	The Committee discussed and subsequently noted the report.		
69	27 February 2025	Hospital University status	None noted	The Committee considered and subsequently noted the report.		
70	27 February 2025	Delivery of the Research Strategy and associated plans & programmes	None noted	The Committee considered and subsequently noted the report.		
71	27 February 2025	Innovation Strategy	None noted	The Committee discussed and subsequently noted the report.		
72	27 February 2025	Top 10 Innovation Projects	None noted	The Committee considered and subsequently noted the report.		
73	27 February 2025	Work Plan and Attendance Matrix	None noted	The Committee noted the Workplan and Attendance Matrix		
74	27 February 2025	Development of Dashboards/KPI's	None noted	The Committee discussed and subsequently noted the report.		
75	27 March 2025	ICS Digital Strategy and Peer Review with David Maruta	None noted	The Committee discussed and subsequently noted the report.		
76	27 March 2025	Corporate Risk Register	None noted	The Committee considered and subsequently noted the report.		
77	27 March 2025	Chair's Report	None noted	The Committee noted the following Chair Reports: EPR Implementation Assurance Meeting, Digital Transformation Programme Board, Multidisciplinary Education Working Group and Research Meeting		
78	27 March 2025	Digital Security Report	None noted	The Committee considered and subsequently noted the report.		
79	27 March 2025	PACS Update	None noted	The Committee discussed and subsequently noted the report.		
80	27 March 2025	Research Strategy	None noted	The Committee Approved the Research Strategy		
81	27 March 2025	SimLab Presentation and Demo	None noted	The Committee considered and subsequently noted the report.		

DERIC Committee - ACTIVITY / DECISION LOG
Updated: March 2025

Decision Ref No.	Meeting Date	Topic/Agenda item	Conflicts of interest considered and agreed treatment of the conflict	Conclusion/Decision (e.g. Approved, Noted, Recommended ... etc. SEE " <i>Decision</i> " Types tab for guidance)	If applicable - results of vote and/or dissenting views	If Recommendation - destination for onward submision?
82	27 March 2025	Workplan and Attendance Matrix	None noted	The Committee noted the Workplan and Attendance Matrix		

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1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Digital, Education, Research, Innovation and Commercialisation (DERIC) 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 and Executive Directors of the Trust and shall consist of:

- Up to 4 Non-Executive Directors
- Chief Medical Officer (Executive Lead)
- Chief People and Culture Officer
- Chief Finance and Commercial 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 Chairman 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 2 Non-Executive members and 2 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 following will be expected to attend each meeting:

- Director of Digital;
- Director of Research, Audit, Outcomes and Innovation;
- Chief Nursing Information Officer;
- Nursing / AHP Workforce Lead
- Trust Secretary; and
- Radiology Service Manager

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.

Senior Managers and Unit Representatives will be required to attend the meeting when presenting a paper. This may include, but is not limited to, the following:

- Outcomes Manager
- Clinical Audit Lead
- Director of Medical Education
- Training Programme Directors

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Terms of Reference

Digital, Education, Research, Innovation and Commercialisation Committee

- Head of Knowledge and Learning
- Research Manager
- EPR Manager

The Chief Medical 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 at least 10 times a year for regular business. The Committee will not normally meet in August and December. The Chair of the Committee may call additional meetings.

5. Authority

The Committee is authorised by the Board to develop and implement research, education, training and business development strategies, and to monitor, investigate and address any activity within its terms of reference. It is authorised to seek a range of views and expertise and request the attendance of individuals and advisors with relevant experience and expertise where necessary.

The Committee is also authorised to undertake or consider on behalf of the Chairman or the Board such other related tasks or topics as the Chairman or the Board may from time to time entrust to the Committee.

6. Reporting

The Chair of the Committee will report to the Board at the first Board meeting following the meeting of the Committee. 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.

Terms of reference are reviewed annually or in light of changes in practice or national/local guidance. The Committee will undertake an annual self-assessment, which will be presented to the Trust's Board. This will include a summary of activity undertaken and an assessment of how effectively the Committee has delivered its terms of reference.

7. Key Responsibilities**Digital**

- Consider the Trust's digital and data strategy and make a recommendation to the Board on its approval.

Terms of Reference

Digital, Education, Research, Innovation and Commercialisation Committee

- Oversee the delivery of the Trust's digital and data strategy.
- Consider the underpinning governance arrangements that support delivery of the Trust's digital and data strategy / agenda.
- Receive Chair's Assurance reports from relevant meetings that support delivery of this strategy / agenda.

Research

- Consider the Trust's research strategy and make a recommendation to the Board on its approval.
- Oversee the delivery of the Trust's research strategy.
- Consider the underpinning governance arrangements that support delivery of the Trust's research strategy / agenda.
- Receive Chair's Assurance reports from relevant meetings that support delivery of this strategy / agenda.

Education

- Consider the Trust's education strategy and make a recommendation to the Board on its approval.
- Oversee the delivery of the Trust's education strategy.
- Consider the underpinning governance arrangements that support delivery of the Trust's education strategy / agenda.
- Receive Chair's Assurance reports from relevant meetings that support delivery of this strategy / agenda.

Innovation

- Consider the Trust's innovation strategy and make a recommendation to the Board on its approval.
- Oversee the delivery of the Trust's innovation strategy.
- Consider the underpinning governance arrangements that support delivery of the Trust's innovation strategy / agenda.
- Receive Chair's Assurance reports from relevant meetings that support delivery of this strategy / agenda.

Commercialisation

- Consider the Trust's commercialisation opportunities and make appropriate recommendations to the Board.
- Oversee the delivery of any of the Trust's commercial / business development activities.
- Consider the underpinning governance arrangements that support delivery of the Trust's business development strategy / agenda.
- Receive Chair's Assurance reports from relevant meetings that support delivery of this strategy / agenda.

Policies

- Review and ratify the Trust's digital, research, innovation, education, training and business development policies.
- Review compliance with policies relevant to the remit of the Committee.

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Terms of Reference

Digital, Education, Research, Innovation and Commercialisation Committee

Oversight and Scrutiny

- Receive and consider chair's reports from meetings/groups that support the work of the Committee.
- Monitor progress in delivering relevant internal audit report recommendations.
- Oversee arrangements for managing Board Assurance Framework and other high-level risks related to the remit of the Committee.

DRAFT

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Digital Strategy

Committee/Meeting, Date

Board of Directors, 02 July 2025

Author:Name: Simon Adams
Role/Title: Digital Director**Contributors:**Name:
Role/Title:**Report sign-off:**

Digital, Education, Research, Innovation and Commercialisation Committee, 24 April 2025

Is the report suitable for publication?:

Yes

Key issues and considerations:

The purpose of this report is to present the Digital Strategy for approval - outlining the key initiatives and technological advancements necessary to enhance patient care, operational efficiency, and research capabilities.

This strategy aligns with the hospital's broader goals for digital transformation and seeks approval and support from the Digital, Education, Research, Innovation, and Commercialisation Committee to ensure successful implementation.

The Strategy has been through internal governance in both the development and approval process.

This paper is being presented to this committee as the strategy falls within the committee's terms of reference, particularly regarding the integration of digital solutions in education, research, innovation, and clinical practice.

The committee's approval is requested for moving forward with the outlined initiatives, ensuring alignment with both the hospital's strategic vision and evolving digital healthcare trends.

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 ✓

Digital Strategy

2	Tackle inequalities in outcomes, experience and access	✓
3	Support broader social and economic development	✓
4	Enhance productivity and value for money	✓

Report development and engagement history:

The development of the Digital Strategy 2025–2027 has been informed by extensive engagement across a broad range of stakeholders to ensure it reflects the needs and priorities of the organisation. Input was gathered through multiple forums, including the Executive Team Meeting, Apollo Engagement Sessions, and one-to-one discussions with senior leaders. Key clinical and operational perspectives were incorporated through the MSK Board Meeting, Specialist Services Board Meeting, and sessions with senior nurses and allied health professionals. The Patient Engagement Group provided valuable insight from a service user perspective, while strategic oversight and alignment were supported through the Digital Transformation Board and the Trust Management Board. To ensure inclusivity and staff-wide input, open drop-in sessions were also made available to all staff across the Trust.

Next steps:

Following feedback and endorsement at the Digital, Education, Research, Innovation and Commercialisation Committee, the strategy is presented to the Board for formal approval by the Trust Board.

Following approval, a detailed implementation plan will be developed, including clear timelines, resource requirements, and defined responsibilities. Key performance indicators will be established to monitor progress against strategic objectives. Ongoing engagement with clinical and operational teams will continue to ensure alignment with frontline needs, and regular updates will be provided to the Digital Transformation Board and other relevant governance groups to track delivery, manage risks, and adapt to emerging opportunities or challenges.

Digital Services Strategy 2025-29



*Improving Lives through
excellent and innovative care*



www.rjah.nhs.uk

NHS



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Foreword by Chief Nursing Information Officer

As the Chief Nursing Information Officer at the Robert Jones and Agnes Hunt Orthopaedic Hospital, I am proud to introduce our **Digital Strategy for 2025-2029**. At the heart of this strategy is our commitment to providing the highest quality of care to our patients, ensuring that we **harness the power of technology** to enhance both clinical outcomes and patient experiences.

Over the next few years, we aim to build upon our strong foundation in digital healthcare by integrating innovative solutions that support the multidisciplinary work of our teams. This will include advancing our digital systems, improving data accessibility, and promoting collaboration between care providers. By doing so, we will not only streamline processes but also ensure that our clinical teams have the tools they need to deliver personalised, efficient, and safe care.

Our goal is to create a forward-thinking, digitally enabled environment that empowers our staff and fosters a culture of continuous improvement. Through this strategy, we are excited to shape the future of care at the Robert Jones and Agnes Hunt Orthopaedic Hospital, prioritising the wellbeing of our patients and improving lives through excellent and innovative care.

Sam Young

Chief Nursing Information Officer



As a clinician, I know that better information leads to better outcomes. The Trust has spent years planning the £10 million Apollo programme, integrating digital pharmacy and Order Communications to enhance care. Managing this change will require focus, especially during the first phase, as some processes will take longer than paper-based systems.

Building on Apollo, AI offers adoption opportunities, reformatting patient encounters into records and correspondence. Deeper AI and Apollo integration will simplify care delivery with voice-driven interactions for clinic outcomes, test requests, and prescriptions. Clinicians' focus will remain on patients, increasing job satisfaction.

Digital patient connections through the NHS App will provide education and support, helping refine care. We must ensure no patients are left behind digitally.

Another focus is extracting value from collected information, offering insights to improve clinical services. This links to innovation and research. Operational performance data will be available on-demand for staff, improving care and services. Extensive data from Apollo will require Clinical Scientists in Health Informatics to turn summaries into actionable insights.

Andrew Roberts

Chief Clinical Information Officer

Transforming healthcare through digital innovation at RJAH

RJAH are committed to invest in **new innovative technologies** if we are to provide the best services to our patients and staff.

The Digital landscape is changing rapidly both in our personal and work lives and is no different in health. Artificial Intelligence is already helping the NHS tackle some of the increasing demands being placed on the health service and RJAH need to be able to embrace the technologies that are coming, ensuring we have processes and procedures so they can be adopted safely and quickly to maximise benefit.

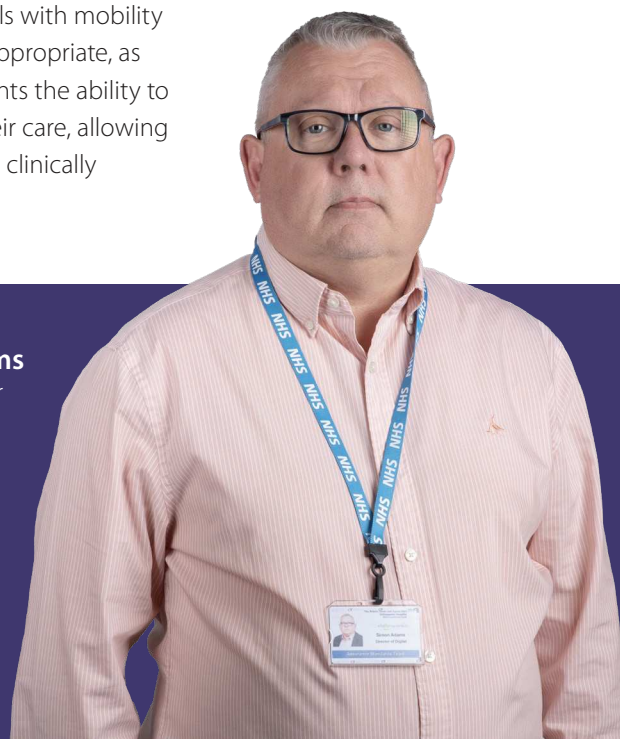
The use of leading-edge technology in and around the Trust will help to drive improvements in safety and enables us to assist more patients. Robotic technology at the simplistic end can remove tasks for people, transcribing data from one system to another and adding it digitally, removing the need for repetitive workflows. At the more complex end it can be used to improve safety in theatres when performing surgery. Technology is and will continue to change therapies and treatments for patients. Developments such as neuro links trials are now commencing to enable control of devices, such as a tablet, with the use of the patients' eyes, giving them greater independence.



The use of leading-edge technology in and around the Trust will drive improvements in safety and enables us to assist more patients

Telehealth and virtual care models continue to expand, providing patients with convenient access to healthcare services from the comfort of their homes. This will be particularly beneficial for individuals with mobility issues or those living in remote areas. Where appropriate, as part of our service offerings, we will give patients the ability to provide information remotely in relation to their care, allowing clinicians to review the information and where clinically appropriate negate the need for attendance.

Simon Adams
Digital Director



New technologies are continually changing how care will be delivered. With safe and secure options in the future for how the patient's record is kept updated – whether this be via 'wearables', updates from the patients device, or from the actual consultation with the patient and clinician, enabling the patient to have a wider conversation about their condition with a copy at the end of their outpatient visit.

The use of 'apps' is now common with people accessing from their mobile phones everyday – at RJAH, we will link our Electronic Patient Record (EPR) to provide access via the NHSapp to allow patients to see and change appointments, view letters and results. At RJAH we will make this the 'front door' for suppliers so patients can view everything in one place.

The new Apollo electronic patient record is due to go live in the late Spring 2025, which will create the foundations for delivering better care models – improving clinical safety through electronic prescribing and ensuring access to the clinical record in multiple care settings as we continue our digital journey.

Improving the digital literacy of our staff and patients is essential to success. We must ensure that we provide access to relevant training, staff have the correct skills, and that patients are aware of the how to take advantage of the technologies we offer so we improve health inequality measures for our population.

Digital services at RJAH will enable service transformation, providing improved access to data, ensuring that data is accessible quickly, and enabling staff to use the data as they require.

The structures of the team will reflect the new technology and embedding clinical safety in the heart of Digital to ensure patients and staff retain their confidence in their data.

RJAH will create a digital enabled hospital, allowing us to measure against organisations worldwide and deliver the best clinical outcomes for our patients.

AI use case 1

Category	Area where AI products are available to support care provision and support functions
Corporate	- Communications - Corporate governance and legal - Estates and facilities - Finance - Human resources and training - Procurement
Administrative Operations	- Booking and scheduling - Logistics and supply management - Performance management and reporting - Quality, safety, and clinical governance - Staff rostering and deployment - Smart automation

AI use case 2

Category	Area where AI products are available to support care provision and support functions
Clinical Operations	- Clinical interactions (automated or simulated) - Medicines management - Clinical decision support - Staff efficiency, including ambient voice technology
Diagnostics	- Medical imaging - Digital pathology - Other imaging modalities



Supporting our patients



NHS England 10 Year Plan



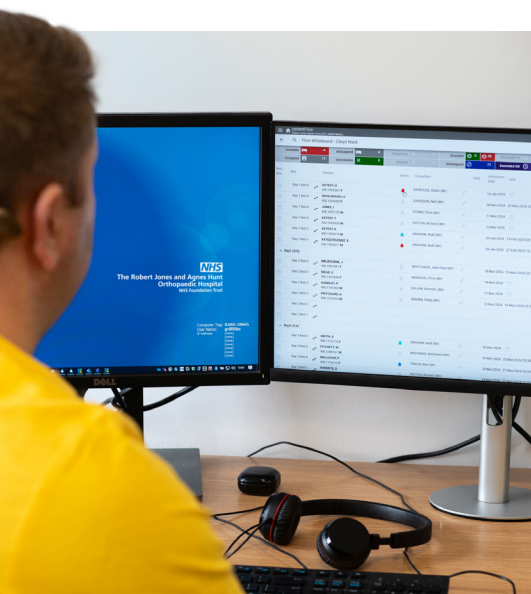
The need for the NHS to deal with the increased patient demand requires new and innovative ways to deliver elective care. The government are currently developing a new 10-year plan for health with Digital solutions integral to its delivery.

Data remains central to the NHS England plan with investment in national contracts to deliver a single platform to enable Trusts and ICS's to see patients across the wider system through The Federated Data Platform, ensuring that patients are seen appropriately. At RJAH we are working with our system partners to deliver a unified pathway across MSK conditions, ensuring continuity from the GP through community and acute care providers

At RJAH the NHSapp will form one of the primary digital routes to communicate with patients. NHS England are continuing to ensure patients will have a better experience and can communicate at their convenience via the NHSapp and ultimately with their healthcare specialist. RJAH will link in so patients from England only have to look in one place.



*The ICS have provided a system called **One Health and Care** which provide summary information across all partners of which RJAH will contribute feeds via the new Apollo EPR*



Shropshire, Telford and Wrekin ICS Digital plan sets out the roadmap for system wide investments to ensure that digital transformation across health and care will continue to enhance patient outcomes. The ICS have provided a system called One Health and Care which provides summary information across all partners of which RJAH will contribute feeds via the new Apollo EPR, enabling a single point of access to see patient information.

It is essential to retain the trust of our patients and ensure their data remains safe. The ICS are actively working to create a central cyber strategy to continue to support organisations and will lead to a 'defend as one' principal. RJAH's involvement in the ICS is vital for improving digital maturity and healthcare delivery across the region. By collaborating with other organisations within the ICS, RJAH can leverage shared resources and expertise to drive digital transformation and help enhance patient care across our population.

RJAH will ensure that we have the agility required within our strategy to meet the needs of the future.

Developing the Strategy

This strategy has been developed through comprehensive collaboration with both our staff and our patients. We have engaged with system partners while focusing on key developments within the NHS and conducting horizon scanning to gain valuable insights from our suppliers and the broader market.

Internally, we have participated in a variety of forums and gathered valuable feedback from sessions conducted in the latter half of 2024 and early 2025 as part of the Apollo development initiative. Our team has met with clinical leads, attended unit meetings, and engaged in discussions to better understand the needs of both staff and patients. Positive feedback has been received from Unit Boards, as well as from the Patient Experience Panel. Events were organised to provide all staff with the opportunity to participate and contribute to the development of this strategy. This collaborative approach has continued with ongoing feedback and updates, incorporating input from both the MSK and Specialist Boards, to ensure the strategy aligns with the needs of those we serve.

Key Messages from Staff and patient groups:

Knowing what is out there – being able to get a view of new technologies

Better hardware and speed*

Increased usability of some software – notable areas include the Radiology department and Orthotics (but not limited to)

Access to training and availability of training

Better and quicker access to data - being able to see it in real time

Better user design

Better processes for purchasing new kit to include integration

Access systems from home as if in the Trust

Understanding how the NHS app works and how letters are 'sent'

NHS and Global Benchmarking

Security

In terms of security RJAH complete the Data Security and Protection Toolkit. From 2024/2025 the toolkit is adopting the Cyber Assurance Framework adopted by Government. The NHS intend that all organisations must meet the assurance standards for their health care setting, and that each year the standards will be reviewed with increased levels of

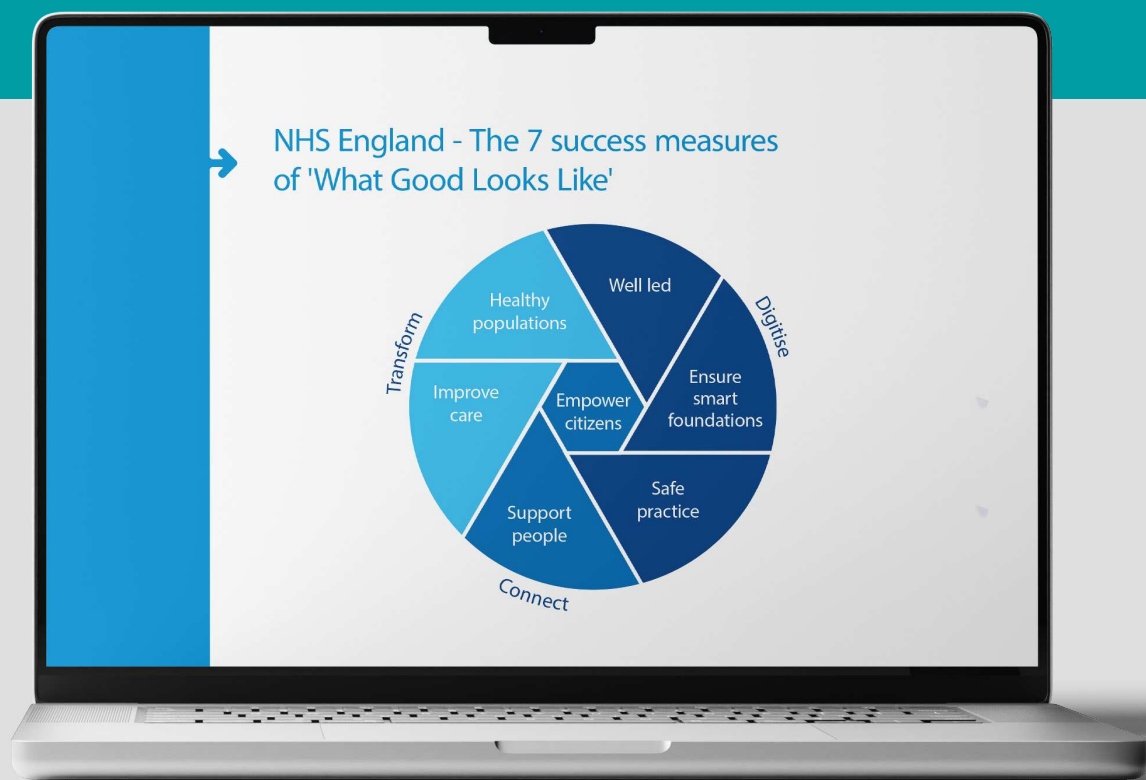
assurance against the framework that Trusts will be required to maintain. RJAH is committed to ensuring compliance with this standard.

NHS England have adopted two frameworks for Trusts to submit data to assess how they are measured digitally.

What Good Looks Like (WGLL) & Digital Maturity Assessment (DMA)

The 'What Good Looks Like' (WGLL) digital framework's aim is to have a health and social care system that will be faster, more effective, and delivering more personalised care to patients and citizens. We will attain the core digital capabilities needed to deliver WGLL and will carry out an annual review against this as both part of the digital maturity assessment and as part of our Frontline Digitisation funding agreement for the implementation of our Apollo EPR.

The purpose of the Digital Maturity Assessment (DMA) is used by the NHS to provide a comprehensive baseline of digital maturity metrics, which are refreshed, audited, and published annually – it is used to assess the access and availability of information in a digital format. Once the Trust have implemented the new Electronic Patient Record Apollo, the Trust are expected to have met the core requirements.





Global Health Measurement

Considerations for the Future - HIMMS

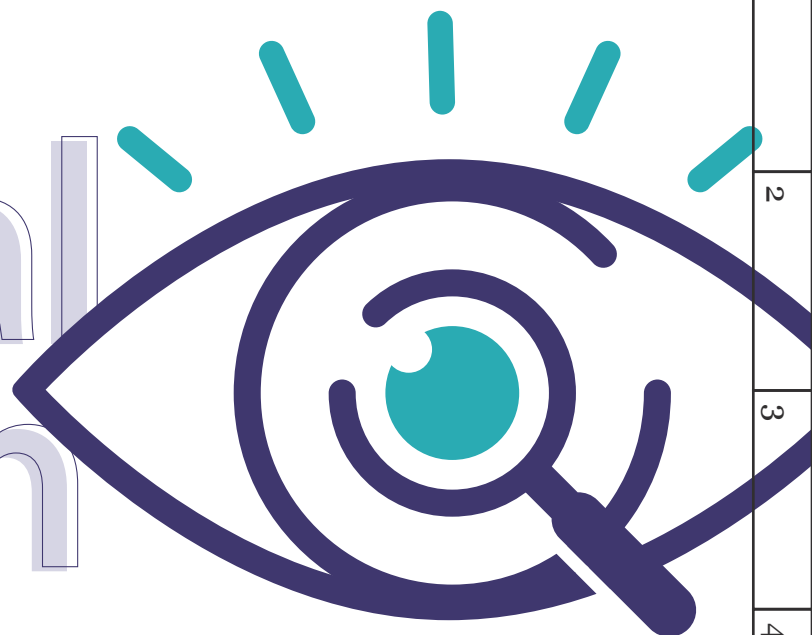
With the adoption of digital workflows and the greater reliance placed on technology, it is essential that RJAH's infrastructure is resilient and used effectively. By using The Healthcare Information and Management Systems Society (HIMSS) benchmarking we can assess how we are performing. There are two standards; one that measures the resilience of care infrastructure; the other looks at the maturity of the EPR.

Infrastructure Adoption Model Assessment (INFRAM) provide a measurement for digital infrastructure capability. A high INFRAM score ensures that services will not suffer disruption in the event of failures.

The Electronic Medical Record Adoption Model (EMRAM) demonstrates that EPR healthcare providers that reach this level deliver safer more reliable care, more efficiently, and to a higher quality standard. Studies have shown the seamless flow of information in a digital environment (a hallmark of stage five) has been associated with informed decision making to improve patient outcomes, as well as a reduction in manual errors in care.

Our aim is to ensure we have resilient infrastructure and will aim for a minimum score of 5 or higher by 2030.

Digital Vision



To provide the best digital experience to our staff and patients,
by improving patient care, that is supported by technology.

What this will mean for our patients and staff...

Patients	
Convenient Access to Care	- Online appointment bookings and the ability to upload information for review. - Virtual consultations will reduce waiting times and unnecessary hospital visits. - Self-service options to empower patients to manage their care.
Improved Personalised Care	- Improved access to clinical record. - Ability to share data from patient medical devices.
Connect via NHSapp	- A single digital patient portal will allow service users to access clinic letters, test results, and rehabilitation plans in one place.

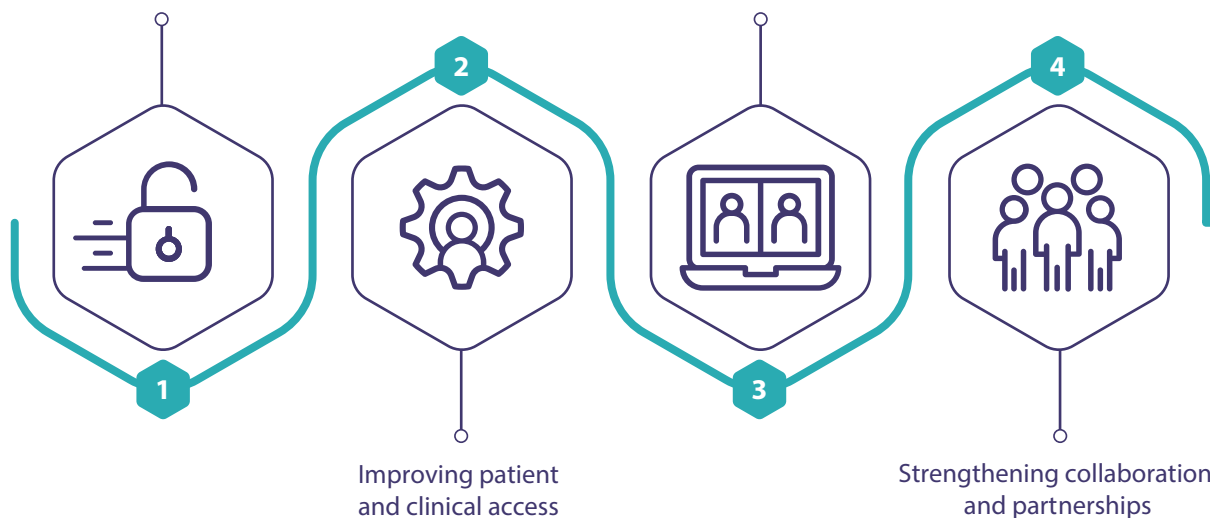
Staff	
Improved Personalised Care	- Use of artificial intelligence to support staff with the introduction of tools such as medical scribing. - AI-driven decision support tools will help clinicians tailor treatments more effectively based on individual health data.
Enhanced Patient Safety and Quality of Care	- Real-time data sharing will improve patient safety by ensuring clinicians have the most up-to-date information. - Clinical audit information can be accessed electronically. - AI-assisted diagnostics will enable data analysis which was not previously available, supporting early detection of conditions.
More Efficient and Sustainable Services	- Improvement through the use of ambient AI and robotic technology to improve patient care and remove administrative overhead. - Paperless workflows and remote monitoring will contribute to a greener NHS with reduced carbon emissions.

Objectives and outcomes

To deliver our strategy, we will focus on **4 objectives that will enable digital transformation at RJAH:**

Improving technology infrastructure to support our staff and patients

Improving digital literacy



Our aim is to **deliver these outcomes:**

- 1 Improving technology infrastructure to support our staff and patients:** To deliver fast & secure access to data to provide staff with seamless, reliable access to data at the point of care.
- 2 Improving patient and clinical access:** Introduction and extending the use of ambient AI, data and business intelligence tools will to enabling near/real-time reporting for staff and a single point of contact/ access for patients. Improving the integration between our systems and medical devices so information is available directly in the patient record enabling better decision making and safer systems.
- 3 Improving digital literacy:** Improve digital training for staff and patients, to better patient care. Providing leading conference and training facilities for our staff to learn and improve their ability to interact with systems.
- 4 Strengthening collaboration and partnerships:** Cross-departmental and external partnerships will improve digital solutions leading to better patient care.



Improving technology infrastructure to support our staff and patients

Outcome

We will deliver fast & secure access to data to provide staff with seamless & resilient access to data at the point of care.

To do this, we will...

Modernise our infrastructure

- Ensuring our network infrastructure remains scalable, with future-proof design that supports the staff and all the devices which daily, including patients' devices.
- Ensure the Wi-Fi network is available across all Trust locations. This network will support our staff to access information at the point of care, and enable patients to connect their own devices to access services.
- We will maintain support for all inpatients by providing the necessary tools to access the network when they do not have their own devices.
- Maintain effective hosting of digital systems by continuing to adopt "cloud first" and our transition to a hybrid infrastructure, combining on-premises and cloud-based solutions, to ensure consistent and reliable system performance.
- Maintain an environment that reduces the need for unnecessary travel, supporting virtual appointments, collaboration, and staff working from home or other locations.
- We will ensure that our staff have access to the right devices to support their roles:
 - Ensure devices in clinical areas are kept updated and available to facilitate real-time notetaking and observations.
 - Enhance our infrastructure to achieve minimum of EMRAN Level 5.
 - Ensure staff have the correct devices for their roles and equipment.
- Ensure new infrastructure procured meets our commitment to net zero, and will improve energy efficiency as standard in order to meet our goals. The equipment will use less electricity, generate less heat, and reduce strain on environmental control systems.
- Ensure integration from medical devices and the Trust EPR in order to achieve one clinical record.

Ensure the security of our data

- We will ensure the security of information by adhering to National Cyber Security Centre best practices and continue to meet the requirements as set out in the NHS Cyber Assurance Framework template and meet our Data Security Protection Toolkit standards.
- We will investigate and use the most appropriate technologies (including use of Artificial intelligence) to protect our staff and patient data to meet ongoing and evolving cyber threats.
- Deploy advanced networking technologies and tools to enhance the protection of patient and staff information and the Trust's digital assets against cyber-attacks.

Implementation and adoption of technology to improve workflows

- Adopt and implement policies and procedures for the safe adoption of Artificial Intelligence at RJAH, utilising established guidelines and policies mandated by NHS England and other recognised bodies.
- Assist in the adoption of robotic process automation to remove the need for repetitive tasks at RJAH and system level
- Use "BOT" technology in current systems to aid and facilitate signposting, without the need to speak to an individual should they not be required.





Improving patient and clinical access to data

Outcome

Introducing and extending the use of ambient AI, ensuring data and business intelligence tools enable near/real-time reporting for staff and a single point of contact/access for patients.

Improving the integration between our systems and medical devices so information is available directly in the patient record enabling better decision making and improved patient safety.



To do this, we will...

Provide data to facilitate decision-making

- Enhance the utilisation of our core digital systems to streamline and optimise the information they contain, applying this approach to both our clinical and business systems.
- Implement business intelligence tools to integrate and analyse clinical, operational, and financial data, providing real-time insights for informed decision-making and performance improvement across the Trust. This will enable staff to access data to enhance service planning, research, and overall patient care.
- Leverage industry-standard, tried-and-tested Business Intelligence (BI) tools over in-house development. This approach will align our processes with industry best practices, improve our support capacity, accelerate the realisation of benefits, and strengthen system resilience.
- As our data becomes richer, create a model to look to the future for reporting, rather than retrospectively.
- Pilot and implement artificial intelligence tools to support clinicians in supporting improvements to deliver care.

- Invest in AI and machine learning technologies to improve data categorisation, analysis, and predictive capabilities, enabling more proactive decision-making and personalised patient care.
- Create reports from Apollo to assist in audits, for example administration of prescribed drugs.
- Continued utilisation of Microsoft Co-Pilot to help aid improvements in administration workflow and reporting.

Integrate medical devices with our Electronic Patient Records (EPR)

- Ensure a seamless and automated flow of data from a wide range of medical devices (e.g. vital signs monitors, infusion pumps, ventilators, diagnostic imaging equipment) directly into the patient's electronic record. This will eliminate the need for manual transcription, reducing the risk of data entry errors and improving data accuracy.
- Ensure all Digital Imaging & Communications in Medicine (DICOM) images are available with a single vendor neutral archive, ensuring access for clinicians for any device.

- Improved links with Estates to ensure new devices are integrated and supported by the EPR.

Improve Workflow Automation and Integration

- Expand the use of robotic process automation (RPA) to handle routine administrative tasks such as appointment scheduling, patient check-ins. This will free up clinical and administrative staff to focus on patient care, reducing administrative burden and increasing overall efficiency.
- Establish continuous feedback loops from both staff and patients regarding the usability and effectiveness of digital solutions. This will allow for iterative improvements, ensuring the digital infrastructure evolves in line with the Trust's needs and technological advancements.

Align Research and Decision-Making with Trust Priorities

- Continue to improve our approaches to data governance: Establish clear governance protocols to ensure data integrity, security, and compliance with regulatory requirements.
- Streamline the process of accessing data to support research and evidence-based decision-making. Ensure research data is aligned with Trust priorities.

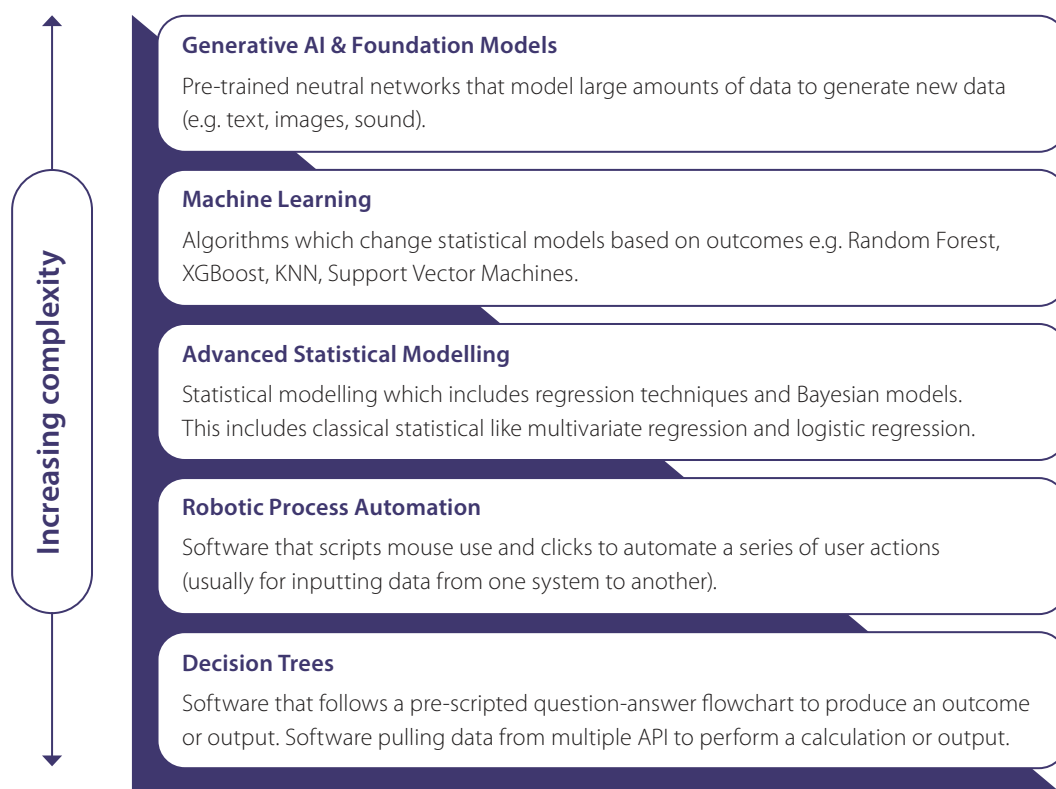
Create Patient Care Enhancement Applications and a Patient-Centric Platform

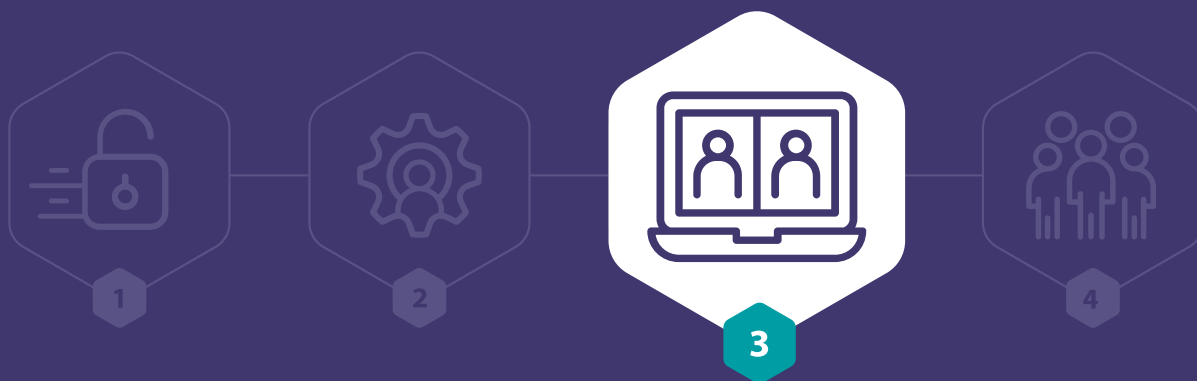
- Ensure "apps" to facilitate patient care are linked for the patient via the NHSapp.

- Provide alternative methods for patients who do not have access to "digital" to ensure that they are not negatively affected by the use of Apps and where appropriate to assist patients.
- Implement a patient-centric platform that integrates appointment booking, clinical records access, and patient education resources to support the Trust's patient engagement goals, Digital Front Door
- Continue to support the implementation of applications to enhance patient care and seek to standardise where appropriate across to the System.

Assess Accessibility for Patients and Staff

- We will assess the accessibility of our digital platforms for both patients and staff. We will collaborate with our suppliers to implement necessary improvements, ensuring that the information we provide is accessible according to our patients' preferences and in full compliance with the Accessible Information Standard (AIS) as set out by government.
- We will continue to collaborate with all our system partners to digitally share key clinical documentation. Our aim is to provide a seamless care experience for our patients, regardless of which hospital they visit.





Improving digital literacy

Outcome

Improving digital training for staff and patients to drive more effective system adoption, leading to improved patient care. Ensuring we have conference and training facilities for our staff that facilitate learning and improvement with access to technology to improve their ability to learn.



To do this, we will...

Create a new approach to Digital learning at RJAH

- Improve collaboration with the Trust's Learning and Development team ensuring all colleagues are proficient in the digital capabilities required for their roles. This will directly support operational efficiency and enhance patient care outcomes.
- Offer comprehensive training programmes and regular refresher courses to equip staff with the essential skills needed to effectively adopt and utilise emerging technologies.
- Help staff navigate and respond effectively to digital system challenges with suitable training, thereby safeguarding service continuity and patient safety.
- Establish a fully equipped, modern training space that supports hands-on, interactive learning experiences while meeting the needs of digital system training.
- Ensure our conference suites are equipped to assist in facilitated learning, and have modern technology to facilitate wider training.
- Integration with the Sim Laboratory to model scenarios for staff on how to use our digital systems
- Provide sessions in the community for our patients to be aware of our systems and help to avoid digital exclusion.
- Ensure we offer training to all levels of staff and patients to give them the confidence to thrive and use technology confidently.
- Providing a regular forum for digital teams to share with staff, exploring and showcase the 'Art of the Possible'. Ensure we showcase what technology can offer to staff and a process for how staff can bring solutions they have seen to a wider audience.





Strengthening Collaboration and Partnerships

Outcome

Drive cross-departmental and external partnership collaboration focusing on digital solutions to improve patient care and improve efficiency. By developing shared digital platforms across organisational boundaries, we can enhance data interoperability, improving care coordination for our patients. Strategic partnerships with universities, research institutions, and the private sector will enable us to advance innovation and opportunities required to innovate at RJAH.



To do this, we will implement

Local Health System Digital Collaboration

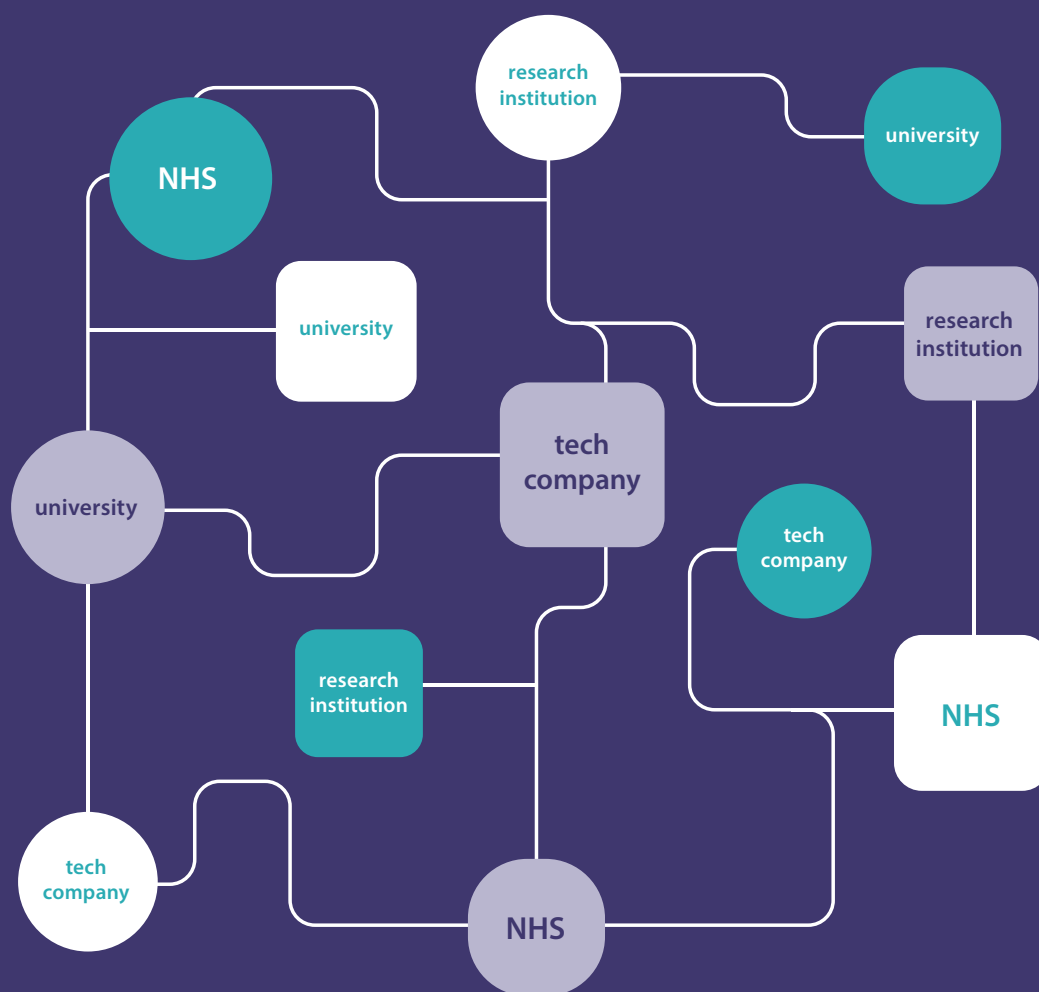
- Leverage shared digital platforms, including the NHS Federated Data Platform (FDP), to enable secure and efficient data exchange between NHS Trusts, local authorities, primary care, and other health services. This will enhance interoperability, support coordinated care pathways, and improve patient journeys through seamless information sharing.

Development of Shared Digital Services

- Explore the establishment of shared services, accessible to staff across multiple Trusts, offering shared technical assistance, troubleshooting, and system maintenance.

Collaboration with Specialist Hospitals and External Tech Partners

- Establish innovation hubs or digital accelerators in collaboration with NHS and private tech companies, creating environments for testing and co-developing next-generation healthcare technologies.



- Launch shared training programs and digital health seminars that include staff from local health systems and academic institutions, creating an interconnected knowledge base.

Data Sharing and Interoperability

- Work on enhancing interoperability across local health systems, ensuring that data can be securely shared between NHS Trusts, GP surgeries, social care, and other health and care providers. Collaborate with NHS Digital on initiatives like the NHS Data Quality Framework.

Co-Design and User-Centric Digital Health Services

- Run user-centric design workshops with staff and patients from both local health systems and wider NHS networks, gathering feedback on digital services like patient portals to ensure they are intuitive and effective.

- Foster collaborations with leading universities and research institutions to facilitate joint research and development projects.

Encourage Public-Private Sector Partnerships

- Promote partnerships between the NHS and private tech companies to leverage digital tools that advance research and healthcare delivery, including advancing commercialisation of products.

- Encourage the use of open-source platforms for developing digital health solutions, allowing for shared innovation.

Delivering the Strategy Years 1-3

The NHS is evolving and the use of Digital for delivery of health care is now a primary goal to help manage people's health and wellbeing. The NHS is currently awaiting delivery of a new 10 year plan and this strategy will need to have the ability to be reviewed and adapted to ensure it remains relevant.

If we are to deliver the outcomes from the strategy it will be necessary to focus and adjust how digital and information services are delivered within the Trust and our contributions to the wider system.

At RJAH we need to ensure that digital transformation is seamlessly integrated into the Trust's core operations, driving both operational and clinical excellence. With active engagement from digital clinical leaders and staff, we will prioritise initiatives that align with both RJAH and national objectives.

Digital will need to remain flexible and agile in terms of team structures. As we build a richer clinical environment, we will need new staff incorporating broader capability and skills including data scientists.

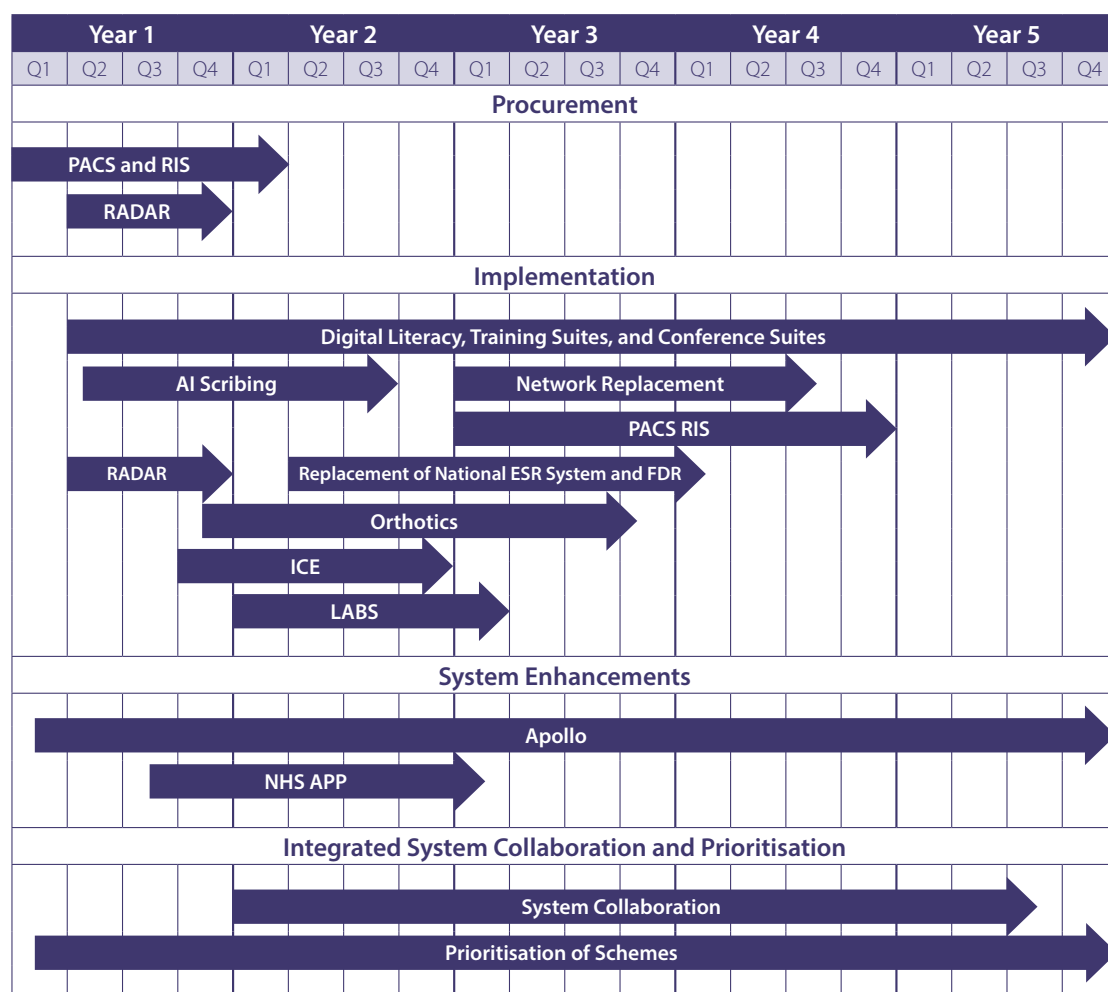
With good governance and robust project management, we will create a culture of continuous improvement, ensuring our systems are clinically safe.

Wherever possible we will utilise existing meetings and forums to agree and manage the programme of works. Post Apollo go live, the Digital Transformation Programme Board will become the vehicle for prioritising and monitoring the work and delivery of the strategy – with updates provided to both the Executive group and DERIC on progress.





*In fostering collaboration, inclusivity, and ongoing engagement, we will build a sustainable, patient-centric digital future that **benefits all our staff & patients***



Year 1

- A formal review of the strategy is undertaken annually and presented to the Digital Transformation Programme Board (DTPB).
- Confirmation of governance for DTPB
 - Agree prioritisation methods for resources
 - Monitoring of progress and workplan
 - Investment cases and ongoing resource funding
 - Review of shared resources
 - Rotation chair – non-digital clinician/manager
 - Policy Review/Approvals – including AI
- Increase the size, capability and capacity of the teams to deliver the programme of works to be undertaken, incorporating potential for shared services etc.
- Creation of a working group to agree a plan for improvement of Digital Training for staff and patients, including facilities

- Increase the number of digital clinical safety officers to enable the successful implementation of new clinical systems by Q3
- Improve Information Governance training to ensure staff understand data flow
- Review and agree benchmarking and KPI's

Year 2

- Plans for benchmarking
- Benefit review of Apollo
- Formal review strategy progression

Year 3

- Commence benchmarking
- Formal review strategy progression

Year 4 and 5

- Update as part of the annual review process

Chair's Assurance Report Audit and Risk Committee

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 02 July 2025

Author:

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Contributors:

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 13 May 2025 and the Extraordinary Committee on 23 June 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.

Annual Report and Annual Accounts 2024/25

Following an extraordinary meeting on the 23 June 2025, the Audit and Risk committee recommended the Annual Report and Accounts be approved by the Board of Directors. This was supported by the external auditor's annual report and the annual internal audit report which provided the Trust with a substantial assurance rating.

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:

Information Governance – Historic Records Access

While no current alerts were raised, concerns persist over challenges in accessing older dated patient records, particularly as more paper records are archived and not captured in the EPR. A scheduled meeting with the IG Manager will review how these risks are captured and mitigated.

System Integrated Improvement Plan – Risk Escalation Process

The Committee noted continued difficulty progressing elements of the plan due to ICB changes and merger activity. Risk escalation mechanisms require testing to assess effectiveness.

Finance Governance Pack - Aged Debtors – Veterans NCA Invoices

Longstanding debts remain unresolved despite ICB support, which may impact cash flow if not resolved. NHS England is supporting resolution.

Reference Costs – Triangulation with Quality Ratings

Improvements in cost efficiency (notably in critical care) were observed, and the committee requested that the reference cost data be triangulated with the annual quality report to understand the correlation between cost efficiency and service quality. The themes from the reference cost update to be taken through the Finance and Performance committee for further analysis and improvement.

Risk Management – Orthotics Department

A notable concentration of red-rated risks remains in the Orthotics Department. These will be examined further through the Quality and Safety Committee.

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.

Cyber Assessment Framework: Transition work from DSPT is underway with no current concerns.

Freedom of Information: A breach was reported due to pharmacy staffing, but is now resolved.

Finance Governance: Stable cash balance, improved single source waiver controls, and ongoing theatre wastage monitoring noted.

Chair's Assurance Report Audit and Risk Committee

Register of Interest and Hospitality: No breaches reported. Policy broadened to include all medical suppliers.

Annual Reports (Committee & Trust): Governance and committee effectiveness considered appropriate. HFMA tool to be used for self-assessment.

Counter Fraud: No emerging themes locally; national trends (e.g. working while off sick) are monitored. High training compliance achieved.

Internal Audit: Plan approved, and progress reported. Annual report gives Substantial assurance rating.

Risk Management: Improvements in training compliance and regular governance processes were highlighted. The Board Assurance Framework was positively reviewed with emphasis on futureproofing and clarity.

Corporate Risk Register: 22 new risks added over the year; improvements in risk tracking noted.

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.