

# Board of Directors | Public Meeting 01.07.2026

MEETING  
1 July 2026 09:30 BST

PUBLISHED  
1 July 2026



# Agenda

Location  
Board Room, Main Entrance

Date  
1 Jul 2026

Time  
09:30 BST

	Item	Owner	Time	Page
1	Welcome		09:30	-
1.1	Apologies	All Attendees		-
1.2	Minutes of the previous meeting (06 May 2026)	Chair		4
1.3	Action Log / Matters Arising	Chair		-
1.4	Declarations of Interest	All Attendees		16
2	A Spotlight on Orthotics Manufacturing Presentation	Chief Medical Officer	09:40	17
3	Chair and Deputy CEO Update	Chair and Deputy Chief Executive Officer	09:50	25
3.1	Board and Committee Reporting Structure			29
3.2	National Oversight Framework Update			32
4	Quality and Safety		10:05	-
4.1	IPR Exception Report	Interim Chief Nurse Patient Safety Officer / Chief Medical Officer		38
4.2	Chair Report from Quality and Safety Committee	Non-Executive Director		53
4.2.1	QS Committee Annual Report (inc Terms of Reference)			59
4.2.2	IPC Annual Report			80
4.2.3	Patient Experience and Complaints Annual Report			110
4.2.4	Health and Safety Annual Report			134
	<b>BREAK</b>		10:35	-
5	People and Workforce		10:45	-
5.1	IPR Exception Report	Chief People Officer		143
5.2	Chair Report from People and Culture Committee	Non Executive Director		152
5.2.1	PC Committee Annual Report (inc Terms of Reference)			158
5.2.2	Freedom to Speak Up Annual Report			176
6	Performance and Finance		11:10	-
6.1	IPR Exception Report	Chief Operating Officer		184
6.2	Finance Performance Report	Chief Finance and Commercial Officer		207
6.3	Chair Report from Finance and Performance Committee	Non-Executive Director		228
6.3.1	FP Committee Annual Report (inc Terms of Reference)			233

1

2

3

4

5

6

7

8

9

10

11

2

	Item	Owner	Time	Page
7	DERIC		11:35	-
7.1	Chair Report from Digital, Education, Research, Innovation and Commercialisation Committee	Non-Executive Director		252
7.1.1	DERIC Committee Annual Report (inc Terms of Reference)			257
8	Audit and Risk		11:50	-
8.1	Chair Report from Audit and Risk Committee	Non-Executive Director		276
8.1.1	Risk Management Policy			280
9	Questions from the Governors and Public	Chair	12:05	-
10	Risk Reflection / Values Reflection	Chair	12:15	-
11	Any Other Business	All	12:20	-
11.1	Next Meeting: 29 July 2026			-

**BOARD OF DIRECTORS | PUBLIC MEETING**  
**WEDNESDAY 06 MAY 2026 AT 9:30AM AT RJAH ORTHOPAEDIC HOSPITAL**  
**MINUTES OF MEETING**

**Voting Members in Attendance**

Name (and identifying Initials)	Role	Attending
Harry Turner (HT)	Chair	✓
Sarfraz Nawaz (SNa)	Non-Executive Director	✓
Martin Newsholme (MN)	Non-Executive Director	✓
Penny Venables (PV)	Non-Executive Director	✓
Lindsey Webb (LW)	Non-Executive Director	✓
Martin Evans (ME)	Non-Executive Director (joined from 11am)	✓
Stacey Keegan (SK)	Chief Executive Officer	✓
Angela Mulholland-Wells (AMW)	Chief Finance and Commercial Officer	✓
Clair Hobbs	Interim Chief Nurse and Patient Safety Officer	✓
Ruth Longfellow (RL)	Chief Medical Officer	✓
Mike Carr (MC)	Deputy CEO and Chief Operating Officer	✓

**Others in Attendance**

Name (Initial)	Role	Attending
Paul Maubach (PM)	Associate Non-Executive Director	✓
Atif Ishaq (AI)	Associate Non-Executive Director	✓
John Pepper (JP)	Associate Non-Executive Director	✓
Denise Harnin (DH)	Chief People and Culture Officer	✓
Dylan Murphy (DM)	Trust Secretary	✓
Mary Bardsley (MB)	Assistant Trust Secretary (minutes)	✓
Chris Hudson (CH)	Head of Communications	✓
Colin Chapman (CC)	Governor – observing	✓
Neil Turner (NT)	Governor – observing	✓
Victoria Sugden (VS)	Governor – observing	✓
Kate Betts (KB)	Governor – observing	✓
Jan Greasley (JG)	Governor – observing	✓
Nicki Bellinger (NB)	Governor – observing	✓

Ref	Discussion and Action Points
<b>1.0</b>	<b>Welcome and introductions</b>
	<p>The Chair opened the meeting by welcoming all attendees.</p> <p>A warm welcome was extended to the Governors, as well as to Clair Hobbs, Interim Chief and Patient Safety Officer, and John Pepper, Associate Non-Executive Director, who both joined the Board on 1 April.</p>
<b>1.1</b>	<b>Apologies</b>
	<p>There were no formal apologies to note. HT informed the Board that Martin Evans will be joining the meeting from 11am.</p> <p>It was formally confirmed that the Board was quorate, enabling the meeting to proceed with full decision-making authority.</p>
<b>1.2</b>	<b>Declarations of Interest</b>
	<p>The Chair reminded attendees of their obligation to declare any interest which may be perceived as a potential conflict of interest with their Trust role and their role on this Board.</p> <p>There were no conflicts of interest identified in relation to the items for discussion which required members to withdraw from discussion or decision-making.</p>

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11

Ref	Discussion and Action Points
1.3	<b>Minutes of the previous meeting</b>
	The minutes of the Board of Directors (Public) Meeting held on 04 March 2026 were approved as an accurate reflection of the meeting.
1.4	<b>Matters Arising and Action Log</b>
	<p>It was confirmed that there were no outstanding actions to discuss, and the attendees had no further comments.</p> <p>There were no matters arising shared.</p>
2.0	<b>Service Presentation: Acute Pain Opioid Project</b>
	<p>RL introduced Amr Selim to the Board, who attended to provide an overview of the role of the Academic Clinical Lectureship and to deliver a presentation on optimising day-case arthroplasty using machine learning, work that recently won an award at the Trust Research Day.</p> <p>Amr opened his presentation with an overview of his role and highlighted the structure of the clinical academic training pathway. He explained that the university appoints a small number of integrated clinical academic posts each year, including Academic Clinical Fellows (ACFs) before the PhD stage, and Academic Clinical Lecturers (ACLs) afterwards. Unlike traditional “time out of programme” research posts, the ACL role is fully integrated, there is no separate research job on the side. Instead, clinical and academic responsibilities run in parallel.</p> <p>He noted that only four to five ACL posts are available each year, making them highly competitive. The role is designed to protect research time and to develop consultants who continue academic work throughout their careers. ACLs typically work on a 50/50 split between clinical duties and academic commitments. Clinically, they undertake the same responsibilities as their peers. Academically, their work includes designing and running studies, analysing data, teaching, supervising trainees, and writing grant applications.</p> <p>Amr described his research portfolio, which centres on four main themes:</p> <ol style="list-style-type: none"> <li>1. Hip and knee arthroplasty outcomes, including enhanced recovery pathways.</li> <li>2. Machine-learning models to predict outcomes following hip and knee replacement.</li> <li>3. Regenerative medicine projects in collaboration with specialist teams.</li> <li>4. Large multicentre clinical trials, including the setup of a UK national arthroplasty registry.</li> </ol> <p>He shared that his team recently secured a major grant of £2.1 million to run a multicentre RCT investigating the optimal duration of blood-thinning medication after hip replacement. Current practice is four weeks, but emerging evidence suggests this may be longer than necessary. The trial aims to resolve this uncertainty while also studying infection-prevention strategies.</p> <p>Amr then discussed the value academic trainees bring to the Trust. He clarified that academic posts are funded centrally: money flows from NIHR to the university, which then pays the academic trainee’s salary. This means the cost does not fall on the Trust. In return, the Trust benefits from 50% clinical service contribution and the academic outputs generated.</p> <p>He shared examples from his own work over the past 18 month before emphasising that developing academic capacity locally is one of the most reliable ways to build the next generation of consultant researchers. The academic-clinical partnership strengthens the Trust’s reputation and helps attract high-calibre trainees and consultant applicants.</p> <p>Finally, he noted that academic work helps make the Trust’s high-complexity clinical activity more visible. Many consultant-level innovations and service developments are not widely known outside the department; academic dissemination helps showcase this work more broadly.</p> <p>Amr continued his presentation by sharing findings from one of his award-winning research projects, recognised at the Trust Research Day: Optimising Day-Case and Early-Discharge Pathways After Hip and Knee Surgery.</p> <p>This study focused on improving the day-case pathway, particularly important over the last decade as the NHS has increasingly prioritised shorter inpatient stays to improve outcomes, reduce costs, and maintain patient safety. The central question was: Can we use our existing data to identify which patients are most likely to benefit from the day-case pathway, and which variables within the pathway most strongly influence success?</p>

Ref	Discussion and Action Points
	<p>The project builds on a study published last year examining the safety and effectiveness of the enhanced recovery pathway. On the left-hand side of the slide, Amr showed an interrupted time-series analysis comparing outcomes before and after April 2023, when the pathway was fully implemented. The analysis demonstrated no deterioration in patient safety outcomes, there was no signal of increased complications or readmissions, confirming that the pathway is safe. More importantly, it showed a clear reduction in length of stay, indicating that the pathway is effective. The next stage of the research asked whether we could predict in advance which patients are most likely to achieve same-day discharge, and which factors are most influential in determining success. To do this, the team analysed every patient who underwent a primary hip, knee, or uni-compartmental knee replacement between April 2020 and April 2024, just over 3,000 patients.</p>
	<p>Importantly, this was an unselected cohort: patients were not pre-screened for fitness, so the findings reflect real-world practice. Using a series of machine-learning models, the team explored two key outcomes:</p> <ol style="list-style-type: none"> <li>1. Whether a patient would fail same-day discharge and require an overnight stay.</li> <li>2. Whether a patient would be discharged the following day.</li> </ol>
	<p>The aim was to identify which variables could be refined to improve future pathway performance. The median age of the cohort was around 70, with an even split between men and women and between hip and knee procedures.</p>
	<p>The most useful insight from the modelling was identifying what actually drives successful same-day discharge. The single strongest predictor was time to mobilisation, patients who mobilised earlier were far more likely to go home the same day. Following that, the next most influential factor was who delivered the mobilisation, with specially trained physiotherapists and enhanced-recovery nurses associated with better outcomes. Patients living with supportive family members were also more likely to be discharged safely on the same day. Other factors, such as anaesthetic technique, contributed but to a lesser degree.</p>
	<p>The key take-home messages are:</p> <ul style="list-style-type: none"> <li>• These predictive models can be integrated into our clinical systems to identify patients at risk of longer stays, allowing us to plan resources more effectively.</li> <li>• Several pathway elements, such as mobilisation timing and staffing, can be standardised to improve outcomes.</li> <li>• Tools such as spinal-tracking systems may help refine anaesthetic choices in the future.</li> </ul>
	<p>Overall, this work has the potential to significantly improve the performance of our day-case pathway and enhance patient outcomes.</p>
	<p>HT, on behalf of the Board, thanked Amr for attending the meeting and presenting his work. The meeting was then opened for questions and discussion.</p>
	<ul style="list-style-type: none"> <li>• <b>Clinical Outcomes and Enhanced Recovery Pathway:</b> A question was raised about how outcomes are defined, particularly when comparing patients who go through the Enhanced Recovery (ENH) pathway versus those who do not. Current evidence shows no significant difference in peri-operative outcomes such as infection rates, revision rates, or other key clinical indicators. Comparisons across THR, TKR, and non-ENH groups also show no statistically significant variation. It was noted that patients undergoing knee replacement benefit from day-one discharge, supported by RJAH data.</li> </ul>
	<ul style="list-style-type: none"> <li>• <b>Research Activity and Opportunities:</b> JP emphasised the importance of research, noting that services actively engaged in research tend to achieve better outcomes. This is particularly relevant for teams with NIHR-funded roles. Discussion followed on opportunities for consultants. There is strong clinical and surgical expertise within the Trust, but relatively few consultants are research-active compared with centres like Stanmore. The Trust could do more to promote and showcase research capability. Research requires appropriate infrastructure and support, including a robust data-collection platform. Improving the Trust's research data systems would be highly beneficial.</li> </ul>
	<ul style="list-style-type: none"> <li>• <b>Data, AI, and Personalised Pathways:</b> AI and data-driven approaches were highlighted as key future enablers. The group discussed: How to strengthen data-driven decision-making. Moving towards personalised treatment pathways. Using machine</li> </ul>

Ref	Discussion and Action Points
	<p>learning to predict factors such as length of stay, based on non-modifiable patient characteristics. The need to feed high-quality patient information into models to improve predictive accuracy.</p> <p>RL confirmed that plans are underway to present the proposed research-related changes to the Anaesthetics Department to secure their support for pathway adjustments. The committee discussed incorporating key statistics into the dashboard, benchmarking performance, and setting clear improvement goals.</p> <p>HT reiterated the Board's commitment to supporting this agenda and thanked Amr again for his contribution.</p>
3.0	<b>Chair and CEO Update</b>
	<p><b>Chair Update</b></p> <p>HT reflected on a successful year for the Trust, highlighting the improvement in RTT performance, reductions in the waiting list, successful EPR implementation, strengthened relationships with the consultant body, and the absence of significant patient safety or quality concerns. He thanked staff for their contribution to these achievements, acknowledged future challenges, and noted that a celebration event had been arranged to recognise successes and share learning across the organisation.</p> <p>HT also provided an update on the following:</p> <ul style="list-style-type: none"> <li>• <b>National Recognition:</b> Jim Mackey offered his congratulations to the Trust on its achievements and recognised the significant progress that has been made. He encouraged the organisation to maintain its focus on getting the fundamentals right and to continue building on the strong foundations already in place. There was an emphasis on the importance of celebrating success, not only to acknowledge the hard work and dedication of staff, but also to sustain momentum, engagement and confidence as the Trust continues its improvement journey.</li> <li>• <b>National Meeting Feedback:</b> Elizabeth O'Mahony (NHSE) highlighted the strength of the NHS financial position, noting that there had been no requirement to call upon Treasury reserves. She acknowledged this as a significant achievement and a testament to the prudent financial management, discipline and collective efforts of organisations across the NHS. Her comments reflected the importance of maintaining a strong focus on financial sustainability whilst continuing to deliver high-quality patient care.</li> <li>• <b>Non-Executive Director Appointment:</b> Mike Hallissey, a Consultant Surgeon at University Hospitals Birmingham (UHB), has been appointed as a Non-Executive Director and joined the Trust on 1 June. Mike brings a wealth of clinical expertise, leadership experience and strategic insight, gained through a distinguished career within the NHS. His appointment further strengthens the Board's breadth of experience and will provide valuable support and challenge as the Trust continues to deliver its strategic objectives.</li> </ul> <p><b>Chief Executive Officer Update</b></p> <p><b>SK provided the following updates:</b></p> <ul style="list-style-type: none"> <li>• <b>Interim CNO:</b> Welcomed Clair Hobbs to her first public Board meeting as Interim Chief Nurse. Clair joins from Shropshire Community Health NHS Trust and brings extensive nursing leadership experience, making her a valuable addition to the Trust as it delivers its strategic priorities.</li> <li>• <b>End of Year Reflection:</b> The Trust achieved strong year-end results, including RTT performance of 62.15%, exceeding the national target, and delivery of its break-even financial plan. These achievements reflect the commitment of staff across the organisation and place the Trust in a stronger position for 2026/27.</li> <li>• <b>National Oversight Framework:</b> RJAH maintained Segment 2 status in the latest National Oversight Framework ratings and improved its national ranking from 25th to 22nd out of 134 trusts, demonstrating continued progress towards Segment 1.</li> <li>• <b>Planning and Priorities 2026/27:</b> The Trust provided feedback on the ICS three-year strategic planning response, emphasising the role of specialist providers, workforce and digital transformation, and the risks associated with provider transition.</li> </ul>

Ref	Discussion and Action Points
	<ul style="list-style-type: none"> <li>• <b>Cross-Border Care:</b> Provided evidence to the Welsh Affairs Select Committee on the challenges and opportunities associated with cross-border healthcare, including waiting lists, funding arrangements and policy changes affecting Welsh patients.</li> <li>• <b>Federation of Specialist Hospitals:</b> Received updates on the Health Data Research Service, communications initiatives to raise the profile of specialist hospitals, and progress developing Integrated Healthcare Organisations, to which FoSH members have contributed.</li> <li>• <b>National Clinical Leadership Role:</b> Congratulations were extended to Mr Rob Freeman on his appointment as NHS England GIRFT clinical lead for paediatric orthopaedics, supporting service improvement and reduced waiting times nationally.</li> <li>• <b>Veteran Aware Status:</b> RJAH has successfully secured a further three-year Veteran Aware accreditation, recognising its continued commitment to supporting veterans, serving personnel and their families.</li> <li>• <b>Long Service Awards:</b> Congratulations were extended to thirteen staff members who achieved 30 years of NHS service, recognising their exceptional dedication, loyalty and contribution to patient care.</li> <li>• <b>RJAH Star Award – April:</b> Ashleigh Heath received the April Star Award for leading service evaluation work that identified opportunities to improve patient care, staff experience and therapy services.</li> <li>• <b>RJAH Star Award – May:</b> Liv Roberts received the May Star Award in recognition of her vital contribution to ensuring the availability of implants and equipment required to deliver safe and effective surgical care.</li> </ul> <p>The Board noted the updates provided, and HT invited further comments from members. In response to a query, SK confirmed that the Trust's contribution to the wider System work would be presented at a future Board meeting, following the workshop held in May.</p>
3.1	<p><b>Corporate Objectives 2026/27</b></p>
	<p>SK presented the revised Corporate Priorities for 2026/27, which translate the Trust's strategic ambitions into clear objectives aligned to the Trust Strategy 2023–2028, national NHS priorities, and local population needs. The report reflected feedback received at the Board seminar in April 2026 and included updated priority headings, proposed measurable outcomes, and alignment to Board Committees for assurance purposes.</p> <p>PM welcomed the revised priorities and their level of ambition, suggesting that benchmarking against comparable organisations should be incorporated within performance reporting to support assessment of progress.</p> <p>The Chairs of each assurance Committee, confirmed that the relevant discussion took place at the Committee throughout April and were supportive of the proposed priorities. There was a specific note from the Finance and Performance Committee where it was requested further development of reporting arrangements to strengthen oversight and monitoring of delivery.</p> <p>It was noted that the Board Assurance Framework would be aligned to the final Corporate Priorities and that the Executive Team was reviewing governance reporting arrangements to enhance oversight of strategic objectives.</p> <p>The Board approved the Corporate Priorities for 2026/27 and thanked the Executive Team for incorporating Board feedback and developing the final proposal. Members highlighted the importance of a clear organisational launch and communication plan to support implementation across the Trust.</p>
4.0	<p><b>Quality and Safety</b></p>
4.1	<p><b>Performance Report – Quality and Safety Committee</b></p>
	<p>The Board received the Quality and Safety Performance Report (by exception) and noted the following key points:</p> <ul style="list-style-type: none"> <li>• Complaints performance remains above the required trajectory, with a number of complaints overdue against response timescales. Further assurance was requested regarding the actions being taken to address this. These include daily monitoring, additional support for the team, and a deep dive review of processes to identify wider</li> </ul>

Ref	Discussion and Action Points
	<p>opportunities for improvement. Patient experience is included as a substantive agenda item for further discussion.</p> <ul style="list-style-type: none"> <li>• With regard to delayed discharges, the Board noted that additional data is required to support further action and analysis. Patient transport continues to be a contributory factor, particularly in relation to the Midlands Centre for Spinal Injuries (MCSI).</li> <li>• The Committee noted the positive position that there have been no cases of <i>Clostridioides difficile</i> (<i>C. difficile</i>) infection since August.</li> <li>• One case of <i>E. coli</i> bacteraemia was reported in March and was subsequently assessed as unavoidable. The Board noted the learning identified and the assurance that appropriate practices remain in place.</li> <li>• Surgical Site Infection (SSI) rates were considered within the context of performance and trends over the last seven years.</li> <li>• One death occurred on HDU during the reporting period. The death was not unexpected, and the usual review and governance processes were followed.</li> </ul> <p>The Board noted the performance report.</p>
4.2	<p><b>Chair's Assurance Report – Quality and Safety Committee</b></p>
	<p>LW presented the key points from the Quality and Safety Committee Chair's Assurance Report. The following matters were highlighted:</p> <ul style="list-style-type: none"> <li>• <b>KPI Development:</b> The inclusion of Patient-Reported Experience Measures (PREMs) and Patient-Reported Outcome Measures (PROMs) within the KPI framework remains under consideration, pending further national guidance.</li> <li>• <b>Electronic Patient Record (EPR):</b> The Committee reviewed EPR-related risks and agreed there was a need to refine these into more specific risk areas. Long-term follow-up activity and harm reviews were discussed, with no patient harms identified to date.</li> <li>• <b>EPR Clinical Records Interface:</b> Improvements to the clinical records viewing interface have been piloted successfully and rolled out to additional consultants. A further update will be provided to the Committee in due course.</li> <li>• <b>DBS Compliance:</b> Significant improvements in Disclosure and Barring Service (DBS) compliance were noted. The Committee requested continued oversight until all outstanding actions have been completed.</li> <li>• <b>Emergency Preparedness, Resilience and Response (EPRR):</b> A discussion was held regarding EPRR and the Board Assurance Framework (BAF), particularly in relation to supply chain risks. It was agreed that current challenges and emerging issues should be more clearly reflected within the relevant documentation.</li> <li>• <b>Go See Programme:</b> Progress continues through the Improvement Team, with a pilot taking place this month and a planned go-live date in June.</li> <li>• <b>MCSI Deep Dive:</b> The Committee undertook a deep dive into MCSI, focusing on quality and safety matters within the service. Hannah Cheeseman attended and provided assurance regarding culture, patient safety, and the actions being taken to address identified issues.</li> <li>• <b>Clinical Audit Annual Report:</b> The report demonstrated continued strong engagement with clinical audit activity over recent years and highlighted the contribution of audit work to ongoing service improvement and performance.</li> </ul> <p>Following discussion, the Board confirmed that it was satisfied with the level of assurance provided and acknowledged the Committee's continued focus on key quality and safety risks.</p>
4.3	<p><b>EPRR Business Continuity Policy</b></p>
	<p>The Committee was advised that the Business Continuity Policy provides the overarching framework for business continuity management across the Trust. While individual service areas maintain their own detailed business continuity plans, the purpose of this policy is to set out the organisational governance, responsibilities and principles that underpin those plans. As such, the document is intentionally detailed and should not be viewed as an operational response plan for use during a major incident.</p> <p>Members were informed that the policy had been developed in consultation with both regional and local Emergency Preparedness, Resilience and Response (EPRR) expertise and had been further refined following review through the Quality and Safety governance process.</p>

Ref	Discussion and Action Points
	<p>A minor amendment was identified to update the job title <b>Director of Digital</b>, which will be corrected prior to publication.</p> <p>LW confirmed that the QS Committee noted that the policy had been developed in consultation with regional and system partners and, subject to the amendment outlined above and recommended the EPRR Business Continuity Policy for approval to the Board.</p> <p>The Board approved the policy.</p>
<b>4.4</b>	<b>Learning From Deaths Q3 Report</b>
	<p>RL presented the Learning from Deaths Quarter 4 Report and expressed thanks to James Neil, Mortality Lead, for his comprehensive work in preparing the report. The following key points were highlighted:</p> <ul style="list-style-type: none"> <li>• Four deaths were recorded during the reporting period.</li> <li>• Three deaths were anticipated and one death was classified as unexpected.</li> <li>• The report identified examples of positive learning, including good clinical practice and positive feedback received from patients and families.</li> <li>• Oversight and scrutiny of Learning from Deaths activity continues through the Quality &amp; Safety Committee.</li> </ul> <p>RL advised that the unexpected death had been subject to all required processes, including completion of the Medical Examiner review and the organisation's internal review procedures. The case demonstrated strong adherence to established processes and reflected the diligence and professionalism of the clinical teams involved.</p> <p>The family provided positive feedback and expressed appreciation for the specialist advice received from the Trust. They also commended staff for the sensitive, compassionate, and proactive communication provided to both the patient and their family during a difficult period. Members noted that the report had been reviewed in detail by the Quality &amp; Safety Committee in and were assured that appropriate governance and oversight arrangements were in place. The Board noted the assurance provided within the report.</p>
<b>5.0</b>	<b>People and Workforce</b>
<b>5.1</b>	<b>Performance Report</b>
	<p>The Board received the People and Workforce Performance Report (by exception) and noted the following key points:</p> <ul style="list-style-type: none"> <li>• All People and Workforce KPIs are currently performing in line with their respective targets.</li> <li>• Temporary staffing bank expenditure increased during the reporting period. This was anticipated and reflects planned workforce support to deliver the Quarter 4 operational improvement programme. The increase is considered a temporary and expected variation rather than a cause for concern.</li> </ul> <p>The Board noted the report and was assured by the overall performance position. No significant workforce issues or concerns were raised for further Board action.</p>
<b>5.2</b>	<b>Chair's Assurance Report – People and Culture Committee</b>
	<p>PM provided an overview of the key matters discussed at the People and Culture Committee for Board assurance. The following points were highlighted:</p> <ul style="list-style-type: none"> <li>• Agency expenditure continues to reduce, resulting in increased resources being available to support direct patient care.</li> <li>• Mandatory training compliance remains high. As part of the ongoing review process, the Committee considered the Mandatory Training Policy and discussed statutory and mandatory training requirements, including how compliance is managed where staff are absent due to sickness. A further update will be brought back to the Committee.</li> <li>• Sickness absence rates remain a topic of focus due to ongoing workforce challenges. The Committee noted that both long-term and short-term sickness absence rates are currently below target levels and that the Trust's performance in this area is being recognised. It was suggested that benchmarking against comparator organisations be undertaken to provide additional context and assurance.</li> </ul> <p>The Board acknowledged the strong workforce metrics and positive performance reported and expressed its thanks for the continued efforts of staff across the Trust.</p>

Ref	Discussion and Action Points
5.3	<b>Guardian of Safe Working Hours Report</b>
	<p>RL presented the report and began by thanking Chris Marquis, Lead for Safe Working Hours, for their continued contribution and support. The following key points were highlighted:</p> <ul style="list-style-type: none"> <li>• The Allocate/Electronic rostering system has now been embedded, supporting improved data collection and reporting.</li> <li>• There continue to be no exception reports recorded within the Trust, which was acknowledged as a positive reflection of the hard work and commitment of clinical teams.</li> <li>• Progress continues to be made in implementing the 10-Point Plan for Safe Working Hours.</li> <li>• It was confirmed that ME, Non-Executive Director, has been aligned to this area of work to provide Board-level assurance and oversight.</li> </ul> <p>The Board was assured and took confidence from the report and expressed its thanks for an excellent performance.</p>
6.0	<b>Performance and Finance</b>
6.1	<b>IPR Exception Report (inc. Long Waiting Patients)</b>
	<p>MC presented the Integrated Performance Report (IPR), highlighting current performance against key operational standards, areas of improvement, and ongoing challenges.</p> <p><b>Referral to Treatment (RTT) and Long Waits</b></p> <ul style="list-style-type: none"> <li>• The Trust reported three 62-week breaches during the month. Whilst performance remains volatile, the position continues to fluctuate at relatively low levels.</li> <li>• At year-end, RTT performance stood at 62.15%, exceeding both the Trust's planned trajectory of 60% and the stretch target. This represents an improvement of almost 18% alongside the implementation of Apollo.</li> <li>• Members noted the importance of benchmarking the Trust's performance against other organisations, particularly in the context of national discussions regarding the impact of Electronic Patient Record (EPR) implementations on operational performance.</li> <li>• Significant improvements have also been seen in Welsh patient waits for first outpatient appointments.</li> <li>• The Board noted the progress made in reducing long waiting patients and recognised the benefits achieved through improved data quality and the bringing together of patient pathway information.</li> </ul> <p><b>52-Week Waits</b></p> <ul style="list-style-type: none"> <li>• The Trust continues to focus on reducing 52-week waits, with performance currently at approximately 1%, aligned with the internal target.</li> <li>• It was emphasised that the ambition remains to eliminate 52-week waits wherever possible during the current financial year, ensuring patients receive treatment in a timely manner.</li> <li>• Members acknowledged the significant effort undertaken by clinical and operational teams to reduce long waits and improve patient outcomes.</li> </ul> <p><b>Operational Performance and Sustainability</b></p> <ul style="list-style-type: none"> <li>• The Board reflected on the substantial improvements delivered through targeted performance management arrangements overseen by the Finance and Performance Committee.</li> <li>• Members discussed the importance of ensuring that recent performance gains become embedded within routine operational practice, rather than being viewed as a short-term response to external targets.</li> <li>• It was recognised that the primary objective is to improve patient experience and outcomes, with performance targets serving as indicators of effective patient care rather than outcomes in themselves.</li> <li>• The Board noted that continued scrutiny of patient tracking processes, performance management arrangements and waiting list governance would provide assurance that progress is sustained.</li> </ul> <p>Day Surgery Metric</p>

Ref	Discussion and Action Points
	<ul style="list-style-type: none"> <li>Day surgery performance continues to be monitored as a national requirement, although it was recognised that the current metric is not always reflective of the Trust's specialist orthopaedic activity.</li> <li>As a member of the National Orthopaedic Alliance (NOA), the Trust is working collaboratively with other specialist providers to explore alternative measures that would provide more meaningful and representative benchmarking for specialist orthopaedic services.</li> </ul> <p>Elective Activity</p> <ul style="list-style-type: none"> <li>The Trust achieved 102% of planned elective activity in March, representing a significant achievement against plan.</li> <li>It was noted that this level of performance was influenced by increased activity associated with the DEXA pathway and enhanced infusion capacity, which had subsequently returned to more typical levels.</li> <li>Members discussed whether the March position represented an exceptional month or a sustainable level of performance going forward.</li> </ul> <p>The Board discussed the following:</p> <ul style="list-style-type: none"> <li>Members praised the commitment and determination of staff in delivering the improvements achieved to date.</li> <li>The importance of maintaining momentum and embedding improvement into day-to-day operational management was emphasised, ensuring that patients continue to progress through pathways in a timely manner.</li> <li>The Board noted that the Trust's corporate objectives support continued focus on reducing waits and improving access to care.</li> </ul> <p>The Board acknowledged the progress made against key performance standards and reaffirmed the importance of maintaining momentum to ensure delivery of the operational plan, further reduction in long waits, and timely treatment for patients.</p>
<b>6.2</b>	<b>IPR Annual Review</b>
	<p>The Board received the Integrated Performance Report (IPR) Annual Review, which had previously been presented to the relevant committees.</p> <p>It was noted that the report has been aligned to the National Oversight Framework (NOF), statutory and national reporting requirements, and incorporates improvements identified by the Trust. The use of NED and Executive Committee reviews was highlighted as an important element of the process, although these are not intended to be static arrangements.</p> <p>Members suggested that research metrics should be incorporated within future report. The Board also welcomed the addition of the iconography on page 153 of the report pack, which aligns measures to the NOF metrics and was considered a helpful enhancement.</p> <p>The Board noted the forthcoming changes to the National Oversight Framework and confirmed that these had already been considered by the committees.</p> <p>During discussion, reference was made to research reporting considered through DERIC. It was acknowledged that further work is required in this area, and the committee will continue to consider the development of research metrics and reporting over the coming months.</p> <p>The Board approved the Integrated Performance Report Annual Review.</p>
<b>6.3</b>	<b>Finance Performance Report</b>
	<p>AMW presented the Finance Performance Report and highlighted the following key points:</p> <ul style="list-style-type: none"> <li>At Month 12, the Trust delivered its planned underlying financial position, achieving a break-even position and performing slightly ahead of plan. This enabled the Trust to benefit from national deficit support funding. As a result, the Trust will receive £1.6 million in additional funding, which will be recognised in both income and cash balances.</li> <li>Agency expenditure remained below plan, although variable pay costs were higher than anticipated. This reflected the additional activity undertaken to support improvements in</li> </ul>

Ref	Discussion and Action Points
	<p>Referral to Treatment (RTT) performance. The increased use of bank and overtime staffing was managed within the overall workforce budget envelope approved for the year.</p> <ul style="list-style-type: none"> <li>Productivity continued to improve throughout the year. The Trust has closely monitored the national productivity metric, which carries a target of a 2% improvement across provider organisations. Productivity performance was impacted by a number of factors, including the Electronic Patient Record (EPR) implementation and the prior-year effects of significant insourcing activity. Whilst performance has improved progressively, the Trust ended the year at approximately -1.6% against the productivity measure, and this will remain a key area of focus in 2026/27.</li> <li>Cash and capital positions remained positive. The Trust ended the financial year with a cash balance of £16.2 million, slightly below plan due to the timing of income receipts and payments. The additional £1.6 million national funding allocation will further strengthen the cash position.</li> <li>The capital programme was delivered in line with the Trust's internal capital plan and included expenditure supported through grant funding, such as the rheumatology programme and elective theatre development. Total capital expenditure for the year was £12 million. Despite significant activity in the final month to maximise available allocations, all available capital funding was utilised successfully.</li> <li>From an efficiency perspective, the Trust delivered its most challenging efficiency programme to date, with a target of £9.6 million, representing 6% of expenditure. The programme was delivered in full, with a further £1.3 million achieved through non-recurrent measures. This reflected the significant efforts of departments across the organisation to identify and deliver efficiencies.</li> <li>Looking ahead to 2026/27, efficiency requirements remain challenging, with a target of 5.4%, including an additional stretch target introduced late in the planning process following completion of contract negotiations with the ICB.</li> </ul> <p>AMW concluded that, despite a challenging financial environment, the Trust had successfully delivered its planned financial position, secured additional national funding, achieved its efficiency targets, and maintained strong cash and capital performance, representing a positive outcome for the year.</p> <p>The Board commended the clarity and presentation of the financial and operational performance slides and was content with the assurance provided.</p>
6.4	<p><b>Chair Report from Finance and Performance Committee</b></p>
	<p>SN presented the Chair's Assurance Report and highlighted the following key points:</p> <ul style="list-style-type: none"> <li>The Trust successfully delivered its operational plan and achieved its financial target for the year.</li> <li>Recognition was given to teams across the organisation for their significant contribution, reflecting the positive commentary included within previous reports.</li> <li>The Efficiency Programme remained a significant challenge throughout the year. Delivery of the financial target relied on both recurrent and non-recurrent measures; however, the level of assurance provided throughout the year demonstrated the scale of achievement. It was noted that there are important lessons from this year's programme which can be applied moving forward.</li> <li>Looking ahead, the Committee had a positive discussion regarding the Assurance Review Committee (ARC) and the future direction of the meeting. Subject to achieving the remaining two constitutional standards, it is hoped that the Committee can be stood down in the coming months.</li> <li>Overall, the Trust is ending the year in a strong and positive position.</li> </ul> <p>In response to a question regarding the risk profile for next year and whether a greater proportion of high-risk schemes were expected later in the year, it was explained that planning is still underway and a number of programmes currently assessed as high risk will become more clearly defined over time. It is anticipated that these schemes will be de-risked as plans are further developed.</p> <p>The Board sought assurance regarding when confidence in delivery plans would be established. It was confirmed that significant programmes are expected to be agreed by the end of Quarter 1,</p>

Ref	Discussion and Action Points
	<p>with schemes carrying either low or medium levels of risk. In addition, a pipeline of further opportunities will continue to be developed and reported throughout the year.</p> <p>A correction was noted within the report, where reference had been made to a low level of assurance. This was identified as a typographical error, and the intended assessment was that a high level of assurance had been received. Strong assurance was therefore confirmed.</p> <p>The Committee also noted that the Deputy Chief Financial Officer, Gayle Wells, had recently commenced in post and was commended for the positive contribution she had made since joining the Trust at the beginning of the month.</p> <p>The Board noted the Chair's Report and confirmed that it was satisfied with the assurance provided.</p>
7.0	<b>Digital, Education, Research, Innovation and Commercialisation</b>
7.1	<b>Chair Report from Digital, Education, Research, Innovation and Commercialisation Committee</b>
	<p>ME presented the Chair's Assurance Report and highlighted the following key points:</p> <ul style="list-style-type: none"> <li>• The Committee discussed opportunities for both internal and external funding to support improvements across the organisation. Robust internal governance arrangements are now in place to support the development, prioritisation and approval of business cases where funding opportunities arise. However, members noted that there is currently limited discussion at system and regional level regarding wider funding priorities and opportunities. DERIC highlighted this as a potential gap and suggested that further consideration may be required regarding how the Trust can influence and engage in these conversations across the wider system.</li> <li>• An update was provided on the Electronic Patient Record (EPR) Programme. While significant progress continues to be made, the Committee emphasised the importance of ensuring a clear link between programme activity, delivery milestones and associated risks. Further assurance has been requested through the EPR Assurance Meeting, including clearer timelines and evidence of risk mitigation alongside programme progress.</li> <li>• The Committee received assurance regarding ongoing digital security work and welcomed the proactive approach being taken across the organisation in relation to phishing simulation exercises and cyber security awareness activities. Members recognised the value of this work and encouraged continued efforts to maximise organisational learning and staff awareness.</li> <li>• A positive update was received regarding research activity, including the appointment of a Research Project Officer. The role is expected to support the development of research opportunities, particularly for nursing and Allied Health Professional (AHP) staff. The Committee also discussed the ongoing challenge of creating sufficient protected time and capacity for clinical staff to engage in research activity and agreed this would require further consideration.</li> </ul> <p>ME also suggested that the presentation earlier in the meeting could be shared with DERIC for information.</p> <p>JP noted that there has been limited visibility within DERIC of innovation relating to robotic surgery. Whilst acknowledging that some robotic technologies are already in use within the Trust, members agreed that there would be value in receiving greater oversight of developments in this area. It was confirmed that this would be explored further through the planned as part of the Innovation Deep Dive scheduled for a future DERIC meeting.</p> <p>The Board noted the Chair's Report and confirmed that it was satisfied with the assurance provided.</p>
8.0	<b>Questions from the Governors and Public</b>
	<p>There were no specific comments or questions raised by the Governors or members of the public. The Chair thanked the Governors for their attendance at the meeting.</p> <p>NT offered congratulations to the Trust for its achievement in meeting the target and for the excellent performance demonstrated.</p>

Ref	Discussion and Action Points
	HT also extended thanks to the Governors, recognising their role in Trust and holding the Non-Executive Directors to account.
<b>9.0</b>	<b>Any Other Business</b>
	<p>There being no further business for discussion, HT thanked all attendees for their time and contributions before closing the meeting.</p> <p>Attendees were then invited to join the Sam Young Award Presentation, celebrating the Path of Positivity in memory of a greatly missed colleague.</p>
<b>9.1</b>	<b>Date and time of next meeting:</b> Wednesday 01 July 2026 at 9:30am

DRAFT

1
2
3
4
5
6
7
8
9
10
11

Member	First Name	Surname	Email	Position	Type of Interest	Description of Interest (including for indirect interests, details of the relationship with the person who has the interest)	Date interest relates From	Date interest relates To
Board	Harry	Turner		Chairman	Non-Financial Personal Interests	Presiding Justice West Mercia judiciary	01/10/2026	Ongoing
Board	Sarfraz	Nawaz		Non Executive Director	Financial Interests	Wakefield Council – Corporate Director of Resources	01/02/2026	Ongoing
Board	Sarfraz	Nawaz		Non Executive Director	Non-Financial Professional Interests	Member of CIPFA	01/01/2021	Ongoing
Board	Sarfraz	Nawaz		Non Executive Director	Non-Financial Professional Interests	S151 Officer for West Yorkshire Joint Services, and YPO	01/09/2025	Ongoing
Board	Martin	Evans		Non Executive Director	Financial Interests	Non-Executive Director at North Staffordshire Combined Healthcare NHS Trust	28/08/2024	Ongoing
Board	Martin	Evans		Non Executive Director	Financial Interests	Director at MJE Associates Ltd.	01/04/2020	Ongoing
Board	Martin	Evans		Non Executive Director	Financial Interests	Coach for the National Neighbourhood Health Implementation Programme	01/09/2025	Ongoing
Board	Penny	Venables		Non Executive Director	Financial Interests	Consultant – In-Form Solutions Ltd, Lichfield Business Hub, Lichfield Council House, 20 Frog Lane, Lichfield, Staffordshire, WS13 6YY. Work as a management consultant via this business.	01/01/2021	Ongoing
Board	Penny	Venables		Non Executive Director	Financial Interests	Trustee Board of Birmingham University Guild of Students	01/01/2025	Ongoing
Board	Penny	Venables		Non Executive Director	Financial Interests	Member of the Members Council of the West Bromwich Building Society	01/10/2024	Ongoing
Board	Penny	Venables		Non Executive Director	Non-Financial Professional Interests	Husband has also just been appointed as Interim CEO to the Devon, Cornwall and Scilly Isles	19/03/2026	Ongoing
Board	Penny	Venables		Non Executive Director	Non-Financial Personal Interests	Husband is NED at Birmingham and Black Country ICB	01/02/2026	Ongoing
Board	Penny	Venables		Non Executive Director	Non-Financial Personal Interests	Chair Kore Wellness, Tipton Sports Academy, Wednesbury Oak Road, Tipton, West Midlands DY4 0BS.	01/11/2023	Ongoing
Board	Martin	Newsholme		Non Executive Director	Financial Interests	Non executive Chairman of Shropshire Doctors Co-operative Limited	01/08/2019	Ongoing
Board	Martin	Newsholme		Non Executive Director	Financial Interests	Non executive director at Warrington Housing Association	01/09/2018	Ongoing
Board	Lindsey	Webb		Non Executive Director	Indirect Interests	Husband is a Deputy Chair at Birmingham, Black Country and Solihull ICB	17/11/2025	Ongoing
Board	Mike	Hallissey		Non Executive Director	Non-Financial Professional Interests	Non-Executive Director of Sandwell and West Birmingham NHS Trust	01/01/2022	Ongoing
Board	Mike	Hallissey		Non Executive Director	Non-Financial Professional Interests	Consultant Surgeon, University Hospitals Birmingham NHS Foundation Trust	01/05/1995	Ongoing
Board	Mike	Hallissey		Non Executive Director	Indirect Interests	Director, Pegasus Classic Car Parts Ltd	01/11/2025	Ongoing
Board	John	Pepper		Associate Non Executive Director	Financial Interests	GP appraiser for NHSE	2012	31/03/2026
Board	Paul	Maubach		Associate Non Executive Director	Non-Financial Professional Interests	Member of CIPFA	01/03/2023	Ongoing
Board	Paul	Maubach		Associate Non Executive Director	Financial Interests	Director for Neighbourhood Health (Department of Health)	01/08/2024	Ongoing
Board	Paul	Maubach		Associate Non Executive Director	Financial Interests	Director and Owner of Maubach Consulting Ltd	01/04/2023	Ongoing
Board	Stacey	Keegan		Chief Executive Officer	Non-Financial Professional Interests	Lead CEO for the NOA	01/12/2025	Ongoing
Board	Stacey	Keegan		Chief Executive Officer	Non-Financial Professional Interests	A member of the National Orthopaedic Alliance Board	03/05/2024	Ongoing
Board	Ruth	Longfellow		Chief Medical Officer	Financial Interests	Private Practice work for RJAH	01/01/2011	Ongoing
Board	Ruth	Longfellow		Chief Medical Officer	Non-Financial Professional Interests	Member and chair of the Jenner Society at Morton Hall and organiser of the annual MMI evening at RJAH	01/01/2016	Ongoing
Board	Ruth	Longfellow		Chief Medical Officer	Non-Financial Professional Interests	Member of Orthopaedic Institute	01/01/2016	Ongoing
Board	Mike	Carr		Chief Operating Officer	Indirect Interests	Parent is Chief Executive of Midlands Partnership NHS Trust.	01/05/2022	Ongoing
Board	Mike	Carr		Chief Operating Officer	Non-Financial Personal Interests	Trustee at Stay Charity	01/02/2025	Ongoing
Board	Denise	Harnin		Chief People and Culture Officer	Non-Financial Personal Interests	Spouse is completing consultant work at Johnson Fellows Charter House, Birmingham, Ad hoc HR consultancy Johnson Fellows (previously a senior partner)		Ongoing
Board	Angela	Mulholland-Wells		Chief Finance and Commercial Officer	Non-Financial Professional Interests	Board Trustee and chair of the Audit, Finance and Risk Committee for Mines Advisory Group.	01/10/2023	Ongoing
Board	Clair	Hobbs		Interim Chief Nurse and Patient Safety Officer	No interest to declare	N/A	N/A	N/A



The Robert Jones and Agnes Hunt  
Orthopaedic Hospital  
NHS Foundation Trust

# A Spotlight on Orthotics Manufacturing

Steven Bishton, Technical Lead for Orthotics Manufacturing

→ *Improving lives through excellent and innovative care*



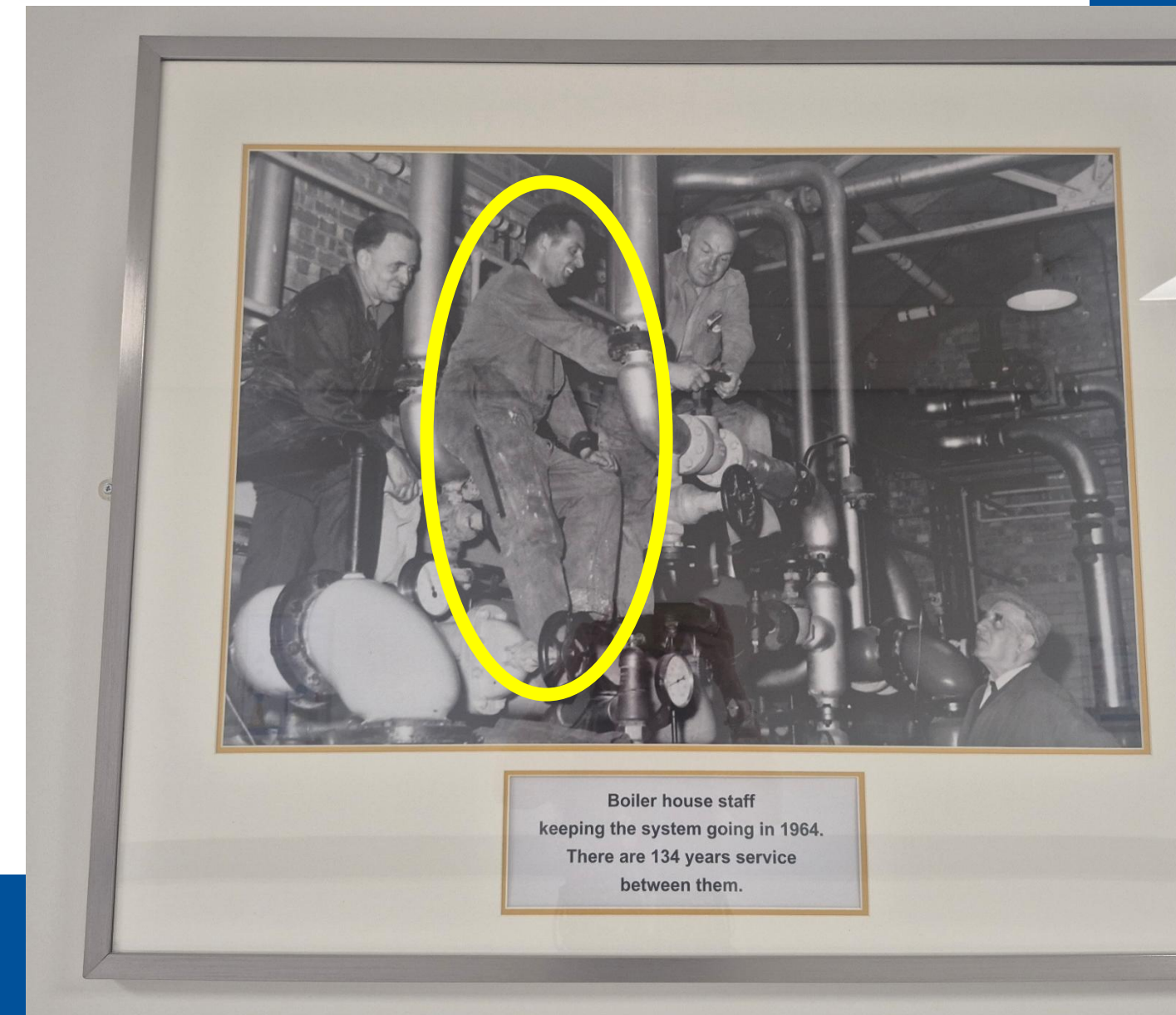
1
2
3
4
5
6
7
8
9
10
11

## → About Me

- Over 20 years at RJAH
- Started as Orthotic Technician
- Currently Technical Lead
- Passionate about developing people and the service



**NHS**  
and Agnes Hunt  
opaedic Hospital  
NHS Foundation Trust



# What is Orthotics Manufacturing?

- Design and manufacture bespoke external devices.
- Support, protect and improve movement.
- Examples:
  - Insoles
  - AFOs (leg braces)
  - Spinal jackets



- Bespoke manufacturing for every patient.
- Supporting a team of 17 orthotists.
- Services delivered across RJAH and SaTH.
- Key role in high-risk areas (e.g. diabetic foot care).

## ➔ Growing the Workforce

- New partnership with University of Derby
- First recognised training pathway:
  - Level 3 Manufacturing Apprenticeship
  - Level 5 Clinical Apprenticeship
- 2 apprentices qualified and 2 more starting in September 2026



# → Our People & Culture

Adaptable and supportive team culture...



The Robert Jones and Agnes Hunt Orthopaedic Hospital  
NHS Foundation Trust



**Mental Health First Aider**

MHFA England

## Ren Yates

Part of the LGBTQ+ community, atheist but open-minded. Loves the outdoors and take part in man...

[ren.yates@nhs.net](mailto:ren.yates@nhs.net)

Prosthetics and Orthotics  
The Robert Jones & Agnes Hunt  
NHS Foundation Trust



## Teri Jones

This is hard to put together without sounding like some sort of dating profile!! Jokes aside t...

[teri.jones@nhs.net](mailto:teri.jones@nhs.net)

Prosthetics and Orthotics  
The Robert Jones & Agnes Hunt  
NHS Foundation Trust

Health

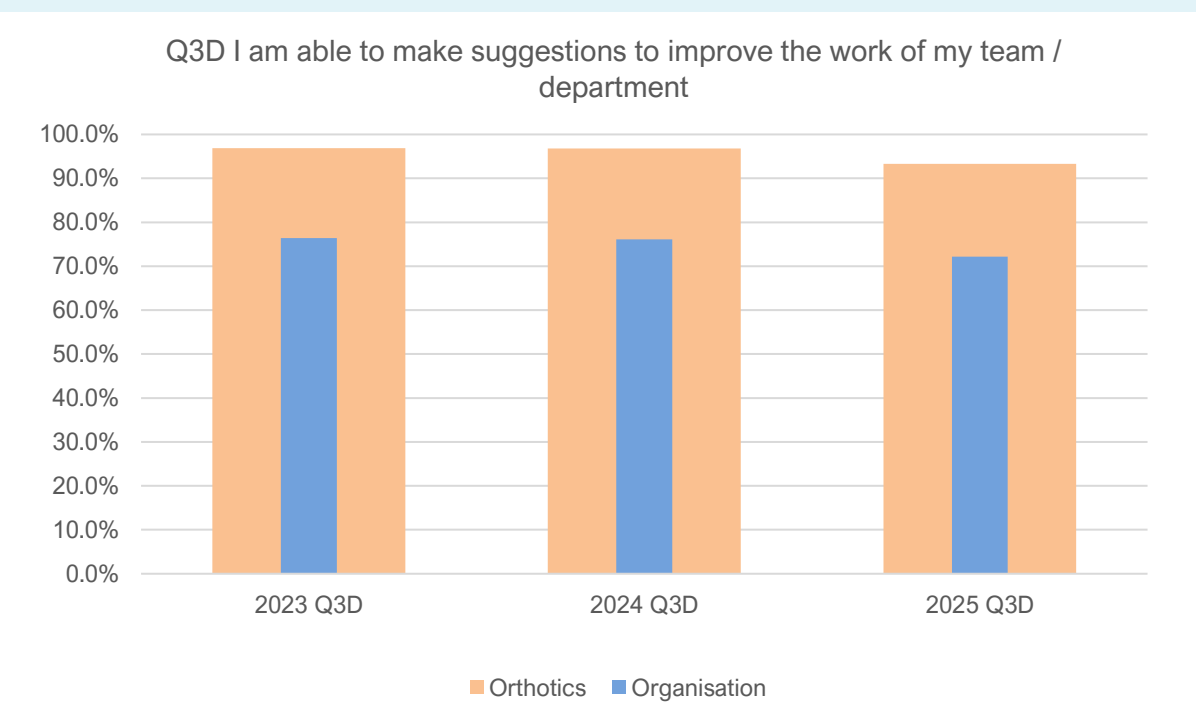
## Shropshire hospital team creates protective visors for care homes and hospices

Orthotics makers at Shropshire's specialist orthopaedic hospital have been churning out hundreds of face visors to support care homes and hospices with the Covid-19 response.

By Lisa O'Brien  
Digital Content Manager



Production and manufacturing team at The Robert Jones and Agnes Hunt Orthopaedic Hospital (RJA), near Oswestry, usually make a wide range of orthoses, to help patients with mobility issues.



Orthotics staff survey results were one of the highest against improvement questions!



Teri is now a member on the Technician Panel for the British Association of Prosthetists and Orthotists.

London Marathon for RJA Charity 2026

Orthotics Manufacturing Retention Rate: 90.91% against Trust target of 82%



## → Quality & Governance



- Preparing for MHRA registration
  - Strengthening governance and compliance
  - Clear documentation
  - Robust quality assurance systems
- Why does this matter?
  - Safer care
  - Greater confidence for patient and clinicians
  - Enables future commercialisation opportunities

# → Innovation & Improvement

Development of **satellite workshop** at SaTH to:

- Improve turnaround times
- Bringing manufacturing closer to clinics

**The Impact:**

- Better patient experience + responsiveness

New **Voxelcare 3D printing** technology:

- Manual production >2 hours
- 3D printer <60 mins

**The Impact:**

- Increased capacity
- More consistent production
- Frees up skilled staff time

Sharing more detail at  
DERIC Committee in the  
coming months!





The Robert Jones and Agnes Hunt  
Orthopaedic Hospital  
NHS Foundation Trust

# Thank you

Any questions?

➔ *Improving lives through excellent and innovative care*

# NHS

1
2
3
4
5
6
7
8
9
10
11

Chief Executive Officer Update

**Committee / Group / Meeting, Date**

Board of Director, Public Meeting, 01 July 2026

**Author:**

Name: Mike Carr  
Role/Title: Deputy Chief Executive Officer

**Contributors:**

Chris Hudson,  
Head of Communications

**Report sign-off:**

Mike Carr, Deputy Chief Executive Officer

**Is the report suitable for publication:**

Yes

**Key issues and considerations:**

This paper provides an update regarding key activities and updates not covered within the main agenda since the last Board from the Chief Executive Officer.

**Recommendations:**

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

Acronyms	
BMA	British Medical Association
FTSU	Freedom To Speak Up
HSJ	Health Service Journal
NED	Non-Executive Director
NHS	National Health Service
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust

## Chief Executive Officer Update

### 1. National Oversight Framework

Since the last public Board meeting, we have seen the fourth iteration of the National Oversight segmentation published for quarter 4 of 25/26. Based on their performance, each trust is placed into one of four core segments - segment 1 represents the organisations with the narrowest range of challenges while segment 4 contains those with the broadest. The dashboard shows what segment each trust is in as well as the data that has been used to make this decision. This latest update saw RJAH improve again, moving into segment 1 for the first time – and climbing from 22<sup>nd</sup> to 17<sup>th</sup> out of 134 Trusts. Moving into the top 20 and getting placed in segment 1 is a moment to be proud of for the Trust and reflects the huge progress we have made over the last 12 months. We had planned to mark a strong year with a celebration event last week, but postponed that due to the heatwave. It will be re-arranged, as it is important that we acknowledge and celebrate our successes, while maintaining our focus on continuous improvement.

### 2. Welcome to new NED Mr Mike Hallisey

We were delighted to announce the appointment of Mr Mike Hallisey to the post of Non-Executive Director. Mike took up his post on 1 June, and is attending his first public Board meeting today. Mike brings with him a wealth of leadership experience, deep clinical expertise, and a longstanding connection to RJAH. Throughout his distinguished career, he has played a significant role in training and mentoring generations of orthopaedic surgeons, many of whom have developed their careers here at RJAH and across the wider NHS.

### 3. Corporate Priorities

We recently launched our corporate priorities for 2026/27. These are a set of agreed actions to be achieved in 2026/27, aligned to our five-year Trust Strategy. Against each of the five strategic priorities within our overarching Trust Strategy, a number of corporate priorities have been set, as well as agreed actions for delivery, associated outcomes. There is also an assigned Senior Responsible Officer for each priority, as well as a Delivery Lead and an Assurance Committee. This process assures accountability across the year to monitor progress and delivery. We have already begun rolling this out to the organisation, aiming to ensure that everyone who works here has a feel for where they, in their own individual role, fit into the big picture, and how their contributions are helping the Trust achieve its goals.

### 4. Mann Review into antisemitism and racism in the NHS

Earlier this month, we saw the publication of Lord Mann's review into antisemitism and other forms of racism within the NHS. The experiences described by some Jewish staff and patients are deeply concerning and have no place in a modern NHS. The review also serves as a reminder that all healthcare organisations must remain vigilant in tackling racism, discrimination and exclusion in all their forms. We shouldn't think that none of this applies to us here at RJAH. We are clear that everyone has the right to be treated with dignity, respect and fairness — whether they are receiving care, visiting our hospital or working as part of our team. Racism, discrimination and hatred have absolutely no place at RJAH, within the NHS or anywhere. Every member of staff deserves to feel safe, valued and respected at work, and every patient deserves to receive compassionate care in an environment where they are treated with dignity and kindness.

While we are proud of the culture we have built at RJAH, we recognise that creating an inclusive organisation is not something we can ever take for granted. It requires continuous learning, listening and action. We fully support the recommendations of the Mann Review and the national commitment to strengthen the NHS response to racism and discrimination.

### 5. RJAH shortlisted for prestigious national patient safety award

I was delighted to see that we have got a shortlisted finalist in the HSJ Patient Safety Awards. The awards recognise the individuals, teams and organisations who are improving patient safety and addressing the complexities of delivering safe care amidst times of significant change and long-standing pressures. We were shortlisted in the 'Harnessing a Human Factors Approach to Improve Patient Safety category'. The project that we have been shortlisted for is called 'Blending Human Factors and Improvement Magic'. It focused on giving staff at every level of the organisation the confidence, skills and support to improve the way care is delivered. By combining Human Factors with quality improvement, RJAH has created a culture where staff are encouraged to identify risks, challenge the status quo and test new ideas that make a real difference for patients and colleagues. This approach has already inspired a growing network of Improvement Champions, with staff leading projects that have strengthened patient safety, improved patient experience and enhanced the way

## Chief Executive Officer Update

teams work together. Well done to everyone involved, and we wish you well at the awards themselves later in the year.

### 6. Industrial Action

Earlier this month, we were due to see the latest round of industrial action across England by Resident Doctors, as part of a dispute with the government over pay. This action was called off less than two days before it was due to begin, after a new deal was reached between the government and the British Medical Association. That deal, which focusses on working conditions for Resident Doctors rather than further pay rises at this time, will now be voted on by members of the BMA. We welcome the progress made towards a resolution, but should there be any further rounds of industrial action then we will maintain our focus on ensuring patient safety and minimising disruption for our patients.

### 7. Thank you to our incredible London Marathon runners

We are hugely grateful to the 13 remarkable runners who took part in this year's London Marathon, in aid of the RJAH Charity. The money has now all been collected, and we were delighted to reveal last month that their collective efforts had raised an incredible £29,000. To thank them, we hosted a celebration event at the hospital. The London Marathon is the biggest fundraiser on the calendar, and all runners play a huge part in enabling us to provide the best possible support to patients and staff at RJAH. The funds raised by the team will go into our wider charitable funds pot, which is used to fund projects across the hospital to support patient care and improve staff services.

### 8. Galvanise Ethnic Minority Leadership Programme

We are delighted to be supporting the rollout of the Galvanise Ethnic Minority Leadership Programme, which is running across Shropshire, Telford and Wrekin. The programme is aimed at ethnic minority staff with leadership aspirations – whether they are in clinical or non-clinical roles. It focusses on self-awareness, leadership development, relationship building, networks and development planning to equip you with the skills, confidence, and knowledge to be ready for promotion opportunities and/or future development opportunities. The next cohort of the programme will start in September.

### 9. New Freedom To Speak Up Guardian

We are delighted to have last week welcomed Kate Hannah to the Trust as our new Freedom To Speak Up Guardian. This is an important role for RJAH, helping ensure that colleagues have a safe, confidential and supportive route to raise concerns, share ideas and speak openly where they feel something is not right. The Guardian is a valuable source of independent support for staff and an important part of our wider patient safety and improvement culture, helping us listen, learn and act on the issues that matter to colleagues and patients. Kate's appointment also comes at a time when NHS organisations are being asked to take even greater responsibility for embedding effective Freedom To Speak Up arrangements, and we look forward to working with her to continue strengthening our approach.

### 10. RJAH Stars Award

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

- Our April winner was **Dan Booth**, our Clinical Audit Quality Lead, who was recognised for the vital role he has played in guiding teams during the implementation of Radar Healthcare – a system used to support patient safety, patient experience, risk management and clinical and quality audits. Dan was nominated by Louise Arnold, the Deputy Radiology Services Manager and Quality Lead, who said Dan was always incredibly helpful and supportive whenever she has a query, but his support during the rollout of Radar was particularly outstanding.
- Our May winner was **Dylan Murphy**, our Trust Secretary, who received his award in recognition of the significant impact he's made in strengthening governance and assurance across the Trust. As Trust Secretary, Dylan's role involves working independently across the Board of Directors, executive team and wider staff as a trusted and impartial advisor. He was nominated by Mary Bardsley, Assistant Trust Secretary, who praised both his leadership and the positive impact he has on colleagues across the Trust.

## Chief Executive Officer Update

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

### 14. Conclusion

---

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

1
2
3
4
5
6
7
8
9
10
11

## Board and Committee meeting pattern, 2026/7

### (Part 1) Covering paper

<b>Committee / Group / Meeting, Date</b>	
Board of Directors, 1 July 2026	
<b>Author:</b>	<b>Contributors:</b>
Name: Dylan Murphy Role/Title: Trust Secretary	Members of the Board of Directors (via discussion at the session on 3 <sup>rd</sup> June 2026)
<b>Report sign-off:</b>	
N/A	
<b>Is the report suitable for publication?:</b>	
YES	
<b>Executive Summary:</b>	
<p>At the private session of the Board in June 2026, it was agreed that thought should be given to reconfiguring the Board committee meeting arrangements. The aim of this was to support Board effectiveness through:</p> <ul style="list-style-type: none"> <li>• Updating the assurance reporting arrangements to reflect the current state of performance and Board assurance;</li> <li>• Providing time in the schedule to react to issues as they arise and/or concentrate on longer-term, strategic thinking;</li> <li>• Aligning committee meetings and associated assurance reporting with public Board meetings;</li> <li>• Optimising the use of executives' time by reducing the need for routine reporting;</li> <li>• Enhancing the quality of papers, and the timeliness of paper circulation, to support effective assurance committee meetings</li> </ul> <p>The proposal is to hold formal committee meetings, requiring the full suite of assurance reports, in alternate months. Those meetings will be scheduled to feed the public Board meetings the following month. That pattern will begin from the July committee meetings onward. That requires a switch in the sequence of public Board meetings from "August" onward, resulting in consecutive public Board meetings (in July and "August")</p> <p>The Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee has operated to a slightly different model, reflecting its dual assurance and developmental role. Further thought is being given to how DERIC can best deliver its role in line with the revised Board assurance arrangements.</p> <p>In the intervening months, committee chairs will meet with the relevant lead execs (probably virtually) to consider key performance issues, risks, developments etc. that relate to the remit of their committee. Individual committee chairs will discuss the assurance requirements for these sessions, but they should not involve a significant reporting burden.</p> <p>The move to committee meetings in alternate months will mean that:</p> <ul style="list-style-type: none"> <li>• The Corporate Risk Register will be considered at every "full" committee meeting and public Board meeting (i.e. at two monthly intervals).</li> <li>• The Board Assurance Framework (BAF) will be considered every other "full" committee meeting and public Board meeting (i.e. at four monthly intervals).</li> </ul>	
<b>Recommendations:</b>	
<p>That the Board:</p> <ol style="list-style-type: none"> <li>1. CONSIDER the revised pattern of committee meetings and formal assurance reporting on the Board Assurance Framework and Corporate Risk Register; and</li> <li>2. APPROVE implementation of the revised arrangements</li> </ol>	

\* "August" meeting actually scheduled for 29 July.

## Board and Committee meeting pattern, 2026/7

### (Part 2) Strategic alignment and supporting detail

#### Strategic objectives and associated risks:

The work of the committees, and the Board assurance arrangements, support delivery of all of the Trust's strategic objectives:

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

The work of the committees, and the Board assurance arrangements, are relevant to all of the Board Assurance Framework (BAF) themes and associated strategic risks:

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

#### Trust values:

Board and committee meeting agendas each include an opportunity to reflect on the extent to which the agenda / discussion reflect and support the Trust's values:

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

#### Report development and engagement:

The Board discussed the proposed revision to the sequencing of committee meetings at its private session on 3<sup>rd</sup> June.

Each committee has considered its own terms of reference, in order to amend the frequency of meetings, at the July round of meetings.

#### Next steps:

The revised sequence will start from the July committee / August Board meetings.

In line with a request from the Council of Governors (CoG), thought will be given to aligning CoG meetings with public Board meetings.

Each committee will need to review its work plan to fit the revised meeting pattern.

A revised paper approval and submission process will be implemented to support the effective running of the "full" committee meetings.

The arrangement will be kept under review to ensure it continues to provide the necessary degree of assurance to the Board.

Attachment: Board and Committee meeting pattern 2026/7 V01

Proposed committee and Board meeting sequence proposal, showing changes in Board Assurance Framework (BAF), Corporate Risk Register (CRR) reporting and Council of Governors' (COG) meetings in tracked-change style):

	JUN	JUL	AUG*	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
<b>BOARD</b>	Priv. / devel.	<b>Pub</b>	<b>Pub</b>	Priv. / devel.	<b>Pub</b>	Priv. / devel.	<b>Pub</b>	Priv. / devel.	<b>Pub</b>	Priv. / devel.	<b>Pub</b>
<b>CTTE</b>	<b>Full</b>	<b>Full</b>	Inf. / devel.	<b>Full</b>	Inf. / devel.	<b>Full</b>	Inf. / devel.	<b>Full</b>	Inf. / devel.	<b>Full</b>	Inf. / devel.
<b>CRR</b>		X		X		X		X		X	
<b>BAF</b>		X			X	X		X		X	X
<b>COG</b>	X			X (AGM)			X			X	X

\* "August" meeting actually scheduled for 29 July.

Priv. / devel. = Private Board meeting, or "paper light, forward-looking" Board development / strategy sessions.

Inf. / devel. = Informal Committee Chair / Exec sessions, or "paper light, forward-looking" Committee development / strategy sessions.

# National Oversight Framework

## (Part 1) Covering paper

<b>Committee / Group / Meeting, Date</b>	
Board of Directors – Public Meeting. 01 July 2026	
<b>Author:</b>	<b>Contributors:</b>
Name: Steph Wilson Role/Title: Head of Improvement and Business Insight	
<b>Report sign-off:</b>	
Name: Mike Carr Role/Title: Deputy Chief Executive Officer	
<b>Is the report suitable for publication?:</b>	
Yes	
<b>Executive Summary:</b>	
<p>The revised and evolved 2025/26 NHS England Oversight Framework (NOF) went live and became public facing during the 2025/26 financial year. Quarter 4 (Q4) has now been published. This paper provides oversight of latest Q4 positions and movements seen for 2025/26.</p> <ul style="list-style-type: none"> <li>The Trust overall moved from segment 2 (Above Average) to segment 1 (High Performing).</li> </ul> <p>Oversight continues across NOF metrics. Example reflections from the latest publication include;</p> <ul style="list-style-type: none"> <li>The Trust has continued to improve its 'Access to Services'</li> <li>Staff survey metrics are now reflective of 2025 results.</li> <li>Financial plans have continued to be met.</li> <li>Infection rates remain low.</li> </ul> <p>The NOF metrics are to further evolve for 2026/27, and committee/board reports will be updated accordingly to align with any changes.</p> <p>RJAH board is requested to review the latest published performance for Q4; noting the performance and movements for 2025/26.</p>	
<b>Recommendations:</b>	
<p>RJAH will continue:</p> <ul style="list-style-type: none"> <li>To review evolvments to future NOF metrics and to ensure our board reports align.</li> <li>To ensure the Trust has oversight and actions in place to mitigate as far as possible current risks and/or is taking actions to support improvements. The Trust recognises the opportunities that could further support support improvements to the Trust NOF scores.</li> </ul>	

## (Part 2) Strategic alignment and supporting detail

### Strategic objectives and associated risks:

The following strategic objectives, developed in light of national and system priorities, are relevant to the content of this report:

Trust Objectives	
1 Deliver high quality clinical services	✓
2 Develop our veterans service as a nationally recognised centre of excellence	✓
3 Integrate the MSK pathways across Shropshire, Telford and Wrekin	✓
4 Grow our services and workforce sustainably	✓
5 Innovation, education and research at the heart of what we do	✓
The NOF contains metrics that relate and support delivery to Trust Objectives:	
<ul style="list-style-type: none"> <li>Caring for Staff</li> <li>Caring for Patients</li> </ul>	

## National Oversight Framework

- Caring for Finances

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

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

### Trust values:

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

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

### Report development and engagement:

The Q4 NOF ratings have been presented as part of performance reporting through our sub-committees of the Trust board for June 2026. The latest results are also available to the public via the public facing NHS England dashboard.

### Next steps:

The Trust will continue to monitor NOF ratings internally through its Integrated Performance Reports. Internal reports will further evolve. NOF metrics for 2026/27 have now been released to providers.

### Supporting detail (if required):

Trusts have been made aware of the Q4 2025/26 National Oversight Framework (NOF) scores, and these are shown in Attachment A.

A high-level summary of the Trust overall positive NOF movement seen for each quarter is shown in the table below:

	Segment	Average Metric Score (and improvement since previous quarter)	Metric score improvement since Q1	League table position out of 134 (and change since previous quarter)	League position improvement since Q1
2025/6, Q4	1	1.93 (0.26)	0.38	17 (+5)	+10
2025/6, Q3	2	2.19 (0.03)	0.12	22 (+3)	+5
2025/6, Q2	2	2.22 (0.09)	0.9	25 (+2)	+2
2025/6, Q1	2	2.31	-	27	-

## National Oversight Framework

### Acronyms

---

NOF	National Oversight Framework
Q4	Quarter 4
Q1	Quarter 1
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
RTT	Referral to Treatment

### Attachments

---

<b>Attachment A</b>	<b>National Oversight Framework</b>
---------------------	-------------------------------------

## National Oversight Framework

### Background: - National Oversight Framework

The published National Oversight Framework from NHS England is with an aim to ensure consistency and transparency in assessing integrated care boards (ICBs) and NHS trusts and foundation trusts. It provides a foundation for how NHS England works with systems and providers to support improvement.

The framework is supported by a focused set of national priorities, including those that are set out in the NHS England planning guidance for 2025/26.

These are presented alongside wider contextual metrics that reflect medium-term goals in areas such as inequalities and outcomes.

2025/26 focused metrics are categorised into five domains: - 'Access to Services', 'Effectiveness and Experience', 'Patient safety', 'People and Workforce', 'Finance and Productivity'. Trust performance is published via an NHS England dashboard available to the public.

The NHS England published dashboard provides a view of how NHS trusts are performing in key services including urgent and emergency care, elective services, mental health and more.

The league tables show how local trusts compare with others across England on both these individual services and at an overall level. The league tables also include a 'Trust Rank' as part of benchmarking this position.

Based on their performance each trust is placed into one of four core segments - segment 1 represents the organisations with the narrowest range of challenges while segment 4 contains those with the broadest.

For the first time, RJAH has been placed in segment 1, having been in segment 2 since the new NOF was established for 2025/26. Only 21 Trusts are in segment 1 in this latest iteration of the league tables.

### Positive Movement for 2025/26: - National Oversight Framework

RJAH for Q4 has been ranked 17th among all 134 NHS Acute Trusts in the latest league tables published as part of the NHS National Oversight Framework (NOF). This is a positive movement from Q1 where RJAH was 27th.

The published results for RJAH quarter 4 (Attachment A) are reflective of the continuous improvement efforts within our hospital throughout 2025/26.

For example, as part of published 2025/26 Planning Priorities NHS England set out the following expectation that is reflective in 'Access to Services' metrics:

- *"Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement against the November 2024 baseline, with all providers required to increase their RTT performance to a minimum of 60%."*

For Q1 RJAH had 45.29% of people waiting less than 18 weeks. For Q4 this had improved to 62.2% and met NHS England planning priorities set for our Trust. Overall; 'Access to Services' metrics positively moved from segment 4 to segment 3 and a Trust rank from 131/131 to 85/131. This is a movement of 46 places. The Trust continuous improvement focus is ongoing.

All NOF metrics are reviewed across domains, and organisation actions are taken accordingly for any opportunities to improve. This is inclusive of reviewing the 2025 staff survey results reflective in Q4 publication for example.

# National Oversight Framework

## Attachment A – National Oversight Framework

SUB-CATEGORY	METRIC	Score				Performance				Rank			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Elective Care	Percentage of people waiting less than 18 weeks score	4	3.82	3.45	3.19	45.39%	52.72%	55.8%	62.2%	131/131	123/131	107/131	95/130
	Difference between planned and actual 18 week performance score	3	1	1	1	-0.93%	5.23%	3.46%	2.13%	108/131	11/131	15/131	42/130
	Percentage of patients waiting over 52 weeks score	3.98	3.94	3.85	3.13	7.75%	6.95%	4.09%	1.80%	130/131	128/131	124/131	104/130
<b>Access to Services Overall Segment</b>		4	4	3	3	3.66	2.92	2.77	2.44	131/131	109/131	95/131	85/131
Patient experience	CQC inpatient survey satisfaction rate score	1	1	1	1								
Effective flow and discharge	Average number of days from discharge ready date to actual discharge date score	1.91	1.7	3.36	1.52	0.60	0.44	1.28	0.34	39/126	30/125	100/127	23/128
<b>Effectiveness and experience of care Overall Segment</b>		1	1	2	1	1.46	1.35	2.18	1.26	15/134	12/134	62/134	12/134
Patient safety	NHS Staff Survey - raising concerns sub-score score	2.17	2.17	2.17	2.35	6.51	6.51	6.51	6.36	53/134	53/134	53/134	61/134
	CQC safe inspection score (if awarded within the preceding 2 years)												
	12 month rolling count of MRSA cases score	1	1	1	1	0.00	0.00	0.00	0.00				
	12 month rolling count of C. difficile cases as a proportion of trust threshold score	1	3.7	1	1	1.00	1.50	0.50	0.50				
	12 month rolling count of E. coli cases as a proportion of trust threshold score	1	1	1	1	0.67	0.22	0.11	0.22				
<b>Patient Safety Overall Segment</b>		1	1	1	1	1.59	2.04	1.59	1.68	3/134	21/134	3/134	9/134
Retention and Culture	Sickness absence rate score (quarter)	2.69	2.66	2.19	1.88	5.49%	4.97%	5.01%	5.29%	87/134	86/134	67/134	50/134
	NHS staff survey engagement theme score	1.2	1.2	1.2	1.56	7.34	7.34	7.34	7.04	10/134	10/134	10/134	26/134
<b>People and Workforce Overall Segment</b>		1	1	1	1	1.95	1.93	1.7	1.72	36/134	35/134	27/134	29/134
Finance	Combined finance score	1	1	1	1								
	Planned surplus/deficit score	1	1	1	1	0	0	0	0	12/134	12/134	12/134	12/134
	Variance year-to-date to financial plan score	1	1	1	1	0.03	0.01	0.00	0.96	25/134	30/134	33/134	7/134
Productivity	Implied productivity level score	3.44	3.98	3.91	3.57	-0.27	-13.82	-4.90	-0.65%	109/134	133/134	130/134	115/134
<b>Finance and Productivity Overall Segment</b>		3	3	3	3	2.22	2.49	2.45	2.29	59/134	72/134	56/134	69/134
<b>OVERALL SEGMENT, AVERAGE METRIC AND LEAGUE TABLE POSITION</b>		2	2	2	1	2.31	2.22	2.19	1.93	27/134	25/134	22/134	17/134

**Key:**

- Low performing
- Below average
- Above average
- High performing



Contextual metrics accompanying quarter 4 positions are:

	Performance	Time Period
EFFECTIVENESS AND EXPERIENCE OF CARE DOMAIN: - Percentage of patients readmitted within 30 days of discharge – comparative band	Provider value of 1 given when 2024/25 data observed. 1 is the best performing comparative band.	2024/25
PATIENT SAFETY DOMAIN: - Percentage of hospital spells with at least one pressure ulcer diagnosis	RJAH has been given a rate of 0.73% for Dec 2025. This is within quartile 2 when benchmarked nationally. <i>(Quartile 1 is the best performing)</i>	Dec-25
PEOPLE AND WORKFORCE DOMAIN: - National Education and Training Survey “Overall experience” survey score	RJAH 91.25% for 2025. This is within quartile 4 (best performing) when benchmarked nationally. RJAH is one of the top 3 providers.	2025
NEW DOMAIN: - IMPROVING HEALTH AND REDUCING INEQUALITY. Preventing ill health:- Percentage of people waiting 6 weeks or over for a diagnostic procedure or test	RJAH 11.33% for Dec 2025. This is within quartile 2 when benchmarked nationally. <i>(Quartile 1 is the best performing)</i>	Dec-25

1
2
3
4
5
6
7
8
9
10
11

# Trust Board - Quality & Safety

## May 2026 – 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:

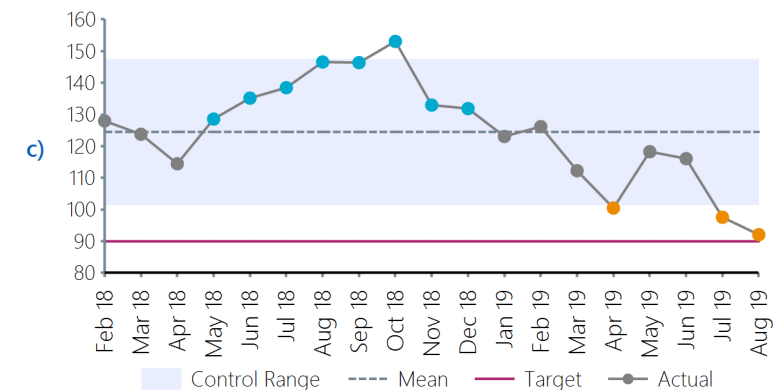
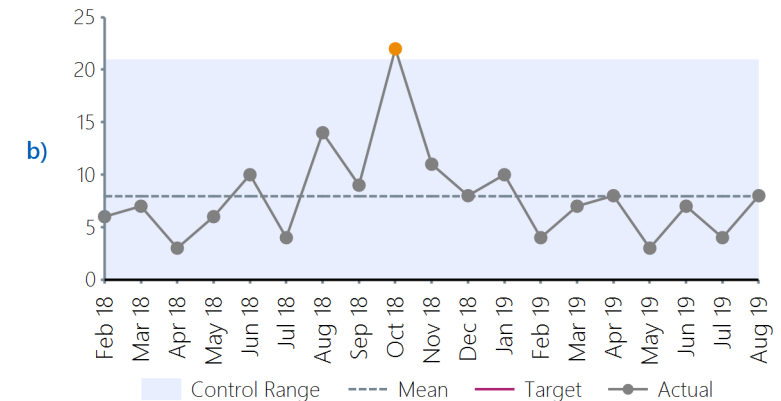
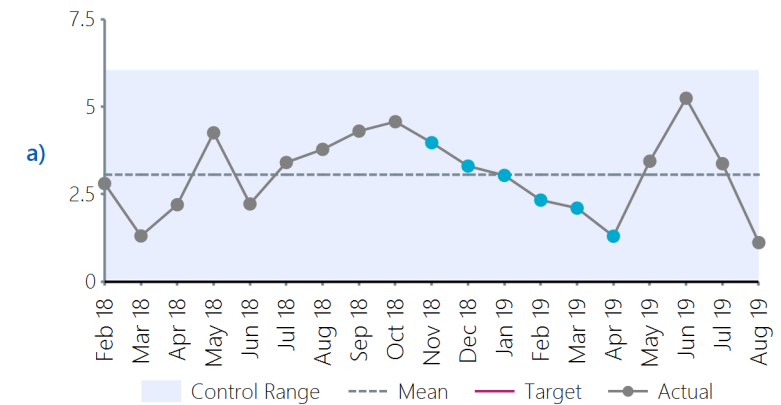
- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of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

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.

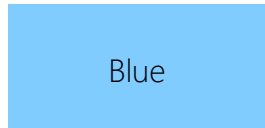
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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



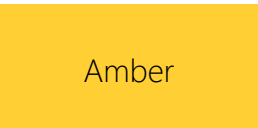
Blue

No improvement required to comply with the dimensions of data quality



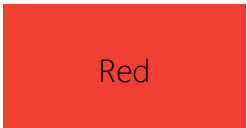
Green

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.

1
2
3
4
5
6
7
8
9
10
11



# Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
Patient Safety Incident Investigations		0						
Number of Complaints	14	19				+		
Discharge Ready Date to Actual Discharge Date	0.61	0.30				+		+
RJAH Acquired C.Difficile	0	0				+		+
RJAH Acquired E. Coli Bacteraemia	0	0				+		+
RJAH Acquired MRSA Bacteraemia	0	0				+		+
RJAH Acquired MSSA Bacteraemia	0	0						
RJAH Acquired Klebsiella spp	0	0						
RJAH Acquired Pseudomonas	0	0						
Surgical Site Infections	0	0				+	04/03/24	



# Summary - Caring for Patients

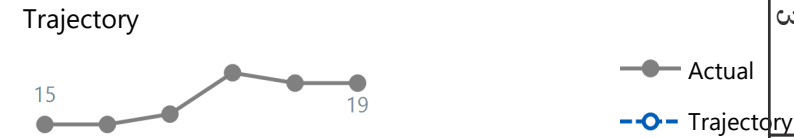
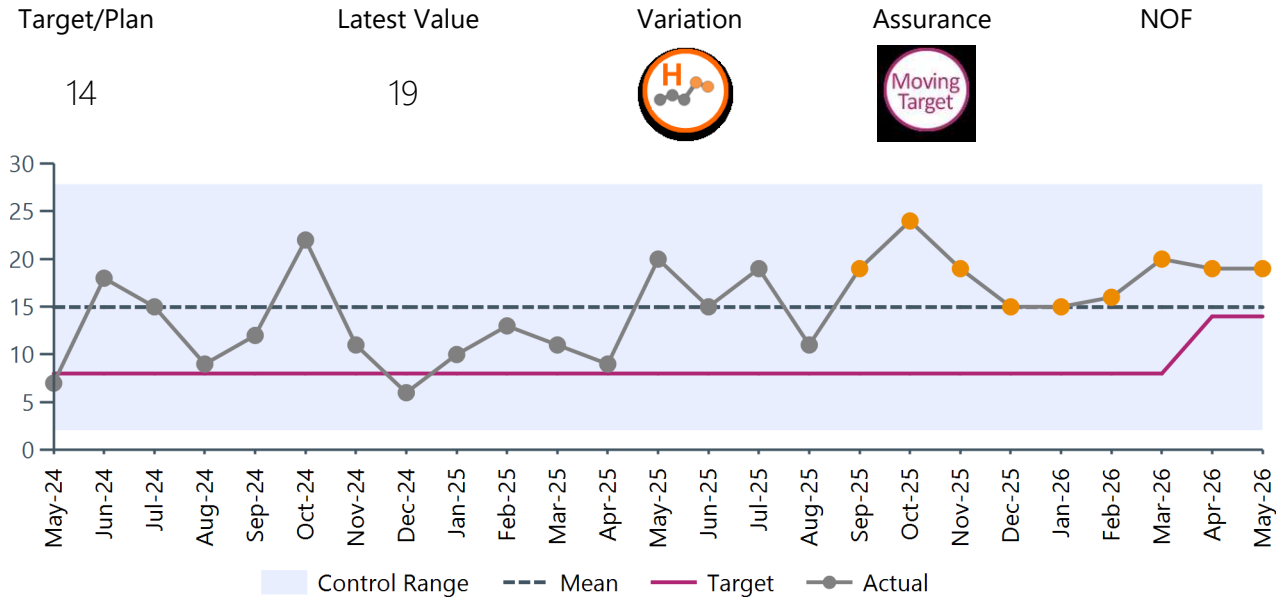
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
Outbreaks	0	1				+	04/03/24	3
Number of Deteriorating Patients	5	3						4
Total Deaths	0	1				+	12/09/23	5
WHO Quality Audit - % Compliance against NatSSIPs 2	95%	100%						6

1
2
3
4
5
6
7
8
9
10
11

# Number of Complaints

Number of complaints received in month 211105

Exec Lead:  
 Chief Nurse and Patient Safety Officer



## What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. Following the target change, the assurance icon indicates a moving target.

## Narrative

There were nineteen complaints received throughout May. The volume continues to exceed the tolerance and remains reported as special cause variation of a concerning nature with the data points since September all reported above the mean. A breakdown of reasons:

- \* Waiting Times (5)
- \* Communications (4)
- \* Staff Values and Behaviour (3)
- \* Admissions, discharge and transfers excluding delayed discharge due to absence of care package (3)
- \* Patient Care including Nutrition / Hydration (2)
- \* Appointments including delays and cancellations (2)

When reviewing the volume of complaints it is important to consider the impact of increased activity levels.

## Actions

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

Focus on improved communications and waiting well being reviewed as part of specific Task and Finish Group. Actions have been identified by this group and are monitored through the Quality & Safety Committee.

As 'Values and Behaviour' has been identified as a theme, a deep dive will be presented to Patient Experience in June.

A review of the complaints process has been undertaken and discussed with the Exec Team. It has highlighted early resolution as a main area of focus with a new approach offering patients, and their families, the opportunity to discuss complaints in the first instance. The aim is to include more engagement from teams within the Units as part of this process with the hope that it will assist with improving response rates. Work to streamline the complaints process will continue into quarter two.

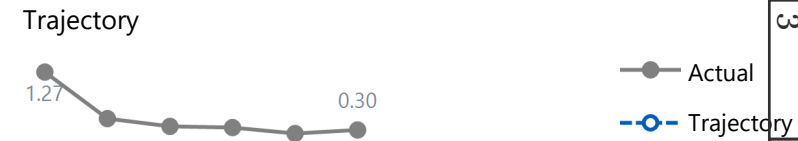
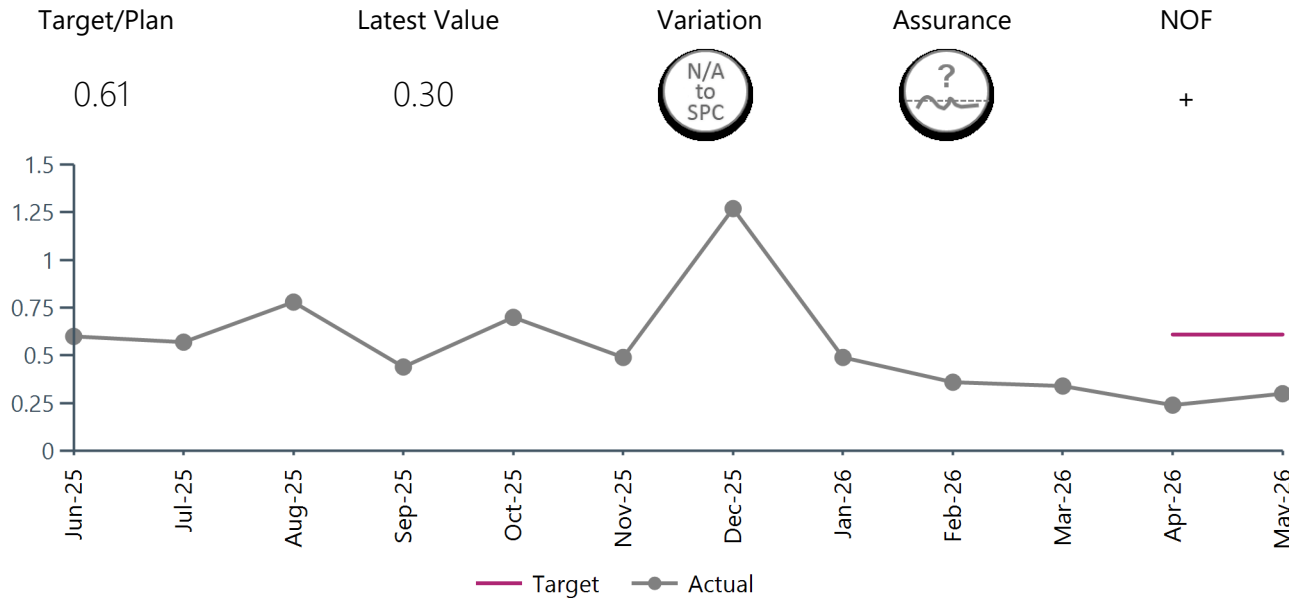
May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
20	15	19	11	19	24	19	15	15	16	20	19	19

- Staff - Patients - Finances -

# Discharge Ready Date to Actual Discharge Date

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

Exec Lead  
 Chief Nurse and Patient Safety Officer



### What these graphs are telling us

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

### Narrative

This metric reports on the 'Average Days from Discharge Ready Date to Actual Discharge Date'; it includes zero days - as per NHSE methodology. It measures the extent of delays experienced by patients who are medically ready for discharge but are unable to be discharged from hospital.

For those patients discharged in May the average days was 0.30 days so sits within the target. This metric has been included as an exception to reference the latest NOF publication.

The latest NOF Publication relates to Quarter 4 where the NOF score for this metric is 1.52.

### Actions

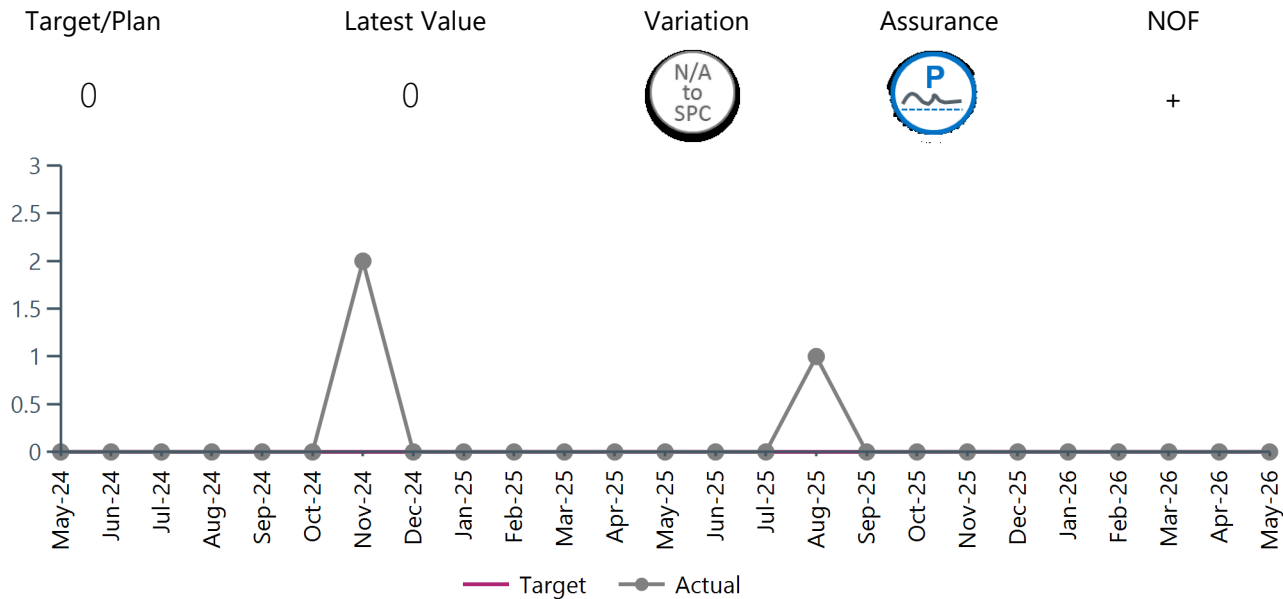
May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	0.60	0.57	0.78	0.44	0.70	0.49	1.27	0.49	0.36	0.34	0.24	0.30

- Staff - Patients - Finances -

1
2
3
4
5
6
7
8
9
10
11

# RJAH Acquired C.Difficile

Number of cases of C.Difficile in Month 211149



### What these graphs are telling us

This measure is not appropriate to display as SPC. Metric is consistently reported within the tolerance.

### Narrative

There were no RJAH Acquired C.Difficile reported in May. This metric has been included as an exception to reference the latest NOF publication.

The latest NOF Publication relates to Quarter 4 where the NOF score for this metric is 1. This position relates to the rolling twelve months period of April-25 to March-26 where in that period the Trust reported one infection in August-25.

### Actions

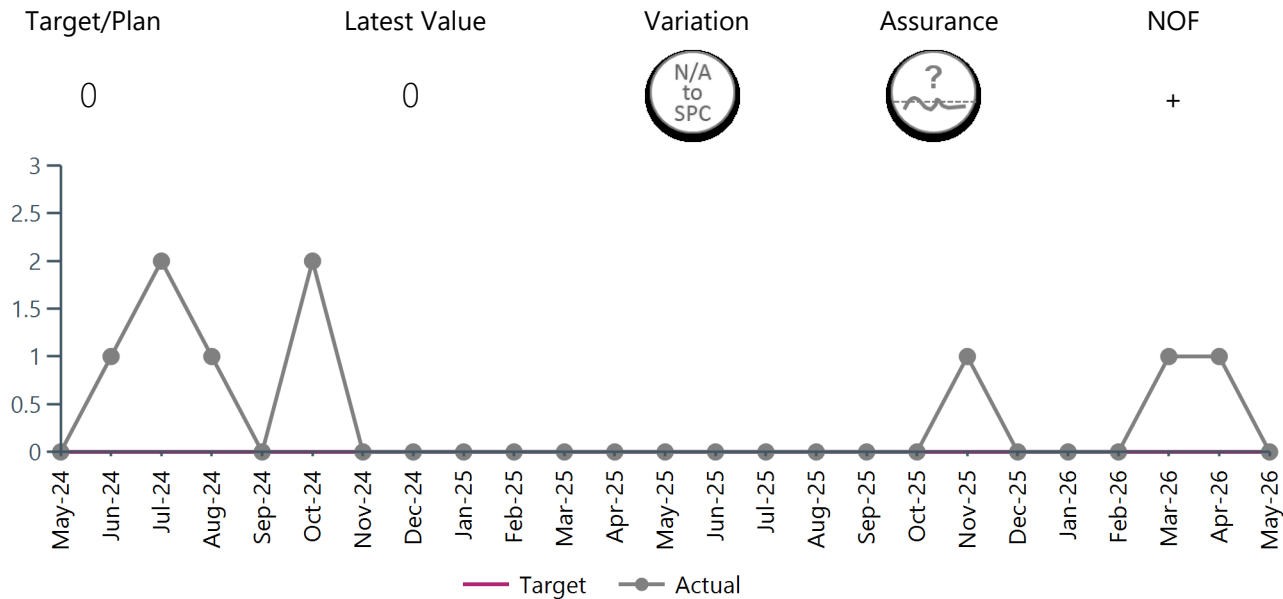
May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
0	0	0	1	0	0	0	0	0	0	0	0	0

- Staff - Patients - Finances -

1
2
3
4
5
6
7
8
9
10
11

# RJAH Acquired E. Coli Bacteraemia

Number of cases of E. Coli Bacteraemia in Month. 211150



### What these graphs are telling us

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

### Narrative

There were no RJAH Acquired E. Coli Bacteraemia reported in May. This metric has been included as an exception to reference the latest NOF publication.

The latest NOF Publication relates to Quarter 4 where the NOF score for this metric is 1. This position relates to the rolling twelve months period of April-25 to March-26 where in that period the Trust reported two infections; November-25 (1) and March-26 (1).

### Actions

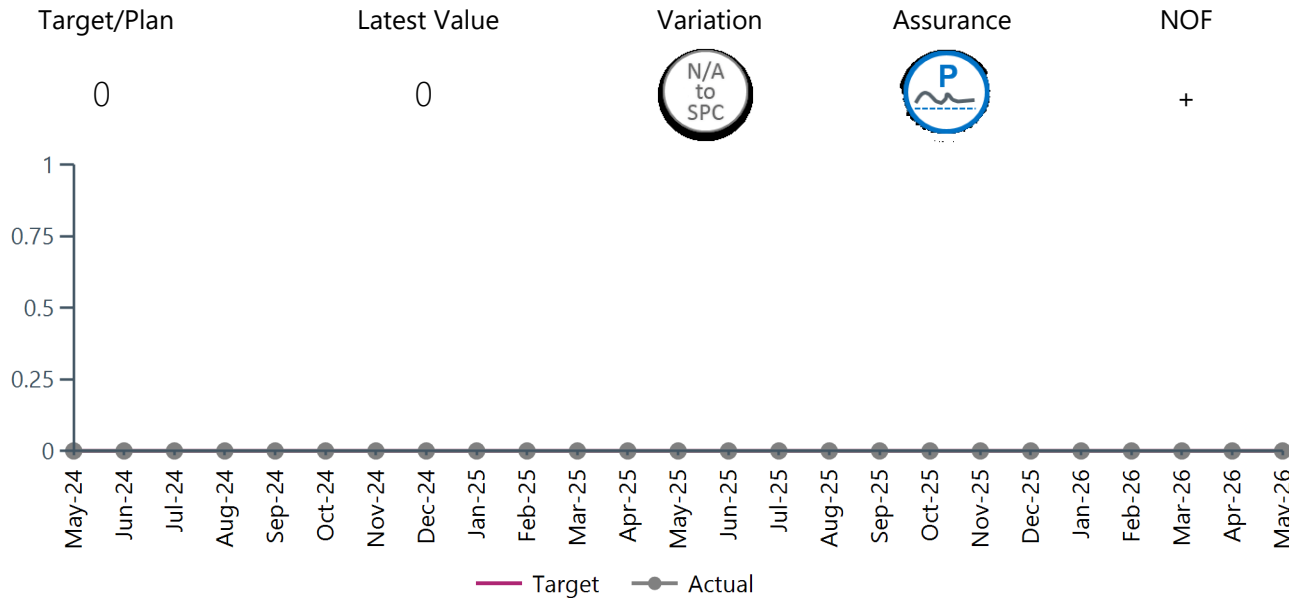
May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
0	0	0	0	0	0	1	0	0	0	1	1	0

- Staff - Patients - Finances -

1
2
3
4
5
6
7
8
9
10
11

# RJAH Acquired MRSA Bacteraemia

Number of cases of MRSA bacteraemia in month 211151



+



### What these graphs are telling us

This measure is not appropriate to display as SPC. Metric is consistently reported within the tolerance.

### Narrative

There were no RJAH Acquired MRSA Bacteraemia reported in May. This metric has been included as an exception to reference the latest NOF publication.

The latest NOF Publication relates to Quarter 4 where the NOF score for this metric is 1. This position relates to the rolling twelve months period of April-25 to March-26 where in that period there have been none reported.

### Actions

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

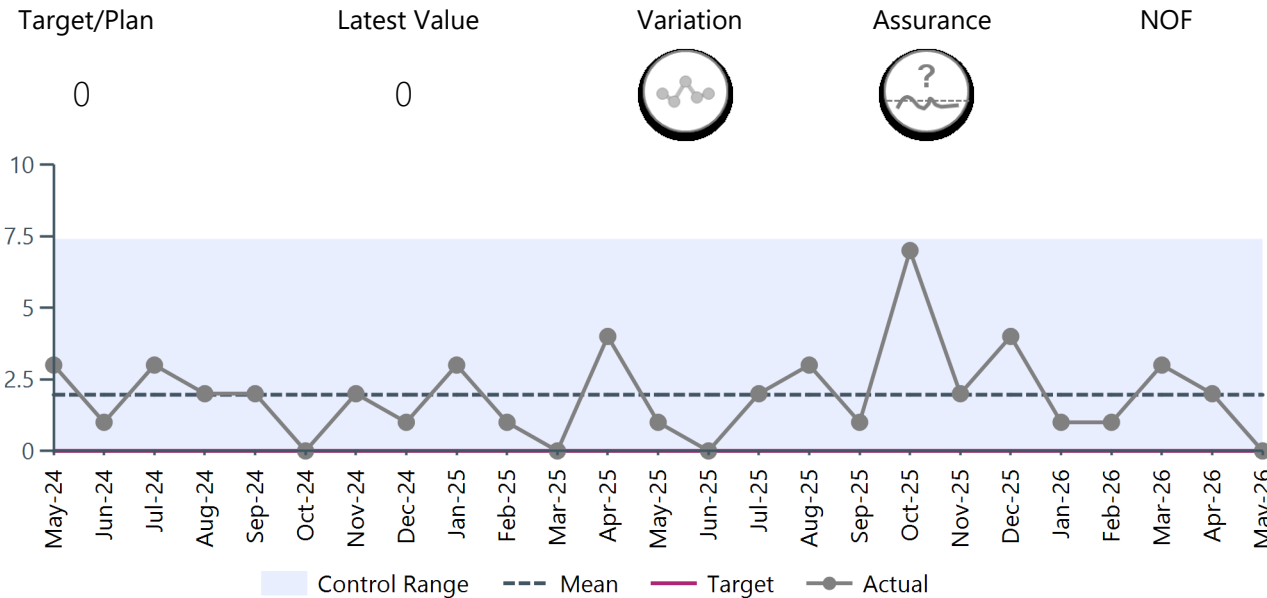
- Staff - Patients - Finances -

1
2
3
4
5
6
7
8
9
10
11

# Surgical Site Infections

Surgical Site Infections reported for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement in previous twelve months.  
 217727

Exec Lead:  
 Chief Nurse and Patient Safety Officer



## What these graphs are telling us

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

## Narrative

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

There were four infections confirmed in May, as outlined below:

- \* 1x THR - Clywd Ward - Procedure took place in March-26
- \* 1x TKR - Clywd Ward - Procedure took place in March-26
- \* 1x THR - Clywd Ward - Procedure took place in April-26
- \* 1x Spinal Surgery - Powys Ward - Procedure took place in April-26

## Actions

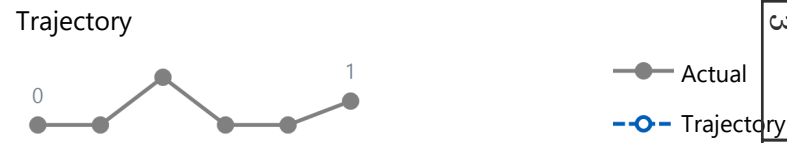
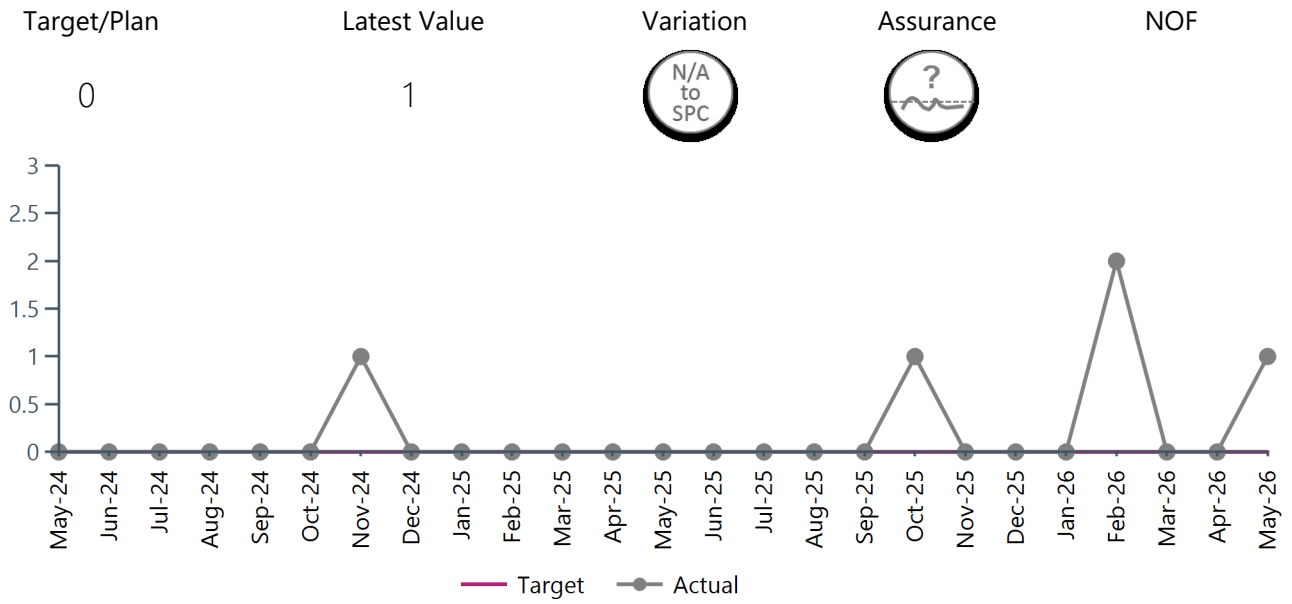
As there has been an increase seen in the October-December25 period, a clinical review of 7 years' worth of data has been assessed and will be presented to the Patient Safety Meeting in June. The Chair's report will then be fed into the Quality & Safety Committee.

May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
1	0	2	3	1	7	2	4	1	1	3	2	0

# Outbreaks

Number of declared outbreaks in month 217806

Exec Lead:  
 Chief Nurse and Patient Safety Officer



### What these graphs are telling us

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

### Narrative

There was one Outbreak reported in May. This was a Norovirus outbreak on Sheldon ward that affected seven patients and three staff.

### Actions

The After Action Review has been shared with the Patient Safety Working Group and IPC team will report to IPCCM.

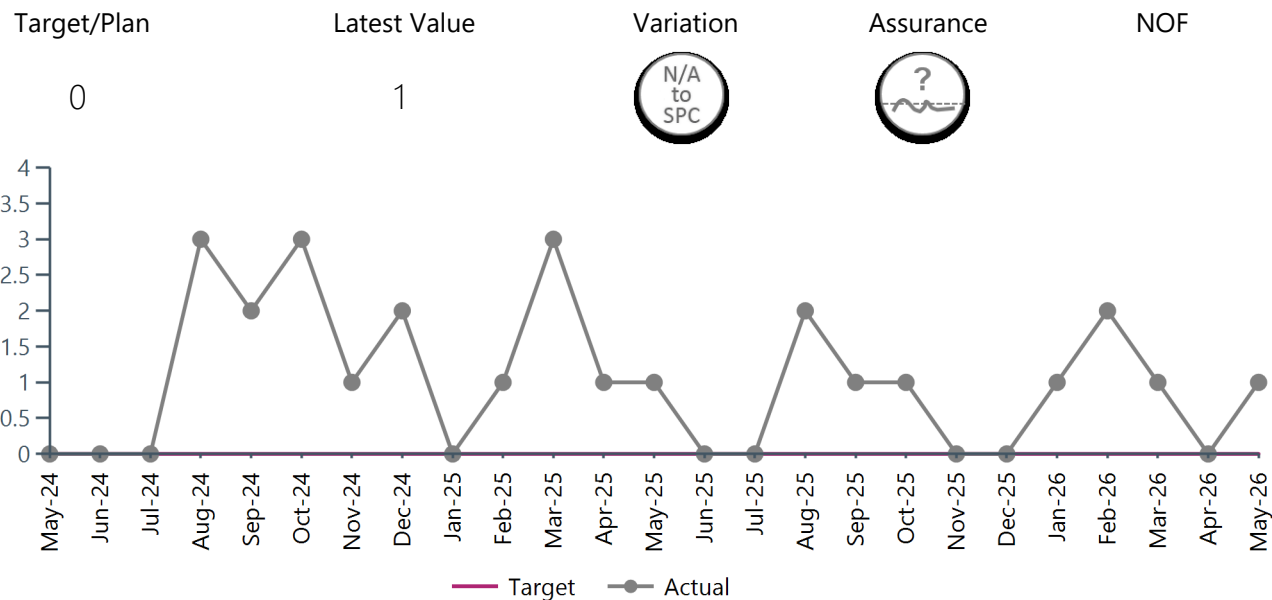
May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
0	0	0	0	0	1	0	0	0	2	0	0	1
					- Staff	- Patients	- Finances					

1
2
3
4
5
6
7
8
9
10
11

# Total Deaths

Number of Deaths in Month 211172

Exec Lead:  
 Chief Medical Officer



## What these graphs are telling us

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

## Narrative

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

## Actions

Learning from Deaths Reviews are completed by the Trust Lead.

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

- Staff - Patients - Finances -

1
2
3
4
5
6
7
8
9
10
11

1
2
3
4
5
6
7
8
9
10
11

# Chair's Assurance Report Quality and Safety Committee

## Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 01 July 2026

### Author:

Name: Mary Bardsley  
Role/Title: Assistant Trust Secretary

### Contributors:

### Report sign-off:

Lindsey Webb, Chair of the Quality and Safety Committee

### Is the report suitable for publication?:

Yes

## 1. Key issues and considerations:

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

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

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

This report provides a summary of the items considered at the Quality and Safety Committee on 21 May 2026 and 19 June 2026. It highlights the key areas the Quality and Safety Committee wishes to bring to the attention of the Council.

## 2. Strategic objectives and associated risks:

The following strategic objectives, developed in light of national and system priorities, are relevant to the content of this report:

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

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

Board Assurance Framework Themes		
1	Continued focus on excellence in quality, safety and patient experience.	✓
2	Focus on equity of service and addressing health inequalities	✓
3	Effective engagement with the workforce to support a positive staff experience and a culture of continuous improvement	
4	Delivering financial sustainability	
5	Delivering the required levels of productivity, performance and activity	
6	Delivering innovation, improvement and growth	✓
7	The challenges of operating in both the Welsh and English health systems	✓

# Chair's Assurance Report Quality and Safety Committee

8	Responding to a significant disruptive event	✓
9	Security of digital, data and AI systems and ability to respond to cyber threats	

### Trust values:

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

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

## 3. Assurance Report from Quality and Safety Committee

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

**ALERT** - The Quality and Safety Committee wishes to bring the following issues to the Board's attention as they:

Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address;

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

Require the approval of the Board for work to progress.

**MCSI admissions (May) / MCSI LoS Research Presentation (June):** Ongoing MCSI pathway pressures, particularly delays for spinal injury admissions, were highlighted as a significant risk to patient outcomes requiring system-wide action. An initial system wide summit took place in early June to begin to address this.

**Quality Account (May and June):** The Committee reviewed the draft Quality Account and was satisfied with the level of assurance provided. It endorsed the report for submission to the Trust Board, which subsequently approved it at the Extraordinary Meeting on 24 June. The final Quality Account is now available on the Trust's website in line with national reporting requirements.

**Review the Committee Effectiveness and Annual Report (May):** Concerns regarding the timeliness and quality of papers was highlighted, representing a risk to effective scrutiny, with recent improvements acknowledged. Assurance was provided that revised processes, including earlier executive review and clearer timelines, are in place to address this. The Committee approved the self-assessment and Terms of Reference for submission to the Trust Board.

**Patient Experience and Complaint Annual Report (June):** The Committee took assurance from the annual report, noting that patient feedback remains positive and welcoming the implementation of Radar to strengthen oversight of patient experience. Whilst complaints and PALS concerns increased during the year and response times remain challenging, members acknowledged early signs of improvement over the past month. Assurance was provided that a complaints deep dive has identified opportunities to streamline processes, improve communication, strengthen learning from complaints and address concerns relating to rheumatology and staff behaviours, with a further update to be provided at the next meeting. The annual report is presented to the Board for assurance.

**Health and Safety Annual Report (June):** The Committee was assured by continued improvements in health and safety performance, including reductions in incidents and RIDDOR-reportable events, full compliance with safety alerts, and effective management of regulatory actions. Members noted the need to strengthen theatre representation at Health and Safety meetings and received assurance that a further update on the independent review will be presented in due course. The annual report is presented to the Board for assurance.

## Chair's Assurance Report Quality and Safety Committee

**IPC Annual Report (June):** The Committee was assured by the IPC Annual Report, noting strong progress across the IPC programme, high levels of education and audit activity, excellent cleanliness standards, and achievement of key screening and training targets. Members acknowledged the team's resilience and Sam Young's lasting legacy, requested a summary of IPC priorities for 2026/27, and sought assurance regarding the monitoring of infection status alerts within the EPR. The report was approved. The annual report is presented to the Board for assurance.

**ROG Chair report (May and June):** The committee received insufficient assurance with regard to DBS checks and hepatitis B / Blood borne virus immunisation status. Further executive assurance was requested in all of these areas for the next meeting.

### 3.2 Areas of on-going monitoring with new developments

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

**Great Ormond Street Hospital (GOSH) Report (May):** The committee considered the recent report into concerns within the paediatric orthopaedic service at GOSH. Assurance was taken from a number of areas within the RJAH service, including structured surgical planning, dual consultant operating, consultant-led care, and established outcome review processes, supported by strong network collaboration. However, the Committee recognised opportunities to further formalise MDT processes, strengthen documentation and audit trails, and ensure consistent application across services. A key risk was identified in relation to access to patient information within Apollo, where limitations in visibility of historical records present a potential patient safety concern. The Committee requested ongoing organisational reflection, strengthened governance oversight, and the development of more structured reporting through the Clinical Effectiveness Meeting to ensure risks are effectively identified, mitigated, and monitored.

**Enhanced Recovery (May):** Assured by sustained improvements in Enhanced Recovery outcomes over recent years, including reductions in DVT, mortality and readmissions, with a continued focus on quality rather than length of stay. However, some concerns remain regarding readmissions for knee replacements, and further interrogation of the data is being undertaken to better understand this. The current data lacks sufficient granularity to determine causality or distinguish between related and unrelated cases of readmissions, limiting confident interpretation. The presence of outliers and variable patterns, including geographically atypical readmissions, further highlights the need for more detailed local case review and strengthened data analysis. While strong assurance was provided overall, the Committee noted the need to enhance evidence of comparative benefit, better capture wider system impacts, and incorporate patient-reported experience to support a more comprehensive assessment and inform targeted quality improvement.

**Corporate Risk Register (May):** The Committee welcomed the introduction of the Corporate Risk Register in its new RADAR format, noting improved visibility of high-scoring risks and their relevance to quality and patient safety. However, as an early-stage product, inconsistencies in recording, gaps in controls, and variable data quality currently limit assurance. Members raised specific concerns regarding clarity of risk articulation, robustness of mitigations, and alignment of target scores with risk appetite, alongside risks linked to workforce sustainability, patient compliance, and external capacity constraints. While further refinement is underway, the Committee took assurance on the process in place is being developed, recognising progress but noting the need to strengthen consistency and confidence in mitigation effectiveness.

**Performance Report (May and June):** The Committee received partial assurance in May and June from the Performance Report/Integrated Performance Report. While concerns remained regarding complaints performance, data quality, staffing metrics and aspects of patient safety, members noted improvements in operational and quality performance, including achievement of NOF 1 status, reduced surgical cancellations and positive patient safety reporting. Ongoing improvement plans were in place across complaints management, theatre utilisation, health inequalities, medication safety and diagnostic performance, with regular monitoring providing assurance that identified risks and areas for improvement were being actively addressed.

## Chair's Assurance Report Quality and Safety Committee

**PSRIF Report (May and June):** The report highlighted a risk relating to actions that remain behind plan, alongside the need to strengthen governance through timely SOP approval and the introduction of an audit process. Members were informed that five patient safety reviews were commissioned in May, with no PSIs required and no patient safety concerns identified. While this provided assurance, the Committee took partial assurance due to outstanding actions from previous reviews and overdue VTE actions. It was noted that these areas are currently being reviewed and strengthened to ensure clearer, measurable learning and improvement, with further assurance expected at the July meeting.

**Waiting Well and Patient Communication (May):** Noted good progress in improving communication with patients while waiting, including planned introduction of urgent appointment allocation and referral acknowledgements. However, system constraints have prevented implementation of delayed clinic letters, with alternative solutions still being explored. While assurance was taken, the Committee highlighted the need to sustain focus and demonstrate impact, noting ongoing risks from system limitations and demand pressures, and requested a further update in September.

**Patient Harm Reviews (May):** While assurance was provided that a risk-based approach is being taken, prioritising high-risk areas such as spinal and paediatric pathways, progress remains constrained by the need to validate records prior to clinical review. Data quality challenges and the scale of the backlog present ongoing risks to timely harm identification and recovery of standard turnaround times. Mitigating actions are in place, including allocation of protected time for validation activity, with an anticipated recovery trajectory over the next three months, subject to sufficient resourcing. The Committee will maintain oversight through continued monthly updates and therefore took partial assurance on current arrangements.

**West Midland Critical Care Peer Review (May):** Positive findings included strong leadership and no immediate patient safety concerns; however, the unit does not fully meet GPICS standards due to workforce limitations, including restricted consultant cover, limited specialist input, and no formal SLA with a Level 3 unit. An action plan is in development to address these gaps and will return for Committee oversight. The Committee took assurance, subject to review of the action plan.

### 3.3 Areas of assurance

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

**Legal Claims Update (May):** Assured that activity remains stable, with a small number of new claims, including a serious CNST case, and continued progress in settlements and closures. Ongoing employer liability, GDPR, and coronial matters require oversight, with upcoming inquests noted. Members highlighted the decision to settle hand-arm vibration claims following legal advice, with associated financial risk. Overall, assurance was taken, with key risks relating to financial exposure, reputational impact, and timely resolution of claims.

**Quality Accreditation (May):** Assured of progress in developing bespoke accreditation frameworks, including for theatres, with early improvements seen in documentation, falls management and IPC. Noted risks relate to the reliance on system-driven gains (e.g. Apollo) and the need to sustain and evidence improvements as accreditation assessments commence and mature.

**EPRR Quarterly Report (May):** Assured that no items required approval and that there were no high-risk issues or significant concerns at this stage. It was noted that priority conversations and alignment work remain ongoing, with plans for completion before year end, and that early planning for a live exercise is underway, with stakeholder engagement due to commence in June. The Committee took assurance from the progress reported but will continue to monitor delivery against planned timelines and the effective coordination of forthcoming exercise activity.

**Cost Improvement Plan EQIA Q4 (June):** The Committee received assurance that no quality, safety, safeguarding, or equality concerns had been identified in relation to Q4 CIP schemes. Robust Quality Impact Assessment processes for 26/27 are in place, with any adverse impacts to be escalated through the Quality and Safety Committee for further scrutiny.

## Chair's Assurance Report Quality and Safety Committee

The Committee received the following Chair Reports from sub-meetings:

- **Chair Report: Patient Experience Meeting (May and June)** - The Committee took assurance from the Patient Experience report, noting continued progress against the improvement plan with no new concerns identified regarding Radar implementation. Assurance was also received regarding the commencement of the transport SPOC pilot, which is supporting patients awaiting transport and is beginning to stabilise following initial implementation challenges. The Committee approved the updated Terms of Reference and noted that the pilot would be reviewed at the next meeting to assess effectiveness and identify any emerging risks.
- **Chair Report: IPC Meeting (May and June)** - approved the Terms of Reference and ratified the Transmission Based Precautions Policy. Concerns regarding inconsistent therapies attendance and reporting were acknowledged, with work underway to strengthen oversight and assurance mechanisms. The Committee also considered an increase in surgical site infections (SSIs); however, deep-dive analysis has not identified any specific or actionable cause. Ongoing monitoring will continue through established governance arrangements, and the Committee took assurance from the report.
- **Chair Report: Trust Performance and Operational Improvement Group (May and June)**– received assurance on actions being taken to address operational performance issues, including high levels of therapy cancellations and DNAs, with further analysis underway to identify contributory factors and opportunities to improve service accessibility. Assurance was also provided regarding the management of risks within the risk management system through targeted staff training and ongoing monitoring, with no patient safety concerns identified in relation to the manual reappointment process, although a retrospective review is in progress and a further update will be provided next month. The Committee also noted that the on-call payment issue has been escalated to the People and Culture Committee.
- **Chair Report: Drugs and Therapeutic Meeting** - The Committee was assured on updates to medicines governance and pathways, including a revised approach to managing pharmaceutical interactions and changes to HIV post-exposure prophylaxis arrangements. The ongoing national bone cement shortage remains a risk, with local mitigations in place but continued fragility in supply requiring close oversight.
- **Chair Report EPR Meeting** - The Committee noted progress in stabilising the EPR system, including improvements in data quality, communication, and system functionality. However, risks remain relating to data quality backlogs, reliance on supplier delivery, and pressures arising from the Trust's role as a first-of-type site with System C. The Committee took assurance, noting the need for continued focus on system stability, delivery confidence, and resource capacity.
- **Chair Report Regulatory Oversight Meeting (May and June)** - progress in strengthening regulatory compliance was noted, including renewed clinical interest in re-establishing oversight of the biobank and continued improvements in orthotics governance. Risks remain in relation to documentation accessibility identified during the UKAS inspection, all subject to ongoing mitigation. The Committee emphasised the need for robust biobank governance
- **Chair Report Adult and Children Safeguarding (May)** – took assurance from the position described. It was noted that system limitations continue to impact delivery of CPIS Phase 2, necessitating reliance on manual processes, which present operational challenges and limit current assurance regarding full compliance with child protection checks. This risk will remain under close review through the Committee and risk register. The Committee approved the Terms of Reference and was satisfied that appropriate oversight arrangements are in place, whilst recognising the need for ongoing monitoring of system-related risks.
- **Chair Report: Health and Safety Meeting (May)** - took assurance from progress across key actions, including completion of the health and safety audit, closure of the NR Fit CAS alert, and ongoing procurement of occupational health services. Members noted that changes to RIDDOR reporting may increase recorded incidents due to revised national requirements rather than worsening performance. A specific risk was highlighted at Baschurch Unit relating to patient belongings, with mitigation actions in progress. Overall, assurance was received, with continued monitoring required on reporting impacts and local risks.

## Chair's Assurance Report Quality and Safety Committee

- **Clinical Effectiveness Meeting (June)** - received positive assurance with evidence of effective review of national audit and registry data and appropriate oversight of clinical performance. Whilst some actions remained overdue, assurance was provided that these are being actively monitored and progressed.
- **Patient Safety Meeting (June)**: Assurance was provided that actions are underway to address EPALS training compliance, particularly on Alice Ward, following a previous pause in training delivery which contributed to current gaps. Ongoing monitoring and the exploration of both internal and external training solutions are intended to ensure all required staff complete training and that compliance is achieved and maintained. The Committee noted that a number of risks, incidents and overdue actions had been considered elsewhere on the agenda.
- **Health Inequalities Meeting (June)** - received assurance that improved analysis of whole-system data is providing a clearer understanding of health inequalities and will support the development of more targeted, population-focused interventions and service planning.

### 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.

1
2
3
4
5
6
7
8
9
10
11

(Part 1) Covering paper

<b>Committee / Group / Meeting, Date</b>	
Board of Directors, 01 July 2026	
<b>Author:</b>	<b>Contributors:</b>
Name: Mary Bardsley Role/Title: Assistant Trust Secretary	
<b>Report sign-off:</b>	
Name: Dylan Murphy, Trust Secretary Quality and Safety Committee	
<b>Is the report suitable for publication?:</b>	
Yes	
<b>Executive Summary:</b>	
<p>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.</p> <p>The purpose of the Quality and Safety Committee is to assist the Board obtaining assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. The Committee will work with the Audit Committee and Risk Management Committee to ensure that there are adequate and appropriate quality governance structures, processes, and controls in place throughout the Trust. Its particular responsibilities are set out at section 1 of the following report</p> <p>In line with good practice, the committees of the Board undertake an annual review of their operation and effectiveness. This involves:</p> <ul style="list-style-type: none"> <li>• Reviewing the role of the committee, its key responsibilities, membership and business considered during the year.</li> <li>• A questionnaire on the effectiveness of the operation of the committee (completed by individual members / core attendees).</li> <li>• A self-assessment against key governance questions (for collective consideration).</li> <li>• Review of the terms of reference to ensure the focus of the Committee remains relevant in 2026/27.</li> </ul> <p>No significant issues were identified during the review but some minor revisions to the terms of reference (TOR) have been made. The main change to the TOR is to reflect the move to meeting in alternate months. That move will be supported by a revised process for the review and approval of papers to support the production of high-quality papers in good time for consideration by the committees.</p>	
<b>Recommendations:</b>	
<p>That the Board NOTE that the Committee has:</p> <ol style="list-style-type: none"> <li>1. <b>Considered</b> the outcome of the committee effectiveness survey and did not identify any significant issues;</li> <li>2. <b>Considered and agreed</b> the self-assessment document;</li> <li>3. <b>Noted</b> the 2025/26 Decision / Activity log.</li> <li>4. <b>Considered</b> the draft Terms of Reference for 2026/27 and recommended that the Board approve them.</li> </ol> <p>The Board is therefore asked to CONSIDER and APPROVE the proposed terms of reference for 2026/27.</p>	

1
2
3
4
5
6
7
8
9
10
11

(Part 2) Strategic alignment and supporting detail

<b>Strategic objectives and associated risks:</b>		
The work of the committees, and the Board assurance arrangements, support delivery of all of the Trust's strategic objectives:		
<b>Trust Objectives</b>		
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	✓
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	✓
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	✓
The work of the committees, and the Board assurance arrangements, are relevant to all of the Board Assurance Framework (BAF) themes and associated strategic risks but this Committee has a particular focus on:		
<b>Board Assurance Framework Themes</b>		
1	Continued focus on excellence in quality, safety and patient experience.	✓
2	Focus on equity of service and addressing health inequalities	✓
3	Effective engagement with the workforce to support a positive staff experience and a culture of continuous improvement	
4	Delivering financial sustainability	
5	Delivering the required levels of productivity, performance and activity	
6	Delivering innovation, improvement and growth	
7	The challenges of operating in both the Welsh and English health systems	
8	Responding to a significant disruptive event	✓
9	Security of digital, data and AI systems and ability to respond to cyber threats	
<b>Trust Values:</b>		
Board and committee meeting agendas each include an opportunity to reflect on the extent to which the agenda / discussion reflect and support the Trust's values:		
<b>Trust Values</b>		
1	Professional	✓
2	Excellence	✓
3	Respect	✓
4	Friendly	✓
5	Inclusive	✓
6	Caring	✓
<b>Report development and engagement history:</b>		
The Committee considered the annual review documentation at its meeting in April 2026.		
The Committee considered an updated Terms of Reference at its meeting in June.		
<b>Next steps:</b>		
The Committee will operate in line with the revised Terms of Reference. The workplan will be reviewed and updated as required to work to the new meeting pattern.		
Any issues of concern, or apparent gaps in the governance arrangements, identified during the Committee reviews would be reported to the Audit and Risk Committee for consideration. No such gaps were identified.		

1
2
3
4
5
6
7
8
9
10
11

## Quality and Safety Committee Annual Report

### 1. Committee Roles and Responsibilities (2025/26)

The key responsibilities of the Committee are as follows:

- Promote excellence in patient care in all aspects of quality and safety, and monitor and review the “Quality Improvement Strategy”.
- To ensure the Trust is meeting core standards and is compliant with national guidelines to include (but not be limited to) prevention and control of infection and effective and efficient use of resources through evidence based clinical practice.
- To consider NHSE Quality Governance Framework in the delivery of its key responsibilities
- To receive an agreed level of clinical data and trend analysis from clinical forums and working groups, which provides adequate clinical matrix to inform and analyse the clinical services provided at the Trust.
- To ensure that the Committee has adequate information on which to advise and assure the Board on standards of care provision.
- To receive reports chair reports the following assurance meetings which report into the Committee.
- The Quality and Safety Committee shall review the draft Quality Accounts before submission to the Trust Board
- The Committee shall ratify such policies as the Board has not reserved to itself and as required by the Trust’s Policy Approval Framework.
- Clinical outcomes
  - Monitoring the effectiveness of the Trust's arrangements for the systematic monitoring of mortality and other patient outcomes.
  - Receiving and commenting on action plans and progress reports proposed by management in response to monitoring data on patient outcomes.
- Incident reporting and investigation
  - Monitoring the effectiveness of the Trust's compliance with the requirements of the Patient Safety Incident Response Framework.
  - Reviewing the outcomes of investigations, ensuring that the information is presented in sufficient detail to enable systemic failings in patient care to be identified; receiving and commenting on action plans and progress reports proposed by management in response to SIs, near misses and other incidents.
- Patient Experience
  - Monitoring the effectiveness of the Trust's systems for complaints handling and reviewing complaints for trends and themes.
  - Monitoring the effectiveness of the Trusts systems for advocacy and the encouragement of feedback from patients and relatives.
- Review of compliance with statutory and regulatory requirements relevant to the remit of the Committee, including CQUIN and CQC requirements.
- Patient Information Governance
  - Monitoring the arrangements to ensure the security of personally identifiable data.

### 2. Membership (2025/26)

The membership section of the current terms of reference is:

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

## Quality and Safety Committee Annual Report

### 3. Meetings (2025/26)

During 2025/26, the Committee met on twelve occasions to consider its routine monthly agenda, and held one Extraordinary Committee meeting to review the Equality Quality Impact Assessment in advance of the annual plan submission. All meetings were confirmed as quorate.

### 4. Committee Attendance (2025/26)

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

Name	Title	Attendance
<b>Core Membership</b>		
Lindsey Webb	Non-Executive Director (Chair)	13 / 13 = 100%
Penny Venables	Non-Executive Director	09 / 09 = 100%
Martin Newsholme	Non-Executive Director	11 / 13 = 85%
Darius Mirza	Non-Executive Director	01 / 06 = 8%
John Pepper	Associate Non-Executive Director	02 / 03 = 67%
Ruth Longfellow	Chief Medical Officer	11 / 13 = 85%
Mike Carr	Chief Operating Officer	08 / 13 = 62%
Sam Young / Sarah Needham	Interim Chief Nurse and Patient Safety Officer	10 / 13 = 77%
*Stacey Keegan	Chief Executive Officer	07 / 13 = 54%
<b>In Attendance</b>		
Dylan Murphy	Trust Secretary	13
Kirsty Foskett	Head of Clinical Governance and Quality	11
Fiona Bevan/Carrie Jenkins	Chief Pharmacist	10
Nick Huband/Phil Davies	Director of Estates and Facilities	03

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

### 5. Committee Activity and Decision Log (2025/26)

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

### 6. Conduct of Meetings (2025/26)

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 (2025/26)

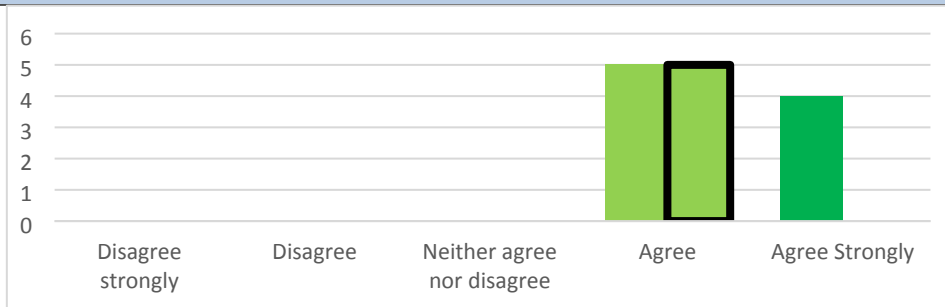
The Committee effectiveness survey was circulated to a total of 9 people (core members and frequent attendees of the meeting). There was a total of 5 responses received.

The 2025/26 results (the second of the two columns, with the black outline) are displayed alongside the 2024/25 results (based on the 9 returns received last year).

## Quality and Safety Committee Annual Report

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

Responses – 2024/25 and 2025/26

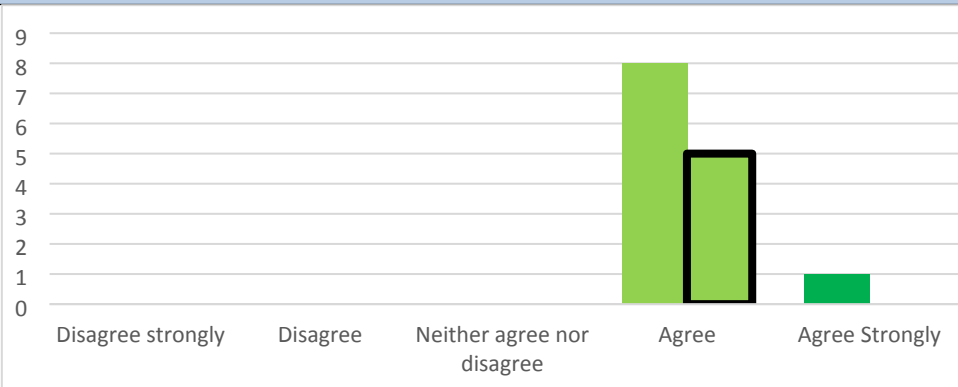


**Comments**

- There were no responses.

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

Responses – 2024/25 and 2025/26

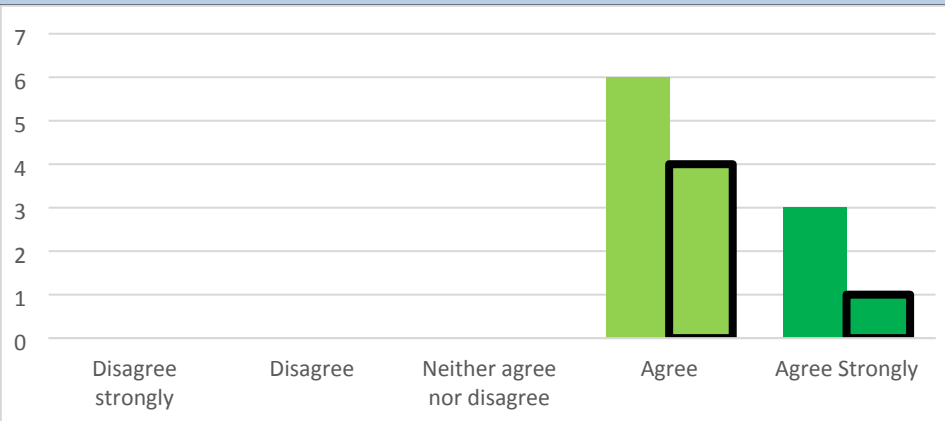


**Comments**

- It is a heavy agenda but we do get through the key areas

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

Responses – 2024/25 and 2025/26



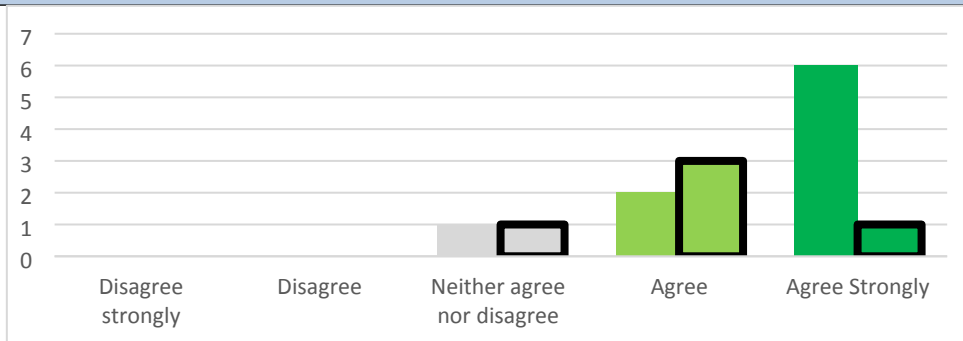
**Comments**

- There were no responses.

## Quality and Safety Committee Annual Report

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

Responses – 2024/25 and 2025/26

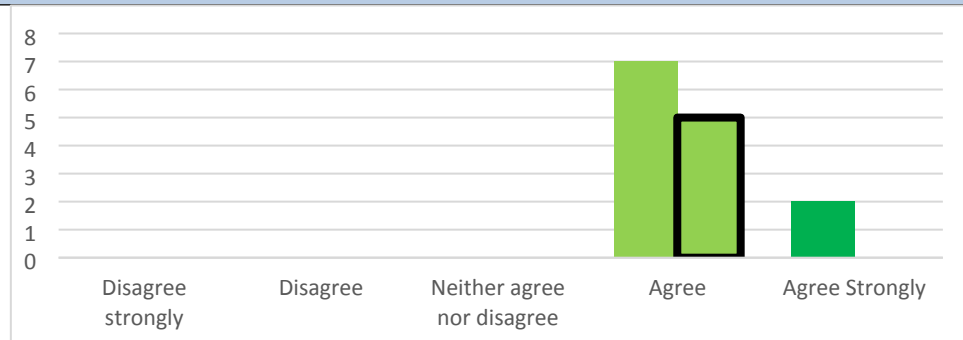


**Comments**

- There were no responses.

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

Responses – 2024/25 and 2025/26

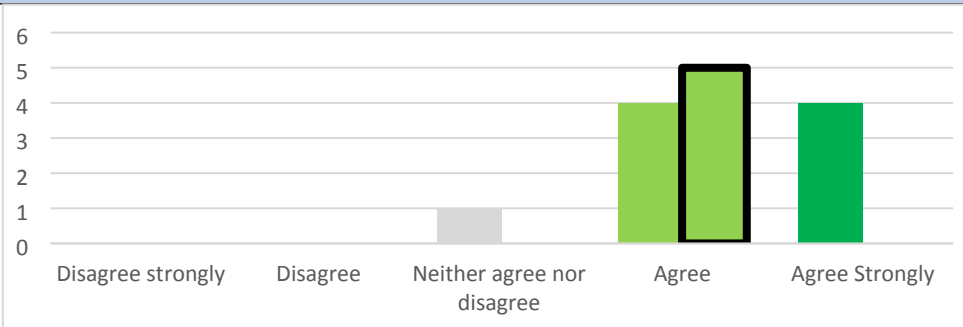


**Comments**

- There were no responses.

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

Responses – 2024/25 and 2025/26



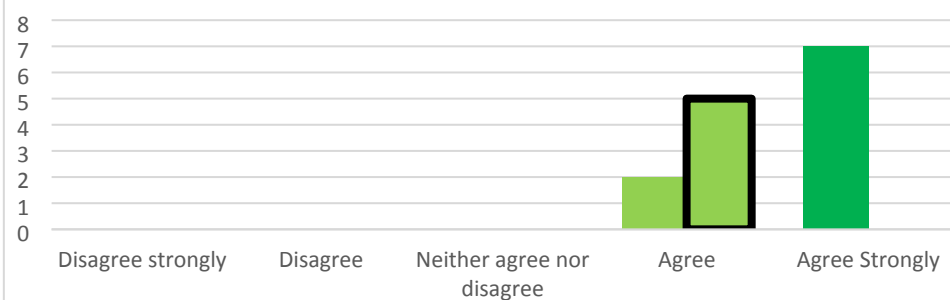
**Comments**

- There were no responses.

## Quality and Safety Committee Annual Report

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

Responses – 2024/25 and 2025/26

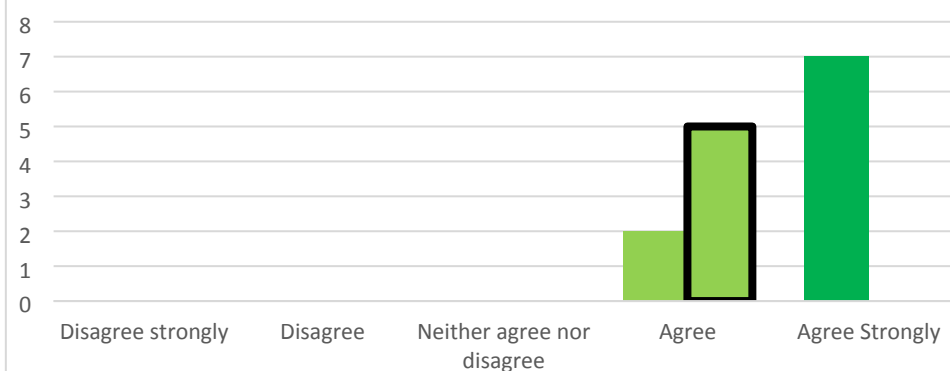


#### Comments

- There were no responses.

### Q8 The Committee has had sufficient time/information to consider patient safety matters

Responses – 2024/25 and 2025/26

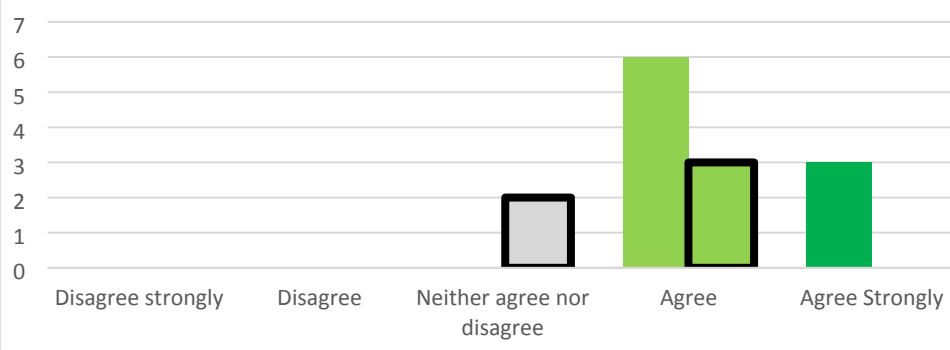


#### Comments

- There were no responses.

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

Responses – 2024/25 and 2025/26



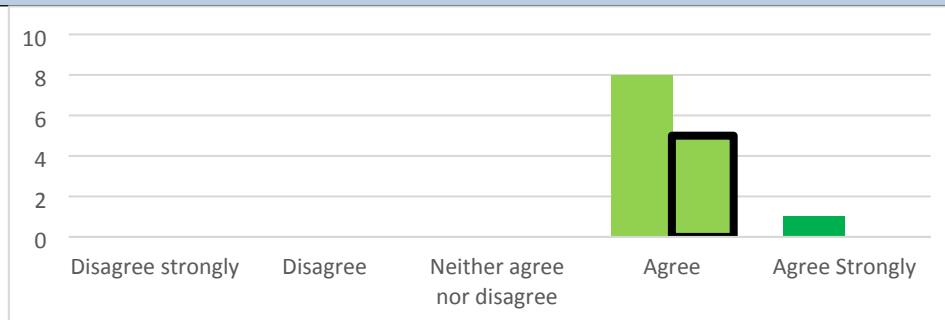
#### Comments

- Timeliness of certain papers can still be an issue
- There have been papers presented which have been based on inaccurate data and have not been adequately reviewed. This results in confusing discussions resulting in potentially inaccurate conclusions
- Quality and timeliness of papers should be improved upon

## Quality and Safety Committee Annual Report

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 – 2024/25 and 2025/26



### Comments

- There were no responses.

### 8. Committee Self-Assessment (2025/26)

Area / Question	Response	Comments / Action
<b>Composition, Establishment and Duties</b>		
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 Nurse and Chief Medical 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 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

## Quality and Safety Committee Annual Report

		monthly basis. (Public = written / Private = verbal)
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 supported by the attendance matrix. This detail is reported to the Board as part of the assurance report.
<b>Compliance with the Law and Regulations Governing the NHS</b>		
Does the committee review assurance and regulatory compliance reporting processes?	Yes	This is undertaken by the committee in relation to issues of quality and assurance is provided to the Board via the Chair's report.
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.
<b>Internal Control</b>		
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. An annual review is also presented to the Committee for consideration.
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 revised the Corporate Stands Manual in 2025/26 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.
<b>Administrative Arrangements</b>		
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

## Quality and Safety Committee Annual Report

		committee would not have sufficient time to consider them, they are deferred to the next meeting with the Chairs approval.
Does the committee meet the appropriate number of times a year?	Yes	The committee meets 10 times per year and additional meeting can be scheduled upon request.
<b>Other Issues</b>		
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 2026/27

To support with continuous improvement of the Quality and Safety Committee, members are asked to review the Terms of Reference and consider any required revisions for 2026/27 (appendix B)

#### Appendices

---

Appendix A	QS Decision / Activity Log from 2025/26
Appendix B	QS Draft Terms of Reference for 2026/27

**Quality and Safety Committee | DECISION LOG 2025.26**

Updated: 23 March 2026

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?	If a recommendation - date of subsequent consideration at approval body
1	24-Apr-2025	Integrated Performance Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
2	24-Apr-2025	KPI Proposal 2025/26	None noted.	Approved - The Committee discussed the circulated report and subsequently approved.			
3	24-Apr-2025	Critical Care Review	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
4	24-Apr-2025	Patient Safety Report (PSIRF)	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
5	24-Apr-2025	PSIRF Internal Audit Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
6	24-Apr-2025	Learning from Deaths Q4 Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
7	24-Apr-2025	Quality Strategy Progress Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
8	24-Apr-2025	Clinical Safety Case Report	None noted.	Noted - The Committee noted the verbal update			
9	24-Apr-2025	Clinical Audit Annual Report	None noted.	Approved - The Committee discussed the circulated report and subsequently approved.			
10	24-Apr-2025	IPC Q4 Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
11	24-Apr-2025	Chair Reports	None noted.	Noted - chair reports from the following meetings were noted by the Committee: MHRA Working Group, Patient Safety Meeting, IPCC Meeting, Regulatory Oversight Meeting, Clinical Effectiveness Meeting, Drugs and Therapeutics Meeting.			
12	24-Apr-2025	Committee Effectiveness and Annual Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
13	24-Apr-2025	Terms of Reference	None noted.	Approved - The Committee discussed the terms of reference and subsequently approved.		Board of Directors	07-May-25
14	24-Apr-2025	Review of the Workplan and Attendance Matrix	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
15	22-May-2025	Board Assurance Framework	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
16	22-May-2025	Corporate Risk Register	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
17	22-May-2025	Performance Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
18	22-May-2025	Cost Improvement Plan Q4 2025/25 - QIA	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
19	22-May-2025	EQIA Operational Plan 2025/26	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
20	22-May-2025	OsCell Business Case and QEIA	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
21	22-May-2025	PSIRF Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
22	22-May-2025	PSII: Retained Fragment from Oxford Knee	None noted.	Approved - The Committee discussed the report and subsequently approved.			
23	22-May-2025	PSII: Retained Drill Guide	None noted.	Approved - The Committee discussed the report and subsequently approved.			
24	22-May-2025	Patient Safety Visits Presentation	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
25	22-May-2025	Quality Accreditation Q4 Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
26	22-May-2025	Legal Claims Q4 Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
27	22-May-2025	Draft Quality Account	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
28	22-May-2025	EPRR Policy	None noted.	Approved - The Committee discussed the plan and subsequently approved.		Board of Directors	04-Jun-25
29	22-May-2025	Corporate Business Continuity Plan	None noted.	Approved - The Committee discussed the plan and subsequently approved.		Board of Directors	04-Jun-25
30	22-May-2025	Mass Casualties Plan	None noted.	Approved - The Committee discussed the plan and subsequently approved.		Board of Directors	04-Jun-25

**Quality and Safety Committee | DECISION LOG 2025.26**

Updated: 23 March 2026

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?	If a recommendation - date of subsequent consideration at approval body
31	22-May-2025	Chair Reports	None noted.	Noted - chair reports from the following meetings were noted by the Committee: patient experience meeting, adult and childrens safeguarding meeting, ipcc meeting, health and safety meeting, regulatory oversight meeting, mhra working group, health inequalities.			
32	22-May-2025	Review of the Workplan	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
33	22-May-2025	Apollo Implementation Update - Clinical Safety	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
34	19-Jun-2025	Performance Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
35	19-Jun-2025	Apollo Update	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
36	19-Jun-2025	PSIRF Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
37	19-Jun-2025	Bone Tumour Action Plan	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
38	19-Jun-2025	Cleanliness and Estates IPC Quarterly Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
39	19-Jun-2025	Patient Complaints and Experience Annual Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
40	19-Jun-2025	IPC Annual Report	None noted.	Approved - The Committee discussed the circulated report and subsequently approved.			
41	19-Jun-2025	Health and Safety Annual Report	None noted.	Endorsed - The Committee discussed the circulated report and subsequently endorsed.			
42	19-Jun-2025	Quality Account	None noted.	Recommended - The Committee discussed the circulated report and recommended for Board approval.		Board of Directors	02-Jul-25
43	19-Jun-2025	Improving Experience in Care Framework	None noted.	Approved - The Committee considered the circulated report and subsequently approved.			
44	19-Jun-2025	Chair Reports	None noted.	Noted - chair reports from the following meetings were noted by the Committee: patient safety meeting, patient experience meeting, ipcc meeting, regulatory oversight meeting, mhra working group, clinical effectiveness meeting, drugs and therapeutics meeting.			
45	19-Jun-2025	Review of the Workplan/Attendance Matrix	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
46	19-Jun-2025	Policy Tracker	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
47	19-Jun-2025	Medical Device Training/Blood Cultures	None noted.	Noted - The Committee considered the update and subsequently noted.			
48	24-Jul-2025	Orthotics Deep Dive	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
49	24-Jul-2025	Performance Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
50	24-Jul-2025	PSIRF Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
51	24-Jul-2025	PSII: MHRA	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
52	24-Jul-2025	Coroner's Letter Response	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
53	24-Jul-2025	Safe Staffing Reviews	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
54	24-Jul-2025	Complaints Deep Dive	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
55	24-Jul-2025	Apollo Update	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
56	24-Jul-2025	GIRFT Pre-op Presentation	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
57	24-Jul-2025	MHRA/JC Os Cell Lab	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
58	24-Jul-2025	EPRR Quarterly Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			

**Quality and Safety Committee | DECISION LOG 2025.26**

Updated: 23 March 2026

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?	If a recommendation - date of subsequent consideration at approval body
59	24-Jul-2025	Quality Strategy Action Plan	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
60	24-Jul-2025	Quality Accreditation	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
61	24-Jul-2025	Quality Priorities	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
62	24-Jul-2025	Learning from Deaths Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
63	24-Jul-2025	IPC Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
64	24-Jul-2025	Controlled Drugs and Accountable Officer Annual Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
65	24-Jul-2025	Chair Reports	None noted.	Noted - chair reports from the following meetings were noted by the Committee: patient safety meeting, patient experience meeting,, regulatory oversight meeting, drugs and therapeutics meeting, health and safety meeting, health inequalities.			
66	24-Jul-2025	Situation Report Plan	None noted.	Approved - The Committee discussed the circulated report and subsequently approved.			
67	24-Jul-2025	Incident Control Centre Plan	None noted.	Approved - The Committee discussed the circulated report and subsequently approved.			
68	24-Jul-2025	Incident Response Plan	None noted.	Approved - The Committee discussed the circulated report and subsequently approved.			
69	24-Jul-2025	Evacuation and Shelter Plan	None noted.	Approved - The Committee discussed the circulated report and subsequently approved.			
70	24-Jul-2025	Trust Adverse Weather and Health Plan	None noted.	Approved - The Committee discussed the circulated report and subsequently approved.			
71	24-Jul-2025	Terms of Reference	None noted.	Approved - The Committee considered the circulated report and subsequently approved.			
72	24-Jul-2025	Review of the Workplan/Attendance Matrix	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
73	21-Aug-2025	Corporate Risk Register	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
74	21-Aug-2025	Board Assurance Framework	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
75	21-Aug-2025	Performance Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
76	21-Aug-2025	PSIRF Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
77	21-Aug-2025	CIP Quality Impact Assessment Update	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
78	21-Aug-2025	Patient Safety Visits Presentation	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
79	21-Aug-2025	Powys Contract Update	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
80	21-Aug-2025	Legal Claims Q1 Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
81	21-Aug-2025	Cleanliness and Estates IPC Quarterly Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
82	21-Aug-2025	Training Compliance	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
83	21-Aug-2025	Security Annual Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
84	21-Aug-2025	Safeguarding Annual Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted.			
85	21-Aug-2025	Business Continuity Policy	None noted.	Approved - The Committee considered the circulated report and subsequently approved.			

**Quality and Safety Committee | DECISION LOG 2025.26**

Updated: 23 March 2026

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?	If a recommendation - date of subsequent consideration at approval body
86	21-Aug-2025	Chair Reports	None noted.	Noted - chair reports from the following meetings were noted by the Committee: patient safety meeting, patient experience meeting, regulatory oversight meeting, health and safety meeting, health inequalities, trust performance and operational improvement group, mhra working group, digital transformation programme board, adult and childrens safeguarding meeting, clinical effectiveness meeting, ipcc meeting.			
87	21-Aug-2025	Emergency Critical Incident Mutual Aid	None noted.	Approved - The Committee discussed the circulated report and subsequently approved.			
88	21-Aug-2025	Countermeasures Plan	None noted.	Approved - The Committee discussed the circulated report and subsequently approved.			
89	21-Aug-2025	CBRN/HAZMAT Plan	None noted.	Approved - The Committee discussed the circulated report and subsequently approved.			
90	21-Aug-2025	Review of the Workplan/Attendance Matrix	None noted.	Noted - The Committee considered the update and subsequently noted.			
91	18-Sep-2025	Apollo Risks	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
92	18-Sep-2025	Bone Tumour Action Plan	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
93	18-Sep-2025	Performance Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
94	18-Sep-2025	PSIRF Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
95	18-Sep-2025	QIA: Portland - out of hours work and safety requirements	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
96	18-Sep-2025	HSE Inspection Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
97	18-Sep-2025	Patient Story: Improvement Approach	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
98	18-Sep-2025	Consent Policy	None noted.	Approved - The Committee considered the circulated report and subsequently approved.			
99	18-Sep-2025	Chair Reports	None noted.	Noted - chair reports from the following meetings were noted by the Committee: patient safety meeting, patient experience ipcc meeting, trust performance and operational improvement group, regulatory oversight meeting, health inequalities, clinical effectiveness meeting, digital transformation programme board.			
100	18-Sep-2025	Review of the Workplan/Attendance Matrix	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
101	18-Sep-2025	Policy Tracker	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
102	23-Oct-2025	Corporate Risk Register	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
103	23-Oct-2025	Performance Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
104	23-Oct-2025	Quality Strategy Action Plan	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
105	23-Oct-2025	Quality Accreditation Q2 Update	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
106	23-Oct-2025	PSIRF Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
107	23-Oct-2025	Learning from Deaths Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
108	23-Oct-2025	CQC Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
109	23-Oct-2025	MCSI Clinical Pathway	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
110	23-Oct-2025	HSE Inspection Report Action Plan	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
111	23-Oct-2025	Delivery Model Assurance Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted			

**Quality and Safety Committee | DECISION LOG 2025.26**

Updated: 23 March 2026

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?	If a recommendation - date of subsequent consideration at approval body
112	23-Oct-2025	Apollo - Waiting List Issues	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
113	23-Oct-2025	Chair Reports	None noted.	Noted - chair reports from the following meetings were noted by the Committee: patient safety meeting, patient experience ipcc meeting, trust performance and operational improvement group, regulatory oversight meeting, clinical effectiveness meeting, digital transformation group, NSSG meeting.			
114	19-Nov-2025	Review of the Workplan/Attendance Matrix	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
115	19-Nov-2025	Board Assurance Framework	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
116	19-Nov-2025	Performance Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
117	19-Nov-2025	EPR Apollo Update	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
118	19-Nov-2025	HSE Action Plan	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
119	19-Nov-2025	CQC Adult Inpatient Survey	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
120	19-Nov-2025	PSIRF Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
121	19-Nov-2025	HTA Progress Report	None noted.	Noted - The Committee considered the update and subsequently noted			
122	19-Nov-2025	Legal Claims Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
123	19-Nov-2025	Quality Priorities	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
124	19-Nov-2025	IPC Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
125	19-Nov-2025	Cleanliness and Estates IPC Quarterly Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
126	19-Nov-2025	EPRR Report	None noted.	Approved - The Committee considered the circulated report and subsequently approved.			
127	19-Nov-2025	Chair Reports	None noted.	Noted - chair reports from the following meetings were noted by the Committee: patient safety meeting, patient experience ipcc meeting, trust performance and operational improvement group, regulatory oversight meeting, NSSG meeting, drugs and therapeutics meeting, health and safety meeting			
128	19-Nov-2025	Well Led Review Action Plan	None noted.	Approved - The Committee considered the circulated report and subsequently approved.			
129	18-Dec-2025	Performance Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
130	18-Dec-2025	Chairs Report EPR Implementation Assurance Meeting	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
131	18-Dec-2025	PSIRF Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
132	18-Dec-2025	Health Inequalities Deep Dive	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
133	18-Dec-2025	Premises Assurance Model Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
134	18-Dec-2025	Review of the Workplan/Attendance Matrix	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
135	18-Dec-2025	Chair Report NSSG Meeting	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
136	22-Jan-2026	Corporate Risk Register Discussion	None noted.	Noted - The Committee noted the verbal update			
137	22-Jan-2026	Performance Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
138	22-Jan-2026	PSIRF Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			

**Quality and Safety Committee | DECISION LOG 2025.26**

Updated: 23 March 2026

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?	If a recommendation - date of subsequent consideration at approval body
139	22-Jan-2026	HTA Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
140	22-Jan-2026	PLACE Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
141	22-Jan-2026	MHRA License	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
142	22-Jan-2026	Quality Strategy Action Plan	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
143	22-Jan-2026	Quality Accreditation	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
144	22-Jan-2026	Nursing and AHP Strategy	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
145	22-Jan-2026	Learnig from Deaths	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
146	22-Jan-2026	Legal Claims	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
147	22-Jan-2026	Chair Reports	None noted.	Noted - chair reports from the following meetings were noted by the Committee: patient safety meeting, patient experience ipcc meeting, regulatory oversight meeting, NSSG meeting, epr implementation meeting, health inequalities, icb quality meeting.			
148	22-Jan-2026	Review of the Workplan/Attendance Matrix	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
149	22-Jan-2026	Policy Tracker	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
150	22-Jan-2026	Infection Event and Outbreak Management Policy	None noted.	Ratified - The Committee considered the circulated policy and subsequently ratified.			
151	22-Jan-2026	CEO Letter to Healthwatch Shropshire	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
152	04-Feb-2026	Operational Plan 2026-2031 - Quality and Equality Impact Assessment	None noted.	Approved - The Committee discussed the circulated report and subsequently approved.		Board of Directors	04-Feb-26
153	19-Feb-2026	Performance Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
154	19-Feb-2026	PSIRF Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
155	19-Feb-2026	PSII Report: Wrong Size Implant	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
156	19-Feb-2026	CQC Action Plan	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
157	19-Feb-2026	EDS2 Assessment	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
158	19-Feb-2026	Patient Safety Visits	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
159	19-Feb-2026	Cleanliness and Estates Quarterly Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
160	19-Feb-2026	IPC Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
161	19-Feb-2026	Quality Priorities Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
162	19-Feb-2026	CIP QIA	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
163	19-Feb-2026	EPRR Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
164	19-Feb-2026	EQIA Policy	None noted.	Approved - The Committee considered the circulated report and subsequently approved.			
165	19-Feb-2026	Domestic Abuse Policy	None noted.	Approved - The Committee considered the circulated report and subsequently approved.			
166	19-Feb-2026	Managing Allegations (People in Position of Trust - PIPoT) Policy	None noted.	Approved - The Committee considered the circulated report and subsequently approved.			

**Quality and Safety Committee | DECISION LOG 2025.26**

Updated: 23 March 2026

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?	If a recommendation - date of subsequent consideration at approval body
167	19-Feb-2026	Chair Reports	None noted.	Noted - chair reports from the meetings were noted by the Committee: regulatory oversight meeting, clinical effectiveness meeting, EPR implementation meeting, patient safety meeting, patient experience meeting, ipcc meeting, health inequalities, adult and childrens safeguarding meeting, nssg meeting.			
168	19-Feb-2026	Well Led Action Plan	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
169	19-Feb-2026	Review of the Workplan/Attendance Matrix	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
170	19-Feb-2026	QEIA Planning Submission	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
171	19-Mar-2026	Board Assurance Framework	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
172	19-Mar-2026	Corporate Risk Register	None noted.	Noted - The Committee considered the verbal update and subsequently noted.			
173	19-Mar-2026	Performance Report	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
174	19-Mar-2026	Deep Dive: 28-day Faster Diagnosis	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
175	19-Mar-2026	PSIRF Report	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
176	19-Mar-2026	Harms Review Update (including missing review dates)	None noted.	Noted - The Committee discussed the circulated report and subsequently noted.			
177	19-Mar-2026	Trust Incident Reponse Plan	None noted.	Approved - The Committee considered the circulated report and subsequently approved.		Board of Directors	06-May-26
178	19-Mar-2026	Chair Reports	None noted.	Noted - chair reports from the following meetings were noted by the Committee; regulatory oversight meeting, EPR implementation meeting and benefits paper appendix, patient safety meeting, patient experience meeting, ipc&c meeting, health inequalities, health and safety meeting, drugs and therapeutics meeting, feedback from icb quality meeting, NSSG Meeting.			
179	19-Mar-2026	Review of the Workplan/Attendance Matrix	None noted.	Noted - The Committee considered the circulated report and subsequently noted			
180	19-Mar-2026	Policy Tracker	None noted.	Noted - The Committee considered the circulated report and subsequently noted			

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11

Quality and Safety Committee  
Terms of Reference (April-June 2026)

**1. Constitution**

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

**2. Membership and Quorum**

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

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

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

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

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

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

**3. Attendance**

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

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

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

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

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

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.

1
2
3
4
5
6
7
8
9
10
11

#### 4. Frequency of meetings and meeting administration

The Committee will meet at least 4-6 times a year for regular business. The Chair of the Committee may call additional meetings.

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

#### 5. Authority

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

#### 6. Reporting

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

1. Alert the Board to any issues that:
  - Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address; OR
  - Represent significant developments / improvements that will help the Trust deliver its objectives and/or
  - Require the approval of the Board for work to progress.
2. Advise the Board of any areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives.
3. Assure the Board on other items considered where the Committee did not identify any issues that required escalation to the Board.

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

#### 7. Key responsibilities

- Promote excellence in patient care in all aspects of quality and safety, and monitor and review the "Quality Improvement Strategy".
- The purpose of the Quality and Safety Committee is to assist the Board obtaining assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. The Committee will work with the Audit Committee and Risk Management Committee to ensure that there are adequate and

1
2
3
4
5
6
7
8
9
10
11

Quality and Safety Committee  
Terms of Reference (April-June 2026)

appropriate quality governance structures, processes and controls in place throughout the Trust to:

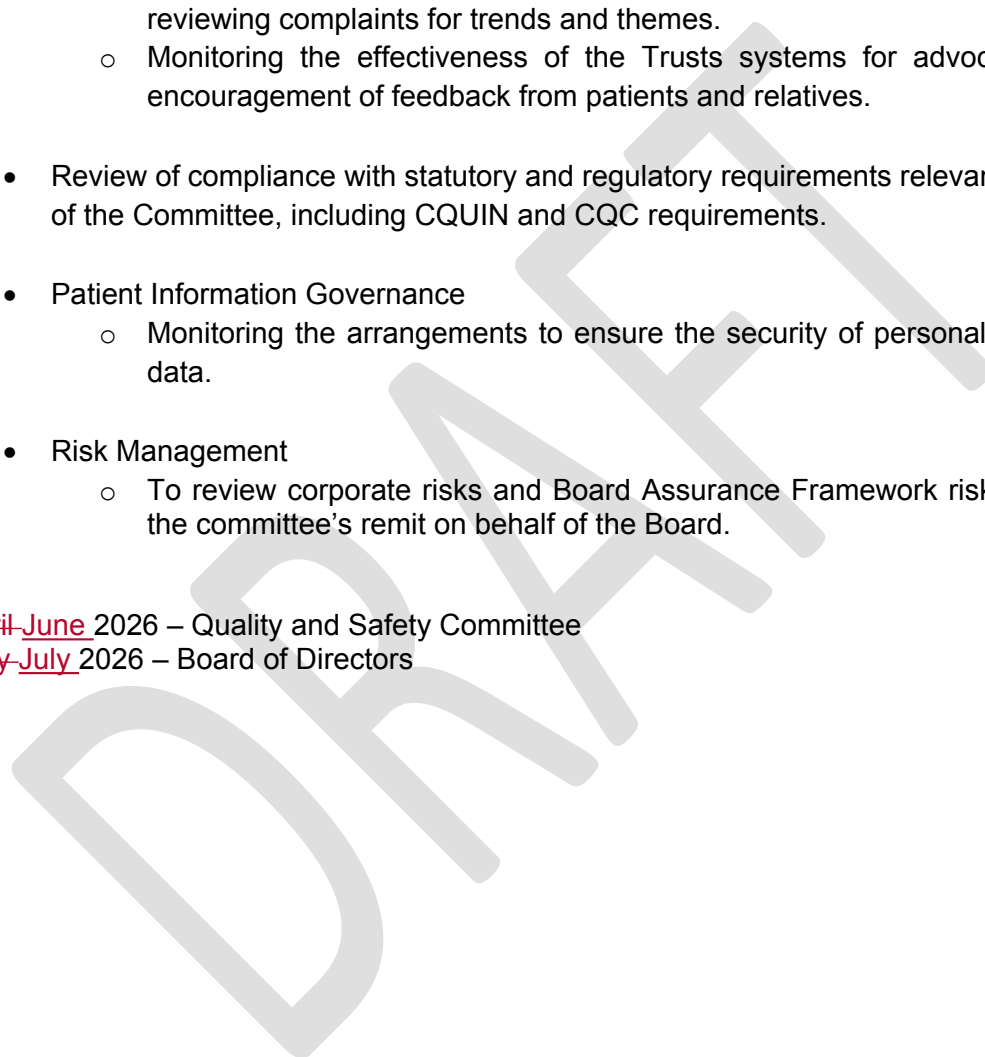
- Promote safety and excellence in patient care
  - Identify, prioritise and manage risk arising from clinical care
  - Ensure efficient and effective use of resources through evidence based clinical practice
- To ensure the Trust is meeting core standards and is compliant with national guidelines to include (but not be limited to) prevention and control of infection and effective and efficient use of resources through evidence based clinical practice.
  - To consider NHSE Quality Governance Framework in the delivery of its key responsibilities
  - To consider opportunities for partnership working when discussing issues relevant to the Committee's remit.
  - To receive an agreed level of clinical data and trend analysis from clinical forums and working groups, which provides adequate clinical matrix to inform and analyse the clinical services provided at the Trust.
  - To ensure that the Committee has adequate information on which to advise and assure the Board on standards of care provision.
  - To receive reports from the following assurance meetings:
    - Adult and Children Safeguarding Meeting
    - Infection Prevention and Control Meeting
    - Clinical Effectiveness Meeting
    - Patient Safety Meeting
    - Patient Experience Meeting
    - Health and Safety Meeting
    - Drugs and Therapeutics Meeting
    - Health and Inequalities Meeting
    - MRHA Meeting
    - Regulatory Oversight Meeting
  - The Quality and Safety Committee shall review the draft Quality Accounts before submission to the Trust Board
  - The Committee shall ratify such policies as the Board has not reserved to itself and as required by the Trust's Policy Approval Framework.
  - Clinical outcomes
    - Monitoring the effectiveness of the Trust's arrangements for the systematic monitoring of mortality and other patient outcomes.
    - Receiving and commenting on action plans and progress reports proposed by management in response to monitoring data on patient outcomes.

1
2
3
4
5
6
7
8
9
10
11

Quality and Safety Committee  
Terms of Reference (April-June 2026)

- Incident reporting and investigation
  - Monitoring the effectiveness of the Trust's compliance with the requirements of the Patient Safety Incident Response Framework.
  - Reviewing the outcomes of investigations, ensuring that the information is presented in sufficient detail to enable systemic failings in patient care to be identified; receiving and commenting on action plans and progress reports proposed by management in response to SIs, near misses and other incidents.
  
- Patient Experience
  - Monitoring the effectiveness of the Trust's systems for complaints handling and reviewing complaints for trends and themes.
  - Monitoring the effectiveness of the Trusts systems for advocacy and the encouragement of feedback from patients and relatives.
  
- Review of compliance with statutory and regulatory requirements relevant to the remit of the Committee, including CQUIN and CQC requirements.
  
- Patient Information Governance
  - Monitoring the arrangements to ensure the security of personally identifiable data.
  
- Risk Management
  - To review corporate risks and Board Assurance Framework risks relevant to the committee's remit on behalf of the Board.

April-June 2026 – Quality and Safety Committee  
May-July 2026 – Board of Directors



1
2
3
4
5
6
7
8
9
10
11

## **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 2025/26. It describes the achievements of the Trust under the specialist advice, guidance and support of our Infection Prevention and Control (IPC) Team.

The Robert Jones and Agnes Hunt (RJAH) faced profound loss this year with the passing of Interim Chief Nurse and Director for IPC, Sam Young.

The sudden passing of Sam in June 2025 was a profound loss to our organisation and particularly the IPC Team, who she worked closely with to oversee the IPC programme. Her professionalism, kindness and compassionate leadership leave a lasting legacy, and she is deeply missed by her colleagues.

This year we have continued to focus on sustaining high levels of IPC compliance across the Trust. The Trust continues to build on the significant improvements made in relation to Infection Prevention and Control, to ensure that providing quality care remains at the heart of everything we do, every day.

This report highlights our journey through 2025-26, and the key achievements that have been made in infection prevention and control at RJAH and shows that we are committed to providing excellent and innovative care in a safe and clean environment. The detail within clearly demonstrates the dedication, expertise and collaborative approach from our IPC Team and wider teams.

I extend my thanks to all colleagues who have been part of making this a successful year including our IPC Team, operational and clinical colleagues, Pharmacy and our Estates and Facilities departments.

Clair Hobbs

**Interim Chief Nurse and Director of Infection Prevention & Control**

1
2
3
4
5
6
7
8
9
10
11

### 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
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

# Infection Prevention & Control and Cleanliness Annual Report 2025/26

TSSU	Theatre Sterile Services Unit
UKHSA	UK Health Security Agency
WTE	Whole Time Equivalent

## Contents Page

<b>Introduction</b> .....	<b>4</b>
<b>Health and Social Care Act 2008: code of practice on the prevention and control of infections</b> .....	<b>4</b>
<b>Key Achievements 2025/26</b> .....	<b>5</b>
<b>Criterion 1: Systems to manage and monitor the prevention and control of infection.</b> .....	<b>8</b>
<b>Criterion 2: Provide and maintain a clean and appropriate environment.</b> .....	<b>13</b>
<b>Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.</b> .....	<b><a href="#">1847</a></b>
<b>Criterion 4: Provide suitable accurate information on infections to service users.</b> .....	<b><a href="#">2224</a></b>
<b>Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection.</b> .....	<b><a href="#">2322</a></b>
<b>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.</b> .....	<b><a href="#">2726</a></b>
<b>Criterion 7: Provide or secure adequate isolation facilities.</b> .....	<b><a href="#">2827</a></b>
<b>Criterion 8: Secure adequate access to laboratory support as appropriate.</b> .....	<b><a href="#">2827</a></b>
<b>Criterion 9: Have and adhere to policies, designed for the individual’s care and provider organisations that will help to prevent and control infections.</b> .....	<b><a href="#">2827</a></b>
<b>Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.</b> .....	<b><a href="#">2827</a></b>
<b>Conclusion</b> .....	<b><a href="#">2928</a></b>

## 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.

This annual report outlines the activities of RJAH relating to Infection Prevention & Control for the year April 2025 to March 2026, showing the arrangements RJAH has in place to reduce the spread of infections. The report fulfils its statutory requirements under the Health and Social Care Act 2008: code of practice on the prevention and control of infections. The prevention and management of infection is the responsibility of all staff employed by RJAH and is integral to patient safety.

## 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).

	<b>What providers will need to show evidence of</b>
<b>Criterion 1</b>	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.
<b>Criterion 2</b>	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
<b>Criterion 3</b>	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
<b>Criterion 4</b>	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
<b>Criterion 5</b>	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.
<b>Criterion 6</b>	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.

# Infection Prevention & Control and Cleanliness Annual Report 2025/26

<b>Criterion 7</b>	Provide or secure adequate isolation facilities.
<b>Criterion 8</b>	Secure adequate access to laboratory support as appropriate
<b>Criterion 9</b>	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
<b>Criterion 10</b>	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

## Key Achievements 2025/26

- We created a 2-year IPC Ambitions programme of works under the following primary categories
  - Education
  - Collaboration
  - Integration & Innovation
  - Digital Technology

One year into this programme, we are proud of the achievements we have made so far:

Ambition - Education	
We will introduce diverse ways to learn which adapts to staff needs	<ul style="list-style-type: none"> <li>• The IPC Team have delivered over 100 education sessions for staff this year, ranging from bitesize sessions within clinical areas, lectures to delegates of the Orthopaedic/Spinal Injuries course, refresher training for Cleanliness Technicians, Trust inductions, Student Nurse/AHP shadowing, Pharmacy Student sessions and many more.</li> <li>• The IPC Team have supported shadow experiences for Student Nurses, and Pharmacy students</li> </ul>
We will develop the IPC Team knowledge by keeping up-to-date with evidence-based practice and attending IPC related courses and events	<ul style="list-style-type: none"> <li>• The IPC Clinical Lead Nurse completed a Water Safety Responsible Person Accreditation course this year, refreshing knowledge around water safety risks, and empowering ideas to improve the awareness of water safety risks to clinical staff.</li> <li>• IPCN started IPC course as part of professional development as an IPC subject matter expert.</li> <li>• The IPC Team attending an annual IPC Conference</li> <li>• An IPC Team member enrolled into an accredited IPC course</li> </ul>
We will align IPC education to the National IPC Education Framework	<ul style="list-style-type: none"> <li>• We developed education materials for students and Allied Healthcare Professionals in line with the National IPC Education Framework to support those on placement within the Trust.</li> </ul>
We will ensure staff have access to IPC support	<ul style="list-style-type: none"> <li>• We introduced an IPC Buddy system to support staff with all aspects of IPC. This system has helped provide consistency across the Trust, with all areas having a direct point of contact during weekdays.</li> <li>• The IPC intranet pages have been redesigned to ensure that information is relevant, current and easy to understand. The pages have links to key documents to support clinical staff. The IPC team are monitoring the usage of the pages and have seen a notable rise in staff accessing the page, giving staff more access to IPC advice when they need it.</li> </ul>

# Infection Prevention & Control and Cleanliness Annual Report 2025/26

We will provide a yearly IPC Fayre to promote best IPC practice in collaboration with key stakeholders

- The annual IPC fayre was held on 17th September in collaboration with Estates and Facilities colleagues. The fayre provided staff with opportunities to learn about the chain of infection, HAIs and how to prevent them, CDI, AMS, and involved interactive games which staff enjoyed. The IPC Team were particularly impressed by the engagement of the Cleanliness Technician teams who showed good understanding around different infections and how they would enhance cleaning to prevent infections from spreading.



IPC Team with CEO Stacey Keegan



Estates & Facilities Team supporting the IPC Fayre



Cleanliness Technicians learning about IPC


## Ambition – Collaboration

We will share our learning from the IPC journey with other Trusts to support improvements

- In September, the Facilities Compliance Manager and IPC Clinical Lead delivered a presentation entitled '*Collaborative leadership and culture change in delivering a clean safe environment*' at the Healthcare Facilities Management conference in Birmingham. The presentation summarised the key learning points from the RJAH journey through from being escalated on the National Oversight Framework, to achieving Exemplar status for cleanliness, and shared and honest reflection of difficulties that were faced.

This promoted excellent networking opportunities with other providers, who were keen to visit RJAH and learn about the collaboration between IPC Teams and Estates & Facilities, which we believe is the key to the sustained improvements seen across the Trust.

# Infection Prevention & Control and Cleanliness Annual Report 2025/26

	 <p><i>Facilities Manager and IPC Lead Nurse presenting at conference</i></p>
<p>We will represent RJAH on regional collaboratives</p>	<ul style="list-style-type: none"> <li>We worked in collaboration with NHS England to develop an IPC competency booklet to support staff in practice which will be implemented in 2026-27.</li> </ul>
<p>We will work in partnership with the ROH in Birmingham to share infection data, benchmark, and work on improvement projects</p>	<ul style="list-style-type: none"> <li>We share quarterly infection data with the Royal Orthopaedic Hospital (ROH) and have developed key working relationships with their IPC Team to share learning</li> </ul>
<p>We will work with the Lead Antimicrobial Steward to support initiatives to reduce antimicrobial resistance in line with the National Action Plan</p>	<ul style="list-style-type: none"> <li>The IPC Team supported the Antimicrobial Pharmacist during World Antimicrobial Awareness Week in November. A board was created and placed in the hospital restaurant to raise the profile of the importance around appropriate antimicrobial usage.</li> </ul>

## Ambition - Integration & Innovation

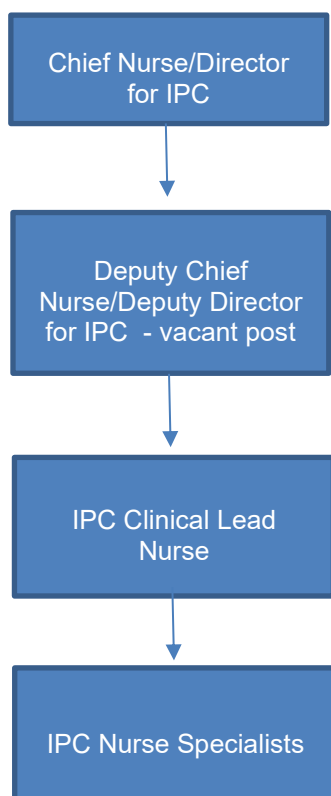
<p>Use evidence-based practice to support optimisation of patients before surgery to reduce risk of SSI</p>	<ul style="list-style-type: none"> <li>We extended the MSSA decolonisation programme this year to include all elective patients undergoing joint replacement surgery. These patients are provided with a 5-day course of MSSA decolonisation therapy before their procedure to reduce skin colonisation with Staphylococcus aureus and lower the risk of surgical site infection. This proactive approach forms an important part of the wider surgical infection prevention pathway, helping to optimise patients before surgery, reduce avoidable harm, and support safer postoperative outcomes.</li> </ul>
<p>We will integrate with teams to provide IPC support for off-site services</p>	<ul style="list-style-type: none"> <li>We have provided IPC advice and guidance to Orthotics this year to support improvements to IPC compliance on off-site services.</li> </ul>
<p>We will report key themes from HAIs and work with wards and departments on quality improvement projects</p>	<ul style="list-style-type: none"> <li>We are delighted that the Trust has maintained under the national thresholds set by NHS England for healthcare associated infections this year.</li> <li>We conduct reviews into all reportable Healthcare Associated Infections to learn about good practice and IPC improvements. We share this learning throughout the Trust.</li> </ul>

## Ambition - Digital Technology

<p>We will use the new electronic patient record to ensure that patient alerts are identified in a timely manner to ensure that precautions can be put in place to prevent spreading infections</p>	<ul style="list-style-type: none"> <li>A new function was introduced this year which includes an 'alert' on the electronic patient record to enable the correct patient placement across the Trust.</li> </ul>
<p>We will provide a central space for IPC data</p>	<ul style="list-style-type: none"> <li>We have made improvements to the Quality Management System to ensure that the data is presented concisely.</li> </ul>

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

**Team Structure**



**Chief Executive Officer (CEO)**

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

**Director of Infection Prevention & Control (DIPC)**

The 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 IPC Clinical Lead.

**Infection Control Doctor**

The Trust utilises an Infection Control Doctor who is employed by Shrewsbury and Telford Hospitals (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 Infection Prevention and Control Team (IPCT)**

The Infection Prevention and Control Team (IPCT) are the 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:

- Director of IPC (also Chief Nurse and Patient Safety Officer) (1.0 WTE)
- Infection Prevention and Control Lead Nurse (1.0 WTE)

# Infection Prevention & Control and Cleanliness Annual Report 2025/26

- Infection Prevention & Control Nurse Specialists (2.0 WTE)

## The Antimicrobial Pharmacist

The Trust has a designated Antimicrobial Pharmacist. 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

## The IPC Programme of Work/Workplan

The IPC Programme of Work 2025-27 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 continues provide the following:

- 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 Control & Cleanliness Meeting

The purpose of the Infection Prevention and Control & Cleanliness Meeting (IPCCM) is to ensure compliance with the requirements of the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, and to ensure that the Trust has safe and effective IPC practice and processes embedded across the organisation, within an environment that has consistently high levels of cleanliness.

The IPCCM is held monthly and chaired by the DIPC with Multi-disciplinary representation across Nursing, AHPs, and Estates & Facilities teams. A monthly Chair report is provided to the Quality & Safety committee for oversight, which in turn, reports to the Trust Board.

## 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 IPCCWG met monthly throughout 2025/26. 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 Group provides effective communication between the IPC team, operational areas, and Estates & Facilities by identifying and resolving issues in line with Trust priorities.

# Infection Prevention & Control and Cleanliness Annual Report 2025/26

Our continued collaboration through the IPCCWG has been the driving force behind this year's improvements to the estate, including replacement floor coverings in several ward and clinic areas, sluice replacement, Theatre operating lights replacement, and staff rest room refurbishments.

## 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 given some changes to the way that Link meetings are held across the Trust. The IPC team have provided a central hub of information for link staff to ensure that up to date information is shared.

## 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.

The Trust achieved a 99% regulatory compliance rate this year, with continued efforts to strengthen performance against Criteria 3.

We close the year reporting 1 open action related to antimicrobial stewardship which is in progress.

Compliance to both frameworks is monitored by the IPC Team and reported through the IPC&C 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. The introduction of the new electronic patient record Apollo now gives the function for the IPC Team to add alerts directly to the patient's notes; allowing for patients to be placed accordingly to their infection status on future admissions.

## 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

## Infection Prevention & Control and Cleanliness Annual Report 2025/26

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 6 HAIs across this year, compared to 14 last year:

Organism	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	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	0	0	1	1	0	0	2	N/A
C Diff	0	0	0	0	1	0	0	0	0	0	0	0	1	2
E.coli	0	0	0	0	0	0	0	1	0	0	0	1	2	9
Klebsiella	0	0	0	0	1	0	0	0	0	0	0	0	1	1
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 it 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 1 RJAH acquired, unavoidable case of CDI this year; improving on last year's total of 3 cases.

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

There were 2 cases of MSSA, 3 cases of E.Coli, and 1 case of Klebsiella bloodstream infections this year. Bloodstream infections occur when microorganisms enter the bloodstream, sometimes through medical devices such as urinary catheters and cannulas. All of the cases were reviewed as part of the hospital's Patient Safety Incident Response Framework, and all of the cases were unavoidable due to various risk factors.

All learning from case reviews is shared through the Trust's governance groups to ensure that key themes, contributory factors and examples of good practice are identified and acted upon. This shared learning supports continuous improvement, strengthens accountability, and helps teams apply lessons more widely across services, reducing the risk of similar incidents recurring and improving patient safety outcomes.

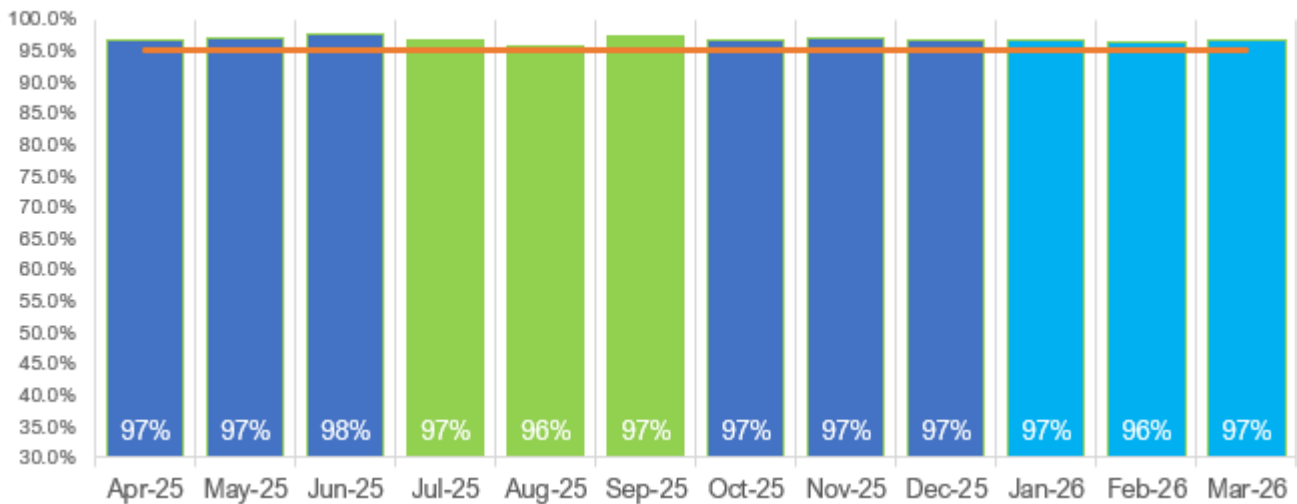
### Infection Prevention & Control Ward/Department Audits

All wards and departments are responsible for completing IPC audits as part of routine clinical practice. These audits are essential in providing assurance that infection prevention standards are being consistently applied, identifying areas of good practice, and highlighting where further support or improvement is needed. By monitoring compliance with key IPC measures, audits help teams to reduce variation in practice, strengthen accountability, and take timely action to address risks, ultimately supporting safer care for patients, staff, and visitors.

The graph below shows Trust-wide audit scores and frequency compliance from April 2025. Overall, scores consistently met or exceeded the 95% target.

# Infection Prevention & Control and Cleanliness Annual Report 2025/26

## IPC Audit Performance



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

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 (QA Walks) across the Trust to seek assurance on standards of infection prevention across the Trust, in line with national standards of infection prevention.

The schedule is aligned to 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)

RED	Below 90%
AMBER	90% - 94%
GREEN	95% And Over

QA Walks continue to be scored using a RAG (Red, Amber, Green) rating.

This year the IPC Team undertook 178 QA walks 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. Actions are monitored through the Infection Prevention and Control & Cleanliness Working Group to ensure that actions are dealt with in a timely manner.

The table below shows the overall compliance related to the scoring thresholds based on 178 completed QA Walks:

Scoring Threshold	Number of QA Walks
RED Below 90%	11
AMBER 90%-94%	47
GREEN 95% and over	120

# Infection Prevention & Control and Cleanliness Annual Report 2025/26

Results show that most areas achieved over the Trust target. For areas that fell below the Trust target, the IPC Team performed spot checks to support timely action around IPC noncompliance and to aid assurance. Matrons, Ward and Department Managers are responsible for ensuring that all actions related to IPC noncompliance are completed to ensure that standards of IPC remain high across the Trust.

Areas scoring RED relate to mostly to wards with long-term patients, where volume of equipment and patient belongings is high, resulting in challenges in maintaining clear spaces, due the nature of the patient needs. Other challenges related to accessibility for the Estates Team to rectify

The IPC Team continue to support clinical areas to improve IPC compliance by adopting an 'IPC Buddy' system. This means that all wards and departments have a named IPC Team member as their point of contact, providing timely advice, practical support and guidance tailored to the needs of each area. The system helps to strengthen relationships between clinical teams and the IPC Team, promotes consistency in practice, and enables issues to be identified and addressed promptly. It also supports staff confidence, encourages shared ownership of IPC standards, and helps wards and departments to sustain improvements in patient safety and quality of care.

## 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.

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 PLACE assessment 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 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.

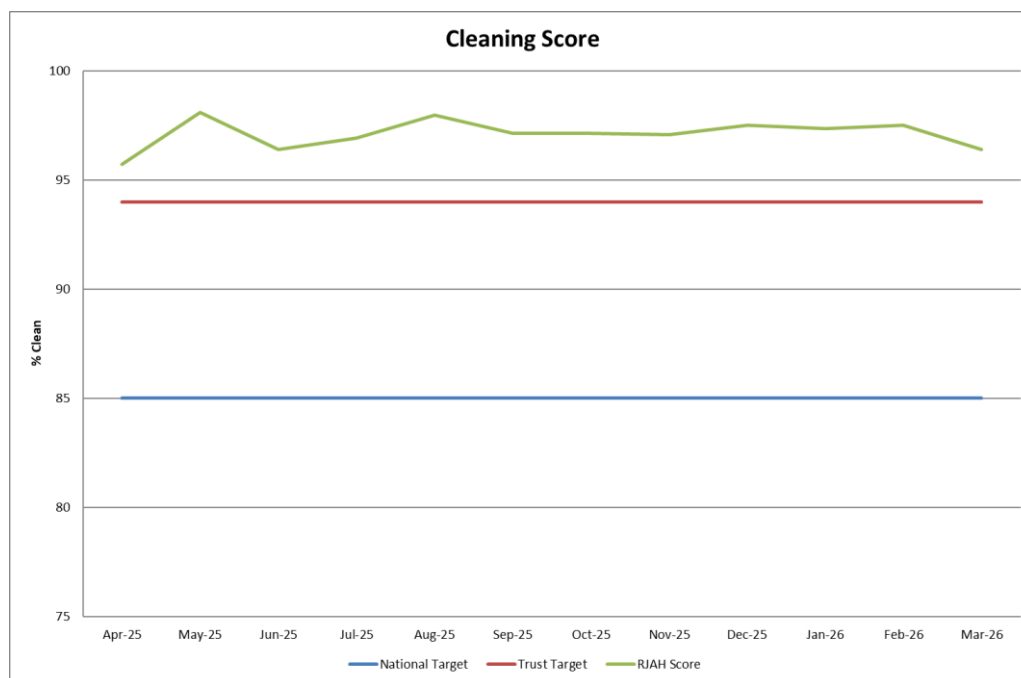
The Trust employed an external contractor to complete HPV fogging; responses to date have been quick, effective, and professional.

33 individual rooms and 2 complete bays have required a red terminal clean in 2025/26; 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.

# Infection Prevention & Control and Cleanliness Annual Report 2025/26

## 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 2025/26 the Trust achieved an average score of 97.10%.

## 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 reapply for Exemplar Status in 2026, following the same process aligned to the updated 2025 National Standards of Cleanliness.

## 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

## Infection Prevention & Control and Cleanliness Annual Report 2025/26

The Trust kitchen retained its 5-star food hygiene rating at last inspection in February 2026, 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 refurbishment works within the kitchen have been completed to a high standard and supported the plans for works to ventilation systems later in 2026.

The onsite Nursery is registered with Shropshire Council environmental health and retained its 5-star food hygiene rating in August 2025.

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. The Trust maintains the services of an external Food Safety Specialist, who along with completing biannual audits, supports with specialist advice, including review of relevant food safety policies and standard operating procedures specific to catering.

### CQC Inpatient Survey

The CQC Inpatient Survey 2024 results were published in September 2025, 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 9.90. 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 2025.

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 Shropshire Community Health Trust to take part in the assessment, gaining valuable insight from their perspective alongside Healthwatch patient panel and volunteer representation.

Domain	2025 score
Cleanliness	99.93%
Food	93.22%
Privacy, Dignity & Wellbeing	92.23%
Condition, Appearance & Maintenance	98.76%
Dementia	87.98%
Disability	88.35%

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).

### 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.

## Infection Prevention & Control and Cleanliness Annual Report 2025/26

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. The strategy further advocates the use of reusable sharps containers, which have been in place at the Trust since February 2025. 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.

1
2
3
4
5
6
7
8
9
10
11

# Infection Prevention & Control and Cleanliness Annual Report 2025/26

## 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 & Cleanliness Meeting.

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 RJAH 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 disinfection, including thermal and chemical. 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. All positive samples have a microbiological filter fitted. The Water Safety Group discusses positive results, control measures and any actions required. An independent Water Authorising Engineer is an active member of the group.

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 Trust has a mixed Estate in relation to facilities that situate air handling units. Re-verification is done in line with current guidance and enhanced mitigations are put in place for aging parts of the estate where design specification differs from guidance,

The RJAH Estates Team conduct Quarterly PPMs on all Air Handling units (AHU's) to ensure they are clean, fully functional, and proactively manage any issues that should arise.

Accredited third party contractors revalidate Specialised Ventilation Units on an annual basis, including Theatres, Critical Care and Laboratories, providing an inspection and reverification report. These reports are then reviewed by the Trusts Authorising Person (AP(V)) and the AE(V)

# Infection Prevention & Control and Cleanliness Annual Report 2025/26

## Decontamination Group

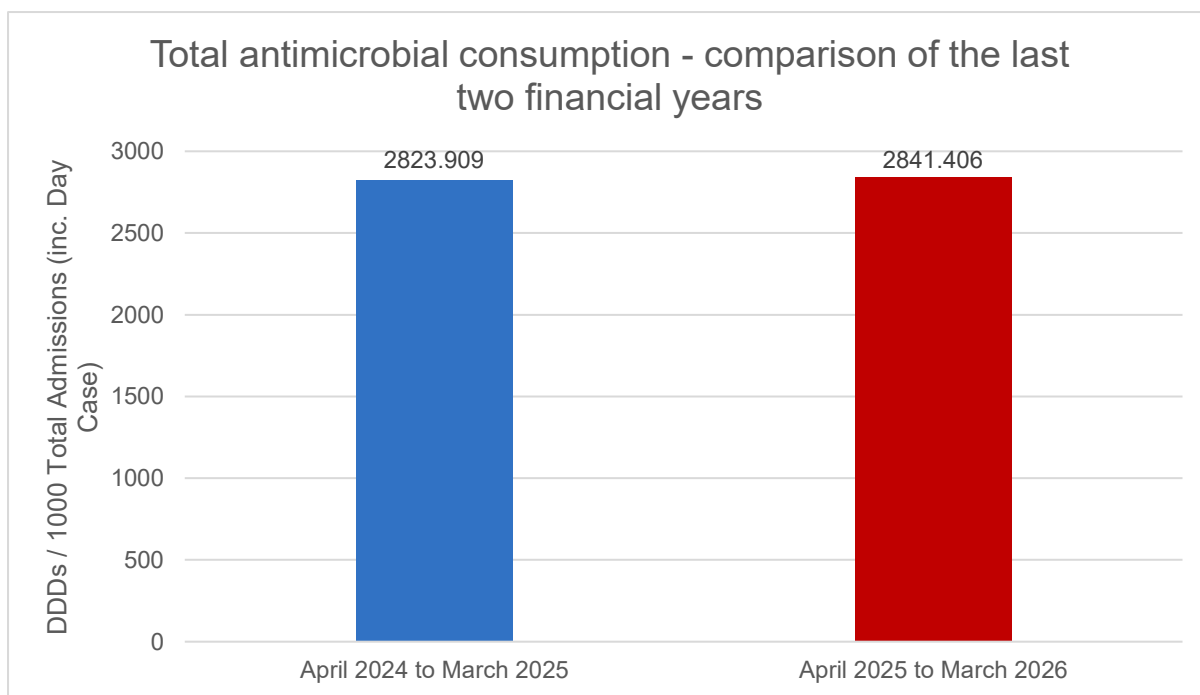
Decontamination, which covers the Theatre and Sterile Services environment, is led and monitored by the Estates Department supported by their third party accredited Authorising Engineer for Decontamination AE(D), who is appointed in writing. The AE(D) is a 'independent advisor,' a requirement of National 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.

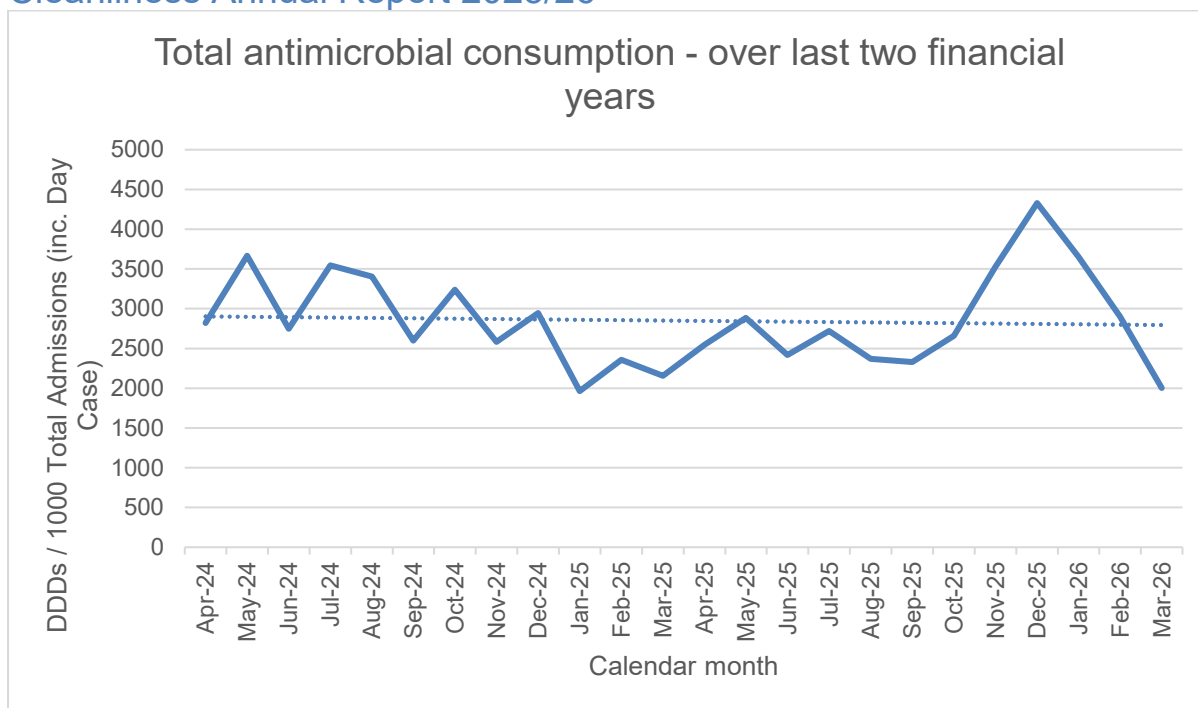
### Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

The graph below shows that when comparing the total antimicrobial consumption between April 2024 to March 2025 and April 2025 to March 2026 there is not much difference in the usage. However, the second graph displays that overall, there has been a downward trend which contradicts the first graph. There are peaks and troughs in usage throughout the last two financial years, but this variability occurs due to the type of patients admitted e.g. spinal patients admitted for pressure ulcer management who have osteomyelitis, surgical patient with infected joint replacements – these patient groups require antimicrobials for a longer period. 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).

1
2
3
4
5
6
7
8
9
10
11

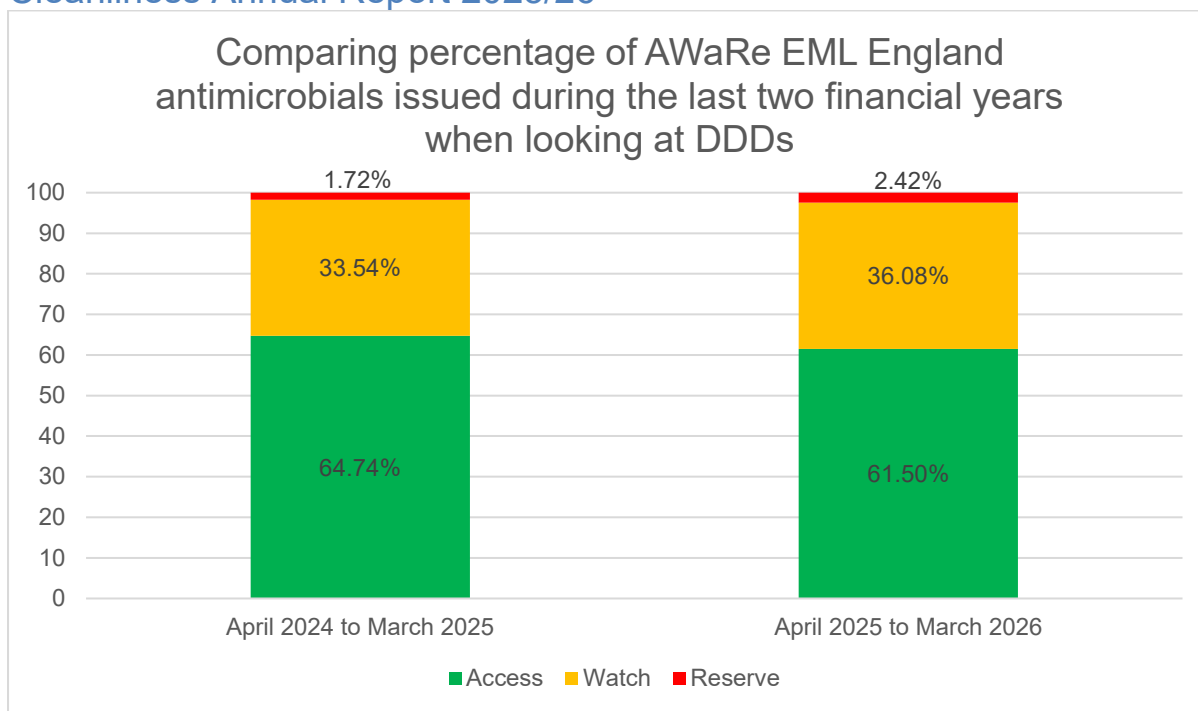


#### AWaRe antimicrobials review

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. In the last financial year 2025/26 there has been an increase in the percentage of watch and reserve antimicrobials and a decrease in access antimicrobials issued compared to 2024/25. 'The UK revised its AWaRe classification in 2024, aiming for 70% of antibiotic use to come from the 'Access' category'<sup>11</sup> but our Trust falls below this target. 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. Since the implementation of electronic prescribing (EPMA), an indication must be selected before an antibiotic can be prescribed. Although this is an essential and useful prompt, there is not always an appropriate indication to choose meaning that it doesn't always match what is documented in the notes.

Dalbavancin is a reserve antimicrobial as well as a high-cost drug. It should only be used in patients who have grown a gram-positive organism, undergone a DAIR procedure or single stage revision and are ready for discharge and must be recommended by microbiology. If a patient is prescribed dalbavancin it should be administered on the day that it is prescribed. This has been monitored and, more often than not, the patient is discharged on the same day.

<sup>1</sup> [ESPAUR report 2024 to 2025: extended summary - GOV.UK](#) (accessed 20/05/2026).



EML – List of Essential Medicines

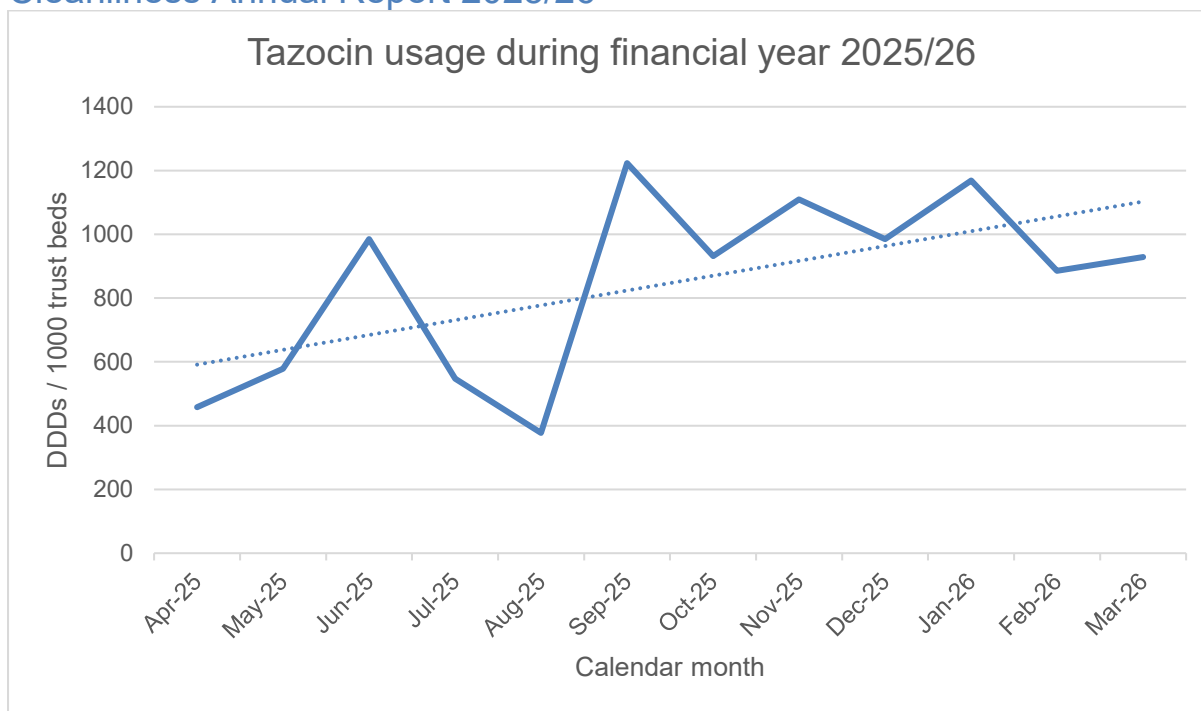
AWaRe – This is a WHO classification for antimicrobials which is split into Access, Watch and Reserve:

- **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 2025/26 when looking at DDDs/1000 Trust beds. Overall, there is an upward trend with usage peaking in September 2025. Every quarter those patients prescribed Tazocin are reviewed to check for appropriateness. Tazocin is often prescribed in surgical patients for e.g. revision arthroplasties, infected arthroplasties according to the Sheffield guidelines. However, when looking at patients with more medical related issues, microbiology advice is very rarely sought when Tazocin is prescribed - Tazocin often appears to be the go-to antibiotic when a patient spikes a temperature/is unwell or if the patient deteriorates whilst already on treatment for an infection. It is essential that the antimicrobial guidelines are being followed, recent cultures and sensitivities are reviewed and acted upon and that Microbiology involvement is sought when necessary. It is also vital that an indication or suspected diagnosis is specified as documentation is often lacking regarding this. Tazocin usage should be kept to a minimum where possible especially with the rising rate of antimicrobial resistance.

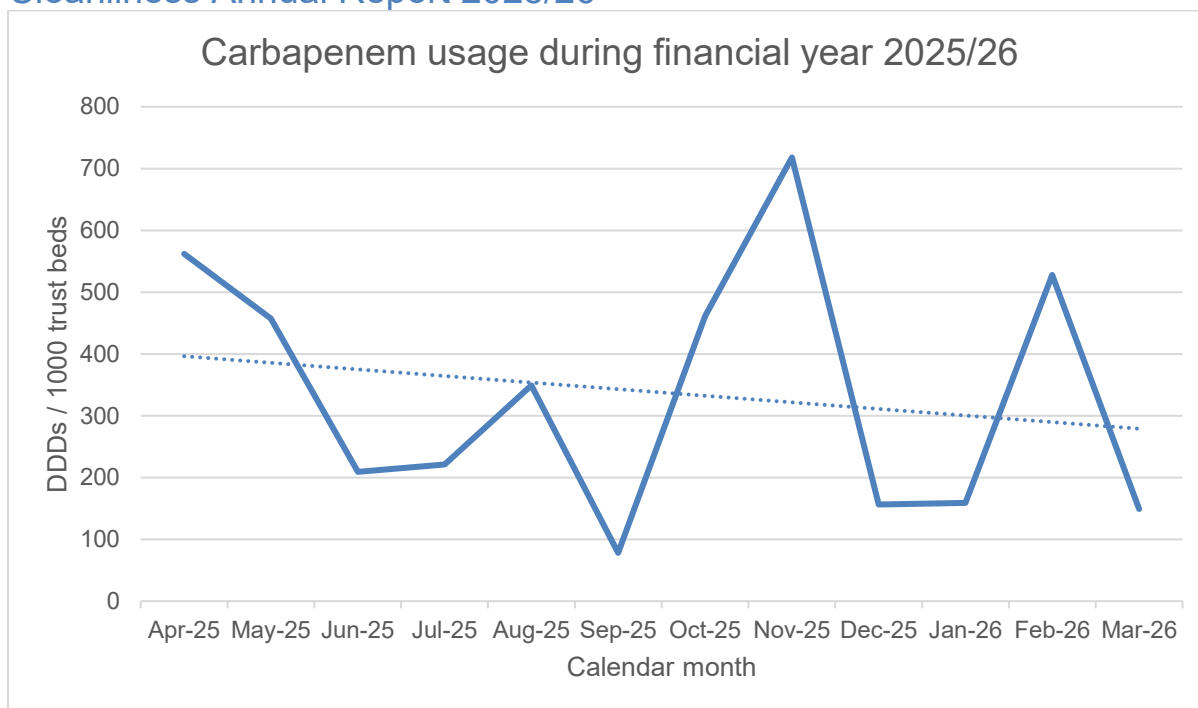
# Infection Prevention & Control and Cleanliness Annual Report 2025/26



This graph shows the overall usage of carbapenems (Ertapenem and Meropenem) during the last financial year 2025/26 when looking at DDDs/1000 trust beds. There are peaks and troughs in usage although the overall trend is downward. Most patients prescribed carbapenems during the financial year were appropriate and prescribed according to sensitivities, guidelines or as per microbiology advice. Occasionally documentation is lacking meaning that it is difficult to determine appropriateness.

1
2
3
4
5
6
7
8
9
10
11

## Infection Prevention & Control and Cleanliness Annual Report 2025/26



### Future actions

- Implement a weekly antimicrobial ward round with the antimicrobial pharmacist and IPC lead when EPMA is in place. This will provide greater insight into the use of antimicrobials within the Trust.
- Incorporating the Sheffield antimicrobial guidelines with the current antimicrobial guidelines will help to improve antimicrobial stewardship and the awareness of guidelines among prescribers.
- Once published on EOLAS a QR code will be available in Theatres for easy access to the most up-to-date version of the guidelines.

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

Patients who are identified to be carrying (colonised) 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.

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.

### 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

# Infection Prevention & Control and Cleanliness Annual Report 2025/26

- 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.

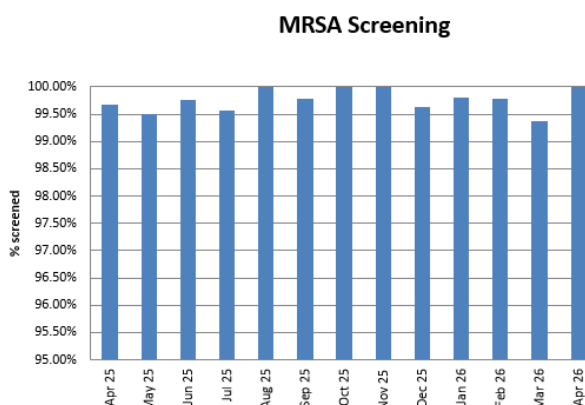
### Oswestry Infection Control (OIC)

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%.

	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
Eligible patients	935	810	834	902	838	953	1027	981	799	1010	911	960	980
Screened for MRSA	932	806	832	898	838	951	1027	981	796	1008	909	954	980
% achieved	99.68%	99.51%	99.76%	99.56%	100.00%	99.79%	100.00%	100.00%	99.62%	99.80%	99.78%	99.38%	100.00%
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

## Infection Prevention & Control and Cleanliness Annual Report 2025/26

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.
- The Trust extended the MSSA decolonisation programme this year to include all elective patients undergoing joint replacement surgery. These patients are provided with a 5-day course of MSSA decolonisation therapy before their procedure to reduce skin colonisation with *Staphylococcus aureus* and lower the risk of surgical site infection. This proactive approach forms an important part of the wider surgical infection prevention pathway, helping to optimise patients before surgery, reduce avoidable harm, and support safer postoperative outcomes.

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.

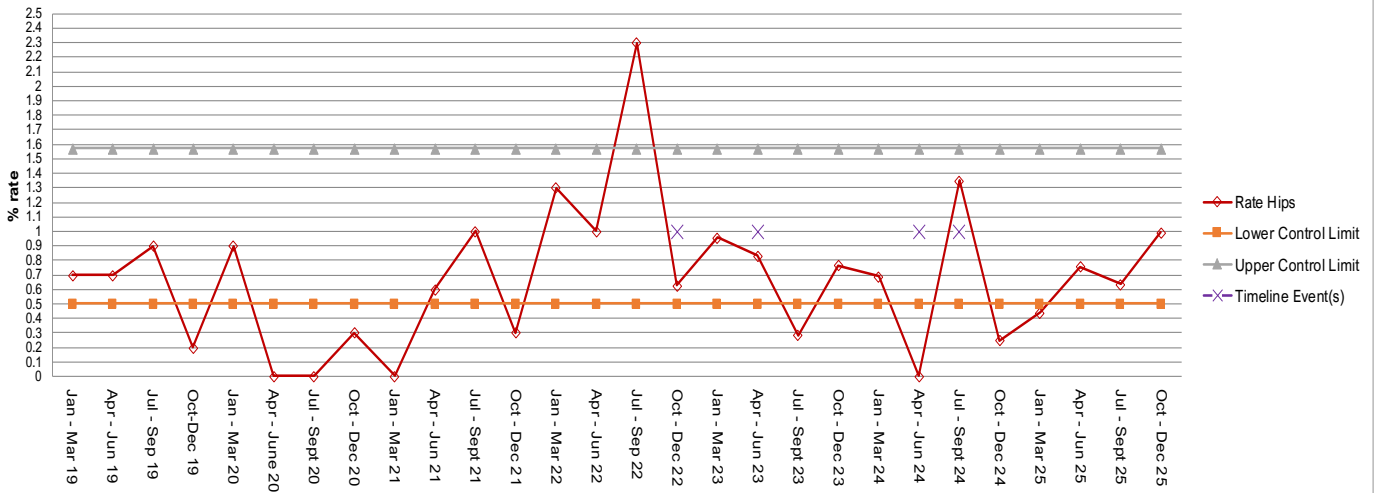
The UK Health Security Agency (UKHSA) analyses the submitted data at quarterly intervals to identify hospitals whose SSI incidence may be high or low, enabling the Trust to benchmark against the national rate of infection.

From April 2025 – December 2025, RJAH submitted data to SSISS on total of 3306 operations – 1371 Total Hip Replacements (THR), 1288 Total Knee Replacements (TKR) and 647 Spinal surgeries was collected by the RJAH surgical site surveillance team. During this period, there have been a total of 24 reported, with 11 THR, 7 TKR, and 6 spinal surgeries.

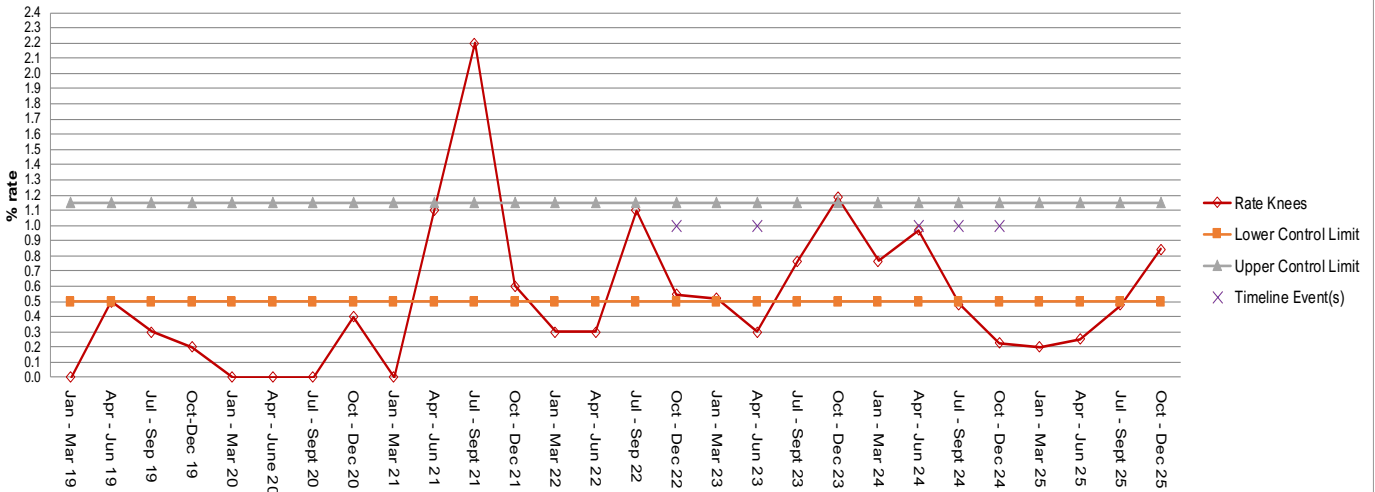
The following graphs show the breakdown in RJAH rate of surgical site infections reported to UKHSA between April 2025 and December 2025. At the time of writing this report, UKHSA have not yet reconciled SSI data for Jan-March 2026, as it is reported one quarter behind to allow time for any infections to present, which is why it is not shown below.

# Infection Prevention & Control and Cleanliness Annual Report 2025/26

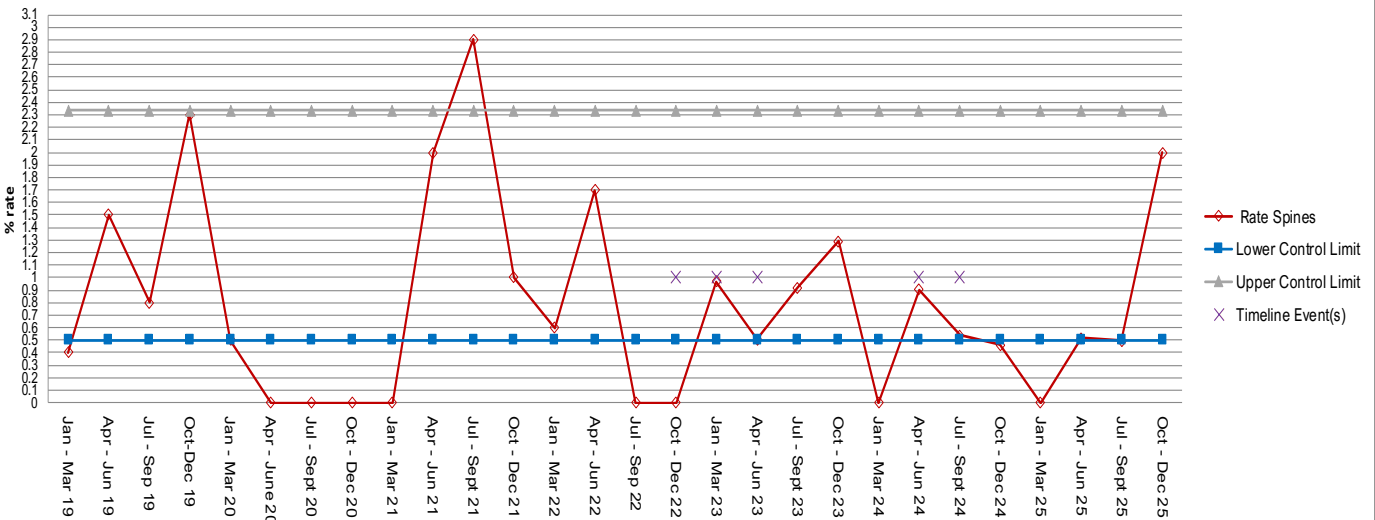
Rates of RJAH Total Hip Replacement Surgery SSIs Reported on the Surgical Site Infections Surveillance Service per Qtr



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



Rates of RJAH Spinal Surgery SSIs Reported on the Surgical Site Infections Surveillance Service per Qtr



## Infection Prevention & Control and Cleanliness Annual Report 2025/26

The Trust continues to assess standards across the surgical pathway using the OneTogether assessment toolkit. This toolkit is an important quality improvement resource because it provides a structured framework for monitoring key elements of SSI prevention across the patient journey, including skin preparation, prophylactic antibiotics, patient warming, maintaining asepsis, the surgical environment, wound management and surveillance. By using the toolkit, the Trust can identify variation in practice, provide assurance that evidence-based standards are being followed, and highlight areas where further action or improvement is needed. This supports a consistent approach to safer surgical care and helps reduce the risk of surgical site infection by strengthening oversight of the whole pathway.

A review into a spike in SSIs from Oct-Dec 2025 was undertaken finding no single attributable cause but identified several relevant themes, including patient co-morbidities, uncertainty regarding completion of MSSA decolonisation, post-operative wound issues, Staphylococcus Aureus as the most common organism, and possible associations with timing of surgery. A wider analysis of cases from 2018 to 2025 also suggested small associations with outside temperature, number of ward moves, weekend surgery and post-operative HDU admission, reinforcing the multifactorial nature of SSI risk.

### **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 Infection Event and Outbreak Management Policy to ensure a standardised response to outbreak management that includes external reporting.

The Table below summarises the outbreaks declared in RJAH during 2025/26:

Area	Date	Causative Organism
Sheldon Ward	26/06/2025	COVID-19
Ludlow Ward	25/10/2025	Diarrhoea and vomiting (no microorganism identified)
Kenyon	09/02/2026	Diarrhoea and Vomiting (no microorganism identified)
Ludlow	09/02/2026	Diarrhoea and Vomiting (no microorganism identified)

# Infection Prevention & Control and Cleanliness Annual Report 2025/26

## Serious Incidents

There were no serious incidents related to IPC to report in 2025/26.

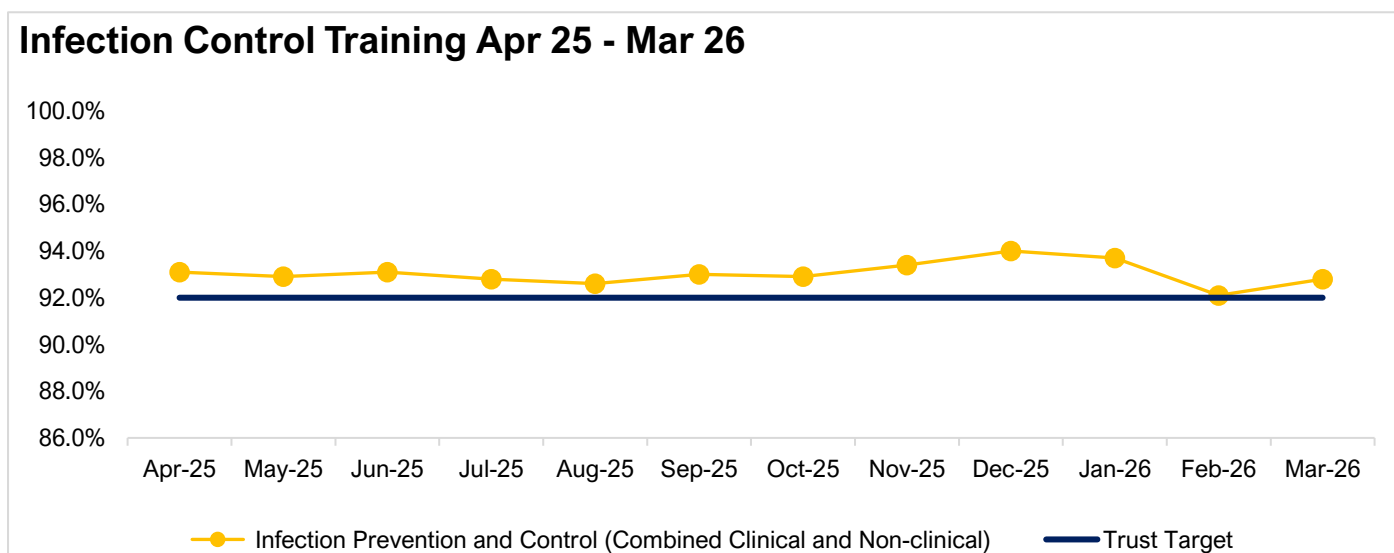
### **Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.**

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 Prevention & Control Training Clinical & Non-Clinical
- 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.
- Cleanliness Technicians receive a yearly IPC refresher session

The IPC Team have provided over 100 education sessions throughout the year as part of the IPC strategy, including:

- MRSA Decolonisation
- Handwashing
- Donning and doffing
- Standard IPC precautions
- Transmission-based precautions
- Surgical site infection prevention
- Ad-hoc sessions in ward/departmental areas
- Student shadowing
- IPC in relation to patients with spinal injuries

## 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 an updated 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 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.

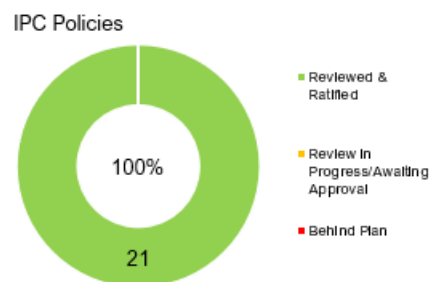
Cleaning and management of our isolation facilities is conducted by our facilities team in accordance with our policy, the National Cleaning Standards, and the National IPC Manual.

## 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. Since then, a policy tracker has been maintained including review dates, to ensure that policies are updated in a timely way. The IPC Team provide assurance that policies are maintained through the IPC Quality Management System. The IPC Team maintain 100% compliance to IPC policies.



## 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

Occupational health work collaboratively with the Trust in enabling the Trust to meet the occupational requirements for their workforce. General work health assessments standards are based on NHS Employer recommendations. The immunity and immunisation standards are based on the Department of Health and Social Care guidance, the Department of Health (DOH) Green Book *Immunisation against infectious disease* and the UK Health Security Agency (UKHSA).

The day-to-day service provision include:

#### Pre-employment/pre-placement screening

New starters or those who are changing role within the Trust are required to complete a health questionnaire in determining medical fitness to undertake the position which they are applying for. This is referred to as pre-employment questionnaire (PPQ) screening which provides the Trust with assurance that the candidate has satisfactory health clearance prior to the offer of a job role. PPQ screening also assists the Trust in determining whether reasonable adjustments need to be considered for a potential recruit who has a long-term condition; this aligns with the disability provisions of the Equality Act (2010).

# Infection Prevention & Control and Cleanliness Annual Report 2025/26

For those candidates whose job role may expose them to substances hazardous to health, in line with Health and Safety Legislation, they will be enrolled onto the health surveillance (HS) and/or the immunisation programmes. For candidates who are in exposure prone procedure (EPP) roles and, they are living with a blood borne virus (BBV) they are enrolled in the close monitoring programme in line with the UK Advisory Panel (UKAP) for healthcare workers living with a BBV.

## Body Fluid Exposure (BFE) incidents

A dedicated clinician is assigned daily during business hours to handle enquires related to BFEs in line with Optima policy; which is underpinned by government guidance and BASHH guidelines. The initial call involves undertaking a risk assessment and organizing follow-up attendance for a blood test or vaccination plus setting out a timetable for follow-up surveillance bloods. The Trust will be informed of BBV exposure incidents that may be reportable under RIDDOR (2013) Regulations.

For incidents occurring out of hours, emergency departments provide initial treatment, with Optima Health completing all required follow-up assessments and blood tests.

## Management Referrals

This is a pathway for the Trust to seek advice about fitness for work once a member of staff has employee status. Changes in health or circumstances can occur during the period of employment with the organization. If there are concerns about the impact of work upon health or vice versa, referring an employee to occupational health can yield benefit in terms of an earlier return to work if sickness absence is a feature or, advice in terms of preventative measures with regards to sickness absence.

## Case Conferences

For complex health and employment situations, a virtual meeting for all relevant parties can be helping in terms of finding appropriate solutions in moving forwards.

## **Data Requests and Reports**

Reporting into the IPC and H&S committees provides an opportunity to inform the Trust of concerns or trends related to IPC and H&S. Optima work with the Trust in terms of projects related to vaccine compliance for assurance purposes.

## Safer sharps

Following a HSE inspection in July 2025, the Trust was served an Improvement Notice which required changes in practice in relation to the use of insulin needles. A further Notice of Contravention required that improvements be made to the management of medical sharps across the site. All requirements were met within deadlines, and no further enforcement action was taken.

It should be noted that sharps (including needlestick) injuries remained at a low level with 15 'dirty' and 6 'clean' incidents reported. No incident meeting the criteria for reporting to the HSE under RIDDOR. Safer sharps are the default devices of choice for all procedures wherever clinically practicable. The use of standard sharps is by exception and supported by robust risk assessments

## Conclusion

Overall, this report demonstrates that infection prevention and control remains firmly embedded across RJAH, supported by strong leadership, collaborative working and a clear commitment from staff at every level. During 2025/26 the Trust has sustained high standards of practice, strengthened systems for assurance and surveillance, and continued to make measurable progress in reducing healthcare-associated infections. While national challenges remain, the achievements outlined in this report reflect a positive culture of continuous improvement and shared ownership, providing a strong foundation for the year ahead as we continue to deliver safe, clean and effective care for our patients.

Clair Hobbs

Interim Chief Nurse and Director of Infection Prevention and Control (DIPC)

Anna Morris

Clinical Lead for Infection Prevention & Control

Infection Prevention & Control and  
Cleanliness Annual Report 2025/26  
May 2026

1
2
3
4
5
6
7
8
9
10
11

**Committee / Group / Meeting, Date**

Patient Experience Committee 15 June 2026

**Trust Annual Patient Experience Report April 2025- March 2026**

**Author:**

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

**Contributors:**

Matthew Hughes, Clinical Governance Assistant

**Report sign-off:**

Sheela Vepuri, Interim Assistant Chief Nurse and Patient Safety Officer  
Clair Hobbs, Interim Chief Nurse and Patient Safety Officer

**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 2025 - March 2026

This report summarises patient experience feedback collected during 2025/26 from the Patient Advice and Liaison Service (PALS), formal complaints, Patient feedback, Compliments, Friends and Family Test (FFT) surveys, patient stories, patient engagement activity, and the national CQC Inpatient Survey.

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	

1
2
3
4
5
6
7
8
9
10
11

1
2
3
4
5
6
7
8
9
10
11

**Recommendations:**

The committee is asked to note the feedback detailed in the Patient Experience Annual report for 2025-26.

**Next Steps:**

Progress with actions being taken outlined below:

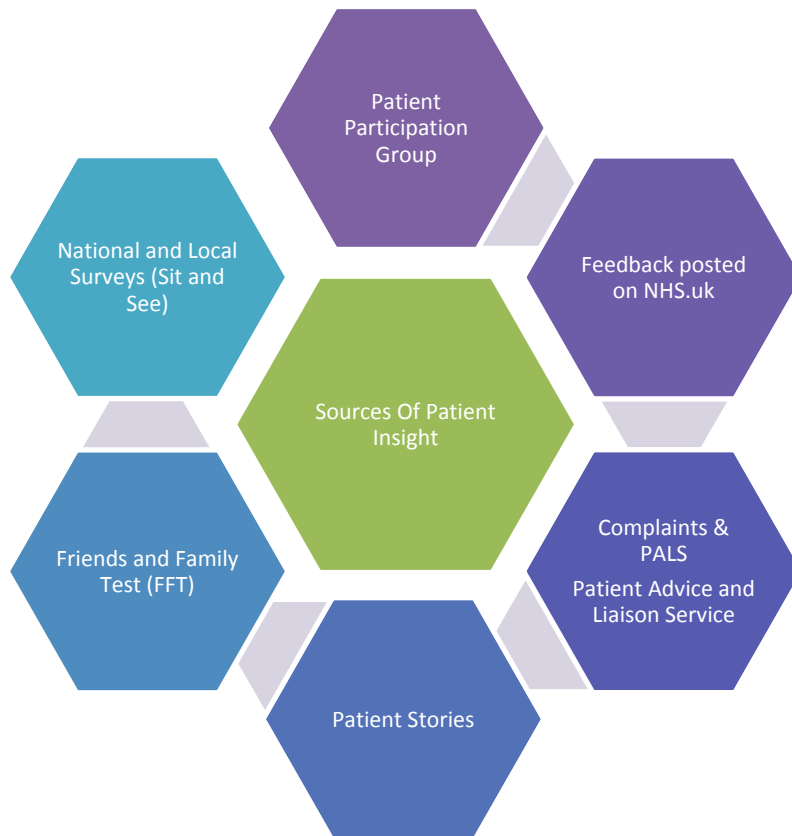
**Acronyms**

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 2025 - March 2026



1
2
3
4
5
6
7
8
9
10
11

## Summary

This report summarises patient experience feedback collected during 2025/26 from the Patient Advice and Liaison Service (PALS), formal complaints, Patient feedback, Compliments, Friends and Family Test (FFT) surveys, patient stories, patient engagement activity, and the national CQC Inpatient Survey.

Alongside clinical effectiveness and safety, a positive experience of care is a fundamental part of high-quality health and social care. A person's experience begins with their first contact with NHS services and continues through to discharge and follow-up care.

Improving the experience of care requires a whole-system approach to listening, collecting feedback, analysing themes, learning from insight, and using that learning to drive continuous improvement.

This helps the Trust focus improvement activity on what matters most to patients and on the changes that are most likely to make a difference to their experience of care.

The table below shows overall patient feedback in 2025/2026 compared to 2024/2025:

Feedback	2024/25	2025/2026	Diff from 2024/25 to 2025/2026	% Change
Complaints	144	200	56	40%
Local Resolution	51	118	67	131%
PALS concerns	618	763	145	24%
Trust enquiries (via RJAH emails, PALS email, PALS telephone and website). Not PALS concerns	6211	6972	761	11%
Compliments	13207	9835*	-3372	-26%
FFT result	98%	98%	0	-

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

## Key highlights April 2025 to March 2026

- Results from the National Inpatient Survey 2024 were highly recognised by the CQC, with RJAH identified as one of three trusts achieving “much better than expected”. For overall patient experience, RJAH was ranked 2nd in the country.
- Monthly patient feedback collected over 2025/2026 remained positive, with 9,835 compliments received and 98.2% of patients (18,446 of 18,804) rating their experience as good or very good in the Friends and Family Test.
- Three Patient Engagement meetings were held in 2025/2026, with a work plan covering patient experience strategy, quality priorities, PLACE inspections, patient information, and improvement initiatives.
- The Trust uses patient stories as a source of patient insight and the Trust Board often starts with a patient story. Two patient stories were shared at Trust Board during 2025/2026.
- 200 formal complaints were received in 2025/2026, an increase of 46 complaints (40%) from 2024/2025.
- The main themes for complaints were waiting times for treatment, communication, and values and behaviours.
- 72% of standard complaints were closed within timescales and 53% of complex complaints. Complaints received in 2025/2026 were more complex in nature.
- 39 complaints were re-opened, with no trends identified as separate issues were raised in each case.
- The Trust recognises that complaint resolution provides an opportunity to learn and helps drive quality improvement. For complaints closed during 2025/2026, 88 actions and improvements were identified.
- 763 PALS concerns were reported in 2025/2026, an increase of 145 concerns (23%) from the previous year. The top reasons for patients contacting PALS were waiting times for treatment (265), communication (140), and appointments (132).
- The Trust received 6,972 enquiries dealt with by PALS (from RJAH emails, PALS email enquiries, PALS telephone and website), an 11% increase compared to the previous year. These were not recorded as PALS concerns.
- Results from the monthly IQVIA patient feedback surveys were positive across all questions asked. IQVIA was replaced by RADAR on 1 March 2026.

## Heat Map Summary April 2025 – March 2026

	target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total 2025/2026
Total Complaints received in month	8	9	20	15	19	11	19	24	19	15	13	16	20	200
Standard complaints		5	15	10	16	9	15	16	13	7	10	8	14	138
complex complaints		4	5	5	3	2	4	8	6	8	3	8	6	62
% Standard Complaints Response Rate Within 30 Days due in month (from KPI)	90%	100%	100%	67%	77.80%	89%	93%	65%	56%	75%	64%	40%	38%	72%
% Complex Complaints Response Rate Within 45 Days due in month (from KPI)	90%	50%	67%	50%	14%	25%	100%	100%	67%	86%	43%	29%	0%	53%
PALS converted to complaint - Initiated by Patient	n/a	0	2	1	3	1	5	7	0	1	1	1	4	26
PALS converted to complaint - Initiated by Trust	n/a	1	1	1	0	1	0	0	0	0	0	0	0	4
% Complaints progressed from PALS	no target	11%	15%	13%	16%	18%	26%	29%	0%	7%	8%	6%	20%	14%
Complaint FULLY upheld (closed in month)	no target	0	2	2	2	1	1	2	2	5	0	0	1	18
Complaint NOT upheld (closed in month)	no target	3	4	1	6	4	6	3	5	5	4	4	4	49
Complaint PARTIALLY upheld (closed in month)	no target	1	6	6	13	8	18	14	11	16	6	7	9	115
re-opened complaint	0	0	5	3	7	2	2	6	0	4	2	5	3	39
Complaints referred to the Ombudsman	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Local resolutions	no target	15	7	9	5	25	11	13	7	8	9	5	4	118
PALS concerns	no target	80	56	75	75	60	64	89	64	44	61	50	45	763
Trust enquiries (via RJAH emails, PALS email, PALS telephone and website). Not PALS concerns		554	575	603	722	615	581	611	563	501	609	579	459	6972
FFT	95%	98.55%	97.73%	100.00%	98.18%	97.88%	97.96%	97.65%	98.56%	98.37%	97.69%	98.33%	98.18%	98
negative FFT scores (not Good or very good)	no target	29	14	0	39	37	43	52	30	31	52	30	1	358
Compliments	no target	1059	320	62	1063	877	1027	1161	1123	1015	1150	905	73	9835

## National Adult Inpatient Survey 2024 results

The CQC 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 2024 were publicised in September 2025.

A total of 162,308 patients were invited to participate in the CQC’s Adult Inpatient survey across 131 acute and specialist NHS trusts

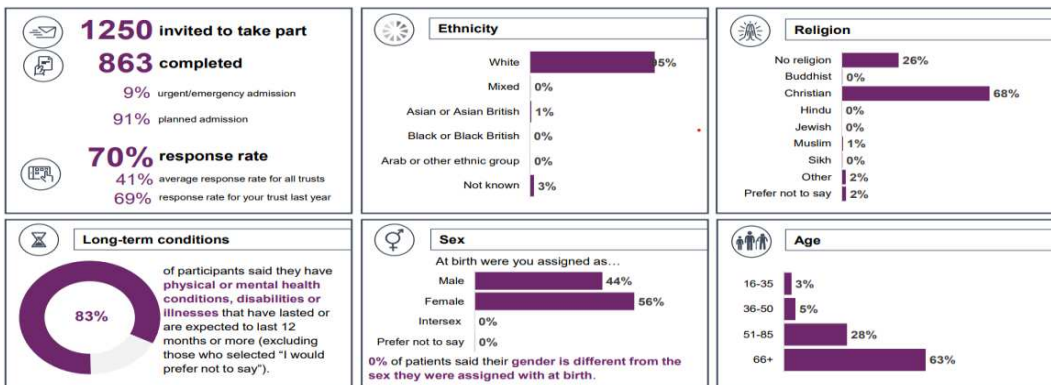
- The RJAH results from 2024 were highly positive with the Care Quality Commission (CQC) recognised the RJAH as one of three Trusts, achieving “much better than expected”.
- For overall patient experience, RJAH was ranked 2<sup>nd</sup> in the country.

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	2025
National Average	8.1	8.1	8.4	8.1	8.1	8.1	8.2	Data not published until July 26
RJAH Orthopaedic Hospital NHS Trust	9.1	9.2	9.5	9.4	9.4	9.3	9.4	
Highest	9.1	9.2	9.5	9.4	9.4	9.3	9.4	
Lowest	7.3	7.4	7.5	7.4	7.4	7.5	7.4	

### Response Rate & Demographic of patient completing the survey:

- 70% of patients completed the survey:



### Notable Feedback:

Areas identified as good and could improve.

#### Where patient experience is best

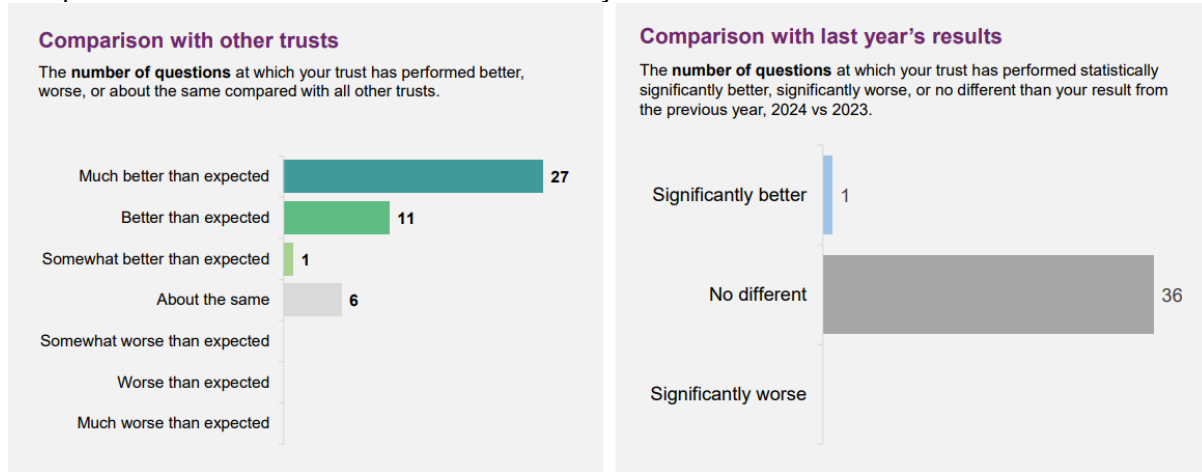
- ✓ **Wait to get a bed:** The wait to get a bed on a ward after arrival
- ✓ **Leaving hospital:** Family / carers being involved in discussions about the patient leaving hospital
- ✓ **Waiting in the hospital:** Length of time waited (in another location) before admission to a ward
- ✓ **Food:** Patients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

#### Where patient experience could improve

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

### Comparison with other trusts and 2023 results

There were no questions identified as significantly worse than in 2023 or “worse than expected” when compared to other trusts involved in the survey.



### Best performing questions relative to the national average

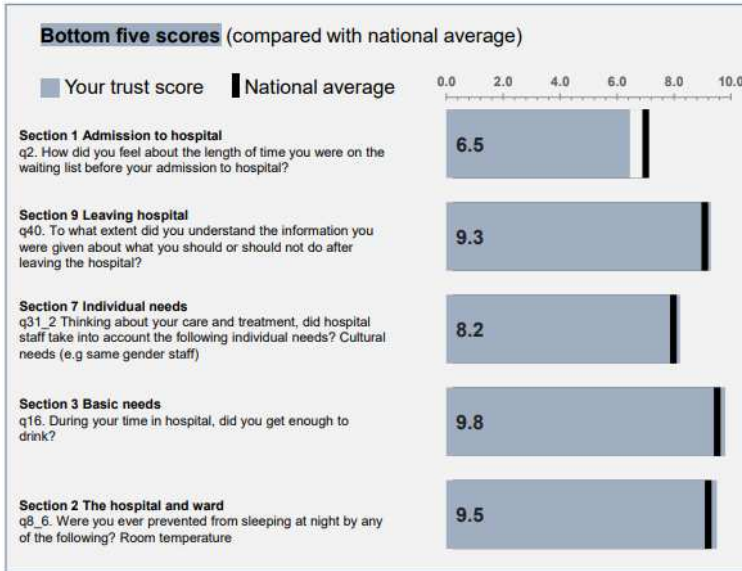
The table below shows the areas that the Trust have scored highest against the national average.



### Areas identified for improvement

The table below shows the areas that the Trust have scored lowest compared to the national average.

- The only question that was below the national average was: How *did you feel about the length of time you were on the waiting list before your admission to hospital?*



This area highlighted for improvement correlated with the increase of complaints seen in 2024/25 on patient waiting times for admission compared to 2023/24 and so a deep dive of complaints was undertaken in July 2025. See results in Learning from Complaint sections.

## 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.

Meetings are held every quarter with three Patient Engagement meetings were held during 2025/2026 April 25, July 25 October 25. (The February 2026 meeting was cancelled due to the implementation of the RADAR system).

The workplan in 25/26 covering the following agenda items:

- Patient Experience Strategy and Patient Experience Improvement Plan
- Monthly and Annual Patient Experience reports
- Quality Priorities 2025-2026
- Quality Improvement Team update
- Inpatient Survey results 2024
- Patient Safety Incident Response Framework (PSIRF) properties 2025-2026
- PLACE inspections
- Experience in Care Improvement Framework
- Facilities and Estates update including the AccessAble Project
- MyRecovery App
- Equality Delivery System (EDS)
- League of Friends 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, Patient Safety Partner and attending the Patient Safety Committee, Nutrition and Hydration Group, PLACE inspections, staff stakeholder interview panels, and Waiting Well task and finish group.

## Patient Stories

The Trust uses patient stories as a source of patient insight and the Trust Board often starts with a patient story. 2 patient stories were shared at the Trust Board, which are detailed below.

- **Trust Board May 25**

A Patient shared her patient story at the May 25 Trust Board of her experience of staying on Ludlow ward following the removal of metal work after having hip surgery (periacetabular and femoral osteotomy), summarising what went well and what can be improved.

**Outcome:**

A number of improvements were identified and actions taken forward on:

- ✚ Vegan food options
- ✚ Holders for crutches/walking sticks
- ✚ Call bell placement options on Ludlow ward
- ✚ Information on MyRecovery App
- ✚ Hospital Passport
- ✚ Consideration of POTS in surgery scheduling on day of surgery as should have been first on list

- **Trust Board September 2025**

A patient story was shared about a patients wait to see a Spinal Surgeon after being told the wait for an appointment was 52 weeks. The patient highlighted improvements on patient communication on long waiting times before referral to aid decision and choice of hospital as well communication whilst waiting to help manage **patient** expectation. The patient had been a patient at RJAH for many years and in last 2 years, noticed changes with booking administration such as last-minute clinic changes, not receiving letters for treatment dates.

**Outcome**

Patient invited to attend the Waiting Well and improving Patient Communications task and finish group and the Patient Engagement meeting to help drive improvements.

## Compliments

9835 compliments were received in 2025/2026 decreased from 2024/2025 due to a disruption in SMS feedback texts not being sent in late May 2025 and early June 2025 and March 2026. Compliments are captured via the IQVIA patient feedback system from April 2025 to February 2026 and in March 2026 via RADAR and are received in real time for sharing with staff across the Trust.



## Healthwatch

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



Healthwatch routinely share a report on the feedback data collected about the Trust for 2025-2026 but no report has been received.

## Experience in Care Improvement Framework

In February 2025, NHS England launched the Experience in Care Improvement Framework. The framework is to help analyse and review the experiences for people using NHS services to:

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

During April 25 to June 25, a group of key stakeholders, including Clinical Governance, People Services, Volunteer Lead and the Improvement Hub have completed the assessment.

On review the benchmarking exercise showed the Trust was progressing or achieving in most sections, with some areas identified as excelling.

It identified the below as an area requiring improvement:

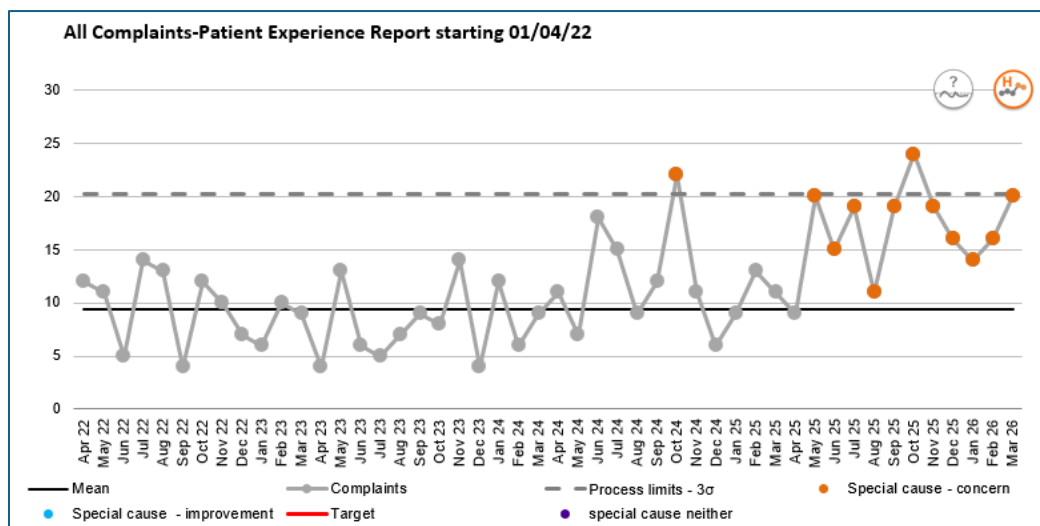
- Understanding of and reduce health inequalities, ensuring improvements are sustained.

To help improve this area, it was agreed the following objectives on patient experience would be included in the Trusts Quality Strategy to be delivered across 2025- 2027

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

## Formal Complaints received in 2025/2026

- 200 formal complaints were reported an increase of 46, (40%) from 2024/2025.
- Complaints have increased both in number and complexity when comparing the standard and complexity of complaints.
- It has also been noted that some complainants are using AI tools in writing a complaint letter.
- 138 complaints were standard complaints (69%) and 62 (31%) were complex complaints.
- October 25 was the highest month for complaints received similar to 2024. The main reason was waiting times.



### Theme of Complaints:

The main theme of complaints is aligned to previous years with the top theme of waiting times for treatment.

- Waiting times (38)
- Communication (34)
- Values and behaviours (34)

	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec-25	Jan-26	Feb-26	Mar-26	Total
Waiting Times	0	3	2	3	2	6	10	2	3	4	1	2	38
Communications	1	4	3	3	1	4	4	5	1	2	3	3	34
Values & Behaviours (Staff)	4	0	3	3	2	2	4	3	4	3	3	3	34
Admissions, discharge and transfers	1	4	0	4	2	1	2	4	1	0	3	2	24
Patient Care	1	2	0	3	0	2	1	0	4	3	3	5	24
Appointments including delays and canc	0	2	0	3	1	2	1	2	1	1	2	3	18
Management of Future care	1	4	4	0	2	1	0	2	0	0	0	0	14
Other	1	0	1	0	0	0	1	0	0	0	0	0	3
Trust Administration	0	0	0	0	1	0	1	0	0	0	0	1	3
Consent to treatment	0	0	1	0	0	0	0	0	1	0	0	0	2
Facilities Services	0	1	1	0	0	0	0	0	0	0	0	0	2
Prescribing Errors	0	0	0	0	0	0	0	1	0	0	1	0	2
Access to treatment or Drugs	0	0	0	0	0	0	0	0	0	0	0	1	1
Privacy, dignity and wellbeing	0	0	0	0	0	1	0	0	0	0	0	0	1
<b>Total</b>	<b>9</b>	<b>20</b>	<b>15</b>	<b>19</b>	<b>11</b>	<b>19</b>	<b>24</b>	<b>19</b>	<b>15</b>	<b>13</b>	<b>16</b>	<b>20</b>	<b>200</b>

Theme of complaints received compared to 2025/26 v 2024/25

	2024/2025	2025/26	Diff
Waiting Times for Treatment	32	38	6
Appointments including delays and cancellations	8	18	10
Communications	17	34	17
Values & Behaviours (Staff)	21	34	13
Admissions, discharge and transfers (including cancelled surgery)	8	24	16
Patient Care	16	24	8
Management of Future Care	25	14	-11
Other	2	3	1
Trust Administration	2	3	1
Consent to treatment	1	2	1
Facilities Services	4	2	-2
Prescribing Errors	4	2	-2
Privacy, dignity and wellbeing	1	1	0
Access to treatment or drugs	3	1	-2
<b>Total</b>	<b>144</b>	<b>200</b>	<b>56</b>

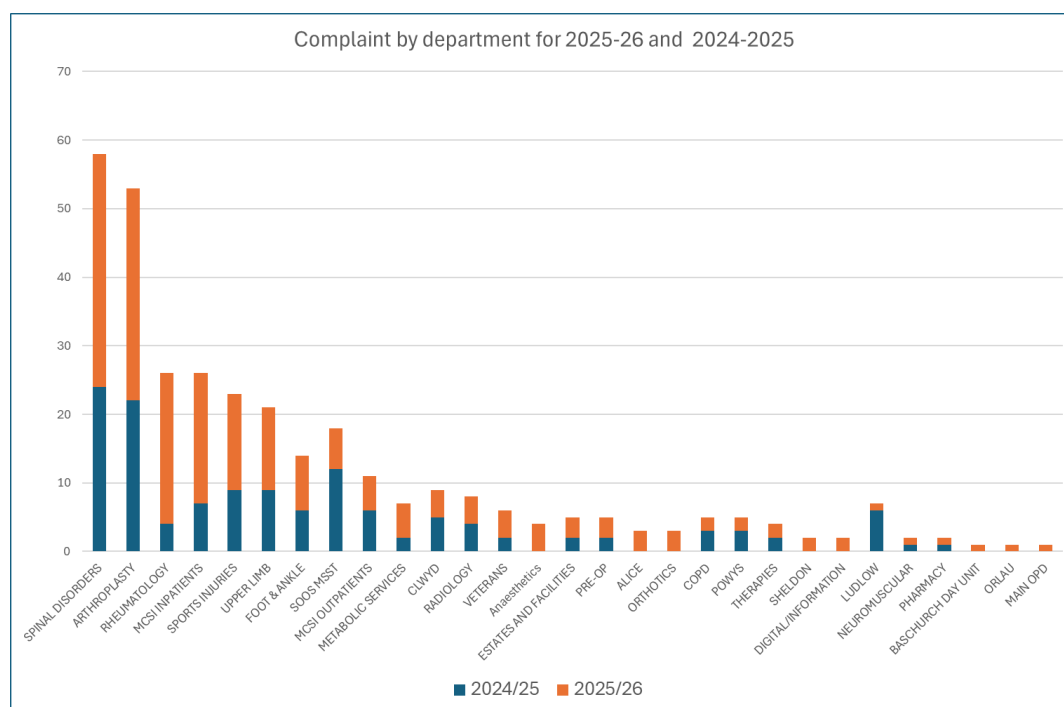
- Areas where complaints have increased are; Waiting times for treatment, +6, appointment delays +10, communications +17, values and behaviours +13, admission and discharge (includes cancelled surgery) +16, patient care +8.

- Areas where complaints have decreased are; Management of future care -11.

The increase in communication concerns and decrease in management of care complaints is due to complaints being logged aligned to the national KO41a (subject codes) in 25/26. For example, a patient unhappy with delays in their patient pathway are now logged under communication rather than management of care.

**Complaints by department/Specialty**

The graph below shows the themes of complaints by area/specialty. The top areas are Spinal Disorders, Arthroplasty, Rheumatology, MCSI Inpatients.



• **Waiting times complaints for treatment by speciality (38)**

The table below summarises the specialties with the highest number of waiting-time-for-surgery complaints.

	Complaints
ARTHROPLASTY	13
SPINAL DISORDERS	13
KNEE/SPORTS INJURIES	4
FOOT & ANKLE	1
ORLAU	1
RHEUMATOLOGY	1
SOOS MSST	2
UPPER LIMB	1
VETERANS	1
X-RAY	1
Grand Total	38

• **Staff behaviour complaints by profession (34):**

Complaints – Staff Behaviours					
	Consultant	Nursing staff	Other Clinical	Admin/Clerical staff	Grand Total
RHEUMATOLOGY	10	1			11
MCSI INPATIENTS		5			5
SPINAL DISORDERS	5				5
ARTHROPLASTY	2				2
CHILDREN'S OUTPATIENTS	2				2
MAIN OPD		1	1		2
ALICE		1			1
ANAESTHETIC	1				1
METABOLIC SERVICES				1	1
PHARMACY			1		1
PRE-OP		1			1
Trust				1	1
<b>Grand Total</b>	<b>20</b>	<b>9</b>	<b>2</b>	<b>3</b>	<b>34</b>

## Complaint Response timescales

- The Trust is required to acknowledge all new complaints within three working days; this target was met.
- From April 25 - March 26, the Trust internal target to resolve standard complaints was within 30 working days and complex complaints within 45 working days.
- **72% of standard** complaints were closed within timescales (97 out of 134) and **53% of complex** complaints (25/52).
- Reasons for delays in complaint responses include delay in receiving comments from staff, complex nature of complaints and Governance Staff work priorities since the implementation of RADAR began in November 2025.

## Complaints re-opened.

- 39 complaints were re-opened with a further reply provided. No trends identified as separate issues raised in each. This is increased from 2024/25 with 23 complaints were re-opened.

## Complaints Upheld (complaints closed)

For 25/26, 18 complaints were fully upheld complaints, 115 partially upheld and 49 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.

Following an 47% increase in complaint in from 2023-24 to 2024-2025 a deep dive into the themes complaints was undertaken in July 2025 to understand what is driving the increase and to help identify any improvements.

The deep dive ascertained the main concern raised by patients is the length of time they must wait for an appointment or for their surgery.

The key recommendations were identified as below and are being followed up via the Waiting Well task and finish group.

Recommendation	Suggested improvement actions
To reduce the number of rescheduled outpatient appointments	<ul style="list-style-type: none"> <li>To review the annual/study leave sign off process</li> <li>To monitor the number of rescheduled appointments so there is a continuous understanding of what is driving the rescheduling, to identify opportunities for improvement.</li> </ul>
To improve the accuracy of clinic letters and share information in a way patients understand	<ul style="list-style-type: none"> <li>To scope a digital solution for recording and transcribing clinic appointments, which includes a patient explanation of the medical terminology used.</li> </ul>
To introduce a call centre facility across the Patient Access Team	<ul style="list-style-type: none"> <li>To introduce a call centre facility across the Patient Access Team</li> </ul>
To ensure there is a robust process in place for learning from complaints	<ul style="list-style-type: none"> <li>Implement a robust learning from complaints process, in line with the approach for patient safety.</li> <li>Clearly identify the opportunities for learning in the Trust complaint responses to patients.</li> </ul>
Managing patient expectations regarding waiting times	<ul style="list-style-type: none"> <li>On vetting of a referral, write to the patient to inform them that the Trust has received their referral and provide an average waiting time by specialty.</li> </ul>

	<ul style="list-style-type: none"> <li>Encourage all Consultant teams to advise patient on their average waiting time when adding them to their inpatient waiting list and whether they are considered urgent or routine (rather than 'P' status).</li> </ul>
To ensure there is a clear understanding on what drives the volume of rework within the Patient Access Team	<ul style="list-style-type: none"> <li>To ensure there is sufficient oversight of KPIs relating to such things as rescheduling of appointments, Annual/Study Leave approval, call response times, typing of patient letters, processing of patient referrals that allows the Trust to have a continuous understanding of the challenges, support required and opportunities for improvement.</li> </ul>
To review the complaints handling process for concerns relating to waiting times for patients who fall under Welsh commissioning.	<ul style="list-style-type: none"> <li>Patients' complaints should be redirected to their respective health board if it specifically relates to waiting time, and the patient has waited for less time than the commissioning arrangements</li> </ul>

## Patient Experience Improvement Plan

- For complaints closed during 2025/2026, 88 actions /improvements were identified. Any actions or learning from complaints are being logged in the Patient Experience Improvement Plan.

Actions from complaints are shared in the monthly Unit Governance reports, and at the Patient Experience Meeting.



### Examples of learning from closed complaints:

**CRP 0925-02 MCSI Inpatients:**  
Concerns on Nursing Care including answering call bells, medication administration procedures, patient privacy, and overall patient care.  
**Learning:**  
Staff have been reminded to answer call bells in a timely manner"  
Staff have been reminded of the importance of regularly turning patients and conducting timely skin assessments.  
The ward has ordered nail care kit.

**CRP 1025-01 Clwyd Ward.**

Following a hip replacement surgery, patient experienced severe post-discharge complications including collapse, vomiting, and dehydration, which led to emergency admission on day off discharge.

**Learning:**

Written guidance to be given to patients on what to do if they experience post-operative dizziness or fainting after discharge e should this occur.

Improved communication between therapy and nursing teams to share any relevant symptoms or changes in a patient's condition, such as dizziness, with the ward nursing staff before discharge.

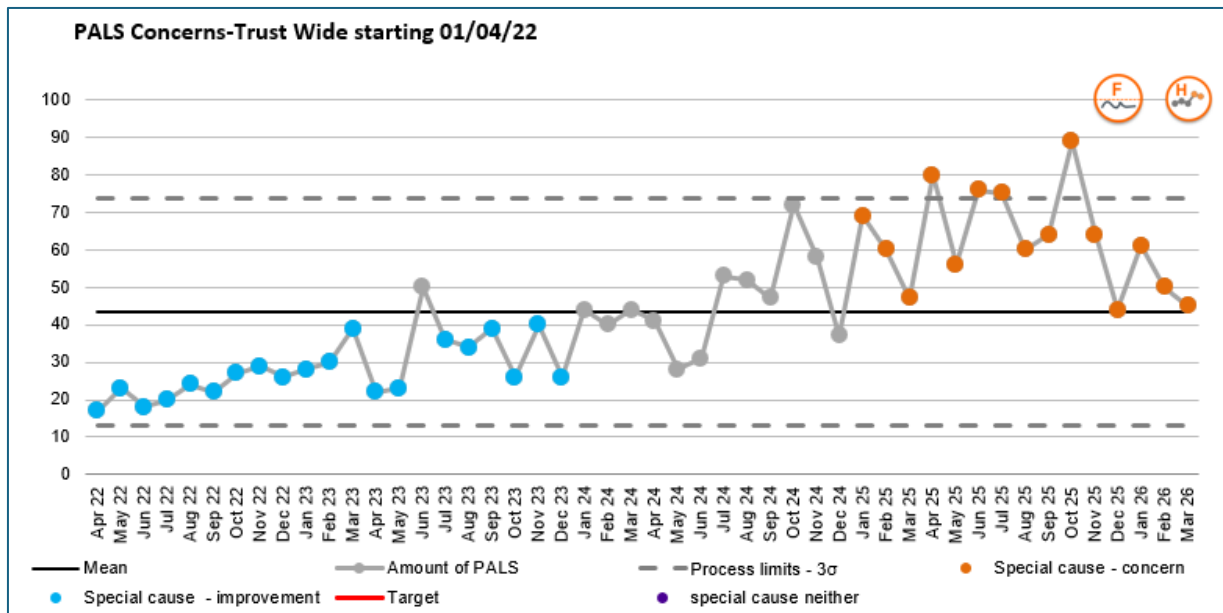
**CRP 1125-03 Spinal Disorders**

Email from patient with complaint on attitude of spinal booking clerk in having to rearrange an appt due to ill health and conflicting information given by RJAH regarding attending appts while unwell

**Learning:** In collaboration with our Infection Prevention and Control Team the website has been updated to advise; If patients feel unwell, have a temperature, or are experiencing diarrhoea/vomiting, to rearrange their appointment. If patients have a cough or cold but feel well in themselves, please wear a face mask when attending an appointment.

**PALS concerns**

In 2025-26, there were 763 PALS concerns received, 145 more than in the previous year, an increase by 23%



**Top theme of PALS concerns:**

- The top reasons for a patient contacting PALS are:
  - Waiting times for treatment (265)
  - Communications (140)
  - Appointments (132)
  - Values and Behaviours (51)

PALS	2024/25	2025/26	Diff
Waiting Times	206	265	59
Communications	74	140	66
Appointments, delays and canc	75	132	57
Values & Behaviours (Staff)	50	51	1
Admissions, discharge and transfers	27	35	8
Other	28	33	5
Patient Care	23	31	8
Management of future care and treatment	79	21	-58
PALs - General Enquiries	10	18	8
Facilities Services	18	11	-7
Prescribing Errors	6	10	4
Trust Administration	8	6	-2
Access to treatment or drugs	9	4	-5
Privacy, dignity and wellbeing	6	4	-2
Transport	1	2	1
<b>Grand Total</b>	<b>625</b>	<b>763</b>	<b>138</b>

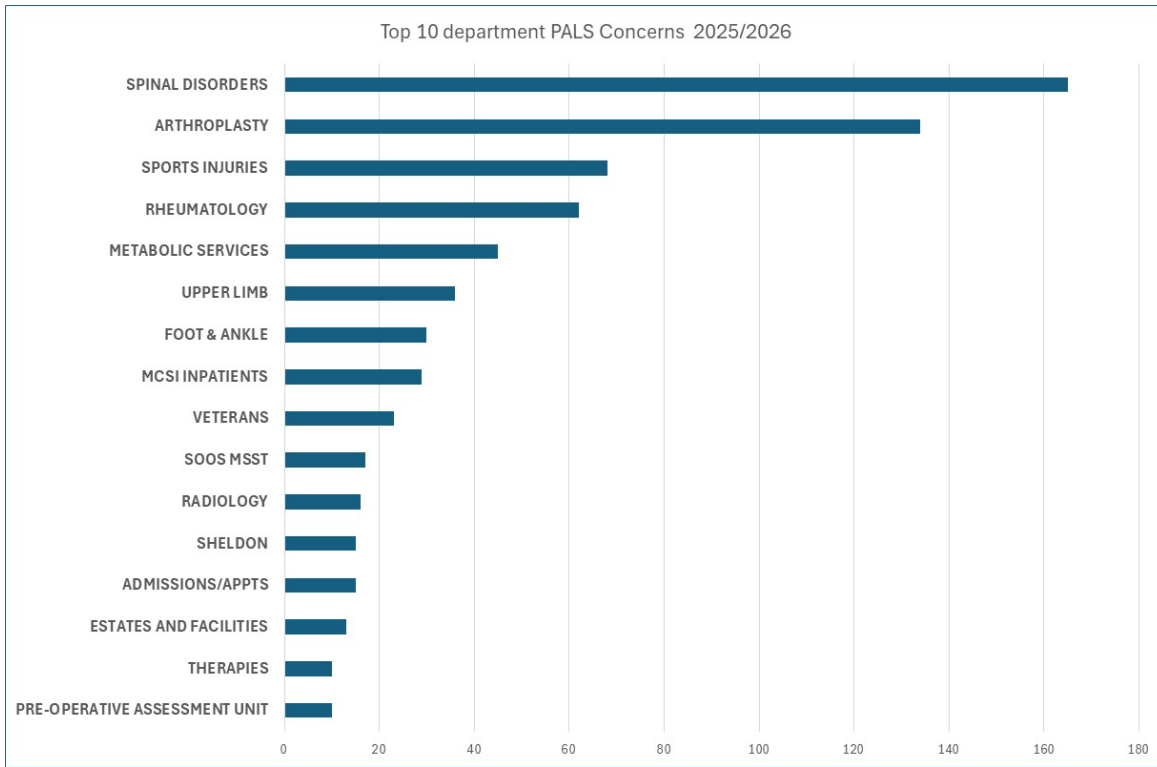
- PALS waiting times concerns by speciality (above 10)

	PALS concerns waiting times by specialty
SPINAL DISORDERS	96
ARTHROPLASTY	66
SPORTS INJURIES	33
VETERANS	16
FOOT & ANKLE	11
UPPER LIMB	10

### PALS concerns by department:

- In 2025/26 MSK Unit received 364 PALS concerns, Specialist received 366 and corporate services received 33 PALS concerns.

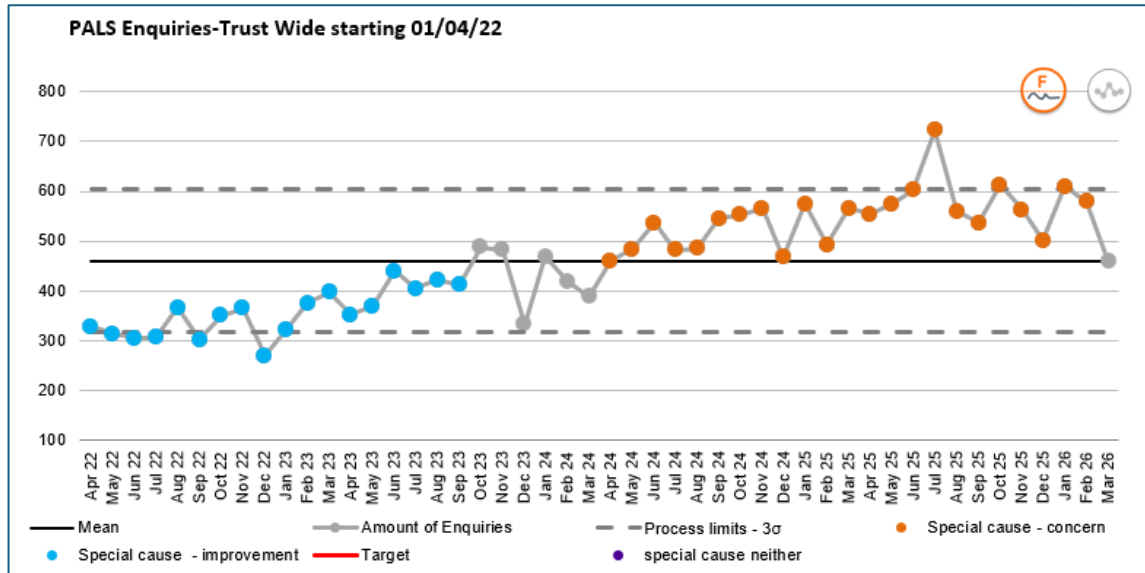
The graphs below show PALS concerns received by department for 2025/26 (above 10)



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

The Trust received 6972 Trust enquiries dealt with by PALS (from RJAH emails, PALS email enquiries, PALS telephone and website), this is a 11% increase compared to the previous year. These are not PALS concerns. The main theme of enquiries relates to general queries, GP emails and results, and emails for consultants.

Trust enquiries	2024/2025	2025/2026	Diff
Total	6211	6972	761
RJAH emails	4205	4376	171
PALS email (not PALS concerns)	536	1172	636
telephone	926	870	-56
website	544	554	10



### Locally resolved issues.

There were 118 local resolutions reported from the ward/department in 25/26. These are concerns resolved on the spot by ward or department staff.

	PATIENT CARE	VALUES_AND_BEHAVIOURS_STAFF	COMMUNICATIONS	ADMISSIONS_AND_DISCHARGES	APPOINTMENTS	FACILITIES	PRIVACY_DIGNITY_WELLBEING	Grand Total
MCSI INPATIENTS	32	24	11	5	0	0	2	74
LUDLOW	6	3	5	1	0	2	0	17
OUTPATIENTS DEPARTMENT	0	0	2	0	5	0	0	7
POWYS	0	2	1	0	0	0	0	3
KENYON	1	1	0	0	0	0	0	2
ALICE	1	0	0	1	0	0	0	2
METABOLIC SERVICES	0	0	0	0	2	0	0	2
SHELDON	0	1	0	1	0	0	1	3
SPINAL DISORDERS				1	1			2
PRE-OPERATIVE	0	0	0	0	1	0	0	1
PEOPLE SERVICES	0	0	0	0	0	1	0	1
MONTGOMERY	0	1	0	0	0	0	0	1
MUSCLE CLINIC (PAEDIATRIC)	0	0	0	1	0	0	0	1
ORTHOTICS	0	0	1	0	0	0	0	1
RHEUMATOLOGY	0	1	0	0	0	0	0	1
Total	40	33	20	10	9	3	3	118

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

No cases referred to the PHSO throughout 2025/2026

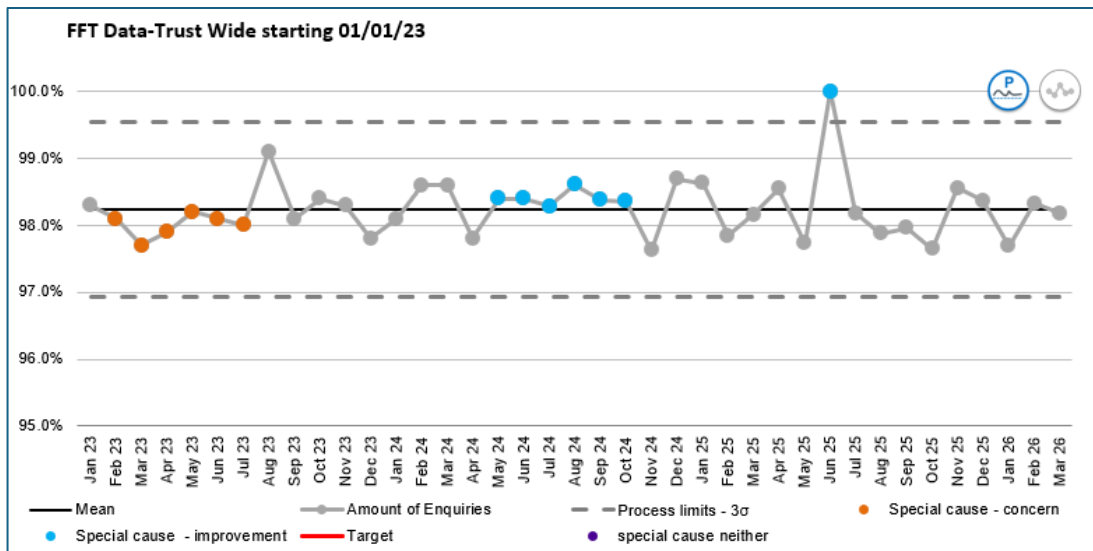
### Friends and Family Test (FFT)

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.

FFT data is collected in real time, 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 2025/2026, 18,804 patients completed a FFT feedback survey.
- 98.2% of patients (18,446) 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).

	2021/22	2022/23	2023/24	2024/25	2025/2026
National Average	94%	94%	94%	94%	94%*
Highest Score	100%	100%	100%	100%	100%*
Lowest Score	64%	73%	75%	69%	56%*
The Robert Jones and Agnes Hunt	98%	98%	98%	98%	98%

\* data only available nationally up to Feb 26

For the 358 patients who did not rate their care as good or very good; the top themes of the negative comments are shown below for 2025/26.

- For Baschurch the main theme is cancelled surgery and waiting time before surgery
- For Clwyd ward the comments are being discharged too early as these are predominantly the Enhanced Recovery patients

Inpatients								
	Baschurch	Clwyd	Ludlow	Kenyon	Sheldon	MSCI Inpatients	Powys	Grand Total
cancelled surgery	15		1					16
Care/Discharge	1	8			3	1	2	15
waiting times	10						1	11
Car Park/Facilities/ Signposting			3			1		4
staff attitude	1					1		2
<b>Grand Total</b>	<b>27</b>	<b>8</b>	<b>4</b>	<b>3</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>48</b>

- The main theme for outpatient in waiting time in clinic and unhappy with outcome in clinic examples are; appointment too short, or and felt questions were not addressed

Outpatients								
	Main OPD	Radiology	Pre-Op	Therapy	Childrens Outpatients	ORLAU	Orthotics	Grand Total
waiting times	63	21	14	4	3	2	2	109
Outcome of appt	41	17	2	3	4	3		70
bookings error/cancelled appt	16	8	1	1				26
Car Park/Facilities/ Signposting	16	2		1				19
staff attitude	5	5						10
Care/Discharge	2	3						5
Communication/Interpreters		1	1					2
<b>Grand Total</b>	<b>143</b>	<b>57</b>	<b>18</b>	<b>9</b>	<b>7</b>	<b>5</b>	<b>2</b>	<b>241</b>

### 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 2025/26 for the IQVIA inpatient and outpatient surveys are shown below with all questions receiving high scores:

IQVIA was replaced by RADAR on 1/3/26 so data collected below is for April 25-Feb 26.

Question text	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Total
7. Were staff caring and compassionate?	99	99	98	98	99	98	98	99	99	99	99	99	99
8. Did you like the food provided, if you were offered any? (If not please leave blank)	89	90	90	90	90	90	89	90	90	91	89	90	90
9. Did you feel the ward was clean?	99	99	99	99	99	99	100	99	99	99	99	100	99
10. Did you find the staff welcoming and friendly?	99	99	99	98	99	99	99	99	99	99	99	99	99
11. Did you feel that the noise levels were acceptable at night?	90	88	92	89	90	86	90	89	90	90	88	87	89
12. Did the staff practice good hand hygiene?	99	99	99	99	99	98	98	99	99	99	99	99	99
13. Was your privacy/ dignity & comfort respected?	99	99	99	99	99	99	99	99	99	99	99	99	99
14. Was your admission date changed by the hospital?	91	91	92	89	91	87	91	93	91	91	91	90	91
15. After leaving hospital, did you get enough support from staff ?	91	91	92	88	95	94	94	94	95	95	93	94	93
16. Were you involved as much as you wanted to be in decisions about your care and treatment?	94	95	93	95	94	96	95	95	97	96	94	95	95
<b>Total</b>	<b>95</b>	<b>96</b>	<b>96</b>	<b>95</b>	<b>96</b>	<b>95</b>	<b>96</b>	<b>96</b>	<b>96</b>	<b>96</b>	<b>95</b>	<b>96</b>	<b>96</b>
<b>Overall</b>	<b>96</b>	<b>96</b>	<b>96</b>	<b>95</b>	<b>96</b>	<b>95</b>	<b>96</b>	<b>96</b>	<b>96</b>	<b>96</b>	<b>95</b>	<b>96</b>	<b>96</b>
<b>Total number of surveys</b>	<b>345</b>	<b>309</b>	<b>156</b>	<b>176</b>	<b>322</b>	<b>276</b>	<b>308</b>	<b>367</b>	<b>349</b>	<b>307</b>	<b>398</b>	<b>289</b>	<b>3,602</b>

Question text	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Total
3. Did you feel that the department was clean?	99	99	99	98	99	99	99	99	99	99	99	99	99
4. Were you informed about waiting times?	88	88	86	87	86	86	85	86	87	87	86	87	87
5. Did you find the staff welcoming and friendly?	99	99	98	98	99	99	99	98	99	98	98	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	98	98	98	99	98	98	98	99	98	98	98	98
8. Were staff caring and compassionate?	99	98	98	98	99	99	98	98	99	98	98	99	98
9. Did the Healthcare Professional introduce themselves?	98	98	99	97	98	98	97	97	98	97	98	98	98
10. Did the Health Care Professional listen to you?	100	99	98	98	99	99	99	99	100	99	99	99	99
<b>Total</b>	<b>97</b>	<b>97</b>	<b>97</b>	<b>97</b>	<b>97</b>	<b>97</b>	<b>97</b>	<b>97</b>	<b>98</b>	<b>97</b>	<b>97</b>	<b>98</b>	<b>97</b>
<b>Overall</b>	<b>97</b>	<b>97</b>	<b>97</b>	<b>97</b>	<b>97</b>	<b>97</b>	<b>97</b>	<b>97</b>	<b>98</b>	<b>97</b>	<b>97</b>	<b>97</b>	<b>97</b>
<b>Total number of surveys</b>	<b>1,001</b>	<b>906</b>	<b>555</b>	<b>566</b>	<b>1,100</b>	<b>900</b>	<b>1,056</b>	<b>1,052</b>	<b>1,000</b>	<b>946</b>	<b>1,009</b>	<b>857</b>	<b>10,948</b>

## Patient feedback in the Radiology and Sheldon ward department:

### Radiology – February 2025

Click here for patient feedback comments

The Robert Jones and Agnes Hunt Orthopaedic Hospital  
NHS Foundation Trust

#### Patient feedback

Percentages of Very good/good and poor/very poor (Trust FFT, Feb 2025)

98.73%

% very good or good

0.64%

% poor or very poor

Response	Percentage	Number of times response selected
Very good	92.36%	580
Good	6.37%	40
Neither good nor poor	0.64%	4
Poor	0.32%	2
Very poor	0.32%	2
Don't know	0.00%	0

Export

Number of surveys completed each month (Trust FFT From Apr 2025 to Mar 2026) 7045 Surveys

Month	Surveys
Apr	815
May	371
Jun	274
Jul	552
Aug	596
Sep	758
Oct	777
Nov	759
Dec	564
Jan	851
Feb 2026	828

**How was your experience of our CT scanning service?**

Excellent service, put you at ease very polite.

Staff were great and reassuring. Procedure was explained.

**How was your experience of our Ultrasound service?**

Friendly, caring, things explained well, timely.

Excellent - compassionate approach with professional care.

**How was your experience of our general x-ray service?**

You could not have done anything better.

The radiographers were friendly accommodating and very professional.

**How was your experience of our MRI service?**

On time, kind staff, felt looked after.

Absolutely brilliant

## PATIENT FEEDBACK - FEB 2026

### 11 SURVEYS 92-100%

- Always someone there to help. Liked the activities!
- Professional care and kindness of all the staff. Could not have been nicer.
- Care Wonderful. Everything has been excellent, can't fault it at all!
- Clean! Tidy! Polite staff in comparison to all the other hospitals - outstanding!
- Staff are extra special. Food was excellent, staff work well together.
- Here to receive help and the help has been the best! Everyone is so helpful!



#### Room for Improvement!

- More consistent physio.
- Monitoring excessive sound from TV if nobody is watching it!
- Improved food choices!

100%  
Involvement in  
treatment decision

100%  
Ward Cleanliness  
& Hand Hygiene

100%  
Privacy and  
dignity

1

2

3

4

5

6

7

8

9

10

11

(Part 1) Covering paper

<b>Committee / Group / Meeting, Date</b>	
Quality and Safety Committee, 18 <sup>th</sup> June 2026	
<b>Author:</b>	<b>Contributors:</b>
Name: Ian Gingell Role/Title: Health and Safety Manager	Name: Role/Title:
<b>Report sign-off:</b>	
Name: Nick Huband, Director of Estates and Facilities Name: Clair Hobbs, Interim Chief Nurse and Patient Safety Officer	
<b>Is the report suitable for publication?:</b>	
YES	
<b>Executive Summary:</b>	
<p>The paper presents the Trust's position on health and safety performance, governance, and compliance for 2025/26. Overall, the Trust maintained effective health and safety management arrangements aligned to statutory requirements, with a strengthened team structure and clear governance routes through the Health and Safety Working Group to the Health and Safety Meeting and onwards to the Quality and Safety Committee.</p> <p>Health and safety performance improved compared to the previous year. Total reported incidents reduced to 124 (a 22% reduction), alongside a reduction in Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations (RIDDOR)-reportable incidents to three, with no enforcement action taken in relation to the reported incidents.</p> <p>Compliance actions resulting from a Health and Safety Executive (HSE) inspection, including an Improvement Notice relating to the management of sharps, were completed within required timescales. However, the Trust incurred £6,569.70 in HSE Fee for Intervention charges following a material breach, indicating areas where statutory compliance required strengthening.</p> <p>National Patient Safety Alert compliance is strong with all 2025/26 alerts completed within deadline.</p>	
<b>Recommendations:</b>	
<p>The Committee is asked to:</p> <ul style="list-style-type: none"> <li>• CONSIDER the submitted report and</li> <li>• AGREE the level of assurance it provides.</li> </ul>	

Health and Safety Annual Report  
2025/26

(Part 2) Strategic alignment and supporting detail

**Strategic objectives and associated risks:**

The following strategic objectives, developed in light of national and system priorities, are relevant to the content of this report:

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

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	

**Trust values:**

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

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

**Report development and engagement:**

The report was presented and endorsed at the Health and Safety Meeting in June 2026.

**Supporting detail:**

This report provides assurance on the Trust's health and safety performance, compliance with statutory requirements, and effectiveness of governance and management systems during 2025/26. It is particularly relevant to the Committee in providing assurance that risks to staff, patients, and visitors are being effectively managed and that legal duties are met.

During 2025/26, the Trust experienced a HSE inspection which resulted in enforcement action (Improvement Notice and Notice of Contravention), alongside Fee for Intervention (FFI) costs. This highlighted that, while systems were established, there were areas requiring improvement. All enforcement requirements were completed within required timescales, and no further action was taken.

National Patient Safety Alert compliance was strong; however, one safety alert remained outstanding from a prior year, representing a residual compliance risk

**Acronyms**

---

CAS	Central Alerting System
HSE	Health and Safety Executive
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

1
2
3
4
5
6
7
8
9
10
11

## Health and Safety Annual Report 2025/26

### 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.

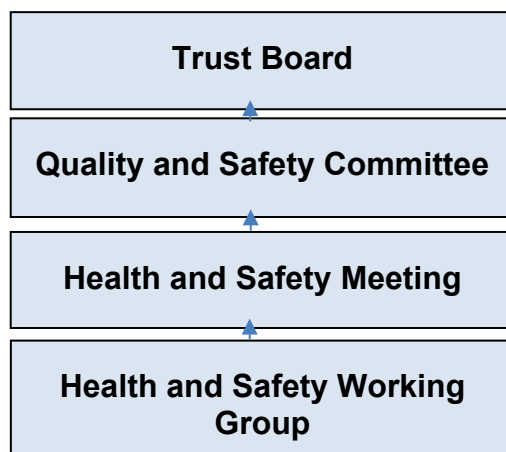
The HSE focus their investigations on systemic failure of management systems, which may include:

- 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 Interim Chief Nurse and Patient Safety Officer held Board-level responsibility for health and safety. The Trust employed a health and safety team comprising of a Health and Safety Manager, and a Health and Safety 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 June 2025, the health and safety establishment was increased by the appointment of a Health and Safety Officer.

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

### 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 £183 an hour (increasing to £188 in 2026/27) 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 incurred fees for intervention, relating to enforcement action following a HSE inspection, totalling £6569.70 in 2025/26.

### 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.

A summary of the activities related to the framework are detailed below.

#### **PLAN**

The Health and Safety Meeting 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 and a Health and Safety Officer, to undertake the role of Competent Person as required by the Management of Health and Safety Regulations 1999.

#### **DO**

Following a HSE inspection, significant improvements were made to the management of medical sharps and the management of dermatitis within the Trust

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 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 Officer.

The Trust had a comprehensive incident reporting system in operation. The incident reporting 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.

#### **ACT**

1
2
3
4
5
6
7
8
9
10
11

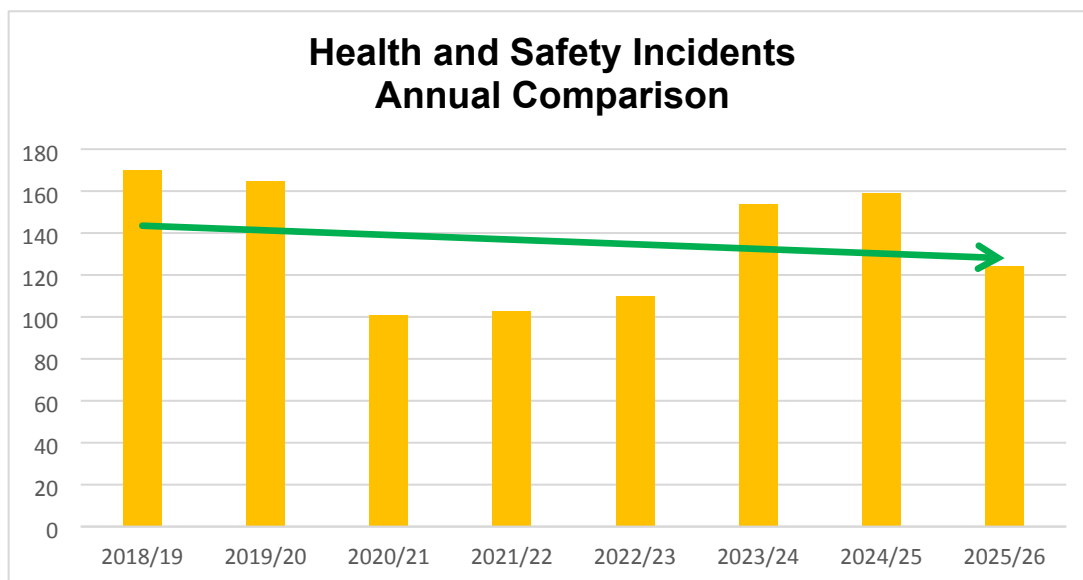
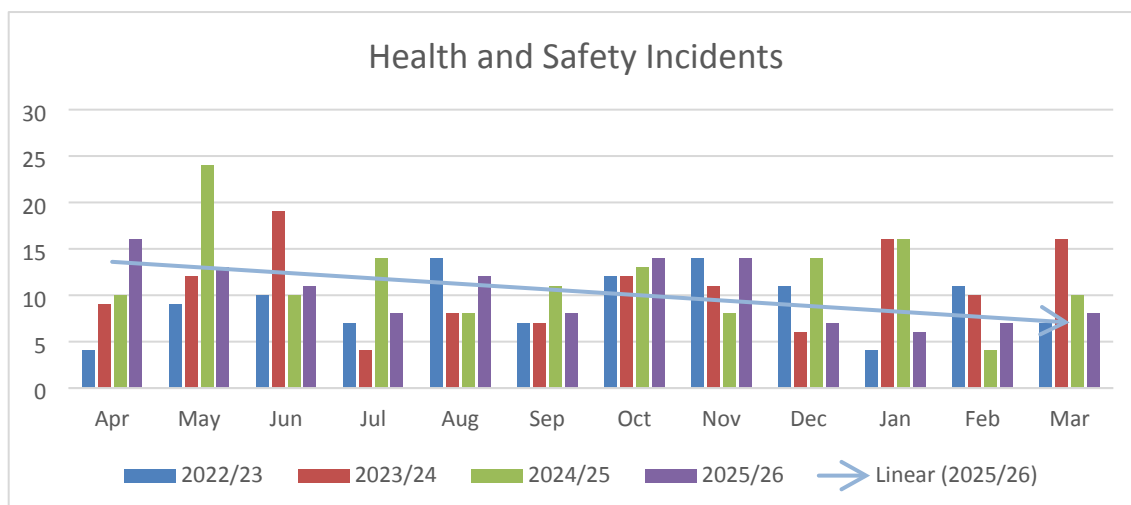
Health and Safety Annual Report  
2025/26

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 Advisor/Officer and Staff Side Union Safety Representatives.

**1.5 Incident Reporting (Trends and Analysis)**

A total of 124 health and safety incidents were reported during the 2025/26 financial year, a 22% decrease over the previous year's total of 159.



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

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).

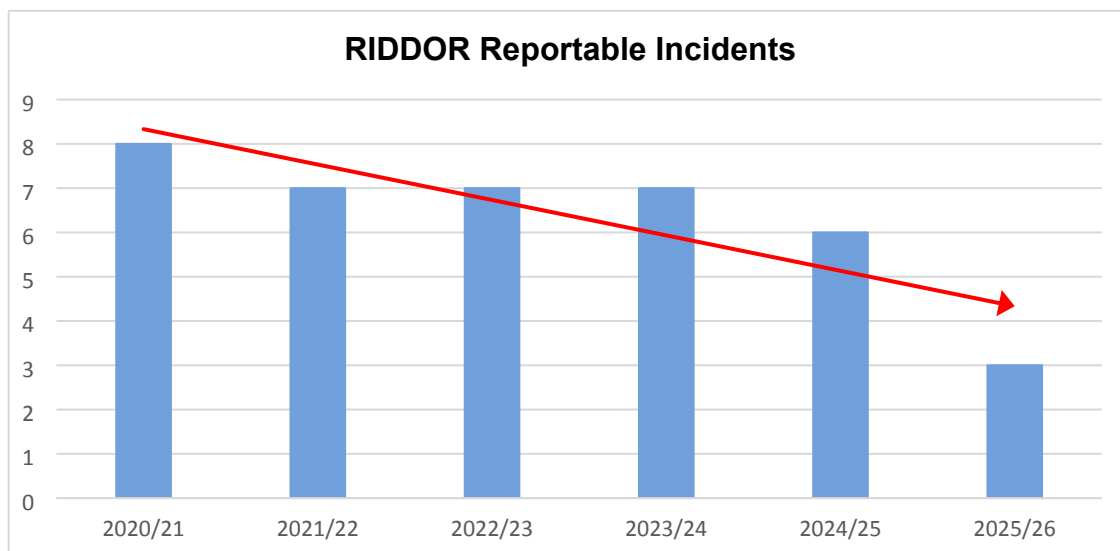
Health and Safety Annual Report  
2025/26

During 2025-26 there were three incidents reported to the HSE under the requirements of the RIDDOR regulations, a significant reduction on the previous year. No regulatory action or sanction was received in respect of the reported incidents.

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

**RIDDOR Trend Analysis**

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



Two of the incidents involved members of staff, one involved a patient. No visitors or other site users sustained reportable injuries. The incidents were recorded on the Trust’s incident reporting system and were investigated by ward or department managers in accordance with Trust policy. The Health and Safety team ensured all RIDDOR reportable incidents were notified to Staff Side Safety Representatives in accordance with the Safety Representatives and Safety Committees Regulations 1977.

**1.7 Safer sharps**

Following a HSE inspection in July 2025, the Trust was served an Improvement Notice which required changes in practice in relation to the use of insulin needles. A further Notice of Contravention required that improvements be made to the management of medical sharps across the site.

All requirements were met within deadlines and no further enforcement action was taken.

It should be noted that sharps (including needlestick) injuries remained at a low level with no incident meeting the criteria for reporting to the HSE under RIDDOR. Safer sharps are the default devices of choice for all procedures wherever clinically practicable. The use of standard sharps is by exception and supported by robust risk assessments.

1
2
3
4
5
6
7
8
9
10
11

## Health and Safety Annual Report 2025/26

### 1.8 Dermatitis

The HSE inspection also noted deficiencies in the management of Dermatitis within the Trust. The Notice of Contravention issued for the management of sharps extended to the management of dermatitis.

All requirements within the Notice were met within deadline and no further enforcement action was taken.

### 1.9 Health and Safety Meeting

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

Health and Safety Meeting Attendance 2025/26						
	April 2025	June 2025	Aug 2025	Oct 2025	Dec 2025	Feb 2026
Chair	✓	✓	✓	✓	Meeting cancelled	✓
Head of Estates and Facilities (Deputy Chair)	✓	✓	X	X		X
Health and Safety Manager / Advisor	✓	✓	✓	✓		✓
Governance Representation	✓	✓	✓	X		✓
Theatre Representation	X	✓	X	X		X
Clinical Representation	✓	✓	✓	X		X
People Services Business Partner	✓	✓	✓	X		✓
Training and Development Lead	✓	X	✓	✓		✓
Staff side Representation	✓	✓	✓	X		✓
Manual Handling Coordinator	✓	✓	✓	✓		✓
Occupational Health Representative	✓	✓	✓	✓		✓
Quorate	✓	✓	✓	X		✓

### 1.10 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.

## Health and Safety Annual Report 2025/26

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 12 Safety Alerts through CAS in 2025/26, of which 8 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 on 31<sup>st</sup> January 2024 which breached its completion deadline of 31<sup>st</sup> January 2025. The alert was signed off as completed on 3<sup>rd</sup> June 2026 following delays in adoption in Radiology. NatPSA/2024/002/NHSPS, 'Transition to NRFit connectors for intrathecal and epidural procedures, and delivery of regional blocks'. Works are ongoing to achieve compliance by the end of June 2026.

### 2.0 Recommendation

The Committee is asked to:

- Consider the content of the report
- Agree the level of assurance it provides

### Appendix 1: Acronyms

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

1
2
3
4
5
6
7
8
9
10
11

# Trust Board - People & Workforce

## May 2026 – 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:

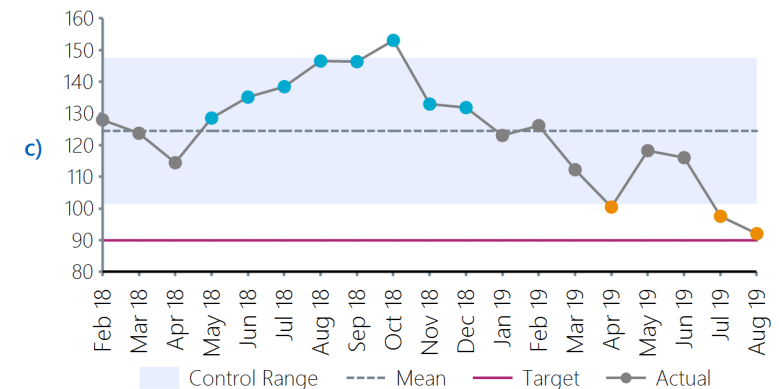
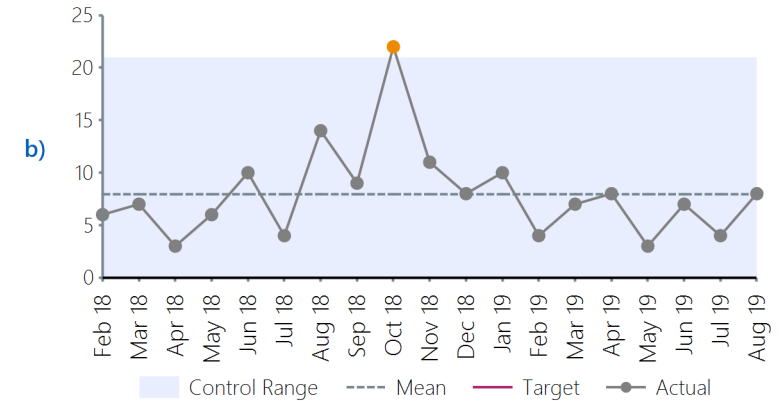
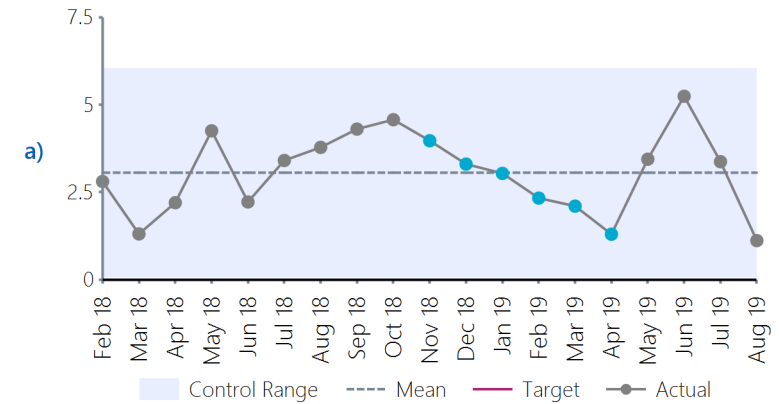
- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of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

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.

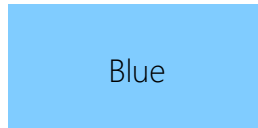
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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



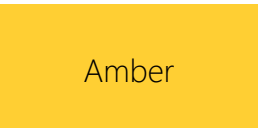
Blue

No improvement required to comply with the dimensions of data quality



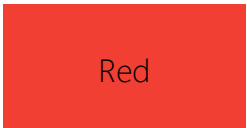
Green

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.

1
2
3
4
5
6
7
8
9
10
11



# Summary - Caring for Staff

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
Sickness Absence	4.74%	4.47%				+		+
Staff Turnover - FTE	9.77%	9.75%						
Leavers per Month	12	8						
Vacancy Rate	8.00%	6.90%						

1
2
3
4
5
6
7
8
9
10
11



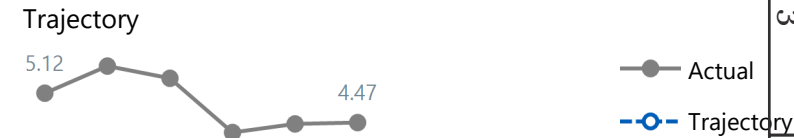
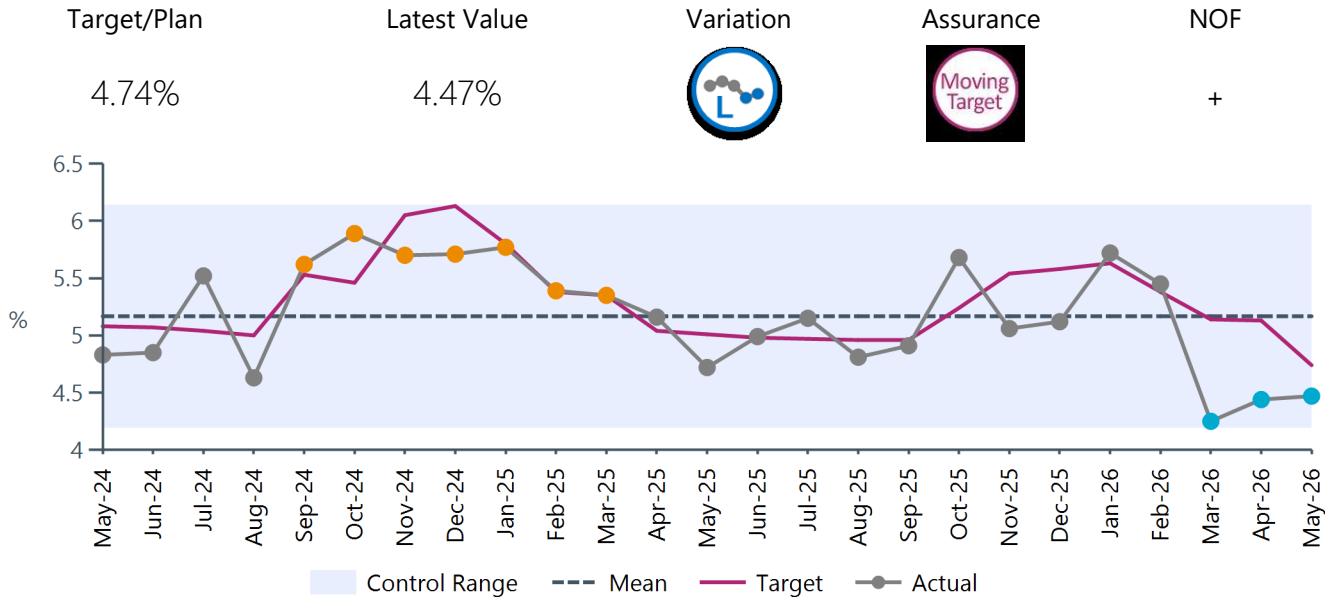
# Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
Agency Spend against Plan	86	57						
Proportion of Temporary Staffing as a % of the Trust Pay Costs	6.94%	7.10%				+		
Bank Spend against Plan	587	583						

1
2
3
4
5
6
7
8
9
10
11

# Sickness Absence

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



### What these graphs are telling us

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

### Narrative

The overall Sickness Absence rate was 4.47% for the month of May. As demonstrated in the SPC above, the last few months are showing as special cause variation of an improving nature and the position remain below the target.

The top three reasons for absence throughout May were 'Anxiety/stress/depression/other psychiatric illnesses', 'Other musculoskeletal problems' and 'Other known causes - not elsewhere classified'.

The latest NOF Publication relates to Quarter 4 where the NOF score for this metric is 1.88; this relates to the 5.29% sickness absence for the quarter ending December-25 as the methodology used represents a quarter of aggregated monthly figures.

### Actions

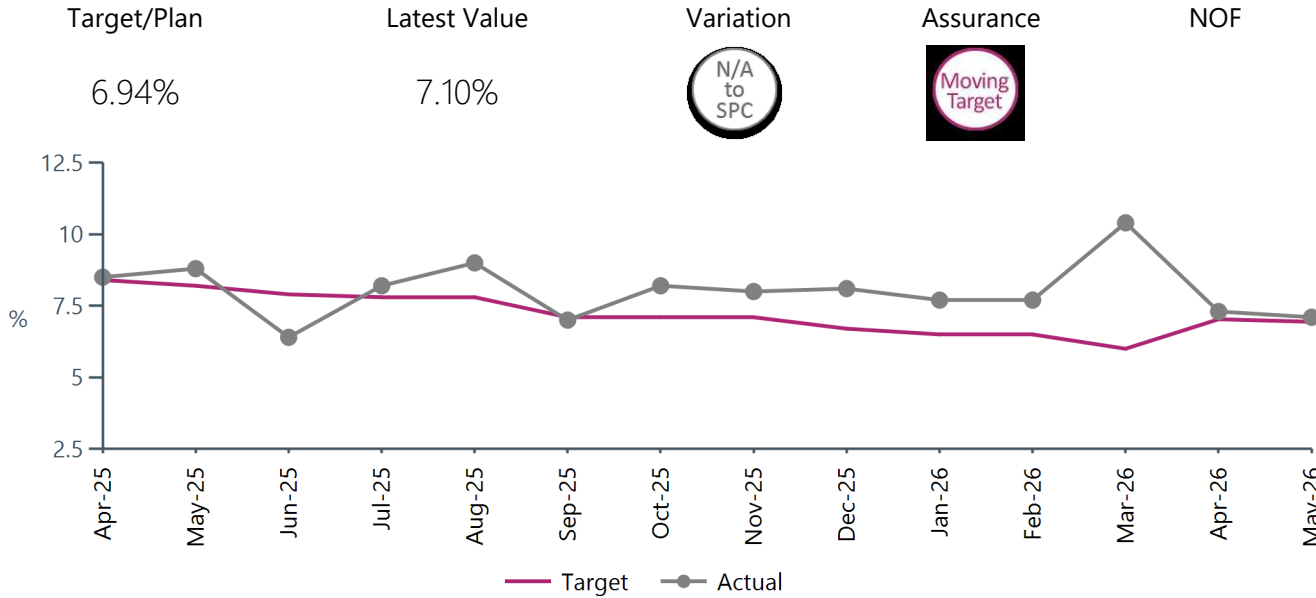
Month	Actual (%)	Target (%)
May-25	4.72%	5.05%
Jun-25	4.99%	5.05%
Jul-25	5.15%	5.05%
Aug-25	4.81%	5.00%
Sep-25	4.91%	5.45%
Oct-25	5.68%	6.05%
Nov-25	5.06%	6.15%
Dec-25	5.12%	6.05%
Jan-26	5.72%	6.05%
Feb-26	5.45%	5.45%
Mar-26	4.25%	5.15%
Apr-26	4.44%	5.15%
May-26	4.47%	4.75%

- Staff - Patients - Finances -

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

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

Exec Lead:  
 Chief Finance & Commercial Officer



### What these graphs are telling us

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

### Narrative

Proportion of temporary staff 7.1%, which is 0.16% adverse to plan.

### Actions

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

- Staff - Patients - Finances -

1
2
3
4
5
6
7
8
9
10
11

## Chair's Assurance Report People and Culture Committee

### Committee / Group / Meeting, Date

Board of Director – Public Meeting, 01 July 2026

### Author:

Name: Emma Jones  
Role/Title: Executive Personal Assistant

### Contributors:

Name: Mary Bardsley  
Role/Title: Assistant Trust Secretary

### 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 receive regular assurance reports from each of these "Meetings" and escalates issues to the Board as necessary via this report.

This report provides a summary of the items considered at the People and Culture Committee on 21<sup>st</sup> May 2026 and 18<sup>th</sup> June 2026. It highlights the key areas the People and Culture Committee wishes to bring to the attention of the Board

## 2. Strategic objectives and associated risks:

The following strategic objectives, developed in light of national and system priorities, are relevant to the content of this report:

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

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

Board Assurance Framework Themes		
1	Continued focus on excellence in quality, safety and patient experience.	
2	Focus on equity of service and addressing health inequalities	✓
3	Effective engagement with the workforce to support a positive staff experience and a culture of continuous improvement	✓
4	Delivering financial sustainability	✓
5	Delivering the required levels of productivity, performance and activity	

## Chair's Assurance Report People and Culture Committee

6	Delivering innovation, improvement and growth	✓
7	The challenges of operating in both the Welsh and English health systems	
8	Responding to a significant disruptive event	
9	Security of digital, data and AI systems and ability to respond to cyber threats	

### Trust values:

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

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

### 3. Assurance Report from People and Culture Committee

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

**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;

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

Require the approval of the Board for work to progress.

**Review the Committee Effectiveness and Annual Report:** Concerns regarding the timeliness and quality of papers was highlighted, representing a risk to effective scrutiny, with recent improvements acknowledged. Assurance was provided that revised processes, including earlier executive review and clearer timelines, are in place to address this. The Committee approved the self-assessment and Terms of Reference for submission to the Trust Board

**FTSU Annual Report (May):** The Committee reviewed the report and welcomed the more detailed breakdown of concerns raised, including the themes reported and the staff groups from which concerns originated. Members noted that a significant proportion of concerns had been recorded under staff safety and wellbeing. Assurance was provided that this largely reflected a change in categorisation, whereby staff are now encouraged to identify where an issue has had a detrimental impact on their wellbeing, rather than indicating standalone safety concerns. The Committee welcomed plans to broaden the Guardian role so that it is more strongly focused on organisational learning, staff engagement and culture development, rather than solely case management. The Committee reflected on the absence of reported sexism and racism cases within the period and noted that, while this may be positive, it will remain important to ensure staff feel confident to raise such concerns. Members also noted the low number of concerns attributed to registered nurses and agreed this should be kept under review, recognising that some staff may choose not to disclose their staff group or may use alternative routes to raise concerns.

#### 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:

**HR Triangulation Dashboard (June):** The Committee was advised that the development of HR triangulation dashboards, has been delayed due to payroll-related challenges. The Committee recognised that improved workforce data is essential to provide stronger visibility of key workforce risks, trends and progress against improvement actions. Work is ongoing to develop the dashboard, with further updates expected at the next meeting.

## Chair's Assurance Report People and Culture Committee

**Staff Sickness (June):** Although sickness levels are within target, the Committee noted that anxiety, stress and depression remain among the leading causes of staff sickness absence. This presents a significant issue, particularly in relation to staff wellbeing, absence levels, service resilience and productivity. The Committee discussed limitations in the current occupational health provision, including the inability to differentiate clearly between work-related and personal stress, and noted that previous funding streams for wellbeing support have been withdrawn. The Committee agreed that the staff support offer requires further review once the new occupational health contract is in place, to ensure that support is appropriate, accessible and aligned to the current needs of staff.

**Six-week Roster Approval Compliance (June):** The Committee received a detailed update on six-week roster approval compliance and noted that performance remains below the required standard. This represents a risk to effective workforce planning, operational grip and the Trust's ability to ensure safe and efficient staffing arrangements. The Committee was advised that the causes of non-compliance have been reviewed with relevant teams and that a three-month recovery plan is being developed. However, until sustained improvement is demonstrated, this remains an area requiring escalation and close oversight. The Committee have requested a clear recovery trajectory, with milestones through which progress will be monitored.

**Job planning compliance and organisational assurance (June):** The Committee considered the current position in relation to job planning compliance and noted that, while Level 1 has been achieved, progression against Level 2 remains incomplete and further work is required to deliver Levels 3 and 4. The Committee was concerned that the current level of compliance provides limited organisational assurance and may impact the Trust's ability to demonstrate effective workforce planning, productivity and service alignment. A phased improvement plan is being developed, supported by engagement with operational leads and the Chief Medical Officer, but the Committee recognised that meaningful progress will require clear ownership, clinical engagement and realistic timescales. This has therefore been escalated as an area of risk requiring continued Committee oversight.

**Internal Facebook Moderation Arrangements (June):** The Committee was advised of proposed changes to internal Facebook moderation arrangements following an incident involving inappropriate posting. All new posts will need a member of the communications team to approve it, prior to the post being published. The Committee noted the importance of ensuring that all communication platforms remain constructive, respectful and aligned with Trust values, while continuing to support staff engagement. This is being monitored as an emerging risk in relation to organisational culture, professionalism and reputational management.

**Human Factors & Just Culture and Learning Culture Alignment (June):** The Committee received an update on work to align Human Factors, Just Culture and Learning Culture activity. Progress includes the development of an internal group, engagement with external organisations and plans for a workshop to define and embed a learning culture across the Trust. The Committee noted that this work is important in supporting openness, psychological safety, learning from incidents and improvement across services. Further work is required to mainstream Human Factors training and ensure that the programme is accessible and relevant for all staff groups.

**Equality, Diversity and Inclusion Progress (June):** The Committee considered the annual Equality, Diversity and Inclusion (EDI) report, plan on a page and associated Workforce Race Equality Standard (WRES) / Workforce Disability Equality Standard (WDES) updates. Positive progress was noted, including increased disability declaration rates, delivery of equality system domains and publication of pay gap reports. However, the Committee also noted ongoing risks around staff network engagement and the need for consistent managerial ownership of EDI actions. The Committee discussed the importance of executive sponsorship, practical support for network chairs and embedding EDI into routine management conversations. The Committee noted that progress is evident, but sustained leadership focus will be required to ensure actions translate into meaningful cultural change.

## Chair's Assurance Report People and Culture Committee

**NHS England Nurse Band 5 Job Evaluation (June):** The Committee was advised of the national requirement to submit a readiness report and delivery plan in relation to nurse band 5 job evaluation, by 31 July. Claire Hobbs has been identified as the Senior Responsible Officer, and the Committee was assured that the Trust is on track to meet the required deadline. This will remain under review to ensure that the submission is completed and that any implications for workforce planning, temporary staffing controls and compliance are understood.

**Staff Survey (June):** The Committee received an update on staff survey action planning, including progress across teams, arrangements for monitoring delivery and the importance of demonstrating "you said, we did" outcomes. It was noted that action plan progress is now being monitored through monthly performance meetings, providing a clearer accountability mechanism for managers. The Committee also discussed the need for targeted support for low-scoring teams and the importance of measuring the impact of actions rather than simply confirming completion. The Committee highlighted the need to see some 'You said, we did' outcomes before being able to be fully assured that the required improvement work is being delivered.

**Corporate Risk Register (May):** The Committee reviewed the new risk management reporting arrangements and welcomed improved visibility of people-related risks, whilst noting that the system remains immature and that risk entries are still variable in quality and completeness. Members queried whether the low number of high-scoring people-related risks fully reflects the pressures facing the organisation and agreed to keep this under review as reporting matures.

**Workforce Performance (May and June):** remains generally positive; however, recruitment delays, particularly in support worker posts, and slower than expected progress in some job planning and rostering measures require continued monitoring was noted at the May meeting. The Committee requested review and benchmarking of the current 90% six-week roster approval target, clearer timelines for improvement, and consideration of whether the current process is suitable for all staff groups, particularly corporate teams. The Committee noted positive delivery in vacancy, sickness and retention levels, with sustained improvement in retention. The Committee requested an update on workforce readiness for the forthcoming theatre development, including whether staffing plans are sufficiently aligned to delivery timescales to support implementation of the new service.

**Premium Workforce Costs (May):** Temporary workforce expenditure was positive against the NHS England agency reduction target in month one, but overall temporary staffing remains adverse to plan because of Bank pressures, including consultant waiting list payments and other medical staffing costs. The Committee will continue to monitor progress in reducing these pressures, including the impact of substantive recruitment in key specialties.

**Case Management (May)** The quarterly case management report prompted discussion about whether the low number of formal performance management activity is proportionate for an organisation of this size. Members noted the need for greater assurance that performance concerns are being identified and escalated appropriately and requested proposals to strengthen the evidence required to be able to assess appropriate level of assurance.

### 3.3 Areas of assurance

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

**Midland Centre for Spinal Injuries (MCSI) Absence Management (June):** The Committee received a detailed presentation from the Matron on absence management within MCSI and was assured by the evidence of strong leadership, cultural improvement, quality improvement activity and targeted staff support. The presentation demonstrated a proactive approach to reducing short-term absence, improving communication, supporting staff wellbeing and strengthening recruitment and retention. The Committee were pleased to see how the new staff room is supporting the wellbeing of staff. The Committee recognised the value of capturing learning from this work and sharing it more widely through nursing forums, management forums and internal communications.

## Chair's Assurance Report People and Culture Committee

The Committee was assured that the approach provides useful learning for other areas of the organisation..

**Workforce Recruitment (June):** The Committee received updates on workforce recruitment activity, including healthcare support worker and allied health professional vacancies, consultant recruitment and new theatre staffing. Positive progress was noted in relation to consultant appointments, including areas where long-term agency reliance is expected to reduce following new appointments. The Committee was assured that recruitment pipelines are being monitored and that further reporting will continue to link vacancy pressures, recruitment timelines and agency spend. This provides assurance that workforce pressures are being actively managed, while recognising that some areas will continue to require close oversight.

**Policy approvals:** The Committee reviewed a number of policies as follows:

- Internal Transfer Policy – approved
- Statutory and Mandatory Training Policy – approved
- Study Leave and CPD Funding Policy – approved subject to further review of the repayment clause, delegating final decision once done to the Chief People Officer.

Improvements to policy governance, including the introduction of change tracking and clearer version control, were also discussed.

**Governance Arrangements (June):** The Committee considered its governance arrangements, including the locally employed doctors action plan, revised terms of reference, policy tracker and workforce plan. The move to six formal meetings per year, supported by alternate executive catch ups, was agreed as a means of improving meeting effectiveness, paper quality and timeliness. The Committee was assured that governance arrangements are being strengthened and that the work plan will be aligned to the revised meeting cycle, with flexibility retained to respond to organisational priorities.

**Advance Workforce Planning (May):** The project focuses on advanced roles within nursing and allied health professions to support sustainable workforce planning and future service delivery. Assurance was received on progress to date, including the establishment of a task and finish group, workforce data analysis, engagement with managers, collaboration with peer organisations, review of qualifications and capability requirements, and development of supporting documentation such as a generic job description.

**Sexual Safety Plan on a Page (May):** Considered and approved the plan which provides a consolidated overview of the Trust's strategic priorities within the scope of the project. It was noted that the sexual safety focus group continues to meet monthly, with both clinical and non-clinical representation. The Committee were updated that sexual safety has been embedded in recruitment and induction processes, including the inclusion of relevant documents within job adverts and dedicated discussion at monthly induction.

**Ethnic Diverse Pay Gap Report (May):** Noted that this was the Trust's first report of this kind. It was noted that overall the median pay gap is higher for staff from global majority backgrounds and the Committee requested a further breakdown excluding the medical and consultant workforce to better understand the underlying position. The Committee approved the report which will be published on the Trust website.

**Disability Pay Gap Report (May):** Reviewed the report and noted that, although the Trust is not currently required to collect, analyse or publish disability pay gap information, it had undertaken the analysis as part of its wider inclusion agenda. It was noted that the disability declaration rate is low at 7%, with additional staff recorded under categories such as not declared, prefer not to answer, or unspecified. The Committee recognised that this limits confidence in the data and suggests that the reported position is likely to under-represent the true number of staff with a disability. It was acknowledged that further work is needed to understand barriers to declaration and to support staff to feel safe and confident in disclosing disability status. Members also noted that the reported pay

## Chair's Assurance Report People and Culture Committee

gap itself appears to show only a small difference, with nothing significant identified at this stage. The Committee approved the report which will be published on the Trust website

Chair Reports received by the reporting sub-meetings included:

- **Chair Report from Trust Performance and Operational Improvement Group** - there were no specific items to raise with the Committee
- **Chair report from Non-Medical Staffing Sub-Group** – there were no specific items raised to the Committee. The Committee approved the revised terms of Reference and workplan for 2026/27.
- **Chair Report from Joint Consultancy Group** – there were no specific items to raise with the 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.

(Part 1) Covering paper

<b>Committee / Group / Meeting, Date</b>	
Board of Directors, 01 July 2026	
<b>Author:</b>	<b>Contributors:</b>
Name: Mary Bardsley Role/Title: Assistant Trust Secretary	
<b>Report sign-off:</b>	
Name: Dylan Murphy, Trust Secretary People and Culture Committee	
<b>Is the report suitable for publication?:</b>	
Yes	
<b>Executive Summary:</b>	
<p>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.</p> <p>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.</p> <p>In line with good practice, the committees of the Board undertake an annual review of their operation and effectiveness. This involves:</p> <ul style="list-style-type: none"> <li>• Reviewing the role of the committee, its key responsibilities, membership and business considered during the year.</li> <li>• A questionnaire on the effectiveness of the operation of the committee (completed by individual members / core attendees).</li> <li>• A self-assessment against key governance questions (for collective consideration).</li> <li>• Review of the terms of reference to ensure the focus of the Committee remains relevant in 2026/27.</li> </ul> <p>No significant issues were identified during the review but some minor revisions to the terms of reference (TOR) have been made. The main change to the TOR is to reflect the move to meeting in alternate months. That move will be supported by a revised process for the review and approval of papers to support the production of high-quality papers in good time for consideration by the committees.</p>	
<b>Recommendations:</b>	
<p>That the Board NOTE that the Committee has:</p> <ol style="list-style-type: none"> <li>1. <b>Considered</b> the outcome of the committee effectiveness survey and did not identify any significant issues;</li> <li>2. <b>Considered and agreed</b> the self-assessment document;</li> <li>3. <b>Noted</b> the 2025/26 Decision / Activity log.</li> <li>4. <b>Considered</b> the draft Terms of Reference for 2026/27 and recommended that the Board approve them.</li> </ol> <p>The Board is therefore asked to CONSIDER and APPROVE the proposed terms of reference for 2026/7.</p>	

(Part 2) Strategic alignment and supporting detail

<b>Strategic objectives and associated risks:</b>		
The work of the committees, and the Board assurance arrangements, support delivery of all of the Trust's strategic objectives:		
<b>Trust Objectives</b>		
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	✓
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	✓
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	✓
The work of the committees, and the Board assurance arrangements, are relevant to all of the Board Assurance Framework (BAF) themes and associated strategic risks but this Committee has a particular focus on:		
<b>Board Assurance Framework Themes</b>		
1	Continued focus on excellence in quality, safety and patient experience.	
2	Focus on equity of service and addressing health inequalities	
3	Effective engagement with the workforce to support a positive staff experience and a culture of continuous improvement	✓
4	Delivering financial sustainability	
5	Delivering the required levels of productivity, performance and activity	
6	Delivering innovation, improvement and growth	
7	The challenges of operating in both the Welsh and English health systems	
8	Responding to a significant disruptive event	✓
9	Security of digital, data and AI systems and ability to respond to cyber threats	
<b>Trust Values:</b>		
Board and committee meeting agendas each include an opportunity to reflect on the extent to which the agenda / discussion reflect and support the Trust's values:		
<b>Trust Values</b>		
1	Professional	✓
2	Excellence	✓
3	Respect	✓
4	Friendly	✓
5	Inclusive	✓
6	Caring	✓
<b>Report development and engagement history:</b>		
The Committee considered the annual review documentation at its meeting in April 2026.		
The Committee considered an updated Terms of Reference at its meeting in June.		
<b>Next steps:</b>		
The Committee will operate in line with the revised Terms of Reference. The workplan will be reviewed and updated as required to work to the new meeting pattern.		
Any issues of concern, or apparent gaps in the governance arrangements, identified during the Committee reviews would be reported to the Audit and Risk Committee for consideration. No such gaps were identified.		

## People and Culture Committee Annual Report

### 1. Committee Roles and Responsibilities (2025/26)

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 (2025/26)

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 Commercial Officer

### 3. Meetings (2025/26)

During 2025/26, the committee met on 12 occasions (monthly). It was noted that all meetings were quorate.

### 4. Committee Attendance (2025/26)

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

Name	Title	Attendance
<b>Core Membership</b>		
Paul Maubach	Associate Non-Executive Director (Chair)	12 / 12 = 100%
Sarfraz Nawaz	Non-Executive Director	02 / 05 = 40%
Atif Ishaq	Associate Non-Executive Director	10 / 12 = 83%
John Pepper	Associate Non-Executive Director	02 / 03 = 67%
Martin Evans	Non-Executive Director	10 / 12 = 83%
Darius Mirza	Non-Executive Director	01 / 04 = 25%
Denise Harnin	Chief People and Culture Officer	11 / 12 = 92%
Mike Carr	Chief Operating Officer	09 / 12 = 75%
Craig Macbeth	Chief Finance and Planning Officer	01 / 01 = 100%
Angela Mulholland-Wells	Chief Finance and Commercial Officer	03 / 04 = 75%
Sam Young / Sarah Needham	Interim Chief Nurse and Patient Safety Officer	08 / 12 = 67%
*Stacey Keegan	Chief Executive Officer	08 / 12 = 67%
<b>In Attendance</b>		
Dylan Murphy	Trust Secretary	12
Andrea Martin	Deputy Chief People and Culture Officer	10
Caroline Nokes Lawrence	Associate Chief People and Culture Officer	11

\*The Chief Executive Officer has an open invitation to the meeting and does not require to attend the

## People and Culture Committee Annual Report

meeting.

### 5. Committee Activity and Decision Log (2025/26)

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

### 6. Conduct of Meetings (2025/26)

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.

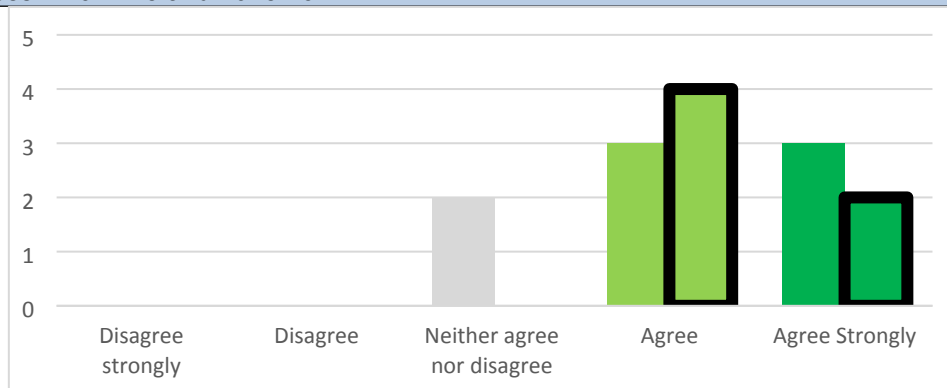
### 7. Committee Effectiveness Survey (2025/26)

The Committee effectiveness survey was circulated to a total of 9 people (core members and frequent attendees of the meeting). There was a total of 6 responses received.

The 2025/26 results (the second of the two columns, with the black outline) are displayed alongside the 2024/25 results (based on the 8 returns received last year).

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

Responses – 2024/25 and 2025/26

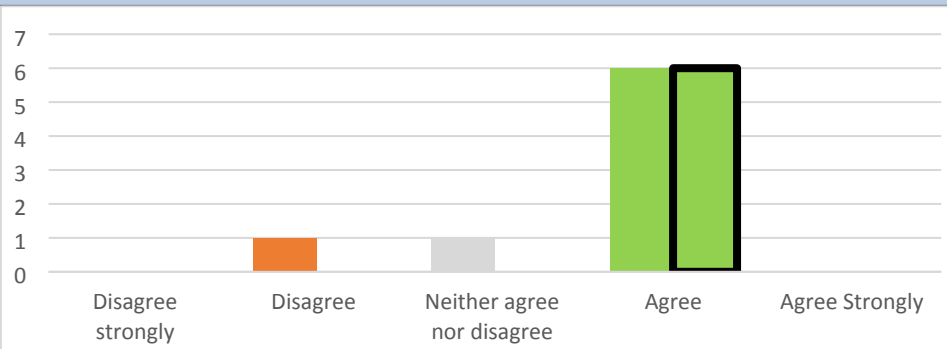


#### Comments

- The work of the committee is driven by the work plan together with People Services strategic agenda appropriately

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

Responses – 2024/25 and 2025/26



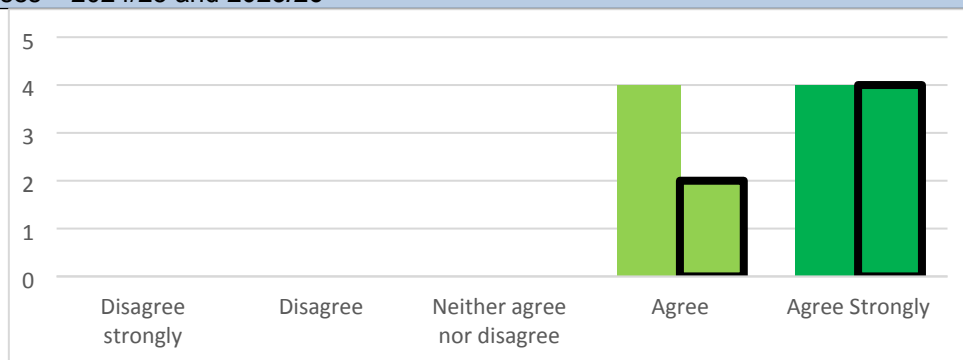
#### Comments

- Agreement in general, though sometimes agenda can be over loaded

## People and Culture Committee Annual Report

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

Responses – 2024/25 and 2025/26

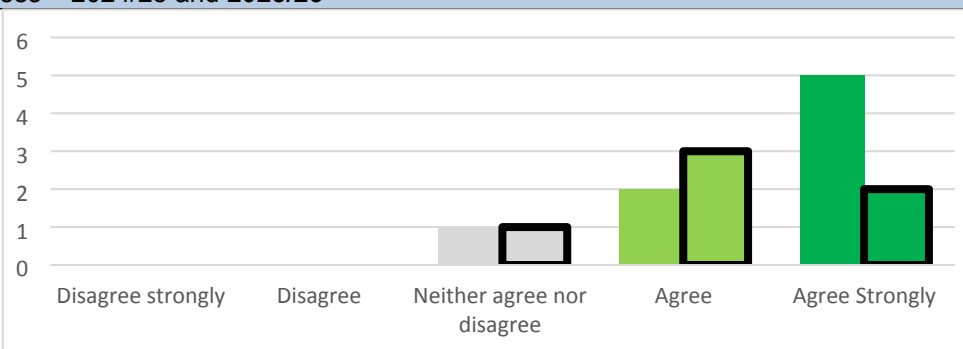


Comments

- There were no responses.

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

Responses – 2024/25 and 2025/26

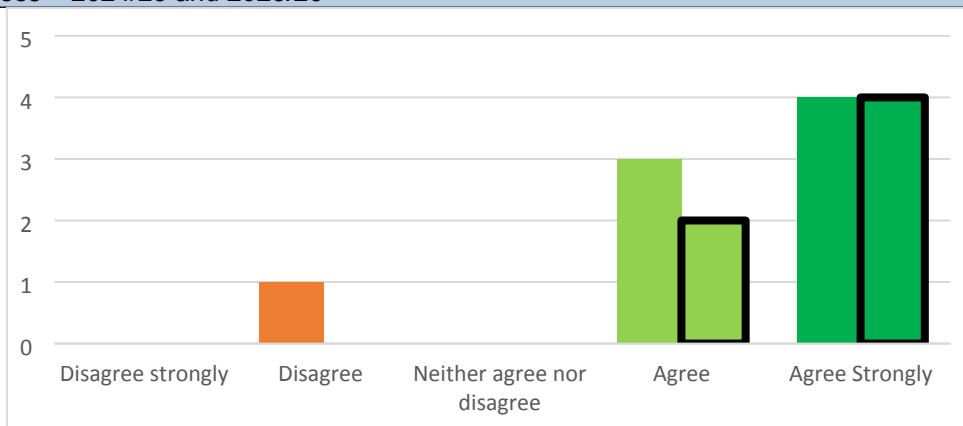


Comments

- Overall chaired well though it would be good to get input from other members first
- Consideration to go bi-monthly, sometimes with leave or BH there's only 15 working days between meetings

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

Responses – 2024/25 and 2025/26



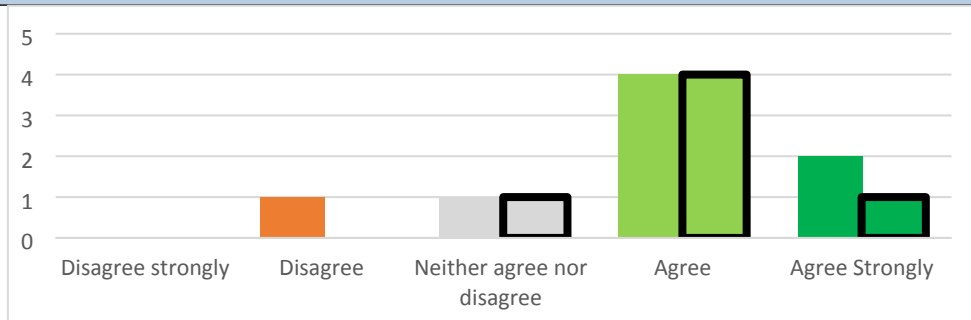
Comments

- There were no responses.

## People and Culture Committee Annual Report

**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

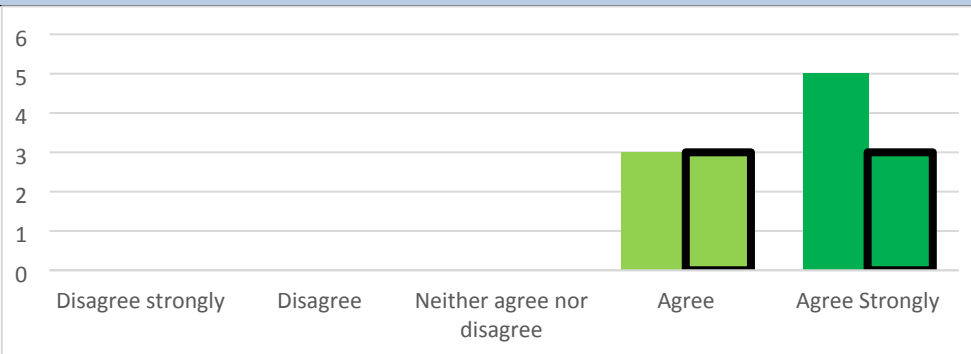


Comments

- There were no responses.

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

Responses – 2024/25 and 2025/26

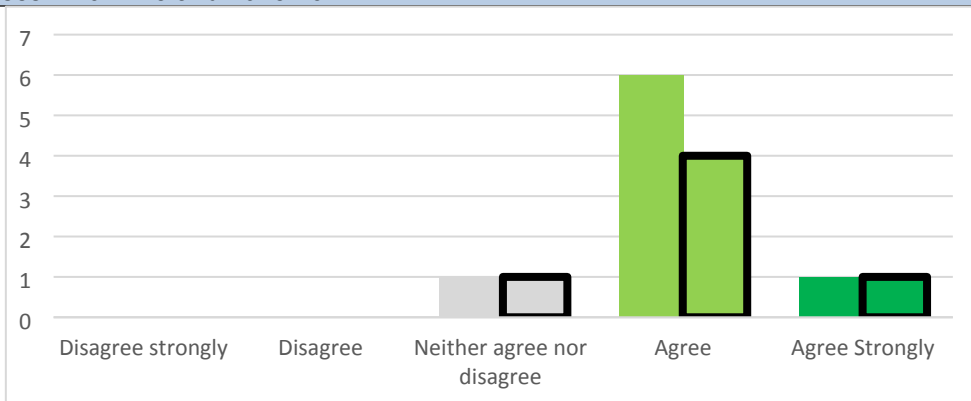


Comments

- . We could do more to promote the work of the committee

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

Responses – 2024/25 and 2025/26



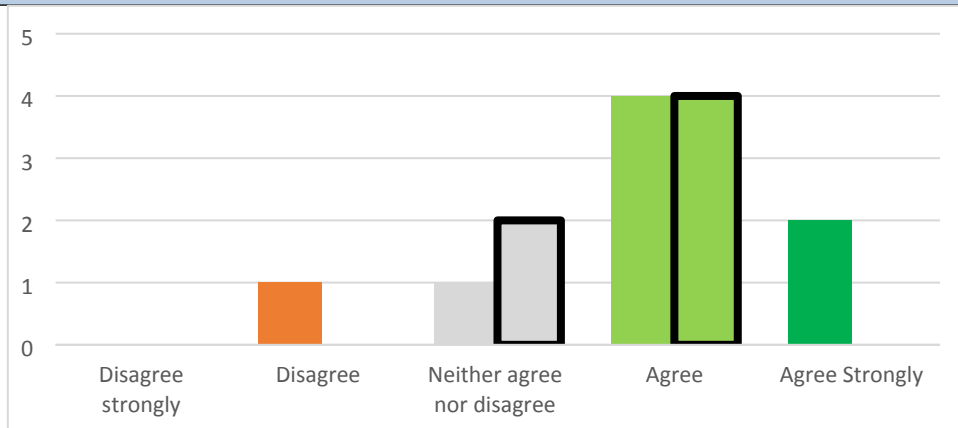
Comments

- At times papers are late therefore impacting on ability for preparation.

## People and Culture Committee Annual Report

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

Responses – 2024/25 and 2025/26

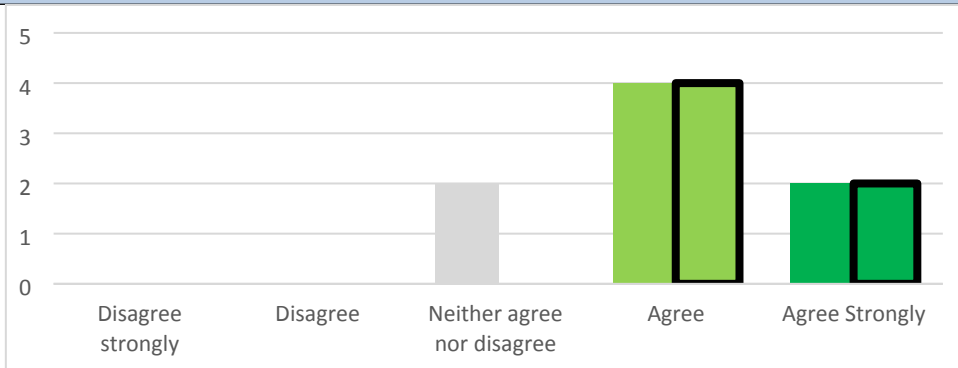


### Comments

- The papers could be improved further with summaries of key issues / decisions required / actions to focus the attention of committee members, as the papers can be quite long and not always clear what the salient points requiring discussion are.
- In the main Yes, I agree with this statement.
- Papers sometimes miss the 'so what' and feel are information sharing. Verbal updates are at times common in this committee.

**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 – 2024/25 and 2025/26



### Comments

- This committee continues to develop in maturity to consider, direct and take assurance from ever growing workforce matters.
- Will be enhanced in the future once we are able to triangulate relevant data sources

## People and Culture Committee Annual Report

### 8. Committee Self-Assessment (2025/26)

Area / Question	Response	Comments / Action
<b>Composition, Establishment and Duties</b>		
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 Nurse and Chief Medical 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 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. (Public = written / Private = verbal)
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 supported by the attendance matrix. This detail is reported to the Board as part of the assurance report.
<b>Compliance with the Law and Regulations Governing the NHS</b>		
Does the committee review assurance and regulatory compliance reporting processes?	Yes	This is undertaken by the committee in relation to issues of workforce and

## People and Culture Committee Annual Report

		assurance is provided to the Board via the Chair's report.
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.
<b>Internal Control</b>		
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. An annual review is also presented to the Committee for consideration.
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 revised the Corporate Stands Manual in 2025/26 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.
<b>Administrative Arrangements</b>		
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 with the Chairs approval.
Does the committee meet the appropriate number of times a year?	Yes	The committee meets 10 times per year and additional meeting can be scheduled upon request.
<b>Other Issues</b>		
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 2026/27

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 2026/27 (appendix B)

# People and Culture Committee Annual Report

## Appendices

---

- Appendix A      PC Decision / Activity Log from 2025/26
- Appendix B      PC Draft Terms of Reference for 2026/27

1
2
3
4
5
6
7
8
9
10
11

**People and Culture Committee | DECISION LOG 2025.26**

Updated:20/04/2026

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?	If a recommendation - date of subsequent consideration at approval body
1	24-Apr-2025	Workforce Performance Report	N/A	The Committee noted the report.			
2	24-Apr-2025	KPIs 2025/26	N/A	The Committee approved the proposals as discussed in the meeting.			
3	24-Apr-2025	Premium Workforce (M12) Report	N/A	The Committee noted the report.			
4	24-Apr-2025	Core Training Compliance Report	N/A	The Committee noted the report.			
5	24-Apr-2025	Guardian of Safe Working Hours	N/A	The Committee noted the report.			
6	24-Apr-2025	Chair Report LNC	N/A	The Committee noted the report.			
7	24-Apr-2025	Chair Report JCG	N/A	The Committee noted the report.			
8	24-Apr-2025	Chair Report Trust Performance and Operational Improvement Group	N/A	The Committee noted the report.			
9	24-Apr-2025	Internal Transfer Policy	N/A	The Committee considered and noted the policy, further amendments are required.			
10	24-Apr-2025	Special Leave Policy	N/A	The Committee considered and noted the policy, further amendments are required.			
11	24-Apr-2025	Formal Review of the Committee (including Terms of Reference)	N/A	The Committee considered and noted the reports, with recommendation of the terms of reference to the Board of Directors.		<b>The Board of Directors</b>	
12	24-Apr-2025	Review of Workplan and Attendance Matrix	N/A	The Committee noted the workplan and attendance matrix.			
13	22-May-2025	Sexual Safety Training	N/A	The Committee noted the update.			
14	22-May-2025	Board Assurance Framework	N/A	The Committee noted the report.			
15	22-May-2025	Corporate Risk Register	N/A	The Committee noted the report.			
16	22-May-2025	Workforce Performance Report	N/A	The Committee noted the report.			
17	22-May-2025	Agency Slides	N/A	The Committee noted the report.			
18	22-May-2025	System Integrated Improvement Plan	N/A	The Committee noted the report.			
19	22-May-2025	Supreme Court Gender Ruling	N/A	The Committee noted the update.			
20	22-May-2025	National Education and Training Survey	N/A	The Committee noted the report.			
21	22-May-2025	Freedom to Speak Up Quarterly and Annual Reports	N/A	The Committee noted the report.			
22	22-May-2025	Regular Assurance Reports	N/A	The Committee noted the following chair reports: Education & Training Oversight Group, Non-Medical Staffing Subgroup, Trust Performance and Operational Improvement Group and Multidisciplinary Education Strategy Meeting			
23	22-May-2025	Fixed term contracts (verbal)	N/A	The Committee noted the update.			
24	22-May-2025	Review of Workplan and Attendance Matrix	N/A	The Committee noted the workplan and attendance matrix.			
25	19-Jun-2025	Workforce Report	N/A	The Committee noted the update.			
26	19-Jun-2025	Workforce Costs Presentation	N/A	The Committee noted the update.			
27	19-Jun-2025	Workforce Reduction Update	N/A	The Committee noted the update.			

**People and Culture Committee | DECISION LOG 2025.26**

Updated:20/04/2026

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?	If a recommendation - date of subsequent consideration at approval body
28	19-Jun-2025	Apollo Update	N/A	The Committee noted the update.			
29	19-Jun-2025	Occupational Health Service Contract	N/A	The Committee approved the report.			
30	19-Jun-2025	EDI Updates including Annual Report	N/A	The Committee were assured with the actions and noted the Report.			
31	19-Jun-2025	WRES/WDES Report	N/A	The Committee approved the report.			
32	19-Jun-2025	Job Evaluation – National Profiles	N/A	The Committee noted the update.			
33	19-Jun-2025	Ethnicity Pay Gap Report	N/A	The Committee noted the update.			
34	19-Jun-2025	Chair Report- Education & Training Oversight Group	N/A	The Committee noted the update.			
35	19-Jun-2025	Chair Report - Trust Performance and Operational Improvement Group	N/A	The Committee noted the update.			
36	19-Jun-2025	Chair Report - Equality, Diversity and Inclusion Meeting	N/A	The Committee noted the update.			
37	19-Jun-2025	Chair Report- Non-Medical Staffing Subgroup	N/A	The Committee noted the update.			
38	19-Jun-2025	Chair Report – Local Negotiation Committee	N/A	The Committee noted the update.			
39	19-Jun-2025	Chair Report- Joint Consultative Group	N/A	The Committee noted the update.			
40	19-Jun-2025	Review of Workplan and Attendance Matrix	N/A	The Committee noted the update.			
41	19-Jun-2025	System Integrated Improvement Plan	N/A	The Committee noted the update.			
42	19-Jun-2025	Policy Tracker	N/A	The Committee noted the update.			
43	24-Jul-2025	Workforce Report	N/A	The Committee took partial assurance from the report.			
44	24-Jul-2025	Agency Report	N/A	The Committee noted the update.			
45	24-Jul-2025	NHS 10 Year Plan	N/A	The Committee noted the update.			
46	24-Jul-2025	Core Training Compliance Q1	N/A	The Committee noted the update.			
47	24-Jul-2025	Leadership Update	N/A	The Committee noted the update.			
48	24-Jul-2025	System Integrated Improvement Plan	N/A	The Committee noted the update.			
49	24-Jul-2025	Apollo Update	N/A	The Committee noted the update.			
50	24-Jul-2025	Guardian of Safe Working Hours Q1	N/A	The Committee noted and took assurance from the report.			
51	24-Jul-2025	Freedom to Speak Up Q1	N/A	The Committee noted and took assurance from the report.			
52	24-Jul-2025	Chair Report: Trust Performance and Operational Improvement Group	N/A	The Committee noted the update.			
53	24-Jul-2025	Chair Report- Non-Medical Staffing Subgroup	N/A	The Committee noted the update.			
54	24-Jul-2025	Chair Report- EDI Meeting	N/A	The Committee noted the update.			
55	24-Jul-2025	Chair Report- Education and Training Oversight Meeting	N/A	The Committee noted the update.			
56	21-Aug-2025	Access Able Presentation	N/A	The Committee noted the presentation.			
57	21-Aug-2025	Corporate Risk Register	N/A	The Committee approved the register.			
58	21-Aug-2025	Board Assurance Framework	N/A	The Committee approved the framework.			
59	21-Aug-2025	Workforce Report	N/A	The Committee noted the update.			
60	21-Aug-2025	Agency Report	N/A	The Committee noted the update.			
61	21-Aug-2025	Case Management Summary	N/A	The Committee noted the update.			
62	21-Aug-2025	Staff Survey Update	N/A	The Committee noted the update.			
63	21-Aug-2025	Leng Review	N/A	The Committee noted the update.			
64	21-Aug-2025	Job Evaluation – National Profiles	N/A	The Committee noted the update.			
65	21-Aug-2025	EDS Domain 2	N/A	The Committee noted the update.			
66	21-Aug-2025	Chair Report - LNM	N/A	The Committee noted the report.			
67	21-Aug-2025	Chair Report - JCG	N/A	The Committee noted the report.			

**People and Culture Committee | DECISION LOG 2025.26**

Updated:20/04/2026

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?	If a recommendation - date of subsequent consideration at approval body
68	21-Aug-2025	Chair Report - TPOIG	N/A	The Committee noted the report.			
69	21-Aug-2025	Chair Report - NSSG	N/A	The Committee noted the report.			
70	21-Aug-2025	Chair Report - Education & Training Oversight	N/A	The Committee noted the report.			
71	21-Aug-2025	Anti Racism Strategy	N/A	The Committee noted the update.			
72	21-Aug-2025	System Integrated Improvement Plan	N/A	The Committee noted the update.			
73	21-Aug-2025	Review of Workplan and Attendance Matrix	N/A	The Committee approved the plan.			
74	18-Sep-2025	Performance Report	N/A	The Committee noted the update.			
75	18-Sep-2025	Age Profile Deep Dive	N/A	The Committee noted the update.			
76	18-Sep-2025	Premium Costs	N/A	The Committee noted the update.			
77	18-Sep-2025	Workforce Reduction Update	N/A	The Committee noted the update.			
78	18-Sep-2025	Occupational Health Service Contract	N/A	The Committee noted the update.			
79	18-Sep-2025	Staff Survey Update	N/A	The Committee noted the update.			
80	18-Sep-2025	Job Planning and Attainment	N/A	The Committee noted the update.			
81	18-Sep-2025	Job Evaluation – National Profiles	N/A	The Committee noted the update.			
82	18-Sep-2025	Sexual Safety Self Assessment	N/A	The Committee noted the update.			
83	18-Sep-2025	Global Majority Update	N/A	The Committee noted the update.			
84	18-Sep-2025	10 Point Plan	N/A	The Committee noted the update.			
85	18-Sep-2025	Chair Report - NSSG	N/A	The Committee noted the update.			
86	18-Sep-2025	Chair Report - Education & Training Oversight	N/A	The Committee noted the update.			
87	18-Sep-2025	Chair Report - JCG	N/A	The Committee noted the update.			
88	18-Sep-2025	Chair Report - TPOIG	N/A	The Committee noted the update.			
89	18-Sep-2025	Review of Workplan and Attendance Matrix	N/A	The Committee noted the update.			
90	18-Sep-2025	Medical Engagement Strategy	N/A	The Committee noted the update.			
91	23-Oct-2025	Leadership Development Programme	N/A	The Committee took assurance from the presentation.			
92	23-Oct-2025	Risk Management	N/A	The Committee took assurance from the presentation.			
93	23-Oct-2025	Performance Report	N/A	The Committee took partial assurance from the report.			
94	23-Oct-2025	Premium Costs Report	N/A	The Committee took partial assurance from the report.			
95	23-Oct-2025	Delivery Model Progress	N/A	The Committee took assurance from the presentation.			
96	23-Oct-2025	Training Compliance	N/A	The Committee could not take assurance from the report			
97	23-Oct-2025	Sexual Safety Self Assessment	N/A	The Committee took assurance from the presentation.			
98	23-Oct-2025	Framework of Quality Assurance - Appraisal Annual Report	N/A	The Committee approved the report.			
99	23-Oct-2025	Nursing and Midwifery Job Evaluation - NHS Profiles	N/A	The Committee took partial assurance from the report.			
100	23-Oct-2025	Shared Services Collaboration	N/A	The Committee took assurance from the report.			
101	23-Oct-2025	Letter - NHS on racism including antisemitism	N/A	The Committee took assurance from the letter.			
102	23-Oct-2025	On-Call Policy	N/A	The Committee approved the policy			
103	23-Oct-2025	Pay Protection Policy	N/A	The Committee did not approve the policy			
104	23-Oct-2025	Grievance Policy	N/A	The Committee approved the policy			
105	23-Oct-2025	Staff Smoke Free Policy	N/A	The Committee approved the policy			
106	23-Oct-2025	Management of Change Policy	N/A	The Committee did not approve the policy			
107	23-Oct-2025	Chair Report - NSSG	N/A	The Committee took assurance from the report.			
108	23-Oct-2025	Chair Report - Education & Training Oversight	N/A	The Committee took assurance from the report.			
109	23-Oct-2025	Chair Report - JCG	N/A	The Committee took assurance from the report.			
110	23-Oct-2025	Chair Report - Trust Performance and Operational Improvement Group	N/A	The Committee took assurance from the report.			
111	23-Oct-2025	Chair Report - LNM	N/A	The report was not presented			

**People and Culture Committee | DECISION LOG 2025.26**

Updated:20/04/2026

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?	If a recommendation - date of subsequent consideration at approval body
112	23-Oct-2025	Chair Report - EDI	N/A	The Committee took assurance from the report.			
113	23-Oct-2025	Review of Workplan and Attendance Matrix	N/A	The Committee approved the workplan			
114	20-Nov-2025	Board Assurance Framework	N/A	Approved			
115	20-Nov-2025	Performance Report	N/A	Noted			
116	20-Nov-2025	Agency Update	N/A	Noted			
117	20-Nov-2025	Planning Update	N/A	Noted			
118	20-Nov-2025	Workforce Retention Update	N/A	Noted			
119	20-Nov-2025	Case Management Summary	N/A	Noted			
120	20-Nov-2025	Guardian of Safe Working Hours	N/A	Noted			
121	20-Nov-2025	Global Majority Update	N/A	Approved			
122	20-Nov-2025	Core Training Compliance Report	N/A	Noted			
123	20-Nov-2025	Freedom to Speak Up	N/A	Noted			
124	20-Nov-2025	EDS2 Domain 3 Annual Report	N/A	Approved			
125	20-Nov-2025	Chair Report - NSSG	N/A	Noted			
126	20-Nov-2025	Chair Report - ETOG	N/A	Noted			
127	20-Nov-2025	Chair Report - JCG	N/A	Noted			
128	20-Nov-2025	Chair Report - TPIOG	N/A	Noted			
129	20-Nov-2025	Chair Report - LNM	N/A	Noted			
130	20-Nov-2025	Well Led Review	N/A	Noted			
131	20-Nov-2025	Review of Workplan and Attendance Matrix	N/A	Noted			
132	18-Dec-2025	Performance Report	N/A	Noted			
133	18-Dec-2025	Agency Update	N/A	Noted			
134	18-Dec-2025	Workforce Reduction Update	N/A	Noted			
135	18-Dec-2025	Sexual Safety Action Plan	N/A	Noted			
136	18-Dec-2025	Management of Change Policy	N/A	Approved			
137	18-Dec-2025	Review of Workplan and Attendance Matrix	N/A	Noted			
138	18-Dec-2025	Risk Reflection	N/A	Noted			
139	22-Jan-2026	Corporate Risk Register	N/A	Approved			
140	22-Jan-2026	Workforce Plan 2026/27	N/A	Approved			
141	22-Jan-2026	Workforce Performance Report	N/A	Noted			
142	22-Jan-2026	Premium Costs Update	N/A	Noted			
143	22-Jan-2026	Core Training Compliance	N/A	Noted			
144	22-Jan-2026	Access Able Presentation	N/A	Noted			
145	22-Jan-2026	Widening Participation Presentation	N/A	Noted			
146	22-Jan-2026	EDI Quarterly Report	N/A	Noted			
147	22-Jan-2026	Guardian of Safe Working Hours	N/A	Noted			
148	22-Jan-2026	Chair Report - EDI Meeting	N/A	Noted			
149	22-Jan-2026	Chair Report - Non- Medical Staffing Sub-Group	N/A	Noted			
150	22-Jan-2026	Chair Report - Education & Training Oversight	N/A	Noted			
151	22-Jan-2026	Chair Report - JCG	N/A	Noted			
152	22-Jan-2026	Chair Report - LNM	N/A	Noted			
153	22-Jan-2026	Medical Appraisal Policy	N/A	Approved			
154	22-Jan-2026	Corporate Local Induction Policy	N/A	Approved			
155	22-Jan-2026	Special Leave Policy	N/A	Approved			
156	22-Jan-2026	Annual Leave Policy	N/A	Approved			
157	22-Jan-2026	Senior Manager On-Call Policy	N/A	Approved			
158	19-Feb-2026	Workforce Performance Report	N/A	Noted			

**People and Culture Committee | DECISION LOG 2025.26**

Updated:20/04/2026

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?	If a recommendation - date of subsequent consideration at approval body
159	19-Feb-2026	Premium Costs Update	N/A	Noted			
160	19-Feb-2026	Job Planning and Attainment	N/A	Deferred			
161	19-Feb-2026	GMC Training Survey	N/A	Deferred			
162	19-Feb-2026	Shared Services Collaboration	N/A	Noted			
163	19-Feb-2026	Freedom to Speak Up	N/A	Noted			
164	19-Feb-2026	Case Management Summary	N/A	Noted			
165	19-Feb-2026	Absence Management Report	N/A	Noted			
166	19-Feb-2026	Gender Pay Gap Report	N/A	Approved			
167	19-Feb-2026	NHSE - Band 5 Review Letter	N/A	Noted			
168	19-Feb-2026	Chair Report - EDI	N/A	Noted			
169	19-Feb-2026	Chair Report - NMSSG	N/A	Noted			
170	19-Feb-2026	Chair Report - ETOG	N/A	Noted			
171	19-Feb-2026	Chair Report - JCG	N/A	Noted			
172	19-Feb-2026	Chair Report - LNM	N/A	Noted			
173	19-Feb-2026	Chair Report - TPIOG	N/A	Noted			
174	19-Feb-2026	Pay Banding Policy	N/A	Approved			
175	19-Feb-2026	Reserves Forces Training Policy	N/A	Approved			
176	19-Feb-2026	Disciplinary Policy	N/A	Not approved			
177	19-Feb-2026	Managing Allegations Policy	N/A	Noted			
178	19-Feb-2026	Well Led Action Plan	N/A	Noted			
179	19-Feb-2026	Workplan and Attendance Matrix	N/A	Noted			
180	19-Feb-2026	ESR / Payroll MIAA Audit	N/A	Noted			
181	19-Mar-2026	Board Assurance Framework	N/A	Noted			
182	19-Mar-2026	Corporate Risk Register	N/A	Noted			
183	19-Mar-2026	Workforce Performance Report	N/A	Noted			
184	19-Mar-2026	Premium Costs Update	N/A	Noted			
185	19-Mar-2026	GMC Training Survey	N/A	Noted			
186	19-Mar-2026	Job Planning and Attainment	N/A	Noted			
187	19-Mar-2026	EDS2 Report	N/A	Approved			
188	19-Mar-2026	Staff Engagement & Communications	N/A	Noted			
189	19-Mar-2026	Organisational Development	N/A	Noted			
190	19-Mar-2026	Chair Report - NMSSG	N/A	Noted			
191	19-Mar-2026	Chair Report - ETOG	N/A	Noted			
192	19-Mar-2026	Chair Report - TPIOG	N/A	Noted			
193	19-Mar-2026	Chair Report - JCG	N/A	Noted			
194	19-Mar-2026	Disciplinary Policy	N/A	Approved			
195	19-Mar-2026	Minimum Periods of Notice Policy	N/A	Approved			
196	19-Mar-2026	Workplan and Attendance Matrix	N/A	Noted			
197	19-Mar-2026	Policy Tracker	N/A	Noted			

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11

## People and Culture Committee Terms of Reference (~~April~~June 2026)

### 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/Deputy CEO

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

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

The Board of Directors will appoint a Committee Chair from the Non-Executive 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 to chair the meeting.

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

### 3. Attendance

The Trust Secretary, Deputy Chief 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 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.

### 4. Frequency of meetings and meeting administration

The Committee will meet ~~10~~6 times within the year for regular business. The Chair of the Committee may call additional meetings.

1

2

3

4

5

6

7

8

9

10

11

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
  - Represent significant developments / improvements that will help the Trust deliver its objectives and/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 consider opportunities for partnership working when discussing issues relevant to the Committee's remit.
- To receive progress reports on the delivery of the enabling strategies which are aligned to the Committee including the Education Strategy.
- To receive quarterly reports from the Freedom to Speak Up Guardian.

1

2

3

4

5

6

7

8

9

10

11

- 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' agenda item such as; staff survey and guardian of safe working hours reports.
- To receive reports from meetings that report into the Committee, currently including:
  - Equality Diversity and Inclusion 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
- To review corporate risks and Board Assurance Framework risks relevant to the committee's remit on behalf of the Board.

1
2
3
4
5
6
7
8
9
10
11

# Freedom to Speak Up Report Q4, 2025/6: January to March 2026 (and 2025/6 Annual Report)

## (Part 1) Covering paper

### Committee / Group / Meeting, Date

People and Culture Committee, May 2026

### Author:

Name: Dylan Murphy  
Role/ Title: Trust Secretary

### Contributors:

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

### Report sign-off:

### Is the report suitable for publication?

YES

### Executive Summary:

This paper is provided as a summary on Freedom to Speak Up (FTSU) activity for Q4, 2025/6: January to March 2026 and 2025/6 in total.

### Key Points:

- This quarter, FTSU has received a total of nine cases. Of the 9 cases:
  - Two were treated as advice and seven were treated as concerns and were escalated to an appropriate Manager.
  - 2 were anonymous.
  - Two cases had an element of Patient Safety/Quality.
  - All had an element of Worker Safety/Wellbeing.
  - Four had an element of Attitudes and Behaviours.
  - Three had elements categorised as “Other”
  - All of the cases were raised with the Guardian.
  - There were no concerns raised around Apollo.
  - No cases had a recorded element of sexism.
  - No cases had a recorded element of racism.
- During the year, there were 47 contacts with the FTSU service. These contacts are referred to as “cases” in this report. In 2024/25 the figure was 54. In 2023/4 it was 46.
- When looked at across the year as a whole, the three most frequently cited categories of concern related to:
  - “Other” (often relating to policy / procedural / contractual queries) – with 23 instances;
  - “Attitudes and behaviours” – with 22; and
  - “Worker safety / wellbeing” – with 17.
- During the year, the breakdown of professional groups that contacted the service was:
  - Nurses - 12 contacts;
  - Allied Health Professional - 9 contacts;
  - Administrative and clerical staff - 7 contacts;
  - Additional clinical services - 5 contacts; and
  - Medics - 4 contacts.
- All cases raised were responded to within 48hrs and escalated to the appropriate department when required.

### Recommendation:

That the Committee:

1. NOTE the report on the operation of the FTSU service during 2025/6;
2. NOTE the ongoing and planned actions to further develop the arrangements in 2026/7; and.
3. CONSIDER the level of assurance received from the report and the planned developments.

(Part 2) Strategic alignment and supporting detail

**Strategic objectives and associated risks:**

The following strategic objectives, developed in light of national and system priorities, are relevant to the content of this report:

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

The FTSU service provides staff an opportunity to raise any concerns they have around the quality / safety of services, or issues that have an adverse impact on individuals / teams. It supports efforts to address those concerns and learn wider lessons.

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

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

The FTSU service provides staff an opportunity to raise any concerns they have around the quality / safety of services. A healthy culture of “speaking up” is crucial to the delivery of excellence in quality and safety.

**Trust values:**

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

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

The FTSU service provides staff an opportunity to raise any concerns they have around behaviours and values. A culture that values both “speaking up” and “listening up” is crucial in promoting and protecting the Trust values.

**Supporting detail:**

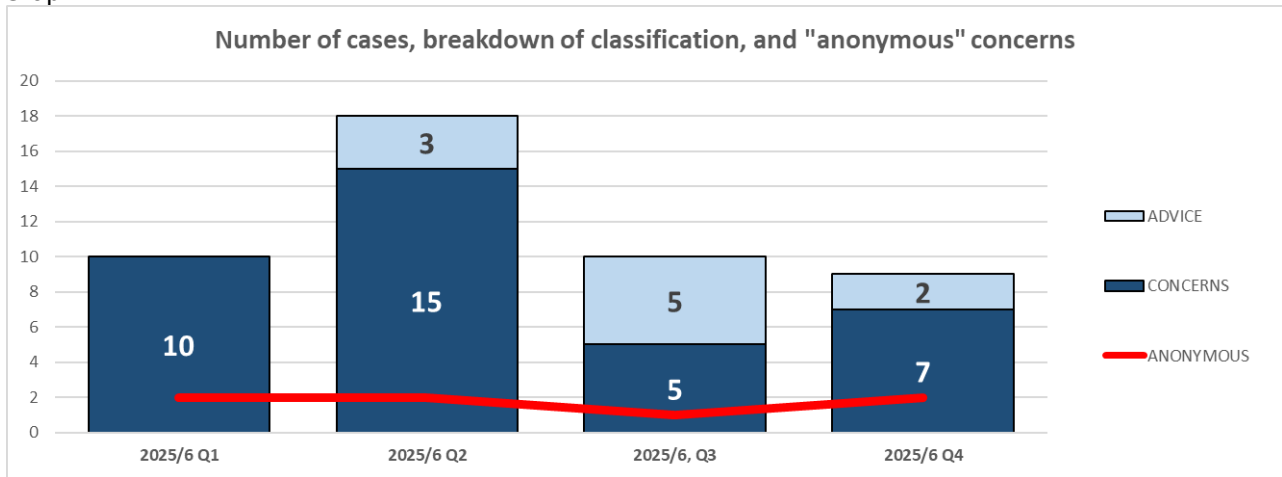
**1. Overall number of cases**

Staff have multiple ways of contacting the service. These include direct contact with the Guardian, or Champions; a dedicated FTSU email inbox; a QR Code for submitting anonymous concerns; and a post box for submitting concerns. The service is promoted by posters across the site, regular communications, and the physical presence of the Guardian and Champions. There is also a programme of mandatory training (with multiple modules that are appropriate to individuals' roles).

Graph 1 shows the total of cases raised during 2025/6, and how many:

- Were treated as "concerns" (i.e. the cases were escalated for action),
- Resulted in "advice" only (i.e. people were advised or redirected as appropriate, and no further action was required). Note: One case of advice related to queries around an HR processes. The other related to a query around the recruitment process.
- Were received as anonymous concerns.

Graph 1



**Commentary**

- Overall numbers have fluctuated between 9 and 18 per quarter over the last four quarters.
- 78 percent of contacts were treated as concerns in quarter 4.
- The line in the chart above shows the number of concerns that were raised anonymously. When considered as a percentage, the figures over the year are:

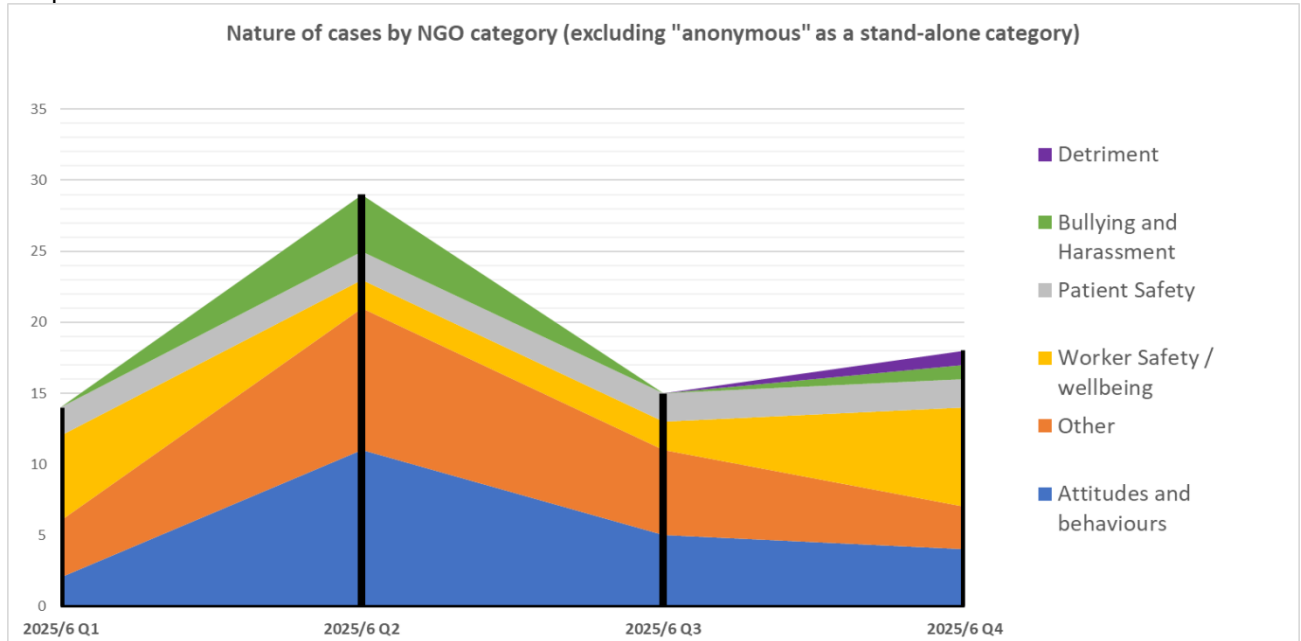
2025/6, Q1	2025/6, Q2	2025/6, Q3	2025/6, Q4
20%	11.11%	10.00%	22%

**2. Cases raised broken down by type of concern**

Graph 2a shows the concerns raised broken down by the reporting categories required by the NGO (excluding "anonymous" as a category in its own right). These categories are as agreed with the person who raised the concerns, or as recoded directly by the person who raised the concern (dependent on the route the individual took in raising their concerns). This presents the types of concern received over the year – Q1 2025/6 to Q4, 2025/6.

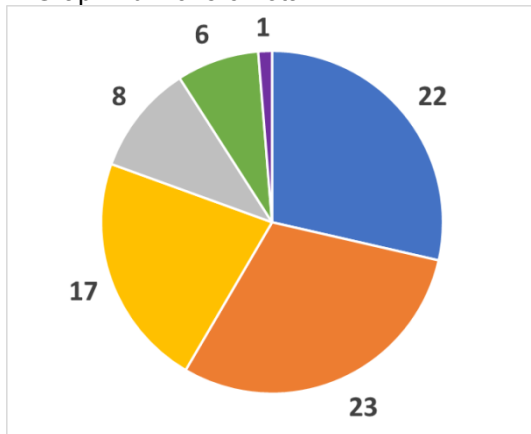
Please note that a concern may cover a number of elements. e.g. A single contact may be reported as a case involving "attitudes and behaviours", "worker safety / wellbeing", and "bullying and harassment". As a result, the number of "concerns by category" (which focuses on the content of concerns) is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

Graph 2a

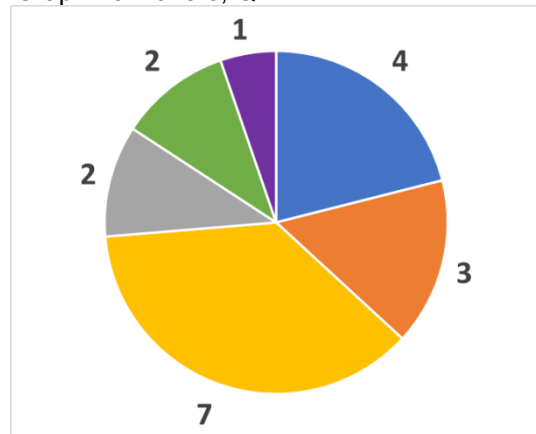


The breakdown of concerns raised by “type” is presented in an alternative format below. The first chart (Graph 2b) shows the breakdown for the full year (Q1, 2024/5 to Q4, 2025/6). The second chart (Graph 2c) shows the breakdown for Q4, 2025/6. Both are provided to show how the profile this month reflects the longer-term profile. The colour scheme is consistent with Graph 2a and the table below:

Graph 2b: 2025/6 Total:



Graph 2c: 2025/6, Q4



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

	2025/6 Q1	2025/6 Q2	2025/26 Q3	2025/26 Q4
Attitudes and behaviours	2	11	5	4
Other	4	10	6	3
Worker Safety / wellbeing	6	2	2	7
Patient Safety	2	2	2	2
Bullying and Harassment	0	4	0	2
Detriment	0	0	0	1

Commentary

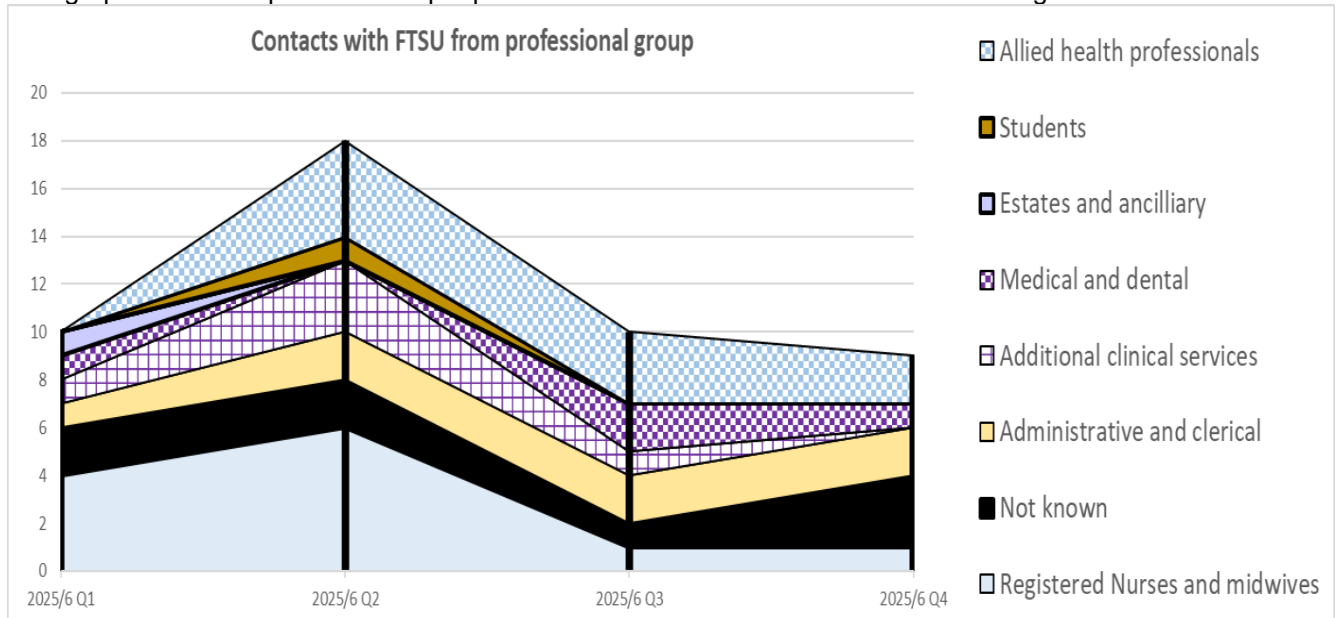
- When looked at across the year as a whole, the three most frequently cited categories of concern related to: “Other” (often relating to policy / procedural / contractual queries); “Attitudes and behaviours”; and “Worker safety / wellbeing”.
- Many cases record “Worker safety / wellbeing” as a constituent element of their concern – if an individual reports that their mental health has affected by their concern, that will be captured under the “welfare” element of the “worker safety / wellbeing” category. This quarter, for example, every case of “Inappropriate attitudes and behaviours” reported, also included a reported aspect of “worker safety / wellbeing”. There were no cases where this was the only factor recorded.
- A relatively large number of concerns are not covered by the NGO classification and are therefore reported as “Other”. The “Other” concerns this quarter were linked to:
  - Interpretation / application of recruitment and appointment processes (which was subsequently addressed via correspondence).
  - A query regarding an apparent gap in an existing policy / procedure (which was subsequently addressed)
  - A query around the use of Trust resources.
- The reported detriment is one aspect of a case that has multiple elements. This has been escalated to Executive Director level. This relates to a complex situation that has a number of elements, each of which are being addressed through the appropriate channels.
- There were no cases with any reported element of sexism or racism. These two categories are not a distinct reportable category of concern (to the NGO) but the Trust has started to record cases that have elements of either sexual harassment, a racial element, or some other discriminatory element.
- No cases related to Apollo.

**3. Nature of cases raised by the profession of the person raising them**

The graphs in this section present the profession of the individuals who have contacted the FTSU service, and compares the figures with previous quarters.

Graph 3a

This graph shows the profession of people who have contacted the FTSU service during 2025/6:



# Freedom to Speak Up Report

## Q4, 2025/6: January to March 2026 (and 2025/6 Annual Report)

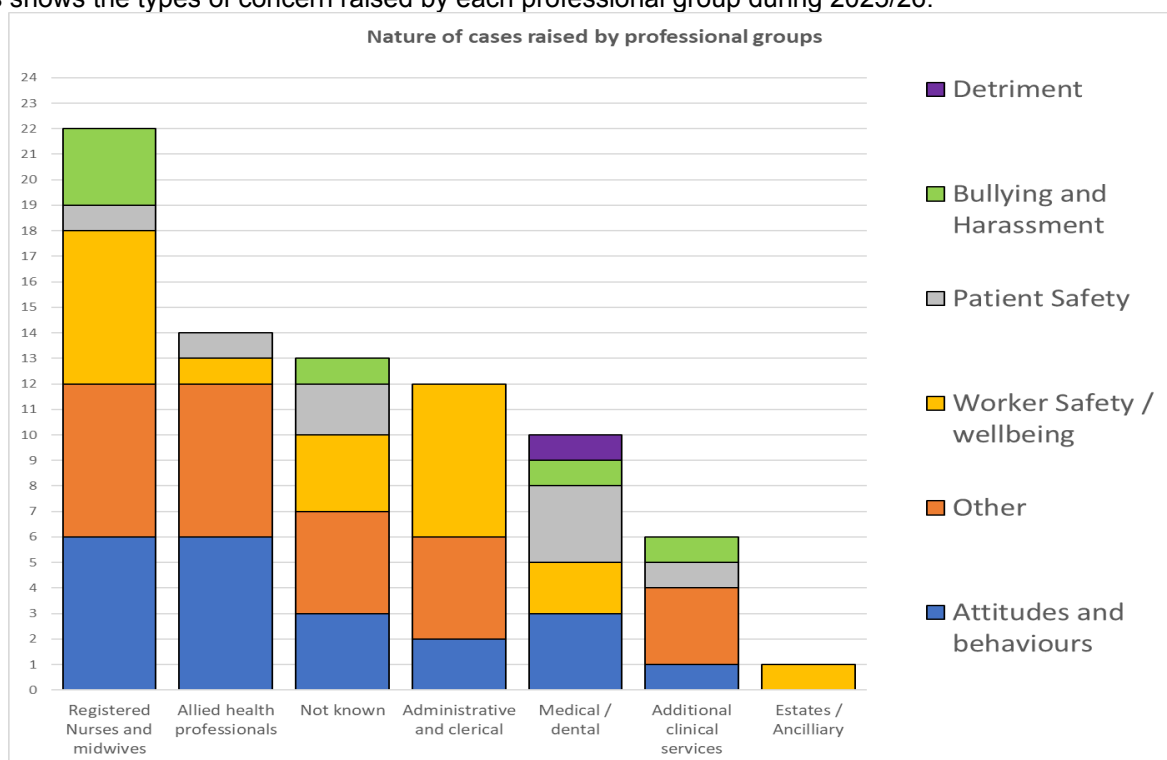
During the year, the groups most likely to contact the service were:

- Nurses, with 12 contacts;
- Allied Health Professional, with 9 contacts;
- Administrative and clerical staff, with 7 contacts;
- Additional clinical services, with 5 contacts; and
- Medics, with 4 contacts.

(The professional group of 8 individuals who contacted the service is not known).

Graph 3b

This shows the types of concern raised by each professional group during 2025/26:



(NOTE: cases may include more than one category of concern. As such, these figures are greater than the number of contacts made).

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

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

#### 4. **Outcomes / Learning**

As a result of the concerns raised this quarter:

- There has been particular learning for individuals around policy requirements (which clarified the position);
- One case was escalated to Executive Director level for review / investigation. That related to a complex situation that had a number of elements, each of which are being addressed through the appropriate channels.
- A team did some work on appropriate communication, with reference to the Trust values and behaviours;
- A policy/process was reviewed and improved to address an existing gap (which improved the clarity of the process, resulting in a greater level of assurance around service delivery and continuity);
- There was a management review of staffing / operational procedures in one area to address concerns around high work-load and associated pressure on the team and the service it provided. That situation subsequently improved.

#### 5. **National Reporting**

FTSU data has previously been reported on the National Guardian's Office (NGO) website. This has enabled the Trust to benchmark its figures against similar trusts. From 1 July 2026, following a recommendation in July 2025 by the [Dash review](#) of patient safety across health and care, NHS England will deliver some activities previously undertaken by the National Guardian's Office (NGO).

Under the new arrangements, NHS England will:

- support existing guardian networks and individual guardians, including managing general enquiries through the national contact centre and escalating specialist queries to the NHS England Freedom to Speak Up team
- provide and maintain the platform for free online guardian foundation training
- collect Freedom to Speak Up data nationally and use both qualitative and quantitative insights to strengthen system learning. Insight will be shared routinely with guardian networks
- review national Freedom to Speak Up policy and guidance across all sectors, starting with primary care organisations

There is currently a gap in the national data reporting as the last set of data published by the NGO relates to Q3, 2025/6.

#### 6. **External review**

During the summer of 2025, an independent developmental well-led review was undertaken. That review considered arrangements around speaking up and the report noted that:

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

#### 7. **Other activities undertaken**

During the year, the FTSU Guardian undertook the following activities:

- Completion of the mandatory annual NGO annual training by the Guardian.
- Completion of a review in line with the NGO's *Freedom to Speak Up Development Guide* and the identification of improvement actions (subsequently delivered, or planned).
- Attendance at the Regional NGO meetings and FTSU bi-monthly meetings.
- Roll out of a learning and improvement tool. This tool is sent to the manager with the initial e-mail escalating a concern. The form has four boxes for the manager to complete and return once the concern has been action and learning has been identified. These forms allow the anonymised learning to be shared, where applicable, across the Trust. It also allows the manager to implement their own improvements and promote the education of staff.
- Routine recording of cases with elements of racism, sexism, or inappropriate sexual conduct to support initiatives around sexual safety and the promotion of equality.

# Freedom to Speak Up Report

## Q4, 2025/6: January to March 2026 (and 2025/6 Annual Report)

- During Speak Up Month in October the FTSU Champions and Guardian did a walk about to introduce themselves and explain about the FTSU service available at RJAH.
- Engagement with the Violence and Prevention & Reduction Standards Group to share data around bullying and harassment, attitudes and behaviours and detriment.

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

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

This work is to be developed in 2026/7 under the leadership of the new FTSU Guardian.

### **8. Current position and future of the service**

Liz Hammond, our previous Freedom to Speak Up (FTSU) Guardian recently retired. The Trust is grateful for the work Liz has done to embed the Guardian role within the Trust and develop the wider FTSU service.

The Trust took the opportunity to review the Guardian role before recruiting a new Guardian. The Trust has broadened the scope of the role and has increased the hours, from 0.6 WTE, to a full-time position accordingly. The role will provide a visible, accessible presence and a develop a robust supporting infrastructure to deliver:

- a comprehensive programme of staff engagement / awareness-raising;
- individual “case management”;
- comprehensive engagement with HR, clinical governance colleagues and others;
- broader “raising concerns” analysis and reporting;
- input to the development and promotion of the wider culture of staff wellbeing / a robust safety culture; etc

The Trust has successfully appointed to the role. The appointed person is currently working their notice period at their current employer and is due to join the Trust in June. More information about the new Guardian will be shared with staff via the regular communication channels nearer the time.

In the meantime, Claudette Jones, FTSU Guardian at the Royal Orthopaedic Hospital NHS Foundation Trust, has kindly agreed to provide Guardian support to the Trust. As well as being able to submit a concern through the usual channels, staff have the option of contacting Claudette as a trained Guardian and independent, external source of advice.

The recent appointment and the interim arrangements have been communicated to staff.

#### **Acronyms**

<b>FTSU</b>	Freedom to Speak Up
<b>NGO</b>	National Guardians Office

# Trust Board - Performance

## May 2026 – 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:

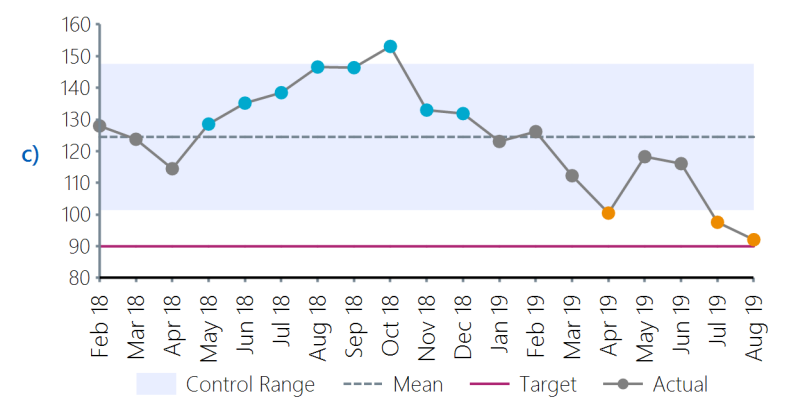
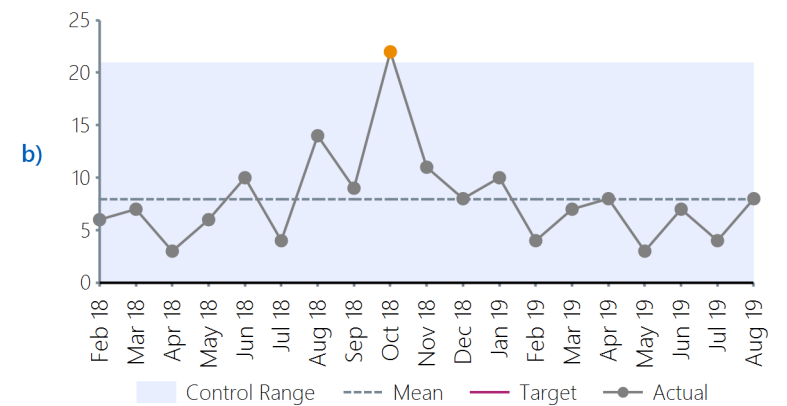
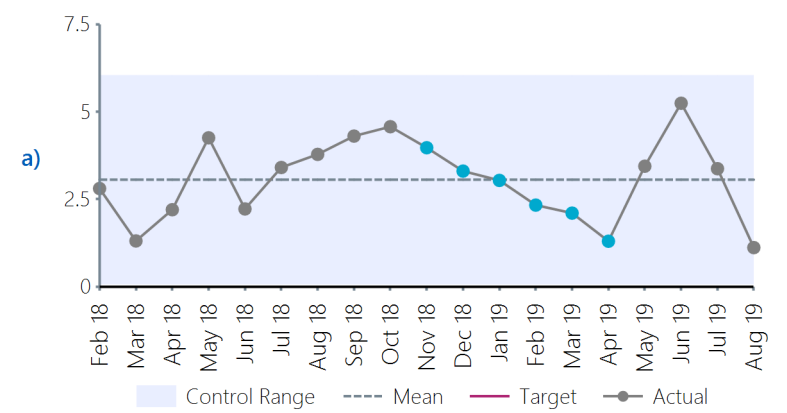
- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of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



1
2
3
4
5
6
7
8
9
10
11

# 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



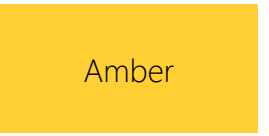
Blue

No improvement required to comply with the dimensions of data quality



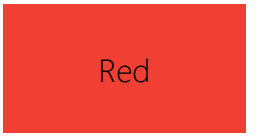
Green

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.

1
2
3
4
5
6
7
8
9
10
11



# Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
31 Day General Treatment Standard*	96.00%	100.00%	100.00%					
62 Day General Standard*	85.00%	75.00%	50.00%			+	12/09/23	
28 Day Faster Diagnosis Standard*	77.00%	75.00%	89.47%			+		
18 Weeks RTT Open Pathways	62.36%	64.52%				+	24/06/21	+
18 Week Performance - Difference Between Planned and Actual	0.00%	2.16%				+		+
26 Weeks RTT Open Pathways		50.60%				+		
Time to First Appointment - English Patients (18 Weeks)	80.37%	79.37%				+		
Time to First Appointment - Welsh Patients (26 Weeks)		62.66%				+		
% of Patients Waiting Over 52 Weeks - English	1.25%	1.27%				+		+
Patients Waiting Over 104 Weeks - Welsh (Total)		393				+		



# Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
6 Week Wait for Diagnostics - English Patients	95.00%	95.64%	95.20%					
8 Week Wait for Diagnostics - Welsh Patients	100.00%	97.64%				+	04/03/24	

1
2
3
4
5
6
7
8
9
10
11



# Summary - Caring for Finances

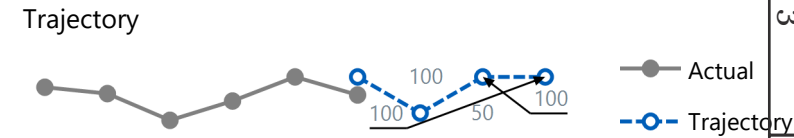
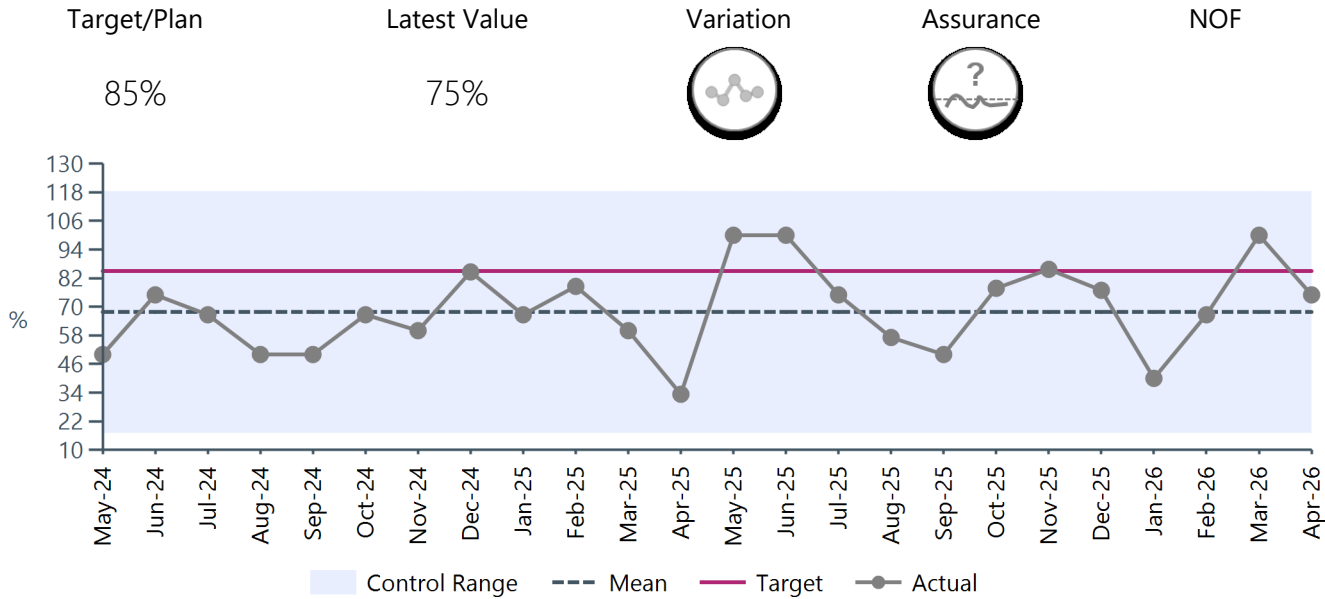
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
Elective Activity Against Plan (volumes)	1,145	1,173			+	24/06/21		
% Combined BADS Performance	85.00%	34.11%			+			
Total Outpatient Activity against Plan (volumes)	12,072	12,529			+	24/06/21		
Total Outpatient Activity - % Moved to PIFU Pathway	7.51%	8.19%			+			
Total Diagnostics Activity against Plan - Catchment Based	2,512	2,462			+			

1
2
3
4
5
6
7
8
9
10
11

# 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 75% in April; this is reported in arrears. There was one patient who breached the standard with reasons associated with multiple diagnostic tests that the patient chose to delay in order for them to take place at a location closer to home.

### Actions

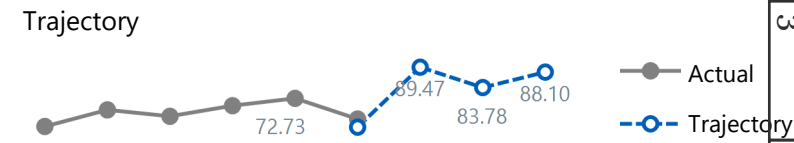
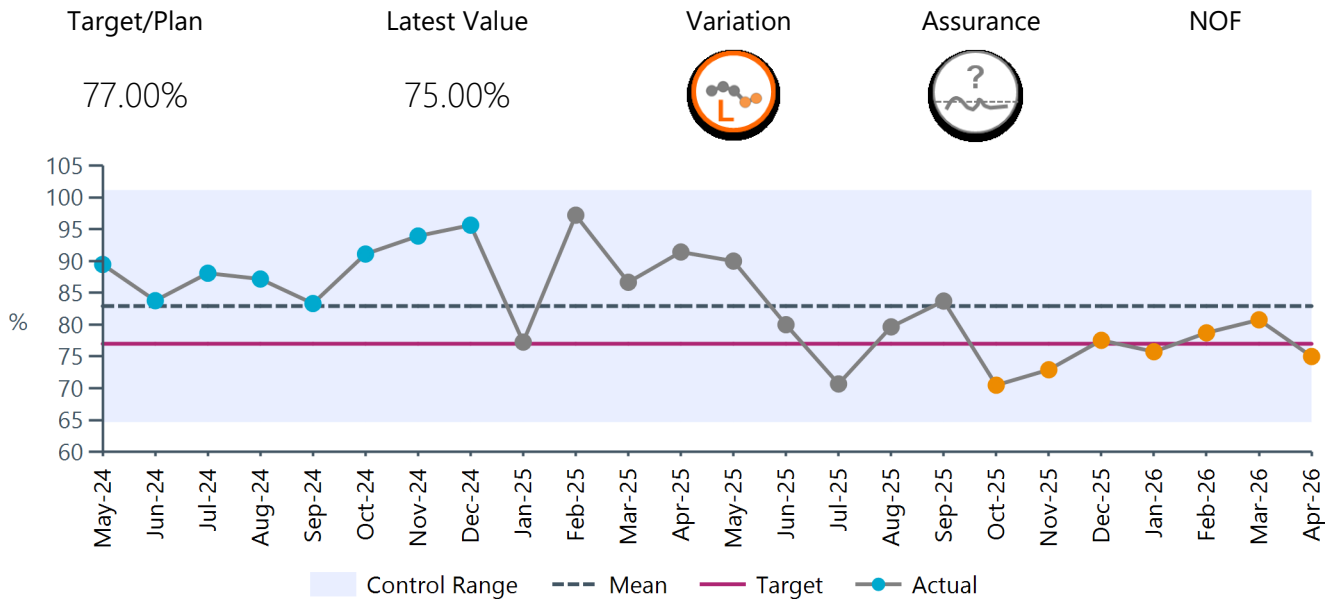
No applicable actions.

May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
100.00%	100.00%	75.00%	57.14%	50.00%	77.78%	85.71%	76.92%	40.00%	66.67%	100.00%	75.00%	
- Staff - Patients - Finances -												

# 28 Day Faster Diagnosis Standard\*

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

Exec Lead:  
 Chief Operating Officer



## What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. The assurance is indicating variable achievement (will achieve target some months and fail others).

## Narrative

The 28 Day Faster Diagnosis Standard is reported at 75% in April; this is reported in arrears. The breaches were associated with the following reasons:

- \* Patients requiring multiple diagnostics and biopsies
- \* Patients delaying initial appointments
- \* Patients received from other Trusts already on pathways

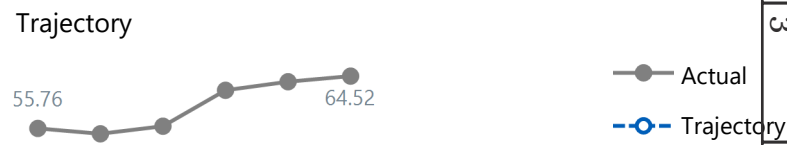
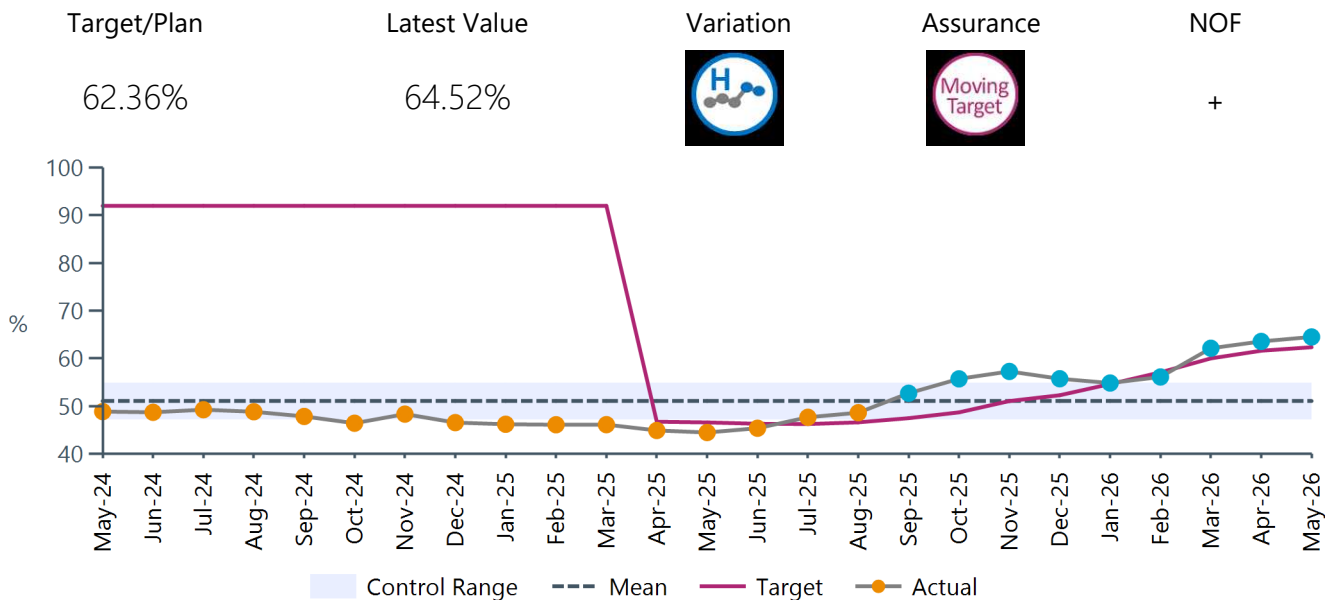
## Actions

May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
90.00%	80.00%	70.69%	79.66%	83.72%	70.49%	72.92%	77.55%	75.76%	78.72%	80.77%	75.00%	

- Staff - Patients - Finances -

# 18 Weeks RTT Open Pathways

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



### What these graphs are telling us

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

### Narrative

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

Our May performance was 64.52% for patients waiting 18 weeks or less to start their treatment. As shown on the SPC above, this metric remains reported as special cause of an improving nature and is the highest position reported by the Trust since May 2020. This metric is included in the NOF where the latest position for March scored the Trust at 3.19.

The performance breakdown by milestone is as follows:

- \* MS0 - 90 patients of which 7 are breaches
- \* MS1 - 7900 patients waiting of which 1675 are breaches
- \* MS2 - 1144 patients waiting of which 715 are breaches
- \* MS3 - 4501 patients waiting of which 2441 are breaches

### Actions

For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:

- \* Work towards internal ambitions where sub-speciality level targets have been set
- \* Improve clinical oversight and engagement
- \* Reducing 1st Outpatient Waits below 18/26 weeks
- \* Prioritisation of Welsh 104+ and English 52+ waits
- \* Exploring the inclusion of a Health Inequalities lens within the Trust's waiting list recovery
- \* Applying productivity improvements from recent reviews
- \* Head of Business Intelligence has remodelled our RTT data based on the latest available to provide an updated trajectory. Further work to look at the impact of improving time to Outpatient 1st Appointments and the potential deterioration this will have on 18 weeks % performance

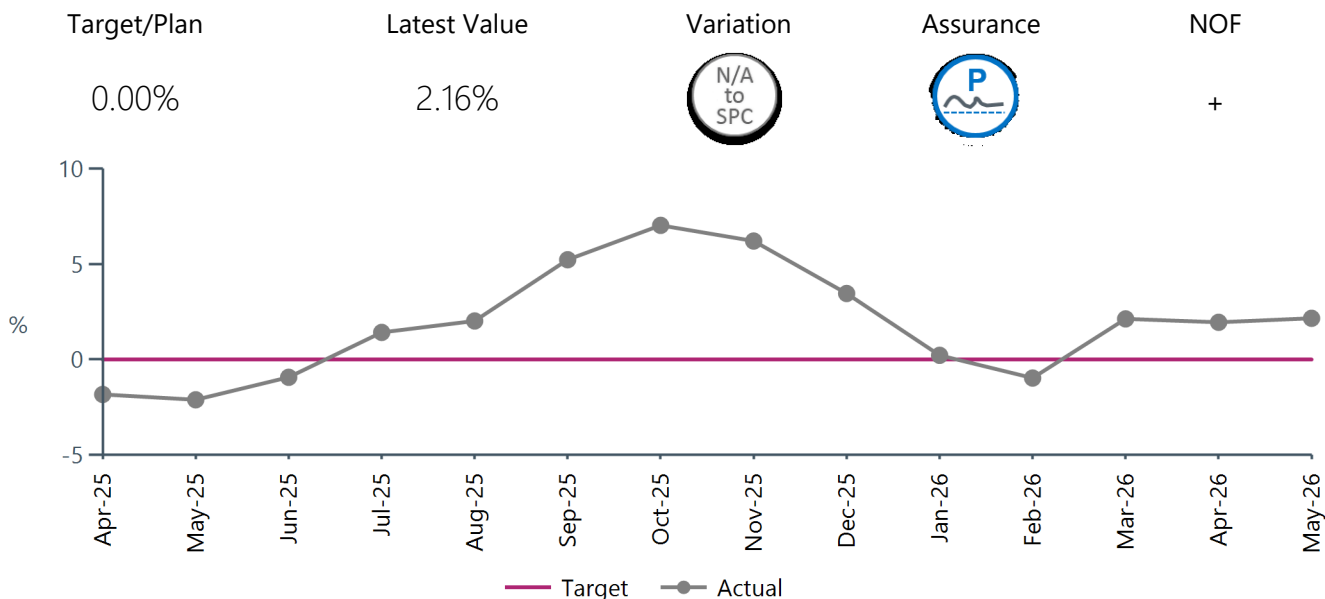
May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
44.49%	45.39%	47.68%	48.64%	52.72%	55.74%	57.29%	55.76%	54.86%	56.13%	62.15%	63.58%	64.52%

- Staff - Patients - Finances -

# 18 Week Performance - Difference Between Planned and Actual

Difference between planned and actual 18 week performance 217889

Exec Lead  
Chief Operating Officer



### What these graphs are telling us

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

### Narrative

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

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

At the end of May, the position reported for month end is 64.52%; above the plan of 62.36% by 2.16%.

### Actions

For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:

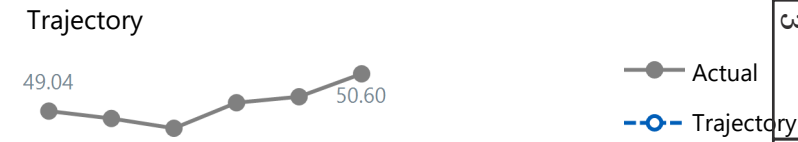
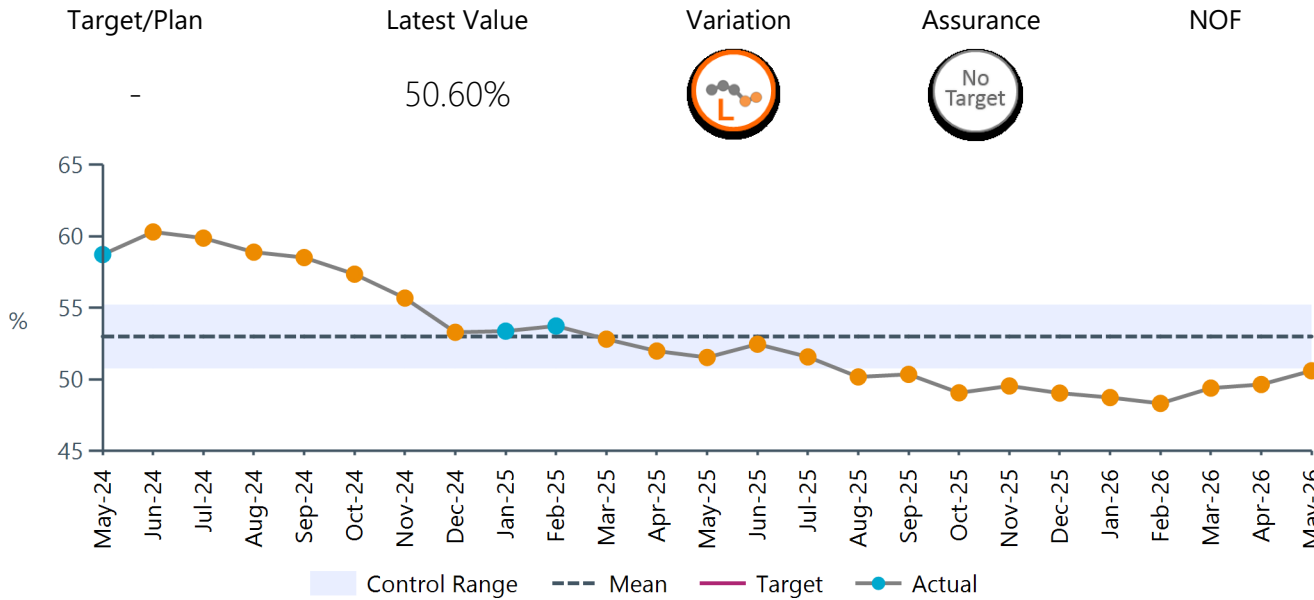
- \* Work towards internal ambitions where sub-speciality level targets have been set
- \* Improve clinical oversight and engagement
- \* Reducing 1st Outpatient Waits below 18/26 weeks
- \* Prioritisation of Welsh 104+ and English 52+ waits
- \* Exploring the inclusion of a Health Inequalities lens within the Trust's waiting list recovery
- \* Applying productivity improvements from recent reviews
- \* Head of Business Intelligence has remodelled our RTT data based on the latest available to provide an updated trajectory. Further work to look at the impact of improving time to Outpatient 1st Appointments and the potential deterioration this will have on 18 weeks % performance

May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
-2.11%	-0.93%	1.42%	2.02%	5.23%	7.03%	6.21%	3.46%	0.22%	-0.97%	2.13%	1.95%	2.16%

- Staff - Patients - Finances -

# 26 Weeks RTT Open Pathways

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



### What these graphs are telling us

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

### Narrative

Our May performance was 50.60% for Welsh patients waiting 26 weeks or less to start their treatment. As shown on the SPC above, this metric is reported as special cause variation of a concerning nature with the position reported below the control range from August-25 to date but there has been some steady improvement over recent months.

- The performance breakdown by milestone is as follows:
- \* MS0 - 3 patients of which 0 are breaches
  - \* MS1 - 6212 patients waiting of which 2337 are breaches
  - \* MS2 - 778 patients waiting of which 491 are breaches
  - \* MS3 - 2855 patients waiting of which 2037 are breaches

### Actions

- For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
- \* Work towards internal ambitions where sub-speciality level targets have been set
  - \* Improve clinical oversight and engagement
  - \* Reducing 1st Outpatient Waits below 18/26 weeks
  - \* Prioritisation of Welsh 104+ and English 52+ waits
  - \* Applying productivity improvements from recent reviews

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

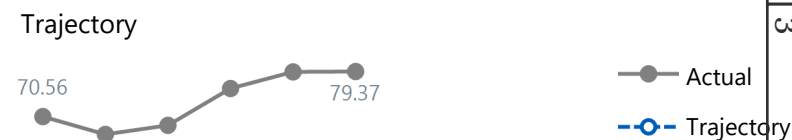
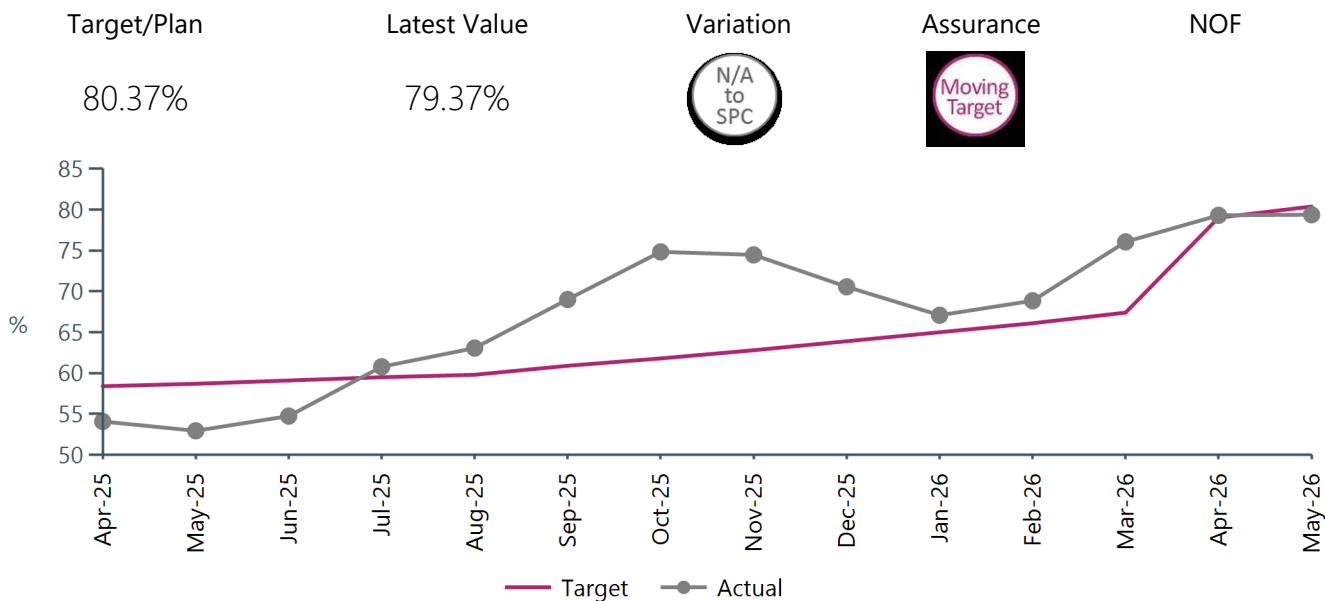
May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
51.53%	52.46%	51.57%	50.17%	50.35%	49.06%	49.54%	49.04%	48.73%	48.32%	49.39%	49.64%	50.60%

- Staff - Patients - Finances -

# Time to First Appointment - English Patients (18 Weeks)

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

Exec Lead  
Chief Operating Officer



### What these graphs are telling us

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

### Narrative

This metric focuses on the time to first appointment waiting for first event and of those patients, the % waiting less than 18 weeks. The reported position is taken from the Waiting List MDS position for week ending 31st May 2026. NHSE Guidance stipulates the week ending positions we should officially report that fall closest to month end. This is an unvalidated position.

For week ending 31st May 79.37% of patients waiting for first appointment were under 18 weeks; below the 80.37% plan. Performance ranges from 45.87% in Spinal Disorders to 100% in Elderly Medicine, Muscle, Physiotherapy and Occupational Therapy.

### Actions

- For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
  - \* Work towards internal ambitions where sub-speciality level targets have been set
  - \* Improve clinical oversight and engagement
  - \* Reducing 1st Outpatient Waits below 18/26 weeks
  - \* Prioritisation of Welsh 104+ and English 52+ waits
  - \* Exploring the inclusion of a Health Inequalities lens within the Trust's waiting list recovery
  - \* Applying productivity improvements from recent reviews

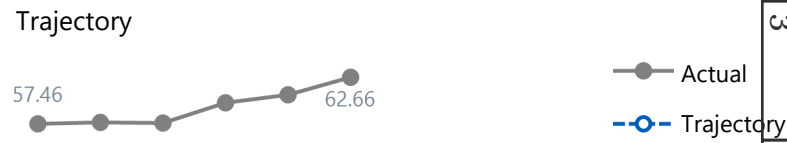
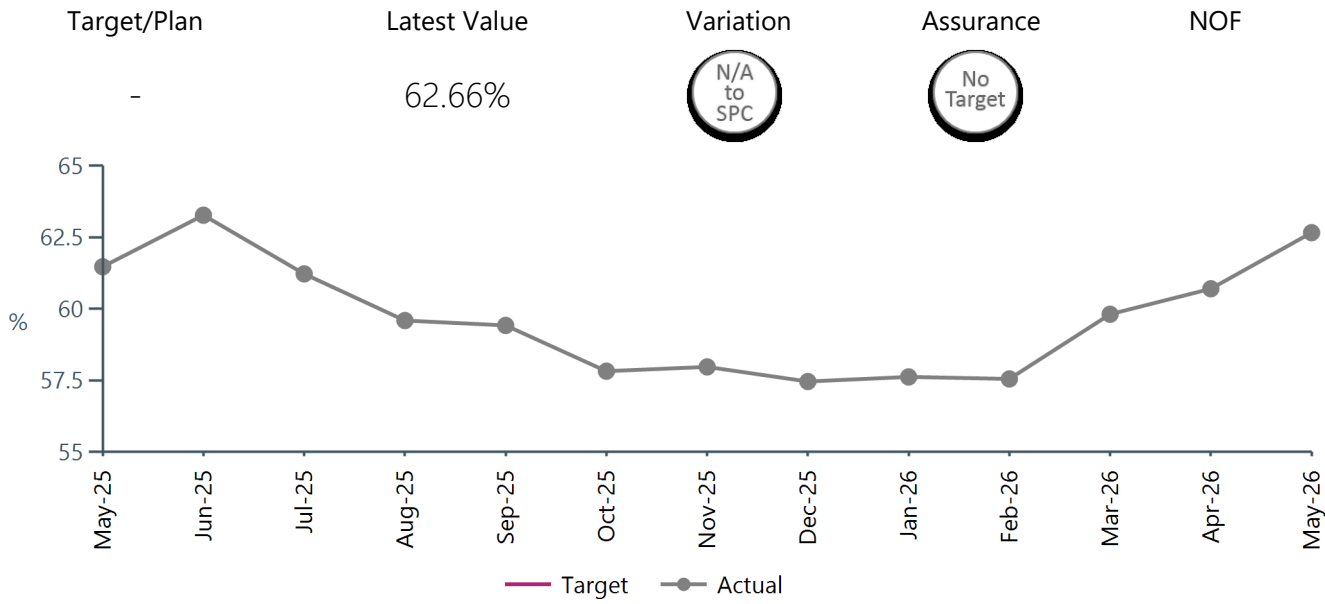
May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
52.95%	54.75%	60.78%	63.07%	69.01%	74.83%	74.46%	70.56%	67.08%	68.85%	76.05%	79.30%	79.37%

- Staff - Patients - Finances -

# Time to First Appointment - Welsh Patients (26 Weeks)

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

Exec Lead  
Chief Operating Officer



**What these graphs are telling us**  
This is not applicable to SPC until there are sufficient data points.

### Narrative

Following the annual review of the IPR this is a new metric that was added this month. Whilst the IPR throughout 25/26 did report on the patients waiting for their first appointment, it focused on this against 18 weeks as the English planning guidance for 25/26 had stipulated so as a Trust it was decided to also ensure there was oversight on this for Welsh patients. The NHS Wales Performance Framework for 2026/27 has now been published where it expects no patients to be waiting more than 26 weeks for a new outpatient appointment.

For week ending 31st May 62.66% of patients waiting for first appointment were under 26 weeks. Performance ranges from 35.63% in Spinal Disorders to 100% in Muscle, Occupational Therapy, Paediatric Medicine, Rheumatology and Tumour. There has been dedicated focus on patients waiting for DEXA where performance at this snapshot date was 82.85%.

### Actions

- For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
  - \* Work towards internal ambitions where sub-speciality level targets have been set
  - \* Improve clinical oversight and engagement
  - \* Reducing 1st Outpatient Waits below 18/26 weeks
  - \* Prioritisation of Welsh 104+ and English 52+ waits
  - \* Applying productivity improvements from recent reviews

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

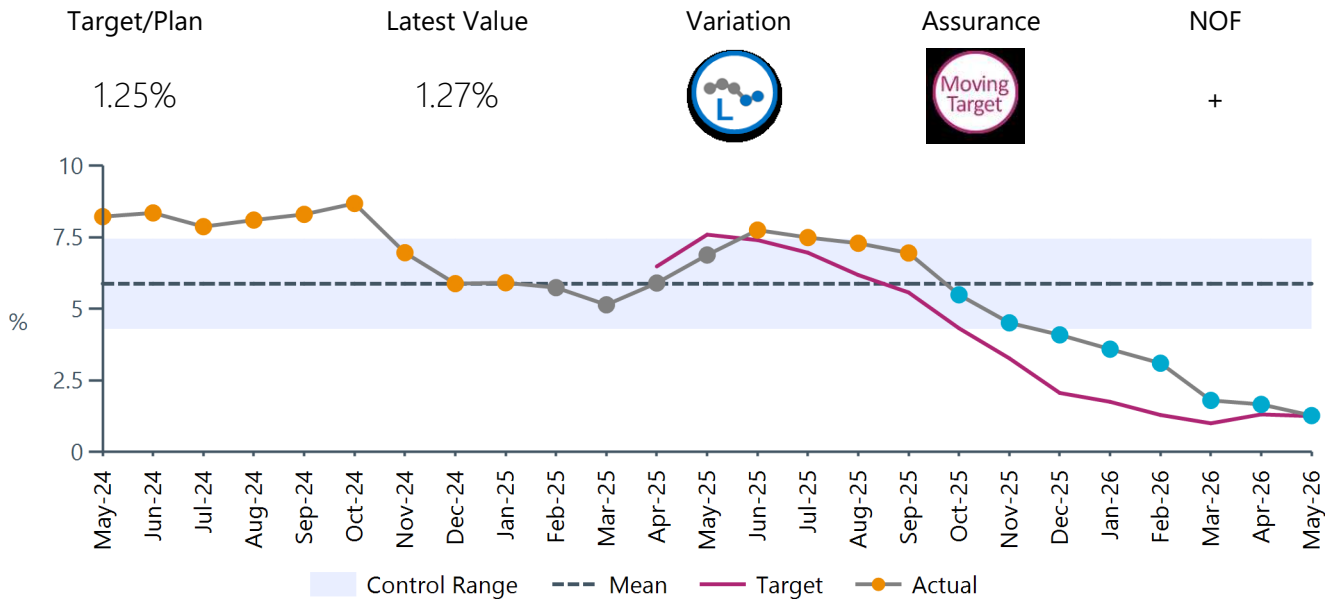
May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
61.47%	63.27%	61.22%	59.59%	59.42%	57.82%	57.97%	57.46%	57.62%	57.55%	59.81%	60.70%	62.66%

- Staff - Patients - Finances -

# % 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



### What these graphs are telling us

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

### Narrative

At the end of May, 173 patients were waiting over 52 weeks, this equates to 1.27% of the English list size. As shown on the SPC above, there has been a period of sustained improvement since August. In that same period, the actual position has followed the plan but the May position almost achieves plan at just 0.02% above.

- Patients waiting, by weeks brackets is:
- \* >52 to <=65 weeks - 154 patients
  - \* >65 to <=78 weeks - 14 patients
  - \* >78 weeks - 5 patients
  - \* No patients waiting greater than 104 weeks

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

### Actions

- For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:
- \* Work towards internal ambitions where sub-speciality level targets have been set
  - \* Improve clinical oversight and engagement
  - \* Reducing 1st Outpatient Waits below 18/26 weeks
  - \* Prioritisation of Welsh 104+ and English 52+ waits
  - \* Exploring the inclusion of a Health Inequalities lens within the Trust's waiting list recovery
  - \* Applying productivity improvements from recent reviews

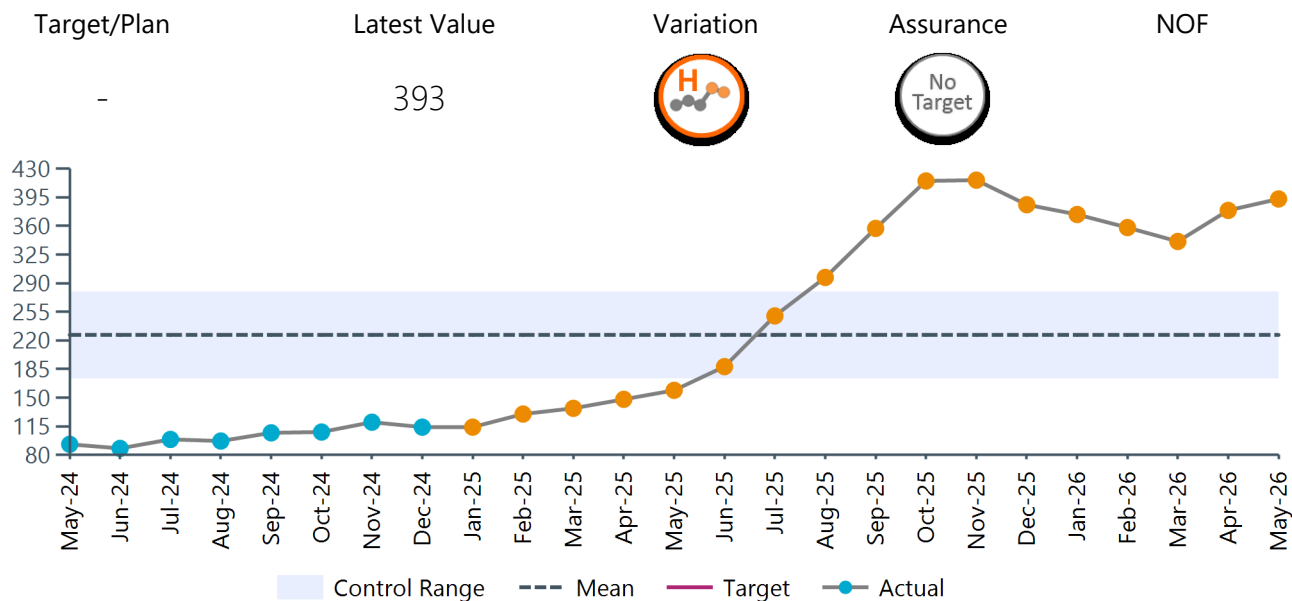
May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
6.88%	7.75%	7.49%	7.29%	6.95%	5.49%	4.51%	4.09%	3.59%	3.10%	1.80%	1.66%	1.27%

- Staff - Patients - Finances -

# 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

At the end of May there were 393 Welsh patients waiting over 104 weeks. The patients are under the care of these sub-specialities; Spinal Disorders (203), Foot & Ankle (58), Knee & Sports Injuries (55), Arthroplasty (43), Hand & Upper Limb (28), Paediatric Orthopaedics (3), Veterans (2) and Metabolic Medicine (1).

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

## Actions

For the 2026/27 financial year, plans have been revised and submitted to NHSE. The focuses for this year include:

- \* Work towards internal ambitions where sub-speciality level targets have been set
- \* Improve clinical oversight and engagement
- \* Reducing 1st Outpatient Waits below 18/26 weeks
- \* Prioritisation of Welsh 104+ and English 52+ waits
- \* Applying productivity improvements from recent reviews

Specifically for our Welsh patients:

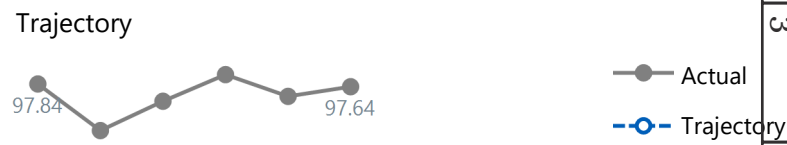
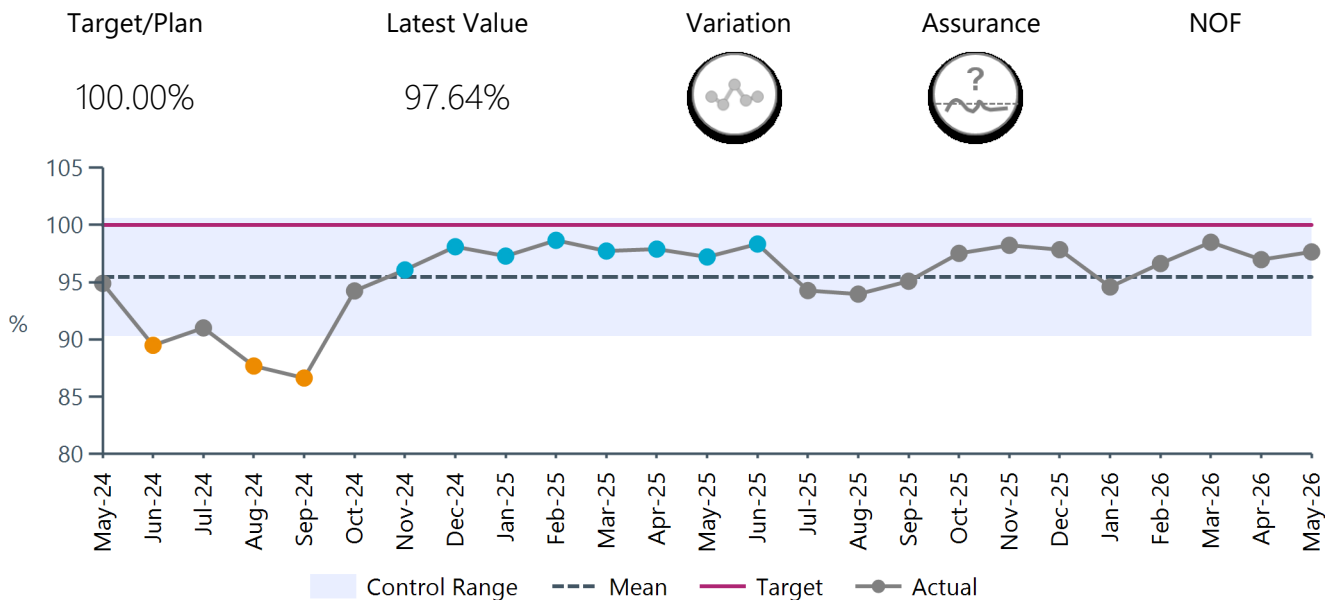
- \* Dedicated focus on patients waiting for DEXA following an improved position for English patients
- \* Increased oversight of Welsh RTT performance through Senior Operational Delivery Group
- \* Health Inequalities Working Group will be monitoring the rate of improvement for Welsh patients, alongside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

May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
159	188	250	297	357	415	416	386	374	358	341	379	393

- Staff - Patients - Finances -

# 8 Week Wait for Diagnostics - Welsh Patients

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



## What these graphs are telling us

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

## Narrative

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

The 8-week standard for diagnostics is reported at 97.647%. The reporting position includes 11 patients who waited beyond 8 weeks.

Performance and breaches by modality:

\* MRI – 97.04% - D2 (Urgent - 0-2 weeks) – 2 dated, D4 (Routine - 6-12 weeks) – 9 with 8 dated

\* CT – 100%

\* Ultrasound – 100%

\* DEXA Scans - 100%

CT activity plan was met in May.

## Actions

Across our commissioners, there were 60 breaches in total (49 English, 11 Welsh). 58% of these breaches were linked to two key themes:

\* Midlands Centre for Spinal Injuries (MCSI) patient transfers (12 breaches) — Radiology is working with the interim Chief Nurse to pilot a dedicated transfer area to better accommodate MCSI patients. Staff are also receiving targeted training on complex patient transfers to reduce the risk of future breaches.

\* Booking delays (22 breaches) — Newly recruited staff within the booking team are now in post and undergoing initial training to improve booking turnaround times and minimise delays.

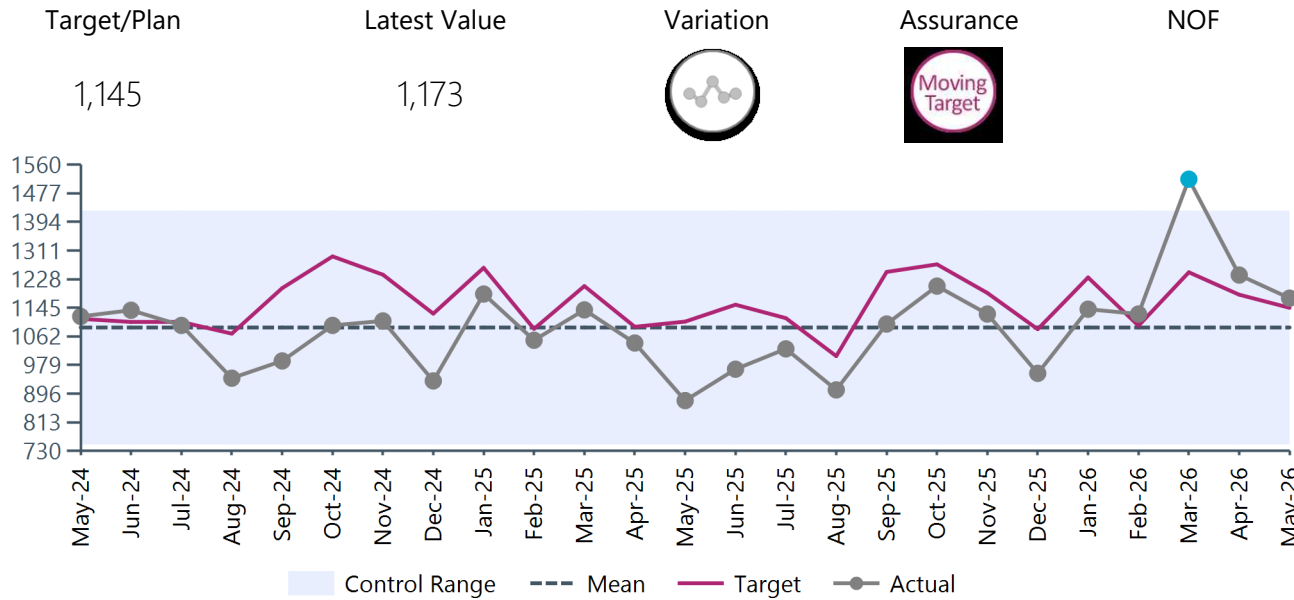
\* The Radiology Service is working with the Information Team to set up routine forecasting information for Imaging Services.

May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
97.20%	98.33%	94.27%	93.96%	95.09%	97.52%	98.22%	97.84%	94.58%	96.63%	98.49%	96.97%	97.64%

- Staff - Patients - Finances -

# Elective Activity Against Plan (volumes)

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



## Trajectory



## What these graphs are telling us

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

## Narrative

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

In May, the Trust planned for 1,145 elective spells and delivered 1173 spells, achieving 102.45% of plan and delivering 28 spells above target.

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

## Actions

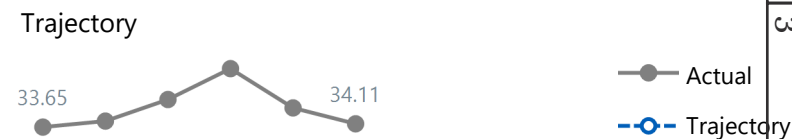
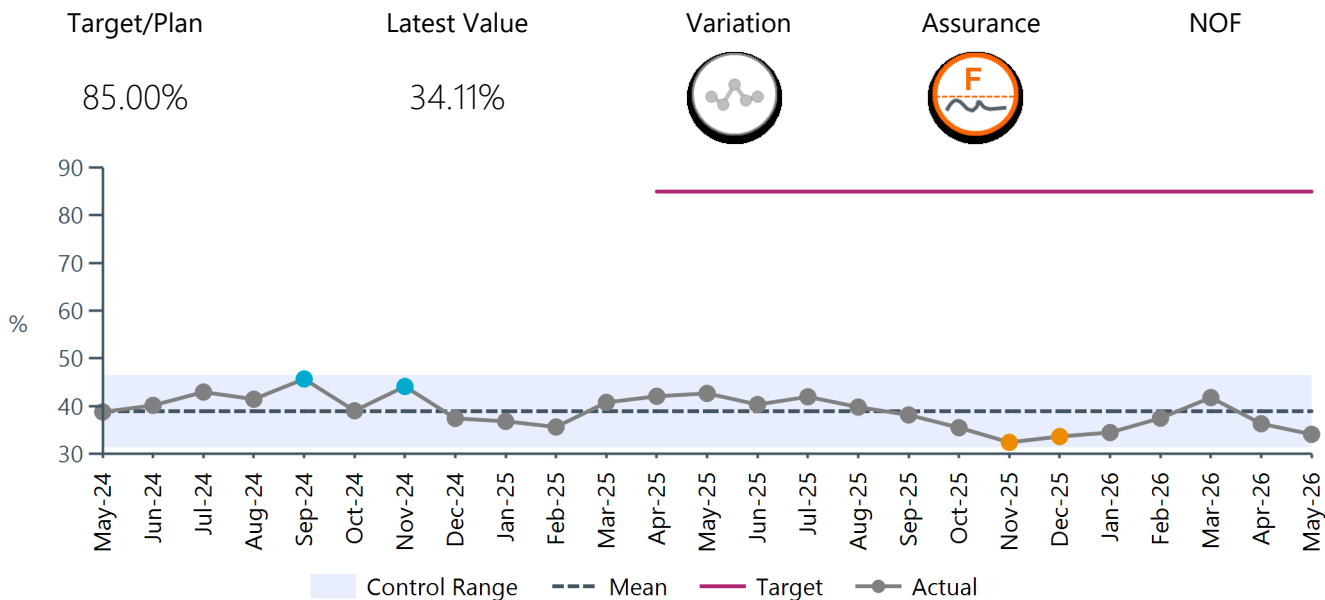
May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
876	967	1026	907	1098	1208	1127	955	1141	1127	1518	1240	1173

- Staff - Patients - Finances -

# % Combined BADS Performance

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

Exec Lead  
Chief Operating Officer



## What these graphs are telling us

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

## Narrative

The metric measures the percentage of Combined BADS Performance, aligned with the Orthopaedic and Urology sections of the BADS Directory of Procedures (January 2026 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 34.11%. If patients discharged on day zero—regardless of their intended management—were included, the metric would have reached 49.51%.

BADS Improvement Project is paused due to wider Trust initiatives, some of which may have a positive impact on the identified BADS issues.

May's performance is below the mean and remains within statistical control limits, consistent with common-cause variation. This metric relies on having a fully coded position for the reporting month and may therefore be subject to further changes.

## Actions

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

The Trust is aiming for continuous improvements with Clinically led monthly day case surgery meeting. Data quality issues have been identified with Clinical audits and further investigations being undertaken:

- \* Focus on correct booking of high-volume BADS procedures e.g. carpal tunnels.
- \* Explore use of default day case coding for lower limb arthroplasty under enhanced recovery programme.
- \* 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.

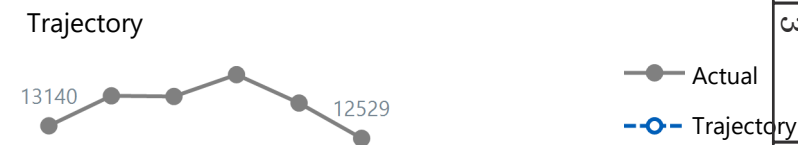
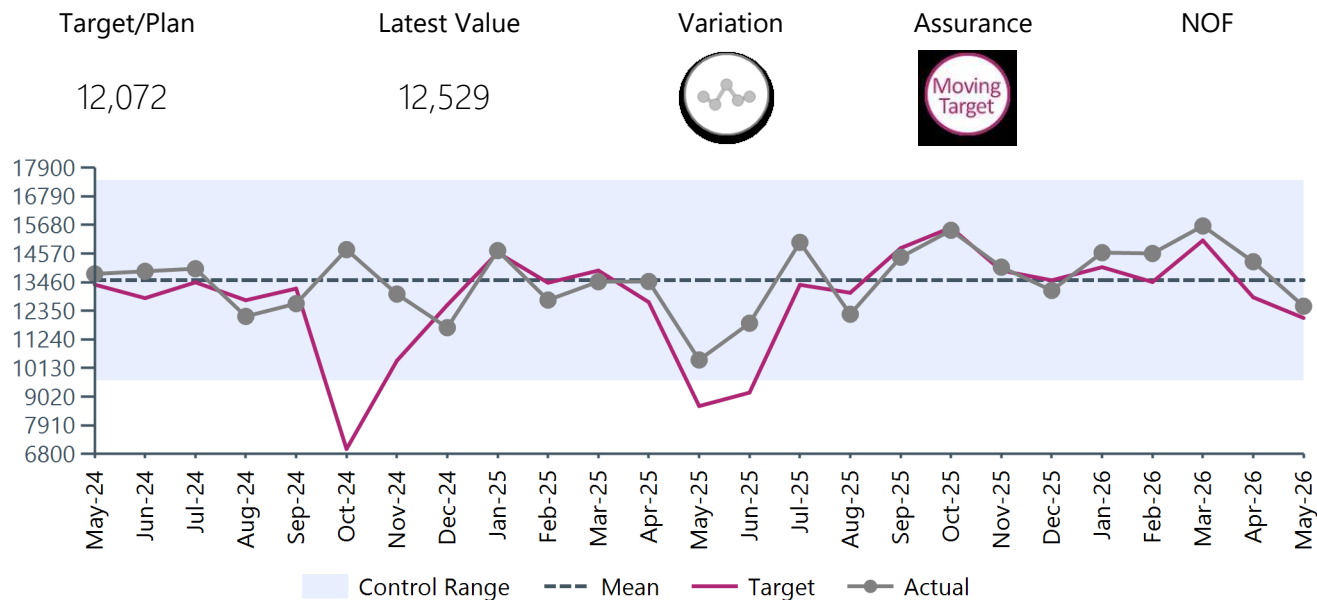
May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
42.69%	40.35%	41.98%	39.82%	38.17%	35.51%	32.43%	33.65%	34.49%	37.50%	41.81%	36.33%	34.11%

- 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



**What these graphs are telling us**  
 Metric is experiencing common cause variation. Metric has a moving target; in line with the Trust's Operational Plan.

## Narrative

The Outpatient Activity plan was met in May with +457 attendances over plan and the position reported at 103.79%. It must also be noted, at the point of IPR production and when this data was extracted on 5th working day, there still remained outcomes to be processed on Careflow so this position will continue to increase as they are transacted.

A breakdown of Outpatient activity below:

- \* IJP activity was +37 at 100.32%, \* OJP activity was +175 at 160.34%, \* Insourcing activity was +165 at 265.00% \* 80 appointments were delivered via Outsourcing that had no plan
- \* New activity 99.62%, \* Follow Up activity 105.44%

## Actions

- Some areas fell behind plan in May with reasons outlined below:
- \* Paediatric Medicine - new paediatrician has commenced but referral management centre was not aware so flow of referrals was not coming through to the Trust. Operational Lead has address this and referrals are now being received.
- \* Spinal Disorders - 3 new AHP roles were part of planning assumptions from April but there have been delays in recruitment process. Lost activity in this area due to consultant sickness also.
- \* Physiotherapy - this area continues to see high levels of DNAs and late cancellations. Lost activity in gym and hydro classes due to hot weather.

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

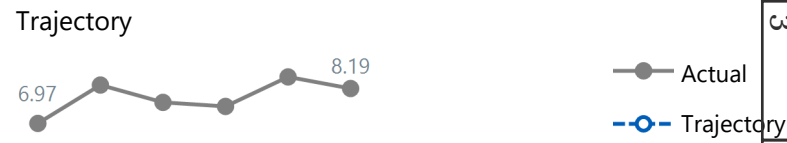
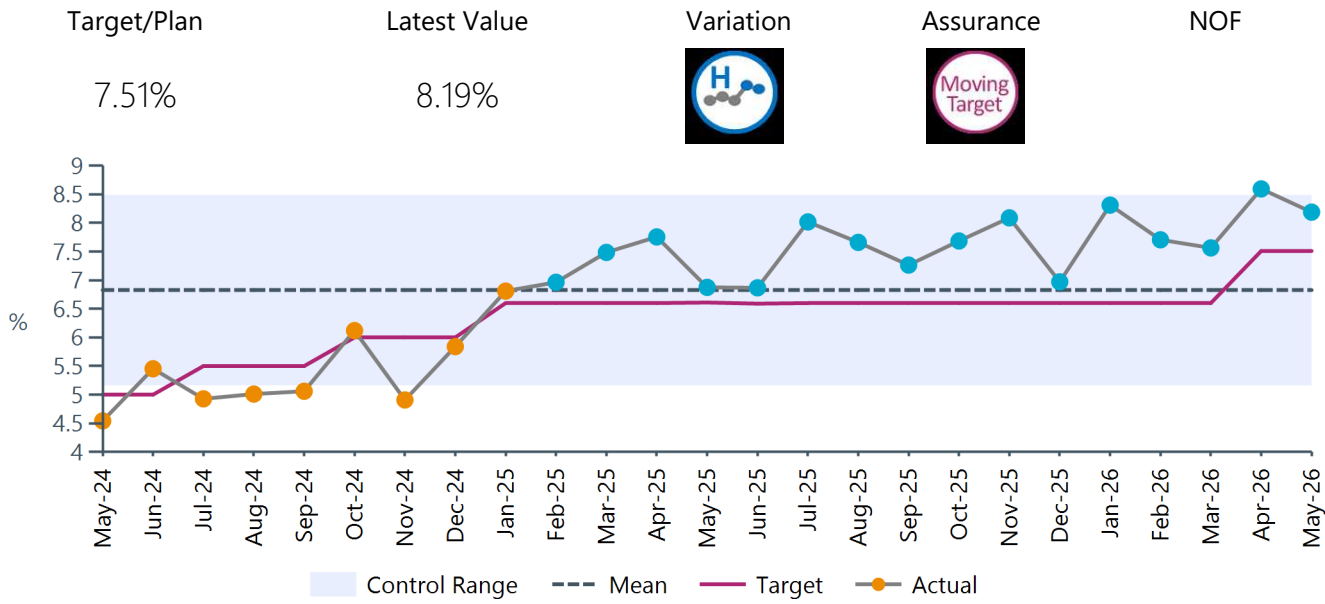
May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
10444	11869	15004	12218	14427	15472	14044	13140	14606	14574	15640	14253	12529

- Staff - Patients - Finances -

# 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 7.51% of all outpatients attendances. In May this was exceeded with 8.19% of total outpatient activity moved to a PIFU pathway. As demonstrated on the SPC above, this has now been reported as sustained improvement since January-25.

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

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

### Actions

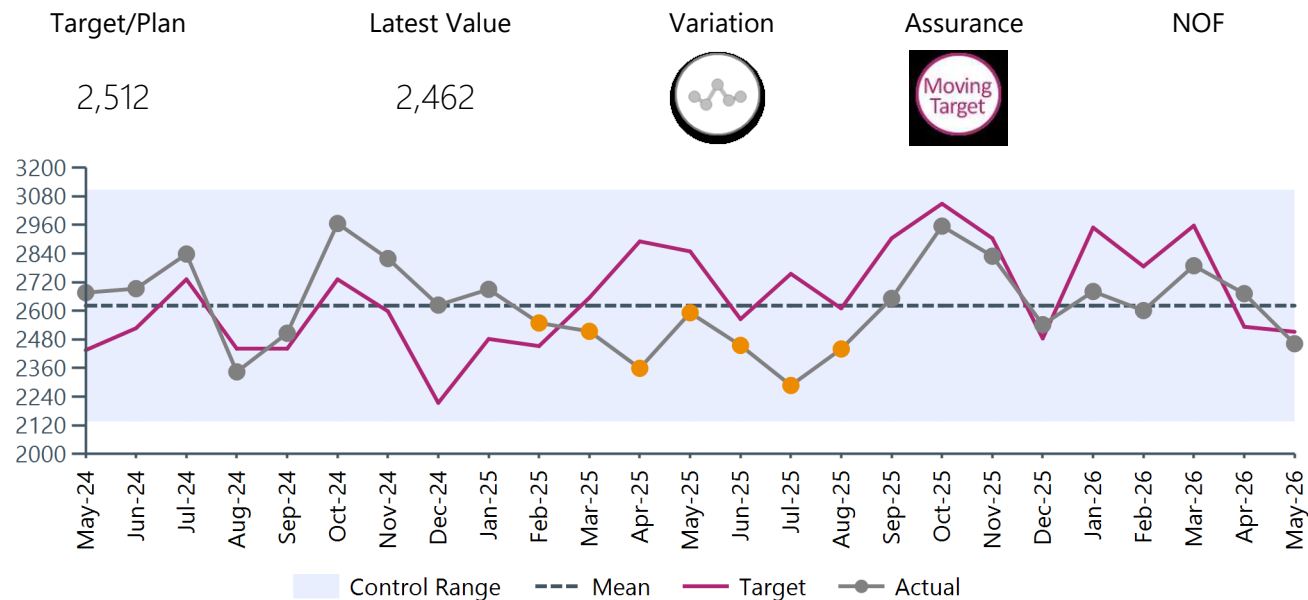
May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
6.87%	6.87%	8.02%	7.66%	7.26%	7.68%	8.09%	6.97%	8.31%	7.71%	7.56%	8.59%	8.19%

- 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. Metric has a moving target; in line with the Trust's Operational Plan.

## Narrative

The Diagnostic activity plan was not in May. Overall activity is reported at 98.01% with a breakdown as follows:  
 \* U/S - 802 against 817; equating to 98.16%  
 \* MRI - 1303 against plan of 1368; equating to 95.25%  
 \* CT - 357 against plan of 327; equating to 109.17%

## Actions

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

May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
2592	2455	2287	2440	2652	2955	2829	2542	2681	2601	2789	2672	2462

- Staff - Patients - Finances -

1
2
3
4
5
6
7
8
9
10
11



The Robert Jones and Agnes Hunt  
Orthopaedic Hospital  
NHS Foundation Trust

# M2 Financial Position Update

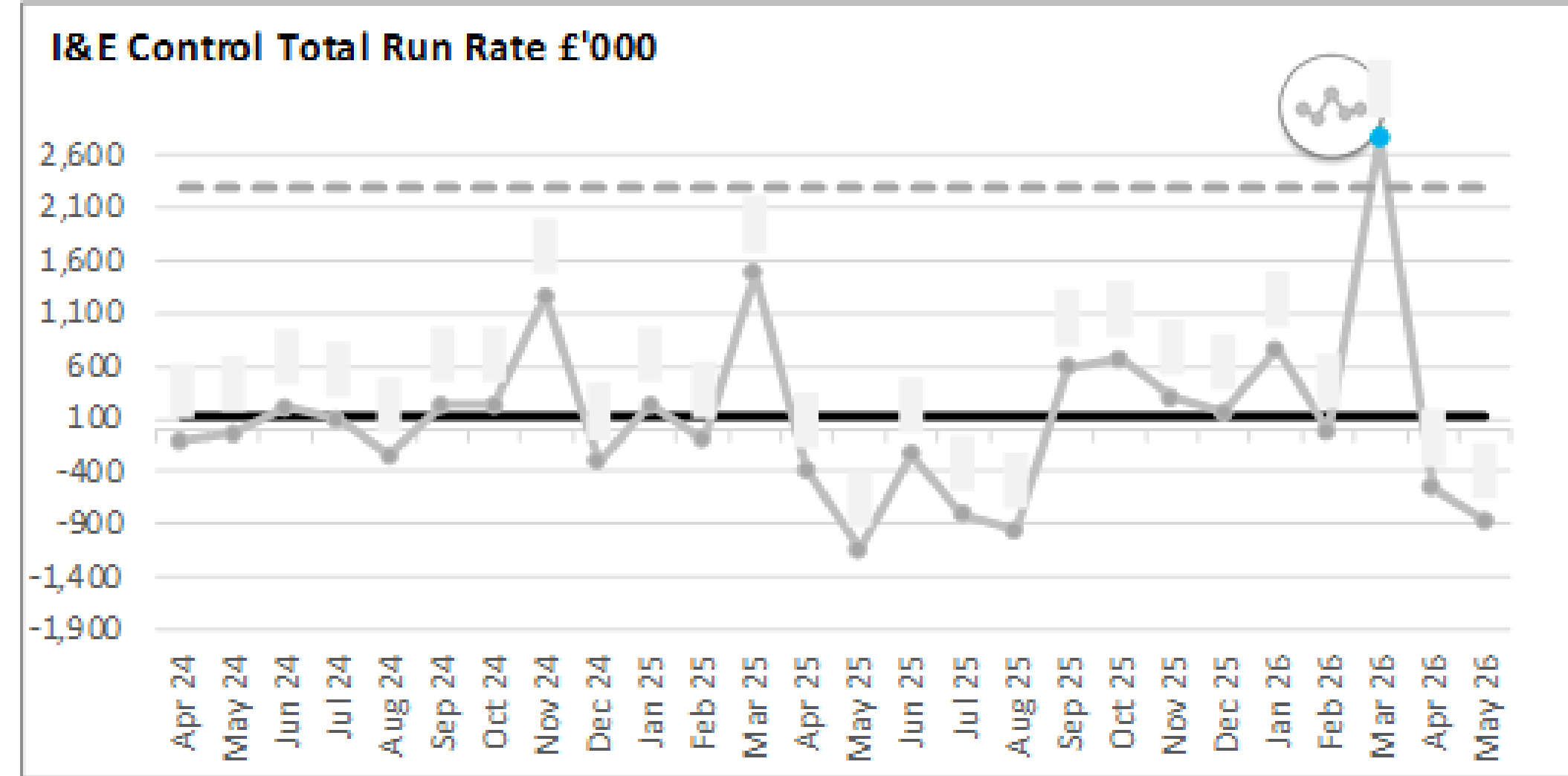
→ *Improving lives through excellent and innovative care*



1
2
3
4
5
6
7
8
9
10
11

# Income & Expenditure Position May 2026

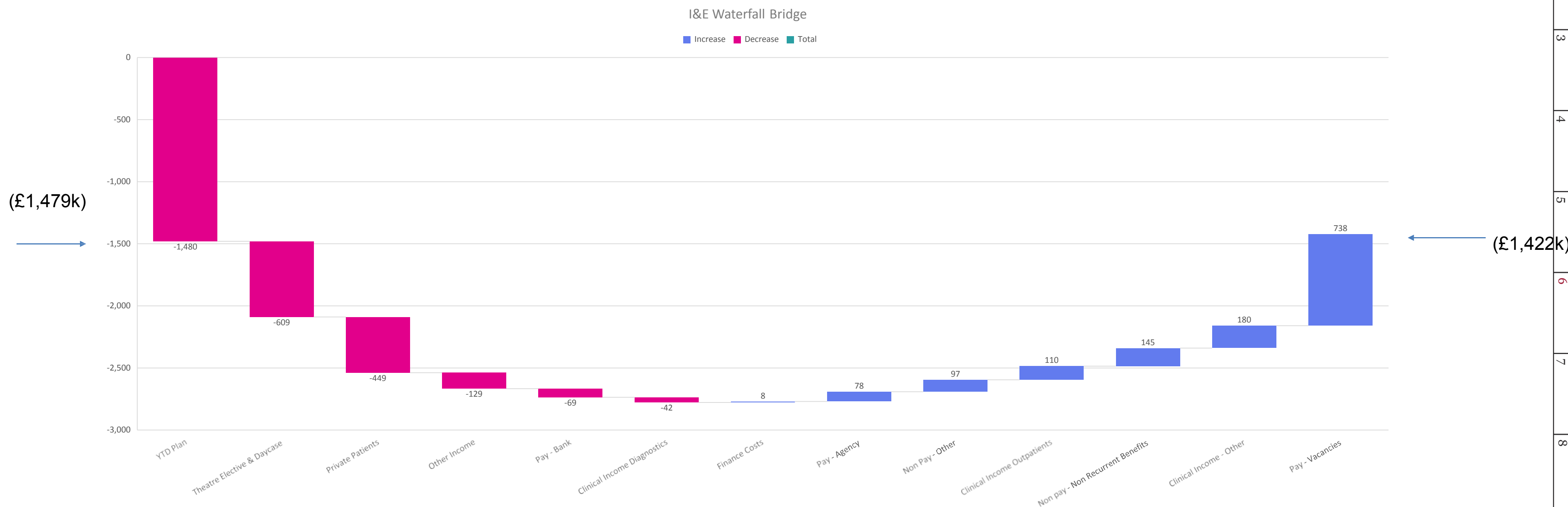
	Annual Plan	In Month Position			YTD Position		
		Pass through adj Plan	Actual	Variance	Pass through adj Plan	Actual	Variance
Clinical Income	168,015	12,729	12,452	(277)	25,742	25,204	(538)
Private Patient income	12,343	1,041	877	(164)	2,144	1,618	(526)
Other income	7,753	663	581	(82)	1,326	1,197	(129)
Pay	(116,804)	(9,707)	(9,323)	384	(19,441)	(18,694)	747
Non-pay	(62,267)	(4,871)	(4,725)	146	(9,759)	(9,263)	496
<b>EBITDA</b>	<b>9,040</b>	<b>(145)</b>	<b>(138)</b>	<b>7</b>	<b>12</b>	<b>62</b>	<b>50</b>
Finance Costs	(9,904)	(817)	(799)	18	(1,634)	(1,626)	8
Capital Donations	3,350	388	134	(254)	768	134	(634)
<b>Operational Surplus</b>	<b>2,486</b>	<b>(574)</b>	<b>(803)</b>	<b>(229)</b>	<b>(854)</b>	<b>(1,430)</b>	<b>(576)</b>
Remove Capital Donations	(3,350)	(388)	(134)	254	(768)	(134)	634
Add Back Donated Dep'n	809	69	70	1	143	142	(1)
<b>Control Total</b>	<b>(56)</b>	<b>(893)</b>	<b>(867)</b>	<b>25</b>	<b>(1,479)</b>	<b>(1,422)</b>	<b>57</b>



## In month: £0.87m deficit, £0.03m favourable to plan

- **NHS Clinical Income £0.28m adverse** - driven by £0.1m adverse theatres internal delivery (11 cases adverse to plan), £0.2m adverse theatre insourcing (39 cases adverse to plan); partially offset by £0.1m favourable theatre outsourcing and non-theatre delivery.
- **Non-NHS income £0.24m adverse** – driven by £0.16m adverse private patient income, half of which results from volume (12 patients adverse to plan) and the other half case mix. There is an adverse variance of £0.08m on other income (TSSU efficiency slippage, estates and research, offset in cost reductions)
- **Pay expenditure £0.38m favourable** – driven by £0.22m favourable workforce recruitment slippage, £0.1m favourable enhanced controls (vacancy and temporary staffing) and £0.03m favourable agency partially offset by £0.02m adverse bank ( Inpatient & Outpatient OJP, Anaesthetic OJP, AHP)
- **Non-Pay £0.17m favourable** - driven by £0.1m favourable insourcing below plan

# Bridge: YTD plan £1,479k deficit versus actual £1,422k deficit



The bridge shows the key drives of the variances to plan YTD in delivery of the £1,422k deficit

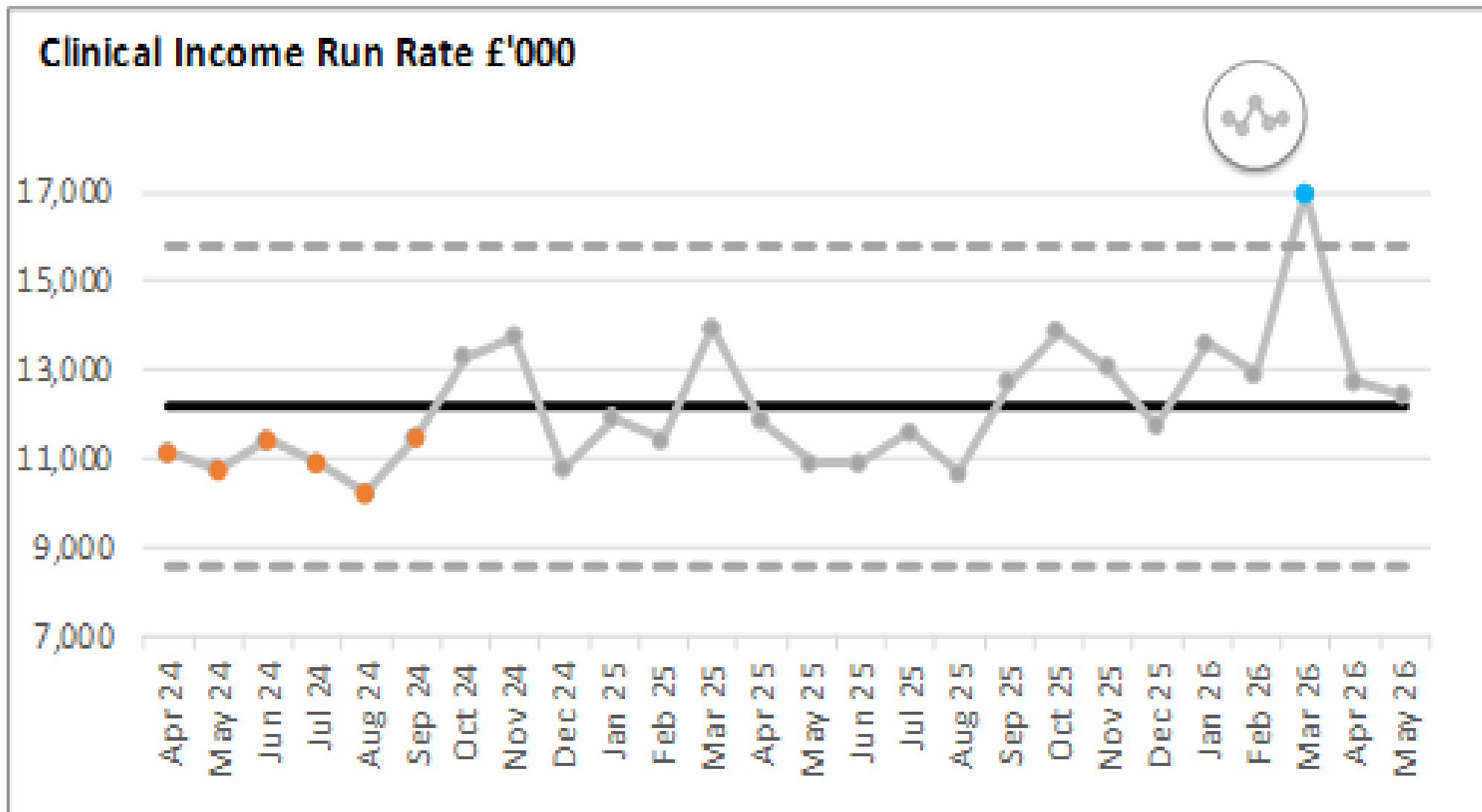
Adverse income performance linked to lower than planned elective theatre activity and private patients is offset by improved outpatient performance (partially offset in cost) along with lower than planned pay due to vacancies & enhanced controls and non-pay expenditure (marginal costs and non-recurrent).

Non recurrent items include in year mitigations - purchase order closure review and VAT rebate

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

# Clinical Income Run Rate

Summary Income Position		2026-27 Month 2 YTD						
		Plan Activity	Actual Activity	Difference	Actual Income £m	Fixed Adjustment £m	Variance Income £m	
				Activity				Plan income £m
<b>Variable Contract Income</b>								
Elective Day case	Theatres	809	633	(176)	2.38	1.90	0.01	(0.46)
Elective Inpatient	Theatres	1,039	965	(74)	7.72	7.55	(0.09)	(0.26)
Elective Inpatient & Day case	Non Theatres	463	823	360	0.37	0.55	(0.01)	0.18
Outpatient First Attendance		7,695	7,402	(293)	1.89	1.84	(0.01)	(0.06)
Outpatient Procedures		1,301	1,667	366	0.38	0.55	(0.00)	0.16
Diagnostics		7,012	7,076	64	0.72	0.68	0.00	(0.04)
High Cost Drugs/Devices					1.69	1.38	0.18	(0.13)
Other Allocations					0.86	0.63	0.00	(0.23)
<b>Total Variable Contract Income</b>		<b>18,319</b>	<b>18,566</b>	<b>247</b>	<b>16.02</b>	<b>15.08</b>	<b>0.09</b>	<b>(0.85)</b>
<b>Fixed Contract Income</b>								
Non Elective Inpatients		95	131	36	0.76	1.32	(0.56)	(0.00)
Regular Day case		336	249	(87)	0.31	0.23	0.08	0.00
Critical Care					0.36	0.19	0.17	0.00
Outpatient Follow Ups		16,665	18,085	1,420	1.77	2.05	(0.29)	(0.00)
Other Fixed Income					6.84	5.46	1.38	0.00
<b>Total Fixed Contract Income</b>		<b>17,096</b>	<b>18,465</b>	<b>1,369</b>	<b>10.04</b>	<b>9.25</b>	<b>0.79</b>	<b>(0.00)</b>
<b>Total Clinical Income from Contracts</b>		<b>35,415</b>	<b>37,031</b>	<b>1,616</b>	<b>26.05</b>	<b>24.33</b>	<b>0.88</b>	<b>(0.85)</b>



## Clinical Income by Point of Delivery (POD)

Clinical income is £0.85m adverse to plan YTD

- Elective inpatient and day case theatre performance is £0.72m adverse to plan driven by adverse theatre activity delivery.
- Other elective inpatient and day case performance is £0.18m favourable to plan driven by overperformance against metabolic medicine & rheumatology day cases.
- Outpatient first attendances and procedures performance is £0.1m favourable to plan driven by outpatient procedure volumes above plan.
- Diagnostics assessments are £0.04m adverse to plan due to lower than planned unbundledscans.
- Other Allocations Actual performance includes £44k of RTT sprint funding and £28k of Prioryear income

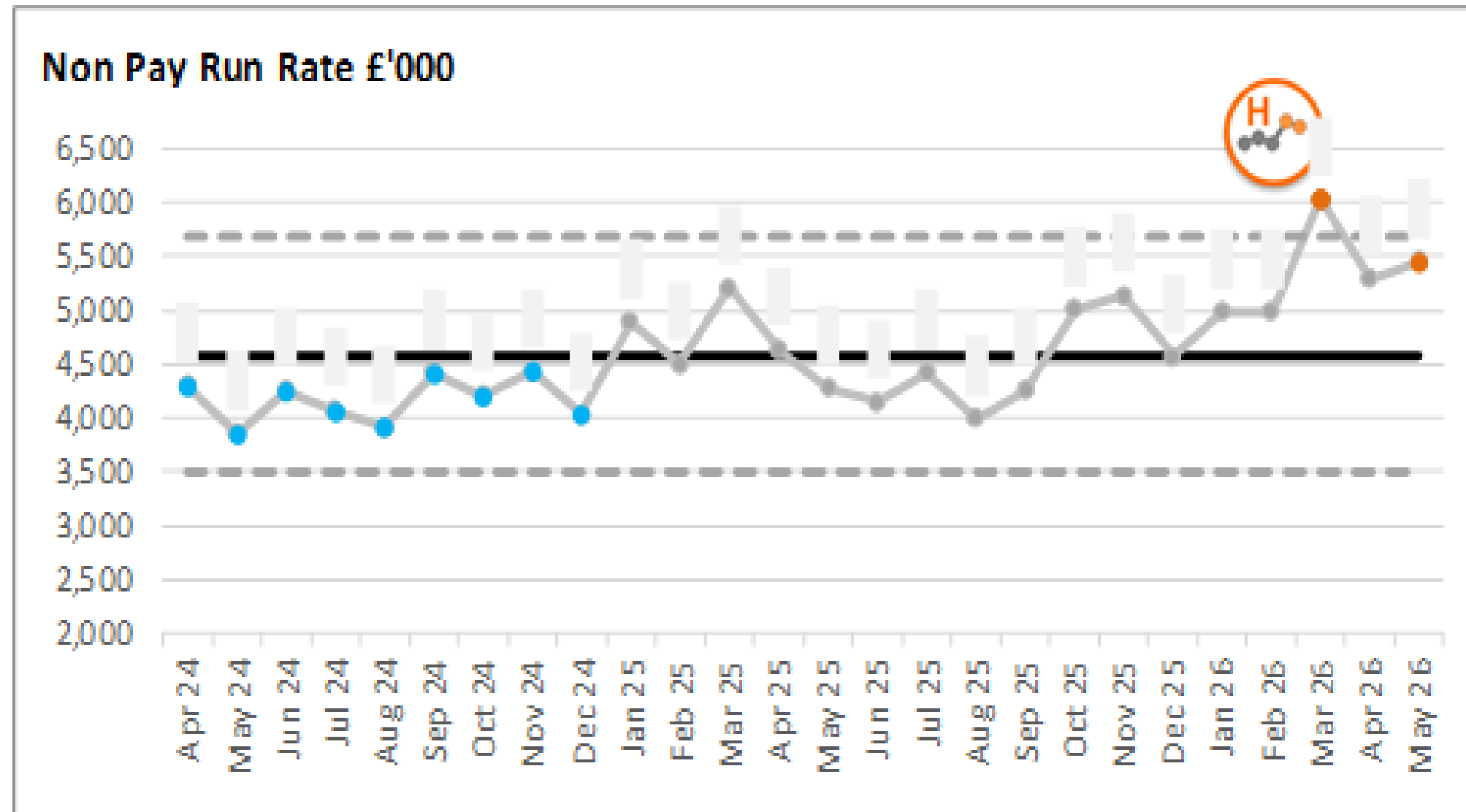
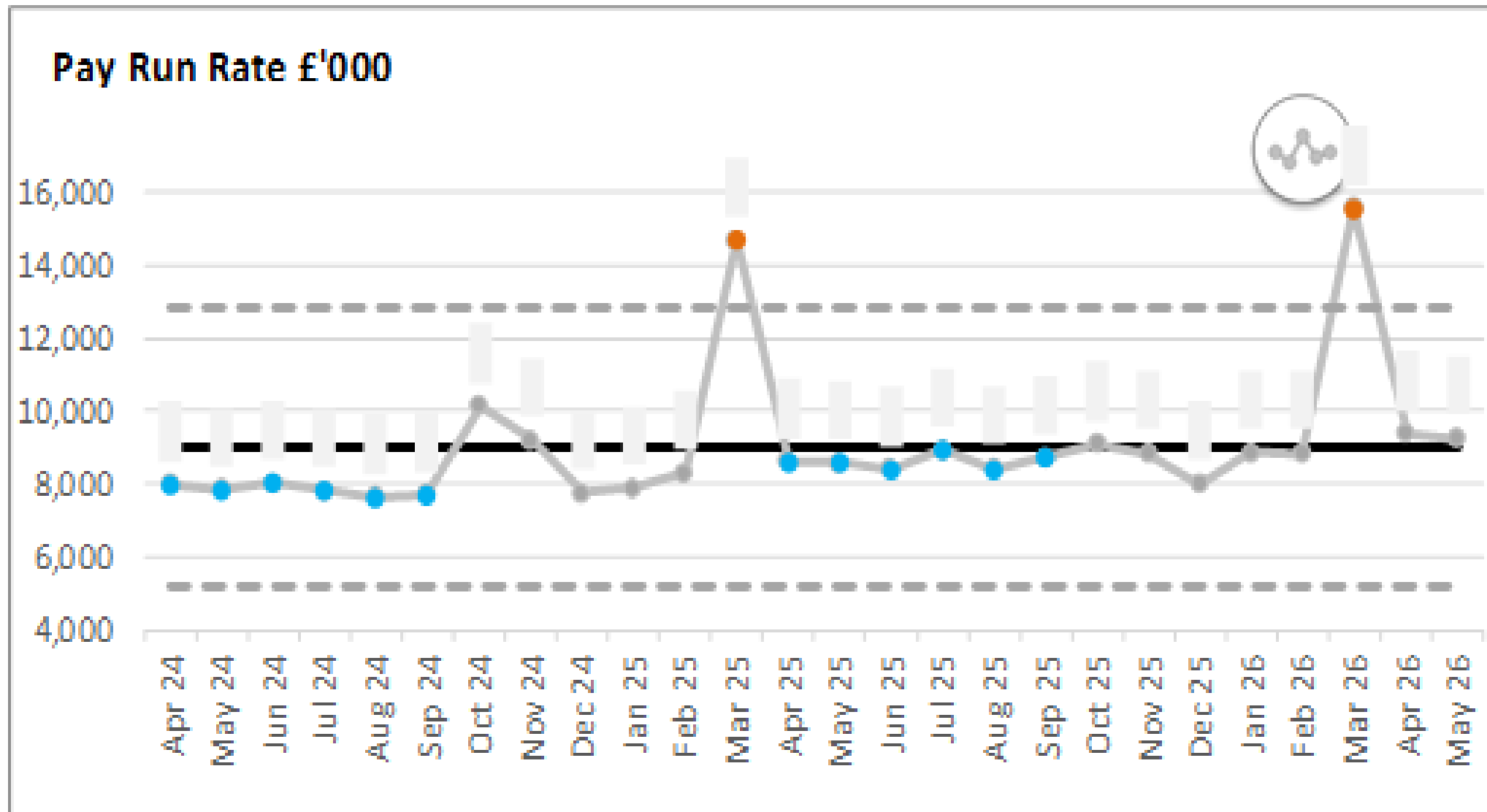
## Clinical Income Run Rate

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

The 24/25 assigned cause variation is linked to the cessation of insourcing capacity through the Oswestry Orthopaedic LLP contract.

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

# Expenditure Run Rate



## Pay Run Rate

The favourable spike in M9 is due to restatement of pay provision, the spike in M12 of both years relates to the central pension contribution for the Trust accounts.

Enhanced pay controls are in place :

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

## Non-Pay Run Rate

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

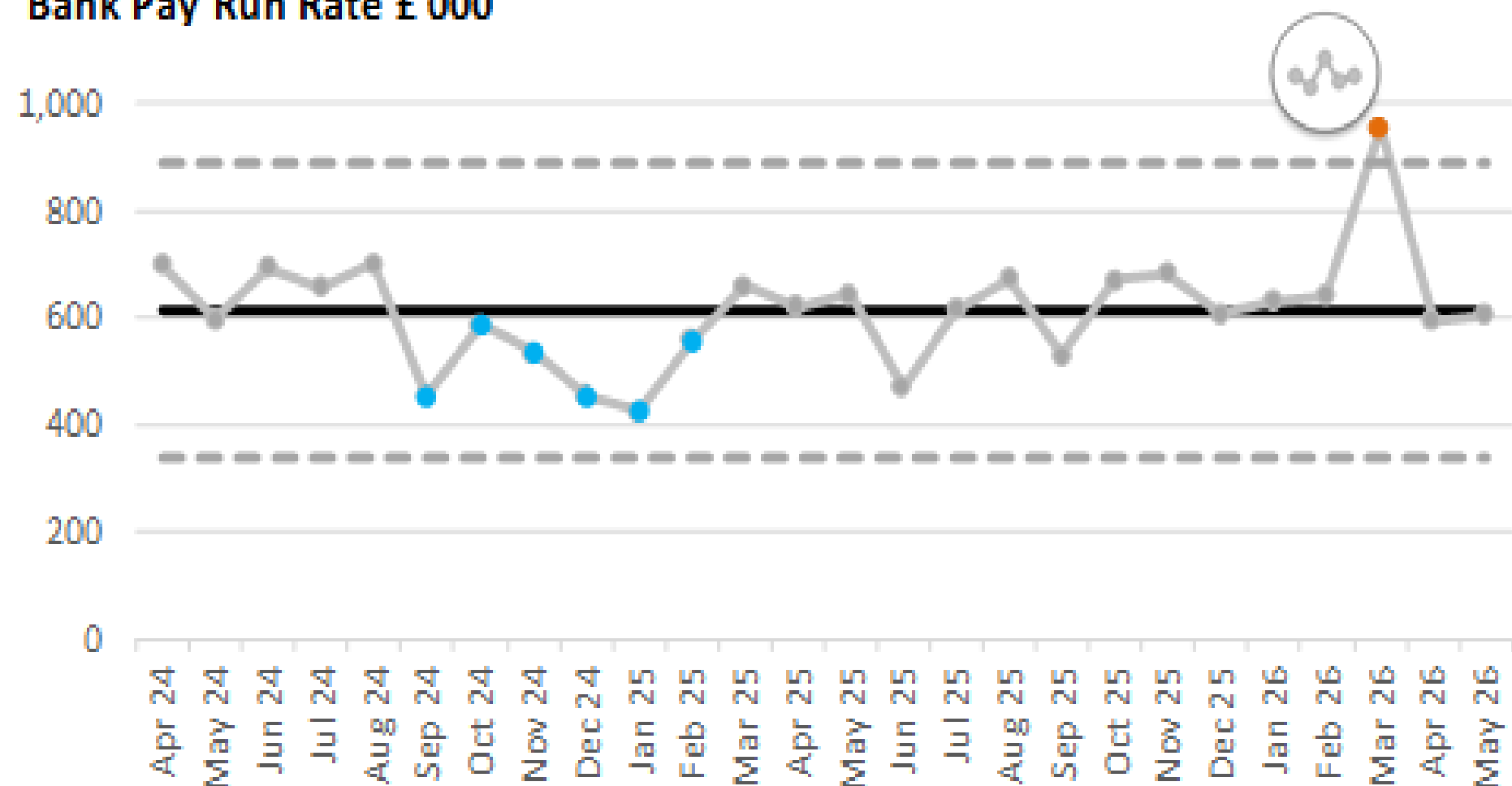
October 25 onwards shows a more normalised run rate driven by the increased activity levels, utilities (linked to phasing in the plan) and award of new insourcing contract. March 26 spike relates to validation sprint, insourcing, consumables and year end adjustments.

Enhanced controls are in place :

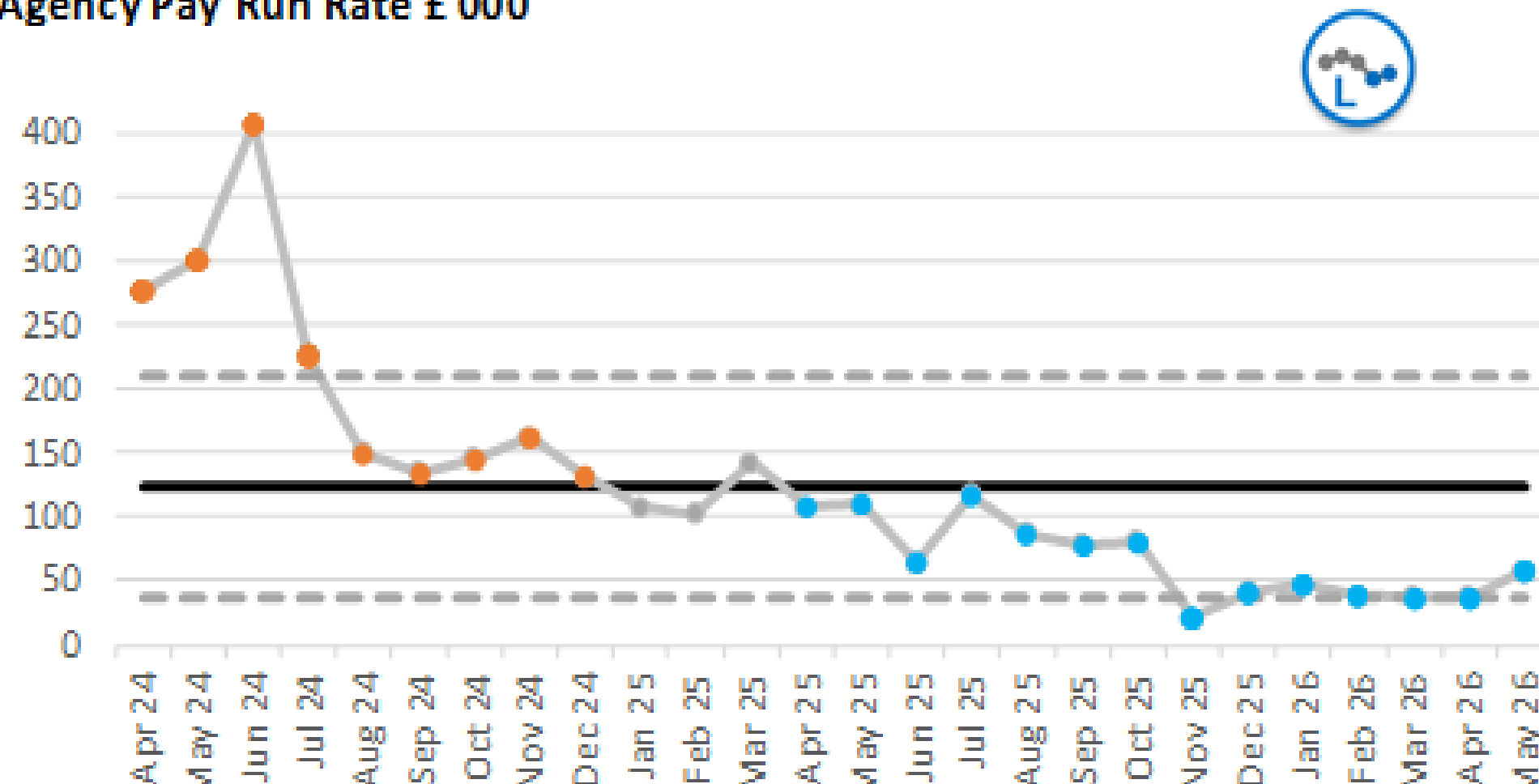
- Non-clinical orders >£10k must be approved by the CFO
- Discretionary non-clinical orders are reviewed by finance before proceeding

# Bank & Agency Run Rate

**Bank Pay Run Rate £'000**



**Agency Pay Run Rate £'000**



**Bank Run Rate**

Bank run rate showed assignable cause variation in 24/25 linked to the reduction in bank rates and implementation of enhanced controls. 25/26 shows common cause variation. March 26 spike is linked to high OJP spend and recognition of TOIL liability.

Enhanced controls are in place :

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

**Agency Run Rate**

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

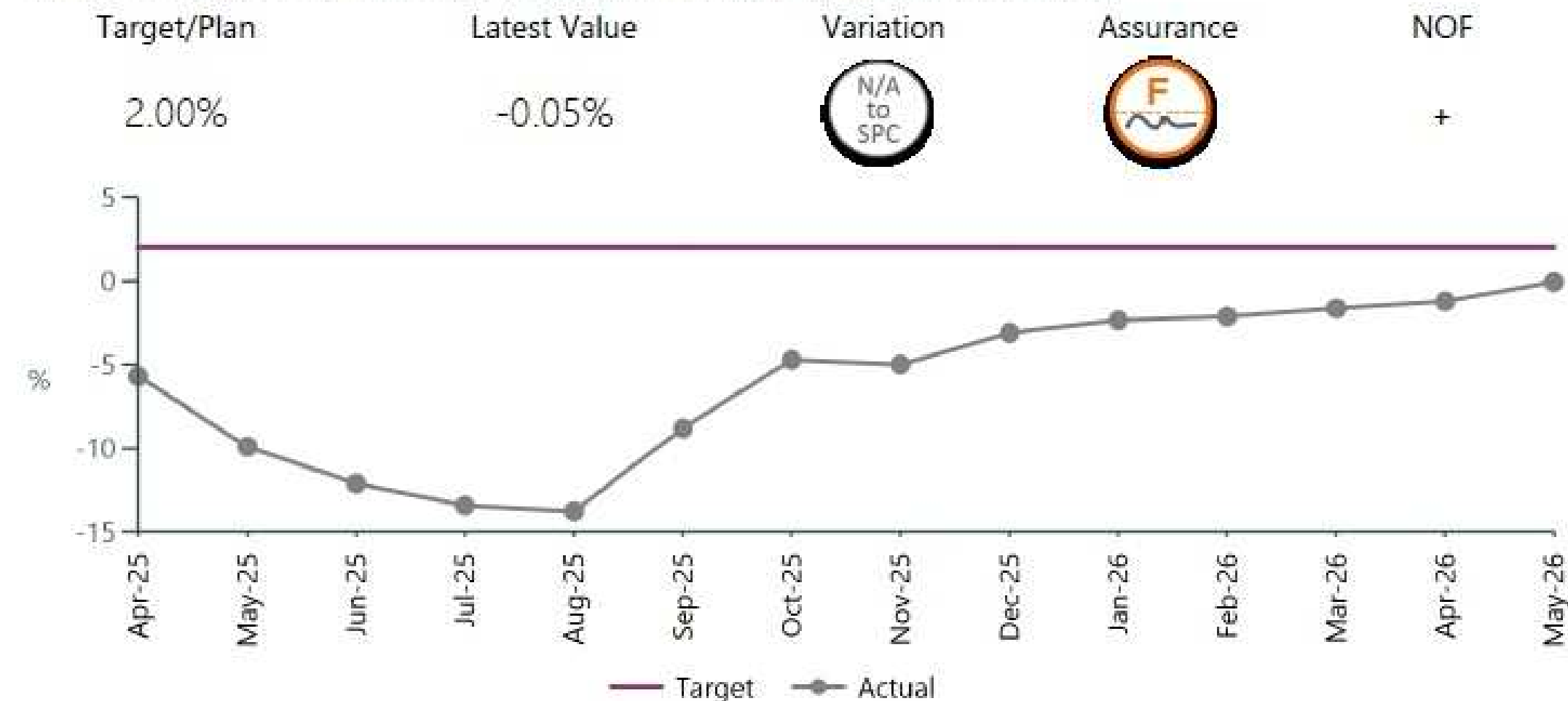
Enhanced controls are in place :

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

# Implied Productivity

## Implied Productivity

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



### Implied Productivity

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

### Calculation

**Cost weighted activity growth** – this takes activity during the two periods 25/26 and 26/27 and applies a national average cost based on data from the National Cost Collection (NCC) then divides the two numbers to give a growth %. Maximising activity increases the numerator and leads to an improved score.

**Real terms cost growth** – this takes operational expenditure excluding impairments but including Public Dividend Capital (PDC) charges during the two periods 25/26 and 26/27 then divides the two numbers to give a growth %. Spend is adjusted for inflation across periods.

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

Implied productivity for **May** is **-0.05%** against the minimum target set by NHSE of 2%.

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

# Commissioner Performance

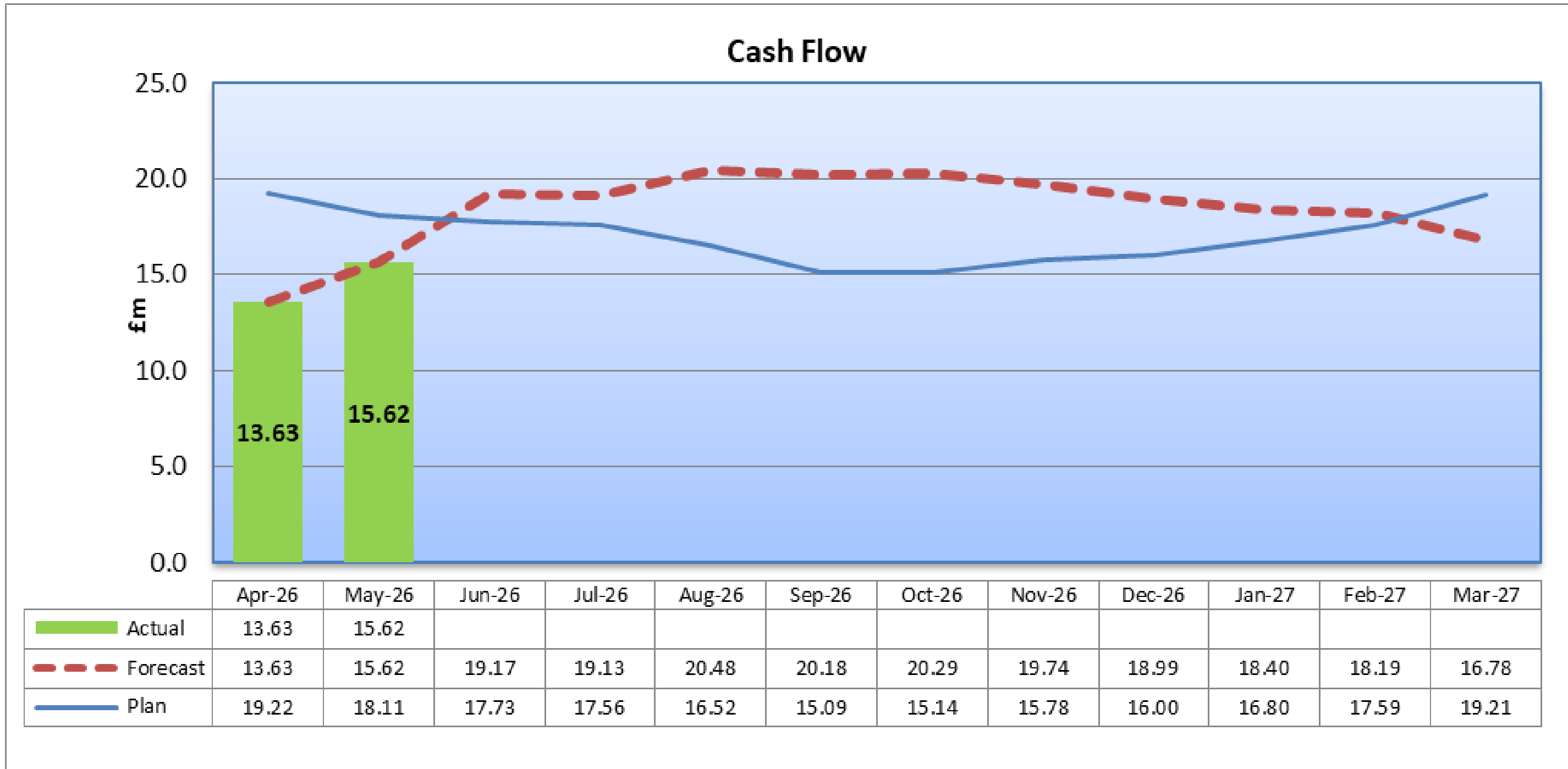
NHS Clinical Income - by Contract									
Contracts		Month 2 - May 2026				2026/27 Month 2 YTD			
		Actual Exc Pass				Actual Exc Pass			
		Plan £'000	Through £'000	Pass Through £'000	Variance £'000	Plan £'000	Through £'000	Pass Through £'000	Variance £'000
Shropshire, Telford & Wrekin ICB	API	5,950	5,852	272	174	12,435	12,400	543	508
NHS England Contract (Including Delegated)	API	1,504	1,350	274	120	2,999	2,650	511	162
Cheshire & Merseyside ICB	API	955	943	7	-4	1,915	1,964	24	73
Staffordshire & Stoke-on-Trent ICB	API	333	281	1	-51	662	596	3	-63
Herefordshire & Worcestershire ICB	API	337	354	0	17	675	699	0	25
Black Country ICB	API	135	192	2	57	270	305	2	36
Betsi Cadwaladr UHB	API	1,363	1,363	85	85	2,730	2,629	138	36
Powys TLHB	API	907	800	54	-53	1,819	1,427	109	-283
Hywel Dda UHB	API	56	46	1	-9	111	84	10	-16
<b>API Contracts Total</b>		<b>11,540</b>	<b>11,181</b>	<b>696</b>	<b>337</b>	<b>23,616</b>	<b>22,754</b>	<b>1,340</b>	<b>477</b>
Low Value Activity (LVA)	Block	378	378		0	757	757		0
Joint Commissioning Wales (JCW)	Block / NCA	154	154		0	308	308		0
<b>Fixed Contracts Total</b>		<b>532</b>	<b>532</b>	<b>0</b>	<b>0</b>	<b>1,065</b>	<b>1,065</b>	<b>0</b>	<b>0</b>
Other Non Commissioned Activity (NCA)	NCA	12	17	0	4	25	19	0	-7
Overperformance Reserve / DtB Plan Reduction		775	0	0	-775	1,348	0	0	-1,348
Other		0	28	0	28	0	28	0	28
<b>Other Subtotal</b>		<b>787</b>	<b>44</b>	<b>0</b>	<b>-743</b>	<b>1,373</b>	<b>46</b>	<b>0</b>	<b>-1,327</b>
<b>Total</b>		<b>12,859</b>	<b>11,757</b>	<b>696</b>	<b>-406</b>	<b>26,054</b>	<b>23,865</b>	<b>1,340</b>	<b>-849</b>

## M2 YTD performance £849k adverse to plan: £311k adverse pass through variance and £538k adverse clinical income versus plan

- Largest underperformance is with Powys TLHB £0.28m driven by levels of activity delivery. The 26/27 contract is not agreed, revised commissioning intentions have been received, and the negotiations are ongoing to agree planned growth from 2025/26 to achieve the required Welsh performance targets. Contract negotiations from a finance perspective are becoming increasingly challenging as there is lack of confidence in the Trusts delivery of the stated activity plan.
- Overperformance for Shropshire Telford & Wrekin ICB is £0.5m driven by activity mix and the recognition of a £44k allocation for RTT sprint funding in Month 1.

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

# Cash Position



- Cash balances increased as expected in May by £2m to £15.6m following the receipt of £1.6m from STW (25/26 deficit support funding) and agreement being reached with Cheshire & Mersey ICB for a £0.5m 25/26 performance related payment.
- The YTD position has improved accordingly but is still adverse to plan by £2.5m due to the April (opening) position being adverse to the plan submitted in Feb 2026. This will continue to be a variance throughout the year as the plan cash trajectory was set months before the actual cash position was set b

# Capital Position

Capital Programme Position as at 2627-02								
Project	Annual Plan £000s	In Month Plan £000s	In Month Actual £000s	In Month Variance £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Forecast Outturn £000s
Backlog maintenance	300	30	5	25	30	5	25	400
Digital investment & replacement	400	100	15	85	100	20	80	400
Capital project management	180	15	16	-1	30	32	-2	180
Equipment replacement	900	0	24	-24	0	24	-24	1,000
Diagnostic equipment replacement	500	0	0	0	0	0	0	500
Compliance (IPC/health & safety/quality)	200	0	0	0	0	0	0	200
Estates reconfiguration	150	20	0	20	20	0	20	150
Developments subject to business cases	1,180	0	0	0	0	0	0	1,310
Theatre replacement strategy	2,950	400	0	400	800	0	800	2,300
Energy/decarbonisation plan (internal)	100	0	0	0	0	0	0	100
Apollo EPR improvement programme	0	0	46	-46	0	46	-46	320
Charitable donations to support capital	150	8	34	-26	8	34	-26	150
Rheumatology hub (charitable elements)	800	180	0	180	360	0	360	690
Energy/decarbonisation plan (grant)	2,400	200	100	100	400	100	300	2,400
Critical infrastructure funding (CIR)	1,304	120	0	120	120	7	113	1,304
Menzies lease	833	0	0	0	0	0	0	833
Leased vehicles & equipment	117	0	0	0	0	0	0	117
<b>Total Capital Funding</b>	<b>12,464</b>	<b>1,073</b>	<b>240</b>	<b>833</b>	<b>1,868</b>	<b>268</b>	<b>1,600</b>	<b>12,354</b>
Less donated / grant capital	-3,350	-388	-134	-254	-768	-134	-634	-3,240
<b>NHS Capital Funding - Charge to CDEL</b>	<b>9,114</b>	<b>685</b>	<b>106</b>	<b>579</b>	<b>1,100</b>	<b>134</b>	<b>966</b>	<b>9,114</b>
Less PDC funded schemes	-1,304	-120	0	-120	-120	-7	-113	-1,304
<b>Charge to Operational Capital</b>	<b>7,810</b>	<b>565</b>	<b>106</b>	<b>459</b>	<b>980</b>	<b>127</b>	<b>853</b>	<b>7,810</b>

Capital expenditure continued to be low in May due to the high levels of expenditure on Theatre 12 and the Rheumatology hub incurred in March which is now resulting in an underspend of £1.6m at M2.

The overall forecast charge against Operational Capital (the key measure for NHSE) however remains the same and is in line with the plan.

A planned approach to approve and allocate in year Development Capital (£1.2m ring-fenced) has been implemented. A Capital Prioritisation Group (CPG) has been established that will first review capital requests and recommend follow on action to the Capital Management Group (CMG)

Urgent capital expenditure will undergo review outside of cycle if presenting a clinical and/or safety risk. Unit or Corporate Directors or Executives will review and propose action with approval by CFO, reported to CMG thereafter.

# Appendix 1 - I&E Unit split

	2627-02 YTD						
	Plan	Actual	Variance	MSK	Spec	Corporate	Non-rec benefits/ pressure
<b>Clinical Income</b>							
Elective & Daycase	£9,741	£9,372	-£369	-£328	-£41	£0	£0
Outsourcing	£661	£702	£40	£40	£0	£0	£0
Insourcing	£797	£375	-£422	-£361	-£60	£0	£0
Outpatients	£4,036	£4,082	£47	£84	-£38	£0	£0
Diagnostics	£725	£683	-£42	-£69	£27	£0	£0
Other Variable	£6,273	£6,167	-£106	£41	£33	-£180	£0
Fixed	£3,821	£3,824	£2	£0	£2	-£0	£0
Sub-Total	£26,054	£25,205	-£849	-£592	-£77	-£180	£0
Private Patients	£2,144	£1,618	-£527	-£526	-£1	£0	£0
Other	£1,305	£1,196	-£109	-£88	-£10	-£11	£0
Total Income	£29,503	£28,018	-£1,485	-£1,207	-£88	-£191	£0
<b>Pay</b>							
Substantive	-£18,049	-£17,372	£677	£356	£397	-£76	£0
Bank	-£1,182	-£1,227	-£45	-£22	-£2	-£21	£0
Agency	-£173	-£95	£78	£54	£24	£0	£0
Pay Total	-£19,404	-£18,694	£710	£388	£419	-£97	£0
<b>Non-Pay</b>							
Prosthesis	-£2,384	-£2,333	£51	£189	£0	£0	£3
Consumables	-£598	-£577	£21	-£42	£74	-£11	£0
Other Supplies & Services	-£1,991	-£1,856	£135	-£110	£69	£127	£49
Outsourcing	-£610	-£411	£199	-£81	-£1	£281	£0
Insourcing	-£374	-£233	£141	£172	-£31	£0	£0
Drugs	-£1,745	-£1,515	£231	-£2	£204	£28	£1
Consultancy	-£40	-£20	£20	-£3	£0	-£22	£52
Establishment	-£239	-£223	£15	-£15	-£2	£26	£6
Premises	-£1,016	-£1,090	-£74	£1	-£12	-£50	£19
Transport	-£70	-£65	£5	-£3	£2	£5	£1
Audit Fees	-£41	-£37	£4	£0	£0	£4	£0
Clinical Negligence	-£350	-£343	£7	£0	£0	£7	£0
Leases	-£16	-£43	-£27	-£0	-£39	£12	£0
Other	-£617	-£517	£100	£41	-£73	£59	£73
Non-Pay Total	-£10,089	-£9,262	£827	£147	£190	£467	£203
Finance Costs	-£1,635	-£1,627	£8	£2	-£0	£6	£0
Operational Surplus/Deficit	-£1,624	-£1,564	£60	-£670	£521	£185	£203
Add back Donated Depreciation	£143	£142	-£1	£0	£0	-£1	£0
<b>Control Total</b>	<b>-£1,479</b>	<b>-£1,422</b>	<b>£57</b>	<b>-£670</b>	<b>£521</b>	<b>£184</b>	<b>£203</b>

The table shows the trust position split by Unit view

Key points :

- Adverse income in MSK reflects theatre activity position for NHS and Private Patients, this is partially offset due to marginal cost reductions.
- Other income driven by TSSU efficiency slippage and research both of which are partially offset in cost.
- Pay position is favourable overall in both clinical Units due to vacancies (some of which direct impact on activity delivery) and enhanced controls on vacancies and premium costs. Bank spend is adverse driven by the use of OJP.
- Other suppliers and services in corporate relates to reserves slippage in month (inflation, and cost pressures)
- Drugs driven by pass through drugs underperformance.
- Non recurrent benefits of purchase order closure and VAT rebate in month.

# Trust Board - Finance

## May 2026 – 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:

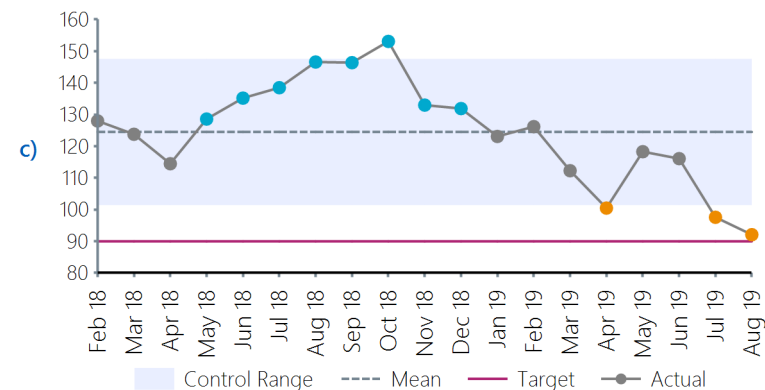
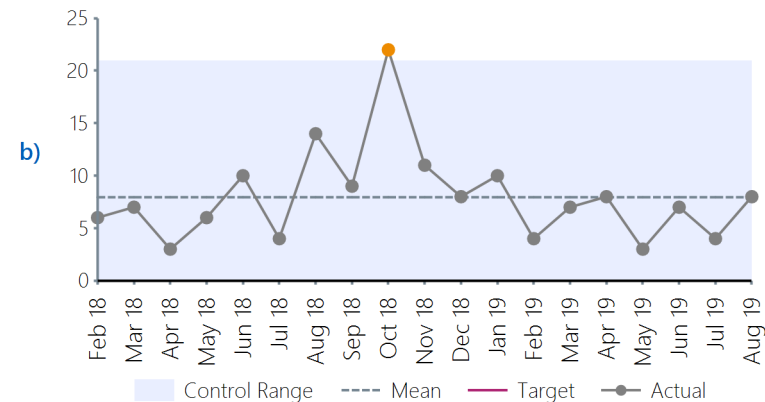
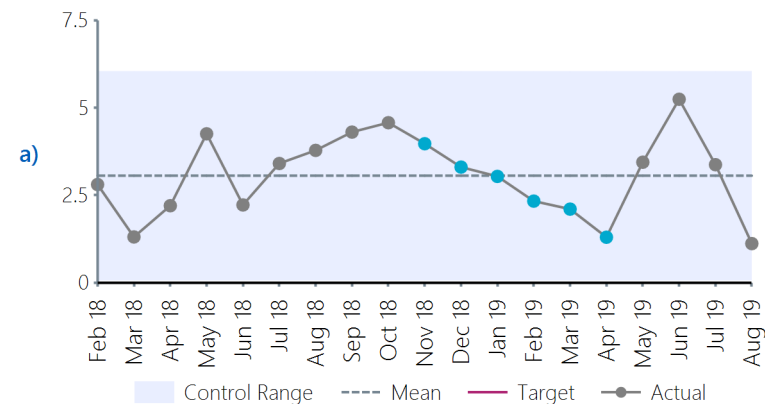
- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of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

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.

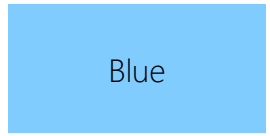
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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



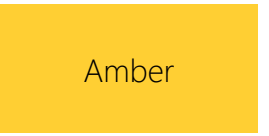
Blue

No improvement required to comply with the dimensions of data quality



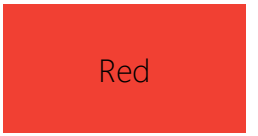
Green

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.

1
2
3
4
5
6
7
8
9
10
11

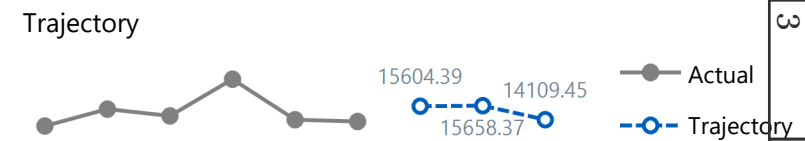
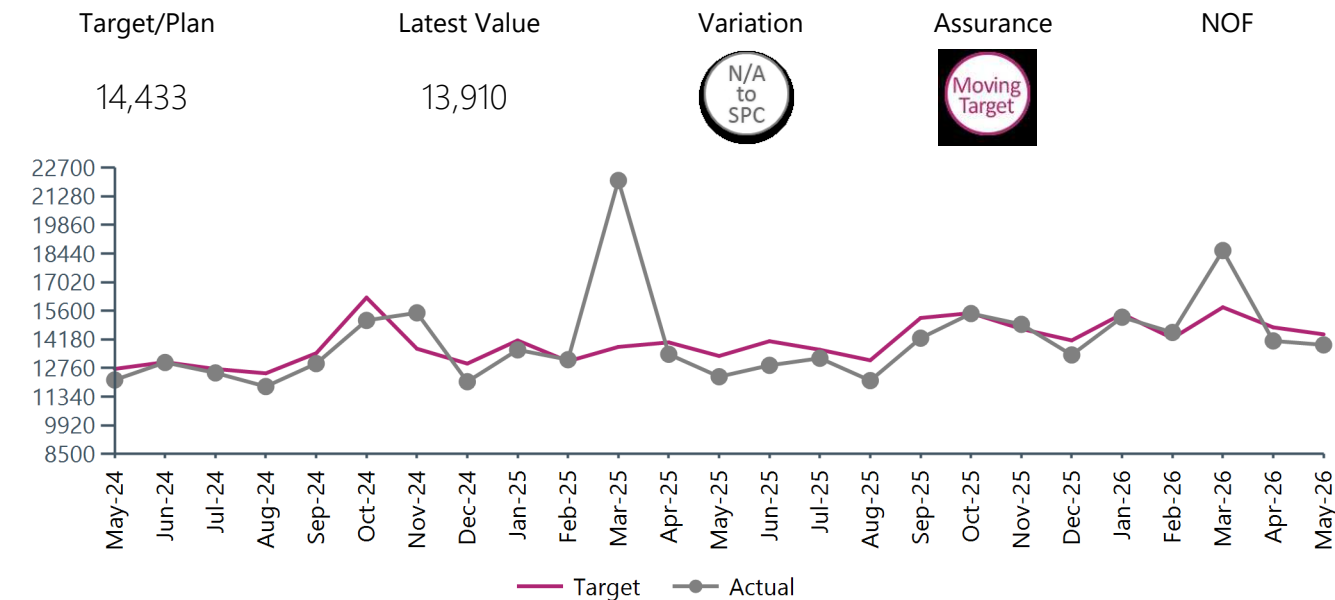


# Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
Financial Control Total	-892.44	-867						
Income	14,433	13,910				+		
Expenditure	15,326	14,777						
Efficiency Delivered	590	631						
Cash Balance	18,106	15,624				+		
Capital Expenditure	1,073	240						
Performance (£'000k) against Low Value Agreement Block	0.00	62.72				+		
Planned Surplus/Deficit	-1,478.44	-1,422.00						+
Variance Year-to-Date to Financial Plan	0	26						+
Implied Productivity	2.00%	-0.05%				+		+

# Income

All Trust Income, Clinical and Non-Clinical 216333



## What these graphs are telling us

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

## Narrative

Overall income £523k adverse to plan:

NHS Clinical income £277k adverse to plan:

- Theatre performance £321k adverse (11 cases adverse internally & 39 cases adverse insourcing)
- Outpatients and radiology procedures delivery £19k favourable
- Non theatre procedures and stays £37k favourable (driven by metabolic medicine)
- Theatres outsourcing £39k favourable

Non NHS income £246k adverse to plan: driven by shortfalls on private patient delivery and other income.

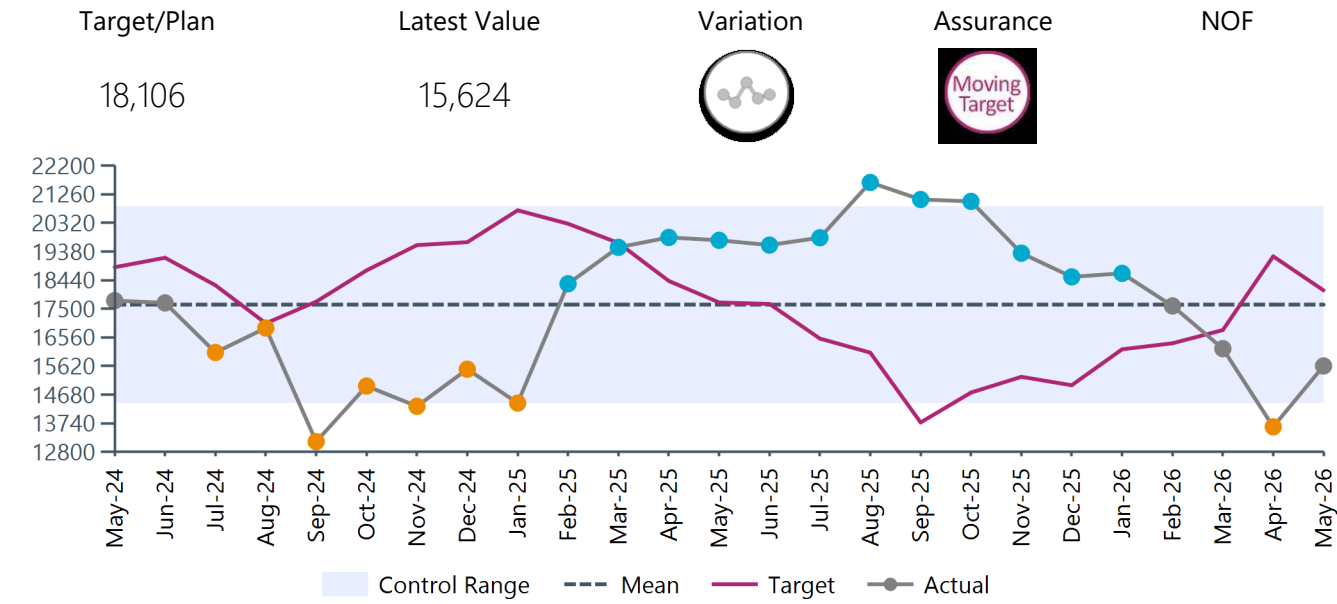
## Actions

May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
12330	12895	13246	12137	14242	15463	14928	13410	15282	14527	18589	14106	13910

- Staff - Patients - Finances -

# Cash Balance

Cash in bank 215300



Exec Lead:  
 Chief Finance & Commercial Officer



## What these graphs are telling us

Metric is experiencing common cause variation. Metric has a moving target.

## Narrative

Cash balances increased in May by £2m to £15.6m mainly because of the £1.6m received from STW for 25/26 deficit support funding and a £0.5m 25/26 overperformance payment from Cheshire & Merseyside ICB. The position compared to the plan has improved but is still adverse by £2.5m due to the opening plan adverse variance noted last month because the plan was completed at a time when higher levels of clinical income receipts were forecast for 25/26 than were subsequently received.

## Actions

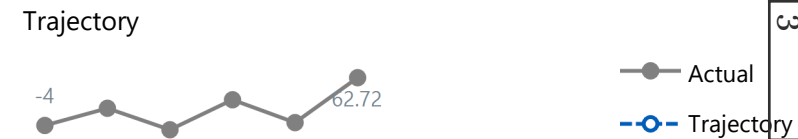
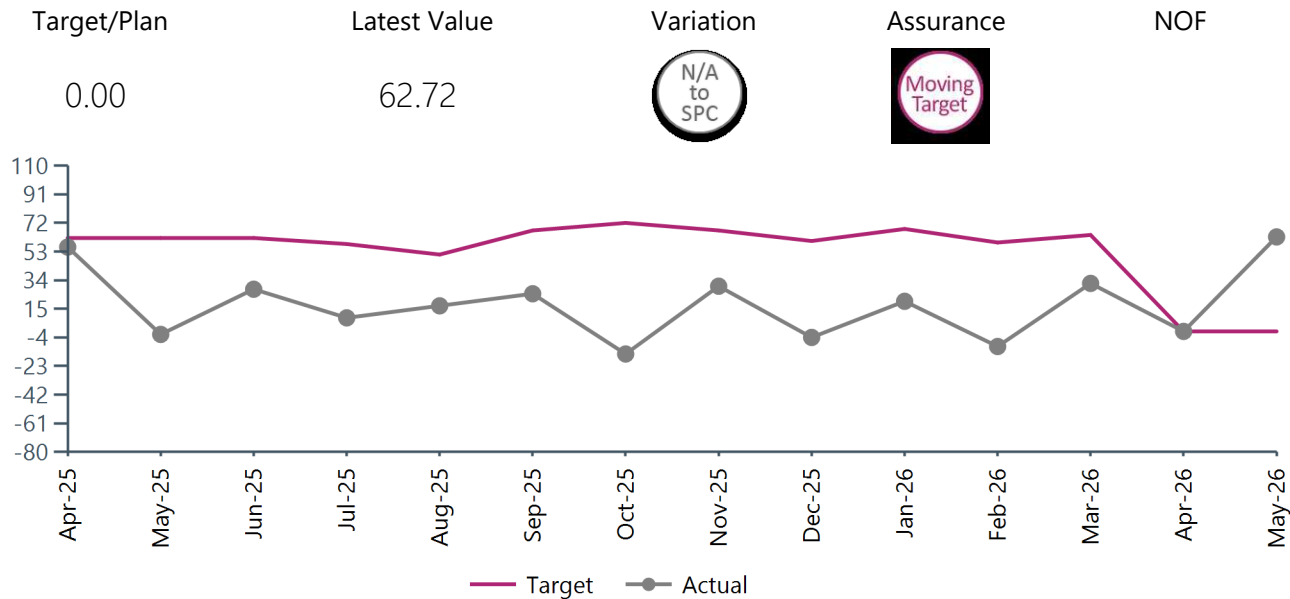
May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
19750	19593	19835	21650	21090	21028	19328	18549	18665	17594	16191	13625	15624

- Staff - Patients - **Finances** -

# 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 & Commercial Officer



### What these graphs are telling us

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

### Narrative

Veteran's activity is billed only if it is above the level of baseline Veterans activity from prior years (2019/20, 2022/23, 2023/24). The plan is set at the forecast level of overperformance based on prior year commissioner referrals and the planned Veterans activity.

M2 performance was £63k above the forecast baseline.

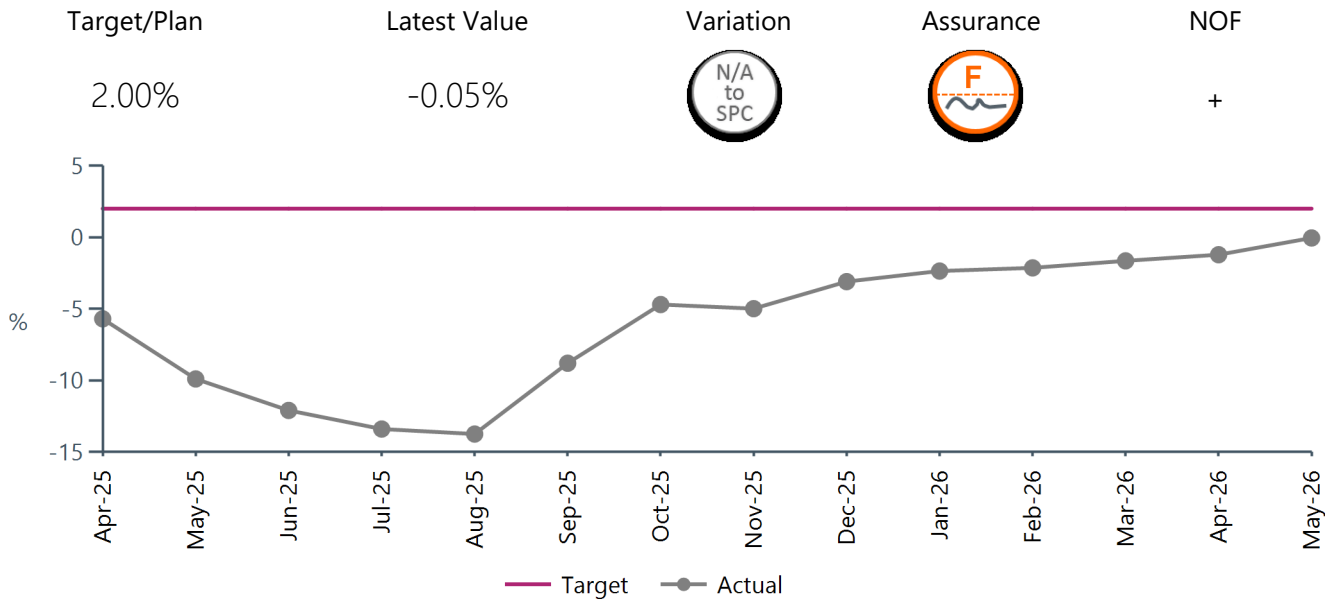
### Actions

May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
-2	28	9	17	25	-15	30	-4	20	-10	31	0	62
					- Staff	- Patients	- Finances	-				

# Implied Productivity

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

Exec Lead:  
 Chief Finance & Commercial Officer



**What these graphs are telling us**  
 This measure is not appropriate to display as SPC. Assurance indicates metric is consistently failing the target.

**Narrative**

Implied productivity is -0.05% YTD when comparing M2 26/27 with M2 25/26, primarily related to the underperformance of planned activity levels in May.

This metric is under review internally for 26/27 to align with the nationally published values.

**Actions**

May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
-9.90%	-12.10%	-13.40%	-13.75%	-8.80%	-4.70%	-4.99%	-3.10%	-2.36%	-2.14%	-1.65%	-1.22%	-0.05%

- Staff - Patients - **Finances** -

1
2
3
4
5
6
7
8
9
10
11

## Chair's Assurance Report Finance and Performance Committee

### Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 01 July 2026

### 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 Committee meeting held on 22 May and 20 June 2026. It highlights the key areas the Committee wishes to bring to the attention of the Board.

### 2. Strategic objectives and associated risks:

The following strategic objectives, developed in light of national and system priorities, are relevant to the content of this report:

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

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

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

## Chair's Assurance Report Finance and Performance Committee

### Trust values:

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

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

### 3. Assurance Report from Finance and Performance Committee

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

**ALERT** - The Finance and Performance Committee wishes to bring the following issues to the Board's attention as they:

Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address;

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

Require the approval of the Board for work to progress.

**Review the Committee Effectiveness and Annual Report:** Concerns regarding the timeliness and quality of papers was highlighted, representing a risk to effective scrutiny, with recent improvements acknowledged. Assurance was provided that revised processes, including earlier executive review and clearer timelines, are in place to address this. The Committee approved the self-assessment and Terms of Reference for submission to the Trust Board.

**Performance Update (May and June):** The Committee received assurance that performance has remained broadly positive across the reporting period, with sustained improvements in RTT performance, overall waiting list position, long-wait reductions, Welsh pathway delivery, outpatient activity, and operational productivity. Members noted that enhanced reporting, clinician-led dashboards, and targeted operational actions are supporting recovery, with cases per session improving to their highest level in the past year and Welsh performance continuing to move towards planned trajectories.

The Committee also noted several ongoing risks requiring continued oversight, including inpatient activity below plan, theatre cancellations and capacity constraints, DEXA waiting time pressures, 65-week and Welsh 104-week waits, spinal injury admission delays, discharge challenges, and complexities associated with cross-border pathways. Recovery plans and mitigating actions are in place, including additional capacity, improved booking practices, strengthened discharge planning, insourcing procurement, and system-wide engagement with partners and commissioners. The Committee was assured that appropriate actions are being progressed to address these challenges while maintaining focus on delivery of performance objectives.

**Specialist Unit Efficiency Delivery Update (June):** The Committee was assured that the current adverse position is largely attributable to short-term workforce and operational pressures, with recruitment completed in key areas and recovery plans in place. Whilst confidence remains that year-end delivery can be achieved, members emphasised the need to reduce reliance on non-recurrent mitigations and maintain oversight of recurrent efficiency improvements to ensure sustainable delivery.

#### 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

**Corporate Risk Register (May):** Noted the updated Corporate Risk Register as a positive step forward in structure and consolidation. However, further assurance is required due to inconsistencies in data quality, particularly in the recording of controls and mitigations, and gaps within some entries. Key risks relate to variable use of the system and a lack of clear articulation of how risks are being managed towards tolerance. The Committee emphasised the need for greater consistency, improved focus on controls and actions, and clearer, more concise presentation to support effective oversight.

**Four Eyes Discussion (May):** Acknowledged the Four Eyes review represents a substantial piece of analytical work, bringing together insight on theatre productivity and operational performance; however, it has not yet been formally adopted as the organisation's agreed position. Members raised concerns regarding the accuracy and validity of some of the underlying data and assumptions, particularly where findings were not consistent with clinical and operational experience, and emphasised the need for internal validation before key conclusions are accepted. While aspects of the review's interpretation and recommendations were challenged, the Committee recognised that it reinforces existing organisational understanding of the need to optimise productivity from current capacity, and highlights opportunities to better utilise data, improve scheduling, and reduce unwarranted variation. A key risk identified is the potential for fragmented improvement activity and the adoption of untested external recommendations without sufficient scrutiny. The Trust recognised the need for a single, coherent transformation programme, underpinned by robust governance, PMO oversight, and clear ownership, with a focus on practical, deliverable improvements supported by clinical and operational engagement.

**Insourcing Update (May):** The Committee took assurance from progress in delivering activity within the agreed financial envelope, the extension of existing arrangements to July 2026, and the development of a longer-term procurement framework to March 2029 supported by appropriate legal advice. However, members noted a number of risks and concerns, including underperformance against current activity expectations with limited contractual recourse, a strained provider relationship, and emerging value-for-money considerations where delivery does not meet planned levels. The Committee further recognised risks associated with reliance on short-term arrangements and the transition to a new model, but was assured that lessons learned have informed the future specification, including strengthened governance, clearer operational controls, and independent booking processes. Ongoing Board oversight will be required through procurement to ensure delivery, value and contractual robustness are achieved.

**Financial Performance (May and June):** The Committee received assurance that the Trust remains on track to deliver its planned financial position, supported by improved financial discipline, effective expenditure controls, and ongoing pay and vacancy management. While income delivery risks, commissioner uncertainties (particularly in Wales), productivity challenges, and cash performance continue to require close monitoring, members were assured that mitigating actions remain in place. Further work was requested to strengthen understanding of implied productivity and cash trends to support ongoing Board assurance.

**Trust Efficiency Delivery Update (May and June):** The Committee was assured that the Trust's efficiency programme has made a positive start to the year and remains on plan overall, despite the introduction of additional stretch targets. Members noted that while some schemes continue to be rated red or amber, the current RAG methodology may overstate delivery risk and does not always reflect the underlying performance of individual scheme components. The Committee supported a review of the RAG rating approach to provide a more accurate and proportionate assessment of delivery risk and welcomed ongoing monitoring of non-recurrent mitigations to ensure sustainable delivery of recurrent efficiencies. Overall, the Committee received moderate assurance regarding programme delivery, whilst recognising the need for continued focus on risk management and reporting accuracy.

**MSK Unit Efficiency Delivery Update (May):** Noted the targeted interventions to address pathway and productivity challenges, including strengthened pre-operative management and enhanced oversight through the 6-4-2 process. While these actions are expected to improve patient flow, reduce

## Chair's Assurance Report Finance and Performance Committee

cancellations, and support overall efficiency, significant risks remain. In particular, delivery is constrained by limited theatre capacity, anaesthetic availability, MRI staffing shortages, and increased reliance on agency staffing. Performance against private patient activity remains below plan, reflecting both capacity and workforce challenges, and poses a risk to income delivery. Although further mitigations are being explored, overall confidence in achieving full delivery remains cautious, with continued dependency on resolving workforce constraints and improving cases per session productivity. The Committee also noted a discrepancy between Model Hospital and internal productivity data, with further clarification awaited.

**Service Line Reporting (May):** Received assurance that Service Line Reporting demonstrates a positive full-year financial position, with a £2.1m operational surplus and generally strong performance across most service lines. However, risks remain in specific areas, notably therapies (the only core service line in negative contribution) and MSK within the trading account, alongside ongoing pressures from cost allocation methodologies, incomplete cost recovery for certain services, and challenges in accurately attributing activity and income. Members noted that variability in costing approaches and limited accessibility of reports continue to affect confidence, engagement, and consistent use of SLR to drive improvement. While recognising its value as a tool for insight and benchmarking, the Committee highlighted the need to strengthen the translation of SLR intelligence into demonstrable operational and financial actions, improve usability and visibility, and ensure systematic capture of improvements.

### 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.

**Theatre Productivity and Efficiency Transformation (June):** The Committee received assurance on the development of the programme is progressing with clear governance, defined workstreams and implementation plans in development. Members welcomed the coordinated approach and emphasised the need for robust benefit realisation and clearer articulation of patient impact. The Committee noted the update and agreed to receive quarterly progress reports through the workplan.

**MSK Development (June):** The Committee received assurance on the continued progress of the MSK transformation programme, including development of community-based services and ongoing engagement with commissioners and system partners. The Committee welcomed the pragmatic refocusing of the strategy onto a smaller number of achievable priorities and noted the update.

The committee received Chairs Assurance Report from the following sub-meetings:

- **Chair Report from Trust Performance and Operational Improvement Group (May and June):** The Committee received assurance that actions are being taken to improve operational performance and maximise income capture, Additional support has been seconded into the Access Service for a defined period to review and improve current processes, while the Therapies team is actively reviewing cancellation trends and appointment notification processes to reduce avoidable cancellations and address increased DNA rates.
- **Chair Report from Theatre 12 Programme (June):** Robust arrangements are in place to support operational readiness, including workforce recruitment, equipment procurement and activity planning to maximise benefits ahead of full utilisation. The principal risk relates to anaesthetic staffing; however, mitigating actions are being actively progressed through targeted recruitment, revised job planning and wider collaborative workforce initiatives. The Committee was assured that clinical engagement remains strong and that appropriate measures are in place to maintain delivery of the programme and support achievement of the planned theatre opening.
- **Chair Report from Activity Recovery Committee (June):** The Committee received assurance that elective recovery performance remains on track, with continued reductions in long waits and improved performance relative to other providers. Whilst a small number of long waits remain, primarily linked to a longstanding consultant-specific backlog and Welsh pathway challenges, mitigations are in place and progress is being made. Reduced oversight

## Chair's Assurance Report Finance and Performance Committee

from both the Trust and NHS England reflects growing confidence in delivery of the recovery trajectory.

- **Chair Report from Theatre Board Meeting (May):** The Committee requested an anaesthetic workforce gap review, including recruitment and capacity planning, to ensure sufficient cover for both core activity and extended sessions following the information shared in relation to the growing risk in anaesthetic recruitment.
- **Chair Report from Veterans Strategy Group (May):** Previously there has been no mechanism within Careflow to record whether a patient was a veteran, highlighting a gap in data capture. To fully realise the benefits of this, there is a need to ensure accurate and consistent data entry, including consideration of making this field mandatory to provide assurance that it is being recorded reliably. A Veterans Strategy session has been scheduled for July.
- **Chair Report from Capital Management Group (May and June):** confirmed there were no specific alerts to raise at this stage, noting that the Trust is entering another significant year of capital expenditure. The update focused on recent capital activity and governance, noting that a significant number of digital capital business cases have been submitted, though no feedback has yet been received from the system.
- **Chair Report from Sustainability Group (June):** no specific updates or issues were raised from the Sustainability Development Group, with no additional highlights or risks brought forward for discussion at this meeting.

### Recommendation

The Board is asked to:

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

(Part 1) Covering paper

<b>Committee / Group / Meeting, Date</b>	
Board of Directors, 01 July 2026	
<b>Author:</b>	<b>Contributors:</b>
Name: Mary Bardsley Role/Title: Assistant Trust Secretary	
<b>Report sign-off:</b>	
Name: Dylan Murphy, Trust Secretary Finance and Performance Committee	
<b>Is the report suitable for publication?:</b>	
Yes	
<b>Executive Summary:</b>	
<p>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.</p> <p>The Finance and Performance Committee is responsible for seeking assurance that the Trust is operating within its financial constraints, is delivering value for money, and is performing inline with its activity plan. Particular responsibilities are outlined in section 1 of the attached Report.</p> <p>In line with good practice, the committees of the Board undertake an annual review of their operation and effectiveness. This involves:</p> <ul style="list-style-type: none"> <li>• Reviewing the role of the committee, its key responsibilities, membership and business considered during the year.</li> <li>• A questionnaire on the effectiveness of the operation of the committee (completed by individual members / core attendees).</li> <li>• A self-assessment against key governance questions (for collective consideration).</li> <li>• Review of the terms of reference to ensure the focus of the Committee remains relevant in 2026/27.</li> </ul> <p>No significant issues were identified during the review but some minor revisions to the terms of reference (TOR) have been made. The main change to the TOR is to reflect the move to meeting in alternate months. That move will be supported by a revised process for the review and approval of papers to support the production of high-quality papers in good time for consideration by the committees.</p>	
<b>Recommendations:</b>	
<p>That the Board NOTE that the Committee has:</p> <ol style="list-style-type: none"> <li>1. <b>Considered</b> the outcome of the committee effectiveness survey and did not identify any significant issues;</li> <li>2. <b>Considered and agreed</b> the self-assessment document;</li> <li>3. <b>Noted</b> the 2025/26 Decision / Activity log.</li> <li>4. <b>Considered</b> the draft Terms of Reference for 2026/27 and recommended that the Board approve them.</li> </ol> <p>The Board is therefore asked to CONSIDER and APPROVE the proposed terms of reference for 2026/7.</p>	

(Part 2) Strategic alignment and supporting detail

**Strategic objectives and associated risks:**

The work of the committees, and the Board assurance arrangements, support delivery of all of the Trust's strategic objectives:

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

The work of the committees, and the Board assurance arrangements, are relevant to all of the Board Assurance Framework (BAF) themes and associated strategic risks but this Committee has a particular focus on:

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

**Trust Values:**

Board and committee meeting agendas each include an opportunity to reflect on the extent to which the agenda / discussion reflect and support the Trust's values:

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

**Report development and engagement history:**

The Committee considered the annual review documentation at its meeting in April 2026.

The Committee considered an updated Terms of Reference at its meeting in June.

**Next steps:**

The Committee will operate in line with the revised Terms of Reference. The workplan will be reviewed and updated as required to work to the new meeting pattern.

Any issues of concern, or apparent gaps in the governance arrangements, identified during the Committee reviews would be reported to the Audit and Risk Committee for consideration. No such gaps were identified.

## Finance and Performance Committee Annual Report

### 1. Committee Roles and Responsibilities (2025/26)

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 (2025/26)

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 Commercial Officer

### 3. Meetings (2025/26)

During 2025/26, the Committee met on eleven occasions to consider its routine agenda.

### 4. Committee Attendance (2025/26)

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

## Finance and Performance Committee Annual Report

Name	Title	Attendance
<b>Core Membership</b>		
Sarfraz Nawaz	Non-Executive Director (Chair)	09 / 11 = 82%
Martin Newsholme	Non-Executive Director	11 / 11 = 100%
Paul Maubach	Associate Non-Executive Director	11 / 11 = 100%
Lindsey Webb	Non-Executive Director	10 / 11 = 91%
Mike Carr	Chief Operating Officer	10 / 11 = 91%
Angela Mulholland-Wells	Chief Finance and Commercial Officer	11 / 11 = 100%
*Stacey Keegan	Chief Executive Officer	10 / 11 = 91%
<b>In Attendance</b>		
Dylan Murphy	Trust Secretary	09
Mark Salisbury	Deputy Chief Finance Officer	10
Steph Wilson	Head of Improvement and Business Insight	07
Nia Jones	Managing Director for Planning and Strategy	11
Richard Potter	Deputy Chief Medical Officer	05

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

### 5. Committee Activity and Decision Log (2025/26)

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

### 6. Conduct of Meetings (2025/26)

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.

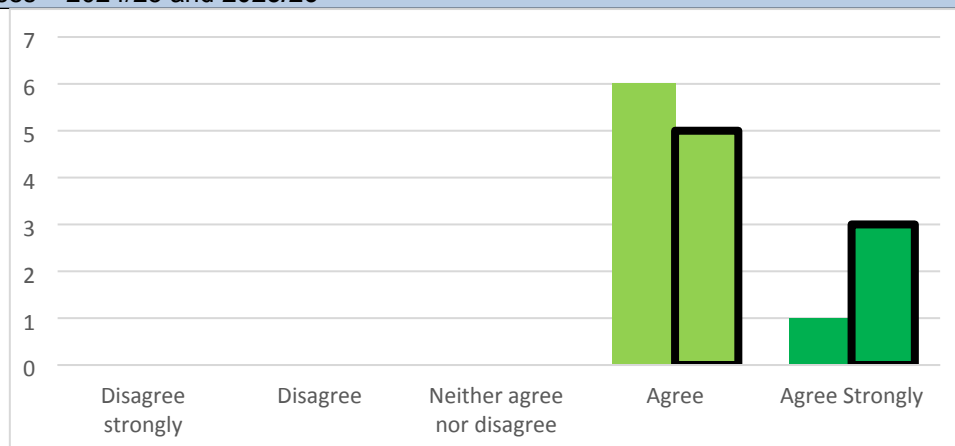
### 7. Committee Effectiveness Survey (2025/26)

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 2025/26 results (the second of the two columns, with the black outline) are displayed alongside the 2024/25 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 – 2024/25 and 2025/26



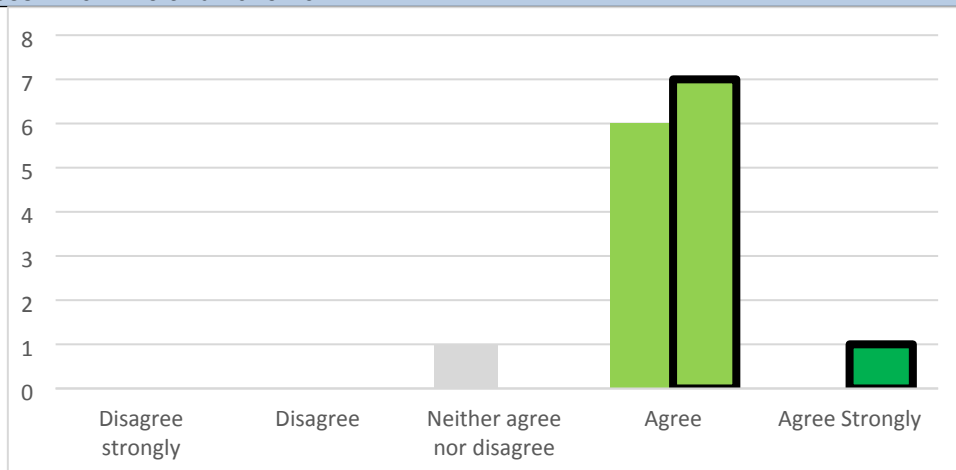
#### Comments

- There are no responses

# Finance and Performance Committee Annual Report

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

Responses – 2024/25 and 2025/26

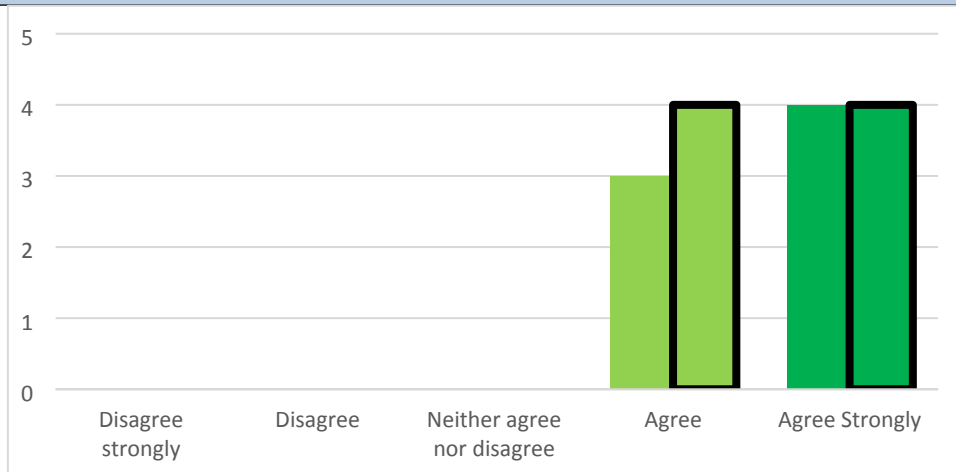


### Comments

- Will need review when incorporating ARC back into F&P

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

Responses – 2024/25 and 2025/26



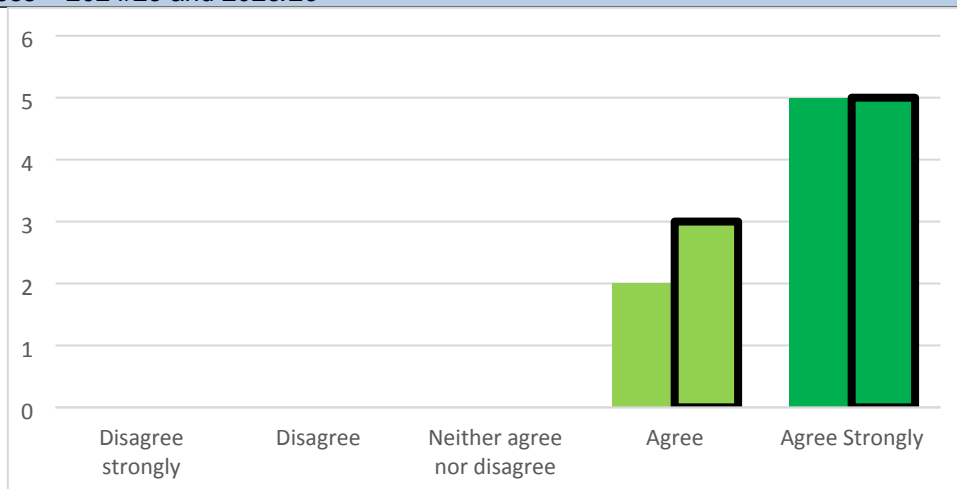
### Comments

- There are no responses

## Finance and Performance Committee Annual Report

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

Responses – 2024/25 and 2025/26

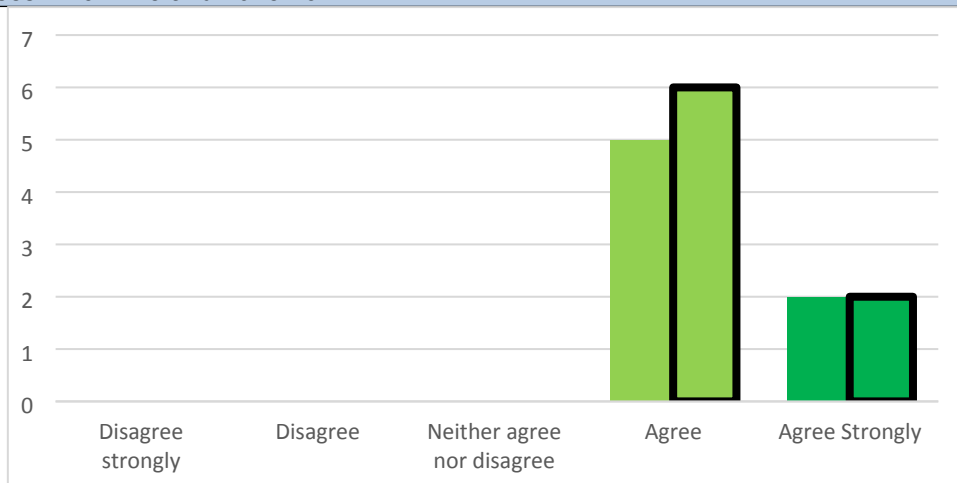


**Comments**

- There are no responses

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

Responses – 2024/25 and 2025/26



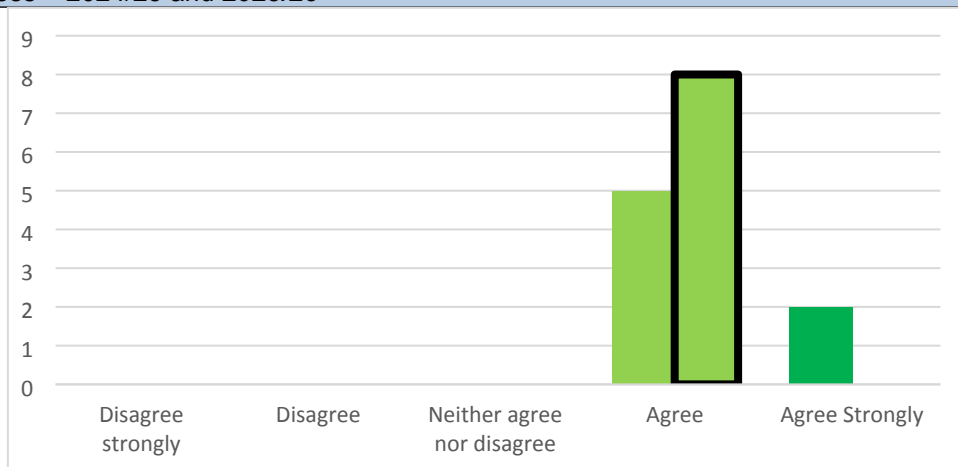
**Comments**

- There are no responses.

## Finance and Performance Committee Annual Report

**Q6 I have received the information which I require to consider the Trust's financial/activity delivery risks and their mitigations**

Responses – 2024/25 and 2025/26

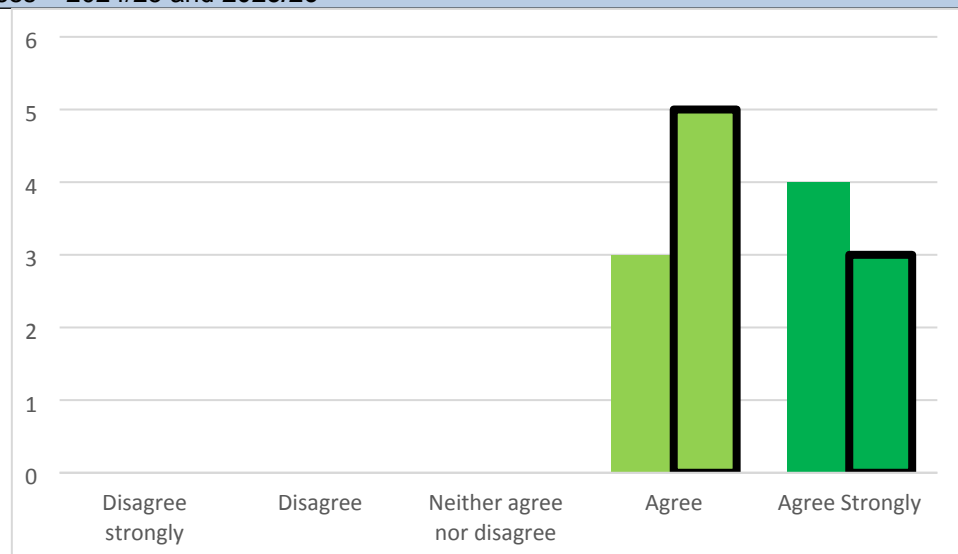


**Comments**

- More focus could be made on the activity delivery versus plan for theatre, outpatient and diagnostic activity. this is discussed in the IPR but only high level run rate

**Q7 The Committee has added value to the Trust's assurance processes**

Responses – 2024/25 and 2025/26



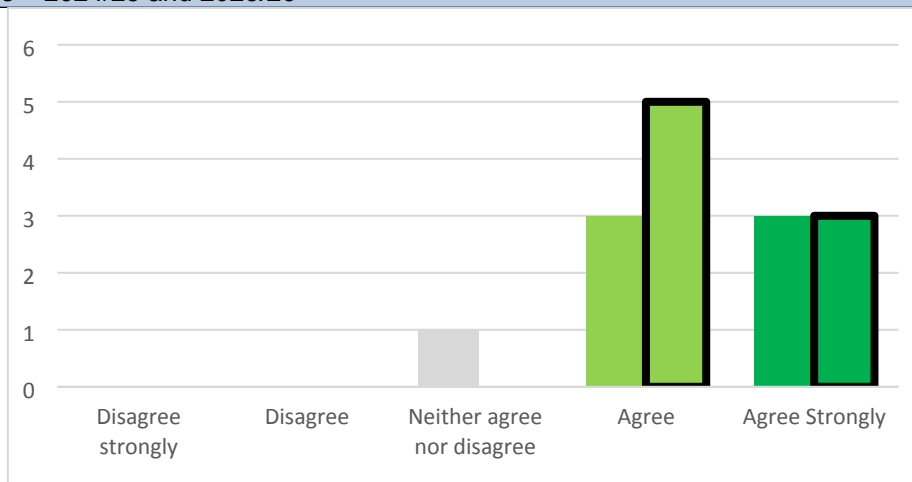
**Comments**

- There are no responses.

# Finance and Performance Committee Annual Report

## Q8 The Committee has had sufficient time/information to consider major investments

Responses – 2024/25 and 2025/26

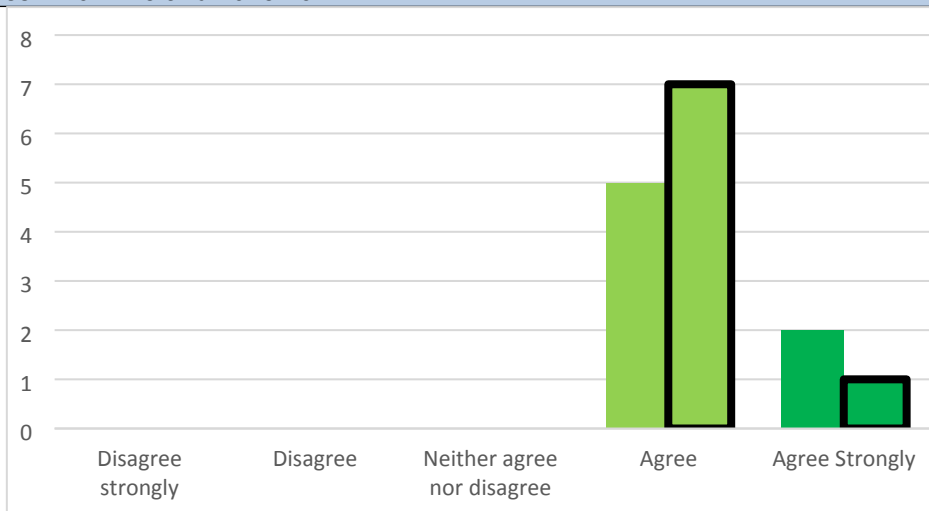


### Comments

- There are no responses.

## 9. I have received the information which I require to consider the Trust's digital aspects including their risks and mitigations.

Responses – 2024/25 and 2025/26



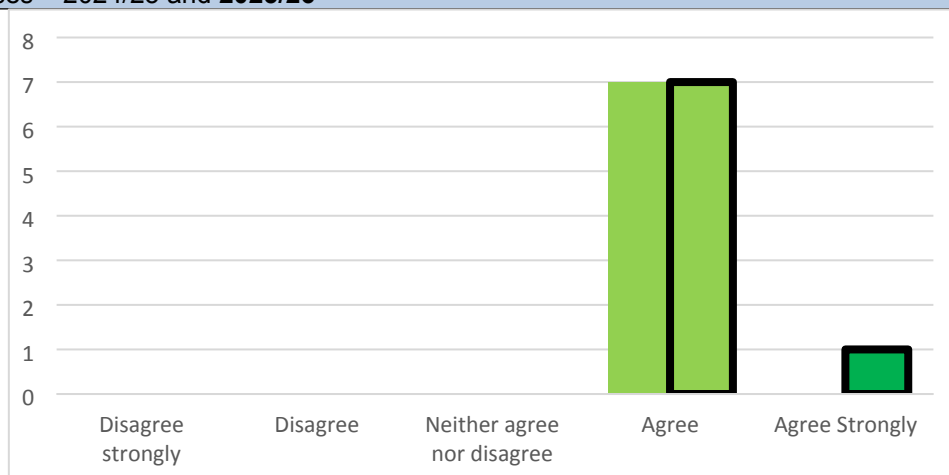
### Comments

- There are no responses

## Finance and Performance Committee Annual Report

**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 – 2024/25 and 2025/26



### Comments

- Opportunity to triangulate further the financial impacts into activity forecast modelling and vice versa. Separate reporting still seen in instances.
- Finance papers are very strong, activity performance papers whilst sufficient could be stronger.

### 8. Committee Self-Assessment (2025/26)

Area / Question	Response	Comments / Action
<b>Composition, Establishment and Duties</b>		
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 Nurse and Chief Medical 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 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.

## Finance and Performance Committee Annual Report

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. (Public = written / Private = verbal)
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 supported by the attendance matrix. This detail is reported to the Board as part of the assurance report.
<b>Compliance with the Law and Regulations Governing the NHS</b>		
Does the committee review assurance and regulatory compliance reporting processes?	Yes	This is undertaken by the committee in relation to issues of finances and assurance is provided to the Board via the Chair's report.
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.
<b>Internal Control</b>		
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. An annual review is also presented to the Committee for consideration.
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 revised the Corporate Stands Manual in 2025/26 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.
<b>Administrative Arrangements</b>		

## Finance and Performance Committee Annual Report

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 with the Chairs approval.
Does the committee meet the appropriate number of times a year?	Yes	The committee meets 10 times per year and additional meeting can be scheduled upon request.
<b>Other Issues</b>		
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 Finance and Performance, members are asked to review the Terms of Reference and consider any required revisions for 2026/27 (appendix B)

#### Appendices

Appendix A	FP Decision / Activity Log from 2025/26
Appendix B	FP Draft Terms of Reference for 2026/27

**Finance and Performance Committee | DECISION LOG 2025.26**

Updated: 20/04/2026

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?	If a recommendation - date of subsequent consideration at approval body
1	28-Apr-2025	Performance Report including Long Waiters	N/A	The Committee noted the update.	N/A	N/A	N/A
2	28-Apr-2025	KPI's 2025/2026	N/A	The Committee noted the update.	N/A	N/A	N/A
3	28-Apr-2025	Financial Performance Report	N/A	The Committee noted the update.	N/A	N/A	N/A
4	28-Apr-2025	Efficiency Plan Update	N/A	The Committee noted the update.	N/A	N/A	N/A
5	28-Apr-2025	Service Line Reporting	N/A	The Committee noted the update.	N/A	N/A	N/A
6	28-Apr-2025	Corporate Cost Reduction Schedule	N/A	The Committee noted the update.	N/A	N/A	N/A
7	28-Apr-2025	Operational Plan (April Submission)	N/A	The Committee noted the explanation of changes to something that has been previously approved by the Board of Directors.	N/A	N/A	N/A
8	28-Apr-2025	Capital Management Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
9	28-Apr-2025	Financial Improvement Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
10	28-Apr-2025	Activity Recovery Group Chair Report including Terms of Reference	N/A	The Committee noted the update.	N/A	N/A	N/A
11	28-Apr-2025	Procurement Steering Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
12	28-Apr-2025	Veterans Strategy Oversight Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
13	28-Apr-2025	Trust Performance and Operational Improvement Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
14	28-Apr-2025	STW MSK Provider Collaborative Board Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
15	28-Apr-2025	Formal Review of the Committee including Terms of Reference	N/A	The Committee noted the update.	N/A	N/A	N/A
16	28-Apr-2025	Review of Workplan and Attendance Matrix	N/A	The Committee noted the update.	N/A	N/A	N/A
17	2nd-June-2025	Board Assurance Framework	N/A	The Committee noted the update.	N/A	N/A	N/A
18	2nd-June-2025	Corporate Risk Register	N/A	The Committee noted the update.	N/A	N/A	N/A
19	2nd-June-2025	Medium Term Financial Plan	N/A	The Committee noted the update.	N/A	N/A	N/A
20	2nd-June-2025	Integrated Performance Report (IPR)	N/A	The Committee noted the update.	N/A	N/A	N/A
21	2nd-June-2025	Long Waiters	N/A	The Committee noted the update.	N/A	N/A	N/A
22	2nd-June-2025	System Finance Strategy	N/A	The Committee noted the update.	N/A	N/A	N/A
23	2nd-June-2025	Financial Performance Report	N/A	The Committee noted the update.	N/A	N/A	N/A
24	2nd-June-2025	Trust Efficiency Update	N/A	The Committee noted the update.	N/A	N/A	N/A
25	2nd-June-2025	TIF2 Closure Report	N/A	The Committee noted the update.	N/A	N/A	N/A
26	2nd-June-2025	Capital Management Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
27	2nd-June-2025	Financial Improvement Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
28	2nd-June-2025	Delivery Model Implementation Oversight Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
29	2nd-June-2025	Delivery Model Implementation Oversight Group Terms of Reference	N/A	The Committee approved the terms of reference.	N/A	N/A	N/A
30	2nd-June-2025	Trust Performance and Operational Improvement Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
31	2nd-June-2025	STW MSK Provider Collaborative Board Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
32	2nd-June-2025	Sustainability Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
33	2nd-June-2025	Review of Workplan and Attendance Matrix	N/A	The Committee noted the update.	N/A	N/A	N/A
34	2nd-June-2025	Risk Reflection	N/A	The Committee noted the update.	N/A	N/A	N/A
35	23-Jun-2025	Performance Report (OPOD) Including Long Waits	N/A	The Committee noted the update.	N/A	N/A	N/A
36	23-Jun-2025	Spinal Disorders Deep Dive	N/A	The Committee noted the update.	N/A	N/A	N/A
37	23-Jun-2025	RJAH Financial Performance Report Month 2	N/A	The Committee noted the update.	N/A	N/A	N/A
38	23-Jun-2025	M2 Efficiency Delivery Update	N/A	The Committee noted the update.	N/A	N/A	N/A

**Finance and Performance Committee | DECISION LOG 2025.26**

Updated: 20/04/2026

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?	If a recommendation - date of subsequent consideration at approval body
39	23-Jun-2025	Unit Efficiency Delivery Update	N/A	The Committee noted the update.	N/A	N/A	N/A
40	23-Jun-2025	Financial Improvement Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
41	23-Jun-2025	Delivery Model Implementation Oversight Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
42	23-Jun-2025	Procurement Steering Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
43	23-Jun-2025	Review of Workplan and Attendance Matrix	N/A	The Committee noted the update.	N/A	N/A	N/A
44	23-Jun-2025	Policy Tracker	N/A	The Committee noted the update.	N/A	N/A	N/A
45	23-Jun-2025	TIF 2 Update	N/A	The Committee noted the update.	N/A	N/A	N/A
46	31-Jul-2025	Performance Report	N/A	The Committee noted the update.	N/A	N/A	N/A
47	31-Jul-2025	RJAH Financial Performance	N/A	The Committee noted the update.	N/A	N/A	N/A
48	31-Jul-2025	Productivity Delivery vs Plan	N/A	The Committee noted the update.	N/A	N/A	N/A
49	31-Jul-2025	Efficiency Delivery Programme	N/A	The Committee noted the update.	N/A	N/A	N/A
50	31-Jul-2025	Specialist Unit Efficiencies	N/A	The Committee noted the update.	N/A	N/A	N/A
51	31-Jul-2025	Rheumatology Deep Dive	N/A	The Committee noted the update.	N/A	N/A	N/A
52	31-Jul-2025	MCSI Inpatients Length of Stay	N/A	The Committee noted the update.	N/A	N/A	N/A
53	31-Jul-2025	Apollo Update	N/A	The Committee noted the update.	N/A	N/A	N/A
54	31-Jul-2025	Trust Performance and Operational Improvement Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
55	31-Jul-2025	Capital Management Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
56	31-Jul-2025	Financial Improvement Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
57	31-Jul-2025	Activity Recovery Committee Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
58	31-Jul-2025	Activity Recovery Committee Terms of Reference	N/A	The Committee noted the terms of reference and requested they go to the Board for formal approval.	N/A	N/A	N/A
59	31-Jul-2025	STW MSK Provider Collaborative Board Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
60	31-Jul-2025	System Improvement Plan	N/A	The Committee noted the update.	N/A	N/A	N/A
61	31-Jul-2025	Finance and Performance Committee Terms of Reference	N/A	The Committee approved the terms of reference.	N/A	N/A	N/A
62	31-Jul-2025	Review of Workplan and Attendance Matrix	N/A	The Committee noted the update.	N/A	N/A	N/A
63	18-Aug-2025	Children and Young People (CYP) Revised RTT Trajectories	N/A	The Committee noted the update.	N/A	N/A	N/A
64	18-Aug-2025	Board Assurance Framework	N/A	The Committee noted the update.	N/A	N/A	N/A
65	18-Aug-2025	Corporate Risk Register	N/A	The Committee noted the update.	N/A	N/A	N/A
66	18-Aug-2025	Spinal Disorders Options Appraisal	N/A	The Committee noted the update.	N/A	N/A	N/A
67	18-Aug-2025	Performance Report	N/A	The Committee noted the update.	N/A	N/A	N/A
68	18-Aug-2025	RJAH Financial Performance M4	N/A	The Committee noted the update.	N/A	N/A	N/A
69	18-Aug-2025	Efficiency Delivery Programme	N/A	The Committee noted the update.	N/A	N/A	N/A
70	18-Aug-2025	MSK Unit Efficiency Delivery	N/A	The Committee noted the update.	N/A	N/A	N/A
71	18-Aug-2025	Financial Forecast	N/A	The Committee noted the update.	N/A	N/A	N/A
72	18-Aug-2025	NHSE Grip and Control Review	N/A	The Committee noted the update.	N/A	N/A	N/A
73	18-Aug-2025	Trust Performance and Operational Improvement Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
74	18-Aug-2025	Capital Management Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
75	18-Aug-2025	Procurement Steering Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
76	18-Aug-2025	Financial Improvement Group Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
77	18-Aug-2025	Activity Recovery Committee Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
78	18-Aug-2025	STW MSK Provider Collaborative Board Chair Report	N/A	The Committee noted the update.	N/A	N/A	N/A
79	18-Aug-2025	System Integrated Improvement Plan	N/A	The Committee noted the update.	N/A	N/A	N/A

## Finance and Performance Committee | DECISION LOG 2025.26

Updated: 20/04/2026

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?	If a recommendation - date of subsequent consideration at approval body
80	18-Aug-2025	Review of Workplan and Attendance Matrix	N/A	The Committee noted the update.	N/A	N/A	N/A
81	18-Aug-2025	Letter: Tiering Status Q2	N/A	The Committee noted the update.	N/A	N/A	N/A
82	22-Sep-2025	Spinal Disorders Improvement Plan	N/A	The Committee noted the update.	N/A	N/A	N/A
83	22-Sep-2025	Chair Report from Activity Recovery Committee	N/A	The Committee noted the update.	N/A	N/A	N/A
84	22-Sep-2025	RJAH Financial Performance (M5)	N/A	The Committee noted the update.	N/A	N/A	N/A
85	22-Sep-2025	Activity and Finance Forecast	N/A	The Committee noted the update.	N/A	N/A	N/A
86	22-Sep-2025	Efficiency Delivery Programme	N/A	The Committee noted the update.	N/A	N/A	N/A
87	22-Sep-2025	Specialist Unit Efficiency Delivery	N/A	The Committee noted the update.	N/A	N/A	N/A
88	22-Sep-2025	Green Plan 2025-2028	N/A	The Committee endorsed the update with onward approval to the Board.	N/A	N/A	N/A
89	22-Sep-2025	Theatre Business Case Update	N/A	The Committee noted the update.	N/A	N/A	N/A
90	22-Sep-2025	Planning Update	N/A	The Committee noted the update.	N/A	N/A	N/A
91	22-Sep-2025	Chair Report from Trust Performance and Operational Improvement Group	N/A	The Committee noted the update.	N/A	N/A	N/A
92	22-Sep-2025	Chair Report from STW MSK Provider Collaborative Board	N/A	The Committee noted the update.	N/A	N/A	N/A
93	22-Sep-2025	Review of the Workplan and Attendance Matrix	N/A	The Committee noted the update.	N/A	N/A	N/A
94	22-Sep-2025	CMO Letter: Powys Intentions (for information)	N/A	The Committee noted the update.	N/A	N/A	N/A
95	24-Oct-2025	Corporate Risk Register	N/A	The Committee noted the update.	N/A	N/A	N/A
96	24-Oct-2025	Spinal Disorders Improvement Plan	N/A	The Committee noted the update.	N/A	N/A	N/A
97	24-Oct-2025	Theatre Business Case Update	N/A	The Committee approved the Theatre Business Case.	N/A	N/A	N/A
98	24-Oct-2025	Chair Report from Activity Recovery Committee	N/A	The Committee noted the update.	N/A	N/A	N/A
99	24-Oct-2025	Performance Report	N/A	The Committee noted the update.	N/A	N/A	N/A
100	24-Oct-2025	RJAH Financial Performance (M6)	N/A	The Committee noted the update.	N/A	N/A	N/A
101	24-Oct-2025	Activity and Finance Forecast	N/A	The Committee noted the update.	N/A	N/A	N/A
102	24-Oct-2025	Efficiency Delivery Programme	N/A	The Committee noted the update.	N/A	N/A	N/A
103	24-Oct-2025	MSK Unit Efficiency Delivery	N/A	The Committee noted the update.	N/A	N/A	N/A
104	24-Oct-2025	Productivity Delivery	N/A	The Committee noted the update.	N/A	N/A	N/A
105	24-Oct-2025	Shared Services Progress Report	N/A	The Committee noted the update.	N/A	N/A	N/A
106	24-Oct-2025	Delivery Model Progress Report	N/A	The Committee noted the update.	N/A	N/A	N/A
107	24-Oct-2025	Chair Report from Trust Performance and Operational Improvement Group	N/A	The Committee noted the update.	N/A	N/A	N/A
108	24-Oct-2025	Chair Report from Capital Management Group	N/A	The Committee noted the update.	N/A	N/A	N/A
109	24-Oct-2025	Chair Report from Veterans Strategy Oversight Group	N/A	The Committee noted the update.	N/A	N/A	N/A
110	24-Oct-2025	Chair Report from Procurement Working Group	N/A	The Committee noted the update.	N/A	N/A	N/A
111	24-Oct-2025	Chair Report from Performance and Financial Improvement Group	N/A	The Committee noted the update.	N/A	N/A	N/A
112	24-Oct-2025	Review of the Workplan and Attendance Matrix	N/A	The Committee noted the update.	N/A	N/A	N/A
113	28-Nov-2025	Board Assurance Framework	N/A	The Committee noted the update.	N/A	N/A	N/A
114	28-Nov-2025	Delivery Model Progress	N/A	The Committee noted the update.	N/A	N/A	N/A
115	28-Nov-2025	Planning Update – Operational & Financial	N/A	The Committee noted the update.	N/A	N/A	N/A
116	28-Nov-2025	Spinal Disorders Improvement Plan	N/A	The Committee noted the update.	N/A	N/A	N/A

## Finance and Performance Committee | DECISION LOG 2025.26

Updated: 20/04/2026

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?	If a recommendation - date of subsequent consideration at approval body
117	28-Nov-2025	Chair Report from Activity Recovery Committee	N/A	The Committee noted the update.	N/A	N/A	N/A
118	28-Nov-2025	Performance Report	N/A	The Committee noted the update.	N/A	N/A	N/A
119	28-Nov-2025	RJAH Financial Performance (M7)	N/A	The Committee noted the update.	N/A	N/A	N/A
120	28-Nov-2025	Activity and Finance Forecast	N/A	The Committee noted the update.	N/A	N/A	N/A
121	28-Nov-2025	Efficiency Delivery Programme	N/A	The Committee noted the update.	N/A	N/A	N/A
122	28-Nov-2025	Specialist Unit Efficiency Delivery	N/A	The Committee noted the update.	N/A	N/A	N/A
123	28-Nov-2025	Portland Insourcing Contract	N/A	The Committee <b>approved</b> the Portland Insourcing Contract Extension	N/A	N/A	N/A
124	28-Nov-2025	Service Line Review	N/A	The Committee noted the update.	N/A	N/A	N/A
125	28-Nov-2025	Case of Need: Rheumatology Hub	N/A	The Committee <b>approved</b> the Case of Need: Rheumatology Hub <b>in principle, requesting a final review to come back to the committee for full approval.</b>	N/A	N/A	N/A
126	28-Nov-2025	Chair Report from Trust Performance and Operational Improvement Group	N/A	The Committee noted the update.	N/A	N/A	N/A
127	28-Nov-2025	Chair Report from Performance and Financial Improvement Group	N/A	The Committee noted the update.	N/A	N/A	N/A
128	28-Nov-2025	Chair Report from STW MSK Provider Collaborative Board	N/A	The Committee noted the update.	N/A	N/A	N/A
129	28-Nov-2025	Well Led Review Action Plan	N/A	The Committee noted the update.	N/A	N/A	N/A
130	28-Nov-2025	Review of the Workplan and Attendance Matrix	N/A	The Committee noted the update.	N/A	N/A	N/A
131	23-Jan-2026	Corporate Risk Register Discussion	N/A	The Committee noted the update.	N/A	N/A	N/A
132	23-Jan-2026	Business Case: Rheumatology Hub	N/A	The Committee <b>approved</b> the Rheumatology Hub Business Case pending minor amendments.	N/A	N/A	N/A
133	23-Jan-2026	Business Case: Heat Decarbonisation (SALIX)	N/A	The Committee <b>approved</b> the Heat Decarbonisation (SALIX) business case, pending minor amendments to be taken to the Board of Directors.	N/A	N/A	N/A
134	23-Jan-2026	Development of Plans for 2026/27	N/A	The Committee noted the update.	N/A	N/A	N/A
135	23-Jan-2026	Chair Report from Activity Recovery Committee	N/A	The Committee noted the update.	N/A	N/A	N/A
136	23-Jan-2026	Performance Report	N/A	The Committee noted the update.	N/A	N/A	N/A
137	23-Jan-2026	Finance Report (M9)	N/A	The Committee noted the update.	N/A	N/A	N/A
138	23-Jan-2026	FY25-26 Financial Forecast Update	N/A	The Committee noted the update.	N/A	N/A	N/A
139	23-Jan-2026	Chair Report from Veterans Group	N/A	The Committee noted the update.	N/A	N/A	N/A
140	23-Jan-2026	Chair Report from Procurement Steering Group	N/A	The Committee noted the update.	N/A	N/A	N/A
141	23-Jan-2026	Review of the Workplan and Attendance Matrix	N/A	The Committee noted the update.	N/A	N/A	N/A
142	23-Jan-2026	Risk Reflection	N/A	The Committee noted the update.	N/A	N/A	N/A
143	23-Jan-2026	Financial Controls External Review – MIAA Report	N/A	The Committee noted the update.	N/A	N/A	N/A
144	23-Jan-2026	Efficiency Delivery Programme	N/A	The Committee noted the update.	N/A	N/A	N/A
145	23-Jan-2026	MSK Unit Efficiency Delivery	N/A	The Committee noted the update.	The Committee noted the update.	The Committee noted the update.	The Committee noted the update.
146	27-Feb-2026	Chair Report from Activity Recovery Committee	N/A	The Committee noted the update.	N/A	N/A	N/A
147	27-Feb-2026	Activity Recovery Committee Terms of Reference	N/A	The Committee approved the ARC Terms of Reference.	N/A	N/A	N/A

**Finance and Performance Committee | DECISION LOG 2025.26**

Updated: 20/04/2026

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?	If a recommendation - date of subsequent consideration at approval body
148	27-Feb-2026	Performance Report	N/A	The Committee noted the update.	N/A	N/A	N/A
149	27-Feb-2026	Finance Report (M10)	N/A	The Committee noted the update.	N/A	N/A	N/A
150	27-Feb-2026	FY25-26 Financial Forecast Update	N/A	The Committee noted the update.	N/A	N/A	N/A
151	27-Feb-2026	Efficiency Delivery Programme	N/A	The Committee noted the update.	N/A	N/A	N/A
152	27-Feb-2026	Specialist Unit CIPS	N/A	The Committee noted the update.	N/A	N/A	N/A
153	27-Feb-2026	Service Line Reporting	N/A	The Committee noted the update.	N/A	N/A	N/A
154	27-Feb-2026	Chair Report from Veterans Group	N/A	The Committee noted the update.	N/A	N/A	N/A
155	27-Feb-2026	Chair Report from STW MSK Provider Collaborative Board	N/A	The Committee noted the update.	N/A	N/A	N/A
156	27-Feb-2026	Chair Report from Trust Performance and Operational Improvement Group	N/A	The Committee noted the update.	N/A	N/A	N/A
157	27-Feb-2026	Chair Report from Procurement Steering Group	N/A	The Committee noted the update.	N/A	N/A	N/A
158	27-Feb-2026	Chair Report from Capital Management Group	N/A	The Committee noted the update.	N/A	N/A	N/A
159	27-Feb-2026	Well Led Action Plan	N/A	The Committee noted the update.	N/A	N/A	N/A
160	27-Feb-2026	Review of the Workplan and Attendance Matrix	N/A	The Committee noted the update.	N/A	N/A	N/A
161	27-Feb-2026	ESR/Payroll Review (MIAA Review)	N/A	The Committee noted the update.	N/A	N/A	N/A
162	27-Feb-2026	Risk Reflection and Value Reflection	N/A	The Committee noted the update.	N/A	N/A	N/A
163	27-Mar-2026	Board Assurance Framework	N/A	The Committee noted the update.	N/A	N/A	N/A
164	27-Mar-2026	Spinal Disorders Plan	N/A	The Committee noted the update.	N/A	N/A	N/A
165	27-Mar-2026	Theatre Development Business Case	N/A	The Committee approved the business case with onward approval to Board.	N/A	N/A	N/A
166	27-Mar-2026	Chair Report from Activity Recovery Committee	N/A	The Committee noted the update.	N/A	N/A	N/A
167	27-Mar-2026	Activity Progress Slide	N/A	The Committee noted the update.	N/A	N/A	N/A
168	27-Mar-2026	Performance Report	N/A	The Committee noted the update.	N/A	N/A	N/A
169	27-Mar-2026	Fiancne Report (M11)	N/A	The Committee noted the update.	N/A	N/A	N/A
170	27-Mar-2026	Draft M12 Forecast Position (Theatre/Outpt./Finance)	N/A	The Committee noted the update.	N/A	N/A	N/A
171	27-Mar-2026	Efficiency Delivery Update - MSK Unit	N/A	The Committee noted the update.	N/A	N/A	N/A
172	27-Mar-2026	FY26/27 Contract Update	N/A	The Committee noted the update.	N/A	N/A	N/A
173	27-Mar-2026	Chair Report from TPOIG	N/A	The Committee noted the update.	N/A	N/A	N/A
174	27-Mar-2026	Chair Report from Sustainability Group	N/A	The Committee noted the update.	N/A	N/A	N/A
175	27-Mar-2026	Chair Report from Capital Management Group	N/A	The Committee noted the update.	N/A	N/A	N/A
176	27-Mar-2026	Reivew of the Work Plan and Attendance Matrix	N/A	The Committee noted the update.	N/A	N/A	N/A
177	27-Mar-2026	Risk Reflection and Value Reflection	N/A	The Committee noted the update.	N/A	N/A	N/A

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11

## Terms of Reference (~~April-June~~ 2026) Finance and Performance Committee

### 1. Constitution

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

### 2. Membership and Quorum

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

- Up to four Non-Executive members
- Chief Finance and Commercial Officer
- Chief Operating Officer

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

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

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

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

### 3. Attendance

Other Executive Directors and Managing Directors will be required to attend when appropriate.

The Trust Secretary, Managing Director for Planning and Strategy, ~~Head of Improvement and Business Insight~~ ~~Performance Insight and Improvement Manager~~, Deputy Chief Finance Officer and Deputy Chief Medical Officer 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~~ 6 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.

## Terms of Reference (April-June 2026) Finance and Performance Committee

The Chief Finance and Commercial 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
  - Represent significant developments / improvements that will help the Trust deliver its objectives and/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.

## Terms of Reference (April-June 2026) Finance and Performance Committee

- 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.
- To consider opportunities for partnership working when discussing issues relevant to the Committee's remit.
- 
- 

### 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.

April-June 2026 - Finance and Performance Committee  
May-July 2026 – Board of Directors

## Chair's Assurance Report DERIC Committee

### Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 01 July 2026

### Author:

Name: Mary Bardsley  
Role/Title: Assistant Trust Secretary

### Contributors:

### Report sign-off:

Martin Evans, Chair of the DERIC Committee

### Is the report suitable for publication?:

Yes

### 1. Key issues and considerations:

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

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

This report provides a summary of the items considered at the Committee meeting held on insert 21 May and 26 June 2026. It highlights the key areas the Committee wishes to bring to the attention of the Board.

### 2. Strategic objectives and associated risks:

The following strategic objectives, developed in light of national and system priorities, are relevant to the content of this report:

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

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

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

## Chair's Assurance Report DERIC Committee

### Trust values:

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

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

### 3. Assurance Report from DERIC Committee

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

**ALERT** - The DERIC Committee wishes to bring the following issues to the Board's attention as they:  
Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address;  
Represent significant developments / improvements that will help the Trust deliver its objectives; AND / OR  
Require the approval of the Board for work to progress.

**University Status (May):** The Committee noted the progress towards University Hospital status, with the application largely complete and discussions underway with Keele University regarding the Academic Associate Non-Executive Director role. This is a key strategic development supporting research, education and workforce ambitions. While national approval timescales remain unclear, assurance was gained on progress, with further detail on governance arrangements and timelines requested.

**Review the Committee Effectiveness, Terms of Reference and Annual Report (May and June):** Concerns regarding the timeliness and quality of papers was highlighted, representing a risk to effective scrutiny, with recent improvements acknowledged. Assurance was provided that revised processes, including earlier executive review and clearer timelines, are in place to address this. The Committee approved the self-assessment and Terms of Reference for submission to the Trust Board.

#### 3.2 Areas of on-going monitoring with new developments

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

**Corporate Risk Register (May):** The Committee noted the introduction of the Corporate Risk Register in the new Radar format, which improves visibility of risk histories and supporting information, but is not yet fully embedded. Further work is required to ensure consistent recording and clearer distinction between controls, mitigations and actions. While the system offers enhanced scrutiny, the Committee highlighted gaps in reporting, particularly around action plan timescales, impact on risk scores and delivery confidence, and agreed these should be strengthened to support assurance.

**Chairs Assurance Report – EPR Implementation Assurance Meeting (May):** Reasonable assurance was provided regarding the overall direction of travel; however, the programme requires continued close oversight given its scale and the extent of ongoing operational and technical work. Key concerns relate to the trajectory and management of programme risks, with further clarity required on the alignment of mitigation actions to specific risks, how their effectiveness will be measured, and when risk scores are expected to reduce. Positive progress was noted in relation to clinician engagement, with structured work underway to address user experience issues and system functionality as part of ongoing optimisation. Work is also progressing to define the resource requirements for the next phase of delivery, with any proposals subject to Executive approval. The Committee emphasised the importance of maintaining strong clinical engagement, clear escalation processes, and robust

## Chair's Assurance Report DERIC Committee

assurance arrangements to support continued improvement in system performance and user experience.

**PACS Update (June):** The Committee acknowledged the progress made since previous reports and is now more assured regarding the programme's trajectory – seeking an extension to current contract whilst awaiting progress of a new West Midlands Network system. Committee agreed that future progress updates would be reported via the Digital Operational meeting. Strengthening governance of digital risks remains a priority as concerns were raised regarding visibility, ownership, and escalation of digital risks within Radiology following migration to the new risk management system.

**Chair Reports from Digital Operational Meeting (May and June):** It was noted that clinician-raised issues are now informing the second phase of the EPR recovery plan, supported by a six-month roadmap to improve visibility of actions and progress. A historical information security issue in theatres was confirmed as resolved and under monitoring. The Committee emphasised the need for clear communication with clinicians and staff and was assured that appropriate actions and engagement mechanisms are in place.

**Training Centre (May):** The Committee noted early-stage progress on the proposed education and training centre, aligned to the Trust's strategic ambitions. A working group has been established and initial scoping is underway; however, further detail on scope, costs, governance and delivery is required to provide full assurance, with an update scheduled for September.

**Performance Report (May and June):** The Committee noted continued progress in developing the Integrated Performance Report, with new measures added across education, simulation, research, and commercial activity. As datasets mature, the report is expected to show clearer trends rather than isolated activity figures. Members reiterated the need to strengthen assurance by shifting from activity-based reporting to clearer evidence of outcomes, impact, and strategic delivery, supported by trend analysis and alignment with organisational priorities. Further refinement is underway, including review of commercial and digital indicators and development of reporting against the clinical education strategy.

### 3.3 Areas of assurance

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

**RADAR Healthcare Progress and Dashboard (May):** The Committee noted that Phase One is nearing completion, delivering enhanced analytics, improved governance and risk visibility, and centralised document management to address current risks with fragmented storage. Progress was welcomed, with assurance provided, subject to continued focus on staff training, system adoption and embedding. Some timelines have been adjusted, including Freedom to Speak Up and SMS functionality. The Committee noted that the RADAR dashboard will replace legacy systems and improve visibility across services, risks and performance through enhanced reporting and drill-down functionality. Early benefits are being realised; however, continued focus on optimisation, consistency and maximising system use is required. Overall assurance was provided.

**Digital Road Map Update (June):** The Committee received assurance regarding progress against the Digital Roadmap, noting that no significant changes to delivery plans were reported. Members were encouraged by the positive outcome of external funding applications, with over £1 million of NHS England funding expected to support delivery of key digital ambitions. The Committee also supported the proposal to enhance future roadmap reporting by including the anticipated benefits and impact of digital initiatives on organisational performance, patient experience and staff experience, to provide greater assurance of value realisation and strategic delivery.

**Digital: EPR Benefits Communication (June):** The Committee received assurance that communications continue to improve to promote realised EPR benefits and sustain staff engagement as digital services develop. The importance of consistent, effective communication was acknowledged.

## Chair's Assurance Report DERIC Committee

**EPR SRO Update (June):** The Committee received assurance that the business case for additional EPR resources has been subject to detailed review, with benefits reassessed and validated by the EPR team and Finance. Whilst some originally forecast benefits have changed, alternative and additional benefits have been identified, ensuring the anticipated return on investment remains achievable. The Committee was further assured that arrangements are being put in place to monitor and track benefits realisation and noted the opportunity to secure matched investment from NHS England to maximise the value of the Trust's investment.

**Chair Report from Research Meeting (May and June):** Research governance and capacity-building activity within the Trust continued to progress positively across May and June. The annual audit undertaken in May confirmed that research governance arrangements remain robust, providing strong assurance to the Committee. Work to enhance research capacity has also advanced, supported by new roles and partnership activity with Keele University, with emerging opportunities particularly in prevention and health inequalities. The Committee reiterated the importance of improving the visibility of research impact, and case studies are now in development to support this. Recruitment challenges have been resolved with the appointment of an Allied Health Professional, enabling planned activity to proceed as intended. The baseline survey has closed with 91 responses across a range of professional groups, showing notably higher engagement from Allied Health Professionals compared with nursing staff. Use of a validated national tool provides reliable data and allows future benchmarking. Detailed analysis will now be undertaken to identify priority areas for strengthening research capability across the Trust.

**ASCOT Research Presentation (June):** The Committee received an update on the ASCOT cartilage repair research programme that had been running for almost 20 years. The study had been designed to determine whether stem cells harvested from bone marrow could repair joint damage more effectively than cultured cartilage cells, or whether a combination of both approaches produced improved patient outcomes. The committee noted significant benefits reported by participants, alongside the potential to influence future NICE guidance and regenerative medicine practice. Members recognised the strategic opportunity for RJAH to develop and commercialise this innovative therapy, with programme governance and commercial partnerships now being established to support future national adoption and service growth.

**T-cell Derived Extracellular Vesicles Research Presentation (June):** The Committee received an RJAH award-winning research presentation from Henry Barrett, a final-year PhD student at Keele University based at RJAH, on the potential use of regulatory T-cell derived extracellular vesicles as a novel treatment for autoimmune and inflammatory conditions. Members noted the promising early findings and the clear translational pathway towards future clinical application. The Committee was assured of this high quality research and innovation activity being undertaken through RJAH and its academic partnerships, supporting the Trust's strategic ambition to advance research, innovation and patient care. The Committee highlighted the opportunity and need for more communication internally and externally in relation to some of the groundbreaking research that is taking place.

**Sim Lab Development (May):** The Committee noted progress in developing simulation capabilities, including collaboration with external partners and alignment to the Trust's educational ambitions. A gap in dedicated simulation space was identified, with opportunities to address this through the proposed education and training centre. Increased use of immersive and digital approaches, including virtual reality, was highlighted, with overall assurance provided, subject to further work on infrastructure and collaborative faculty arrangements.

**Education Strategy (May):** The Committee received an update on the refreshed Education Strategy and dashboard aligned to 2026/27 priorities. Discussion focused on DERIC-relevant elements, including a shift towards competence-based education, alignment with the NHS England Education Quality Framework, and development of scalable, digitally enhanced training. Opportunities for innovation, research, and commercialisation were noted. The Committee received reasonable assurance, noting the need for clearer reporting on DERIC-specific priorities, including innovation, education governance and assurance metrics.

## Chair's Assurance Report DERIC Committee

**National Education and Training Survey (NETS) (May):** The Committee noted strong NETS performance, with the Trust above the national average in fourteen domains and none below, particularly in trainee satisfaction and supervision. While this provides high assurance, improvements are required in reporting and escalation, feedback, teamwork, and handover. Actions are underway, and the Committee emphasised the need for clear evidence of measurable improvement over time.

### 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.

(Part 1) Covering paper

<b>Committee / Group / Meeting, Date</b>	
Board of Directors, 01 July 2026	
<b>Author:</b>	<b>Contributors:</b>
Name: Mary Bardsley Role/Title: Assistant Trust Secretary	
<b>Report sign-off:</b>	
Name: Dylan Murphy, Trust Secretary DERIC Committee	
<b>Is the report suitable for publication?:</b>	
Yes	
<b>Executive Summary:</b>	
<p>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.</p> <p>The DERIC Committee supports the Board by providing assurance on all areas relating to <b>Digital</b>, Education, Research, Innovation, and Commercialisation. It also offers the Board dedicated space to think strategically and develop work within this remit, while ensuring that delivery is monitored and any risks to quality are identified early and addressed robustly.</p> <p>In line with good practice, the committees of the Board undertake an annual review of their operation and effectiveness. This involves:</p> <ul style="list-style-type: none"> <li>• Reviewing the role of the committee, its key responsibilities, membership and business considered during the year.</li> <li>• A questionnaire on the effectiveness of the operation of the committee (completed by individual members / core attendees).</li> <li>• A self-assessment against key governance questions (for collective consideration).</li> <li>• Review of the terms of reference to ensure the focus of the Committee remains relevant in 2026/27.</li> </ul> <p>No significant issues were identified during the review but some minor revisions to the terms of reference (TOR) have been made. The main change to the TOR is to reflect the move to meeting in alternate months. That move will be supported by a revised process for the review and approval of papers to support the production of high-quality papers in good time for consideration by the committees.</p>	
<b>Recommendations:</b>	
<p>That the Board NOTE that the Committee has:</p> <ol style="list-style-type: none"> <li>1. <b>Considered</b> the outcome of the committee effectiveness survey and did not identify any significant issues;</li> <li>2. <b>Considered and agreed</b> the self-assessment document;</li> <li>3. <b>Noted</b> the 2025/26 Decision / Activity log.</li> <li>4. <b>Considered</b> the draft Terms of Reference for 2026/27 and recommended that the Board approve them.</li> </ol> <p>The Board is therefore asked to CONSIDER and APPROVE the proposed terms of reference for 2026/7.</p>	

(Part 2) Strategic alignment and supporting detail

**Strategic objectives and associated risks:**

The work of the committees, and the Board assurance arrangements, support delivery of all of the Trust's strategic objectives:

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

The work of the committees, and the Board assurance arrangements, are relevant to all of the Board Assurance Framework (BAF) themes and associated strategic risks but this Committee has a particular focus on:

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

**Trust Values:**

Board and committee meeting agendas each include an opportunity to reflect on the extent to which the agenda / discussion reflect and support the Trust's values:

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

**Report development and engagement history:**

The Committee considered the annual review documentation at its meeting in April 2026.

The Committee considered an updated Terms of Reference at its meeting in June.

**Next steps:**

The Committee will operate in line with the revised Terms of Reference. The workplan will be reviewed and updated as required to ensure the committee provides the necessary assurance to the Board inline with the agreed Board meeting pattern.

Any issues of concern, or apparent gaps in the governance arrangements, identified during the Committee reviews would be reported to the Audit and Risk Committee for consideration. No such gaps were identified.

**Appendix**

Digital, Education, Research, Innovation and Commercialisation Committee Annual Review, 2025/6

## DERIC Committee Annual Report

### 1. Committee Roles and Responsibilities (2025/26)

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 (2025/26)

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

## DERIC Committee Annual Report

### 3. Meetings (2025/26)

During 2025/26, the Committee met on ten occasions to consider its routine monthly agenda. It was noted that all meetings were quorate

### 4. Committee Attendance (2025/26)

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

Name	Title	Attendance
<b>Core Membership</b>		
Martin Evans	Non-Executive Director (Chair)	09 / 10 = 90%
Penny Venables	Non-Executive Director	07 / 07 = 100%
Atif Ishaq	Associate Non-Executive Director	10 / 10 = 100%
John Pepper	Associate Non-Executive Director	02 / 03 = 67%
Darius Mirza	Non-Executive Director	03 / 04 = 75%
Sarfraz Nawaz	Non-Executive Director	04 / 06 = 67%
Ruth Longfellow	Chief Medical Officer	08 / 10 = 80%
Denise Harnin	Chief People and Culture Officer	09 / 10 = 90%
Angela Mulholland-Wells	Chief Finance and Commercial Officer	07 / 09 = 78%
Stacey Keegan	Chief Executive Officer	05 / 10 = 50%
<b>In Attendance</b>		
Dylan Murphy	Trust Secretary	10
Mike Carr	Chief Operating Officer	06
Jayne Johnson	Nursing and AHP Workforce Lead	00
Simon Adams	Director of Digital	08
Sam Young	Deputy CNO / CNIO	02
Andrew Roberts	Director of Research, Audit, Outcomes and Innovation	07
Steph Kelly	Radiology Service Manager	03

\*The Chief Executive Officer has an open invitation to the meeting and isn't required to attend the meeting.

### 5. Committee Activity and Decision Log (2025/26)

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

### 6. Conduct of Meetings (2025/26)

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.

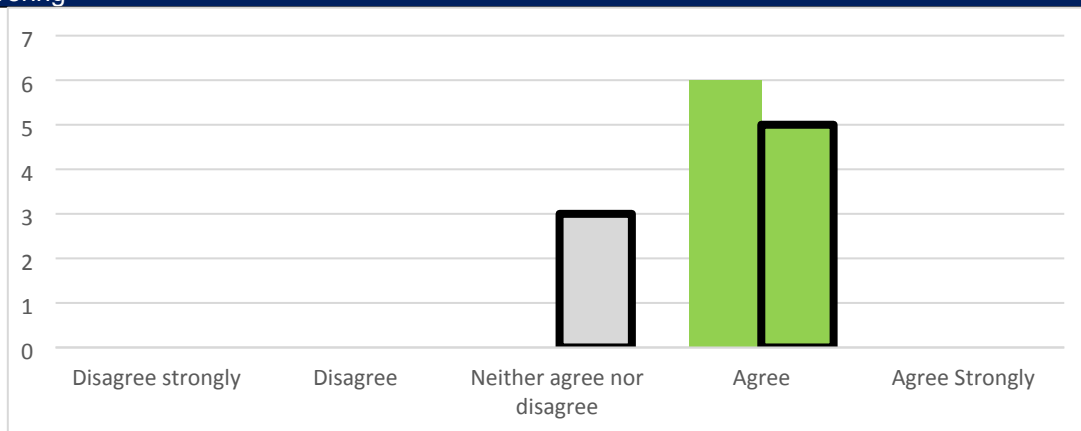
### 7. Committee Effectiveness Survey (2025/26)

The Committee effectiveness survey was circulated to a total of 13 people (core members and frequent attendees of the meeting). There was a total of 8 responses received.

The 2025/26 results (the second of the two columns, with the black outline) are displayed alongside the 2024/25 results (based on the 6 returns received last year).

# DERIC Committee Annual Report

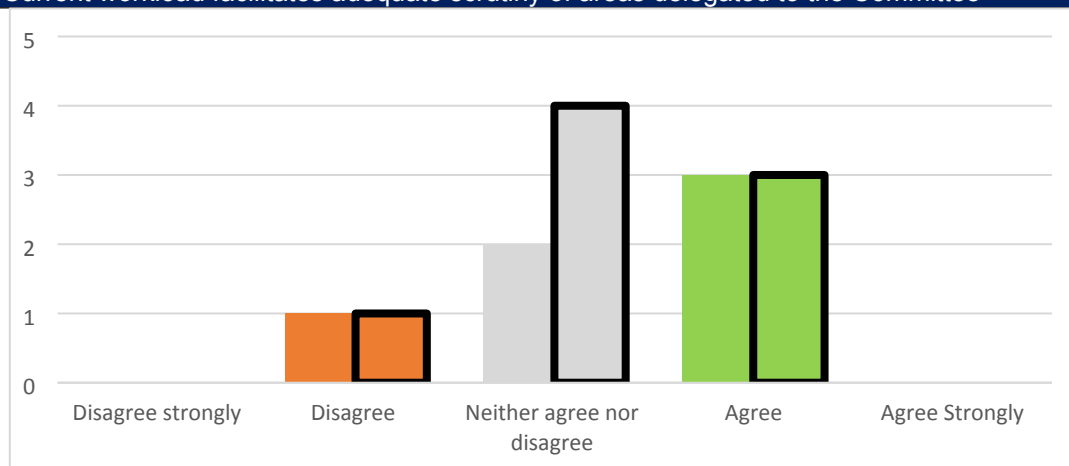
## Q1 The work plan gives appropriate coverage to the areas which I consider that it should be covering



### Comments

- I agree generally, though not all areas developing at same pace
- Improving
- The "I" in DERIC is referred to as "Innovation". What about "Improvement" recognising the differences between the words?

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

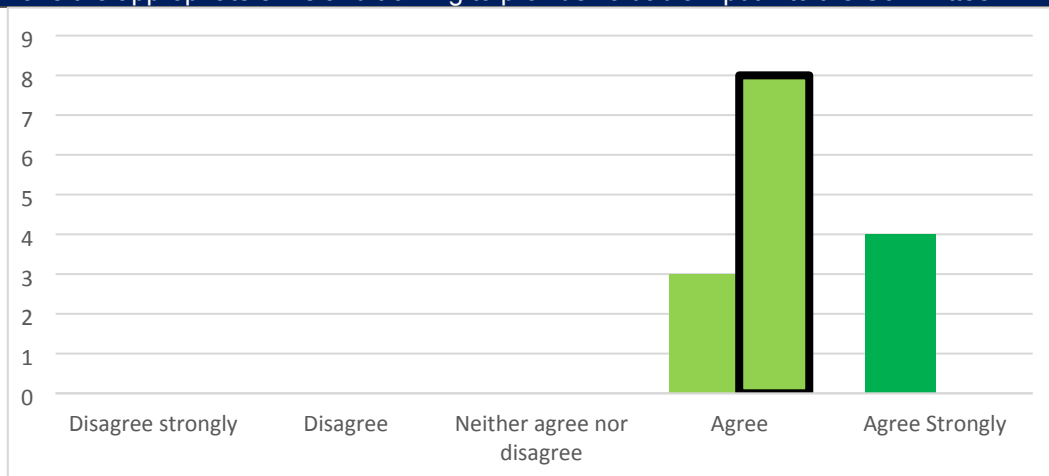


### Comments

- There is a lot of topics to cover in the time and often there is a large focus on digital. There has been some work to sequence the agenda differently each meeting but this has not been fully operationalised yet.
- Due to the nature of this committee, it doesn't have hard outcomes and KPIs ' hence scrutiny is different. Maybe this committee should focus on accountability of lead for each area
- There is a large range of areas to cover and it is sometimes difficult to cover all the areas within the meeting timeframe
- Some KPIs still in development / limited regular oversight.
- Will be enhanced by introducing focus sessions for each of the 5 strands in future meetings.

# DERIC Committee Annual Report

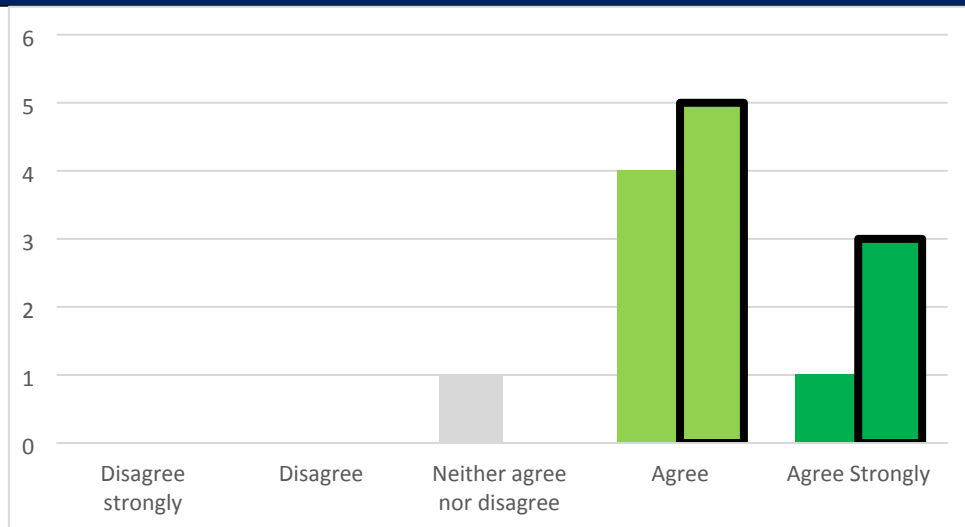
## Q3 I have the appropriate skills and training to provide valuable input into the Committee



### Comments

- There are no responses.

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

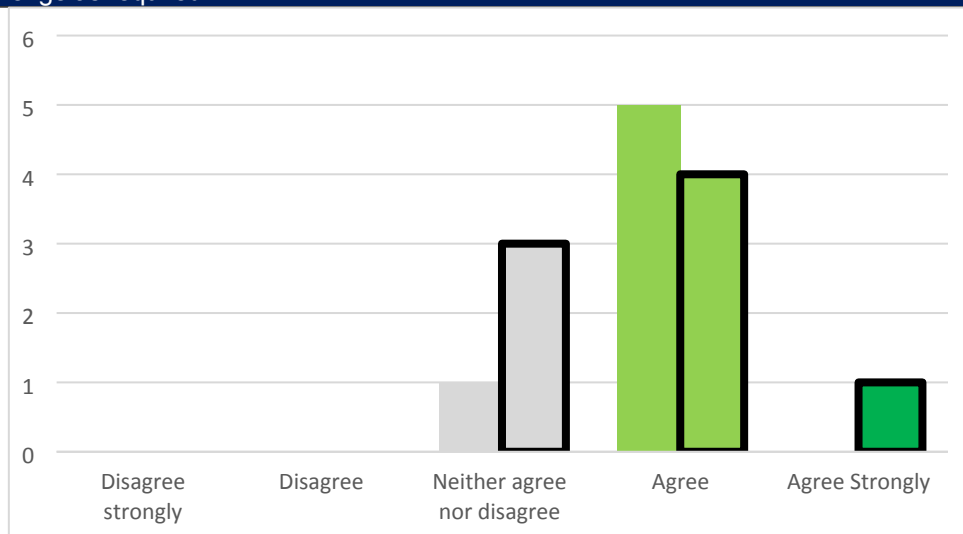


### Comments

- There are no responses

## DERIC Committee Annual Report

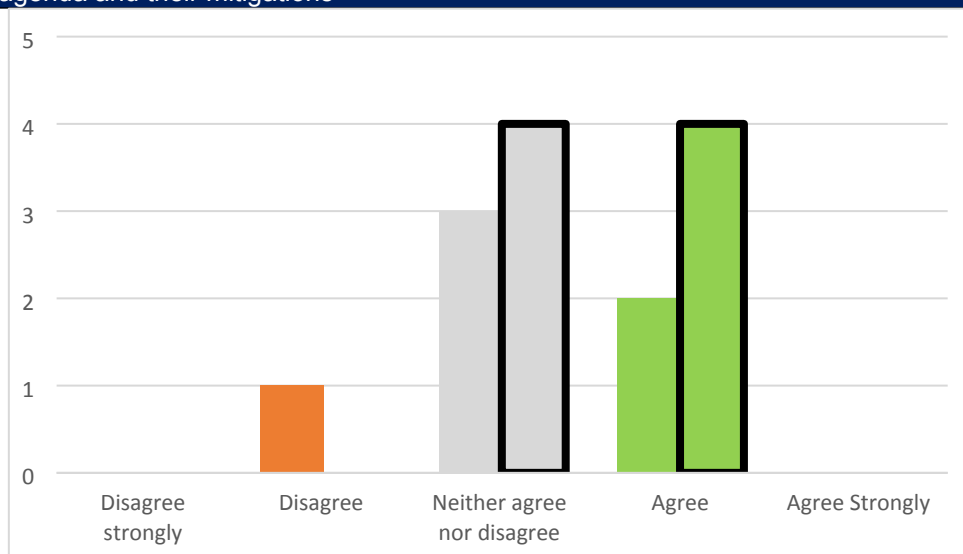
**Q5 I consider that the time spent on each agenda item is appropriate and sufficient for scrutiny and challenge as required**



### Comments

- Will be enhanced by introducing focus sessions for each of the 5 strands in future meetings.

**Q6 I have received the information which I require to consider the Trust's risks to delivery of the DERIC agenda and their mitigations**

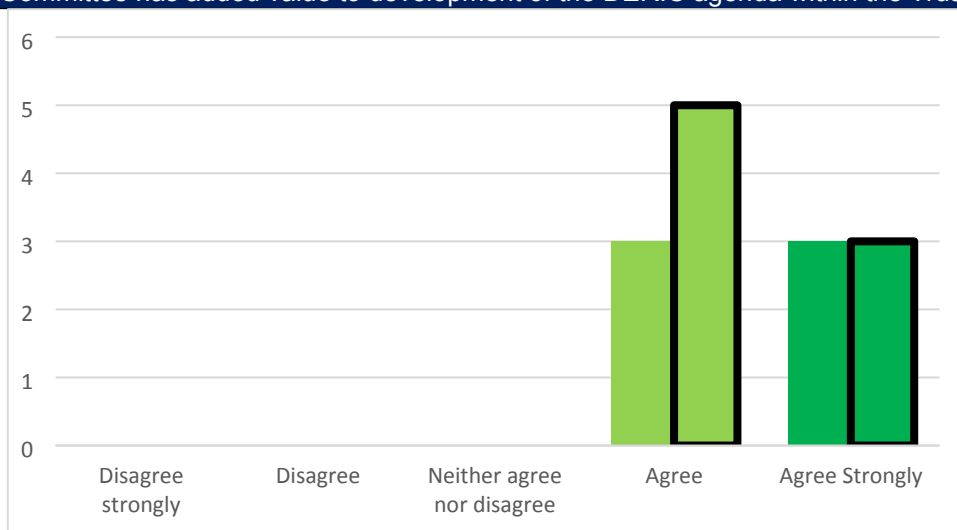


### Comments

- There needs to be further work done to link the different strategies together so it is clear how the agenda and mitigations are all working towards the trust's goals.
- not all areas have risks attached to them
- Developing
- The timeliness of papers is still an issue and the development of the key KPIs still needs further work
- we've discussed the purpose of the committee

## DERIC Committee Annual Report

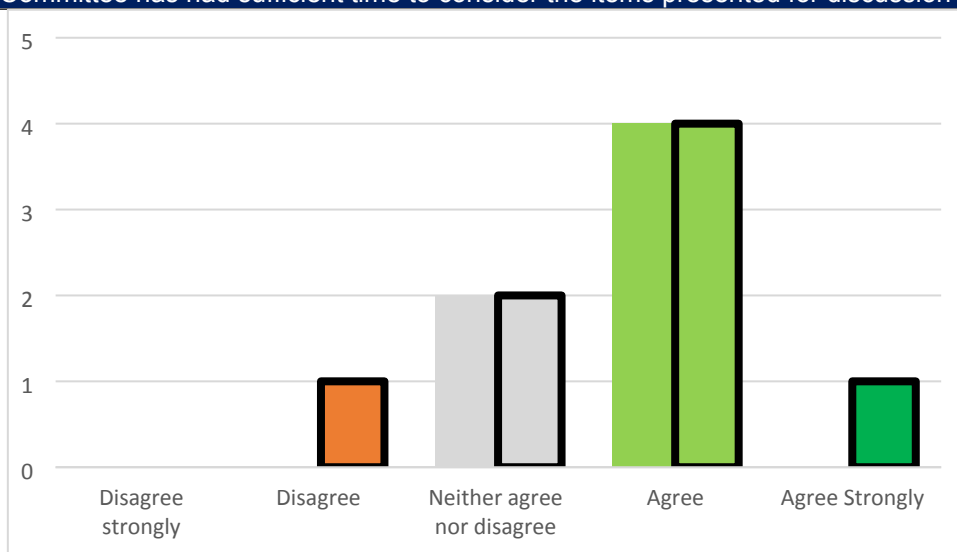
**Q7 The Committee has added value to development of the DERIC agenda within the Trust**



**Comments**

- There were no responses.

**Q8 The Committee has had sufficient time to consider the items presented for discussion**

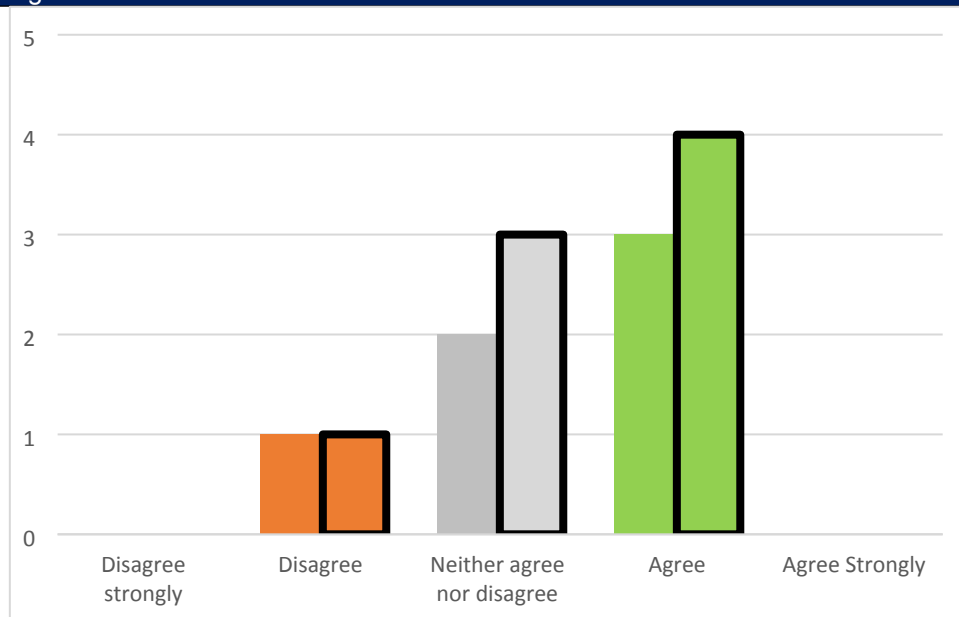


**Comments**

- There were no responses.

## DERIC Committee Annual Report

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



### Comments

- Papers are often late and/or actions to be deferred.
- Some still in development at this point in time.

## 8. Committee Self-Assessment (2025/26)

Area / Question	Response	Comments / Action
<b>Composition, Establishment and Duties</b>		
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 Nurse and Chief Medical 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 induction meetings.

## DERIC Committee Annual Report

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. (Public = written / Private = verbal)
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 supported by the attendance matrix. This detail is reported to the Board as part of the assurance report.
<b>Compliance with the Law and Regulations Governing the NHS</b>		
Does the committee review assurance and regulatory compliance reporting processes?	Yes	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 however and its outlook is more developmental / forward-looking.
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.
<b>Internal Control</b>		
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?	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.

## DERIC Committee Annual Report

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 revised the Corporate Stands Manual in 2025/26 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.
<b>Administrative Arrangements</b>		
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 with the Chairs approval.
Does the committee meet the appropriate number of times a year?	Yes	The committee meets 10 times per year and additional meeting can be scheduled upon request.
<b>Other Issues</b>		
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 2026/26

To support with continuous improvement of the DERIC Committee, members are asked to review the Terms of Reference and consider any required revisions for 2026/27 (appendix B)

#### Appendices

Appendix A	DERIC Decision / Activity Log from 2025/26
Appendix B	DERIC Draft Terms of Reference for 2026/27

**DERIC Committee - ACTIVITY / DECISION LOG**

Updated: 21/04/2026

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?	If a recommendation - date of subsequent consideration at approval body
1	24.04.2025	Innovation Story: Commercialisation of the Orthotic CCD Lever	None noted	The Committee considered and subsequently noted the report.			
2	24.04.2025	Digital Security Report	None noted	The Committee considered and subsequently noted the report.			
3	24.04.2025	Digital Strategy	None noted	The Committee approved the Digital Strategy		<i>For onward approval at Board</i>	May-26
4	24.04.2025	Chair Report: Research Meeting	None noted	The Committee considered and subsequently noted the report.			
5	24.04.2025	Innovation and Improvement Strategy	None noted	The Committee considered and subsequently noted the strategy with a request to come back for a further review following amendments			
6	24.04.2025	Work Plan and Attendance Matrix	None noted	The Committee noted the Workplan and Attendance Matrix			
7	24.04.2025	Development of Dashboard/KPI's	None noted	The Committee considered and subsequently noted the report.			
8	24.07.2025	Chair Report: Digital Transformation Programme Board	None noted	The Committee considered and subsequently noted the report.			
9	24.07.2025	Chair Report: EPR Implementation Assurance Meeting	None noted	The Committee considered and subsequently noted the report.			
10	24.07.2025	Cyber Security Report	None noted	The Committee considered and subsequently noted the report.			
11	24.07.2025	RJAH PACS/RIS Procurement Project	None noted	The Committee considered and subsequently noted the report.			
12	24.07.2025	Digital Strategy Progress Update	None noted	The Committee considered and subsequently noted the report.			
13	24.07.2025	Digital EPR Metrics	None noted	The Committee considered and subsequently noted the report.			
14	24.07.2025	Quality Improvement Audits	None noted	The Committee considered and subsequently noted the report.			
15	24.07.2025	Innovation and Improvement Strategy Progress Report	None noted	Following consideration and subsequent discussion, the Committee approved the strategy subject to suggested amendments.			
16	24.07.2025	Chair Report: Education and Training Oversight meeting	None noted	The Committee noted the report.			
17	24.07.2025	Chair Report: Research meeting	None noted	The Committee considered and subsequently noted the report.			
18	24.07.2025	Research Strategy Progress Report	None noted	The Committee noted the update			
19	24.07.2025	Audit Report: Tissue Sample	None noted	The Committee considered and subsequently noted the report.			
20	24.07.2025	Work Plan and Attendance Matrix	None noted	The Committee noted the Workplan and Attendance Matrix			
21	18.09.2025	Innovation Story - Pre-Operative Screening Changes	None noted	The Committee considered and subsequently noted the report.			
22	18.09.2025	Corporate Risk Register	None noted	The Committee considered and subsequently noted the report.			
23	18.09.2025	Board Assurance Framework	None noted	The Committee considered and subsequently noted the report.			
24	18.09.2025	Chair Report: Digital Transformation Group	None noted	The Committee considered and subsequently noted the report.			
25	18.09.2025	Chair Report: EPR Implementation Assurance Meeting	None noted	The Committee considered and subsequently noted the report.			
26	18.09.2025	Apollo Update	None noted	The Committee considered and subsequently noted the update.			
27	18.09.2025	Apollo Risks	None noted	The Committee considered and subsequently noted the report.			
28	18.09.2025	Cyber Security Report	None noted	The Committee considered and subsequently noted the report.			

**DERIC Committee - ACTIVITY / DECISION LOG**

Updated: 21/04/2026

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?	If a recommendation - date of subsequent consideration at approval body
29	18.09.2025	Sim Lab Progress Update	None noted	The Committee considered and subsequently noted the report.			
30	18.09.2025	Chair Report: Education and Training Oversight meeting	None noted	The Committee considered and subsequently noted the report.			
31	18.09.2025	Chair Report: Research meeting	None noted	The Committee considered and subsequently noted the report.			
32	18.09.2025	Research Strategy		Following consideration and subsequent discussion, the Committee approved the strategy subject to suggested amendments.			
33	18.09.2025	Work Plan and Attendance Matrix	None noted	The Committee noted the Workplan and Attendance Matrix			
34	18.09.2025	Research Governance MIAA Report	None noted	The Committee considered and subsequently noted the report.			
35	22.10.25	Private Patient Unit Independent Review Feedback	None noted	The Committee considered and subsequently noted the report.			
36	22.10.25	Corporate Risk Register	None noted	The Committee noted the Workplan and Attendance Matrix			
37	22.10.25	Update on development of commercialisation capability	None noted	The Committee considered and subsequently noted the report.			
38	22.10.25	Innovation and Improvement Strategy- progress report	None noted	The Committee considered and subsequently noted the report.			
39	22.10.25	Chair Report: Education and Training Oversight Meeting (for noting)	None noted	The Committee considered and subsequently noted the report.			
40	22.10.25	Chaire Report: Research Meeting	None noted	The Committee considered and subsequently noted the report.			
41	22.10.25	Apollo Update	None noted	The Committee considered and subsequently noted the report.			
42	22.10.25	Chair Report: DTG	None noted	The Committee considered and subsequently noted the update.			
43	22.10.25	Chair Report: EPR Implementation Assurance Meeting	None noted	The Committee considered and subsequently noted the report.			
44	22.10.25	Cyber Security Report	None noted	The Committee considered and subsequently noted the report.			
45	22.10.25	Digital Strategy Progress Report	None noted	The Committee considered and subsequently noted the report.			
46	22.10.25	RJAH PACS Update	None noted	The Committee considered and subsequently noted the report.			
47	22.10.25	IPR Dashboard	None noted	The Committee considered and subsequently noted the report.			
48	22.10.25	Attendance matrix and workplan	None noted	The Committee considered and subsequently noted the report.			
49	22.10.25	PARt 2: NHSE Cyber Posture	None noted	The Committee considered and subsequently noted the report.			
50	20.11.2025	Innovation Story: Opiate reduction QI project Presentation	None noted	The Committee considered and subsequently noted the report.			
51	20.11.2025	Performance report	None noted	The Committee considered and subsequently noted the report.			
52	20.11.2025	Board Assurance Framework	None noted	The Committee considered and subsequently noted the report.			
53	20.11.2025	Chair Report: DTG	None noted	The Committee considered and subsequently noted the report.			
54	20.11.2025	Chair Report: EPR Implementation Assurance Meeting	None noted	The Committee considered and subsequently noted the report.			
55	20.11.2025	Digital Security Report	None noted	The Committee considered and subsequently noted the report.			
56	20.11.2025	Proposal of Exec Leads for Education Streams	None noted	The Committee considered and subsequently noted the report.			
57	20.11.2025	Education and Training Strategy Progress Report	None noted	The Committee considered and subsequently noted the report.			

**DERIC Committee - ACTIVITY / DECISION LOG**

Updated: 21/04/2026

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?	If a recommendation - date of subsequent consideration at approval body
58	20.11.2025	Chair Report: Multiprofessional Education Strategy Working Group	None noted	The Committee considered and subsequently noted the report.			
59	20.11.2025	Well Led Review Action Plan	None noted	The Committee considered and subsequently noted the report.			
60	20.11.2025	Review of the workplan/Attendance matrix	None noted	The Committee considered and subsequently noted the report.			
61	22.01.2026	Post Operative Blood Transfusion audit	None noted	The Committee considered and subsequently noted the report.			
62	22.01.2026	Corporate Risk Register	None noted	The Committee considered and subsequently noted the report.			
63	22.01.2026	Chair Report: DTG	None noted	The Committee considered and subsequently noted the report.			
64	22.01.2026	Chair Report: EPR Implementation Assurance Meeting	None noted	The Committee considered and subsequently noted the report.			
65	22.01.2026	EPR/Apollo Progress Report	None noted	The Committee considered and subsequently noted the report.			
66	22.01.2026	Digital/Cyber Strategy	None noted	The Committee considered and subsequently noted the report.			
67	22.01.2026	Benefits/Potential Opportunities of RADAR	None noted	The Committee considered and subsequently noted the report.			
68	22.01.2026	Medical Students	None noted	The Committee considered and subsequently noted the report.			
69	22.01.2026	Chair Report: Research Meeting	None noted	The Committee considered and subsequently noted the report.			
70	22.01.2026	Research Strategy	None noted	The Committee considered and subsequently noted the report.			
71	22.01.2026	Innovation and Improvement Update	None noted	The Committee considered and subsequently noted the report.			
72	22.01.2026	Update on development of commercialisation capability	None noted	The Committee considered and subsequently noted the report.			
73	22.01.2026	Commerical Strategy update	None noted	The Committee considered and subsequently noted the report.			
74	22.01.2026	Review of DERIC Committee	None noted	The Committee considered and subsequently noted the report.			
75	22.01.2026	Review of the workplan/Attendance matrix	None noted	The Committee considered and subsequently noted the report.			
76	22.01.2026	Integrated Performance Report	None noted	The Committee considered and subsequently noted the report.			
77	19.02.2026	PACS Assurance Progress	None noted	The Committee considered and subsequently noted the report.			
78	19.02.2026	Chair Report DTG	None noted	The Committee considered and subsequently noted the report.			
79	19.02.2026	Chair Report EPR	None noted	The Committee considered and subsequently noted the report.			
80	19.02.2026	Digital Security Report	None noted	The Committee considered and subsequently noted the report.			
81	19.02.2026	DERIC Digital Development	None noted	The Committee considered and subsequently noted the report.			
82	19.02.2026	DERIC Education Development	None noted	The Committee considered and subsequently noted the report.			
83	19.02.2026	Chair Report: Research Meeting	None noted	The Committee considered and subsequently noted the report.			
84	19.02.2026	DERIC research development	None noted	The Committee considered and subsequently noted the report.			
85	19.02.2026	DERIC Commercialisation development	None noted	The Committee considered and subsequently noted the report.			
86	19.02.2026	DERIC Survey Feedback	None noted	The Committee considered and subsequently noted the report.			
87	19.02.2026	Integrated Performance Report	None noted	The Committee considered and subsequently noted the report.			

**DERIC Committee - ACTIVITY / DECISION LOG**

Updated: 21/04/2026

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?	If a recommendation - date of subsequent consideration at approval body
88	19.02.2026	Well led development review action plan	None noted	The Committee considered and subsequently noted the report.			
89	19.02.2026	Review of the workplan/Attendance matrix	None noted	The Committee considered and subsequently noted the report.			
90	19.03.2026	Board Assurance Framework	None noted	The Committee considered and subsequently noted the update.			
91	19.03.2026	Corporate Risk Register	None noted	The Committee considered and subsequently noted the report.			
92	19.03.2026	Digital Productivity Funding Opportunities	None noted	The Committee considered and subsequently noted the update.			
93	19.03.2026	Research Development	None noted	The Committee considered and subsequently noted the report.			
94	19.03.2026	Sim Lab Progress	None noted	The Committee considered and subsequently noted the update.			
95	19.03.2026	Private Patient Unit Progress	None noted	The Committee considered and subsequently noted the report.			
96	19.03.2026	Chair Report: EPR Implementation Assurance Meeting	None noted	The Committee considered and subsequently noted the update.			
97	19.03.2026	Chair Report: Digital Transformation Programme Group	None noted	The Committee considered and subsequently noted the report.			
98	19.03.2026	Digital Security Report	None noted	The Committee considered and subsequently noted the update.			
99	19.03.2026	Chair Report: Research Meeting	None noted	The Committee considered and subsequently noted the report.			
100	19.03.2026	Education Strategy	None noted	The Committee considered and subsequently noted the update.			
101	19.03.2026	Integrated Performance Report	None noted	The Committee considered and subsequently noted the report.			
102	19.03.2026	Review of the 2026/27 Workplan & Attendance Matrix	None noted	The Committee considered and subsequently noted the update.			
103	19.03.2026	Risk Reflection/Values Reflection	None noted	The Committee considered and subsequently noted the report.			

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11

## 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 (Joint Executive Lead)
- Chief People and Culture Officer
- Chief Finance and Commercial Officer (Joint Executive Lead)

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:

- Chief Digital and Information Officer
- Director of Research, Audit, Outcomes and Innovation;
- Chief Nursing Information Officer;
- Chief Clinical Information Officer
- Nursing / AHP Workforce Lead; ~~and~~
- Trust Secretary
- Director of Medical Education
- Director of Commercial
- Head of Improvement and Business Insight

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

1
2
3
4
5
6
7
8
9
10
11

- Clinical Audit Lead
- Training Programme Directors
- [Head of Education, Training and Development](#) ~~Head of Knowledge and Learning~~
- Research Manager

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

#### 4. Frequency of meetings and agenda setting

The Committee will ~~hold at least six meetings a year to conduct regular business and provide assurance reports to the Board. meet at least 10 times a year for regular business.~~ The Committee ~~may hold additional meetings to progress issues within its remit but will~~ not normally meet in August and December. The Chair of the Committee may call additional meetings.

The Chief Medical Officer ~~and Chief Finance and Commercial Officer~~ shall jointly agree the agenda with the Chair of the Committee and other attendees. The ~~Assistant Trust Secretary~~ Executive Assistant to the Chief Medical Officer 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 opportunities for developing strategies relevant to its remit that will support the Trust in delivering its strategic objectives and corporate priorities. It will support and promote the development of such strategies and provide assurance to the Board on their delivery. 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:

- 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~~
  - [Represent significant developments / improvements that will help the Trust deliver its objectives and/or](#)
  - Require the approval of the Board for work to progress.

1
2
3
4
5
6
7
8
9
10
11

Terms of Reference

Digital, Education, Research, Innovation and Commercialisation Committee

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**

The Committee shall consider both assurance reports and developmental discussions relating to its remit. Meeting agendas shall be structured to support this dual role. Key areas for consideration will include the following:

**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 (as it applies to the remit of this Committee).
- Consider the underpinning governance arrangements that support delivery of the Trust’s education strategy / agenda (as it applies to the remit of this Committee).
- Receive Chair’s Assurance reports from relevant meetings that support delivery of this strategy / agenda (as it applies to the remit of this Committee).

(\*in relation to the broader education strategy and how that supports the Trust’s strategic objectives as they relate to this Committee – i.e. in supporting the Digital, Research, Innovation agenda etc. Training compliance and other operational aspects of the education agenda will be overseen by the relevant committee People and Culture Committee).

**Innovation and improvement**

- Consider the Trust’s improvement and innovation strategy and make a recommendation to the Board on its approval.
- Oversee the delivery of the Trust’s improvement and innovation strategy.

1
2
3
4
5
6
7
8
9
10
11

Terms of Reference

Digital, Education, Research, Innovation and Commercialisation Committee

- Consider the underpinning governance arrangements that support delivery of the Trust's improvement and 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.

**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.
- [To consider opportunities for partnership working when discussing issues relevant to the Committee's remit.](#)

1
2
3
4
5
6
7
8
9
10
11

# Chair's Assurance Report Audit and Risk Committee

## Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 01 July 2026

## Author:

Name: Mary Bardsley  
Role/Title: Assistant Trust Secretary

## Contributors:

## Report sign-off:

Martin Newsholme, Chair of the Audit and Risk Committee.

## Is the report suitable for publication?:

Yes

## 1. Key issues and considerations:

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

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

This report provides a summary of the items considered at the Committee meeting held on 11 May 2026 and an Extraordinary Committee on 24 June 2026. It highlights the key areas the Committee wishes to bring to the attention of the Council of Governors.

## 2. Strategic objectives and associated risks:

The following strategic objectives, developed in light of national and system priorities, are relevant to the content of this report:

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

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

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

## Chair's Assurance Report Audit and Risk Committee

### Trust values:

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

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

### 3. Assurance Report from Audit and Risk Committee

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

**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;

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

Require the approval of the Board for work to progress.

**Annual Report and Annual Accounts:** The Committee convened an Extraordinary Meeting on 24 June to undertake a detailed review of the Annual Report and Annual Accounts, supported by the presentation of the external auditor's annual report. Members scrutinised the core documents alongside all associated materials, including the Annual Governance Statement, the Letter of Representation, and the supporting financial disclosures, to ensure completeness, accuracy, and compliance with statutory requirements.

Following thorough consideration, the Committee agreed to recommend that the Board approve the full suite of documentation. The Board subsequently endorsed the recommendation, and the Annual Report, Accounts, and all associated documents will be formally submitted in accordance with NHS guidance and required timelines.

#### 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:

**Receipt of Annual Internal Audit Report and Associated Opinions:** The Committee received the Annual Internal Audit Report, noting a "Substantial Assurance" opinion for 2025/26, reflecting significant continuing improvements in governance, assurance processes, and audit recommendation tracking. The opinion was supported by the Board Assurance Framework review and demonstrated that risks are being effectively identified and managed, with no matters requiring escalation. The Committee commended the Trust on their achievement.

**Counter Fraud Annual Report 2025/26:** The Committee was assured that the Trust has taken a proactive approach to the "failure to prevent fraud" agenda, with strong compliance against national standards and no significant concerns identified from fraud prevention activity. Work undertaken has strengthened policies, awareness and risk assessment processes, while a recent fraud case relating to AI in recruitment has informed control improvements and highlighted emerging risks. Planned work for 2026/27 appropriately focuses on further strengthening awareness and controls in key risk areas, including AI, cyber-enabled fraud and recruitment.

**Finance Governance Pack:** The Committee received the Finance Governance Pack and noted improvements in the aged debt position following the resolution of historic veterans' invoices through the issue of credit notes, with provisions remaining for potential bad debts. Members discussed the risks of unrecoverable income balances and were assured that strengthened controls, revised billing arrangements with ICBs, and limits on unfunded activity would be implemented. Concerns were raised

## Chair's Assurance Report Audit and Risk Committee

regarding recurring salary overpayments despite existing controls, with further management oversight introduced. Losses and special payments included a private patient bad debt, and clarification was sought on the escalation requirements for high-value, multi-year SFI waivers. Cashflow was reported as broadly in line with plan, with strong performance against invoice payment targets.

**Declaration of Interest and Hospitality Register:** The Committee noted improved compliance following strengthened processes and increased follow-up, alongside an improvement in the quality and transparency of declarations, particularly in relation to indirect interests. However, it was recognised that declarations may not yet be fully comprehensive, with internal audit highlighting the relatively low level of hospitality declarations and advising appropriate scrutiny. While processes are in place to support declaration and review, the Committee was not assured that there is a fully embedded, systematic approach to evidencing how conflicts are actively mitigated and managed in practice. Further work is therefore required to strengthen assurance on the accuracy of declarations and the consistent documentation of mitigation actions.

**Counter Fraud Workplan 2026/27:** The Committee approved the Counter Fraud Work Plan for 2026/27, noting a change in leadership to Paul McGrath, supported by the wider MIAA team. The plan reflects a risk-based approach, focusing on new "failure to prevent fraud" requirements, cyber and fraud awareness, AI usage, and emerging risks such as social media and secondary employment. The Committee was assured that staff engagement would be strengthened to support awareness and responsiveness to evolving fraud risks.

**Internal Audit Progress Report:** Noted that delivery of the 2025/26 internal audit plan was substantially complete ahead of the final annual opinion, with key reviews undertaken in relation to:

- Waiting list management (moderate assurance rating). The report highlighted concerns regarding the complexity and burden of governance arrangements supporting waiting list management and requested clearer, phased implementation and oversight of SOPs, with revised delivery timescales proposed.
- Assurance Framework – which confirmed the Trust has a structure to meet the NHS requirements of assurance best practice model and has robust processes in place.
- Risk management core controls (high assurance rating)

**Annual Report – Annual Governance Statement:** The Committee reviewed the draft Annual Governance Statement and was satisfied that it broadly reflects the Trust's governance arrangements. Members agreed the content was appropriate but the report should be streamlined to reduce unnecessary detail if this was aligned to the national guidance. Further revisions will be made in line with Committee feedback.

**Risk Management Report:** The Committee noted that the transition to Radar Healthcare has improved oversight of risk management, with 22 high-rated risks reported for February to April 2026, including new and closed risks. Key areas of risk include Orthotics, digital risks linked to Apollo, and patient access. Training compliance remains strong, and new dashboards are supporting improved monitoring, with further development planned to enhance analysis and reporting. The Committee was assured that risk management processes are strengthening.

### 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.

**Reference Cost:** The Committee received assurance that the reference cost submission is on track, with no material changes expected and clear plans in place to meet national deadlines. Chief Finance Officer sign-off is scheduled for 5 June 2026, ahead of the submission window opening in mid-June.

**Clinical Audit Structure Process:** The Committee was assured that robust clinical audit governance arrangements are in place, with regular monitoring of activity, compliance and actions through established reporting structures. Improvements to oversight and forward planning have addressed previous backlogs and strengthened delivery.

## Chair's Assurance Report Audit and Risk Committee

**VFM Risk Assessment:** The Committee received assurance from KPMG that the Trust has effective arrangements in place to secure value for money, based on a detailed review of governance, management and organisational processes supported by audit evidence and engagement with senior staff. No significant weaknesses or risks were identified, and the Committee noted that no VFM risks required formal reporting.

**External Audit Progress Report:** The Committee received assurance that the external audit is progressing in line with the agreed timetable following commencement of fieldwork on 1 May 2026, with all required documentation provided. It was noted that the final audit report will be presented to the next meeting, and that a one-off additional fee of c.£10k will be incurred for specialist valuation work, which management has accepted.

**Risk Management Policy:** The Committee reviewed and approved the risk management policy and will be recommended to the Board for approval.

**Risk Management Terms of Reference:** The Committee revised and approved the revised terms of reference for the group.

**Board Assurance Framework:** The Committee received assurance on the Board Assurance Framework (BAF), noting it had been refreshed, is regularly reviewed, and is supported by effective governance arrangements. Members agreed the framework is operating well, becoming embedded within organisational processes, and providing appropriate oversight of principal risks, and therefore noted their assurance.

**Well Led Review Action Plan:** The Committee reviewed progress against the Well Led Review Action Plan, including actions within its remit (actions 6 and 9), and noted that delivery is supported by developing work on communications, Board development, and committee arrangements. The Committee was assured by the progress made to date.

**Committee Annual Report and Self-Assessment:** The Committee noted the annual Self-Assessment update, including alignment with HFMA guidance, and identified a minor correction to the reported Chair. No immediate amendments to the Terms of Reference were proposed, with agreement to revisit this following completion of members' self-assessments. Internal audit confirmed no recommended changes, and the Committee endorsed the next steps.

### Recommendation

The Board is asked to:

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

# The Robert Jones and Agnes Hunt Orthopaedic Hospital



NHS Foundation Trust

<b>Title:</b>	Risk Management Policy		
<b>Unique Identifier:</b>	SGY001	<b>Document Type:</b>	Policy
<b>Version Number:</b>	6.0	<b>Status:</b>	Approved
<b>Responsible Director:</b>	Chief Nurse and Patient Safety Officer		
<b>Author:</b>	Assistant Chief Nurse and Patient Safety Officer		
<b>Scope:</b>	Trust Directors, Senior Managers and all staff groups		
<b>Replaces:</b>	Version 5.0		
<b>To be Read in Conjunction with the Following Documents: (list related policies)</b>	<ul style="list-style-type: none"> <li>• Health and Safety Policy</li> <li>• Violence Prevention and Reduction Policy</li> <li>• Policy for the Investigation of Incidents, Complaints and Claims.</li> <li>• Trust Safe Moving and Handling (Manual Handling) Policy</li> <li>• Control of Substance Hazardous to Health Policy</li> <li>• Trust Openness Whistleblowing Policy</li> <li>• Trust Incident Reporting Policy</li> <li>• Prevention and Management of Falls Policy</li> <li>• Security Policy</li> <li>• Duty of Candour Policy</li> </ul>		
<b>Keywords:</b>	Risk Management, Risk Assessment, Strategy		
<b>Endorsed by:</b>	Risk Management Group	<b>Date Endorsed:</b>	09.04.2026
<b>Considered By Executive Owner:</b>	Chief Nurse and Patient Safety Officer	<b>Date Considered:</b>	13.04.2026
<b>Reviewed By:</b>	Audit and Risk Committee	<b>Date Endorsed:</b>	
<b>Approved By:</b>	Board of Directors	<b>Date Approved:</b>	
<b>Issue Date:</b>		<b>Review Date:</b>	
*A minor revision to v5.0 to reflect the Board-approved update to the risk appetite statement was approved by the Responsible Director on 17 January 2024.			
<b>Security Level:</b>	Open Access ✓	Restricted	Confidential
<p>Trust Values</p>			

Version 5.1  
Approved  
January 2024

**Risk Management Policy**  
Current version held on the Intranet  
Check with Intranet that this printed copy is the latest issue

Page 1 of 28

## Template for Recording Amendments

<b>V6 Record of Amendments to Risk Management Policy</b>					
Section number	Amendment	Deletion	Addition	Reason	Date
6	Updated Datix to Radar Healthcare			Implementation of Trusts new quality management system	April 2026
<b>V5.1 Record of Amendments to Risk Management Policy</b>					
Section number	Amendment	Deletion	Addition	Reason	Date
4.3.3	Updated Risk Appetite Statement table			To reflect the updated risk appetite statement approved by the Board of Directors in December 2023.	January 2024
<b>V5.0 Record of Amendments to Risk Management Policy</b>					
Section number	Amendment	Deletion	Addition	Reason	Date
4.2	Update to job titles		<p>Director of Finance has had Planning added to job title.</p> <p>Director of Strategy and Planning has become Director of Performance, Improvement and Organisational Development</p> <p>Safety and Risk Manager role has been removed and replaced with Health and Safety Officer</p>	To align with current structure	October 2019
4.2	Reference to Risk Owners and Handlers		The role of the risk owner and handler has been referenced	Internal audit recommendation	October 2019

Version 5.1 Approved January 2024	<b>Risk Management Policy</b> <b>Current version held on the Intranet</b> Check with Intranet that this printed copy is the latest issue	Page 2 of 28
---	--	--------------

Throughout document	Updating of terminology and job titles to take account of organisational restructure within the trust and the wider NHS	Old job and organisation titles	Changes of job titles for executive directors e.g. Director of Nursing is now Chief Nurse and Patient Safety Officer; change of name of national bodies e.g. Monitor is now NHS England / Improvement.	To align with current structure at local and national level	March 2023
---------------------	---	---------------------------------	--	---	------------

DRAFT

Version 5.1 Approved January 2024	<b>Risk Management Policy</b> <b>Current version held on the Intranet</b> Check with Intranet that this printed copy is the latest issue	Page 3 of 28
---	--	--------------

1
2
3
4
5
6
7
8
9
10
11

V5.0 Record of Amendments to Risk Management Policy					
Section number	Amendment	Deletion	Addition	Reason	Date
Throughout document	Document described as a 'policy' rather than a 'strategy'	N/A	Change of terminology	Document more closely matches the definition of a policy than a strategy in current form	March 2023
1, 2	Deletion of executive summary and re-wording of introduction	Executive summary	Simplified text	To make the document more concise	March 2023
1	Adoption of the definitions of risk and risk management set out in the ISO 31000 global standard	Previous definition	Standard definitions extracted from ISO 31000	To reflect current international guidance and best practice	March 2023
3 (renumbered to 2)	Revised definitions of strategic and operational risk	Previous definition	New definition	To differentiate more clearly between the two	March 2023
3 (renumbered to 2)	Added definitions of clinical and workforce risks	N/A	New definitions	To provide more comprehensive definitions	March 2023
4.1 (renumbered to 3.1)	Amended details of committees to reflect revised corporate governance structure in the trust	N/A	More generic description of committee responsibilities	To align with new committee structure	March 2023
4.1 (renumbered to 3.1)	Added a new risk meeting for corporate services which will review risks for these areas in the same way that business unit management teams review risks in clinical services	N/A	Description of role of meeting (section 3.1.7)	To align with current organisational structure	March 2023
4.2 (renumbered to 3.2)	Amended executive director and management responsibilities to reflect current portfolios	Removed reference to Director of Performance, Improvement and Organisational Development, Director of Governance and Director of Operations as these roles no longer exist	Role of Chief Operating Officer; added Caldicott Guardian and informatics responsibilities to Chief Medical Officer role; added Head of Clinical Governance and Quality role	To align with current organisational structure	March 2023
4.2.11	Removed reference to Local Security Management Specialist	Whole subsection	N/A	Not relevant to this policy	March 2023
4.4 (renumbered to 3.4)	Additional information re; clinical audit as a means of identifying risks to quality	N/A	Further detail re: clinical audit forward plan	To provide a more comprehensive definition	March 2023
5.3.2 and 5.3.3	Revised definitions of risk appetite and risk tolerance	Previous definitions	New definitions as recommended by the Good Governance Institute	To reflect current guidance and best practice	March 2023

Version 5.1 Approved January 2024	<b>Risk Management Policy</b> Current version held on the Intranet Check with Intranet that this printed copy is the latest issue	Page 4 of 28
---	---	--------------

Section number	Amendment	Deletion	Addition	Reason	Date
5.3.3 (renumbered to 4.3.3)	Expressed risk tolerance in terms of numerical target scores, and simplified risk categories based on Good Governance Institute risk appetite matrix	Previous definitions	Numerical target scores	To provide clearer guidance to staff	March 2023
5.3.4	Deleted section and moved content	Whole section	Now included in section 4.3.1 instead	To remove duplication	March 2023
6 (renumbered to 5)	Replaced diagram with updated version	Old diagram	Revised diagram	To reflect current guidance and best practice	March 2023
6.1 (renumbered to 5.1)	Additional examples of risk sources	N/A	Extra examples	To provide additional guidance to staff	March 2023
6.2 (renumbered to 5.2)	Additional guidance about phrasing of risks	N/A	Risks to be described in terms of cause and effect, and in plain English; also risks to be checked by clinical governance managers before going live on the risk registers	To provide additional guidance to staff	March 2023
6.3 (renumbered to 5.3)	Additional guidance about risk scoring	N/A	Advice to consult with colleagues as risk scoring can be judgemental and subjective	To provide additional guidance to staff	March 2023
6.4.1 (renumbered to 5.4.1)	Additional detail regarding different approaches to managing a risk and drafting action plans	N/A	More information about tolerated, transferred and treated risks, and target scores; requirement for action plans to be SMART	To provide a clearer explanation of the concepts	March 2023
6.4.2 and 6.4.3 (renumbered to 5.4.2 and 5.4.3)	Additional guidance about how frequently risks should be reviewed, including tolerated risks	N/A	Review timescales set based on current risk score – new subsection added (5.4.4)	To provide additional guidance to staff	March 2023
7 (renumbered to 6)	Abbreviated this section which describes the purpose of risk registers and added an explanatory diagram	Previous narrative	New diagram	To make the document more concise	March 2023

7.2 (renumbered to 6.2)	Clarification regarding risk registers in non-patient facing corporate services, which do not form part of the business unit structure	N/A	Requirement for a combined risk register for these services similar to a business unit risk register	To align with current organisational structure	March 2023
<b>Section number</b>	<b>Amendment</b>	<b>Deletion</b>	<b>Addition</b>	<b>Reason</b>	<b>Date</b>
7.3 (renumbered to 6.3)	Change in practice re: inclusion of high risks in the corporate risk register	Requirement for all risks scored 15 or higher to be included in the CRR	Risk Management Group now acts as gatekeeper to CRR and escalation of high risks to this register is not automatic	To focus the CRR on risks which cannot be managed locally in business units and need corporate / executive input	March 2023
8 (renumbered to 7)	Simplified definition of the Board Assurance Framework	Old definition	New definition	To provide a clearer explanation of the concept	March 2023
9	Deleted this section	Whole section	Information about risk review now included in section 6 instead	To remove duplication	March 2023
12 (renumbered to 10)	Updated titles of policies referred to in this section	Old policy titles	New policy titles	To bring this section up to date	March 2023
13 (renumbered to 11)	Additional detail regarding training requirements for staff at different bands	N/A	Participation requirements for training at levels 1, 2, 3 and 4	To provide additional guidance to staff	March 2023
Appendix 1	Removed organogram	Old organogram	N/A	To make the document more concise	March 2023
Appendix 2 (renumbered to App 1)	Replaced GGI risk appetite matrix with updated version	Old matrix	New matrix	To reflect current guidance and best practice	March 2023

# Risk Management Policy

## Table of Contents

1. Introduction.....	8
2. Purpose and Scope .....	8
3. Organisational structure, duties and responsibilities .....	9
4. Approaches to Risk.....	14
5. The Risk Management Process.....	16
6. Risk Registers.....	19
7. The Board Assurance Framework.....	21
8. Organisational Learning.....	21
9. Communication of the Policy.....	22
10. Associated Documentation.....	22
11. Training.....	22
Appendix 1 Risk Appetite .....	23
Appendix 2 Risk Considerations.....	24
Appendix 3 Risk Assessment Matrix.....	25

DRAFT

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11

## 1. Introduction

The International Standards Organisation, in its global risk management standard, ISO 31000 (2018), defines risk as *“the impact of uncertainty on objectives”*, and risk management as *“coordinated activities to direct and control an organisation with regard to risk”*. While risk is generally understood in terms of negative consequences and failure to achieve objectives, risks can sometimes represent an opportunity, as well as a threat.

ISO define risk management processes as the *“systematic application of management policies, procedures and practices to the tasks of communication, consultation, establishing the context, identifying, analysing, evaluating, treating, monitoring and reviewing risk”*.

RJAH is a specialist provider of orthopaedics, specialist medicine, bone tumour services and paediatrics. The specialist nature of its services contributes to the complexity of the organisation. Providing specialist services carries inherent risk, with the potential for harm to service users, employees and visitors to the Trust if not adequately managed. The trust takes a holistic approach to all risks incorporating clinical, business and financial, as well as traditional safety-related topics. The risk management policy provides a basis to deliver safe high quality services, and to learn from experience.

By implementing this policy, the Trust aims to embed risk management throughout the organisation. For example, risk management can be used to question effectiveness of organisational structures and processes, and the functionality of control systems. The Board is expected to have in place a system for continuous risk management which extends from the front line through to the Board and back to the Ward. It should be able to assess the risks to the achievement of its strategic objectives and whether the trust has the right management processes and controls to achieve them.

The policy will support the Board in fully understanding current and future risks to the organisation, in ensuring that risk reduction/mitigation strategies are developed to address the risks, and in providing assurance that the controls in place to reduce those risks are working effectively. The risk management process should be:

- embedded in the day-to-day operations of the organisation
- part of the culture and way of working
- capable of responding quickly to evolving risks and escalating them to the right level of the organisation, and
- straightforward to understand and apply

To ensure that this document remains current and reflect the organisation’s requirements, it will be reviewed by the Risk Management Group on an annual basis and ratified by the Audit and Risk Committee at least once every three years, and whenever significant changes to practice are proposed.

## 2. Purpose and Scope

The purpose of this policy is to detail the framework through which the Trust identifies and controls risks affecting its key functions and the quality of its services and furthermore, to fulfil regulatory and statutory requirements.

It applies to all substantive and temporary staff working at the Trust.

This document covers the identification and management of all risks which will predominantly fall into the following categories:

Version 5.1 Approved January 2024	<b>Risk Management Policy</b> Current version held on the Intranet Check with Intranet that this printed copy is the latest issue	Page 8 of 28
---	---	--------------

1
2
3
4
5
6
7
8
9
10
11

Risk	Description
Clinical	Risks affecting the quality of care and treatment provided to patients, encompassing patient safety, clinical effectiveness and patient experience.
Workforce	Risks relating to the trust's ability to recruit, retain, and develop a high-performing workforce in both clinical and non-patient facing roles, and to provide a supportive working environment.
Health and Safety	Risks which do not have the ability to directly affect individual patient care or harm the patient in a clinical or treatment focused way but may affect patients and others on site such as visitors, contractors and staff, e.g. fire, security, environmental and health and safety issues.
Financial	Risks which have the ability to affect the financial wellbeing of the Trust, including risk of fraud and claims against the Trust. This also includes protecting intellectual property.
Information Governance	Risks which pose the possibility of a breach of confidentiality, either personal or professional (e.g. leak of information sensitive to the Trust)
Reputational	Risks which affect the reputation of the Trust and its relationships with partner organisations within the health care system
Compliance	Risks of failing to fulfil the requirements of external regulators and auditors

It is also helpful to distinguish between strategic risks, which are recorded in the Board Assurance Framework, and operational risks, which are recorded in the corporate and local risk registers. Definitions are provided below:

**Strategic Risks:** concern the long-term strategic objectives of the trust. They can be affected by such areas as capital availability, political, legal and regulatory changes, and reputation. These will usually be identified at Board, or Executive level ('top down')

**Operational Risks:** Operational risks concern the day-to-day issues that the trust faces as it strives to deliver its strategic objectives. The majority of risks identified will fall into this category. An operational risk can become a strategic risk if it is serious enough to prevent achievement of the strategic objectives. Mostly, though not always, these are identified by departments or business units themselves ('bottom up') but may be escalated to executive or board level if they are sufficiently serious.

The boundaries between these categories are not always obvious, and some risks may fall into more than one category.

The Trust is committed to ensuring the safety of patients, staff and the public through risk management. This is best achieved through an open and honest culture, where concerns and challenges are discussed frankly, mistakes and adverse events are reported quickly and dealt with in a positive way, and there is an emphasis on learning and improving.

### 3. Organisational structure, duties and responsibilities

#### 3.1 Committee Responsibilities

Clear lines of reporting and accountability are essential for effective risk management, and clarity about roles and responsibilities promotes a culture of transparency in decision-making. The Trust has a hierarchy of reporting arrangements to ensure the Board receives evidence-based assurance in relation to strategic and operational risks.

The Board, the Audit and Risk Committee, Quality and Safety Committee, Finance Performance and Digital Committee, People and Culture Committee, and the Risk Management Group all have a critical function in considering policy and strategic issues, and overseeing the management of risk. These structures are designed to ensure accountability and the flow of information. In this way the Trust can identify themes and trends, and promote good practice throughout the organisation.

### 3.1.1 Board of Directors

The Board gains assurance that strategic risks are being appropriately managed through the Board Assurance Framework (BAF), which records the principal strategic risks facing the organisation. The Board also receives the Corporate Risk Register, and is thus sighted on the most significant operational risks. The Board accepts prime responsibility for corporate governance and the development of systems of internal control, including risk management, the BAF and compliance with Care Quality Commission (CQC) regulations, although it delegates many of its responsibilities to its committees and to management.

### 3.1.2 Audit and Risk Committee

The Audit and Risk Committee reviews the effectiveness of the system of risk management and internal control across the Trust. As part of this work it reviews the Board Assurance Framework in detail and receives the Corporate Risk Register, which lists major operational risks (scored 15 or higher) which cannot be managed locally in business units or departments. Furthermore, it is responsible for approving this policy.

The Audit and Risk Committee oversees the work of internal audit, external audit, the local counter fraud service, as well as the role of trust management in maintaining internal control and ensuring compliance with laws and regulations.

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

### 3.1.3 Board Assurance Committees

The Board has established a number of other committees covering topics such as finance and workforce. Those committees oversee strategic risks relating to their remit, as defined in their terms of reference, primarily through scrutiny of the Board Assurance Framework.

### 3.1.4 Risk Management Group

The Risk Management Group is an operational management committee chaired by the Chief Nurse and Patient Safety Officer, which consists of senior managers.

The group's duties and responsibilities include the following:

- Monitoring the risk register by exception, with a focus on new risks, closed risks, risks overdue for review, and risks whose score has remained unchanged or not reached their target scores for more than twelve months
- Ensuring that risk is managed effectively in business units and non-patient facing corporate services by means of deep dive reviews of local risk registers
- Ensuring a common approach to risks which cut across business unit or departmental boundaries, and avoid duplication
- Discussing the outcomes of assessments of the risk management process, e.g. internal audit reports, and ensuring that their recommendations are implemented promptly and fully
- Adding to the Corporate Risk Register significant operational risks which cannot be managed locally within a business unit or non-patient facing corporate service, and require involvement by one or more executive directors
- De-escalating risks from the Corporate Risk Register to business unit or local risk registers when they have been mitigated such that they no longer require corporate-level oversight
- Contributing to identification and review of strategic risks for inclusion in the Board Assurance Framework

- Developing a training needs analysis for risk management and monitoring levels of participation in the training

### **3.1.5 Business Unit Governance Meetings and Corporate Services Risk Reviews**

Each business unit holds a regular governance meeting at which it reviews its risk register in line with section 5.4.4 of this policy. For non-patient facing corporate services such as finance, informatics, estates, communications etc., which do not form part of a business unit, there are regular meetings which review risks to these services. The business unit governance meetings and corporate service meetings that consider risk report upward to the Risk Management Group.

## **3.2 Individual Responsibilities of Key Personnel**

All staff are responsible for identifying, reporting and escalating risks and incidents promptly, thereby allowing risks to be managed and added to the risk register. In addition, staff are responsible for taking steps to avoid injuries and risks to patients, staff and visitors. Specific duties and roles of key individuals in the risk management process are summarised below:

### **3.2.1 Chief Executive**

The Chief Executive has ultimate responsibility and accountability for risk with the Trust. They are required to sign an Annual Governance Statement, outlining the Trust's governance and assurance systems, and a Statement of Accounting Officer's Responsibilities which are submitted to NHS England, and published in the Trust's Annual Report. Generally the Chief Executive provides leadership and strategic direction, while delegating responsibility for managing different types of risks to executive directors and senior managers. However, within the executive team, they have specific management responsibility for communications and charities, and for the associated risks.

### **3.2.2 Chair of the Audit and Risk Committee**

There is a named non-executive director who has responsibility for risk management and chairs the Audit and Risk Committee.

### **3.2.3 Chief Nurse and Patient Safety Officer**

The Chief Nurse and Patient Safety Officer has joint lead responsibility with the Chief Medical Officer for clinical governance, for the management of risks affecting the quality and safety of patient care. In this capacity they chair the Risk Management Group, and line manage the Head of Clinical Governance and Quality and Safety. The Chief Nurse and Patient Safety Officer has individual responsibility for compliance with the CQC fundamental standards and is the Director for Infection Prevention and Control (DIPC). They also lead on safeguarding issues at executive level and are the accountable officer for controlled drugs.

### **3.2.4 Chief Finance and Commercialisation Officer**

The Chief Finance and Commercial Officer is responsible for the management of financial and estates risks. The Chief Finance and Commercial Officer ensures that the Trust carries out its business providing healthcare while complying with standing financial instructions and budgeting and accounting processes designed to control financial risks.

### **3.2.5 Chief People Officer**

The Chief People Officer is responsible for the management of risk in relation to staff, including safe recruitment processes, negotiation with staff side, co-ordination of training and development programmes, and the adoption of human resources policies which enable the trust to comply with employment law.

### **3.2.6 Chief Medical Officer**

The Chief Medical Officer has joint lead responsibility with the Chief Nurse and Patient Safety Officer for clinical governance, and thus for the management of risks affecting the quality and safety of patient care.

The Chief Medical Officer leads on the trust's digital programme and associated risks at executive level. In this capacity, they act as the Trust Caldicott Guardian. The Caldicott Guardian champions information

Version 5.1 Approved January 2024	<b>Risk Management Policy</b> Current version held on the Intranet Check with Intranet that this printed copy is the latest issue	Page 11 of 28
---	---	---------------

governance within the organisation, ensuring that it meets the highest practical standards for handling patient information safely and confidentially.

### 3.2.7 Chief Operating Officer

The Chief Operating Officer is responsible for the performance and day-to-day management of the trust's clinical services, including their compliance with constitutional standards and patient access targets, and is therefore responsible for the management of risks relevant to their portfolio. They are also responsible for emergency planning, preparedness and resilience at executive level.

### 3.2.8 Assistant Chief Nurse and Patient Safety Officer

The Assistant Chief Nurse and Patient Safety Officer has operational responsibility for the upkeep of the risk register, for the trust's programme of risk management training, and for line management of the Clinical Governance Managers and Assistant Governance Managers.

### 3.2.9 Trust Secretary

As the lead for corporate governance in the trust, the trust secretary is responsible for:

- ensuring compliance with the Constitution
- accessing legal advice where appropriate
- maintaining the Trust Policy Database, to ensure version control, and Records Management
- drafting the Annual Governance Statement and the Board Assurance Framework
- maintenance of appropriate insurances and indemnities
- ensuring compliance with Freedom of Information

### 3.2.10 Health and Safety Manager

The Health and Safety Manager oversees the management of health and safety risks within the Trust and provides expert advice to managers to maintain best health and safety practice. The Health and Safety Manager acts as a Trust link with the Health and Safety Executive (HSE) and ensures trust wide health and safety audits are undertaken and action plans carried forward within the business units. The Health and Safety Manager will ensure RIDDOR reportable adverse incidents are reported to the HSE and identifies trends to mitigate recurrence.

### 3.2.11 Business Unit Management Teams and managers of corporate departments

The Business Unit Management Teams, and managers of central corporate departments, are responsible for applying this policy in their areas. This includes:

- Ensuring risk assessments are undertaken and action implemented.
- Implementing and monitoring risk control measures within their areas of responsibility
- Ensuring that local and business unit risk registers are kept up to date.
- Ensuring staff undertake mandatory and statutory training.
- Ensuring that incidents are reported and, where necessary, investigated.

### 3.2.12 Clinical Governance Managers

The Clinical Governance Managers are responsible for supporting the business unit management teams with the implementation of this policy, for acting as a link between the business units and the Clinical Governance Team, and for promoting good governance within the business units. Clinical Governance Managers also complete an initial quality review of all new draft risks from their business units before they go live on the risk register.

### 3.2.13 Risk Owner

Identified Risk Owners are responsible for ensuring an identified risk that has been allocated to them is managed in line with this strategy. Risk owners will normally be executive directors or senior managers of the trust.

### 3.2.14 Risk Handler

Version 5.1 Approved January 2024	<b>Risk Management Policy</b> Current version held on the Intranet Check with Intranet that this printed copy is the latest issue	Page 12 of 28
---	---	---------------

1
2
3
4
5
6
7
8
9
10
11

Identified Risk Handlers are responsible for the day-to-day management of identified risks that have been allocated to them. There may be occasion when a risk handler is also the risk owner of the same risk.

### 3.2.15 All Trust Employees

All employees of the Trust have a responsibility to:

- Work in accordance with corporate policies and procedures
- Practice within the standards of their professional bodies, relevant national standards and trust clinical guidelines.
- Identify through their own departments self-assessment process and line management arrangements, any risks which they feel exist within the service and their practice.
- Provide incident reports and supporting documentation for any unexpected event or incident arising from clinical care or treatment provided.
- Attend corporate induction and participate in mandatory training.

### 3.3 Specialist Advice

Advice and expertise in specific areas of risk is available from:

- Caldicott Guardian (Chief Medical Officer)
- Research and Development Manager
- Assistant Chief Nurse and Patient Safety Officer
- Clinical Governance Managers
- Trust Secretary
- Health and Safety Team
- Infection Control Lead Nurse
- Local Security Management Specialist
- Local Counter Fraud Specialist

### 3.4 Audit

#### 3.4.1 Internal Audit

The Trust commissions an internal audit service which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit and Risk Committee, Chief Executive and Board. They provide an independent, objective opinion on the design and operation of the trust's risk management and governance processes. The internal audit programme is risk-based.

#### 3.4.2 Clinical Audit

The Chief Medical Officer sets out an annual forward programme of clinical audits, to be undertaken by the trust's own clinicians, and report results back to the Quality and Safety Committee. Risks affecting the quality of care and treatment provided by the trust may be identified through clinical audits.

#### 3.4.3 External Audit

The Trust is required to commission an external audit service, which is provided by a firm of chartered accountants. External audit is an essential element of corporate governance, contributing to accountability for use of resources and financial stewardship. The scope of audits covers not just the financial statements but also arrangements to secure value for money. External audit reports to the Audit and Risk Committee.

1
2
3
4
5
6
7
8
9
10
11

## 4. Approaches to Risk

The Trust will adopt both a proactive and reactive approach to risk management as follows:

### 4.1 Pro-active Approaches to Risk Management

- Developing and maintaining the BAF and Risk Registers
- Ensuring a consistent approach to risk assessments/development of risk registers
- Developing policies and procedures, as well as a process to keep them up to date and monitor their implementation.
- Maintaining an effective Safety Alert System
- Clinical Audit
- Emergency Planning, Preparedness and Resilience arrangements
- Dissemination of newly published National Institute of Clinical Excellence (NICE) guidelines and completion of gap analyses and action plans
- Ensuring training and development of staff

### 4.2 Reactive approaches to Risk Management

- Learning from serious incident investigations and making improvements
- Learning from complaints and Patient Advice and Liaison Service (PALS) contacts and making improvements
- Making changes in response to litigation brought successfully against the trust, or to coroner's reports
- Implementing recommendations from National Enquiries, internal/external reviews/recommendations etc
- Implementing legislative changes and NHS national policy directives
- Using information in public domain published by the regulatory bodies such as the CQC

### 4.3 Risk Taking, Appetite, Tolerance and Opportunities

#### 4.3.1 Risk Taking

The Trust acknowledges that embracing opportunities, for example developing new services or creating new job roles, usually involves taking risks. Risk is not always negative and we should be aware of the possibility of 'upside risk', i.e. uncertainties that could actually have a beneficial effect and help us to achieve our objectives.

Risk is a fact of life in healthcare. We cannot create a risk-free environment, but rather one in which risk is considered as an integral part of everything we do, and is clearly identified and controlled. The trust aims to be 'risk aware' rather than 'risk averse'.

#### 4.3.2 Risk Appetite

Risk appetite is defined as *"the decision about the level of risk that an organisation is prepared to accept, after balancing the potential opportunities and threats a situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings."*

Our aim is to ensure an appropriate balance between uncontrolled innovation and excessive caution, while guiding staff on the level of risk permitted and encouraging a consistent approach.

### 4.3.3 Risk Tolerance

Risk tolerance is defined as "the boundaries within which the Board is willing to allow the true day-to-day risk profile of the enterprise to fluctuate, while executing strategic objectives in accordance with the trust's strategy and risk appetite. It is the level of residual risk below which the Board expects its committees to operate and management to manage". Risk tolerance is expressed in terms of the maximum permissible target score to which we aim to reduce risks through additional control measures. We have differing risk tolerances for different types of risk.

The Trust's risk appetite and tolerance are set out in the table below:

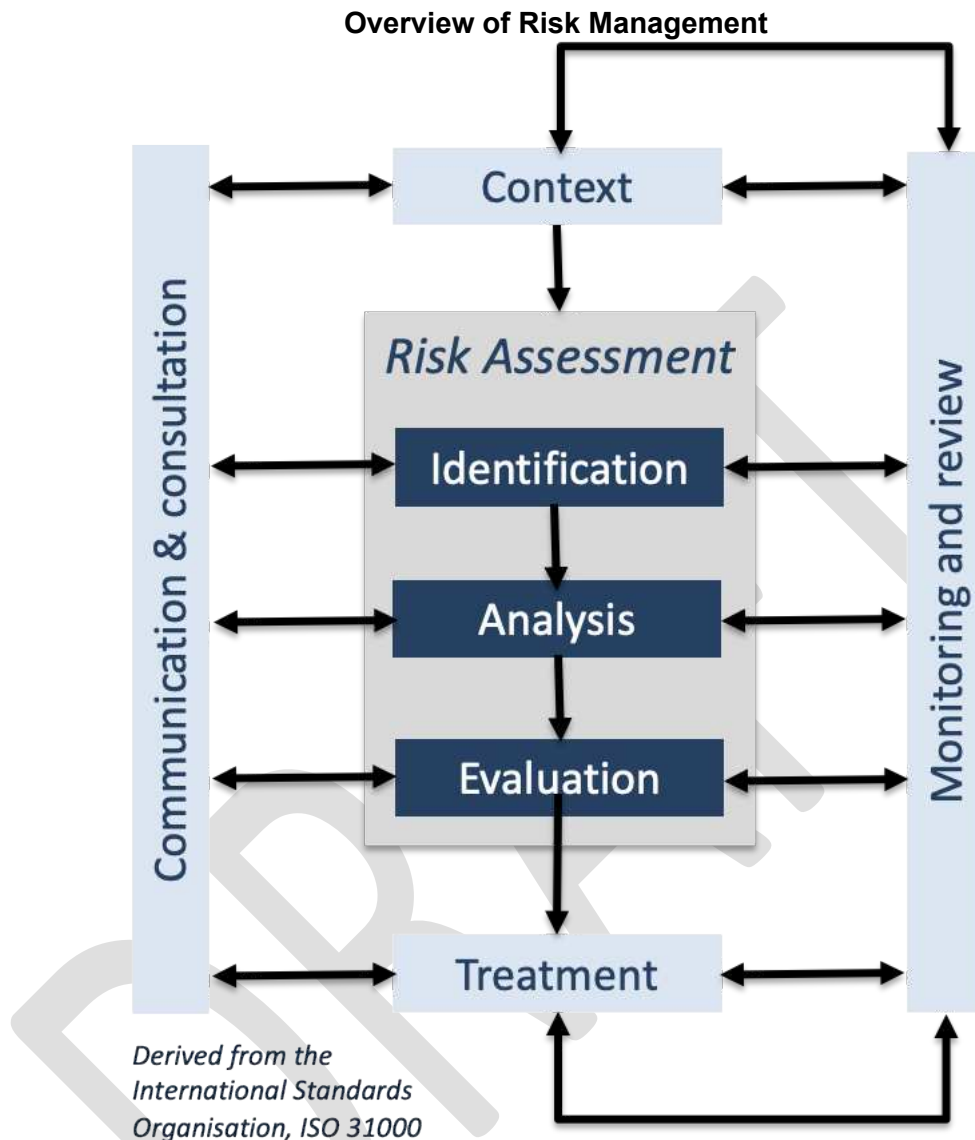
Type of Risk	Risk Appetite	Risk Tolerance*	Rationale
Quality	Cautious	6	The trust exists to provide optimal clinical care and treatment. Therefore, we take a <b>cautious</b> approach – we prefer to avoid risks which would adversely affect the quality of services but recognise that it is rarely possible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

\* Maximum permissible target score for risk

Version 5.1 Approved January 2024	<b>Risk Management Policy</b> Current version held on the Intranet Check with Intranet that this printed copy is the latest issue	Page 15 of 28
---	---	---------------

## 5. The Risk Management Process

An overview of the risk management process in use in the Trust is shown in the diagram below.



### 5.1 Risk Identification

The Trust takes both a proactive and reactive approach to identifying risks with the potential to cause any of the following: injury, complaint, litigation, damage to the environment or property, failure to maintain services and/or the quality of services provided by the Trust, failure to meet national targets, damage to reputation, financial loss etc.

The first stage is to identify the risks the Trust carries. This will be achieved by considering the Trust strategic objectives and the area's ability to achieve these. Other considerations are listed below and in Appendix 3. It should be noted that the list is not exhaustive.

Sources of risk are both internal and external:

- **Internal sources of risk** may include, for example: adverse incidents complaints or claims; non-compliance by the trust with legal duties; environmental hazards; obsolete or faulty equipment; ineffective communication channels, unclear policies and procedures; etc.

- **External sources of risk** include, for example: the economic climate; cybersecurity threats; changes in national policy and legislation; also hazard warnings and recommendations received by the Trust from regulators - such as the Medicines & Healthcare Products Regulatory Agency (MHRA), National NHS England, Care Quality Commission, National Institute for Clinical Excellence (NICE), Health and Safety Executive (HSE), etc.

For a further non-exhaustive list of risk considerations refer to Appendix 3.

## 5.2 Risk Assessment

All risks that are identified will be assessed using the Trust risk grading matrix at Appendix 3. The risk assessment process may identify single or multiple risks that require the creation of a risk record(s) on the risk register.

Risk assessments should be carried out by a manager with suitable experience and knowledge of the subject. Risk assessments should be discussed with the appropriate managers and clinicians to agree actions to mitigate or reduce potential risks. The key steps in the process are as follows:

1. Identify hazards (a hazard is anything which has the potential to cause harm or loss)
2. Establish which hazards are most dangerous and to whom
3. Assess adequacy of existing controls (the measures already in place to reduce the level of risk)
4. Assess how likely the risk is it to occur and what the impact would be if it did
5. Multiply the likelihood score by the impact score using the matrix to define the level of risk
6. Assign responsibility for the risk to an appropriate senior manager or clinician
7. Devise plans to meet any shortcomings
8. Establish how changes can be introduced

When completing a risk assessment, it is essential to describe the risk in terms of its cause and effect, i.e. what is giving rise to the risk, and what may happen if the risk materialises, rather than simply stating an issue or concern, such as “low staffing levels” or “obsolete equipment”. Risks should also be described in plain English, without excessive jargon or acronyms that may not be understood by people working outside the service or business unit which has identified the risk.

All risk assessments originating from within business units will be reviewed by a Clinical Governance Manager before going live on the risk register. The clinical governance manager will check that all sections of the assessment have been completed, that the risk is expressed clearly, and that the risk score (see 5.3 below) appears reasonable given what is known about the issue.

For risks originating in non-patient facing corporate services, which do not form part of business units and do not therefore have a clinical governance manager, draft risk assessments should be reviewed by a senior manager within the department which has identified the risk, before going live on the risk register.

## 5.3 Risk Evaluation

Risks are evaluated to establish the level of risk as part of the risk assessment process above, using the risk matrix which enables a systematic approach to risk evaluation (see Appendix 3). The level of risk is estimated by quantifying and combining consequences and likelihoods. Three risk ratings should be calculated for each risk: initial, current and target:

- **Initial** risk rating reflects the level of risk in the absence of any controls. In other words, this is the *inherent* risk.
- **Current** risk rating reflects the level of risk taking into account the controls currently in place (this enables assessment of the effectiveness of the controls, and is sometimes known as the *residual* risk)

Version 5.1 Approved January 2024	<b>Risk Management Policy</b> <b>Current version held on the Intranet</b> Check with Intranet that this printed copy is the latest issue	Page 17 of 28
---	--	---------------

- **Target** risk rating is the level of risk that could realistically be achieved once further actions have been taken and extra controls put in place. The target risk rating should not be higher than the trust's risk tolerance for that type of risk (see section 4.3.3)

Scoring of risks requires judgement and can sometimes be subjective. Thus, it is advisable to consult with one's colleagues or manager about the scores to be assigned to the risk before finalising the risk assessment.

## 5.4 Risk Treatment or Acceptance

Once the risk has been identified and assessed a plan must be put in place to manage the risk. The Trust is committed to ensuring that the severity of any risk is minimised to an acceptable level, i.e. within the Trust's agreed risk tolerance. Whatever action is to be taken should be documented in an action plan, which will be recorded on the relevant risk registers alongside the risk assessment. The action plan should make clear who is responsible for the action and the deadline for completion. Actions should be SMART: specific, measurable, achievable, relevant, and time-limited.

### 5.4.1 Risk Treatment

In the NHS, by far the most common approach to managing a risk is to take action intended to reduce the likelihood of the risk materialising, or its impact if it does ('treating' the risk). However, this is not the only way that risks are managed and in some circumstances a different approach may be appropriate. The four main approaches are described below:

- **Terminate** - some risks may only be managed by terminating them entirely (avoiding the risk by not undertaking the activity that leads to the risk occurring, e.g. by closing down a service)
- **Treat** - existing controls are measures currently in place when a risk is identified to control the risk. If existing controls are not adequate, i.e. gaps are identified, an action plan should be produced to mitigate the risk by implementing additional controls.
- **Transfer** – the best way of managing some risks is to transfer them to a third party who will carry the risk on the trust's behalf, usually in return for payment, for example by taking out an insurance policy, or outsourcing a service.
- **Tolerate (accept the risk)** – where the current score of the risk is already within the trust's risk tolerance levels and no further controls are necessary, or where the cost of reducing or eliminating the risk any further may be disproportionate and / or create significant new risks elsewhere.

We can access internal expertise to decide on the most appropriate options to manage the risks and seek external advice, if required (e.g. from the CQC, NHS Resolution, NHS England, Health and Safety Executive, Internal Audit, other local NHS trusts, etc.).

### 5.4.2 Risk Acceptance

If following a risk assessment and consideration of the controls in place, it is considered that the risk has been adequately mitigated to an acceptable level, i.e. in line with the Trust's risk tolerance, then the risk should be marked as tolerated, but should be reviewed annually thereafter to ensure the risk has not increased to a level where further action becomes necessary.

### 5.4.3 Risk Escalation

The level of the organisation at which a risk is monitored and managed, and in which risk register it appears, depends primarily on the current risk score. Operational risks may appear on the local, business unit or corporate risk registers. Risks directly affecting the delivery of the Trust's strategic objectives are recorded on, and managed through the Board Assurance Framework. The table below sets out the appropriate level of escalation for each of the risk levels:

Version 5.1 Approved January 2024	<b>Risk Management Policy</b> Current version held on the Intranet Check with Intranet that this printed copy is the latest issue	Page 18 of 28
---	---	---------------

1
2
3
4
5
6
7
8
9
10
11

Risk Rating	Responsible for Remedial Action	Responsible for Risk on Register	Risk Register Escalation Level
Green 1-3 Very Low Risk	Departmental Managers	Departmental Managers	Local Risk Register Business Unit (or combined corporate departments) Risk Register
Yellow 4-6 Low Risk	Departmental Managers	Departmental Managers	Local Risk Register Business Unit (or combined corporate departments) Risk Register
Orange 8-12 Moderate Risk	Business Unit (or corporate service) Management Teams	Business Unit (or corporate service) Management Teams	Business Unit (or combined corporate departments) Risk Register
Red 15-25 High Risk	Business Unit or corporate service) Management Teams	Business Unit or corporate service) Management Teams with oversight from central Governance Team	Business Unit (or combined corporate departments) Risk Register Corporate Risk Register (if escalated by Risk Management Group)
Strategic risks (any score)	Executive Directors	Executive Directors	Board Assurance Framework

A rolling programme of review is in place to ensure that the risks are captured, recorded and scored correctly, mitigated to the greatest extent possible, and escalated to the right level of the organisation.

#### 5.4.4 Review of live risks

The business units review their risk registers at their unit governance meetings to monitor progress of the implementation of action plans. Non-patient facing corporate services, such as estates or informatics do the same through the corporate services risk meeting. How frequently an individual risk is reviewed depends on its score – see table below:

Risk Type	Score	Review Frequency
Very Low	1-3	Annually
Low	4-6	6 monthly
Moderate	8-12	Bimonthly
High	15+	Monthly
Tolerated	Any	Annually

They have authority to adjust the risk score once actions have been implemented to close gaps, and/or tolerate a risk if necessary. Business units and non-patient facing corporate departments are held to account for their management of risk by the Risk Management Group through a rolling programme of deep dives.

## 6. Risk Registers

A risk is formally registered through the creation of a risk record. This is an electronic record on the Radar Healthcare (see below) of the risk assessment and the actions required to mitigate the risk. Each risk will have a risk owner and an accountable person assigned (see section 4.2 for the responsibilities of risk owners and handlers). Together, these risk records form a risk register. There are risk registers at departmental, business unit and corporate level.

Risk registers are vital tools which support management and review of risks and the prioritisation of risk reduction activities according to risk scores. The risk registers feed into the BAF where there is potential for

Version 5.1 Approved January 2024	<b>Risk Management Policy</b> Current version held on the Intranet Check with Intranet that this printed copy is the latest issue	Page 19 of 28
---	---	---------------

impact on delivery of the Trust’s strategic objectives. They are dynamic living documents which are populated through the organisation’s risk assessment process and are updated regularly.

Radar Healthcare is the organisation’s risk management database system. It is used to generate risk registers and other reports about the management of risks, incidents, complaints and claims. It enables risks to be escalated to appropriate level of risk register. These are outlined in more detail below, and summarised in the following diagram:



### 6.1 Local Risk Register

This register relates to risks with a current risk rating of 1-6 and will be managed by departmental managers and escalated to the relevant business unit management team (or to the corporate services risk review meeting for non-patient facing corporate departments) as and when required. These risks will be discussed at local team meetings.

### 6.2 Business Unit Risk Register

The business unit risk register includes all risks relating to the business unit irrespective of the risk level. However the risks are escalated upwards through different levels of management according to the risk level. As outlined above, risks with a rating of 1-6 are managed at departmental level. Risk from 6-12 are managed by the business units with support from the Clinical Governance Managers. Any risks rated as 15+ remain the responsibility of the business units but may also require escalation to executive and Board level via the corporate risk register (see below).

Non-patient facing corporate services (finance, informatics, estates, human resources, communications, etc.) will also retain risk registers similar to a business unit risk register. These will be reviewed via local management arrangements and the risks will be overseen and escalated as appropriate to the Risk management meeting. (see section 3.1.5).

### 6.3 Corporate Risk Register

All new risks scored 15 or higher will be considered by the Risk Management Group for inclusion in the corporate risk register (CRR) so that they can be monitored and managed at an organisation-wide level. Escalation to the CRR is not automatic, as some risks scored 15 or higher may be capable of being managed locally in business units or non-clinical corporate departments. Risks should be added to the CRR where they require executive director involvement to resolve, or solutions which need input from more than one business unit or corporate service.

1
2
3
4
5
6
7
8
9
10
11

The Risk Management Group can also remove risks from the CRR (de-escalation) if it judges that the level of risk has reduced, e.g. because of actions taken by management. Risks de-escalated from the CRR will be assigned to one of the business units, or the relevant corporate department, to manage.

The Corporate Risk Register will be monitored by the Risk Management Group, and will also be reported to the Audit and Risk Committee, and Board.

## 6.4 Risk Register Format

The risk registers, regardless of the level, must include the following information:

- Source of the risk (including, but not limited to, incident reports, risk assessments and local risk registers. These can be internal and external sources)
- Description of risk
- Categorisation of risk as strategic, operational or both
- Existing control measures
- Initial, current and target risk scores
- Action plan to manage the risk
- Date the risk was identified
- Review date of risk
- Risk owner and risk handler

## 7. The Board Assurance Framework

A Board Assurance Framework is defined by HM Treasury as “a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect”. The BAF brings together the trust’s strategic objectives with the principal risks which may prevent those objectives from being achieved. It lists the controls in place to manage those risks, and how the board obtains assurance that those controls are working effectively. It identifies any gaps in controls or assurances, and includes an action plan to close those gaps. It is a robust, evidence-based and objective document.

The BAF helps the board to focus its scrutiny on the issues of greatest risk, and also shapes the work of the board and its committees through their cycles of business.

It is maintained by the Trust Secretary and reviewed at the Audit and Risk Committee at each meeting and by the Board of Directors quarterly. Other board committees scrutinise those strategic risks in the BAF which are relevant to their terms of reference.

## 8. Organisational Learning

The Trust will continue to promote an open learning culture so that we can learn from experience – including when things go wrong - and share local examples of good practice. In particular, analysis of themes and trends from incidents, complaints, litigation and clinical audits can draw attention to emerging risks in the trust.

These are some of the ways in which Trust learns from its risk management and governance processes:

- Adverse incidents, complaints and claims are triangulated in monthly reports and discussed at the Quality and Safety Committee and disseminated to business unit management teams;
- National reports and external enquiries are reviewed at the Quality and Safety Committee or its sub-groups. A local action plan is drawn up and implemented in the business units;
- Adaptations to training programmes are made in response to learning from risks and incidents;
- Financial forecasts are adjusted in the light of identified risks; and,

Version 5.1 Approved January 2024	<b>Risk Management Policy</b> Current version held on the Intranet Check with Intranet that this printed copy is the latest issue	Page 21 of 28
---	---	---------------

1
2
3
4
5
6
7
8
9
10
11

- Identified groups consisting of executive directors and senior clinical managers receive daily or weekly incident reports.

## 9. Communication of the Policy

The Trust's Risk Management Policy will be made available on the intranet. Managers should make new staff aware of arrangements for risk management and governance in their departments through local induction. All staff are introduced to the principles outlined in the policy at corporate induction.

Amendments to the policy will be communicated as and when they occur.

## 10. Associated Documentation

This policy provides an overall framework for managing risks. It is recommended, therefore, that it be read in conjunction with the following documents which provide guidance about managing specific types of risk.

- Health and Safety Policy
- Violence Prevention and Reduction Policy
- Policy for the Investigation of Incidents, Complaints and Claims.
- Trust Safe Moving and Handling (Manual Handling) Policy
- Control of Substance Hazardous to Health Policy
- Trust Openness Whistleblowing Policy
- Trust Incident Reporting Policy
- Trust Duty of Candour Policy
- Prevention and Management of Falls Policy
- Security Policy

## 11. Training

To ensure that all staff can access the training needed to fulfil their job roles and to develop professionally, the trust has a Learning and Development Policy. The training required for Risk Management is planned, delivered and audited in accordance with this policy. The Risk Management Group complete a training needs analysis for risk and governance and review it annually.

The level of training which staff are required to undertake depends on their seniority and level of management responsibility. All staff will receive a basic awareness of risk management through mandatory training, while managers and clinical leaders will receive more tailored and in-depth training. Executive and non-executive directors will be kept up to date with developments in risk management, and clinical governance more generally, through the board development programme. Training requirements are set out in detail in the training needs assessment.

In addition to formal training, the clinical governance team can provide ad hoc support with use of the Datix system and a risk management 'how to' guide will be made available.

1
2
3
4
5
6
7
8
9
10
11

# Appendix 1 Risk Appetite Matrix

RISK APPETITE LEVEL ▶	<b>0 NONE</b> Avoidance of risk is a key organisational objective.	<b>1 MINIMAL</b> Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	<b>2 CAUTIOUS</b> Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	<b>3 OPEN</b> Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	<b>4 SEEK</b> Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	<b>5 SIGNIFICANT</b> Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
<b>RISK TYPES ▼</b>						
<b>FINANCIAL</b> How will we use our resources?	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
<b>REGULATORY</b> How will we be perceived by our regulator?	We have no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
<b>QUALITY</b> How will we deliver safe services?	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
<b>REPUTATIONAL</b> How will we be perceived by the public and our partners?	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
<b>PEOPLE</b> How will we be perceived by the public and our partners?	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.

Version 5.1 Approved January 2024	<b>Risk Management Policy</b> Current version held on the Intranet Check with Intranet that this printed copy is the latest issue	Page 23 of 28
---	---	---------------

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11

## Appendix 2 Risk Considerations

- The Trust will review compliance with the Care Quality Commission requirements on an on-going basis to identify any risks
- Effective health and safety audits and inspections and implementation of resulting action plans
- Each Director will be responsible for ensuring that departmental risk assessments are carried out, producing directorate risk registers and taking action to avoid/minimise risk as appropriate
- Regular multi-disciplinary review of incidents, complaints and claims data
- Patient and staff feedback surveys
- Public perceptions of the NHS e.g. media reviews
- Root Cause Analysis following serious adverse incidents
- Underlying root causes of incidents, complaints and claims
- Concerns raised by Trade Unions
- Whistle blowing
- Coroners reports
- Financial forecasting and reports Board Quality walkabouts
- New legislation and guidance
- Recommendation and reports from assessment/inspections from internal and external bodies
- Safety alerts
- Non Clinical/Generic Risk Assessments completed by staff
- Incident Reports
- Serious Adverse Incident Reports
- Directorate Risk Registers (for the Corporate Risk Register)
- Health and Safety Audits
- Regular Health and Safety Checks e.g. Window checks, Fire Inspections
- Complaints
- National Guidance/Reports
- Patient's conditions (e.g. inherent risk of falls in people with dementia)
- Major incident (drill or live)
- Deficiencies with effective controls assurance standards
- Deficiencies with various elements of the CQC standards
- Recommendations and reports from external agencies such as NHSLA, Health and Safety Executive, Patient-led Assessments of the Care Environment (PLACE) etc
- Actions taken to reduce risks which could not be or were not implemented for various reasons such as resource limitations
- Any other sources of information that could be considered to be a threat to patient, staff visitors, environmental safety or the organisations wellbeing
- Estates risk profile
- Financial/business plans/IT reports
- Underlying causes related to poor trends identified from key performance indicators
- Considerable deficiencies in/non-compliance with staff mandatory training

1
2
3
4
5
6
7
8
9
10
11

## Appendix 3 Risk Assessment Matrix

**Table 1 Consequence scores**

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Insignificant	Minor	Moderate	Major	Catastrophic
<b>Impact on the safety of patients, staff or public (physical/psychological harm)</b>	Minimal injury requiring no/minimal intervention or treatment.  No time off work	Minor injury or illness, requiring minor intervention  Requiring time off work for <3 days  Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention  Requiring time off work for 4-14 days  Increase in length of hospital stay by 4-15 days  RIDDOR/agency reportable incident  An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability  Requiring time off work for >14 days  Increase in length of hospital stay by >15 days  Mismanagement of patient care with long-term effects	Incident leading to death  Multiple permanent injuries or irreversible health effects  An event which impacts on a large number of patients
<b>Quality/complaints/audit</b>	Peripheral element of treatment or service suboptimal  Informal complaint/inquiry	Overall treatment or service suboptimal  Formal complaint (stage 1)  Local resolution  Single failure to meet internal standards  Minor implications for patient safety if unresolved  Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness  Formal complaint (stage 2) complaint  Local resolution (with potential to go to independent review)  Repeated failure to meet internal standards  Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved  Multiple complaints/ independent review  Low performance rating  Critical report	Totally unacceptable level or quality of treatment/service  Gross failure of patient safety if findings not acted on  Inquest/ombudsman inquiry  Gross failure to meet national standards

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Insignificant	Minor	Moderate	Major	Catastrophic
<b>Human resources/ organisational development/staffing/ competence</b>	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff  Unsafe staffing level or competence (>1 day)  Low staff morale  Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff  Unsafe staffing level or competence (>5 days)  Loss of key staff  Very low staff morale  No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff  Ongoing unsafe staffing levels or competence  Loss of several key staff  No staff attending mandatory training /key training on an ongoing basis
<b>Statutory duty/ inspections</b>	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation  Reduced performance rating if unresolved	Single breach in statutory duty  Challenging external recommendations/ improvement notice	Enforcement action  Multiple breaches in statutory duty  Improvement notices  Low performance rating  Critical report	Multiple breaches in statutory duty  Prosecution  Complete systems change required  Zero performance rating  Severely critical report
<b>Adverse publicity/ reputation</b>	Rumours  Potential for public concern	Local media coverage – short-term reduction in public confidence  Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)  Total loss of public confidence
<b>Business objectives/ projects</b>	Insignificant cost increase/ schedule slippage	<5 per cent over project budget  Schedule slippage	5–10 per cent over project budget  Schedule slippage	Non-compliance with national 10–25 per cent over project budget  Schedule slippage  Key objectives not met	Incident leading >25 per cent over project budget  Schedule slippage  Key objectives not met
<b>Finance including claims</b>	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget  Claim less than £10,000	Loss of 0.25–0.5 per cent of budget  Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget  Claim(s) between £100,000 and £1 million  Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget  Failure to meet specification/ slippage  Loss of contract / payment by results  Claim(s) >£1 million
<b>Service/business interruption Environmental impact</b>	Loss/interruption of >1 hour  Minimal or no impact on the environment	Loss/interruption of >8 hours  Minor impact on environment	Loss/interruption of >1 day  Moderate impact on environment	Loss/interruption of >1 week  Major impact on environment	Permanent loss of service or facility  Catastrophic impact on environment

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11

**Table 2 Likelihood score (L)**

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Occasionally / Possible	Likely	Almost certain
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

**Table 3 Risk scoring = Consequence x Likelihood (C x L)**

Likelihood	Consequences				
	1	2	3	4	5
	Insignificant	Minor	Moderate	Major	Catastrophic
5 Almost certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Occasionally / Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

	1 - 3	Low Risk
	4 - 6	Moderate Risk
	8 - 12	Significant Risk
	15 -25	High Risk

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11

DRAFT

1
2
3
4
5
6
7
8
9
10
11