

Board of Directors | Public Meeting 06.05.2026

MEETING
6 May 2026 09:30 BST

PUBLISHED
6 May 2026



Agenda

Location
Meeting Room 1, Main Entrance

Date
6 May 2026

Time
09:30 BST

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BOARD OF DIRECTORS | PUBLIC MEETING
WEDNESDAY 04 MARCH 2026 AT 9:30AM AT RJA 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	✓
Stacey Keegan (SK)	Chief Executive Officer	✓
Angela Mulholland-Wells (AMW)	Chief Finance and Commercial Officer	✓
Paul Kavanagh Fields (PKF)	Chief Nurse and Patient Safety Officer	✗
Sarah Needham (SNe)	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	✓
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	✓
Kirsty Foskett (KF)	Assistant Chief Nurse and Patient Safety Officer	✓
Colin Chapman (CC)	Governor – observing	✓
Gill Pitcher (GP)	Governor – observing	✓
Jan Greaslet (JG)	Governor – observing	✓
Nicki Bellinger (NB)	Governor – observing	✓

Ref	Discussion and Action Points
1.0	Welcome and introductions
	<p>The Chair opened the meeting by welcoming all attendees.</p> <p>The Board welcomed Kirsty Foskett, Assistant Chief Nurse and Patient Safety Officer, who attended to represent the nursing portfolio.</p>
1.1	Apologies
	<p>Apologies for absence were received from Sarah Needham and Paul Kavanagh-Fields.</p> <p>It was formally confirmed that the Board was quorate, enabling the meeting to proceed with full decision-making authority.</p>
1.2	Declarations of Interest
	<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>

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Ref	Discussion and Action Points
1.3	Minutes of the previous meeting
	<p>The minutes of the Board of Directors (Public) Meeting held on 07 January 2026 were approved subject to the following amendments:</p> <ul style="list-style-type: none"> Page 3, second paragraph – digital aseptic system
1.4	Matters Arising and Action Log
	<p>It was confirmed that there were no outstanding actions to discuss, and the attendees had no further comments.</p>
2.0	Service Presentation: Acute Pain Opioid Project
	<p>RL introduced Sarah, Laura and Melanie, who form the Acute Pain Team leading a project to reduce opioid use in patients ahead of elective surgery. The team has presented this work across several forums within the ICS, where it has been very well received.</p> <p>The presentation covered:</p> <ul style="list-style-type: none"> Research and background - The team shared an overview of the evidence base, including key research papers and their findings. Why this matters to RJAH - Shropshire, Telford & Wrekin are among the highest prescribers of daily morphine equivalent doses over 120mg per 1,000 patients nationally. This aligns with findings from the GIRFT review and NICE guidance, highlighting the importance of targeted intervention. Qualitative baseline data - Early qualitative data shows that 90% of patients would engage with the service if offered. Collaborative working - The team recognised early that collaboration across the system would be essential. Although challenging—given that many teams work in silos—they have worked hard to build relationships and establish a working group including RJAH, GPs, community pharmacists, and a lifestyle/fitness specialist. This has laid the foundations for a research project aligned with the Neighbourhood Health model, which aims to deliver joined-up care and improve wellbeing. Barriers to progress - The team outlined several challenges: <ul style="list-style-type: none"> Apollo system – anticipated improvements in identifying and referring high-dose opioid patients have not yet materialised. Engagement – difficulties engaging some clinical groups and wider community partners. Time constraints – the pain team is a limited resource, with clinical care taking priority. Resource requirements – particularly if lifestyle interventions are included. Geographical limitations – community support is currently only available for Shropshire patients. Potential outcomes - The project aims to support pre-operative health optimisation, leading to improved surgical outcomes, reduced complications, and lower readmission rates. <p>HT thanked the team for their presentation and invited questions and comments from Board members.</p> <p>The Board discussed the following:</p> <ul style="list-style-type: none"> High prescribing rates in STW - The cause is unclear, though rurality may play a role. There is no chronic pain service locally, meaning GPs often manage complex pain cases themselves. Opportunities for wider system working - There is potential to strengthen collaboration with community care, though GP engagement remains a challenge. Alignment with the Neighbourhood Plan - The project fits within the broader neighbourhood health approach. Engagement with primary care - MN asked how primary care could be better engaged to support alternative approaches. The team noted this requires system-wide motivation beyond the Trust alone. Engagement challenges - ME shared that the project was presented at the DERIC Committee, where similar challenges with GP engagement were noted. The STW

Ref	Discussion and Action Points
	<p>Neighbourhood Health Lead has made contact. ME offered support in facilitating further regional conversations, emphasising the need for collective system working.</p> <ul style="list-style-type: none"> • Additional support - MC offered support outside the meeting, including around Apollo. It was noted that the community pain service is likely to be tendered within the next six months, presenting an opportunity to develop a primary-care-based service. • Outcome measurement - the Board highlighted the importance of auditing and tracking patient outcomes to demonstrate impact. The team hopes to work with the myRecovery system to support this. • Pharmacy engagement - A question was raised about links with the lead pharmacist at STW ICB. The team was encouraged to connect with Vanessa Whatley to explore opportunities. • System-wide opioid reduction work - there is ongoing work across the system focused on reducing opioid use. • Clinical effectiveness and reporting - LW asked about intended outcomes and whether the project is on the radar of the Clinical Effectiveness Committee. The team was encouraged to link in so progress can be reported into QS via CEC. • Powys patients - noted that current data does not separate Powys patients. • Project support - there are several blockers at present, and the team highlighted the need for project support to progress the work. • PMO involvement - noted that the initiative began as a small project but has grown significantly with stakeholder involvement. PMO support is now being considered. <p>The Board thanked the team for taking their time to present to the Board.</p>
3.0	<p>Chair and CEO Update</p>
	<p>Chair Update</p> <p>HT provided the Board with the following updates:</p> <ul style="list-style-type: none"> • Darius Mirza has stepped down from his position as a Non-Executive Director. The Chair expressed appreciation for his contribution and service to the Board. To ensure continuity, JP will rejoin the Board in April on an interim basis for a 12-month period. HT will be engaging with the Council of Governors (CoG) to seek approval to commence the formal recruitment process for a substantive appointment. • A comprehensive Skills and Experience Review of Board skills, experience, and succession planning is nearing completion. Once it has been considered by the CoG, the final version will be shared publicly. The review takes a holistic view of Board capability and future needs, ensuring alignment with organisational priorities. Further discussion and associated actions are scheduled for the April meeting. <p>Chief Executive Officer Update</p> <p>SK provided the Board with the following updates:</p> <ul style="list-style-type: none"> • Planning - The Trust has submitted its three-year financial, operational and workforce plans to NHSE, aligned to national targets. Feedback is awaited. • High Potential Scheme - The High Potential Scheme (HPS) has now opened to NHS staff across Shropshire, Telford and Wrekin. As Senior Responsible Officer, SK supported the pilot, which has already delivered positive development outcomes for staff at RJAH. The next cohort will begin a tailored, one-year programme focused on practical placements, projects and shadowing. • ICB and NHSE Restructures - Recruitment to the Integrated Care Board's executive and non-executive roles is close to completion. Management-of-change processes continue within both the ICB cluster and NHSE. The Trust remains mindful of the impact on colleagues. Work to finalise cluster governance arrangements is ongoing. • Digital Transformation - SK attended the HSJ Digital Summit and the NHSE Midlands Leadership Event, both highlighting the essential role of digital innovation in future NHS delivery. Themes included interoperability, scaling effective digital solutions and improving productivity through smarter infrastructure. • Royal National Visit - A visit to the Royal National Orthopaedic Hospital provided an opportunity to discuss strategic opportunities for specialist orthopaedic services. A reciprocal visit to RJAH is planned.

Ref	Discussion and Action Points
	<ul style="list-style-type: none"> • Bone Cement Supply Issues - A national shortage of medical bone cement has caused concern for patients awaiting joint surgery. The Trust has mitigated any impact through alternative suppliers and continues to monitor the situation closely to maintain safe, uninterrupted care. • Charity Award Supporting Staff Wellbeing - RJAH Charity has secured £50,000 from NHS Charities Together to support a major wellbeing initiative for theatre staff. The project, Renovation, Rejuvenation and Revitalisation—will improve rest areas and create more supportive spaces in response to staff feedback and NHS Staff Survey results. • STAR Award – February - Dawn Taylor, Medical Clinical Placement Facilitator, recognised for her outstanding commitment to medical education and her dedication to supporting future doctors. As a Trust, we have been working towards welcoming medical students on placement for some time, and Dawn’s contribution has been instrumental in making this a success. The feedback we receive from students is consistently excellent and stands as a testament to Dawn’s hard work, professionalism, and passion for education. • STAR Award – January – Jo Davies, Practice Development Nurse, celebrated for her exceptional leadership and unwavering commitment to improving patient safety within the Midland Centre for Spinal Injuries. Jo has been part of RJAH since qualifying five and a half years ago and stepped into the Practice Development role just over a year ago. In that time, she has played a pivotal role in supporting and developing nursing staff across MCSI. Jo exemplifies the dedication and professionalism we value, and it was a pleasure to recognise her achievements with this award. <p>The Board noted the updates provided, and HT invited further comments from members. The following points were discussed:</p> <ul style="list-style-type: none"> • Digital - Productivity frontline funding is being offered to the System, with a very quick turnaround for submissions. We need to be clear on the steps required to access this funding. A meeting is scheduled for March, which Adam will attend, and discussions are already underway. The Trust’s developing digital roadmap will support engagement with digital priorities and is being presented to DTG for endorsement. It outlines the Trust’s key priorities. The benefits realisation programme is critical in this area, and benefits will be expected to be embedded. Preparatory work will be completed in advance. The team structure is being reviewed in relation to the wider system, and an update could be shared with DERIC. SK attended a meeting last week focused on enhanced collaborative working across the system, aiming to think and work differently to avoid siloed approaches. • HPS - An update will be presented at a future PC Committee meeting. Some of our staff are joining the scheme, and several executives are acting as sponsors. • Cement Supply - The Board discussed confidence in supply risks. While there is always some level of risk, the Trust is in a stronger position than many due to the range of implants procured. An EPRR forum was established in response to the incident, and the operational and clinical teams were commended for their leadership throughout. <p>The Board noted the updates from HT and SK.</p>
3.1	<p>Provider Capability Assessment</p> <p>SK presented the letter to the Board, which follows the comprehensive review undertaken by the Trust in 2025. During the review, the Trust provided detailed evidence demonstrating their performance and underpinning their self-assessment. The letter has been shared for information and confirms completion of this stage of the process.</p> <p>The following key points were highlighted:</p> <ul style="list-style-type: none"> • As part of the NOF requirements, the full capability view has been completed. • The Trust’s self-assessment was submitted in a timely manner and supported with robust evidence. • It has been verbally indicated that the Trust is currently assessed as Amber/Green. • This indicative rating does not alter the existing oversight segmentation, and the organisation continues to meet all quarterly expectations. <p>The Board sought clarification on what actions the Trust is required to take in response to the Amber/Green rating and what steps would be needed to improve it. SK confirmed that she has</p>

Ref	Discussion and Action Points
	<p>requested further detail, as no specific criteria have been provided to support or benchmark the rating.</p> <p>The Board commended the letter and the outcome, noting that it is a credit to the organisation — a strong piece of work and well done.</p>
4.0	Quality and Safety
4.1	Performance Report – Quality and Safety Committee
	<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"> • 15 complaints were received. Learning has been identified for each case and shared with the relevant departments and at the PEM meeting. • Discharge-ready rate: this is a new metric that supports the NOF rating and will continue to be monitored. • MSSA bacteremia – 1 case was reported; this is currently under review by the IPC team. • 5 surgical site infections (SSI) were recorded (2 from October 3 from November). An MDT review is being commissioned as this number is higher than expected. • 1 expected death was reported
4.2	Chair’s Assurance Report – Quality and Safety Committee
	<p>LW presented the key points from the Quality and Safety Committee Chair’s Assurance Report. The following items were highlighted:</p> <ul style="list-style-type: none"> • Electronic Patient Record (EPR): The Committee remains concerned about fragmented patient records and instances of missing data. Further detailed reporting is expected, including the outcomes of associated harm reviews, to ensure full visibility and mitigation of risks. • ROG Meeting: Matters relating to DBS checks and professional development were explored in depth, with actions and oversight now being progressed through the People Committee to ensure organisational compliance and workforce assurance. • Blood Transfusion Standards: Work is actively underway to strengthen compliance with national standards. Early indications suggest this may emerge as a key quality priority for the forthcoming year, given its importance to patient safety. • PSII Report: A wrong-site implant incident was reviewed. The Committee received robust assurance that the actions taken in response are appropriate, comprehensive, and being implemented at pace. • Scan for Safety – DERIC Programme: An update was provided on progress within the DERIC initiative, highlighting ongoing improvements in traceability and safety processes. • CQC Action Plan: The Committee reported strong assurance regarding progress against the action plan, particularly in relation to training compliance and the strengthening of identified improvement areas. • HTA and MHRA Reports: Both regulatory reports have now been formally closed, with all required actions completed to the satisfaction of the respective bodies. <p>Following discussion, the Board confirmed it was satisfied with the level of assurance provided and acknowledged the Committee’s continued focus on key quality and safety risks.</p>
4.2.1	Learning From Deaths Q3 Report
	<p>RL presented the Learning From Deaths Q3 Report and extended thanks to James Neil, Mortality Lead, for his thorough work in preparing the document – the following was highlighted:</p> <ul style="list-style-type: none"> • One death was recorded in Quarter 1, classified as unexpected. RL confirmed that all standard procedures were followed promptly and appropriately, including completion of the medical examination and the required internal reviews. • The case demonstrated strong adherence to established processes, reflecting the diligence and professionalism of the clinical teams involved. • The family provided positive feedback, expressing appreciation for the specialist advice they received from the organisation. They also commended staff for the sensitive, respectful, and proactive communication offered to both the patient and the family during a difficult period.

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	The members of the People and Culture Committee confirmed the paper was reviewed in February. The Board noted the assurance provided within the report.
5.0	People and Workforce
5.1	Performance Report
	<p>The Board received and noted the latest People and Workforce Performance Report. The following key points were highlighted during discussion:</p> <ul style="list-style-type: none"> • All KPIs are currently on or above target. • During a walkaround of the department yesterday, the Board observed the relentless pace of work and commended the team for their continued dedication and resilience. <p>The Board noted the performance report – there were no issues to raise with the Board.</p>
5.2	Chair’s Assurance Report – People and Culture Committee
	<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"> • Sickness Absence - noted that some departments are overspending, with a clear correlation to sickness levels. There is a continued focus is needed on reducing sickness across the Trust, including exploring new opportunities and interventions. It was suggested that the teams also engage with staff who <i>do not</i> take sickness absence, to gather broader feedback on health and wellbeing. Their insights may help shape future support initiatives. • Triangulation of Workforce Data - discussion took place on how to triangulate data at departmental level to identify hotspots or areas of concern, even where overall Trust performance appears positive. There is a need to look beyond the IPR data and incorporate staff survey responses, performance oversight, and quality/safety data to build a more complete picture. It may be beneficial to cross-reference dashboards across committees. Each unit has its own IPR, and further support may be needed to bring this information together. MC noted that we do not currently have a tool that makes this exercise straightforward. The new BI platform under development will support this work in time. It was suggested that TPOIG could bring forward hotspot areas from within their units to support this triangulation. • HCA Support Vacancies - HCA vacancies remain a persistent challenge. A recruitment campaign is planned to attract a wider pool of candidates, and the Board noted the positive work already undertaken. There was some discussion about whether the current IPR target is appropriate, specifically, whether the vacancy rate target should reflect the natural turnover within these teams or allow for a higher tolerance. <p>The Board acknowledged the strong metrics and positive performance, expressing thanks for the continued efforts across the Trust.</p>
5.2.1	Freedom to Speak Up Report
	<p>DM presented the Quarter 3 Freedom to Speak Up Report was presented to the Board, following prior review by the People and Culture Committee in February. The report was brought to the Board and the public meeting to ensure full visibility and transparency.</p> <p>The Board was invited to raise any questions regarding the contents of the report. The Board was asked to:</p> <ul style="list-style-type: none"> • Note the Quarter 3 FTSU report. • Acknowledge the ongoing development and strengthening of the FTSU service. • Consider the level of assurance provided through this reporting cycle. <p>It was noted that Elizabeth Hammon, Freedom to Speak Up Guardian is retiring at the end of March, and the Board expressed their thanks for her contribution to the FTSU service. Recruitment for the new Freedom to Speak Up Guardian is currently underway, with the post out to advert.</p> <p>PM confirmed that the report had already been scrutinised by the People and Culture Committee, and members of the Committee had taken assurance from the findings.</p>

Ref	Discussion and Action Points
	<p>The Board discussed the following points:</p> <ul style="list-style-type: none"> PV queried the category relating to non-payment of bank shifts and whether this indicated any wider concern. No specific issues are currently known to the Trust. This will be taken away for further consideration. LW asked about the implementation of RADAR and whether there was any risk associated with transitioning from the current system. It was confirmed that RADAR is not yet being used for FTSU cases, so there is no risk of losing information. The expectation is that RADAR will support improved triangulation in the future. ME commended the Trust on the positive feedback received. ME also suggested considering how internal communications might share examples, where individuals are comfortable being named, to help reinforce learning and transparency. SN emphasised the importance of communications, particularly as confidentiality often prevents full closure of the loop with individuals who raise concerns. SN suggested sharing anonymised examples to reinforce the culture and demonstrate that the Guardian supports staff throughout the process. <p>The Board noted the report and took assurance from the discussion. It was acknowledged that the annual staff survey provides an additional data source, and work continues to triangulate data sets to strengthen insight and assurance.</p>
5.2.2	Guardian of Safe Working Hours Q3 Report
	<p>RL presented the report and began by extending thanks to Chris Marquis, Lead for Safe Working Hours for their contribution. The following key points were highlighted:</p> <ul style="list-style-type: none"> A new exception-reporting framework has been introduced, along with strengthened security measures within the digital reporting system. The Trust has implemented the required security actions outlined in the national 10-Point Plan, and an action plan is now in place. No exception reports were submitted during this quarter. <p>The Board discussed the following:</p> <ul style="list-style-type: none"> A briefing on the 10-Point Plan is scheduled to be shared with the People and Culture Committee. RL clarified that Trust-appointed doctors are excluded from this reporting. The new middle-grade anaesthetic posts are also not included, as the system only covers doctors in training (resident doctors). The Board noted that monitoring for Trust-appointed staff is not required under the national framework; any issues are instead managed through standard Trust employment processes. There is a national requirement for resident doctors to be included in this reporting, while Trust-employed staff continue to be overseen through internal employment procedures. <p>The Committee expressed thanks for an excellent report.</p>
6.0	Performance and Finance
6.1	IPR Exception Report (inc. Long Waiting Patients)
	<p>MC presented the Integrated Performance Report to the Board, outlining current performance, areas of improvement, and ongoing operational challenges.</p> <ul style="list-style-type: none"> 62-week waits: There were two breaches within the month. This remains a volatile metric, with numbers fluctuating at similar levels. 28 days: the trust were compliant in December, following a prolonged period of being below average 18-week RTT: Performance is slightly ahead of the operational plan, placing the Trust in the top quartile of most improved organisations. The focus for the Q4 sprint includes rheumatology and diagnostic activity to support year-end delivery. The year-end target is 60%, and the Trust remains on track. Time to first appointment – England: Performance is at 67%. A slight reduction has been seen due to the balance of the waiting list. Time to first appointment – Wales: Performance has improved. MSK has launched a new interface service, which has contributed to reductions in waiting times for the Trust.

Ref	Discussion and Action Points
	<ul style="list-style-type: none"> • 52-week waits (England): Performance is at 3.95%, on track to reduce to 1% by year-end. The Q4 sprint includes outsourcing, temporary changes to the trauma rota, MBI review and validation of patient lists. The case mix is notable, with focused work on spinal disorders now reflected in the data. • 104-week waits (Wales): Performance has improved over recent months, particularly in spinal pathways. • Diagnostics: Performance remains on track, although a dip was noted in January due to staffing and referral pressures. These issues have now been resolved. • Elective activity: Activity is at 92%, with 37 cases off plan. Cases per session remain lower than expected. Four Eyes has been commissioned to undertake a review to support delivery. • Elective hub optimisation: A meeting is scheduled, with collaborative work underway with RNOH, ROH and Wrightington. • Outpatients: Performance is at 99.9% and on plan for delivery. A comparison with last year (excluding May–June) shows an additional 5,000 patient reviews completed, supporting the delivery model. <p>The Board discussed the following:</p> <ul style="list-style-type: none"> • Noted and commended several positive areas of performance within the report. • Highlighted that the 18-week trajectory is above plan despite a recent downturn in activity. As the March target increases, most patients should now be booked, giving confidence in delivery. MC confirmed that the waiting list has reduced from 6,144 to 5,678 patients. • Queried whether teams remain focused on replacing patients when theatre lists are reduced or cancelled. MC confirmed they do, and emphasised the need to maintain theatre activity. Additional metabolic infusions and rheumatology weekend clinics are being delivered, and some patients are being seen at the Nuffield. • PM reported that the ARC Committee had a high degree of assurance due to improved service-line reporting and strengthened oversight of activity monitoring. • Noted a successful first draft of the case throughput report, which identifies opportunities for the Trust. • ME raised the link between performance and assurance, particularly regarding sickness levels within the booking team. Understanding pinch points and resilience would support more meaningful conversations and improve service levels and patient experience. • Queried whether outpatient modelling is being undertaken and whether Four Eyes could extend its review to outpatients. MC confirmed that outpatient transformation is one of the largest programmes for the coming year. Work is underway with the GIRFT team, and clinical leads have met with Professor Tim Briggs to discuss outpatient activity and modelling. • MC added that virtual outpatient activity, PIFU rates, and communication initiatives are supporting patients to “wait well.” • Confirmed that Four Eyes commenced their review in theatres last week, and there is potential for this to be extended to outpatients. • The Board noted significant administrative changes over the past 12 months. With support from the improvement team, a series of workshops will be held to review administrative processes, undertake deep dives, and complete process mapping. <p>The Board acknowledged the progress made to date and reaffirmed the importance of maintaining momentum to ensure full delivery of the operational plan and timely treatment for patients.</p>
6.2	Finance Performance Report
	<p>AMW presented the finance performance report, highlighted the following:</p> <ul style="list-style-type: none"> • The Month 10 position shows a £757k surplus, which is in line with the financial plan. • Year-to-date performance remains on track with two months left in the financial year. • Variances in activity and franchise income are reducing as the year progresses. • The Board noted the ongoing challenges and risks associated with delivering the full-year plan. • The Trust is expected to remain in segment 2 in relation to its financial position. • Clinical income continues to fall behind plan by £3.6m.

Ref	Discussion and Action Points
	<ul style="list-style-type: none"> • Lower income levels are being partially offset by increased internal sourcing and reduced outsourcing, which supports internal continuity. • Pay expenditure is below plan, reflecting lower levels of activity. • Cost pressures remain, and cost-control measures continue to be reviewed at the weekly PFIG meeting, where teams are challenged and supported to mitigate risks. • A year-end review meeting will be held to reset plans and strengthen performance monitoring for the challenging year ahead. • The efficiency programme has been on plan for several months and is forecast to deliver £1m above plan, helping to reduce the financial gap, although next year will require a further 5% increase in efficiency. • The capital plan remains on track, with a slight underspend due to programme timing. • Some financial risk will remain until month-end closure, although mitigations are in place and being delivered. <p>AMW invited questions from Board members, and the following points were discussed.</p> <ul style="list-style-type: none"> • Sought clarification on the non-recurrent waterfall graph seeking to understand the benefits supporting this year's position and whether this creates risk for the next financial year. AMW explained that balance-sheet flexibility is reducing as provisions and released and that cash balances also contribute to this picture. • Highlighted the positive trend in implied productivity and asked when performance might rise above the red line, noting that next year's plan requires productivity above 2%. AMW acknowledged the complexity of the issue and noted that similar discussions had taken place at the Finance and Performance Committee. AMW confirmed that the metrics supporting implied productivity are clearly articulated within the organisational plan, including the key drivers used for monitoring and reporting. Further detail will be provided to the Finance and Performance Committee. <p>The Board commended the clarity and presentation of the operational detail slides and were content with the assurance provided.</p>
6.3	Chair Report from Finance and Performance Committee
	<p>SNA presented the Chair's Assurance Report and highlighted the following key points:</p> <ul style="list-style-type: none"> • The committee received a comprehensive presentation pack in relation to the delivery of the operational and financial plan. • The revised Activity Recovery Committee Terms of Reference were reviewed; the updated clarifications were welcomed and endorsed by the Committee. The revised document is presented to the Board for approval. • Ongoing procurement / bone cement issues were discussed and it was commended that there have been no cancellations to date due to this issue. • The committee requested that the "four-eyes" outcome report is to be shared at the Finance and Performance Committee once the review has been completed. • The next Finance and Performance Committee will take a broader focus on outpatient transformation in order to gain further assurance within this area. • In relation to the financial position, there is a risk relating to capital delivery however, this has since progressed positively since the report which was received at the Committee. • The committee commended the teams for their strong performance within the delivery of the large efficiency programme, noting that the usual level of scrutiny was not required due to the high quality of work completed. <p>The Board noted the Chair's Report and confirmed that it was satisfied with the assurance provided.</p>
6.3.1	Activity Recovery Committee Terms of Reference
	<p>Following a recommendation from the Finance and Performance Committee, the Board approved the revised Terms of Reference for the Activity Recovery Committee.</p> <p>It was noted that the Committee's meetings will focus on the four constitutional standards that the Trust must achieve in order to deliver the operational plan.</p>

Ref	Discussion and Action Points
	The Committee agreed to schedule a discussion at the next meeting regarding whether the Committee will continue into the new financial year. It was also agreed that the meeting currently in the diary for two weeks' time will be removed.
7.0	Digital, Education, Research, Innovation and Commercialisation
7.1	Digital, Education, Research, Innovation and Commercialisation Committee Performance
	The Board noted the performance report in relation to the DERIC committee.
7.2	Chair Report from Digital, Education, Research, Innovation and Commercialisation Committee
	<p>ME presented the Chair's Assurance Report and highlighted the following points:</p> <ul style="list-style-type: none"> • Electronic Patient Record (EPR): Progress continues, with a short-term plan in place that is advancing well alongside the System. Further clarity is expected on the next steps, with an EPR meeting scheduled for next week. • DERIC Review: The Committee has reviewed recent meeting outcomes, including the terms of reference and the Well-Led action plan. A refreshed approach will see the Committee focus on one specific thematic area at each meeting, allowing more time for forward-looking, innovative discussion while maintaining robust assurance. • National Funding Opportunities: The next meeting will include discussion on national funding opportunities to ensure clarity on priorities and focus within the digital agenda. • Medical Education Developments: Work continues on increasing the number of medical students in partnership with the University of Chester as part of the Trust's progression toward university hospital status. <p>The Board noted the Chair's Report, and no specific questions were raised</p>
8.0	Chair Report from Audit and Risk Committee
	<p>MN presented the following updates from the Audit and Risk Committee:</p> <ul style="list-style-type: none"> • Internal Audit completed two reviews: Key Financial Controls and NHSE Grip and Control. Both received Substantial Assurance, which the Committee noted as a strong and positive outcome. • The FPPT Policy and the SFI and SoD Policy were reviewed, and both policies are recommended for approval by the Board. • The MIAA reappointment does not require Board approval. The auditors are now in the fourth year of their contract, and the Committee approved a further three-year reappointment. The Trust remains satisfied with the auditors' performance, engagement, and value for money. <p>Following the updated in relation to the MIAA reappointment, the Board ratified the Committee's recommendation of the MIAA reappointment.</p> <p>The Board was content with the assurance received through the chair report.</p>
8.1	Fit and Proper Person Policy
	<p>This policy has been created following the recent FPPT review undertaken by MIAA Internal Audit. One of the key recommendations from the review was to bring together all documentation and evidence relating to the Fit and Proper Persons Test into a single, consolidated policy.</p> <p>The Trust already had a strong FPPT process in place, and no changes to the process itself were required. However, the review highlighted the need for clearer documentation and for the process to be formally captured within a dedicated policy. This new policy therefore reflects the existing arrangements but documents them more clearly and comprehensively, in line with the audit recommendation.</p> <p>The Audit and Risk Committee has endorsed the policy and recommends it for approval by the Board.</p> <p>The Board approved the FPPT Policy.</p>

Ref	Discussion and Action Points
8.2	Standing Financial Instructions and Scheme of Delegation Policy
	<p>The Standing Financial Instructions (SFI) and Scheme of Delegation (SoD) have been revised, with the main change focused on simplifying the control processes. The updated policy was presented to the Board with a recommendation for approval following a review at the Audit and Risk Committee.</p> <p>The Board noted that the policy will continue to be reviewed annually and highlight that procurement levels have been updated to ensure alignment with SATH and SCHAT.</p> <p>It was also recognised that further internal communication and engagement will be required to ensure teams fully understand their responsibilities under the revised SFI and SoD. This work will link to the new performance and accountability framework, which will be launched shortly and will support delivery of the well-Led action plan.</p> <p>The members of the Audit and Risk Committee recommended the policy to the Board. The policy was approved.</p> <p>During the discussion, PV highlighted that the SFI references petty cash and corporate credit cards. PV asked what systems are currently in place to audit corporate credit card usage. AMW agreed to provide a response to PV following the meeting.</p>
9.0	Questions from the Governors and Public
	There were no specific comments or questions raised by the Governors. HT thanked the Governors for their attendance at the meeting.
10.0	Any Other Business
	<p>There were no further items of business for discussion.</p> <p>HT thanked all attendees for their time and contribution to the discussion before closing the meeting.</p>
10.1	Date and time of next meeting: Wednesday 06 May 2026 at 9:30am

Member	First Name	Surname	Position	Type of Interest	Description of Interest (including for indirect interests, details of the relationship with the person who has the interest)	Date interest relates From	Date interest relates To	Comments, including action taken to mitigate any potential conflict of interest.
Board	Harry	Turner	Chairman	Non-Financial Personal Interests	Presiding Justice West Mercia judiciary	01/10/2026	Ongoing	
Board	Sarfraz	Nawaz	Non Executive Director	Financial Interests	Wakefield Council – Chief Finance Officer	01/09/2025	Ongoing	
Board	Sarfraz	Nawaz	Non Executive Director	Financial Interests	Wakefield Council – Corporate Director	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 Integrated care System	19/03/2026	Ongoing	
Board	Penny	Venables	Non Executive Director	Non-Financial Professional Interests	Non-Executive Director – British Dietetic Association, 3rd Floor Interchange Place, 151 – 165 Edmund Street, Birmingham B3 2TA. Sit on the Board of Directors of the BDA.	01/06/2020	01/10/2024	
Board	Penny	Venables	Non Executive Director	Non-Financial Personal Interests	Husband is NED at Birmingham and Black Country ICB	01/02/2026	Ongoing	
Board	Penny	Venables	Non Executive Director	Non-Financial Personal Interests	Chair Sandwell Leisure Trust, 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 director of Shropshire Doctors Co-operative Limited	01/08/2019	Ongoing	To my knowledge Shropdoc and RJAH do not trade with each other
Board	Martin	Newsholme	Non Executive Director	Financial Interests	Non executive director at Warrington Housing Association	01/09/2018	Ongoing	Warrington Housing is not in the healthcare section and doesn't trade with RJAH
Board	Lindsey	Webb	Non Executive Director	Indirect Interests	Husband is a Deputy Chair at Birmingham, Black Country and Solihull ICB	17/11/2025	Ongoing	
Board	Lindsey	Webb	Non Executive Director	Indirect Interests	Husband is a NED at Birmingham and Solihull ICB		16/11/2025	
Board	John	Pepper	Associate Non Executive Director	Financial Interests	GP appraiser for NHSE	2012	31/03/2026	Position ending 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	Senior Advisor for Primary Care (Department of Health)	01/03/2023	31/07/2024	
Board	Paul	Maubach	Associate Non Executive Director	Financial Interests	Director for Neighbourhood Health (Department of Health)	01/08/2024	Ongoing	
Board	Paul	Maubach	Associate Non Executive Director	Financial Interests	Director and Owner of Maubach Consulting Ltd – through which I provide management consulting and advisory services to different organisations. If it transpires either at a committee or Board meeting of the Trust, the meeting is either discussing or engaging with an organisation that my company is also engaged with, then I will declare a potential conflict of interest to the Chair.	01/03/2023	Ongoing	
Board	Atif	Ishaq	Associate Non Executive Director	Financial Interests	Enterprise AI & Advanced Analytics Director at Mars Inc	04/2025	Ongoing	
Board	Atif	Ishaq	Associate Non Executive Director	Financial Interests	Owner of Digital Clinician Ltd	01/01/2018	Ongoing	
Board	Atif	Ishaq	Associate Non Executive Director	Financial Interests	Digital Advisor and Webmaster to Quest Legal Advocates LTD	01/01/2011	Ongoing	
Board	Atif	Ishaq	Associate Non Executive Director	Financial Interests	Webmaster for Shrawley, North Claines and Hanbury Parish Councils	01/01/2011	Ongoing	
Board	Atif	Ishaq	Associate Non Executive Director	Financial Interests	Self-employed webhosting provider	01/01/2011	Ongoing	
Board	Atif	Ishaq	Associate Non Executive Director	Non-Financial Personal Interests	Justice of the Peace for West Mercia Judiciary	01/01/2017	Ongoing	
Board	Stacey	Keegan	Chief Executive Officer	Non-Financial Professional Interests	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	Withdraw from discussions as appropriate.
Board	Ruth	Longfellow	Chief Medical Officer	Financial Interests	Member of GAS (Gobowen Anaesthetic Services)	01/11/2019	01/06/2025	GAS was set up as an LLP, but no longer functions as an LLP since the recent pension rule changes
Board	Mike	Carr	Chief Operating Officer	Indirect Interests	Parent is Chief Executive of Midlands Partnership NHS Trust.	01/05/2022	Ongoing	Withdraw from discussions as appropriate.
Board	Mike	Carr	Chief Operating Officer	Non-Financial Personal Interests	Trustee at Stay Charity	01/02/2025	Ongoing	Withdraw from discussions as appropriate
Board	Denise	Harnin	Chief People and Culture Officer	Non-Financial Personal Interests	Spouse is a senior partner at Johnson Fellows Charter House, Birmingham, Ad hoc HR consultancy Johnson Fellows		Ongoing	
Board	Angela	Mulholland-Wells	Chief Finance and 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	Paul	Kavanagh-Fields	Chief Nurse and Patient Safety Officer	Non-Financial Professional Interests	Chair of the NOA workforce network	01/06/2024	Ongoing	
Board	Paul	Kavanagh-Fields	Chief Nurse and Patient Safety Officer	Non-Financial Professional Interests	Member of the Cavell Advisory Panel, supporting a UK charity that assists nurses, midwives, and maternity support staff facing financial hardship.	01/10/2024	Ongoing	
Board	Clair	Hobbs	Interim Chief Nurse and Patient Safety Officer	No interest to declare	N/A	N/A	N/A	

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The NIHR Academic Clinical Lectureship

Bridging research and clinical care at RJAH

Amr Selim

MBBCh (Hons), MSc, PhD, FRCS (Tr&Orth), PGCert ClinEd

NIHR Academic Clinical Lecturer | ST6 Trauma & Orthopaedics | Keele University

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What is the NIHR Academic Clinical Lectureship?

A nationally competitive, post-doctoral training post for future clinical academics



What it is

A 4-year integrated clinical academic post awarded by the NIHR. Combines specialty training with protected research time.



How time splits

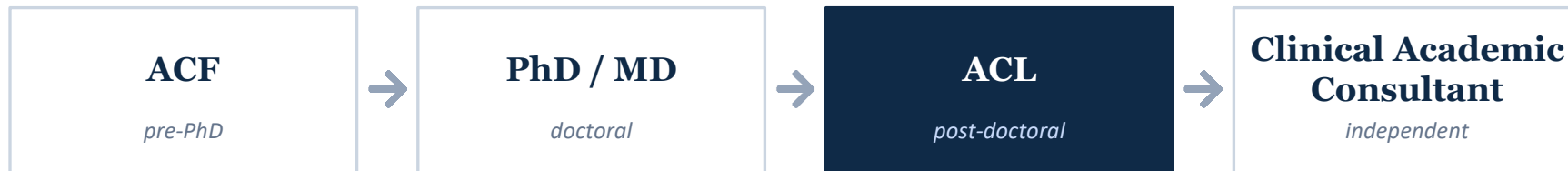
50% NHS clinical training (T&O specialty programme).
50% protected academic time at the host university.



Why it matters

Designed to build the next generation of clinical academic consultants

THE CLINICAL ACADEMIC PATHWAY



← I am here

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How my role works in practice

Hosted by Keele University — clinical training across UHNM and RJAH

MY WORKING WEEK

50 / 50

Clinical training / Protected research

CLINICAL

RESEARCH

Clinical: ST6 Trauma & Orthopaedics rotations across UHNM and RJAH — full on-call commitments.

Research: Protected academic days at Keele — design and delivery of trials, data analysis, supervision, grant writing.

CURRENT RESEARCH THEMES



Hip & knee arthroplasty

Outcomes, enhanced recovery, day-case pathways



AI & machine learning

Predicting PROMs, discharge failure, surveillance



Cartilage & regenerative

Autologous conditioned plasma; UK cartilage registry



Hip fracture & VTE

Apixaban duration trial (HTA-funded, £2.09M)

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What the Trust gets back

Tangible returns from one academic trainee post — last 18 months



£2.14M

Research grants secured

incl. £2.09M NIHR HTA award (2025)



18+

Peer-reviewed publications

JBJS, J Arthroplasty, BJO, Injury...



12+

International podium presentations

AAOS, EFORT, BOA, BHS, SICOT



10+

Trust audits & QI projects

VTE, NoF consent, paediatric admissions...

Beyond the numbers: national awards (BOA AI 2025, AAOS top-15 international presentations), trainee teaching, and a growing Keele–RJAH research footprint.

Why this matters for RJAH

A specialist orthopaedic trust is the ideal platform for clinical academic training



Sustainable academic capacity

Builds the local pipeline of clinical academic consultants — securing RJAH's future research leadership.



Research income & visibility

NIHR-funded posts attract grant capture and collaborative trials hosted with RJAH partnership.



Reputation & recruitment

Strengthens the Keele–RJAH alliance; attracts high-calibre trainees and consultants to the Trust.



Better care for our patients

Translates Trust data and specialist practice into national evidence that changes patient outcomes.

Academic trainees turn RJAH's specialist clinical excellence into national evidence.

Thank you

The Robert Jones and Agnes Hunt
Orthopaedic Hospital



Welcome to

The
Robert Jones
and
Agnes Hunt
Orthopaedic
Hospital



Aspiring to deliver
world class patient care

Main
Entrance



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Optimising Day Case and Early Discharge Pathways After Hip and Knee Arthroplasty Using Machine Learning

Amr Selim, Abdelrahman Ibrahim, Rebecca Warren,
Niall Graham, Dan Redfern,
Geraint Thomas

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Introduction

- This study developed and validated ML models to predict Day Case discharge failure after THR and TKR, aiming to optimise discharge pathways and resource allocation.

Pre-operative patient education via the 'Joint School' service

Nutritional status optimization with high-energy drinks pre- and post-operatively

Standardisation of peri-operative spinal anaesthetic



Early post-operative mobilisation

Early telephone follow-up following discharge

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Non-selective enhanced recovery pathway in primary hip and knee arthroplasty: a propensity score matched analysis on safety and efficacy



Amr Selim^{1,2}, Deepak Menon^{3,4}, Eleanor Rouse³, Rebecca Warren³, Dan Redfern³, Samantha Davies³, Niall Graham³, Geraint Thomas^{3,4}

Affiliations: [collapse](#)

Affiliations

- 1 Robert Jones & Agnes Hunt Orthopaedic Hospital, Oswestry, SY10 7AG, UK. amr.selim@nhs.net.
- 2 School of Medicine, Keele University, Staffordshire, SY10 7AG, UK. amr.selim@nhs.net.
- 3 Robert Jones & Agnes Hunt Orthopaedic Hospital, Oswestry, SY10 7AG, UK.
- 4 School of Medicine, Keele University, Staffordshire, SY10 7AG, UK.

PMID: 41656317 PMCID: [PMC12884631](#) DOI: [10.1186/s42836-026-00367-w](#)



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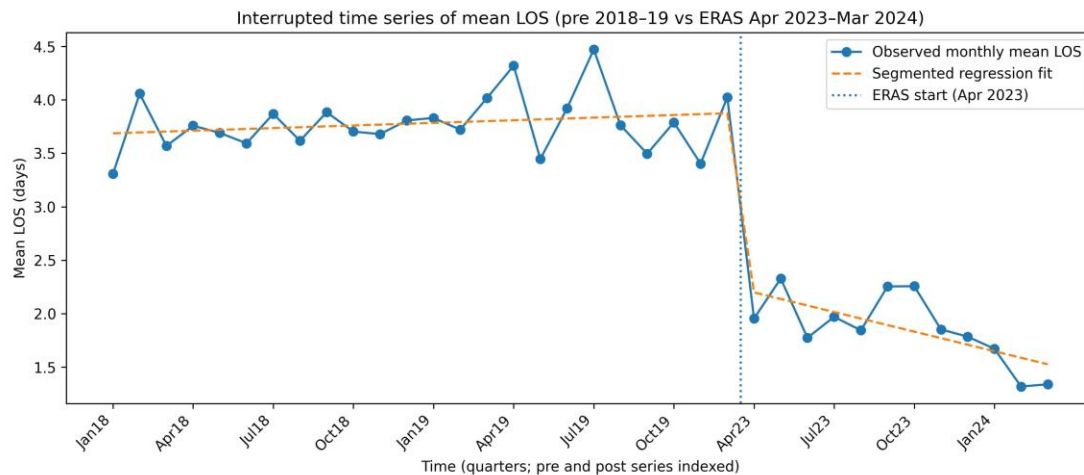
View Complete Issue

Abstract

Background: Enhanced Recovery After Surgery (ERAS) was introduced in hip and knee arthroplasty to expedite recovery, shorten inpatient stay, and reduce costs. This study aims to investigate the safety and efficacy of implementing a universal standardized non-selective ERAS service for all patients admitted for primary hip and knee arthroplasty in a single high-volume tertiary orthopaedic centre.

Methods: All patients who underwent primary hip or knee arthroplasty under ERAS from April 2023 to March 2024 were compared with a matched cohort between January 2018 and December 2019. Patients were matched at a 2:1 ratio based on procedure, age, sex, ASA grade, and BMI (ERAS = 1811, Standard Care = 3549 patients). Outcomes included Length of Stay (LOS), 30-day readmission, overall infection, superficial infection, deep infection, 30- and 90-day mortality rates.

Results: The median LOS was 1 day (IQR 1-2) in the ERAS group versus 3 days (IQR 2-4) in the Standard Care group ($W = 5.415769$, $P < 0.001$). Rates of 30-day readmission (1.7% vs. 2.1%)



Methods

All patients undergoing primary THA, TKA, or PKR under a universal non-selective ERAS pathway between April-2024 and May-2025 were included (3,025 patients).

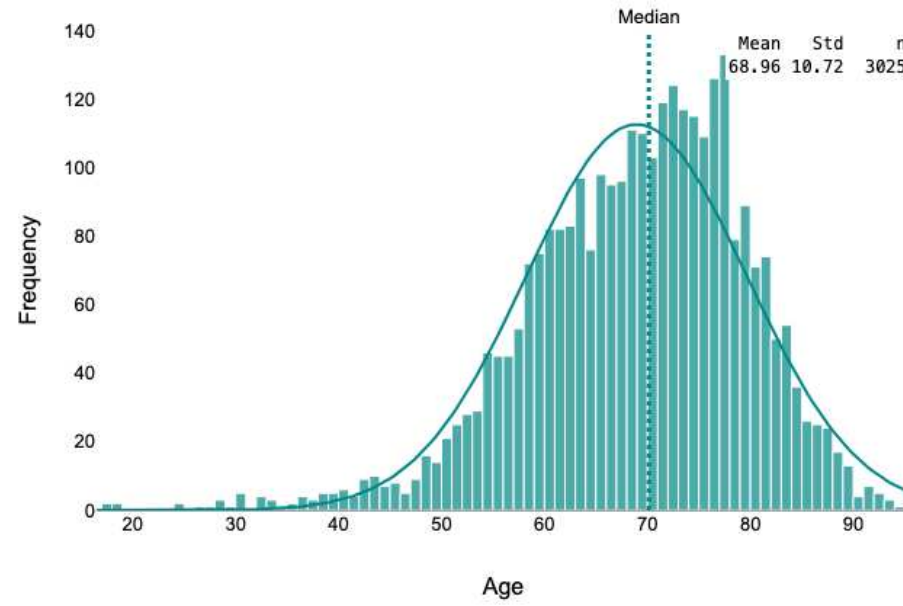
Supervised ML models, including Logistic Regression, Random Forest, Gradient Boosting, Support Vector Machines (SVM), and Decision Tree, were developed using Python.

Predictors were patient demographics, baseline characteristics, anaesthetic variables, and pathway variables.

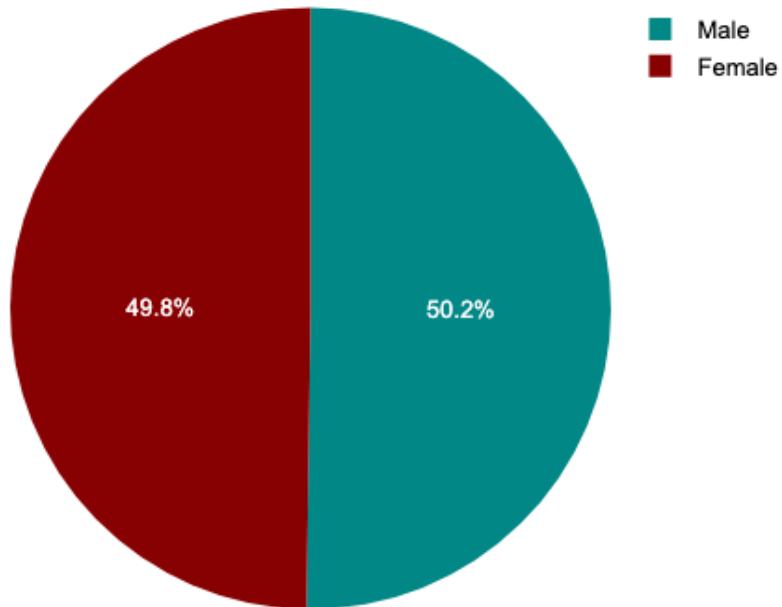
Two prediction targets were defined: (1) failure to discharge at Day 0 or Day 1, and (2) failure of Day-0 (day-case) discharge.

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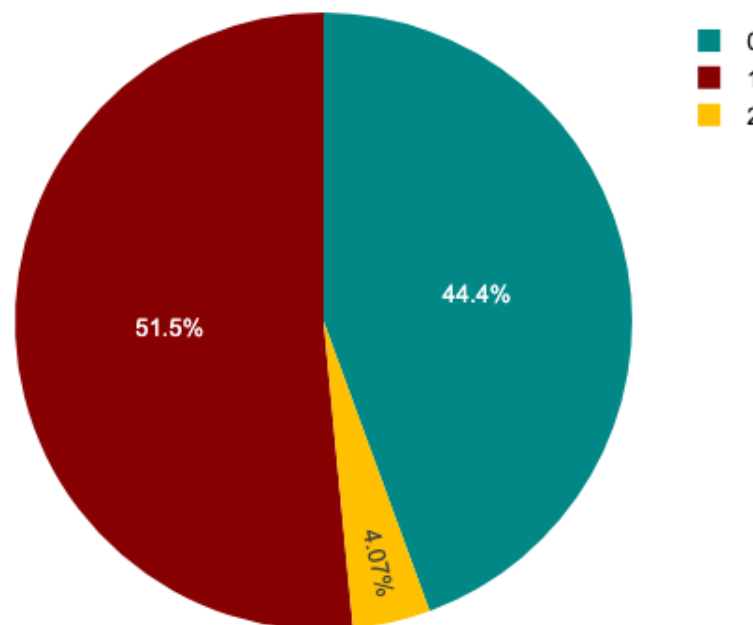
Results



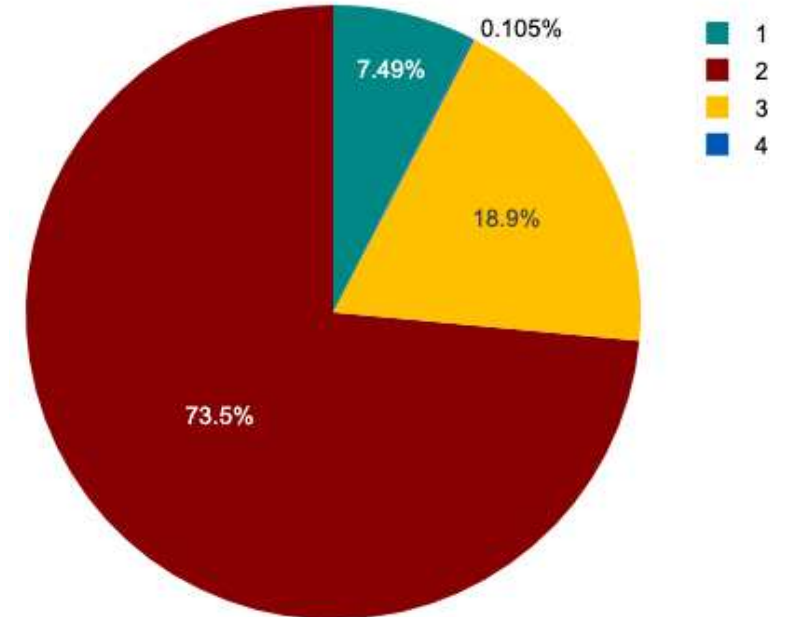
Sex



Joint_



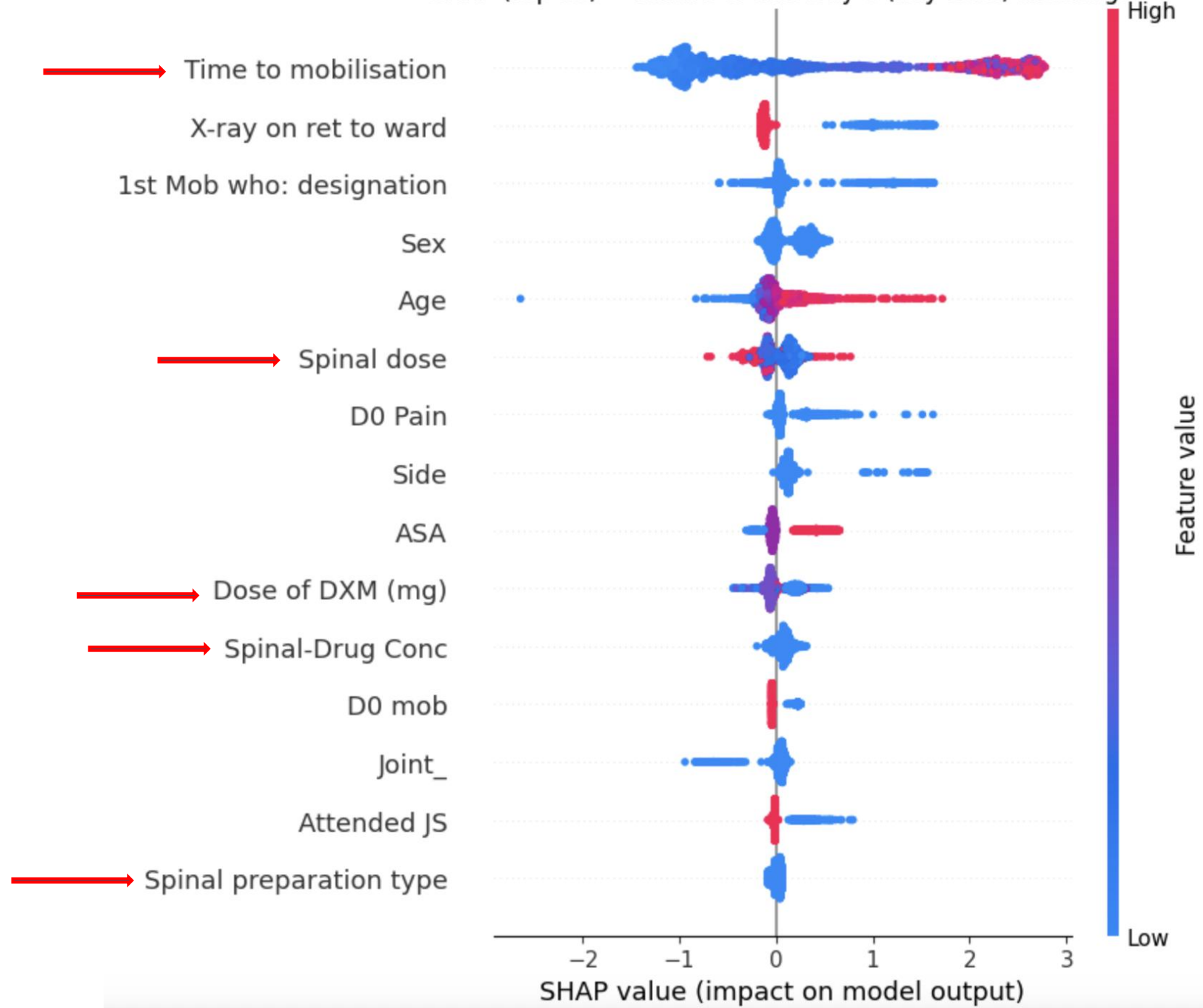
ASA



Performance of ML models for prediction of Day-0 discharge failure

Model	Train ROC AUC	Train Precision	Train Recall	Train F1	Train Brier	Test ROC AUC	Test Precision	Test Recall	Test F1	Test Brier	Test Confusion Matrix (TN FP / FN TP)
Logistic Regression	0.849	0.931	0.688	0.791	0.166	0.807	0.901	0.677	0.773	0.181	[[129, 33] / [143, 300]]
Support Vector Machine	0.847	0.938	0.689	0.795	0.167	0.807	0.916	0.666	0.771	0.182	[[135, 27] / [148, 295]]
Random Forest	0.941	0.952	0.851	0.899	0.111	0.800	0.827	0.777	0.801	0.161	[[90, 72] / [99, 344]]
Gradient Boosting	0.888	0.895	0.829	0.861	0.125	0.811	0.845	0.801	0.823	0.156	[[97, 65] / [88, 355]]
Decision Tree	0.902	0.946	0.777	0.853	0.121	0.756	0.879	0.702	0.780	0.196	[[119, 43] / [132, 311]]

SHAP (Top 15) — Failure of true Day-0 (day-case) discharge



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Conclusions

ML models can be integrated into the Day case and ERAS protocols to predict discharge failure, optimise outcomes and refine the service.

Gradient Boosting achieved the best overall performance for predicting Day Case discharge failure.

Time to mobilisation was the dominant contributing feature, followed by postoperative X-ray on return to ward, designation of rehabilitation staff, patient sex, and age.

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Conclusions



Spinal-only anaesthesia (without GA) was consistently associated with improved discharge success.



Prilocaine better than Bupivacaine.



Higher spinal doses and concentrations were associated with increased predicted failure (with Bupivacaine Not Prilocaine).



Hyperbaric spinal preparations were associated with better early discharge outcomes than isobaric preparations.



Higher DXM dose was associated with better discharge outcome.



Peripheral nerve blocks did not significantly improve discharge success.

Thank you

The Robert Jones and Agnes Hunt
Orthopaedic Hospital

Welcome to

The
Robert Jones
and
Agnes Hunt
Orthopaedic
Hospital



Aspiring to deliver
world class patient care

Main
Entrance



Chief Executive Officer Update

Committee / Group / Meeting, Date

Board of Director - Public Meeting, 06 May 2026

Author:

Name: Stacey Keegan
Role/Title: Chief Executive Officer

Contributors:

Chris Hudson,
Head of Communications

Report sign-off:

Stacey Keegan, Chief Executive Officer

Is the report suitable for publication:

Yes

Key issues and considerations:

This paper provides an update 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	
AHP	Allied Health Professional
CEO	Chief Executive Officer
EHRC	Equality and Human Rights Commission
FoSH	Federation of Specialist Hospital
GIRFT	Getting It Right First Time
HDRS	Health Data Research Service
ICB	Integrated Care Board
ICS	Integrated Care System
IHOs	Integrated Healthcare Organisations
LGBT+	Lesbian, Gay, Bisexual, Transgender, +
MSK	Musculoskeletal
NHS	National Health Service
NHSE	National Health Service England
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust
ROH	Royal Orthopaedic Hospital
RTT	Referral To Treatment
UK	United Kingdom
VCHA	Veterans Covenant Healthcare Alliance

Chief Executive Officer Update

1. Welcome to our new Interim Chief Nurse and Patient Safety Officer

I would like to formally welcome our new Interim Chief Nurse, Clair Hobbs, to the Board as she joins us for her first public Board meeting today. Clair has joined us from Shropshire Community Health NHS Trust, where she was Executive Director of Nursing and Clinical Delivery. A registered nurse, she has extensive experience in senior nursing positions and, having worked within the Shropshire, Telford and Wrekin system for a number of years now, is someone who is well known to us. She has proven ability and an outstanding track record that will make her a real asset and an inspiring leader for our Nursing and AHP teams. I am confident she will be a valuable addition to our team as we look to drive forward our strategic priorities.

2. Year-End update

During the forthcoming Board meeting, the year-end performance reports will be reviewed, highlighting significant accomplishments across our key activity, finance, and workforce plans. Notably, the Trust achieved a Referral To Treatment (RTT) performance rate of 62.15%, surpassing the challenging national target of 60%. This improvement over the past ten months, ranks among the most notable improvements nationally. From a financial perspective, the Trust successfully delivered its break-even plan, a commendable outcome given the current fiscal challenges facing the wider NHS. These results are a testament to the dedication and focus of teams throughout the Trust, across both clinical and non-clinical areas, who have consistently prioritised delivering high-quality care for patients. Their contributions are acknowledged and appreciated. While it is recognised that further progress is required, the Trust enters the 2026/27 period in a stronger position compared to the same point last year.

3. National Oversight Framework

Since the last public Board meeting, we have seen the third iteration of the National Oversight segmentation published for quarter 3 of 25/26. This saw RJAH improve again, maintaining segment 2 – moving from 25th to 22nd out of 134 Trusts. Our ambition is to be placed and recognised in segment 1 and we are showing steady progress to realise that.

4. Planning and Priorities 2026/27

Via a letter from Sir Jim Mackey, each ICS has been asked to submit, by Friday 15 May, a single system response setting out how commissioners and providers will work together over the next three years. The letter requested a strengthened strategic commissioning narrative, clarity on neighbourhood development ambitions, and proposals for changes to financial flows and payment arrangements. The ICS have drafted a response setting out a system position, covering: the development of a more mature, population-led strategic commissioning approach across the two systems; ambitions for neighbourhood-working as the default model for planning and delivery, including governance, delegation and delivery arrangements; and how strategic commissioning will be used to drive the key system shifts from hospital to community, analogue to digital, sickness to prevention, and improved access and productivity. The response also addresses stewardship of public resources and payment reform, market and workforce development, quality and assurance, the use of digital and population health intelligence, and the system's asks of NHS England to support delivery. We have reviewed the draft and provided feedback to the ICS to strengthen the provider lens, particularly from a specialist trust perspective. Our feedback focused on clearer articulation of provider transition risks across finance, workforce and digital; explicit recognition of the role of specialist providers within neighbourhood-led and delegated models; stronger emphasis on people, culture and change capability as enablers of delivery; positioning digital as a productivity driver as well as an integration tool.

5. Shropshire Council Corporate Plan

The Trust was invited by Shropshire Council to review their latest corporate plan and provide partner feedback as a key strategic ally. As a specialist NHS Trust with a national and regional role in musculoskeletal (MSK) care, rehabilitation and elective recovery, we see strong alignment between the priorities set out in the plan and our own strategic objectives. In our response we have confirmed that support and suggested that digital enablement is another area the authority may wish to consider more explicitly. We look forward to continuing to work closely with Shropshire Council and system partners to deliver the ambitions set out in the plan, and would be pleased to contribute further as delivery and implementation plans are developed.

Chief Executive Officer Update

6. Cross-border care – Welsh Affairs Select Committee

Recently, I travelled to Westminster to provide evidence before the Welsh Affairs Select Committee as part of their inquiry into the complexities of cross-border healthcare. Given our organisation's location in Shropshire, adjacent to the Welsh border, we routinely manage a substantial caseload of Welsh patients. The committee expressed a strong interest in understanding our operational experiences and the specific challenges encountered in this context. In particular, they sought detailed insight into our approaches for managing Welsh waiting lists, referral funding processes, and the implications of evolving policy changes. I was among several witnesses invited to present evidence to the committee. The information gathered through these sessions will inform the committee's recommendations to the Government, which will be published in their forthcoming report.

7. NHSE Regional and National events

In April, the Regional NHSE meeting provided a valuable platform to connect with Russell Hardy, the newly appointed Regional Chair, who shared their preliminary perspectives and strategic priorities for the region. The presence of the national team as part of a series of roadshows allowed attendees to reflect on progress from 2025/26 and to consider the priorities and ambitions for 2026/27.

Additionally, the NHSE National CEO event took place in April, featuring insights from Sir Jim Mackey, NHSE CEO, alongside other national colleagues. Key topics included the updated National Oversight Framework for 2026/27, the imminent National Quality Strategy, and an introduction to the vision for the Leadership Management College presented by new Chair Ed Smith.

Crucially, both events fostered opportunities for meaningful networking among peers, enabling participants to share their improvement journeys and explore potential areas for collaboration. These gatherings not only facilitated the exchange of ideas but also strengthened the sense of community within the region, as colleagues discussed strategies to drive further progress.

8. The NHS Alliance LGBTQ+ Guiding Group

NHS England has commissioned The NHS Alliance to develop board-level training in response to the LGBTQ+ Health Evidence Review, targeting Chairs and Non-Executive Directors, with delivery planned for April–June 2026 pending funding confirmation.

Following the Supreme Court ruling on the Equality Act 2010, there is uncertainty pending Equality and Human Rights Commission (EHRC) guidance and NHS England response; NHS Alliance will advocate for clear guidance and support members with implementation, particularly regarding trans healthcare challenges and regional equity issues.

9. Federation of Specialist Hospitals member meeting

During our March meeting, members tackled a variety of priority topics. We received an update from the Health Data Research Service (HDRS), which is working to establish a centralised access point for UK health data. This initiative not only aims to streamline the process for researchers seeking relevant datasets but also plans to enhance support for data-driven clinical trials and patient recruitment. Additionally, HDRS is coordinating its efforts across all four UK nations with guidance from a dedicated council.

FoSH has also launched a communications collaboration designed to elevate the visibility of Specialist Hospitals.

The group discussed progress on developing Integrated Healthcare Organisations (IHOs) and explored the valuable role Specialist Hospitals might play within the Model IHO framework. Notably, through FoSH, members have actively contributed to the draft guidance shaping these developments.

10. RJAH/ROH board to board

Last month, our Board had the valuable opportunity to convene with peers from the Royal Orthopaedic Hospital in Birmingham. This meeting marked a significant step forward in refining the

Chief Executive Officer Update

focus areas for collaborative efforts in the coming year, under the strategic alliance established between our two organisations. The session, held in Walsall, was characterised by productive discussions and a strong sense of shared purpose. We look forward to the promising opportunities this partnership presents and are committed to delivering meaningful improvements for patients through our joint initiatives.

11. Theatre redevelopment and Rheumatology Hub

Currently, significant construction activity is underway across the site. The new Theatre development, which commenced in March, is projected to deliver an additional operating theatre by the end of the summer, increasing our total to 14 theatres. This expansion is expected to enhance our capacity for surgical procedures and contribute to further reductions in waiting lists. In support of this growth, recruitment efforts are ongoing, including a dedicated Theatres recruitment day scheduled for next week.

In parallel, we are progressing with the establishment of a new Rheumatology Hub, located in the former Maternity Unit and Vaccination Centre. The creation of this specialised facility will offer substantial benefits to both rheumatology patients and staff, and anticipation is high for its forthcoming opening.

12. RJAH surgeon appointed to national clinical leadership role

Congratulations to one of our paediatric consultants, Mr Rob Freeman, who has been appointed to work as a clinical lead for the NHS England Getting It Right First Time (GIRFT) programme, alongside the current clinical lead James Hunter until Mr Hunter retires later this year. During the handover period, they will work jointly to support providers to reduce waiting times and improve services across England for the benefit of young patients.

13. Veteran Aware status

I am pleased to report that RJAH has recently been re-accredited with Veteran Aware status by the Veterans Covenant Healthcare Alliance (VCHA). The Trust first achieved Veteran Aware designation in November 2018, and this important recognition was reaffirmed in March 2023. Following a successful application, the Trust has now secured a further three-year accreditation. By the time of the next reaccreditation process, RJAH will have maintained Veteran Aware status for over a decade. This accreditation is a testament to the Trust's ongoing commitment to upholding the highest standards of care for the Armed Forces community, including serving personnel, veterans, and their families, in alignment with the principles of the Armed Forces Covenant.

14. Long Service Awards

The annual Long Service Awards represent a significant occasion for the organisation, offering an opportunity to formally recognise individuals who have demonstrated exceptional dedication to the NHS over several decades. It is widely acknowledged that the NHS's most valuable asset is its people, and RJAH is fortunate to be supported by a workforce distinguished by both excellence and commitment. In 2026, thirteen staff members achieved the notable milestone of thirty years of service. Many of these individuals have devoted their entire NHS careers to RJAH, exemplifying remarkable loyalty and professionalism. Their unwavering dedication is deeply appreciated, and it is a privilege to extend gratitude to them on behalf of all patients served by the Trust.

15. Anniversary for spinal disorders service

This month sees us celebrating 50 years of its dedicated spinal disorders service – marking a major milestone in the development of spinal surgery in the UK. While spinal surgery and deformity correction at RJAH dates to the early 20th century, the Trust's specialist spinal centre was established in 1976 by Professor Brian O'Connor and Professor Jack O'Brien. They went on to introduce pioneering spinal surgery techniques, significantly advancing the treatment of spinal deformities and positioning RJAH at the forefront of spinal innovation. Today, RJAH is widely recognised as one of the UK's leading centres for spinal surgery, with a global reputation for excellence in clinical care,

research and training. Over the past 50 years, generations of spinal surgeons have been trained at the hospital. We are incredibly proud of the teams – both past and present – who have built this reputation and continue to drive it forward.

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Chief Executive Officer Update

16. 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 **Ashleigh Heath**, physiotherapist in the Trauma and Orthopaedic Therapy Team, who has led on a service evaluation of spinal disorders on Powys Ward which has identified opportunities to enhance patient care, improve staff experience and strengthen therapy services across the hospital. Ashleigh's work is a fantastic example of how service evaluation and quality improvement can make a real difference. Her commitment to continuously improving services and supporting colleagues is exactly what the RJAH Stars Award is designed to recognise, and she is a deserving recipient.
- Our March winner was **Liv Roberts**, our Theatre Implant and Resource Manager, in recognition of her vital role in ensuring surgical teams have the correct implants and equipment they need to deliver safe and effective care for patients, especially during a period when there have been significant challenges. I've received such positive feedback about the work Liv has been doing – she is truly deserving of the RJAH Stars Award.

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.

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Corporate Priorities 2026/27

(Part 1) Covering paper

Committee / Group / Meeting, Date	
Board of Directors – Public Meeting, 06 May 2026	
Author:	Contributors:
Name: Nia Jones Role/Title: Managing Director for Planning and Strategy	Name: Executive Directors
Report sign-off:	
Executive Team Meeting, 21 April 2026 Assurance Committees, April 2026	
Is the report suitable for publication?:	
YES.	
Executive Summary:	
<p>The Trust's corporate priorities translate high-level strategic ambitions into clear, actionable objectives that guide organisational operations, performance, and service delivery. They ensure alignment with national NHS requirements, local population health needs, and the Trust's commitment to continuous improvement.</p> <p>As set out in the Trust Strategy 2023–2028, the overarching objectives are to:</p> <ol style="list-style-type: none"> 1. Deliver high-quality clinical services 2. Develop our Veterans' Service as a nationally recognised centre of excellence 3. Integrate MSK pathways across Shropshire, Telford and Wrekin (STW) 4. Grow our services and workforce sustainably 5. Embed innovation, education, and research at the heart of our work <p>Following the Board discussion in April 2026, the corporate priorities have been updated to reflect the feedback provided. Track changes have been retained within the report to support Board members in reviewing amendments since the previous iteration.</p> <p>Additional changes to the document include:</p> <ul style="list-style-type: none"> • Updated priority headings in line with Board feedback • Inclusion of an initial assessment of proposed measurable outcomes for 2026/27, subject to further refinement • Proposed alignment of priorities to Board Committees for assurance purposes <p>The Board Assurance Framework has been reviewed alongside the 2026/27 objective-setting process to ensure appropriate alignment, which will be reflected in the final documentation.</p> <p>The Executive Team is also reviewing the governance reporting process for strategy to strengthen oversight of progress against strategic objectives. Any enhancements will be incorporated into the governance framework for 2026/27.</p>	
Recommendations:	
<p>The Board is asked:</p> <ul style="list-style-type: none"> • Consider the corporate priorities for 2026/27 • Review the quantifiable measures that demonstrate achievement of each objective • Approve the corporate priorities following a recommendation from the assurance committees. 	

Corporate Priorities 2026/27

(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 corporate priorities underpin the delivery of the Trust Strategy		

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 corporate priorities support the delivery of the Trust's strategic objectives and ensure the successful delivery of the overall Trust strategy.		

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 corporate priorities promote the Trust's values.		

Report development and engagement:

The initial draft corporate priorities were shared with the Executive Team in April for comment, ahead of the draft being presented for comments at the Board meeting on 1 April 2026.

Feedback from the Board has since been incorporated into the report, which was then presented to the Executive Team on 21 April 2026 for further consideration and endorsement.

The Assurance Committees reviewed the updated version throughout April, with a recommendation scheduled to be presented to the Board of Directors in May 2026 subject to the following:

- Ensure that the corporate priorities are captured within the committee workplan
- A structured reporting framework to committees aligned to corporate objectives, including milestones and outcome metrics

Appendices

Appendix A Full Corporate Priorities

Corporate Priorities 2026/27

Strategic Objective:



1

Deliver high quality clinical services



Recognised as outstanding
for quality of care

Corporate Priorities	Actions for Delivery	Associated Outcomes	SRO	Delivery Lead	Assurance Committee
Ensure the highest standards of care for our patients	Systematic use of patient feedback, Patient-reported experience measures (PREMs) and Patient-Reported Outcome Measures (PROMs) informing continuous improvement ensuring patients are actively involved in informing service design and improvement.	<ul style="list-style-type: none"> PROMS metrics Phased rollout of PREMS measures relating to: Communication & Information Respect, Dignity & Compassion Access & Timelines Co-ordination & Continuity of Care Environment & Practical Experience Feeling Safe and Reassured Patient Engagement evidenced in service pathway redesign. 	CNO	ACN and Patient Safety Officer	Quality & Safety Committee
	Redesign our outpatient services to modernise pathways, utilise digital enablement, and improve flow adopting GIRFT best practice.	<ul style="list-style-type: none"> Reduction in waiting list for new and follow up appointments. Increased patient satisfaction for access to services 	CMO	MD Specialist Unit	Finance & Performance Committee
	Improve the utilisation and efficiency of our operating theatres, including increasing our sessions per day and weekend utilisation adopting GIRFT best practice	<ul style="list-style-type: none"> Reduction in waiting list for elective admissions. Increased patient satisfaction for access to services 	COO	MD MSK Unit	Finance & Performance Committee
Address equity of access and health inequalities for our catchment population	Reduce variation between English and Welsh waiting times to access services, by improving access to first appointments within 26 weeks and addressing our longest waiting patients.	<ul style="list-style-type: none"> % of Welsh patients accessing first appointments within 26 weeks improved No Welsh patients waiting over 104 weeks for first definitive treatment 	COO	MD Specialist Unit MD MSK Unit	Finance & Performance Committee

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Corporate Priorities 2026/27

	Reduce variation in accessing services for our most deprived population to address health inequalities for our catchment population	<p>Metrics to focus on:</p> <ul style="list-style-type: none"> DNA rate variation 	COO	MD Specialist Unit MD MSK Unit	Quality & Safety Committee
Develop our services through partnership and shared decision-making	Expand and embed integrated digital tools for our patients to improve accessibility to information and improve patient experience	<ul style="list-style-type: none"> My Recovery extended in line with implementation plan NHS App further roll out in line with implementation plan DrDoctor patient booking roll out 	CMO	Deputy CMO	Digital, Education, Research, Innovation & Commercialisation Committee
	Strengthen the interface between GP and hospital services through enhancement of the Advice & Guidance and other established mechanisms to ensure seamless primary-care to secondary-care collaboration.	<ul style="list-style-type: none"> Adherence to A&G turnaround time Increase in A&G for Specialist advice 	CMO	Deputy CMO	Quality & Safety Committee
Create a compassionate, inclusive and engaging cultural environment for our staff	Strengthen organisational development, internal communications, and staff engagement to create a culture where people feel empowered, informed, and aligned with our values.	<ul style="list-style-type: none"> Implementation Plan agreed and monitored Strengthened mechanisms to receive staff feedback to ensure actions deliver intended outcomes. 	CP&CO	Associate CP&CO Communication	People and Culture Committee
	Implement actions to increase staff confidence in arrangements for raising and addressing concerns.	<ul style="list-style-type: none"> Improved staff survey results for raising and addressing concerns. 	CP&CO	Trust Secretary Freedom to Speak Up Guardian	People and Culture Committee
Recruit, retain and transform our workforce to provide an exemplar experience for our staff and patients	Invest in our nursing and allied health professional workforce through advanced practice development and expanding our advanced practice workforce.	<ul style="list-style-type: none"> Increased AHP workforce aligned to workforce plan Staff feedback demonstrating that are opportunities to improve my career in this organisation 	CNO	Nursing & Allied Professions Lead - Workforce	People and Culture Committee
	Invest in our medical I workforce through recruitment and opportunities for professional development and research	<ul style="list-style-type: none"> Increased Medical workforce aligned to workforce plan Professional development area: 'train the trainer' development 	CMO	Director of Medical Education	People and Culture Committee

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Corporate Priorities 2026/27

Strategic Objective:



2

Develop our Veterans Service as a nationally recognised centre of excellence



Centre of Excellence for Veterans rehabilitation

Corporate Priorities	Actions for Delivery	Associated Outcomes	SRO	Delivery Lead	Assurance Committee
Veterans strategy in place that sets out the sustainable future model for veterans services.	Set out the Trust's long-term vision, priorities, and commitments for Veterans care working in collaboration with NHS commissioners, partners and Veterans.	<ul style="list-style-type: none"> Trust Veterans Strategy agreed by the Trust to meet the Trust/s strategic objective. 	COO	MD Specialist Unit	Finance & Performance Committee
	Work with our partners to establish a NHS Veterans network to develop consistent models of excellence in care for veterans	<ul style="list-style-type: none"> Veterans NHS network established 	COO	MD Specialist Unit	Finance & Performance Committee
	Working in collaboration with NHS commissioners at a local and national level to establish clearer funding streams for the veterans' service and better access to specialist veterans' services.	<ul style="list-style-type: none"> Reduce the funding stream risk associated with LVA or IPFR for our patients Improved patient experience in accessing our services 	COO	MD Specialist Unit	Finance & Performance Committee
Develop our veterans rehabilitation pathway	Headley Court Veteran rehabilitation Programme Pilot to commence in May 2026 and be implemented for an 18-month period with monitoring and evaluation throughout the pilot phase to inform future decision making.	Demonstrate the benefit realisation of pilot to inform future service developments <ul style="list-style-type: none"> PROMS Admission avoidance Patient experience 	COO	MD Specialist Unit	Finance & Performance Committee

Corporate Priorities 2026/27

Strategic Objective:



3 Integrate the MSK pathways across Shropshire, Telford and Wrekin



Single seamless local MSK service

Corporate Priorities	Actions for Delivery	Associated Outcomes	SRO	Delivery Lead	Assurance Committee
Develop a single seamless MSK pathway from prevention, early intervention to specialist care	Strengthen partnership working and collaboration across the system, full integration of the MSK pathway.	<ul style="list-style-type: none"> Prevention programme for MSK established in partnership with Local Authority and NHS partners GP practices and Primary Care Networks collaboration embedded as part of the integrated MSK pathway. Integrated provider delivery model across provider partners 	COO	MD MSK Unit	Finance & Performance Committee
	Work in partnership with PTHB to develop their CMATs single point of access model and support their GIRFT improvement programme.	<ul style="list-style-type: none"> Reduction in patients referred to secondary care to receive treatment that can be offered locally. 	COO	MD MSK Unit	Finance & Performance Committee
Deliver an MSK service that ensures equity of access and improves population health by meeting the needs of our population	Implementation of the agreed spinal pathway to ensure consistent, evidence-based care and the development of community and complex pain services to prevent requirement for surgical intervention and improve patient experience,	<ul style="list-style-type: none"> Reduction in spinal disorders referrals to secondary care to receive treatment that can be offered locally Increase in patients accessing pain services to prevent the need for surgical intervention 	COO	MD Specialist Unit MD MSK Unit	Finance & Performance Committee

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Corporate Priorities 2026/27

<p>Preparing our workforce to deliver Neighbourhood Health models for MSK.</p>	<p>Undertake a comprehensive review of therapy and MSST services to ensure services are efficient, seamless and aligned to future neighbourhood health models.</p>	<ul style="list-style-type: none"> • Workforce requirement to deliver MSK Neighbourhood health quantified and agreed across STW • Workforce and service development programme agreed with system partners based on best practice. 	<p>COO</p>	<p>MD MSK Unit</p>	<p>People and Culture Committee</p>
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Corporate Priorities 2026/27

Strategic Objective:



4

Grow our services and workforce sustainably



Outreach of our specialist expertise

Corporate Priorities	Actions for Delivery	Associated outcomes	SRO	Delivery Lead	Assurance Committee
Delivering our services sustainably to meet the needs of our patients.	New theatre to be commissioned and operationalised to deliver improved access to services to return to constitutional standards.	<ul style="list-style-type: none"> Increase in the number of elective patients treated per annum. Reduction in waiting list for elective admissions. 	COO	MD MSK Unit	Finance & Performance Committee
	Ensuring that our workforce is able to deliver services sustainably to meet the needs of our patients.	<ul style="list-style-type: none"> Workforce recruitment and development programme in place informed by best practice and future service models 	CPO	Associate CP&CO	People and Culture Committee
Develop our commercial strategy and support unlocking value for reinvestment into NHS services	Develop a comprehensive commercial strategy over the coming year, focusing on delivery of opportunities that create value for reinvestment in NHS patient care and hospital services.	<ul style="list-style-type: none"> Increase in commercial income contribution to deliver NHS services per annum 	CF&CO	Commercial Director	Digital, Education, Research, Innovation & Commercialisation Committee
	Enhancing income commissioning through the development and application of best-practice approaches for reviewing tariffs and payment structures	<ul style="list-style-type: none"> NHS clinical income reflecting service delivered 	CF&CO	Deputy CFO	Finance & Performance Committee
Expanding our reach and specialist expertise to other providers and sectors	Collaborate with Royal Orthopaedic Hospital to deliver particular project workstreams based on an agreed set of objectives.	<ul style="list-style-type: none"> 2026/27 deliverables to be confirmed 	All	Project specific: TBC following Board to Board session.	Trust Board Relevant Committees to have oversight of specific priority areas

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Corporate Priorities 2026/27



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

University Hospital level
education, research and
innovation

Strategic Objective:

Corporate Priorities	Actions for Delivery	Associated Outcomes	SRO	Delivery Lead	Assurance Committee
Create the cultural environment to promote continuous Improvement	Develop the capability and capacity of our workforce to drive service transformation, adopt new models of care, and contribute to long-term organisational sustainability of services whilst improving productivity	<ul style="list-style-type: none"> Targeted staff feedback to assess confidence and capability in making and implementing improvements, including specific questions aligned to continuous improvement behaviours. 	CNO & CPO	Associate CP&CO Head of Improvement and Business Insights PMO lead	Digital, Education, Research, Innovation & Commercialisation Committee
Enhance Leadership and Management capabilities	Leadership Development programme to strengthen leadership and management capability across the Trust.	<ul style="list-style-type: none"> Roll out of Leadership development programme for 2026/27 	CPO	Associate CP&CO	People and Culture Committee
Optimise the potential of digital technologies to transform care and improve outcomes	Stabilise and optimise existing digital technologies adopted by the Trust	<ul style="list-style-type: none"> Delivery of the 2026/27 programmes from the Digital Roadmap 	CF&CO	CDIO	Digital, Education, Research, Innovation & Commercialisation Committee
	Embed the necessary infrastructure and governance to deliver a clinically led, digitally enabled innovation programme to support delivery of the Trust's digital roadmap and supporting productivity improvement.	<ul style="list-style-type: none"> Clinical membership and supporting clinical stakeholder groups defined within our digitally enabled innovation programme 	CF&CO CMO	CDIO	Digital, Education, Research, Innovation & Commercialisation Committee



Corporate Priorities 2026/27

Recognition of our innovation, educational and research capabilities as an organisation	Application for university hospital status assessment to be completed.	<ul style="list-style-type: none"> <u>University hospital status achieved</u> 	CMO	Research Manager	Digital, Education, Research, Innovation & Commercialisation Committee
	Partnership working and collaboration regional and national teams to deliver innovation, education and research programmes.	<ul style="list-style-type: none"> Number of regional and national improvement programmes with RJAH participation Number of regional and national research studies with RJAH participation Educational programmes delivered by RJAH to other partners and in partnership with other organisations 	COO CMO CPO	Head of Improvement and Business Insights PMO lead Associate Medical Officer for Research and Outcomes and Research Manager Associate CP&CO	Digital, Education, Research, Innovation & Commercialisation Committee

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Executive Summary - Quality & Safety Committee

Assurance



Will consistently pass the target if nothing changes



Will not consistently pass or fail the target if nothing changes



Will consistently fail the target if nothing changes



No Target or Moving Target



Improving variation (high or low) or 3 months better than target

Safe Staffing



No significant change or N/A to SPC

RJAH Acquired C.Difficile
RJAH Acquired E. Coli Bacteraemia
RJAH Acquired MRSA Bacteraemia

Outbreaks

Total Deaths

Number of Patient Safety Reviews
Complaints Re-opened
Discharge Ready Date to Actual Discharge Date
Medication Errors
Pts Returning to Theatre Within 28 Days
Theatre Cancellations On Day of Surgery



Concerning variation (high or low) or 3 months off target

Number of Complaints
No of Spinal Injury Patients Fit for Admission
Surgical Site Infections
Medication Errors with Harm
62 Day General Standard

Standard Complaints Response Rate - 30 Days
Complex Complaints Response Rate - 45 Days
Number of Compliments

Variation

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

Metric placed in boxes above based on the variation icon for latest data point, but over-ridden by whether meeting/failing target for last three months.

If metric placed in a box based on meeting/failing plan, but does show improvement or deterioration - text colour will indicate that.

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Trust Board - Quality & Safety

March 2026 – Month 12



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:

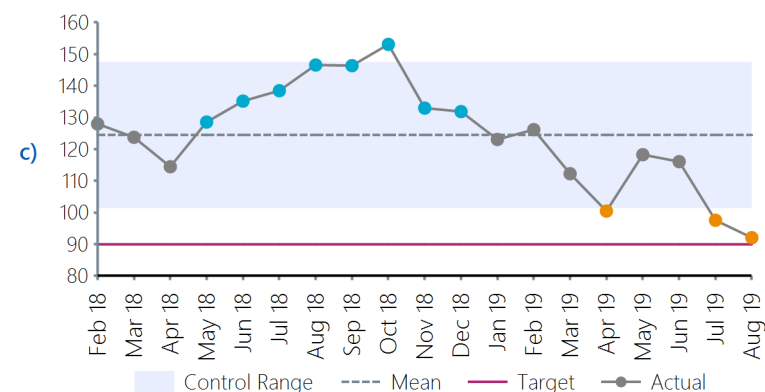
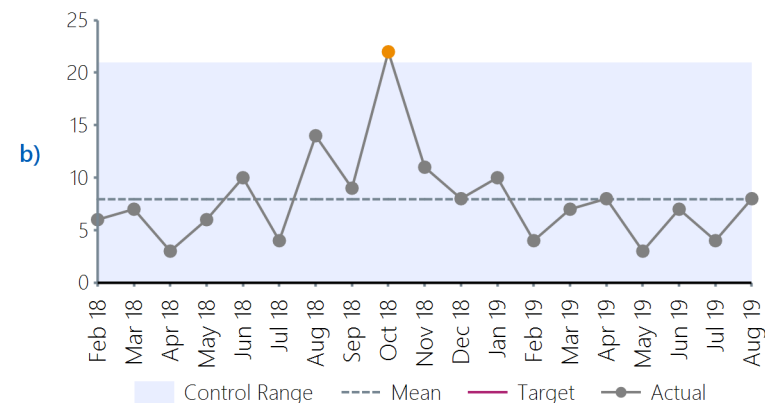
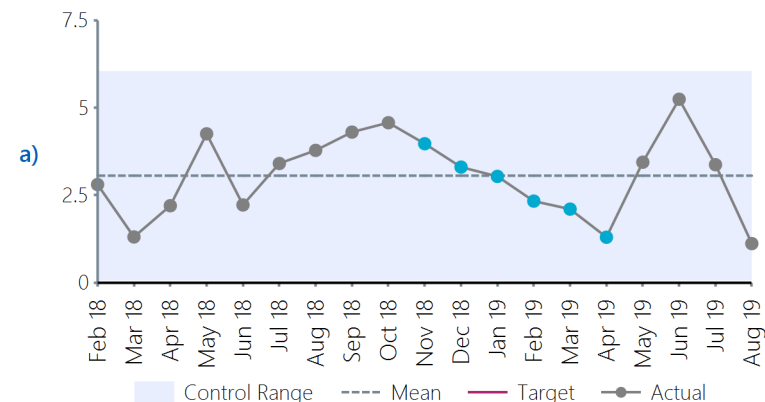
- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of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

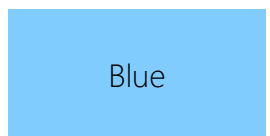
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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



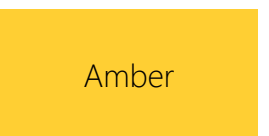
Blue

No improvement required to comply with the dimensions of data quality



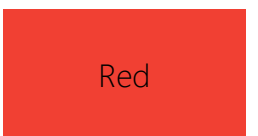
Green

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.

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Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Patient Safety Incident Investigations		0					
Number of Complaints	8	20				+	
Discharge Ready Date to Actual Discharge Date		0.35				+	
RJAH Acquired C.Difficile	0	0				+	
RJAH Acquired E. Coli Bacteraemia	0	1				+	
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

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Summary - Caring for Patients

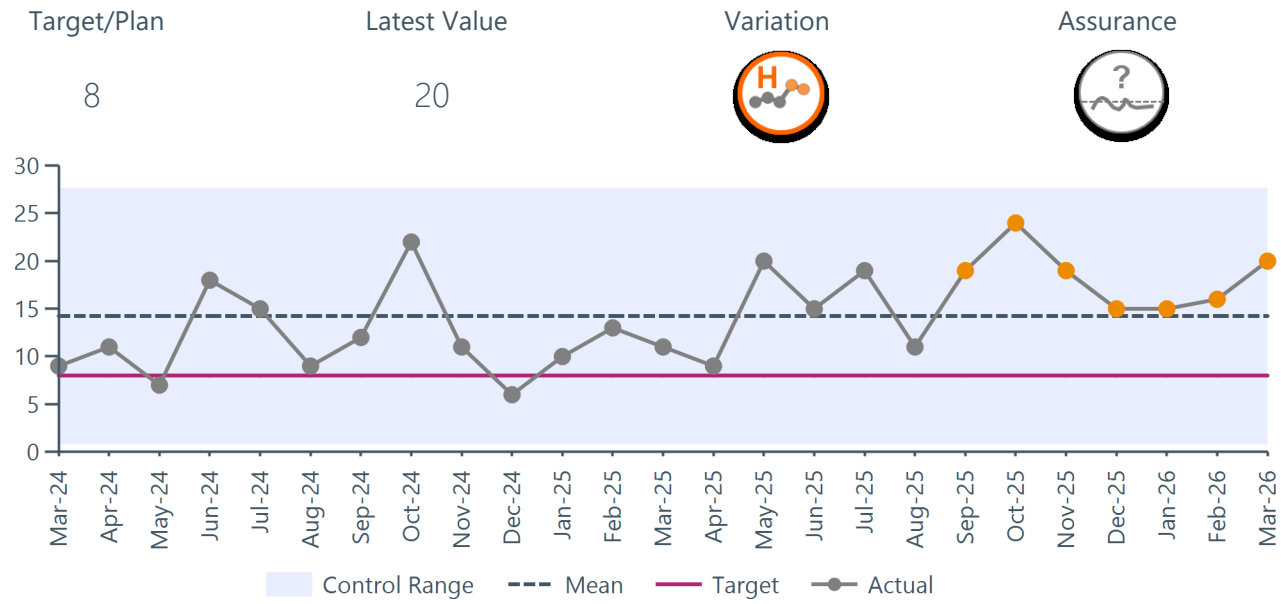
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Outbreaks	0	0				+	04/03/24
Number of Deteriorating Patients	5	6					
Total Deaths	0	1				+	12/09/23
WHO Quality Audit - % Compliance against NatSSIPs 2	95%	100%					

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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. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

There were twenty complaints received throughout March and the volume continues to exceed the tolerance. A breakdown of reasons:

- * Patient Care (5)
- * Staff Values and Behaviour (3)
- * Communications (3)
- * Appointments (3)
- * Waiting Times (2)
- * Admissions/Discharges (2)
- * Access to Treatment/Drugs (1)
- * Trust Admin (1)

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; next scheduled meeting w/c 13th April. Clear communications regarding Welsh Waiting Times being discussed.

The volume of PALs has also increased throughout this year, this is proposed as a new KPI for the IPR in 26/27.

A review of the complaints process and appropriate resource required is underway and will be taken to the Executive Team for discussion.

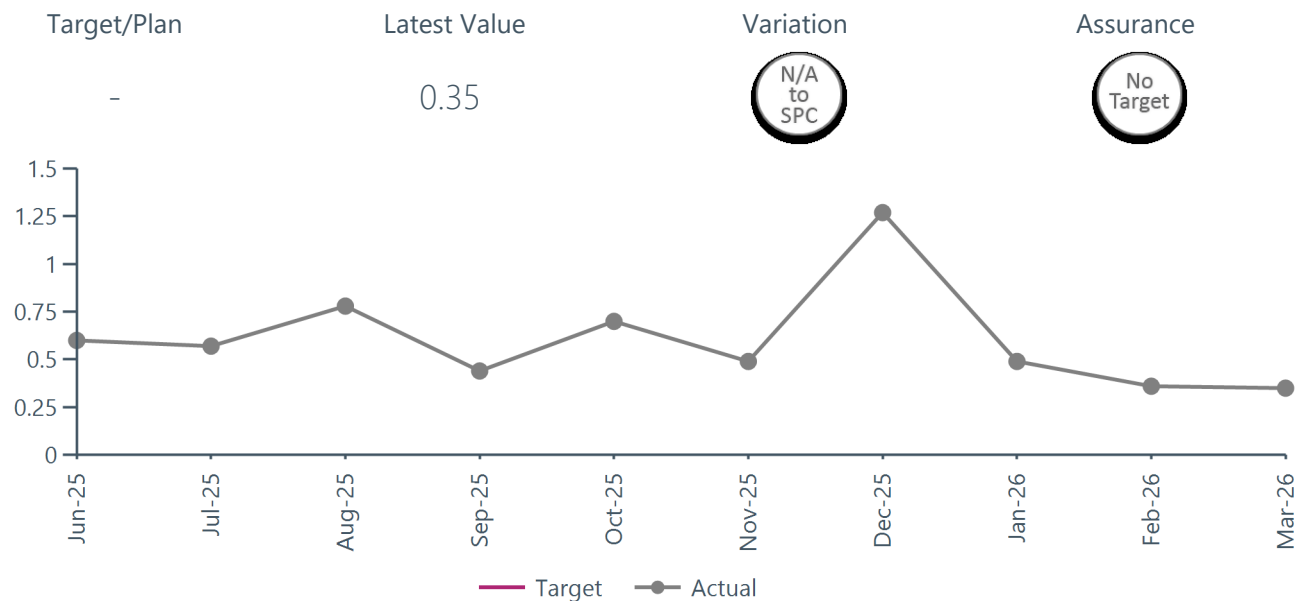
Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
11	9	20	15	19	11	19	24	19	15	15	16	20

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

Narrative

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

For those patients discharged in March the average days was 0.35 days. The Information Department has set up supporting data to report at ward and unit level.

The latest NOF Publication relates to Quarter 3 where the NOF score for this metric is 3.36.

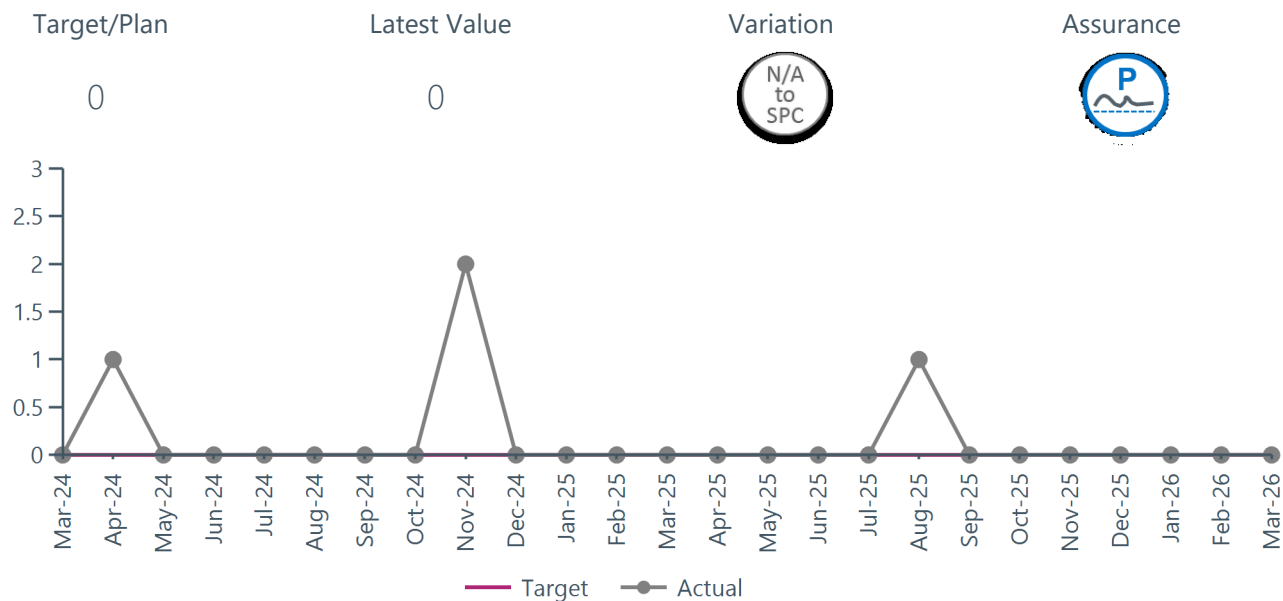
Actions

Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
			0.60	0.57	0.78	0.44	0.70	0.49	1.27	0.49	0.36	0.35

- Staff - **Patients** - Finances -

RJAH Acquired C.Difficile

Number of cases of C.Difficile in Month 211149



Target/Plan: 0

Latest Value: 0

Variation:

Assurance:

Exec Lead:

Trajectory:

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 March. This metric has been included as an exception to reference the latest NOF publication.

The latest NOF Publication relates to Quarter 3 where the NOF score for this metric is 1. This position relates to the rolling twelve months period of January-25 to December-25 where in that period the Trust reported one infection in August-25.

Actions

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

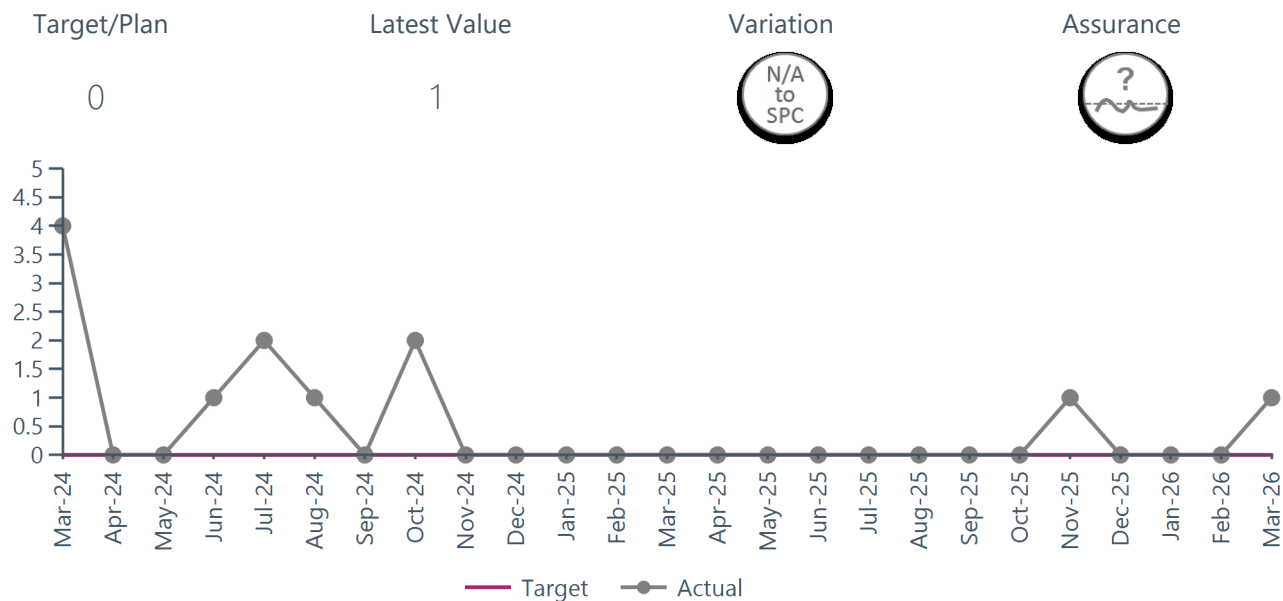
- Staff - **Patients** - Finances -

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RJAH Acquired E. Coli Bacteraemia

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

Exec Lead
 Chief Nurse and Patient Safety Officer



What these graphs are telling us

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

Narrative

There was one RJAH Acquired E. Coli Bacteraemia reported in March on Sheldon Ward.

The latest NOF Publication relates to Quarter 3 where the NOF score for this metric is 1. This position relates to the rolling twelve months period of January-25 to December-25 where in that period the Trust reported one infection in November-25.

Actions

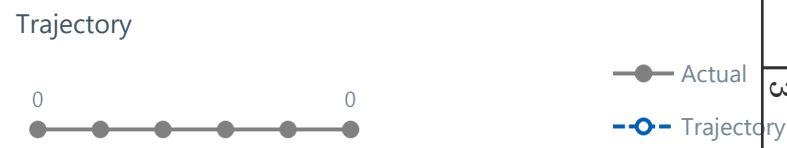
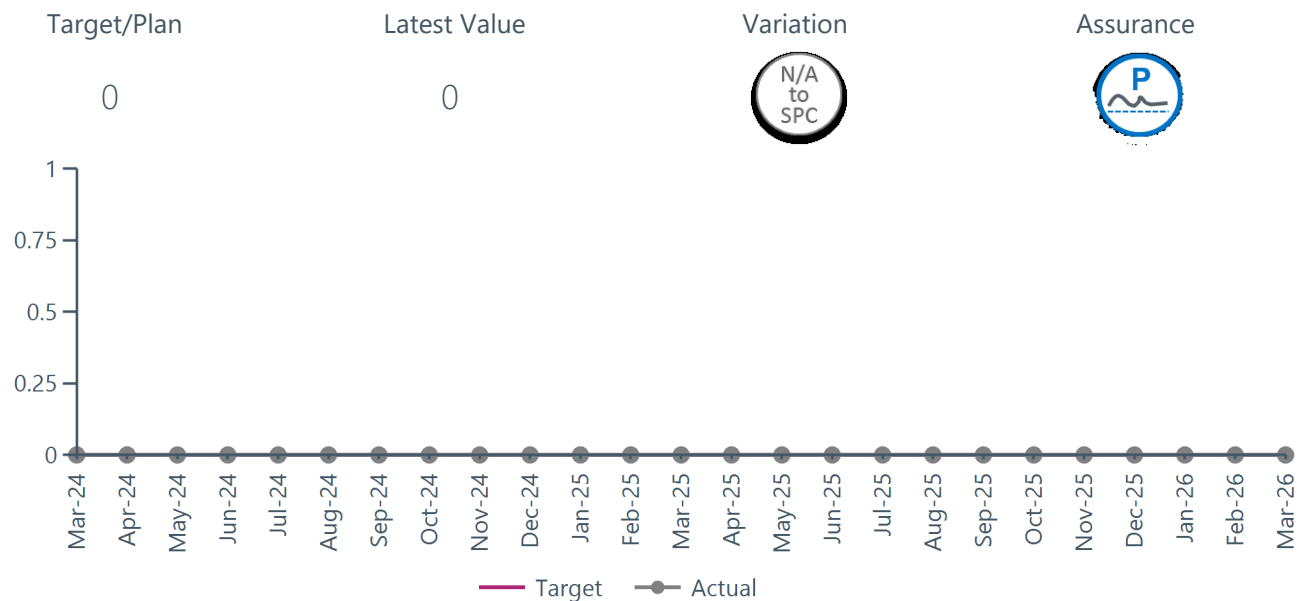
The post infection review has been completed with several positive practices observed. The infection was deemed as an unavoidable bacteraemia with urosepsis source. The lessons learnt will be shared with appropriate areas.

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

- Staff - **Patients** - Finances -

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 March. This metric has been included as an exception to reference the latest NOF publication.

The latest NOF Publication relates to Quarter 3 where the NOF score for this metric is 1. This position relates to the rolling twelve months period of January-25 to December-25 where in that period the Trust reported no infections.

Actions

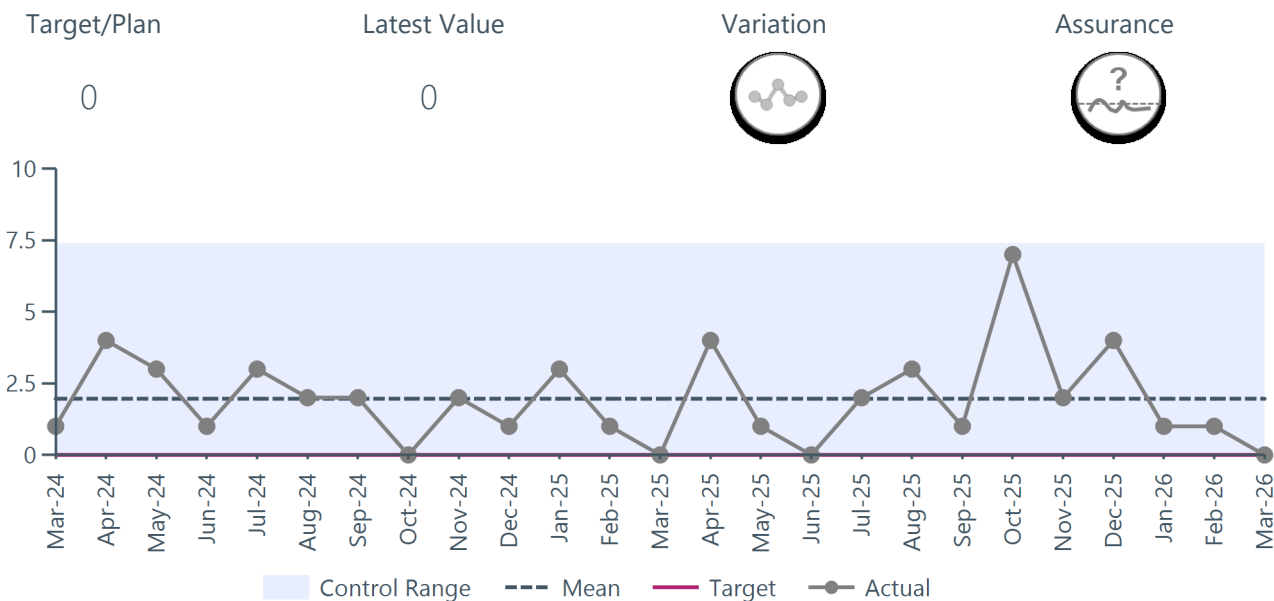
Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
0	0	0	0	0	0	0	0	0	0	0	0	0

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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 was one infection confirmed in March, as outlined below:
 * 1x THR - Ludlow Ward - Procedure took place in February-26.

Please note, the IPC Clinical Lead and Principal Analyst have reconciled the year-to-date data for accuracy whereby there has been a few updates to data previously reported; two SSIs moved to different months, one added that had been missed as reported, one removed as it not longer met the criteria for a reportable SSI.

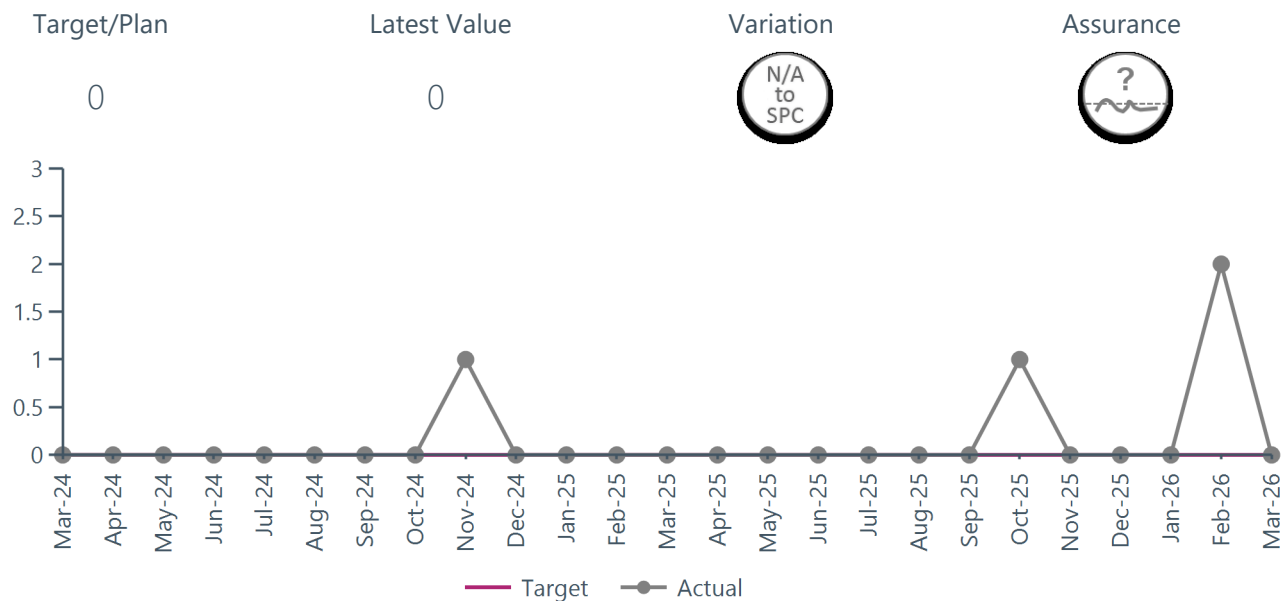
Actions

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 Quality and Safety Committee in May.

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

Outbreaks

Number of declared outbreaks in month 217806



Target/Plan: 0

Latest Value: 0

Variation: N/A to SPC

Assurance: ?



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 Outbreaks reported within the Trust in March. This metric is included as an exception to provide an update on data previously reported. There was an outbreak of CPE reported on MCSI in December. At the time, the situation met the criteria of an outbreak but since then the Trust has received results back for the patients that confirms the strains of CPE were unique to them so not an official outbreak. The data has been updated to reflect this.

Actions

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

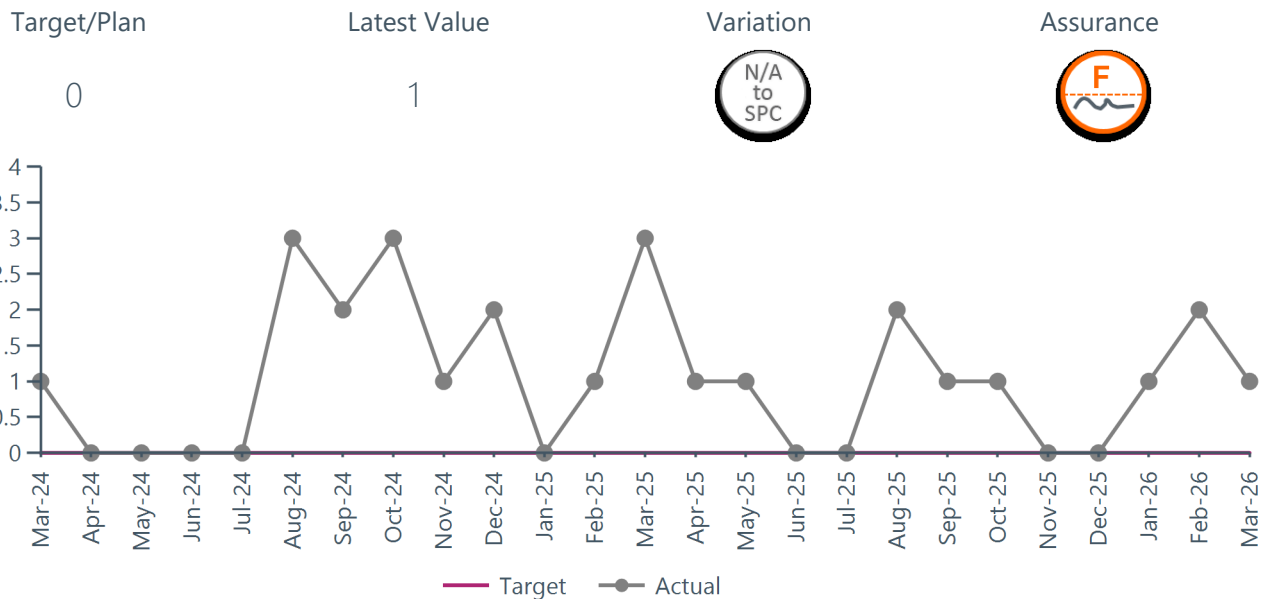
- Staff - Patients - Finances -

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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.

Narrative

There was one death within the Trust in March. This was on HDU and categorised as an Sudden but not Unexpected.

Actions

Learning from Deaths Reviews are completed by the Trust Lead.

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

- Staff - Patients - Finances -

Chair's Assurance Report Quality and Safety Committee

Committee / Group / Meeting, Date

Board of Directors Meeting – Public Meeting, 06 May 2026

Author:

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Contributors:

Report sign-off:

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

Is the report suitable for publication:

Yes

1. Key issues and considerations:

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

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

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

This report provides a summary of the items considered at the Quality and Safety Committee on 19 March and 23 April 2026. It highlights the key areas the Quality and Safety Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

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

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

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

Assurance framework themes	Relevant	Overall level of assurance
1 <i>Continued focus on excellence in quality and safety.</i>	✓	MEDIUM
2 <i>Creating a sustainable workforce.</i>	×	
3 <i>Delivering the financial plan.</i>	×	
4 <i>Delivering the required levels of productivity, performance and activity.</i>	×	
5 <i>Delivering innovation, growth and achieving systemic improvements.</i>	×	

Chair's Assurance Report
Quality and Safety Committee

Assurance framework themes		Relevant	Overall level of assurance
6	<i>Responding to opportunities and challenges in the wider health and care system.</i>	×	
7	<i>Responding to a significant disruptive event.</i>	✓	MEDIUM

3. Assurance Report from Quality and Safety Committee

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

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

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

Require the approval of the Board for work to progress.

Integrated Performance Report Annual Review (April): The Committee endorsed the proposed KPIs for 2026/27 for approval by the Board noting that additional KPIs pertaining to PREMS and PROMS will be added following the imminent release of national guidance in this area.

Corporate Objectives (April): Members noted that amendments requested by the Board had been fully incorporated into the paper, and noted that further work is planned to align the Board Assurance Framework with the revised objectives. The Committee endorsed the Corporate Objectives for approval by the Board

Patient Harms and Data Quality Assurance (March / April): Risks relating to data quality following the implementation of Apollo have been more clearly defined into five separate areas. The Committee's focus is now on the two highest risk areas; long term follows ups and harm reviews. Whilst work is underway to address both these linked areas, starting with the highest risk areas (with no harms being identified to date) additional resource is required to conclude this in a timely manner. Further assurance has been requested on this.

EPR revised clinical record viewing interface. Whilst the pilot of this is underway and has been extended for those wishing to adopt it the full implementation has not yet been achieved.

DBS Compliance (April): Concerns were raised at the March meeting about the number of outstanding DBS checks resulting in a renewed focus in this area. The April meeting saw an improved position and the Committee will continue providing oversight through ROM until this issue is resolved.

Complaints March / April): There has been an ongoing increase in complaints and PALS contacts, alongside a delay in response times linked to year-end operational pressures and the implementation of Radar. Assurance was provided that the Executive Team has recognised this risk and is progressing actions to address the backlog, improve response times and strengthen accountability, with ongoing oversight through the Patient Experience Meeting. Further assurance will be provided at the next meeting.

Supply chain disruption – The potential for disruption to supply chains was discussed in relation to a number of agenda items and will be reflected more specifically in the revised BAF and via the EPRR group.

3.2 Areas of on-going monitoring with new developments

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

Board Assurance Framework (April): Revised descriptors and risk scoring were reviewed and the Committee is content with the proposed approach and score rationale. Further work is underway to update assurance measures so they align with the risk and the Committee specifically requested an

Chair's Assurance Report Quality and Safety Committee

update to BAF 7 to reflect supply chain risks using the inhibiting factors section. This is being presented to the private Board for further discussion ahead of approval

Go See (April): Progress on the development of this was provided with a planned go-live of the revised process in June 2026. Assurance was provided that clear guidance, revised tools and hands-on support will underpin consistent implementation, with plans to broaden staff, patient and visitor engagement across clinical and non-clinical areas.

28 Day Faster Diagnosis (March): Reviewed performance against the 28-Day Faster Diagnosis standard, noting a period of decline linked to rising demand and pathway pressures. The Committee was assured that national standards have been met consistently since December, supported by improved triage, radiology capacity and closer operational coordination. While demand-related risks remain, mitigations are in place and oversight arrangements are robust.

3.3 Areas of assurance

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

PSII: Never Event – Wrong Side PRP Injection (April): The Committee received assurance that the wrong-side PRP injection was managed appropriately and in line with current national guidance. Proportionate investigation identified clear learning around consent, communication and site verification in outpatient settings, with specific actions agreed and strengthened to reduce the risk of recurrence.

Learning from Deaths Q4 Report (April): Noted that four deaths were recorded during the period, with no concerns identified through the Medical Examiner process or by the coroner. Positive feedback was received from families, and the Committee took assurance from the report.

MCSI Presentation (April): The Committee was assured that the MCSI service is delivering safe, high-quality care within a complex specialist environment. The report and presentation demonstrated that higher levels of incident reporting reflect a mature and improving reporting culture rather than increased harm, with the majority of incidents assessed as no or low harm and learning from moderate and severe incidents appropriately shared and acted upon. Benchmarking against other wards and centres provided helpful context, confirming that the service is not an outlier when bed base and patient complexity are taken into account. Strong governance arrangements, effective multidisciplinary working, active quality improvement support, and close oversight of workforce training and competence were evidenced. Members were further reassured by consistently positive patient feedback and a compassionate ward culture. While challenges remain in relation to waiting times and system flow for spinal patients, these risks are recognised, under active clinical review, and subject to ongoing improvement work.

Quality Strategy Action Plan (April): Noted that progress is being made and there is clear direction of travel.

Quality Priorities 2026/27 (April): Endorsed the proposed 2026/27 Quality Priorities, which reflect learning from patient safety, priorities for improving patient experience, and relevant contractual requirements, including health inequalities. Members supported inclusion of the priorities within the Trust's Quality Account and were assured that delivery will continue to be subject to appropriate oversight by the Council of Governors.

IPC Report (April): Took assurance that IPC performance, whilst an increase in surgical site infections was noted and is subject to further review, early analysis and benchmarking with ROH provide reassurance, with no statistically significant concerns identified at this stage. A deep dive is being undertaken into an increase in SSIs seen in Q3.

Clinical Audit Plan (April): Noted strong progress with 94% of the previous year's forward plan delivered, enhanced triangulation through the implementation of Radar Healthcare, and improved assurance through an increased focus on re-audits and updated NICE guidance. The Committee also

Chair's Assurance Report Quality and Safety Committee

welcomed the strengthening of multidisciplinary engagement across the Trust and endorsed the forward plan for submission to the Audit and Risk Committee.

Well-Led Action Plan (April): Progress is being tracked with evidence of completion; updates will be provided every two months with the expectation all actions complete by the end of the calendar year.

Committee Annual Report and Self-Assessment (April): The paper was deferred to the next meeting encouraging comments from the members of the meeting.

RADAR System Implementation (March): The transition to the RADAR system for risk management has been successfully implemented, with no immediate concerns identified

Chair Reports were received from the following Meeting and Groups:

- **Regulatory Oversight Meeting (March and April):** A comment was raised regarding the microbiology SLA, noting concerns linked to financial issues and whether these had been escalated appropriately.
- **EPR Meeting (March and April):** a numerical update at the next Committee on uptake of the revised clinical record-viewing configuration, including numbers of clinicians using the new version is to be shared.
- **Patient Safety Meeting (March / April):** requested for Medical and AHP representation to be reflected in the Terms of Reference for oversight. Non-compliance with the HDU booking process was noted, with further work required to embed the policy within the critical care strategy. A gap in strategic AHP leadership was acknowledged as a workforce issue rather than a direct patient safety risk.
- **IPCC Meeting (March):** the two cases of CPE on MCSI were unique strains and this was therefore not an outbreak.
- **Drugs and Therapeutics Meeting (March):** medicines governance remains effective, with improvements in antimicrobial stewardship, medicines safety responsiveness, and policy oversight. Whilst pressures on pharmacy capacity and stockholding vulnerability were noted, mitigating actions are in place, including a workforce review, strengthened stock management, enhanced governance controls, and consistent processes for managing company representatives.
- **Health and Safety Meeting (March):** noted the Health and Safety report, including ongoing actions relating to occupational health, mandatory training compliance, and historical HAVS concerns, and requested further assurance in future reports.
- **Clinical Effectiveness Meeting (April):** noted that there are alerts relating to VTE and anticoagulation, which will continue to be monitored, with an update to be brought back to the next meeting.
- **Patient Experience Meeting (March / April):** took assurance from the report
- **Health Inequality Meeting (April):** took assurance from the report
- **Trust Performance and Operational Improvement Group: (March / April):** highlighted that the orthopaedic satellite clinics at SaTH sites remain a concern, with the current clinical environment assessed as not fit for purpose following review. It was confirmed that the Trust is actively exploring alternative accommodation for these services.

Policy Approvals (March / April): The Committee reviewed and.

- Approved the Incident Management Policy
- Endorsed EPRR and Business Continuity Policy which is recommended to the Board for approval
- Approved the accompanying EPRR plan
- Approved the Trust Incident Response Plan

Recommendation

The Board is asked to:

1. CONSIDER the overall assurance level listed at section 2 and.

Chair's Assurance Report Quality and Safety Committee

2. CONSIDER the remaining content of section 3.1 and agree any action required.
3. NOTE the content of section 3.2 and CONSIDER whether any further action is required; and
4. NOTE the content of section 3.3.

Committee / Group / Meeting, Date	
Board of Directors – Public Meeting, 06 May 2026	
Author:	Contributors:
Name: Hannah Howells Role/Title: Health & Safety Advisor / EPRR Lead	Name: Nick Huband Role/Title: Director of Estates and Facilities
Report sign-off:	
Name: Mike Carr, Accountable Emergency Officer Quality and Safety Committee, 23 rd April 2026	
Is the report suitable for publication?	
Yes	
Executive Summary:	
<p>This policy sets out the arrangements by which the Trust prepares for, responds to, and recovers from emergencies and service disruptions, ensuring the continuity of critical services and compliance with statutory requirements. As a Category 1 responder under the Civil Contingencies Act 2004, the Trust is required to maintain robust emergency preparedness, resilience, response, and business continuity arrangements that protect patients, staff, and infrastructure.</p> <p>The policy establishes a comprehensive and integrated framework aligned to NHS Core Standards and ISO 22301. It applies to all staff, departments, and services, embedding emergency preparedness and business continuity into organisational processes, planning, and decision-making.</p> <p>The approach is structured around defined incident types and escalation levels, supported by a clear command and control model operating across strategic, tactical, and operational tiers. Core principles include preparedness, effective communication, subsidiarity in decision-making, and strong multi-agency collaboration.</p>	
Recommendations:	
Following a recommendation from the Quality and Safety Committee, the Board is asked to approve the EPRR and BC policy.	

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 content of this report supports the Trust's strategic objectives by ensuring the organisation is resilient, responsive, and able to maintain the delivery of high-quality patient care in all circumstances. By embedding robust emergency preparedness and business continuity arrangements, the policy underpins the Trust's ability to sustain clinical services, support workforce resilience, and deliver safe, effective care aligned to its organisational priorities.

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 content of this report directly supports the Trust's ability to deliver its strategic themes by strengthening resilience, safeguarding service delivery, and ensuring preparedness for disruption.

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	

Supports the Trust's core values by demonstrating a strong commitment to patient safety, quality of care, and organisational responsibility.

Report development and engagement:

- Various RJAH staff and leads at meetings.
- Shrewsbury and Telford Hospital EPRR Teams and leads.
- Shropshire Community Health Trust Senior EPRR Lead.
- Shropshire Telford and Wrekin Integrated Care Board (ICB) Senior EPRR Lead
- NHS England Midland Region EPRR Team

Supporting detail:

This policy outlines how the Trust prepares for, responds to, and recovers from emergencies and service disruptions, ensuring the continuity of critical services and compliance with its statutory duties as a Category 1 responder.

It establishes an integrated framework for Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Management, aligned with NHS Core Standards and ISO 22301. The policy applies across all services and is embedded within organisational planning, governance, and operational processes.

Clear accountability is defined, with executive leadership provided by the Accountable Emergency Officer and delivery supported by the EPRR Lead and operational managers. Governance and assurance are maintained through established committees, including the Trust Board.

The Trust's approach is underpinned by risk assessment, business impact analysis, and defined recovery priorities to ensure critical services are maintained. A structured command and control model supports effective incident response, with recovery and organisational learning integral to all incidents.

Regular training, exercising, and review processes ensure ongoing preparedness and continuous improvement. Overall, the policy provides assurance that the Trust has robust and compliant arrangements in place to protect patients, staff, and services during disruption.


Acronyms

EPRR	Emergency Preparedness Resilience and Response
BC	Business Continuity
AEO	Accountable Emergency Officer
ICB	Integrated Care Board

Appendices

Appendix 1	EPRR and BC Policy
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Title:	EPRR & BC Policy (Emergency Preparedness, Resilience and Response) (Business Continuity)		
Unique Identifier:	POL255	Document Type:	Policy
Version Number:	4	Status:	Draft
Responsible Director:	Chief Operating Officer / Accountable Emergency Officer (AEO)		
Author:	Health and Safety Advisor / EPRR Lead		
Scope:			
Replaces:	3		
To be Read in Conjunction with the Following Documents:	Incident Response Plan Corporate Business Continuity Plan		
Keywords:	Emergency Preparedness, Resilience and Response. Business Continuity. Business Continuity Management System. Plan, Do, Check, Act (PDCA) cycle.		
Considered By Responsible Director:	Accountable Emergency Officer (AEO)	Date Considered:	02/01/2026
Approved By:	EPRR Group Quality & Safety Committee Trust Board	Date Approved:	19.03.2026 23.04.2026 06.05.2026 TBC
Consulted By:	NHS Shropshire, Telford & Wrekin ICB EPRR Lead NHS England - Midlands Region	Date Reviewed:	08/01/2026 24/03/2026
Issue Date:		Review Date:	02/01/2029
Security Level:	Open Access ✓	Restricted	Confidential
 Trust Values			

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0.0 Version Control tracker

Record of Amendments: EPRR & Business Continuity Policy				
Version No	Comments received by Who	Amendment	Date	Lead updating document:
3	STW EPRR Lead	Amendments made to whole document following input from ICB Lead. All comments reviewed and embedded into document. Previous revisions of document stored - U:\CENSERV\Secure Group\1. EPRR and BCP\EPRR (RJAH)	29/01/2025	EPRR Lead
3	EPRR Engagement Manager (Staffordshire and Stoke-On-Trent, Derbyshire and West Mercia) NHS England - Midlands Region	Amendments made to whole document following input from NHSE Midlands Region Team. All comments reviewed and embedded into document. Previous revisions of document stored - U:\CENSERV\Secure Group\1. EPRR and BCP\EPRR (RJAH)	31/01/2025	EPRR Lead
4	Deputy Chief Finance Officer	Updated section 4.0 – Chief Finance Officer responsibilities	07/11/2025	EPRR Lead
4	NHS England Midlands Regional Team	All comments received during Confirm and challenge process, added and embedded into policy.	12/11/2025	EPRR Lead.
4	STW ICB EPRR Lead	BC policy statement added to EPRR Policy	09/12/2025	EPRR Lead
4	EPRR Lead	EPRR policy and BCP policy combined into this single document.	Dec 2025	EPRR Lead
4	STW ICB EPRR Lead	Consultation review returned by STW ICB EPRR Lead	January 2026	EPRR Lead
4	NHS England Midlands Team	Consultation review returned by Emergency Preparedness Resilience and Response (Midlands) NHS England (Midlands)	March 2026	EPRR Lead

Part 1

EPRR Policy (Emergency Preparedness, Resilience and Response)

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1.0 Introduction

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care.

This programme of work is referred to, in the health community as emergency preparedness resilience and response (EPRR). In the NHS, EPRR is designed to meet the statutory requirements placed upon responding organisations under the Civil Contingencies Act 2004 (CCA 2004). The CCA 2004 defines specific statutory duties for responding organisations depending on them being a Category 1 or Category 2 responder.

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Trust (RJAH) is a designated Category 1 responder under the Civil Contingencies Act 2004. RJAH has a legal duty to:

1. Assess the risk of emergencies occurring to inform contingency planning
2. Put in emergency plans
3. Put in place business continuity management arrangements
4. Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
5. Share information with other local responders to enhance coordination
6. Co-operate with other local responders to enhance coordination and efficiency

This policy sets out the emergency preparedness, resilience and response (EPRR) arrangements within the Trust. Arrangements are put in place for emergency preparedness, resilience and response which:

- Ensure the Accountable Emergency Officer's commitment to the plans and resourcing, give a member of the executive management board and/or governing body overall responsibility for the Emergency Preparedness Resilience and Response, and Business Continuity Management agendas.
- Assess risk of emergencies occurring and use this to inform contingency planning.
- Put in place emergency plan.
- Put in place Business Continuity Management arrangements.
- Share information with other local responders to enhance co-ordination.
- Cooperate with other local responders to enhance coordination

2.0 Purpose and Scope

The Trust is identified as a Category One responder under the Civil Contingencies Act 2004. The Trust is legally required to assess risks, develop and maintain emergency and business continuity plans, ensure the continuity of critical services, communicate effectively with the public, and work collaboratively with partner agencies to manage and respond to major incidents.

The NHS Emergency Preparedness, Resilience and Response (EPRR) Framework places the requirement for organisations, including NHS Foundation Trusts, to have an overarching EPRR policy in place for building resilience across the organisation, so that EPRR and business continuity issues are mainstreamed in processes, strategies and embed into action plans across the organisation, to ensure alignment with the Trust Strategic Objectives. [Uploader.ashx](#)

To support this responsibility, the Trust continues to ensure it meets the requirements set out in the current NHS Core Standards for Emergency Preparedness, Resilience and Response (Core Standards). These Core Standards are in accordance with the CCA 2004, 2005 Regulations and the NHS Act 2006. These frameworks set out the procedures and coordinated response measures to be

enacted in circumstances where service disruption impacts the Trust's ability to fulfil its standard operational commitments.

RJAH Strategic objectives are:

- Deliver high quality clinical services
- Develop our Veterans services as a nationally recognised centre of excellence
- Integrate the MSK pathway within and across Shropshire, Telford and Wrekin
- Grow our services and workforce sustainably
- Innovation, education and research at the heart of what we do.

This policy relates to all The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) staff. This includes staff working directly at RJAH, of which is a singular site, and those staff in clinical services, contractors, students, other visiting staff, those working in corporate services, including for example, Finance, Estates and Facilities and People Services. This policy is to be read in conjunction with the Trust Incident Response Plan and other emergency plans and policies. The Trust Incident Response Plan and other emergency plans and policies are stored electronically on the Trust Intranet dedicated EPRR Page (see hyperlink below). Hard copies are stored in the Trust Incident Control Centre (ICC) cupboard (CSM Office location 21) and at Switchboard.

<https://rjah.interactgo.com/Interact/Pages/Section/Default.aspx?section=4832>

3.0 Definitions

LHRP – Local Health Resilience Partnership. The Strategic Planning Group is made up of Trust Accountable Emergency Officers with responsibility for EPRR and Local Authority leads, plus Directors of Public Health.

RJAH – The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust.

Emergency Preparedness is defined as: The extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of, and response to emergencies.

Resilience is defined as: Ability of the community, services, area, or infrastructure to detect, prevent and, if necessary, to withstand, handle and recover from disruptive challenges.

Response is defined as: Decisions and actions taken in accordance with the strategic, tactical, and operational objectives defined by emergency responders.

Under Section 1 of the Civil Contingencies Act (CCA) 2004 an “emergency” means:

- (a) “an event or situation which threatens serious damage to human welfare in a place in the UK;”
- (b) “an event or situation which threatens serious damage to the environment in a place in the UK;”
- (c) “war, or terrorism, which threatens serious damage to the security of the UK”.

3.1 Incident Classifications

There are three main types of incident classifications used within the NHS, which are set out below. Each could potentially impact on service delivery within our Trust and would therefore require our business continuity plans to be implemented.

The three main types of incidents used within the NHS are: -

3.1.1 Business Continuity Incident – an event or occurrence that disrupts, or might disrupt, an organisation’s normal service delivery, to below acceptable pre-defined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

3.1.2 Critical Incident - any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions. A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services.

3.1.3 Major Incident - The Cabinet Office, and the Joint Emergency Services Interoperability Principles (JESIP), define a Major Incident as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency.

- An incident that significantly impacts health services and requires a coordinated response (any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented).
- An event that causes a surge in casualties beyond normal capacity, requiring special measures.
- A situation that disrupts NHS services such as hospitals, primary care, or emergency response.
- A public health emergency such as an infectious disease outbreak or contamination event.
- A critical infrastructure failure affecting the delivery of healthcare, like IT system failures or power outages.

3.2 Incident Levels

As an event evolves it may be described in terms of its level as shown. For clarity these levels must be used by all organisations across the NHS when referring to incidents.

Level 1	An incident that can be responded to and managed by an NHS-funded organisation within its respective business as usual capabilities and business continuity plans.
Level 2	An incident that requires the response of a number of NHS-funded organisations within an Integrated Care System (ICS) and NHS coordination by the Integrated Care Board in liaison with the relevant NHS England region.
Level 3	An incident that requires a number of NHS funded organisations within an NHS England region to respond. NHS England to coordinate the NHS response in collaboration with the ICB. Support may be provided by the NHS England Incident Management Team (National).
Level 4	An incident that requires NHS England national command and control to lead the NHS response. NHS England Incident Management Team (National) to coordinate the NHS response at the strategic level. NHS England regions to coordinate the NHS response, in collaboration with the ICB, at the tactical level.

3.2.1 Statutory requirements and underpinning principles of EPRR

The statutory requirements and principles of EPRR are underpinned by the Civil Contingencies Act 2004, the NHS Act 2006, and the Health and Care Act 2022. These laws mandate that NHS-funded organizations in England must be prepared to respond to a wide range of incidents and emergencies that could affect health or patient care. The EPRR framework provides a structured approach to planning, preparedness, response, and recovery, ensuring that organizations can effectively manage incidents and minimize their impact on healthcare delivery.

The NHS is there to help the public when they need it most, this is especially true during an incident or emergency. Extensive evidence has shown following incidents such as the Terrorist attacks in London and Manchester, the Ebola threat faced by the UK and Large-Scale Flooding events that good planning and preparation for any incident saves lives and expedites recovery. All NHS funded services must therefore ensure they have robust and well tested arrangements in place to respond to and recover from these situations.

4.0 Roles and Responsibilities

The Chief Executive Officer - The Chief Executive Officer has overall responsibility for health and safety within our Trust and must ensure the identification and control of all risks, including EPRR, is undertaken and managed.

The Chief Finance Officer - The Chief Finance Officer will ensure that adequate resources are made available to enable the organisation to meet the requirements of The NHS Core Standards for EPRR, and /or, provide the finance to the AEO to ensure resources are available.

This budget and resource must be proportionate to the size and scope of the organisation.

- Non urgent / critical expenditure would follow the Trust processes for approval.
 - For capital this would be an urgent capital bid following the Capital Bid Procedure which can be approved by the Capital Management Group Chair (CFO).
 - For revenue this would be an urgent case of need following the Trust Business Case and Investment Policy.
- For emergency funding requirements this would be managed by the on-call managers and executive following the Trust Scheme of Delegation. Should approval requirement exceed the on-call executive approval limits the CFO and/or CEO should be contacted for approval (Limits can be found in the Trust [Scheme of Delegation - Percy](#))

The Chief Operating Officer / Deputy CEO is the Accountable Emergency Officer (AEO):

The Chief Operating Officer / Deputy CEO / AEO is responsible for and will assume overall responsibility for the Emergency Preparedness Resilience and Response, and Business Continuity Management including:

- Assume responsibility to the Board of Directors to ensure compliance with The NHS Core Standards for EPRR.
- The AEO as a duty to attend the West Mercia LHRP. The LHRP will provide a strategic forum for NHS organisations to facilitate health sector preparedness and planning for emergencies. As a minimum the AEO must attend 75% of the West Mercia LHRP meetings, unless due to annual leave/unexplained absence etc, they nominate an Executive Director to attend on their behalf (Chief Medical Officer or Interim Chief Nurse).
- Overall responsibility and accountability for the management of the on-call arrangements within our Trust and ensuring all on-call staff are appropriately trained and equipped supported by the Business Operations Manager.

- Reporting to the Executive and Trust Board as the AEO on Business Continuity, Preparedness, training and exercising, incidents experienced, lessons and learning, compliance with the assurance process, within our Trust.
- Provide an annual report to the Board of Directors on the organisation's final self-assessed position of the NHS Core Standards for EPRR; ensuring any sub-contractors are compliant with the EPRR requirements as set out in the CCA 2004, the 2005 Regulations, the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract, including this Framework and The NHS Core Standards for EPRR.

The Director of Estates and Facilities will:

- Chair the Trust-wide EPRR Group on behalf of the AEO, to ensure coordination of the EPRR portfolio seeking feedback on draft plans and policies and potential training and exercising, share best practice and act proactively to embed EPRR within teams across the organisation.
- In conjunction with the EPRR Lead ensure this document is reviewed on an annual basis to ensure its continued relevance.
- The Director of Estates and Facilities has professional managerial responsibility of the EPRR Lead.

The Director of Digital will:

- The Director of Digital is responsible for ensuring that digital systems and infrastructure support EPRR requirements.
- This includes overseeing the critical IT systems, ensuring robust cybersecurity measures, and maintaining digital communication channels for emergency coordination.
- Ensure that essential digital services have suitable backups to facilitate DR processes and ensure that monitoring is carried out,
- Support business continuity planning and align digital strategies with national EPRR standards.

The EPRR Lead (Health & Safety Advisor) is responsible for:

- Providing an operational lead on EPRR matters across all Trust business.
- Act as Tactical Advisor during declared internal or multiagency incidents.
- Prepare EPRR Plans and Policies and ensure these are distributed for consultation by the EPRR Group and externally as appropriate.
- Consult with staff at all levels as appropriate to assist with their understanding of EPRR requirements.
- Provide the EPRR Group with an annual EPRR training and exercising schedule for approval and deliver what has been approved.
- Represent the Trust at external meetings and exercises.
- Consult with the AEO and Trust Secretary to ensure EPRR risks are considered within internal risk processes.
- Provide quarterly updates on the EPRR annual work programme to Trust Quality and Safety Committee, and Trust Board annually.
- Develop, coordinate, and oversee the implementation of the Trust's EPRR testing and exercise programme, ensuring effective planning, scheduling, and delivery.
- Ensure that professional development and Continuing Professional Development (CPD) related to EPRR are maintained at an up-to-date standard, appropriately documented, and aligned with the needs of the Trust, ensuring that all training undertaken contributes effectively to service delivery.

The Business Operations Manager is responsible for:

- Supporting the AEO and the management of the on-call arrangements within our Trust and ensuring all on-call staff are appropriately trained and equipped.
- Manage and maintain the Trust's Business Continuity Management System in accordance with the legal duty RJAH has as a Category 1 responder identified under the Civil Contingencies Act 2004.

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Managing Directors / Ward / Department Managers are responsible for:

- Ensuring that their departments/areas have reviewed the Trust Incident Response Plan and are aware of the impact on their departments.
- Ensuring that all relevant staff have a clear understanding of and have received training in the plan.
- Managing Directors / Ward/ Department Managers are responsible for ensuring Business continuity plans are in place, reviewed and tested periodically for each of their areas with the support of the Business Operations Manager.

All Staff - All Staff are responsible for ensuring that they are aware of the contents of our Trust's Incident Response Plan, their ward/service/department business continuity plan, and all associated EPRR plans (such as Evacuation and Shelter, CBRNe etc) and their individual responsibilities should the plan be activated.

The Trust Incident Response Plan and other emergency plans and policies are stored electronically on the Trust Intranet dedicated EPRR Page (see hyperlink below). Hard copies are stored in the Trust Incident Control Centre (ICC) cupboard (CSM Office location 21) and at Switchboard.

<https://rjah.interactgo.com/Interact/Pages/Section/Default.aspx?section=4832>

5.0 Underpinning principles of EPRR

The NHS Core Standards for EPRR apply to the arrangements the Trust has in place to prepare for and respond to an emergency. Emergency Plans and Policies will:

- Have a change control process and version control detailed for each document. RJAH documents have version control in the front page and a version control table on the first page of each document.
- Each new version will have a new version number displayed on the documents front page. For example, version 1.0 would become version 2.0. Any draft copies of the documents will be stored securely on the Trust Server within the dedicated EPRR Folder.
- Changes to all EPRR Plans will be subject to an annual review at RJAH, and approval by the appropriate Trust Committee.
- Take account of changing business objectives and processes. This will be detailed and led from the Trust's Strategy and Trust Clinical Strategy, by the Board of Directors.
- Take account of any changes in the organisation's functions and/ or organisational and structural and staff changes. Where changes to structure and staff take place that directly impact on EPRR, plans and policies must be updated immediately. All EPRR Plans will be reviewed by the EPRR Group in light of any changes to the Trust's function, organisational structure or staff.
- Take account of change in key suppliers and contractual arrangements.
- Use consistent unambiguous terminology and include glossaries where required.
- Include appropriate distribution lists.
- Be available on the Trust Intranet Percy – see below hyperlink - Hard copies are stored in the Trust Incident Control Centre (ICC) cupboard (CSM Office location 21) and at Switchboard.

<https://rjah.interactgo.com/Interact/Pages/Section/Default.aspx?section=4832>

- Have an expectation that a lesson's identified report must be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place (A documented process is in place via the Trust EPRR Group, to monitor action plans and ensure their completion. Action plans are assigned to Trust leads/owners and due dates, tracked through the EPRR Group. Progress and completion are

verified and recorded via the EPRR Group meeting minutes/action log, with overdue actions followed up as required.)

- Include references to other sources of information and supporting documentation.
- Adhere to Trust policy regarding different groups of people and different needs of people with protected characteristics and ensure plans consider, e.g., age, disability, race, sex, sexual orientation, gender reassignment, pregnancy and maternity, marriage and civil partnership, religion or belief and disadvantaged groups.

5.1 Risk Assessment

- The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally. The Trust's process for this is detailed within the Trust's Risk Management Policy. This policy is available on the Trust's Intranet page "Percy": - [Risk Management Policy - Percy](#)
- The Trust EPRR Group will agree the Trust's EPRR Risks based on information contained within the West Mercia LHRP risk register and risks contained within the Trust Corporate Risk Register.
- All RJAH Trust EPRR risks are held on the Trust corporate risk register (owned by the AEO, managed by the EPRR Lead).
- The information within the EPRR Risks will then inform the Trust emergency and business continuity plans. This information will be cascaded to staff via the Trust EPRR Group and EPRR Lead.
- The AEO will attend the West Mercia LHRP and West Mercia LRF and collaboratively with System partners review new, emerging and existing risks which may impact the Trust, community, system partners and other agencies.
- If any external risk information is received this will be cascaded by the AEO or the EPRR Lead to the EPRR Group who will decide if an amendment to the Trust EPRR Risks is required

5.2 CBRN response

The Trust CBRN & HAZMAT Plan provides comprehensive details relating to the Trust's CBRN response arrangement, roles and responsibilities, outlining the resources available to support an effective and coordinated response. This includes access to specialist equipment (such as PPE and dry decontamination battle boxes), trained personnel, and established procedures for escalation, communication, and multi-agency working. The document also reflects current guidance and ensures alignment with wider EPRR and partner agency arrangements.

[CBRN / HAZMAT Procedure - Percy](#)

5.3 Preparedness and Anticipation

RJAH needs to anticipate and manage consequences of incidents and emergencies through identifying the risks and understanding the direct and indirect consequences, where possible.

All individuals and Departments/Units that might have to respond to incidents will be properly prepared, including having clarity of roles and responsibilities, specific and generic plans, and will rehearse arrangements periodically. RJAH will have a clear training and exercising schedule that delivers against this principle led by the EPRR Lead.

5.4 Continuity

The response to incidents must be grounded within RJAH's existing functions and their familiar ways of working – although inevitably, actions will need to be carried out at greater pace, on a larger scale and in more testing circumstances during response to an incident.

5.5 Subsidiarity

Decisions within RJAH will always be taken at the lowest appropriate level, with coordination at the highest necessary level. Responders within individual departments will be the building block of any response for an incident of any scale.

5.6 Communication

Good two-way communications will be critical to RJAH in achieving an effective response. Reliable information must be passed correctly and without delay between those who need to know, including the public, emergency services, responders etc.

As per the Trust's Incident Response Plan, communication would be received and cascaded via the Incident Management Team, and their outlined roles during an incident.

The Trust Incident Response Plan is stored electronically on the Trust Intranet dedicated EPRR Page (see hyperlink below). Hard copies are stored in the Trust Incident Control Centre (ICC) cupboard (CSM Office location 21) and at Switchboard.

<https://rjah.interactgo.com/Interact/Pages/Section/Default.aspx?section=4832>

5.7 Cooperation and Integration

Please refer to Trusts Information Sharing Procedure –

<https://rjah.interactgo.com/Utilities/Uploads/Handler/Uploader.ashx?area=composer&filename=Information%2bSharing%2bProcedure.doc&fileguid=7da9bb22-8ea6-4a2a-981f-78aea845b283>

Positive engagement based on mutual trust and understanding will facilitate information sharing. Effective coordination will be exercised between other NHS and multi-agency organisations along with interfacing as appropriate with local, regional, and national tiers of a response. Active mutual aid will be provided upon request, within the UK as appropriate. The Trust's process for Mutual aid during an incident is detailed within the Trust's Incident Response plan: The Trust Incident Response Plan is stored electronically on the Trust Intranet dedicated EPRR Page (see hyperlink below). Hard copies are stored in the Trust Incident Control Centre (ICC) cupboard (CSM Office location 21) and at Switchboard.

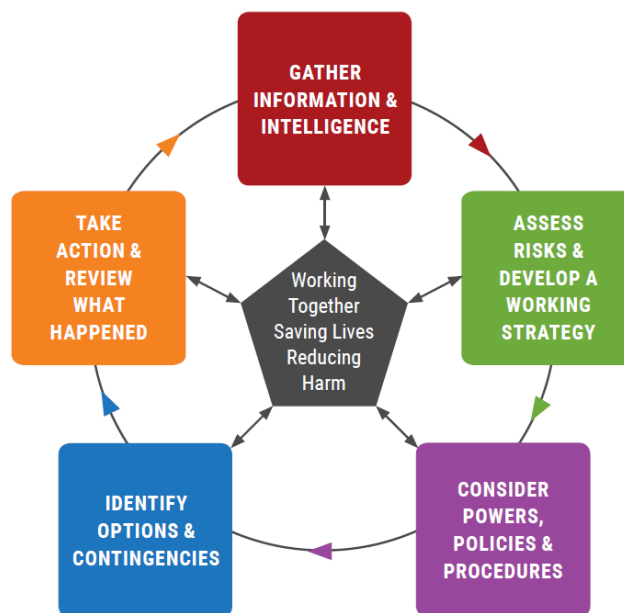
<https://rjah.interactgo.com/Interact/Pages/Section/Default.aspx?section=4832>

5.8 Joint Decision Model (JDM)

One of the difficulties facing incident commanders/coordinators from different agencies is how to bring together the available information, reconcile potentially differing priorities and then make effective decisions together. The Joint Decision Model (JDM), shown below, was developed to resolve this issue.

All joint decisions, and the rationale behind them, should be recorded in a 'joint decision log'. Responding agencies should work together to build shared situational awareness, recognising that this requires continuous effort as the situation, and responders' understanding, will change over time. The sections following work through the various elements of the model.

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5.9 Direction

Clarity of purpose will be delivered through an awareness of the strategic aim and supporting objectives for the response. These will be agreed by the Trust CEO and or AEO and understood by all involved in managing the response to an incident in order to effectively prioritise and focus the response.

6.0 Corporate Responsibility Obligations

Our Trust also has a number of specific corporate responsibilities and obligations relating to patient safety and staff welfare that support Emergency Preparedness, Resilience and Response good practice. These include:

- Health & Safety – RJAH will, so far as is reasonably practicable, act in accordance with the Health and Safety at Work etc. Act 1974, the Management of Health and Safety at Work Regulations 1999 and associated legislation and approved codes of practice. It will provide and maintain, so far as is reasonable, a working environment for employees which is safe, without risks to health, with adequate facilities and arrangements for health at work.
- Risk Management - Our Trust's emergency and incident response plans are informed by the assessment of risks within the national, regional, and local area, as well as internal risks within the organisation. Our Trust will record any specific emergency planning risks on the Corporate Risk Register.
- Equality Act 2010 and the Public-Sector Equality Duty - RJAH will act in accordance with the Equality Act 2010, which bans unfair treatment and helps achieve equal opportunities in the workplace.
- The Equality Duty has three aims, requiring public bodies to have due regard to:
 - eliminating unlawful discrimination, harassment, victimization and any other conduct prohibited by the Act.
 - advancing equality of opportunity between people who share a protected characteristic and people who do not share it; and

- fostering good relations between people who share a protected characteristic and people who do not share it.
- Information governance – RJAH recognises that its records and information must be managed, handled, and protected in accordance with the requirements of the Data Protection Act 2018, UKGDPR 2021 and other legislation, not only to serve its business needs, but also to support the provision of highest quality patient care and ensure individual's rights in respect of their personal data are observed.
- As per the NHS EPRR Framework section 8.9.1, documents relating to incidents should be retained for 30 years. There are, however, provisions under the CCA 2004 for Category 1 and 2 responders to share information, in order to effectively fulfil their duties during an emergency. Also see these resources for further info on data sharing during an emergency:

[Cabinet Office Data Protection and Sharing – Guidance for Emergency Planners and Responders 2007](#)

[Data sharing in an urgent situation or in an emergency | ICO](#)

- The Civil Contingencies Act 2004 includes provisions that allow Category 1 and Category 2 responders to share information where necessary to effectively fulfil their duties during an emergency. These provisions support timely and proportionate information sharing to enable an effective response while remaining compliant with data protection requirements. Further guidance on data sharing during emergencies is available through the Cabinet Office *Data Protection and Sharing – Guidance for Emergency Planners and Responders (2007)* and the Information Commissioner's Office guidance on *data sharing in urgent or emergency situations*.
- As per the Trust's Corporate Records Management Policy, it is responsibility of the author of each plan/policy to retain/store this documentation.
- Emergency Preparedness, Resilience and Response - The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from severe weather to an infectious disease outbreak or a major transport accident. Under the Civil Contingencies Act (2004), NHS organisations and sub-contractors must show that they can deal with these incidents while maintaining services to patients. This work is referred to in the health service as 'emergency preparedness, resilience and response' (EPRR).

7.0 Command, Control, Coordination and Communication

An integral element of Command and Control within RJAH is a clear chain of command from the top of the organisation to the lowest level and across agencies as required. Every person involved in the response to an incident must exactly know their roles and responsibilities.

- **Command** is the exercise of vested authority that is associated with a role or rank within the organisation to give direction in order to achieve defined objectives
- **Control** is the application of authority, combined with the capability to manage resources, in order to achieve defined objectives
- **Coordination** is the integration of multi-agency efforts and available capabilities, which may be interdependent, in order to achieve defined objectives. The coordination function will be exercised through control arrangements and requires that command of individual organisations' personnel and assets is appropriately exercised in pursuit of the defined objectives.
- **Communication** – sharing information to support the response.

RJAH will follow the nationally recognised '**Strategic, Tactical and Operational**' framework as laid out in the Trust Incident Response Plan.

The Trust Incident Response Plan is stored electronically on the Trust Intranet dedicated EPRR Page (see hyperlink below). Hard copies are stored in the Trust Incident Control Centre (ICC) cupboard (CSM Office location 21) and at Switchboard.

<https://rjah.interactgo.com/Interact/Pages/Section/Default.aspx?section=4832>

7.1 Communication and Information Sharing

RJAH has a duty to communicate with the public in the event of any health emergencies as well as cooperating and sharing information with other responders. Detail internal and external communicating during an incident can be found within the Trust Incident Communication Plan, and Communication Team business continuity plan.

Our Trust subscribes to the arrangements in place through West Mercia LRF and the specific guidance Data Protection and Sharing – Guidance for Emergency Planners and Responders.

RJAH has a duty to work with partners in the multi-agency Local Resilience Forum (LRF) and health sector Local Health Resilience Partnership (LHRP) to ensure that it is part of a joined-up planning, response, and recovery process.

The Trust must ensure that the engagement and information shared, with Trust partners and stakeholders of West Mercia LRF and LHRP, enhance any response and recovery phase during and following an incident.

Please refer to Trusts Information Sharing Procedure –

<https://rjah.interactgo.com/Utilities/Uploads/Handler/Uploader.ashx?area=composer&filename=Information%2bSharing%2bProcedure.doc&fileguid=7da9bb22-8ea6-4a2a-981f-78aea845b283>

8.0 Recovery

In contrast to the response to an emergency, the recovery may take months or even years to complete as it seeks to address the enduring human, physical, psychological, environmental, social, and economic consequences. Response and recovery are not; however, two discrete activities and the response and recovery phases may not occur sequentially.

Recovery will be an integral part of the combined response within our Trust from the beginning, as action taken at all times during an emergency can influence the long-term outcomes for communities.

Recovery expectations, timescales and proposed core names to enable this are detailed within the Trust's Incident Response Plan.

9.0 Debriefing and Supporting

RJAH will be responsible for debriefing and provision of support to staff where required following an emergency. This is the responsibility of individual line managers, coordinated by the Accountable Emergency Officer (AEO).

Debriefing may also be on a multi-agency footprint. After any incident or emergency, a debrief will be held to ensure any lessons learned are captured so that any policies, procedures, and other preparedness measures can be reviews and emended if required. The debriefing process will be coordinated by the EPRR Team and outcomes of these debriefs will form part of reports to Trust Board.

The following debriefs, and reports must be carried out within the stated timeframes:

- hot debrief – immediately after the incident or period of duty, but within 48 hours of stand down
- cold/structured/organisational debrief – within 28 days post incident
- multi-agency debrief – within eight weeks of the close of the incident (actual timing will be set by the lead organisation for the response)
- post-incident reports – within four weeks of the debrief.

10.0 Post Incident Reports

The post incident report must be written within 4 weeks of the incident. The Trust AEO and or EPRR Lead is responsible for creating the post incident report. The report will be supported by action plans and recommendations in order to update any relevant plans with achievable timeframes as agreed by the AEO. In addition, other investigations may be conducted as per the ICB's relevant policies.

Post incident reports will be presented to the EPRR Group for peer review, then to the Health & Safety Meeting which then feeds into the Trust Quality and Safety Committee, of which is a subcommittee to the Board.

11.0 Continuous Improvement

Identifying Lessons from Incidents and Exercises: A structured approach is essential to effectively identify lessons from both live incidents and planned exercises. This process for RJAH includes:

- Post-Incident/Exercise Debriefs: Conducting immediate hot debriefs for initial observations, followed by structured cold debriefs within the defined timescale set out within section 10 of this policy.
- Multi-Agency Reviews: Engaging with relevant System partners, including West Mercia Local Health Resilience Partnerships/Forum (LHRP/LRF) to identify cross-organisational learning.
- Data and Trend Analysis: Reviewing reports, key performance indicators (KPIs), and audit findings to identify recurring themes and systemic issues requiring action for RJAH. This will take place through the Trust EPRR Group following an incident.

Capturing Lessons and Establishing Clear Ownership: Ensuring that lessons are captured effectively:

- Lessons identified will be recorded in a structured lesson tracker and reviewed for continuous improvement at the Trust EPRR Group. Lessons (actions) will have an assigned lead (e.g., EPRR Lead, AEO, or Ward/Department Managers), ensuring clear responsibility for action. Lesson owners will also report back to this group for progress action monitoring.
- Formal Reporting Channels: Regular submission of findings to West Mercia LRF/LHRP and HEPOG) to ensure oversight and shared learning.

Embedding Learning into Organisational Processes: For lessons to drive meaningful change at RJAH following an incident, the Trust EPRR Group will embed learning within policies, training, and operational practices.

- Integrating lessons into ongoing staff EPRR training and future EPRR exercises to reinforce learning and practical application.

- Evaluation of previously identified lessons to ensure corrective actions are sustained.

Regional Lessons Process: Reporting, Assessment, and Monitoring: To align with wider regional learning mechanisms, the Trust will remain engaged in regional forums, including LHRP/LHRF, to track implementation progress and assess whether shared lessons have been effectively embedded. The Trust will also use the NHSE Midlands lessons identified report to review the document and include any relevant lessons into our planning arrangements and future exercising.

12.0 Testing and Monitoring of Plans

RJAH's emergency plans will be reviewed annually as required by the AEO / Accountable Emergency Officer produced by the Trust EPRR Lead. As part of our Trust's emergency preparedness and planning, our Trust will participate in exercises both locally and across the Midlands with our partners.

This helps staff to understand their roles and responsibilities when a situation occurs.

The Trust will carry out its own internal exercising programme in line with the requirements below.

- communications exercise every six months
- tabletop exercise once a year
- live exercise every three years
- command post exercise every three years
- Live incidents which require the plans to be evoked, have a debrief process and lead to review / improvements of the plans will be considered as the annual test where applicable.

The Trust EPRR Lead is responsible for drafting, scheduling, managing and implementing the Trust exercise programme. This is approved and authorised by the Trust AEO and EPRR Group. All documentation relevant is stored on the Trust secure U Drive.

13.0 Record Keeping

All staff in the response of any incident must keep records of actions or decisions taken and submit these to the Accountable Emergency Officer within 72 hours. Loggist's will be required to record actions throughout any business continuity, critical or major incident and submit these to the Accountable Emergency Officer within 72 hours. The Trust Incident Response Plan details the role and responsibility of a Loggist during an incident, including the requirement of NO ELBOWS (No, Erasures, Leaves torn out, Blank pages, Overwriting, Writing between the Lines, Spare Pages). Hyper below to electronic copy of Trust Incident Response Plan. All incident logs will be stored on the Trusts Secure Server, by the EPRR Lead.

<https://rjah.interactgo.com/Interact/Pages/Section/Default.aspx?section=4832>

14.0 Implementation and Monitoring

14.1 Training and Dissemination

The Trust's approach to Emergency Preparedness, Resilience and Response (EPRR) training is designed by the EPRR Lead, approved by the AEO, to ensure that all staff are appropriately trained for their role in responding to incidents.

Responsibility for developing, implementing, and maintaining the EPRR training programme sits with the designated EPRR Lead, supported by relevant subject matter experts.

A Training Needs Analysis will be developed, and implemented by the EPRR Lead, to identify training requirements for different staff groups who may have a role during an incident, aligned to National

Occupational Standards and NHS Minimum Occupational Standards for EPRR. Staff are required to maintain Personal Development Portfolios to evidence relevant training, competencies, and experience. Training uptake and compliance are monitored and reported regularly to the Board to provide assurance of organisational preparedness.

- Accountable Emergency Officer (Chief Operating Officer)
- Director of Estates and Facilities
- Director of Digital
- EPRR Lead
- Managing Directors
- Assistant Chief Nurses
- Matrons
- Ward Managers
- Department Managers
- Individual Business Continuity Plan Authors

14.2 Implementation Plan

This policy will be available on the Trust Document Centre and will be the responsibility of all Ward and Department managers to ensure all their staff have read and understood the content.

14.3 Monitoring / Audit

The effectiveness of the document will be monitored by the EPRR Group with a six-monthly chair report being presented to the Quality and Safety Committee by the Accountable Emergency Officer.

15.0 Review Date

This policy will be subject to review no later than every 3 years. In the event of new guidance requiring update of the policy before the stipulated time, an update should be done and the revised version goes through the governance process for approval.

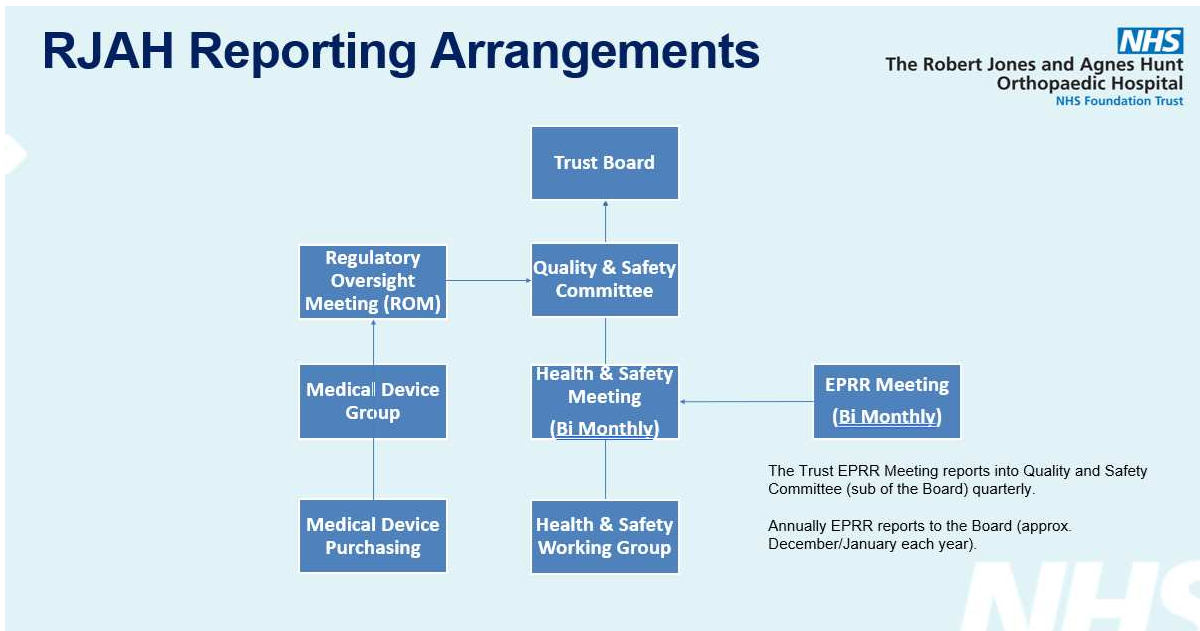
16.0 References

All of the below documents are stored electronically on the Trust Intranet on the dedicated EPRR Page (see below), and hard copies are stored in the ICC (Incident Control Centre, cupboard).

[EPRR - Percy](#)

- NHS Core Standards for EPRR
- The Civil Contingencies Act 2004 (CCA 2004).
- RJAH Emergency Preparedness, Resilience and Response Policy
- RJAH Health, Safety and Welfare Policy
- RJAH Lockdown Policy
- RJAH Incident Response Plan

17.0 RJAH EPRR Reporting Arrangements



The Trust Incident Response Plan and EPRR/BCP Policy are submitted to Trust Board for Approval, whilst EPRR plans are presented to the Quality and Safety Committee for review and approval, in line with established governance arrangements. All plans are subject to EPRR Group peer review and challenge prior to submission for Committee/approval.

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Part 2

Business Continuity Policy

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1. Introduction

This combined EPRR and Business Continuity Policy sets out the requirements for Business Continuity (BC) plans at The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH). The policy aligns with the overall objectives of the organisation Strategic Objectives Plan 2025/26. The policy is also developed in conjunction with the NHS Trust guidance and aligns to the international standard for business continuity ISO 22301.

Whilst the Trust will make every effort to cover everything in relation to all Business Continuity Systems, there will be limitations and unforeseen risk. A Business Continuity Incident is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level.

Under the Civil Contingencies Act 2004 and the Health and Social Care Act 2012 all NHS organisations have a duty of care to have in place Business Continuity plans, for when an incident occurs, impacting upon their ability to maintain critical functions. The incident can be anything that has the potential to disrupt normal service delivery but essentially, all events that could cause a loss of a resource (e.g. buildings, people, equipment, systems, supply chain), or a change in demand (e.g. an infectious disease outbreak).

The strategic intent of this policy is to ensure that each department has operational BC Plans that are developed in line with national guidance, the BC toolkit, and also in line with IOS standard, consulted and exercised accordingly. Within each BCPs there will be a detailed business impact analysis (BIA) of critical functions and recovery measures that will be implemented in the event of a business continuity incident.

The Trust Business Operations Manager leads and delivers the Business Continuity Management (BCM) programme through the effective coordination of its practical implementation activities. This includes the development and regular review of business continuity plans, undertaking risk assessments and business impact analyses to inform preparedness, and delivering a programme of training and exercising to ensure organisational readiness. The role also involves proactive engagement with departments and key stakeholders to embed business continuity across the Trust, alongside driving continuous improvement to strengthen resilience and ensure alignment with organisational priorities.

2. Aim of the Policy

The aim of the Business Continuity Policy is to provide a clearly defined strategic intent that will ensure the resilience and continuation of critical functions and dependencies at RJAH, as well-set requirements for suppliers to assure themselves towards ensuring supply chain are aligned with RJAH maximum tolerable disruption time.

3. Key Objectives

- To define critical activities of the Trust and the resources that should be planned for in the BCPs. This will be achieved by conducting a Business Impact Analysis (BIA) at both tactical (divisional) and operational (Departments/service) levels.
- To ensure that Business Continuity plans are managed at all appropriate levels of the Trust in order to ensure continuity of critical functions in the event of a disruption. The implementation will be described in the business continuity management system (BCMS) document.

4. Business Continuity Policy Governance structure

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The business continuity policy will go through 2 routes for consultation. The first route is the RJAH EPRR Group (Emergency Preparedness, Resilience and Response Group). This is a working group of all BC plan holders in the trust. The group meet every two months to deliberate on the operations of new guidelines, exercises, workshops, and training. All business continuity actions, and planning are followed up in EPRR Group for assurance that they are completed and embedded into organisation business as usual.

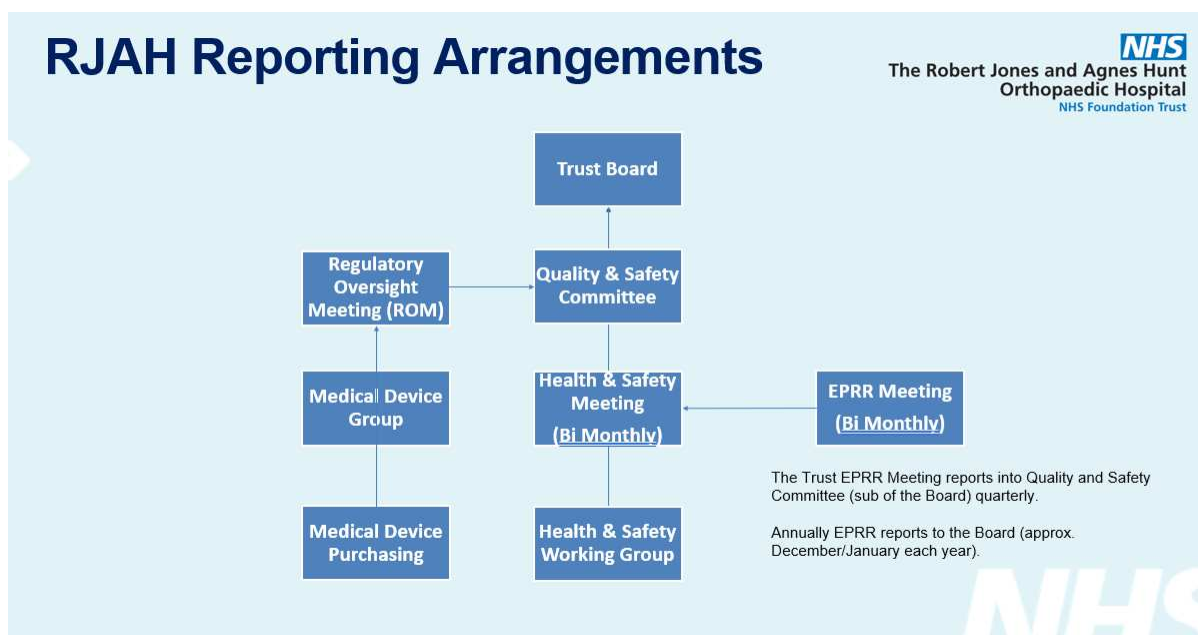
The second route is the Quality and Safety Committee (Q&S). This committee monitors all risks reported on Datix System. All risk scoring more than 15 are discussed and action plans agreed to address the risks identified. The committee also ensures that open extreme risks that needs to be linked to a BCP is actioned and those that requires a business case are identified.

The emergency planning and business continuity leads work in collaboration with appropriate leads to ensure that any reported risk requiring BCP is written and exercised. The ratification of this policy goes through the EPRR Group, then to Health and Safety Meeting, then to the Quality and Safety Committee, then final Trust Board.

This meeting includes departments and divisional leads who meets quarterly to consult on new and updated plans and policies, get updates on EPRR core standard compliance, and share information on best practices.

EPRR annual report including the BC policy and dashboard of key performance indicators are submitted to Quality and Safety Committee. The committee is responsible for ratifying and signing off the Business Continuity Policy and arrangements for the trust. The EPRR & BCP Policy will have final sign off at RJAH Trust Board.

The Accountable Emergency Officer (AEO) who is the Chief Operating Officer / Deputy Chief Executive Officer (Deputy CEO) will be responsible for presenting this policy the trust board.



5. Responsibilities, Accountabilities, and Duties.

It is the responsibility of the Trust EPRR Lead and Operations Business Manager to ensure that the Business Continuity Policy, BCMS, Corporate, divisional and departmental BCPs are written and exercised to ensure that these documents reflect the trust procedures and national guidance and any changing situations or intelligence which may affect the contents of the documents.

The below roles and responsibilities have been drawn up in consultation with our multi-agency partners and will be updated every year in the BCPs & BCMS document and 3 yearly in the BC policy, or following a significant incident, multi-agency event, exercise and review to test resilience and preparedness, in which lessons learnt need to be incorporated into the roles and responsibility.

5.1 The Chief Executive or nominated Deputy (Strategic Commander) is responsible for:

- Ensuring that the organisation has effective BCM systems and processes in place.
- Making the decision to invoke a Business Continuity Plan.
- Making the decision on when to convene / chair the Strategic Command Group.
- Notify and liaise with external agencies / ICB who will then notify /NHS England Regional and National teams as appropriate on Trust behalf.
- Establish effective communications framework is in place between the tactical and operational command.
- Monitoring Business Continuity activity and escalating to a critical or Major Incident when necessary.
- Gather / retain strategic overview of response to the incident.
- Manage potential harm to RJAH's reputation.
- Ensuring records are kept for governance, audit and future reviews.
- Plan for timely recovery process.

5.2 The Accountable Emergency Officer is responsible for:

- Be the Accountable Emergency officer (AEO) for the trust a hence the default strategic commander except when incident requires an expert Lead e.g. A new and emerging pandemic. The role of Strategic Commander may also be delegated to the On-Call Director.
- Have oversight of Emergency Preparedness, Resilience and Response for the trust.
- Establish effective communications framework is in place between the tactical and operational command.
- Ensures that all managers in designated areas of responsibility/leadership portfolios have robust Business Continuity and recovery plans which are exercised and tested.
- Making the decision to invoke a Business Continuity Plan.
- Making the decision on when to convene / chair the Strategic Command Group.
- Chair the Strategic Command Group.
- Meeting the strategic requirements during an incident as per the Trust Incident Response Plan.
- Carrying out any delegated responsibilities from CEO, ICB, LHRP and NHS England.
- Monitoring Business Continuity activity and escalating to a critical or Major Incident when necessary.
- Ensuring records are kept as per this policy / strategy document for governance and audit.
- Updating other Executives on situation.

5.3 Trust Executive Directors are responsible for:

- Ensuring that all managers in designated areas of responsibility / leadership portfolios have robust Business Continuity and recovery plans, which are exercised and tested.
- Being a member of the Strategic Command Group.
- Meeting the Strategic requirements during an incident as per the Trust Incident Response Plan.
- Carrying out any delegated responsibilities from CEO, AEO, ICB, LHRP and NHS England.
- Ensuring records are kept as per this policy / strategy document for governance and audit.
- Activating plans and procedures and notifying Chief Executive or COO of any such activity if acting as Senior Executive On-Call.
- Assure themselves that effective communications framework is in place between the tactical and operational command.

- Liaising with medical leads of neighbouring hospitals and the private sector and seek support as required.

5.4 The Divisional Managing Directors are responsible for:

- Accepting overall ownership of the trust's Business continuity Plans and BIA.
- Ensuring that every Divisional Director/Centre Manager / Operational Managers have robust BC and Recovery Plans.
- Ensuring that every Divisional Director/Centre Manager /Operational Manager accepts responsibility for their plans.
- Ensuring that all plans are tested and exercised.
- Carrying out any delegated responsibilities from CEO, AEO, ICB, LHRP and NHS England.
- Assure themselves that effective communications framework is in place between the tactical and operational command
- Taking responsibility as Tactical Commander when necessary.
- Making the decision on when to convene / chair the Tactical Command Group.
- Being a member of the Tactical Command Group.
- Providing SITREPs and briefings to Executives and wider groups affected by the incident.
- Ensuring records are kept as per this policy / strategy document for governance and audit.
- Meeting operational requirements.

5.5 The EPRR Lead and Operations Business Manager are responsible for:

- Providing specialist role and advice to the organisation, both in planning and response to BusinessContinuity incidents.
- Responsible for the writing/reviewing of RJAH's Business Continuity Policy, Business Continuity management System and supporting Ward/Department and Services Managers in completing BIA to inform the BC plans.
- Providing support and advice to managers on their business continuity plans and incidents.
- Organising exercises and scenarios to test business continuity/emergency planning arrangements.
- Developing and maintaining a training programme in conjunction with workforce development.
- Laise with the ICB, NHSE, Business continuity partners and local health resilience forums, meeting and engagement on behalf of RJAH.
- Conducting debriefs after a BC events, documenting best practices and using improvement methodologies to explore innovations in BC management and sharing of learnings through debrief reports with the LHRP footprint and with NHSE as part of the regional lessons process.

5.6 Ward and Departmental Managers are responsible for:

- Production and ownership of Business Impact Analysis documents.
- Production and ownership of Business Continuity plans in line with this policy and strategy.
- Attendance at peer review and training workshops.
- Testing and exercising of plans to be carried out at least once every 12 months.
- Reviewing plans after BC incidents to ensure plans are effective, adequate and fit for purpose.
- Monitoring BC activity, activating plans and alerting Senior Managers.
- Keeping training records of staff.
- Maintaining communication channels during periods of disruption - mobiles, red phones, radio's etc.
- Acting as a member of the Operational/ tactical Group as directed or required.
- Providing Situation reports (SITREPs) during a Business Continuity incident.

5.7 Action Cards for Business Continuity, critical or major incident.

Action Cards for Strategic, Tactical and key Operational personnel can be found in:

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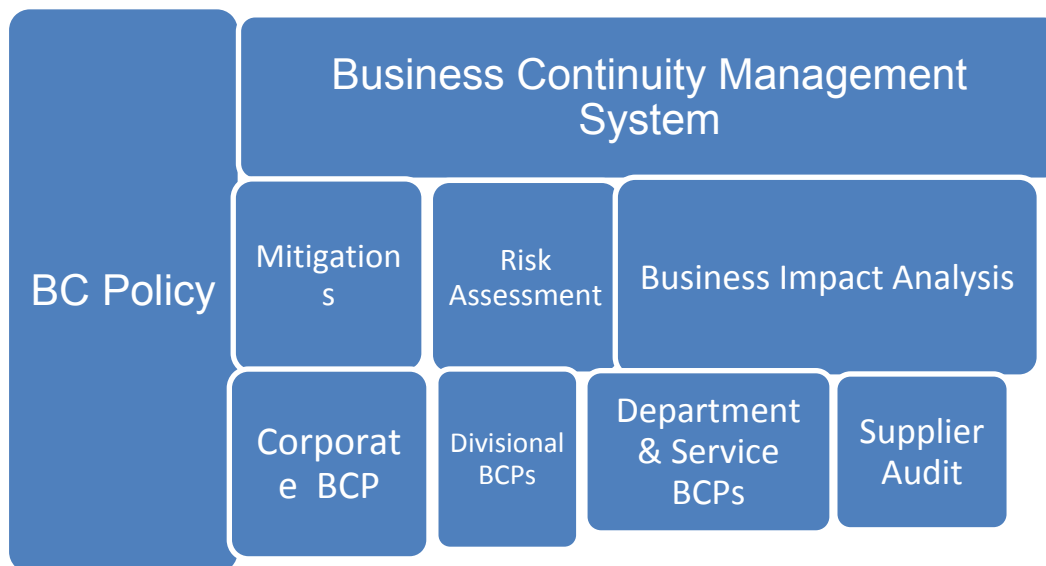
Business continuity encompasses the policy, plans (departmental, services, division & corporate) and BC management system. These documents explore the different components of the business continuity toolkit and the ISO 22301 recommendations for management of business continuity. The documents ensure that guidance and best practices are considered and followed.

In reference to Core Standard 44, RJAH is required to assess climate change risks and how to plan to manage them. Considering that complex business continuity events can often be linked to climate change. The Trust Adverse weather and Health plan will ensure monitoring of weather warning e.g. Heat and Cold Weather alerts from the Met Office. The Trust Sustainability Group is responsible for the oversight of this.

This risk is likely to influence the operational ability of RJAH services (usually Level 2 and above), the Estates Administration Team, and Trust Communications Team will send out the weather warning or alert (Amber and red) ensuring its distribution throughout the Trust. The Trust will also keep a close watch on climate change and emerging conditions and changes in weather patterns and diseases that may affect its business continuity. This risk will be reported on the Datix system and reported through the corporate risk theme to board assurance framework (BAF).

The NHSE Midlands Core Standards assessment guidance requires Specialist Acute Trusts to consider business continuity for EPRR arrangements such as decontamination (Core Standard 47). This BC policy reflects the core standard 44 guidance that requires adequate arrangement in place for minimum acceptable risk to the business as usual at RJAH.

The Business Continuity Management system (BCMS) database will reflect core standard 28,45-55 detailing arrangements for managing BC issues at corporate, division and departmental level. The BCMS will itemize all the arrangement that should be in place to ensure that risk assessment, business impact assessment, mitigations and supplier audits are done at the right time.



The corporate BCP will be written at a strategic level addressing the critical functions identified from the tactical BCPs. **The ward/departmental BCPs** will be at operational level of command and cover the grassroot risks that are reported on Datix, risk assessments and BC events or incidents.

The procurement team, system and service owners will lead in carrying out supplier audits to ensure that all level of RJAH BCPs is aligned with the suppliers BCPs. Assurance for this KPI will be tracked by the emergency planning and resilience lead for the trust and reported in the governance routes.

8. Business Impact Analysis

The Business Impact Analysis (BIA) is the foundation work from which the whole Business Continuity Management (BCM) process is built. It identifies all business functions and allows you to distinguish between critical and non-critical functions. The BIA will be done in a bottom-up approach. The analysis is at the department/ services levels and written in details in the Business continuity Plans.

Critical functions are those functions or activities.

- which cannot be interrupted.
- where disruption is regarded as unacceptable.
- where the function must resume within a set period, usually a short time frame.

Having identified what resources are required to run the service, the BIA should describe what actions will be taken to recover the service, by whom and within what time period. RJAH documentation will consider impact effect and recovery over the following defined periods post incident:

- First 24 hours
- 24 – 48 hours
- Up to 1 week
- Up to 2 weeks

9. Defining Essential or Critical services

A business Continuity Incident is an event or occurrence that disrupts, or might disrupt, an organisations normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level.

The below definitions will be used to inform the departmental, services, tactical plans and if possible, a corporate Business continuity Plan.

Based on the Maximum Time Period of Disruption (MTPD), this represents the estimated or predefined maximum duration that an organisation's critical business services or operations can sustain a disruption before it reaches a point of critical impact or unacceptable consequences.

Essential Activities: Class 0

MTPD: None permissible

Activities which cannot tolerate any disruption. If activities are not resumed immediately it may result in:

- The loss of life
- Significant patient outcome impact
- Significantly impact on other NHS services

High Priority Activities: Class A

MTPD: 24 Hours

Activities which can tolerate very short periods of disruption. If activities are not resumed within 24 hours:

- Patient care may be compromised
- Infrastructure may be lost

- There may be a significant loss of revenue

Medium Priority Activities: Class B

MTPD: 48 Hours

Activities which can tolerate disruption between 24 hours and 48 hours. If service or functions are not resumed in this timeframe it may result in the deterioration of:

- Patient condition
- Infrastructure
- Revenue loss

Low Priority Activities: Class C

MTPD: 72 Hours+

Activities that could be delayed for 72 hours or more but are required to return to normal operation conditions and alleviate further disruption to normal conditions.

It may not be possible to recover all the service at once. In such cases, BC plans should be aimed at restoring services to a pre-determined level over a time (e.g. service recovery to 50% within 24 hours, 75% recovery after 3 days, and 100% within 5 days).

Using the define MTPD, the template below should be used to prioritise critical services and functions in all departmental/service BCPs and summarised in the divisional BC Plan. In the event of a business continuity incident that is developing or affecting specific areas of business, this template aims to support information gathering to inform decision making and action as to which function must be always continued, to be reinstated first or scaled down.

Activities which must be continued at all times:

Priority	Critical function/service	Resources required	Risk if function is suspended
1			

Activities which could be scaled down if necessary:

Priority	Critical function/service	Resources required	Risk if function is suspended
1			

Activities which could be suspended if necessary:

Priority	Critical function/service	Resources required	Risk if function is suspended
1			

10. Risk Assessment

The Trust takes an integrated approach to risk management, regardless of whether risks are clinical, non-clinical, financial, operational, business, or strategic. The Risk Register identifies and prioritises all of the principal risks to the Trust's strategic objectives and is populated via the risk assessment and evaluation process. Risks are graded and ranked using the Trust's Risk Matrix to establish a priority level. Action plans are drawn up for each risk to reduce the likelihood of occurrence and best practice is

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embedded into the appropriate BCPs.

The extreme risk scored 15 and above (including Business continuity themes) are monitored and managed by the Governance Team, EPRR Lead and Business Operations Manager. The Risk Management Group (RMG) reviews all extreme risk scored 15 and above in Monthly meetings.

Responsibility for the management and control of a particular risk lies within the division or ward, department concerned, however the risk management team and the emergency planning team must ensure oversight and escalate to appropriate levels for risk to be addressed. **Risks scoring 15 or over (extreme) must be signed off by the appropriate director or senior executive and then presented to the Risk Management Group (RMG) for agreed actions.**

The RMG will discuss the risk and agree the risk scoring, considering all known factors. All these extreme risks may require a Business Continuity plan or embedded into an already existing department, service, tactical or corporate BCPs. The below template will be used for risk assessment in all BCPs in the trust. It can be adopted, adapted and reviewed to suit the risk assessment and needs.

Hazard	Risk	Likelihood (1-5)	Impact (1-5)	Mitigation in Place	Residual Risk Matrix Score (L, M,H,VH)
Loss/ Theft of Data	Data Loss				
Destruction of Paper Files/records					
Temporary loss of connection					
Damage to internal telephone network	ICT Failure				
Localised hardware failure					
Loss of major application					
Loss of mobile/telephone networks					
Loss of switchboard					
Server Failure					
Contamination	Loss of Premises				
Disruption to direct medical gas					
Disruption to water supplies					
Electric supply					

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disruption					
Fire					
Flooding					
Introduction of a Cordon					
Loss of heating/cooling					
Structural defect/failure					
Clustered notice giving	Staffing shortage				
Epidemic					
Industrial Action					
Pandemic Illness					
School closures					
Transport disruption					
Severe weather					
Contamination/product quality	Supplier Failure				
Contract breach					
Failure to fund/supply					
Industrial action by drivers					
Industrial action in supplier					
Stock management failure					
Supplier goes into administration					
Supply chain collapse					
Under production by supplier					

11. RJAH Risk Score Matrix (as per the Trust Risk Management Policy)

Risk scoring = Consequence x Likelihood (C x L)

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	Consequences				
Likelihood	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

12. Business Continuity Classifications

Business Continuity Classifications according to ISO22301 business continuity Maturity is aligned to the NHS incident levels below.

Level	Category 1 - External Environment	Category 2 - Internal Environment
		Incidents outside the Trust e.g. utilities, terrorism
Local Disruption	The member of staff managing the incident should inform the relevant Directors (clinical & non-clinical) and/or Divisional Directors who will assess the severity of the incident and its possible consequences. If the incident is unlikely to escalate beyond Level 1 status, then control of the incident will be handled locally.	
Minor Disruption	Where the incident is deemed to be Level 2 by Directors (clinical & non-clinical) and/or Divisional Directors then the Trust's Operational Management Team (CEO/AEO) will be informed of the incident immediately and escalation to ICB, who will then escalate with the relevant NHS England region for decision to manage the incident regionally or system.	
Major Disruption	Where the incident is deemed to be Level 3 by the Chief Executive/On Call Executive on Call all other Directors and Directors must be informed immediately. The decision to convene a West Mercia Local Resilience Forum, activate RJAH Incident Command Centre (strategic, tactical and operational) to manage the Level 3 incident is designated to the Chief Executive, AEO, On-call Executive and will depend on their assessment of the threat to the wellbeing of staff, patients or visitors: damage to property or disruption to	

	operations.
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Indication of severity will provide guidance for those officers involved in the management of the incident as to how to manage it most effectively. The list is not exhaustive, as it's representing a small proportion of the potential hazards/threats.

Therefore, it is essential to have a robust logging of all situational awareness, decisions, actions and rationale always during and after an incident. Continual reviews of hazards/threats, which have the potential to cause disruption to the Trust, should be monitored by means of information sharing with other Category 1 Responders.

13. Business Continuity policy Review Timeline

This EPRR & BCP Policy is expected to be reviewed every 3 years. In the event of new guidance requiring update of the policy before the stipulated time, an update should be done, and the revised version goes through the governance process for approval.

14. Implementation Plan

This policy will be available on the Trust Document Centre and will be the responsibility of all Ward and Department managers to ensure all their staff have read and understood the content.

15. Monitoring / Audit

The effectiveness of the document will be monitored by the EPRR Group with a six-monthly chair report being presented to the Quality and Safety Committee by the Accountable Emergency Officer.

16. References

All of the below documents are stored electronically on the Trust Intranet on the dedicated EPRR Page (see below), and hard copies are stored in the ICC (Incident Control Centre, cupboard).

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- RJAH Emergency Preparedness, Resilience and Response Policy
- RJAH Health, Safety and Welfare Policy
- RJAH Incident Response Plan

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Learning From Deaths Quarterly Report

(Part 1) Covering paper

Committee / Group / Meeting, Date	
Board of Directors – Public Meeting, 06 May 2026	
Author:	Contributors:
Name: Dr James Neil Role/Title: Mortality Lead	Name: N/A Role/Title: N/A
Report sign-off:	
Name: Dr Ruth Longfellow, Chief Medical Officer Quality and Safety Committee, 23 April 2026	
Is the report suitable for publication?:	
YES	
Executive Summary:	
<p>A summary report on Learning from Deaths is presented to the Quality and Safety Committee. After a death is reported on Radar, it is then reviewed at the Patient Safety Working Group, using PSIRF methodology and a decision is made as to whether a Patient Safety Incident Investigation (PSII) is required.</p> <p>A Structured Judgement Review (SJR) is then completed in a timely manner using the SJR Plus methodology developed by NHS England.</p> <p>All deaths are reported to the Board of Directors. They are also reviewed and discussed at the Multi-disciplinary Clinical Audit Meeting. A more detailed discussion takes place at the Mortality Steering Group, which meets quarterly, and the Governance Team continues to support the bereavement process with the family throughout.</p> <p>The Mortality Steering Group report is subsequently presented and discussed at the Patient Safety Committee.</p> <p>There have been four deaths in total during Q4 2025/27 — three classified as *expected and one as sudden but not unexpected.</p> <p><i>*“Expected”, “sudden but not unexpected”, and “unexpected” are NHSE-defined categories that describe whether a death is predictable in relation to an individual’s underlying medical condition.</i></p>	
Recommendations:	
<p>Following a recommendation from the Quality and Safety Committee, the Board is asked to:</p> <ul style="list-style-type: none"> • CONSIDER the content of the report • CONFIRM the level of assurance provided following presentation of the paper 	

Learning From Deaths Quarterly Report

(Part 2) Strategic alignment and supporting detail

Strategic objectives and associated risks:

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

Trust Objectives		
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	
4	Grow our services and workforce sustainably	
5	Innovation, education and research at the heart of what we do	
<p>The Learning from Deaths report supports the Trust objective to deliver high quality clinical services by ensuring all inpatient deaths are systematically reviewed, providing assurance that care is safe, effective, and not compromised by avoidable failures. Where learning is identified, it is acted upon through service improvements, strengthened clinical governance, and enhanced end-of-life care, embedding continuous quality improvement into everyday clinical practice.</p>		

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

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	✓
<p>All inpatient deaths are systematically reviewed, providing assurance that care is safe, effective, and not compromised by avoidable failures. Where learning is identified, it is acted upon through service improvements.</p>		

Report development and engagement:

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

Supporting detail:

To provide an update on the current position and emerging trends for In-Patient Learning from Deaths (LFD) for Q4 2025. NHS England requires a quarterly report to the Board outlining the status of LFD investigations, including current numbers, progress against actions, and key themes identified

Learning From Deaths Quarterly Report

Date	Total In-patient Deaths	Number for case record (SJR) review	Death likely due to problems with care	ME review/Family feedback.	Coroner review.
January 26	1 (Expected)	1	0	n/a as coroner's case.	Fast track inquest as due to previous fall. No concerns.
February 26	2 (Expected)	2	0	No family concerns or learning from ME. Care was out of this world, Both doctors and nurses.	N/A
March 26	1 (Sudden but not unexpected)	1	0	No family concerns or learning from ME.	CN1A due to previous fall. No concerns.

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

Learning from Structured Judgment Reviews:

- *Good care in frail patient. Good documentation of appropriate conversations with family and patient. Good EOL care.*
- *Excellent EOL CARE. Good flexibility shown by MDT to changing priorities due to rapid deterioration*
- *Good care in frail patient. Good documentation of appropriate conversations with family.*

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

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

Next Steps:










- Discussions with SATH regarding integration with their Medical Examiner and Bereavement system have been completed. The service went live in June 2023.
- The LFD lead is now working as a Medical Examiner within SATH, strengthening the link between services.

Acronyms

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

Executive Summary - People Committee

Assurance

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

Please note - this is defined by the associated SPC graph within the IPR. Many KPIs show as a moving target due to the change of targets/plans as we moved into new financial year and monthly phasing. Metric placed in boxes above based on the variation icon for latest data point, but over-riden by whether meeting/failing target for last three months. If metric placed in a box based on meeting/failing plan, but does show improvement or deterioration - text colour will indicate that.

Trust Board - People & Workforce

March 2026 – Month 12



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:

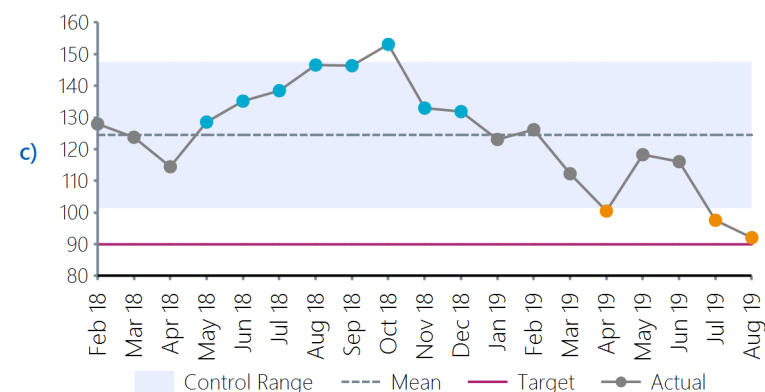
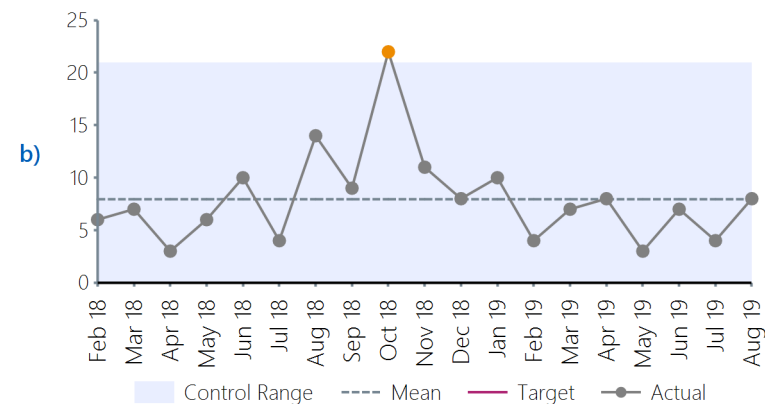
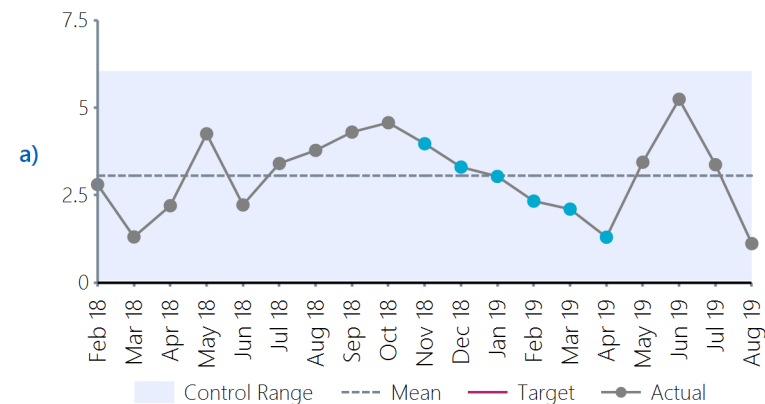
- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of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

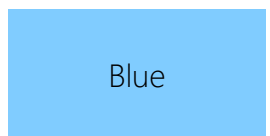
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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



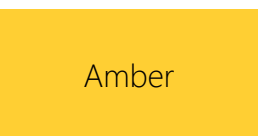
Blue

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.

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Summary - Caring for Staff

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Sickness Absence	5.14%	4.25%				+	3
Staff Turnover - FTE	9.98%	9.37%					4
Leavers per Month	12	12					4
Vacancy Rate	8.00%	6.19%					5

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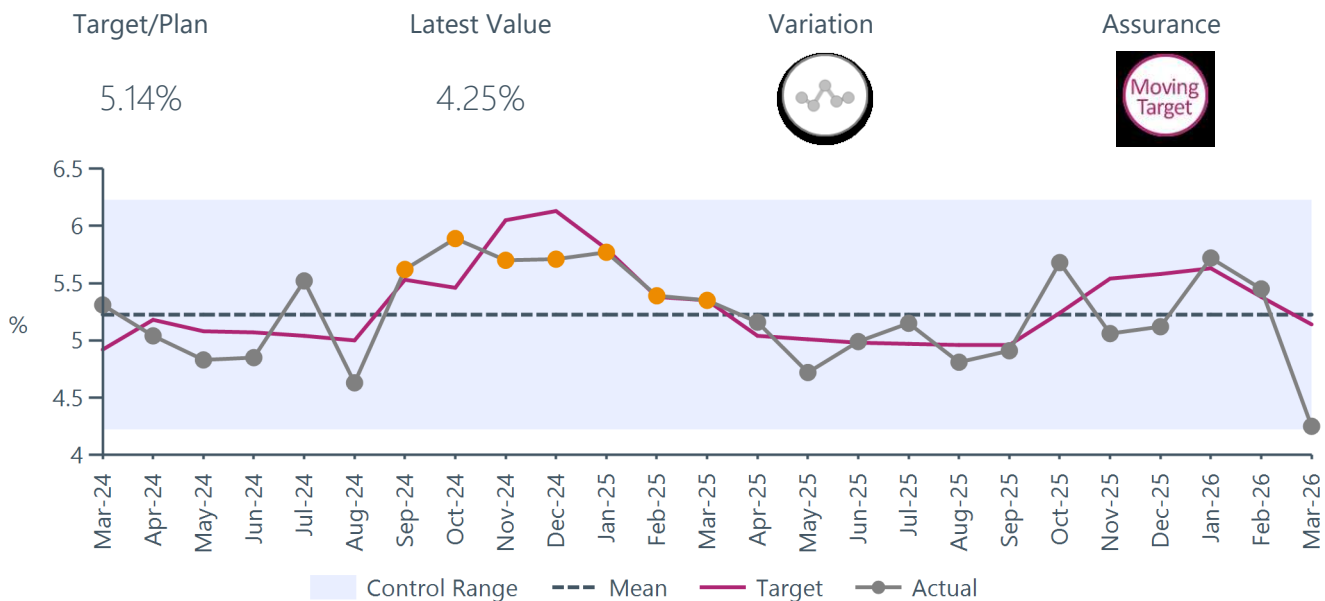
Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Agency Spend against Plan	1.30	0.40					
Proportion of Temporary Staffing as a % of the Trust Pay Costs	6.00%	10.40%				+	
Bank Spend against Plan	4.70	10.30				+	

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

Narrative

The Sickness Absence rate for March is reported at 4.25%; below the 5.14 plan. As shown on the SPC graph above, this remains normal variation but the lowest position seen in the period reported on the graph. Throughout March there has been a reduction in both short-term and long-term sickness. The metric has been included as an exception this month in order to reference the updated NOF publication.

The latest NOF Publication relates to Quarter 3 where the NOF score for this metric is 2.19; this relates to the 5.01% sickness absence for the quarter ending September-25 as the methodology used represents a quarter of aggregated monthly figures.

Actions

Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
5.35%	5.16%	4.72%	4.99%	5.15%	4.81%	4.91%	5.68%	5.06%	5.12%	5.72%	5.45%	4.25%

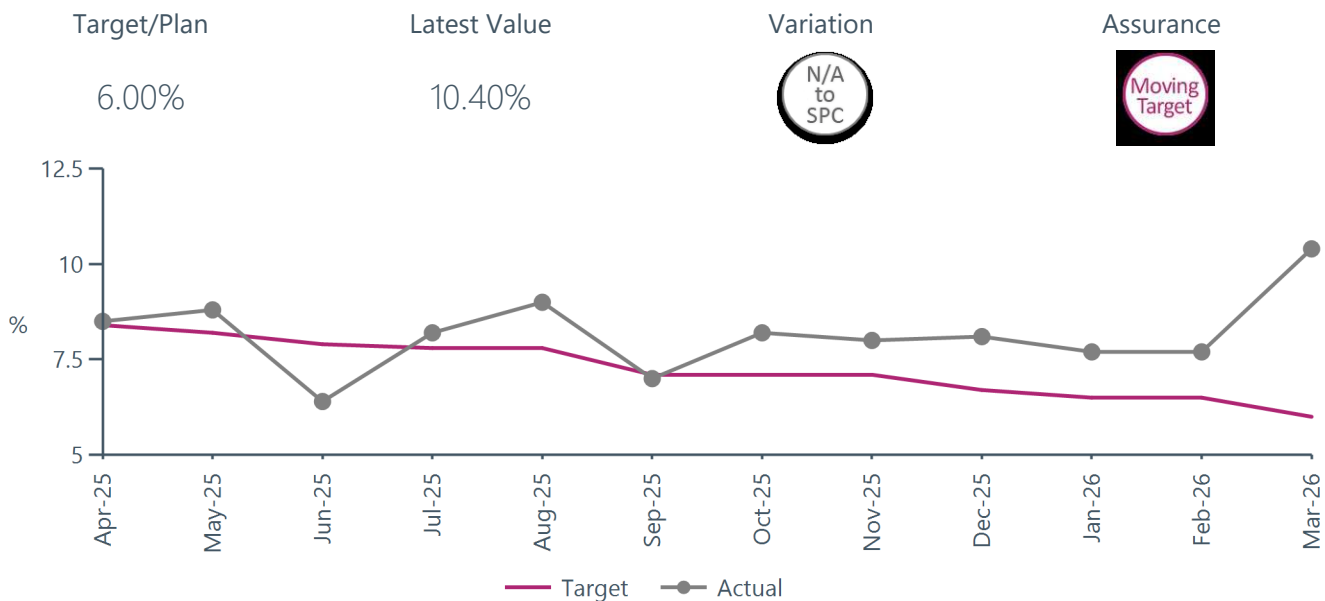
- Staff - Patients - Finances -

Exec Lead
 Chief People Officer

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 10.1%, which is 4.4% adverse to plan.

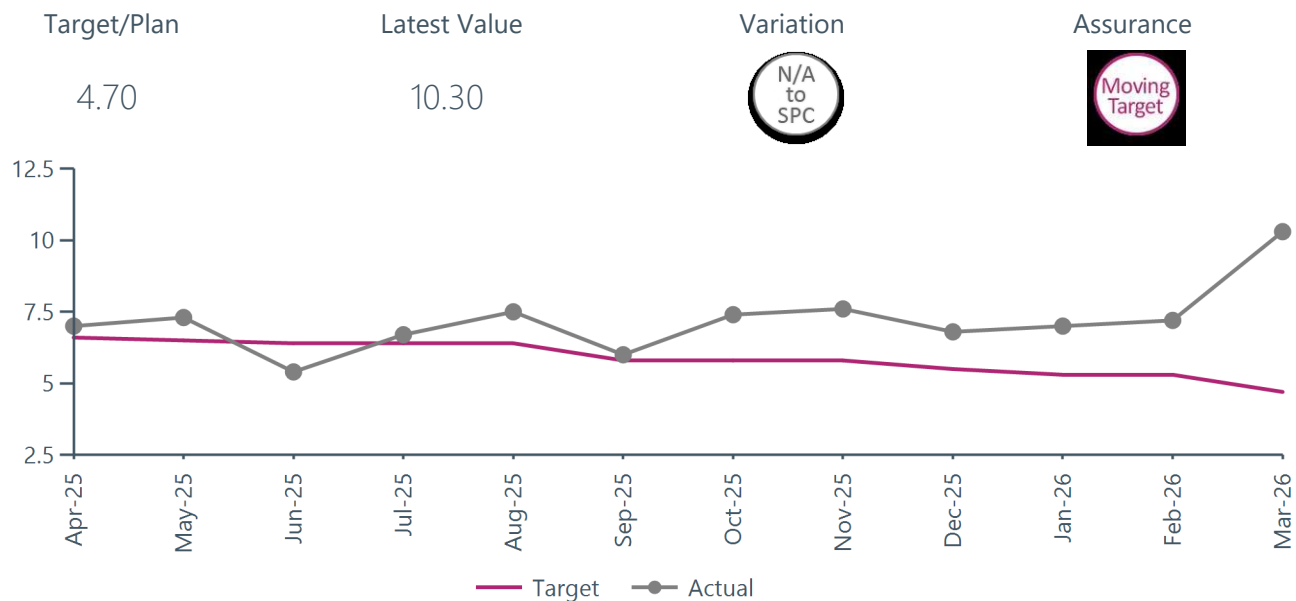
Actions

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

Bank Spend against Plan

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

Exec Lead
 Chief Finance & Commercial Officer



What these graphs are telling us
 This measure is not appropriate to display as SPC. Metric has a moving target.

Narrative

Bank usage 10.3% of total pay plan in month, 5.6% adverse to plan.

Actions

Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	7	7	5	6	7	6	7	7	6	7	7	10

Chair's Assurance Report People and Culture Committee

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 06 May 2026

Author:

Name: Amber Scott
Role/Title: Executive Assistant

Contributors:

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Report sign-off:

Paul Maubach, Chair of the People and Culture Committee

Is the report suitable for publication?:

Yes

1. Key issues and considerations:

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

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

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

This report provides a summary of the items considered at the Committee meeting held on 23 April 2026 and 19 March 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 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 following strategic themes, as outlined in the Board Assurance Framework, are overseen by this Committee. The relevant themes, and the Committee’s overall level of assurance on their delivery is:

Assurance framework themes	Relevant	Overall level of assurance
1 <i>Continued focus on excellence in quality and safety.</i>	×	
2 <i>Creating a sustainable workforce.</i>	✓	STRONG
3 <i>Delivering the financial plan.</i>	×	
4 <i>Delivering the required levels of productivity, performance and activity.</i>	×	

Chair's Assurance Report People and Culture Committee

Assurance framework themes		Relevant	Overall level of assurance
5	<i>Delivering innovation, growth and achieving systemic improvements.</i>	×	
6	<i>Responding to opportunities and challenges in the wider health and care system.</i>	×	
7	<i>Responding to a significant disruptive event.</i>	×	

3. Assurance Report from 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.

Statutory and Mandatory Training Policy – thresholds and consequences for non-compliance (including bank staff): While overall compliance is high (91.5%), bank staff compliance remains lower (83.7%). The Committee agreed the revised policy needs clearer thresholds/actions (including when shifts should be restricted for non-compliance in critical training) before final approval.

Integrated Performance Report Annual Review (April): The Committee supported proposed adjustments to sickness and turnover targets (alignment with the operational plan and turnover target set using the mean of the past two years), subject to any national requirements. The Board endorsed the proposal for 2026/27 for approval by the Board.

Premium cost pressures – bank spend (April): Bank spend was £956k in-month (£500k adverse to plan), driven mainly by RTT delivery. The Board is asked to note the ongoing in-year pressure and the expectation that any overspends are clearly justified and monitored for impact on quality/safety.

Job Planning Compliance (April): Level of attainment for E-Job Planning reported at level 1 with 89.77% of employees with an active job plan. An implementation plan is currently in development to address adherence with levels 2, 3 and 4.

GMC National Training Survey Overall Performance (March): The Trust performed above the national average in the majority of domains, including overall satisfaction, clinical supervision, educational supervision, and local teaching.

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:

Board Assurance Framework (April): Revised descriptors and risk scoring were reviewed and the Committee is content with the proposed approach and score rationale. Further work is underway to update assurance measures so they align with the new organisational development (OD) agenda (moving beyond recruitment/retention measures). This is being presented to the private Board for further discussion ahead of approval

Workforce performance – sickness absence (April): Sickness absence reduced to the lowest level in the financial year. Monitoring continues for both short- and long-term cases, supported by a departmental deep dive to identify effective interventions. The Committee requested further analysis of anxiety/stress/depression-related absence (including the extent of work-related cases) and

Chair's Assurance Report People and Culture Committee

demographic insights (e.g., age profile) for targeted interventions. A workstream is in place to benchmark sickness absence performance and review policies/approaches used by high-performing trusts.

Healthcare Support Worker (HCSW) vacancies and establishment review (April): Persistent vacancy levels remain a pressure. The Committee requested a timeline to reach low/zero vacancies and noted that applicant quality and pay dynamics affect progress. Biannual staffing reviews will be undertaken to confirm establishment levels remain appropriate and reflect operational need.

Bank/agency usage and impact on safety (April): Planned reductions in HCSW bank usage will be monitored carefully to ensure safe staffing is maintained. The Committee agreed that overly rapid reductions could compromise flexibility and quality/safety.

10 Point Plan for resident doctors – compliance trajectory (April): Current compliance is 82% (top quartile benchmarked against peers). Remaining gaps are process-driven (e.g., annual leave/payroll/study leave processes) and are expected to be resolved ahead of the next intake; progress will continue to be monitored.

Staff survey action plan (April): The Committee supported the approach focused on local ownership and managerial accountability and requested future updates demonstrate measurable impact and outcomes, not solely activity.

Well-led action plan (April): Progress is being tracked with evidence of completion; updates will be provided every two months with the expectation all actions complete by the end of the calendar year.

Committee effectiveness and Terms of Reference (April): Annual review indicates improvement year-on-year. Terms of Reference will be updated to include education strategy, system engagement, and explicit reference to Freedom to Speak Up, and remove outdated references and presented to the Board for approval in due course.

Workforce Data Quality and Assurance Risks (March): Concerns were raised regarding the accuracy and reliability of workforce metrics, particularly job planning (particularly in relation to rheumatology) and e-rostering attainment figures. The Committee discussed the impact of false positive assurance being reported to the Board and requested a review to strengthen data quality and validation processes. Since the discussion, the Board has received an update on the reporting and an explanation received on the triangulation of data.

Communications Risks and Governance (March/April): In March, the Committee noted significant weaknesses in the Trust's current communications approach, including a largely reactive model, lack of stakeholder mapping, and limited strategic oversight. Of particular concern is the internal Facebook group, which was identified as posing legal and reputational risks due to insufficient moderation and unclear governance. The executive team has committed to taking action and providing assurance. The Committee received an update in April and Early engagement following the communications review and organisation development planning indicates positive executive buy-in and clear direction of travel was shared.

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.

Premium cost – agency spend: Agency spend was £76k favourable to plan in-month and £642k favourable year-to-date. The proposed agency cap for 2026–27 (£1.033m) was noted as achievable.

Oversight of bank and agency requests: Assurance was provided that bank and agency requests are scrutinised weekly to confirm necessity.

Chair's Assurance Report People and Culture Committee

Safe staffing: Assurance was provided that safe staffing levels are being maintained for registered and unregistered staff, with appropriate use of bank to support safe care.

EDI policy: The Committee ratified the EDI policy (including updates on redeployment and inclusive language) and received assurance on implementation, including practical examples of reasonable adjustments.

Guardian of Safe Working Hours: No exception reports were received; ongoing scrutiny continues to provide assurance.

Policy Approvals (March / April): The Committee reviewed and approved:

- Disciplinary Policy, including strengthened processes and clearer guidance,
- Minimum Periods of Notice Policy with no material changes,
- EDI Policy, subject to formatting improvements

Further confirmation is being given to the Statutory and Mandatory Training Policy and the Study Leave Policy following a review by the Committee

RADAR System Implementation (March): The transition to the RADAR system for risk management has been successfully implemented, with no immediate concerns identified.

Recommendation

The Board is asked to:

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

Safe Working Hours Report

(Part 1) Covering paper

Committee / Group / Meeting, Date	
Board of Directors – Public Meeting, 06 May 2026	
Author:	Contributors:
Name: Chris Marquis Role/Title: Trust Lead	Name: N/A Role/Title: N/A
Report sign-off:	
Name: Dr Ruth Longfellow, Chief Medical Officer People and Culture Committee, 23 April 2026	
Is the report suitable for publication?:	
YES	
Executive Summary:	
<p>As part of the 2016 Terms and Conditions for Resident Doctors, it was agreed that additional safeguards would be introduced to protect the working hours of doctors in training. This included the establishment of a Guardian of Safe Working, responsible for championing safe working practices and providing assurance to the Board on compliance with these safeguards.</p> <p>The Trust has an appointed Guardian of Safe Working, and this paper presents the April 2026 annual report. The report summarises the work undertaken to date, highlights the key challenges currently being experienced, and provides available data on rota vacancies, as well as agency and locum usage. The format has been updated to align with the latest national standards.</p> <p>The Trust has had no exception reports.</p> <p>The Trust continues to work hard to fulfil its responsibilities under the terms of the new resident doctors' contract and based on available information and assessments appear to be compliant.</p>	
Recommendations:	
<p>Following consideration at the People and Culture Committee, the Board is asked to:</p> <ul style="list-style-type: none"> • CONSIDER the content of the report • CONFIRM the level of assurance received from the report - 	

(Part 2) Strategic alignment and supporting detail

Strategic objectives and associated risks:

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

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

Providing assurance that doctors work within safe limits and identifying issues early through exception reporting. This strengthens patient safety, supports a stable and engaged medical workforce, and gives the Board confidence that clinical services are delivered safely, effectively, and in line with national standards.

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

Safe Working Hours Report

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	
Providing assurance that doctors work within safe limits and identifying issues early through exception reporting. This strengthens patient safety, supports a stable and engaged medical workforce, and gives the Board confidence that clinical services are delivered safely, effectively, and in line with national standards.		

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	✓
Ensures the Trust is held to account so that staff consistently uphold the organisation's values.		

Report development and engagement:

The report is presented to the People and Culture Committee for assurance ahead of presentation at the Board of Directors public meeting.

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

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

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

The Guardian will:

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

Safe Working Hours Report

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

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

Other new features of the 2016 contract include:

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

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

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

3.2 Guardian of Safe Working Report

3.2.1 High level data

For the period January 2026

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

3.2.2 Number of exception reports submitted

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

3.2.3 Categories of exception report submitted

Type of exception report	Outcome	Number of exception reports
--------------------------	---------	-----------------------------

Safe Working Hours Report

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

3.2.3 Experiences of actual or threatened detriment

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

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

Safe Working Hours Report

3.2.4 Withdrawals

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

Number of exception reports withdrawn over the last quarter	0
---	---

3.2.5 Access to individual doctors' exception reporting data

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

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

Number of exception reports disclosures over the last quarter	0
---	---

3.2.6 Work schedule reviews

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

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

3.2.7 Resident Doctor Agency and Locum usage and Rota Vacancy Report

Trauma and Orthopaedics

Number of vacancies

Jan 26	3
Feb 26	0
Mar 26	0

Vacant shifts

Jan 26	14
Feb 26	4
Mar 26	6

Total cost - £26490

Safe Working Hours Report

Medicine

Number of Vacancies

Jan 26	0
Feb 26	0
Mar 26	0

Vacant shifts

Jan 26	0
Feb 26	6
Mar 26	4

Total Cost £5910

MCSI

Number of Vacancies

Jan 26	0
Feb 26	0
Mar 26	0

Vacant Shifts

Jan 26	2
Feb 26	2
Mar 26	8

Total cost - £900

3.2.5 Fines

The Trust has received no fines in relation to this area of work.

Safe Working Hours Report

3.2.6 Annual report requirements

3.2.7 Work schedule reviews relating to education and training

Number of work schedule reviews related to education and training	0
---	---

3.2.8 Rota gaps

Total number of rota gaps on all shifts over the last year	214
--	-----

3.3 Challenges

3.3.1 Adapting to new resident doctor roles

The number of resident doctors and their roles in the Trust have increased. This has required departments to review their roles and responsibilities to them, while working collaboratively with our colleagues at SATH.

Oversight of all resident doctor positions in the Trust with clear points of contact and communication lack clarity.

3.3.2 Weekend work and cover

Increased volume of weekend work, combined with new IT systems is leading to concern regarding volume of work and duplication of effort. Initial meetings and fact finding have occurred and further meetings with the involved parties will take place.

3.3.3 RDF

RDF format is being updated to reflect national trends. Format and updated TOC will be established.

3.4. Conclusion

The Trust has had no exception reports.

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

Christopher Marquis

Guardian of Safe Working

Executive Summary - Finance & Performance Committee

Assurance



Will consistently pass the target if nothing changes



Will not consistently pass or fail the target if nothing changes



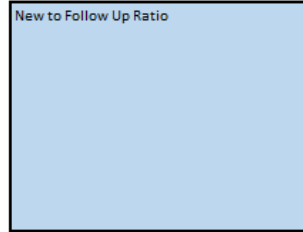
Will consistently fail the target if nothing changes



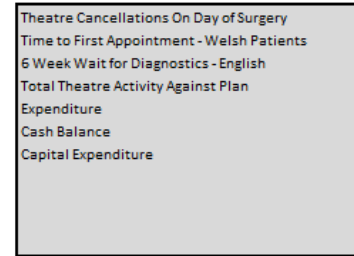
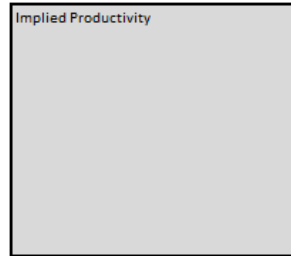
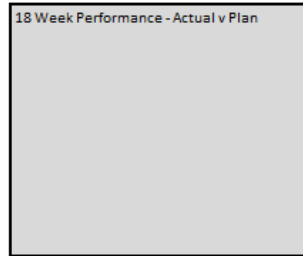
No Target or Moving Target



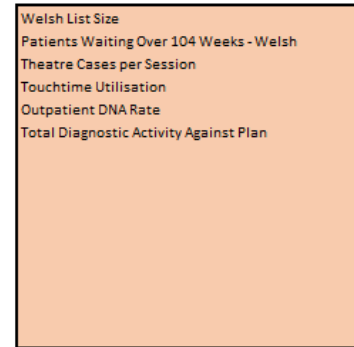
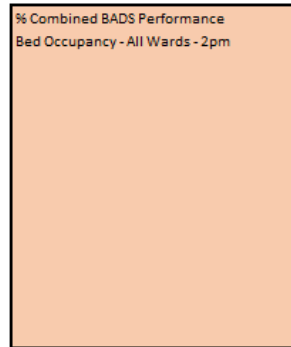
Improving variation (high or low) or 3 months better than target



No significant change or N/A to SPC



Concerning variation (high or low) or 3 months off target



Variation

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

Metric placed in boxes above based on the variation icon for latest data point, but over-ridden by whether meeting/failing target for last three months.

If metric placed in a box based on meeting/failing plan, but does show improvement or deterioration - text colour will indicate that.

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Trust Board - Performance

March 2026 – Month 12



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:

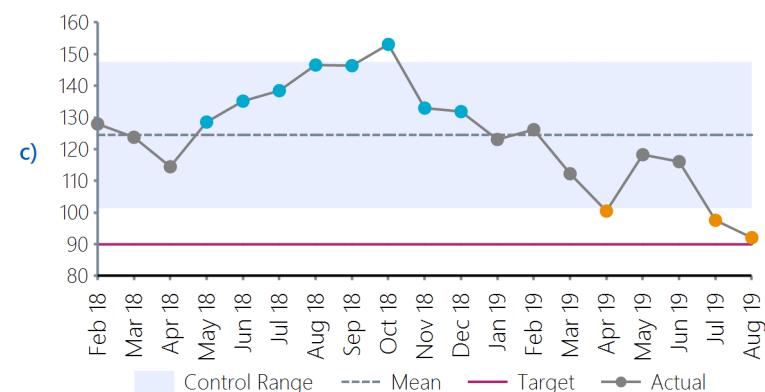
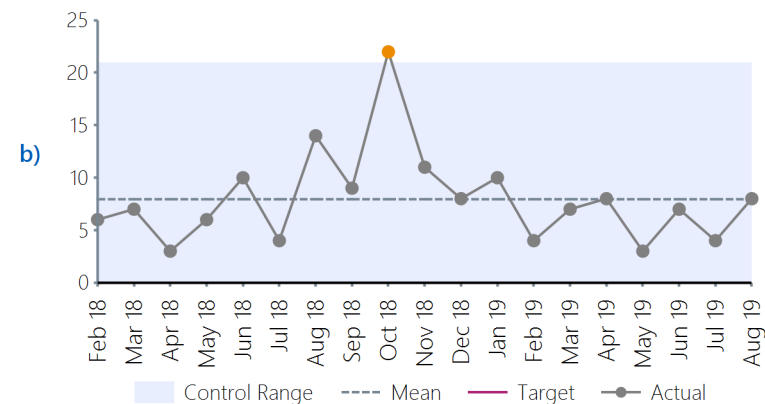
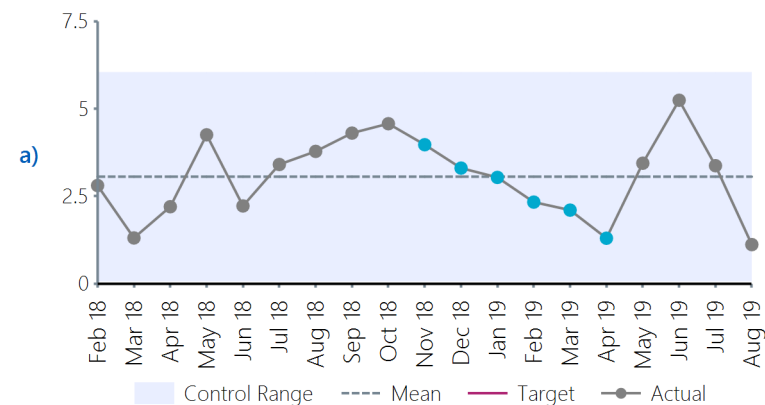
- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of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

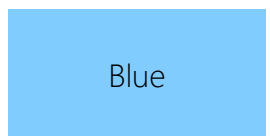
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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



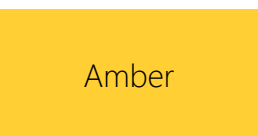
Blue

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.

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Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
31 Day General Treatment Standard*	96.00%	100.00%					
62 Day General Standard*	85.00%	66.67%	100.00%			+	12/09/23
28 Day Faster Diagnosis Standard*	77.00%	78.72%	89.19%				
18 Weeks RTT Open Pathways	60.02%	62.15%				+	24/06/21
18 Week Performance - Difference Between Planned and Actual	0.00%	2.13%				+	
Time to First Appointment - English Patients	67.40%	76.05%				+	
Time to First Appointment - Welsh Patients		47.24%				+	
% of Patients Waiting Over 52 Weeks - English	1.00%	1.80%				+	
Patients Waiting Over 104 Weeks - Welsh (Total)		341				+	
6 Week Wait for Diagnostics - English Patients	95.00%	96.70%	100.00%			+	04/03/24



Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
8 Week Wait for Diagnostics - Welsh Patients	100.00%	98.49%				+	04/03/24

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Summary - Caring for Finances

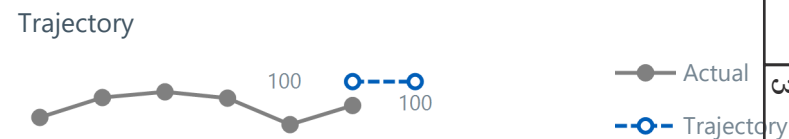
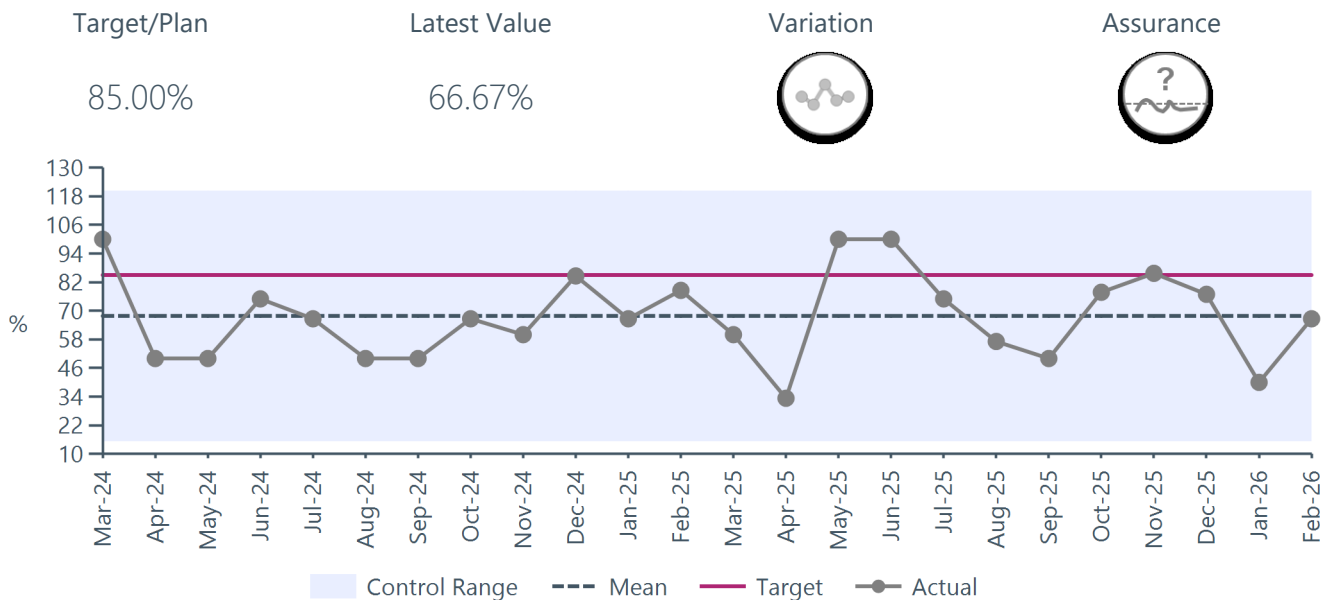
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Elective Activity Against Plan (volumes)	1,248	1,511				+	24/06/2
% Combined BADS Performance	85.00%	41.10%				+	
Total Outpatient Activity against Plan (volumes)	15,078	15,441				+	24/06/2
Total Outpatient Activity - % Moved to PIFU Pathway	6.60%	7.60%				+	
Total Diagnostics Activity against Plan - Catchment Based	2,957	2,791				+	

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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 66.67% in February; this is reported in arrears. There were three patients who breached the standard with reasons outlined below:
 * Patient was being worked up for a trial at another provider and was considering egg harvesting before chemotherapy commenced; other Trust did not record an adjustment for this.
 * Complex diagnostic pathway - Original plan was for ultrasound scan that was then changed to MRI. Tru-cut biopsy and MDT as part of GMOSS. Patient required joint appointment with plastics and oncology at another provider to plan the necessary treatment.
 * Patient needed to attend third provider in pathway for a PET scan before treatment could be planned which had a 10 day turnaround for the result.

Actions

Actions with Service Manager and Assistant Service Manager in relation to breach reasons:
 * Meeting held with Cancer Programme Lead for Shropshire to discuss late referrals from other Trusts. They are going to liaise with ICBs to ensure GPs are informing patients that they are on a cancer pathway and the importance of attending appointments. The Shropshire Lead also agreed to look into late referrals from other Trusts and felt assured that RJAH were doing all they could for each patient.
 * This will be continue to be monitored by Service Leads to assess for any improvements or requirement to escalate further.

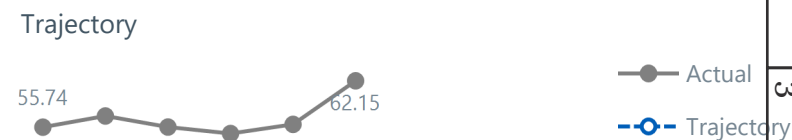
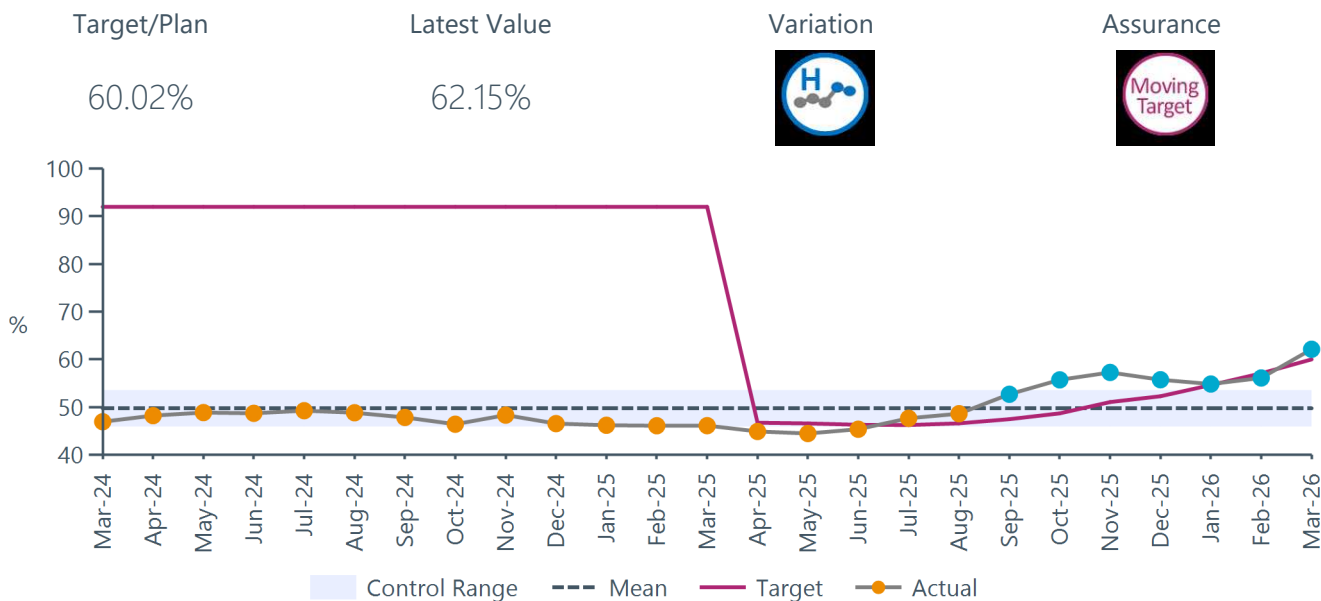
Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
60.00%	33.33%	100.00%	100.00%	75.00%	57.14%	50.00%	77.78%	85.71%	76.92%	40.00%	66.67%	

- Staff - Patients - Finances -

18 Weeks RTT Open Pathways

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

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

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

Our March performance was 62.15% for patients waiting 18 weeks or less to start their treatment; exceeding the Q4 stretch target set at 62.02%. 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 December scored the Trust at 3.45.

The performance breakdown by milestone is as follows:

- * MS0 - 110 patients of which 0 are breaches
- * MS1 - 8043 patients waiting of which 1925 are breaches
- * MS2 - 1209 patients waiting of which 690 are breaches
- * MS3 - 4719 patients waiting of which 2715 are breaches

Actions

As we transition into the 2026/27 financial year, plans have been revised and submitted to NHSE forecasting the Trust working towards 67% for its 18 Weeks Waits by the end of the financial year.

A strategy session is being held on 21st April that will encompass:

- * Internal ambitions with sub-speciality level targets
- * Approach to reducing 1st Outpatient Waits below 18 weeks (which will have a negative impact on the overall 18-week performance in the short term)
- * 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

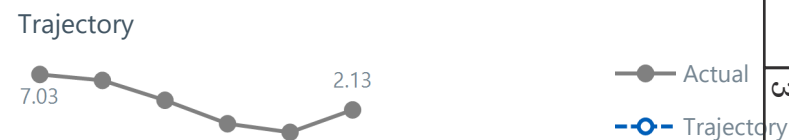
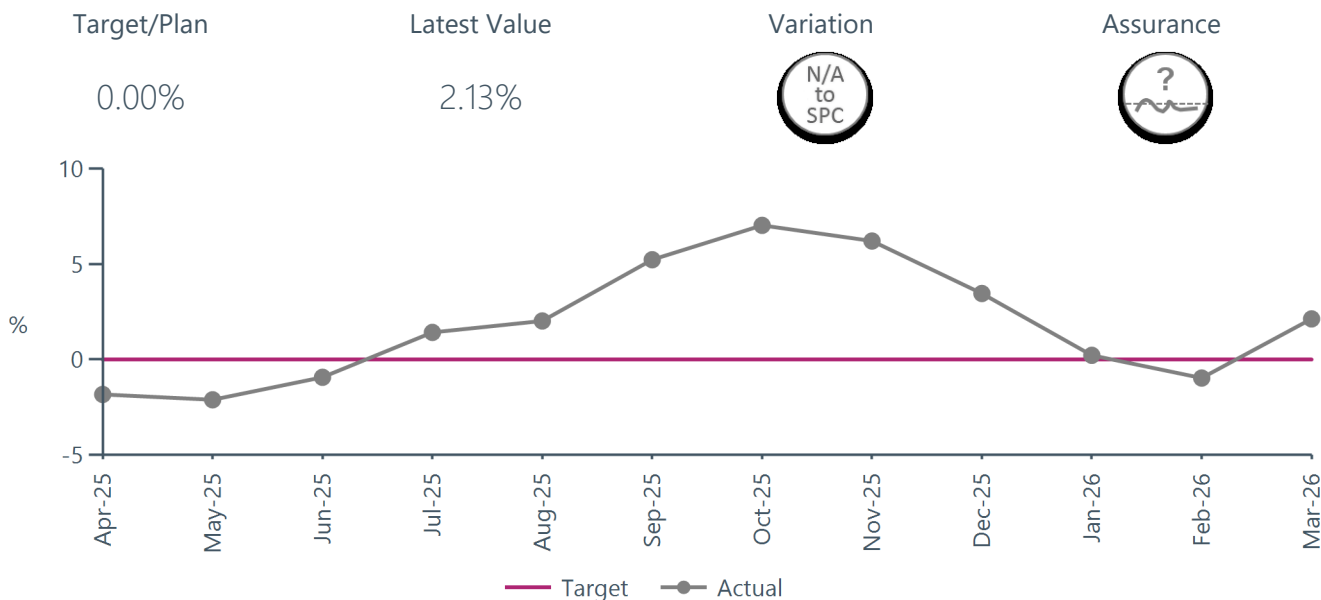
Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
46.14%	44.92%	44.49%	45.39%	47.68%	48.64%	52.72%	55.74%	57.29%	55.76%	54.86%	56.13%	62.15%

- 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 3 where the NOF score for this metric is 1; this reflected the December-25 position where the Trust was 3.46% better than it planned to be.

At the end of March, the position reported for month end is 62.15%; above the plan of 60.02%. This position also exceeds the Q4 stretch target of 62.02%.

Actions

As we transition into the 2026/27 financial year, plans have been revised and submitted to NHSE forecasting the Trust working towards 67% for its 18 Weeks Waits by the end of the financial year.

- A strategy session is being held on 21st April that will encompass:
 - * Internal ambitions with sub-speciality level targets
 - * Approach to reducing 1st Outpatient Waits below 18 weeks (which will have a negative impact on the overall 18-week performance in the short term)
 - * 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

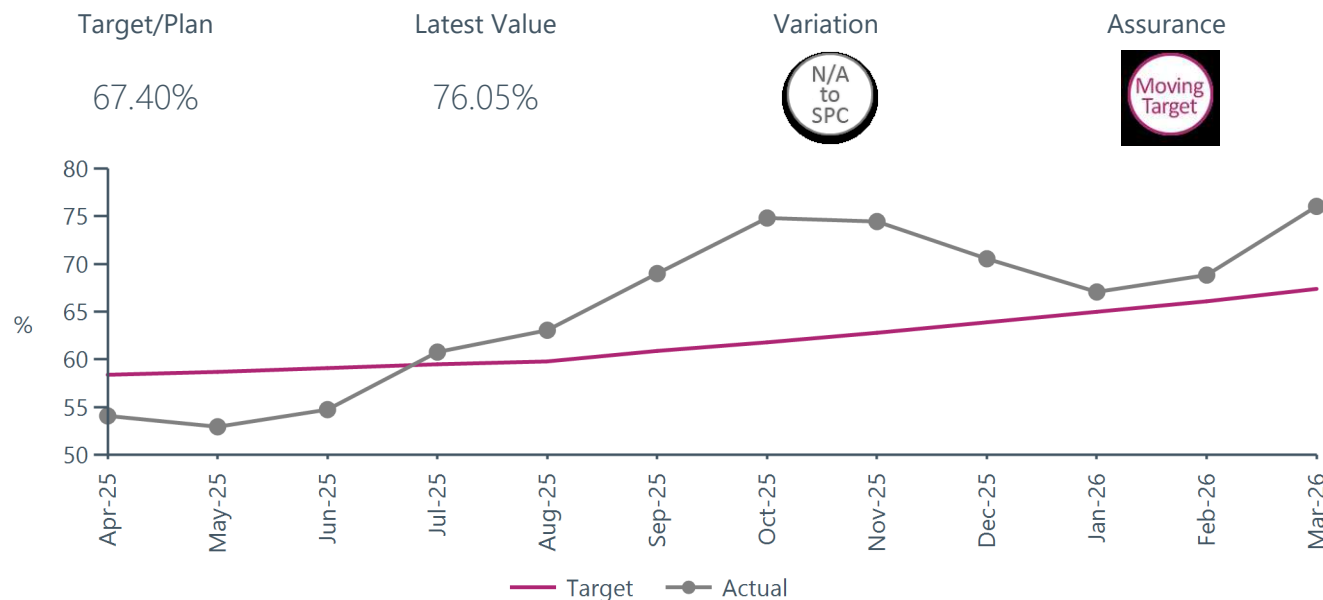
Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	-1.83%	-2.11%	-0.93%	1.42%	2.02%	5.23%	7.03%	6.21%	3.46%	0.22%	-0.97%	2.13%

- Staff - Patients - Finances -

Time to First Appointment - English Patients

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

Exec Lead
Chief Operating Officer



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 29th March 2026. NHSE Guidance stipulates the week ending positions we should officially report that fall closest to month end. This is an unvalidated position.

2026/26 English National Planning Guidance stipulates that every organisation should improve their 18-weeks for a first appointment performance by 5% as a minimum and all Trusts to achieve 67%. The Trust began at a position of 54.09% at the end of April-25 and there has been 21.96% improvement on this.

For week ending 29th March 76.05% of patients waiting for first appointment were under 18 weeks; 8.65% above the 67.40% plan. The data is reviewed at the weekly Outpatient Activity meeting at sub-speciality level. Performance ranges from 46.23% in Spinal Disorders to 100% in Muscle, Neurophysiology, Occupational Therapy, Orthotics and Tumour.

Actions

As we transition into the 2026/27 financial year, plans have been revised and submitted to NHSE forecasting the Trust working towards 67% for its 18 Weeks Waits by the end of the financial year.

A strategy session is being held on 21st April that will encompass:

- * Internal ambitions with sub-speciality level targets
- * Approach to reducing 1st Outpatient Waits below 18 weeks (which will have a negative impact on the overall 18-week performance in the short term)
- * 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

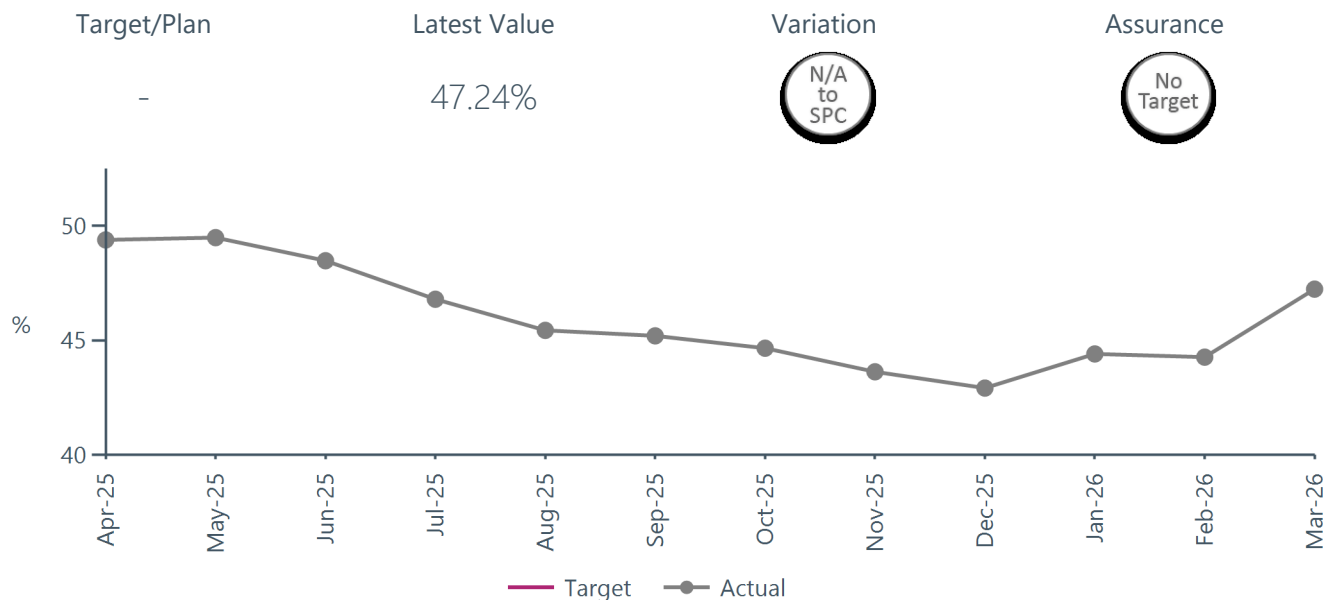
Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	54.09%	52.95%	54.75%	60.78%	63.07%	69.01%	74.83%	74.46%	70.56%	67.08%	68.85%	76.05%

- Staff - Patients - Finances -

Time to First Appointment - Welsh Patients

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

Exec Lead
Chief Operating Officer



What these graphs are telling us

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

Narrative

This metric focuses on the time to first appointment waiting for first event and of those patients, the % waiting less than 18 weeks. The reported position is taken from the Waiting List MDS position for week ending 29th March 2026. NHSE Guidance stipulates the week ending positions we should officially report that fall closest to month end. This is an unvalidated position. This metric forms part of English expectations.

For week ending 29th March 47.24% of Welsh patients waiting for first appointment were under 18 weeks; there is no plan for Welsh patients. Performance ranges from 26.24% in Spinal Disorders to 100% in Neurophysiology, Occupational Therapy, Orthotics and Physiotherapy. The position has now improved for three consecutive months.

This metric will be removed from the IPR next month, being replaced by monitoring time to 1st appointment to 26 weeks for Welsh patients instead.

Actions

As we transition into the 2026/27 financial year, plans have been revised and submitted to NHSE forecasting the Trust working towards 67% for its 18 Weeks Waits by the end of the financial year.

A strategy session is being held on 21st April that will encompass:

- * Internal ambitions with sub-speciality level targets
- * Approach to reducing 1st Outpatient Waits below 18 weeks (which will have a negative impact on the overall 18-week performance in the short term)
- * 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

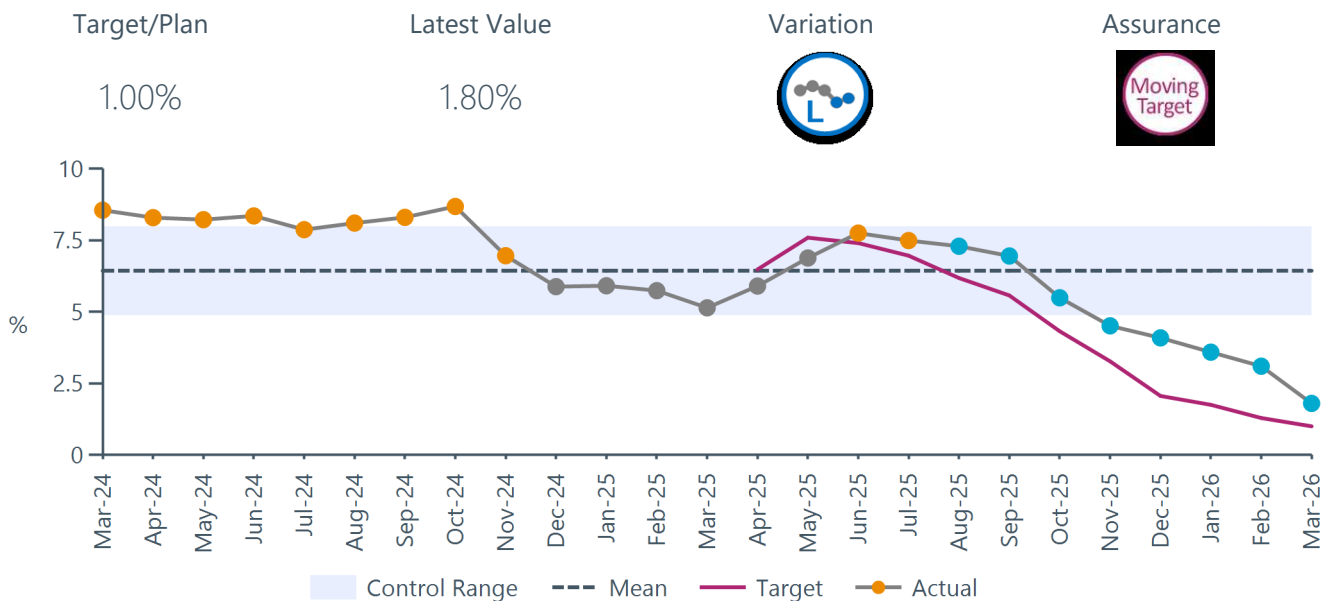
Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	49.39%	49.49%	48.48%	46.80%	45.44%	45.20%	44.66%	43.63%	42.92%	44.41%	44.27%	47.24%

- 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



Trajectory



What these graphs are telling us

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

Narrative

2025/26 English National Planning Guidance stipulates that every organisation should reduce the volume of patients waiting over 52 weeks to <1% of their list size. The Trust's Operational Plan forecast a position of 1% for the year-end. At the end of March, 254 patients were waiting over 52 weeks, this equates to 1.80% of the English list size. As shown on the SPC above, there has been a period of sustained improvement since August where at that time there were 1239 patients waiting over 52 weeks.

Patients waiting, by weeks brackets is:

- * >52 to <=65 weeks - 223 patients
- * >65 to <=78 weeks - 26 patients
- * >78 weeks to 5 patients
- * No patients waiting over 104 weeks

This metric is part of the NOF, with the latest score for Quarter 3 reported at 3.85 for the December month end position of 4.09%.

Actions

As we transition into the 2026/27 financial year, plans have been revised and submitted to NHSE forecasting the Trust working towards 67% for its 18 Weeks Waits by the end of the financial year.

A strategy session is being held on 21st April that will encompass:

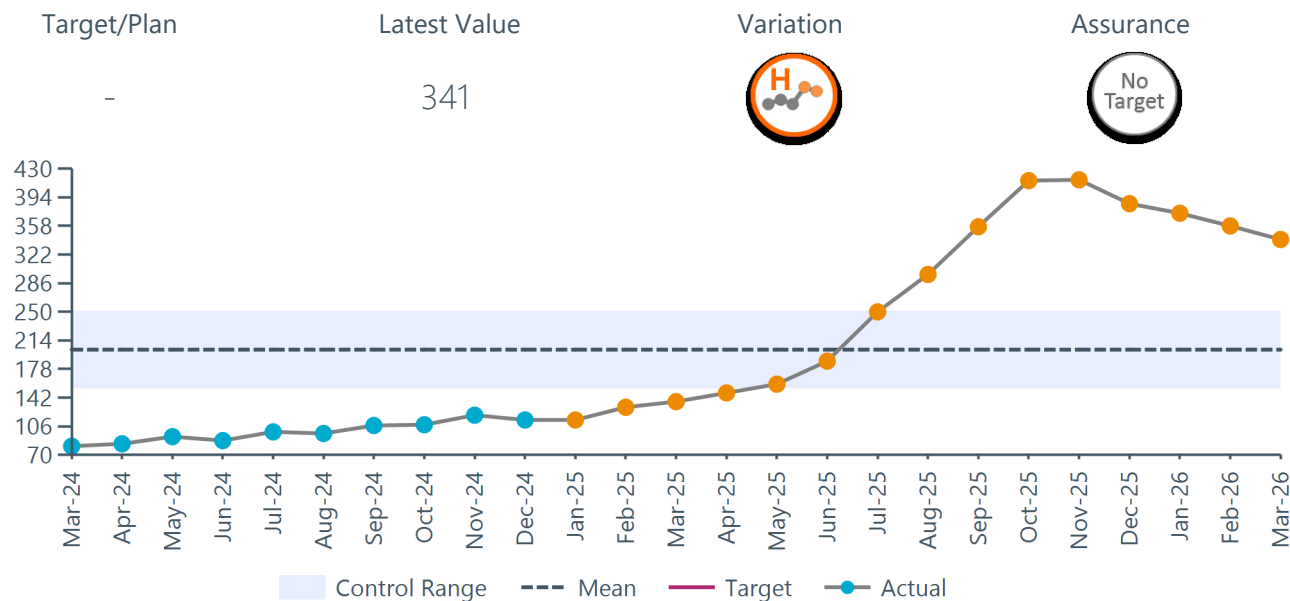
- * Internal ambitions with sub-speciality level targets
- * Approach to reducing 1st Outpatient Waits below 18 weeks (which will have a negative impact on the overall 18-week performance in the short term)
- * Prioritisation of Welsh 104+ and English 52+ waits
- * Exploring the inclusion of a Health Inequalities lens within the Trust's waiting list recovery
- * Applying productivity improvements from recent reviews

Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
5.14%	5.90%	6.88%	7.75%	7.49%	7.29%	6.95%	5.49%	4.51%	4.09%	3.59%	3.10%	1.80%

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 March there were 341 Welsh patients waiting over 104 weeks. This peaked at 416 patients at the end of November but as shows above, there has been a gradual decrease each month since.

The patients are under the care of these sub-specialities; Spinal Disorders (184), Arthroplasty (44), Knee & Sports Injuries (43), Foot & Ankle (42), Hand & Upper Limb (13), Veterans (5), Neurology (4), Neurophysiology (3) and Paediatric Orthopaedics (3).

Actions

As we transition into the 2026/27 financial year, plans have been revised and submitted to NHSE forecasting the Trust working towards 67% for its 18 Weeks Waits by the end of the financial year.

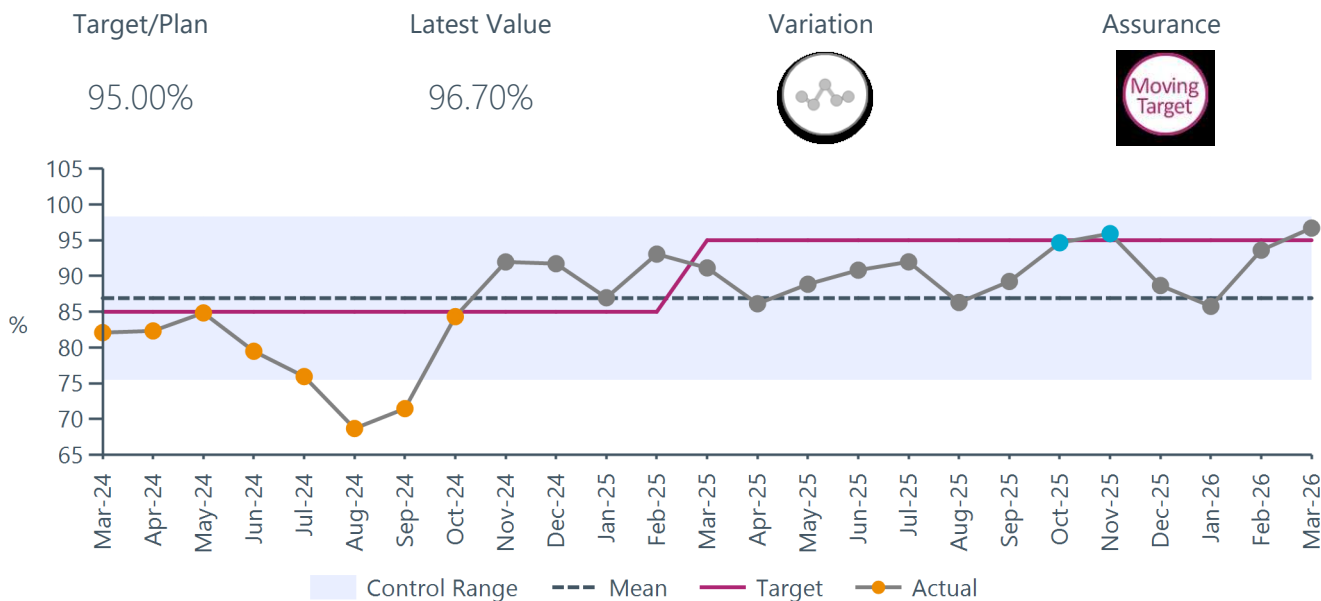
- A strategy session is being held on 21st April that will encompass:
- * Internal ambitions with sub-speciality level targets
 - * Approach to reducing 1st Outpatient Waits below 18 weeks (which will have a negative impact on the overall 18-week performance in the short term)
 - * Prioritisation of 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

Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
137	148	159	188	250	297	357	415	416	386	374	358	341

6 Week Wait for Diagnostics - English Patients

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

Exec Lead
Chief Operating Officer



Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. Metric has a moving target.

Narrative

March performance was 96.70%, above the 95% standard and the first month all modalities exceeded target, though still below the 100% trajectory in the Operational Plan.

There were 37 breaches, including 3 over 13 weeks, all in MRI.

Performance and breaches by modality:

* MRI - 95.86% - D2 (Urgent - 0-2 weeks) - 4 with 3 dated, D4 (Routine - 6-12 weeks) - 24 with 7 dated

* CT - 97.69% - D4 (Routine - 6-12 weeks) - 3 dated

* Ultrasound - 98.01% - D2 (Urgent - 0-2 weeks) - 2 with 1 dated, D4 (Routine - 6-12 weeks) - 4 with 2 dated

* DEXA - 100%

None of the modality activity plans were met in March.

National target - 0 patients waiting over 13 weeks by end of September 2024 and 95% against the 6-week standard within all modalities.

Actions

Across our commissioners, there were 44 breaches in total (37 English, 7 Welsh). 48% of these breaches were linked to two key themes:

* Midlands Centre for Spinal Injuries (MCSI) patient transfers (10 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.

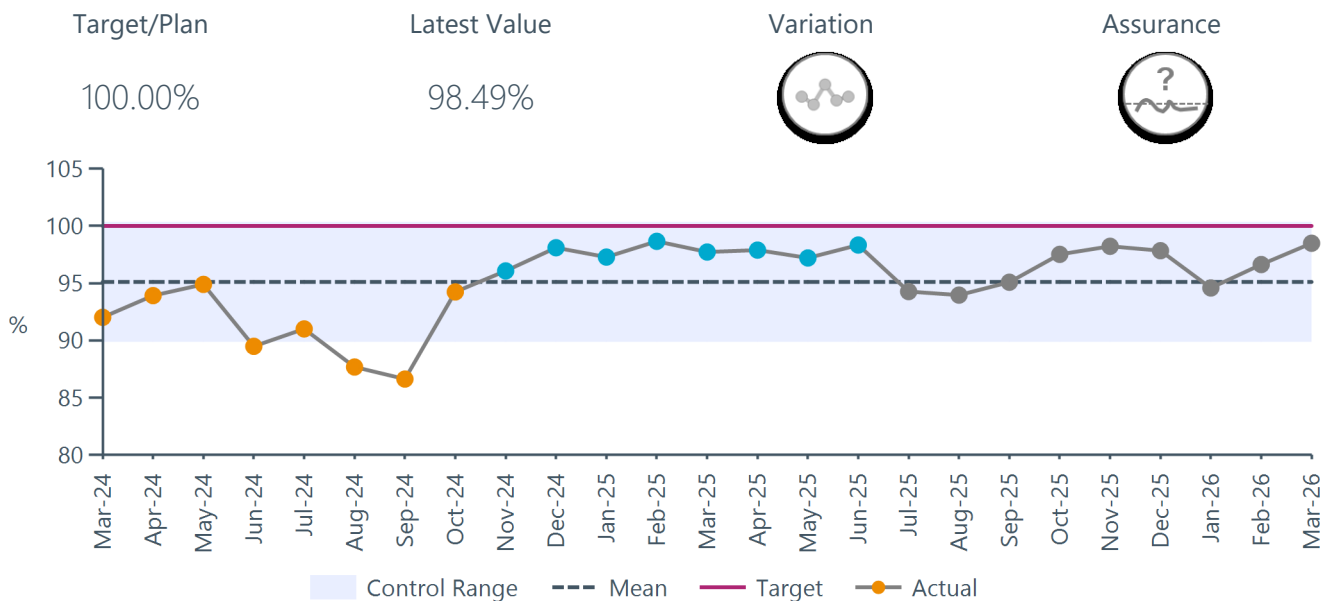
* Booking delays (11 breaches) — Newly recruited staff within the booking team are now in post and undergoing initial training to improve booking turnaround times and minimise delays.

Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
91.13%	86.13%	88.85%	90.82%	91.98%	86.30%	89.24%	94.65%	95.93%	88.67%	85.77%	93.61%	96.70%

8 Week Wait for Diagnostics - Welsh Patients

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

Exec Lead
Chief Operating Officer



What these graphs are telling us

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

Narrative

The 8-week standard for diagnostics is reported at 98.49%. The reporting position includes 7 patients who waited beyond 8 weeks.

Performance and breaches by modality:

* MRI - 98.38% - D2 (Urgent - 0-2 weeks) - 3 with 2 dated, D4 (Routine - 6-12 weeks) - 12 with 11 dated

* CT - 100%

* Ultrasound - 98.31% - D2 (Urgent - 0-2 weeks) - 1 undated

* DEXA Scans - 100%

None of the modality activity plans were met in March.

Actions

Across our commissioners, there were 44 breaches in total (37 English, 7 Welsh). 48% of these breaches were linked to two key themes:

* Midlands Centre for Spinal Injuries (MCSI) patient transfers (10 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 (11 breaches) — Newly recruited staff within the booking team are now in post and undergoing initial training to improve booking turnaround times and minimise delays.

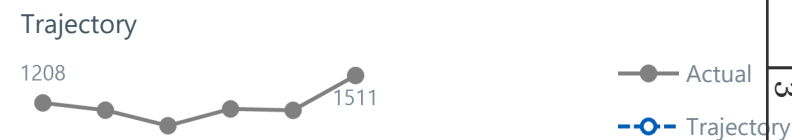
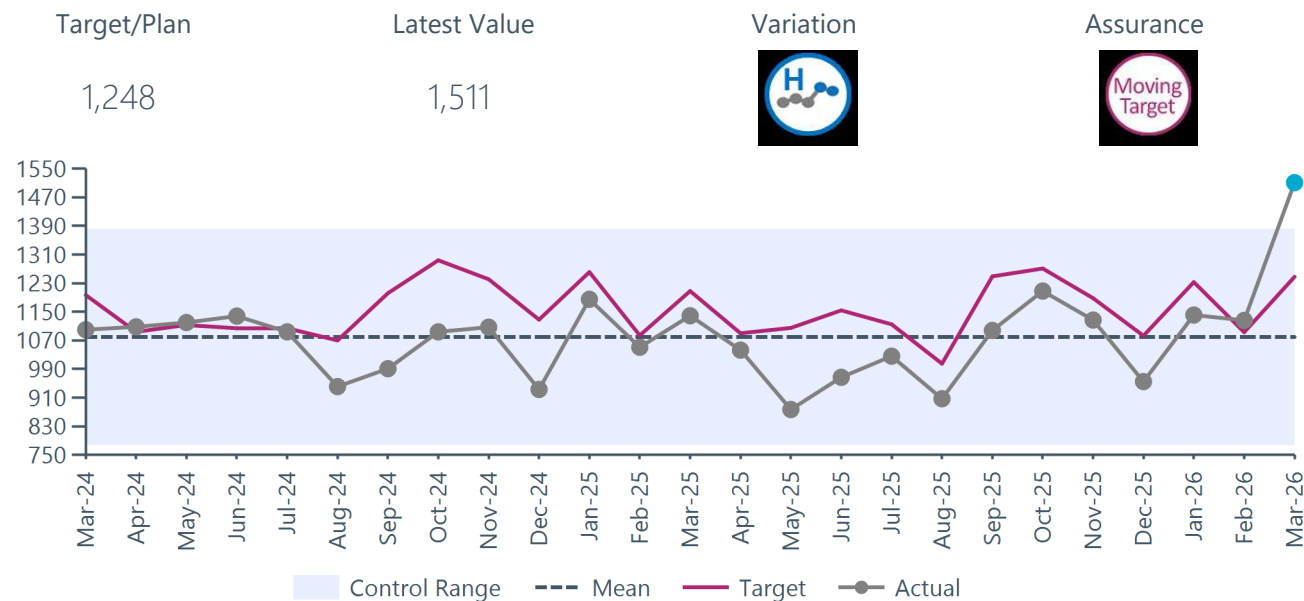
Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
97.72%	97.89%	97.20%	98.33%	94.27%	93.96%	95.09%	97.52%	98.22%	97.84%	94.58%	96.63%	98.49%

- Staff - Patients - Finances -

Elective Activity Against Plan (volumes)

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

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

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

In March, the Trust planned for 1,248 elective spells and delivered 1,511 spells, achieving 121.07% of plan and delivering 263 spells above target.

March's exceptional performance, exceeding plan by 21%, sits above the upper control limit, indicating the presence of special cause variation. Several factors contributed to this result. Increased session capacity within Theatres (108.92% of plan) enabled a higher volume of cases to be undertaken (102.15% of NHS plan), with notable increases across Arthroplasty, Hand & Upper Limb, Knee & Sports Injuries, Spinal Disorders, Spinal Injuries, and Foot & Ankle specialties. In addition, the provision of extra infusion clinics for Metabolic Medicine during March contributed to improved elective performance, with 194 more discharges than planned in month.

As shown in the graph, March achievement represents the highest activity volume of the reporting period and provides clear evidence of special cause variation of an improving nature.

Actions

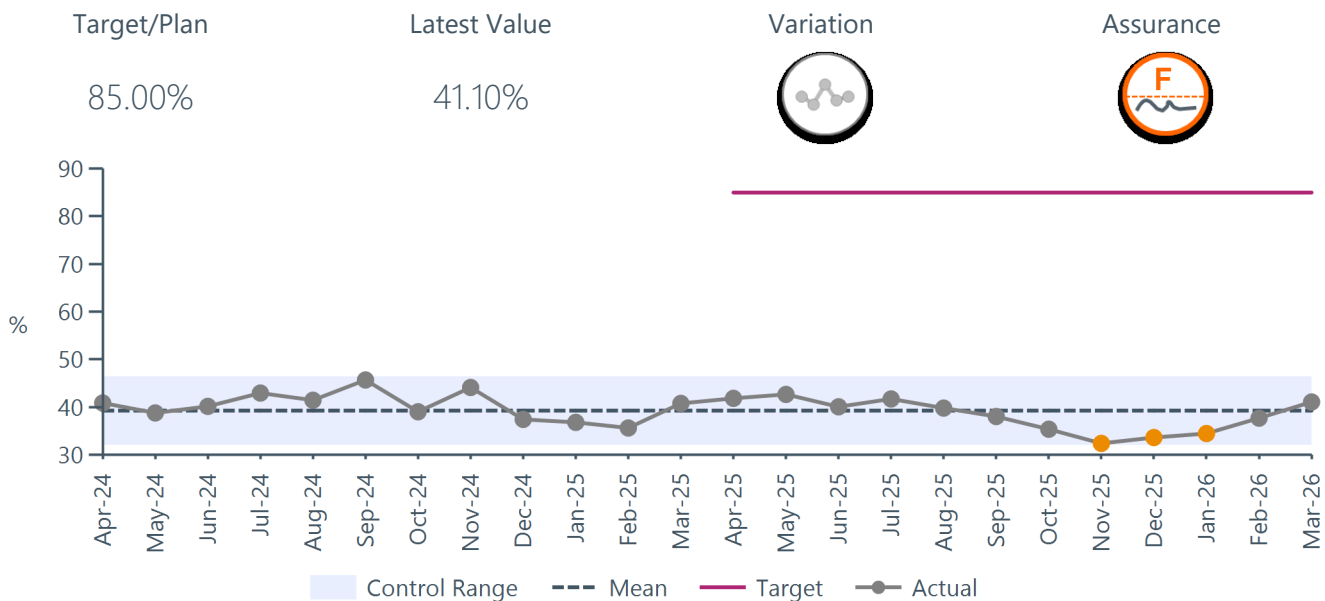
Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
1139	1043	877	967	1026	907	1098	1208	1127	955	1141	1126	1511

- 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 March, BADS performance was reported at 41.10%. If patients discharged on day zero—regardless of their intended management—were included, the metric would have reached 60.11%.

March performance is above the mean following four months of improvement. 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.

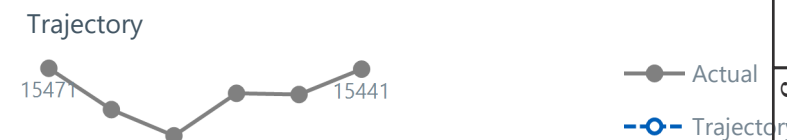
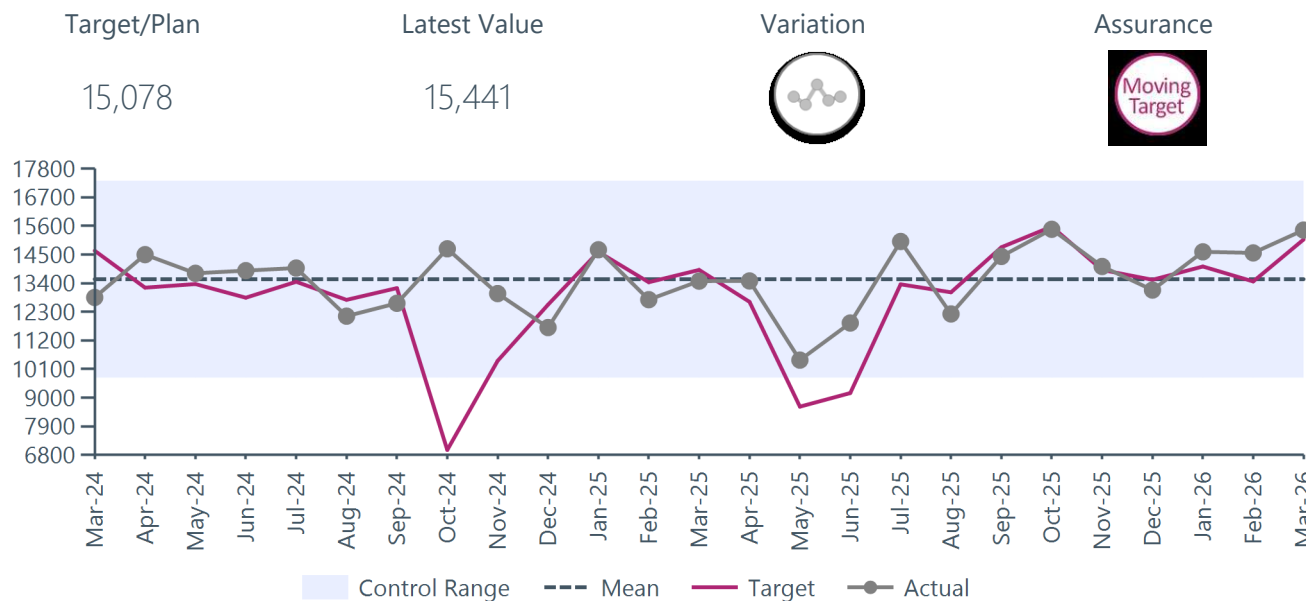
- The Trust is aiming for continuous improvements with Clinically led monthly day case surgery meeting. Data quality issues have been identified with Clinical audits and further investigations being undertaken:
- * Focus on correct booking of high-volume BADS procedures e.g. carpal tunnels.
 - * Explore 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.

Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
40.80%	41.86%	42.69%	40.09%	41.74%	39.82%	38.05%	35.39%	32.42%	33.65%	34.49%	37.72%	41.10%

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 March with +363 attendances over plan and the position reported at 102.41%.

A breakdown of Outpatient activity below:
 * IJP activity was -575 at 96.12%, * OJP activity was +230 at 185.50%, * Insourcing activity was 444; there had originally been no plan for this in March
 * New activity 109.08%, * Follow Up activity 103.69%

Monitoring of delivered activity against plan remains under focus at weekly activity meeting.

Actions

- Actions in this area include
- * New Clinic Utilisation report being remains in trial to assist with booking process across all areas. Information Team working with relevant stakeholders to refine report content and formatting to ensure report is robust operational tool.
- * Physiotherapy has been identified as an area of concern. The senior physio team have been tasked with conducting a deep-dive that will be presented to TPOIG.

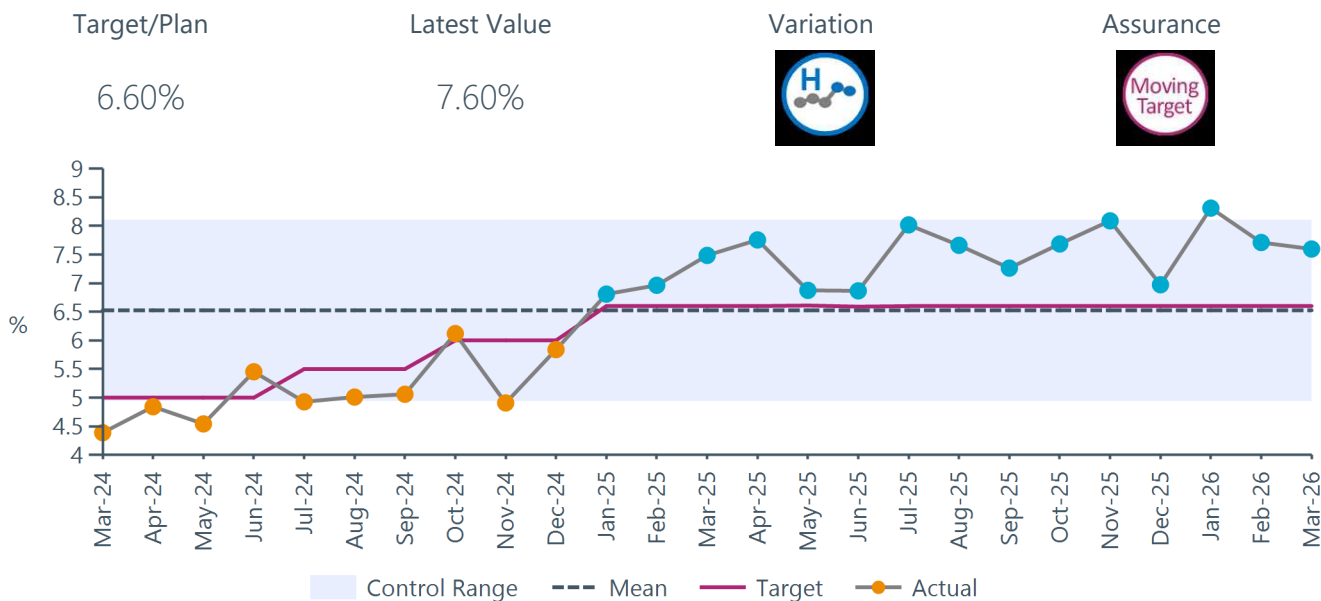
Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
13480	13486	10444	11870	15003	12217	14428	15471	14043	13137	14606	14564	15441

- 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 6.60% of all outpatients attendances. In March this was exceeded with 7.60% of total outpatient activity moved to a PIFU pathway. As demonstrated on the SPC above, this has now been reported as a period of improvement for sixteen months.

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

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

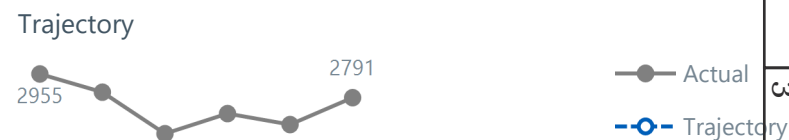
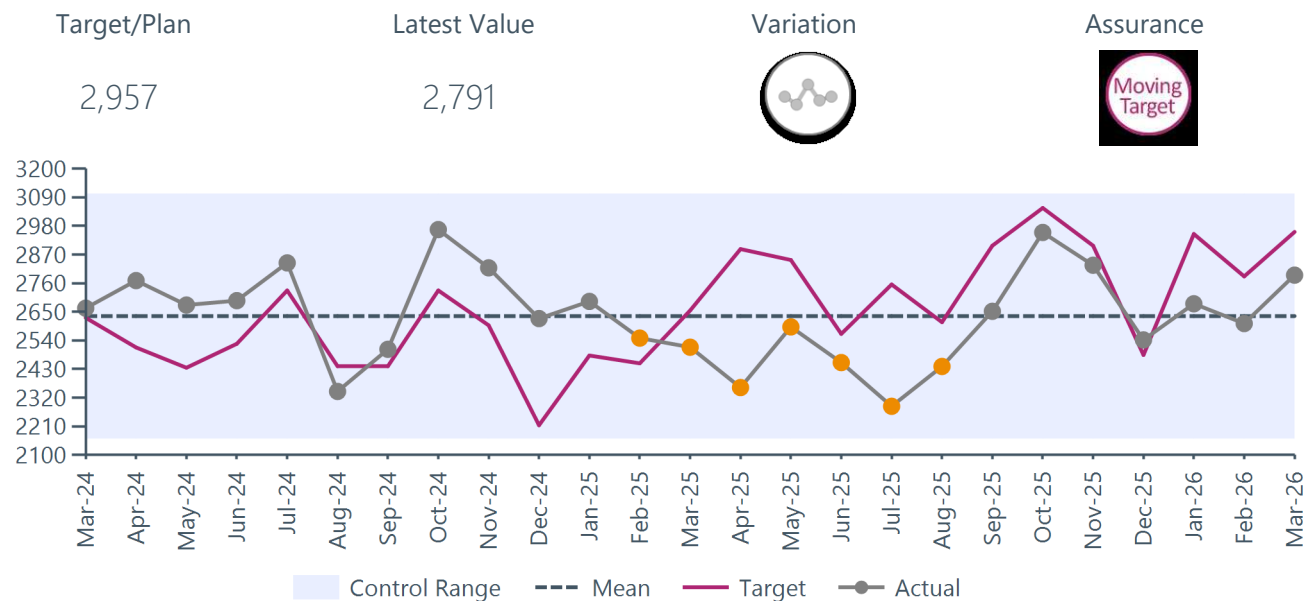
Actions

Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
7.49%	7.76%	6.87%	6.87%	8.02%	7.66%	7.26%	7.69%	8.09%	6.97%	8.31%	7.71%	7.60%

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 March. Overall activity is reported at 94.39% with a breakdown as follows:
 * U/S – 914 against 946; equating to 96.62%
 * MRI - 1490 against plan of 1541; equating to 96.69%
 * CT – 387 against plan of 470; equating to 82.34%

Actions

Newly recruited booking team staff are now in post and completing initial training to improve booking turnaround times, increase activity, and enhance capacity utilisation.

Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
2514	2359	2592	2455	2287	2440	2652	2955	2829	2542	2681	2605	2791

- Staff - Patients - Finances -

IPR Annual Review

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 06 May 2026

Author:

Name: Mike Carr
Role/Title: Chief Operating Officer

Contributors:

Claire Jones, Principal Analyst & Data Quality Lead

Report sign-off:

Assurance Committee, April 2026

Is the report suitable for publication?:

YES

Key issues and considerations:

Discussion and agreement on proposed changes outlined in the paper are required.

Strategic objectives and associated risks:

The Integrated Performance Report provides overall performance oversight to support the delivery of all Trust 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	✓

System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system.

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

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

Recommendations:

The Executive Team, Board and its sub-committees are asked to discuss and consider the proposals made in section 4 before implementation into IPR in 26/27.

Report development and engagement history:

Proposed changes that are outlined in this report are a result of discussions with key stakeholders in the Trust such as Executive Leads of reporting areas and Non-Executive Directors who Chair committees.

Acronyms

IPR Integrated Performance Report

1
2
3
4
5
6
7
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9

IPR Annual Review

1. Background / Context

This paper provides details on the changes that have taken place in the Integrated Performance Report (IPR) throughout the 2025/26 financial year and references future changes and proposals to be made for 2026/27.

This paper is submitted to the Executive Team, all sub-committees, as well as Board of Directors, to ensure full oversight across metrics and committees.

The purpose of the Integrated Performance Report (IPR) is to provide the Board and sub-committees with the evidence of achievement against the national regulatory standards, identifications of key risks impacting our performance and the key initiatives and improvements in place that positively impact our performance.

This paper outlines the changes made to IPR reporting throughout 2025/26 and a number of proposals for 2026/27. Where changes relate to mandated reporting, these will be reflected in month 1 IPR. Other changes will be phased into the IPR as data sources are established and evolve.

2. Introduction

The principles of the IPR are to ensure it contains the appropriate and focused metrics that allow the Board, and its sub-committees, to seek assurance and instigate actions where required. The metrics included reflect the following:

- Those outlined in the National Oversight Framework
- National planning stipulations
- National reporting requirements
- System reporting requirements
- Those determined appropriate to our organisation

As a result of both national and internal drivers, there have been changes to the IPR throughout the 2025/26 financial year. These are all outlined in the paper below.

The Principal Analyst has carried out a review of the IPR to ensure it meets all the areas stipulated in the NHS Oversight Framework.

In addition to this, Principal Analyst has met with key stakeholders within the Trust and Executive Directors who lead on reporting areas. In addition, the Chief Operating Officer and Principal Analyst have met with the Sub-Committee Chairs to discuss and review each committee-version of the IPR.

3. Summary of Changes Made Throughout 2025/26

3.1 People & Workforce

The table below outlines the KPIs that have been added or removed, in relation to People & Workforce throughout this financial year:

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IPR Annual Review

KPIs Removed	KPIs Added
Staff Turnover - Headcount <i>(KPI removed and replaced with new metric with different methodology)</i>	Staff Turnover - FTE
Time to Hire <i>(KPI removed and replaced with new metric with different methodology)</i>	Time to Hire - Recruitment <i>(New KPI based on 'Vacancy Created to Unconditional Offer')</i>
In Month Leavers <i>(KPI removed and replaced with new metric with different methodology)</i>	Leavers per Month <i>(New KPI based on leavers in month, excluding non-voluntary reasons, retire and return and rotational doctors)</i>
Total Headcount in Post	Agency Spend against Plan
Agency Proportion of Pay Plan	Proportion of Temporary Staffing as a % of the Trust Pay Costs
Proportion of Temporary Staff	Bank Spend against Plan

The following reporting changes have been made:

- Sickness Absence – targets aligned to Trust's submitted operational plan
- Staff Retention – target added based on average for previous financial year
- Healthcare Support Worker Vacancy Rate – 8% target added, in line with Trust-wide target, as specific target for this workforce not included in the Operational Plan for 25/26

3.2 Quality & Safety

The table below outlines the KPIs that have been added or removed, in relation to Quality and Safety, throughout this financial year:

KPIs Removed	KPIs Added
Standard Complaints Response Rate Within 25 Days <i>(KPI removed and replaced with new metric monitored against 30 Days)</i>	Standard Complaints Response Rate Within 30 Days
Complex Complaints Response Rate Within 40 Days <i>(KPI removed and replaced with new metric monitored against 45 Days)</i>	Complex Complaints Response Rate Within 45 Days
C Diff Infection Rates Per 100,000 Bed Days	RJAH Acquired Tissue Viability Events
E Coli Infection Rates Per 100,000 Bed Days	WHO Quality Audit - % Compliance against NatSSIPs 2
WHO Quality Audit - % Compliance	Unplanned return to theatre
	Martha's Rule - Number of Times Enacted
	Discharge Ready Date to Actual Discharge Date

The following reporting changes have been made:

- RJAH Acquired Infections – some infections form part of the National Oversight Framework (NOF) so a move to monitoring over a rolling 12-months position was made in the IPR to align with this. On reflection, it was felt this caused some confusion, so the IPR has reverted back to monitoring an 'in-month' position and the covering paper for Q&S contains a table to provide assurance on each infection over a rolling 12-months period.
- Complaints Re-Opened – Target changed from 0 to 2, based on the average for previous financial year.
- Cancer Waits Standards; 28 Day Faster Diagnosis and 62 Day General Standard – trajectories added as per Trust's Operational Plan.
- Overdue Follow Up Backlog – this metric remains on pause following Apollo implement due to data quality issues.

3.3 Performance

The table below outlines the KPIs that have been added or removed, in relation to Performance, throughout this financial year:

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9

IPR Annual Review

KPIs Removed	KPIs Added
Patients Waiting Over 52 Weeks – English <i>(KPI removed and replaced with new metric monitored % 52+ Weeks)</i>	% of Patients Waiting Over 52 Weeks - English
Patients Waiting Over 52 Weeks - Welsh (Total) <i>(KPI removed and Welsh long waits monitored as 104+ Weeks)</i>	Time to First Appointment - English Patients
Patients Waiting Over 52 Weeks - Combined	Time to First Appointment - Welsh Patients
Patients Waiting Over 65 Weeks - English	18 Week Performance - Difference Between Planned and Actual
Patients Waiting Over 65 Weeks - Welsh	Theatre Cancellations On The Day of Surgery
Patients Waiting Over 65 Weeks - Combined	MCSI Admissions - Average Waiting Time <i>(KPI added but later removed)</i>
Overall BADS % <i>(KPI removed and replaced with new metric in line with BADS Directory of Procedures Sept-24 edition)</i>	% Combined BADS Performance
Volume of Theatre Cancellations <i>(KPI removed and replaced with new metric just reporting 'on the day' cancellations)</i>	Report Turnaround Times - % Completed in 28 Days
% Delayed Discharge Rate	Discharge Ready Date to Actual Discharge Date
MCSI Admissions - Average Waiting Time	

The following reporting changes have been made:

- As per Operational Planning – targets were changed/aligned for the following:
 - Electives/Theatres activity
 - Outpatients activity
 - Diagnostics activity and waits
 - RTT
 - 28 Day Faster Diagnosis
- Activity breakdown - IJP/OJP/PP/Insourcing KPIs removed out of main IPR but oversight included in IPR covering paper for F&P Committee

3.4 Finances

The table below outlines the KPIs that have been added or removed throughout this financial year:

KPIs Removed	KPIs Added
Value Weighted Assessment	Performance (£'000k) against Low Value Agreement Block
	Planned Surplus/Deficit
	Variance Year-to-Date to Financial Plan
	Implied Productivity

3.5 DERIC

A new IPR for DERIC Committee was introduced throughout 2025/26 and remains 'work in progress' as its content evolves with proposals for 2026/27 outlined further in this paper.

The IPR has been set up with the initial metrics as follows:

KPIs Added
Research - Total Number of Studies
Research - Number of Grant Applications
Research - Number of Patients Recruited
% Staff that have received Quality Improvement Training

4. Proposal of Changes for 2026/27

4.1 Overall IPR

Proposed changes that reflect overall IPR:

- Covering Papers

IPR Annual Review

- IPR covering papers to continue providing supporting information and analysis to support the exceptions reported within the IPR
- Remove any duplication that repeats what is already included in the exception pages
- **Benchmarking**
 - Principal Analyst to look at incorporating Benchmarking into the routine IPR reporting. Likely to begin as inclusion in IPR covering papers.
- **Presentation of IPR in Committees**
 - Executives are asked to consider and discuss the use of IPR and how it is presented at Committee meetings.
- **National Oversight Framework (NOF)**
 - IPR covering papers will continue to include an appendix providing oversight on latest NOF publications.
 - Continual review of NOF throughout the financial year to ensure the IPR aligns with any new metrics added to the framework.
 - Format change will be made to IPR to clearly identify those metrics that form part of the NOF, as demonstrated below:

IPR Summary Pages:

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating	NOF
Number Of Spinal Injury Patients Fit For Admission To RJAH	7	23				+		NOF
Theatre Cancellations On The Day of Surgery	34	49				+		
18 Weeks RTT Open Pathways	60.02%	62.15%				+	24/06/21	NOF
18 Week Performance - Difference Between Planned and Actual	0.00%	2.13%				+		NOF

IPR Exception Pages:



4.2 People & Workforce

KPIs with proposed changes are outlined below:

- **Sickness Absence**
 - Overall target will be aligned with Operational Plan
 - Short/long term targets will be derived from overall plan, with % split based on actuals reported throughout 25/26
- **Staff Turnover**

IPR Annual Review

- This did not form part of the Workforce Plan for 26/27. It is proposed to consider setting the target to the mean value for the last two years (as displayed on SPC graphs throughout the IPR). The mean for the period of March-24 to March-26 has been 9.77%.

- **NHS Oversight Framework (NOF)**

- The following metrics form part of the NOF:
 - NHS Staff Survey – raising concerns sub-score
 - NHS Staff Survey engagement theme score
- As these are scores available from the NHS Staff Survey on an annual basis, it is proposed that the People Services Team explore obtaining more frequent insight into these areas through staff engagement.
- People Services are at early stages of an 'Engagement Plan'.

4.3 Quality & Safety

The following are proposed as new KPIs:

- Readmissions to Other Trusts (dependent on access to suitable data source)
- Number of PALs Concerns
- Hand Hygiene Audits

KPIs with proposed changes are outlined below:

- **Readmissions**

- The IPR currently reports on Emergency Readmissions back into the Trust within 28 days. Although not part of the NOF ratings, there are some contextual metrics that NHSE includes whereby it reports on Readmissions within 30 days. Proposal to remove the 28 days metric within the IPR and replace with a new one monitoring within 30 days.

- **Complaints**

- The current target for Overall Complaints is set at 8, it is proposed to consider a change to the mean value for the last two years (as displayed on SPC graphs throughout the IPR). The mean for the period of March-24 to March-26 has been 14.
- The current target for Re-Opened Complaints is set at 2, it is proposed to consider a change to the mean value for the last two years (as displayed on SPC graphs throughout the IPR). The mean for the period of March-24 to March-26 has been 3.

- **RJAH Acquired Infections**

- Targets/Tolerances will be updated based on those assigned to the Trust by ICB/NHSE. (The Trust may not receive this ahead of the new financial year so existing will be rolled over until received).

- **Discharge Ready Date to Actual Discharge Date**

- This has been a new metric added throughout 25/26 as it forms part of the NOF.
- Data reported in the IPR goes back to June-25, where in the period June-25 to March-26 the average has been 0.61 days
- It is proposed to take this average as a target for 26/27
- IPR narrative will include reference to ward areas

- **Number of Spinal Injury Patients Fit for Admission to RJAH**

- The target for this metric is currently set at 7
- The average at month ends throughout 25/26 has been 20
- Although discussed and considered with relevant stakeholders, it is deemed appropriate to leave the target at 7

- **Patients Returned to Theatre Within 28 Days – Unplanned**

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IPR Annual Review

- This has been a new metric added throughout 25/26 where for the period of October-25 to March-26 the average has been 6 patients per month.
- It is proposed that a target should be set at this average seen so far.
- **Cancer Waits Standards**
 - As per current year, IPR target will reflect the national standards. Trajectory will reflect the Trust's Operational Plan.
- **Patient Reported Outcome Measures (PROMs) / Patient Reported Experience Measures (PREMs)**
 - We believe there may be further evolution in the metrics that form part of the NOF and they may include PROMs/PREMs. This will be monitored and IPR will align with any new measures.

4.4 Performance

KPIs with proposed changes are outlined below:

- **Activity**
 - All activity measures will have targets as per Operational Plan, or derived from the plan
- **RTT**
 - All targets to be aligned with Operational Plan
 - English KPIs included in the IPR to remain the same
 - Some KPI changes in relation to Welsh patients to align with the Welsh Government Standards
 - New KPI – '26 Weeks RTT Open Pathways – Welsh Patients'
 - Remove KPI – 'Time to First Appointment – Welsh Patients' – this is based on 18 weeks at present
 - New KPI - 'Time to First Appointment at 26 Weeks – Welsh Patients'
- **Referrals**
 - The KPI for Referrals has not been reported throughout 25/26 as a new dataset needed to be built from Careflow once system functionality was understood. This dataset is now built so a new KPI for 'Demand Referrals' will be added to the IPR.
- **BADs / Daycases**
 - '%Combined BADS Performance' to remain within the IPR
 - New KPI to be reported alongside this – to be discussed and agreed by the Trust's Daycase Working Group
- **Touchtime Utilisation**
 - Remove current KPI that is based on Uncapped position
 - New KPI – 'Touchtime Utilisation (Capped)' – this will then align with data published on Model Hospital
- **Pre-Op**
 - New KPI 'Pre Ops Completed – Fit to Proceed'
 - This metric will monitor the number of patients assessed through the Pre-Operative process who are deemed fit to progress to surgery and recorded as such in Apollo. The reported figure will include both dated and undated patients with relevant breakdowns included in the IPR narrative.
- **Outpatients Clinic Utilisation**
 - New metric to report on clinic utilisation
 - A new dataset has recently been built from Careflow data and initial reporting is in a trial period

IPR Annual Review

- Once data accuracy is verified, explore new metric for inclusion in the IPR (likely to be quarter two)
- **Advice & Guidance**
 - New metric to report on 'Advice & Guidance - Number of Days from receipt of an A&G request to a response'
 - NHSE guidance stipulates providers must work towards a maximum of 5 working days

4.5 Finances

There are no proposed changes to Finance metrics for 26/27.

4.6 DERIC

A new IPR for DERIC was introduced throughout 25/26 but very much remains 'work in progress' with some proposed metrics below to help evolve its content.

As part of discussions with the Committee Chair and Chief Operating Officer, it was agreed that where applicable, metrics that can routinely be reported as a monthly KPI will be included in the IPR. Alongside this, there will be areas of focus in the covering paper to align with the committee's workplan to focus on the different areas of DERIC's remit.

In relation to focus on Education, the following are proposed as new KPIs:

- Number of Students – to include breakdown by Medical, Physio, Pharmacy and Nursing Students
- Number of Supervisors – to include breakdown by Education and Clinical Supervisors
- Number of Courses Run (Orthopaedic Institute)
- SIM Lab – Number of Courses Run

In relation to focus on Digital, the following are proposed as new KPIs:

- Number of P1 / P2 Incidents
- Cyber Incidents
- Cyber MDE Score
- Patients Digitally Engaged with the Trust
- Number of New Innovation Projects Reviewed

In relation to Innovation, data collection will be assessed to determine the inclusion of KPIs in relation to monitoring innovative procedures. The committee has already had presentations on Shockwave and Robotic Surgery to date.

5. Recommendation

The Board and its sub-committees are asked to discuss and consider the proposals made in section 4 before implementation into IPR in 2026/27.

Executives are asked to discuss a standardised approach when presenting the IPR in committees.

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Trust Board - Finance

March 2026 – Month 12



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:

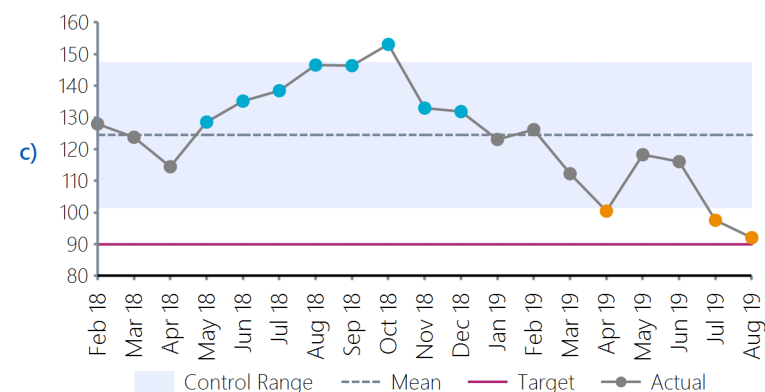
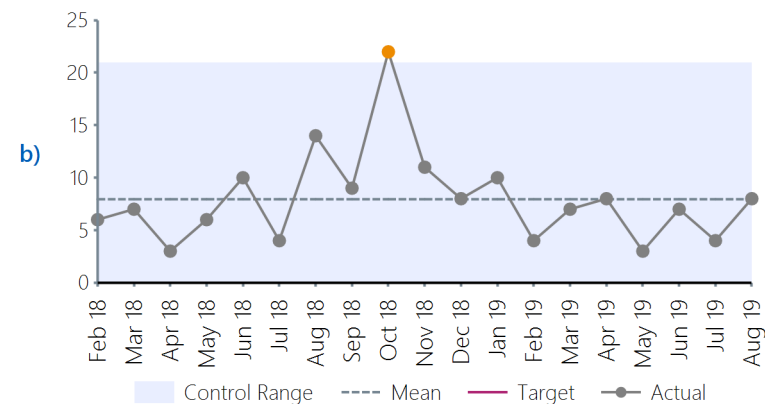
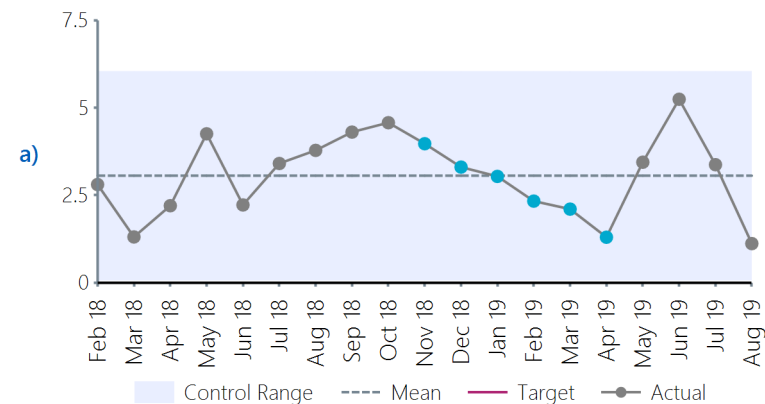
- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of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

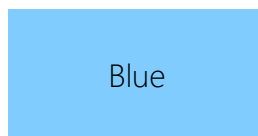
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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



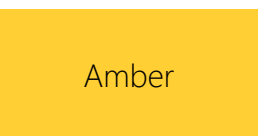
Blue

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.

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Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Financial Control Total	1,070	2,754	1,070				
Income	15,775.46	18,589.46	15,775.46				
Expenditure	14,706.46	15,835.46	14,706.46			+	
Efficiency Delivered	997	1,216	997				
Cash Balance	16,802	16,191				+	
Capital Expenditure	1,624	4,157				+	
Performance (£'000k) against Low Value Agreement Block	64.00	31.88					
Planned Surplus/Deficit	0	1,701					
Variance Year-to-Date to Financial Plan	0	1,701					
Implied Productivity	2.00%	-1.65%				+	

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Expenditure

All Trust expenditure including Finance Costs 216334

Target/Plan

14,706.46

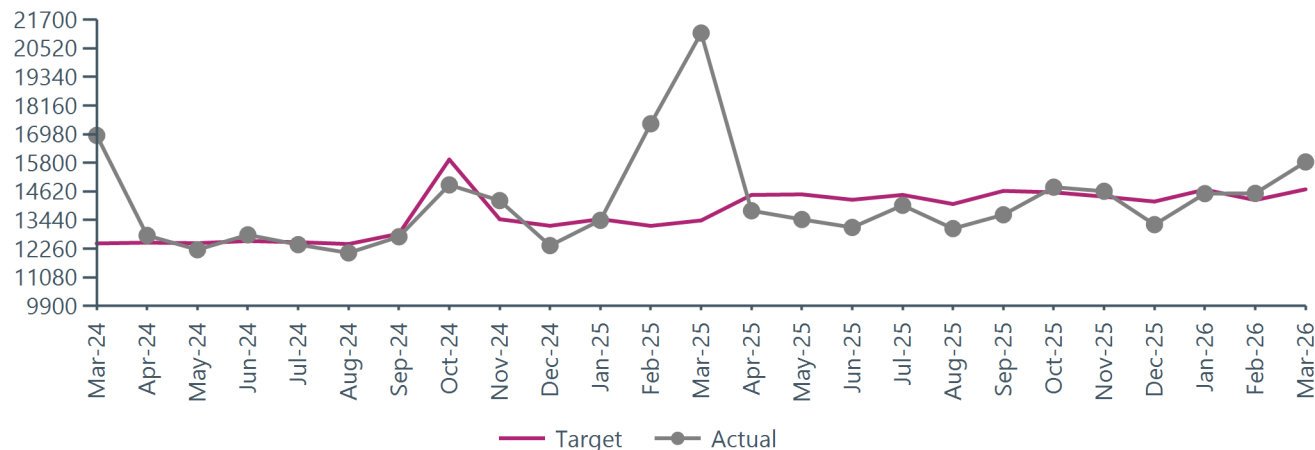
Latest Value

15,835.46

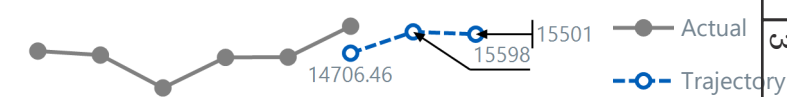
Variation



Assurance



Trajectory



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

Overall expenditure £1,129k adverse to plan.

Pay position £221k adverse to plan;

- Recruitment slippage £188k favourable
- Enhanced controls for vacancies, temporary staffing & recruitment £115k favourable
- Agency spend £82k favourable
- Sprint costs £52k adverse (to support performance delivery and offset by additional income)
- Bank spend (Outpatient and Anaesthetic OJP, & Non-clinical support) £367k adverse
- Year end movements (invoicing catch ups, agreement of balances, contracts etc) £169k adverse

Non-Pay £963k adverse to plan;

- Sprint funding £297k adverse (offset by income)
- Year end movements £225k adverse (estates & facilities, devices, year end invoicing, contracts)
- Implants and consumables £130k adverse (implantable casemix and volumes high in month)

Actions

Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
21149	13823	13463	13136	14047	13087	13657	14795	14627	13250	14529	14541	15835

- Staff - Patients - Finances -

Cash Balance

Cash in bank 215300

Target/Plan

16,802

Latest Value

16,191

Variation



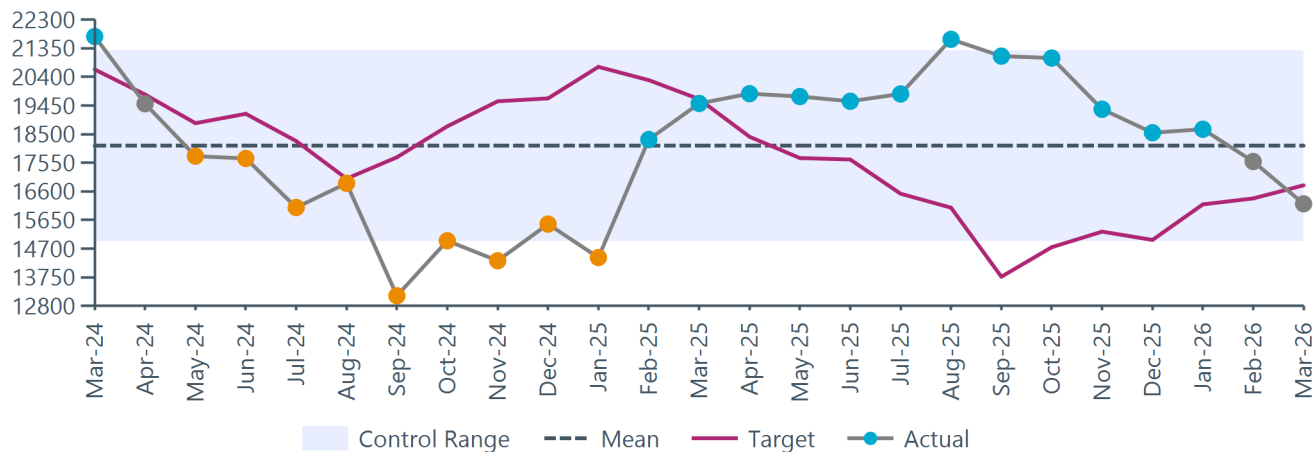
Assurance



Trajectory



Exec Lead
 Chief Finance & Commercial Officer



What these graphs are telling us

Metric is experiencing common cause variation. Metric has a moving target.

Narrative

Closing cash balances £16.2m, £0.6m below plan mainly due to increased capital expenditure in March and additional payments for sprint funding not expected until May.

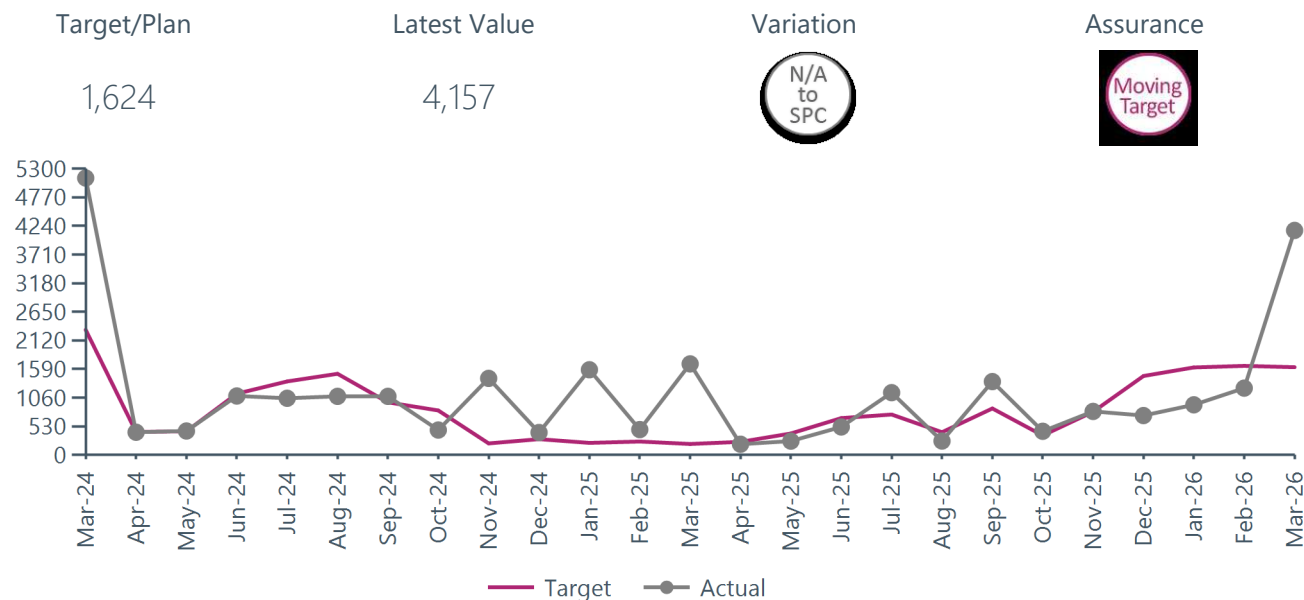
Actions

Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
19519	19844	19750	19593	19835	21650	21090	21028	19328	18549	18665	17594	16191

Capital Expenditure

Expenditure against Trust capital programme 215301

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

As expected spend significantly increased in March leaving us with an overall spend of £12m at year end in line with forecast.

All £3m of PDC monies was spent with a small overspend of £109k on those PDC projects being internally funded as works were completed earlier than originally planned.

Contributing significantly to the £12m as forecast Operating Theatre 12 and the Rheumatology hub works moved quickly in March.

In terms of system operational capital (CDEL) the final position is £157k overspend against the increased plan of £6,636k.

Actions

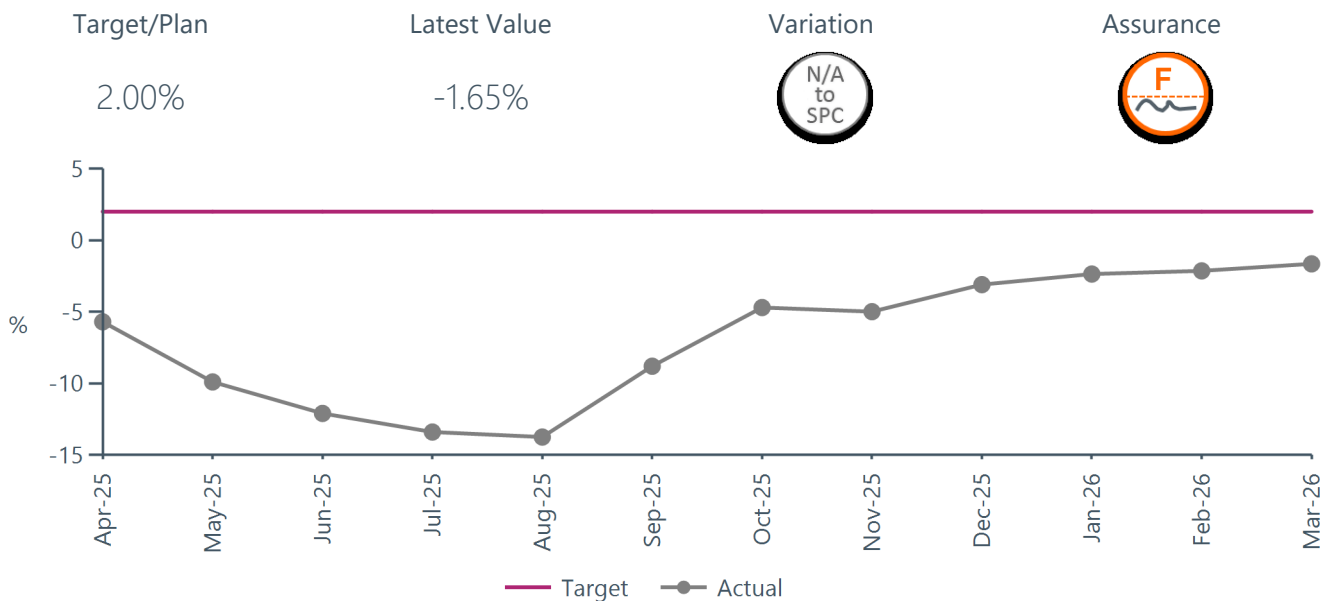
Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
1686	198	256	518	1153	258	1358	438	806	729	928	1237	4157

- 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 -1.65% YTD when comparing M12 25/26 with M12 24/25. The main drivers of the reduced performance are activity driven due to the cessation of the LLP contract (which has Q1 activity in 24/25), the impact of the EPR implementation in 25/26 (in particular M2 & 3) partially offset by the increase in in job plan capacity from recruitment.

Actions

Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	-5.70%	-9.90%	-12.10%	-13.40%	-13.75%	-8.80%	-4.70%	-4.99%	-3.10%	-2.36%	-2.14%	-1.65%

- Staff - Patients - **Finances** -



The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust

M12 Financial Position Update

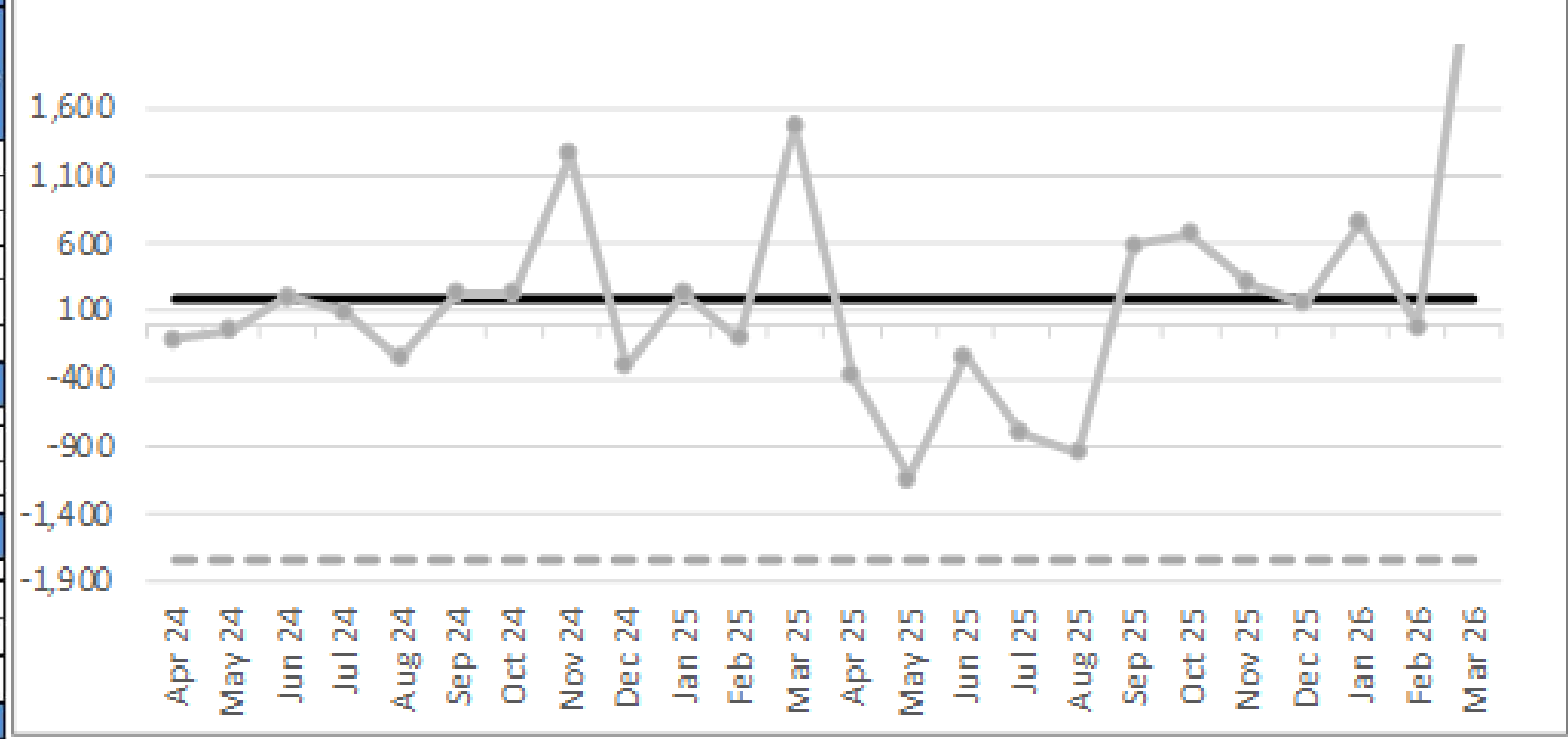
➔ *Improving lives through excellent and innovative care*



Income & Expenditure Position March 2026

	Annual Plan	In Month Position					YTD Position		
		Plan	Pass through	Pass through adj Plan	Actual	Variance	Pass through adj Plan	Actual	Variance
Clinical Income	153,952	13,957	286	14,243	16,985	2,742	154,182	150,971	(3,211)
Private Patient income	11,987	942	0	942	791	(151)	11,987	11,098	(889)
Other income	6,849	564	6,447	7,011	7,233	222	14,145	14,850	705
Pay	(107,200)	(8,891)	(6,436)	(15,327)	(15,550)	(223)	(113,995)	(110,840)	3,155
Non-pay	(57,111)	(4,772)	(297)	(5,069)	(6,029)	(960)	(57,843)	(56,437)	1,406
EBITDA	8,477	1,800	0	1,800	3,430	1,630	8,476	9,642	1,166
Finance Costs	(9,285)	(800)	0	(800)	(746)	54	(9,285)	(8,779)	506
Capital Donations	1,620	260	0	260	490	230	1,620	1,202	(418)
Operational Surplus	812	1,260	0	1,260	3,174	1,914	811	2,065	1,254
Remove Capital Donations	(1,620)	(260)	0	(260)	(490)	(230)	(1,620)	(1,202)	418
Add Back Donated Dep'n	809	69	0	69	70	1	809	840	31
Control Total	0	1,070	0	1,070	2,754	1,684	0	1,702	1,702

I&E Control Total Run Rate £'000



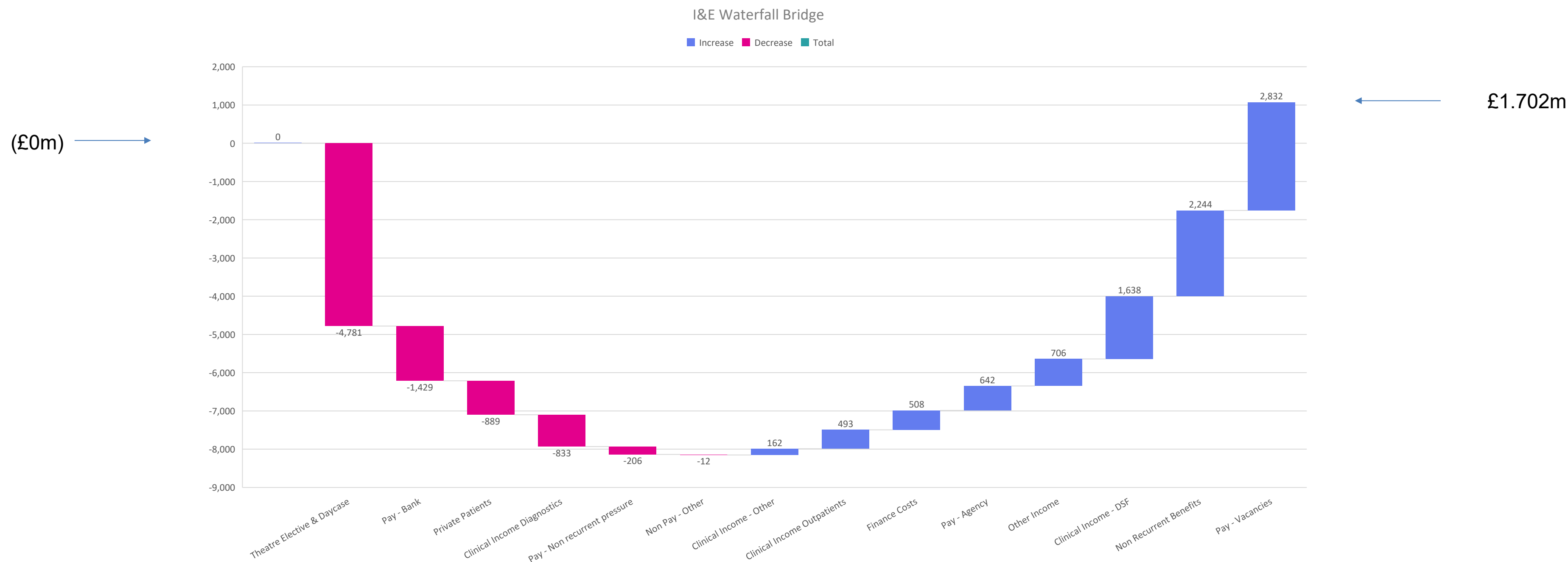
In month: £2.76m surplus, £1.7m favourable

- **NHS Clinical Income £2.7m favourable** - driven by £1.6m favourable redistributed Deficit Support Funding (DSF), £0.6m favourable Q4 Sprint Funding (offset in expenditure), £0.2m outpatient income (insourcing), £0.2m non theatre inpatients (metabolic) and £0.1m theatre income (insourcing). FY £3.2m adverse to plan driven by lower than planned theatre and diagnostic activity partially mitigated by redistributed DSF and Q4 sprint funding.
- **Non-NHS income £0.07m favourable** - driven by £0.2m favourable Injury Cost Recovery (ICR) and education income partially offset by £0.15m adverse private patient income (8 patients adverse to plan). FY £0.2m adverse driven by adverse private patient income (activity lower than planned) partially offset by in year mitigations of additional income (Serive lev1 agreement reviews, Injury cost recovery notifications, Health Education England).
- **Pay expenditure £0.22m adverse** - driven by £0.5m adverse bank (Outpatient OJP, Anaesthetic OJP, TOIL/Year end technical adjustments), £0.1m validation sprint work; partially offset by £0.2m favourable workforce recruitment slippage, £0.1m grip & control and £0.1m favourable agency. FY £3.2m favourable driven by vacancies above plan (linked to activity), reduced agency spend, grip & control actions (vacancy panel, temporary staffing controls) and provision adjustments.
- **Non-Pay £0.95m adverse** - driven by £0.3m adverse performance sprint, £0.3m adverse year end adjustments (ICR debt, invoicing catch ups), £0.1m adverse insourcing (income offset but pressure to plan), £0.1m adverse implants/consumables (volume & casemix), £0.1m adverse estates (materials, health & safety). FY £1.4m favourable driven by reduced marginal costs linked to activity below plan, non-recurrent mitigations linked to financial recovery plan and grip & control actions.

Note: to ensure consistency the position excludes year end pension adjustment c£6.4m income and pay expenditure which will form part of the accounts.

YTD: £1.7m deficit, £1.7m favourable.

Bridge from YTD plan breakeven versus Actual £1.702m surplus



The bridge shows the key drives of the variances to plan YTD in delivery of the £1.7m surplus

Adverse income performance linked to lower than planned elective theatre activity, outpatients, private patients and diagnostics is partially offset by lower than planned pay & non pay expenditure.

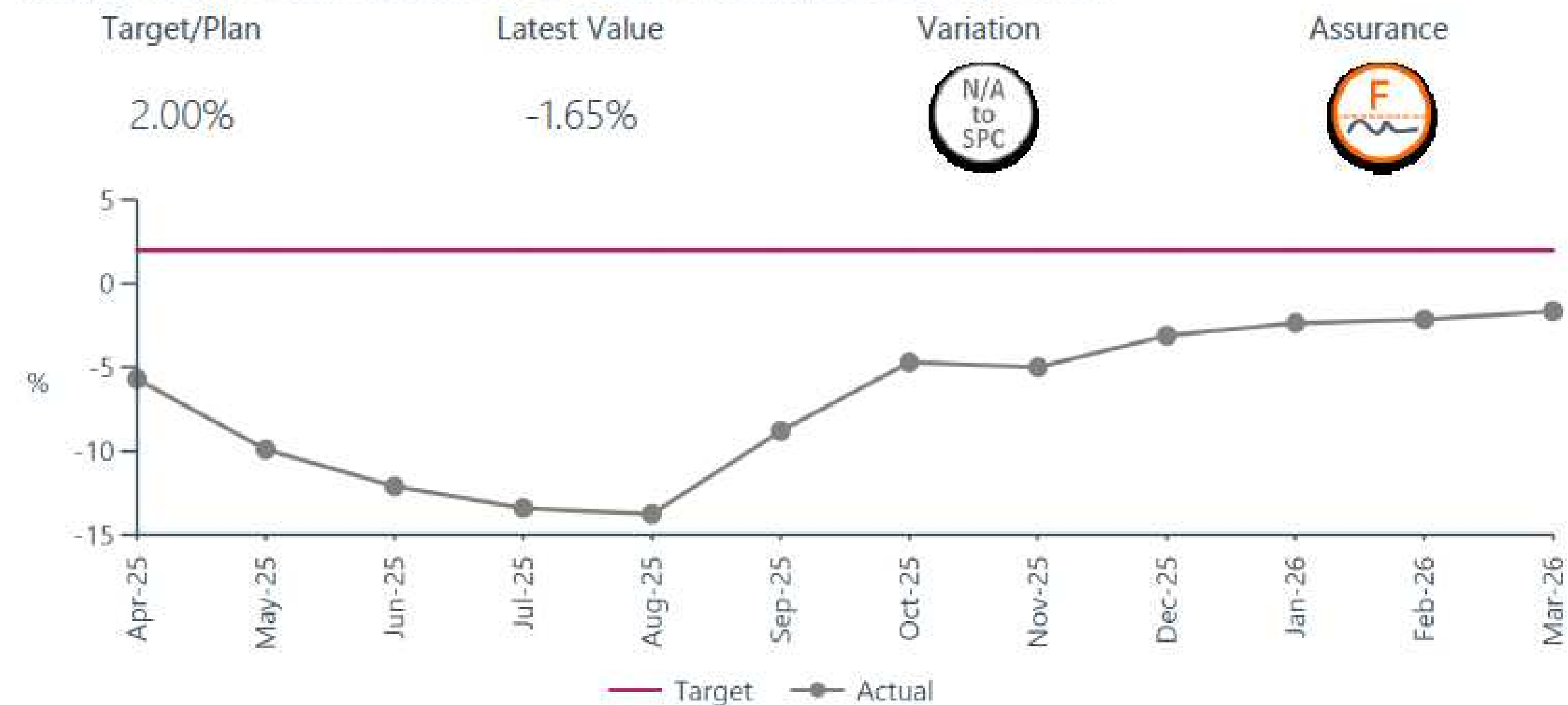
Non recurrent items include £2.2m of in year mitigations (balance sheet, other income), £1.6m redistributed deficit support funding and £0.5m of interest receivable.

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

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

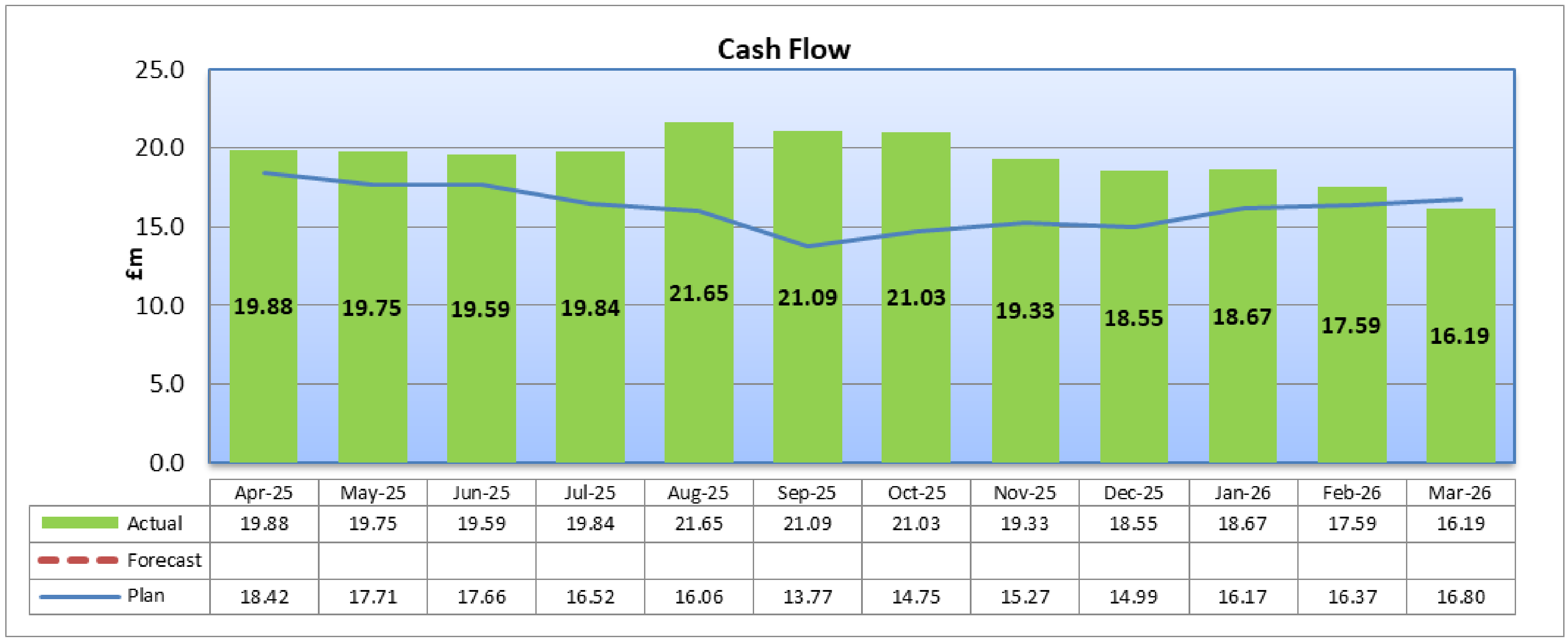
Real terms cost growth – this takes operational expenditure excluding impairments but including Public Dividend Capital (PDC) charges during the two periods 24/25 and 25/26 then divides the two numbers to give a growth %. Spend is adjusted for inflation across periods.

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

Implied productivity deteriorated during the implementation of the Apollo EPR system and plateaued during **August at -13.8%**, the position has recovered since then due to improvements in activity levels with **March delivering -1.65%**.

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

Cash Position



Year-end cash performance £16.2m, £0.6m below plan due to increased capital expenditure above original plan, validation sprint funding payable in May 26 and settlement of commissioner under & over performance falling into 26/27.

Capital Position

Project	Original Annual Plan £000s	In Month Plan £000s	In Month Completed £000s	In Month Variance £000s	YTD Plan £000s	YTD Completed £000s	YTD Variance £000s
Solar works / energy & decarbonisation	3,307	957	998	-41	3,307	3,481	-174
Digital investment and electronic patient record	1,500	22	429	-407	1,500	1,651	-151
Equipment replacement	1,700	120	28	92	1,700	1,528	172
Critical infrastructure investment (PDC funded)	500	100	1,013	-913	500	1,442	-942
Additional elective theatre	0	0	659	-659	0	870	-870
Surgical innovations	750	0	0	0	750	725	25
Rheumatology hub	1,000	200	600	-400	1,000	614	386
Backlog maintenance	500	40	74	-34	500	494	6
Compliance (IPC/health & safety/quality)	360	20	140	-120	360	393	-33
Donated / Granted medical equipment	220	10	0	10	220	234	-14
Leases (IFRS16)	250	70	19	51	250	227	23
Estates reconfiguration	206	16	108	-92	206	184	22
Invest to save	200	50	41	9	200	165	35
Capital project management	170	14	-14	28	170	157	13
Other in year PDC allocations	0	0	45	-45	0	85	-85
PACS/RIS replacement	200	5	0	5	200	0	200
Contingency	0	0	16	-16	0	-215	215
Total Capital Funding	10,863	1,624	4,157	-2,533	10,863	12,036	-1,173
Less donated / grant capital	-1,620	-260	-490	230	-1,620	-1,202	-418
NHS Capital Funding - Charge to CDEL	9,243	1,364	3,666	-2,302	9,243	10,834	-1,591
Less PDC funded schemes	-2,907	-907	-1,566	659	-2,907	-4,041	1,134
Original System Operational Capital	6,336	457	2,100	-1,643	6,336	6,793	-457
Additional System Operational Capital allocation	300	300	0	300	300	0	300
Charge to System Operational Capital	6,636	757	2,100	-1,343	6,636	6,793	-157

Total capital expenditure for 25/26 £12.0m in line with forecast £0.15m adverse to System Operational Capital Limit.

Minor overspends on PDC projects were funded internally and significant expenditure incurred on the initial phases of new Operating Theatre 12 and Rheumatology Hub projects in March.

Note the final position includes an increase of £300k (not cash backed) to the System Operational Capital allocation giving a total allowance of £6,636k.

Material schemes include :

- Decarbonisation/energy improvements and solar works aligned to NHS carbon reduction strategy £3.5m
- Digital infrastructure replacement and improvements £1.7m (including the Go Live of new Electronic Patient Record)
- Critical infrastructure backlog across the site £1.4m (supported through additional central funding)
- Equipment replacement programme £1.5m
- New elective theatre £0.9m (to open in 26/27)
- Surgical innovations (new navigation equipment for spinal surgery) £0.7m
- Rheumatology hub development £0.6m (to open in 26/27)



The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust

FY 25/26 Efficiency Delivery and FY 26/27 Plan

➔ *Improving lives through excellent and innovative care*



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Month 12 Performance Summary



The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust



25/26 Month 12 Planned Savings £992k	25/26 Month 12 Actual Savings £1,216k	25/26 Month 12 Savings Variance £224k	25/26 Full Year Planned Savings £9,594k	25/26 Full Year Actual Savings £10,941k	25/26 Full Year Savings Variance £1,347k
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Internal Plan & Actuals	Month 12			YTD		
	Plan	Actual	Variance	YTD Plan	YTD Actual	Variance
MSK	424	458	34	4,623	4,486	-137
Spec	417	385	-32	3,377	3,001	-376
Corporate	151	224	73	1,594	2,087	493
Total Recurrent	992	1,067	75	9,594	9,574	-20
YTD Non-Recurrent	0	149	149	0	1,367	1,367
Total including Mitigations	992	1,216	224	9,594	10,941	1,347

Performance

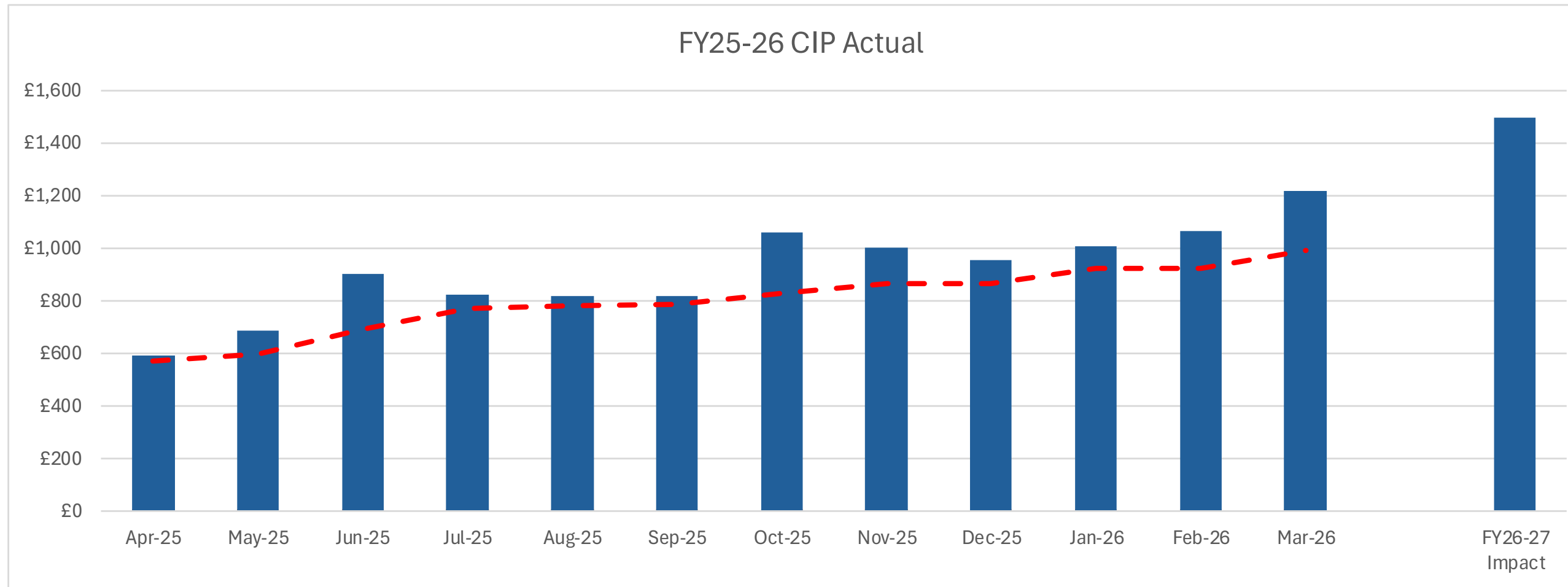
- In month £1,216k efficiencies achieved, £224k favourable to plan.
- In month recurrent delivery £75k favourable to plan, with an additional £149k of non-recurrent mitigations recognised.
- Full year £10,941k efficiencies achieved, £1,347k favourable to plan.
- Recurrent delivery £20k adverse to plan, offset by £1,367k non recurrent mitigations.



Full Year impact of schemes delivered in Month 12



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NHS Foundation Trust



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	FY26-27 Impact
Target (£000)	£568	£598	£689	£772	£783	£786	£826	£866	£866	£923	£925	£992	
<i>% of total plan</i>	<i>6%</i>	<i>6%</i>	<i>7%</i>	<i>8%</i>	<i>8%</i>	<i>8%</i>	<i>9%</i>	<i>9%</i>	<i>9%</i>	<i>10%</i>	<i>10%</i>	<i>10%</i>	
Forecast													
Red													£0
Amber													£0
Green													£0
Delivered	£593	£684	£900	£823	£817	£815	£1,061	£1,001	£956	£1,008	£1,067	£1,216	£1,495
TOTAL	£593	£684	£900	£823	£817	£815	£1,061	£1,001	£956	£1,008	£1,067	£1,216	£1,495



Efficiency Plan FY26/27



The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust

Overall position

The Trust has an overall efficiency target of £9.2m, broken down between £8.35m as submitted per the final plan and an additional £0.9m post-plan stretch target related to the deconstructing the blocks income reduction.

Of the submitted Trust efficiency plan of £8.35m, £8.2m has been identified and aligned to specific schemes. This leaves £0.2m currently unidentified, 2% of total efficiency plan, which represents a £1.2m improvement to the position included within the submitted plan.

A scheme of outpatient improvement worth £0.5m has been identified against the additional stretch target, leaving a balance of £0.4m as unidentified at this stage to be managed through non recurrent efficiency delivery.

Work continues through the unit structures to identify further additional schemes and to de-risk existing schemes while also working on the finalisation and sign-off of Project Initiation Documentation and Quality Impact Assessments as appropriate.

RAG	£'000	%
U	159	2%
R	2,031	24%
A	2,594	31%
G	3,566	43%
Final Plan Submission	8,350	
U	369	42%
R	500	58%
Post-Plan Stretch Target	869	
Total Plan	9,219	

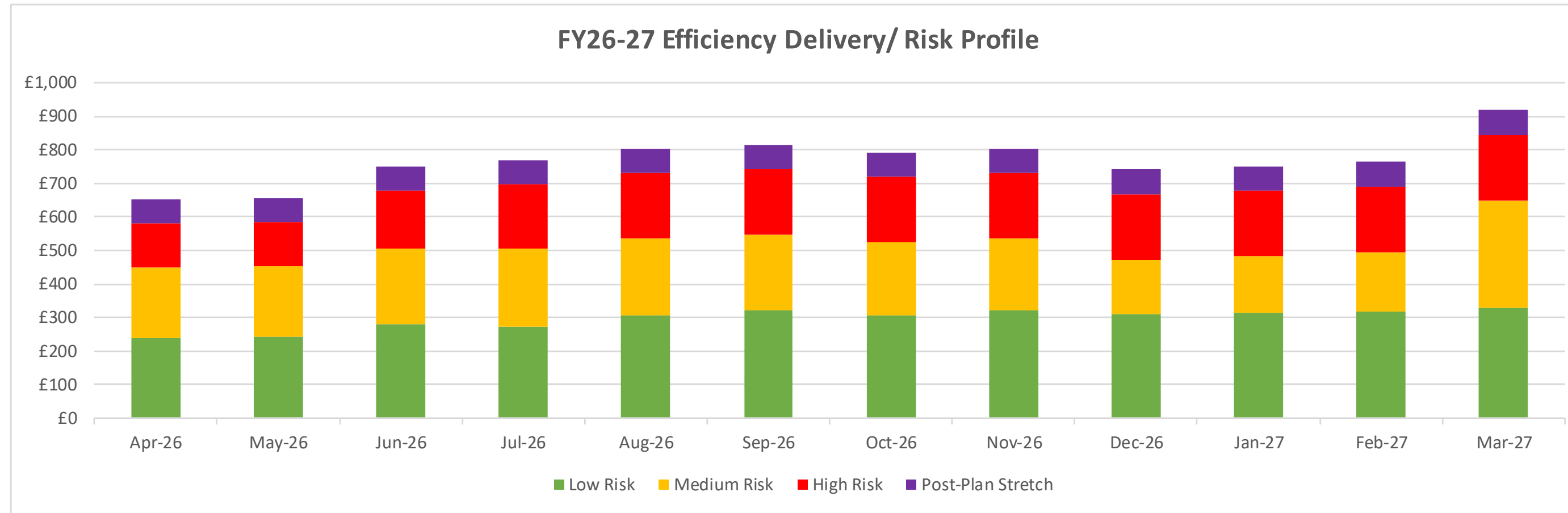
Gateway Status	£'000
G1: Opportunity	0
G2: Plans in progress	3,595
G3: Fully developed	1,162
G4: Implemented	3,434
Unidentified	159
Final Plan Submission	8,350
G2: Plan in progress	500
Unidentified	369
Post-Plan Stretch Target	869
Total Plan	9,219



Efficiency Plan FY26/27: Delivery/ Risk Profile



The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust



	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Total
Low Risk	240	241	280	274	306	320	308	323	312	315	319	328	3566
Medium Risk	208	211	226	232	231	228	217	212	161	169	177	322	2594
High Risk	132	132	174	192	193	195	195	195	196	195	195	196	2190
Post-Plan Stretch	72	72	72	72	72	72	72	73	73	73	73	73	869
Total	652	656	752	770	802	815	792	803	742	752	764	919	9219
% of Total	7%	7%	8%	8%	9%	9%	9%	9%	8%	8%	8%	10%	100%



Chair's Assurance Report Finance and Performance Committee

Committee / Group / Meeting, Date

Board of Directors - Public Meeting, 05 May 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 Finance and Performance Committee on 27 March and 24 April 2026. It highlights the key areas the Finance and Performance Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

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

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

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

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

Chair's Assurance Report Finance and Performance Committee

3. Assurance Report from Finance and Performance Committee

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

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

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

Require the approval of the Board for work to progress.

Activity Recovery Committee (ARC) and Waiting List Performance March / April): The Committee was assured that significant improvement has been achieved in RTT and outpatient performance, placing the Trust among the most improved nationally. Governance arrangements are effective, and routine reporting is now appropriate for these areas. The Committee agreed that focused scrutiny should continue on long waits (52/65 weeks and Welsh waits), given residual risk and complexity. Oversight will be maintained by exception.

Finance Performance (April): The Committee was assured that the Trust delivered its break-even plan for 2025/26, with a small underlying surplus before additional nationally allocated non-recurrent funding. Capital delivery, cash management and productivity performance were robust. The Committee received assurance that audit preparation is progressing well with no emerging issues identified.

New Theatre Full Business Case (March): The Committee scrutinised the Full Business Case for the new theatre development and was assured on the commercial, financial and management case. Members noted a fixed-price contract below the Outline Business Case estimate, robust governance arrangements, and mitigation of key risks, including learning from previous builds. The Committee agreed to recommend the Business Case to the Board for approval, taking high assurance on value for money, deliverability and oversight arrangements. This was subsequently approved at the private board meeting.

3.2 Areas of on-going monitoring with new developments

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

Outpatient Transformational Plans (April): The Committee received assurance that a robust programme of outpatient improvement activity is underway, underpinned by national guidance, clinical engagement and evolving intelligence at firm and consultant level. Early performance indicators demonstrate positive impact on activity, referrals and waiting times. The Committee took **partial assurance** pending development of a clearer delivery plan, including defined milestones, benefits realisation, governance oversight and alignment with the efficiency programme. Further assurance is required on capacity, PMO support and the articulation of "transformation" versus productivity improvement. The Committee requested the item be returned for further scrutiny.

MSK Spine Pathway / MSST Service Redesign (March): The Committee received a detailed presentation on the proposed MSK spine pathway redesign, including a single point of access model, advanced practitioner roles, and integration with MSST services. Assurance was taken on the clinical logic, workforce model, and benchmarking against established best practice. The Committee noted strong engagement with system partners and clear plans to improve patient flow and waiting times. Further assurance will be sought through delivery milestones, impact on RTT performance, and confirmation of sustained implementation.

Efficiency Delivery – 2025/26 Final Position and 2026/27 (April): The Committee was assured that the reported 2025/26 outturn accurately reflects performance, with the Trust delivering its efficiency programme overall and maintaining appropriate governance and grip. The 2026/27 efficiency target is fully identified, with strong early engagement and delivery discipline. The Committee noted a proportion of schemes remain high risk, particularly transformational elements linked to outpatient reforms, and that further mitigation may be required. Assurance was provided that risks are visible, owned and subject to close in-year monitoring.

Board Assurance Framework (March / April): The Committee was assured that the revised BAF entries better reflect the Trust's strategic risks relating to financial sustainability, performance delivery,

Chair's Assurance Report Finance and Performance Committee

and health inequalities. The Committee supported the overall direction of travel and strengthened narrative. The Committee requested further refinement around:

- Equity of access and health inequalities, particularly in relation to Welsh and English commissioning arrangements
- Target risk scores and time horizons
- Clear articulation of external inhibiting factors and governance arrangements

Efficiency Programme – 2026/27 Delivery (April): The Committee was assured that the 2026/27 efficiency programme is fully identified earlier than in previous years, providing a stronger starting position. Governance and transparency around delivery risk were appropriate. The Committee noted the additional stretch requirement and the need for continued active management of non-recurrent mitigation strategies.

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.

Productivity (April): The Committee was assured that productivity is improving and that the Trust is using a balanced, system-wide approach, recognising the limitations of national metrics and supplementing these with local intelligence, clinical engagement and improvement capability. The Committee welcomed continued work on workforce, process and cultural enablers to sustain improvement.

Integrated Performance Report Annual Review (April): The Committee supported proposed IPR and noted the alignment with the operational plan. The Board endorsed the proposal for 2026/27 for approval by the Board.

Corporate Objectives (April): The Committee was assured that relevant corporate objectives are appropriately aligned to the Committee, including outpatient reform, productivity, MSK services, veterans' care and commissioning relationships. The Committee requested quarterly updates for MSK and Veterans programmes will be built into the Committee work plan to support ongoing assurance.

Well-led action plan (April): Progress is being tracked with evidence of completion; updates will be provided every two months with the expectation all actions complete by the end of the calendar year.

Committee Annual Report and Self Effectiveness Report - The Committee was assured that it continues to function effectively, with positive feedback from members and appropriate coverage of its responsibilities. No material changes to the Terms of Reference were required, subject to minor updates.

Green Plan Q4 Update (April): The Committee was assured that progress is being made against Green Plan actions. Further reporting was requested on the benefits realisation from solar investment.

Chair's Assurance Reports were received:

- **Capital Management Group** - assured that capital delivery in 2025/26 was successful and that governance arrangements are robust. The revised approach to holding central capital reserves for prioritisation was supported, given ongoing funding constraints.
- **Procurement Steering Group** - assured that procurement risks, including supply chain vulnerabilities, are being actively monitored through established internal and system-wide arrangements.
- **Sustainability Group** – took assurance from the report










Recommendation

The Board is asked to:

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

Executive Summary - DERIC Committee

Assurance

	 Will consistently pass the target if nothing changes	 Will not consistently pass or fail the target if nothing changes	 Will consistently fail the target if nothing changes	 No Target or Moving Target
Variation	  Improving variation (high or low) or 3 months better than target			
	 No significant change or N/A to SPC			% Staff - Quality Improvement Training Research - Total Number of Studies Research - Number of Grant Applications Research - Number of Patients Recruited
	  Concerning variation (high or low) or 3 months off target			

Please note - this is defined by the associated SPC graph within the IPR. Many KPIs show as a moving target due to the change of targets/plans as we moved into new financial year and monthly phasing. Metric placed in boxes above based on the variation icon for latest data point, but over-ridden by whether meeting/failing target for last three months. If metric placed in a box based on meeting/failing plan, but does show improvement or deterioration - text colour will indicate that.

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

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 06 May 2026

Author:

Contributors:

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

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

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

This report provides a summary of the items considered at the Committee meeting held on 19 March 2026 and It highlights the key areas the Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

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

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

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

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

Assurance framework themes		Relevant	Overall level of assurance
1	Continued focus on excellence in quality and safety.		
2	Creating a sustainable workforce.	✓	HIGH
3	Delivering the financial plan.		
4	Delivering the required levels of productivity, performance and activity.		

Chair's Assurance Report

Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee

5	Delivering innovation, growth and achieving systemic improvements.	✓	HIGH
6	Responding to opportunities and challenges in the wider health and care system.	✓	MEDIUM
7	Responding to a significant disruptive event.	✓	HIGH

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

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

ALERT - The Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee wishes to bring the following issues to the Board's attention as they:

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

Require the approval of the Board for work to progress.

Digital Funding Opportunities (April): The committee took some assurance that the Trust is taking a proactive and pragmatic approach in seeking to maximise external digital funding opportunities, such as the Digital Frontline Productivity Programme, including aligning applications with existing planned investment where appropriate. Noted that proposed funding priorities are appropriately focused on EPR optimisation and stabilisation, infrastructure resilience (including wireless capability), and cyber security. The committee discussed the internal governance structure route for approval of such funding bids which have been recently developed and have requested a detailed schematic of the new governance model and decision-making flows to enable ongoing assurance and avoid duplication or gaps in accountability.

The committee noted that the funding bids being considered were very Trust focused and that there was little or no evidence of any system level or joint working with other organisations. It was highlighted that there does not currently appear to be any cluster or system level strategic governance structures through which a wider digital and data vision and funding strategy is being developed and agreed. The committee felt it appropriate to raise this as an area of concern to the Board.

Annual Review of IPR (April): The Committee endorsed the proposed KPIs for 2026/27 for approval by the Board but noted that there was a need to continue to develop the performance measures for each of the strands of DERIC over the coming months.

3.2 Areas of on-going monitoring with new developments

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

Chair Report: EPR Implementation Assurance Meeting (March / April): Committee were updated that EPR governance arrangements have been strengthened through the establishment of a Design and Safety Authority. The importance of strong and inclusive clinical engagement is critical to the success of the EPR programme and further assurance has been requested that the revised governance arrangements will continue to secure broad and representative clinician input into system design, workflow optimisation, and safety assurance. Members requested improved clarity on how EPR risks are expected to reduce over time, including clearer timelines linked to programme milestones. Further assurance was also requested on how EPR Assurance, Digital Transformation Group, and design governance interact to ensure coherent escalation, avoid duplication, and provide clear lines of accountability.

Chair Report Digital Transformation Group (March / April): Assurance provided that the recent governance reset has strengthened the Group's ability to align digital initiatives with organisational strategy and available capacity. Members were more assured that clear routes are now in place for initiatives to be assessed through prioritisation and innovation forums before being escalated for executive consideration. The Committee welcomed the increasing alignment between digital and research activity and noted opportunities to strengthen this further. The need for concise,

Chair's Assurance Report

Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee

assurance-focused reporting that clearly articulates delivery progress, key risks, and benefits realisation to support effective oversight was requested.

Digital Security Report (March / April): Cyber security remains a key organisational focus and that appropriate monitoring and testing arrangements are in place. Members noted the high volume of attempted cyber-attacks and welcomed the proactive use of phishing simulations to test organisational resilience and staff awareness. The Committee supported plans to strengthen communication of cyber risks through system messaging and welcomed the development of cyber incident simulation exercises in collaboration with the Emergency Preparedness, Resilience and Response team. Further assurance is required on the outcomes of phishing simulations and the impact of improvement actions over time.

Chair Report: Research Meeting (March / April): The research profile and external engagement continue to grow, with increasing opportunities through national and regional partners. The appointment of a Research Project Officer was welcomed as a positive step in supporting workforce development, particularly for nurses and Allied Health Professionals. The Committee identified workforce capacity and the lack of backfill as a significant and systemic barrier to delivering the Trust's research ambitions. Despite funded fellowship opportunities, uptake remains limited due to operational pressures. The Committee agreed that action is required to address these constraints and to strengthen performance reporting, including clearer metrics, benchmarking, and narrative to support assurance.

Board Assurance Framework (March / April): Assured that further refinement is underway to strengthen alignment with corporate objectives and improve the clarity of risk articulation. Members confirmed that digital, research, innovation, and commercial risks are appropriately identified as principal strategic risks. However, it was noted that several BAF entries reference the existence of strategies without clearly detailing how these are operating as effective controls or are reducing risk exposure.

Integrated Performance Report (April): Digital - highlighted the need for digital reporting to evolve to include more strategic measures, such as indicators of digital maturity, progress against long-term transformation objectives, and evidence of benefits realisation, including improvements in efficiency, quality, and user experience. Commercial - acknowledged that defining and measuring commercial activity within an NHS context is complex, and that further work is required to establish a clear definition of what constitutes commercial activity and ensure alignment with the Trust's strategic objectives.

3.3 Areas of assurance

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

Digital Road Map (April): Assured that it provides improved visibility of the scale and breadth of digital activity across the organisation. The expansion of the roadmap to reflect the growing number of initiatives was welcomed, as was its communication across the Trust, including via staff engagement events. The Committee noted that initial steps have been taken to establish a structured prioritisation process, with the first formal prioritisation meeting scheduled. Members were assured that this process is intended to support the development of robust business cases and align investment decisions with organisational capacity and strategic priorities. A number of digital initiatives are currently progressing outside the formal roadmap and require alignment to ensure coherence, transparency, and effective use of resources. Opportunities for automation, particularly within corporate functions, were identified as an area of potential efficiency gain. The Committee also highlighted limited visibility of innovation and robotics activity across the Trust and has requested improved oversight and reporting, including a specific update on robotics at a future innovation-focused meeting.

Research Development (March): Assured that appropriate actions are underway to strengthen research capacity, improve delivery performance, and increase the Trust's profile as a research-active organisation. Noted plans to rebalance the research portfolio to increase commercial research activity, supporting reinvestment and long-term sustainability, while continuing to deliver aligned non-commercial studies. Assurance was provided that performance against national expectations, including study set-up and recruitment timelines, is a key focus, alongside workforce review and strengthened collaboration with academic and innovation partners.

Chair's Assurance Report

Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee

Private Patient Review (March): Good progress is being made in implementing the recommendations from the external review of the Private Patient Unit, with a pragmatic focus on early improvements alongside longer-term development. Growth in private activity is being carefully balanced against NHS capacity pressures, with risks recognised and managed, and further assurance will be provided through the development of a clear short-, medium- and long-term plan for private patient services.

Sim Lab Progress (March): Assured that simulation activity is being integrated within the Trust's education and workforce development arrangements, supported by appropriate governance and monitoring. Progress will be reported through periodic education updates, with future focus on utilisation, capacity and impact, alongside consideration of sustainability, staffing and alignment with wider Trust plans.

Committee Annual Report and Effectiveness Survey (inc. TOR) (April): Annual review indicates improvement year-on-year. Terms of Reference will be updated to include education strategy and system engagement, along with consideration on how to record members of the meeting which have an open invitation.

Education Strategy (March): Progress is being taken forward through defined workplans and appropriate reporting routes to support workforce readiness and longer-term organisational objectives. The committee asked for further consideration on how digital enables can support.

Well-led action plan (April): Progress is being tracked with evidence of completion; updates will be provided every two months with the expectation all actions complete by the end of the calendar year.

Corporate Objectives (April): The Committee reviewed the updated Corporate Objectives and is assured that DERIC elements are clearly embedded as core enablers of the Trust's strategy. The Committee welcomed the alignment of these objectives with the remit of DERIC and the recognition of digital and research activity as critical to delivering high-quality, sustainable services. The need for clear delivery plans, measurable outcomes, and structured reporting against these objectives, with strong alignment to the Board Assurance Framework and Integrated Performance Report was noted.

RADAR System Implementation (March): The transition to the RADAR system for risk management has been successfully implemented, with no immediate concerns identified.

Recommendation

The Board is asked to:

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