The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Board of Directors 04.03.2026

MEETING
4 March 2026 09:30 GMT

PUBLISHED
4 March 2026

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Agenda

Location	Date	Time
Meeting Room 1, Main Entrance	4 Mar 2026	09:30 GMT

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1	Welcome and Introduction	Chair	09:30	-
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1.4	Action Log / Matters Arising	All Attendees		-
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3	Chair and CEO Update	Chair and Chief Executive Officer	09:55	26
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4	Quality and Safety		10:10	-
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5	People and Workforce		10:30	-
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8	Chair Report from Audit and Risk Committee	Non-Executive Director	11:35	140

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10	Any Other Business	All	11:55	-
10.1	Next Meeting: 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
Board	Harry	Turner	Chairman	Non-Financial Personal Interests	Presiding Justice West Mercia judiciary	01/10/2026	Ongoing
Board	Harry	Turner	Chairman	Financial Interests	In Form Solutions Management Consultancy	01/02/2024	Ongoing
Board	Sarfraz	Nawaz	Non Executive Director	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	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 Acadamy, Wednesbury Oak Road, Tipton, West Midlands DY4 0BS.	01/11/2023	Ongoing
Board	Martin	Newsholme	Non Executive Director	Financial Interests	Non executive director of Shropshire Doctors Co-operative Limited	01/08/2019	Ongoing
Board	Martin	Newsholme	Non Executive Director	Financial Interests	Non executive director at Warrington Housing Association	01/09/2018	Ongoing
Board	Lindsey	Webb	Non Executive Director	Indirect Interests	Husband is a Deputy Chair at Birmingham, Black Country and Solihull ICB	17/11/2025	Ongoing
Board	Lindsey	Webb	Non Executive Director	Indirect Interests	Husband is a NED at Birmingham and Solihull ICB		16/11/2025
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	STW ICB Partner Member	01/07/2022	Ongoing
Board	Stacey	Keegan	Chief Executive Officer	Non-Financial Professional Interests	Lead CEO for the NOA	01/12/2025	Ongoing
Board	Stacey	Keegan	Chief Executive Officer	Non-Financial Professional Interests	A member of the National Orthopaedic Alliance Board	03/05/2024	Ongoing
Board	Ruth	Longfellow	Chief Medical Officer	Financial Interests	Private Practice work for RJAH	01/01/2011	Ongoing
Board	Ruth	Longfellow	Chief Medical Officer	Financial Interests	Member of GAS (Gobowen Anaesthetic Services)	01/11/2019	01/06/2025
Board	Mike	Carr	Chief Operating Officer	Indirect Interests	Parent is Chief Executive of Midlands Partnership NHS Trust.	01/05/2022	Ongoing
Board	Mike	Carr	Chief Operating Officer	Non-Financial Personal Interests	Trustee at Stay Charity	01/02/2025	Ongoing
Board	Denise	Harnin	Chief People and Culture Officer	Non-Financial Personal Interests	Spouse is a senior partner at Johnson Fellows Charter House, Birmingham, Ad hoc HR consultancy Johnson Fellows		Ongoing
Board	Angela	Mulholland-Wells	Chief Finance and Commerical Officer	Non-Financial Professional Interests	Board Trustee and chair of the Audit, Finance and Risk Committee for Mines Advisory Group.	01/10/2023	Ongoing
Board	Paul	Kavanagh-Fields	Chief Nurse and Patient Safety Officer	Non-Financial Professional Interests	Chair of the NOA workforce network	01/06/2024	Ongoing
Board	Paul	Kavanagh-Fields	Chief Nurse and Patient Safety Officer	Non-Financial Professional Interests	Member of the Cavell Advisory Panel, supporting a UK charity that assists nurses, midwives, and maternity support staff facing financial hardship.	01/10/2024	Ongoing
Board	Sarah	Needham	Interim Chief Nurse and Patient Safety Officer	No interest to declare	N/A		

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

BOARD OF DIRECTORS | PUBLIC MEETING

WEDNESDAY 07 JANUARY 2026 AT 9:30AM AT RJAH ORTHOPAEDIC HOSPITAL

MINUTES OF MEETING

Voting Members in Attendance

Name (and identifying Initials)	Role	Attending
Harry Turner (HT)	Chair	✓
Sarfraz Nawaz (SNa)	Non-Executive Director	✓
Martin Newsholme (MN)	Non-Executive Director	×
Penny Venables (PV)	Non-Executive Director	×
Lindsey Webb (LW)	Non-Executive Director	✓
Martin Evans (ME)	Non-Executive Director	✓
Darius Mirza (DMi)	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	✓
Kate Betts (KB)	Governor – observing	✓
Victoria Sugden (VS)	Governor – observing	✓
Colin Chapman (CC)	Governor – observing	✓
Sheila Hughes (SH)	Governor – observing	✓
Peter David (PD)	Governor – observing	✓
Craig Emery (CM)	Governor – observing	✓
Peter David (PD)	Governor – observing	✓
Nicki Bellinger (NB)	Governor – observing	✓

Ref	Discussion and Action Points
1.0	**Welcome and introductions**
	The Chair opened the meeting by welcoming all attendees and extending best wishes for a happy New Year. The Board welcomed Kirsty Foskett, Assistant Chief Nurse and Patient Safety Officer, who attended the meeting to represent the nursing portfolio. It was noted that there would be no patient story presented this month.
1.1	**Apologies**
	Apologies for absence were received from Penny Venables, Martin Newsholme and Sarah Needham and Paul Kavanagh-Fields. It was formally confirmed that the Board was quorate, enabling the meeting to proceed with full decision-making authority.

Ref	Discussion and Action Points
1.2	**Declarations of Interest**
	The Chair reminded attendees of their obligation to declare any interest which may be perceived as a potential conflict of interest with their Trust role and their role on this Board. There were no conflicts of interest identified in relation to the items for discussion which required members to withdraw from discussion or decision-making.
1.3	**Minutes of the previous meeting**
	The minutes of the Board of Directors (Public) Meeting held on 05 November 2025 were approved subject to the following amendments: • Attendance table: Add DMI as an attendee. • Item 4.1 – National Oversight Framework: Update the league table figure to 27 out of 134. • Item 5.2.1 – CQC Inspection and Report: Amend the paragraph under the HDU areas of improvement to clarify that the feedback applied to all staff, and that the staff survey results were not specific to HDU staff
1.4	**Matters Arising and Action Log**
	It was confirmed that there were no outstanding actions to discuss, and the attendees had no further comments.
2.0	**Chair and CEO Update**
	Chair Update The Board continues to acknowledge the position the Trust remains in regarding the 65-week waiters, and noted that this remains a key area of focus for the organisation. **Chief Executive Officer Update** The Chief Executive provided the Board with the following updates: • **Christmas at the Trust** - The Board noted the successful delivery of Christmas services across the Trust, with staff once again going above and beyond to support patients spending the festive period in hospital. Thanks were recorded to all colleagues who worked over Christmas, with recognition for the Catering Team's exceptional contribution. Patient feedback was reported as highly positive. • **National Oversight Framework Q2 Report** - NHS England published the latest National Oversight Framework (NOF) update in December, including refreshed performance league tables. RJAH has ranked 25th out of 134 NHS Acute Trusts in England, reflecting an improvement of two places since the first publication in September. Trusts are assigned to one of four segments, with segment 1 indicating the narrowest range of challenges and segment 4 the broadest; RJAH has been placed in segment 2. Only 28 Trusts, around one in five nationally, are currently in segments 1 or 2 in this second iteration. • **ROH Strategic Alliance** - In November SK and HT met with our counterparts at the Royal Orthopaedic Hospital, Birmingham to discuss areas of opportunity, potential priorities and next steps for the strategic alliance. A Board to Board is planned for April 2026. • **SaTH Pathology Lab Partnership** - noted the establishment of a new collaborative partnership between the Cellular Pathology Departments at RJAH and The Shrewsbury and Telford Hospital NHS Trust (SaTH). This development builds on existing cross-system working within blood sciences and aims to strengthen diagnostic capacity and enhance patient care. The partnership will provide greater service resilience through a larger combined team and will support shared learning, training, and the adoption of new technologies. • **Flu Vaccination Campaign** - noted the focus this winter on increasing staff uptake of the flu vaccine, recognising it as a key measure to protect colleagues, patients, and families. Last year's uptake was just over 25%, consistent with national trends, and the Trust was set a target to improve by five percentage points. The Board was pleased to note that this ambition has been significantly exceeded, with approximately 52% of staff having received the vaccine to date. The vaccine remains available for those who have yet to take it up, and with colder weather and high community prevalence of flu, promotion of the campaign will continue. • **Sam Young, Innovation and Improvement Award** – commended the creation of the new Sam Young Innovation and Improvement Award, established in memory of our late Interim Chief Nurse, Sam Young, whose sudden passing last year was deeply felt across the organisation. The award has been introduced to honour her commitment to continuous improvement and her passion for driving positive change. The inaugural award was

Ref	Discussion and Action Points
	presented to Lisa Davies-Jones, Pre-Operative Assessment Unit Manager, at the Annual Nursing and Allied Health Professionals Celebration Event, recognising her leadership in delivering an innovative health screening initiative. • **RJAH STAR Award** – December winner was Dr Shu Ho, one of our Consultant Physicians, who was put forward for the award by Dr Danielle Hilton in recognition of the positive and lasting impact he has on patients and colleagues alike. In her nomination, she wrote that Dr Ho fosters a workplace which strives for excellence whilst empowering his team to work independently under his supervision. His positive attitude and always putting the patient first is exemplary. He speaks to all staff members as equals and looks after patients as though they were his own family. • **RJAH STAR Award** - November winner was Rima Chowdhury, a booking clerk who was nominated in recognition of her outstanding commitment to patient care. She was put forward by Laura Crump and Rob Freeman, who wrote that Rima plays a key role within our service, and her resilience has been remarkable. She consistently looks for solutions to challenges, no matter how complex, and approaches her work with positivity and professionalism. The Board noted the updates provided, and HT encouraged further comments from members. The following was discussed: • ME requested an update at the next DERIC Committee meeting regarding the changes to the Pathology Service, and asked that this be picked up through the usual meeting cycle. • A query was raised about the RADAR healthcare system, specifically seeking clarification on what the system does and how it will be brought to life operationally. It was suggested that this should also be discussed through the DERIC Committee. • Members expressed delight regarding the award made in memory of Sam. • In relation to Shu Ho's work on civility, a question was asked as to whether he could support the organisation's civility campaign. • SNa raised a point regarding patient communications, asking whether this should be explored further through either the Quality & Safety (QS) Committee or DERIC, noting that recent stories raised at the public forum had focused on improving communication. LW confirmed that this issue is being actively picked up at the QS Committee meeting and that assurance on the Doctor Doctor system will be included in the upcoming presentation. SK added that several effective measures are already in place, including the complaints process, which provides useful data for monitoring and improvement. • AI asked whether there might be an opportunity to integrate the digital aseptic system with the wider information strategy to enhance how data is captured and used. AMW confirmed that the Trust Interim Chief Digital and Information Officer are providing support and driving improvements in this area.
3.0	**Quality and Safety**
3.1	**Performance Report – Quality and Safety Committee**
	The Board received the Quality and Safety Performance Report (by exception) and noted the following key points: • **Complaints:** 19 complaints were reported against a target of 8. Learning has been identified and shared, with further discussion held at the Patient Experience Committee. • **Discharge Dates:** This is a new metric within the NOF, currently reported at 0.49. • **Infections:** 1 E. coli infection reported. • **Surgical Site Infections (SSI):** 4 SSIs were recorded in November from surgeries undertaken in October. Learning has been identified and shared at the MDT meeting.
3.2	**Chair's Assurance Report – Quality and Safety Committee**
	LW presented the key points from the Quality and Safety Committee Chair's Assurance Report. The following items were highlighted: • **Inpatient Staff Survey** – highlighted as a separate report being presented as part of the Board agenda. • **Board Assurance Framework (BAF)** – The Committee discussed whether the BAF accurately reflects the feedback received from patients and the themes emerging from complaints, as well as the amendments required following the Apollo review. These elements will be revised as part of the next review.

Ref	Discussion and Action Points
	• **Emergency Preparedness, Resilience and Response (EPRR)** – highlighted as a separate report being presented as part of the Board agenda. The Board discussed the following: • **Complaints Deep Dive** - the Board noted an increase in the number of complaints, with patient communication identified as a recurring theme. Work is underway to address this, including a deep dive at the upcoming Patient Experience Meeting. • **Clinical Outcomes and Concerns** - A question was raised regarding whether there are any clinical concerns and whether further assurance could be provided on outcomes versus processes. It was requested that this be incorporated into future reporting of the complaints deep dive which is reviewing patient communication. LW confirmed that a new metric 'unplanned returns to theatre' has been added, providing an additional source of outcome-based data. • **Infection rates** - The Board discussed infection rates and agreed that assurance had been provided across all relevant metrics. • **Infections and NOF Rating** – SK informed the Board that although the annual Trust target is set at 1, the rolling nature of NOF reporting means the Trust will appear as non-favourable. This issue has been escalated nationally, and given the very low numbers reported by the Trust, it has been agreed that the organisational target will be removed. A footnote will also be added to the report to provide clarity. This approach is intended to maintain patient confidence in the Trust's infection-rate reporting, and the Board was assured by this explanation. The Board concluded that it was content with the level of assurance received.
3.2.1	**Inpatient Survey**
	KF presented the paper outlining the very positive report, noting the strong assurance and responses received. While the findings were excellent, there remain areas for continued improvement. The action plan arising from the survey will be reported through the appropriate governance channels. A total of 131 Trusts took part in the survey, which was conducted, as usual, in November 2024. During that period, 1,250 of our patients were invited to complete the survey and 863 responded, a response rate of 70%, the highest in the country. The Trust has been categorised as one of only three Trusts achieving a rating of "much better than expected". Overall, RJAH was ranked second nationally. Across all questions in the survey, responses were rated as better than other Trusts, with six responses rated as on par with other Trusts. Importantly, no responses were rated worse than other Trusts. Key highlights and notable practice included: • The Trust scored "somewhat" too "much" better than expected in 87% (39 out of 45) of questions. The remaining six questions were rated as "about the same" as other Trusts. • Q37 Support for discharge planning: The Trust saw a significant improvement, increasing from a score of 8.7 in the 2023 survey to 9.4 this year. • Overall experience was rated 9.4, showing continued improvement from 9.2 in 2023 and 9.3 in 2022. The survey identified one question where the Trust scored below the national average: Q2 Waiting list experience: "How did you feel about the length of time you were on the waiting list before your admission to hospital?" The Board discussed the work being undertaken to support patient waiting well which is being reported through the Quality and Safety Committee. As a Board, the team are aware of theme of complaints which triangulates with the survey results. The Board congratulated staff for this fantastic achievement and noted the exceptional consistency in maintaining such high standards.
3.2.2	**EPRR Annual Report**
	MC presented the annual report for emergency, preparedness, resilience and response annual report to the Board, highlighted the following:

Ref	Discussion and Action Points
	• The Annual Standards Assessment was completed in August. • There has been significant improvement made during the year, with the Trusts compliance position increasing from 64% to 83%. • This progress has also helped provide far greater clarity on the remaining actions required. • Importantly, the workload for the coming year is now much more manageable due to the substantial progress achieved over the last 12 months. • As set out on page 3, the Trust has an identified Accountable Emergency Officer, which is fulfilled by MC and reported the Quality and Safety Committee. • The Trusts continues to maintain 24/7 tactical on-call arrangements from an EPRR perspective to support any incidents that may arise. • The report provides a summary of the training and exercises undertaken during the year. Activity has been significant and includes exercises related to flu planning, major incident readiness, adverse weather, BAU disruptions, and a range of business-as-usual and mandatory EPRR training. • One of the key areas of progress this year has been the strengthening of our Business Continuity Management System (BCMS). This was highlighted as an area of good practice in our Annual Assessment and has since been shared with other Trusts as an example of effective oversight. • The team has a robust process in place for maintaining and auditing departmental business continuity plans, ensuring they remain current and well understood. • Members of Quality and Safety Committee will recognise the substantial number of policies and procedures that have been reviewed and updated over the past 12 months. This work was undertaken to ensure readiness for reassessment and supports compliance across multiple EPRR domains. • The key incidents managed during the year are always captured with in the report. Since the report was drafted, further events have occurred, including ongoing industrial action and the adverse weather experienced earlier this week. All of these have been effectively managed through established EPRR processes. In summary, there has been significant progress over the past year, and the Trust has a clearer and achievable route to reaching full compliance and the Trusts progress has been acknowledged by the System meetings. Members of the Quality and Safety Committee confirmed the report was considered at the recent meeting and recommended for approval by the Board. The Board confirm it is assured by the progress made.
4.0	**People and Workforce**
4.1	**Performance Report**
	The Board received and noted the latest People and Workforce Performance Report. The following key points were highlighted during discussion: • **Performance Metrics** - Overall performance remains on target or marginally below target across most metrics. • **Significant Work Underway** - A substantial amount of effort continues across the workforce programme to maintain stability and progress improvement actions. • **Bank Workforce Controls -** Extensive focus and energy have been directed toward strengthening bank workforce controls. Enhanced processes are now in place, including stronger managerial oversight and tighter approval arrangements for bank shift sign-off. While agency use continues to be well-managed, restricted primarily to known exceptional areas previously reported to the Executive Team, bank utilisation is expected to benefit further from the strengthened controls now implemented. • **Recruitment Metrics (HCA) -** Issues raised in the recent Executive Team Meeting highlighted concerns regarding the static nature of HCA recruitment figures, which appear unchanged month-to-month. There is uncertainty as to whether this reflects an inaccurate target, or a genuine pattern of losing approximately 10 staff each month while gaining 10. This does not presently align with operational experience. Therefore, a deep dive review will be undertaken and findings will be brought back to the Committee next month. The Board noted the performance report.

Ref	Discussion and Action Points
4.2	**Chair's Assurance Report – People and Culture Committee**
	PM provided an overview of the key matters discussed at the People and Culture Committee for Board assurance. The following points were highlighted: • Workforce reduction plan – the actions scheduled for later in the year remain on track. • Workforce targets are currently being met, and consideration is being given to the non-recurrent elements. • Back pay for Global Majority staff members has been approved and will be supported accordingly. A discussion took place regarding mandatory training. LW queried whether progress had been made in improving the accuracy of reporting to prevent recurring issues. It was noted that accuracy concerns continue to be worked through, and further clarity is needed on any remaining areas of risk relating to non-compliance, particularly in high-risk clinical training areas. The Committee agreed that delays should be avoided where possible. The Board acknowledged the strong metrics and positive performance, noting thanks for the continued efforts.
4.2.1	**Freedom to Speak Up Report**
	The Quarter 2 Freedom to Speak Up (FTSU) Report was presented, having previously been considered by the People and Culture Committee in November. It has been brought to the Board and the public meeting to ensure full visibility and transparency. The Board was invited to pose any questions regarding the contents of the report. The recommendations presented to the Board were to: • **Note** the Quarter 2 FTSU report. • **Acknowledge** the ongoing development and strengthening of the FTSU service. • **Consider** the level of assurance provided through this reporting cycle. It was formally confirmed that the report had already undergone scrutiny by the People and Culture Committee and PM confirmed that the members of the Committee had taken assurance from the report. The Board discussed the following: • The People and Culture Committee reflected on the recently reviewed sexual safety report, noting that elements of bullying and harassment had also been identified within that context. PM emphasised the importance of gaining a deeper understanding of these areas, acknowledging that this work is already underway. DH commented on the relationship between sexual safety cases and overall safety culture, stressing the importance of strengthening triangulation across all concerns raised. DH emphasised that intelligence can and does come through multiple informal and formal routes. • SNa expressed appreciation for the revised reporting format, describing it as a significant step forward. The enhanced structure and increased depth of data provide more actionable insights, enabling the Trust to better interpret themes, identify patterns, and understand the lived experiences of staff. SNa stressed the importance of fully utilising these insights to strengthen the organisational culture and ensure that staff feel genuinely supported and listened to. • Raised an important point regarding the absence of anonymous cases this quarter. While this may reflect increased confidence in the service, ME asked how the Board might gain assurance that low levels of anonymous reporting are genuinely positive, rather than indicative of staff feeling unable to speak openly. This was highlighted as an area to continue monitoring. SNa responded that triangulation, alongside the overall volume and nature of reporting, can help build confidence in the data and provide some reassurance. • It would be beneficial to gather feedback directly from staff who have used the FTSU process, specifically whether they would be willing to use the service again. This would offer valuable insight into staff experience and perceptions of psychological safety within the process. HT proposed that, alongside regular patient stories, the Board could also benefit from hearing an anonymised Freedom to Speak Up story at a future meeting. This would support learning and visibility, provided that confidentiality is maintained.

Ref	Discussion and Action Points
	• DM cautioned against making assumptions about reporting behaviour. A *decrease* in the number of staff approaching the service could, in fact, be a cause for concern, and patterns over time would need to be monitored carefully. • LW asked whether the upcoming staff survey would include any new questions or data points that could support additional triangulation alongside FTSU reporting. The survey was recognised as another key source of information for understanding staff sentiment. • HT reiterated that Freedom to Speak Up should not become the *sole* mechanism through which staff feel able to raise concerns. A healthy organisational culture requires multiple safe, accessible avenues. The Board noted the report and took assurance from the discussion. It was acknowledged that the staff survey is conducted annually and work is being undertaken to triangulate data sets.
5.0	**Performance and Finance**
5.1	**IPR Exception Report (inc. Long Waiting Patients)**
	MC presented the Integrated Performance Report to the Board, providing an overview of current performance, areas of improvement, and ongoing challenges. • **Day Case Length of Stay Breach** - The Board noted the details of the single patient breach relating to days stayed. We narrowly missed the 85% target due to the complexity of the patient involved. • **18-Week RTT Performance –** 57.29% performance has improved since April and remains on a positive trajectory. The organisation is currently reporting 6% points ahead of plan and remain on track to reach the target by the end of March, in line with the three-year recovery plan. • **Time to First Outpatient Appointment** - a strategic decision was taken to focus on addressing the disparity between English and Welsh access times, given that we are performing ahead of national standards. Improvements were seen throughout December and January. • **52-Week Waits -** the trend continues in the right direction; however, performance is slightly behind where the team anticipated. The Board held a detailed discussion regarding whether the resources are in place to achieve the 1% target by year-end. • **65-Week Waits** - there were 67 patients waiting over 65 weeks at the end of November, with progress continuing into December. A return to NHSE is required to update on progress, and Board members will be copied into this submission. • **Welsh 104-Week Waits - t**he growth in long waiters has halted, and numbers began to reduce in January. This is a positive development, reflecting continued focused effort. • **Diagnostics, 95% Standard -** performance remains below the 95% diagnostic standard. • **Elective Activity - e**lective activity continues to be behind plan at 94.36%. Theatre cases per session remain an area of focus, particularly in relation to case complexity, insourcing capacity, and delivery against job plans to ensure anticipated activity is completed. • **BADS Management -** the Trust continues to perform within the top decile for length of stay in orthopaedics, acknowledging the reporting complexities unique to our site. • **Outpatient Activity -** Outpatient activity is at 99% of plan. We are progressing towards reinstating all outpatient templates following the implementation of Apollo, which will increase activity from January onwards. The Board discussed the following: • **NHSE Submission** – The Board requested that the NHSE submission be circulated to all Board members for oversight. • **BADS Reporting and Performance** –highlighted that the intended management measure relates to patients discharged on the same day, and noted that the national GIRFT metric is not fully applicable to the Trust. It was suggested the Trust explores a partnership with the Royal Orthopaedic Hospital (ROH) to develop more appropriate standards for specialist trusts. MC agreed to discuss this with their ROH counterpart, noting that the differing case mix between organisations limits comparability. The Trust is taking a national lead on areas such as shoulder replacement pathways, and there is potential to shape new national standards for orthopaedics. Further work is also planned on same-day discharge intended management definitions. PM observed that the national oversight framework applies a standardised approach that does not always reflect

Ref	Discussion and Action Points
	specialist services; there may be merit in influencing the development of orthopaedic-specific standards. • **18-Week Target Query** – AI asked whether the 18-week year-end target could be updated to 60%. MC confirmed this aligns with the profile agreed with NHSE and reflects the planned trajectory. • **Job Plan Attainment** – ME queried the alignment between job plan attainment reviewed by the People Committee and operational achievement. He asked whether there is sufficient correlation across performance areas and whether this could be developed further, particularly in terms of productivity. MC noted that over the past two months, detailed consultant-level data, including conversion and discharge rates has been reviewed, supporting ongoing development in this area. AMW noted that consultant job plan utilisation and productivity indicators cannot yet be shared as they remain under development. However, this work is informing planning for the forthcoming year. • **Welsh Waits** – SNa noted that Welsh waiting times remain an area of discomfort but acknowledged that the latest graphs show emerging improvements. They recognised the work underway to support differing commissioning requirements and requested an update on commissioning arrangements. • **Commissioning Update** – MC explained that Powys' intentions regarding 52-week inpatient waits and 104-week outpatient waits have not been agreed, as they pose risks for the Trust. The Trust's performance is expected to be better than Powys' stated intention, and it does not support patients waiting a minimum of 52 or 104 weeks. Regular meetings are held with Powys to monitor performance, address concerns, whilst ensuring appropriate "waiting well" support is available for all patients. A mutually agreed approach needs to be developed for the next financial year, with Powys highlighted as a priority area. A recent meeting with the Powys team, including MDT input, was constructive and focused on continuing progress for patients. 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.
5.2	**Finance Performance Report**
	AMW provided assurance that the Trust remains on plan at Month 6, with all core financial objectives achieved. An in-month surplus of £300k was reported. It was particularly positive to note that the Trust achieved its clinical income target for the month, which has been a challenge in recent periods. While internal theatre and outpatient clinical income were in deficit, a year-to-date Best Practice Tariff payment was received, which helped mitigate the position. Private Patient (PP) activity continues to be monitored, and further detail will be included in future reports. The Research Team is actively exploring opportunities for additional clinical trials and commercial partnerships to generate further income. Regarding pay expenditure, strengthened controls are now in place covering bank, agency, and overtime usage, which must be approved in advance of shifts being worked. These controls are reported through PFIG and are proving effective; however, further work is required to minimise avoidable cost pressures. Pay budgets were adversely affected by not achieving the expected theatre income and by increased outsourcing activity, which has created an additional cost pressure. There remains a £200k variance to plan, with the Trust targeting delivery of a £1.7m deficit, compared with the current reported position of £1.9m. Productivity slides were reviewed as part of the Integrated Performance Report (IPR), reflecting the new NOF (National Oversight Framework) metric. This metric shows how productive the organisation is, and the calculation method was set out in the presentation. Productivity remains a challenge, particularly as recent high levels of activity.

Ref	Discussion and Action Points
	Nationally, the expectation is that organisations achieve productivity improvements equating to 2% per year for the next three years. The Trust previously reported –14%, but has now improved to –5%. PM emphasised that productivity improvements must progress at a faster rate than the rising cost of delivering services. In response to a query from SNa, it was confirmed that case complexity is factored into the national productivity metric through expected cost comparisons for different types of surgical activity. The importance of accurate reporting was reiterated. The Trust continues to work towards delivery of the £9.6m efficiency target, which is considered low risk overall, with only a small non-recurrent gap remaining to be addressed. In relation to capital, the Trust received an additional percentage of the £840k of national funding to support maintenance requirements. The Board noted that the financial performance remains on plan and emphasised the interdependencies between operational and financial delivery.
5.3	**Chair Report from Finance and Performance Committee**
	SNa presented the Chair's Assurance Report and highlighted the following key points: • Spinal Disorders Improvement Plan - The committee received a presentation on the ongoing work within the Spinal Disorders team, which had also been shared at the last public Board meeting. Members were provided with a clear plan outlining the direction of travel. The committee received assurance that appropriate plans are now in place, and further assurance will be provided as implementation progresses. • Financial Forecast - SN commended the teams for delivering the first-half financial position without any deterioration in quality standards, which is a significant achievement. The report highlighted the underlying deficit of £1.5m and emphasised that failing to address this will prevent the Trust from achieving financial balance. It was noted that current income losses exceed the underlying deficit. • Efficiency Performance - Efficiency performance was identified as a risk at the beginning of the year. SN commended the teams for their strong performance in achieving, and potentially exceeding the organisation's high efficiency target. The Board noted the Chair's Report and confirmed that it was satisfied with the assurance received.
6.0	**Chair Report from Digital, Education, Research, Innovation and Commercialisation Committee**
	ME presented the Chair's Assurance Report and highlighted: • **Research Income** - Recent finance updates, noting a reduction in research income coming into the organisation. The Committee held a constructive discussion about opportunities to address this and potential actions moving forward. Some of these opportunities will be incorporated into the future agenda. • **Education and training** - emphasised the ongoing challenge regarding limited facilities within the organisation. This continues to be a barrier, but there is a strong desire to address it. Progress is being made on the organisational education agenda, and the long-standing issue regarding the educational strategy appears to be nearing resolution. ME reported that the DERIC Committee is now receiving clearer data, enabling better alignment of funding to the correct areas within the educational structure. • **RJAH/ROH** - The Committee also discussed the position on research income. There are new opportunities emerging with RJAH/ROH strategic alliance, and the Committee explored how to advance these collaboratively. It was noted that stronger links could be developed between the respective Non-Executive Directors, and RL offered support to enable further discussion between the NED and the Medical Director in relation to research. A meeting date is currently being arranged and will be extended to ME to support. The Board noted the Chair's Report, and no specific questions were raised.
7.0	**Chair Report from Audit and Risk Committee**

Ref	Discussion and Action Points
	LW presented the following updates in relation to the Audi and Rosk Committee@ • **Summary of DSPT Compliance Update** - The organisation remains compliant with the Information Governance Toolkit. One incident was reported to the ICO via the DSPT, and one FOI breach occurred due to human error. The Committee is assured that incidents have been managed appropriately, with FOI/SAR compliance maintained and remedial actions in place. Continued oversight is needed to strengthen FOI processes and improve visibility of data quality reporting. • **Internal Audit Progress** – the report remains on track for delivery within the agreed timeframe. Internal actions and associated workstreams continue to progress as planned and remain on track. The Board discussed the following: • Register of Interests - A query was raised regarding the requirement for counter-signatures on the Register of Interests. LW explained that this was introduced as part of a revised process designed to strengthen governance and ensure appropriate management scrutiny. The counter-signature provides an audit trail confirming that mitigations have been reviewed and implemented. However, this step is currently being reconsidered as part of a wider review to ensure that the process remains proportionate and effective.
8.0	**Questions from the Governors and Public**
	Welsh Waiting List SH thanked the Board for the reassurance that the Welsh waiting list is reducing. SH specifically asked whether this also applies to the Betsi waiting list. MC confirmed that the lists are combined and are being collectively reduced, noting that the main volume relates to Powys. **NOF – Segmentation 2** VS welcomed the continued progress in Segment 2. **Rheumatology Hub Business Case** VS enquired about the timing of proposed rheumatology business case and funding, whether this is expected this year or next. This proposal will be represented to the Executive Team Meeting and onward to the Finance and Performance Committee at the end of the month. Further clarity will be available at that point. AMW and MC agreed that an update would be provided to VS in good time, particularly given the charity support involved. PD confirmed that the League of Friends will continue to support the hub, which remains a key area of development for many stakeholders. AMW confirmed that further confirmation is required regarding the hub's location, sustainability, and the availability of legacy funding to ensure ongoing development. PD emphasised that communication will be essential. **Staff Survey and Pulse Survey** CE asked about the pulse survey, how it fits into wider conversations, and how it reports into Freedom to Speak Up reporting? DH noted that while the survey has a purpose, it is now a limited tool. Typically conducted in the autumn, results are not released until 1 April the following year, meaning feedback is already six months out of date. The survey also lacks the ability to drill down into specific issues or localised areas. The plan is to reverse the usual approach and begin working directly with these teams now. This will involve honest conversations about barriers to engagement, issues of trust and confidence, and what support is needed to build stronger relationships. The aim is to generate meaningful dialogue and feedback without relying solely on the staff survey. A work programme will be developed to begin this immediately, starting with localised areas but with wider organisational benefits expected. In summary, the goal is to build a range of activities that encourage open dialogue and reduce reliance on the staff survey as the primary feedback tool. This work will be developed through the People and Culture Committee. Thank you for the question.
9.0	**Any Other Business**
	There were no further items of business for discussion.

Ref	Discussion and Action Points
	HT thanked all attendees for their time and contribution to the discussion before closing the meeting.
9.1	**Date and time of next meeting:** Wednesday 04 March 2026 at 9:30am


NHS
The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust
QIP aimed to reduce pre-operative opioid use in chronic pain patients
Sarah Holgate – Acute Pain Management Sister
Laura Thomas – Acute Pain Management Sister
Mel Bloor – Consultant Anaesthetist
Improving lives through excellent and innovative care
NHS

Research and background

- Opioid use has surged over the past 30 years with many patients presenting for surgery
- Chronic use makes pain management options complex and increases the risk of adverse postoperative outcomes

- Long term opioid use associated with
  - Longer lengths of stay
  - Surgical site infections
  - Higher readmissions and medical costs
  - Higher rates of early revision surgery

- Pre-operative reduction may reverse many of these risks

* Quinlan et al. BJA 127 (3):327-331 (2021)

SHOULDER · Volume 30, Issue 5, P1025-1033, May 2021 Download Full Issue

Preoperative opioid use is an independent risk factor for complication, revision, and increased health care utilization following primary total shoulder arthroplasty

Jacob M. Wilson, MD · Kevin X. Farley, BS · Michael B. Gottschalk, MD · Charles A. Daly, MD · Eric R. Wagner, MD

- Primary total shoulder arthroplasty
- 29,454 patients (44% received preoperative opioids)
- Odds ratio-
  - Wound complication- 2.04 (95% CI 1.44-2.89 p<0.001)
  - Surgical site infection- 2.33 (95% CI 1.63-3.34 p<0.001)
  - Prosthetic joint infection- 3.41 (95% CI 2.5-4.67 p<0.001)
  - Pneumonia- 1.95 (95% CI 1.39-2.75 p<0.001)
  - Thrombolytic event- 1.42 (95% CI 1.18-1.72 p<0.001)

PRIMARY ARTHROPLASTY · Volume 33, Issue 7, Supplement , S154-S156, July 2018

Download Full Issue

Does Preoperative Opioid Use Increase the Risk of Early Revision Total Hip Arthroplasty?

Nicholas A. Bedard, MD · David E. DeMik, MD · S. Blake Dowdle, MD · Jessell M. Owens, MD · Steve S. Liu, MD · John J. Callaghan, MD

- Primary total hip arthroplasty
- 17,695 patients (36.7% received preoperative opioids)
    - Early total hip arthroplasty revision- 1.2% vs 0.7% ($p<0.001$)

Why is this important to RJAH

- **Shropshire, Telford & Wrekin are noted as the top prescribers of daily morphine equivalent doses over 120mg per 1000 patients in the country (*OpenPrescribing & EPACT2*)**

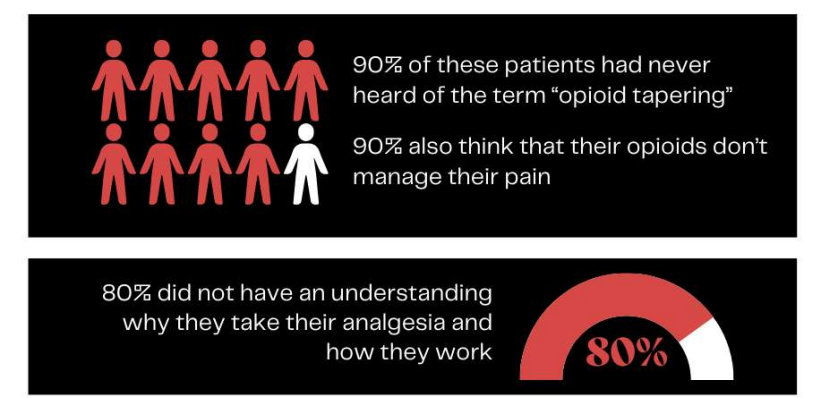
The recent 2023 GIRFT review provided the following recommendations in relation to pain management:

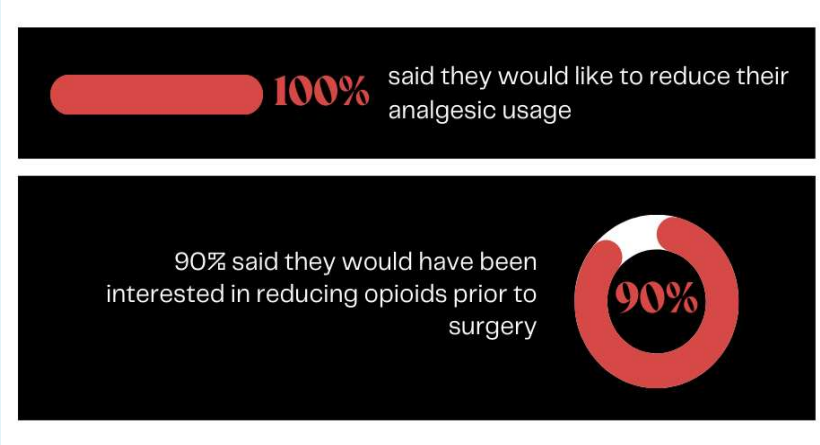
X	Delivering Outpatients	Health optimisation for key conditions	A pain management pathway is provided for patients taking opioids prior to surgery which aims to reduce use before surgery where possible, manage pain effectively during surgery, and minimise opioid use after surgery, in line with recommendations in NICE guidance.	R
X	Delivering Outpatients	Overview on early screening, risk assessment and health optimisation	Patients are screened for perioperative risk factors as early as possible in their pathway i.e. as soon as surgery is being considered, and at the latest as soon as possible after being added to the waiting list.	R

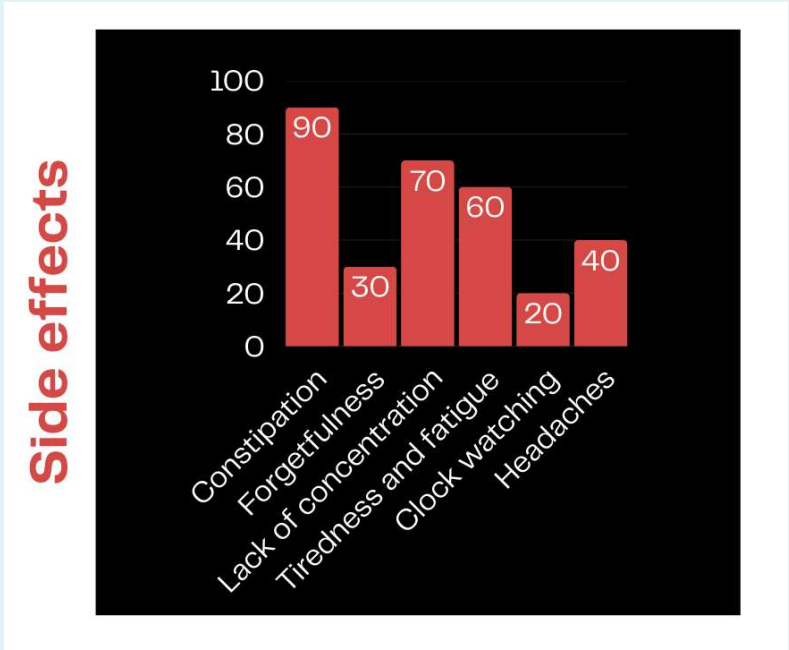
- Delivering high-quality clinical services is one of the five strategic objectives of the Trust. A key aspect of this goal is empowering departments to enhance and develop services to optimise patient care

Qualitative baseline data – patient feedback

A qualitative survey was undertaken with patients taking opioids pre-surgery, January to March. The findings were as follows:







Collaborative working

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

What are our barriers?

Apollo

Engagement

Time

Resources

Geographical limitations

Potential outcomes

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Increased patient engagement → Reduced opioid consumption post-operatively → Lower readmission rates and revision surgery → Improved patient journey

Pre-operative health optimisation → Improved surgical outcomes → Fewer complications → Reduced length of stay

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Thank you for listening
Any questions

Chief Executive Officer Update

Committee / Group / Meeting, Date

Board of Director, Public Meeting, 04 March 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 to Board members on key activities across several business areas not covered within the main agenda.

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

Recommendations:

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

Acronyms	
CEO	Chief Executive Officer
CFO	Chief Finane Officer
MSCI	Midland Spinal Cord Injury
ICB	Integrated Care Board
HSJ	Health Service Journal
NHSE	National Health Service England
FEI	Four Eyes Insight
HPS	High Potential Scheme
NHS	National Health Service
SRO	Senior Responsible Officer
NOA	National Orthopaedic Alliance
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust

Chief Executive Officer Update

1. ICB and NHSE restructures

Recruitment of the executive and non-executive Integrated Care Board (ICB) leadership team is almost complete with a few posts remaining to be appointed. Formal management of change is active in both the ICB cluster and NHSE which will be concluded in the coming months. We are conscious of the impact on our colleagues and are supportive of those who are part of both processes.
Cluster ICB board and committee governance is work in progress.

2. NHSE Leadership Event

On the 27 January, I attended an NHSE Leadership event in London. Sir Jim Mackey, CEO and Elizabeth O'Mahoney, CFO, reiterated the expectation of the whole NHS to maintain financial discipline and delivery its financial and operational plans for 2025/26.
The event also described the challenging environment for the medium-term planning round, but clear expectations on delivery for the three-year period.

3. National Orthopaedic Alliance

I attended the National Orthopaedic Alliance Board meeting in January. We agreed our workplan for 2026/27 which includes a balance of workstreams to improve operational delivery and performance of member orthopaedic hospitals, but also items of a more strategic nature with a focus on issues relevant to specialist hospitals in the new NHS infrastructure.

4. Digital Transformation

In February I attended both the HSJ Digital Summit and the NHSE Midlands Regional Leadership event; both agendas geared to the need and opportunities digital can bring to the NHS. The summit focused on embedding transformational technologies, enabling true interoperability, and supporting the leadership required to scale digital solutions that work. The NHSE event examined how digital transformation can drive systemic value, enhance productivity and build trust through transparency, co-design, scale and smarter infrastructure.
Both events offered opportunity to connect strategic ambition with local delivery and ensure digital becomes foundational, not optional in the decade ahead.

5. Royal National Visit

I was delighted to visit The Royal National Orthopaedic hospital in February where I met with Paul Fish, CEO and had the opportunity to visit various departments. An excellent opportunity to share and discuss strategic opportunities for specialist orthopaedic services. A huge thank you to Paul and those I met, and I look forward to welcoming Paul to RJAH in the near future.

6. Medium Term Planning

The Trust submitted its medium term financial, operational and workforce plans aligned to the national targets for the next three years to NHSE earlier this month.
At the time of writing this paper we are yet to receive feedback.

7. Operating Theatre Optimisation Programme

We are currently in the midst of an Operating Theatre Optimisation Programme. Phase One of this programme will run for five weeks and is focussed on insight and discovery. This work is being delivered in partnership with Four Eyes Insight (FEI) and Prism Improvement, who have been commissioned to provide specialist analytical and improvement support alongside our internal theatre programme. Elective performance remains a significant challenge; despite the considerable efforts already underway, we continue to face pressure from long waits, capacity constraints, and the need to better align demand, workforce, and theatre utilisation. This phase is about ensuring we have a shared, data-driven understanding of the issues, so that any future changes are clinically led, operationally realistic, and sustainable.

8. Bone cement supply issues

Board members will likely be aware of a shortage of medical bone cement affecting the NHS, following temporary production halts at one of the main global suppliers. We understand that this

situation may have been worrying for patients awaiting joint surgery. Fortunately, we have mitigated any impact on our services, and with alternative suppliers now having been sourced we are hopeful that

this will remain the case. We continue to monitor the situation closely, and work with colleagues both regionally and nationally to maintain our focus on safe, high-quality care, which is free from disruption as far as possible.

9. Flooding issues

Board members will know that, for a long time now, RJAH has been impacted by flooding on the main road outside the hospital, close to Entrance 2, every time we experience heavy rain. We appreciate that this causes significant disruption and difficulty for patients, staff and visitors alike. Our Estates and Facilities team is actively engaging with Shropshire Council on this issue, and the authority accepts there is an ongoing issue and are investigating ways to resolve it. Through conversations with relevant staff at the council, we are exploring the construction of an enhanced soakway (an above-ground drainage system sometimes referred to as a mound system) to alleviate the problem. There is no specific timeframe for this work at this stage, but we will continue to provide updates.

10. Solar Carports

The work to install new solar carports on car parks across the site is progressing well. These canopies will help reduce carbon emissions, lower energy costs, and support our long-term Net Zero objectives. We are aware this work can be disruptive and have used all channels at our disposal to communicate with patients and visitors, to apologise for the inconvenience, especially if they have struggled to find a parking space of late. We know the work has made it harder for staff to find a space as well and thank them for their patience. The good news is that the bulk of the work will be done by the end of this month – and I am sure you will agree that the benefits we reap in the long term will make this short-term inconvenience worthwhile.

11. New X-Ray facilities

Patients who attend for an x-ray are now benefiting from improved, state-of-the-art facilities, supporting safer and more efficient diagnostic imaging. A £324,500 investment has seen two rooms within the Radiology Department fully upgraded with modern, fully digital equipment, replacing technology that was more than 10 years old. The new rooms use Fuji technology and are now standardised across the department, improving consistency, efficiency and image quality for both patients and clinicians, while supporting faster diagnosis and a smoother patient experience.

12. Partnering with AccessAble to improve accessibility for all

I very much appreciated the chance to support the launch earlier this month of our comprehensive Detailed Access Guides for our wards, services and departments. This has been achieved through a partnership with AccessAble, the UK's leading provider of detailed accessibility information. The new guides provide clear, factual and easy-to-use information to help patients, visitors and staff plan their visit with confidence, reducing anxiety and supporting greater independence. From the very beginning, this collaboration has been about strengthening our commitment to accessibility and inclusion for everyone who uses or works at our hospital. By helping people plan ahead, the guides can reduce anxiety and enable patients, visitors and staff to feel more in control and independent when visiting our services. We're looking forward to continuing to work closely with AccessAble as the guides are maintained and expanded over time.

13. Charity award supporting staff wellbeing

I was delighted that the RJAH Charity has secured an award of £50,000 from NHS Charities Together, which will be used to deliver a major project supporting the wellbeing of our theatre workforce. The grant has been awarded as part of an £11million programme – which includes a £5million contribution from NHS England – and is one of 29 ambitious projects across England to receive funding from the programme. RJAH Charity will use the grant to deliver the Theatres Department Staff Wellbeing Initiative – Renovation, Rejuvenation and Revitalisation. Staff consultation and NHS Staff Survey results highlighted that theatre staff face unique pressures, often unable to leave the department during shifts and working in outdated facilities that negatively impact morale. This project will create brighter, more supportive spaces and make it easier for staff to rest, recharge and access help when they need it.

14. End of life care

I am delighted that we have secured funding to appoint a full-time End-of-Life Specialist Nurse, enhancing compassionate care for patients, families and staff across the hospital. Although most patients at RJAH recover from their treatments, there are occasions when end-of-life care is needed.

Together with the adoption of the Swan Model of Care, the appointment of a dedicated End-of-Life Specialist Nurse will ensure that all patients, families, and staff receive the highest standard of support. The funding, provided by the Charles Walker Charitable Trust alongside support from the Lady Forester Trust, the Much Wenlock Forester Trust, and RJAH Charity, will allow the hospital to expand its palliative care provision beyond the Montgomery Unit to the wider hospital.

15. High Potential Scheme

I am delighted that the High Potential (HPS) has been opened to NHS staff across Shropshire, Telford and Wrekin. I am Senior Responsible Officer (SRO) for HPS and was an advocate for the pilot of this programme, which is aimed at leaders aspiring for an executive role in Health and Care. I saw powerful stories of how it has helped staff to develop, and indeed we have benefitted from that here at RJAH. I now look forward to seeing this next cohort get started on their journey, with the programme offering a uniquely tailored, one-year career development opportunity to help accelerate a career journey. The HPS is not an academic programme. It focuses on talent development, providing hands-on, immersive development through work placements, projects and shadowing opportunities.

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 February winner was **Dawn Taylor**, a Medical Clinical Placement Facilitator, in recognition of her outstanding commitment to medical education and supporting future doctors. As a Trust, we have been working towards having medical students join us on placement for some time, and the support Dawn provides has been invaluable in making that a success. The feedback we receive from students is excellent and is a real credit to Dawn's hard work, commitment and passion for education.

- Our January winner was **Jo Davies**, a Practice Development Nurse, who was recognised for her exceptional leadership and commitment to improving patient safety on the Midland Centre for Spinal Injuries. Jo has worked at RJAH since qualifying five and a half years ago, stepped into the Practice Development role just over a 12 months ago and has played a pivotal role in supporting and developing nursing staff across MCSI. She is a fantastic example of the dedication and professionalism we value, and I was delighted to recognise her with the award

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

12. Conclusion

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

NHS England Midlands

Rebecca Farmer
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Wellington House
133-155 Waterloo Road
London
SE1 8UG

E: Rebecca.farmer14@nhs.net
W: www.england.nhs.uk

Sent via email

Harry Turner - Chair
Stacey Keegan - CEO
The Robert Jones and Agnes Hunt
Orthopaedic Hospital NHS Foundation Trust

6 February 2026

Dear Stacey and Harry,

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust - Capability Rating

You will be aware that the NHS Oversight Framework 2025/26[1] (NOF), published on the 26 June 2025 and updated 24 October 2025, outlines a consistent and transparent approach to assessing integrated care boards (ICBs), NHS trusts and foundation trusts. This seeks to ensure public accountability for performance and provides a foundation for how NHS England works with systems and providers to support improvement.

As part of the NOF, NHS England will assess NHS trust boards' capability, using this alongside their NOF segment to determine what actions and/or support may be needed. As a key element of this, NHS trust boards were asked to self-assess their organisation's capability against a range of expectations across six areas derived from *The Insightful Provider Board*, namely:

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

We wrote to you at the end of August confirming the commencement of the first Provider Capability self-assessment process[2] and requested that you complete and submit the national self-assessment template by the end of October for NHS England regional assessment. Thank you and your team for having completed your self-assessment and submitted in accordance with the ask.

During October – November 2025 the regional team reviewed your submission statements and evidence, which we triangulated with our own views, your historical track record of delivery, any recent regulatory history, and relevant third-party information (including ICB and CQC) to support us in reaching a holistic view across the six domains and to assign a single overall capability rating. These ratings were subject to review and final ratification by NHS England's Executive Board.

[1] NHS England » NHS Oversight Framework 2025/26
[2] NHS England » Assessing provider capability: guidance for NHS trust boards

Following this process we have allocated The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust an overall capability rating of **Amber-Green** for 2025/26[3].

As part of our oversight responsibilities, we will continue to monitor trust performance, which may lead to in year changes in the overall assessment rating if concerns arise across any of the assessment areas or, alternatively, there is evidence of improvement.

We will publish provider capability ratings in Q1 2026/27 taking account of the implications of Q4 2025/26 segmentation and planning outcomes in an updated view of organisations' capability.

If you wish to discuss the rating in more detail, please contact Donna Hadley, Deputy Director of Intensive Support, in the first instance, email: donna.hadley1@nhs.net

Finally, I would like to take this opportunity to thank you and your teams for your continued hard work towards delivering improvements to ensure the population of the Midlands has timely access to high quality care.

Yours sincerely

Rebecca Farmer
Director of System Co-ordination and Oversight *on behalf of Dale Bywater, Regional Director*
NHS England – Midlands

Cc: Simon Whitehouse, CEO, Staffordshire and Shropshire ICBs
Donna Hadley, Deputy Director of Intensive Support, NHS England - Midlands

[3] Implications of ratings are as follows:
Green: no concerns have arisen from the assessment. Boards should continue to strengthen their capability.
Amber-Green/Amber-Red: some concerns of varying seriousness across one or more areas to be addressed. We will work with providers to ensure that appropriate support is in place.
Red: material and/or long-running concerns. Providers with a delivery segment of 4 will move to NOF segment 5, indicating the provider is among the most challenged in the country. NHS England will subsequently:

- Withhold pay awards from those VSMs in post at the provider for over two years;
- Enrol the provider in the National Provider Improvement Programme (NPIP), designed to ensure the most challenged providers have the conditions in place to deliver sustainable improvement and a credible plan to do so; and
- Review existing regulatory action at the provider.

Note: A small number of organisations are continuing to receive RSP support. This will continue until end of March 2026, regardless of confirmed NOF segment, to support sustainable improvement. For these providers now in NOF5, support will transition to NPIP.

NHS England will contact providers separately to confirm the arrangements above.

Executive Summary - Quality & Safety Committee

Assurance

Variation	Will consistently pass the target if nothing changes	Will not consistently pass or fail the target if nothing changes	Will consistently fail the target if nothing changes	No Target or Moving Target
Improving variation (high or low) or 3 months better than target	Safe Staffing			
No significant change or N/A to SPC		RJAH Acquired MSSA Bacteraemia Surgical Site Infections Medication Errors with Harm Martha's Rule - Number of Times Enacted Total Deaths 62 Day General Standard		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		Standard Complaints Response Rate - 30 Days Complex Complaints Respone Rate - 45 Days 28 Day Faster Diagnosis Standard

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

Trust Board - Quality & Safety

January 2026 – Month 10

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

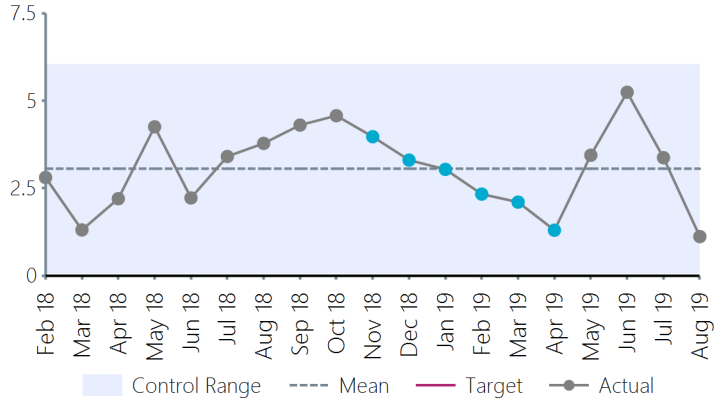
Some examples of these are shown in the images to the right:

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

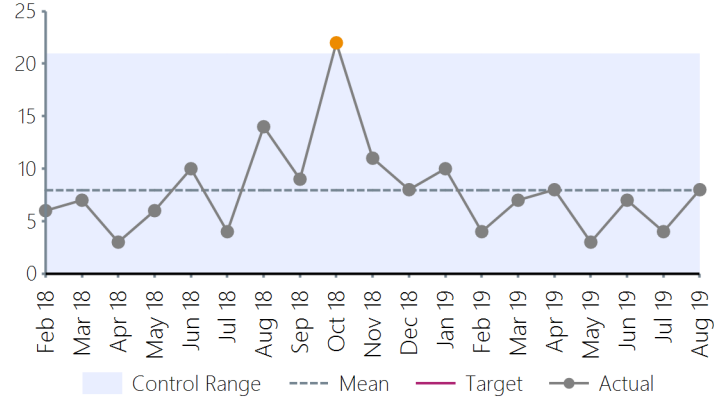
b) shows a point of concern sitting above the control range.

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

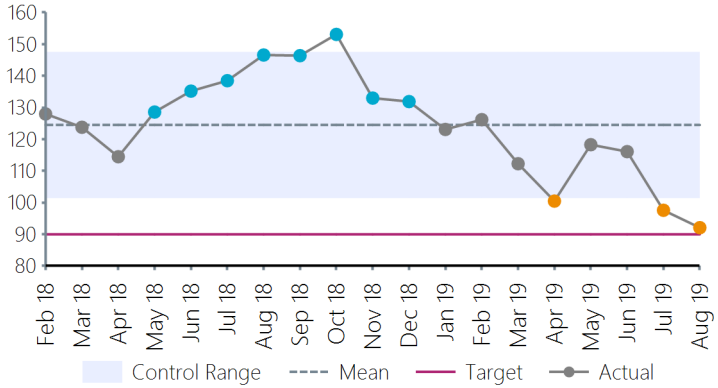
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Patient Safety Incident Investigations		0		N/A to SPC	No Target		
Number of Complaints	8	15			?	+	
Discharge Ready Date to Actual Discharge Date		0.49		N/A to SPC	No Target	+	
RJAH Acquired C.Difficile	0	0		N/A to SPC	P		
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	?		
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		
RJAH Acquired MSSA Bacteraemia	0	1		N/A to SPC	?	+	
RJAH Acquired Klebsiella spp	0	0		N/A to SPC	P		
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		
Surgical Site Infections	0	0			?	+	04/03/24

Summary - Caring for Patients

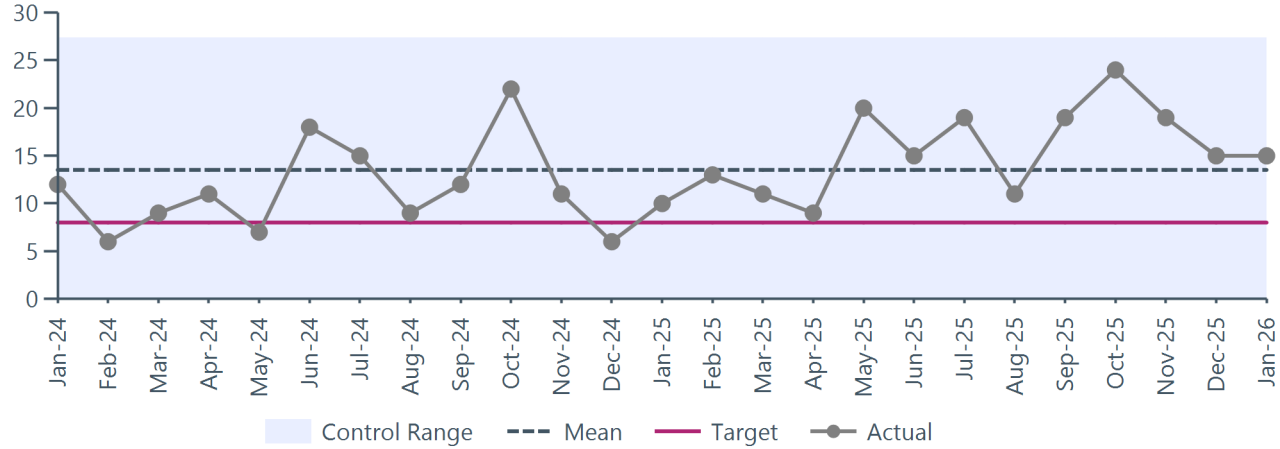
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Outbreaks	0	0		N/A to SPC	?		04/03/24
Number of Deteriorating Patients	5	5			?		
Total Deaths	0	1		N/A to SPC	?	+	12/09/23
WHO Quality Audit - % Compliance against NatSSIPs 2	95%	99%		N/A to SPC	P		

Number of Complaints

Number of complaints received in month 211105

Exec Lead
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
8	15		



Trajectory

What these graphs are telling us

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

Narrative

There were fifteen complaints received throughout January and the volume continues to exceed the tolerance throughout the whole calendar year. A breakdown of reasons:

* Care received (4)
* Waiting times (3), of which two related to conflicting information in relation to Welsh waiting times
* Staff behaviour (3)
* Appointment/Surgery bookings process (2)
* Clinic note / letter (2)
* Veteran pathway (1)

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.

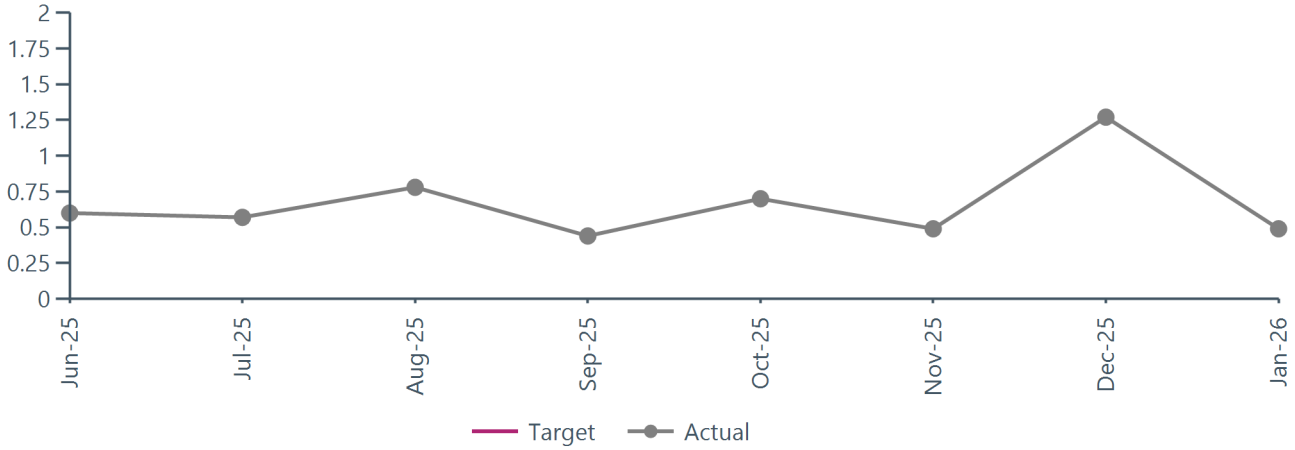
Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
10	13	11	9	20	15	19	11	19	24	19	15	15

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

Target/Plan	Latest Value	Variation	Assurance
-	0.49	N/A to SPC	No Target



Trajectory

Actual
Trajectory

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 January the average days was 0.49 days. Since this measure was recently introduced to the IPR , the Information Department has now set up additional supporting data to report at ward and unit level.

The latest NOF Publication relates to Quarter 2 where the NOF score for this metric is 1.7.

Actions

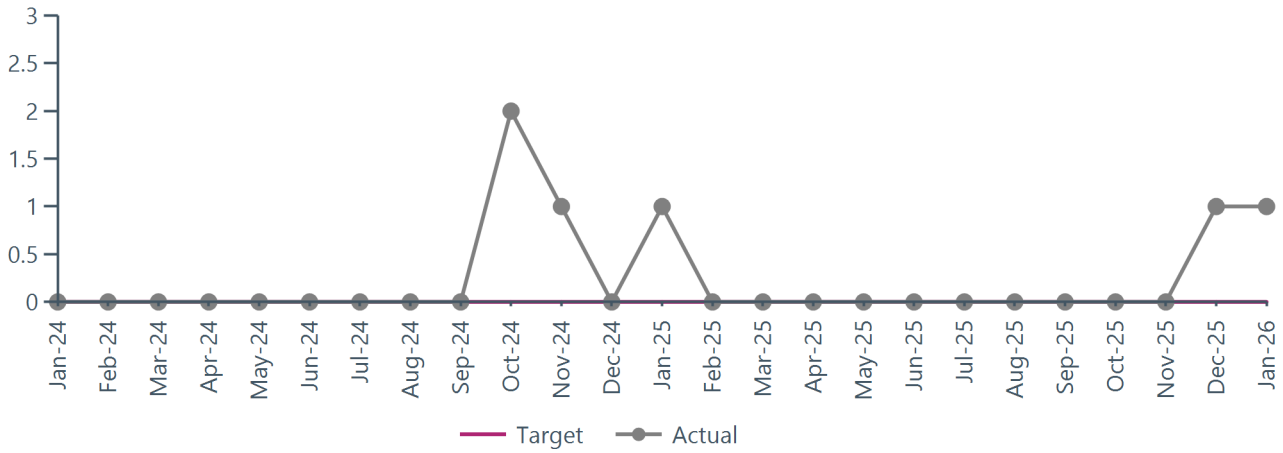
Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
					0.60	0.57	0.78	0.44	0.70	0.49	1.27	0.49

RJAH Acquired MSSA Bacteraemia

Number of cases of MSSA bacteraemia in month 211152

Exec Lead:
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
0	1	N/A to SPC	?



Trajectory

What these graphs are telling us

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

Narrative

There was on RJAH Acquired MSSA Bacteraemia reported in January on Kenyon Ward.

Please note, from this month all IPC metrics have reverted back to an in-month position rather than reported as a rolling twelve-months. The rolling twelve-months position is available for oversight in the covering paper that accompanies the IPR to the Quality & Safety Committee.

Actions

At the time of IPR production, post infection review scheduled to take place w/c 9th February.

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

- Staff - Patients - Finances -

Surgical Site Infections

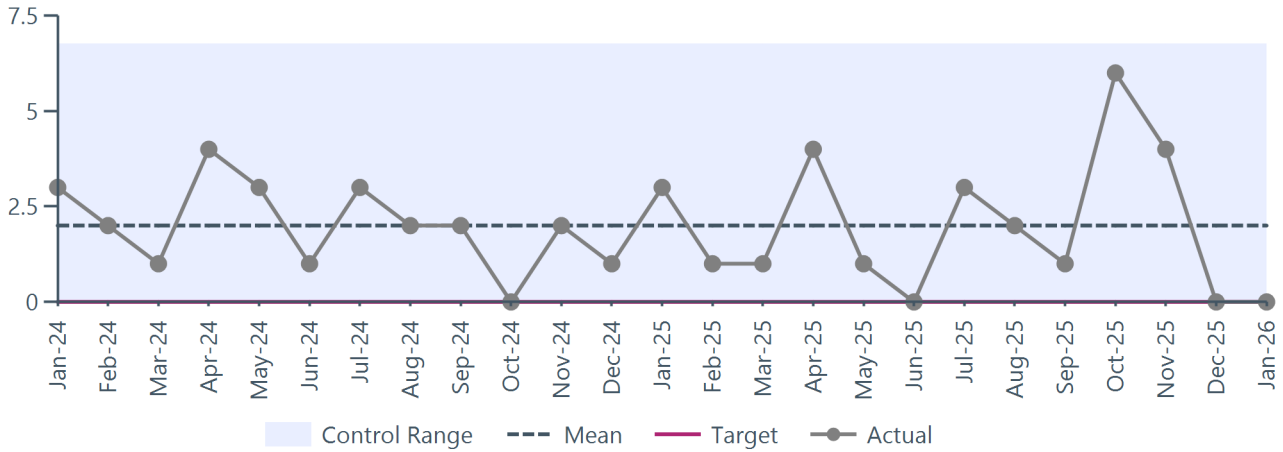
Surgical Site Infections reported for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement in previous twelve months.

Exec Lead
Chief Nurse and Patient Safety Officer

217727

Target/Plan	Latest Value	Variation	Assurance
0	0		

Trajectory



What these graphs are telling us

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

Narrative

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

There were five infections confirmed in January, as outlined below:
* 1x THR - Ludlow Ward - Surgery in October-25
* 1x THR - Clwyd Ward - Surgery in October-25
* 1x THR - Ludlow Ward - Surgery in November-25
* 1x THR - Clwyd Ward - Surgery in November-25
* 1x Spines - Powys Ward - Surgery in November-25

As there has been an increase seen in the October-December25 period, an MDT has been requested to review this.

Actions

Also see Patient Safety Reviews - and MDT has been requested to assess the increased volume of SSIs. The output of this will be reported to IPC&CM and Patient Safety Committee.

Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
3	1	1	4	1	0	3	2	1	6	4	0	0

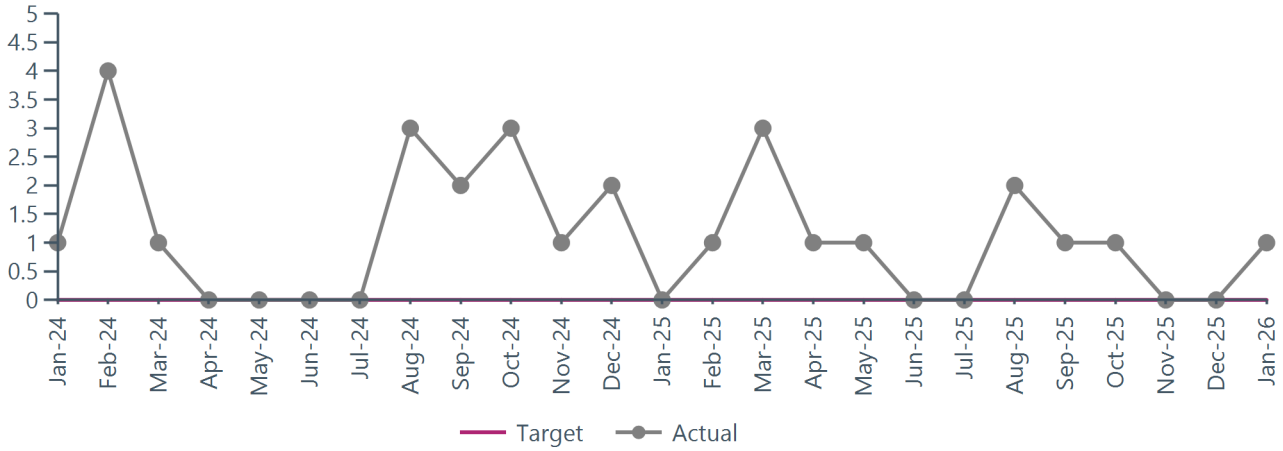
Total Deaths

Number of Deaths in Month 211172

Exec Lead:
Chief Medical Officer

Target/Plan	Latest Value	Variation	Assurance
0	1	N/A to SPC	?

Trajectory



What these graphs are telling us

This measure is not appropriate to display as SPC.

Narrative

There was one death within the Trust in January; this has been classified as an Expected Death (Sheldon Ward). A fast track inquest was conducted by coroner for this case.

Actions

Learning from Deaths Reviews are completed by the Trust Lead.

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Quality and Safety Committee

Committee / Group / Meeting, Date

Board of Directors Meeting, 04 March 2026

Author: **Contributors:**

Name: Sophie Donnelly
Role/Title: Executive Assistant

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."*

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

This report provides a summary of the items considered at the Quality and Safety Committee on 22 January and 19 February 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	

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

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

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

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

3. Assurance Report from Quality and Safety Committee

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

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

Chair Report: EPR Implementation Assurance Meeting (January and February)
The Committee noted significant ongoing clinical risk arising from fragmented patient records, order comms issues, medicines management problems and persistent data-quality backlogs across both months. Interim mitigations were in place but offered limited assurance, with the missing follow-up dates issue now one of the highest organisational risks. Members emphasised concern about the pace of improvement, the operational impact of data validation delays and the dependency on future system upgrades. Actions included mandating follow-up date fields, progressing the improvement plan with System C, and returning with clarity on the backlog size and timescales for resolution at the next meeting.

Chair Report: Regulatory Oversight Meeting (January and February)
The Committee received limited assurance across both meetings regarding compliance with DBS checks, BBV vaccination data, and professional registration validation. This will be overseen by the People Committee. Blood transfusion standards compliance remains a risk, with further work and a re-audit of blood transfusion processes underway. Assurance was sought that these issues were accurately reflected within the Corporate Risk Register.

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:

Performance Report (January and February)
Across both months, the Committee was partially assured, noting increasing SSIs, complaint response delays, medication errors, and operational variation such as discharge-ready times and cancellations. Members observed themes including regional increases in orthopaedic SSIs, the need for clearer benchmarking of discharge metrics, and concerns around the national 28-day faster diagnostic standard. They also welcomed improved visibility of unplanned returns to theatre and Martha's Rule use. Actions included commissioning a deep dive into the diagnostic standard for March, reviewing ward-level variation in discharge data, improving Waiting Well communications (to return in May), and continuing enhanced monitoring of infection-related trends.

PSII Report – Wrong Size Implant
The Committee heard that while theatre teams demonstrated strong engagement and effective workarounds, the underlying processes for implant checking and scan-for-safety required

strengthening. Members explored human-factors improvements and highlighted risks associated with equipment scanning outside barns theatres. Actions included defining the role of company representatives, improving communication via whiteboards, reviewing implant scanning processes, and raising scan-for-safety improvements at the DERIC Committee.

CQC Action Plan (February)
Although safeguarding training compliance reached the required threshold and weekend anaesthetic cover was progressing, the Committee noted that full MDT arrangements for critical care were still under development. Members asked for precision regarding whether actions were appropriately recorded as "complete" and sought assurance on consistency of interpretation against CQC wording. A further update was scheduled for May to confirm progress toward full 24/7 cover and broader workforce development.

Chair Report: Adult and Childrens Safeguarding Meeting (February)
Training compliance was improving, although further progress was needed in violence-prevention training. The Committee discussed the forthcoming Families First Partnership Framework and its potential impact on provider-level safeguarding responsibilities. Members highlighted future capacity risks given the Trust currently has only one named children's safeguarding nurse. Further clarity will be sought once national guidance is finalised.

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.

Corporate Risk Register
The Committee discussed risks reported within the Committee remit; highlighting the following:

- System Migration to RADAR - The risk management and recording system has transitioned from the previous platform to RADAR, which went live this week, with ongoing data transfer and the need to develop new dashboards and assurance reports.
- Temporary Reporting Adjustments - Due to the system change, the usual detailed corporate risk register report will be deferred until March, with any significant or emerging risks to be reported through other committee agenda items or assurance reports in the interim.
- Governance Review - A review of risk management governance is underway,

The Committee took assurance from the processes in place while data is transitioned.

PSIRF Report (January and February)
The Committee took assurance from the report, noting several overdue or delayed actions in January and five actions still behind plan in February. Themes included overdue Duty of Candour letters, reliance on visiting theatre representatives, and delays in implementing SOPs for VTE and pressure ulcers. Members requested continued strengthening of governance oversight and emphasised the importance of closing long-outstanding SOPs. Planned actions included holding an extraordinary Drugs & Therapeutics Meeting to progress approvals, following up Duty of Candour cases with consultants, and escalating SOP delays through the appropriate unit governance routes.

Patient Safety Visits (February)
The Committee received generally positive findings for ward culture, patient experience and adherence to standards. However, issues requiring continued monitoring included air-conditioning limitations, Apollo-related workflow frustrations and recruitment delays caused by high applicant volumes and AI processing. Members welcomed the positive feedback for Ludlow Ward and asked that the new Board Go-See programme be embedded into the 2026/27 annual cycle.

IPC Report (February)
The Committee took assurance from the report noting strong IPC audit compliance (>95%). Members held discussions focused on reduced audit frequency, clusters of superficial spinal infections in November and ongoing issues in orthotics at SATH. Members queried accuracy of hand-hygiene compliance figures and requested validation of the list. Follow-up actions included revisiting audit coverage and reviewing infection-related themes at future IPC meetings.

Chair Report: Health Inequalities (January & February)
The Committee discussed commissioning inconsistencies between Telford and Shropshire, variations in access to community pain services and the lack of a single digital strategy across the system. Members encouraged increased use of Radar demographic data to identify underserved groups and asked for further updates in March on whether similar inequalities exist in other services.

HTA Report (January)
The Committee was assured by substantial progress against CAPAs, with only one outstanding SLA remaining. Members supported completing the SLA with SATH and agreed updates would continue through Estates and ROM as part of the wider security review.

PLACE Report (January)
The PLACE assessment provided strong assurance around cleanliness, food, accessibility and environment. Members discussed outpatient space constraints, wayfinding issues and opportunities to enhance patient experience, particularly for visually impaired patients. Improvements will be taken forward via the Patient Experience Meeting.

MHRA Update (January)
The Committee was assured that all requirements following the MHRA inspection were complete and that licence revocation did not impact remaining regulatory duties. No further risks were identified.

Quality Strategy Action Plan (January)
Members were assured that key deliverables remained on track and noted that the National Quality Strategy may require alignment updates in the next cycle.

Quality Accreditation Report (January)
The Committee was assured by steady progress, noting minor delays due to sickness. Members discussed inappropriate fluid-balance chart usage and welcomed digital improvements scheduled via Vital PACs.

Learning from Deaths Report (January)
The Committee was assured that the one unexpected death reviewed in October raised no concerns, with positive family communication and clinical documentation.

Legal Claims Report (January)
The Committee was assured by the governance arrangements in place for managing claims and inquests, with training and support for staff being strengthened.

Chair Report: IPC&C Meeting (January)
The Committee took assurance from the report noting the progress in IPC trust wide, estates and storage challenges being actively addressed and positive flu vaccination uptake.

Chair Report: Patient Experience Meeting (January & February)
The Committee took assurance from the report, noting ongoing developments including AccessAble, EQIA updates and improved waiting-period communications, all progressing well, with no escalations required.

Chair Report: Clinical Effectiveness Meeting (February)
The Committee took assurance from the report which provided updates on pharmacy services, improved patient experience feedback and restoration of PROMs data collection following system fixes.

Chair Report: NSSG Meeting (January & February)
The Committee was assured by stable safer-staffing levels and ongoing work to prepare for the safer nursing care audit. Tables included below for Board level reporting.

Ward	Safe Staffing for November 2025	Day				Night				Day		Night			Care Hours Per Patient Day		
		Registered		Care Staff		Registered		Care Staff									
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	At midnight (monthly total)	CHPPD Registered Midwives / Nurses	CHPPD Care Staff	CHPPD Overall
Alice	110 - TRAUMA & ORTHOPAEDICS	929.75	948.00	0.00	0.00	648.00	659.00	0.00	0.00	102.0%	-	101.7%	-	127	12.7	0.0	12.7
Clwyd	110 - TRAUMA & ORTHOPAEDICS	1075.50	1112.50	950.00	960.75	724.00	724.00	570.00	613.25	103.4%	101.1%	100.0%	107.6%	429	4.3	3.7	7.9
MCSI Inpatients	400 - NEUROLOGY	2874.75	2980.75	4720.00	4160.25	2160.50	2201.50	1730.50	1749.25	103.7%	88.1%	101.9%	101.1%	1,339	3.9	4.4	8.3
Kenyon	110 - TRAUMA & ORTHOPAEDICS	869.00	880.00	703.25	665.25	720.00	757.00	365.58	368.08	101.3%	94.6%	105.1%	100.7%	337	4.9	3.1	7.9
Oswald	110 - TRAUMA & ORTHOPAEDICS	728.00	733.00	567.75	521.75	720.00	720.00	12.00	0.00	100.7%	91.9%	100.0%	0.0%	208	7.0	2.5	9.5
Ludlow	110 - TRAUMA & ORTHOPAEDICS	1078.00	1071.00	720.00	629.50	720.00	753.50	468.00	430.50	99.4%	87.4%	104.7%	92.0%	366	5.0	2.9	7.9
Powys	110 - TRAUMA & ORTHOPAEDICS	1030.75	991.75	687.75	625.92	720.00	720.00	566.42	507.92	96.2%	91.0%	100.0%	89.7%	253	6.8	4.5	11.2
Sheldon	300 - GENERAL MEDICINE	1279.50	1237.50	1399.50	1422.00	722.50	722.50	1092.00	1092.00	96.7%	101.6%	100.0%	100.0%	525	3.7	4.8	8.5
HDU	110 - TRAUMA & ORTHOPAEDICS	995.50	923.00	187.50	113.00	953.50	891.50	0.00	0.00	92.7%	60.3%	93.5%	-	64	28.4	1.8	30.1
Totals		10860.75	10877.50	9935.75	9098.42	8088.50	8149.00	4804.50	4761.00	100.2%	91.6%	100.7%	99.1%	3648	5.2	3.8	9.0
MSK Unit		5048.75	4978.25	3248.50	2994.42	3837.50	3846.00	1970.00	1919.75	98.6%	92.2%	100.2%	97.4%	1449	6.1	3.4	9.5
Specialist Unit		5812.00	5899.25	6687.25	6104	4251	4303.00	2834.5	2841.25	101.5%	91.3%	101.2%	100.2%	2199	4.6	4.1	8.7

Table 1 (above) shows the individual ward and divisional CHPPD for November.

Ward	Safe Staffing for September 2024	Day				Night				Day		Night			Care Hours Per Patient Day (CHPPD)		
		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff									
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	At midnight (monthly total)	CHPPD Registered Midwives / Nurses	CHPPD Care Staff	CHPPD Overall
Alice	110 - TRAUMA & ORTHOPAEDICS	934.50	965.25	0.00	0.00	744.00	744.75	0.00	0.00	103.3%	-	100.1%	0.0%	120	14.3	0.0	14.3
Clwyd	110 - TRAUMA & ORTHOPAEDICS	888.00	893.00	684.00	657.50	480.00	487.50	381.00	369.00	100.6%	96.1%	101.6%	96.9%	353	3.9	2.9	6.8
MCSI Inpatients	400 - NEUROLOGY	2966.25	3043.00	4601.00	4133.92	2229.50	2176.00	1777.00	1732.00	102.6%	89.8%	97.6%	97.5%	1259	4.1	4.7	8.8
Kenyon	110 - TRAUMA & ORTHOPAEDICS	560.75	578.67	453.00	434.50	436.52	429.50	216.00	203.00	103.2%	95.9%	98.4%	94.0%	212	4.8	3.0	7.8
Oswald	110 - TRAUMA & ORTHOPAEDICS	746.50	749.25	580.50	669.92	744.00	756.08	166.00	3.00	100.4%	115.4%	101.6%	1.8%	200	7.5	3.4	10.9
Ludlow	110 - TRAUMA & ORTHOPAEDICS	1073.00	1044.00	679.25	707.75	744.00	770.50	389.00	424.00	97.3%	104.2%	103.6%	109.0%	323	5.6	3.5	9.1
Powys	110 - TRAUMA & ORTHOPAEDICS	1079.75	1178.33	862.00	855.25	744.00	770.00	670.50	610.50	109.1%	99.2%	103.5%	91.1%	376	5.2	3.9	9.1
Sheldon	300 - GENERAL MEDICINE	1295.75	1273.25	1469.50	1452.50	744.00	756.00	1134.50	1204.50	98.3%	98.8%	101.6%	106.2%	525	3.9	5.1	8.9
HDU	110 - TRAUMA & ORTHOPAEDICS	993.50	972.00	150.00	139.75	948.00	936.00	0.00	0.00	97.8%	93.2%	98.7%	0.0%	79	24.2	1.8	25.9
Totals		10538.00	10696.75	9479.25	9051.09	7814.02	7826.33	4734.00	4546.00	101.5%	95.5%	100.2%	96.0%	3447	5.4	3.9	9.3
MSK Unit		4595.00	4666.00	2828.25	2794.75	3352.52	3393.50	1656.50	1606.50	101.5%	98.8%	101.2%	97.0%	1343	6.0	3.3	9.3
Specialist Unit		5943.00	6030.75	6651.00	6256.34	4461.50	4432.83	3077.50	2939.50	101.5%	94.1%	99.4%	95.5%	2104	5.0	4.4	9.3
Trust					98.60												

Table 2 (above) shows the individual ward and divisional CHPPD for December.

CIP QIA Report (February)
The Committee took assurance from the report which highlighted that QIA oversight had strengthened and that revised standards would reduce unnecessary Committee scrutiny.

EQIA Policy (February)
The Committee approved the EQIA Policy, subject to one amendment regarding the approval pathway.

Domestic Abuse Policy (February)
The Committee approved the Domestic Abuse Policy, which consolidates multiple SOPs into one document.

Infection Event and Outbreak Management Policy (January)
The Committee ratified the policy.

PiPoT (Managing Allegations – People in Position of Trust) Policy (February)
The Committee approved the updated PiPoT Policy, subject to amendments to strengthen references to support available for staff undergoing allegations.

Nursing and AHP Strategy Update (January)
The Committee was assured that although progress against the Nursing and AHP Strategy had slowed over the past year due to leadership changes, work had now been refreshed, and key actions reallocated to appropriate owners. Quarterly meetings had been scheduled to maintain momentum, and members welcomed the commitment to clarifying delivery timelines across the five-year strategy.

Policy Tracker (January)
The Committee received assurance that policy management remained on track, with all required updates expected to be completed by the end of February. Members discussed prioritisation of medicines-related policies and SOPs, recognising that some could be extended while essential updates

were finalised. No areas of concern were identified, and the Committee was satisfied with ongoing oversight.

CEO Letter to Healthwatch Shropshire (January)
The Committee noted the CEO's letter to Healthwatch Shropshire and was assured that the communication was appropriate and would also be reviewed through the Patient Experience Meeting.

EQIA 26/27 Planning Submission (February)
The Committee noted the EQIA planning submission and received assurance that all necessary amendments had been completed prior to submission.

Recommendation

The Board is asked to:

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

Learning From Deaths

0. Reference Information

Author:	Dr James Neil	Paper date:	22-01-2026
Executive Sponsor:	Dr Ruth Longfellow	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety (Feb 2026)	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

Learning from Deaths summary report to Q and S.

After a death is reported on Radar, it is reviewed using the PSIRF system and a decision is made as to whether a PSII (Patient Safety Incident Investigation) is needed.

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

Deaths are reported through the Board of Directors.

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

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

MSG report discussed at Patient Safety committee.

2. Executive Summary

2.1. Context

To report the current numbers and trends in Q3 2025 for In-patient Learning from Deaths (LFD).

2.2. Summary

See Numbers Below.

2.3. Conclusion

No trends identified.

Learning from deaths identified (see below).

3. The Main Report

3.1. Introduction

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

3.2. Learning From Deaths Summary.

Date	Total In-patient Deaths	Number for case record (SJR) review	Death likely due to problems with care	ME review/Family feedback.	Coroner review.
October 25	1 (unexpected, not predictable)	1	0	No concerns raised.	N/a
November 25	0	0	0	N/a	N/a
December 25	0	0	0	N/a	N/a

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

3.3. Associated Risks.

None.

3.4. Next Steps

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

LFD lead now working as a Medical Examiner at SATH.

3.5. Learning from SJR's.

Well documented plans for care.
Good evidence of seeking specialist advice.
Good documentation of discussions with family and patient during stay.

All learning passed on to consultant teams.

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

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

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

SJR to be included within RADAR April 2026 on.

Appendix 1: Acronyms

LFD	Learning From Deaths
SJR	Structured Judgment Review

MSG	Mortality Steering Group

Executive Summary - People Committee

Assurance

P – Will consistently pass the target if nothing changes

? – Will not consistently pass or fail the target if nothing changes

F – Will consistently fail the target if nothing changes

No Target or Moving Target

Variation

H / L – Improving variation (high or low) or 3 months better than target

- Vacancy Rate
- AHPs Vacancy Rate
- % of Staff on E-Rostering System

- Staff Retention
- % of Staff with an Active E-Job Plan
- HCSW Vacancy Rate

No significant change or N/A to SPC

- E-Rostering Level of Attainment
- E-Job Planning Level of Attainment
- % Staff Availability

H / L – Concerning variation (high or low) or 3 months off target

- % of E-Rosters Approved 6 Weeks Ahead
- Sickness Absence - Short Term
- Proportion of Temporary Staffing
- Bank Spend against Plan

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

Trust Board - People & Workforce
January 2026 – Month 10

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

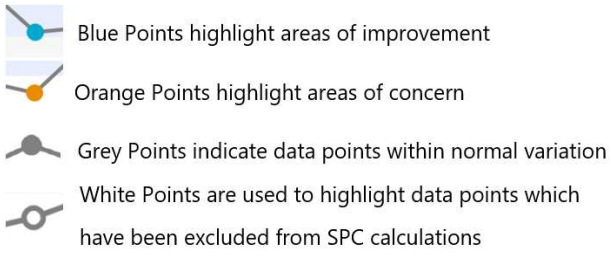
Different colours have been used to separate these trends of special cause variation:

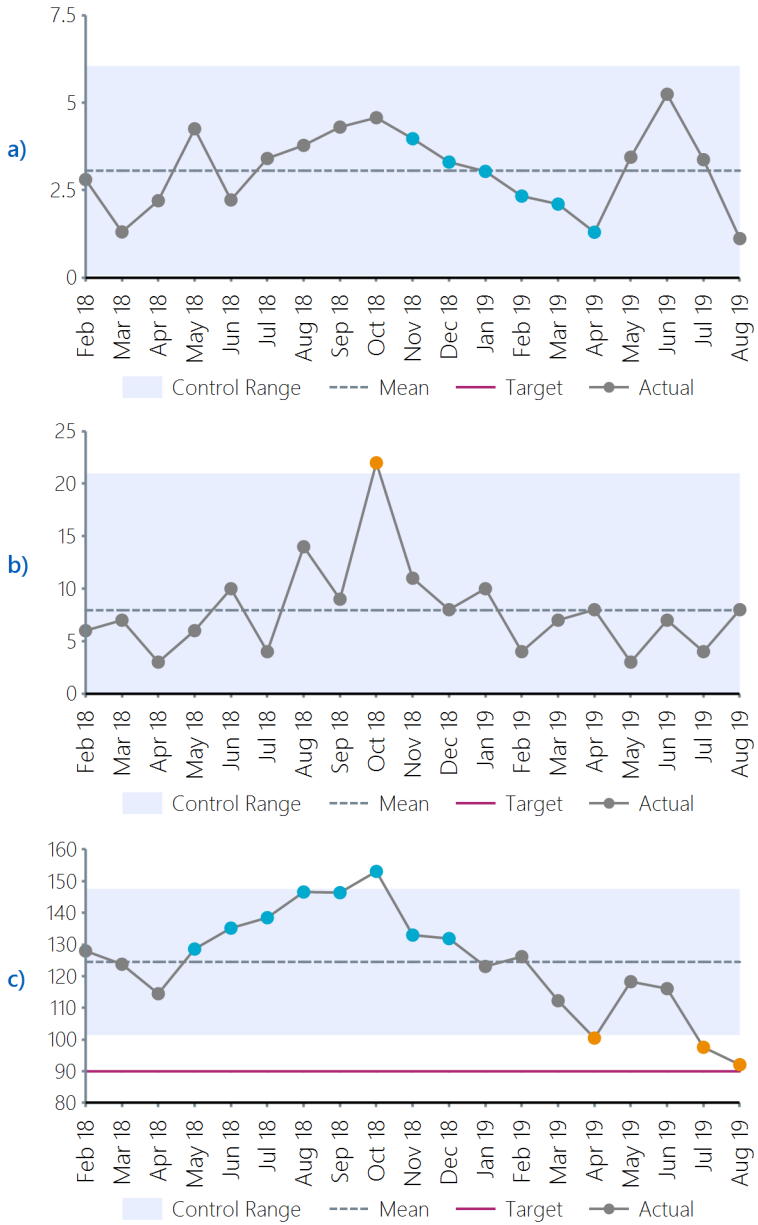
Some examples of these are shown in the images to the right:

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

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

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





Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Staff

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Sickness Absence	5.63%	5.72%			Moving Target		
Staff Turnover - FTE	9.98%	9.38%			?		
Leavers per Month	12	11			?		
Vacancy Rate	8.00%	6.46%		H	P	+	15/04/24

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Agency Spend against Plan	1.30	0.50		N/A to SPC	Moving Target		
Proportion of Temporary Staffing as a % of the Trust Pay Costs	6.50%	7.70%		N/A to SPC	Moving Target	+	
Bank Spend against Plan	5.30	7.10		N/A to SPC	Moving Target	+	

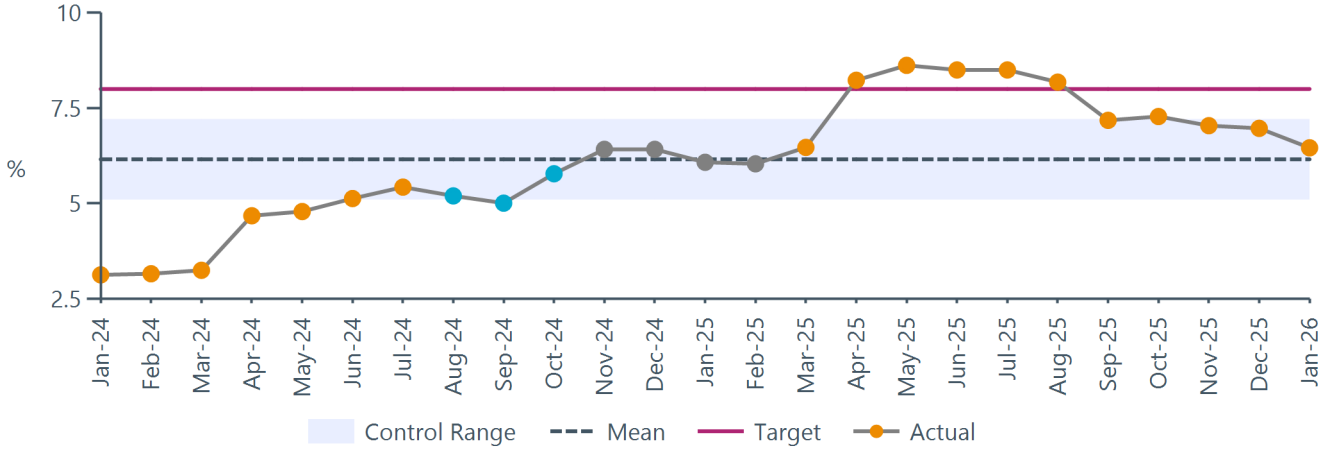
Vacancy Rate

% of Posts Vacant at Month End 211183

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
8.00%	6.46%	H	P

Trajectory



What these graphs are telling us

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

Narrative

The Vacancy Rate reported for the end of January is 6.46%, below the 8% target. The metric is reported as special cause variation of a concerning nature with data points throughout this financial year all above the mean. As shown in the graph above, there was an increase in April attributable to a budget increase in line with financial reconciliation and workforce plan submission.

Actions

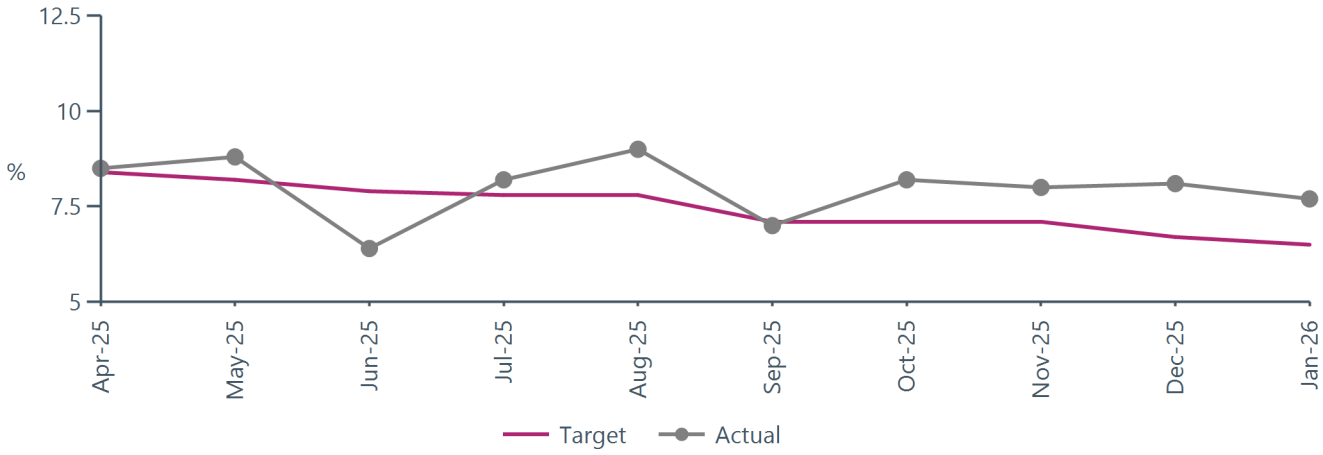
Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
6.08%	6.04%	6.47%	8.23%	8.62%	8.50%	8.50%	8.18%	7.18%	7.28%	7.04%	6.97%	6.46%

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

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

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
6.50%	7.70%	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Proportion of temporary staff 7.7%, which is 1.7% adverse to plan.

Actions

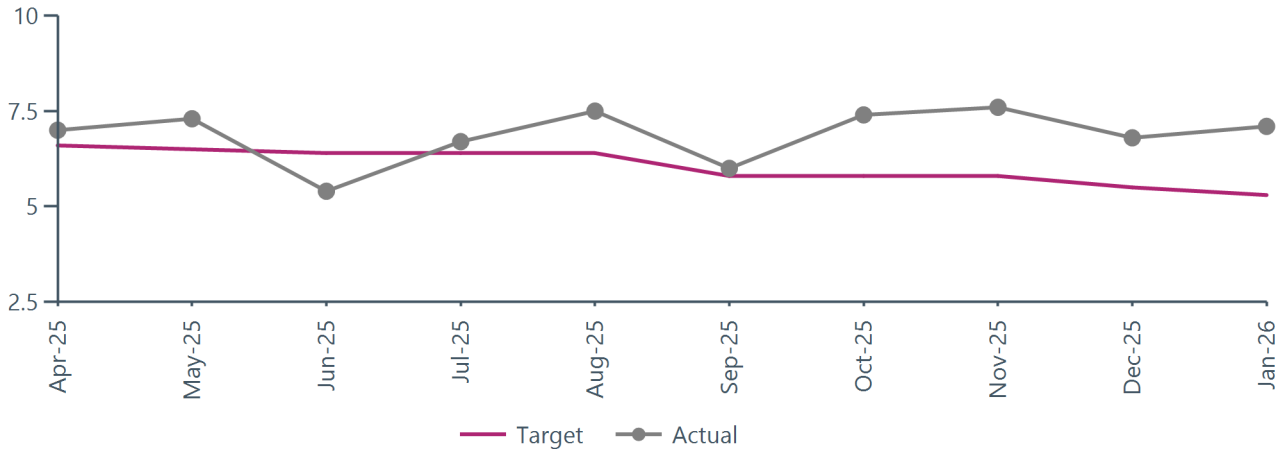
Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
			8%	8%	6%	8%	9%	7%	8%	8%	8%	7%

Bank Spend against Plan

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

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
5.30	7.10	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Bank usage 7.1% of total pay plan in month, 2.4% adverse to plan.

Actions

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

- Staff - Patients - Finances -

Chair's Assurance Report
People and Culture Committee

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Committee / Group / Meeting, Date

Board of Directors Meeting, 04 March 2026

Author:	**Contributors:**
Name: Amber Scott Role/Title: Executive Assistant	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 sub-committees (known as "Meetings") which focus on particular areas of the Committee's remit. The People and Culture Committee receives regular assurance reports from each of these "Meetings" and escalates issues to the Board as necessary via this report.

This report provides a summary of the items considered at the People and Culture Committee on 22 January 2026 and 19 February 2026. It highlights the key areas the People and Culture Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

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

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

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

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

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

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

3. Assurance Report from People and Culture Committee

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

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

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

There were no specific area to evaluate to the Board.

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:

Corporate Risk Register

The Committee discussed risks reported within the Committee remit; highlighting the following:

- System Migration to RADAR - The risk management and recording system has transitioned from the previous platform to RADAR, which went live this week, with ongoing data transfer and the need to develop new dashboards and assurance reports.
- Temporary Reporting Adjustments - Due to the system change, the usual detailed corporate risk register report will be deferred until March, with any significant or emerging risks to be reported through other committee agenda items or assurance reports in the interim.
- Governance Review - A review of risk management governance is underway,

The Committee took assurance from the processes in place while data is transitioned.

Guardian of Safe Working Hours Q3 Report / Resident Doctor Engagement

The Committee received an update from Chris Marquis (Trust Lead) on the forthcoming national changes to the exception reporting framework for resident doctors. The Committee took assurance from the comprehensive update and thanked Chris Marquis for the detailed overview.

As part of the 10-point plan to improve resident doctors' working lives, work is ongoing to appoint a resident doctor representative and to clarify their role in chairing or leading forums. The Committee noted the importance of ensuring job plans appropriately recognise and support these responsibilities to maintain engagement and professionalism.

The report is shared with the Board for assurance and oversight.

Freedom to Speak Up Q3 Report

The Committee received and reviewed the Quarter Three Freedom to Speak Up (FTSU) report, noting steady activity levels, positive engagement, and encouraging developments in organisational learning. The Committee took assurance from the report, recognising the positive progress in case handling, feedback, and the developing approach to data integration.

The Report is shared with the Board for assurance and oversight.

Workforce Plan Delivery and Assumptions

The workforce plan is being finalised for Board submission in February, with forecasts to 2027

and assumptions of no further workforce growth beyond that point unless new developments arise. The Committee advises continued scrutiny of these assumptions, particularly in light of service developments, activity growth, and hard-to-fill roles.

Training Compliance – Bank Staff and Non-Attendance
While overall statutory and mandatory training compliance is strong, bank staff compliance remains very low, and non-attendance at training carries both financial and operational consequences. The Committee advises further granular analysis and targeted management action, particularly in critical training areas such as safeguarding, resuscitation, and manual handling.

EDI and Legislative Environment
The Committee noted ongoing work on anti-racist action plans, pay gap reporting, and system-level collaboration, alongside monitoring of emerging guidance from the Equality and Human Rights Commission. This remains an evolving area requiring continued attention and engagement.

Absence Management Deep Dive
The Committee received a comprehensive deep dive into absence management, with a particular focus on persistent hotspots, benchmarking insights, and opportunities for more proactive and targeted interventions.

- Eleven areas were identified as having consistently high levels of sickness absence.
- Five of these hotspots have remained persistent over a two-year period.
- While management actions have reduced absence in some areas, new hotspots continue to emerge, demonstrating the dynamic nature of the challenge

The Committee took assurance from the depth of analysis presented and the management actions underway. The work demonstrates a clear understanding of the drivers of absence and a commitment to continuous improvement. A deeper analysis will be undertaken in longstanding high-absence areas, including engagement with resilient staff and exploration of novel interventions to improve working conditions. The team will also consult with HR Directors from other organisations to identify and adopt best practice

Vacancy Reduction Progress and Residual Gaps
Healthcare support worker vacancies have reduced significantly (from 23.79 to 13.93 WTE). Plans are in place to close the remaining 4.7 WTE gap. While progress is positive, the Committee will continue to monitor delivery against trajectory.

Premium Staffing Costs and Data Triangulation
Agency spend for the month was £47k (£65k favourable to plan). Bank spend reduced by £162k to £632k, and overtime totalled £55k (two-thirds in clinical areas). MCSI remains the largest year-to-date pay overspend area, though January's run rate improved.
The Committee emphasised the importance of triangulating workforce metrics (sickness, vacancies) with financial performance to better understand cost drivers, particularly one-to-one care requirements. Financial data will be integrated into existing departmental triangulation work rather than reviewed separately. Forecasting of one-to-one care costs using historic data and rostering intelligence is being progressed.

Case Management and Organisational Learning
Quarter three HR casework included five new disciplinary cases (including one medical), one grievance, and no new dignity at work or formal performance cases. Two protracted cases are nearing closure.
The Committee discussed strengthening organisational learning from casework, ensuring robust feedback loops between disciplinary data, staff survey themes, and Freedom to Speak Up intelligence. A slight skew toward global majority staff in casework was noted; collaborative work is underway with the Ethnic Diverse Network to develop a framework to measure and improve equity of outcomes.

Nursing Review
A national review of Band 5 nursing roles is underway. Local structures have been established to review job descriptions against national profiles, with potential progression to Band 6 where

enhanced skills are evidenced. Communications have been issued. Further national detail is expected by 10 March. The Committee will monitor implications for workforce planning, affordability, and governance

3.3 Areas of assurance

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

Well-Led Action Plan

The committee reviewed progress on well-led action plan items, focusing on embedding values, responding to staff survey results, and performance frameworks. It was agreed to bring these items earlier in future agendas and to define clear success criteria for each action. With a further request for the Committee to review and approve any changes to the actions to ensure oversight and agreement of the detail.

Accessibility Platform (AccessAble) Implementation

The Committee received assurance regarding the successful launch of the AccessAble platform, funded through charitable funds, providing detailed accessibility information for patient and staff areas. Arrangements for promotion, feedback, usage monitoring, and regular updates are in place.

Widening Participation and Community Engagement

The Committee was assured regarding the breadth and impact of widening participation activity, including school and college engagement, work experience placements, careers events, and supported internships, all of which contribute positively to long-term workforce sustainability and community engagement.

Policy Updates

The Committee considered and reviewed several policies over January and February including:

- Reserve Forces Training
- Pay Banding policy
- Disciplinary policy introduces strengthened accountability, harm avoidance measures (including buddy arrangements and wellbeing assessments), cross-referencing with safeguarding, and a structured four-step just and learning culture process.
- Medical Appraisal Policy
- Corporate Local Induction Polic
- Annual Leave Policy
- Special Leave Policy
- Senior Manager on call Policy

The Committee received Chair Assurance Repots from the following meetings:

- **EDI Meeting** – the Committee noted the report with no concerns escalated
- **Education and Training Oversight Group** – the Committee noted the report with no concerns escalated
- **JCG** – the Committee noted the report with no concerns escalated
- **LNM** – the Committee noted the report with no concerns escalated
- **Trust Performance and Operational Improvement Group** – the Committee noted the report with no concerns escalated
- **Non-Medical Staffing Sub-Group** – the Committee noted the report with no concerns escalated. The staffing graph is presented below for oversight:

Ward	Safe Staffing for September 2024	Day				Night				Day		Night			Care Hours Per Patient Day (CHPPD)		
		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	At midnight (monthly total)	CHPPD Registered Midwives / Nurses	CHPPD Care Staff	CHPPD Overall
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
Alice	110 - TRAUMA & ORTHOPAEDICS	934.50	965.25	0.00	0.00	744.00	744.75	0.00	0.00	103.3%	-	100.1%	0.0%	120	14.3	0.0	14.3
Clwyd	110 - TRAUMA & ORTHOPAEDICS	888.00	893.00	684.00	657.50	480.00	487.50	381.00	369.00	100.6%	96.1%	101.6%	96.9%	353	3.9	2.9	6.8
MCSI Inpatients	400 - NEUROLOGY	2966.25	3043.00	4601.00	4133.92	2229.50	2176.00	1777.00	1732.00	102.6%	89.8%	97.6%	97.5%	1259	4.1	4.7	8.8
Kenyon	110 - TRAUMA & ORTHOPAEDICS	560.75	578.67	453.00	434.50	436.52	429.50	216.00	203.00	103.2%	95.9%	98.4%	94.0%	212	4.8	3.0	7.8
Oswald	110 - TRAUMA & ORTHOPAEDICS	746.50	749.25	580.50	669.92	744.00	756.08	166.00	3.00	100.4%	115.4%	101.6%	1.8%	200	7.5	3.4	10.9
Ludlow	110 - TRAUMA & ORTHOPAEDICS	1073.00	1044.00	679.25	707.75	744.00	770.50	389.00	424.00	97.3%	104.2%	103.6%	109.0%	323	5.6	3.5	9.1
Powys	110 - TRAUMA & ORTHOPAEDICS	1079.75	1178.33	862.00	855.25	744.00	770.00	670.50	610.50	109.1%	99.2%	103.5%	91.1%	376	5.2	3.9	9.1
Sheldon	300 - GENERAL MEDICINE	1295.75	1273.25	1469.50	1452.50	744.00	756.00	1134.50	1204.50	98.3%	98.8%	101.6%	106.2%	525	3.9	5.1	8.9
HDU	110 - TRAUMA & ORTHOPAEDICS	993.50	972.00	150.00	139.75	948.00	936.00	0.00	0.00	97.8%	93.2%	98.7%	0.0%	79	24.2	1.8	25.9
Totals		10538.00	10696.75	9479.25	9051.09	7814.02	7826.33	4734.00	4546.00	101.5%	95.5%	100.2%	96.0%	3447	5.4	3.9	9.3
MSK Unit		4595.00	4666.00	2828.25	2794.75	3352.52	3393.50	1656.50	1606.50	101.5%	98.8%	101.2%	97.0%	1343	6.0	3.3	9.3
Specialist Unit		5943.00	6030.75	6651.00	6256.34	4461.50	4432.83	3077.50	2939.50	101.5%	94.1%	99.4%	95.5%	2104	5.0	4.4	9.3

Chair's Assurance Report
People and Culture Committee

Recommendation

The Board is asked to:

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

Freedom to Speak Up Report
Q3, 2025/6: October to December 2025

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Committee / Group / Meeting, Date

Board of Directors -Public Meeting,04 March 2026

Author: Contributors:

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

Report sign-off:

Name: Dylan Murphy, Trust Secretary
People and Culture Committee, February 2026

Is the report suitable for publication?

YES

Key issues and considerations:

This paper is provided as a summary on Freedom to Speak Up (FTSU) activity for Q3, 2025/6: October to December 2025.

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

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

Key Points:

- This quarter, FTSU has received a total of ten cases:
  - Of the ten cases received, seven have been closed and three require further follow-up.
  - Of the three cases which remain open, the Guardian is awaiting feedback from managers dealing with the concerns.
  - Of the seven cases closed, an average of 1.2 days was required to close them.

- Of the 10 cases raised:
  - Five were treated as advice and five were treated as concerns and were escalated to an appropriate Manager.
  - 1 was anonymous.
  - Two cases had an element of Patient Safety/Quality.
  - Two had an element of Worker Safety/Wellbeing.
  - Five had an element of Attitudes and Behaviours.
  - Six had elements categorised as “Other”
  - All of the cases were raised with the Guardian.
  - There were no concerns raised around Apollo.
  - One case had an element of sexism.
  - No cases had elements of racism.

- Cases can have several elements. For example, one case may have elements that relate to patient safety/quality and elements that relate to attitudes and behaviour. The NGO also includes ‘anonymous’ as a reporting category. “Anonymous” is not presented as a category of complaints in its own right in this report.

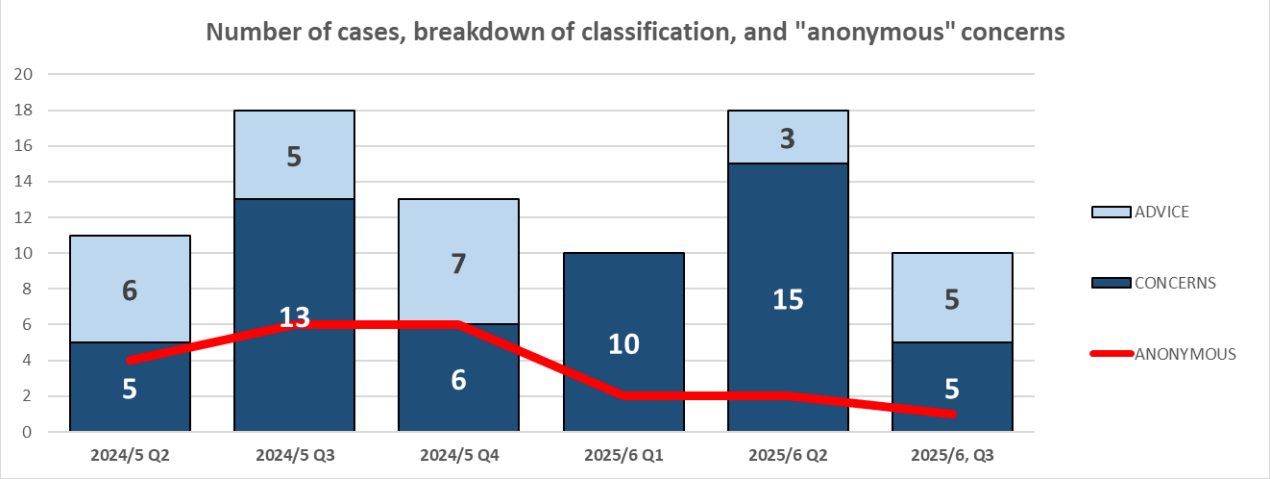
- All cases raised have been responded to within 48hrs and escalated to the appropriate department when required.

1. Overall number of concerns

Graph 1 shows the total of cases raised, and how many:

- Were treated as “concerns” (i.e. the cases were escalated for action),
- Resulted in “advice” only (i.e. people were advised or redirected as appropriate and no further action was required),
- Were received as anonymous concerns.

Graph 1



Commentary

- Overall numbers have fluctuated between 10 and 18 per quarter over the last six quarters.
- Fifty percent of contacts were treated as concerns in quarter 3.
- The line in the chart above shows the number of concerns that were raised anonymously. When considered as a percentage, the figures over the last six quarters are:

2024/5, Q2	2024/5, Q3	2024/5, Q4	2025/6, Q1	2025/6, Q2	2025/6 Q3
36.36%	33.33%	46.15%	20%	11.11%	10.00%

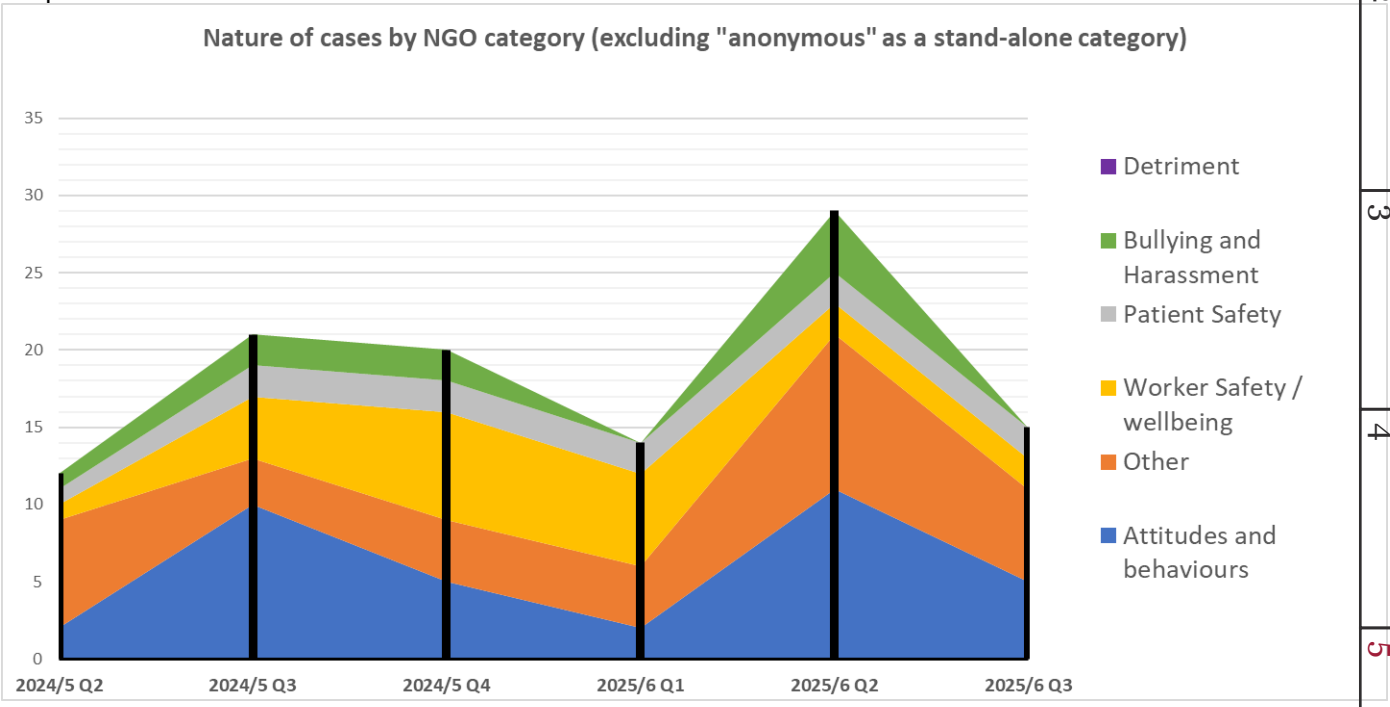
There are multiple options for staff to raise concerns anonymously but the last couple of quarters have seen a decrease in the proportion of people choosing to do so. That is regarded as a positive sign. It suggests that people are comfortable raising concerns openly; it enables more detailed investigation of issues raised; and it enables individual feedback to the person raising the concern.

2. Concerns raised broken down by type of concern

Graph 2a shows the concerns raised broken down by the reporting categories required by the NGO (excluding “anonymous” as a category in its own right). These categories are as agreed with the person who raised the concerns, or as recoded directly by the person who raised the concern (dependent on the route the individual took in raising their concerns). This presents the types of concern received over six quarters - up to, and including Q3, 2025/6.

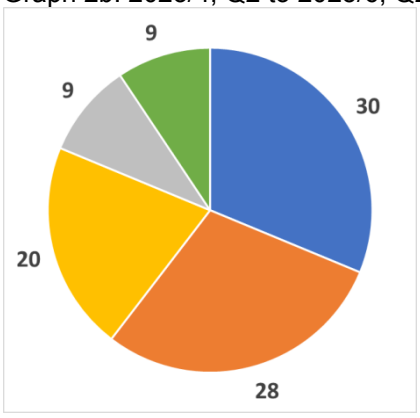
Please note that a concern may cover a number of elements. e.g. A single contact may be reported as a case involving “attitudes and behaviours”, “worker safety / wellbeing”, and “bullying and harassment”. As a result, the number of “concerns by category” (which focuses on the content of concerns) is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

Graph 2a

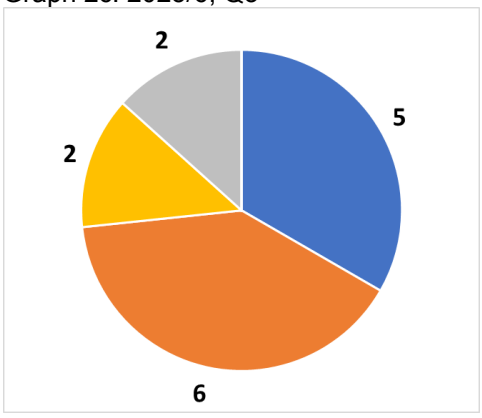


The breakdown of concerns raised by "type" is presented in an alternative format below. The first chart (Graph 2b) shows the breakdown for the previous five quarters (Q2, 2024/5 to Q2, 2025/6). The second chart (Graph 2c) shows the breakdown for Q3, 2025/6. Both are provided to show how the profile this month reflects the longer-term profile. The colour scheme is consistent with Graph 2a:

Graph 2b: 2023/4, Q2 to 2025/6, Q2



Graph 2c: 2025/6, Q3



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

	2024/5 Q2	2024/5 Q3	2024/5 Q4	2025/6 Q1	2025/6 Q2	2025/26 Q3
Attitudes and behaviours	2	10	5	2	11	**5**
Other	7	3	4	4	10	**6**
Worker Safety / wellbeing	1	4	7	6	2	**2**
Patient Safety	1	2	2	2	2	**2**
Bullying and Harassment	1	2	2	0	4	**0**
Detriment	0	0	0	0	0	**0**

Commentary

When looked at in comparison with the longer-term position, this quarter saw:

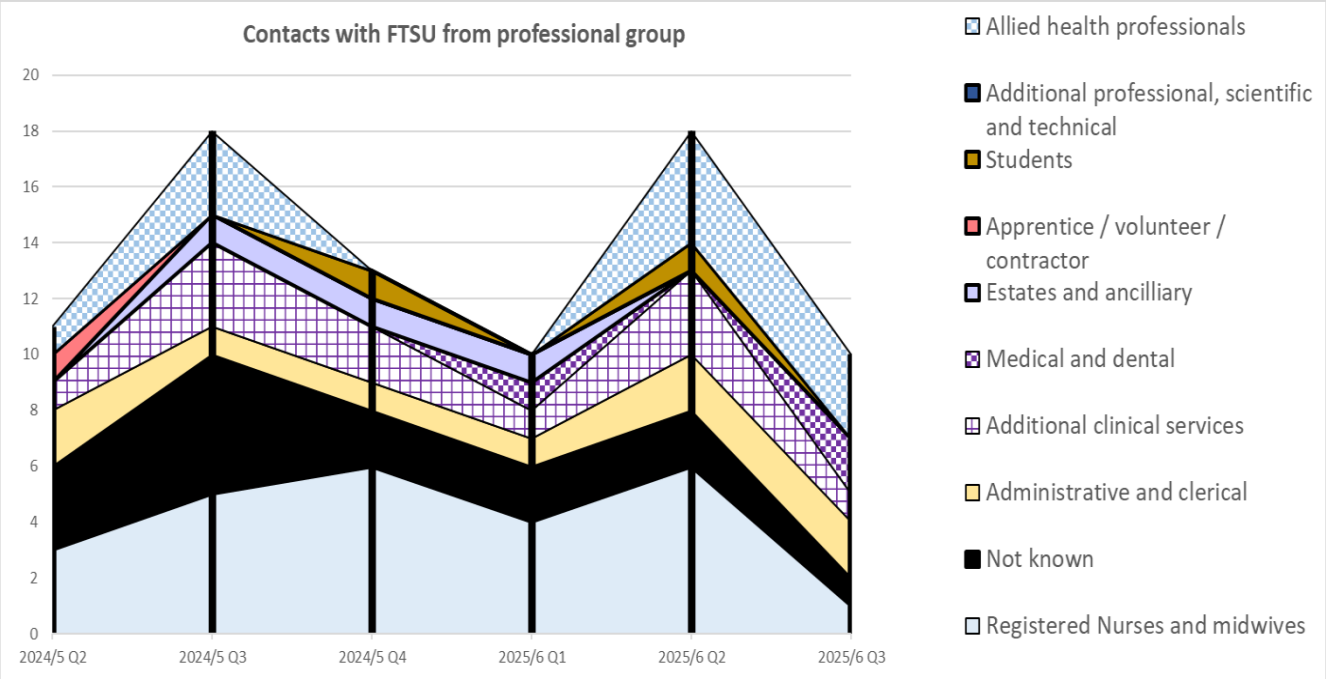
- A lower number of cases involving "Attitudes and Behaviours". Apart from Q3 in 24/25 and Q2 25/26, Q3 has come in line with previous quarters.
- There have been no cases involving "Bullying and Harassment "in Q3 25/26.
- There was one case this quarter that had any reported element of sexism and no cases of racism. These two categories are not a distinct reportable category of concern (to the NGO) but the Trust has started to record cases that have elements of either sexual harassment, a racial element, or some other discriminatory element.
- Relatively few cases involving "Worker safety / wellbeing". This had accounted for the greatest number of concerns in Q4 of 2024/5 and Q1 of 2025/6. This rise was due to the added element of "wellbeing" which meant that cases where staff reported stress, feeling overwhelmed, and other mental health issue were recorded under this category. Those relatively large numbers have not been reflected in the last couple of quarters.
- A relatively large number of concerns are not covered by the NGO classification and are therefore reported as "Other". The "Other" concerns this quarter were linked to:
  - underpayment of bank shifts;
  - contract of employment;
  - indiscriminate use of disabled carparking places by staff without disability blue card; and
  - managers perceived to have not followed policies/procedures.
- No cases this quarter were related to Apollo. That would suggest that staff are using the other engagement mechanism to raise concerns / issues, rather than FTSU arrangements.

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

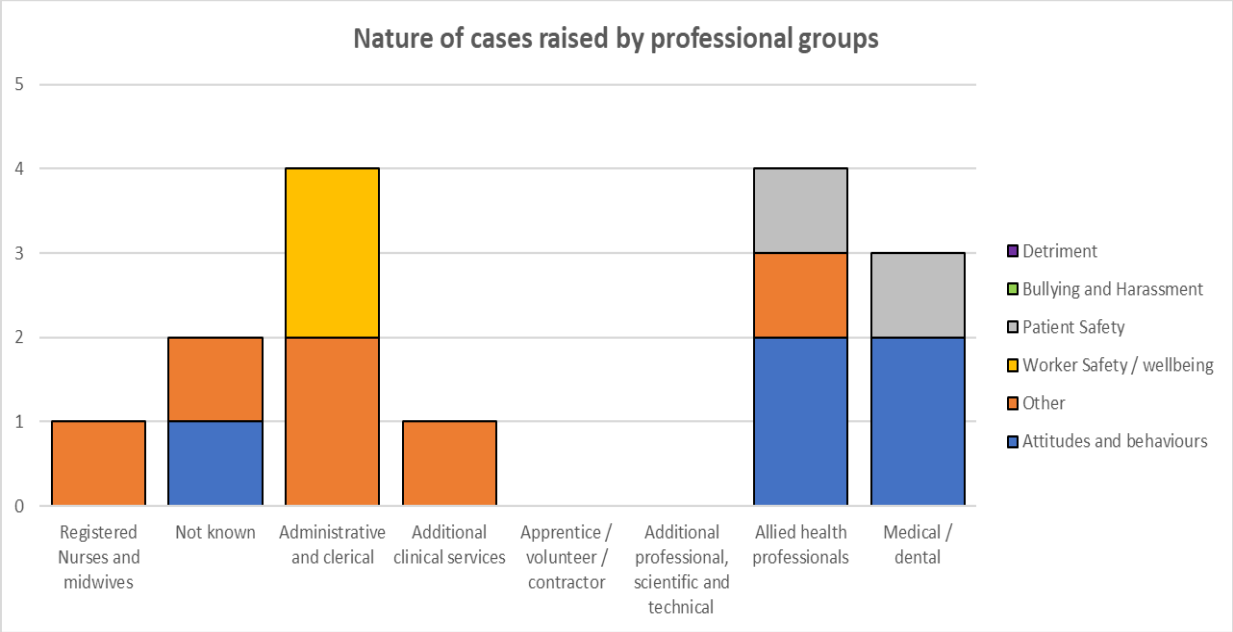
The graphs in this section present the profession of the individuals who have contacted the FTSU service, and compares the figures with previous quarters.

Graph 3a

This graph shows the profession of people who have contacted the FTSU service over six quarters:



Graph 3b
This shows the types of concern raised by each professional group during Q3, 2025/26 :



The figures that support graph 3a are outlined below:

	2024/5 Q2	2024/5 Q3	2024/5 Q4	2025/6 Q1	2025/6 Q2	2025/6 Q3
Registered Nurses and midwives	3	5	6	4	6	**1**
Not known	3	5	2	2	2	**1**
Administrative and clerical	2	1	1	1	2	**2**
Additional clinical services	1	3	2	1	3	**1**
Medical and dental	0	0	0	1	0	**2**
Estates	0	1	1	1	0	**0**
Apprentice / volunteer / contractor	1	0	0	0	0	**0**
Students	0	0	1	0	1	**0**
Additional professional, scientific and technical	0	0	0	0	0	**0**
Healthcare scientists	0	0	0	0	0	**0**
Allied Health Professionals	1	3	0	0	4	**3**

4. Triangulation

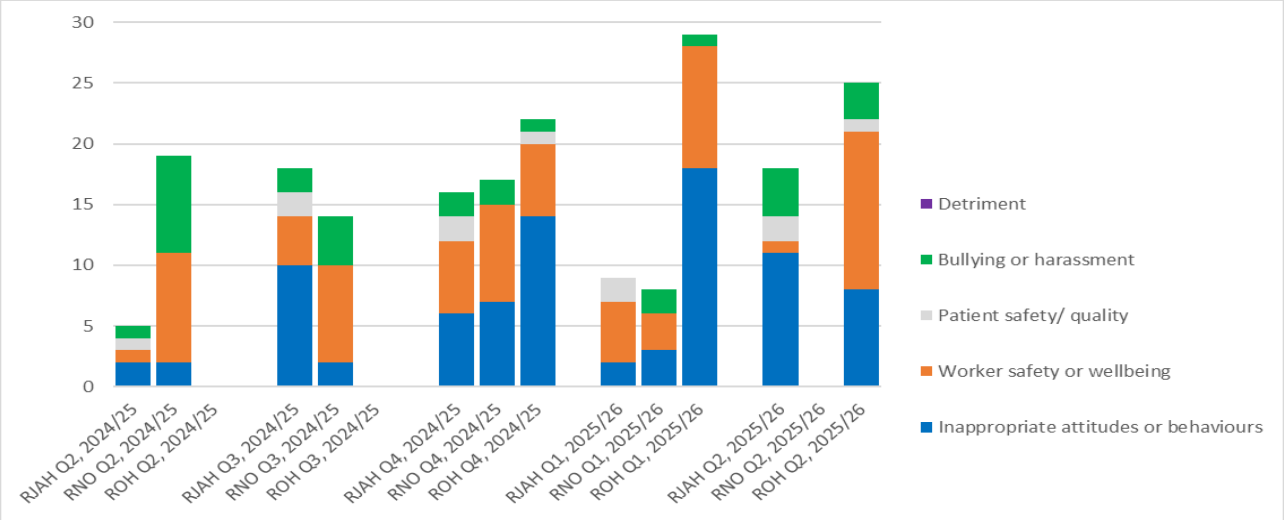
Similar Trusts

Comparison data for the last four quarters, as reported by the National Guardian's Office, is included below for the three specialist orthopaedic trusts:

- RJAH;
- Royal National Orthopaedic (RNO) Hospital London; and
- The Royal Orthopaedic Hospital (ROH), Birmingham;

The most frequently reported concerns for each of the three Trusts relate to "attitudes and behaviour" and "worker safety and wellbeing". Those two things are often linked, as people who are experiencing inappropriate attitudes and behaviours will report that their wellbeing has suffered as a result.

Graph 4a
The categories of concern reported by the NGO are:



(The data for some quarters is missing for RNO and ROH)

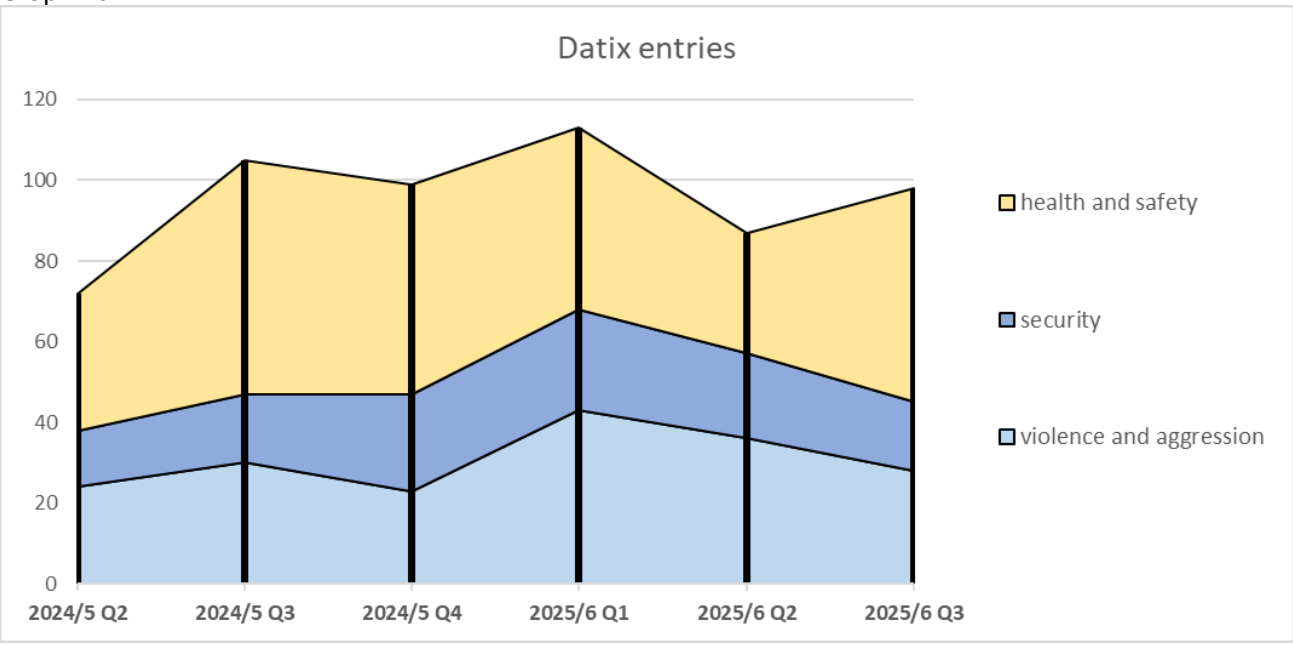
The number of cases brought to Freedom to Speak Up Guardians reported by the NGO are:

	Q2, 2024/5	Q3, 2024/5	Q4, 2024/5	Q1, 2025/6	Q2 2025/26
RJAH	11	18	13	10	18
ROH*	-	25	17	26	19
RNO*	12	12	8	7	-

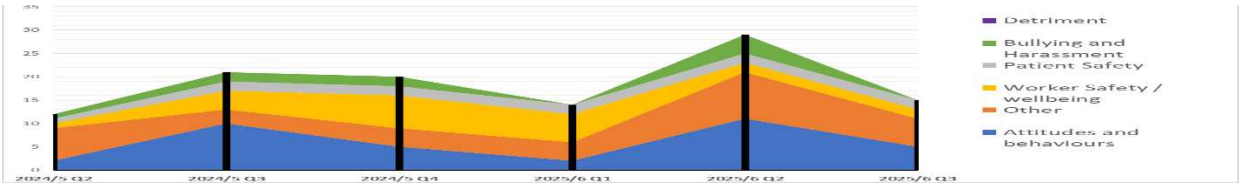
Datix entries

It is not possible to make straightforward, direct comparisons when considering FTSU concerns and Datix entries. When it comes to Violence and Aggression reporting on Datix, for example, these will generally relate to patients' behaviors towards staff. There is no direct equivalent within the FTSU reporting categories and the focus of FTSU concerns generally relates to staff-to-staff behaviors (though they may highlight areas for improvements for patient care). The relationship between the two sets of data is not straightforward, but consideration of both, particularly over time, may help identify any underlying issues.

Graph 4b:



Graph 4c, FTSU categories of concern (as displayed in Graph 2a) shown to represent the volume relative to Datix reports:



5. Outcomes / Learning

As a result of the concerns raised this quarter:

- There has been particular learning for individuals around policy requirements, and one case where a process has been improved.
- No concerns were raised via FTSU, this quarter, around Apollo.

To improve the level of feedback received from case handlers in FTSU cases, a simple feedback form has been developed. This is included at the Attachment.

6. Feedback

After dealing with a concern, the FTSU Guardian sends a link to a Microsoft feedback form. The forms are anonymous and are sent out in batches, when the concerns are closed, and at the end of each quarter. Out of the six feedback forms sent out, five forms were completed.

The responses to the multiple-choice questions were:

	YES / Extremely satisfied	NO / Not satisfied	MAYBE / Satisfied	NO RESPONSE
Given your experience, would you use FTSU again?	**5**	0	0	**1**
How well do you feel your concern was handled, overall?	**3**	0	**2**	**1**
Did you suffer any detriment?	0	**5**	0	**1**

The response to the open-ended question was:

Is there any other feedback you would like to share to help improve the FTSU service?	1. Sometimes just being able to discuss something is helpful especially with someone who is receptive and empathetic. Often a feeling of a need to speak up engenders worry and angst, and speaking about something with someone with whom one feels it is not going anywhere else, i.e. in complete confidence, is very beneficial from several perspectives 2. I'm so happy with the FTSU team functioning 3. Happy with FTSU Service, at least we were listened to.

Quality Accreditation Assessment

As part of the Quality Accreditation Assessments, ward staff are asked a series of questions that relate to FTSU. Unfortunately, no audits were carried out this quarter.

The FTSUG is working with the nursing team to access these scores and understand how the results for individual questions are used to calculate the overall compliance score.

The FTSUG has also noted that these audits only include the clinical area. It is the Guardians' intention to roll out the same questions in the audit, Trust wide. This would give assurance to the board that staff know what FTSU is, how to contact FTSU, and how to raise a concern.

Additional activity during Q3, 2025/6

FTSU Guardian

During Q3, 2025/6 the FTSU Guardian undertook the following activity:

- Attendance at the Regional NGO meetings and FTSU bi-monthly meetings.
- Continued roll out of a learning and improvement tool. This tool is sent to the manager with the initial e-mail escalating a concern. The form has four boxes for the manager to complete and return once the concern has been action and learning has been identified. See appendix 1 for the form. These forms allow the anonymised learning to be shared, where applicable, across the Trust. It also allows the manager to implement their own improvements and promote the education of staff.
- October was Speak Up Month. The FTSU Champions and Guardian did a walk about to introduce themselves and explain about the FTSU service available at RJAH. This was well received with staff.
- FTSU is part of the Violence and Prevention & Reduction Standards Group. When staff raise a concern some of the concerns can come under this standard. FTSU will now be sharing the data of how many concerns are raise around bullying and harassment, attitudes and behaviours and detriment with sub-sections, attached about protected characteristics or racial issues.

Wider "speaking up" developments

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

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

That goes beyond the FTSU function, but FTSU is an important element. That work supports the findings of the **Review of patient safety across the health and care landscape, July 2025 (the "Dash Review")** which notes that:

"There is a need to strengthen the importance of listening to and acting on staff voice, as identified in the recent publication of the National State of Patient Safety 2024, which highlighted the recent NHS Staff Survey results and the need for greater confidence in the system.

Staff should be supported and encouraged to share concerns about quality and safety as part of a data, evidence and learning-led culture that fosters improvement. The currently variable priority and quality of systems when it comes to supporting the freedom to speak up needs to be addressed by organisations through the work of Freedom to Speak Up Guardians."

7. Next steps

The FTSU guardian / function will support Trust-wide work to

- gather evidence from various existing sources – including the FTSU function, people services, and the clinical governance teams, Violence and Prevention & Reduction Standards Group and also mechanisms such as the Exec "Buddy" visits, Patient Safety Visits, Board visits, etc;
- identify and learn the lessons from that information and act accordingly.
- provide feedback to people who "speak up"; and
- feed key message and learning back into the wider organisation.

Well-led review

The independent developmental well-led review report noted the following:

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

An action plan in response to the report has been developed. There are no recommendations that relate directly to the FTSU function but there are likely to be underpinning actions that support the broader recommendations which the FTSU function can support. Any such actions will be taken forward via the well-

led review action plan and will support the actions already underway in response to the staff survey action plan.

Wider "speaking up" developments

In early 2026, the Trust will be implementing a new system to replace the DATIX complaint / incident / risk reporting system, along with a number of other systems currently in use. That provides an opportunity to improve recording through the implementation of consistent categories / tags across a number of channels that staff can use to "raise concerns". That would support more comprehensive analysis and reporting on the topics that staff are reporting via the various channels available to them. Those opportunities are being explored through a working group which is helping configure the new system.

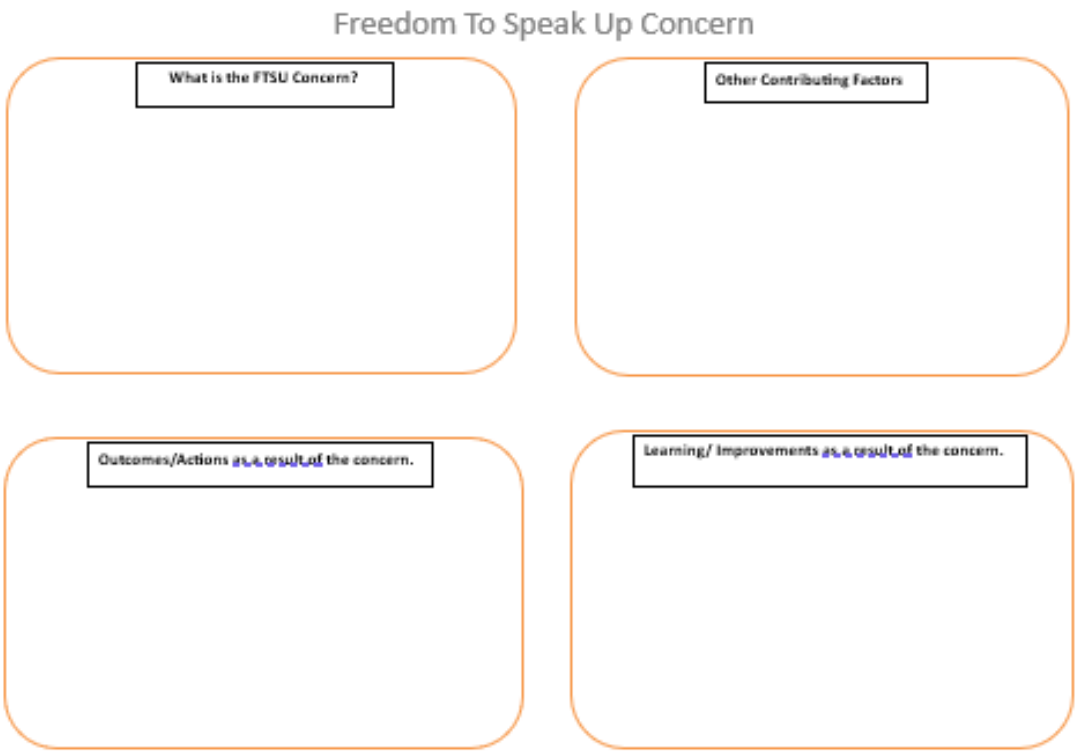
Recommendation:

Following a recommendation from the People and Culture Committee in February 2026, the Board is asked to:

1. NOTE that appropriate FTSU arrangements are in place and that concerns are:
   - Addressed and concluded in a timely manner, with lessons learned and communicated.
   - Categorized and reported to the NGO as required.
   - Triangulated with other sources of data and reviewed over time to identify potential areas of concern that require attention.
2. NOTE the ongoing and planned actions to further develop the arrangements.
3. CONSIDERE the level of assurance received from the report and the planned developments.

Acronyms	
FTSU	Freedom to Speak Up
NGO	National Guardians Office
Attachments	
Attachment 1	Learning and Improvement Tool

Attachment 1



Safe Working Hours: Doctors in Training

0. Reference Information

Author:	Chris Marquis, Guardian of Safe Working	Paper date:	January 2026
Executive Sponsor:	Chief Medical Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	People and Culture Committee	Paper Ref:	N/A
Forum submitted to:	People and Culture Committee	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

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

2.2 Summary

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

2.3. Conclusion

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

Safe Working Hours: Doctors in Training

3. The Main Report

3.1. Introduction

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

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

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

The Guardian will:

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

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

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

Other new features of the 2016 contract include:

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

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

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

3.2 Guardian of Safe Working Report

3.2.1 High level data

For the period January 2026

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

3.2.2 Exception reports (regarding working hours)

The exception reporting system is designed to allow employers to address issues and concerns as they arise, in real time, and to keep doctors' working hours, both rostered and actual, within safe working limits. If the system of work scheduling and exception reporting is working correctly, in anything other than truly exceptional circumstances, the levying of a fine indicates that the system has failed or that someone – the supervisor, Guardian or the individual doctor concerned – has failed to discharge his or her responsibilities appropriately.

Any levying of a fine should therefore be followed by an investigation in to why it was necessary and remedial action to ensure that it does not happen again. The most important thing to remember is that fines should rarely, if ever be applied at all.

The trust continues to engage with the resident doctors regarding rotas and via the Resident Doctor Forum. At all stages care is taken to ensure hour's compliance is achieved without compromise to patient safety and our training responsibilities.

During the financial year we have received an exception report from a trainee in a Welsh placement, on a centralised contract with RJAH. We have engaged with the trainee, responsible department and HR to ensure the issue raised is being addressed. TOIL was provided and a diary exercise instigated.

As it stands the Trust can be reassured, we are compliant with the demands placed upon us.

Please see challenges at the end of the report, for further discussion on changes to the ER system.

3.2.3 Work schedule reviews

Please see above.

Work schedule reviews are triggered by repeat exception reporting highlighting an issue with a position or rota. There have been no formal work schedule reviews.

3.2.4 Resident Doctor Agency and Locum usage and Rota Vacancy Report

Trauma and Orthopaedics

Number of Vacancies (28 posts)

Oct 25	0
Nov 25	0
Dec 25	0

Vacant shifts

Oct 25	3
Nov 25	5
Dec 25	1

Total cost - £7225

Medicine

Number of Vacancies (12 posts)

Oct 25	0
Nov 25	0
Dec 25	0

Vacant shifts

Oct 25	4
Nov 25	9
Dec 25	11

Total Cost £11150

MCSI

Number of Vacancies (9 posts)

Oct 25	0
Nov 25	0
Dec 25	0

Vacant Shifts

Oct 25	3
Nov 25	1
Dec 25	8

Total cost - £4680

Long Term Vacant Shifts

NA

3.2.5 Fines

None – please see exceptions report section 3.2.2

3.3 Challenges

3.3.1 New Framework Agreement for Exception Reporting/ 10 Point plan to Improve Resident Doctors' Working Lives

There is considerable overlap between the new ER framework and the 10PP improvement pathway. Considerable work has taken place, and is ongoing, within the Trust and with our shared partners. Concerns around the process, IT support, and attempts to reach a consensus in approach has galvanised national and regional meetings, webinars and groups.

As an organisation we are improving our policies and procedures around the relevant areas pertinent to this. There is a concerning lack of clear oversight of the resident doctors at the Trust, who they are and it which roles. For the purpose of this report, Resident doctor is being used to refer to doctors in training under the 2016 TCS V13.

Associated Risk

The new ER framework goes live 04/02/2026. This will be a dynamic time of adaption and response.

Next Steps

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

3.4. Conclusion

The Trust has had no exception reports. There are ongoing national concerns about the new ER framework and the necessary software support

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

Christopher Marquis, Guardian of Safe Working

Executive Summary - Finance & Performance Committee

Assurance

Variation	Will consistently pass the target if nothing changes	Will not consistently pass or fail the target if nothing changes	Will consistently fail the target if nothing changes	No Target or Moving Target
Improving varitation (high or low) or 3 months better than target				18 Weeks RTT Open Pathways Time to First Appointment - English Patients 6 Week Wait for Diagnostics - English Total Outpatient Activity - % Moved to PIFU Pathway
No significant change or N/A to SPC	18 Week Performance - Actual v Plan		Implied Productivity	Theatre Cancellations On Day of Surgery Time to First Appointment - Welsh Patients Total Outpatient Activity Against Plan Total Diagnostic Activity Against Plan
Concerning variation (high or low) or 3 months off target		No of Spinal Injury Patients Fit for Admission Report Turnaround Times - % Comp 28 Days New to Follow Up Ratio	8 Week Wait for Diagnostics - Welsh % Combined BADS Performance Bed Occupancy - All Wards - 2pm	English List Size Welsh List Size % Patients Waiting Over 52 Weeks - English Patients Patients Waiting Over 104 Weeks - Welsh Theatre Cases per Session Touchtime Utilisation Total Theatre Activity Against Plan Elective Activity Against Plan Outpatient Procedures - ERF Scope

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

Trust Board - Performance
January 2026 – Month 10

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

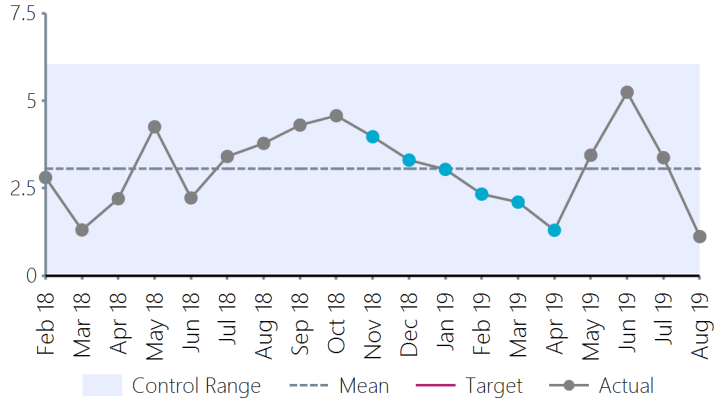
Some examples of these are shown in the images to the right:

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

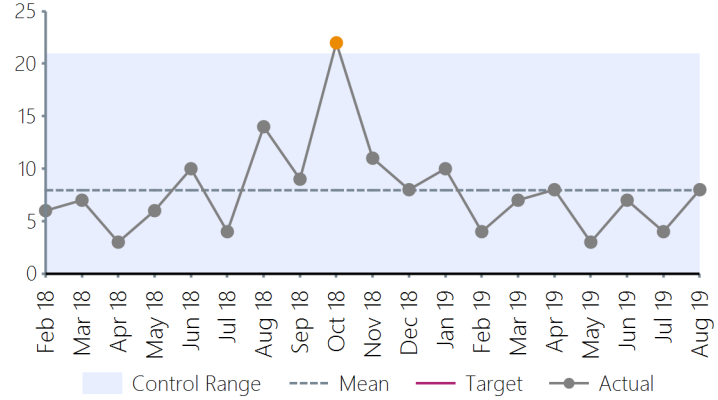
b) shows a point of concern sitting above the control range.

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

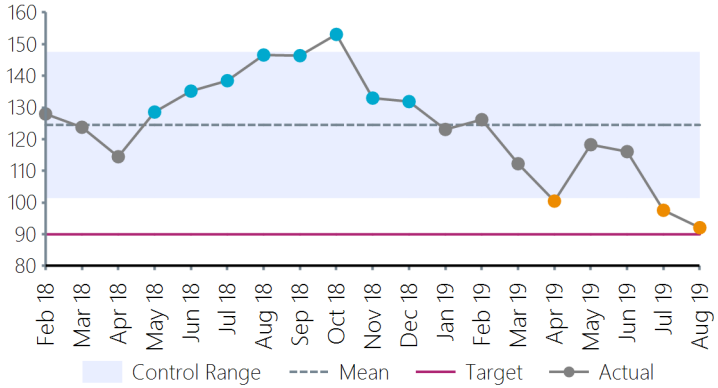
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
31 Day General Treatment Standard*	96.00%	100.00%		H	?		
62 Day General Standard*	85.00%	76.92%	50.00%		?	+	12/09/23
28 Day Faster Diagnosis Standard*	77.00%	77.55%	81.82%	L	Moving Target	+	12/09/23
18 Weeks RTT Open Pathways	54.64%	54.86%		H	Moving Target	+	24/06/21
18 Week Performance - Difference Between Planned and Actual	0.00%	0.22%		N/A to SPC	P	+	
Time to First Appointment - English Patients	65.00%	67.08%		N/A to SPC	Moving Target	+	
Time to First Appointment - Welsh Patients		44.41%		N/A to SPC	No Target	+	
% of Patients Waiting Over 52 Weeks - English	1.75%	3.59%		L	Moving Target	+	
Patients Waiting Over 104 Weeks - Welsh (Total)		374		H	No Target	+	
6 Week Wait for Diagnostics - English Patients	95.00%	85.77%	87.39%	H	Moving Target	+	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%	94.58%			F	+	04/03/24

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Elective Activity Against Plan (volumes)	1,233	1,134			Moving Target	+	24/06/21
% Combined BADS Performance	85.00%	34.83%			F	+	
Total Outpatient Activity against Plan (volumes)	14,041	14,027			Moving Target	+	24/06/21
Total Outpatient Activity - % Moved to PIFU Pathway	6.60%	8.34%		H	Moving Target	+	
Total Diagnostics Activity against Plan - Catchment Based	2,949	2,683			Moving Target	+	

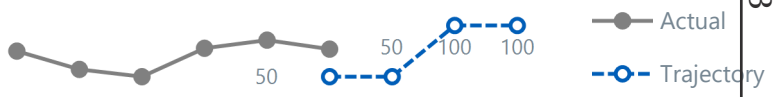
62 Day General Standard*

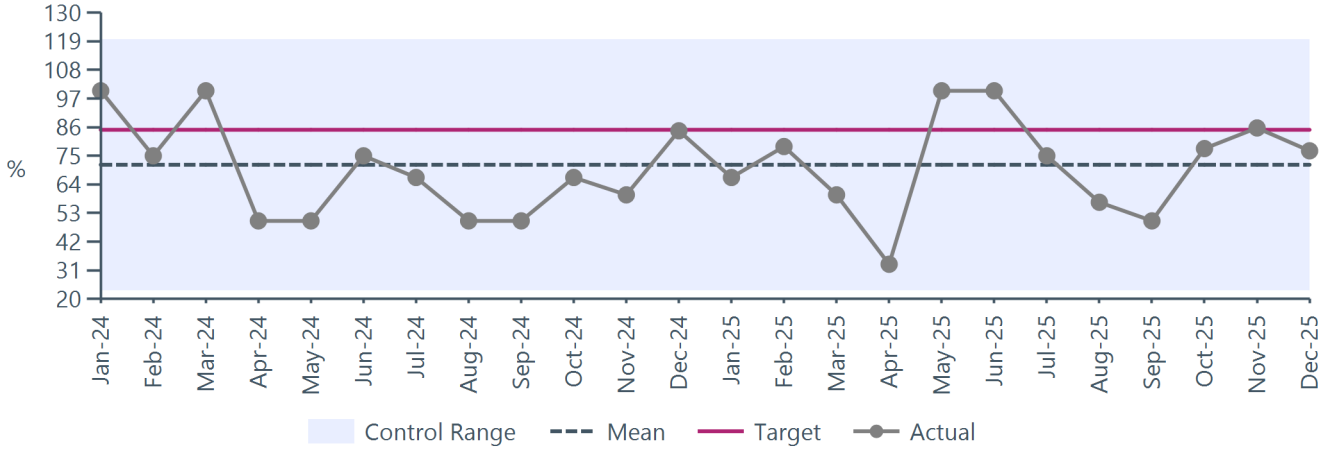
From receipt of an urgent GP referral for urgent suspected cancer, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer. National Target. Trajectory as per Trust's Operational Plans. 217831

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	76.92%		

Trajectory





What these graphs are telling us

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

Narrative

The 62 Day General Standard is reported at 76.92% in December; this is reported in arrears. There were two patients who breached the standard with reasons outlined below:
* Patient required two biopsies, both of these with a results turnaround time of 10 days. Patient requested 21 day delay due to being on holiday. Patient then required GMOSS discussion with referral to another provider on day 62 for surgery.
* Patient required MRI, booked within target however patient then delayed and had MRI on day 34 of pathway. Patient then required USS biopsy and required an off diary CT scan, attempted to bring this forward however patient delayed. Patient then had PET scan and GMOSS discussion before referral to another provider.

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.

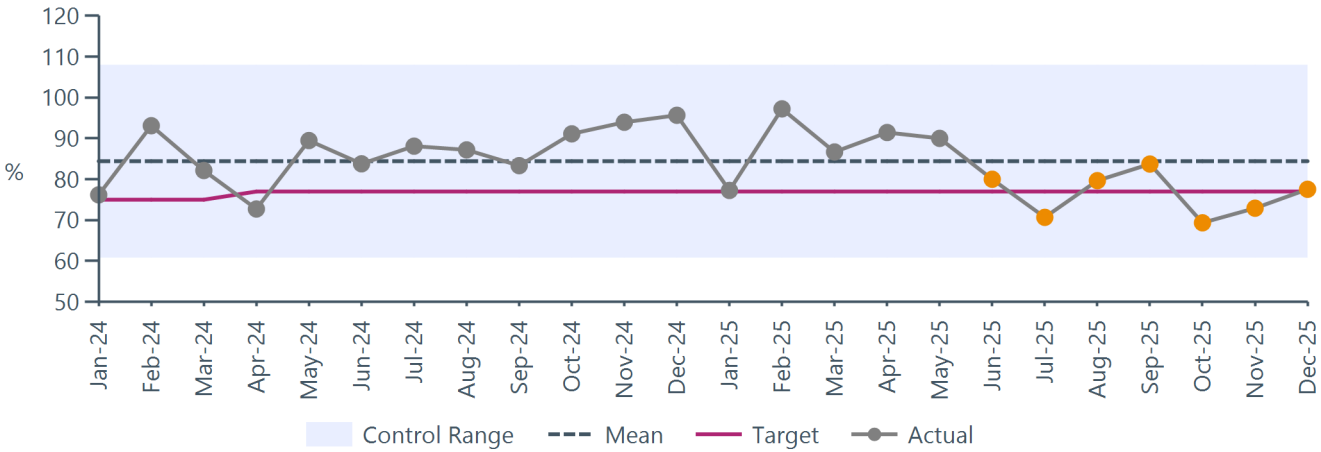
Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
66.67%	78.57%	60.00%	33.33%	100.00%	100.00%	75.00%	57.14%	50.00%	77.78%	85.71%	76.92%	

28 Day Faster Diagnosis Standard*

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
77.00%	77.55%	L	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

The 28 Day Faster Diagnosis Standard is reported at 77.55% in December; this is reported in arrears. Eleven patients breached this standard with reasons associated with patients delays, late referral, multiple diagnostics and capacity issues.

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.

Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
77.27%	97.22%	86.67%	91.43%	90.00%	80.00%	70.69%	79.66%	83.72%	69.35%	72.92%	77.55%	

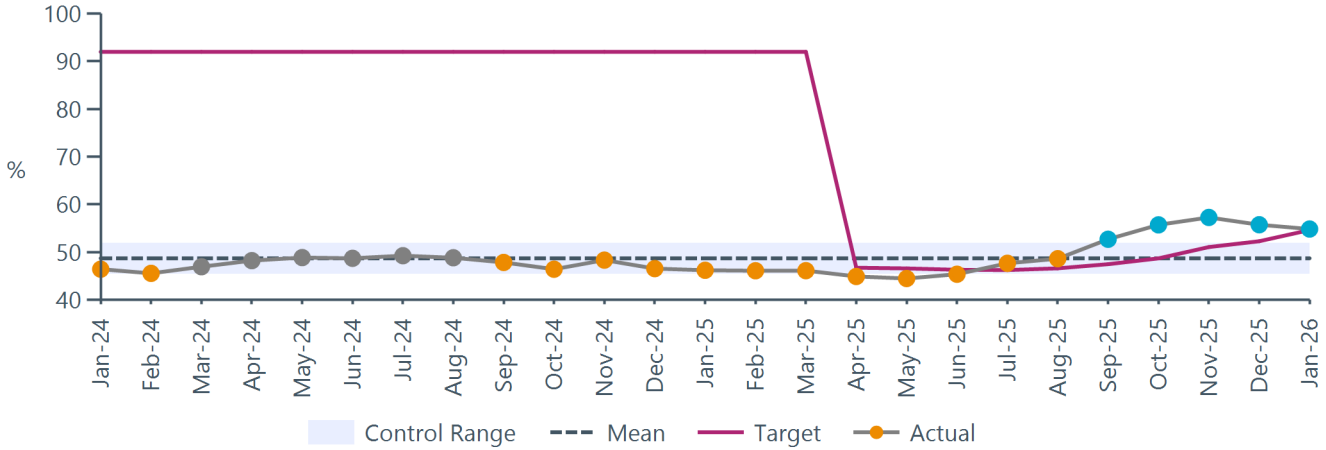
18 Weeks RTT Open Pathways

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
54.64%	54.86%	H	Moving Target

Trajectory



What these graphs are telling us

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

Narrative

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 January performance was 54.86% for patients waiting 18 weeks or less to start their treatment. This was 0.22% better than the position of 54.64% that was planned for the end of January. As shown on the SPC above, this metric remains reported as special cause of an improving nature. This metric is included in the NOF where the latest position for September scored the Trust at 3.82.

The performance breakdown by milestone is as follows:
* MS0 - 91 patients of which 3 are breaches
* MS1 - 9670 patients waiting of which 3226 are breaches
* MS2 - 1329 patients waiting of which 886 are breaches
* MS3 - 5357 patients waiting of which 3309 are breaches

Actions

* Targeted investment from NHSE (Q4 sprint) to improve positions of >18 weeks and >52 weeks cohorts of patients by the end of March.
* Additional infusion clinics for Metabolic Medicine – this should result in additional 100 patients each week from 23rd February to end of March. This will provide an additional 500 infusions slots to assist with backlog clearance.
* DEXA – independent sector support agreed to take 360 patients for scan only that will be completed before the end of March. This should provide enough capacity to clear DEXA to 18 weeks.
* Agile Insourcing for Rheumatology has recommenced – this should provide enough capacity to book the outstanding 301 unbooked patients awaiting a first appointment.
* Additional external resource for Telephone validation/booking – 1330 patients who are in the 52+ week cohort by the end of March will be telephone validated.

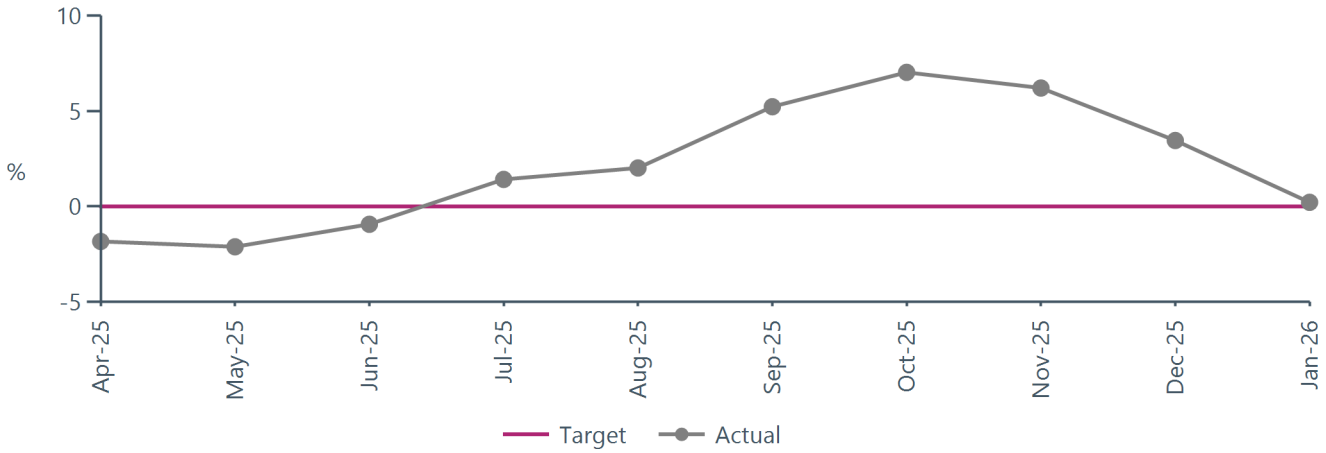
Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
46.22%	46.12%	46.14%	44.92%	44.49%	45.39%	47.68%	48.64%	52.72%	55.74%	57.29%	55.76%	54.86%

18 Week Performance - Difference Between Planned and Actual

Difference between planned and actual 18 week performance 217889

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0.00%	0.22%	N/A to SPC	P



Trajectory

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 2 where the NOF score for this metric is 1; this reflected the September-25 position where the Trust was 5.23% less than it planned to be.

At the end of January, the position reported for month end is 54.86%; this is 0.22% better than the plan of 54.64%. +[@Narrative]

Actions

* Targeted investment from NHSE (Q4 sprint) to improve positions of >18 weeks and >52 weeks cohorts of patients by the end of March.
* Additional infusion clinics for Metabolic Medicine – this should result in additional 100 patients each week from 23rd February to end of March. This will provide an additional 500 infusions slots to assist with backlog clearance.
* DEXA – independent sector support agreed to take 360 patients for scan only that will be completed before the end of March. This should provide enough capacity to clear DEXA to 18 weeks.
* Agile Insourcing for Rheumatology has recommenced – this should provide enough capacity to book the outstanding 301 unbooked patients awaiting a first appointment.
* Additional external resource for Telephone validation/booking – 1330 patients who are in the 52+ week cohort by the end of March will be telephone validated.

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

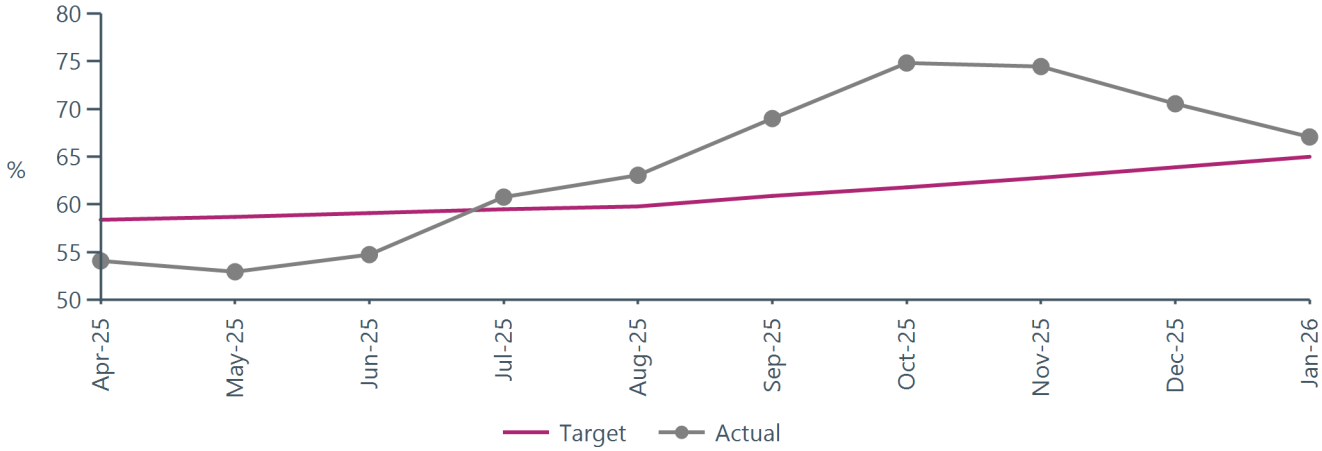
Time to First Appointment - English Patients

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
65.00%	67.08%	N/A to SPC	Moving Target

Trajectory



What these graphs are telling us

This is not applicable to SPC until there are sufficient data points. 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 1st February 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's Operational Plan had forecast a position of 67% by the end of March 2026.

For week ending 1st February 67.08% of patients waiting for first appointment were under 18 weeks; 2% above the 65% plan. The data is reviewed at the weekly Outpatient Activity meeting at sub-speciality level. Performance ranges from 44.84% in Spinal Disorders to 100% in Paediatric Rheumatology, Neurophysiology, Tumour and Occupational Therapy.

Actions

* Additional infusion clinics for Metabolic Medicine – this should result in additional 100 patients each week from 23rd February to end of March. This will provide an additional 500 infusions slots to assist with backlog clearance.
* Agile Insourcing for Rheumatology has recommenced – This should provide enough capacity to book the outstanding 301 unbooked patients awaiting a first appointment.

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

Time to First Appointment - Welsh Patients

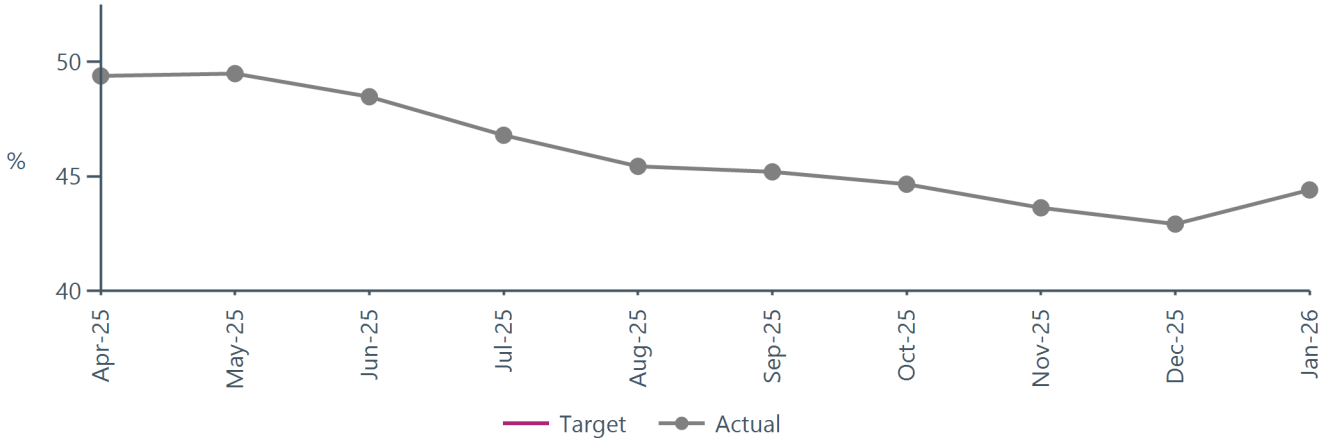
The denominator is the count of incomplete outpatient pathways waiting for a first appointment at the snapshot date. The numerator is the count of incomplete pathways waiting for a first appointment at the snapshot date that have been waiting less that 1 217880

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	44.41%	N/A to SPC	No Target

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

This metric focuses on the time to first appointment waiting for first event and of those patients, the % waiting less than 18 weeks. The reported position is taken from the Waiting List MDS position for week ending 1st February 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 1st February 44.41% of Welsh patients waiting for first appointment were under 18 weeks; there is no plan for Welsh patients. Performance ranges from 17.38% in Spinal Disorders to 100% in Occupational Therapy, Neurophysiology, Tumour & Paediatric Rheumatology.

2025/26 Welsh activity profiles continue to be discussed with Welsh Health Boards, that will impact list size. Since July there are expectations from Powys Health Board to provide first appointment no sooner than 52 weeks that the Trust is not in agreement with due to the potential for clinical risk. Despite Exec to Exec discussions, there is still no agreement on this.

For other Welsh Health Boards, the Trust continues to work with maximum waits standards set out in Welsh Assembly expectations of 52 weeks for Outpatient Activity and 104 weeks for Inpatient Activity.

Actions

* As English RTT performance begins to fall in line with national expectations, the Trust is redressing the equity of access for Welsh patients.
* The Welsh recovery will incorporate a health inequalities lens.
* Validation of Welsh patients ongoing; both technical and administrative. Trust assessing external resource for additional validation of Welsh longest waiting patients.
* Working with Welsh commissioners to review and assess new demand models.

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

% of Patients Waiting Over 52 Weeks - English

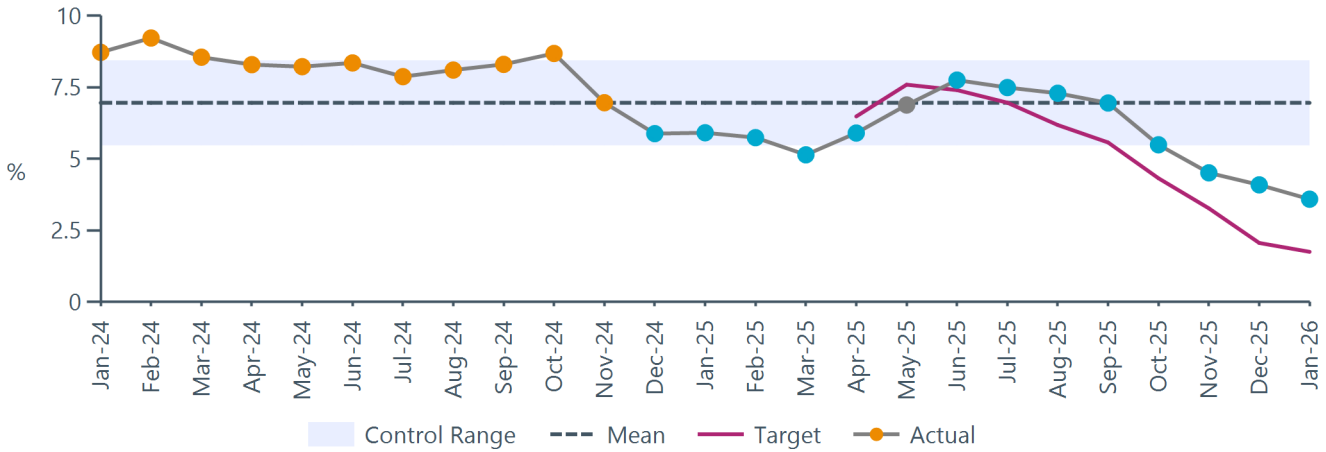
The number of English patients waiting over 52 weeks as a proportion of the English List Size. 217874

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
1.75%	3.59%	L	Moving Target

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

2025/26 English National Planning Guidance stipulates that every organisation should reduce the volume of patients waiting over 52 weeks to <1% of their list size. The Trust's Operational Plan forecasts a position of 1% by the end of March 2026. At the end of January, 586 patients were waiting over 52 weeks, this equates to 3.59% of the English list size; a further reduction throughout the month (89 less patients). The sub-specialties with the highest volume of patients are; Knee & Sports Injuries (151), Arthroplasty (107) and Spinal Disorders (95). Patients waiting, by weeks brackets is:

* >52 to <=65 weeks - 523 patients
* >65 to <=78 weeks - 55 patients
* >78 weeks to <=104 weeks - 7 patients
* > 104 weeks - 1 patient

This metric is part of the NOF, with the latest score for Quarter 2 reported at 3.94 for the September month end position of 6.95%.

Actions

* Evolvement of weekend working for Spinal Disorders complex cases to commence from end of February. One complex spinal case to be operated on through five scheduled dates between 28th February and end of March.
* Knee & Sports Injuries - regular meetings in place to support performance management; chaired by Chief Operating Officer.
* Additional external resource for Telephone validation/booking – 1330 patients who are in the 52+ week cohort by the end of March will be telephone validated.
* Targeted investment from NHSE (Q4 sprint) to improve positions of >18 weeks and >52 weeks cohorts of patients by the end of March.

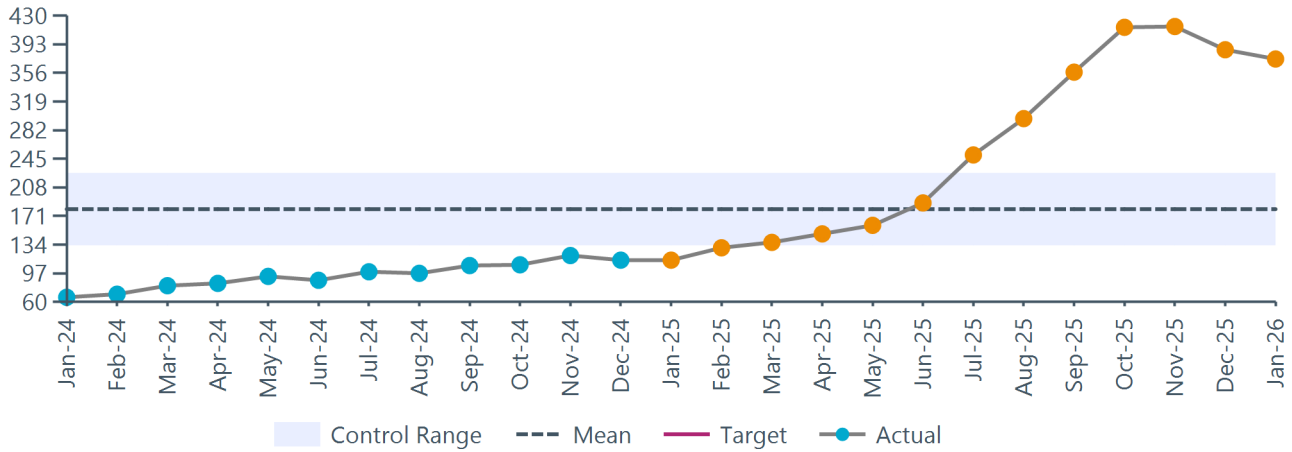
Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
5.91%	5.74%	5.14%	5.90%	6.88%	7.75%	7.49%	7.29%	6.95%	5.49%	4.51%	4.09%	3.59%

Patients Waiting Over 104 Weeks - Welsh (Total)

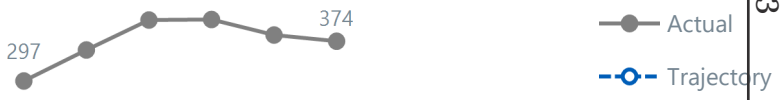
Number of Welsh RTT patients waiting 104 weeks or more at month end 217803

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	374	H	No Target



Trajectory



What these graphs are telling us

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

Narrative

At the end of January there were 374 Welsh patients waiting over 104 weeks. The patients are under the care of these sub-specialities; Spinal Disorders (240), Arthroplasty (40), Knee & Sports Injuries (39), Foot & Ankle (39), Hand & Upper Limb (7), Radiology (4), Neurology (3) and Veterans (2).

2025/26 Welsh activity profiles continue to be discussed with Welsh Health Boards, that will impact list size. Since July there are expectations from Powys Health Board to provide first appointment no sooner than 52 weeks that the Trust is not in agreement with due to the potential for clinical risk. Despite Exec to Exec discussions, there is still no agreement on this.

For other Welsh Health Boards, the Trust continues to work with maximum waits standards set out in Welsh Assembly expectations of 52 weeks for Outpatient Activity and 104 weeks for Inpatient Activity.

Actions

* As English RTT performance begins to fall in line with national expectations, the Trust is redressing the equity of access for Welsh patients.
* The Welsh recovery will incorporate a health inequalities lens.
* Plans in place to treat the Welsh longest waiters (200+ weeks) before the end of April 2026.
* Trust has seen a reduction in Welsh 104+ for last two months. A reduction from its highest point of 415 at the end of November to the latest end of January position reporting 374 patients.
* Validation of Welsh patients ongoing; both technical and administrative. Trust assessing external resource for additional validation of Welsh longest waiting patients.
* Working with Welsh commissioners to review and assess new demand models.

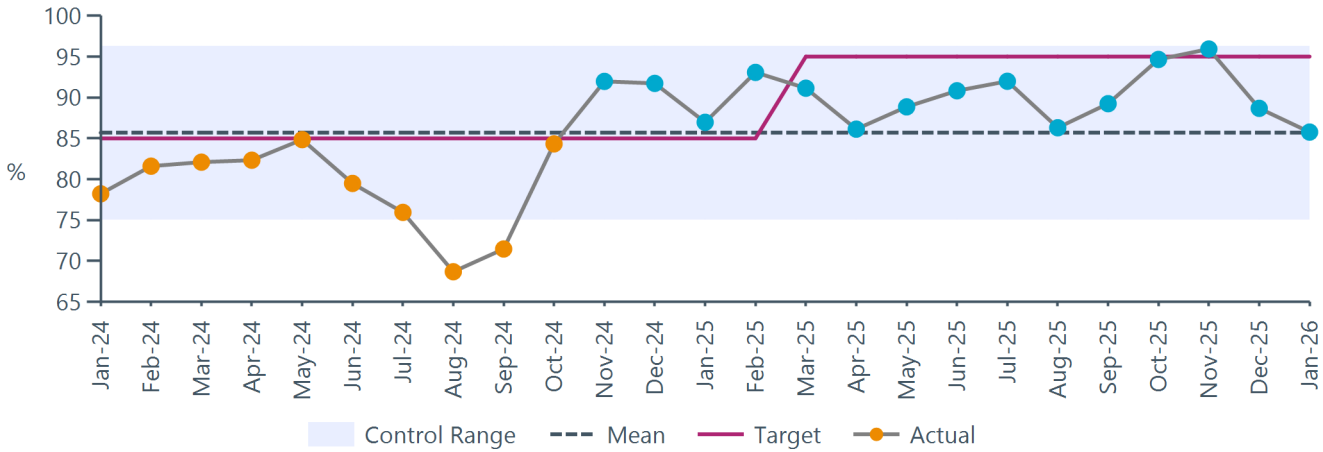
Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
114	130	137	148	159	188	250	297	357	415	416	386	374

6 Week Wait for Diagnostics - English Patients

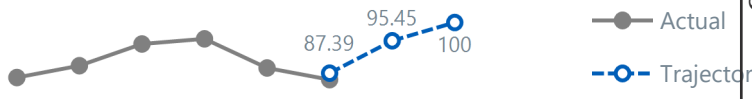
% of English patients currently waiting less than 6 weeks for diagnostics. National Target with Trajectory as per Trust's Operational Plans. 211026

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
95.00%	85.77%	H	Moving Target



Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric has a moving target.

Narrative

Performance for January is 85.77% against the 95% target. This position is below the trajectory for January month end that was planned at 87.39% in the Trust's submitted Operational Plans. Reported position relates to 152 patients who waited beyond 6 weeks. Of the 6-week breaches; 9 are over 13, all within MRI.
Performance and breaches by modality:
* MRI – 79.29% - D2 (Urgent - 0-2 weeks) – 6 with 5 dated, D4 (Routine – 6-12 weeks) – 139 with 100 dated
* CT – 94.02% - D2 (Urgent - 0-2 weeks) – 2 dated, D4 (Routine - 6-12 weeks) – 5 dated
* Ultrasound - 100%
* DEXA - 100%

None of the activity plans were met in January. Sickness and vacancies in the bookings team had a material impact on performance. The lack of available resource to rebook cancellations constrained capacity utilisation, preventing the Trust from achieving the planned activity levels required to remain on the January trajectory. National target – 0 patients waiting over 13 weeks by end of September 2024 and 95% against the 6-week standard within all modalities.

Actions

Ultrasound – on-going improvement – no immediate actions required.

MRI – Radiographic staffing affected by maternity leave in Q1 26/27 (3WTE). Workforce plan to be submitted to MSK MD. MRI bookings affected by workforce absence. People services have been requested to support as per policy. 13 week waits for MRI relate to spinal injury patients and capacity for patient transfer. Radiology working with Specialist Unit ACN to secure a transfer area to accommodated patients and training staff on complex patient transfers to address long waits.

CT – DM01 performance stands at 94.02%, indicating strong compliance – no immediate actions required.

Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
86.97%	93.07%	91.13%	86.13%	88.85%	90.82%	91.98%	86.30%	89.24%	94.65%	95.93%	88.67%	85.77%

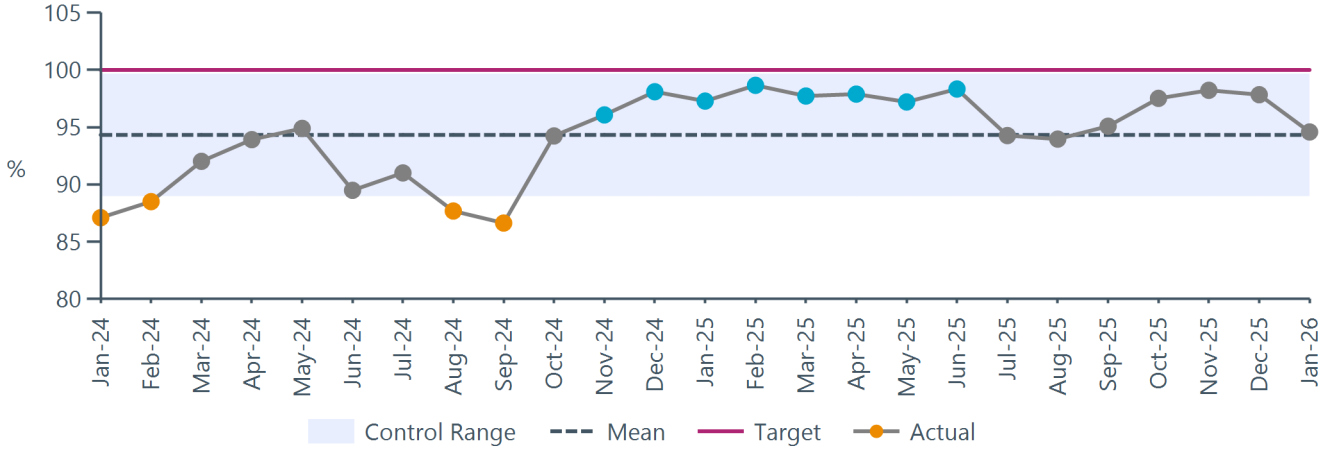
8 Week Wait for Diagnostics - Welsh Patients

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
100.00%	94.58%		F

Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. Metric is consistently failing the target.

Narrative

The 8-week standard for diagnostics is reported at 94.58%. The reporting position includes 24 patients who waited beyond 8 weeks.
Performance and breaches by modality:
* MRI – 93.45% - D2 (Urgent - 0-2 weeks) - 1 dated, D4 (Routine - 6-12 weeks) – 22 with 17 dated
* CT – 97.62% - D4 (Routine - 6-12 weeks) – 1 dated
* Ultrasound - 100%
* DEXA Scans - 100%
None of the activity plans were met in January.

Actions

Ultrasound – on-going improvement – no immediate actions required.

MRI – Radiographic staffing affected by maternity leave in Q1 (3WTE). Workforce plan to be submitted to MSK MD. MRI bookings affected by workforce absence. People services have been requested to support as per policy. 13 week waits for MRI relate to spinal injury patients and capacity for patient transfer. Radiology working with Specialist Unit ACN to secure a transfer area to accommodated patients and training staff on complex patient transfers to address long waits.

CT – DM01 performance stands at 97.62%, indicating strong compliance – no immediate actions required.

Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
97.28%	98.66%	97.72%	97.89%	97.20%	98.33%	94.27%	93.96%	95.09%	97.52%	98.22%	97.84%	94.58%

Elective Activity Against Plan (volumes)

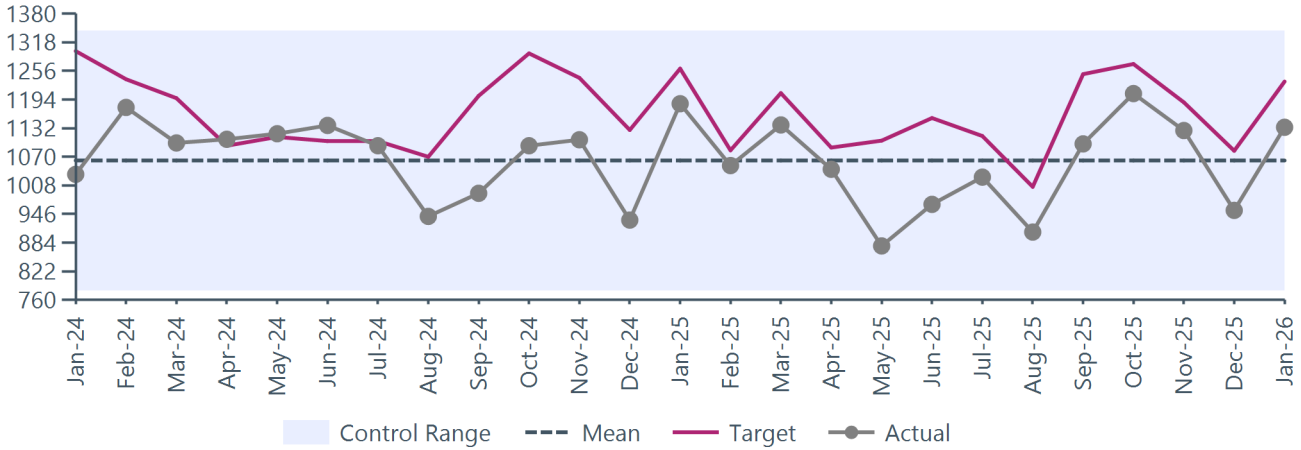
Total elective activity rated against plan. Target as per Trust's Operational Plans. 217796

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
1,233	1,134		Moving Target

Trajectory

Actual
Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. Metric has a moving target; in line with the Trust's Operational Plan.

Narrative

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

For January 2025, the Trust planned for 1233 elective spells, achieving 1134 spells, which equates to 91.97% performance, 99 spells below plan.

Many teams fell short of their planned activity levels in January, notably:

* Spinal Disorders 71.00% of plan (-29)
* Knee & Sports Injuries achieved 81.93% (-30)

January performance is above the mean and within statistical control limits. This indicates the presence of common cause variation.

Actions

* Theatre session cases for NHS and PP are maximised weekly to increase theatre utilisation – attended by MD for MSK Unit.
* Limited levels of activity being undertaken at Independent Sector providers - this is not expected to deliver the levels of activity originally anticipated. Delivered activity in January was Nuffield Shrewsbury -9 patients and Spire Yale – 9 patients. Ongoing usage of Independent Sector is to be reviewed to ensure it aligns with Insourcing arrangements and income.
* Insourcing with Portland Clinical commenced 20th September for additional Theatre Activity however remains under plan.
* Ongoing work regarding the temporary transfer of Orthopaedic activity from PRH to RJAH; commenced with regular sessions offered through 6-4-2 process.

GIRFT Improvement focus includes:
* Increase theatre CPS to 24/25 Q4 levels - Further discussions to be held at Clinical Leads meeting in February with GIRFT to review actions and improvements.

Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
1185	1051	1139	1043	877	967	1026	907	1098	1207	1127	954	1134

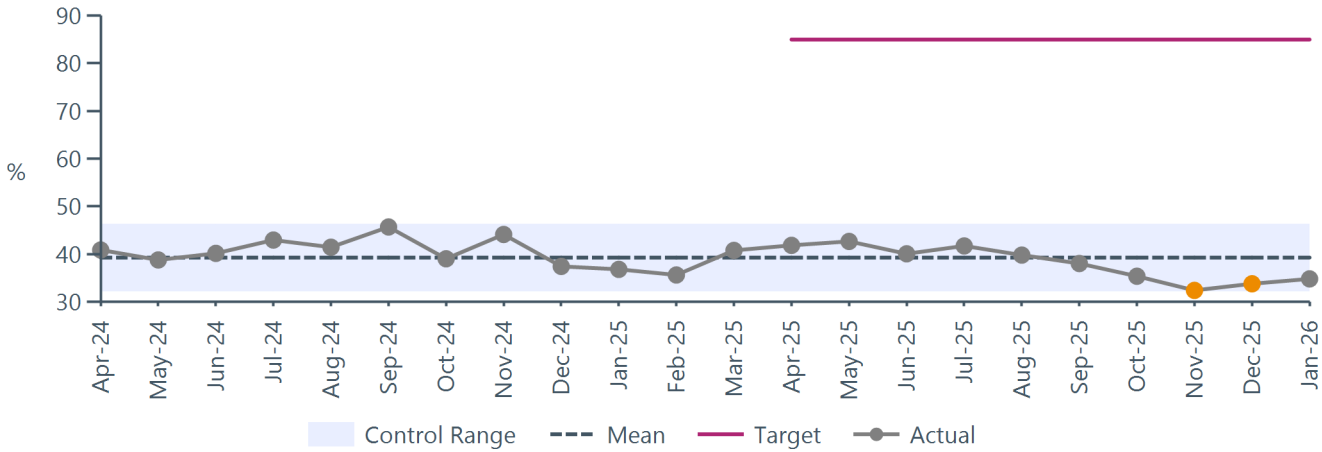
% Combined BADS Performance

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	34.83%		F

Trajectory



What these graphs are telling us

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

Narrative

The metric measures the percentage of Combined BADS Performance, aligned with the Orthopaedic and Urology sections of the BADS Directory of Procedures (September 2024 Edition). It continues to be monitored against the overall 85% target, set under the 2023/24 elective care NHSE planning guidance, reflecting the Trust's delivery of BADS day cases as a proportion of all BADS procedures undertaken.

In January, BADS performance was reported at 34.83%. If patients discharged on day zero—regardless of their intended management—were included, the metric would have reached 54.00%.

1% improvement has brought this KPI within control limits and now reports common cause variation.

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. carpel 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.

Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
36.83%	35.65%	40.80%	41.86%	42.69%	40.09%	41.74%	39.82%	38.05%	35.39%	32.42%	33.81%	34.83%

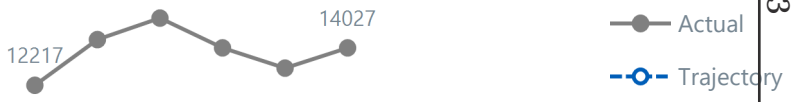
Total Outpatient Activity against Plan (volumes)

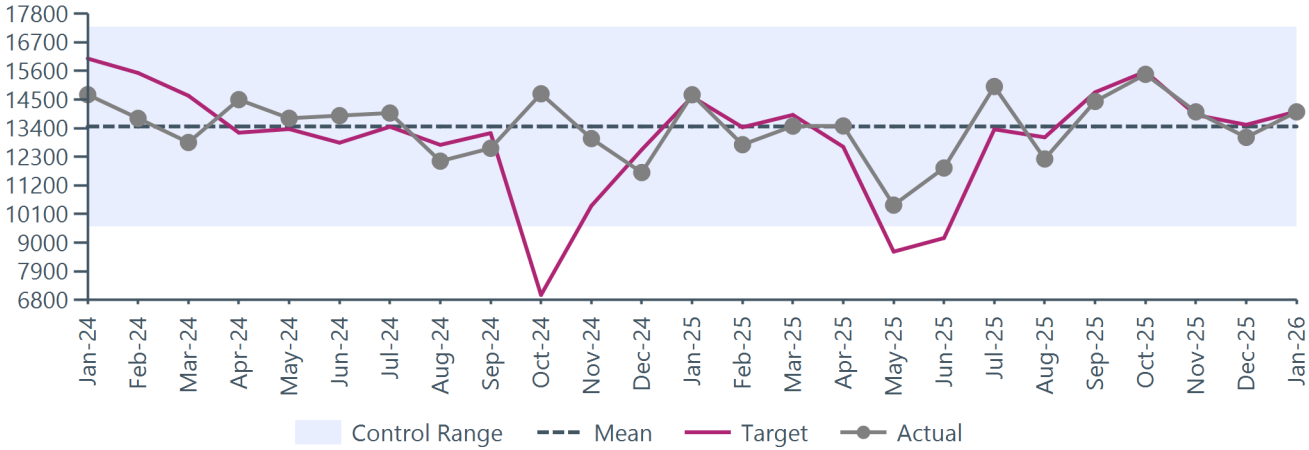
Total outpatient activity (consultant led and non-consultant led) against plan. Target as per Trust's Operational Plans. 217795

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
14,041	14,027		Moving Target

Trajectory





What these graphs are telling us

Metric is experiencing common cause variation. Metric has a moving target; in line with the Trust's Operational Plan.

Narrative

At time of IPR production and data refresh (9th February 2026), the outpatient activity plan was not met for January and is reported -14 of plan at 99.90%. At this time, there were also 581 missing outcomes, therefore, by the time this data is refreshed for next month's reporting it will be reported as achieving plan. Please note, of those missing outcomes, some may be DNAs.

A breakdown of Outpatient activity below:
* IJP activity was -506 at 96.32%, * OJP activity was +183 at 115.64%, * Insourcing activity was 305; there had originally been no plan for this in January
* New activity 94.77%, * Follow Up activity 100.27%

Monitoring of delivered activity against plan remains under focus at weekly activity meeting. Physiotherapy is an area of concern where for the period of April to January the delivered activity is 83% that equates to -3061 attendances.

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 are undertaking a deep dive that will be presented to TPOIG in March.

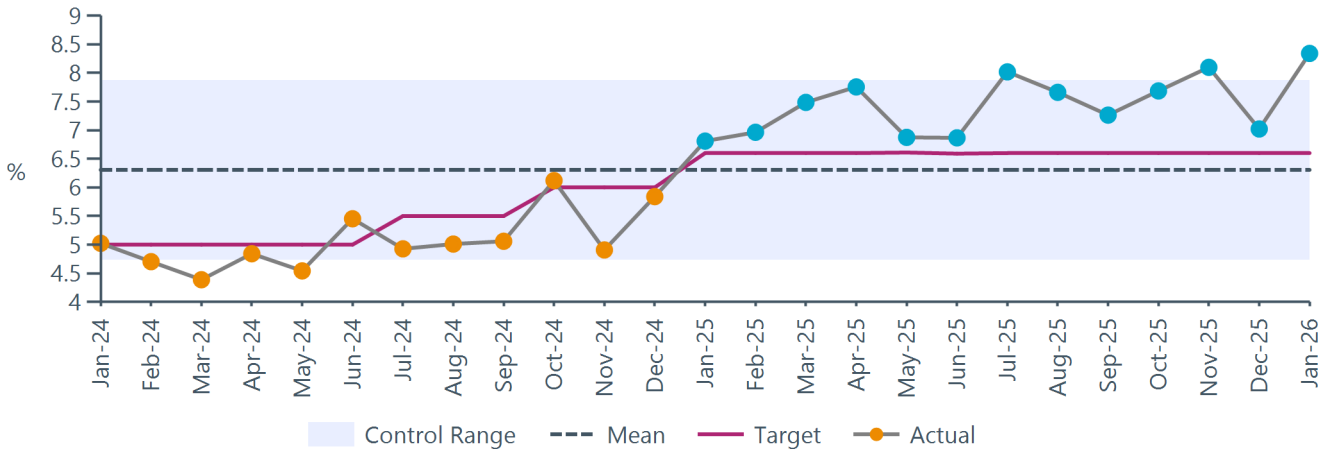
Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
14685	12767	13480	13486	10444	11870	15002	12217	14428	15470	14028	13047	14027

Total Outpatient Activity - % Moved to PIFU Pathway

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
6.60%	8.34%	H	Moving Target



Trajectory

What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. This measure has a moving target.

Narrative

The target for the number of episodes moved to a PIFU Pathway is 6.60% of all outpatients attendances. In January this was exceeded with 8.34% 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 fourteen 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

Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
6.81%	6.96%	7.49%	7.76%	6.87%	6.87%	8.02%	7.66%	7.26%	7.69%	8.10%	7.02%	8.34%

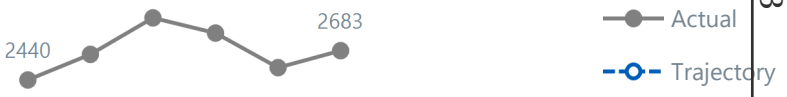
Total Diagnostics Activity against Plan - Catchment Based

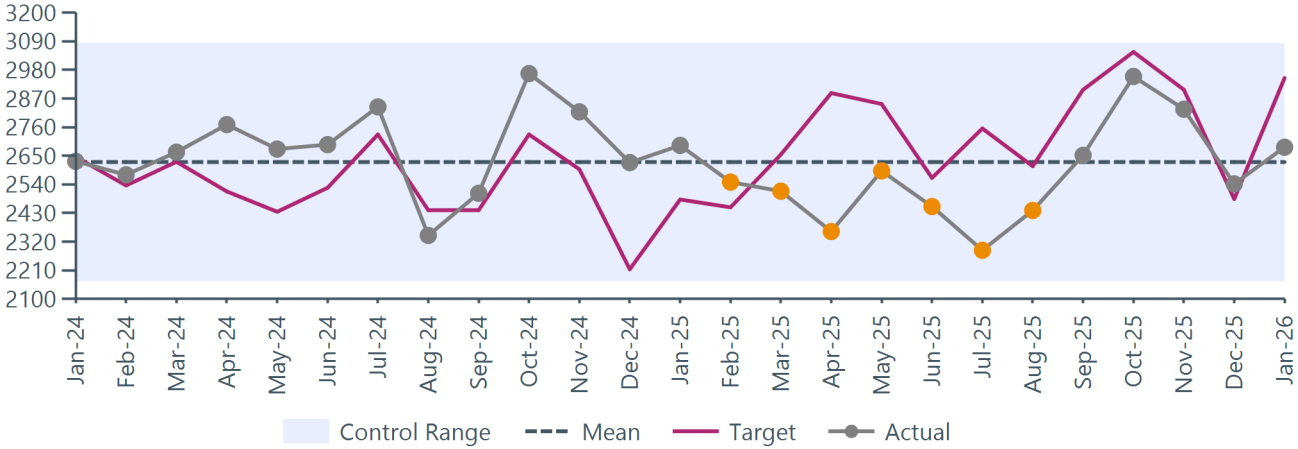
Total Diagnostic Activity against Plan - (MRI, U/S and CT activity) against plan. Target as per Trust's Operational Plans. 217794

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
2,949	2,683		Moving Target

Trajectory





What these graphs are telling us

Metric is experiencing common cause variation. Metric has a moving target; in line with the Trust's Operational Plan.

Narrative

The Diagnostic activity plan was not in January. Overall activity is reported at 90.98% with a breakdown as follows:
* U/S – 941 against 991; equating to 94.95%
* MRI - 1346 against plan of 1503; equating to 89.55%
* CT – 396 against plan of 455; equating to 87.03%

Sickness and vacancies in the bookings team had a material impact on performance. The lack of available resource to rebook cancellations constrained capacity utilisation, preventing the Trust from achieving the planned activity levels .

Actions

MRI bookings affected by workforce absence. People services have been requested to support as per policy.

Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
2690	2549	2514	2359	2592	2455	2287	2440	2652	2955	2829	2542	2683

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

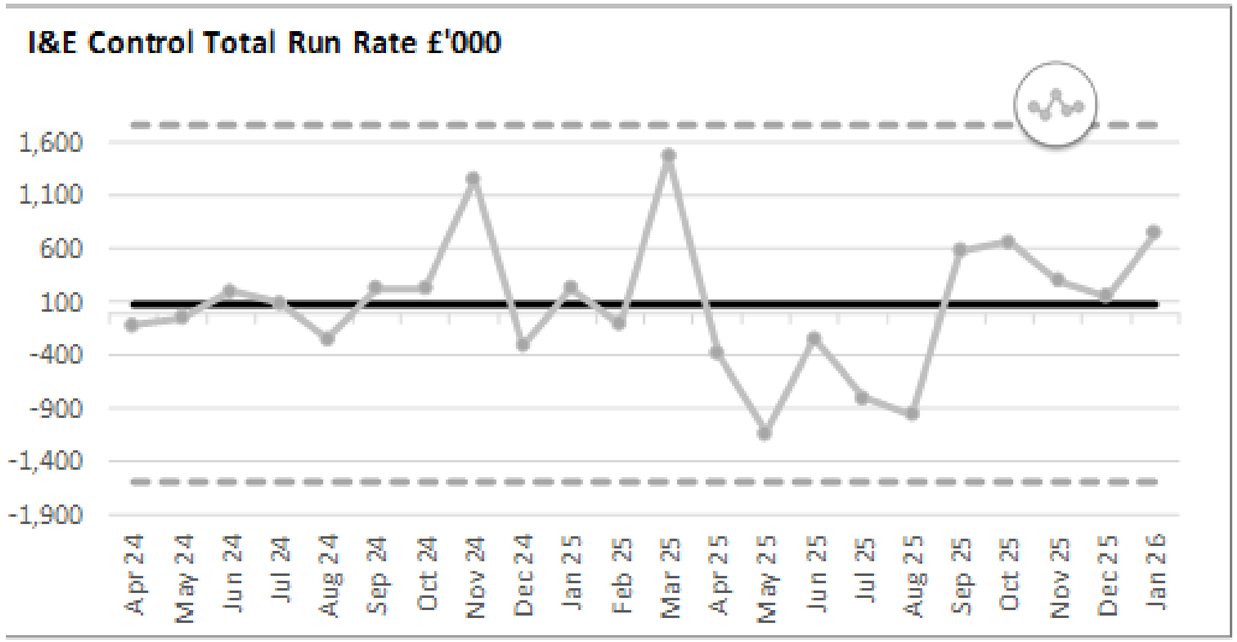
M10 Financial Position Update

Improving lives through excellent and innovative care

NHS

Income & Expenditure Position January 2026

	Annual Plan	In Month Position			YTD Position		
		Pass through adj Plan	Actual	Variance	Pass through adj Plan	Actual	Variance
Clinical Income	153,952	13,752	13,623	(129)	127,404	121,060	(6,344)
Private Patient income	11,987	994	905	(89)	10,025	9,375	(650)
Other income	6,849	697	754	57	6,502	6,946	444
Pay	(107,137)	(9,015)	(8,857)	158	(89,667)	(86,454)	3,213
Non-pay	(57,175)	(4,949)	(4,980)	(31)	(48,295)	(45,424)	2,871
EBITDA	8,476	1,479	1,445	(34)	5,969	5,503	(466)
Finance Costs	(9,285)	(798)	(762)	36	(7,684)	(7,240)	444
Capital Donations	1,620	408	297	(111)	952	531	(421)
Operational Surplus	811	1,089	980	(109)	(763)	(1,206)	(443)
Remove Capital Donations	(1,620)	(408)	(297)	111	(952)	(531)	421
Add Back Donated Dep'n	809	68	71	3	670	700	30
Control Total	(2)	750	753	3	(1,046)	(1,038)	8

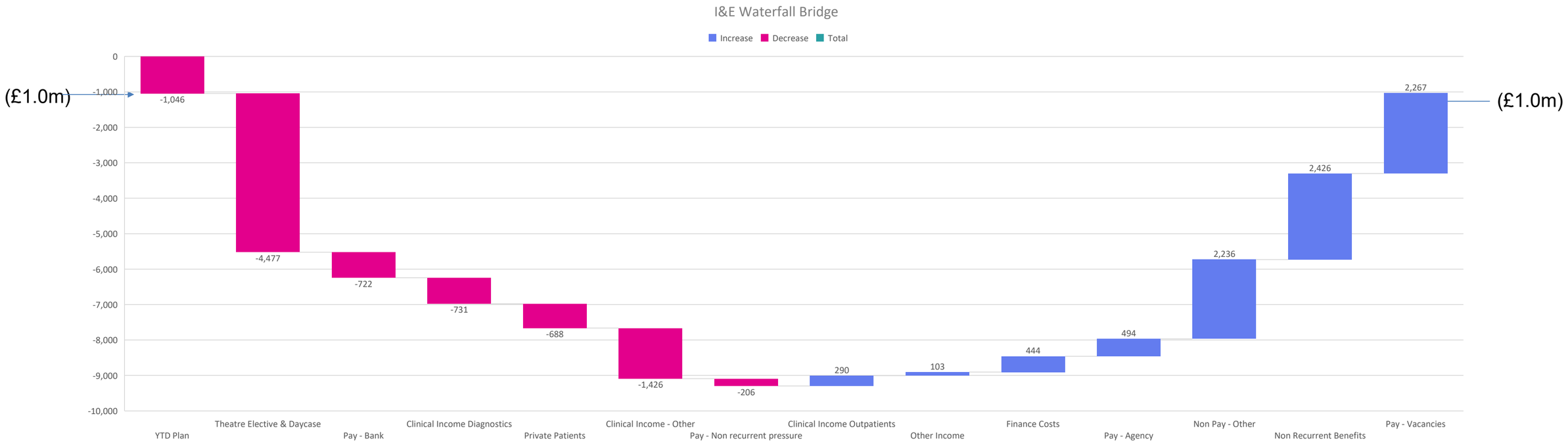


In month: £0.75m surplus, on plan

- **NHS Clinical Income £0.1m adverse -** driven by £0.3m adverse theatre performance and £0.1m adverse outsourcing (offset in expenditure) offset by £0.2m favourable RTT sprint funding from NHSE and £0.1m favourable ERF reconciliation with national reporting.
- **Non-NHS income £0.03m adverse –** driven by £0.09m adverse private patient income, £0.06m favourable other income due to SLA charging YTD catch up
- **Pay expenditure £0.16m favourable –** driven by £0.2m favourable workforce recruitment slippage, £0.07m favourable enhanced pay controls and £0.07m favourable agency. Partially offset by £0.2m adverse bank spend (Outpatient clinics/Anaesthetics OJP, clinical support and non clinical).
- **Non-Pay £0.03m favourable -** driven by £0.1m adverse insourcing (income offset but pressure to plan), offset by £0.1m favourable implants/consumables

YTD: £1.0m deficit, on plan.

Bridge from YTD plan (£1.0m) versus Actual (£1.0m)



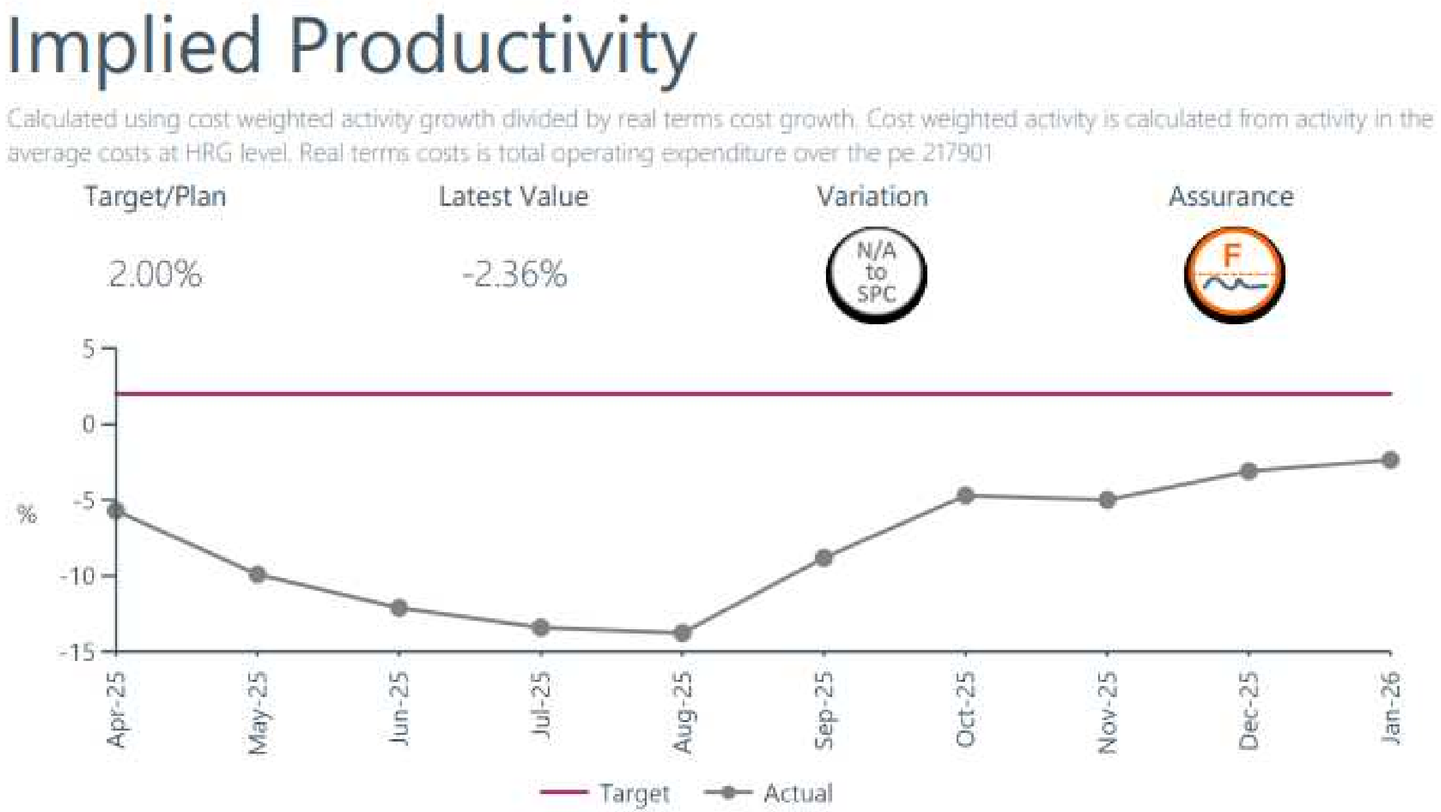
The bridge shows the key drives of the variances to plan YTD in delivery of the £1.0m deficit.

The primary driver is adverse income performance linked to lower than planned elective theatre activity, outpatients and diagnostics which is largely offset by lower than planned pay & non pay expenditure.

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

Further to this £2.2m of non recurrent mitigations and £0.4m of interest receivable are supporting the overall position.

Implied Productivity



Implied Productivity

This metric divides cost weighted activity growth by the real terms (inflation adjusted) cost growth of the Trust to demonstrate how efficiently the Trust is delivering its activity against its cost base. The overall NOF score is then calculated relative to the score of all other organisations.

Calculation

Cost weighted activity growth – this takes activity during the two periods 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 new EPR system and plateaued during **August at –13.8%,** the position has recovered since then due to improvements in activity levels with J**anuary delivering –2.36%.**

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

Month 10 Performance Summary

25/26 Month 10 Planned Savings	25/26 Month 10 Actual Savings	25/26 Month 10 Savings Variance
£923k	£1,008k	£85k

25/26 Full Year Planned Savings	25/26 Full Year Forecast Savings	25/26 Full Year Savings Variance
£9,594k	£10,730k	£1,136k

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Internal Plan & Actuals	Month 10			YTD			Forecast		
	Plan	Actual	Variance	YTD Plan	YTD Actual	Variance	Plan	Forecast	Variance
MSK	420	461	41	3,778	3,607	-171	4,623	4,432	-191
Spec	367	291	-76	2,590	2,329	-260	3,377	3,033	-344
Corporate	136	185	49	1,309	1,638	329	1,594	2,129	535
Total Recurrent	**923**	**937**	**14**	**7,677**	**7,574**	**-103**	**9,594**	**9,594**	**0**
YTD Non-Recurrent	**0**	**71**	**71**	**0**	**1,085**	**1,085**	**0**	**1,136**	**1,136**
Total including Mitigations	**923**	**1,008**	**85**	**7,677**	**8,659**	**982**	**9,594**	**10,730**	**1,136**

Unit	Planned £000's	Forecast £000's	Delivered £000's	Low Risk £000's	Medium Risk £000's	High Risk £000's	Unidentified £000's
Corporate	1,594	3,049	3,048	1	0	0	0
MSK	4,623	4,551	4,129	374	48	0	0
SPEC	3,377	3,130	2,770	207	73	80	0
Total	**9,594**	**10,730**	**9,947**	**582**	**121**	**80**	**0**

Risk Adjusted Forecast £000's	Movement £000's
3,049	0
4,539	-12
3,052	-78
10,640	**-90**

Risk adjusted forecast assumes:
- 100% delivery of Delivered/ Low Risk schemes
- 75% delivery of Medium Risk schemes
- 25% delivery of High Risk schemes

This represents a 'most likely' year end position if no further action is taken.

Performance

- Overall, £1,008k efficiencies achieved, £85k favourable to plan.
- Recurrent delivery £14k favourable to plan, with an additional £71k of non recurrent mitigations recognised in month.
- YTD £8,659k efficiencies achieved, £982k favourable to plan.
- Recurrent delivery £103k adverse to plan, offset by £1,085k non recurrent mitigations.
- Following a review of risk scored the level of red rated schemes stands at £80k, representing less than 1% of the total forecast value for the year.
- In total, just over 98% of the forecast total is flagged as either delivered or green rated for low risk.

Cash Position

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Actual	19.88	19.75	19.59	19.84	21.65	21.09	21.03	19.33	18.55	18.67		
Forecast										18.67	19.14	19.78
Plan	18.42	17.71	17.66	16.52	16.06	13.77	14.75	15.27	14.99	16.17	16.37	16.80

Cash balances remained steady in January, and are currently £18.7m which is £2.5m above plan.

The year end forecast is £19.8m which is £3m above plan. This is due to revised assumptions on provisions liabilities, capital phasing, lease arrangements, and phasing into 26/27 of funding for the Veterans rehabilitation pilot. This also includes £0.8m of expected "Sprint" funding expected before the year end from STW.

Capital Position

Capital Programme Position as at 2526-10									
Project	Annual Plan £000s	In Month Plan £000s	In Month Actual £000s	In Month Variance £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Forecast Outturn £000s	Forecast Variance £000s
Backlog maintenance	500	30	16	14	420	339	82	500	0
Digital investment & replacement	500	22	368	(346)	456	710	(254)	829	329
Capital project management	170	15	14	1	142	143	(1)	170	0
Equipment replacement	1,000	100	12	88	760	824	(64)	890	(110)
Diagnostic equipment replacement	700	0	0	0	700	633	67	635	(65)
Compliance (IPC/health & safety/quality)	360	20	2	18	320	253	67	360	0
Estates reconfiguration	206	20	7	13	170	77	93	206	0
PACS/RIS replacement	200	5	0	5	190	0	190	0	(200)
Invest to save	200	0	0	0	150	123	27	165	(35)
Digital & innovation strategy	500	0	0	0	500	0	500	308	(192)
Surgical innovations	750	0	0	0	750	725	25	725	(25)
EPR implementation	500	0	0	0	500	491	9	491	(9)
Rheumatology hub	500	100	0	100	300	14	286	500	0
Rheumatology hub (donated element)	500	100	0	100	300	0	300	0	(500)
Donated / Granted medical equipment	220	8	(3)	11	202	234	(32)	240	20
Energy/decarbonisation plan (grant)	900	300	297	3	450	297	153	857	(43)
Critical infrastructure funding (CIR)	500	100	166	(66)	300	325	(25)	1,340	840
Solar works (GBE funding)	2,407	800	0	800	800	1,372	(572)	2,616	209
Leases (IFRS16)	250	0	49	(49)	180	208	(28)	230	(20)
Electric Vehicle Charge Points (PDC)	0	0	0	0	0	0	0	14	14
Cyber risk reduction (PDC)	0	0	0	0	0	40	(40)	40	40
Imaging home reporting equipment	0	0	0	0	0	0	0	31	31
Contingency	0	0	0	0	0	(164)	164	327	327
Total Capital Funding	**10,863**	**1,620**	**928**	**692**	**7,590**	**6,642**	**948**	**11,474**	**611**
Less donated / grant capital	(1,620)	(408)	(294)	(114)	(952)	(531)	(421)	(1,097)	523
NHS Capital Funding - Charge to	**9,243**	**1,212**	**635**	**578**	**6,638**	**6,111**	**527**	**10,377**	**1,134**
Less PDC funded schemes	(2,907)	(900)	(166)	(734)	(1,100)	(1,737)	637	(4,041)	(1,134)
Charge to System Operational Capital	**6,336**	**312**	**469**	**(157)**	**5,538**	**4,374**	**1,164**	**6,336**	**0**

Capital expenditure is £948k behind plan YTD. This is mainly due to slippage on digital investment £436k and the Rheumatology Hub £586k, as well as a contingency built up from uncommitted allocations, offset by earlier than expected work on the solar project £572k.

The forecast is £611k above plan. This is due to additional external PDC funding of £1,134k for Estates Safety Works, Solar Works, Electric Vehicle Charging Points, Cyber Security and Home Reporting, offset by the planned £500k donated expenditure on the Rheumatology Hub slipping into 26/27 and other donated and grant adjustments. Neither the PDC funding or the donated/grant expenditure are charged against the System Operational Capital, so that is forecast to breakeven - this is the key measure for NHSE.


NHS
The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust
Financial Forecast Aligned to Recovery Plan
Improving lives through excellent and innovative care
NHS

Summary Recovery Action Impact – Position shared at Board @ M8

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Improvement Actions M9-12	Financial Impact (£'m)
Activity Actions	£0.5
Workforce Actions	£0.4
Finance Actions	£0.8
Sub-Total	**£1.7**

Additional Forecast Adjustments	£'m
Efficiency Programme – Full delivery through non-recurrent schemes, remove forecast risk	£0.3
M8 Actual delivery better than M7 Forecast	£0.3
Total	**£2.3**

Update forecast position – post mitigations

Best £	Likely £	Worst £
(£1.6m)	(£2.3m)	(£2.8m)
£1.7m	**£2.3m**	**£2.3m**
+£0.1m	**£0.0m**	**-£0.5m**

Best Case already includes £0.6m assumption for M8 actual delivery and efficiency

Operational - Actions Update £0.6m

Focus	Action, Assumptions	Impact M9-12 (Best) Activity	Impact M9-12 (Best) Best Case £'k	Agreed Delivery £'k	M9 £'k	M10 £'k	M11 £'k	M12 £'k	Total Delivered £'k	Comments / update
1. Increase Volume of Sessions Increase In-Job Plan % utilisation	• Spinal disorders 6 sessions per month (7 cases) • Arthroplasty 13 sessions per month (22 cases) • Upper limb 4 sessions per month (9 cases) • Knee and sports 10 sessions per month (21 cases)	Q4 impact 177 cases	£800	**£200**	**£0**	**£42**			**£42**	**IJP % increase for KSI**
2. Improve Cases per Session	Return to plan and in line with current activity forecast for Q4 57 cases per month *(Q4 Assumed in current forecast)*	M9 - 20 cases M10-12 plan	£75	**£56**	**£0**	**£0**			**£0**	**No CPS M10**
3. Insourcing Extension M11 & M12	Additional 50 cases per month – month 11 and M12	100 cases	£150	**£113**	**£0**	**£0**			**£0**	**Note phased from M11**
4. Defer Rolling Half Day – January 2026	January 2026, 26 case improvement above plan	M10	£100	**£100**	**£0**	**£31**			**£31**	**5 afternoon sessions**
5. ADDITIONAL MITIGATION RTT validation sprint funding	Validation sprint improvement vs 24/25 baseline @ £30 per patient	M7-9	£100		**£104**	**£0**			**£104**	**Q2 additional funding in relation to the RTT validation sprint £104k.** **Further £84k notified for Q3 sprint £84k to be recognised M11**
	Total	**483**	**£1,225**	**£469**	**£104**	**£73**			**£177**	

Workforce - Actions Update £0.4m

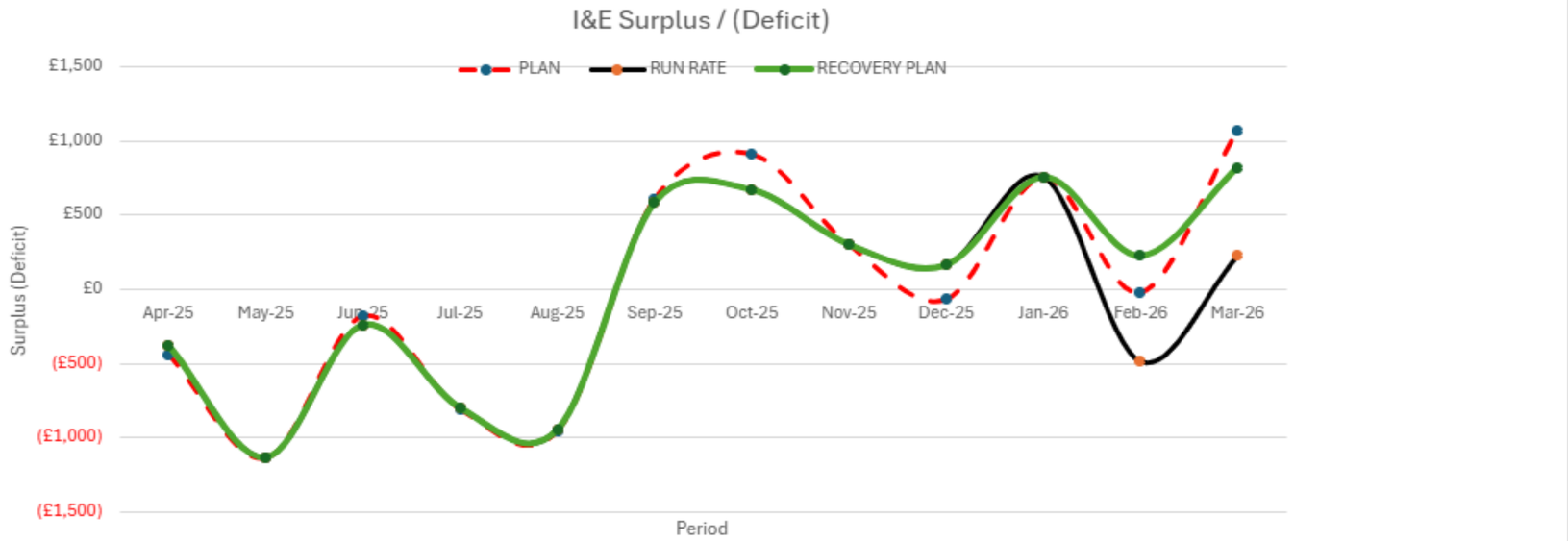
Focus	Action	Assumptions	WTE Delivery	Agreed Delivery £k	M9 £'k	M10 £'k	M11 £'k	M12 £'k	Total Delivered £'k	Comments / update
1. Non-Replacement of Leavers	Delay recruitment / replacement of leavers until April 26	Reduction versus M1-7 run rate	5.84	**£45**	**£0**	**£0**			**£0**	
2. Hold on all Non-Essential Bank	Communicate to all Senior Team and Budget holder - no Bank approved unless Exec agreed	Reduction versus M1-7 run rate	6.06	**£60**	**£0**	**£7**			**£7**	**Run rate improvement excluding the RTT sprint funded bank**
3. Hold on all Non-Essential Overtime	Communicate to all Senior Team and Budget holder - no Overtime approved unless Exec agreed	Reduction versus M1-7 run rate	1.92	**£50**	**£0**	**£5**			**£5**	**Run rate improvement excluding the RTT sprint funded overtime**
4. Enhanced Bank Overpayment Recovery	Confirm date for Allocate to update software to confirm overpayment recovery value	Estimated overpayment value £200k	N/A	**£200**	**£0**	**£0**			**£0**	
		Total		**£355**	**£0**	**£12**			**£12**	

Finance - Actions Update £0.8m

Focus	Action	Agreed Delivery £'k	M9 £'k	M10 £'k	M11 £'k	M12 £'k	Total Delivered £'k	Comments / update
1. Non-Pay Controls	Enhanced non pay controls are proposed for controllable non-clinical spend areas. Reduce run rate for Q4	**£20**	**£0**	**£3**			**£3**	**Reduction versus run rate**
2. SLA & Contracts	Work with operational leads to ensure SLA's reflect the full service delivered. SCHT – MIU SLA Spec Comm – Elbow Hub funding ICB – R Fallows recharge	**£40**	**£0**	**£56**			**£56**	**Uplift MIU and Trauma SLA – Supporting efficiency programme**
3. RTA / ICR Income	Review ICR income recognition. Run rate for H1 can be replicated for H2	**£90**	**£87**	**£0**			**£87**	**RTA income notifications recognised for Q3. Potential for further notifications in Q4.**
4. Rates Review	Business rates challenged with LA re: new theatre complex and Headley Court	**£200**	**£200**	**£23**			**£223**	**Business rates credit , additional in Q4.**
5. TOIL accrual review	MD's to confirm TOIL balances to be paid to surgeons	**£200**	**£201**	**£0**			**£201**	**Prior year TOIL accrual benefit recognised in full in M9.**
6. ERF support funds	Review additional committed ERF costs YTD that are supported by NHSE additional funding	**£170**	**£0**	**£57**			**£57**	
7. Diagnostics	Review of scan grouping and scope to recapture lost exams. Assumes like for like pre-CRIS upgrade and Apollo.	**£30**	**£0**	**£0**			**£0**	
8. ADDITIONAL MITIGATION Industrial action funding	NHSE funding for industrial action support		**£100**	**£0**			**£100**	**Notified of additional NHSE central funding to support the impact of industrial action**
	Total	**£850**	**£588**	**£136**			**£727**	

Forecast Phasing Recovery Plan

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust



I/E Surplus (Deficit)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Surplus (Deficit)
PLAN	(£442)	(£1,140)	(£183)	(£810)	(£957)	£604	£907	£296	(£71)	£750	(£24)	£1,070	**(£0)**
RUN RATE	(£379)	(£1,135)	(£241)	(£801)	(£949)	£584	£667	£299	£161	£754	(£490)	£222	**(£1,308)**
RECOVERY PLAN	(£379)	(£1,135)	(£241)	(£801)	(£949)	£584	£667	£299	£161	£754	£223	£819	**£2**
VARIANCE ASSESSMENT (v's Plan)													
RUN RATE (v Plan)	*£63*	*£5*	*(£58)*	*£9*	*£8*	*(£20)*	*(£240)*	*£3*	*£232*	*£4*	*(£466)*	*(£848)*	*(£1,308)*
LATEST FORECAST (v Plan)	*£63*	*£5*	*(£58)*	*£9*	*£8*	*(£20)*	*(£240)*	*£3*	*£232*	*£4*	*£247*	*(£251)*	*£2*

- The above shows the monthly forecast Net Operating Surplus/Deficit for the most likely, versus Plan
- The Recovery plan breakeven includes current identified operational recovery actions with associated Income and Costs

Scenario Assessment

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

The below table shares a risk adjusted forecast across 3 scenarios based on flexed assumptions:

- Risk assessed best Case £0.0m favourable to plan
- Risk assessed likely Case (£0.1m) adverse
- Risk assessed worst case (£0.8m) adverse

		M10 Scenarios		
		BEST CASE	MOST LIKELY	WORST CASE
Surplus (Deficit) £'000		**£2**	**£2**	**£2**
Risks	**Risk Score**			
Private Patient Delivery	12	Mitigated	Mitigated	(£104)
Efficiency delivery	12	Mitigated	Mitigated	Mitigated
Veterans Service Activity/Income recovery	8	Mitigated	Mitigated	(£33)
Operational Recovery Interventions	**Area**			
PFIG February Theatre Forecast	Theatres	£0	£0	(£296)
PFIG March Theatre Forecast	Theatres	£0	(£119)	(£382)
Adjusted Surplus (Deficit)		**£2**	**(£117)**	**(£812)**

Most likely reflects latest operational forecast discussed at PFIG on a weekly basis with worst case reflecting the current gap in bookings versus the activity forecast

- **Private Patients**: Assumed mitigated in Best and most likely cases based on last 6 months delivery, worst case assumes average YTD run rate
- **Efficiency Programme**: Assumes mitigated under all scenarios through mitigating and non-recurrent schemes as per recovery plan
- **Veterans Income**: Worst case based on run rate, most likely 80% recovery of invoices factored into the position YTD
- **Operational Recovery Interventions:** Interventions aligned to recovery plan, the risk on the theatre forecast from performance and finance improvement group is reflected in the most likely scenario with current gap in bookings/cancellations factored into the worst case

Trust Board - Finance
January 2026 – Month 10

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

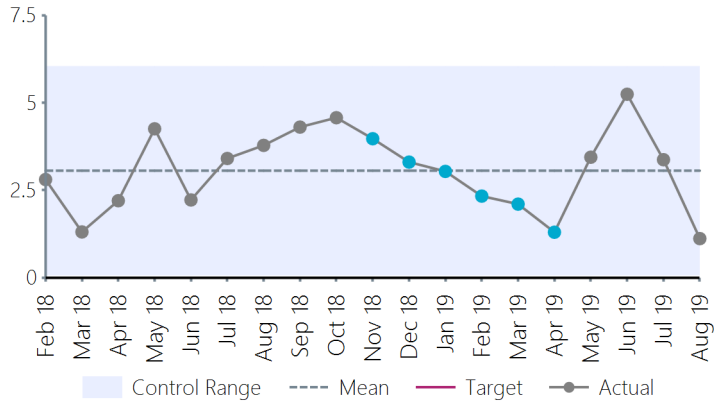
Some examples of these are shown in the images to the right:

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

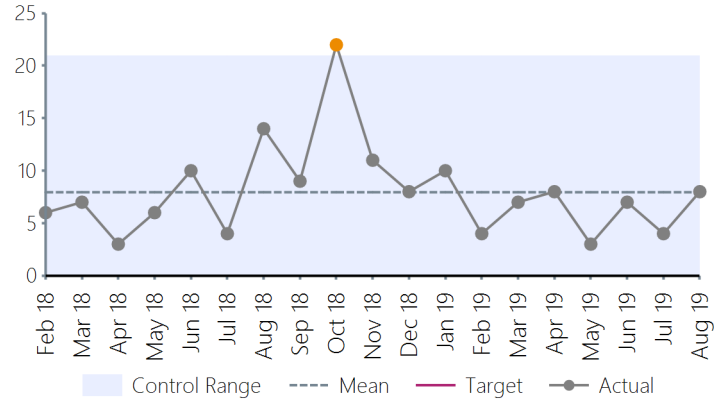
b) shows a point of concern sitting above the control range.

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

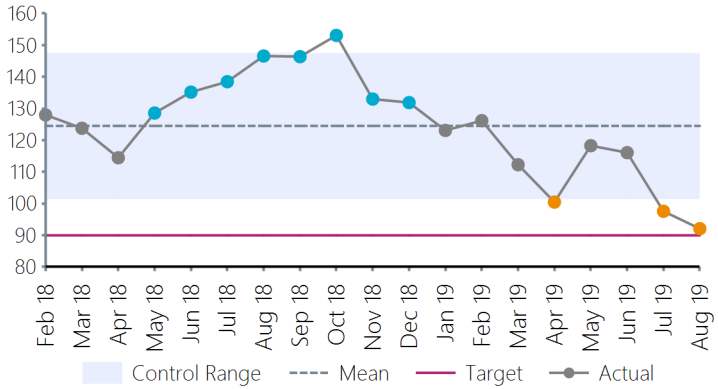
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Finances

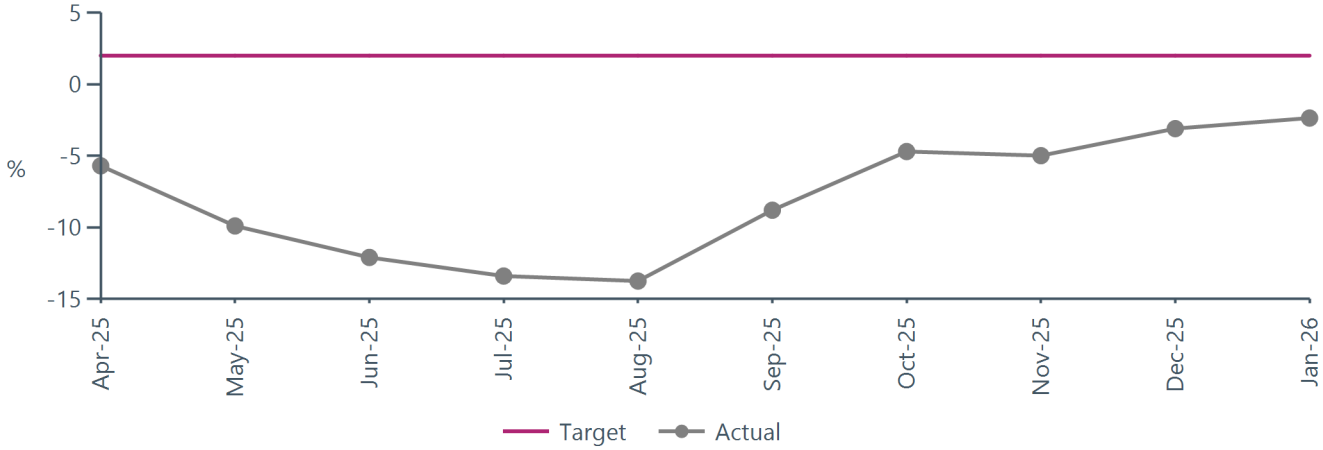
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Financial Control Total	750	752.60		N/A to SPC	Moving Target		
Income	15,443.70	15,282.10		N/A to SPC	Moving Target		
Expenditure	14,693.70	14,529.50		N/A to SPC	Moving Target		
Efficiency Delivered	922	1,008		N/A to SPC	Moving Target		
Cash Balance	16,170	18,665			Moving Target		
Capital Expenditure	1,620	928		N/A to SPC	Moving Target		
Performance (£'000k) against Low Value Agreement Block	68	20		N/A to SPC	Moving Target		
Planned Surplus/Deficit	-1,046.00	-1,038.10		N/A to SPC	Moving Target		
Variance Year-to-Date to Financial Plan	0.00	7.90		N/A to SPC	?		
Implied Productivity	2.00%	-2.36%		N/A to SPC	F	+	

Implied Productivity

Calculated using cost weighted activity growth divided by real terms cost growth. Cost weighted activity is calculated from activity in the period multiped by national average costs at HRG level. Real terms costs is total operating expenditure over the pe 217901

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
2.00%	-2.36%	N/A to SPC	F



Trajectory

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 -2.36% YTD when comparing M10 25/26 with M10 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

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Finance and Performance Committee

Committee / Group / Meeting, Date

Board of Directors - Public Meeting, 04 March 2026

Author: **Contributors:**

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Report sign-off:

Sarfraz Nawaz, Chair of the Finance and Performance Committee

Is the report suitable for publication?

Yes

1. Key issues and considerations:

The Trust Board has established a Finance and Performance Committee. According to its terms of reference: *"The Board of Directors has delegated responsibility for the oversight of the Trust's financial performance to the Finance and Performance Committee. This Committee is responsible for seeking assurance that the Trust is operating within its financial constraints, and that the delivery of its services represents value for money. Further it is responsible for seeking assurance that any investments again represent value for money and delivery the expected benefits. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board."*

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

This report provides a summary of the items considered at the Finance and Performance Committee on 23 January and 27 February 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	

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

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

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

	Assurance framework themes	Relevant	Overall level of assurance
1	*Continued focus on excellence in quality and safety.*		

2	*Creating a sustainable workforce.*		
3	*Delivering the financial plan.*	✓	LOW
4	*Delivering the required levels of productivity, performance and activity.*	✓	LOW
5	*Delivering innovation, growth and achieving systemic improvements.*		
6	*Responding to opportunities and challenges in the wider health and care system.*		
7	*Responding to a significant disruptive event.*		

3. Assurance Report from Finance and Performance Committee

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

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

Chair Report from Activity Recovery Committee (ARC) (January and February)

- Revised ARC Terms of Reference - The purpose has been refined to focus on gaining assurance against the Trust's four key performance measures. Once sustained assurance is reached, ARC could be stood down with oversight returning to standard governance routes. The Board is asked to approve the revised Terms of Reference which is endorsed by the FP Committee.
- Bone Cement Supply Risk - No operations had been cancelled due to supply issues, and two weeks of stock remained at the time of the ARC meeting. The Trust was commended regionally for establishing a formal incident response process. The risk has now reduced from high to medium, and trending low–medium.
- Theatre Efficiency and Productivity - ARC reviewed helpful analysis on cases per theatre session. Follow-up work is underway, and future reporting will move to the main committee as the focus is productivity rather than assurance.
- Areas of Concern 65-Week Waits - The Trust may not achieve the planned reduction to two long waits, with current projections indicating closer to ten due to emerging clinical need.

Performance (January and February)

- Positive assurance is provided through sustained RTT improvement, clearance of operational backlogs (e.g., DEXA), insourcing activity, and favourable external benchmarking.
- Reasonable assurance is offered on the ability to clear >200-week Welsh waiters by April 2026.
- Limited assurance remains on achieving the March 52-week target for knee and sports injuries, and on stabilising DM01 capacity.

Finance Performance (January and February)

- Full-Year Forecast - The Trust continues to forecast breakeven for year-end, supported by anticipated income/expenditure phasing in the final quarter.
- Efficiency Programme - The efficiency programme is performing exceptionally strongly, delivering the highest level of savings in Trust history.
- The Committee took moderate assurance from the Month 10 Finance Report. While the Trust remains on plan and forecasts breakeven, with strong efficiency performance and improving productivity trends, the Committee noted significant risks in capital delivery and the need for clearer visibility of true underlying productivity.

3.2 Areas of on-going monitoring with new developments

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

Chair's Assurance Report
Finance and Performance Committee

Corporate Risk Register (January)
The Committee discussed risks reported within the Committee remit; highlighting the following:

- System Migration to RADAR - The risk management and recording system has transitioned from the previous platform to RADAR, which went live this week, with ongoing data transfer and the need to develop new dashboards and assurance reports.
- Temporary Reporting Adjustments - Due to the system change, the usual detailed corporate risk register report will be deferred until March, with any significant or emerging risks to be reported through other committee agenda items or assurance reports in the interim.
- Governance Review - A review of risk management governance is underway,

The Committee took assurance from the processes in place while data is transitioned.
work.

2026/27 Planning Submission (January)
The Trust completed the 2026/27 planning round in February, following Private Board approval, and all timelines were met.
The operational plan was updated to reflect NHS England's feedback, including strengthened trajectories for waiting list reduction, RTT compliance, spinal 52-week performance and diagnostics. Activity plans remain stable, with delivery models adjusted for workforce changes and additional insourcing added to protect capacity during provider transition. Productivity improvements and early outpatient transformation benefits have been partially incorporated, with further quantification required.
Committee members highlighted risks relating to spinal timelines, unquantified outpatient benefits, workforce succession and dependency on demand-management partners. Further assurance work will take place early in the year to review spinal modelling, outpatient plans and efficiency assumptions.
Financial triangulation is progressing. While income remains stable, delivery costs have increased. Identified efficiencies total £7m, with £1.4m remaining. Capital plans remain steady, with diagnostic and digital funding routes still requiring clarification.
Risks have been consolidated, with narrative to be added where quantification is still being developed.
The committee confirmed actions to finalise triangulation, refine the financial position, strengthen mitigation strategies, and respond to NHS England queries ahead of final submission.
The Committee will continue to monitor delivery against the plan throughout the year, with upward reporting to the Board.

Rheumatology Hub Business Case (January)
The Committee reviewed the updated business case to relocate Rheumatology Outpatient Services to the former maternity unit, improving efficiency, patient experience and space utilisation. The total funding requirement remains £1.3m with all charitable contributions confirmed; tendering is in progress and may reduce overall cost.
Assurance was received on funding, staffing plans, clinical rationale, patient engagement, equipment needs and alignment with the wider estates strategy. Previous queries have been addressed, and only a small additional equipment cost (~£15k) remains under discussion.
The Committee emphasised the need for clear baseline metrics and measurable benefits to support benefits realisation. These will be added before Executive sign-off. Version control issues were noted and will be corrected.
The Committee approved the business case subject to minor amendments, and a 12-month benefits realisation review will return in January 2027.

Heat Decarbonisation (SALIX) Business Case (January)
The Committee received an update on the Heat Decarbonisation (SALIX) business case, noting the award of £7.14m grant funding with a £0.8m Trust contribution. A rigorous procurement process identified Johnson Controls as the preferred supplier. The scheme delivers significant carbon reduction benefits alongside estate resilience improvements and backlog maintenance reduction, with early gains aligned to the Trust's 2028–2032 decarbonisation strategy.
Members sought clarity on the financial appraisal, as the annual profile currently shows a negative return; NH confirmed pressures had reduced following design refinement, with further mitigations being explored. Assurance was also provided on phased implementation to minimise disruption, alignment with the estates risk register, and contingency and inflation protections built into the SALIX framework.
The Committee requested strengthened narrative on governance, risks and financial assumptions before Board submission.

The Committee endorsed the business case subject to minor amendments. The business case was subsequently presented to the Board of Directors' private meeting in February and was approved.

FY25–26 Financial Forecast (January and February)
While some delivery risks remain, particularly within workforce controls and activity volatility, the Trust is in a significantly improved financial position compared with earlier months. The actions taken, coupled with improved operational delivery and additional income streams, provide the Committee with reasonable assurance that the Trust can manage remaining risks and is on course to deliver a break-even position, subject to final confirmation of March activity and continued close oversight.

Efficiency Delivery Programme (including Specialist Unit) (January and February)
Overall, the Committee received substantial assurance on the Trust-wide Efficiency Delivery Programme, which remains strong, well-managed and responsive to risk. While the Specialist Unit faces a notable shortfall this year, the Committee took limited assurance with positive future outlook, recognising strengthened clinical engagement, a clearer transformation pipeline, and actions already underway to build a more robust programme for 2026–27.

Service Line Reporting (February)
The Committee received the Q3 SLR update showing a continued deficit position aligned with the Trust's £2.2m year-to-date deficit. Three services: Therapies, Foot and Ankle, and Neurophysiology/Neurology are making a negative contribution, with further work underway to validate activity, recategorise referral pathways post-Apollo changes, and investigate coding or operational drivers.
Negative contribution was also noted in Other MSK (due to reclassified pre-operative activity) and Research, where income has fallen; a review is in progress to confirm whether any income has been missed.
Improvement actions include national benchmarking on diagnostics and unbundled activity, an implant case mix review, detailed investigation of underperforming services, and a deeper analysis of private patient income to support future commercial strategy.

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.

Well Led Action Plan
The Committee received an update on progress against the Well Led Review. Thirteen actions fall under F&P's remit. The Committee noted the update and requested that RP's clinical role be reflected in future progress reporting.

The Committee received the following Chairs assurance reports for consideration:

- **Veterans Strategy Group** -The Committee received an update from the Veterans Group Chair outlining progress on data capture, service development, and operational priorities. Assurance was provided that key programmes are progressing, although work remains to strengthen performance measurement and formalise future service ambitions.
- **Procurement Steering Group** - delivered exceptionally strong results for 25/26, achieving around £200k above target and providing a valuable contribution to the overall efficiency programme. He also noted ongoing frustrations with NHS Supply Chain, including fluctuations in data quality, reporting, and service timeliness. These issues are being escalated through regional representatives, as they continue to slow the Trust's ability to identify and realise savings at pace.
- **STW MSK Provider Collaborative Board** - Whilst progress is being made across several workstreams, significant risks remain, particularly around digital capability and system integration, that could impede delivery without further action.
- **Trust Performance and Operational Improvement Group** – There were no specific areas escalate to the committee.
- **Performance and Financial Improvement Group** – the Committee noted the report, there were no issues to escalate to the Committee that were no capture separately within the FP agenda.

- **Capital Management Group** - closely monitoring delivery risks associated with the significant capital programmes scheduled for completion before year end. Major tender returns and quotations have now been received, reducing uncertainty around scope and cost. Operational teams are actively progressing all schemes, with focused oversight in place to ensure delivery remains on track within the current financial year. Overall, while delivery timelines remain challenging, the controls and actions described offer reasonable assurance that year-end commitments can be met.

Recommendation

The Board is asked to:

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

Terms of Reference
Activity Recovery Committee (2025/6)

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Activity Recovery Committee (ARC). The Committee is a Non-Executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference. Due to the close links with the work of the Finance and Performance Committee, the ARC will operate as if a sub-group of the Finance and Performance Committee and will report into that Committee (rather than into the Board directly).

The Committee shall meet until such time that it can assure the Board that it has fulfilled its key responsibilities (i.e. the Trust is achieving the required constitutional standards).

2. Membership and Quorum

The Committee shall be appointed by the Board from the Non-Executive Directors and Executive Directors of the Trust and shall consist of;

- Three Non-Executive Directors (including associates)
- Chief Executive Officer – invited to attend as required
- Chief Operating Officer
- Chief Nurse and Patient Safety Officer or Chief Medical Officer
- Chief Finance and Commercial Officer

In exceptional circumstances a deputy may attend in place of an Executive Director.

The Board of Directors will appoint a Committee Chair from the Non-Executive members of the Committee and a Non-Executive Director will be nominated to Chair meetings in the absence of the Chair.

A quorum will be two Non-Executive member and two Executive members.

3. Attendance

The Trust Secretary, Managing Director(s) and Head of Improvement and Business Insights will be expected to attend each meeting.

The Chair of the Board has open invitation to attend.

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

4. Frequency of meetings

The Committee will meet monthly. The Committee will continue to meet until such time as the activity position has recovered sufficiently to return to routine assurance arrangements.

The Chair of the Committee may call additional meetings.

5. Authority

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

6. Reporting

A written Chair's Assurance Report will be presented to the Finance and Performance Committee no later than the next meeting (with verbal reports by exception). The Chair's Report shall:

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

The Board will receive assurance on matters relating to the remit of the ARC via the Chair's Assurance Report from the Finance and Performance Committee.

7. Key responsibilities

The purpose of the Activity Recovery Committee is to assist the Board in obtaining assurance that there are adequate plans in place to achieve the constitutional standards.* The Committee will oversee performance in delivering of four key constitutional standards:

- 65 week waits;
- 52 week waits;
- 18 week waits;
- Time to first outpatient appointment.

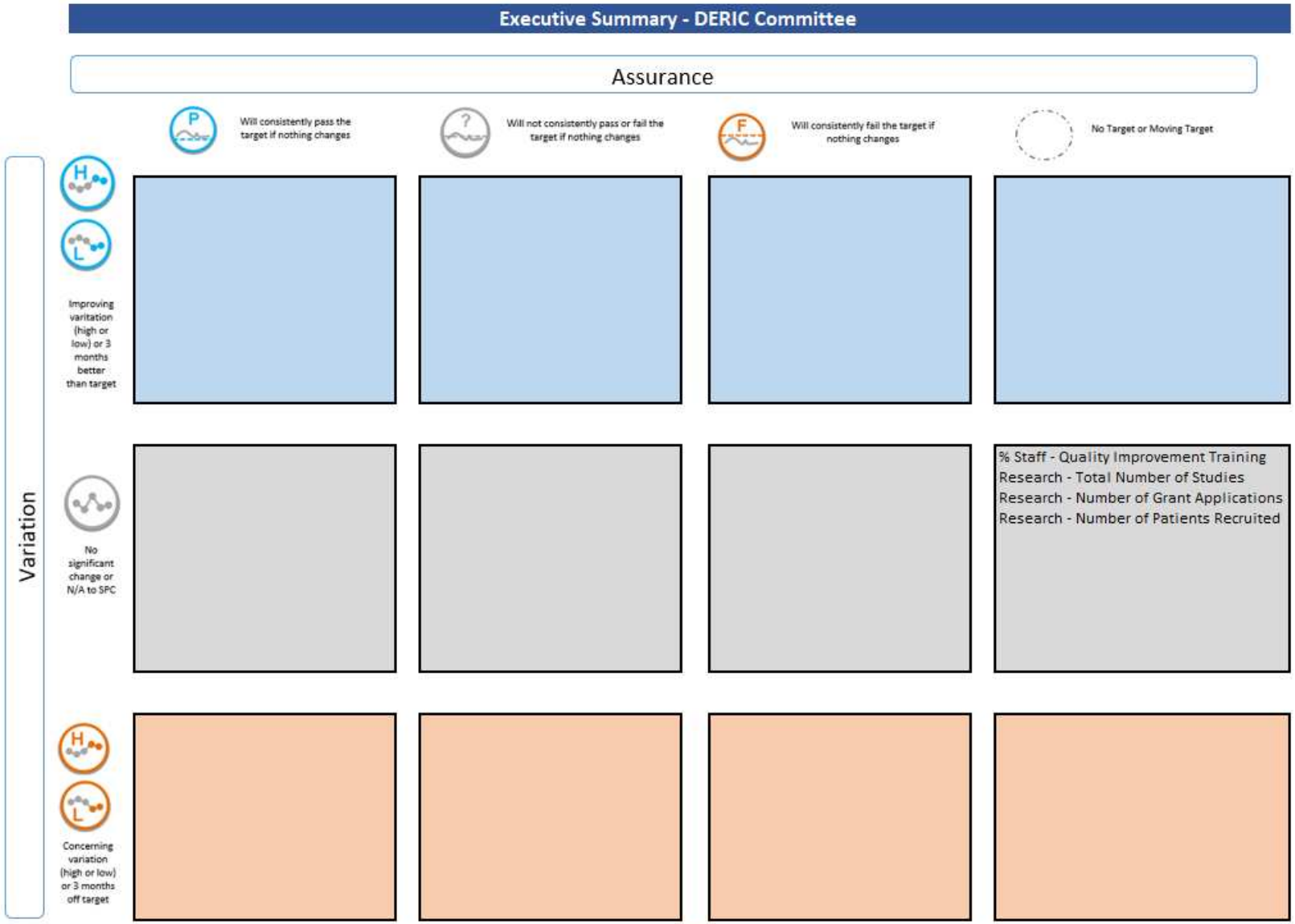
It will do this by:

- Overseeing current and projected performance against the standards;
- Overseeing risks and issues associated with delivering the standards;
- Reviewing the plans in place to deliver the standards, and manage the associated risks to delivery.
- Considering "deep dives" for further assurance on issues relating to its remit, including progress in reducing waits for the very longest waiting patients.
- Providing assurance to the Finance and Performance Committee / Board on matters relating to the Committee's remit, escalating any areas of concern.

* The Finance and Performance Committee will oversee overall delivery of the operational / activity plan. The ARC will concentrate on delivery of the four key standards. The Quality and Safety Committee will consider the impact of actions / initiatives / performance on quality, safety, and health inequalities.

ARC agreed in

Executive Summary - DERIC Committee



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.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

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

Committee / Group / Meeting, Date

Board of Directors– Public Meeting, 04 March 2026

Author: **Contributors:**

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Report sign-off:

Martin Evans, Non-Executive Director, Chair of the DERIC Committee

Is the report suitable for publication:

Yes

1. Key issues and considerations:

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

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

This report provides a summary of the items considered at the Committee meeting held on 22 January and 19 February 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	✓

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

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

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

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

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

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

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

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

There were no specific items to escalate to the Board.

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:

DERIC Review
To enhance the reporting function and strengthen the overall purpose of the DERIC Committee. Staff from the relevant DERIC units were invited to complete a survey to help shape and inform the future DERIC agenda. This approach not only supports strategic development across the programmes but also enables the Committee to identify opportunities for improvement and drive meaningful, sustainable change. The decision to gather staff insights was received positively, generating strong engagement from all areas represented within DERIC.

Well Led Action Plan
The Committee reviewed the action plan and noted that these are supported by a status tracker and timeline for completion. The Committee confirmed that its key developmental priorities are to clearly define DERIC's role, shape its future agenda and work plan, and ensure it provides the appropriate level of assurance to the Board.
Members discussed DERIC's dual assurance function, recognising the importance of both traditional assurance,through monitoring delivery, alongside having protected time to develop its 'blue sky thinking' to support delivery of the Trusts Strategic Objectives.
The Committee concluded that the discussion had addressed the key Well-Led actions and provided clear direction for the development of DERIC's role, Terms of Reference and work plan.

Corporate Risk Register
The Committee discussed risks reported within the Committee remit; highlighting the following:

- System Migration to RADAR - The risk management and recording system has transitioned from the previous platform to RADAR, which has gone live, with ongoing data transfer and the need to develop new dashboards and assurance reports.
- Temporary Reporting Adjustments - Due to the system change, the usual detailed corporate risk register report will be deferred until March, with any significant or emerging risks to be reported through other committee agenda items or assurance reports in the interim.

- Governance Review - A review of risk management governance is underway,

The Committee took assurance from the processes in place while data is transitioned

PACS Assurance Progress

The Committee reviewed the PACS report and noted that the current data format makes it hard to see month-on-month changes or identify trends, limiting assurance. The issue was about presentation and interpretation, not performance.

Members discussed the broader purpose of shared digital services, emphasising that benefits are mainly around resilience, capability, sustainability, and clinical support, rather than cash-releasing savings. Given limited discretionary funding, the case for PACS should focus on service quality and operational effectiveness.

The Committee also highlighted the need to align PACS with wider digital funding discussions, including work with NHS England on long-term productivity programmes and potential early-adopter opportunities. At the next meeting, the team will provide performance data in a clearer format that supports trend analysis.

Chair Report: Digital Transformation Meeting

The Committee received updates on national funding opportunities, including the Frontline Productivity Programme, where the Trust has been proposed as an early adopter. The programme spans mobilisation (Year 1), main delivery (Years 2–3), and consolidation (Year 4).

Progress was reported on the Trust-wide data strategy, which will define data use, standards, roles, and support a distributed data workforce. Consultation and governance will take place in March–April ahead of publication.

The Committee also noted that elements of the Digital Roadmap and Recovery Plan remain unfunded and subject to further capital approval, and should therefore be viewed as a planning framework rather than a fully resourced plan.

Chair Report EPR Assurance Meeting

The Committee reviewed the Chair's report and noted:

- Benefits Realisation: EPR benefits have been categorised into (1) previously identified but unrealised benefits now being reassessed, (2) newly emerging benefits identified through system use, and (3) benefits requiring further investment. This provides a clearer focus on measurable organisational value.
- Digital Patient Communication: Current processes create avoidable cost and inefficiency, illustrated by multiple letters sent to a single patient. Other organisations have achieved significant savings through digital-first communication.
- Time Restoration & Optimisation: Restoring clinical time remains a core aim. A business case is being developed for a dedicated optimisation function to quantify benefits and secure capital investment, with expected strong returns.
- Ambient AI: The Committee emphasised that any AI-supported documentation must preserve the clinician–patient relationship, with technology acting only as an administrative aid.

There is an action to **d**evelop and submit the business case for the optimisation function.

Chair Report: Research Meeting

Assurance was provided that research income is being used strategically, though members requested clearer future reporting on how grant income and academic appointments are reinvested to support Trust priorities. The Committee also emphasised the need to accelerate translation of research findings into clinical practice. A future paper will set out how grant income, academic roles, and research outputs align with and support Trust strategic objectives.

Update on Development of Commercialisation Capability

The Committee received an update on the organisation's progress in building its commercialisation capability and took assurance from the following developments:

- Leadership in place: A Commercial Director has now been appointed, with Mark Salisbury (currently Deputy CFO) taking on the role.
- Team development underway: Work continues to strengthen and expand the commercial team to support the organisation's strategic ambitions.

- Leveraging internal expertise: The approach emphasises making better use of existing organisational resources and knowledge to drive commercial opportunities.
- Clinician engagement recognised as critical: The Committee noted that active involvement from clinicians will be essential to generating a strong and sustainable commercial pipeline.
- A strategic commercial framework is being developed to capture innovation across the Trust, prioritise opportunities, and shape a 3–5-year commercialisation roadmap aligned with organisational strategy and resources.

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 Security Report

The Committee reviewed performance across digital and cyber services and noted continued strong progress. Core cyber security measures remain robust, including high patch compliance and completion of key firewall updates. Work to enhance reporting capacity is ongoing, and staff cyber-awareness communications have now begun.

The Committee also considered the use of Copilot licences. Improved reporting is now available to ensure the licences are allocated appropriately across the organisation.

Progress continues on establishing governance for AI-enabled tools. A Trust AI Policy is being developed, alongside technical controls to prevent the use of unapproved platforms. These steps aim to ensure safe, secure and compliant use of AI within the Trust.

Benefit and Potential Opportunities of RADAR

The Committee noted the successful go-live of Phase One and the planned rollout of further modules, including patient experience, clinical audit integration, document management, and a potential workforce compliance module.

Key benefits identified included a single integrated quality system, improved analytics and accessibility, time savings through automation, and strengthened governance processes. A GDPR-related risk has already been mitigated through the purchase of a Datix read-only licence.

Members agreed RADAR offers good value compared with multiple legacy systems and welcomed its long-term potential to consolidate governance functions. The Committee also noted that RADAR's cloud-based design ensures ongoing access to data and that other trusts, including Bristol, UHB and London Air Ambulance Service, are also using the system.

Medical Student

The Committee received an update on the expanding partnership with Chester Medical School, marking the first time RJAH has hosted medical students at this scale. The initial cohort has grown from 25 to 61 students, with Year 1 and Year 2 placements running successfully. Feedback from both cohorts has been excellent, highlighting well-organised placements, strong registrar engagement, and high-quality teaching, including simulation and weekly registrar-led sessions. MSK block placements are planned for November.

A GMC visit is scheduled for February 2026 to review Chester's programme, with RJAH's contribution forming part of the wider assessment. Work with Keele University continues to ensure both partnerships support the Trust's long-term ambition to become a teaching hospital.

PMO oversight confirms RJAH is close to meeting teaching hospital requirements, with the main remaining gap being the need for more medical staff with formal academic teaching qualifications

Research Strategy Progress

The Committee received and reviewed the Research Strategy progress report and took assurance from the continued delivery of a substantial research portfolio, despite notable operational pressures. The following key points were highlighted:

- The Trust is currently supporting approximately 85 active research studies, demonstrating sustained research activity.
- There is growing public and media interest in the Trust's research, particularly in osteoarthritis and transfusion studies.
- A recent osteoarthritis study has generated significant national attention and has the potential to reduce surgical demand by offering non-surgical alternatives that may alleviate symptoms long-term.

- Research activity spans multiple clinical areas, reflecting a broad and diverse research profile.
- The osteoarthritis study currently has a waiting list of 1,700, indicating demand pressures that may exceed current capacity.
- The research team will review departmental capacity, funding requirements, and the future operating model, and will report back with recommendations to strengthen resilience and sustainability.

Innovation and Improvement Update
The Committee noted steady progress across Improvement Champion cohorts and preparations for the March 2026 showcase events. The NHS Impact framework is now supporting self-assessment, and new corridor digital displays will promote improvement and research activity. The Committee welcomed the continued shift toward embedding continuous improvement methodology and emphasised the need to empower frontline teams and ensure all projects align with Trust strategic priorities.

Innovation Story: Post Operative Blood Transfusion Audit
The Committee reviewed an audit of 25 post-operative patients, which examined compliance with haemoglobin transfusion thresholds and completion of TACO risk assessments. The audit found that several patients were transfused above the Trust's Hb threshold without clear justification, and only 41% of TACO assessments were completed, many of which were poorly documented. Consent was recorded in 82% of cases, while only 5% of discharge summaries noted the transfusion. These issues create risks of unnecessary transfusion, patient harm, and regulatory or reputational impact.
A range of actions has already been introduced, including ward engagement, education for junior doctors, theatre-based training, revised pathways, redesigned forms, and digital improvements such as an Apollo TACO alert and mandatory discharge prompts. A re-audit is planned for March 2026, with full compliance expected to take up to a year due to cultural and educational factors.
During discussion, the Committee noted that culture and discharge pressures may influence practice, though more data is needed. Benchmarking is not yet available, and additional support is required for rotating prescribers and registrars. The Committee thanked Brenda and confirmed ongoing support through Quality and Safety and DERIC Committee.

Recommendation

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Audit and Risk Committee

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 04 March 2026

Author:	**Contributors:**
Name: Mary Bardsley Role/Title: Assistant Trust Secretary	N/A

Report sign-off:

Martin Newsholme, Chair of the Audit and Risk Committee

Is the report suitable for publication:

Yes

1. Key issues and considerations:

The Trust Board has established an Audit and Risk Committee. According to its terms of reference: '*The Board of Directors has delegated responsibility for the oversight of the Trust's system of internal control and risk assurance to the Audit and Risk Committee. This Committee is responsible for seeking assurance that the Trust has adequate and effective controls in place. It sought assurance regarding the Trust's internal and external audit programme, the local counter fraud service and compliance with the law and regulations governing the Trust's activities. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board.'*

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

This report provides a summary of the items considered at the Committee meeting held on 10 February 2026. It highlights the key areas the Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

The Audit and Risk Committee is responsible for seeking assurance that the Trust has adequate and effective controls in place to ensure all objectives and themes supported.

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

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

3. Assurance Report from Activity Recovery Committee

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

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

Fit and Proper Person Policy
The Committee considered the new policy and recommended to the Board for approval.

Standing Financial Instructions (SFI) and Scheme of Delegation Policy
The Committee considered the new policy and recommended to the Board for approval.

Internal Audit Re-appointment
At the end of its last meeting, the Audit and Risk Committee held a private discussion regarding the reappointment of the internal auditors, MIAA. The Committee highlighted that MIAA provides pragmatic and proportionate recommendations, performs well compared with other firms known to members, and maintains an appropriate focus on assurance rather than advisory work. They also stressed the importance of maximising value from limited audit resources. The Committee supports MIAA's reappointment.

3.2 Areas of on-going monitoring with new developments

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

Chair Report from the Information Governance Meeting: DSPT Compliance

- Noted the continued focus on strengthening cyber security resilience and data protection compliance, with DSPT compliance remaining on track for Standards Met.
- Assurance was provided on ongoing improvements to data quality through the introduction of new clinical system metrics, alongside strengthened oversight of digital risks.
- Operationally, the Committee welcomed a 38% reduction in the SAR backlog due to additional temporary resource.
- The Committee emphasised the importance of ensuring that digital and information governance risks are clearly articulated within the Corporate Risk Register and aligned to the Board Assurance Framework

Reference Cost Update
The Committee reviewed the Reference Cost Update and took reasonable assurance that the Trust's costing processes and data quality are improving. Validation errors have reduced to 1.8%, and the costing team is fully resourced with no risks to the 2025/26 submission.
Overall, the Committee is assured that the Trust has strong controls in place, but variances in activity, critical care costing, and outpatient efficiency remain key areas requiring continued focus.

Well Led Action Plan
The Committee reviewed the submitted Well-Led Action Plan and noted progress against the programme. Members highlighted that actions continue to be delivered in line with agreed milestones, supported by strengthened governance structures and improved reporting arrangements. The Committee also welcomed evidence of enhanced triangulation of assurance across key workstreams.

3.3 Areas of assurance

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

Finance Governance

The Committee was assured that financial governance remains strong and well-managed, despite wider system financial pressures and the Trust's ongoing efficiency programme. Members stressed the importance of maintaining this level of oversight as the organisation progresses through a challenging financial environment.

Register of Interests and Hospitality
The Committee received assurance that conflict of interest processes are clearly defined across procurement, recruitment, and decision-making, and are supported by training and guidance. The Committee noted strong compliance, including effective monitoring of gifts and hospitality, continued staff awareness activity, 100% Board compliance, and improved staff compliance of 94% (up from 88%). Automated reminders were also recognised as strengthening timely declarations. Overall, the Committee was assured that conflict of interest arrangements remain robust and continue to improve.

Counter Fraud (MIAA)
The Committee reviewed the LCFS Progress Report and is assured that counter-fraud arrangements remain effective. The Committee noted there have been 7 referrals received, with 3 investigations concluded. The Committee agreed that a strong proactive counter-fraud culture is clearly evident. The Committee approved the **Anti-Fraud Policy.**

Internal Audit Annual Review (MIAA)
The Trust received reports from the following:

- Key financial controls *(substantial assurance opinion)*
- NHSE grip and control / HFMA financial sustainability *(substantial assurance opinion)*

The Committee also considered and approved the internal audit plan for 2026/27, which will focus on mandatory audits as well as specified areas including MSK integration, Business Continuity Planning, and AI governance.

External Audit Progress Report
The Committee received the External Audit Progress Report and took assurance from the effective handover arrangements, early engagement by KPMG, a clear audit approach, ongoing ISA 315 risk assessment work, and the presentation of a detailed year-end timetable.

Agreement of Final Accounts Timetable and Plan
The Committee reviewed and noted the submitted paper outlining the Final Accounts Timetable and Plan. Based on the information presented, the Committee can take assurance that appropriate arrangements are in place to support the timely preparation, review, and approval of the organisation's year-end financial statements.

Review of Accounting Policies
The Committee considered and approved the policy.

Risk Management
The Committee received reasonable assurance that risk management processes are strengthening, noting reduced scores for two risks, the addition of a new digital infrastructure risk, and improved alignment with the BAF. Further work is required on consistent risk scoring, risk-lead training, and strengthening links between operational and strategic risks.

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.

Fit and proper persons policy

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

(Part 1) Covering paper

Committee / Group / Meeting, Date

Board of Directors, March 2026

Author: **Contributors:**

Name: Dylan Murphy
Role/Title: Trust Secretary

Report sign-off:

Name:
Role/Title:

Is the report suitable for publication?:

YES

Executive Summary:

NHSE's Fit and Proper Person Test ("FPPT") Framework was launched in late summer 2023. It was developed in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT. It also took into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles. The Framework come into effect from 30 September 2023. Key elements include:

- A revised FPPT self-attestation form, for use on appointment and annually thereafter;
- The requirement for a series of checks to be undertaken annually, as well as on initial appointment;
- Use of a standard reference for Board members; and
- Linkages with the forthcoming NHS Leadership Competency Framework and associated board appraisal framework.

The Trust's arrangements to comply with the Framework were considered during a Mersey Internal Audit Agency (MIAA) internal audit review in the autumn of 2025.

The MIAA review delivered a "**Substantial Assurance**" opinion and recommended that:
"*The Trust Board may wish to have a ratified FPPT Policy and supporting SOPs in place for managing FPPT, including a process in relation to dispute resolution*."

The management response noted that the Board had *"considered a report on the requirements of the FPPT Framework and the proposed process and associated paperwork to deliver those requirements. The requirements, and the process to ensure compliance, are clearly understood and have been delivered in practice."* It was agreed however that the arrangements would be codified in an RJAH-specific "Policy". That would be a short document that confirmed that the Trust would implement the national guidance and utilise the national templates. As such, adoption of a Fit and Proper Persons Policy does not affect the operation of the FPPT Framework within the Trust in practice.

According to the Trust's Policy Approval Framework, a handful of policies require Board approval. These include *"key policies of general application throughout the Trust, including:*

- *codes of conduct*
- *health and safety policy*
- *whistle blowing*
- *business continuity*
- *risk management"*

The Fit and Proper Person Policy is deemed to fall under that description and is therefore being presented to the Board for formal approval. The Audit and Risk Committee has reviewed the Policy document and agreed that the Trust Board should approve it.

Recommendations:

That the Board APPROVES the Fit and Proper Person Policy, as endorsed by the Audit and Risk Committee.

(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 issues considered in this paper do not directly contribute to delivery of the Trust's strategic objectives but they support sound governance that underpins all of the Trust's activities.		

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 issues considered in this paper do not directly contribute to delivery of the BAF themes but they support sound governance that underpins all of the Trust's activities.		

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 issues considered in this paper reflect the importance of probity and transparency in the delivery of individuals' roles, demonstrating "professionalism" and "excellence".		

Report development and engagement:

This report reflects the MIAA recommendation, subsequent management response and consideration of the MIAA Report at the November 2025 Audit and Risk Committee meeting.

The approach and content of the Policy was agreed by the Chief Executive in November 2025.

The Policy was discussed at the Audit and Risk Committee meeting in February 2026 and the Committee recommended that the Board approve it.

Attachment: Fit and Proper Persons Policy

The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

Title:	Fit and Proper Persons Policy		
Unique Identifier:		**Document Type:**	Policy
Version Number:	1.0	**Status:**	Approved
Responsible Director:	Chief Executive		
Author:	Dylan Murphy, Trust Secretary		
Scope:	Executive and Non-Executive Board Members, including Associate Non-Executives		
Replaces:	n/a		
To be Read in Conjunction with the Following Documents: (list related policies)	https://www.england.nhs.uk/publication/guidance-for-chairs-on-implementation-of-the-fit-and-proper-person-test-for-board-members/ https://www.england.nhs.uk/long-read/fit-and-proper-person-test-for-board-members-guidance-on-electronic-staff-record/		
Keywords:	Fit and Proper; Board Members; Disclosure and Barring Service (DBS); References		

Considered By Executive Owner:	Chief Executive	**Date Considered:**	16 December 2025
Endorsed By:	Audit and Risk Committee	**Date Endorsed:**	February 2026
Approved By:	Board of Directors	**Date Approved:**	March 2026
Issue Date:		**Review Date:**	
Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

Professional
Excellence
Respect
Friendly
Inclusive
Caring

Record of Significant Amendments to: *Fit and Proper Person Policy*				
Section number	**Amendment**	**Deletion**	**Addition**	**Reason**
Version number and date of revision:				
Version number and date of revision:				

Contents

1 Policy Summary

1.1. In 2019, a government-commissioned review (the Kark Review) of the scope, operation and purpose of the Fit and Proper Person Test (FPPT) was undertaken.

1.2. In response to the recommendations in the Kark Review, NHS England developed a FPPT Framework to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS.

1.3. The Framework applies to the board members of NHS organisations and is effective from 30 September 2023.

1.4. NHSE published the Framework and associated Guidance in August 2023. The Trust has implemented the Framework in accordance with the NHSE publication and has adapted the national template for local use. The key requirements of the Framework include:

Full Fit and Proper Person Test (FPPT)

"A documented, full FPPT assessment – a complete assessment by the employing NHS organisation against the core elements (detailed in section 3.7) – will be needed in the following circumstances:

1. *New appointments in board member roles, whether permanent or temporary, where greater than six weeks, this covers:*
   a. *new appointments that have been promoted within an NHS organisation*
   b. *temporary appointments (including secondments) involving acting up into a board role on a non-permanent basis*
   c. *existing board members at one NHS organisation who move to another NHS organisation in the role of a board member*
   d. *individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside the NHS.*
2. *When an individual board member changes role within their current NHS organisation (for instance, if an existing board member moves into a new board role that requires a different skillset, e.g. chief financial officer).*
3. *Annually; that is, within a 12-month period of the date of the previous FPPT to review for any changes in the previous 12 months"*

Annual Self-attestation

As well as the assessment undertaken the employing / appointing body, the FPPT process requires that: *"Every board member will need to complete an annual self-attestation, to confirm that they are in adherence with the FPPT requirements. Self-attestations will be a necessary step that forms a part of the full FPPT assessment".*

Creating references

References are to be created *"at the point where the board member departs, irrespective of whether there has been a request from another NHS employer.*

Therefore, the template should be completed, and retained locally in an accessible archive, for departing board members even where they have indicated they are moving onto a non-NHS role and/or performing a role that is not on the board, or where they have indicated they are to retire."

Seeking references

NHS organisations also need to obtain references before the start of a board member's appointment. The requirements differ, depending on the appointee's current status but the standard template should be used (or, if the appointee "*is entering the*

NHS for the first time or coming from a post which was not at board member level: for board members – The new employing NHS organisation should make every practical effort to obtain such a reference which fulfils the board member reference requirements.").

Use of the Electronic Staff Record
Organisations should use the Electronic Staff Record (ESR) to record completed tests, to support the FPPT assessment process.

2 Roles and Responsibilities

2.1 The Framework sets out particular roles and responsibilities. The key responsibilities outlined include those relating to:

The Chair
The Framework states that "Chairs are accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture of their NHS organisation is maintained to support an effective FPPT regime". Compliance with the FPPT framework will be monitored / assessed through various channels:

The Care Quality Commission (CQC)
"The CQC's role is to ensure NHS organisations have robust processes in place to adequately perform the FPPT assessments, and to adhere to the requirements of Regulation 5 of the Regulations. As such, as part of the Well Led reviews, CQC will consider the:

- quality of processes and controls supporting the FPPT
- quality of individual FPPT assessments
- board member references, both in relation to the new employing NHS organisation but also in relation to the NHS organisation which wrote the reference
- collation and quality of data within the database and local FPPT records."

NHS England
"NHS England will have oversight through receipt and review of the annual FPPT submissions to the relevant NHS England regional director from NHS organisations."

Internal audit/external review
"Every three years, NHS organisations should have an internal audit to assess the processes, controls and compliance supporting the FPPT assessments. The internal audit should include sample testing of FPPT assessment and associated documentation.

NHS organisations should consider inclusion of FPPT process and testing in the specification for any commissioned Well-Led/board effectiveness reviews."

Internal Governance
"For good governance, organisations should be clear about the reporting arrangements across the FPPT cycle. This is likely to include:

- an update to a meeting of the board in public to confirm that the requirements for FPPT assessment have been satisfied at least annually
- consideration by the Audit Committee, for example where there is a related internal or external audit review included in the audit programme
- relevant information to the Council of Governors (CoG) in an NHS foundation trust"

3 Policy Requirements

3.1 The Trust has implemented the requirements of the Framework, as outlined in NHSE Guidance. The requirements are set out in Attachment 1 to this Policy "NHS England Fit and Proper Person Test Framework for board members". That includes the following sections:

- Introduction
- Background
- Purpose and benefits
- Applicability
- Personal data
- Current fit and proper persons regulations
- Related principles and values
- FPPT overview
- Full FPPT assessment
- Self-attestation
- New appointments
- Additional considerations
- Role of the chair in overseeing FPPT
- FPPT assessment – core elements
- Breaches to core elements of the FPPT (Regulation 5)
- Board member references
- Electronic Staff Record (ESR)
- Record retention
- Dispute resolution
- CQC quality assurance
- NHS England quality assurance
- Internal audit/external review
- Governance

4 Implementation of the Framework / Policy

4.1 The Trust Secretary will support the Trust Chair in implementing the requirements of the FPPT Framework, as expressed in the Policy. A series of procedural documents and templates that will be used to deliver the requirements of the Policy are attached to this Policy.

5 Review and monitoring

5.1 This Policy will be reviewed in line with the regular three year review period, or sooner, should national guidance change.

5.2 In line with the Framework / Policy, every three years, an internal audit review should be undertaken to assess the processes, controls and compliance supporting the FPPT assessments. The internal audit should include sample testing of FPPT assessment and associated documentation.

Attachments:

Attachment 1: NHS England Fit and Proper Person Test Framework for board members
Attachment 2: Self-attestation form
Attachment 3: Social media checks
Attachment 4a: Annual test checklist
Attachment 4b: Annual test outcomes form
Attachment 5a: NHSE Annual submission
Attachment 5b: NHSE ad hoc submission
Attachment 6: Board member reference

Classification: Official

Publication reference: PRN00238_i

NHS England

NHS England Fit and Proper Person Test Framework for board members

2 August 2023

NHS England has developed a Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This also takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles.

In the foreword to his review, Tom Kark KC stated that “The culture and management of each hospital Trust flows from the management team. Thus, the quality and culture of the management team is of the greatest significance to the ethos and success of the hospital, the effectiveness, and the working conditions (in the widest sense) of its staff, and ultimately the care, comfort, and safety of the patients to whom the Trust provides health services.”

The framework will introduce a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.

This framework should be read in conjunction with associated guidance documents.

Contents

Section 1: Introduction

1.1 Background

The Kark Review (2019) was commissioned by the government in July 2018 to review the scope, operation and purpose of the Fit and Proper Person Test (FPPT) as it applies under the current Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This included looking at how effective the FPPT is:

> "… in preventing unsuitable staff from being redeployed or re-employed in the NHS, clinical commissioning groups, and independent healthcare and adult social care sectors."

The review highlighted areas that needed improvement to strengthen the existing regime.

The specific recommendations from the Kark Review (2019) have been detailed in Appendix 1.

1.2 Purpose and benefits

This document supports the implementation of the recommendations from the Kark Review, and promotes the effectiveness of the underlying legal requirements by establishing a Fit and Proper Person Test Framework (also known as the 'Framework'). The purpose is to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS.

The Framework is effective from 30 September 2023 and should be implemented by all boards going forward from that date. NHS organisations are not expected to collect historic information to populate ESR or local records, but to use the Framework for all new board level appointments or promotions and for annual assessments going forward.

The Framework should be read in conjunction with the NHS Constitution, NHS People Plan, People Promise and forthcoming NHS Leadership Competency Framework for leaders at board level. This Framework supports transparency and should be the start of an ongoing dialogue between board members about probity and values. It should be seen as a core element of a broader programme of board development, effective

appraisals and values-based (as well as competency-based) appointments – all of which are part of the good practice required to build a 'healthy' board.

The aim of strengthening the FPPT is to prioritise patient safety and good leadership in NHS organisations. The Framework will help board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit board members will be prevented from moving between NHS organisations.

The Framework will be fair and proportionate and has been developed with the intention to avoid unnecessary bureaucratic burden on NHS organisations.

Ensuring high standards of leadership in the NHS is crucial – well-led NHS organisations and better-led teams with both strong teamwork and strong governance translate into greater staff wellbeing and better clinical care. This requires accountable board members with both outstanding personal conduct and professional capabilities to effectively oversee NHS organisations that are often under significant financial restraint and operating in a highly regulated environment with public and political scrutiny.

As the FPPT assessment is on an individual basis, rather than in relation to the board as a whole, it is envisaged that aspirant board members who can demonstrate the characteristics described above should not be deterred from seeking to join the board of a more challenged NHS organisation. The FPPT assessment is one of general competence to act as a board member, and situational context should therefore be taken into account.

Ensuring that board members are demonstrating the right behaviours will help the NHS drive its cultural initiatives: namely, to foster a culture of compassion, respect and inclusion, and a feeling of belonging; as well as setting the tone at the top to encourage a listening and speaking up culture.

1.3 Applicability

The Framework applies to the board members of NHS organisations. Within this guidance, the term 'board member' is used to refer to:

- both executive directors and non-executive directors (NEDs), irrespective of voting rights
- interim (all contractual forms) as well as permanent appointments

- those individuals who are called ‘directors’ within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Those individuals who by virtue of their profession are members of other professional registers, such as the General Medical Council (GMC) or Nursing and Midwifery Council (NMC), should still be assessed against this Framework if they are a board member at an NHS organisation.

The Framework is designed to assess the appropriateness of an individual to effectively discharge their duties in the capacity of a board member.

It is recognised that some organisations may want to extend the FPPT assessment to other key roles, for example, to those individuals who may regularly attend board meetings or otherwise have significant influence on board decisions. The annual submission requirement is, however, limited to board members only.

Within this guidance, the term ‘NHS organisations’ refers to those institutions to which the Framework will apply; for the purposes of this Framework, this includes:

- NHS trusts
- NHS foundation trusts
- integrated care boards (ICBs)
- the following arm’s length bodies in the first instance:
  - Care Quality Commission (CQC)
  - NHS England.

ICB chairs will need to consider FPPT assessment on a member-by-member basis and take into account assurance received from other recruiting/appointing organisations, for example, in the case of partner members.

1.4 Personal data

Personal data relating to the FPPT assessment will be retained in local record systems and specific data fields in the NHS Electronic Staff Record (ESR). The information contained in these records will not routinely be accessible beyond an individual’s own organisation. There will be no substantive change to the data controller arrangements from those already in place for ESR.

Although, as set out below, NHS England will not have day-to-day access to the system or its content, NHS England recognises that it may be considered a (joint) controller of the ESR fields because as the commissioner of the ESR module and author of the Framework, it has a role in determining the nature and purposes of processing.

The organisations that are uploading the content (and determining what is said about each board member), and the NHS Business Services Authority (as the main commissioner of ESR), will also each be a data controller. For the purposes of Article 26 UK GDPR, NHS England has put in place 'transparent arrangements' to set out its responsibilities in this respect.

NHS England has established that the most relevant lawful basis for processing the FPPT data contained in ESR is set out in Article 6(1)(e) UK GDPR. This is on the basis that the processing of personal data is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller (that is, the employer, or indeed NHS England in connection with any role it fulfils as a joint controller).

The aim of the maintaining a record of FPPT outcomes in ESR is to significantly improve the management of the NHS, and ultimately the experience and outcomes for patients, and is therefore in the public interest and done as part of the exercise of the functions of the organisation concerned.

As special category data would be processed as part of the maintenance of the ESR FPPT data fields, controllers will also rely on one of the lawful bases for processing set out in Article 9 UK GDPR: Articles 9(2)(b) – employment; 9(2)(g) – statutory/public functions; and 9(2)(h) (read with Schedule 1, paragraph 2 of the Data Protection Act 2018). This covers processing that is 'necessary for the management of the health service.'

NHS England recognises the requirements of Article 5(1) UK GDPR, and that personal data should be processed lawfully, fairly and transparently. In line with all other ESR data fields, fair processing information will be available to the users of the ESR system. Current ESR fair processing information can be found in the NHS Electronic Staff Record (ESR) privacy notice. The Framework and related guidance documents also help discharge transparency-related obligations.

Information that is the personal data of the applicant is exempt from the Freedom of Information Act under section 40(1) and any request should be processed under section

7 of the DPA. Regulation 5(3) of the EIR is the equivalent provision and has the same effect.

Arrangements for dispute resolution or request for review of content of data (in ESR and local records), or relating to the FPPT assessment outcome, are set out in the guidance document for chairs.

The launch of the Framework will involve NHS England and participating data controllers (NHS trusts, foundation trusts and integrated care boards) communicating to all board members in their organisation whose details will be included in ESR, in advance of the FPPT Framework (and standard reference tools) going live on 30 September 2023. By doing so directors will be afforded the opportunity to object if they have concerns regarding the proposed use of their data, and NHS England and participating data controllers will be able to consider these concerns and amend their approach if necessary. An example of a board member FPPT privacy template is attached at Appendix 6. Organisations should ensure that an appropriate policy document is in place in relation to special category data.

Section 2: Context

2.1 Current fit and proper persons regulations

In 2014, the government introduced a 'fit and proper person' requirement, via Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 'Regulations').

This sets out the requirements for a FPPT which applies to directors and those performing the functions of, or functions equivalent or similar to the functions of, a director in all NHS organisations registered with the CQC, which includes all licence holders and other NHS organisations to which licence conditions apply. For the purposes of this guidance, we have referred to these individuals as 'board members'.

Regulation 5 recognises that individuals who have authority in NHS organisations that deliver care are responsible for the overall quality and safety of that care. The regulation requirements are that:

a) the individual is of good character

b) the individual has the qualifications, competence, skills and experience that are necessary for the relevant office or position or the work for which they are employed

c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks that are intrinsic to the office or position for which they are appointed or to the work for which they are employed

d) the individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) while carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity

e) none of the grounds of unfitness specified in part 1 of Schedule 4 apply to the individual.

The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged

b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland

c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986

d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it

e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland

f) the person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

The good character requirements referred to above in Regulation 5 are specified in Part 2 of Schedule 4 to the Regulated Activities Regulations, and relate to:

a) whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence

b) whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

Integrated care boards (ICBs) are statutory bodies with the general function of arranging for the provision of services for the purposes of the health service in England and are NHS bodies for the purposes of the 2006 Act. The main powers and duties of ICBs are to commission certain health services as set out in sections 3 and 3A of the 2006 Act.

ICBs, together with the CQC and NHS England, are within scope of this Framework. One of the recommendations made by Tom Kark KC was to extend the scope of the FPPT into certain arm's length bodies (ALBs) to:

> "…bolster the strength and width of the test, as well as to put a stop to 'the revolving door,' the FPPT should be extended to commissioners as well as other arms-length bodies. It was described as 'incongruous' that it did not apply to commissioners."

2.2 Related principles and values

This section summarises relevant principles and values that underpin the Framework and provide additional context to understand its aims.

2.2.1 NHS Constitution

The NHS Constitution states:

> The NHS belongs to the people.
>
> It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives.
>
> It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need when care and compassion are what matter most.

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it.

2.2.2 NHS guiding principles

The seven guiding principles that govern the way the NHS operates, and define how it seeks to achieve its purpose:

1. The NHS provides a comprehensive service, available to all.
2. Access to NHS services is based on clinical need, not an individual's ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism.
4. The patient will be at the heart of everything the NHS does.
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities, and the wider population.
6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair, and sustainable use of finite resources.
7. The NHS is accountable to the public, communities, and patients that it serves.

2.2.3 NHS values

These principles are underpinned by the core NHS values, which have been derived from extensive discussions with staff, patients and the public. The values are integral to creating a culture where patients come first in everything the NHS does.

These values are not intended to be limiting. Individual NHS organisations should use them as a basis on which to develop their own values, adapting them to local circumstances. The values should be taken into account when developing services with partner NHS organisations, patients, the public and staff.

The six core values are:

1. Working together for patients.
2. Respect and dignity.
3. Commitment to quality of care.

4. Compassion.
5. Improving lives.
6. Everyone counts.

2.2.4 The Nolan Principles of Standards in Public Life

NHS board members, in their capacity as public office holders, are expected to abide by the 'Nolan Principles' as defined by the Committee on Standards in Public Life:

1. Selflessness
   - Holders of public office should act solely in terms of the public interest.
2. Integrity
   - Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family or their friends. They must declare and resolve any interests and relationships.
3. Objectivity
   - Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
4. Accountability
   - Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
5. Openness
   - Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
6. Honesty
   - Holders of public office should be truthful.
7. Leadership

– Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

Section 3: FPPT Framework

The Framework sets out:

- When the full FPPT assessment is needed, which includes self-attestations (see sections 3.2 and 3.3).
- New appointment considerations (section 3.4).
- Additional considerations in specific situations such as joint appointments, shared roles and temporary absences (section 3.5).
- The role of the chair in overseeing the FPPT (section 3.6).
- The FPPT core elements to be considered in evaluating board members (section 3.7).
- The circumstances in which there will be breaches to the core elements of the FPPT (regulation 5) (section 3.8).
- The requirements for a board member reference check (section 3.9).
- The requirements for accurately maintaining FPPT information on each board member in the ESR record[1] (section 3.10).
- The record retention requirements (section 3.11).
- Dispute resolution (section 3.12).
- Quality assurance over the Framework (section 4).

Ultimate accountability for adhering to this framework will reside with the chair of an NHS organisation.

Throughout this document and the associated guidance, the term 'ESR' refers to the FPPT data fields in ESR. It is important to note that:

- Information held in ESR about board members is accessible by a limited number of senior individuals within their own organisation only.
- There is no access to FPPT information about board members in one organisation by another organisation or individual.

ESR provides a tool for individual organisations to record that testing has been carried out for the chair, who has overall accountability for the FPPT within their organisation. It

[1] For the purpose of the FPPT framework, 'ESR' refers to the FPPT data fields in ESR.

also records that testing is complete and enables reports to be run at local level as an audit trail of completed testing and sign off.

ESR is not a public register – there is no access to it by the public/externally. It provides a tool to help support chairs record some of their key FPPT requirements and provides a sign-off facility in one place. It is good practice for NHS organisations to report on the high-level outcome of the FPPT assessments in the annual report or elsewhere on their websites.

3.1 FPPT overview

The duty to take account of 'fit and proper person' requirements is pervasive, continuous and ongoing. However, for the purposes of the Framework, NHS England considers it appropriate for NHS organisations to be able to consistently demonstrate, on an annualised basis, that a formal assessment of fitness and properness for each board member has been undertaken. NHS organisations should consider carrying out the assessment alongside the annual appraisal.

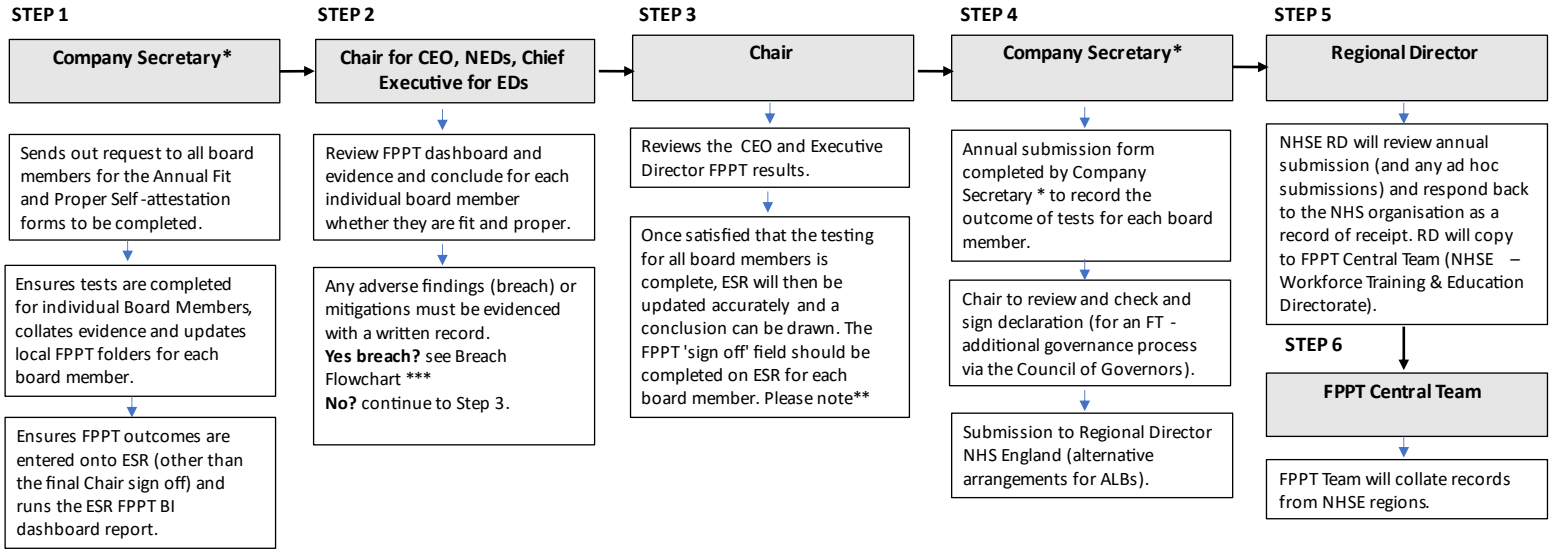
Chairs should ensure that their NHS organisation can show evidence that appropriate systems and processes are in place to ensure that all new and existing board members are, and continue to be, fit and proper (that is, the board members meet the requirement of Regulation 5), and that no appointments breach any of the criteria set out in Schedule 4 of the regulations.

Such systems and processes include (but are not limited to) recruitment, induction, training, development, performance appraisal, governance committees, disciplinary and dismissal processes.

As such, the chair in each NHS organisation will be responsible for ensuring that their organisation conducts and keeps under review a FPPT (in line with the list in section 3.2 below) to ensure board members are, and remain, suitable for their role.

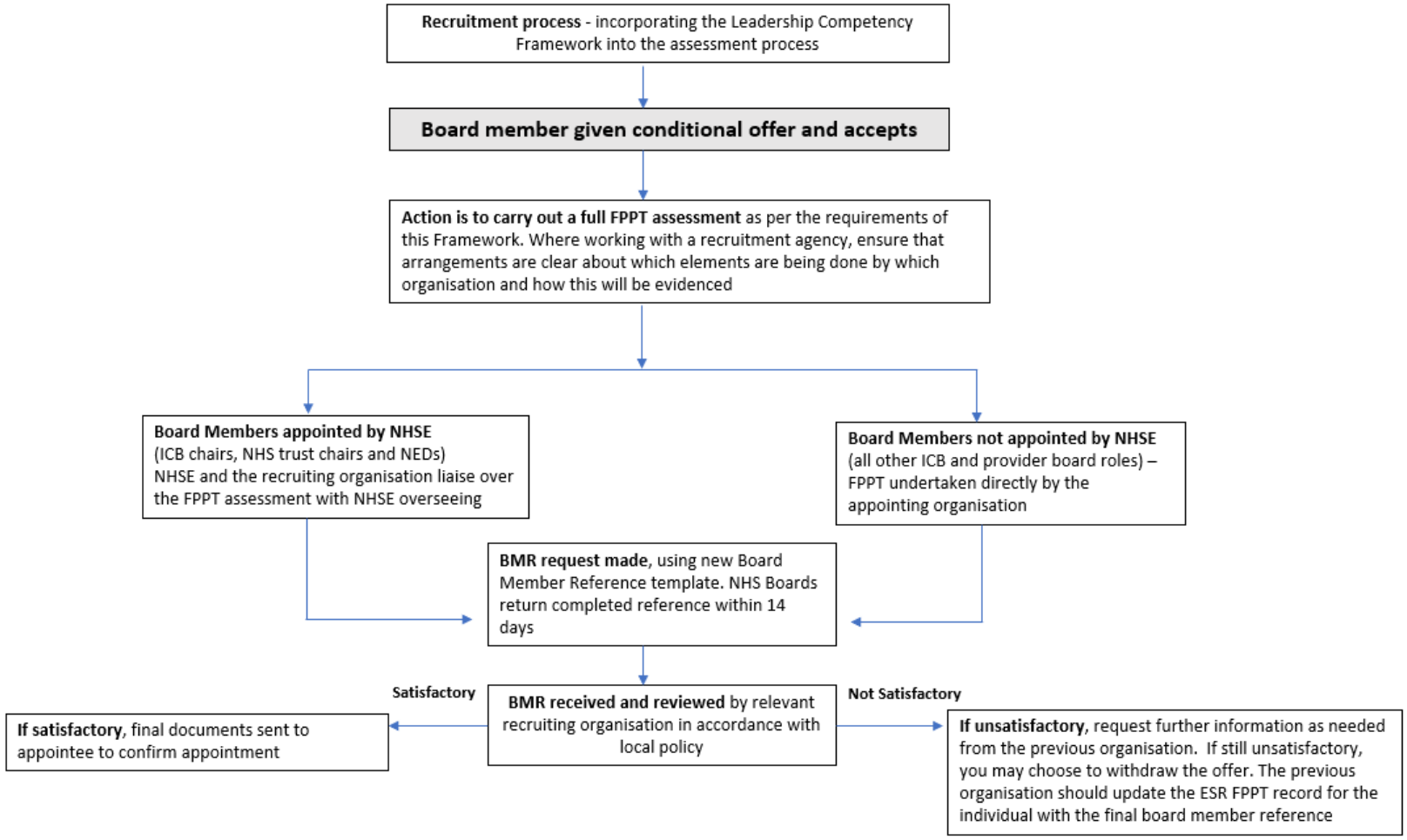
In evaluating a board member's fitness, a decision is expected to be reached on the fitness of the board member that is in the range of decisions that a reasonable person would make. NHS England recognises that chairs will need to make judgements about the suitability of board members and will support balanced judgements made in the spirit of the Framework.

The suggested approach to the assessment, including the Board Member Reference process, is set out in the three flow charts below and is also described in more detail in the supporting chairs' guidance document.

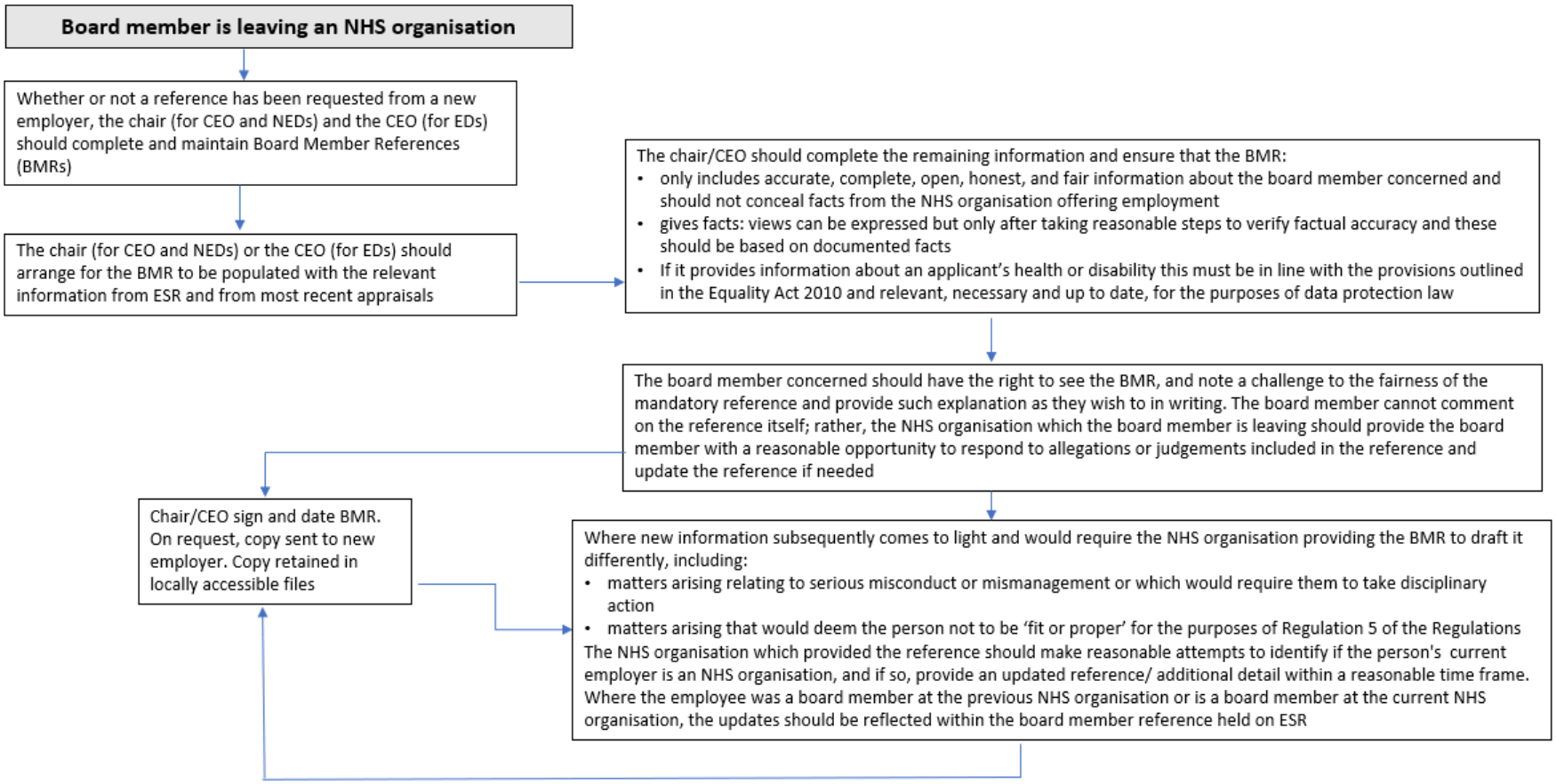


*Or senior member of staff nominated by and behalf of, the Chair, e.g., HRD
** SID/Deputy Chair to carry out FPPT on the Chair and 'sign off'
*** Please refer to the Chairs Guidance for the Breach Flowchart
SID = Senior Independent Director
ESR= Electronic Staff Record

Board Member Reference (BMR) – for appointments



Board Member Reference (BMR) – for leavers



3.2 Full FPPT assessment

A documented, full FPPT assessment – a complete assessment by the employing NHS organisation against the core elements (detailed in section 3.7) – will be needed in the following circumstances:

1. New appointments in board member roles, whether permanent or temporary, where greater than six weeks, this covers:
    a. new appointments that have been promoted within an NHS organisation
    b. temporary appointments (including secondments) involving acting up into a board role on a non-permanent basis
    c. existing board members at one NHS organisation who move to another NHS organisation in the role of a board member
    d. individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside the NHS.

2. When an individual board member changes role within their current NHS organisation (for instance, if an existing board member moves into a new board role that requires a different skillset, eg chief financial officer).

3. Annually; that is, within a 12-month period of the date of the previous FPPT to review for any changes in the previous 12 months.

Note: for points 1a – 1d above (new appointments) the full FPPT will also include a board member reference check (see section 3.9).

For points 2 and 3 above, the board member reference check will not be needed.

The exact requirements for the initial FPPT assessment versus the annual FPPT assessment thereafter are detailed in section 3.10.1.

3.3 Self-attestation

Every board member will need to complete an annual self-attestation, to confirm that they are in adherence with the FPPT requirements. Self-attestations will be a necessary step that forms a part of the full FPPT assessment (see Appendix 3).

3.4 New appointments

NHS organisations should be able to demonstrate that appointments of new board members are made through a robust and thorough appointment process.

As such, no new appointments should be made to the post of board member unless the appointee concerned can demonstrate they have met the FPPT requirements as detailed in section 3.7 of this document.

As part of conducting the initial appointment process for a board member, an inter-authority transfer (IAT)[2] could be submitted to identify any of the applicant's previous or current NHS service/employment history. Alternatively, other arrangements could be made to collate the relevant information. This should also help identify any potential duplicate employment accounts for the appointee, eg when someone has more than one NHS role on ESR.

For the initial appointment of NHS trust and ICB chairs and non-executive directors only, NHS England will obtain board member references and carry out initial social media checks. If satisfactory, NHS England will then send the appointment letter subject to the remaining elements of the fit and proper person assessment carried out by the NHS trust or ICB..

3.5 Additional considerations

There will be additional considerations when applying the FPPT for joint appointments across NHS organisations, shared roles within the same NHS organisation and periods of temporary absence. These additional considerations have been detailed below.

3.5.1 Joint appointments across different NHS organisations

Additional considerations are needed where there are joint appointments to support closer working between NHS organisations in the health and care system.

For instance, where joint appointments of a board member can help foster joint decision-making, enhance local leadership and improve the delivery of integrated care. Joint appointments may occur where:

- two or more NHS organisations want to create a combined role

[2] An IAT is an electronic way of gathering information from an employer for an applicant's previous or current NHS service using the ESR system. How to complete an Inter Authority Transfer (IAT) check in NHS Jobs user guide (nhsbsa.nhs.uk)

- two or more NHS organisations want to employ an individual to work across the different NHS organisations in the same role.

In the scenario of joint appointments, the full FPPT would need to be completed by the designated host/employing NHS organisation and in concluding their assessment they will need input from the chair of the other contracting NHS organisation to ensure that the board member is fit and proper to perform both roles.

The host/employing NHS organisation will then provide a 'letter of confirmation' (Appendix 4) to the other contracting NHS organisation to confirm that the board member in question has met the requirements of the FPPT.

The chair of the other contracting NHS organisation has the responsibility to keep the host/employing NHS organisation abreast of changes and any matters that may impact the FPPT assessment of the board member.

Where there is a joint appointment, the host/employing NHS organisation responsible for the FPPT should also lead on conducting the joint appraisal and ensure adequate input from the other contracting NHS organisation.

Where the joint appointment results in a new board member (for the NHS organisation in question), it will constitute a new appointment and as such, the host/employing NHS organisation should provide a 'letter of confirmation' to the other NHS organisation(s).

For the avoidance of doubt, where two or more organisations employ or appoint (in the case of a chair or NED) an individual for two or more separate roles at the same time, each organisation has a responsibility to complete the FPPT.

If the FPPT assessment at one organisation finds an individual not to be FPP, the chair should update their counterpart of any other NHS organisation(s) where the individual has a board-level role and explain the reason. To note, the issue at one organisation may be one of role-specific competence, which may not necessarily mean the individual is not FPP at the other organisation.

3.5.2 Shared roles within the same NHS organisation

Where two individuals share responsibility for the same board member role (eg a job share) within the same NHS organisation, both individuals should be assessed against the FPPT requirements in line with sections 3.2 and 3.3.

3.5.3 Temporary absence

For the purpose of the FPPT process, a temporary absence is defined as leave for a period of six consecutive weeks or less (eg sick leave, compassionate leave or parental leave) and where the NHS organisation is leaving the role open for the same board member. As such there is no requirement to approve another permanent individual for the role of board member.

Where there is a temporary absence, it is expected that the HR director/company secretary will liaise with the chair and chief executive to ensure temporary cover is provided; and to ensure that local internal systems are adequately updated to record the start and projected end date of the temporary absence.

Where an individual is appointed as temporary/interim cover and is not already assessed as fit and proper, the NHS organisation should ensure appropriate supervision by an existing board member.

A full FPPT assessment should be undertaken for an individual in an interim cover role exceeding six weeks. Therefore, if the interim cover is expected to be in post for longer than six weeks, the NHS organisation should look to commence the FPPT assessment as soon as possible. Where the period of temporary absence is extended beyond six weeks, the FPPT assessment should commence as soon as the NHS organisation is aware of the extension. This FPPT assessment should be carried out in line with the requirements under section 3.2.

3.6 Role of the chair in overseeing FPPT

Chairs are accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture of their NHS organisation is maintained to support an effective FPPT regime. As such, chairs' responsibilities are as below:

a) Ensure the NHS organisation has proper systems and processes in place so it can make the robust assessments required by the FPPT.

b) Ensure the results of the full FPPT, including the annual self-attestations for each board member, are retained by the employing NHS organisation.

c) Ensure that the FPPT data fields within ESR are accurately maintained in a timely manner.

d) Ensure that the board member references/pre-employment checks (where relevant) and full FPPT (including the annual self-attestation) are complete and adequate for each board member.

e) Ensure an appropriate programme is in place to identify and monitor the development needs of board members.

f) On appointment of a new board member, consider the specific competence, skills and knowledge of board members to carry out their activities, and how this fits with the overall board.

g) Conclude whether the board member is fit and proper.

h) Chairs will also complete an annual self-attestation that they themselves are in continued adherence with the FPPT requirements. On an annual basis, chairs should confirm that all board members have completed their own FPPT self-attestation and that the FPPT is being effectively applied in their NHS organisation.

i) Ensure that for any board member approved to commence work or continue in post despite there being concerns about a particular aspect of the FPPT, they document the reason(s) as to why there has been an issue about whether a board member might not be fit and proper and the measures taken to address this. A local record of this should be retained. A summary of this should also be included in the annual FPPT submission form (Appendix 5) to the relevant NHS England regional director.

Accountability for ensuring a new board member meets the FPPT assessment criteria will reside with the chair. In making such decisions the chair will be supported by existing processes and committees.

In considering their overall assessment of board members, chairs should confirm points d) and g) are adequately addressed, and where relevant for point i), appropriate action has been taken to address any concern.

It is good practice for the chair to present a report on completion of the annual FPPT in accordance with local policy, to the board in a public meeting and, where applicable, to the Council of Governors for Non-Executive Directors, for information.

3.6.1 Overseeing the role of the chair

Chairs will be subject to the same FPPT requirement, as per sections 3.2 and 3.3. In completing their own annual self-attestation, chairs will effectively be confirming that they have adequately addressed points a), b), c), e), f) and h) of section 3.6 above.

The accountability for ensuring that chairs in NHS trusts, foundation trusts and ICBs meet the FPPT assessment criteria will reside with NHS England regional directors, as is also the case for the chairs' annual appraisals.

For the chairs of NHS England and the CQC, this accountability will reside with the Department of Health and Social Care (DHSC).

Annually, the senior independent director (SID) or deputy chair will review and ensure that the chair is meeting the requirements of the FPPT.

If the SID and deputy chair are the same individual, another NED should be nominated to review the chair's FPPT on a rotational basis.

Once the NHS organisation has completed their annual FPPT assessment of the chair, they should sign this off within ESR. The annual FPPT submission, which summarises the results of the FPPT for all board members in the organisation, is then sent to the relevant NHS England regional director.

In relation to foundation trusts, there are no proposed changes to the Council of Governors' responsibilities in relation to the chair's FPPT assessment as it is not within the scope of the Framework to do so. However, as the chairs' annual appraisals are presented to the Council of Governors for information, the same should be the case for a summary of the outcome of the FPPT for non-executive board members.

This information can be retained by the Council of Governors as part of future considerations for any reappointments. Similarly, the Council of Governors should be informed of a satisfactory initial FPPT assessment for new chair and NED appointments.

3.7 FPPT assessment – core elements

This section of the Framework details the core elements that should be included in an FPPT assessment. The checks that underpin the core elements reflect the assessment criteria per Regulation 5 and Schedule 4 of the Regulations.

The full FPPT assessment will constitute an assessment against each of the core elements detailed below and should be conducted in accordance with section 3.2. Individual board members should complete self-attestations to confirm they are fulfilling the core elements of the FPPT assessment, as described below.

NHS organisations should assess board members against the following three core elements when considering whether they are a fit and proper person to perform a board role:

- Good character.
- Possessing the qualifications, competence, skills required and experience.
- Financial soundness.

Note: the FPPT checks relating to these core elements will be in addition to standard employment checks, as per the NHS organisation's recruitment and selection procedures and NHS Employers' pre-employment check standard. This can include CV checks, self-declarations, Google searches, proof of qualifications, proof of identity, right to work, etc.

The section below, which considers both Regulation 5 and Schedule 4 of the Regulations, explains matters that the NHS organisation should take account of in relation to the three core elements.

When an NHS organisation assesses a board member against these core elements in relation to being a fit and proper person, they should consider the nature, complexity and activities of their NHS organisation.

3.7.1 Good character

There is no statutory guidance as to how 'good character' in Regulation 5 of the 2014 Regulations should be interpreted. Chairs should be aware of the elements to consider when assessing good character (as detailed below).

To encourage openness and transparency, these should not be considered as a strict checklist for compliance, but rather as points for a conversation between the chair (or chief executive for executive board members) and a prospective board member during the appointment process. This will in turn emphasise the ongoing benefits of openness and transparency among board members.

When assessing whether a person is of good character, NHS organisations should follow robust processes to make sure that they gather appropriate information, and must have regard to the matters outlined in Part 1 and Part 2 of Schedule 4, namely:

- Convictions of any offence in the UK.
- Convictions of any offence abroad that constitutes an offence in the UK.
- Whether any regulator or professional body has made the decision to erase, remove or strike off the board member from its register, whether in the UK or abroad.

As such, NHS organisations should conduct:

- A search of the Companies House register to ensure that no board member is disqualified as a director.
- A search of the Charity Commission's register of removed trustees.
- A Disclosure and Barring Service (DBS) check in line with their local policy requirements:
  - each NHS organisation should outline within their local policy the relevant DBS check (basic, standard, enhanced or enhanced with barred lists) required for each individual board member role
  - in defining the required DBS level, NHS organisations should identify those board roles that fall within the definition of a 'regulated activity', as defined by the Safeguarding Vulnerable Groups Act 2006, as required barred list checks.
- A check with the relevant professional bodies where appropriate.

It is not possible to outline every character trait that a person should have, but it is expected that processes followed take account of a person's honesty, trustworthiness, reliability, integrity, openness (also referred to as transparency), respectfulness and ability to comply with the law.

Furthermore, in considering that a board member is of 'good character,' the relevant NHS organisation should also consider the following in relation to the individual in question:

- Compliance with the law and legal processes.
- Employment tribunal judgements relevant to the board member's history.

- Settlement agreements relating to dismissal or departure from any healthcare-related service or NHS organisation for any reason other than redundancy.
- A person in whom the NHS organisation, CQC, NHS England, people using services and the wider public can have confidence.
- Adherence to the Nolan Principles of Standards in Public Life.
- The extent to which the board member has been open and honest with the NHS organisation.
- Whether the person has been the subject of any adverse finding or any settlement in civil proceedings, particularly in connection with investment or other financial business, misconduct, fraud or the formation or management of a body corporate.
- Whether the person has been involved – as a director, partner or concerned in management – with a company, partnership or other organisation that has been refused registration, authorisation, membership or a licence to carry out a trade, business or profession.
- Whether the person has been a director, partner or concerned in the management of a business that has gone into insolvency, liquidation or administration while the person has been connected with that organisation or within one year of that connection.
- Whether the person involved as a director, partner or concerned with management of a company has been investigated, disciplined, censured, suspended, or criticised by a regulatory or professional body, a court or tribunal, whether publicly or privately.
- Any other information that may be relevant, such as an upheld/ongoing or discontinued (including where a board member has left the NHS organisation prior to an investigation being completed):
  - disciplinary finding
  - grievance finding against the board member
  - whistleblowing finding against the board member
  - finding pursuant to any trust policies or procedures concerning board member behaviour.

3.7.1.1 Serious mismanagement or misconduct[3]

To comply with Regulation 5, consideration of good character should also ensure, as far as possible, the individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of delivering CQC-regulated activity, in England or equivalent activities elsewhere.

In determining what amounts to 'serious misconduct or mismanagement,' beyond the decision by a court or professional regulators regarding individuals, context is paramount. Normally these would require to be findings of serious misconduct or mismanagement that are upheld after a disciplinary process.

NHS organisations should consider the mismanagement and misconduct behaviours in relation to the services they provide, the role of the board member/individual and the possible adverse impact on the NHS organisation or confidence in its ability to carry out its mandate and fulfil its duties in the public interest.

As part of reaching an assessment as to whether any actions or omissions of the board member amount to 'serious misconduct or mismanagement', NHS organisations should consider whether an individual board member played a central or peripheral role in any wider misconduct or mismanagement.

The NHS organisation should also consider whether there are any aggravating or mitigating factors; for instance (including but not limited to):

- The extent to which the conduct was deliberate and reckless.
- The extent to which the conduct was dishonest.
- Whether the issues are frequent or have continued over a long period of time.
- If lack of experience contributed to the issue that has been remediated through training.
- The extent to which the board member (or aspirant board member) demonstrates insight and self-reflection in relation to the conduct/issues identified.

Although NHS organisations have information on when convictions, bankruptcies or similar matters are to be considered 'spent', there is no time limit for considering serious

[3] For the purpose of the FPPT Framework, reference to serious misconduct and serious mismanagement should be read in the context of upheld, ongoing and discontinued investigations relevant to FPPT. All misconduct and mismanagement issues that are relevant to other elements of the FPPT Framework such as good character, should be considered.

misconduct or responsibility for failure in a previous role, for the purposes of Regulation 5.

Below are some examples of misconduct and mismanagement that NHS organisations would be expected to conclude as amounting to serious misconduct or mismanagement, unless there are exceptional circumstances that make it unreasonable to determine that there is serious misconduct or mismanagement.

It is impossible to produce a definitive list of all matters that would constitute serious misconduct or mismanagement and, as such, the list below is not exhaustive.

This list sets the minimum expectations and should be read in conjunction with local policy expectations/requirements to determine whether or not a board member has been involved in serious misconduct or mismanagement:

- Fraud or theft.
- Any criminal offence other than minor motoring offences at work (although this and the issues set out in this section may be relevant to assessing whether an individual is of good character more generally).
- Assault.
- Sexual harassment of staff.
- Bullying or harassment.
- Discrimination as per the Equality Act 2010.
- Victimisation (which falls within the scope of the Equality Act 2010) of staff who raise legitimate concerns.
- Any conduct that can be characterised as dishonest, including:
  - deliberately transmitting information to a public authority or to any other person, which is known to be false
  - submitting or providing false references or inaccurate or misleading information on a CV.
- Disregard for appropriate standards of governance, including resistance to accountability and the undermining of due process.
- Failure to make full and timely reports to the board of significant issues or incidents, including clinical or financial issues.
- Repeated or ongoing tolerance of poor practice, or failure to promote good practice, leading to departure from recognised standards, policies or accepted practices.

- Continued failure to develop and manage business, financial or clinical plans.

In assessing whether misconduct or mismanagement was 'serious', regard should be had to all the circumstances. For instance, an NHS organisation could consider isolated incidences of the following types of behaviour to amount to misconduct or mismanagement that does not reach the threshold of seriousness:

- Intermittent poor attendance.
- Failure to follow agreed policies or processes when undertaking management functions where the failures had limited repercussions or limited effects or were for a benevolent or justifiable purpose.

3.7.2 Qualifications, competence, skills required and experience

NHS organisations need to have appropriate processes for assessing and checking that the candidate holds the required qualifications and has the competence, skills and experience required.

For instance, where possible, checking the websites of the professional bodies to confirm that where required the board member holds the relevant and stated qualification.

Where NHS organisations consider that a board member role requires specific qualifications (for example, the chief financial officer being an accredited accountant, or the chief medical officer being a GMC-registered doctor), they should make this clear and should only appoint those candidates who meet the required specification, including any requirements to be registered with a professional body.

As such, job descriptions and person specifications should be clear in detailing required skills and relevant qualifications and/or memberships. These should be reviewed to ensure that they are appropriate and tailored for each board role.

In assessing competence, skills and experience for the purposes of the FPPT, the NHS organisation should look to use the outcome of their appraisal processes for board members, which will be based on the NHS Leadership Competency Framework (LCF) for board level leaders: a framework that will apply to all NHS organisations.

Given the appraisal process will feed into the full FPPT assessment, the appraisal process should be of an appropriate frequency and should give due consideration to assessing good character and conduct (that is, a behavioural assessment).

The NHS LCF provides guidance for the competence categories against which a board member should be appointed, developed and appraised. The LCF covers the following six competence categories:

- Setting strategy and delivering long term transformation.
- Leading for equality.
- Driving high quality, sustainable outcomes.
- Providing robust governance and assurance.
- Creating a compassionate and inclusive culture.
- Building trusted relationships with partners and communities.

In assessing whether a board member has the competence, skills and experience to be considered fit and proper, the FPPT assessment will:

- not just consider current abilities, but also have regard to the formal training and development the board member has undergone or is undergoing
- take account of the NHS organisation (its size and how it operates) and the activities the board member should perform
- consider whether the board member has adequate time to perform and meet the responsibilities associated with their role.

Regarding formal training:

- NHS organisations should ensure any necessary training is undertaken by board members where gaps in competency have been identified.
  - As such, a tailored learning development plan and training framework should support board members.
  - Both the development plan and training should be updated and delivered respectively with an appropriate frequency.

- Training constitutes continued development for board members.
  - Those consistently failing to undergo required training in a timely manner should be deemed to have missed an important obligation, and appropriate action should be taken in line with the NHS organisation's policies and procedures.
  - In turn, this may mean that a board member is not fit and proper.

3.7.2.1 Reasonable adjustments

In assessing if a board member can properly perform tasks to the requisite level of competence and skill for the office or position for which they are appointed, consideration will be given to their physical and mental health in accordance with the demands of the role and good occupational health practice.

This means all reasonable steps must be made to make adjustments for people to enable them to carry out their role. As a minimum, these must be in line with requirements to make reasonable adjustments for employees under the Equality Act 2010; to prevent discrimination as defined by the Act.

Hence when appointing a person to a role, NHS organisations should have processes for considering their physical and mental health in line with the requirements of the role.

As such, NHS organisations should undertake occupational health assessments (OHA) for potential new board member appointments, in circumstances where the individual in question has indicated a physical or mental health condition as part of pre-employment checks (eg medical assessment questionnaire).

The results of the OHA should be evaluated, and relevant reasonable adjustments should be made in line with the requirements under the Equality Act 2010, so an individual can carry out their role.

While the OHA will not form part of the annual FPPT, it is an integral component of the recruitment process checks to ensure that the NHS organisation can demonstrate that they have taken account of and made any such reasonable adjustments for those in board member roles. This obligation is ongoing in relation to those with disabilities for the purposes of the Equality Act 2010.

The statutory duty to make reasonable adjustments must be considered on an ongoing basis and applies where a disabled person is put at a substantial disadvantage.

3.7.3 Financial soundness

NHS organisations must seek appropriate information to assure themselves that board members do not meet any of the elements of the unfit person test set out in Schedule 4 Part 1 of the regulations.

Robust processes should be in place to assess board members in relation to bankruptcy, sequestration, insolvency and arrangements with creditors. This, as a

minimum, will include search of the insolvency and bankruptcy register and checks over county court judgement (CCJ) or high court judgement for debt.

3.8 Breaches to core elements of the FPPT (Regulation 5)

Regulation 5 will be breached if:

1. A board member is unfit on the grounds of character, such as:
   - an undischarged conviction
   - being erased, removed or struck-off a register of professionals maintained by a regulator of healthcare, social work professionals or other professional bodies across different industries
   - being prohibited from holding a relevant office or position (see section 3.7.1).
2. A board member is also unfit on the grounds of character if they have been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying out a regulated activity.
3. A board member is unfit should they fail to meet the relevant qualifications or fail to have the relevant competence, skills and experience as deemed required for their role.
4. A board member is unfit on grounds of financial soundness, such as a relevant undischarged bankruptcy or being placed under a debt relief order.
5. An NHS organisation does not have a proper process in place to make the robust assessments required by the Regulations.
6. On receipt of information about a board member's fitness, a decision is reached on the board member that is not in the range of decisions a reasonable person would be expected to reach.

With regards to the above points, it is acknowledged that there could be circumstances where, for instance, board members are deemed competent but do not hold relevant qualifications.

In such circumstances there should be a documented explanation, approved by the chair, as to why the individual in question is deemed fit to be appointed as a board

member, or fit to continue in role if they are an existing board member. This should be recorded in the annual return to the NHS England regional director (Appendix 5 part 2).

Furthermore, there may be a limited number of exceptional cases where a board member is deemed unfit (that is, they failed the FPPT) for a particular reason (other than qualifications) but the NHS organisation appoints them or allows them to continue their current employment as a board member.

In such circumstances there should be a documented explanation as to why the board member is unfit and the mitigations taken, which is approved by the chair. This should be submitted to the relevant NHS England regional director for review, either as part of the annual FPPT submission for the NHS organisation, or on an ad hoc basis as a case arises.

The NHS organisation shall determine breaches based on points 1 to 4, whereas any regulatory inspections, such as a CQC inspection will determine breaches of points 5 and 6.

3.9 Board member references

3.9.1 Content of the references

A standardised board member reference is being introduced to ensure greater transparency, robustness and consistency of approach when appointing board members within the NHS.

The aim of this is to help foster a culture of meritocracy, ensuring that only board members who are fit and proper are appointed to their role, and that there is no recycling of unfit individuals within the NHS.

The Leadership Competency Framework will help inform the 'fitness' assessment in FPPT. This is in line with the Kark Review's (2019) recommendations on professional standards.

The Leadership Competency Framework references six competency domains which should be incorporated into all senior leader job descriptions and recruitment processes. It will also form the core of board appraisal frameworks, alongside appraisal of delivery against personal and corporate objectives.

The competency domains in the Leadership Competency Framework should be taken into account when the board member reference is written. It is recognised that no board director will be able to demonstrate how they meet all the competencies in the framework. What is sought as part of the board member reference is evidence of broad competence across each of the six competency domains, and to ensure there are no areas of significant lack of competence which may not be remedied through a development plan.

Board level leaders will be asked to attest to whether they have the requisite experience and skills to fulfil minimum standards against the six competency domains. This attestation will be reviewed by the board director's line manager and overseen by the organisation's chair. The attestation record will be captured on ESR.

The annual attestation by board members is expected to be undertaken at the same time as the annual appraisal process and assessment of competence against the six competency domains will also be used to guide the board member's development plan for the coming year. The line manager will also capture stakeholder feedback as part of the appraisal process and summarise competence against each of the six competency domains. (A board member appraisal framework will be published ahead of the 2023/2024 appraisal process to support this process.) The annual appraisals of the past three years will then be used to guide the board member's reference.

NHS organisations will need to request board member references, and store information relating to these references (see section 3.10) so that it is available for future checks; and use it to support the full FPPT assessment on initial appointment.

NHS organisations should maintain complete and accurate board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Both the initial and board member references should be retained locally.

Board member references will apply as part of the FPPT assessment when there are new board member appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS. This applies whether permanent or temporary where greater than six weeks; specifically:

a. New appointments that have been promoted within an NHS organisation.

b. Existing board members at one NHS organisation who move to another NHS organisation in the role of a board member.

c. Individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside of the NHS.

d. Individuals who have been a board member in an NHS organisation and join another NHS organisation not in the role of board member, that is, they take a non-Board level role.

It is important that board member references checks are carried out in accordance with the data protection principles, as set out within data protection law. In particular, the process should be undertaken fairly, and the information generated should be accurate and up to date.

Requests for board member references should not ask for specific information on whether there is a settlement agreement/non-disclosure agreement in place.

The board member reference request instead asks for any further information and concerns about an applicant's fitness and propriety, relevant to the FPPT to fulfil the role as a director, be it executive or non-executive.

Information on settlement agreements should be retained locally (where applicable) and included in the overall consideration of the fit and proper status of the individual in question.

If there is a historical settlement agreement/non-disclosure agreement already in place which includes a confidentiality clause, NHS organisations should seek permission from all parties prior to including any such information in a board member reference.

Going forward, NHS organisations should consider inclusion of a term in any proposed settlement agreement to state that information about the settlement agreement can be included in ESR, and in doing so will not be a breach of confidence.

The existence of a settlement agreement does not, in and of itself determine that a person is not fit or proper to be a board member.

The board member reference is based on the standard NHS reference and includes additional requests for information as follows (relevant to the FPPT):

- Information regarding any discontinued, outstanding, or upheld complaint(s) tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the organisation's policies and procedures (for example, under the trust's equal opportunities policy).

- Confirmation of any discontinued, outstanding or upheld disciplinary actions under the trust's disciplinary procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct.

- Any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the FPPT to fulfil the role as a director, be it executive or non-executive.

Discontinued investigations are included in the reference request to identify issues around serious misconduct and mismanagement and to deliberately separate them from issues around qualifications, competence, skills, and experience (which it is believed can be remedied) and health (which it is believed can improve), unless such competence and/or health issues could potentially lead to an individual not meeting the requirements of the FPPT.

Investigations (irrespective of reason for discontinuance) should be limited to those which are applicable and potentially relevant to the FPPT, and examples are as follows (this is not an exhaustive list and consideration will be needed on a case-by-case basis):

- Relating to serious misconduct, behaviour and not being of good character (as described in the FPPT Framework).
- Reckless mismanagement which endangers patients.
- Deliberate or reckless behaviour (rather than inadvertent behaviour).
- Dishonesty.
- Suppression of the ability of people to speak up about serious issues in the NHS, eg whether by allowing bullying or victimisation of those who speak up or blow the whistle, or any harassment of individuals.
- Any behaviour contrary to the professional Duty of Candour which applies to health and care professionals, eg falsification of records or relevant information.

The reason for discontinuing (including not commencing) an investigation should be recorded, including whether an investigation was not started or stopped because a compromise, confidentiality or settlement agreement was then put in place (recognising that such an agreement is not necessarily a conclusion that someone is not fit and proper for the purposes of the FPPT).

It will be necessary as a matter of fairness for the employee to have had an opportunity to comment on information that is likely to be disclosed as part of any reference request i.e., as part of any disciplinary procedures/action. NHS organisations should develop local policy about who provides references, when they are provided and what will/will not be included.

NHS organisations should take any advice that they deem necessary in an individual case where they have assessed that the employee or prospective employer is likely to bring a claim.

3.9.2 Obtaining references

At least one board member reference should be obtained when an NHS organisation is appointing a board member.

- For board members:
  - An NHS organisation should obtain a minimum of two board member references (using the board member reference template) where the individual is from outside the NHS, or from within the NHS but moving into the board role for the first time.
  - These two references should come from different employers, where possible.
- For an individual who moves from one NHS board role to another NHS board role, across NHS organisations:
  - Where possible one reference from a separate organisation in addition to the board member reference for the current board role will suffice.
  - This is because their board member reference template should be completed in line with the requirements of the framework so that NHS organisations can maintain accurate references when a board member departs.
- For a person joining from another NHS organisation:

  - The new employing/appointing NHS organisation should take reasonable steps to obtain the appropriate references from the person's current employer as well as previous employer(s) within the past six years.
  - These references should establish the primary facts as per the board member reference template.

- Where an employee is entering the NHS for the first time or coming from a post which was not at board member level:
  - The new employing NHS organisation should make every practical effort to obtain such a reference which fulfils the board member reference requirements.
  - In this scenario, the NHS organisation will determine their own reasonable steps to satisfy themselves they have pursued relevant avenues to obtain the information on potential incoming individuals through alternative means.
  - For example, if a chief financial officer is joining from financial services, they can check the financial services register, or request for a mandatory reference under the financial services regulations.

It is acknowledged that where the previous employer is not an NHS organisation, there may be greater difficulty in obtaining a standardised NHS board member reference.

Nonetheless, for new appointments from outside of the NHS, employers should seek the necessary references to validate a period of six consecutive years of continuous employment (or provide an explanation for any gaps), or training immediately prior to the application being made.

In such cases where references from previous employers are unattainable for the previous six years, additional character or personal references should be sought. Character and personal references should be sought from personal acquaintances who are not related to the applicant, and who do not hold any financial arrangements with that individual.

References should never be used as the sole grounds for assessing an applicant's suitability for a post. Where negative issues are included in a reference, information should be carefully considered and weighed up against the wider range of evidence gathered as part of the recruitment process.

NHS organisations should aim to investigate negative information by sensitively raising it with the individual concerned, giving them the opportunity to explain the situation in more detail and/or, where appropriate, give them a chance to outline any learning from past mistakes or experiences to obtain the necessary assurances about their suitability for a role.

If a reference reveals something which is incompatible with the requirements of Regulation 5 of the Regulations, the individual should not be appointed to the role.

An NHS organisation should obtain references before the start of the board member's appointment. The NHS organisation requesting the reference should make it clear that this is being requested in relation to a person being appointed to the role of board member, or for other purposes linked to the board member's current employment.

The obligation to obtain a reference for a potential candidate for employment/ appointment in the role of board member applies irrespective of how the previous employment ended, for instance, resignation, redundancy, dismissal or fixed term work or temporary work coming to an end.

Where a potential candidate for employment/appointment in the role of board member has a gap between different employments, all reasonable efforts should be made to ensure that references covering those periods/gaps are obtained.

References should be obtained in writing (either via hardcopy or email) and NHS organisations will need to satisfy themselves that both the referee and the organisation are bona fide.

From time to time the information provided in a reference may contradict the information provided by board members.

There may be a reasonable explanation for apparent discrepancies and NHS organisations should proceed sensitively to seek the necessary assurances directly with the board member. In exceptional circumstances where there is serious misdirection, employers may feel it appropriate to report their concerns to the NHS Counter Fraud Authority.

Where an NHS organisation is unable to fully evidence that the incoming board member is fit and proper because of gaps in the board member reference, they may continue to hire the individual but should clearly document within ESR the gaps in relation to the

board member reference and the reasons/mitigations for being comfortable with employing/appointing the board member.

In this scenario, the employing NHS organisation also should be able to demonstrate that they have exercised all reasonable attempts to obtain the missing information.

3.9.3 Providing references

An NHS organisation should aim to provide a reference to another NHS organisation within a 14-day period, which starts from the date that the reference request was received. However, it should be acknowledged that there are occasions of exceptional circumstances, and references may take more than 14 days to provide.

The references referred to above are for a request made in relation to the individual being appointed to the role of board member, or for other purposes linked to the board member's current employment.

Where a current board member moves between different NHS organisations, a board member reference form following a standard format (Appendix 2) should be completed by the employer and signed off by the chair of that NHS organisation.

The previous NHS organisation should provide information in relation to that which occurred:

- in the six years before the request for a reference
- between the date of the request for the reference and the date the reference is given
- in the case of disciplinary action, serious misconduct and/or mismanagement at any time (where known).

NHS organisations should also consider when providing the reference:

- That the process captures accurate, complete, open, honest and fair information about the board member concerned.
  - As such, references should not conceal facts from the NHS organisation offering employment.
- References should give established facts that are part of the history of the person.

  - It is unfair to give partial facts if those result in the offer being withdrawn, for example where this causes the recipient NHS organisation to assume the information is missing because it is negative, so the offer is withdrawn.
  - Views can be expressed but only after taking reasonable steps to verify factual accuracy and should be based on documented facts.
- The reference should be fair, such that the employee concerned should have the right to note a challenge to the fairness of the mandatory reference and provide such explanation as they wish to in writing.
  - This does not mean that the board member can comment on the reference itself; rather, that the NHS organisation (which the board member is leaving) has provided those board members with a reasonable opportunity to respond to allegations or judgements upon which the reference is based.
  - Hence a board member's opinions are not required to be included within the reference, but should be appropriately considered when drafting them.
  - Where the NHS organisation providing the reference has not offered the employee the opportunity to previously (at the time the matter occurred) comment on the allegation, they ought to do so before including that allegation within the reference, rather than leaving the allegation out of the reference.
- Where the reference provides information about an applicant's health or disability this must be in line with the provisions outlined in the Equality Act 2010 and be relevant, necessary, and up to date, for the purposes of data protection law.

3.9.4 Revising references

If an NHS organisation has provided a reference to another NHS organisation about an employee or former employee, and has subsequently:

- become aware of matters or circumstances that would require them to draft the reference differently
- determined that there are matters arising relating to serious misconduct or mismanagement
- determined that there are matters arising which would require them to take disciplinary action
- concluded there are matters arising that would deem the person not to be 'fit or proper' for the purposes of Regulation 5 of the Regulations,

the NHS organisation that provided the reference should make reasonable attempts to identify if the person's[4] current employer is an NHS organisation and, if so, provide an updated reference/additional detail within a reasonable timeframe.

Where the employee was a board member at the previous NHS organisation or is a board member at the current NHS organisation, the updates should be reflected within the board member reference.

Revised references between NHS organisations should cover a six-year period from the date the initial board member reference was provided, or the date the person ceased employment with the NHS organisation, whichever is later. The exception to this are matters that constitute serious misconduct or mismanagement: details of such events should be provided irrespective of time period.

3.9.5 Board member reference template

The board member reference template provided should be used by NHS organisations.

This Framework, along with the board member reference template, sets out the minimum requirements for a reference. An NHS organisation can provide information in relation to additional matters if it deems it necessary to do so.

If references are provided for the role of board member, or for other purposes linked to the board member's current employment, the NHS organisation providing the reference should look to complete all sections of the template even where the NHS organisation requesting the reference does not specifically ask for it.

As mentioned previously, NHS organisations should maintain board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer.

Therefore, the template should be completed, and retained locally in an accessible archive, for departing board members even where they have indicated they are moving onto a non-NHS role and/or performing a role that is not on the board, or where they have indicated they are to retire.

[4] For the avoidance of doubt, this refers to executive board members employed by an NHS organisation and non-executive board members who have been appointed.

Often in these circumstances the individual may go on to act in the capacity of a board member at a future date, even if it is just on a temporary basis, for example to cover staff shortages.

3.10 Electronic Staff Record (ESR)

NHS Business Services Authority (NHSBSA) hosts ESR on behalf of the NHS, as commissioned by the Department for Health and Social Care.

New data fields in ESR will hold individual FPPT information for all board members operating in the NHS and will be used to support recruitment referencing and ongoing development of board members. The FPPT information within ESR is only accessible within the board member's own organisation and there is no public register.

ESR will hold information about each board member in line with the criteria detailed below in section 3.10.1.

NHS England will use its network of regional directors in a direct oversight role to ensure that individual NHS organisations (within the designated regions) are completing their FPPT, via annual submissions to the NHS England regional directors.

The CQC will continue in its regulatory role and as such may determine that reviews are required over the data integrity and controls that a particular NHS organisation has in relation to the records held in ESR.

There should be limited access to ESR in accordance with local policy and in compliance with data protection law. It is reasonably expected that the following individuals have access to the FPPT fields in ESR:

- chair
- chief executive officer (CEO)
- senior independent director (SID)
- deputy chair
- company secretary
- human resources director (HRD)/chief people officer (CPO).

Access will also be provided to relevant individuals within the CQC at a local level, where this information is necessary for their roles, noting the CQC's ability to require information to be provided to it under Regulation 5(5) of the Regulations.

The ESR FPPT data fields need to be maintained to ensure information about the serving board member is current. This will mean that ESR is specifically updated for:

- all board members within an NHS organisation
- new board members who have been appointed within an NHS organisation
- whenever there has been a relevant change to one of the fields of FPPT information held in ESR (as per section 3.10.1 below)
- updates for annual completion of the full FPPT
- annual completion of FPPT confirmed by chairs.

It will be the responsibility of each NHS organisation to ensure that ESR remains current and is updated for relevant changes in a timely manner. As a minimum it is expected that each NHS organisation conducts an annual review to verify that ESR is appropriately maintained.

The chair will be accountable for ensuring that the information in ESR is up to date for their organisation.

NHS organisations will need to establish policies and procedures for collating the relevant information in an accurate, complete and timely manner for updating ESR.

NHS organisations will need to establish a process for individuals to access and exercise their rights in connection with the information held about them, in accordance with the requirements of data protection law.

3.10.1 Information held in ESR

The information that ESR will hold about board members is detailed below and also summarised in the FPPT checklist.

The supplementary guidance document provides specific step-by-step instructions for NHS organisations to update and maintain ESR.

The FPPT assessment on initial appointment of a board member will cover all points mentioned below:

- First name*
- Second name/surname*
- Organisation* (that is, current employer)

- Staff group*
- Job title* (that is, current job description)
- Occupation code*
- Position title*
- Employment history:*
  - This would include detail of all job titles, organisation departments, dates, and role descriptions.
  - Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, would not need to be explained.
- Training and development
- References:*
  - Available references from previous employers, board member references, including resignations or early retirement.
- Last appraisal and date
- Disciplinary findings
  - That is, any upheld finding pursuant to any trust policies or procedures concerning employee behaviour, such as misconduct or mismanagement relevant to FPPT, this includes grievance (upheld) against the board member, whistleblowing claims against the board member (upheld) and employee behaviour upheld finding.
- Any ongoing and discontinued investigations relating to Disciplinary/ Grievance/Whistleblowing/Employee behaviour should also be recorded.
- Type of DBS disclosed* †
- Date DBS received* †
- Disqualified directors register check
- Date of medical clearance* (including confirmation of OHA)
- Date of professional register check (eg membership of professional bodies)
- Insolvency check
- Self-attestation form signed
- Social media check
- Employment tribunal judgement check
- Disqualification from being a charity trustee check
- Board member reference*
- Sign-off by chair/CEO.

It should also be noted that the national insurance number is an additional check where there may have been a change of name highlighted in the initial or annual assessment.

The annual FPPT requires an NHS organisation to validate all fields above – except for:

* Fields marked with an asterisk (*) – these do not require validation as part of the annual FPPT unless a specific reason arises. However, these fields should still be updated in the event of a change to the information held.

† While not requiring annual validation, DBS checks will be done on a three-year cycle.

3.11 Record retention

The ESR FPPT data fields will retain records of completed tests to support the FPPT assessments. All supporting documents/records in relation to the FPPT will be held locally by each individual NHS organisation.

As such, an NHS organisation should establish, implement and maintain adequate policies and procedures to comply with GDPR and the NHS Records Management Code of Practice.

The NHS Records Management Code of Practice sets out expectations in relation to retaining actual staff documents/records for a period of six years.

However, NHS organisational case documents/records may be retained for longer than the standard six years, based on the facts of the case. This will be a local decision for each NHS organisation.

When determining how long to retain documents/records in relation to disciplinary and similar cases and where applicable, NHS organisations should make an assessment as to the severity of the misconduct and/or mismanagement and its impact to the FPPT. The more serious the issue the longer the retention period should be.

In relation to ESR, the information and accompanying references should be kept career long, which at a minimum should be until the 75th birthday of the board member.

3.12 Dispute resolution

1. Data and information

Where a board member identifies an issue with data held about them in relation to the FPPT, they should request a review which should be conducted in accordance with local policies in the first instance.

Where this does not lead to a satisfactory resolution for the board member, the following options are available:

- For NHS England-appointed board members (NHS trust chairs and NEDs and ICB Chairs) – the matter should be escalated to the NHS England Appointments Team.
- For chairs not appointed by NHS England – a further request for review can be made to the SID or deputy chair who would establish a process proportionate to the matter being considered; for example, establishing a panel with at least one independent member.
- For all other board members (including NHS England-appointed board members, and chairs not appointed by NHS England where the above processes have not led to a satisfactory conclusion), the options could include:
  - referring the matter to the ICO
  - (For executive director roles only*) taking the matter to an employment tribunal (ET)
  - instigating civil proceedings.

2. Outcome of FPPT assessment

Where a board member disagrees with the outcome of the FPPT assessment and they have been deemed 'not fit and proper,' the following options are available:

- For NHS England-appointed board member roles – the matter should be escalated to the NHS England Appointments Team for investigation in accordance with extant policy and procedure.
  - Where this results in a board member being terminated from their appointed role, a BMR** must be completed and retained by the local organisation in accordance with the Framework.
- For non-NHS England-appointed roles (executive and non-executive) – local policy and constitution arrangements should be followed first.
  - NHS organisations may wish to take their own legal advice or seek advice from NHS England.

At any point, employees have the right to take the matter to an ET*.

* Chair and non-executive board members cannot take their organisation to ET unless in relation to discrimination, but they can instigate civil proceedings.

** Exit BMR to be drafted by local chair for non-executive directors [NEDs] (with support from the NHS England Appointments Team), and by the NHS England Appointments Team for chairs.

Section 4: Quality assurance and governance

To ensure that the FPPT is being adequately embedded within NHS organisations there will need to be quality assurance checks conducted by the CQC, NHS England and an external/independent review. The quality assurance checks over the various parts of the FPPT Framework have been detailed below.

4.1 CQC quality assurance

The CQC's role is to ensure NHS organisations have robust processes in place to adequately perform the FPPT assessments, and to adhere to the requirements of Regulation 5 of the Regulations. As such, as part of the Well Led reviews, CQC will consider the:

- quality of processes and controls supporting the FPPT
- quality of individual FPPT assessments
- board member references, both in relation to the new employing NHS organisation but also in relation to the NHS organisation which wrote the reference
- collation and quality of data within the database and local FPPT records.

In doing so the CQC will have regard to the evidence that exists as to whether the board members meet the FPPT. For example, this includes, but is not limited to, checking the following forms of evidence:

- That the NHS organisation in question is aware of the various guidelines on recruiting board members and that they have implemented procedures in line with this best practice.
- Personnel files of recently appointed board members (including internal appointments of existing staff).
- Information or records relating to appraisals for board members.
- References and personal development plans.

The CQC may intervene where there is evidence that proper processes have not been followed or are not in place for FPPT. While the CQC does not investigate individual board members, it will pass on all information of concern that is received about the fitness of a board member to the relevant NHS organisation.

The CQC will notify NHS organisations of all concerns relating to their board member and ask them to assess the information received. The board member to whom the case refers will also be informed.

NHS organisations should then detail the steps they have taken to assure the fitness of the board member and provide the CQC with a full response within 10 days. The CQC will then carefully review and consider all information.

Where the CQC finds that the NHS organisation's processes are not robust, or an unreasonable decision has been made, they will either:

- contact the NHS organisation for further discussion
- schedule a focused inspection
- take regulatory action in line with their enforcement policy and decision tree if a clear breach of regulation is identified.

4.2 NHS England quality assurance

NHS England will have oversight through receipt and review of the annual FPPT submissions to the relevant NHS England regional director from NHS organisations.

4.3 Internal audit/external review

Every three years, NHS organisations should have an internal audit to assess the processes, controls and compliance supporting the FPPT assessments. The internal audit should include sample testing of FPPT assessment and associated documentation.

NHS organisations should consider inclusion of FPPT process and testing in the specification for any commissioned Well-Led/board effectiveness reviews.

4.4 Governance

For good governance, organisations should be clear about the reporting arrangements across the FPPT cycle. This is likely to include:

- an update to a meeting of the board in public to confirm that the requirements for FPPT assessment have been satisfied at least annually
- consideration by the Audit Committee, for example where there is a related internal or external audit review included in the audit programme

- relevant information to the Council of Governors (CoG) in an NHS foundation trust as described in section 4.5 below.

4.5 NHS foundation trusts – appointment and removal of the chair and non-executive directors

The document 'Your statutory duties- A reference guide for NHS foundation trust governors' refers to the role of the CoG in appointing and removing the chair and NEDs. The FPPT Framework should be considered alongside this document and the local trust constitution. The CoG in an NHS foundation trust:

- Should continue to make chair and NED appointments in accordance with their statutory duties and local constitution. These continue to be subject to satisfactory recruitment checks, and this will now include consideration of the initial FPPT assessment.
- Should continue to '…receive performance information for the chair and other non-executive directors as part of a rigorous performance appraisal process …' in accordance with their local constitution. Performance appraisals will now include application of the LCF in accordance with the Framework.
- Should be advised of any outcome from a non-executive board member (including the chair) FPPT assessment as 'not fit and proper.' Dependent on the circumstances and in accordance with the local constitution, the CoG would be involved as appropriate with any subsequent removal process, where applicable.

The CoG should receive support from the SID and/or the company secretary and use the governance arrangements already in place in their trusts, such as the nomination committee.

4.5 Integrated care boards

ICBs should apply the Framework alongside relevant statutory requirements and the existing requirements of their organisation's constitution.

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This publication can be made available in a number of alternative formats on request.

Fit and Proper Person Test annual/new starter* self-attestation

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (eg directors disqualification order)
- within the last five years, have not:
  - been convicted of a criminal offence and sentenced to imprisonment of three months or more;
  - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and not been discharged in respect of it;
  - been included on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, any if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	
For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

*Delete as appropriate

Fit and Proper Person Test annual/new starter social media self-attestation

Members of the Board of The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust are required to comply with the Trust's social media policy:

"The Trust recognises that many employees make use of social media in both a professional and personal capacity. Whilst using social media in a personal capacity, employees may not be acting on behalf of the Trust but they need to be aware that they still have a responsibility to ensure that their activities outside of the workplace do not breach the principles of the Use of Social Networking Policy. Below are some guidelines to help staff stay within the limits:

Do:

- *Protect both yourself and your privacy. What you publish will be around for a long time, so consider the content carefully and also be judicious in disclosing personal details.*
- *Always think. The lines between public and private, personal and professional are more blurred online than anywhere else. Think about your reputation and how you present yourself to others.*
- *Use good judgement when deciding what to post online. If you are about to publish something that makes you feel uncomfortable, review the Trust's social media guidelines and think about why that is.*
- *Be responsible – you have sole responsibility for whatever you share online, so think about your reputation. People have been sacked, sued and even jailed because of posts made on social media.*
- *If you make a mistake be upfront about it and correct it quickly. Be honest, if you modify content that was previously posted, such as editing a Facebook post, make it clear that you have done so.*

Don't:

- *Do anything that could be considered discriminatory against, or bullying or harassment of any individual, for example by, making offensive or derogatory comments relating to sex or gender, race, religion, belief or nationality, disability, sexual orientation, or age.*
- *Publish fraudulent, harassing, embarrassing, sexually explicit, profane, obscene, intimidating, defamatory or otherwise unlawful or inappropriate information or footage that would be offensive to readers of the submission or would otherwise breach any Trust Policy or break the law.*
- *Criticise or cause embarrassment to the Trust, its patients, healthcare partners, other stakeholders or staff in a public post.*
- *Breach confidentiality for example by revealing information owned by the organisation; giving away confidential information about an individual (such as a colleague, patient or customer contact). Discussing the Trust's internal workings or its future business plans that have not been communicated to the public.*
- *Post things that you know to be untrue or use social media to start rumours that are baseless, unfair and potentially damaging to other people (whether you know them or not)."*

I hereby declare that I have acted and continue to act in accordance with this Policy:

Name and job title/role:	
Signature of board member:	
Date of signature of board member:	

Under the requirements of the Fit and Proper Person Test Framework for NHS Board members, board members' social media accounts are subject to regular review. To aid this process, please declare any social media accounts you operate:

Platform (e.g. LinkedIn; X; Facebook etc.)	Profile name / handle (or other identifier)

Policy Attachment 4a: **FPPT Annual Checks**

Requirement / Check	Source	Responsible	Completion Date	Notes
Training and development	Appraisal information / ESR record	Trust Secretary		Annual - updated records of training and development completed/ongoing progress.
Disciplinary, Grievance, Whistleblowing, Behaviours	People Services	Trust Secretary		Any upheld finding pursuant to any trust policies or procedures concerning employee behaviour, such as misconduct or mismanagement, this includes grievance (upheld) against the board member, whistleblowing claims against the board member (upheld) and employee behaviour upheld finding. Any ongoing and discontinued investigations relating to Disciplinary/Grievance/Whistleblowing/Employee behaviour should also be recorded
Last appraisal and date	Appraisal information	Trust Secretary		For NEDs, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.
DBS Check completed	People Services via DBS Service	Recruitment Team		Maintain a confidential local file note on any matters applicable to FPPT where a finding from the DBS needed further discussion with the board member and the resulting conclusion and any actions taken/required. DBS data will be entered into ESR.
Professional Registration (if applicable to role)	E.g. NMC, GMC, accountancy bodies, CIPD.	Recruitment Team		GMC/NMC not needed as these will auto-populate. For others, the date of check will be entered into ESR in format DD-MM-YY.
Insolvency and bankruptcy registers	Bankruptcy and Insolvency register	Recruitment Team		Keep a screenshot of check as local evidence of check completed. Dates for both checks will be entered into ESR in format DD-MM-YY.
Search for disqualified directors register	Companies House	Recruitment Team		Keep a screenshot of check as local evidence of check completed. Date will be entered into ESR in format DD-MM-YY.

Policy Attachment 4a: **FPPT Annual Checks**

Requirement / Check	Source	Responsible	Completion Date	Notes
Disqualification from being a charity trustee check	Charities Commission	Recruitment Team		Keep a screenshot of check as local evidence of check completed. Date will be entered into ESR in format DD-MM-YY.
Employment tribunal judgement check	Employment Tribunal Decisions	Recruitment Team		Search by name and, separately, name of previous employers. Keep a screenshot of check as local evidence of check completed. Date will be entered into ESR in format DD-MM-YY.
Web search and social media check of the individual (search by name, then name with "NHS" at the end)	To include Google, Facebook, Instagram, X (formerly Twitter), LinkedIn and any other known accounts (based on individuals' self-declaration).	Comms & Engagement Team?		Keep a screenshot of check as local evidence of check completed. Date will be entered into ESR in format DD-MM-YY.
Self-attestation form	Self-attestation return	Trust Secretary		Date will be entered into ESR in format DD-MM-YY.
Declaration of Interests form	DoI returns	Trust Secretary		

Policy Attachment 4b: **FPPT Annual Checks**

Name:	
Role:	

Requirement / Check	Completion Date	Notes
Disciplinary, Grievance, Whistleblowing, Behaviours		~~Any upheld finding pursuant to any trust policies or procedures concerning employee behaviour, such as misconduct or mismanagement, this includes grievance (upheld) against the board member, whistleblowing claims against the board member (upheld) and employee behaviour upheld finding. Any ongoing and discontinued investigations relating to Disciplinary/Grievance/Whistleblowing/Employee behaviour should also be recorded~~
Last appraisal date		~~For NEDs, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.~~
DBS Check completed		~~Maintain a confidential local file note on any matters applicable to FPPT where a finding from the DBS needed further discussion with the board member and the resulting conclusion and any actions taken/required.~~ ~~DBS data will be entered into ESR.~~
Professional Registration (if applicable to role)		~~GMC/NMC not needed as these will auto-populate. For others, the date of check will be entered into ESR in format DD-MM-YY.~~
Insolvency and bankruptcy register checks		~~Keep a screenshot of check as local evidence of check completed.~~ ~~Dates for both checks will be entered into ESR in format DD-MM-YY.~~
Disqualification from being a company director check		~~Keep a screenshot of check as local evidence of check completed.~~

Policy Attachment 4b: **FPPT Annual Checks**

Requirement / Check	Completion Date	Notes
		~~Date will be entered into ESR in format DD-MM-YY.~~
Disqualification from being a charity trustee check		~~Keep a screenshot of check as local evidence of check completed.~~ ~~Date will be entered into ESR in format DD-MM-YY.~~
Employment tribunal judgement check		~~Search by name and, separately, name of previous employers.~~ ~~Keep a screenshot of check as local evidence of check completed.~~ ~~Date will be entered into ESR in format DD-MM-YY.~~
Web search and social media check of the individual		~~Keep a screenshot of check as local evidence of check completed.~~ ~~Date will be entered into ESR in format DD-MM-YY.~~
Self-attestation form		~~Date will be entered into ESR in format DD-MM-YY.~~
Declaration of Interests form		

Reviewer:	
Date of Review:	
Notes / issues for further review / action:	

Annual NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
The Robert Jones and Agnes Hunt (RJAH) Orthopaedic Hospital NHS Foundation Trust		

Part 1: FPPT outcome for board members including starters and leavers in period

Role	Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Board member reference completed and retained? Yes/No
Chair/NED board members						
Executive board members						
Partner members (ICBs)						
Total						

**** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.***

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC				
Other, e.g., internal audit, review board, etc.				

Add additional lines as needed

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

Part 3: Declarations

DECLARATION FOR RJAH [year]				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No

For the chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:

As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.	
Chair signature:	
Date signed:	
For the regional director to complete:	
Name:	
Signature:	
Date:	

Ad hoc NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST DATE OF AD HOC TEST:
The Robert Jones and Agnes Hunt (RJAH) Orthopaedic Hospital NHS Foundation Trust		

Part 1: FPPT outcome for board members subject to ad hoc FPP test

Role	Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	Have mitigations been put in place relating to identified breaches? *	Have they left the Board - Yes/No?	Board member reference completed and retained - Yes/No?
Chair/NED board members	n/a					
Executive board members	n/a					
Partner members (ICBs)	n/a					
Name / role	n/a					

**** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.***

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC				
Other, e.g., internal audit, review board, etc.				

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR RJAH - AD HOC, [DATE]		
For the chair, or (in the case of a review of the Chair) the SID / Deputy Chair, to complete:		
Has the board member been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:
As Chair / SID / Deputy Chair of RJAH, I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.		
Role:		
Signature:		
Date signed:		
For the regional director to complete:		
Name:		
Signature:		
Date:		

Board Member Reference

STANDARD REQUEST: To be used only AFTER a conditional offer of appointment has been made.

[Date]

Human resources officer/name of referee

Recruitment officer

External/NHS organisation receiving request

HR department initiating request

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [Board Member position]

The above-named person has been offered the board member position of [post title] at the [name of the NHS organisation initiating request]. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

Board Member Reference request for NHS Applicants: To be used only AFTER a conditional offer of appointment has been made. Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.	
1. Name of the applicant (1)	
2. National Insurance number or date of birth	
3. Please confirm employment start and termination dates in each previous role *A:(if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)* *B: (As part of exit reference and all relevant information held in ESR under Employment History to be entered)*	
Job Title: From: To: Job Title From: To: Job Title: From: To: Job Title: From: To: Job Title: From: To:	

4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A): *(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)*		
5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	Starting:	Current:
6. Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*		

7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:
8. Confirmation of reason for leaving:		
9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)		
Date DBS check was last completed.	Date:	
Please indicate the level of DBS check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level:	
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults □ Children □ Both □	
10. Did the check return any information that required further investigation?	Yes □	No □
If yes, please provide a summary of any follow up actions that need to/are still being actioned:		

11. Please confirm if all annual appraisals have been undertaken and completed (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □
Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		

13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS** • **Dishonesty** • **Bullying** • **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. (Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12) **Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)**		

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Review of Standing Financial Instructions & Scheme of Delegation

Committee / Group / Meeting, Date

Trust Board, 4 March 2026

Author:

Name: Diana Owen
Role/Title: Head of Financial Accounting

Report sign-off:

Name: Angela Mulholland-Wells
Role/Title: Chief Finance & Commercial Officer
Committee: Audit & Risk Committee (10th February 2026)

Is the report suitable for publication?:

No – document requires approval first

Key issues and considerations:

The Standing Financial Instructions (SFIs) and Scheme of Delegation are required to be reviewed annually by the Trust Board.

Both documents have been reviewed, including circulation to Executive Directors for comments, and proposed changes detailed below. These were reviewed by the Audit & Risk Committee at its meeting on 10 February 2026 and recommended for approval.

Shropshire Health Procurement Service (SHPS) proposal to standardise quotation/tendering limits across the 3 Shropshire Trusts

The proposal simplifies the threshold requirements as follows:

Goods & Services

- Up to £50,000 – no requirement for a quotation or tender.
- £50,000 to £139,688 (the Procurement Act 2023 (PA23) threshold) – formal quotations (or further competition via a framework agreement).
- >£139,688 – full PA23 tender (or procurement via a framework agreement).

The need for a local tender is removed, as formal quotations have progressed significantly over recent years and the process is broadly the same for a local tender or formal quotation and affords the same protection via T&Cs and procedural processes.

It is important to note that it is possible to undertake a quote/tender below the proposed thresholds should the need arise, or we choose to do so.

Healthcare Contracting

The proposed limits would apply in terms of demonstrating value for money but noting the requirement to follow the Provider Selection Regime (PSR) which applies to all Healthcare Contracting procurements regardless of value.

This proposal requires changes to both the SFIs (Sections 8.2, 8.4, 8.5 and 8.6) and the Scheme of Delegation (Sections 5.1 and 5.2).

The current and proposed limits are shown in the table in Appendix A. This includes, for waiving of quotations and tenders, increasing the limit where both Chief Finance Officer and Chief Executive authorisation is required, to reflect the overall increased limits.

Review of Standing Financial Instructions & Scheme of Delegation

Other Scheme of Delegation amendments

- Job title change : "*Operational Director of Finance*" to "*Deputy Chief Finance Officer*".
- Section 8b re engagement of Trust's solicitors : change "*engagement*" to "*appointment*" as this refers to the initial appointment/re-appointment not each time the solicitors are used.
- References to "*Directors*" is to be more explicit. To aid clarity and understanding of naming conventions in the document, an appendix will be added listing all director roles, differentiating between an Executive Director and other Directors, so approval levels are clearer.
- Changes to Executive Director portfolios:
    - Section 31 re fire precautions and Section 34 re environmental regulations moved from Chief Finance Officer to Chief Nurse.
    - Section 35 re Data Protection Act moved from Chief Nurse to Chief Finance Officer.

Other SFIs amendments

- No other amendments to the SFIs are required.

Recommendations:

The Trust Board is asked to recognise the review of the SFIs and Scheme of Delegation and approve the proposed amendments.

Appendices:

Appendix A : Proposed Amendments to Quotation/Tendering Limits

Review of Standing Financial Instructions & Scheme of Delegation

Appendix A : Proposed Amendments to Quotation/Tendering Limits

Current

5.1 Quotation & tendering limits	
a) Obtaining 2 written quotations for goods/services expected to be from £20,001 to £30,000	Budget Holder in conjunction with SHPS
b) Obtaining 3 written quotations for goods/services expected to be from £30,001 to £60,000	Budget Holder in conjunction with SHPS
c) Obtaining 3 written competitive tenders for goods/services expected to be £60,000 or more	Director in conjunction with SHPS
d) Obtaining competitive tenders in accordance with European legislation for goods/services expected to be over £115,633 (excluding VAT)	Director **and** Chief Finance Officer in conjunction with SHPS
5.2 Waiving of quotations/tenders subject to SFIs	
a) Waiving of quotations from £20,001 to £60,000	Chief Finance Officer
b) Waiving of tenders from £60,001 up to £115,633	Chief Executive **and** Chief Finance Officer
c) Waiving of tenders over £115,633	N/A – no waiver or single tender action is allowed which would exceed the EU procurement limit

Proposed

5.1 Quotation & tendering limits	
e) Obtaining 3 written quotations (or further competition by a framework agreement) for goods/services expected to be from £50,000 to £139,688 (Procurement Act 2023 (PA23) threshold)	Budget Holder in conjunction with SHPS
f) Obtaining competitive tenders in accordance with PA23 for goods/services expected to be over £139,688	Director **and** Chief Finance Officer in conjunction with SHPS
5.2 Waiving of quotations/tenders subject to SFIs	
d) Waiving of quotations from £50,000 to £80,000	Chief Finance Officer
e) Waiving of quotations from £80,001 up to £139,688	Chief Executive **and** Chief Finance Officer
f) Waiving of tenders over £139,688	Chief Executive **and** Chief Finance Officer

The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

Title:	Standing Financial Instructions		
Unique Identifier:	POL028	**Document Type:**	Policy
Version Number:	13.0	**Status:**	Draft
Responsible Director:	Angela Mulholland-Wells, Chief Finance & Commercial Officer		
Author:	Diana Owen, Head of Financial Accounting		
Scope:	Trust wide		
Replaces:	Version 12.0		
To be Read in Conjunction with the Following Documents: (list related policies)	Scheme of Delegation Matters Reserved to the Board		
Keywords:	SFI, SFIs, Standing Financial Instructions, Scheme of Delegation		

Considered By Executive Owner:	Angela Mulholland Wells, Chief Finance & Commercial Officer	**Date Considered:**	10/02/2026
Endorsed By:	Audit & Risk Committee	**Date Endorsed**	10/02/2026
Approved By:		**Date Approved:**	
Issue Date:		**Review Date:**	
Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

Friendly · Caring · Excellence · Professional · Respect

Trust Values

Standing Financial Instructions

1. Contents

2. Introduction

2.1 General

2.1.1 The Trust's Standing Financial Instructions (SFIs) have been compiled in accordance with the requirements and provisions of The NHS Act 2006. They shall have effect as if incorporated in the Trust's Constitution.

2.1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Matters Reserved to the Board and the Scheme of Delegation adopted by the Trust.

2.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Finance Officer.

2.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Finance Officer must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Constitution.

2.1.5 The failure to comply with SFIs and Standing Orders as included in the Constitution can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

2.1.6 Overriding SFIs – if for any reason these SFIs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit & Risk Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these SFIs to the Chief Finance Officer as soon as possible.

2.2 Terminology

2.2.1 Any expression to which a meaning is given in Health Service Acts, or in Directions made under the Acts, shall have the same meaning in these instructions; and

"Constitution" means the constitution, including the annexes, which was approved on authorisation as a Foundation Trust with any subsequent amendments approved in accordance with current legislation.

"Trust" means the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust;

"Accounting Officer" means the person who from time to time discharges the functions specified in paragraph 25 (5) in Schedule 7 to the 2006 Act;

"Board" means the Board of Directors of the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, as constituted in accordance with the Trust's Constitution;

"Budget" means a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"Budget Holder" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;

"Chief Executive" means the chief executive (and accounting officer) of the Trust;

"Director" means a person appointed as a Director in accordance with the Constitution. The Directors of the Trust will be either:

- "Executive Director" which means a Member of the Board of Directors who holds an executive office of the Trust, and who was appointed in accordance with the Constitution;
  or
- "Non-Executive Director" which means a Member of the Board of Directors who does not hold an executive office of the Trust, and who was appointed by the Council of Governors in accordance with the Constitution.

"Chief Finance Officer" means the chief financial officer of the Trust;

"Funds Held on Trust" means those funds which the Trust holds on the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under the 2006 Act. Such funds may or may not be charitable;

"Independent regulator" means the independent corporate body established under the National Health Service 2006 Act, responsible for authorising, monitoring and regulating NHS Foundation Trusts;

"Legal adviser" means the properly qualified person appointed by the Trust to provide legal advice;

"Officer" means employee of the Trust or any other person holding a paid appointment or office with the Trust;

"SIRO" means Senior Information Risk Officer. This role is undertaken by the Chief Finance Officer.

2.2.3 Wherever the title Chief Executive, Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

2.2.4 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

2.3 Responsibilities & Delegation

2.3.1 The Trust Board exercises financial supervision and control by:

(a) Formulating the financial strategy;

(b) Requiring the submission and approval of budgets within approved allocations/overall income;

(c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) Defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document;

(e) Receiving regular reports on financial performance

2.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the "Matters Reserved to the Board" document. All other powers have been delegated to such other committees as the Trust has established, or to the Chief Executive or Chief Finance Officer.

2.3.3 The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

2.3.4 The Chief Executive is ultimately accountable to the Board and, as Accounting Officer, to parliament, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The duties as Accounting Officer are set out in the "NHS Foundation Trust Accounting Officer Memorandum". The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met, and has overall responsibility for the Trust's system of internal control.

2.3.5 It is a duty of the Chief Executive to ensure that Members of the Board and employees and all new appointees are notified of, and put in a position to understand, their responsibilities under these Instructions.

2.3.6 The Chief Finance Officer is responsible for:

(a) Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) Maintaining an effective system of internal financial control, including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

In addition, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Finance Officer include:

(d) The provision of financial advice to other members of the Board and employees;

(e) The design, implementation and supervision of systems of internal financial control;

(f) The preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

2.3.7 All members of the Board and employees, severally and collectively, are responsible for:

(a) The security of the property of the Trust;

(b) Avoiding loss;

(c) Achieving economy, effectiveness and efficiency in the use of resources;

(d) Conforming with the requirements of the Trust Constitution, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation;

(e) Maintaining effective risk management arrangements.

2.3.8 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

2.3.9 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

3. Audit

3.1 Audit & Risk Committee

3.1.1 In accordance with the constitution and with reference to the Audit Code for NHS Foundation Trusts and the Code of Governance, issued by the Independent Regulator, the Board of Directors shall formally establish an Audit & Risk Committee, with clearly defined terms of reference.

3.1.2 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy of:

(a) All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement or other appropriate independent assurances;

(b) The underlying assurance processes that indicates the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

(c) The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification;

(d) The policies and procedures for all work related to fraud and corruptions as set out in the NHS Standard contract and as required by the NHS Counter Fraud Authority, and review and confirm the level of resources assigned for countering fraud;

(e) The Internal Audit Service ensuring that it meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit & Risk Committee, Chief Executive and Board;

(f) The work of the External Auditor and consider the findings, implications and management's responses to their work;

3.1.3 Agree the Accounting Policies to be adopted for the preparation of the financial statements and receive the External Auditor's annual governance report prepared in accordance with the relevant International Accounting Standards. The Audit & Risk Committee shall review the Annual Report and Financial Statements before submission to the Board.

3.1.4 The Audit & Risk Committee must assess the work and the fees of External Audit on an annual basis to ensure that the work is of a sufficiently high standard and that the fees are reasonable. The Audit & Risk Committee shall make a recommendation to the Council of Governors with respect to the re-appointment of the External Auditors. The Trust will undertake market-testing for the appointment of external auditors at least once every five years.

3.1.5 Where the Audit & Risk Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chairman of the Audit & Risk Committee should raise the matter at a full meeting of the Board of Directors. Exceptionally, the matter may need to be referred to the Independent Regulator via the Chief Finance Officer.

3.1.6 It is the responsibility of the Chief Finance Officer to ensure an adequate Internal Audit service is provided and the Audit & Risk Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

3.1.7 Further detail on the role, responsibility and powers of the Audit & Risk Committee are contained in its Terms of Reference.

3.2 Chief Finance Officer

3.2.1 The Chief Finance Officer is responsible for:

(a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) Ensuring that the Internal Audit function is adequate and meets the NHS mandatory audit standards;

(c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d) Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit & Risk Committee and the Board. The report must cover:

(i) A clear opinion on the effectiveness of internal control;
(ii) Major internal financial control weaknesses discovered;
(iii) Progress on the implementation of internal audit recommendations;
(iv) Progress against plan over the previous year;
(v) Strategic audit plan covering the coming three years;
(vi) A detailed plan for the coming year.

3.2.2 The Chief Finance Officer and designated internal and external auditors are entitled without necessarily giving prior notice to require and receive:

(a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) Access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) The production of any cash, stores or other property of the Trust under a member of the Board or an employee's control; and

(d) Explanations concerning any matter under investigation.

3.3 Role of Internal Audit

3.3.1 Internal Audit will review, appraise and report upon:

(a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) The adequacy and application of financial and other related management controls;

(c) The suitability and reliability of financial and other related management data;

(d) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) Fraud and other offences;
(ii) Waste, extravagance, inefficient administration;
(iii) Poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Independent Regulator.

3.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

3.3.3 The Head of Internal Audit will normally attend Audit & Risk Committee meetings and has a right of access to all Audit & Risk Committee members, the Chairman and Chief Executive of the Trust.

3.3.4 The Head of Internal Audit shall be accountable to the Chief Finance Officer. The reporting system for Internal Audit shall be agreed between the Chief Finance Officer, the Audit & Risk Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

3.3.5 The designated officers must carry out agreed audit recommendations within the timescale for action agreed with the Head of Internal Audit. Failure to do so shall be reported to the Audit & Risk Committee and to the Chief Executive who shall take necessary action to ensure compliance with such recommendations.

3.4 External Audit

3.4.1 The External Auditor is appointed by the Council of Governors and paid for by the Trust. The Audit & Risk Committee must ensure a cost-efficient service.

3.4.2 The Trust must ensure that the External Auditor appointed by the Council of Governors meets the criteria set out in the Audit Code for NHS Foundation Trusts at the date of appointment and on an on-going basis throughout the term of their appointment.

3.4.3 External Audit must comply with the responsibilities and functions set out in the Audit Code for NHS Foundation Trusts and under Part 1 of the Health and Social Care Act 2003.

3.5 Fraud & Corruption

3.5.1 In line with their responsibilities, the Trust's Chief Executive and Chief Finance Officer shall monitor and ensure compliance with the requirements included in the NHS Standard Contract on fraud and corruption, and with the requirements of the Bribery Act 2010 and other relevant legislation that has been or may be enacted.

3.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Counter Fraud Authority (NHSCFA).

3.5.3 The Local Counter Fraud Specialist shall report to the Trust's Chief Finance Officer and shall work with staff in NHSCFA in accordance with the NHS Standard Contract.

3.5.4 The Local Counter Fraud Specialist will provide regular reports to the Audit & Risk Committee, including a written Annual Report.

3.6 Security Management

3.6.1 In line with their responsibilities, the Trust's Chief Executive will monitor and ensure compliance with the requirements included in the NHS Standard Contract on NHS security management. The Trust is now held to account by its NHS commissioners for performance against these standards.

3.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by guidance on NHS security management.

3.6.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director and the appointed Local Security Management Specialist.

4. Business Planning, Budgets, Budgetary Control & Monitoring

4.1 Preparation & Approval of Plans & Budgets

4.1.1 The Chief Executive will compile and submit to the Board an Annual Plan which complies with the requirements of the Independent Regulator.

4.1.2 The plan will be approved by the Board of Directors and have regard to the views of the Council of Governors.

4.1.3 The plan will be submitted to the Independent Regulator in accordance with their timetable.

4.1.4 Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Plan;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds;

(e) identify potential risks.

4.1.5 The Chief Finance Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

4.1.6 All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled.

4.1.7 All budget holders will sign to agree their allocated budgets at the commencement of each financial year.

4.1.8 The Chief Finance Officer is responsible for ensuring that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

4.2 Budgetary Delegation

4.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) The amount of the budget;

(b) The purpose(s) of each budget heading;

(c) Individual and group responsibilities;

(d) Achievement of planned levels of service;

(e) The provision of regular reports.

4.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total.

4.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive.

4.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Finance Officer.

4.3 Budgetary Control & Reporting

4.3.1 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

(a) Monthly financial reports to the Board in a form approved by the Board containing:

(i) Income and expenditure to date showing trends and forecast year-end position;

(ii) Movements in working capital;

(iii) Movements in cash and capital;

(iv) Capital project spend and projected outturn against plan;

(v) Explanations of any material variances from plan;

(vi) Details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation;

(b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) Investigation and reporting of variances from financial, workload and manpower budgets;

(d) Monitoring of management action to correct variances; and

(e) Arrangements for the authorisation of budget transfers.

4.3.2 Each Budget Holder is responsible for ensuring that:

(a) Any likely overspending or reduction of income is not incurred without the prior consent of the Board;

(b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised.

(c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

4.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

4.4 Capital Expenditure

4.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. The particular applications relating to capital are contained in SFI Section 13. The Capital Programme and any amendments will be approved in advance by the Board of Directors.

4.5 Monitoring Returns

4.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

5. Annual Accounts & Reports

5.1 The Chief Executive, as the Accounting Officer, will sign the Annual Accounts.

5.2 The Chief Executive will direct the Chief Finance Officer to:

(a) Prepare financial returns in accordance with the accounting policies and guidance given by the Independent Regulator, the Trust's accounting policies, and generally accepted accounting practice;

(b) Prepare and submit annual financial reports to the Independent Regulator and Parliament in accordance with current guidelines; and

(c) Submit financial returns to the Independent Regulator and Parliament for each financial year in accordance with the prescribed timetable.

5.3 The Trust's audited annual accounts must be presented to the Board of Directors for approval and received at a public meeting of the Council of Governors. A copy should be forwarded to the Independent Regulator and made available to the public.

5.4 The Trust will publish an Annual Report in accordance with the Constitution, and present it at the Council of Governors general meeting. The document will comply with the Independent Regulator's Financial Reporting Manual.

6. Bank & Government Banking Service Accounts

6.1 General

6.1.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by the Independent Regulator.

6.1.2 Only the Chief Finance Officer shall open or close bank accounts in the name of the Trust. The Board shall approve the banking arrangements.

6.2 Bank & Government Banking Service Accounts

6.2.1 The Chief Finance Officer is responsible for all bank accounts and the Government Banking Service (GBS) accounts including:

(a) Establishing separate bank accounts for the Trust's non-exchequer funds;

(b) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; and

(c) Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

6.3 Banking Arrangements

6.3.1 The Chief Finance Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) The conditions under which each bank and GBS account is to be operated;

(b) The limit to be applied to any overdraft; and

(c) Those authorised to sign cheques or other orders drawn on the Trust's accounts.

6.3.2 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

6.4 Tendering & Review

6.4.1 The Chief Finance Officer will review the banking arrangements of the Trust at regular intervals, and at least every five years, to ensure they reflect best practice and represent value for money. Following such reviews the Chief Finance Officer shall determine whether or not re-tendering for services is necessary and seek the approval of the Finance & Performance Committee to pursue the proposed course of action.

7. Income, Fees & Charges & Security of Cash, Cheques & other Negotiable Instruments

7.1 Income Systems

7.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

7.2 Fees & Charges

7.2.1 The Trust shall follow the Department of Health guidance in the Operating Framework, or additional guidance issued by NHS England or the Independent Regulator, in setting prices for NHS service agreements.

7.2.2 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

7.2.3 All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.3 Debt Recovery

7.3.1 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

7.3.2 Income not received and deemed to be irrecoverable should be dealt with in accordance with losses procedures.

7.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated promptly.

7.4 Security of Cash, Cheques & other Negotiable Instruments

7.4.1 The Chief Finance Officer is responsible for:

(a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) Ordering and securely controlling any such stationery;

(c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

7.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

7.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

7.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss, before the deposit is accepted.

7.4.5 To comply with money laundering legislation, the Chief Finance Officer will issue instructions that the Trust will not accept cash payments of amounts greater than £8,000 in respect of any single transaction. Any attempts by an individual to effect payment above this amount should be notified immediately to the Chief Finance Officer.

8. Tendering & Contracting Procedure

8.1 General

The tendering and contracting procedure below applies except where the requirement is covered by an existing NHS contract or framework. Dependant on the terms of the framework a direct award or mini-competition may be required to be completed. Shropshire Healthcare Procurment Service can advise on the most appropriate method.

8.1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these SFIs.

8.1.2 The Procurement Act 2023 or Provider Selection Regime prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these SFIs.

8.1.3 The Trust shall comply as far as is practicable with the requirements of the Department of Health and Social Care, NHS England, the Treasury Financial Reporting Manual and "Estatecode" in respect of capital investment and estate and property transactions.

8.1.4 Orders must not be placed for goods or services which have been split or otherwise placed in a manner to avoid the financial thresholds for tendering.

8.2 Commissioning of Healthcare Services

8.2.1 The Trust shall follow the requirements of the Provider Selection Regime and ensure that competitive procurement is undertaken as per the thresholds in the Scheme of Delegation. The Provider Selection Regime applies to all Healthcare Contracts regardless of value.

8.3 Formal Procurement Procedures (Competitive Tenders & Quotations)

8.3.1 General Applicability

The Trust shall ensure that competitive tenders and quotations are invited for:

(a) the supply of goods, materials and manufactured articles;

(b) the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC);

(c) the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens);

(d) for disposals.

8.3.2 Exceptions and instances where formal procurement procedures need not be applied

Formal procurement procedures (competitive tenders and quotations) need not be applied where:

(a) The estimated expenditure or income does not, or is not reasonably expected to, exceed the lower limit laid down in the Scheme of Delegation (currently £50,000); it is a breach of SFIs to split contracts to avoid these thresholds;

(b) Where the supply is proposed under special arrangements negotiated by the DHSC or other NHS procurement agency in which event the said special arrangements must be complied with;

Competitive tenders and quotations may be waived in the following circumstances:

(c) In exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(d) Where the requirement is covered by an existing contract;

(e) Where contracts have been awarded for the benefit of Public Sector Bodies, to which the Trust is entitled to access (e.g. framework contracts);

(f) Where a national or regional consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(g) Where the timescale genuinely precludes competitive tendering (but failure to plan the work properly would not be regarded as a justification for a single tender);

(h) Where specialist expertise is required and is available from only one source;

(i) When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(j) There is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(k) For the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Chief Finance Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the value of such work;

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

8.3.3 Where it is decided that formal procurement procedures are not applicable and competitive tenders or quotations should be waived

The fact of the waiver and the reasons should be documented on a "Competition Waiver Form" (available from Procurement or from the Trust intranet), authorised by the Chief Finance Officer and/or Chief Executive, and forwarded to Procurement for final approval by the Head of Procurement or their deputy.

All waivers must be reported to the next Audit & Risk Committee meeting.

8.3.4 Items estimated to be below the limits set in this SFI for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

8.4 Contracting/Tendering Procedure

Paper based or electronic tenders
The tendering process may be paper based or using an electronic tendering system. For tenders managed by the Procurement department, they use a fully audited electronic sealed bid process, where quotations and tenders cannot be opened until the set date and time. There is a complete electronic audit trail built into this process.
The following paragraphs indicate where the tendering process is different between paper and electronic.

8.4.1 Invitation to tender

(a) Invitations to tender must be sent to a sufficient number of suppliers to provide fair and adequate competition as appropriate, and in no case less than three suppliers, as far as practicable having regard to their capacity to supply the goods or materials or to undertake the services or works required.

(b) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(c) For paper tenders, all invitations to tender shall state that no tender will be accepted unless:

(i) Submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed

to the Chief Executive or nominated Manager;

(ii) tender envelopes/packages do not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(d) For electronic tenders, the invitation shall state that only tenders submitted electronically will be considered.

(e) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable

(f) Every tender for building and engineering works shall reflect DHSC Estates Technical Guidance and, except any tender for maintenance work only, shall embody or be in the terms issued by either the Joint Contracts Tribunal (JCT) Standard Forms of Building Contract, or for major projects, the appropriate New Engineering Contract (NEC) form of contract shall be used. Where appropriate, a Model Form of Engineering Contract should be used when the content of the work is primarily engineering. Procurement of professional services for the delivery of works should also be made using the form of professional services contract appropriate to the construction works being undertaken.

8.4.2 Receipt and safe custody of tenders

(a) For paper tenders, the Chief Executive or their nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

(b) For electronic tenders, the tenders are locked automatically until the published date and time of opening. The date and time of receipt of each tender is stored electronically.

8.4.3 Opening tenders and register of tenders (paper tenders)

(a) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two Executive Directors or Board Directors, who will not be from the originating department.

(b) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(c) Every tender received shall be marked with the date of opening and initialled, alongside the tender total, by those present at the opening.

(d) A register shall be maintained by the Chief Executive, or a person authorised by them, to show for each set of competitive tender invitations despatched;

(i) The name of all firms' individuals invited;

(ii) The names of firms individuals from which tenders have been received;

(iii) The date the tenders were opened;

(iv) The persons present at the opening;

(v) The price shown on each tender;

(vi) A note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present. A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(e) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (paragraph 8.3.5 below).

8.4.4 Opening tenders and register of tenders (electronic tenders)

(a) Because the Procurement department use a fully audited electronic sealed bid process, where quotations and tenders cannot be opened until the set date and time, there is a complete electronic audit trail of viewing, opening dates, times, responses and amendments, automatically built into the process.

(b) After the closing date the tender documents are available electronically to see. Only senior managers in the Procurement department have this access.

8.4.5 Admissibility

(a) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(b) Where only one tender is sought and/or received, the Chief Executive and Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

8.4.6 Late tenders

(a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. dispatched in good time but delayed through no fault of the tenderer.

(b) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer, or if the process of evaluation and adjudication has not started and the provisional results of the tender exercise have not been communicated to the originating department.

(c) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or their nominated officer.

8.4.7 Acceptance of formal tenders

(a) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

(b) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

(c) It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(i) Experience and qualifications of team members;

(ii) Understanding of client's needs;

(iii) Feasibility and credibility of proposed approach;

(iv) Ability to complete the project on time.

(d) Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file prior to requesting tenders, and the reason(s) for not accepting the lowest tender clearly stated.

(e) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(f) The use of these procedures must demonstrate that the award of the contract was:

(i) Not in excess of the going market rate / price current at the time the contract was awarded;

(ii) That best value for money was achieved.

(g) All tenders should be treated as confidential and should be retained for inspection.

8.4.8 Tender reports to the Trust Board

Reports to the Trust Board will be made on an exceptional circumstance basis only.

8.4.9 Approved firms

(a) Firms invited to tender shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, they do not discriminate against any person because of colour, race, ethnic or national origins, religion, gender or sexual orientation and that they comply with the provisions of the Equal Pay Act 1970, Equality legislation, the Bribery Act 2010 or related legislation.

(b) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) The Chief Finance Officer may make or institute any enquiries they deem appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/medical competence.

8.5 Quotations: Competitive and Non-Competitive

8.5.1 Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £50,000 but not exceed £139,688. This is for expenditure where more than one supplier is generally available and excludes:

(a) Custom/bespoke made one-off items for patient care;

(b) High cost implants for complex surgical cases (e.g. scoliosis) where the total cost for the case is less than £50,000 and value for money can be evidenced.

8.5.2 Competitive Quotations

(a) Quotations should be obtained from at least 3 firms/individuals. The quotations will be based on specifications or terms of reference prepared by, or on behalf of, the Trust;

(b) Quotations should be in writing unless the Chief Executive or their nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record;

(c) All quotations should be treated as confidential and should be retained for inspection;

(d) The Chief Executive or their nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why must be recorded in a permanent record.

8.5.3 Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

(a) The supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(b) The supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(c) Where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this paragraph apply.

8.5.4 Quotations to be within financial limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with SFIs except with the authorisation of either the Chief Executive or Chief Finance Officer.

8.6 Authorisation of Competitive Tenders and Quotations

8.6.1 Providing all the conditions and circumstances set out in these SFIs have been fully complied with, formal authorisation and awarding of a contract may be decided by Trust officers within their delegated limits, as laid out in the Scheme of Delegation:

Quotations	
Designated budget holders	Up to £139,688
Tenders	
2 Executive or Board Directors	Up to £249,999
Trust Board	Over £250,000

8.6.2 Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

8.7 Where Formal Competitive Tendering/Competitive Quotation is not required

8.7.1 Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

(a) The Trust shall use the local procurement service for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Trust does not use the local procurement service - where tenders or quotations are not required, because expenditure is below £50,000, the Trust shall procure

goods and services in accordance with procurement procedures approved by the Chief Finance Officer.

8.8 Significant & Material Transactions

8.8.1 All significant and material transactions must comply with the requirements of the Risk Assurance Framework and the Trust's Constitution.

8.8.2 All major transactions whether or not they comply with the definitions of "Significant or Material Transactions" will be risk assessed in line with best practice, and in line with the Trust's Investment Decision Making Policy and approved by the Trust Board

8.8.3 All significant transactions must be explicitly approved by the Board and the Trust's Governors.

8.9 Compliance Requirements for all Contracts

8.9.1 The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Constitution and SFIs;

(b) The Procurement Act 2023, Provider Selection Regime and other statutory provisions;

(c) Any relevant directions including the NHS England capital regime, investment and property business case approval guidance for NHS providers, Estatecode, and guidance on the Procurement of Management Consultants;

(d) Such of the NHS Standard Contract Conditions as are applicable;

(e) Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;

(f) Contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited. If a departure becomes necessary the reasons for the departure must be recorded in a permanent record and in the project file;

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

8.10 Agency or Temporary Staff Contracts

8.10.1 The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment regarding agency staff or temporary staff service contracts via frameworks or the current list of approved suppliers.

8.10.2 The Chief Finance Officer must be consulted and must give authorisation if the contractor is not on a framework/the current list of aproved suppliers.

8.11 Healthcare Services Agreements (see overlap with SFI No. 9)

8.11.1 Service agreements with NHS providers for the supply of clinical and non-clinical support services shall be drawn up in accordance with guidance issued by the independent regulator, or subsequent responsible NHS body.

8..11.2 NHS to NHS Arrangements are not exempt under the Procurement Act 2023 or Provider Selection Regime and the legislation should therefore be considered before entering into any agreements.

8.12 Disposals (see overlap with SFI No. 15)

8.12.1 Competitive tendering or quotation procedures shall not apply to the disposal of:

(a) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;

(b) Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) Items to be disposed of with an estimated sale value of less than £10,000, this figure to be reviewed on a periodic basis;

(d) Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) Land or buildings where DHSC guidance has been issued but subject to compliance with such guidance.

8.13 In-House Services

8.13.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

8.13.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officers and specialist;

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support;

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Finance Officer representative.

8.13.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

8.13.4 The evaluation team shall make recommendations to the Board.

8.13.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

8.14 Applicability of SFIs on Tendering/Contracting to Charitable Funds

8.14.1 These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's charitable funds.

9. Contracts for the Provision of Healthcare Services

9.1 The Chief Executive is responsible for signing the annual legally binding contract, with Commissioners, using the standard NHS contract terms and conditions where appropriate, detailing the basis on which the Trust will provide healthcare services. Any variations to the standard terms and conditions will be approved in accordance with the Scheme of Delegation.

9.2 The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the annual Business Plan. In carrying out these functions, the Chief Executive should take into account the advice of the Chief Finance Officer regarding costing and pricing of services, payment terms and conditions and amendments to service agreements.

9.3 Contracts should be so devised as to achieve activity and performance targets, minimise risk, and maximise the Trust's opportunity to generate income. The Trust will produce a local tariff in accordance with NHS guidelines, for services outside the scope of the national tariff.

9.4 The Chief Finance Officer will report any negotiated contract which uses terms other than those laid down in the NHS Contract or the Operating Framework to the Trust Board.

9.5 The Chief Finance Officer shall ensure that a summary of the Trust's agreed contracts is reported annually to the Board, prior to the start of the financial year. The Chief Finance Officer shall also produce regular reports to the Board detailing actual and forecast contract income with a detailed assessment of the variable elements of income.

10. Terms of Service, Allowances & Payment of Trust Board Members & Executive Employees

10.1 Remuneration & Terms of Service

10.1.1 In accordance with the Constitution the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

The Committee will advise the Board about appropriate remuneration and terms of service for the Chief Executive, and other senior employees not on Agenda for Change terms and conditions, including:

(a) All aspects of salary (including any performance-related elements/bonuses);

(b) Provisions for other benefits, including pensions and cars;

(c) Arrangements for termination of employment and other contractual terms.

There must be proper regard to the Trust's circumstances and performance, and to the provisions of any national arrangements for such members and staff where appropriate.

10.1.2 The Council of Governors will agree the remuneration for the Chairman and Non-Executive members of the Board.

10.2 Funded Establishment

10.2.1 The manpower plans incorporated within the annual plan will form the funded establishment.

10.2.2 The funded establishment of any department may not be varied without the approval of the Chief Finance Officer.

10.2.3 The total funded establishment of the Trust may not be varied without the approval of the Chief Executive.

10.3 Staff Appointments

10.3.1 No officer or member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless the following conditions are met:

(a) They have delegated authority in accordance with the Scheme of Delegation.

(b) The appointment is within the limit of their approved budget and funded establishment.

(c) The appointment has been made in accordance with procedures agreed by the Chief Executive.

10.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc. for employees.

10.4 Processing Payroll

10.4.1 The Chief Finance Officer is responsible for:

(a) Specifying timetables for submission of properly authorised time records and other notifications;

(b) The final determination of pay and allowances;

(c) Making payment on agreed dates;

(d) Agreeing method of payment.

10.4.2 The Chief Finance Officer will issue instructions regarding:

(a) Verification and documentation of data;

(b) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) Maintenance of subsidiary records for pensions, income tax, social security and other authorised deductions from pay;

(d) Security and confidentiality of payroll information;

(e) Checks to be applied to completed payroll before and after payment;

(f) Authority to release payroll data under the provisions of the Data Protection Act;

(g) Methods of payment available to various categories of employee and officers;

(h) Procedures for payment by cheque, bank credit, or cash to employees and officers;

(i) Procedures for the recall of cheques and bank credits;

(j) Pay advances and their recovery;

(k) Maintenance of regular and independent reconciliation of pay control accounts;

(l) Separation of duties of preparing records and handling cash;

(m) A system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

10.4.3 Appropriately nominated managers have delegated responsibility for:

(a) Submitting time records and other notifications in accordance with agreed timetables;

(b) Completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by the Chief Finance Officer;

(c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Finance Officer must be informed immediately.

10.4.4 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.5 Contracts of Employment

10.5.1 The Board shall delegate responsibility to an officer for:

(a) Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation.

(b) Dealing with variations to, or termination of, contracts of employment.

11. Non-Pay Expenditure

11.1 Delegation of Authority

11.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

11.1.2 The levels to be delegated are set out in the Trust's Scheme of Delegation, which should be referred to for further detail.

11.1.3 The Chief Executive will set out:

(a) The list of managers who are authorised to place requisitions for the supply of goods and services;

(b) The maximum level of each requisition and the system for authorisation above that level.

11.1.4 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.2 Ordering, Receipt and Payment for Goods and Services

11.2.1 Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Chief Executive) shall be consulted.

11.2.2 System of Payment and Payment Verification

The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

The Chief Finance Officer will:

(a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SFIs and regularly reviewed;

(b) Prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) Be responsible for the prompt payment of all properly authorised accounts and claims;

(d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of employees (including specimens of their signatures) authorised to approve payments;

(ii) Certification that:

- Goods have been duly received, examined and are in accordance with specification and the prices are correct;
- Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- The account is arithmetically correct;

- The account is in order for payment.

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in paragraph 11.2.3 below.

11.2.3 Prepayments

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. where material, cash flows must be discounted to net present value at the prevailing discount rate);

(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is, at some time during the course of the prepayment agreement, unable to meet their commitments;

(c) The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11.2.4 Official orders

Official Orders must:

(a) Be uniquely identified by use of an internally approved process;

(b) Be in a form approved by the Chief Finance Officer;

(c) State the Trust's terms and conditions of trade, including the need for suppliers to quote a valid order number when submitting invoices for payment;

(d) Only be issued to, and used by, those duly authorised by the Chief Executive. Lists of authorised officers shall be maintained and a copy of each list supplied to the Chief Finance Officer;

(e) May be transmitted by a system of Electronic Data Interchange (EDI) approved by the Chief Finance Officer;

(f) Be authorised, prior to being issued, according to the Trust's Scheme of Delegation.

11.2.5 Duties of Managers and Officers

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

(a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;

(b) Contracts above specified thresholds are advertised and awarded in accordance with The Procurement Act 2023 or Provider Selection Regime as applicable;;

(c) Where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care and NHS England;

(d) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees. As laid out in the Standards of Business Conduct policy, this excludes:

(i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) Conventional hospitality, such as reasonable lunches in the course of working visits.

(e) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(f) All goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash or using the corporate credit card;

(g) Verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(h) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) Goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) Changes to the list of employees and officers authorised to certify invoices are notified to the Chief Finance Officer;

(k) Purchases from petty cash or using the corporate credit card are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;

(l) Petty cash and corporate credit card records are maintained in a form as determined by the Chief Finance Officer;

(m) Drugs shall only be ordered via the Pharmacy Department.

11.2.6 The Chief Executive and Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within NHS Estates guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

11.2.7 All staff have a responsibility for the maintenance of confidentiality of all information. No member of staff shall reveal information that could:

(a) Prejudice fair competition;
(b) Result in the Trust failing to achieve the most advantageous price in respect of purchases or income in respect of sales

Any breach of confidentiality, whether or not for personal gain, may render an individual open to to disciplinary action in accordance with the Trust's Disciplinary Procedures, and may ultimately result in dismissal.

11.2.8 Payments to local authorities and voluntary organisations made under the powers of section 256 of the NHS Act 2006 (previously known as Section 28a payments) shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with this Act.

12. Financial Framework

12.1 External Borrowing

12.1.1 The Chief Finance Officer will advise the Board concerning the ability of the Trust to pay interest and make repayments on any proposed new borrowing. The Chief Finance Officer is also responsible for reporting periodically to the Board concerning any loans or overdrafts.

12.1.2 The Chief Finance Officer will advise the Board if a working capital facility is required to safeguard short term cash flow. If required the Chief Finance Officer will negotiate such a facility with a commercial bank.

12.1.3 Any application for working capital or overdraft facilities will only be made by the Chief Finance Officer and the Chief Executive or by an employee so delegated.

12.1.4 The Chief Finance Officer must prepare detailed procedural instructions concerning applications for working capital facilities or overdrafts.

12.1.5 All short term borrowing should be kept to the minimum period of time possible, consistent with the cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Chief Finance Officer and Chief Executive or an employee so delegated.

12.1.6 All long term borrowing must be consistent with the plans outlined in the Annual Plan and in accordance with the Treasury Management policy.

12.2 Investments

12.2.1 Temporary cash surpluses must be held only in such public or private sector investments as authorised by the Board of Directors and in line with the Treasury Management Policy and the Independent Regulator's guidance, "Managing Operating Cash in NHS Foundation Trusts" as outlined in the Trust's Treasury Management Policy.

12.2.2 The Chief Finance Officer is responsible for advising the Board of Directors on investments and shall therefore report annually to the Board of Directors concerning the performance of investments held.

12.2.3 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12.2.4 The Trust must comply with all relevant guidance published on investments from time to time.

13. Capital Investment, Private Financing, Fixed Asset Registers & Security of Assets

13.1 Capital Investment

13.1.1 The Chief Executive:

(a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to budget;

(c) Shall ensure that the capital investment is not undertaken without confirmation of commissioners' support and the availability of resources to finance all revenue consequences, including capital charges.

13.1.2 For every new capital investment, the Chief Executive shall ensure:

(a) That a business case is completed in line with best practice as set out in the Trust's Business Case & Investment Policy. This should include:

(i) An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) The involvement of appropriate Trust personnel and external agencies;

(iii) Appropriate project management and control arrangements.

(b) That the Chief Finance Officer has reviewed and confirmed the costs and revenue consequences detailed in the business case.

13.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of NHS Estates guidance.

13.1.4 The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised budgets.

13.1.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) Specific authority to commit expenditure;

(b) Authority to proceed to tender (see overlap with SFI No. 8);

(c) Approval to accept a successful tender (see overlap with SFI No. 8).

13.1.6 The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

13.2 Private Finance (including Leasing)

13.2.1 When the Trust proposes to use private finance or leasing the following procedures shall apply:

(a) The proposal must obtain approval commensurate with that which is required were the assets, goods or services to be obtained by outright purchase i.e. employees must follow annual planning guidance;

(b) The Chief Finance Officer shall demonstrate that the financing represents value for money and genuinely transfers risk to the private sector in accordance with relevant guidance.

(c) Any leases must be agreed and signed by the Chief Finance Officer if less than £100,000 and the Chief Finance Officer and Chief Executive above that.

13.3 Asset Registers

13.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

13.3.2 The Trust shall maintain an asset register recording fixed assets.

13.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) Stores, requisitions and payroll records for own materials and labour including appropriate overheads;

(c) Lease agreements in respect of assets held under a lease and capitalised.

13.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

13.3.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

13.3.6 The value of each asset shall be indexed to current values in accordance with the Trust's accounting policies.

13.3.7 The value of each asset shall be depreciated using methods and rates as specified in the Trust's accounting policies.

13.3.8 The Chief Finance Officer of the Trust shall calculate and pay capital charges as specified in the guidance issued by the independent regulator.

13.3.9 The Trust shall maintain a property register recording assets used in the delivery of Commissioner Requested Services, in accordance with guidance issued by the independent regulator.

13.4 Security of Assets

13.4.1 The overall control of capital assets is the responsibility of the Chief Executive.

13.4.2 Asset control procedures (including capital assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. These procedures shall make provision for:

(a) Recording managerial responsibility for each asset;

(b) Identification of additions and disposals;

(c) Identification of all repairs and maintenance expenses;

(d) Physical security of assets;

(e) Periodic verification of the existence of, condition of, and title to, assets recorded;

(f) Identification and reporting of all costs associated with the retention of an asset;

(g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

13.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer.

13.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures. (see SFI No. 15)

13.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses. (see SFI No. 15)

13.4.6 Where practical, assets should be marked as Trust property.

14. Stores & Receipt of Goods

14.1 General

14.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) Kept to a minimum;

(b) Subjected to annual stock take;

(c) Valued in accordance with the Trust's accounting policies.

14.2 Control of Stores, Stocktaking, Condemnations & Disposals

14.2.1 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated Estates Manager.

14.2.2 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

14.2.3 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

14.2.4 Stocktaking arrangements shall be agreed with the Chief Finance Officer, and there shall be a physical check covering all items in store at least once a year.

14.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

14.2.6 The designated manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 25). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

14.3 Receipt of Goods

14.3.1 A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods. All goods received shall be checked by the appropriate department as regards quantity and/or weight and inspected as to quality and specification. Instructions shall be issued to staff covering the procedures to be adopted in those cases where a delivery note is not available.

14.3.2 All goods received, other than from NHS Supply Chain, shall be entered onto an appropriate goods received/stock record (whether a computer or manual system) on the day of receipt. If goods received are unsatisfactory, the records shall be marked accordingly. Further, where the goods received are found to be unsatisfactory or short on delivery, they shall only be accepted on the authority of the designated officer and the supplier shall be notified immediately.

15. Disposals & Condemnations, Losses & Special Payments

15.1 Disposals & Condemnations

15.1.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers

15.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

(a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;

(b) Recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

15.1.4 The Condemning Officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

15.1.5 Any disposal of IT equipment must also comply with the IT Security Policy.

15.2 Losses & Special Payments

15.2.1 The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

15.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Finance Officer, or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Finance Officer and/or Chief Executive. Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform the relevant LCFS.

15.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify the Board and the External Auditor.

15.2.4 The Trust Board shall approve the delegation of the writing-off of losses, on an annual basis.

15.2.5 The Chief Finance Officer shall take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

15.2.6 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

15.2.7 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

15.2.8 All losses and special payments must be reported to the Audit & Risk Committee at every meeting.

16. Information Technology

16.1 Responsibilities & duties of the Senior Information Risk Officer (SIRO)

16.1.1 The Trust's nominated Senior Information Risk Officer (SIRO), who is responsible for the accuracy and security of the computerised data of the Trust, shall:

(a) Devise and implement any necessary procedures to ensure adequate protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 (updated 2000);

(b) Ensure that adequate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient operation of the system;

(c) Ensure that adequate controls exist such that the routine computer operation is separated from system controls including development, maintenance and amendment;

(d) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out;

(e) Ensure that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks;

(f) Ensure that risks to the Trust arising from the use of I/T are effectively identified and considered and appropriate action taken to mitigate or control these risks. This shall include the preparation and testing of appropriate disaster recovery plans.

16.2 Responsibilities & Duties of Other Directors & Officers in Relation to Computer Systems of a General Application

16.2.1 The Trust Secretary shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner.

16.2.2 In the case of computer systems which are procured jointly with other NHS organisations, the responsible officer will send to the Chief Finance Officer:

(a) Details of the outline design of the system;

(b) In the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

16.3 Contracts for Computer Services with other Health Bodies or Outside Agencies

16.3.1 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

16.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

16.4 Requirements for Computer Systems which have an Impact on Corporate Financial System

16.4.1 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that:

(a) Systems acquisition, development and maintenance are in line with corporate policies such as, but not limited to, an Information Technology Strategy;

(b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Chief Finance Officer staff and the Trust's auditors have access to such data;

(d) Such computer audit reviews as are considered necessary are being carried out.

17. Patient's Property

17.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

17.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- Notices and information booklets; (subject to sensitivity guidance)
- Hospital admission documentation and property records;
- The oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

17.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

17.4 Where Department of Health and Social Care instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Chief Finance Officer.

17.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

17.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

17.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

18. Funds Held on Trust

18.1 Corporate Trustee

18.1.1 The Trust Board is responsible, as a corporate trustee, for the management of funds it holds on trust. The Trust Board is responsible for ensuring compliance with Charity Commission latest guidance and best practice.

18.1.2 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

18.1.3 The Chief Finance Officer shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

18.2 Accountability to Charity Commission & Secretary of State for Health

18.2.1 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

18.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

18.3 Applicability of Standing Financial Instructions to Funds Held on Trust

18.3.1 In so far as it is possible to do so, most of the sections of these SFIs will apply to the management of funds held on trust.

18.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

19. Acceptance of Gifts by Staff & Link to Standards of Business Conduct

19.1 The Trust Secretary shall ensure that all staff are made aware of the Trust Standards of Business Conduct policy, which gives guidance on the acceptance of gifts and other benefits in kind by staff.

20. Retention of Records

20.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health and Social Care guidelines.

20.2 The records held in archives shall be capable of retrieval by authorised persons.

20.3 Records held in accordance with latest Department of Health and Social Care guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

21. Risk Management & Insurance

21.1 Programme of Risk Management

21.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current guidance from the Independent Regulator, which must be approved and monitored by the Board.

21.1.2 The programme of risk management shall include:

(a) A process for identifying and quantifying risks and potential liabilities;

(b) Engendering among all levels of staff a positive attitude towards the control of risk;

(c) Management processes to ensure all significant risks and potential liabilities are identified and addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) Contingency plans to offset the impact of adverse events;

(e) Audit arrangements including Internal Audit, clinical audit, health and safety review;

(f) A clear indication of which risks shall be insured;

(g) Arrangements to review the Risk Management programme.

21.1.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by current guidance from the Independent Regulator.

21.2 Insurance: Risk Pooling Schemes Administered by NHS Resolution

21.2.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by NHS Resolution or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

21.3 Insurance Arrangements with Commercial Insurers

21.3.1 Any decision to enter into insurance arrangements with commercial insurers must be taken by the Trust Board, the one exception being that the Trust may enter commercial arrangements for insuring motor vehicles owned/leased by the Trust, including insuring third party liability arising from their use, without Board approval.

21.4 Board Arrangements to be Followed in Agreeing Insurance Cover

21.4.1 Where the Board decides to use the risk pooling schemes administered by NHS Resolution, the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

21.4.2 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

21.4.3 The risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Policy Review

This policy requires consideration by the Audit & Risk Committee prior to approval by the Trust Board.

This policy will be reviewed every year.

Policy updated: March 2026
Next review due by: March 2027

Record of Amendments

Date	Section number	Amendments
Jan 2019	8.5.1	Amended individual authorisation limits for accepting tenders to match those in the Scheme of Delegation
	21	Changed "NHS Litigation Authority" to "NHS Resolution"
Jan 2020	8.2 & 8.5	Clarification around tendering & quotation procedures & amending levels of approval to match those in the revised Scheme of Delegation
	Various	Amended "Director of Finance" to "Chief Finance Officer"
Jul 2021	8.1.2	Note added that rules originating from EU directives are retained in UK law until a new set of regulations is legislated for following the 'Transforming Public Procurement' green paper.
Feb 2023	7.4.5	Amended limit for accepting cash payments from £10,000 to £8,000 to comply with money laundering regulations
	8	Changed references to quotation and tendering limits as a result of changes to the Scheme of Delegation
Mar 2026	8	Added references to the Procurement Act 2023 and the Provider Selection regine
	8	Changed references to quotation and tendering limits as a result of changes to the Scheme of Delegation

The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

Title:	Scheme of Delegation		
Unique Identifier:	POL030	**Document Type:**	Policy
Version Number:	14.0	**Status:**	Draft
Responsible Director:	Angela Mulholland-Wells, Chief Finance & Commercial Officer		
Author:	Diana Owen, Head of Financial Accounting		
Scope:	Trust wide		
Replaces:	Version 13.0		
To be Read in Conjunction with the Following Documents: (list related policies)	Standing Financial Instructions (SFIs) Matters Reserved to the Board		
Keywords:	Scheme of Delegation, Delegation		

Considered By Executive Owner:	Angela Mulholland-Wells, Chief Finance & Commercial Officer	**Date Considered:**	10/02/2026
Endorsed By:	Audit & Risk Committee	**Date Endorsed**	10/02/2026
Approved By:		**Date Approved:**	
Issue Date:		**Review Date:**	
Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

Trust Values

Detailed Scheme of Delegation

The delegation shown below is the lowest level to which authority is delegated. This delegation may be suspended in order to increase control response to special circumstances. Delegation to lower levels is only permitted with written approval of the Chief Executive who will consult with other Senior Officers as appropriate. In the absence of the officer with delegated authority, if arrangements are in place for a deputy to formally act up, the deputy may exercise that delegated authority If no such arrangements are in place, the matter should be referred to the next highest senior officer. All items concerning Finance must be carried out in accordance with Standing Financial Instructions.
All amounts quoted exclude VAT.

DELEGATED MATTER	AUTHORITY DELEGATED TO
1. Management of Budgets	
1.1 Responsibility of keeping revenue expenditure within budgets	
(a) Designation of Budget Holder for each area e.g. corporate, operations	Chief Executive
(b) Designation of delivery unit Budget Holders	Nominated Executive / Clinical Chair
(c) At cost centre level	Managing Director or responsible manager
(d) Other areas (e.g. reserves)	Deputy Chief Finance Officer
1.2 Responsibility of keeping capital expenditure within budgets	Chief Finance Officer
1.3 Responsibility for activity income	Deputy Chief Finance Officer
2. Investment & Banking	
2.1 Opening & closing of bank accounts	Deputy Chief Finance Officer
2.2 Investment of surplus cash	
(a) National Loans Fund (up to £5m)	
• Up to 3 months	Deputy Chief Finance Officer
• Over 3 months	Chief Finance Officer and Finance & Performance Committee
(b) Other institutions (up to £2m)	
• Up to 1 month	Deputy Chief Finance Officer
• Up to 3 months	Chief Finance Officer
• Over 3 months	Chief Finance Officer and Finance & Performance Committee
2.3 External borrowing	Trust Board

DELEGATED MATTER	AUTHORITY DELEGATED TO
3. Non Pay Revenue & Capital Expenditure	
Authorising requisitions & payments (excl. agency staff & locums) includes on-line Oracle requisitions & invoices	
3.1 Routine goods & services	
(a) Approve requisitions/payments up to a level as agreed by the Operational Delivery Lead / Service Lead but no greater than £1,000	Budget Administrator
(b) Approve requisitions/payments up to a level as agreed by the Operational Delivery Lead / Service Lead but no greater than £3,000	Budget Holder
(c) Approve requisitions/payments up to £15,000	Operational Delivery Lead / Service Lead
(d) Approve requisitions/payments up to £50,000	Director
(e) Approve requisitions/payments up to £125,000	Chief Finance Officer
(f) Approve requisitions/payments over £125,000	Chief Executive and Chief Finance Officer
Where operational necessity requires deviation from these approval levels an appropriate variation will be agreed within the budget holder limit of £3,000	Chief Finance Officer
3.2 Specialist goods/services & exceptional items	
(a) Approve **pharmacy** orders/payments up to £75,000	Chief Pharmacist
(b) Approve **pharmacy** orders/payments over £75,000	Chief Pharmacist **and** Chief Finance Officer or Chief Executive
(c) Approve theatre replenishment of agreed implant stock levels orders/payments up to £50,000	Theatre Services Manager or Theatre Procurement lead
(d) Approve **capital/works** requisitions/payments up to £10,000	Director of Estates & Facilities
(e) Approve **capital/works** requisitions/payments, where scheme has been approved by the Board, up to the approved budget	Chief Finance Officer
(f) Approve **theatre** requisitions/ payments up to £10,000	Theatre Services Manager
(g) All orders and contracts for goods/services over £10,000 & **exceeding a 12 month period**	Chief Finance Officer or Chief Executive
The above limits relate to expenditure contained within the Trust's financial plan & budgets. Any new or additional expenditure above approved budgets must be approved by the Chief Finance Officer. Under the approval limits set by the Integrated Care System any additional recurrent expenditure must be approved by the triple lock process (RJAH, ICS & regulator) through the system Investment Panel via a business case.	

DELEGATED MATTER	AUTHORITY DELEGATED TO
4. Capital Schemes & Leases	
a) Selection of architects, quantity surveyors, consultant engineer & other professional advisors	Director of Estates & Facilities
b) Financial monitoring & reporting on all capital scheme expenditure	Chief Finance Officer or Nominated Deputy
c) Granting & termination of leases with annual cost up to £100,000	Chief Finance Officer
d) Granting & termination of leases with annual cost over £100,000	Chief Executive and Chief Finance Officer
5. Quotations, Tendering & Contracting *Limits quoted are excluding VAT*	
5.1 Quotation & tendering limits	
a) Obtaining 3 written quotations (or further competition by a framework agreement) for goods/services expected to be from £50,000 to £139,688 (Procurement Act 2023 (PA23) threshold)	Budget Holder in conjunction with SHPS
b) Obtaining competitive tenders in accordance with PA23 for goods/services expected to be over £139,688	Director **and** Chief Finance Officer in conjunction with SHPS
5.2 Waiving of quotations/tenders subject to SFIs	
a) Waiving of quotations from £50,000 to £80,000	Chief Finance Officer
b) Waiving of quotations from £80,001 to £139,688	Chief Executive **and** Chief Finance Officer
c) Waiving of tenders over £139,688	Chief Executive **and** Chief Finance Officer
5.3 Tender opening /evaluation & acceptance	
a) Opening paper tenders *(electronic ones are automatic)*	2 Executive Directors
b) Evaluation of tenders	Panel including unit lead, Finance manager and appropriate specialist advisor(s)
c) Acceptance of tenders up to £249,999 per year	2 Executive Directors
d) Acceptance of tenders over £250,000 per year	Trust Board
e) Approving expenditure over agreed tender/ quotation where price is > 10%, up to £15,000	Chief Finance Officer
f) Approving expenditure over agreed tender/ quotation where price is > 10% and over £15,000	Chief Executive
g) Maintenance of Tender Register	Trust Secretary

DELEGATED MATTER	AUTHORITY DELEGATED TO
6. Contracts & Tenders for Services Provided	
6.1 Healthcare Contracts *(includes all non-staff arrangements)*	
a) Signing of contracts up to the value of £125,000	Director
b) Signing of contracts up to the value of £250,000	Executive Director
c) Signing of contracts up to the value of £5m	Chief Finance Officer
d) Signing of contracts above the value of £5m	Chief Executive
e) Reporting to the Trust Board where a negotiated contract does not comply with the terms of the NHS Contract or the Operating Framework	Chief Finance Officer
6.2 Pricing	
a) Price of NHS contracts charges for activity not covered by tariff	Chief Finance Officer
b) Private patients, overseas visitors, income generation and other patient related services	Chief Finance Officer
6.3 Tender Submissions	
Sign-off of tender submissions	Service Manager or Operational Delivery Lead / Service Lead
7. Personnel & Pay	
7.1 Appointments	
a) Filling funded posts on the establishment with permanent staff	Chief People Officer (in line with post approval procedures)
b) Appointing staff to posts not on the formal establishment with permanent staff	Chief People Officer (in line with post approval procedures)
c) Appointing additional staff to the agreed establishment with specifically allocated finance	Chief People Officer (in line with post approval procedures)
d) Granting of additional increments to staff within budget and in accordance with Trust policy	Chief People Officer
e) Requests for upgrading/regrading to be dealt with in accordance with Trust Procedure	Chief People Officer
7.2 Pay	
a) Completing standing data forms affecting pay, new starters, variations and leavers	Budget Holder
b) Authorising overtime	Line / Department Manager
c) Authorising travel and subsistence claims	Line / Department Manager

DELEGATED MATTER	AUTHORITY DELEGATED TO
d) Approval of performance related pay	Chief Executive or Nomination & Remuneration Committee
7.3 Leave	
a) Annual leave	Line / Department Manager
b) Annual leave – carry forward up to a maximum of 5 days	Line / Department Manager
c) Annual leave – carry forward in excess of 5 days but less than 10 days.	Chief People Officer
d) Special leave up to 5 days	Line / Department Manager in line with Trust policy
e) Special leave in addition to 5 days	Chief People Officer in line with Trust policy
f) Unpaid leave up to 5 days	Line / Department Manager in line with Trust policy
g) Unpaid leave over 5 days	Chief People Officer in line with Trust policy
h) Medical Staff leave of absence paid and unpaid (over and above normal annual leave entitlement)	Chief Medical Officer **and** Chief People Officer
i) Time off in lieu	Automatic approval of line manager within the requirements of the organisation
j) Maternity leave – paid and unpaid	Automatic approval within guidance
7.4 Sick leave	
a) Any extension of sick leave over employee conditions of service	Operational Delivery Lead / Service Lead in conjunction with Chief People Officer
b) Return to work part-time on full pay to assist recovery.	Chief People Officer in conjunction with Operational Delivery Lead / Service Lead
7.5 Study leave	
a) All study leave outside of the UK	Chief Executive
b) Medical staff CME/professional leave excluding overseas	Chief Medical Officer
c) All other study leave	Operational Delivery Lead / Service Lead with support from line manager
7.6 Relocation expenses	
Authorisation of payment of relocation/removal expenses incurred by officers taking up new appointments (in accordance with local policy)	
a) Up to £5,000	Chief People Officer
b) Over £5,000	Chief Executive

DELEGATED MATTER	AUTHORITY DELEGATED TO
7.7 Car & mobile phone users	
a) Requests for new and existing posts to be authorised as car users	Chief People Officer / Deputy Chief Finance Officer in liaison with Operational Delivery Lead / Service Lead
b) Requests for posts to be authorised as mobile phone users	Chief People Officer / Deputy Chief Finance Officer in liaison with Operational Delivery Lead / Service Lead
7.8 Other	
a) Grievance cases to be dealt with in accordance with the Grievance Procedure, and advice of a Human Resources Officer must be sought	Chief People Officer in accordance with Trust policy
b) Staff retirement – extension of contract beyond agreed retirement age	Chief People Officer in liaison with Operational Delivery Lead / Service Lead
c) Redundancy	Chief Executive **and** Chief People Officer
d) Ill-health retirement – decision to pursue retirement on the grounds of ill-health	Chief People Officer in liaison with Operational Delivery Lead / Service Lead
e) Dismissal	Chief People Officer and authorised directors or Nomination & Remuneration Committee as appropriate
8. Engagement of Staff other than Employees	
a) Non-medical consultancy staff	Chief Executive or Chief Finance Officer
b) Appointment of Trust's solicitors	Chief Executive or Chief Finance Officer **and** 1 other Executive Director
c) Booking of bank or agency staff: - Medical locums - Nursing - Clerical	Chief People Officer (in line with Bank & Agency procedure)
9. Charitable Funds	
9.1 Approval for fundraising/appeal launching	
a) Projected fundraising up to £5,000	Director
b) Projected fundraising between £5,001 and £250,000	Charitable Funds Committee
c) Projected fundraising over £250,000	Trust Board following Charitable Funds Committee approval & Director support
9.2 Expenditure (inclusive of VAT if not exempt	
a) Up to £1,500	Fund Manager
b) From £1,501 to £10,000 per request	Chief Executive or Chief Finance Officer

DELEGATED MATTER	AUTHORITY DELEGATED TO
c) From £10,001 to £20,000 per request	Chief Executive **and** Chief Finance Officer
d) From £20,001 to £50,000 per request	Charitable Funds Committee, or between meetings Chief Finance Officer **and** Chief Executive in consultation with other Trustees
e) Over £50,001	Charitable Funds Committee
10. Agreement/Licences	
a) Preparation and signature of tenancy agreements/licences for staff, subject to Trust Policy on accommodation for staff	Deputy Chief Finance Officer / Chief People Officer / Director of Estates & Facilities
b) Extensions to existing leases	Deputy Chief Finance Officer / Chief People Officer / Director of Estates & Facilities
c) Letting of premises to outside organisations	Deputy Chief Finance Officer **and** Chief Executive
d) Approval of rent based on professional assessment	Deputy Chief Finance Officer
11. Condemning & Disposal of Assets Items which are obsolete, redundant, irreparable or cannot be repaired cost effectively (including x-ray films, mechanical & engineering plant)	
a) With a current estimated value up to £2,500	Operational Delivery Lead / Service Lead
b) With a current estimated value over £2,500	Deputy Chief Finance Officer
12. Losses and Special Payments	All losses and special payments must be reported to the Audit & Risk Committee
12.1 Losses Loss of cash, fruitless payments, bad debts, damage to buildings/equipment and loss of equipment	
a) Up to £10,000	Head of Finance
b) Between £10,001 and £50,000	Chief Finance Officer
c) Between £50,001 and £100,000	Chief Finance Officer **and** Chief Executive
d) Over £100,000	Chief Finance Officer **and** Chief Executive **and** a member of the Audit & Risk Committee
12.2 Special payments : severance payments	Nomination & Remuneration Committee following Treasury approval
12.3 Special payments : expenses claims for cancelled clinics/operations	
a) Up to £50	Clinic staff

DELEGATED MATTER	AUTHORITY DELEGATED TO
b) Over £50	Head of Financial Accounting
12.4 Special payments : other Compensation under legal obligation, personal injury claims, loss of personal effects & maladministration	
a) Up to £1,500	Head of Financial Accounting
b) Up to £50,000	Chief Finance Officer
c) Between £50,001 and £100,000	Chief Finance Officer **and** Chief Executive
d) Over £100,000	Chief Finance Officer **and** Chief Executive **and** a member of the Audit & Risk Committee
12.5 Notification of novel, contentious or repercussive special payments to the Department of Health & Social Care	Chief Finance Officer
13. Reporting of Incidents to the Police	
a) Where a criminal offence is suspected	Duty Manager in conjunction with Local Security Management Specialist
b) Where a fraud is involved	Chief Finance Officer in conjunction with Local Counter Fraud Specialist.
14. Petty Cash Reimbursements	
a) Expenditure up to £50	Authorising manager for non-pay expenditure
b) Expenditure over £50 (exceptional circumstances only)	Head of Financial Accounting
c) Reimbursement of patients monies up to £100	Head of Financial Accounting
d) Reimbursement of patients monies above £100	Head of Finance
15. Implementation of Internal & External Audit Recommendations	Appropriate Director
16. Maintenance & Update of Trust Finance Procedures	Deputy Chief Finance Officer
17. Receiving Hospitality	
Individual & collective hospitality (small items such as pens, diaries or chocolates need not be declared)	All staff required to make declaration in Trust's Hospitality Register & follow Trust's Standards of Business Conduct
DELEGATED MATTER	**AUTHORITY DELEGATED TO**

18. Investment of Funds (including Charitable Funds)	Deputy Chief Finance Officer in conjunction with Finance & Performance Committee
19. Authorisation of New Drugs (inclusive of VAT) Estimated total yearly cost (inclusive of VAT) up to £25,000 Estimated total yearly cost (inclusive of VAT) above £25,000	 Chief Medical Officer **and** Chief Finance Officer following advice from Drugs & Therapeutics Committee Chief Medical Officer **and** Chief Executive in conjunction with Executive Team, following advice from Drugs & Therapeutics Committee
20. Authorisation of Clinical Sponsorship Deals	Chief Medical Officer
21. Authorisation of Research Projects	Chief Medical Officer
22. Authorisation of Clinical Trials	Chief Medical Officer **and** Chief Nurse
23. Insurance Policies	Chief Finance Officer
24. Risk Management	Chief Executive
25. Patients & Relatives Complaints a) Overall responsibility for ensuring that all complaints are dealt with effectively b) Responsibility for ensuring complaints relating to a directorate are investigated thoroughly c) Medico-legal complaints : co-ordination of their management	 Chief Nurse Chief Nurse Chief Nurse
26. Infectious Diseases & Notifiable Outbreaks	Chief Nurse
27. Relationships with Press a) Enquiries within hours b) Emergency enquiries outside hours	 Chief Executive or Head of Communications Duty Officer or Senior Manager on call
28. Extended Role Activities Approval of nurses to undertake duties/ procedures which can properly be described as beyond the normal scope of nursing practice	 Chief Nurse
DELEGATED MATTER	**AUTHORITY DELEGATED TO**

29. Patient Services a) Variation of operating and clinic sessions within existing number for outpatients, theatres & others b) Proposed changes in bed allocation & use - Temporary Change - Permanent Change	Managing Directors Chief Nurse Chief Executive
30. Facilities for Staff not Employed by the Trust to Gain Practical Experience. a) Professional recognition, honorary contracts & insurance of medical staff b) Work experience students	Chief People Officer in accordance with Trust Policy Chief People Officer in accordance with Trust Policy
31. Review of Fire Precautions	Chief Nurse
32. Review of Statutory Compliance with Legislation and Health & Safety Requirements Including Control of Substances Hazardous to Health Regulations	Chief Nurse
33. Review of Medicines Inspectorate Regulations	Chief Nurse in conjunction with Chief Pharmacist
34. Review of Compliance with Environmental Regulations (e.g. those relating to clean air and waste disposal)	Chief Nurse in conjunction with Director of Estates & Facilties
35. Review of Trust's compliance with Data Protection Act	Chief Finance Officer
36. Monitor Proposals for Contractual Arrangements Between Trust and Outside Bodies	Chief Finance Officer
37. Review of Compliance with Code of Practice for Handling Confidential Information in the Contracting Environment and Compliance with "Safe Haven" per EL 92/60	Chief Finance Officer
38. Keeping of a Declaration of Interests Register	Trust Secretary
39. Attestation of Sealings in Accordance with Standing Orders	Chair/Chief Executive or nominated deputy
DELEGATED MATTER	**AUTHORITY DELEGATED TO**
40. Keeping of a Register of Sealings	Trust Secretary

41. Keeping of the Hospitality Register	Trust Secretary
42. Retention of Records	Chief Executive
43. Clinical Audit	Chief Medical Officer

Key
SHPS : Shropshire Health Procurement Service

Policy Review

This policy requires consideration by the Audit & Risk Committee prior to approval by the Trust Board.

This policy will be reviewed every year.

Policy updated: March 2026
Next review due by: March 2027

Record of Amendments (last 5 years only)

Date	Section number	Amendments
Jan 2022	3.1	Amend approval limits for higher value requisitions/payments
	5.1	Amend limit relating to Public Contracts Regulations
Feb 2023	3.1	Amend approval limits for requisitions/payments & removal of differentiation between different directors
	5.1	Amend approval limits for quotations & tendering
Mar 2024	Various	Change Finance Planning & Digital Committee to Finance & Performance Committee
	6	Change approval limits for healthcare contracts so lower value contracts can be approved by Directors instead of the Chief Finance Officer or Chief Executive
Mar 2025	6	Amend "Non-Board Director" to "Non-Board Director (*Very Senior Manager*" as requested by A&RC to add clarification
Mar 2026	5	Amend approval limits for quotations and tendering and add references to the Procurment Act 2023 (PA23)
	31/34/35	Executive Director portfolio changes
	Various	Job title changes
	Appendix	Add appendix to clarify different types of directors

Appendix – Naming Conventions for Director Roles

Executive / Board Directors

Chief Executive

Chief Finance & Commercial Officer
Chief Medical Officer
Chief Nursing & Patient Safety Officer
Chief Operating Officer
Chief People & Culture Officer

Directors

All the above, plus:
Director of Estates & Facilities
Digital Director
Managing Directors