NHS
The Shrewsbury and Telford Hospital
NHS Trust

BOARD OF DIRECTORS' MEETING IN PUBLIC
AGENDA

Date: 8 May 2025
Time: 0930hrs – 1230hrs
Venue: Shropshire Education & Conference Centre
Chair in Common: Mr Andrew Morgan

Time	Item no.	Item	Paper / Verbal	Page	Lead	Action
Procedural Items						
0930hrs	061/25	Welcome and apologies	Verbal	-	Chair in Common	For noting
	062/25	Staff Story	Enc	3	*Chief People Officer	For noting
	063/25	Public Questions Format	Enc	4	Chair in Common	For noting
	064/25	Quorum	Verbal	-	Chair in Common	For noting
	065/25	Declarations of conflicts of interest	Verbal	-	Chair in Common	For noting
	066/25	Minutes of the previous meeting held on 13 March 2025	Enc	8	Chair in Common	For approval
	067/25	Action log	Enc	25	Chair in Common	For approval
	068/25	Matters arising from the previous minutes (not covered elsewhere on the agenda or action log)	Verbal	-	Chair in Common	For discussion
Reports from the Chair in Common and Chief Executive						
0950hrs	069/25	Report from the Chair in Common	Verbal	-	Chair in Common	For noting
	070/25	Report from the Chief Executive	Enc	26	Chief Executive	For noting
Reports from Assurance Committee Chairs						
1000hrs	071/25	Quality & Safety Assurance Committee Chair's Report (March & April 2025)	Enc	31 34	Committee Chair	For assurance
	072/25	Performance Assurance Committee Chair's Report (March and April 2025))	Enc	37 39	Committee Chair	For assurance
	073/25	Finance Assurance Committee Chair's Report (March and April 2025)	Enc	42 44	Committee Chair	For assurance
	074/25	People & OD Assurance Committee Chair's Report (April 2025)	Enc	46	Committee Chair	For assurance
SHORT BREAK						
Strategic, Quality & Performance Matters						
1100hrs	075/25	Integrated Performance Report	Enc	48	Chief Executive	For noting
	076/25	Bi-annual Public Participation Report	Enc (Full report in Info Pack)	136	*Dir of Strategy & Partnerships	For noting
Regulatory & Statutory Reporting						
1115hrs	077/25	Infection Prevention & Control (IPC) Report Q3 2024/25	Enc	142	Interim Chief Nursing Officer	For noting

	078/25	Freedom to Speak Up (FTSU) Annual Report 2024/25 (incorporating Q4)	Enc	**146**	*Director of Governance	For noting
	079/25	Guardian of Safe Working Report Jan-March 2025	Enc	**156**	Executive Medical Director	For noting
Assurance Framework						
1130hrs	080/25	Integrated Maternity & Neonatal Report	Enc	**160**	Interim Chief Nursing Officer	For assurance
	081/25	Board Maternity and Neonatal Safety Champions Report	Enc	**169**	Executive Medical Director	For assurance
	082/25	Annual NHS Staff Survey Results	Enc	**171**	*Chief People Officer	For noting
	083/25	Board Assurance Framework Q4 2024/25	Enc	**186**	*Director of Governance	For assurance
	084/25	System Integrated Improvement Plan (SIIP) Report	Enc	**209**	Chief Executive	For assurance
Items for consent (approval recommended from Board Committees)						
1215hrs	085/25	Safeguarding Adults at Risk of Abuse Policy	Enc	**236**	Interim Chief Nursing Officer	For approval
	086/25	Patient Safety Incident Response Framework (PSIRF) Policy	Enc	**251**	Interim Chief Nursing Officer	For approval
	087/25	Budgetary Control Policy	Enc	**287**	Director of Finance	For approval
	088/25	QSAC Terms of Reference – annual review	Enc	**308**	*Director of Governance	For approval
Procedural Items						
1225hrs	089/25	Any other business – agreed by the Chair	Verbal	-	Chair in Common	For discussion
1230hrs	090/25	Date and time of next meeting: 0930hrs on **Thursday 10 July 2025**	Verbal	-	Chair in Common	Information
Close of meeting						

*Non-voting

ITEMS WITHIN THE BOARD INFORMATION PACK		
Reports / Appendices	**Lead**	**Page No.**
076/25 Bi-Annual Public Participation Report: Full Report	*Dir of Strategy & Ptnrshps	**2**
077/25 IPC Report: Appendices 1-5	Int Chief Nursing Officer	**44**
078/25 FTSU Annual Report: Appendix 1	*Director of Governance	**51**
079/25 Guardian of Safe Working Report: Appendices 1-6	Executive Medical Director	**56**
080/25 Integrated Maternity & Neonatal Report Appendices:	Int Chief Nursing Officer	
Appendix 1: Ockenden Report Action Plan		**63**
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Appendix 3: Summary Maternity & Neonatal Transformation Plan (MNTP) Ph2		**139**
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082/25 Annual NHS Staff Survey Results: Appendices 1-4	*Chief People Officer	**184**

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 8 May 2025

Agenda item		062/25		
Report Title		Staff Story - Galvanise Leadership Development Programme		
Executive Lead		Rhia Boyode, Chief People Officer		
Report Author		Emma Wilkins, Deputy Chief People Officer		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF 2, BAF3, BAF4
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		N/A		
Executive summary:		The story will be told by Liz who works for Shropshire Community Health NHS Trust (SCHT) as a School Nurse with the 0-19 Service for Telford & Wrekin. Liz participated on the Galvanise leadership programme, which is open to colleagues from Black, Asian and Ethnic Minority backgrounds. This programme forms part of our People Strategy and Leadership Development Framework. Other colleagues from SCHT have also joined the programme, as part of our ongoing partnership and collaboration. Over the last three years 37 participants have taken part in 'Galvanise'. To date, 46% of participants have gained a promotion with a further 30% actively seeking new roles. We have seen a positive impact on our NHS National Staff Survey Results and Workforce Race Equality Standard (WRES) data, with an increase of staff from ethnic groups who believe that the organisation provides equal opportunitiees for career progression and growth. In 2021 this was 41.71% and has increased over the last three years to 50.59% in 2024. This is higher than the national average of 49.07%.		
Recommendations for the Board:		The Board is asked to **note** this staff story		
Appendices:		N/A		

Board of Directors' Meeting
8 May 2025

Agenda item		063/25		
Report Title		Public Questions Format		
Executive Lead		Anna Milanec, Director of Governance		
Report Author		Anna Milanec, Director of Governance		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF 13
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		N/A		
Executive summary:		The Board is asked to note and support a change in the way that the Trust deals with questions from the public (and other stakeholders) through the Trust website and at Board meetings. Whilst enquiries have been previously restricted to only questions relating to items on board agendas, and were dealt with through direct, written responses, it is proposed that the parameters for questions be widened so that questions about anything relating to the powers and duties of the Trust be responded to. A 30 minute slot for public questions will be included on the agenda for Board meetings held in public. These changes reflect the NHS Constitution requirement that "The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services." The revised approach is set out in Appendix 1.		
Recommendations for the Board:		The Board is asked to note the contents of the report and to: • Support the new process and procedures outlined		
Appendices		Appendix 1 - website details for new format.		

1.0 Proposal

1.1 In line with other organisations, it is proposed that questions for the Board should be submitted prior to Board meetings, in the period between the papers being published on the Trust website and midday on the Tuesday before the meeting – with a view to the questions being answered at the start of the Board meeting on Thursday of that week.

1.2 Whilst using a timeline associated with Board meetings, it is proposed that questions do not just need to relate to items on the Board agenda, rather they can relate to any matter within the powers and duties of the Trust.

1.3 The questions will be collected, and distributed to the most appropriate executive for a response. This will be co-ordinated by the Director of Governance.

1.4 During the period between receiving the questions and preparing to respond, executives will be responsible for seeking out the information requested, as far as possible, so that a verbal response may be provided at the Board meeting later that week.

1.5 The Chair will allow for up to 30 minutes to address questions, which he will read out, and seek a verbal response from the executive delegated with the responsibility for a response. If time allows, after dealing with written questions, the Chair may at his discretion allow verbal questions to be asked at the Board meeting.

1.6 It is for the Chair to determine whether questions should be answered at that time, or whether an alternative route, such as FOI, would be suitable.

1.7 After the meeting, both the questions and the answers will be included in the minutes of the meeting.

Anna Milanec
Director of Governance
May 2025

APPENDIX 1

Public Questions
at The Shrewsbury and Telford Hospital NHS Trust Board meetings held in public

The Board of Directors usually hold their meetings in public, bi-monthly, on the second Thursday of the month. For 2025/26 this means in May, July, September, November, January and March.

The agenda and papers are published on the website 6 days ahead of the meeting and members of the public are invited to submit questions to the Board in line with the process set out below. Questions must show the name and address of the person submitting the question and, if submitted on behalf of an organisation, the organisation's address must also be stated.

Submitting Your Question:

- Questions can be submitted in writing or via email to sath.trustboardsecretary@nhs.net, to be received by midday on the Tuesday before the meeting on Thursday of that week, to guarantee the question being dealt with at the Board meeting.
- Questions can be submitted on any matter within the powers and duties of the Trust.
- If time allows after responding to written questions, the Chair may at his or her discretion permit verbal questions on the day.
- Normally, no more than one question may be asked by any person for each meeting, to allow the Board to respond to a fair cross-section of questions. At the Chair's discretion and if time allows, additional questions may be allowed from the same person.

At the Meeting:

- Public questions will be taken at the start of the meeting after the patient/staff story. Written questions will be taken first, followed by verbal questions, if these have been permitted by the Chair.
- There will be a maximum of 30 minutes on the agenda for the public questions.
- Questions and the answers to them will be included in the minutes of the meeting.
- Questions will be dealt with in the order in which they were received. We will seek to give an overview of the response to the question, but a more detailed response to questions will be provided as part of the minutes which will be made available on the Trust's website, and directly in writing to the person(s) who asked them following the meeting.
- Any questions received in writing after the Tuesday midday deadline will be responded to by writing to the person directly and will be read out at the subsequent meeting in public, along with the answer.
- Should the 30 minutes given for public questions not be sufficient to allow all submitted questions to be dealt with, then the Chair will read out the question but will indicate that a response will be provided in writing to the person who submitted the question. The question and the response to it will be recorded in the minutes of the meeting.
- If it is felt that a question is better dealt with as a Freedom of Information request, ie requests for large amounts of data or information, the question will be read out at the meeting and it will be confirmed that the request is being dealt with under the Freedom of Information Act with a response to be sent to the requestor within the statutory deadline.

- The Chair reserves the right to refuse to accept any question that is not within the powers and duties of the Trust; is defamatory, frivolous, offensive or vexatious; is deemed to be overtly political; is substantially the same as a question that has already been answered in the previous 6 months; or would require the wrongful disclosure of confidential or exempt information (as per the exemptions under the Freedom of Information Act 2000) - this includes matters relating to specific patients or members of staff.
- You may attend in person to listen to the feedback; the Chair will read out questions whether you are in attendance or not. It is not possible to join the meeting virtually.
- The Public Board Meeting is a meeting held in public and not a public meeting. As such, the public are not permitted to participate in the meeting, may not ask a supplementary question, and there will be no opportunity for discussion on public questions.

The Shrewsbury and Telford Hospital NHS Trust
Board of Directors' meeting in PUBLIC

Thursday 13 March 2025
Held in Shrewsbury Education & Conference Centre

MINUTES

Name	Title
MEMBERS	
Mr A Morgan	Chair in Common
Mrs T Boughey	Non-Executive Director
Mr R Dhaliwal	Non-Executive Director
Ms S Dunnett	Non-Executive Director
Ms R Edwards	Non-Executive Director
Ms P Gardner	Interim Chief Nursing Officer
Mr N Hobbs	Chief Operating Officer
Dr J Jones	Medical Director
Mr R Miner	Non-Executive Director
Ms W Nicholson	Non-Executive Director
IN ATTENDANCE	
Ms I Robotham	Assistant Chief Executive
Mr S Balderstone	Deputy Director of People (Operations) – *representing CPO*
Mr S Crowther	Associate Non-Executive Director
Mr N Lee	Director of Strategy & Partnerships
Ms A Milanec	Director of Governance
Ms B Barnes	Board Secretariat (Minute Taker)
GUEST ATTENDANCE	
Ms L Powell	STW Maternity & Neonatal Independent Senior Advocate *(Agenda Item 051/25)*
APOLOGIES	
Mrs R Boyode	Chief People Officer
Prof T Purt	Non-Executive Director / Vice Chair
Ms H Troalen	Director of Finance
Ms J Williams	Chief Executive

No.	ITEM	ACTION
PROCEDURAL ITEMS		
031/25	**Welcome and Apologies** The Chair in Common welcomed all those present, including observing colleagues and members of the public. Apologies were noted.	
032/25	**Patient Story** The Interim Chief Nursing Officer was pleased to welcome recently new parents to the meeting, with their baby, to share their unique story with the Board of the significant challenges they had overcome in their journey to parenthood. They particularly wished to recognise the amazing support they had received from Specialist Midwife, Claire. In Mum's words, "Claire has been incredible, and helped me through so much. She was, and still is, always at the end of the phone, night or day, even when she has been away on holiday!" Both parents were also keen to stress that Claire was, without any doubt, the reason the family were still together, as she had built their trust in what were very difficult circumstances, encouraging Mum to reach out for help. They now could not be a happier family unit. The Chair in Common, reflecting on such a heartwarming story, was pleased to note this important example of the many fantastic people employed in the Trust, who do not seek the limelight but provide such excellent support to our patients. On behalf of the Board, Mr Morgan therefore wished to publicly say a huge thank you to Claire for her amazing care and dedication. Finally, he thanked Mum and Dad for taking time out of their day to bring baby along to visit us and share their inspiring story. Mr Morgan and his fellow Board colleagues wished them all the very best on their continued journey as happy parents.	
033/25	**Quorum** The meeting was declared quorate.	
034/25	**Declarations of Conflicts of Interest** No conflicts of interest were declared that were not already included on the Register of Directors' Interests. The Board of Directors was reminded of the need to highlight any further interests which may arise during the meeting.	
035/25	**Minutes of the previous meeting**	

	The minutes of the meeting held on 16 January 2025 were accepted and approved by the Board of Directors as an accurate record.	
036/25	**Action Log** The Board of Directors reviewed the action log, and agreed the closure of Action No.4, noting that several improvements had been agreed to the current interim location of the Drs Mess at PRH, including addressing the Drs main concern around lack of privacy. Once the RAAC work at PRH was completed in 2026, the Drs Mess would move to its new permanent location but, in the meantime, the Board was assured that the Drs were very pleased with the interim solutions provided, and delighted with the longer term solution. There were no further actions listed for review.	
037/25	**Matters arising from the previous minutes** The Interim Chief Nursing Officer confirmed, in response to queries from Mrs Boughey at the previous meeting on the use of bank and external staff rather than substantive, that the activity in question had now ceased. The Chair in Common emphasised that the default use of substantive staff would be the direction of travel for the Trust in future. No further matters were raised which were not already covered on the agenda or action log.	
REPORTS FROM THE CHAIR IN COMMON AND CHIEF EXECUTIVE		
038/25	**Report from the Chair in Common** The Chair in Common provided the Board with the following verbal update: • Apologies from the Chief Executive: Ms Williams regretted that she was unable to join today's Board meeting as she had been called to London at short notice for a national meeting of Chairs / Chief Executives. • NHSE resignations and appointments: This week had seen the following NHSE resignations – Amanda Pritchard (CEO), Julian Kelly (CFO), Dame Emily Lawson (COO), Steve Russell (Chief Delivery Officer), and Sir Steven Powis (Medical Director), the latter of whom would leave in Summer 2025. New appointments had been announced of Sir Jim Mackey (CEO) and Penny Dash (Chair). • Recovery Support Programme (RSP) Meeting: SaTH and System colleagues had recently attended the latest RSP national meeting in London. NHSE noted some improvements in the Trust's A&E performance, and had also welcomed the ongoing work to bring SaTH and SCHT closer together. It had been a positive meeting overall, but with recognition that there was still a long way to go to achieve sustained improvement.	

	• Integrated Care Boards: ICBs nationally have been instructed to reduce their running costs by 50% by the end of December 2025. • ICB System Transformation Group: Mr Morgan recently attended his first meeting as Chair of this Group, and he saw early evidence that the Group has the required potential to become more transformational. There was a great deal of enthusiasm at the meeting about 'Place' and Neighbourhood teams. It had been positive to see representatives from the two Local Authorities at the meeting, although it was hoped that representatives from Primary Care would also join future meetings. • Staff Survey Results: Results of the 2024 staff survey had recently been published. Again, there is a lot of work to be done, although some areas have shown improvement. More details would follow at a future Board meeting. • 2025/26 Planning: the annual planning for 2025/26 was well underway and, Mr Morgan understood that it was more progressed this year than at this stage in the previous year. The System had been set a year-end deficit ceiling of c£84m, which must be achieved. • Board agendas: Mr Morgan plans to review the format and content of Board agendas, to ensure that the Board adopts a more forward-focused look. The Board of Directors noted the report.	
039/25	**Report from the Chief Executive** The Board of Directors received the report from the Assistant Chief Executive on behalf of Ms Williams. The report was taken as read, and Ms Robotham advised that there was nothing further to add at this time. The Board of Directors accepted and noted the report.	
REPORTS FROM ASSURANCE COMMITTEE CHAIRS		
040/25	**Audit & Risk Assurance Committee (ARAC) Report** The Board of Directors received the report from Mrs Boughey on behalf of the Committee Chair, Prof Purt. Taking the report as read, the Board's attention was particularly drawn to the following points: • The Committee was disappointed with the 'limited assurance' outcome of the Internal Audit – Waiting List Management, Patient Initiated Follow Up (PIFU). Whilst some good practice had been found, such as having appropriate policies in place,	

	and the reporting of KPIs through the Board IPR, the reliability of the data contained in the figures was determined not to be sufficiently robust, and findings showed that some patients should not have been on the list. Ms Edwards, as Chair of the Performance Assurance Committee (PAC), asked for the report to come to the Committee for further scrutiny and challenge. The Chief Operating Officer confirmed that he shared ARAC's concerns, and was happy to take this through PAC to confirm actions being taken to rectify the limited assurance outcome, and the timelines involved. Mr Hobbs also proposed a change to the draft internal audit plan for 2025/26, which was currently with the executive team for sign off, to ensure stronger assurance could be achieved on Waiting List Management. • Following clarification to the Committee of the terms of reference for a Technical/Digital Review of Medical Devices which had been undertaken by Internal Audit, it had been noted that the responsible executive was not clear due to the audit transversing several executive portfolios. It was subsequently confirmed that Ms Robotham would pick this up as the executive lead, and would advise ARAC what actions were being taken to address the 'moderate assurance' findings. • The Director of Governance clarified that the internal auditors had not yet been able to provide an interim/draft Head of Internal Audit Opinion, as several 2024/25 audits were still outstanding. Additionally, there had been an increase this year in the number of limited and moderate assurance ratings received to date, and several audit recommendations (including high risk recommendations) remained outstanding. The Committee had requested that these be considered and closed by the executive team as far as possible before 31 March 2025. In response to a request for assurance on this from the Chair in Common, executive colleagues confirmed that they were focused on doing so. The Board of Directors accepted and noted the report.	
041/25	**Quality & Safety Assurance Committee (QSAC) Report** The Board of Directors received the report from the Committee Chair, Ms Dunnett. The report was taken as read, and discussion focused on the following points: In response to a request from the Chair in Common for an update on the current situation regarding corridor care, the Chief Operating Officer advised that further improvement had been seen in 4hr, 12hr and ambulance handover metrics during February 2025, however there had still been a need to utilise corridor care on both sites. Whilst the instances were certainly less frequent than December	

	and January, there was more work to do to eradicate corridor care completely. Whilst fully acknowledging that the situation was clearly unacceptable, the Interim Chief Nursing Officer provided assurance that, when unavoidable, care was taking place in an internal corridor which was not a public thoroughfare, proper care and attention was provided to patients, there was appropriate segregation, and a nurse was always present. Ms Gardner added that, when unavoidably used for patient care, she visits the corridor every morning to assess the situation. This led to discussion regarding the impact from delayed discharges of patients with 'No Criteria to Reside' (NCTR). Mr Hobbs advised the Board of the latest situation from that morning, reporting that there were 117 patients across the two sites with NCTR. Out of a bed base of 750, this clearly represented a significant proportion, and continued to have an impact on the need for corridor care. Support from STW colleagues over the Winter period has been helpful but it was self-evident that the Trust still had a lot more to do in reducing the number of NCTR patients. The Chair in Common asked for more detail to be brought to a future meeting on the actions being taken to avoid corridor care, emphasising that this was a 'whole System' issue. It was agreed that a deep dive on this would be undertaken via PAC, with the output subsequently brought to Board. The Director of Strategy & Partnerships added that he and Mr Hobbs were already in discussion about the broader work ongoing to improve/develop the provision of services across the community, including appropriate use of GP practices and community services etc. Recognising the need for a defined balance of actions that could be taken in the short, medium and longer term, Mr Lee welcomed the opportunity to contribute to the deep dive discussions at PAC. The Board of Directors accepted and noted the report.	**PAC Chair / COO**
042/25	**Performance Assurance Committee (PAC) Report** The Board of Directors received the report from the Committee Chair, Ms Edwards. The report was taken as read, and discussion focused on the following points: Linking to the points covered in the QSAC report above, particular reference was made to the ICB-commissioned 12-hour ED length of stay review which had recently taken place. The review had found that, of the random sample of 50 patients reviewed, 62% did not need to come to A&E and that 50% of ambulance conveyances should not have been brought there, with suggestions as part of the review of where and how patients should have been treated.	

	The report was a collective view from all System partners, with external national input, and produced a positive and helpful set of recommendations which reinforced the importance of the basis on which the Hospitals Transformation Programme has been developed, and the need for appropriate and available alternatives to ED to ensure that care can be provided in the right place. Mr Morgan commented on the report demonstrating that our System model was not currently configured correctly. This was supported by Mr Hobbs, emphasising that there was an onus on the whole System to commission and provide easy alternatives to ED. Adding that, in broad terms, there was an acceptance at regional and national level of the need for change, Mr Hobbs advised that the ICS has convened a UEC System Group, and that greater integration forms part of 2025/26 planning. In response to a query from Ms Nicholson, Mr Hobbs clarified that representatives of both Healthwatch groups were on the System UEC Group, to provide an avenue to access the voice of our service users. The Board of Directors accepted and noted the report.	
043/25	**Finance Assurance Committee (FAC) Report** The Board of Directors received the report from the Committee Chair, Mr Miner. The report was taken as read and the following key themes were summarised: The Month 10 deficit stands at £22.7m, and is adverse to plan by £19.1m year to date. The deficit to plan was driven primarily by workforce costs and the shortfall of endoscopy income. The current year end best-case forecast outturn is a deficit (to the agreed deficit) of £23.3m, with a worst-case forecast deficit of £29.3m and a likely outturn of £28.8m. In coming to this figure, savings have already been identified, and work was ongoing to improve that position. That said, the Committee considered that transformational change was the real answer to materially impact on the current forecast deficit position. The pace of implementation of planned workforce changes continued to pose a particular challenge (and also opportunity), with the full run-rate benefits and opportunities necessary to impact from the start of 2025/26 in order to deliver the required performance for the year. The capital expenditure budget requires significant work in order for it to be achieved by the year-end, however plans are in place. With regard to workforce changes, Ms Edwards highlighted the need to ascertain the costs of staffing as well as focusing on headcount. Mr Miner confirmed that the Trust does have aggregate numbers, but agreed that further analysis would be helpful. The Board of Directors accepted and noted the report.	

044/25	**People & OD Assurance Committee (PODAC) Report** The Board of Directors received the report from the Committee Chair, Mrs Boughey. The report was taken as read, and the Board's attention was particularly drawn to the following points: Mrs Boughey was very encouraged to hear from discussions during the meeting that the Board was fully aware of the people agenda not just being about PODAC, with all colleagues around the table recognising their responsibility for the changes which need to be made. Referring to the review of services and whole-time equivalent (WTE) staffing levels which is underway, the Committee was clear that to cut front-line staffing was not necessarily the right approach to take. Ensuring financial sustainability whilst maintaining patient safety was a priority, and there was a need to focus on the reform agenda, which will involve a large scale culture programme and a change of mindset. The Board of Directors accepted and noted the report.	
STRATEGIC, QUALITY AND PERFORMANCE MATTERS		
045/25	**Integrated Performance Report (IPR)** The Board of Directors received the report from the Assistant Chief Executive, providing an update on progress against the Trust's Operating Plan, and associated objectives and enablers. The report provided an overview of the performance indicators to the end of December 2024/January 2025. Whilst several of the key issues had been covered in the previous Committee reports, the IPR provided a comprehensive summary of planned recovery actions, correlated impact, and timescales for improvement. Taking the report as read, Ms Robotham invited executive colleagues to provide the headlines from their sections. **Patient Safety, Clinical Effectiveness & Patient Experience Summary** • Infection Prevention and Control (IPC): Ms Gardner referred to the very difficult Winter period experienced by the Trust, with the extensive challenges of flu and two strains of norovirus. Our annual C.Difficile target was also breached and Ms Gardner has invited the Assistant Director of IPC in the Midlands Region to the Trust to review whether there are any further actions we could be taking. • Pressure ulcers and falls with harm: Numbers of both are of concern and processes are being extensively reviewed. The pressure ulcer review would also include a focus on how delays in ambulances and care in corridors might have an impact. In addition to the ongoing review and training to mitigate against patients experiencing falls with harm, a number of new	

measures are being introduced to help alleviate the risks, including introduction of a sleep charter, removal of caffeinated drinks and taking all appropriate steps to ensure patients do not unnecessarily get out of bed, to avoid postural hypotension.

- Ward management: Prof Brian Dolan, a recognised expert in ward leadership and management, has been commissioned to provide bespoke training for 50 ward managers to support their leadership and autonomy in the role. A complementary book, purchased through Continuous Professional Development (CPD) funding, will also be provided to each individual in support of their ongoing development.

- Focus on early phase of care - antibiotics for children: Dr Jones referred to the level of antibiotics provided to children within 60 minutes standing at only 40% despite ward audit compliance being high. This was under careful review and consideration was also being given to how any delays in administering antibiotics due to prolonged waits in ambulances could be included in the denominator.

Operational Summary

- Waiting times: Whilst further incremental improvement against UEC standards had already been touched upon in the meeting, Mr Hobbs began his operational summary with a degree of humility that, as always, too many patients are waiting too long for care.

- Elective recovery: The Trust continues to be monitored in Tier 1. There were no patients waiting over 104 weeks in January 2025, four 78-week breaches and 162 65-week breaches, however the total waiting list size reduced in January.

- Cancer performance: The Trust also continues to be monitored in Tier 1 for Cancer. The combined backlog at the end of January 2025 was 401 (an increase from 394 at the end of December).

- Diagnostics performance: The diagnostics recovery plan is progressing, with an improvement to 59% in February 2025 from 56% in January. The overall number of over 6-week breaches also decreased from 8376 in December to 7524 in January 2025. The backlog of all CT reporting was cleared by the end of January 2025, and the focus is now on the MRI backlog.

Workforce Summary

Workforce Plan: Numbers at month 10 showed a substantial increase, with the overall workforce position of 247 WTE over the revised planning levels, but Mr Balderstone expected that numbers would decrease by the end of March 2025.

Agency and temporary staffing: Bank usage increased throughout January 2025 which correlated with an increase in staff sickness

	absence and an increase in maternity leave. There was an increase in the migration of agency workers to bank from December to January which increased use but also supported the continuing reduction of nursing agency. Agency usage is now at the lowest levels seen in the last 12 months. **Finance Summary** There was nothing additional to report. The Board of Directors accepted and noted the Integrated Performance Report.	
046/25	**Trust Communication Strategy** The Board of Directors received the report from the Assistant Chief Executive, outlining the approach taken to develop the Trust's Communication Strategy for 2024-2029. Ms Robotham thanked Ms Fullard for the extensive engagement work undertaken by the Communications team with a diversity of stakeholders, and particularly recognised the work of the Patient Information Panel who have worked closely with the Communications team to refine the language and reduce the reading age of the document. The Board noted that in recognition of there being a range of audiences, who may need this strategy in different formats, an Easy Read version will also be produced, which will be shared with local networks to ensure it is accessible. The Communications team will also work to produce a version in British Sign Language. Ms Nicholson suggested also considering a Young People-friendly version, and inviting them to input to the language used, to make it as relevant and as easily accessible as possible to all those across our communities. She also observed that colleagues were not IPC compliant in some of the photos included in the document. Ms Fullard would discuss this with Ms Gardner, to ensure this was rectified. Finally, Ms Fullard emphasised that this document was a starting point, which would be reviewed regularly and developed over time. It was the intention, for example, to make greater use of digital resources going forward. The Board of Directors accepted and approved the Trust Communication Strategy for publication, subject to the suggestions for further refinement.	
REGULATORY AND STATUTORY REPORTING		
047/25	**Medical Examiner & Bereavement Service Report Q3 2024/25**	

	The Board of Directors received the report from the Medical Director, which was taken as read. Dr Jones wished to draw the Board's attention to the Trust now also being the host site of the Medical Examiner (ME) service for ST&W. Despite extensive preparations for the statutory system, the increase in demand to the ME service was heavily felt and the quality of ME referral and medical certificates of cause of death (MCCDs) being received by community clinicians created significant administrative burden on the service. Ensuring a balance between managing community referrals along with hospital deaths has continued to be a priority to ensure the impact on mortuary capacity is limited, and delays to the bereaved kept to a minimum where possible, and this is kept under constant review. Overall, however, Dr Jones feels that it is a service that continues to run well. The Board of Directors accepted and noted the report.	
048/25	**How we learn from deaths Report Q3 2024/25** The Board of Directors received the report from the Medical Director, which was taken as read. Dr Jones wished to refer the Board specifically to mortality in the Emergency Department (ED). He referenced a dataset published by NHS Digital that reports on various aspects of ED performance for 2023/24 including deaths that occurred in the ED as a percentage of the overall number of ED attendances. Based on crude mortality data, which does not consider other relevant variables such as acuity, the rate for SaTH was higher when compared to the CHKS (healthcare intelligence provider) Peer Group and the national figure. The dataset remains under review, with relevant stakeholder involvement, and work continues within the Trust to review harm related to long delays within the ED, in addition to improvement work continuing through the wider Urgent and Emergency Care (UEC) Transformation Programme. Dr Jones advised the Board that, whilst working on the assumption that there will be increased mortality in ED due to long waits, no particular themes have been found to date. A decision has recently been taken to conduct a further detailed review of mortality within the ED (to also include a defined period following 'discharge'), and the terms of reference, scope and anticipated timeframe for the review were currently being finalised. The findings would be reported to Board through QSAC.	

	The Board of Directors accepted and noted the report, and the Chair in Common thanked Dr Jones for a very helpful and informative report.	
049/25	**Report from the Guardian of Safe Working Hours (GoSW)** The Board of Directors received the report from the Medical Director on behalf of Dr Barrowclough, the Trust's Guardian of Safe Working Hours. The report was taken as read, and subsequent discussion covered the following key points: • Tier 2 Urology on call rota: Following persistent breaches in the rota limits for continuous hours on duty and numbers of hours of rest, Dr Jones was pleased to confirm that a job offer had been made following recent interviews. The resulting increase in establishment would allow the rota to be safely converted to a full shift system with resident long days and nights, addressing the safety concerns previously identified. • Drs Mess at PRH: Dr Jones thanked Ms Robotham for her engagement and resolution of the issues raised with the Drs Mess facilities. For accuracy, Ms Robotham highlighted a slight error in the final sentence of section 6.1 of the report, confirming that the Drs will remain displaced from their new permanent facility until the end of March 2026, ie less than the two years shown in the report. The Board of Directors accepted and noted the report.	
050/25	**Board Balance Statement** The Board of Directors received the report from the Director of Governance, presenting an updated draft Board Balance Statement for consideration. The Board of Directors accepted the report, and • **Approved** the content of the Board Balance Statement • **Agreed** to publication of the Board Balance Statement on the Trust's website during March 2025, and within the 2024/25 annual report.	
ASSURANCE FRAMEWORK		
051/25	**Integrated Maternity & Neonatal Report** The Board of Directors received the report from the Interim Chief Nursing Officer. Colleagues were referred to the detail contained within the report, which was taken as read, and the following key points were covered:	

	Ockenden Report action progress: All actions (apart from the seven actions currently de-scoped as they were not within the direct control of the Trust to deliver) were on track for their expected delivery dates. The summary action plan, as at 11 February 2025, was included as Appendix 1 in the Board Supplementary Information Pack. **Invited Neonatology Service Review (2023/24):** Steady progress continues to be made to deliver the recommendations from the invited review report. Assurance was provided to the Board that, with the exception of one action where it has been necessary to extend the completion date to May 2025, as detailed in section 3.3 of the report, all other actions were on track for their expected delivery dates. The summary Neonatal External Mortality Review (NEMR) action plan, as at 11 February 2025, was included as Appendix 2 in the Board Supplementary Information Pack. **Maternity and Neonatal Transformation Plan (MNTP) Phase 2 – high level progress report:** Colleagues were reminded that it was a requirement of the Independent Maternity Review for the Board of Directors to receive an update on the MNTP at each of its meetings in public session. The summary MNTP, which is now in its second phase, was included as Appendix 3 in the Board Supplementary Information Pack. The Board was assured that steady progress was being made on actions within the cultural improvement plans which were devised from feedback from the 2023 staff survey, cultural reviews commissioned by the Division and results from the latest SCORE survey (a validated assessment tool for safety culture). The 2024 staff survey results were embargoed at the time of producing this report, however a comprehensive action plan would be incorporated within Phase 2 of the MNTP following publication of the results, and would be reported in due course. All other actions were progressing well. **NHS Resolution's Maternity (and Perinatal) Incentive Scheme (Clinical Negligence Scheme for Trusts – CNST)**: Self-verification of the Year 6 Maternity Incentive Scheme confirmed achievement of all 10 safety actions in full. Year 7 of the scheme is due to be launched on 28 April 2025, and reporting would continue in line with the Year 6 technical guidance until the Year 7 guidance was received. The Board of Directors formally acknowledged that it had received and read all the reports detailed in section 5, and confirmed that: • (SA1) – it continues to receive quarterly Perinatal Mortality Review Team (PMRT) reports and Board reports, including details of deaths reviewed, any themes identified, and the consequent action plans. Included as **Appendix 4 and 5** in the Board Supplementary Information Pack.	

	• (SA9) – using the minimum data set, the Perinatal Quality Surveillance Model is fully embedded, and a review has been undertaken by the Trust Board. The locally agreed dashboard is included as **Appendix 6** in the Board Supplementary Information Pack. • (SA9) – there is evidence of progress with the Maternity and Neonatal Culture Improvement Plan and any identified support is being considered and implemented. The Perinatal Quad Leadership Team meet bi-monthly. Minutes are presented at **Appendix 7** in the Board Supplementary Information Pack, and support required by the Board has been identified and implemented. Progress with the Neonatal and Maternity Culture Improvement Plan is being monitored, and identified support is being considered and implemented. The Board of Directors, following comprehensive review of the Integrated Maternity & Neonatal Report and all associated CNST appendices, accepted and took assurance from the report. Finally, Ms Gardner was pleased to introduce Ms Liane Powell, STW Maternity and Neonatal Independent Senior Advocate (MNISA), to Board colleagues. Ms Powell had recently been appointed to this new role, which was being piloted by the NHS across England to support women and families, in response to the Ockenden review at SaTH. Ms Powell advised the Board that in addition to supporting women and families to feel heard and listened to, her role included ensuring their concerns were acted upon by their maternity and neonatal care providers when they have experienced an adverse outcome during their maternity and/or neonatal care, and to influence change both for individuals and at System level.	
052/25	**Patient Safety Incident Response Overview Report** The Board of Directors received the report from the Interim Chief Nursing Officer, to provide assurance in relation to the management of patient safety incidents through the PSIRF processes, and the outcomes for patients and families. Taking the report as read, Ms Gardner drew the Board's attention to Table 4 of the report, which summarised System issues highlighted by more than one learning response. She referred in particular to recommendations made to commence a clinical handover improvement project, and a discharge improvement group to understand the themes and issues around patient discharges, which Ms Gardner would co-Chair. In response to a query from Ms Dunnett, it was confirmed that the clinical handover project would be focusing on all elements of handover. Dr Jones added that the project would make it clearer	

	where some of the issues are, and would help to direct our other work. Ms Dunnett observed that, as handover issues come up time and time again, she felt a cultural and mindset change was also needed. Ms Edwards referred to the results handling issues, also included in Table 4, and noted the assumption that the incoming IT system would mitigate a number of the issues and risks. Mr Lee confirmed that the assumptions would undergo full testing and challenge as part of the digital development programme but cautioned that, due to limited digital funding, the system would need to be implemented in phases over a period of time. The Board of Directors accepted and noted the report.	
053/25	**Board Assurance Framework Q3 2024/25** The Board of Directors received the report from the Director of Governance, which was taken as read, and the following key points were noted: • **BAF risk 5** *(The Trust does not operate within its available resources, leading to financial instability and continued regulatory action)*: Discussion had taken place at the Finance Assurance Committee (FAC) on 28 January 2025 regarding whether the score of BAF risk 5 should increase to 25. It was agreed to retain the total current risk score at 20 for Quarter 3, but to review this again in February 2025, along with the risk detail. FAC had reviewed the risk again on 25 February, with no proposed change to the risk score, but with some update to the risk detail. It was agreed to review BAF risk 5 again for Quarter 4 at the March 2025 meeting. • The People & OD Assurance Committee (PODAC) considered and agreed, at its meeting on 3 February 2025, to increase the current total risk score of BAF risk 3 *(If the Trust does not ensure staff are appropriately skilled, supported and valued this will impact on our ability to recruit/retain staff and deliver the required quality of care)* from 12 to 16, as the likelihood of the risk had increased. • A change was proposed to the title of BAF risk 9, with the previous reference to Covid-19 recovery removed and reference to meeting the national elective and cancer care standards included. The updated proposed risk title is: *The Trust is unable to meet the required national elective and cancer care standards.* • It was proposed that a new gap in control, and associated actions, be added to BAF risk 6 *(buildings/infrastructure)* in relation to the aged nurse call system. • The three top scoring risks, with a current total risk score of 20 at Quarter 3, were BAF risks 5 *(as above)*, 7b *(digital*	

	implementations) and 10 *(national urgent and emergency standards).* The Board of Directors accepted the recommendations from the report and, following consideration of the content of the draft BAF and risk scores, **approved** the Quarter 3 BAF.	
054/25	**Risk Management Report Q3 2024/25** The Board of Directors received the report from the Director of Governance, which was taken as read. The following key points were noted: • The Board's attention was drawn to section 4 of the report, demonstrating how the controls and actions of extreme risks (scored>15) had either resulted in a reduced risk score or overall risk closure during Quarter 3. • Ms Milanec also highlighted section 5 of the report, detailing risk management next steps following the recent internal audit. The Board of Directors accepted the report, noting the current risk position, and the mitigation in place to ensure that risk management is practiced consistently across the Trust.	
055/25	**System NHS Accountability and Performance Framework** The Board of Directors received the report from the Director of Governance, which was taken as read. Ms Milanec clarified that this STW ICS Framework was in addition to, and separate from, the System Integrated Improvement Plan, which was covered under agenda item 056/25. The Board of Directors **noted** and strongly **supported** the principles behind the framework, but there was a concensus amongst colleagues that the document would benefit from being simplified.	
056/25	**System Integrated Improvement Plan (SIIP)** The Board of Directors received the report from the Assistant Chief Executive on behalf of Ms Williams, noting that delivery of the plan, which had been developed in conjunction with NHSE colleagues, was designed to transition both the System and SaTH from National Oversight Framework (NOF) segment 4 to segment 3 by March 2026. The report, which was taken as read, contained information and assurance on progress against SaTH elements of the SIIP and associated actions that were due up to and including 28 February 2025, for onward submission to the STW ICB.	

	Ms Robotham advised that there was more to do to make the plan 'live' in the organisation, to allow colleagues to understand the joint contribution of our collective System. Finally, Mrs Boughey wished it to be noted for the record that the PODAC 'Workforce and Leadership' SIIP report at page 258 of the Board pack was not the document which had been seen by the Committee on 3 February 2025. The Chair, with apologies, requested report authors to ensure such an error was not repeated in future reports. The Board of Directors **noted** and **accepted** the recommendations in the report.	
057/25	**Standing Financial Instructions (SFIs) – minor clarification following Board approval in January 2025** The Board of Directors received the report from the Director of Governance, providing clarification of an entry on Appendix A – Authorisation Limits, to the SFIs, relating to the delegation provided to the Director of HTP in the amount of £250k regarding 'Compensatory Events'. The Deputy Director of Finance (Strategic) has confirmed that the amount of £250k is the limit **per transaction**, together with all other criteria stated, ie this is not an annual limit. The Board of Directors **noted** and took assurance from the clarification provided.	
PROCEDURAL ITEMS		
058/25	**Any Other Business** There were no further items of business.	
059/25	**Date and Time of Next Meeting** The next meeting of the Board of Directors in public was scheduled for Thursday 8 May 2025 from 0930hrs–1230hrs.	
STAKEHOLDER ENGAGEMENT		
060/25	**Questions from the public** The Chair in Common reminded observing members of the public that questions are welcomed on any items covered in today's meeting, and these can currently be submitted via the 'Questions for the Board' page on the Trust's website. An amended Board questions process will be introduced from the first Board meeting in the new financial year (May). Details will be confirmed via the Trust's website, and at Board, when finalised.	
The meeting was declared closed.		

Board of Directors **Action Log - Public Meeting**

Log number	Date of meeting	Agenda item	Item	Action	Lead Officer	Deadline	Comment/ Feedback from Lead Officer	Action
2025								
8	13/03/2025	041/25	QSAC Report	The Chair in Common asked for more detail to be brought to a future meeting on the actions being taken to avoid corridor care, emphasising that this was a 'whole System' issue. It was agreed that a deep dive on this would be undertaken via PAC, with the output subsequently brought to Board.	FAC Chair / COO	08/05/2025	COO taking paper to PAC on 22/4/25 covering non-elective length of stay and avoiding corridor care. Output to be reported in PAC Chair's Report to May Board meeting. Confirmed as included in report 24/4/25, and therefore action recommended for closure.	Recommend to close

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
8 May 2025

Agenda item		070/25		
Report Title		Chief Executive's Report		
Executive Lead		Jo Williams, Chief Executive Officer		
Report Author		Jo Williams, Chief Executive Officer		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	-
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	-
Well Led	√	Our partners	√	
Consultation Communication		N/A		
Executive summary:		The end of the financial year is always an important opportunity for the organisation to reflect on what went well and to learn where we can do better. It is also a time to review our ambitions for the coming year. Our "Moving to Excellence" programme represents our commitment to being clear about the work required to deliver our vision. We are determined to provide excellent care to our patients and to make SaTH an outstanding place for our staff to thrive. The work undertaken during 2024/25 has resulted in tangible improvements, and we have made progress in several key areas. However, as Board members are aware, we are an ambitious organisation, and there is always more we can do to further enhance patient care and build a more sustainable future. We have a bold, clear and comprehensive plan in place to deliver the operational and financial objectives we have agreed for 2025/26.		
Recommendations for the Board:		The Board is asked to note the contents of this report and to take assurance where appropriate.		
Appendices		None		

1.0 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last Board meeting on 13 March 2025 from the Chief Executive's position; this includes an overall update, SaTH news and wider NHS updates.

2.0 OVERALL SaTH UPDATE

2.1 As we enter a new financial year, I would like to thank all our staff for their hard work and commitment during 2024/25, which included dealing with the range of operational and financial pressures through the challenging winter months. Despite the challenges, there is much to celebrate across the Trust, demonstrating our commitment to improvement.

2.2 We know that the 2025/26 financial year will continue to be a challenging year. We know that we need to keep up the momentum from recent months, continuing to build our credibility, reduce waiting times, improve operational performance and quality, and remain within our financial budget. In our Operational Plan we have agreed an underlying deficit of £45.1m and cost improvement plan (CIP) efficiencies of £41.4m for 2025/26.

In the 2024/25 financial year we delivered £34m of efficiency savings - nearly double that of 2023/24. We finalised the year in line with our revised trajectory of £18.6m deficit. Agency pay significantly reduced throughout the year with work ongoing to continue to reduce our bank expenditure.

The national expectation requires us to halve the growth in corporate services seen since 2018/19, by 50% during quarter 3 (2025/26). This will require difficult conversations and thoughtful planning. We will need to ensure that we understand the reasons for the growth, whilst maintaining patient safety and delivering the required reduction. Our Financial Recovery Group (FRG) has begun these discussions and will continue to work with our corporate teams to build a credible plan by May 2025.

Looking further ahead, we must plan to eliminate our deficit entirely. This means true transformation, understanding how we use our most important resource, our workforce. We know reform is needed, so that we have the right staff, with the right skills, in the right places to meet our patients' needs. Our recovery plan is achievable and our teams have already shown incredible determination. We want to harness ideas across the organisation to make meaningful, lasting changes. We will face this together, supporting individuals and creating a Trust that we can all be proud to work in.

2.3 We remain strongly focused on reducing long waiting times for patients. As of April 2025, the 65-week wait backlog has continued to decline, with full clearance on track for completion in Quarter One 2025.

Since September 2024:

- The number of patients waiting over 52 weeks has reduced from 4,000 to 1,500.
- The number of patients waiting over 65 weeks has decreased significantly from 1,000 to just 22.

In parallel, our overall waiting list has reduced from 50,000 to 42,000, reflecting our sustained efforts to improve patient access and service delivery. Further reductions are planned in the coming months as we maintain momentum against our recovery targets.

2.4 March and April 2025 have continued to be extremely busy months for our Urgent and Emergency Care (UEC) pathways, with patients experiencing long waits in our Emergency Departments (ED). Whilst we all recognise that this remains a very challenging period with ongoing pressures, our improvement work continues in critical areas. These include ambulance handover delays, 12-hour waits in the EDs, and fit-to-sit times. These areas remain a relentless focus for us and are being overseen through our UEC *Stronger Together* clinically led transformation programme, as well as our NHSE 2025/26 operational improvement plan.

2.5 I am delighted to share that Tracey Cotterill has joined the Trust for six months, supporting us with our financial recovery. Tracey joins us as Director of Financial Recovery and Transformation.

2.6 Following the recent supreme court ruling which defined a woman based on biological sex, we are awaiting national guidance about how we may need to adapt our services and guidance, whilst still ensuring that we provide respectful and inclusive care. We will continue to ensure that our care and employment is supportive and compassionate for our transgender staff and patients.

2.7 Ahead of the Easter break I was able to see first-hand the progress we are making on the new healthcare facilities at RSH. Along with colleagues from the Hospitals Transformation Team (HTP) and two of our volunteers I took part in a small 'topping out ceremony' which marks the achievement of reaching the highest point for one area of the new building. Thankfully the weather was kind, and we had an amazing view of the Shropshire Hills. It's fantastic to reach this significant milestone and to sign a concrete beam on behalf of the Trust.

2.8 Last week we launched "Moving to Excellence" which replaces our "Getting to Good" programme. The programme is to drive our vision to ensure we are striving to provide exceptional care for our patients and be a Trust where staff are proud to work. We are making good progress on our improvement journey, but we know we have more to do to get to where we want to be, and we know how we are going to get there. We have decided that the new financial year is a great time to refresh our ambition and direction of travel. We are aiming higher than good – we want to be excellent.

Our goals – where we want to be:

- Excellence in quality, safety and experience of care
- A centre of excellence for research, innovation and education
- A great place to work
- Clinically and environmentally sustainable
- In financial balance

Our journey – how we will get there:

- Driving quality
- Creating the right culture
- Transforming how we deliver services and digital capability
- Working in partnership
- Achieving university trust status
- Improving performance and restoring financial balance

More updates will be featured in our communications in the coming weeks, where we will be sharing stories about what our teams are doing, how colleagues can get involved and how we are making progress.

2.9 To mark the NHS Birthday, SaTH Charity are giving staff the opportunity to nominate a deserving colleague for a special SaTH Charity Daisy, to recognise individuals who have gone above and beyond. We are all so very busy, we sometimes struggle to take a moment to say a special thank you to a colleague, something we all appreciate.

Each daisy is gifted with your message of thanks to someone who has gone out of their way to be supportive or gone that extra mile. Colleagues nominated for a daisy, who have their location listed as PRH or RSH, will be able to collect them from their respective hospitals on Friday 4 July 2025. If your location is listed as anything other than PRH or RSH, the daisy will be posted to you. Nominations are open from Friday 9 May to Friday 13 June.

3.0 SHROPSHIRE TELFORD & WREKIN (STW) INTEGRATED CARE SYSTEM (ICS) UPDATES

3.1 The latest Integrated Care Board (ICB) Board meeting was held on Wednesday 30 April 2025. The papers can be accessed at NHS-STW-Integrated-Care-Board-Part-1-Agenda-Papers.pdf

3.2 The following meeting is due to be held on Wednesday 28 May 2025.

3.3 On Friday 16 May, the System is hosting a workshop which will bring together all partners to ensure that all our transformation plans, and ambitions, align to our System 5-year forward plan, the national direction and SaTH's Hospitals Transformation Plan (HTP).

4.0 NHSE

4.1 The next NHS Leadership event for ICB and Trust Chief Executives, with national and regional NHS England executives, is scheduled in London on 29 April 2025.

5.0 RECOMMENDATION(S)

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

Jo Williams

Chief Executive

30 April 2025

The Shrewsbury and Telford Hospital NHS Trust

Quality and Safety Assurance Committee, Key Issues Report		
Report Date: 25.03.2025		**Report of:** Quality & Safety Assurance Committee (QSAC)
Date of meeting: 25.03.2025		All NED and Executive Director members, and regular Trust Officer attendees, were present.
1	**Agenda**	The Committee considered the following: • UEC System Integrated Improvement Plan (SIIP) Key Issues Summary Report • Levelling up standards • Maternity & Neonatal Transformation Assurance Committee - items for escalation • Maternity Dashboard - items for escalation • Maternity Services CQIM MSDS Dashboard and AAA • HPSS retrospective review of smoking rates and SATOD • Community Midwifery Forward Plan • Infection Prevention Control (IPC) Assurance Committee Report Q3 • Quality Operational Committee – items for escalation • Quality Indicators Integrated Performance (IPR) Report • Medical Regulatory Group • Omitted dose – observation work • CQC Quarterly update • Patient and Carer Experience (PACE) • PALS, Complaints & Patient Experience Q3 • Safeguarding Assurance Committee Quarterly Report Q3 • Health & Safety mid-year progress update • Adult Safeguarding Policy • PSIRF Policy • QIA signed off as part of cost improvement programme update • QSAC 2025 Effectiveness Survey results • Terms of Reference plus delegated Committee for CNST approvals • Information and Close
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• QSAC received the Q3 report of Infection Prevention Control Assurance Committee. SaTH has breached the target number for Clostridium difficile infections for the year which required a 40% reduction. Actions continue to address areas for improvement. A visit from the NHS England regional lead is planned. Logistical plans are in train to facilitate deep cleaning at both Royal Shrewsbury Hospital and Princess Royal hospital sites. • The Trust had been the subject of one section 42 safeguarding investigation which was substantiated in relation to a pressure ulcer. There were deficiencies in recording care delivery. There was a discussion about how staff were supported to learn and act where there are areas for improvement in response to what happened in response to findings.

2b	**Assurance** *Positive assurances and highlights of note for the Board*	• In maternity, one to one care in labour was maintained at 100%, although there remains high unavailability. A positive acuity scores means that the midwifery staffing is adequate for the level of acuity of the women being cared for on the delivery suite: the maternity positive acuity in February was 94%, which is above the national target of 85%. The Trust remains on track to be compliant with all 10 action areas of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme. Actions taken in relation to early screening have seen an improvement in performance to over 50%, with work continuing to meet the 70% target. • The Safeguarding Assurance Committee Quarterly Report for Q3 report detailed an improvement in the training rates for safeguarding. Training rates for Mental Capacity Act and Deprivation of Liberty safeguards (DoLs) are improving at 85% with plans in place to support delivery of the target rate of 95%. Findings from audits have not found any impact on quality of the operation of DoLs. • QSAC received the Health and Safety Biannual Report covering the first three quarters of 24/25. The Trust has been visited by Environmental Health and is on track to retain rating of 5 for food safety. There have been two unplanned Health and Safety Executive visits: one in relation to the HTP work near the emergency department which resulted in minor verbal advice which has been acted upon. The second related to a contractor for the Hospitals Transformation Programme and there was no action for the Trust.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• There was no report received from Urgent and Emergency Care Transformation and Assurance Committee due to the time between meetings. However, QSAC did receive the System Integrated Improvement Plan which will be brought within UECTAC (Urgent and Emergency care Transformation Assurance Committee) governance. There is a planned presentation on Urgent and Emergency Care to the CQC next month. • QSAC heard that following a positive meeting with CQC where data on Children and Young People's (CYP) services was presented which demonstrated sustained improvement in relation to leaving without being seen and triage of CYP within 15 minutes. SaTH is preparing an application to vary the condition in place relating to follow up on CYP who leave without being seen. • The Trust are on track to respond to a Regulation 28 Report from the HM Coroner relating the administration of high-risk medication. We heard that there were processes in place for the safe administration. Further work is ongoing to ensure accurate recording of actions taken. • The PALS, Complaints & Patient Experience Report for Q3 set out that the Trust continues to be unable to meet targets for investigating complaints. There was agreement that the report would benefit from the addition of a section setting out the actions taken in response to feedback as we heard of several actions that had been taken.

		• The Medical Regulatory Group reported contacts from regulators. These included a visit by the environment agency to nuclear medicine provision at PRH resulted in recommendations to improve the safety of service. Many of the recommendations overlapped with those from IRMER visit in September 2024 and immediate actions are being addressed. QSAC will continue to monitor progress. The unplanned Human Fertilisation and Embryology Authority (HFEA) virtual visit triggered by a concern raised that the Trust was carrying out procedures outside of our licence found that the HFEA have no concerns that we are acting outside our licence. A further combined visit by the CQC and HFEA is planned in May 2025. • QSAC received and approved: ➢ the PSIRF policy and the adult safeguarding policy following minor amendments: ➢ a minor amendment to the Terms of Reference for the Quality Oversight Committee; and ➢ the Terms of Reference for QSAC.		
2d	**Actions** ***Significant*** *follow up actions*	• In response to the findings of the QSAC effectiveness survey actions were agreed to assist with the functioning of the committee: ➢ To ask maternity and neonatal to consider the timing of their meetings to prevent the late submission of papers. ➢ Refusal of late papers to ensure that papers and their authors are afforded sufficient attention. ➢ Review of support available for presenters/authors of papers to promote effective use of time at committee. ➢ Review of the papers coming to QSAC including opportunities to consolidate effort and papers to release capacity. This will also impact on QOC and require a review of their programme. ➢ Agreed the importance of including the impact of actions in reports to strengthen assurance provided in reports.		
3	**Report compiled by**	*Ms Sarah Dunnett* *Chair of Quality and Safety Assurance Committee*	**Minutes available from**	*Julie Wright* *Committee Support*

The Shrewsbury and Telford Hospital NHS Trust

Quality and Safety Assurance Committee, Key Issues Report		
Report Date: 02.05.2025		**Report of:** Quality & Safety Assurance Committee (QSAC)
Date of meeting: 29.04.2025		All NED and Executive Director members, and regular Trust Officer attendees, were present.
1	**Agenda**	The Committee considered the following: • Urgent and Emergency Care Transformation Assurance Group report • UEC System Integrated Improvement Plan (SIIP) Key Issues Summary Report • Getting to Good update • Quality Priorities - agreement for the forthcoming year • ED Report – Patient Experience (as per previous action log) • PEOLC Update Report (as per previous action log) • Maternity & Neonatal Transformation Assurance Committee - items for escalation • Maternity and Neonatal Safety Champions • Maternity Dashboard - items for escalation • MBRRACE Report • Decision to delivery in category 1 & 2 caesarean sections • Quality Operational Committee – items for escalation • Quality Indicators Integrated Performance (IPR) Report • Stroke Therapies and aftercare deep dive • TB business case - financial queries (replacing Antibiotic Stewardship Group overview – deferred to May) • Clinical Audit plan in-year progress update • Legal Report • Safeguarding Children and Young People Policy • BAF – Board Assurance Framework Q4 • Guidance for presenting to Committees • Approve QOC ToR amendments
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• QSAC received the Clinical Audit plan-in year-progress update. The Trust has not participated in two audits and has therefore been identified as an outlier because of a lack of capacity. Both audits relate to respiratory conditions: asthma and COPD. A meeting has taken place to identify actions and a similar approach to that taken in other areas where administrative support has been used to input data is planned. Eight audits were not compliant and will be reaudited.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• In maternity, one to one care in labour was maintained at 100%, although there remains high unavailability. A positive acuity scores means that the midwifery staffing is adequate for the level of acuity of the women being cared for on the delivery suite: the maternity positive acuity in March was 95%, which is above the national target of 85% and has been for the past six months.

		• UECTAC did not meet in February and the escalation report from the March meeting was not available. However, a comprehensive report on the quality oversight and patient experience was received which gathered information from a number of evidence sources, internal and external. There were a number of positive actions identified including a triage process for complaints relating to patients receiving end of life care were contacted as soon as possible. • The Quality Priorities for the coming year have been agreed. A more detailed plan including inputs and outcomes for patients is to be included in the quality account. • Following a deterioration in an indicator in response to a question "Was your relative comfortable" from the Trust Bereavement Survey in Q3 2024/25, an update report was received on Palliative and End of Life Care (PEOLC). The fluctuating score for "was your loved one comfortable" question was due to a fluctuating number of "don't knows" so in future both positive and negative scores will be reported to give a clearer picture. The report also set out the results from the most recent National Audit Care of the End of Life which showed that the Trust had improved across a number of areas including an improvement in symptom control in the last days of life. Improvements were also seen in the number of patients who had an end of life plan of care. Actions will be agreed where further improvements are needed.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• QSAC received a verbal update re the challenges facing the TB service. It has been identified that there is a lack of capacity to support TB screening and treatment. There is a national and regional increase in the number of infections, and the service is currently unable to meet all national standards for a TB service because of a lack of workforce. A business case to expand the service was submitted to the ICB who agreed with the proposals for increased workforce. The ICB requested that the non-pay costs in the business case were looked at again, which have been reviewed and the business case is due to be resubmitted. A copy will be shared with QSAC. Service issues will be monitored at QOC and escalated to QSAC as needed. • A verbal update on the System Integrated Improvement Plan was received. There is still to be agreement about the governance route for the report and this is to be agreed by executives. • The legal report highlighted that the Trust has responded to a Regulation 28 Report from the HM Coroner relating to the administration of high-risk medication. The Trust and NHS England response will be included in the next quarterly report. • The committee noted the updates to the Board Assurance Framework. For the risks overseen by QSAC (1,2,8,9,10 and 12). The committee agreed that the current ratings were appropriate and no changes to risk ratings were made. Risk 10 (Urgent and emergency care standards) remains at 20 and therefore one of the highest risks for the Trust. Some mitigating actions have been added to address identified gaps which were agreed.

		• The Stroke Therapies and aftercare deep dive was presented. There are challenges in recruiting to therapies with particular challenges in recruiting occupational therapists (OT) which is a national issue. In order to support OT provision, from June OTs will be working Monday to Friday on a temporary basis. Patients admitted with a stroke at the weekend will still receive a therapy assessment from other members of the therapy team. The impact of this service change on patients will be monitored and reported to QOC and escalated as needed. • MBRRACE-UK perinatal mortality report 2023 will be published in the summer. A report was presented which looked at the Trust specific data published in February 2025. There were indications of an improving trajectory in the Trust results although the Trust remains an outlier for neonatal deaths. MBRRACE have issued one recommendation which will be discussed in a related paper regarding neonatal deaths which will go through the Neonatal Governance Structure.		
2d	**Actions** ***Significant*** *follow up actions*	• In order to continue improving the effectiveness of QSAC a meeting is to be arranged with NEDs and the medical director and chief nurse to look at how the committee spends its time.		
3	**Report compiled by**	*Ms Sarah Dunnett* *Chair of Quality and Safety Assurance Committee*	**Minutes available from**	*Julie Wright* *Committee Support*

The Shrewsbury and Telford Hospital NHS Trust

Performance Assurance Committee, Key Issues Report		
Report Date: 24.03.2025		**Report of:** Performance Assurance Committee (PAC)
Date of meeting: 24.03.2025		Rosi Edwards (Chair), Sarah Dunnett, Rajindar Dhaliwal, Ned Hobbs, Inese Robotham, Simon Balderstone, Nigel Lee, Rebecca Gallimore, Lisa Mitchell
1	**Agenda**	The Committee considered the following: • Performance Highlights (Including SIIP) • Integrated Performance Report • Draft 25/26 Performance Trajectories (Operational Plan) • Workforce Plan and Performance Impact • Health & Inequalities Update • Data Warehouse Update – Verbal • Digital Programme Update
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• While PAC received positive assurance on the steady improvement in elective waiting time reductions (electives are on track to have zero over 65 weeks at the end of April 2025, excluding Corneal Transplants) it heard there is continuing risk in Urgent and Emergency Care and in access to cancer treatment. Regarding cancer treatment, there is a strengthening of leadership in the cancer service which is expected to lead to improvements in performance. • PAC heard of a potential risk to continued funding of some projects in Shropshire Telford and Wrekin ICB due to the requirement on the ICB to reduce costs by 50%. These projects include those associated with the Asthma and Epilepsy objectives in the National Core20PLUS5 Framework for Children and Young People, and funding for projects dealing with alcohol and tobacco dependency.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Equalities and prevention work: PAC heard of successful collaborative quality improvement work led by SaTH to increase the proportion of children and young people living in areas of high deprivation who are able to access supportive diabetic technologies. This has been highly commended by the Regional Health Inequalities Team. The work was showcased at the NHS England site visit held on Monday 13th January 2025. The project has resulted in more than 200 children starting insulin pump therapy, a reduction in waits from 18 months to 6 months and access to insulin pump technology for children in the lowest deciles of deprivation increasing by 40 percentage points (from 23% to 63.2%). • Data Warehouse Update: PAC heard that SaTH is on track to have this functioning from April 2025 to provide data for clinical and financial management for the 2025-2026 period and will be able to go through the 2024-2025 data in line with the standard stages of finance and activity submission.

2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• 2025-2026 Plan: PAC received a paper on the draft performance trajectories for 2025/2026, considered that the table setting out each national target, SaTH target and current SaTH performance was clear and realistic, and agreed that SaTH also needed to have robust metrics for diagnostics which, while they are not included in the NHSE national targets, are crucial to performance. The committee heard that the 18-week performance trajectory would be increased to 60% if the Trust was successful in securing additional Elective and Diagnostic capital. • Staffing: PAC heard that the measures taken in the final months of 2024-2025 should bring the overall staffing level to 7990. PAC was assured that the movement from agency towards substantive staff and bank staff was sustained and sustainable. For the future PAC wanted to see more information about the cost of staff and to have a bridge showing where staff had been taken on and why and what categories of staff had left. In particular PAC wanted to be clear for 2025-2026 where additional staff had been needed for escalation purposes and was informed that for this forthcoming year what constituted escalation was more clearly defined and had been agreed with the ICB. • Digital programme update: PAC heard that while SaTH has an ambitious programme funding is very scarce nationally. It is important to optimise the systems we have already. Staffing resource is very tight - 50% is committed to infrastructure maintenance and cyber security - so any new requirements need to be carefully prioritised. PAC was assured to hear of the close collaboration between the Digital team and the COO's team including the Deputy COO who is the Senior Ops Digital Lead. • System Integrated Improvement Plan (SIIP) report on Urgent and Emergency Care: PAC received this report as part of the Performance Highlights report and heard it will be brought within UECTAC (Urgent and Emergency care Transformation Assurance Committee) governance and that the action plan is due to be updated.		
2d	**Actions** ***Significant*** *follow up actions*	• PAC asked for a paper on Artificial Intelligence and what it might be able to do for SaTH within our financial constraints and what additional resources would be required to progress other areas of priority - some in-depth research is currently underway.		
3	**Report compiled by**	*Rosi Edwards, Chair, Non-Executive Director*	**Minutes available from**	*Lisa Mitchell Senior Governance Support Officer*

Performance Assurance Committee, Key Issues Report		
Report Date: 22 April 2025		**Report of:** Performance Assurance Committee
Date of meeting: 22 April 2025		Rosi Edwards (Chair) Sarah Dunnett, Ned Hobbs, Inese Robotham, Lisa Mitchell, Nigel Lee, Shona Baugh (Part)
1	**Agenda**	The Committee considered the following: • Performance Highlights • Integrated Performance Report • Non-Elective length of stay & avoiding corridor care • Internal Audit Report – Waiting List Management PIFU • Workforce Plan and Performance Impact • Green Plan • Data Warehouse Update • Board Assurance Framework Update
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• NHSE did not accept the STW plan for Urgent and Emergency Care, requiring STW to be more ambitious in its plans to improve performance on 4-hour and over 12-hour waits. This includes an expectation that the system will increase alternatives to ED and that SaTH will do more to improve flow (see Non-Elective Length of Stay, below.) • Lack of flow from ED and capacity constraints caused long waits and ambulance handover delays in March - when there was also a sharp rise in A&E attendance and ambulance conveyances. • Workforce: PAC noted that while the February position reported in the Workforce Report and IPR was a total of 8013 WTE compared with a planned number of 7670, it heard that the March figure would be a total of 7990. PAC noted the positive achievements regarding agency workforce, but wanted to know what were the enablers that would allow us to reduce headcount while maintaining performance and quality, and how we intended to reduce bank numbers.

2b	**Assurance**
	Positive assurances and highlights of note for the Board
		• Diagnostics: Recovery plan in place to achieve compliance by March 2025 for all modalities including endoscopy and physiological measurement against 85% system target.
		
		• Elective care is showing sustained improvement: from a position in August 2024 of 948 65ww and 49 78ww SaTH is down to down to 27 and 4 respectively at the end of March (unvalidated English position), and from over 50,000 patients on the waiting list in August 2024, to less than 42,000 now.
		
		• Particular initiatives in elective care:
		  • Cone Beam CT's- within Maxfac services patients that require a specialist cone beam CT are referred to Birmingham Dental Hospital for the scan.
		
		  The waiting time for these scans is significant. SaTH has purchased a Cone Beam CT to deliver these at PRH and will be commencing in April 2025 with scan reporting being completed externally.
		  • High volume "HIT" list carried out at PRH Elective Hub where 11 patients with hernias were treated in a day (GIRFT standard is 8).

		An evaluation of the resource and outcome is to be completed towards developing this as a standard way of working. • Same Day Hip surgery was completed in Orthopaedics- Theatres & Ward 5 successfully supported the first patient to have hip replacement surgery and to go home on the same day. This will be the first of many. • Green plan: SaTH has had a 5-year Green Plan since 2021 and has refreshed it following new guidance issued in February 2025. The NHS, and SaTH, are committed to reaching Carbon Net 0 by 2040, with suppliers reaching it by 2045. PAC heard about progress with travel and transport, energy and the estate, and noted the new dashboard from NHSE which shows SaTH's progress so far - a 23% reduction in carbon emissions between 2019/20 and 2023/24. The clinical waste strategy dates from 2023 and includes better waste segregation and classification resulting in a significant reduction in waste classified as "clinical waste" and associated disposal costs and environmental impact. PAC will receive 6 monthly reports on the plan.		
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• PAC received a report on Non-Elective Length of Stay and its impact on corridor care in ED. SaTH's average length of stay (LoS) for emergency admissions benchmarks in the top quartile (good), while its % of emergency admissions with a length of stay of 0-1 day is in the 3rd quartile (room for improvement). To have an impact on corridor care, a combination of measures by SaTH and STW are planned including raising the number of patients having same day emergency care by 5 percentage points and reducing complex LoS from a patient becoming medically fit for discharge to leaving the acute setting from 2.9 to 2 days as well as increasing SaTH inpatient bed numbers through the modular wards at RSH and through an additional 10 bed spaces at PRH, and by reducing numbers with No Criteria to Reside to 60 (current figure 94). • Data Warehouse Update: PAC heard that SaTH is still on track to get the DWH operational and to meet the timetable for submission of the 2024-2025 data, but the work is intensive, relies on a small number of key people both within the digital team and within SaTH. The project's status is now amber (from red) following testing by Finance. • Internal Audit report into Patient Initiated Follow-up: PAC received this report and will seek a follow-up report later in the year (aligned with the follow-up report to ARAC). PAC also wanted to understand more about the impact of PIFU on patient care. • Board Assurance Framework: PAC noted the updates to the BAF. Regarding risk 7B, Digital, PAC had had an update on progress with the Data Warehouse (see above), but did not think it appropriate to change the risk rating. PAC having also discussed elective and cancer care and UEC also did not think it appropriate to change the rating for risks 9 and 10 and was content to leave Estates, risk 6, unchanged.		
2d	**Actions *Significant*** *follow up actions*	• Inquiry into what might have caused the sharp rise in ED attendances in March - is this a one-off or are there underlying problems with the strategies to provide alternatives to ED? • Follow-up report on PIFU to cover progress with action plan and also how we know if the right patients are put on PIFU, and whether there are health inequalities arising from it, indicated by categories of patients not initiating contact.		
3	**Report compiled by**	Rosi Edwards (Chair) Non-Executive Director	**Minutes availablefrom**	*Lisa Mitchell*

Finance Assurance Committee, Key Issues Report		
Report Date: 25 March 2025		**Report of:** Finance Assurance Committee
Date of meeting: 25 March 2025		Richard Miner (Chair), Rosi Edwards, Simon Crowther, Paula Gardner, Adam Winstanley, Simon Balderstone, Lisa Mitchell, Sarah Dixon, Debbie Bryce (Part), Laura Graham (Part), Donna Hadley (Part), Matthew Phillips (Part) & Gordon Wood (Part)
1	**Agenda**	The Committee considered the following: • MEC Financial Recover Plan update • Financial Report M11 • STW ICS Financial Plan 2025/26 and MPFT Update • System Operating Plan • 2025/26 Operating Plan • Annual Budget • Workforce Plan and Financial Impact • Capital Planning Key Issue Report • Efficiency & Sustainability Key Issue Report • SaTH SIIP Transition Criteria Metrics – Finance Key Issue Report • CPG Terms of Reference • FAC Effectiveness Survey Results • Discussions on preparing Chair's annual committee report 2024/25
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• At deficit to date at Month 11 of £27.6m against a profiled deficit of £6.4m, a variance of £21.2m, the main drivers being workforce (including escalation) pressures which had been expected to reduce. • The expected outturn for the year is now a deficit of £18.6m as a consequence of a further £10.2m of escalation funding. • The previously noted data warehouse problems mean that we have not been able to accurately record activity. • There was significant debate about underlying workforce metrics given the pace at which changes are being (or can be) effected, the investments required in new posts as well as reorganization. • Current cash balances are £48.9m. This continues to be monitored carefully and with the additional escalation funding noted above, indicates the Trust may not require any cash support until Q3 of 25/26.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• MEC has worked in conjunction with PwC and others to transform its financial performance and is expecting to carry over improvements into 25/26. • The Committee noted the outcomes of the Board Meeting held immediately prior to the FAC meeting at which the 2025/26 and Operating Plan had been accepted albeit noting that ongoing work was still required. SaTH's plan is integral to achieving STW ICS's Financial Plan for 2025/26. • The CPG terms of reference were approved. • Substantial progress made against the Capital Plan. • Progress has been made against the SIIP Transition Plan but it will very much depend upon progress made on managing the Trusts financial performance.

2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• The Committee has asked for further analysis to be undertaken on the workforce plan, not only to "bridge" and allow a better understanding of workforce numbers but also costs as it is noted that some posts are financially supported and could change (for instance) as a consequence of insourcing/outsourcing decisions. • Due to the lateness of the System Operating Plan and some committee members not having had chance to read, a summary was provided and the potential for some "non-alignment" and uncertainty was noted with the Trusts own plan, particularly in relation to the long term financial model from the agreed HTP business case.		
2d	**Actions** ***Significant*** *follow up actions*	• The FAC Chair's committee report for the year will pick up the positive results for the Effectiveness Survey and also proposals for improvement. • The committee will be exploring changes to the Trust's financial reporting and whether some modified analysis can allow for enhanced decision making.		
3	**Report compiled by**	*Richard Miner (Chair)* *Non-Executive Director*	**Minutes available from**	*Lisa Mitchell* *Senior Governance Support Officer (Minute Taker)*

Finance Assurance Committee, Key Issues Report		
Report Date: 29 April 2025		**Report of:** Finance Assurance Committee
Date of meeting: 29 April 2025		R Miner, S Crowther, A Winstanley, P Gardner, S Balderstone (to item 64), D Bryce (item 67), S Edmonds, T Cotterill, L Mitchell
1	**Agenda**	The Committee considered the following: • Financial Report, M12 • 25/26 Annual Budget • Final 25/26 Operating Plan • Finance System Integrated Improvement Plan (SIIP) 4A Report • National Costs Collection Submission • Workforce Plan and Financial Impact • Efficiency & Sustainability Group Key Issue Report • Board Assurance Framework update • Draft Chair's Annual Committee Report
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Although cash balances were £61.8m at 31 March, the modular ward build will require substantial outlay and cash balances will need to be monitored closely. • The Committee noted the previous decision of the Board to await confirmation of capital support from NHSE before making a final decision but endorsed a recommendation from the finance team to proceed with the project as a capital investment given the pressure on budgets from the alternative lease approach if supported by the SaTH executive team. • The National Cost Collection Data submission highlighted both the limitations caused by the lack of activity data as well as some costs being above expected benchmarks. • The workforce plan and its cost implications for 2024/25 experienced delays in implementation with an emphasis on cost avoidance rather than transformational change and with which the workforce team is now much more "geared up" to deliver and monitor against specific workstreams for 2025/26. Despite much national publicity, the Committee noted these plans must be delivered with sensitivity. • The Committee agreed to maintain BAF Risk 5 (operating within available resources) at a score of 20. Mitigations and strengthening of assurances were noted and the score will be reviewed again at the end of Q1.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• The Trust achieved its forecast outturn for the year of an £18.6m deficit when taking into account the additional escalation support of £10.2m and noting the variations (mainly due to workforce costs) against budgets. • The Trust delivered its forecast capital spend of £69.2m. • The Committee agreed the Annual Committee Report for submission to the Board with particular emphasis on future direction and priorities of the Committee. • The Committee noted the Efficiency and Sustainability Group's 4As.

2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• Delivery of the workforce plan by headcount and costs for 2025/26, a RAG rated (separate) efficiency plan and run rates with an emphasis on “grip and control”. •		
2d	**Actions** ***Significant*** *follow up actions*	• The development of enhanced reporting to embellish the controls necessary. • Budgets as devolved out to budget holders.		
3	**Report compiled by**	*Richard Miner, Non-Executive Director (Chair)*	**Minutes available from**	*Lisa Mitchell, Senior Governance Support Officer*

People & OD Assurance Committee (PODAC) Key Issues Report		
Report Date: 16 April 2025		**Report of:** People & OD Assurance Committee – 07 April 2025
Date of meeting: 07 April 2025		PODAC members present at the 07 April 2025 meeting were: Chief People Officer, Director of Strategy & Partnerships and three Non-Executive Directors. T Purt, Non-Executive Director/Vice Chair chaired the meeting in the absence of T Boughey. The Chief Nursing Officer attended the meeting for the safe staffing position update and the Nursing, Midwifery and AHP & Facilities Steering Group Key Issues Report. The Chief Executive Officer was present for the whole of the meeting.
1	**Agenda**	The Committee considered the following for assurance: • Safe staffing position for registered and non-registered nursing and midwives, reflecting on CNST – Monthly Staffing Report (December data). • Nursing, Midwifery and AHP & Facilities Steering Group 4 A's Reports – January and February 2025. • People & OD Assurance Report, including Culture. • Risk Report – People Risks. • MIAA Audit Recommendations - Action Log (Bank and Agency Review 23-24). • Workforce & Leadership System Integrated Improvement Plan (SIIP) Key Issues Report. • Assurance Committee Items (for PAC / FAC/ ARAC). • Annual Staff Survey Results. • Financial Recovery – Planning 25/26. • Employee Wellbeing and Attendance Management Policy. • Annual Committee Effectiveness Survey Results – PODAC.
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• The safe staffing position report requires further improvement as levels of harm are not correlating with staffing levels. The Chief Nursing Officer agreed to take this forward and also consider the timeliness of the data within the report. • Ward 27 is of concern in relation to bank/agency usage. • The workforce position at quarter 4 is over plan and a reduction is expected. The revised outturn position is now 7990 whole-time equivalent (WTE) for 2024/25 instead of the 7513 WTE target. • Within the workforce dashboard, sickness absence is at 5.5% and above target by 1.05%. Sickness attributed to mental health continues to be the top reason for sickness. • A breakdown of the numbers was requested where staff WTE had increased following the Covid-19 pandemic. • There remains one open extreme people risk in relation to Clinical Support Worker job banding, which carries a significant financial risk. • There are two amber actions within the Workforce & Leadership System Integrated Improvement Plan (SIIP) action plan. Submissions have been made but NHSE approval is awaited.

2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Tight control across agency expenditure continues and bank usage has reduced. • Of the five MIAA Bank and Agency Review internal audit actions, three are closed and evidence has been submitted for the remaining two actions with a recommendation to close these (awaiting confirmation from MIAA). • The 2024 Staff Survey results show that five People Promises/Themes have improved, two have decreased and two have remained the same. • The Committee approved the Employee Wellbeing and Attendance Management Policy which is a policy delegated to PODAC from the Board.		
2c	**Advise** *Areas that continue to be reported on and /or where some assurance has been noted/ further assurance sought.*	• There was a discussion on clinical pathways and aligning the clinical plans/model and recruitment requirements. An HTP clinical workshop model is planned for early July. • Further assurance should be sought on certain areas such as Women's and Children's and HTP as there are some themes arising across different board committees.		
2d	**Actions *Significant*** *follow up actions*	• It was agreed that the financial recovery slides shared at the meeting had been helpful and would be shared with all Non-Executive Directors. • The Chief Nursing Officer to take forward improvement to the safe staffing report. • The PODAC Annual Committee Effectiveness Survey Results were accepted but it was agreed that there would be discussion on this at the next meeting when the regular PODAC Chair is present.		
3	**Report compiled by**	*D Bryce, Head of Corporate Governance and Compliance and T Purt, Non-Executive Director.*	**Minutes available from**	*Julie Wright Executive Support Team Leader*

Board of Directors' Meeting: 8th May 2025

Agenda item		075/25		
Report Title		Integrated Performance Report		
Executive Lead		Jo Williams, Chief Executive Officer		
Report Author		Inese Robotham, Assistant Chief Executive		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF 1, 2, 3, 4, 5, 8, 9, 10, 11, 12
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	All risks
Well Led	√	Our partners	√	
Consultation Communication		Quality Operational Committee 2025.04.15 Performance Assurance Committee 2025.04.22 Quality & Safety Assurance Committee 2025.04.29 Finance Assurance Committee 2025.04.29 Senior Leadership Committee 2025.05.01		
Executive summary:		The report provides an update on progress against the Trust's Operating plan and associated objectives and enablers. The Board's attention is drawn to the sections of Quality, Patient Safety and Clinical Effectiveness, Responsiveness and Well Led, which incorporates both Workforce and Finance. The report provides an overview of the performance indicators to the end of February/March 2025, summarises planned recovery actions, correlated impact, and timescales for improvement.		
Recommendations for the Board:		The Board is asked to **note** the contents of the report.		
Appendices:		Appendix 1: Integrated Performance Report		

The Shrewsbury and Telford Hospital NHS Trust

Integrated Performance Report

Board of Directors Meeting 8 May 2025

Presenting Month 12 performance data

Contents

Operational Plan 2024/25 Objectives

The Shrewsbury and Telford Hospital NHS Trust

Enablers	Month 12 Status Summary	Current Status	Assurance Committee
1: Deliver our Quality Priorities and the next phase of our Getting to Good Programme	The energise project has been extended with funding from ICB until January 8th, after which a report will be submitted from energise with recommendations and outcomes. The ICB were asked at QSAC to confirm funding we are still waiting for a response . This will be shared through Falls steering. Quality Strategy continues to be refreshed and aligning with the Patient Safety Strategy and Patient Experience Strategy. Learning Disabilities and Autism post the successful candidate has withdrawn accepting the role and options on delivering this work are now underway way.	A	QSAC
2: Deliver Elective Services and implement Enhanced Recovery	There were 0 104-week breaches in March, 4 x 78w breaches and 26 x 65w breaches (challenges mainly in ENT, gynae, MaxFax). Progress noted on long waiting position English only: 948 x 65ww in August down to 26 at the end of March showing special cause improvement. A 62% reduction in 52-week waiters has been delivered since the peak in Aug 24 to March, with increased pace of monthly reductions since Dec 24. Overall DM01 has increased from 56.2% in January to 78.2% in March. Daily and weekly performance monitoring meetings are in place. Theatre Utilisation in March was 78%, new theatre timetable increasing elective capacity, externally supported outpatient booking utilisation improvement programme has commenced and the Planned Care Improvement Programme has commenced.	R	PAC
3: Maintain FDS and achieve 62-day referral to treatment standard	Our validated FDS performance in February was 65.1% against a plan of 72.9%. Our 31 day performance in February was 93.8% and continues to show common cause variation. 62 day performance in February was 54.7% against a plan of 61.3%. We remain in Tier 1 due to underperformance on all cancer standards. Additional senior leadership expertise has been introduced and are developing refreshed improvement approach focussed on: operational effectiveness, diagnostic transformation and clinical pathway redesign. Additional capacity has been sourced in the immediate term to optimise performance.	A	PAC

Operational Plan 2024/25 Objectives – cont.

The Shrewsbury and Telford Hospital NHS Trust

Enablers	Month 12 Status Summary	Current Status	Assurance Committee
4: Improve UEC performance in line with GIRFT recommendations	Month 12 4-hour Emergency Access Standard performance is 53.2% against a forecast plan of 70%, demonstrating common cause variation. 18.9% of patients spent more than 12hrs in ED reflecting the very extensive pressure on the UEC pathway. Ambulance handover delays remain significantly challenged with 33% of handovers in excess of 60 minutes. 3268 patients arrived via ambulance in month 12, the highest in the last 12 months, and a 19.4% increase compared to month 11. There continues to be sustained special cause improvement in Time to initial assessment for all patients in ED.	R	PAC
5: Use of Resources – operate within our budget through delivery of efficient and productivity measures	The year end deficit for FY24/25 is £18.6m against a planned breakeven position. This is after receiving funding from NHSE for the FY24/25 planned deficit of £44.3m full year. This deficit to plan is predominantly driven by temporary staffing premiums (£8.5m), endoscopy income (£4.0m), unfunded pay award (£3.6m) and additional resident doctors (£1.0m). Recruiting substantively to reduce the reliance on high-cost agency remains priority along with reviewing the headcount across the Trust alongside further actions to reduce the reliance on escalation capacity. Financial controls have been put in place and are under continuous review.	A	FAC

Operational Plan 2024/25 Enablers

The Shrewsbury and Telford Hospital NHS Trust

Enablers	Month 12 Status Summary	Current Status	Assurance Committee
1: Live the People Promise in our teams through valuing difference and inclusivity	Since 2021 we have utilised the cultural dashboard to measure our culture improvement which is aligned to the NHS Staff Survey. We have seen year on year improvements with our interventions, flagship programmes, numerous local cultural reviews and transformation programmes. As the landscape across the NHS develops and the clear ambitions for the NHS are set out in the Long-Term plan, 2025 will see us recommitting our shared purpose across the Trust in respect of the culture vision, to strengthen our governance, clinical engagement and system level integration. We know to truly live by the People Promise we will deliver and sustain the culture we aspire to for our people and our communities.	A	PODAC
2: Deliver our Workforce plan, including agency cost reduction based on the principles of Train, Retain and Reform	At month 12 the total workforce out-turn is 7973 WTE which although is over planned levels (set at the start of the year) is under our estimated outturn by 17 WTE (set in January) and outlined in our operational plan. Our substantive workforce was 42 WTE over plan, agency came in at our lowest level seen in the year at 109, however our bank workforce remains high which was 353 WTE above planned levels. The medical workforce efficiency programme is a key enabler for 25/26 in terms of reducing temporary staffing costs through improving recruitment performance in our fragile and challenged specialties	A	PODAC
3: Develop an estates plan to optimise our current estate and continue to progress our Hospital Transformation Programme	RAAC removal project has commenced at PRH; temporary servery became operational in April 2025 to enable works in kitchen and restaurant area. Privacy and security improvements made to temporary Drs' Mess in Education Centre. Planning permission obtained for the housing of the new generators and enablement works are in train. LINAC progressing to plan with completion date of June 2025. Preferred option approved for completion of the Modular build. Close working on a daily basis between Estates and Hospital Transformation Programme (HTP) team.	A	PAC

Operational Plan 2024/25 Enablers – cont.

The Shrewsbury and Telford Hospital NHS Trust

Enablers	Month 12 Status Summary	Current Status	Assurance Committee
4: Develop and implement sustainable travel plan to improve patient and staff experience	Working with ICS Partners Shropshire Council and Telford & Wrekin Council - for example a new on demand bus service is commencing in May for members of the public Ironbridge/Madeley to PRH as currently no provision. The Trust has a Sustainable Travel Planner in post where he works with all bus companies and other transport providers to monitor and improve the services. The Trust Green Travel Plan and HTP appendix both have action plans these are currently not fully costed and we have funding requirements to deliver some of these actions.	A	PAC
5: Electronic Patient Record (EPR) - complete Phase 1 (implement and embed Careflow PAS and ED) and commence Phase 2.	The extensive digital programme for 2024/25 continues, including the migration from Windows 10 to Windows 11 which is well underway. There are significant demands on the digital, operational, and clinical teams and continued dialogue and prioritisation continues. National submission reporting remains a closely monitored area, the Trust's Data Warehouse redevelopment project continues, supported by national and regional digital/technical expertise. Significant work is being done now to prepare a costed and prioritised digital programme for 2025/26.	G	FAC/PAC/ QSAC

Operational Plan 2024/25 Objectives

The Shrewsbury and Telford Hospital NHS Trust

Trust Objective	Delivery Metric		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Performance	Assurance
Objective 2: Deliver Elective Services and Implement Enhanced Recovery	Achieve zero 65 week waits by the end of September 2024	Plan	537	465	344	189	53	0	0	0	0	0	0	0		
		Actual	709	824	1185	1025	948	508	327	350	204	166	84	26		
	Achieve 85% theatre capacity by end Q3 2024/25	Plan	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%		
		Actual	78.0%	79.0%	79.0%	78.0%	78.0%	77.0%	78.0%	80.0%	79.0%	80.0%	79.0%	78.0%		
	Achieve 85% daycase by end Q3 2024/25 (BADS)	Plan	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%		
		Actual	84.2%	83.2%	87.5%	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available		
	Achieve PIFU performance to maximise productivity in outpatients	Plan	4.7%	5.4%	6.1%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%		
		Actual	4.1%	4.8%	5.8%	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available		
	Outpatients with procedure - ERF - English only	Plan	6844	7755	7455	7279	7437	7332	7548	7546	5903	7700	7345	7662		
		Actual	7192	7603	2030	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available		
	90% of patients waiting over 12 weeks are validated every 12 weeks	Plan	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%		
		Actual	0%	62.3%	49.3%	37.4%	38.5%	54.4%	62.1%	63.0%	59.0%	61.3%	62.8%	61.7%		
	Diagnostics within 6 week waits (95% by March 2025) *	Plan	76.0%	74.1%	74.8%	76.0%	77.2%	78.9%	80.0%	82.2%	83.2%	84.2%	85.3%	86.3%		
		Actual	70.6%	68.7%	63.1%	61.6%	60.2%	60.8%	60.3%	58.9%	54.7%	58.0%	72.5%	79.1%		
Objective 3: Maintain FDS and achieve 62 day referral to treatment standard	FDS % (77% by March 2025)	Plan	75.1%	73.9%	75.0%	74.7%	75.7%	76.9%	76.7%	76.7%	77.1%	76.8%	77.5%	77.5%		
		Actual	73.6%	68.6%	67.0%	70.5%	67.6%	67.6%	70.4%	69.2%	66.7%	57.5%	65.1%			
	62 Day % (70% by March 2025)	Plan	59.5%	58.6%	58.4%	74.7%	60.2%	60.1%	65.0%	64.2%	65.4%	66.3%	68.1%	70.3%		
		Actual	59.5%	62.3%	56.9%	53.1%	53.3%	51.2%	55.4%	64.0%	63.3%	52.9%	54.7%			

* Diagnostics operational plan - all commissioners - excludes neurophysiology, sleep studies, urodynamics and cystoscopy

Operational Plan 2024/25 Objectives

The Shrewsbury and Telford Hospital NHS Trust

Trust Objective	Delivery Metric		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Performance	Assurance
Objective 4: Improve UEC performance in line with GIRFT recommendations	4 hours (78% by March 2025) Type 1, 2 & 3	Plan	55.0%	56.4%	57.7%	59.1%	60.5%	61.8%	63.2%	64.6%	65.9%	67.3%	68.6%	70.0%		
		Actual	50.0%	48.6%	52.2%	54.8%	55.9%	52.4%	52.4%	50.9%	50.4%	52.4%	52.7%	53.1%		
	Cat 2 Amb response times (AVG=30min) STW ICB	Plan	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00		
		Actual	00:38:17	00:39:20	00:34:30	00:28:04	00:24:07	00:34:43	00:40:20	00:49:21	01:01:01	00:33:42	00:31:04	00:37:17		
	Achieve 33% of discharges before midday	Plan	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%		
		Actual	20.1%	20.5%	20.7%	20.6%	21.9%	23.1%	21.7%	21.6%	21.5%	20.1%	21.0%	21.0%		
	Reduce LOS (<12h) in ED	Plan	0	0	0	0	0	0	0	0	0	0	0	0		
		Actual	2588	2679	2308	2103	2060	2394	2494	2644	2741	2361	2146	2644		
	Minors 4 hour performance	Plan	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%		
		Actual	85.2%	86.3%	90.2%	91.8%	93.6%	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available		
	UTC 4 hour performance	Plan	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%		
		Actual	71.9%	82.3%	90.2%	93.4%	93.7%	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available		
	CYP 4 hour performance	Plan	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%		
		Actual	74.2%	75.9%	81.5%	84.0%	87.2%	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available		
Objective 5: Use of Resources - operate within our budget through delivery of efficiency and productivity measures	Balanced £ position cumulative	Plan	(6,844)	(12,871)	(19,589)	(25,116)	(30,240)	0	0	0	(917)	(3,550)	(6,385)	0		
		Actual	(7,209)	(12,930)	(21,030)	(28,705)	(34,229)	(5,621)	(10,864)	(13,242)	(17,179)	(22,661)	(27,570)	(18,563)		
	Agency Expenditure (max 3.2% of pay bill) **	Plan	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%		
		Actual	6.41%	5.16%	5.28%	5.27%	4.57%	4.16%	3.71%	4.14%	3.63%	3.13%	2.58%	1.27%		
	In month efficiency delivery	Plan	794	1,069	1,731	2,710	2,776	2,636	3,832	3,498	4,291	4,544	4,780	12,046		
		Actual	850	869	1,915	2,125	2,367	2,799	3,390	3,585	2,833	3,654	4,287	5,659		

** National Target 3.2%, STW Target 6.4%

Executive Summary

The Shrewsbury and Telford Hospital NHS Trust

The performance against the 4-hour UEC standard in March 2025 showed a slight improvement compared to February 2025 (53.1% v 52.7%); however, there was an increase in the monthly number of 12-hour trolley breaches (1390 in March 2025 v 1130 in February 2025). The percentage of patients seen within 15 minutes for initial assessment decreased from 61.2% in February 2025 to 57.4% in March 2025.

During month six the Trust received additional funding to cover the planned deficit resetting the annual plan to breakeven and phasing the additional income to also reset the year-to-date position to breakeven. At the end of month twelve the Trust is reporting a deficit of £18.6m against the restated breakeven plan. The drivers of the variance remain largely consistent: temporary staffing premiums (£8.5m), endoscopy income (£4.0m) and non pay (£1.5m), the cost pressure resulting from the pay award increased in line with previous months (£3.6m year to date) and resident doctors at £1.0m. The previously reported variance associated with escalation costs has been eliminated following receipt of the surge funding support. The trust has an efficiency target of £44.7m (7.6%) in 2024/25. At the end of month twelve, £34.3m has been delivered with shortfalls against the planned reduction of escalation capacity and income related schemes which currently cannot be validated. The Trust has set an operational capital programme of £16.8m and externally funded schemes of £52.5m in FY24/25, giving a total capital programme of £69.2m which was expended at month twelve, achieving a balanced year end position. The Trust held a cash balance at end of March 2025 of £61.8m.

The Trust is being monitored in Tier one for Elective delivery. There Trust reported 4 x 78-week breaches at the end of March 2025 and 28 x 65-week breaches. The Trust remains committed to clearing all 65 weeks waits by the end of April 2025. The total waiting list size continues to reduce . Additional capacity is being provided by ISP providers for ENT, maxillofacial, gynaecology, endoscopy and general surgery.

The Trust is being monitored in Tier 1 for Cancer. The combined backlog as at the end of March 2025 was 367 (a decrease from 430 at the end of February). The validated February position for FDS was 65.1% (previous month was 57.5% and against a national target of 75%), 31-day standard was 93.7% (previous month was 88.5% against a national target of 96%) and 62-day standard was 54.7% (previous month was 52.9% against a national target of 85%). Predicted performance for March is expected to be 63% for FDS, 93% for 31-day and 66% for 62-day.

The validated overall DM01 position for March was 78.2%, a further improvement from 71.7% in January and the number of over 6-week breaches reduced by 1239 (3437 in March 2025 v 4676 in February 2025). The backlog of all CT reporting was cleared by end of January 2025. Training posts and sickness in NOUS continue to restrict capacity, with reduced resilience during periods of sickness or annual leave.

Quality Patient Safety, Clinical Effectiveness and Patient Experience

Executive Leads :

Interim Chief Nursing Officer
Paula Gardner

Medical Director
John Jones

Integrated Performance Report

The Shrewsbury and Telford Hospital NHS Trust

Domain	Description	Regularity	National Standard 24/25	Current Month Trajectory (RAG)	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Trend
Patient Safety & Effectiveness	Pressure Ulcers - Category 2		20% < 2023-24	16	15	22	20	17	21	19	21	18	24	32	28	36	15	
	Pressure Ulcers - Category 2 per 1000 Bed Days		20% < 2023-24	0.60	0.59	0.83	0.80	0.62	0.83	0.76	0.84	0.75	0.99	1.25	1.12	1.36	0.62	
	Pressure Ulcers - Category 3		10% < 2023-24	4	5	14	9	9	8	5	5	2	6	4	7	7	8	
	Pressure Ulcers - Category 3 per 1000 Bed Days		10% < 2023-24	0.15	0.20	0.53	0.36	0.33	0.32	0.20	0.20	0.08	0.25	0.16	0.28	0.26	0.33	
	Pressure Ulcers - Category 4		0	0	0	0	0	0	0	0	0	1	0	2	0	0	0	
	Falls - per 1000 Bed Days		5% < 2023-24	3.59	4.35	4.56	5.01	4.65	4.72	4.32	4.38	4.37	4.64	4.05	4.74	4.26	3.96	
	Falls - total		-	96	111	121	125	127	120	110	109	105	117	104	118	113	102	
	Falls - with Harm per 1000 Bed Days		5% < 2023-24	0.14	0.08	0.23	0.08	0.15	0.24	0.24	0.16	0.25	0.16	0.08	0.20	0.23	0.08	
	Falls - Resulting in Harm Moderate or Severe		0	0	2	6	2	4	6	6	4	6	4	2	5	6	2	
Patient Experience	Complaints		-	-	73	70	77	76	80	86	79	84	77	65	66	77	77	
	Complaints - responded within agreed timeframe - based on month response due		85%	85%	45.0%	44.0%	44.0%	46.0%	43.0%	52.0%	52.0%	53.0%	50.0%	40.0%	49.0%	49.0%	50.0%	
	Complaints by Theme - Access to Treatment or Drugs				4	4	3	3	5	4	3	4	1	3	1	3	1	
	Complaints by Theme - Admission / Discharge				13	12	20	14	17	17	22	18	16	17	18	14	18	
	Complaints by Theme - Appointment				6	7	10	20	10	11	6	11	7	11	5	9	9	
	Complaints by Theme - Clinical treatment				46	35	50	40	39	44	55	40	46	37	34	41	49	
	Complaints by Theme - Commissioning Decisions				0	0	0	0	0	0	0	0	0	0	0	0	0	
	Complaints by Theme - Communication				35	38	46	31	40	44	29	40	39	37	37	46	38	
	Complaints by Theme - Consent to treatment				3	0	3	5	0	2	1	3	2	1	3	3	1	
	Complaints by Theme - Dementia Care				0	0	0	0	0	0	0	0	0	0	0	0	0	
	Complaints by Theme - End of life care				4	1	3	3	4	6	3	1	0	1	1	4	3	
	Complaints by Theme - Facilities				8	7	11	2	8	6	5	6	4	7	7	7	3	
	Complaints by Theme - Mortuary				1	0	1	0	0	0	0	0	0	0	0	0	0	
	Complaints by Theme - Other				1	2	0	2	3	0	0	2	1	1	0	0	4	
	Complaints by Theme - Patient care				24	23	20	18	23	25	24	18	19	23	21	17	22	
	Complaints by Theme - Prescribing				3	2	3	5	3	8	5	7	0	8	2	4	1	
	Complaints by Theme - Privacy & Dignity				6	4	6	7	5	14	6	8	3	11	3	10	10	
	Complaints by Theme - Restraint				0	0	1	0	0	1	0	0	0	1	1	0	0	
	Complaints by Theme - Staff numbers				1	5	5	5	3	4	2	3	3	4	1	0	2	
	Complaints by Theme - Trust admin / procedure / records				11	9	17	9	10	10	12	20	3	4	2	2	6	
	Complaints by Theme - Values & Behaviours (staff)				20	28	18	29	18	21	20	25	15	19	19	18	18	
	Complaints by Theme - Waiting time				9	13	20	13	15	17	15	13	9	6	13	13	11	
	PALS - Count of concerns		-	-	311	320	340	374	367	406	402	394	411	401	352	366	352	
	Compliments		-	-	135	151	120	81	121	129	91	94	122	137	87	91	81	
	Friends and Family Test -SaTH		95%	95%	93.3%	91.0%	89.1%	88.4%	89.7%	93.4%	93.0%	97.9%	92.8%	92.7%	88.8%	91.7%	98.1%	
	Friends and Family Test - Inpatient		95%	95%	98.4%	98.2%	98.4%	98.3%	99.2%	97.8%	98.6%	98.9%	98.3%	98.3%	98.0%	98.5%	98.8%	
	Friends and Family Test - A&E		85%	85%	65.2%	62.4%	52.9%	60.3%	56.1%	75.0%	75.9%	53.1%	69.8%	71.2%	60.5%	71.0%	77.7%	
	Friends and Family Test - Maternity		95%	95%	96.8%	94.9%	81.0%	100.0%	100.0%	80.0%	100.0%	85.7%	84.3%	83.2%	83.8%	97.8%	100.0%	
	Friends and Family Test - Outpatients		95%	95%	99.5%	98.5%	97.9%	98.1%	98.1%	98.5%	98.7%	98.7%	98.8%	99.0%	98.9%	99.2%	99.5%	
	Friends and Family Test - SaTH Response rate %		-	-	10.1%	7.9%	8.2%	9.9%	10.0%	9.7%	11.4%	7.6%	11.9%	9.8%	8.9%	9.7%	5.5%	
	Friends and Family Test - Inpatient Response rate %		-	-	19.8%	15.1%	13.5%	16.7%	15.8%	16.1%	20.9%	19.5%	21.7%	16.5%	13.4%	12.9%	11.6%	
	Friends and Family Test - A&E Response rate %		-	-	4.2%	3.8%	5.1%	6.1%	6.6%	5.7%	6.5%	0.3%	5.9%	5.6%	5.9%	7.3%	1.0%	
	Friends and Family Test - Maternity (Birth) Response rate %		-	-	5.0%	1.4%	1.1%	27.3%	1.0%	3.0%	1.0%	2.1%	2.2%	0.9%	0.9%	1.0%	5.7%	

Integrated Performance Report

The Shrewsbury and Telford Hospital NHS Trust

Domain	Description	Regulation	National Standard 24/25	Current Month Trajectory (RAG)	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Trend
Patient Safety & Effectiveness	Trust SHMI (HED)		100	100	96.63	97.69						not available						
	Trust SHMI - Expected Deaths		-	-	236.98	248.75						not available						
	Trust SHMI - Observed Deaths		-	-	229	243						not available						
	SJRs Completed by Month				37	37	28	32	34	40	33	32	25	31	31	32	0	
	MRSA - HOHA				0	0	1	0	1	0	0	0	0	0	1	1	0	
	MRSA - COHA				0	0	0	0	1	0	0	0	0	0	0	0	0	
	MRSA - Total	R	0	0	0	0	1	0	2	0	0	0	0	0	1	1	0	
	MSSA - HOHA		-	-	3	4	3	3	4	3	1	2	3	3	2	2	3	
	C. difficile - HOHA				1	4	3	1	4	6	11	4	5	6	9	8	5	
	C. difficile - COHA				6	3	5	3	4	2	3	2	6	5	6	4	2	
	C. difficile - Total	R	98	8	7	7	8	4	8	8	14	6	11	11	15	12	7	
	E. coli - HOHA				6	2	3	8	2	2	5	5	3	4	8	6	6	
	E. coli - COHA				9	11	15	13	7	11	8	5	5	7	9	11	6	
	E. coli - Total	R	146	12	15	18	18	21	9	19	13	10	8	11	17	17	12	
	Klebsiella - HOHA				2	5	1	0	0	2	1	2	1	4	4	3	4	
	Klebsiella - COHA				0	3	0	3	1	3	0	3	1	2	2	4	2	
	Klebsiella - Total	R	36	3	2	8	1	3	1	5	1	5	2	6	6	7	6	
	Pseudomonas Aeruginosa - HOHA				2	0	0	0	0	1	1	1	1	0	1	1	0	
	Pseudomonas Aeruginosa - COHA				0	2	1	2	0	1	0	1	2	1	1	1	2	
	Pseudomonas Aeruginosa - Total	R	19	1	2	2	1	2	0	2	1	2	3	1	2	2	2	
	VTE Risk Assessment completion - SATH		95%	95%	92.6%	91.8%	-	-	-	-	-	-	-	-	-	-	-	
	Never Events		0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	
	Coroner Regulation 28s		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Psii		-	-	3	0	5	1	0	3	1	0	0	0	0	1	2	
	Serious Incidents - Closed in Month		-	-	5	2	6	2	4	2	3	2	1	0	1	0	1	
	Serious Incidents - Total Open at Month End		-	-	21	18	12	11	9	7	7	7	5	3	1	1	0	
	Mixed Sex Accommodation - breaches		10% < 2023-24	50	86	105	96	116	81	68	58	69	83	92	117	108	60	
	One to One Care in Labour		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Delivery Suite Acuity		85%	85%	88%	81%	84%	85%	85%	82%	89%	78%	88%	94%	90%	99%	94%	
	Smoking Rate at Delivery		6%	6%	10.2%	8.0%	7.4%	6.6%	5.7%	6.1%	7.2%	6.6%	6.7%	5.5%	6.6%	5.8%	5.4%	
	Therapy stroke treatment within 72 hours - Occupational Therapy		100%		80.1%	81.3%	86.2%	91.0%	92.6%	95.7%	72.6%	92.8%	replaced with 24 hr metric					
	Therapy stroke treatment within 72 hours - Physiotherapy		100%		92.6%	91.4%	88.2%	87.7%	96.4%	95.7%	75.9%	91.4%	replaced with 24 hr metric					
	Therapy stroke assessment within 24 hours - Occupational Therapy		100%		New metric introduced October 2024								87.8%	37.5%	36.0%	37.3%	-	
	Therapy stroke assessment within 24 hours - Physiotherapy		100%		New metric introduced October 2024								85.7%	32.4%	34.2%	50.9%	-	
	Therapy stroke assessment within 72 hours - Speech & Language Therapy		100%		87.4%	85.2%	77.8%	78.6%	89.5%	91.3%	71.4%	92.9%	94.4%	72.1%	69.4%	71.0%	-	
	Therapy stroke treatment 45 mins per therapy per day - Occupational Therapy		45		40	38.1	45	50	44.6	49.5	40	46.6	replaced with Psychological					
	Therapy stroke treatment 45 mins per therapy per day - Physiotherapy		45		30	30	30	30	32	36	30	32.5	replaced with Motor therapy					
	Therapy stroke treatment 45 mins per therapy per day - Speech & Language Ther		45		30	30	33	29.4	28.8	29.7	25	31.9	replaced with Comm/Swallowing					
	Therapy stroke treatment 3 hours per day - Motor Therapy		180		New metric introduced October 2024								30	29.2	31.0	30	-	
	Therapy stroke treatment 45 mins per day - Psychological Therapy		45		New metric introduced October 2024								34.3	30	34.9	35	-	
	Therapy stroke treatment 45 mins per day - Communication/Swallowing Therapy		45		New metric introduced October 2024								26.3	30	36	42.2	-	
	Stroke Patients Scanned - within 20 mins of clock start				New metric introduced October 2024								6.30%	10.50%	6.60%	5.20%	-	
	Stroke Patients Scanned - within 1 Hour of clock start				30.2%	45.3%	49.4%	49.3%	39.4%	60.4%	44.1%	42.3%	45.0%	54.7%	52.6%	44.8%	-	
	Stroke Patients Scanned - within 12 Hours of clock start				93.7%	93.8%	94.8%	93.2%	94.4%	95.8%	94.6%	98.7%	replaced with 20 mins metric					
	Readmissions within 28 days		-	-	1097	1298	1170	1100	552				Not Available					
	% readmission within 28 days		-	-	9.4%	10.8%	10.1%	9.5%	4.9%				Not Available					

Partnering Ambitious Caring Trusted

VETERAN AWARE

Our Vision: To provide excellent care for the communities we serve

Patient Safety, Clinical Effectiveness, Patient Experience Executive Summary

The Shrewsbury and Telford Hospital NHS Trust

Deteriorating Patients: NEWS and PEWS recovery actions are included in IPR with detailed work plans for the monitoring of these metrics.

Pressure Ulcers: Whilst remaining above trajectory, there are new governance arrangements in place whereby Ward Managers and Matrons will be asked to present action plans to demonstrate improvements of decreased Hospital acquired pressure ulcers and falls.

Infection Prevention Control: NHSE visited RSH on Tuesday 1 April 2025 to review C:Diff Action Plan, Chief Nursing Officer will provide a verbal update to Quality & Safety Assurance Committee and Board.

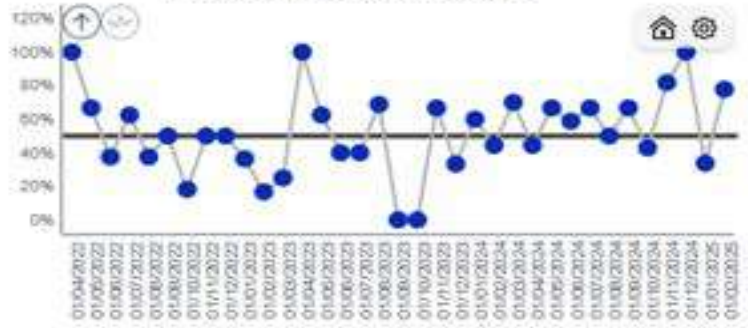
Maternity: Smoking at time of pregnancy target for reducing ladies smoking at time of delivery is on track to meet the government target.

Quality - Safe - Deteriorating Patients - Fragility

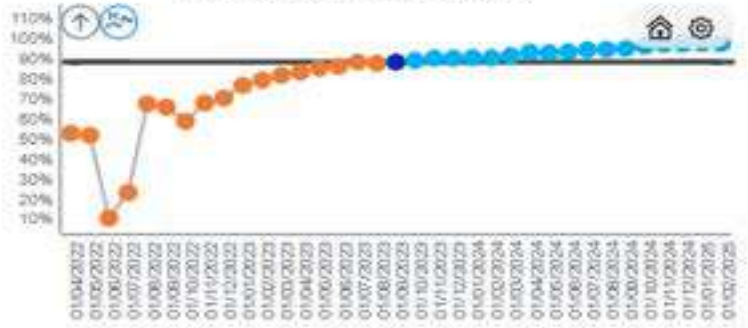
Falls | Deteriorating Patients - NEWS | Deteriorating Patients - PEWS | Medication - Omitted Doses

	Nov-2023	Dec-2023	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025
Improve Dementia screening rates - Patient had an AMT - ED	66.7	33.3	60.0	44.4	70.0	44.4	66.7	58.8	66.7	50.0	66.7	42.9	81.8	100.0	33.8	77.8
Improve Dementia screening rates - Patient had an AMT - Adult IP	58.5	52.3	54.2	47.3	54.4	59.0	60.0	49.1	54.5	70.4	37.3	73.0	67.0	55.7	65.8	51.8
Dementia Awareness Tier 1 3 Yearly	90.08	90.08	90.32	90.23	91.30	93.01	92.79	93.18	94.24	94.44	94.85	96.21	97.22	97.37	97.63	97.42
Dementia Awareness Tier 2 3 Yearly	87.06	86.98	86.85	86.87	87.07	86.02	90.03	91.95	92.37	91.26	91.35	91.95	92.59	92.94	93.19	92.80
Dementia Screening % Score	73	69	73	67	72	77	77	70	73	83	59	67	73	67	72	65
Dementia Screening Audited	285	277	263	267	277	251	249	255	264	262	273	251	246	189	207	202
Complaints by Theme - Dementia Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

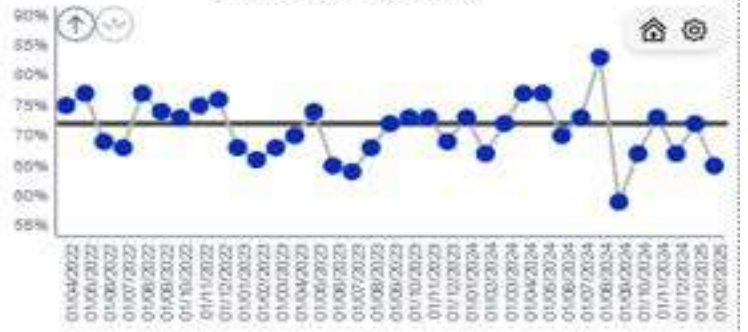
Improve Dementia screening rates - ED



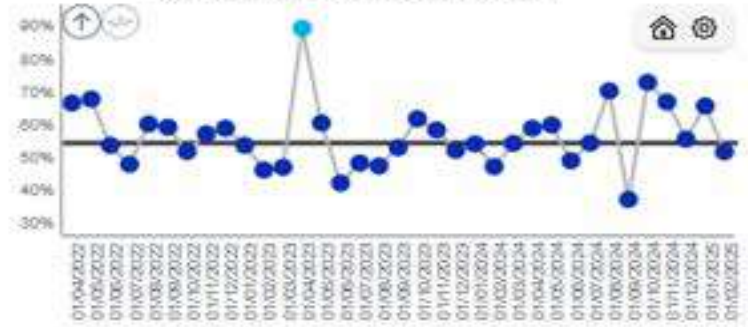
Dementia Awareness Tier 1 - 3 Yearly



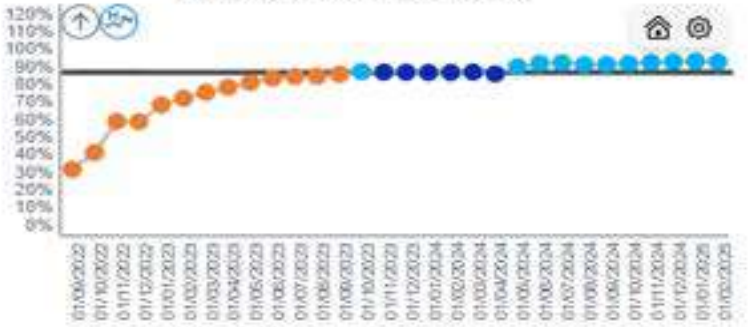
Dementia screening score %



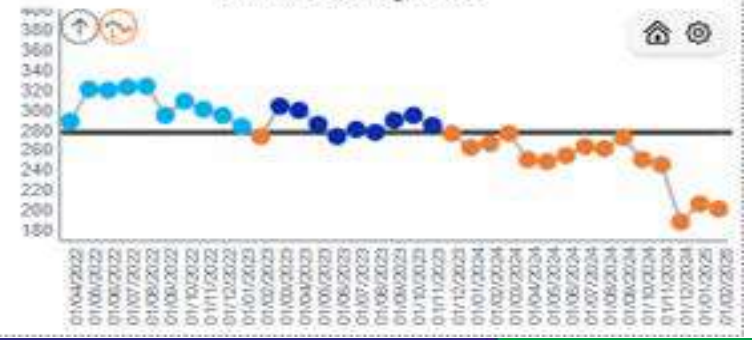
Improve Dementia screening rates - Adult IP



Dementia Awareness Tier 2 - 3 Yearly



Dementia screening audited



Quality - Safe - Deteriorating Patients - NEWS

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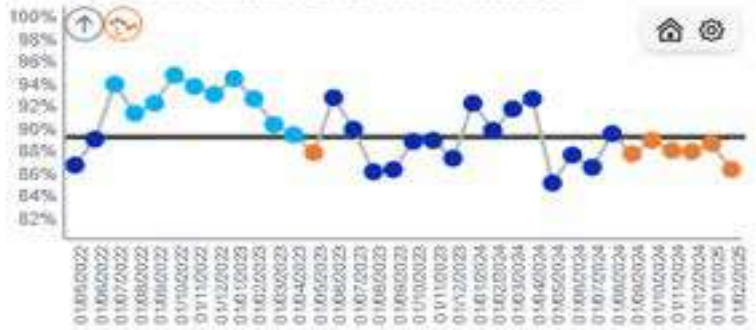
The Shrewsbury and Telford Hospital NHS

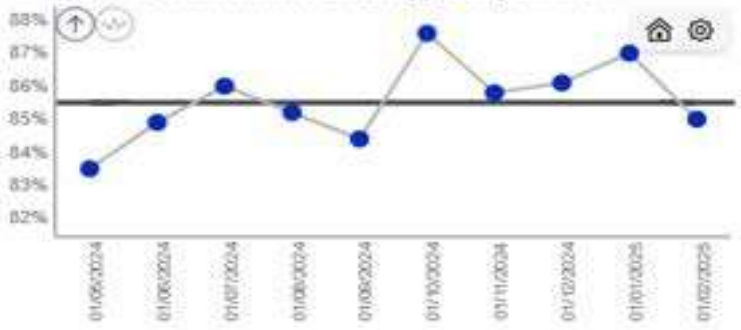
Falls | Deteriorating Patients - Fragility | Deteriorating Patients - PEWS | Medication - Omitted Doses

	Dec-2023	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025
Is there evidence this NEWS2 score was escalated?	87.40	92.30	89.90	91.80	92.70	85.20	87.70	86.60	89.60	87.80	89.00	88.10	88.00	88.70	86.40
Is there evidence of this NEWS2 trigger being reviewed?						83.50	84.90	86.00	85.20	84.40	87.60	85.80	86.10	87.00	85.00
Did the patient have IV antibiotics within 60 mins of triggering risk of Sepsis	87.10	90.00	85.60	64.70	84.70	75.40	83.60	88.00	85.40	87.90	89.40	92.40	86.50	85.10	85.20
Did the management plan include: Investigation plan						81.50	87.50	89.80	91.20	90.70	88.80	92.40	92.60	93.10	89.10
Did the management plan include: Treatment plan						91.30	94.30	94.20	96.00	96.10	92.20	96.60	95.90	95.70	92.80
Did the management plan include: Escalation plan						78.20	82.80	80.70	86.90	88.00	81.50	85.50	85.00	84.70	84.50
Did the management plan include: Review plan						81.40	83.70	78.20	86.60	88.10	82.90	84.50	85.50	86.80	83.40

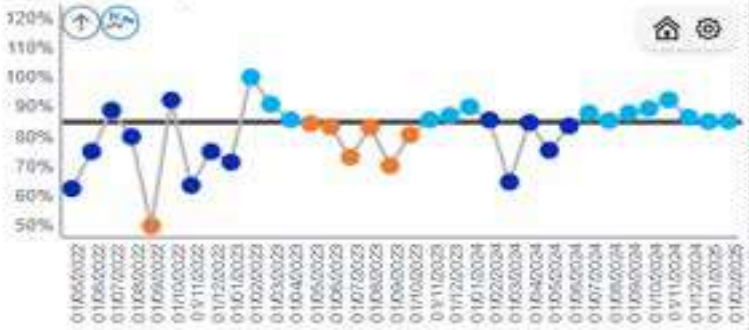
Is there evidence NEWS2 score was escalated?



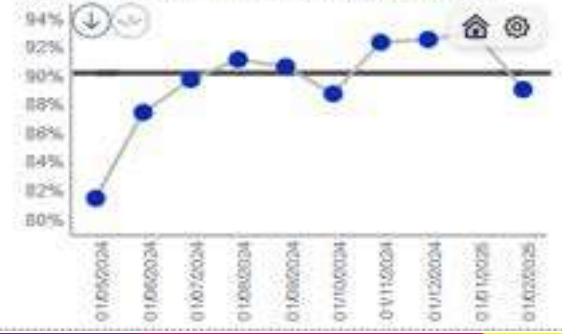
Is there evidence of this NEWS2 trigger being reviewed?



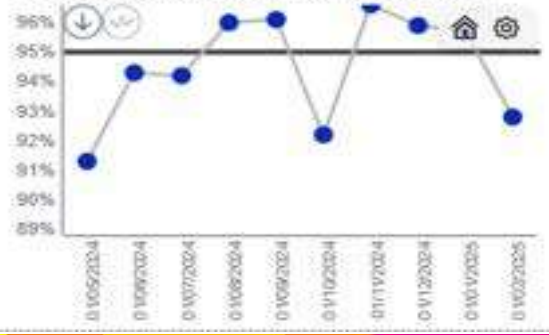
Did the patient have IV antibiotics with 60 minutes?



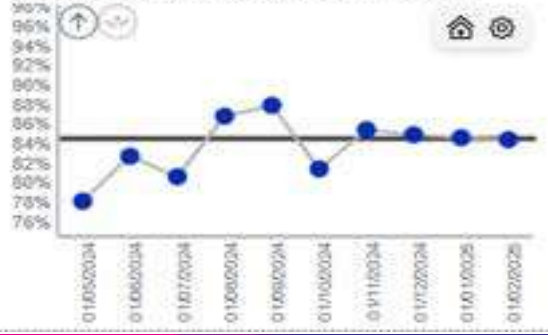
Did the management plan include: Investigation plan



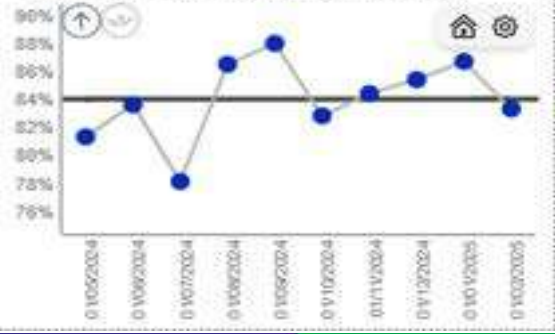
Did the management plan include: Treatment plan



Did the management plan include: Escalation plan



Did the management plan include: Review plan



Deteriorating patients - NEWS

The Shrewsbury and Telford Hospital NHS Trust

Summary: System oversight of deteriorating patient care continues to focus on six key workstreams (Education, Dashboard, Response, Ceilings of Treatment, Guidelines, and Handover). Efforts have significantly improved data accessibility and key performance indicators, enabling targeted interventions in collaboration with transformation teams such as MDTP. In maternity services, ongoing work addresses concerns related to system and process management for deteriorating patients, including technological support. A primary focus is enhancing oversight and visibility of quality indicators, though challenges remain due to the lack of a digitalised track-and-trigger tool, this will assist with drive audit implementation and ensuring accessible data. Work continues to improve data quality and reduce discrepancies across departments. Partnership with Performance and Business Intelligence team has streamlined reporting, reduced audit time and improved efficiency. Additionally, ward-level engagement aims to enhance continuity and understanding of deteriorating patient care. Insights from patient safety incidents are actively informing improvement efforts. While progress is being made across the six workstreams, clinical engagement remains a challenge due to competing priorities and operational pressures. The DPG programme group continues to drive these initiatives, ensuring alignment with overall patient safety objectives.

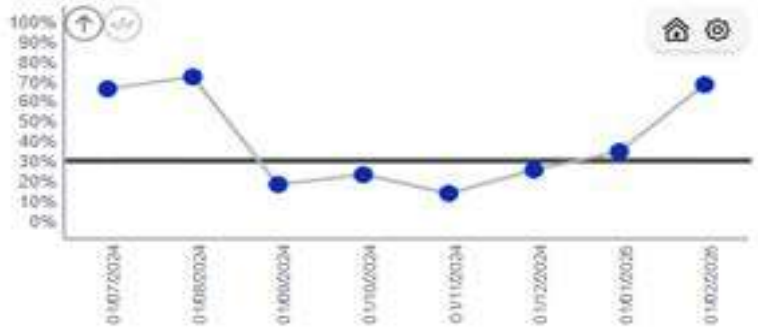
Recovery actions:	**Anticipated impact and timescales**
1. Strengthening Clinical Quality & Care Coordination: The deteriorating patient team is actively collaborating with Workstreams 1 and 4, focusing on Clinical Quality, Outcomes, and Coordination of Care. Engagement with the SHOP model within medicine is ongoing to enhance patient care pathways and improve early recognition of deterioration	1. Initial improvements expected within 3–6 months, with full integration over 12 months
2. Enhancing Data Visibility & Ward Oversight: The newly developed report provides departments with deteriorating patient oversight & is proposed to be integrated within the ward dashboard providing clinical oversight further development of associated actions to address issues identified will be incorporated to the collaborative work and that of the workstream projects	2. 12-18 months
3. Workstream Development & Governance: DPG Programme Group meeting oversees the progress of the six workstreams. Two workstreams are making significant progress, while the remaining four are in the initial stages of development,	3. 12-18 months
4. Supporting Ward Audits & Performance Monitoring: The new Deteriorating Patient Report supports wards in auditing patient deterioration and strengthening oversight. It will also be integrated into the new Ward Managers Dashboard, ensuring seamless access to critical data	4. Initial improvements expected within 3–6 months, with full integration over 12 months
5. Improving Maternity Patient Oversight: The Deteriorating Patient Team is working closely with maternity services to improve the visibility of patients triggering on the Modified Early Obstetric Warning Score (MEOWS). Ongoing evaluations are being carried out to align with national MEWS guidelines, ensuring best practices for early identification and management of deteriorating maternity patients	5. 6-12 months

Recovery dependencies:	Support via PBI teams and transformation project teams and engagement throughout the Trust. Support via governance, clinical and operational teams to prioritise deteriorating patient timely decisions made by DPG. Engagement with the 6 workstreams proposed by DPG for initial focus.

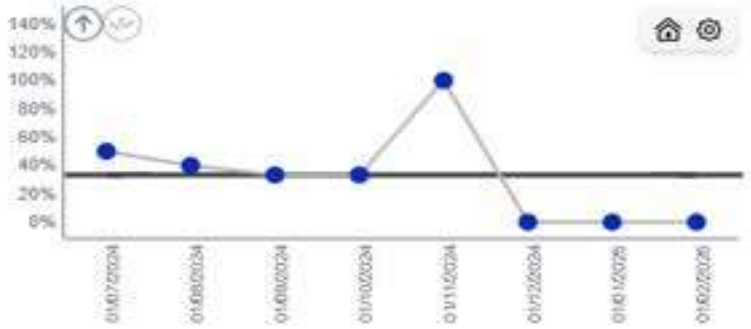
Quality - Safe - Deteriorating Patients - PEWS

	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025
Is there evidence this PEWS score was escalated?	66.70	72.70	18.80	23.70	14.30	26.10	35.30	68.80
Did the CYP have IV antibiotics within 60 mins of triggering risk of Sepsis	50.00	40.00	33.30	33.30	100.00	0.00	0.00	0.00
Did the PEWS management plan include: Investigation plan				45.50	38.10	77.80	77.80	93.30
Did the PEWS management plan include: Treatment plan				95.50	95.20	95.50	73.30	89.50
Did the PEWS management plan include: Escalation plan				13.60	19.00	54.50	46.70	21.10
Did the PEWS management plan include: Review plan				27.30	47.60	66.70	76.90	94.70

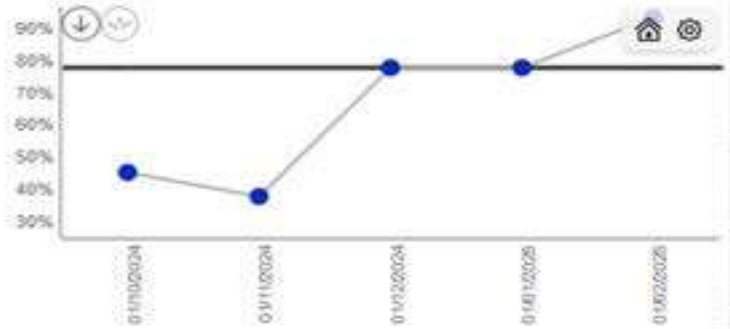
Is there evidence PEWS score was escalated?



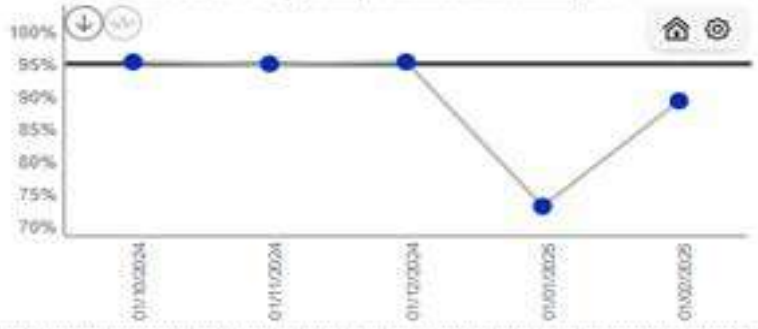
Did the CYP have IV antibiotics within 60 minutes?



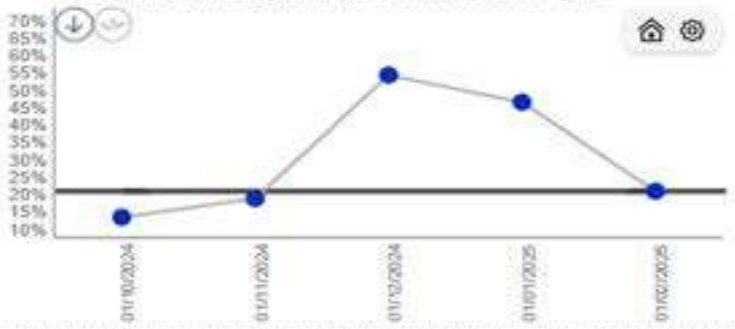
Did the PEWS management plan include: Investigation plan



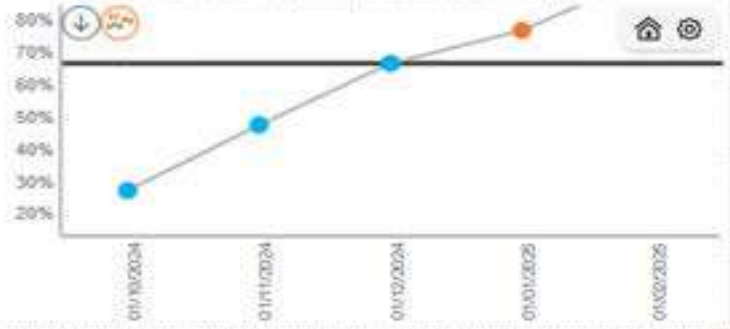
Did the PEWS management plan include: Treatment plan



Did the PEWS management plan include: Escalation plan



Did the PEWS management plan include: Review plan



Deteriorating patients - PEWS

The Shrewsbury and Telford Hospital NHS Trust

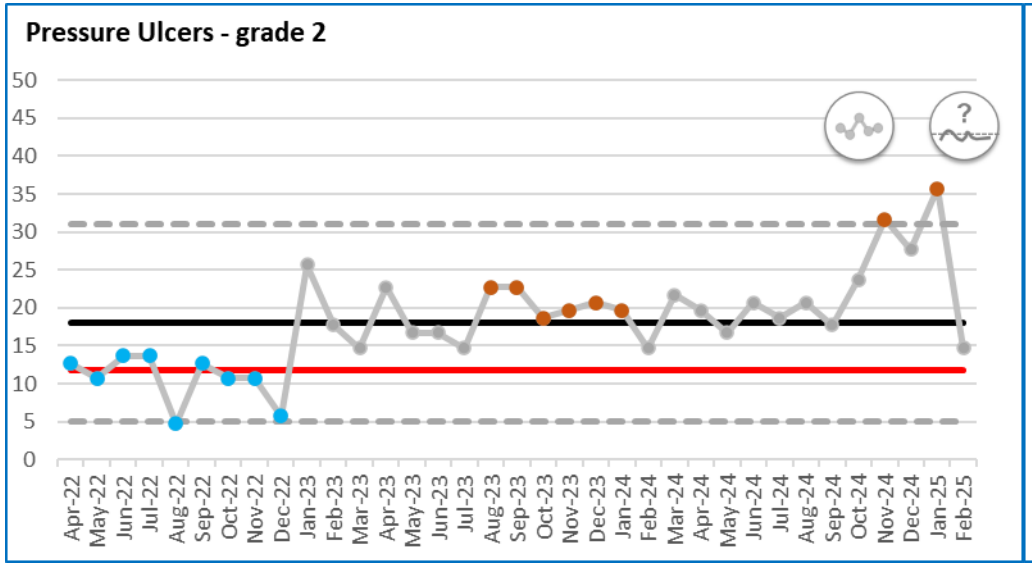
Summary:
System oversight of paediatric deteriorating patient care remains focused on improving data quality to reduce discrepancies and support improvement efforts. Collaboration with PBI teams has streamlined reporting, minimised audit time, and enhanced efficiency. Ward-level engagement continues to strengthen continuity and understanding, with ongoing efforts to further involve teams. Additionally, work is needed to enhance governance processes, ensuring system oversight is embedded in daily practice and effectively interfaces with PTAC and the deteriorating patient group.

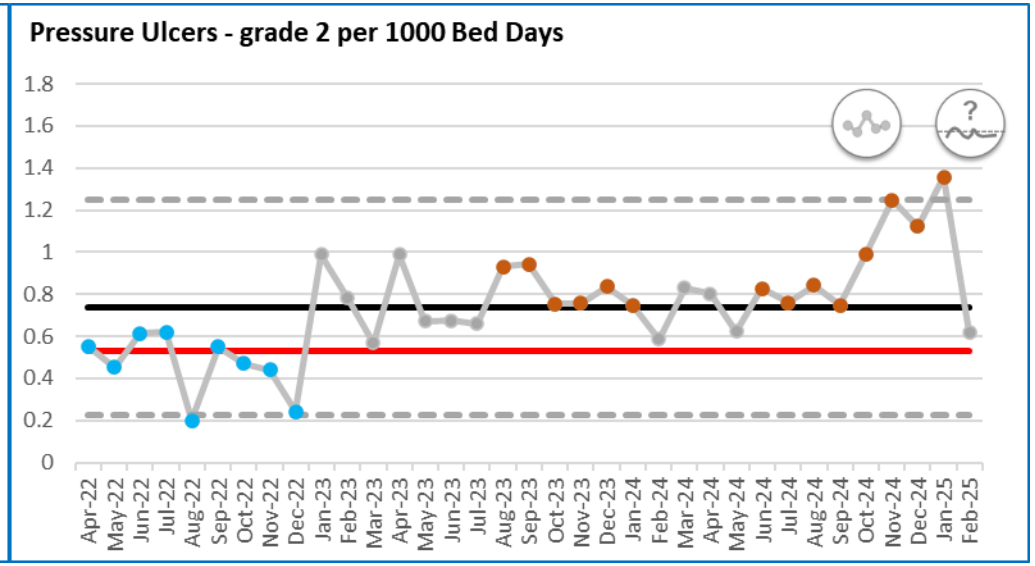
Recovery actions:	**Anticipated impact and timescales for improvement:**
1. Paediatric Vitals & Sepsis Module Implementation Paediatric vitals launched in July, followed by the sepsis module in September. Implementation has highlighted the need to improve reporting and feedback mechanisms across all divisions to enhance awareness of key metrics for deteriorating patient care.	1. Full integration over 12 months
2. Data Consistency & Reporting Improvements Ongoing efforts to standardise data collection and analysis across the trust, ensuring consistency in deteriorating patient and sepsis reporting.	2. 12-18 months
3. Paediatric Team Feedback & Action Monthly feedback provided by auditors on recurring themes related to deteriorating patient care, ensuring oversight and necessary actions are taken.	3. 12-18 months
4. Strengthening Clinical Quality & Care Coordination Collaboration with neonatal teams to enhance clarity on Clinical Quality, Outcomes, and Care Coordination following the introduction of NEWTT.	4. Initial improvements expected within 3–6 months, with full integration over 12 months
5. Enhancing Data Visibility & Ward Oversight A newly developed report offers improved oversight of deteriorating patients. Plans to replicate the adult ward dashboard in paediatrics, improving clinical oversight and enabling targeted actions to address patient deterioration.	5. Initial improvement 6- 2 months

Recovery dependencies:	Support via PBI, transformation project teams and engagement throughout the trust. Support via governance, clinical and operational teams to prioritise deteriorating patient Timely decisions made by DPG

Patient harm – pressure ulcers – Category 2

The Shrewsbury and Telford Hospital NHS Trust

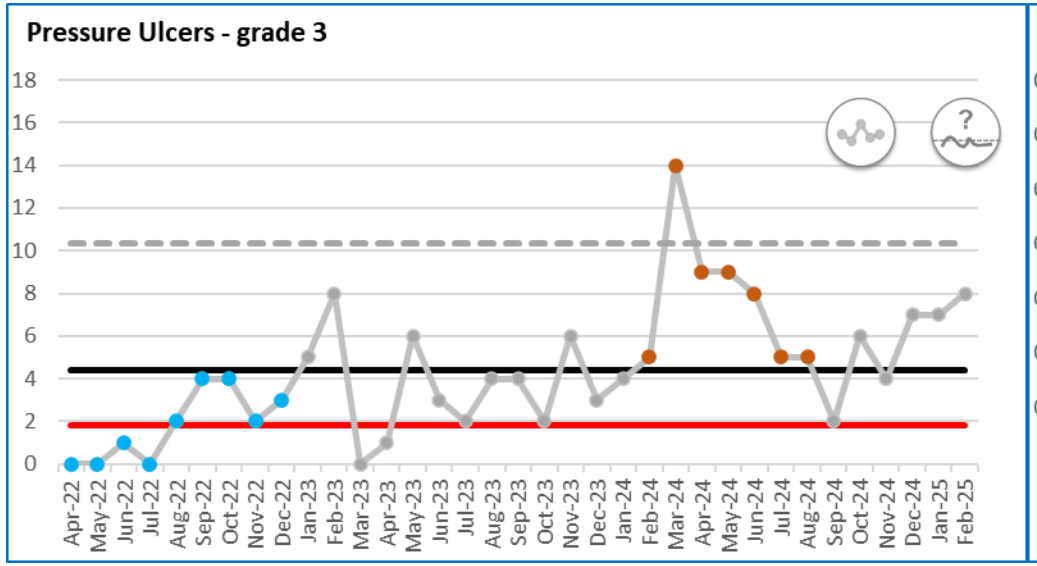


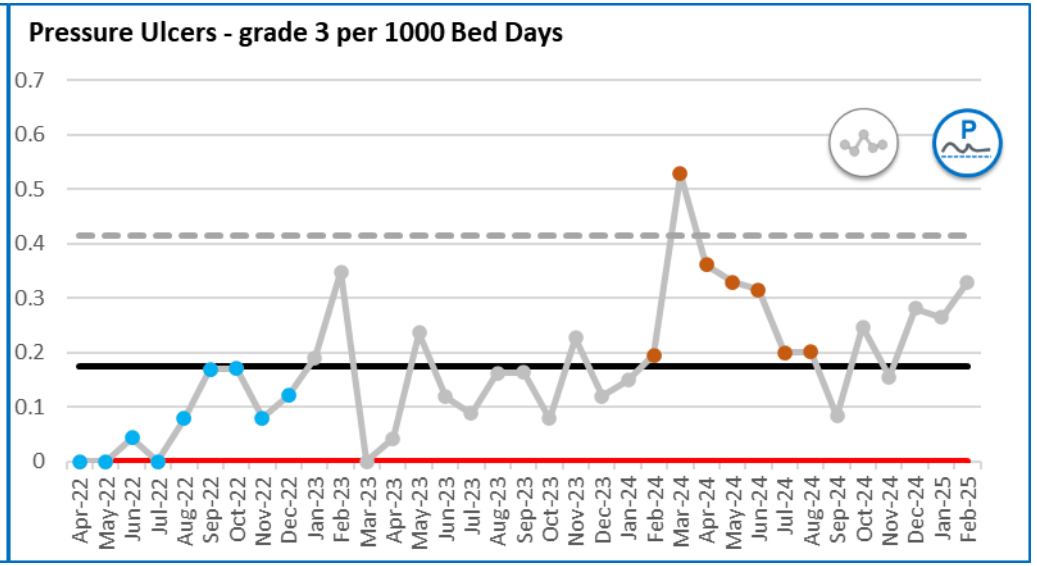


Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	11
Surgery, Anaesthetics and Cancer	4
Women's & Children's	0

Patient harm – pressure ulcers – Category 3

The Shrewsbury and Telford Hospital NHS Trust

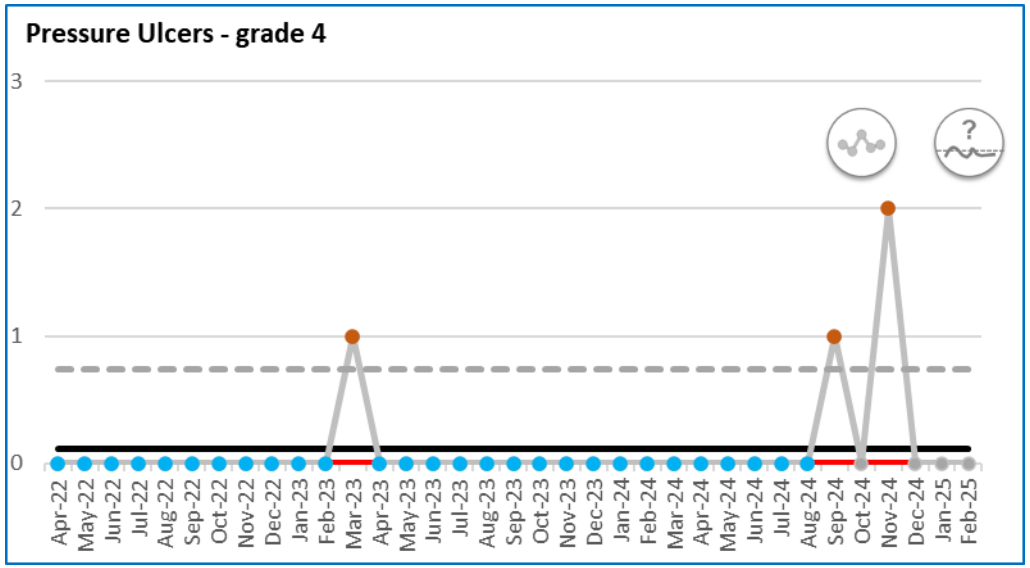




Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	5
Surgery, Anaesthetics and Cancer	3
Women's & Children's	0

Patient harm – pressure ulcers – Category 4

The Shrewsbury and Telford Hospital NHS Trust



Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	0
Surgery, Anaesthetics and Cancer	0
Women's & Children's	0

Patient harm – pressure ulcers

The Shrewsbury and Telford Hospital NHS Trust

Summary:
From September to December 2024, there has been a 32% increase in reported category 2 pressure ulcers and a 32% decrease in category 3/U pressure ulcers. However, there have been 3 acquired category 4 pressure ulcers. With the increase in both acquired ulcers and severity of harm, the Trust is not on track to achieve a 40% reduction by the end of March 2025. A review into the pressure ulcer investigations for all Category 2 or above pressure ulcers has identified issues in relation to the consistency in frequency of patient re-positioning, accuracy of risk assessments, non-completion of the core care plan and associated actions and quality of completed documentation and inconsistency with education given to patients. All of which align with our overarching action plan.
There has been no causative link found between LOS in ED compared with time to develop a pressure ulcer. There were 8 category 3 pressure ulcers reported, 1 in ED RSH, 1 on ward 7, 2 on SAU, 2 on ward 24 and 2 on ITU RSH.

Recovery actions:
There is a focus on the common themes and associated action plans to be implemented to ensure improvements.
Ensure greater ownership at ward and Divisional level with Tissue Viability oversight.
A review of the current processes around pressure ulcer scrutiny and oversight meetings has taken place and a revised process commencing mid-April being implemented linked into the monthly Trust Nursing Metrics meetings.
PURPOSE T- a nationally recommended pressure ulcer risk assessment tool has now been introduced in the Trust. Ongoing face to face education, training and support in areas of high incidence. This work will also include Maternity with a focus on risk assessment currently captured on Badgernet. Quality team commenced 1:1 educational support on the completion of Purpose T.
TVN support to areas with higher incidence and provided monthly support visits based on the ward requirements.
These figures are correct at the time of validation by the Tissue Viability Service, (Bed days for calculation of PU per 1000 bed days is unvalidated and based on average bed days).

Anticipated impact and timescales for improvement:
Reduction in consistent themes in relation to pressure ulcers.

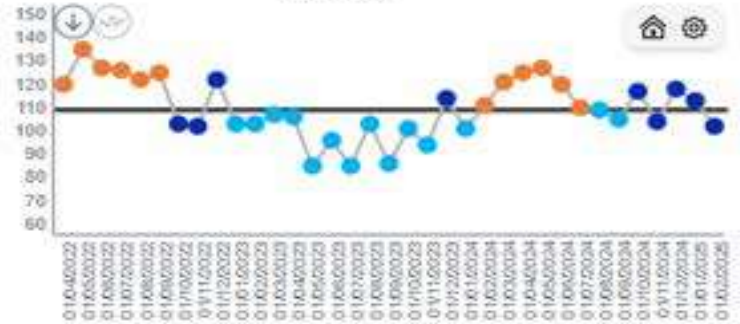
Recovery dependencies:	Ownership of action plans for pressure ulcer prevention at ward and matron level. Monthly review meetings for Category 2,3 and DTIs

Quality - Safe - Falls

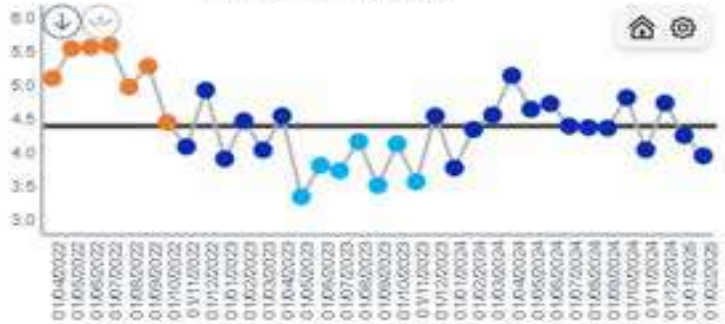
Deteriorating Patient - Fragility | Deteriorating Patients - NEWS | Deteriorating Patients - PEWS | Medication - Omitted Doses

	Oct-2023	Nov-2023	Dec-2023	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025
Falls - Total	101	94	114	101	111	121	125	127	120	110	109	105	117	104	118	113	102
Falls - per 1000 Bed Days	4.14	3.58	4.55	3.78	4.35	4.56	5.14	4.65	4.73	4.40	4.38	4.37	4.82	4.05	4.74	4.26	3.96
Falls - Resulting in Harm Moderate or Severe	5	4	6	4	2	6	2	4	6	6	4	6	4	2	5	6	2
Falls - Resulting in Harm - per 1000 Bed Days	0.20	0.15	0.24	0.15	0.08	0.23	0.08	0.15	0.24	0.24	0.16	0.25	0.16	0.08	0.20	0.23	0.08
Falls Prevention Training Compliance % - 2 Yearly	84.98	86.86	88.50	88.05	88.82	89.12	89.40	90.74	91.20	91.79	91.99	92.28	92.59	92.77	92.63	93.16	89.77
% Completion of Falls Risk Assessments	93	92	93	93	95	93	94	93	93	93	94	94	93	93	95	96	93

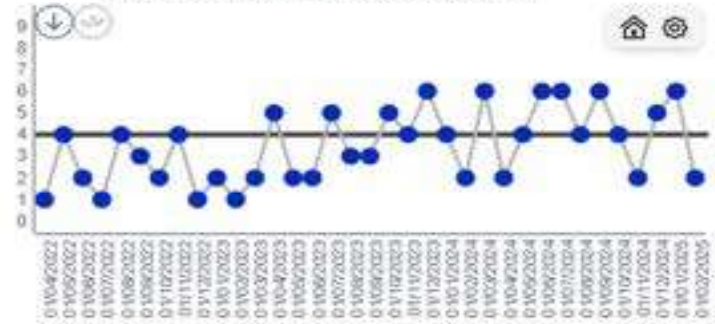
Falls - Total



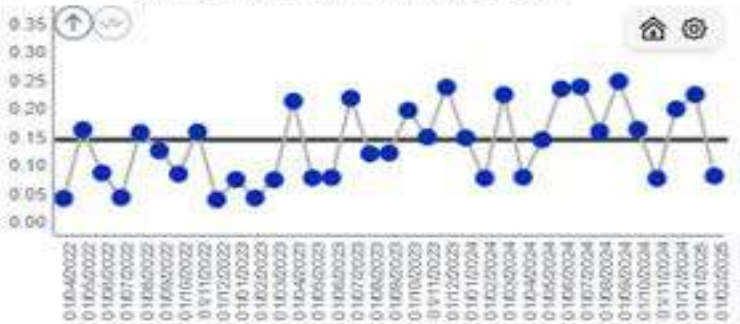
Falls - per 1000 Bed Days



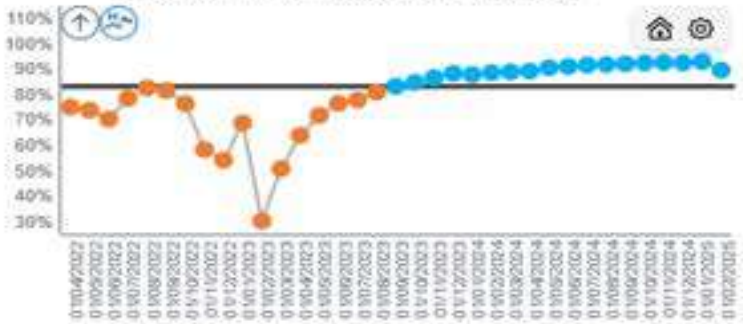
Falls - Resulting in Harm Moderate or Severe



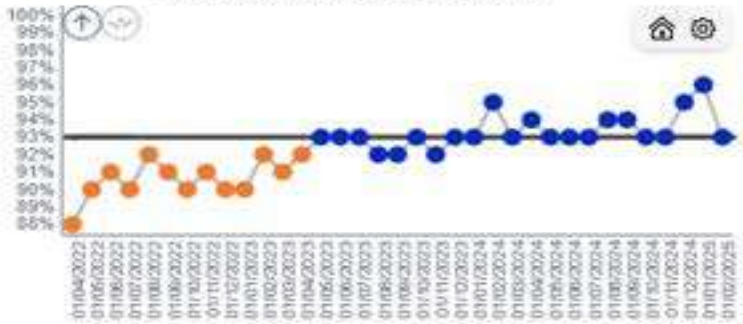
Falls - Resulting in Harm - per 1000 Bed Days



Falls Prevention Training Compliance % - 2 Yearly



% Completion of Falls Risk Assessments



Patient harm - falls

The Shrewsbury and Telford Hospital NHS Trust

Summary:
Falls per 1000 bed days in February continues to show common cause variation, with a steady trend over the past 3 months. It is important to note that due to issues within the data warehouse our bed days data does not include any additional capacity open, and it is hoped that this will be rectified for the new reporting year April 2025. We reported a total falls in month of 101.
There continues to be falls with harm with 3 falls being seen in February 2025 that resulted in moderate harm or above. 1 has since been downgraded and a further 1 likely to also be as a result of a collapse rather than a fall. Common cause variation continues to be seen on the falls with harm and falls with harm per 1000 bed days charts.
Training compliance remains above 90% and completion of risk assessments pre fall also remains above 92%.

Recovery actions:
Energise report has made 4 key recommendations following the project end. Meeting taken place with the Ward and actions agreed however some recommendations are relevant trust wide.

Reconditioning lead continues to work with Ward 9 and Ward 28 – projects started 1st November with outcome measures in place and regular meetings with staff to identify any new ideas

Review of movement matters/falls lead role at end of 12 month post (Sept 25)

Review of bedtime routines in progress in conjunction with Patient Experience team

Anticipated impact and timescales for improvement:

Continue with full implementation and embedding of the falls project plan and merge of the reconditioning project plan
Further improvement work is planned on a number of different wards and progress will be shared through the Falls Steering Group.
Monthly activities have recommenced each month on wards with a timetable for the year planned.

Recovery dependencies:	Support to act on key recommendations trust wide from energise report Senior leadership support to further embed reconditioning into everyday practices

Patient harm – unreported falls

The Shrewsbury and Telford Hospital NHS Trust

Adults Unreported Falls - Annual Audit	May-21	Nov-21	May-22	May-23	Aug-24
Total number of responses	**324**	**285**	**252**	**227**	**206**
Can you remember a fall that happened when on duty on this ward?					
Yes - I can remember a patient fall that happened when I was on duty	68.52%	64.21%	66.67%	63.00%	69.90%
No, there hasn't ever been a fall while I've been on duty	31.48%	35.79%	33.33%	37.00%	30.10%
Who completed the Datix incident form?					
I think I reported it myself	48.65%	52.46%	69.64%	50.35%	34.03%
I think someone else reported it	49.55%	44.81%	28.57%	46.85%	65.97%
I don't know if it got reported or not	1.35%	1.09%	1.19%	2.10%	0.00%
I don't think it got reported at all	0.45%	1.64%	0.60%	0.70%	0.00%
On a scale where 100% represents absolutely certain, how sure are you the Datix was completed and sent off?					
Confident reported (99% to 100% certain)	94.04%	93.26%	93.33%	91.37%	97.22%
Possibly reported (50% to 98% certain)	5.96%	4.49%	6.67%	8.63%	2.78%
Unlikely to have been reported (0% to 49% certain)	0.00%	2.25%	0.00%	0.00%	0.00%

Summary:
The unreported falls audit is a national NHS England audit tool to help trusts to distinguish between increases in reporting falls to real increases in falls. Research suggests that some falls in hospital go unreported and once improvement work starts, reporting tends to improve. The audit first launched in SaTH in May 2021 after a lot of improvement work had already commenced. This was repeated 6 monthly until May 2022 when it moved to an annual audit due to minimal changes in results and an increase in positive reporting. The audit asks staff if they recall a fall occurring when they were on shift, this could be a patient in a different area of the ward being cared for by a colleague. The results are positive showing 100% that a Datix was reported by themselves or a colleague.

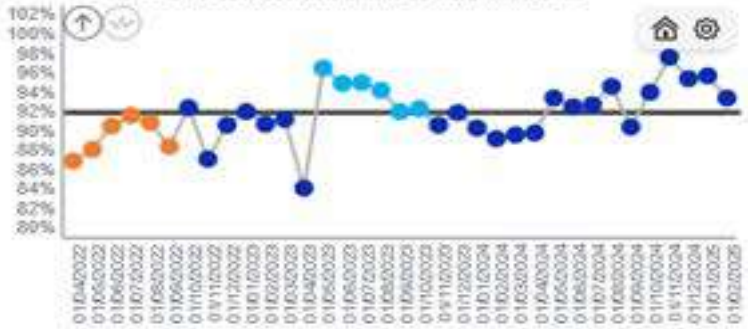
Recovery actions:
Audit is part of the Quality team programme of work and has been added to the action tracker for reaudit in 12 months' time.

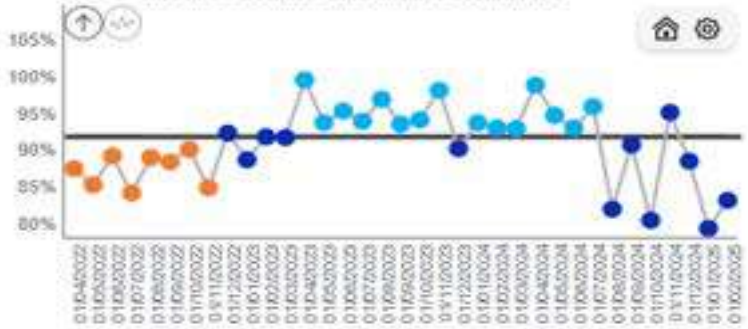
Anticipated impact and timescales for improvement:

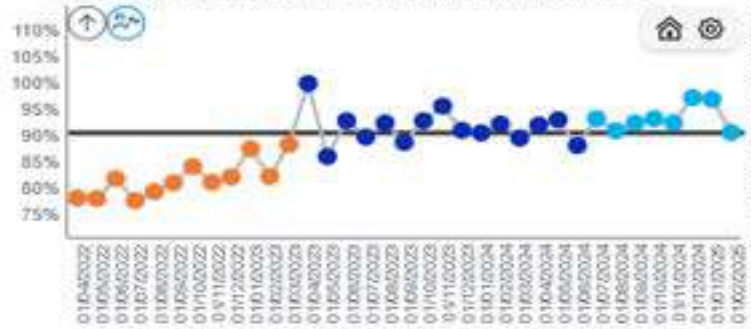
Recovery dependencies:

Quality - Safe - Medication - Omitted Doses

	Nov-2023	Dec-2023	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025
Has all prescribed medication been administered?	90.6	91.9	90.3	89.2	89.6	89.8	93.4	92.5	92.7	94.6	90.4	94.0	97.6	95.4	95.7	93.4
Was the reason for the omission documented?	98.2	90.3	93.8	93.1	93.0	98.9	94.8	93.1	96.0	82.1	90.8	80.6	95.2	88.6	79.5	83.3
Was appropriate action such as ordering medication, documented?	95.7	91.1	90.6	92.3	89.6	92.1	93.1	88.2	93.3	91.0	92.5	93.3	92.5	97.3	97.0	90.7







Medication - omitted doses

The Shrewsbury and Telford Hospital NHS Trust

Summary:
Omitted doses of medication are a leading cause of patient harm within the NHS. It is imperative that patients receive their medication in a timely manner and every effort must be made to obtain medication if unavailable or to escalate if patients are unable to tolerate or refuse prescribed medication.

Omitted doses of time critical medication has been agreed as one of the four Trust priorities within the Trusts PSIRF framework.

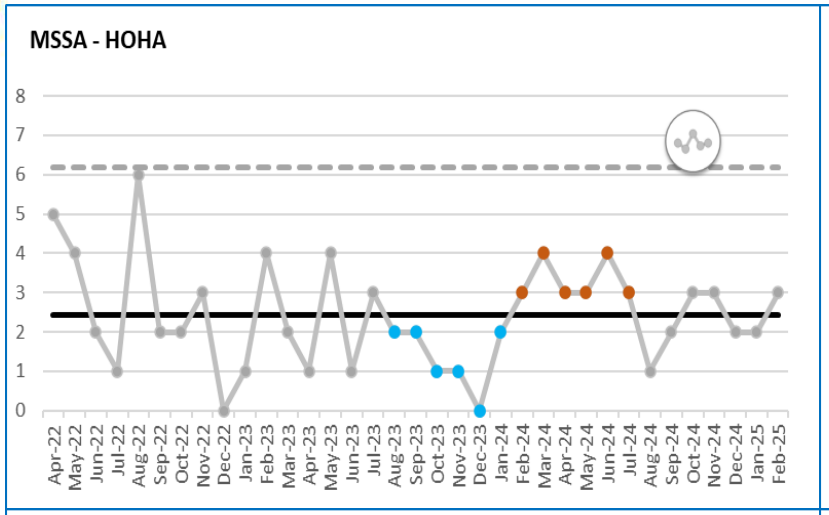
Recovery actions:
- Review clinical documentation to identify and document omitted doses and determine clinical appropriateness
- Observe and discuss processes relating to administration of medication during in-patient admission with clinical teams at the point of care
- Review current policies, procedures and processes relevant to medication management during admission
- Develop an individual ward level action plan outlining local recommendations and required actions
- Identify wider systems and organisational issues and themes to be incorporated into a thematic review and organisational improvement plan

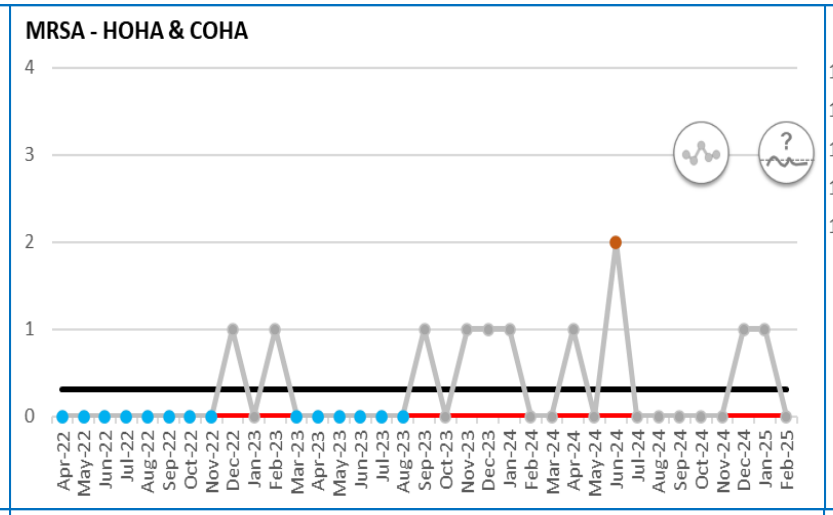
Anticipated impact and timescales for improvement:
To be agreed and approved via Chief Pharmacist and Clinical Director for Medicines Optimisation

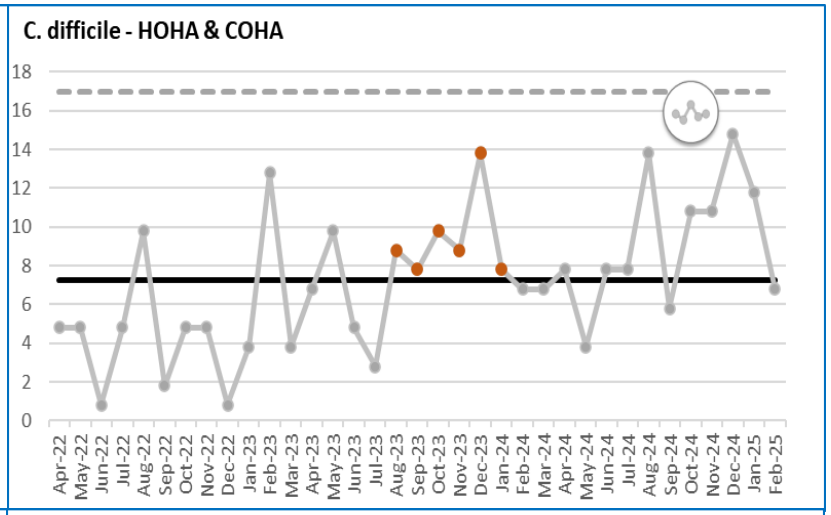
Recovery dependencies:

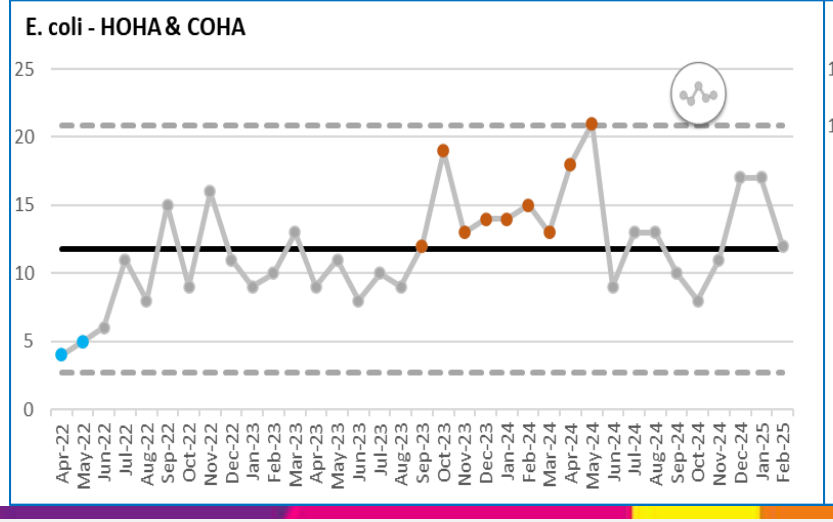
Infection prevention and control

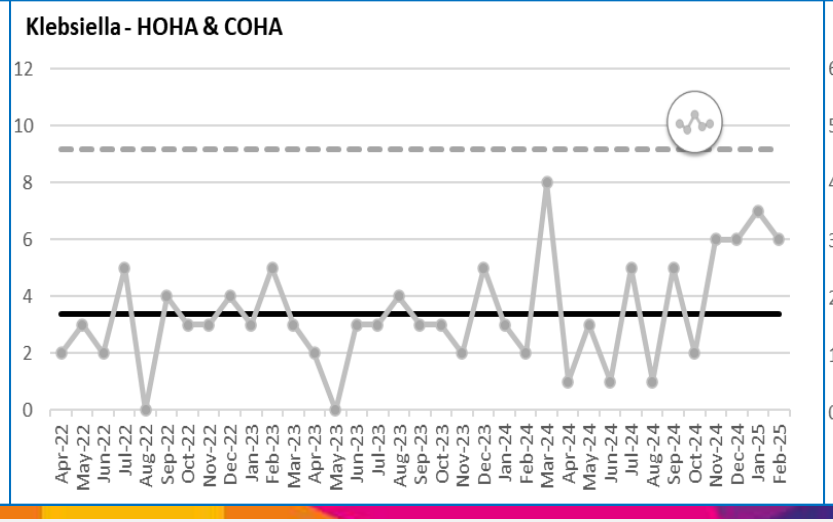
The Shrewsbury and Telford Hospital NHS Trust

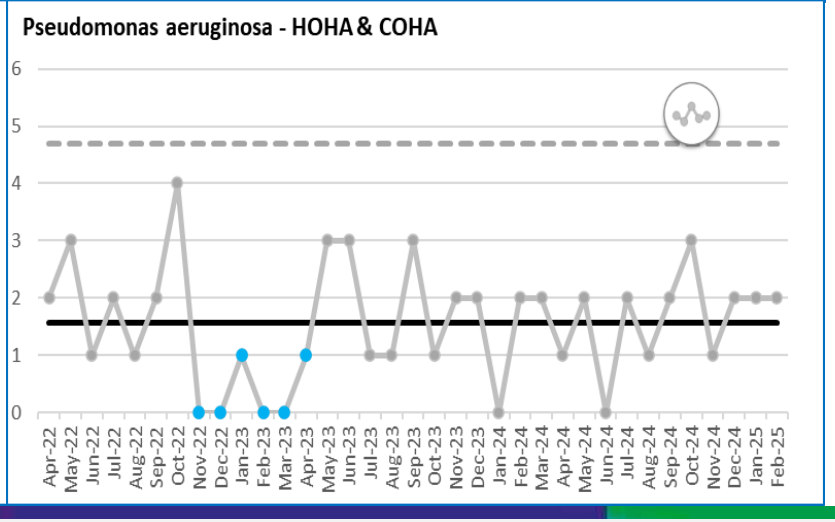












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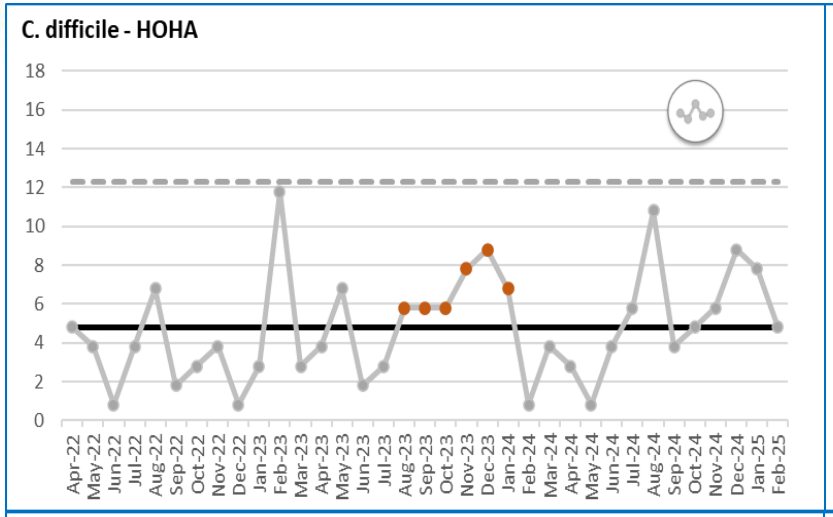
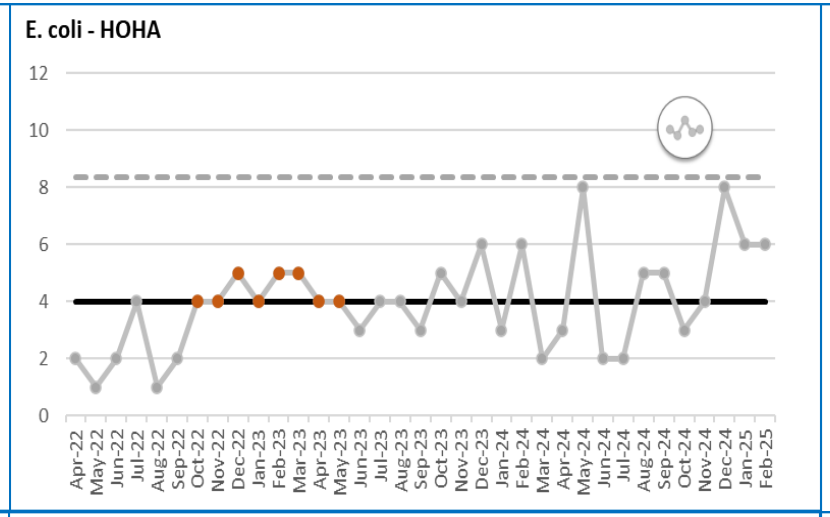
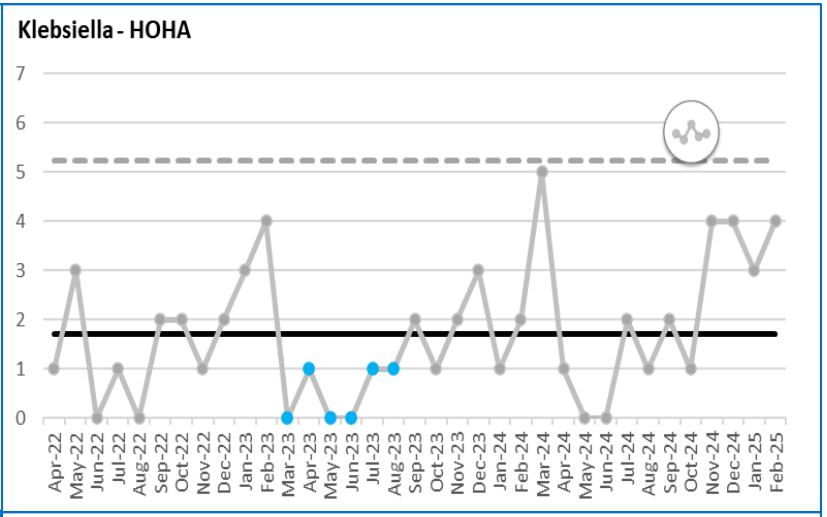
Our Vision: To provide excellent care for the communities we serve

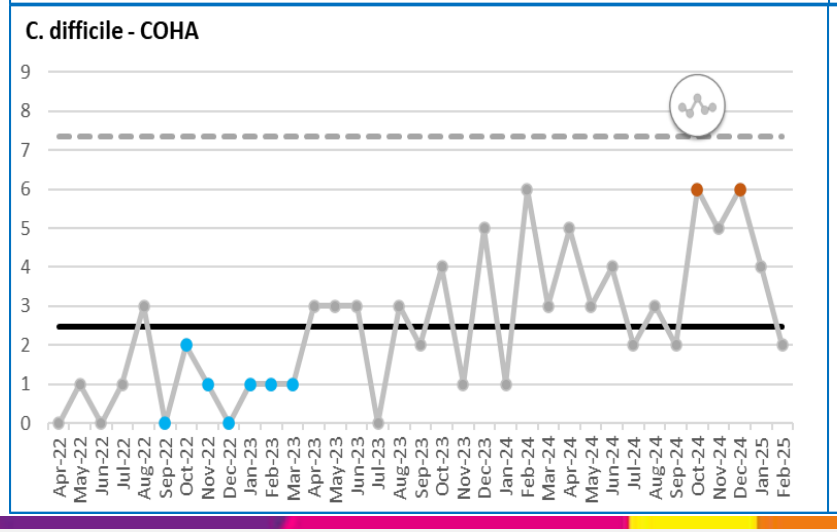
Infection prevention and control

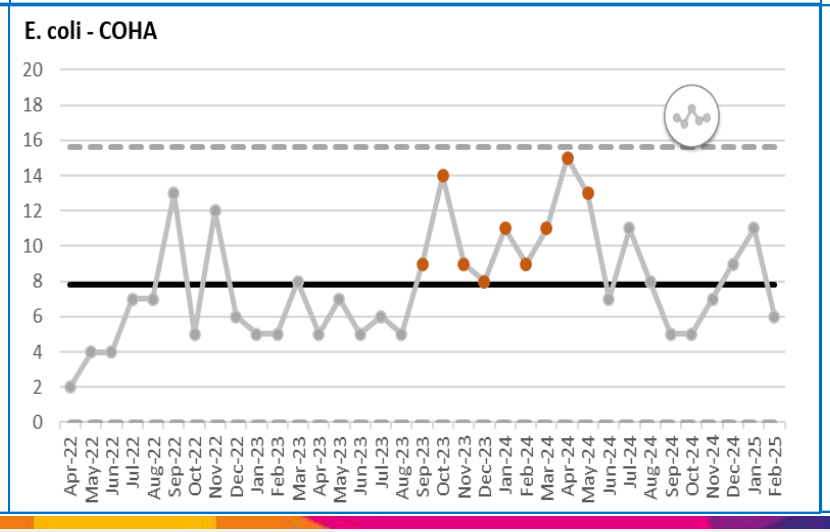
The Shrewsbury and Telford Hospital NHS Trust

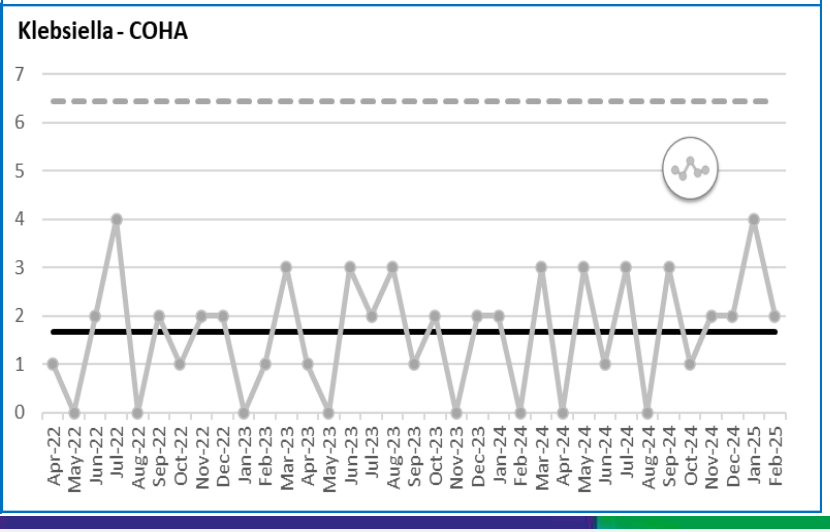












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Our Vision: To provide excellent care for the communities we serve

Infection prevention and control

The Shrewsbury and Telford Hospital NHS Trust

Summary:
In February 2025 there were the following bacteraemia:

- 8 MSSA (3 Healthcare / Hospital Onset - Healthcare Associated (HOHA) & 5 Community Onset - Healthcare Associated (COHA))
- 0 MRSA bacteremia
- 7 C. diff (5 HOHA, 2 COHA)
- 12 E. coli bacteremia (6 HOHA, 6 COHA)
- 6 Klebsiella bacteremia (4 HOHA & 2 COHA)
- 2 Pseudomonas bacteremia (2 COHA)

Recovery actions:
There were 0 MRSA bacteraemia's reported in February 2025

C. diff cases remain high with 104 cases reported until end of February 2025. 62 of these cases occurred greater than 48 hours after admission (HOHA) and the remaining 42 cases had recent contact in the Trust in the 28 days prior to the positive sample (COHA).

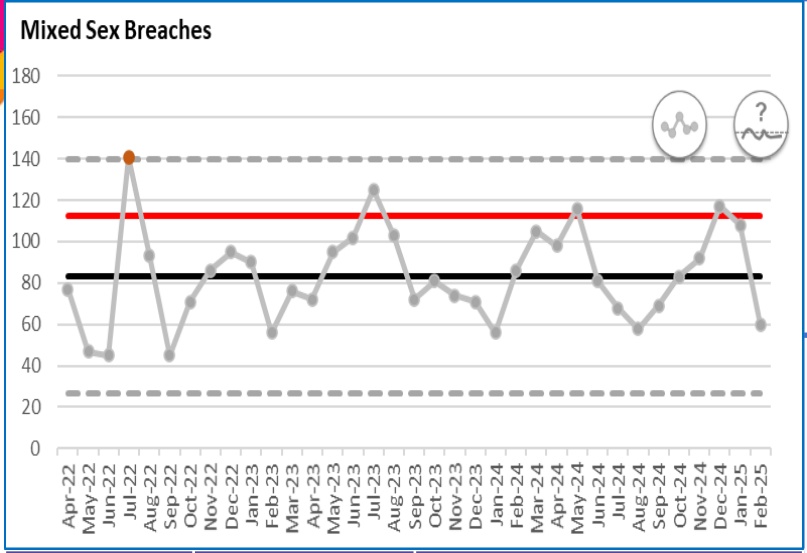
The C. diff action plan is in place, the actions on the current plan were updated in March but a further review of the action plan is currently being undertaken including the improvement subgroups as part of this action plan including the plans for allocation of a decant space to undertake a ward deep clean programme with estates and facilities.

Anticipated impact and timescales for improvement:
To be agreed and approved via the Director of Infection Prevention and Control at the IPC Assurance Committee.

Recovery dependencies:	Integrated Care Board (ICB) IPC improvement work in anti-microbials.

Mixed sex accommodation breaches

The Shrewsbury and Telford Hospital NHS Trust



Location	Number of breaches	Additional Information
AMU (PRH)	21 breaches	Over 4 occasions in AMA
ITU / HDU (PRH)	8 primary breaches	5 medical, 1 Gynae, 1 ENT, 1 T&O
AMA (RSH)	14 breaches	6 occasions (trolly area)
ITU / HDU (RSH)	17 primary breaches	9 surgical, 5 medical, 2 urology, 1T&O

Summary:
Mixed sex accommodation breaches remained high in January, the reasons again relate to the wider capacity issues around bed availability across the Trust with challenges remaining in relation to the step down of patients from HDU/ITU who are stable and no longer require this level of care but require ward-based care, and the use of AMA and AMA & SDEC at PRH overnight for patients requiring admission.
The use of AMA/SDECC to accommodate patients overnight who require an inpatient bed continues to require Executive approval but has continued to be used due to the capacity pressures within the Trust and balance patient safety across all clinical areas.

Recovery actions:

- Review of the Trust's application of the MSA Policy to ensure this is applied consistently across the Trust
- Improvement work in relation to patient flow, discharges earlier in the day (including increasing the number of discharges before midday and 5pm) and a reduction in patients with no criteria to reside continues
- Executive approval to use AMA/SDECC trolleys overnight continues to be required before this area can be used
- Work with System partners to maximise the use of Virtual Ward capacity and OPAT continues
- the Clinical Site Team have try to prioritise step down patients from ITU when this is possible.
- All actions in place to ensure patients comfort and dignity is maintained when AMA/SDEC is used

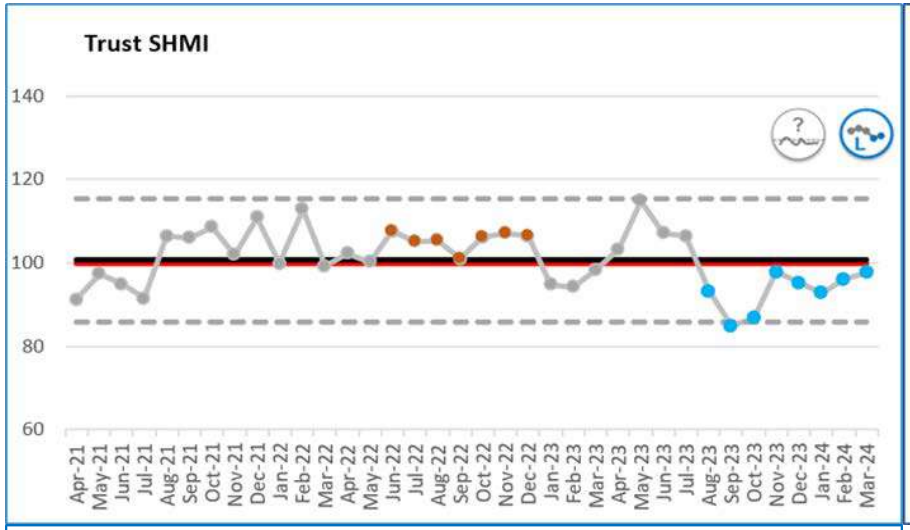
Anticipated impact and timescales for improvement:

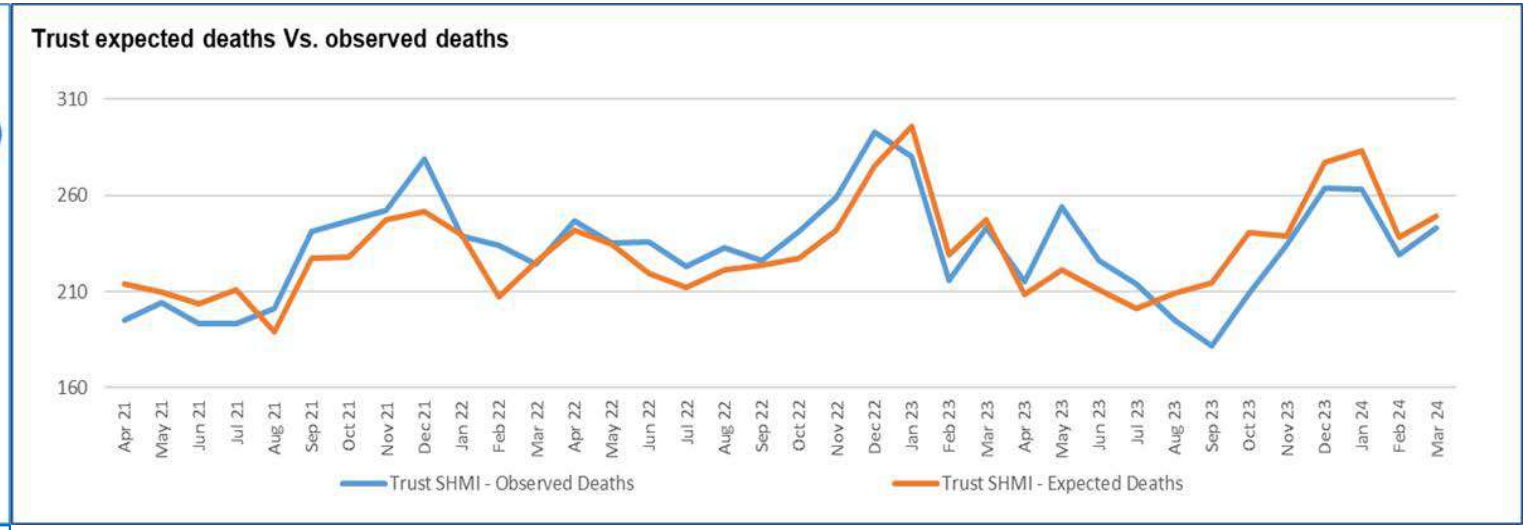
- Beds available earlier in day
- Less patients attending ED with conditions which could be treated on alternative pathways
- Reduction in no criteria to reside patients in hospital
- Patients cared for in the most appropriate environment to meet their needs

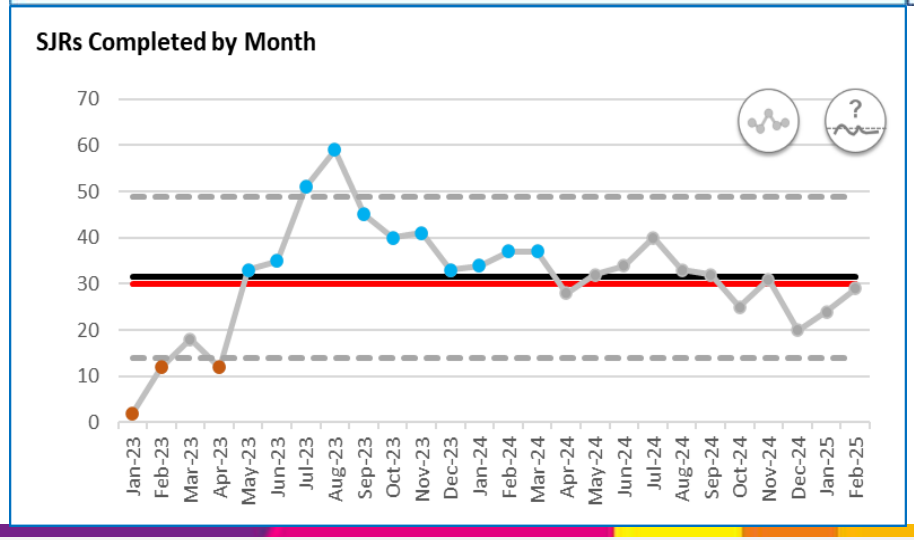
Recovery dependencies:	Patient flow improvement work. System wide work and alternative community pathways of care. Reduction in patients with no criteria to reside

Mortality outcome data

The Shrewsbury and Telford Hospital NHS Trust







Mortality outcome data

The Shrewsbury and Telford Hospital NHS Trust

Summary:

- Due to the ongoing issues with the Data Warehouse, no further update to the Summary Hospital-level Mortality Indicator (SHMI) is available beyond March 2024. The admission codes related to the following: cancer of the pancreas; fracture of the upper limb; coma, stupor, brain damage were indicating excess deaths across the Trust when data last available
- Total number of deaths in the Trust has reduced in February following a sharp increase in Jan 2025 in both inpatient deaths and deaths in ED
- SJR completion rate for deaths in December 2024 (LfD Dashboard presented April 2025), is 11.5%, impacted by delayed notes availability from the Clinical Coding team reducing the ability to complete the review process within the locally agreed 8-week timeframe. Percentage of SJRs completed is also dependent on number of SJRs triggered through all sources including, ME Scrutiny, mortality screening, MTG 'upgrades', and random sampling
- 3% of all deaths in Feb 2025 had an SJR triggered from ME Service on basis of significant concerns raised by the bereaved

Recovery actions:

- Reviews in progress for the primary diagnosis conditions with the highest number of excess deaths across the trust where these are higher than the peer average
- All deaths in low mortality Clinical Classifications System (CCS) groups are reviewed on an individual basis – last available data – no concerns identified following case record review
- Actions taken to increase ad hoc support for SJR completion within the wider multi-disciplinary team / senior nurses has resulted in an additional one reviewer who has now received training in the process. It is anticipated that an additional one day per month will be offered to assist with SJR completion
- Deaths where SJRs are triggered based on significant concerns being raised by the bereaved during ME Scrutiny, are triangulated and then reviewed through using SJR, DATIX, the formal complaint process and / or Coronial processes with learning shared as appropriate

Anticipated impact and timescales for improvement:

- Data acquisition problems within the Data Warehouse prevents further analysis of key performance indicators within the Learning from Deaths agenda and an inability to identify primary diagnosis conditions which need further review with regards to excess deaths or outlying conditions from April 2024 until a resolution is implemented.

Recovery dependencies:	Band 7 Senior Learning from Deaths Manager post remains vacant and subject to appropriate authorisation being provided to recruit to role.

Quality - Effective - Right Care, Right Place, Right Time

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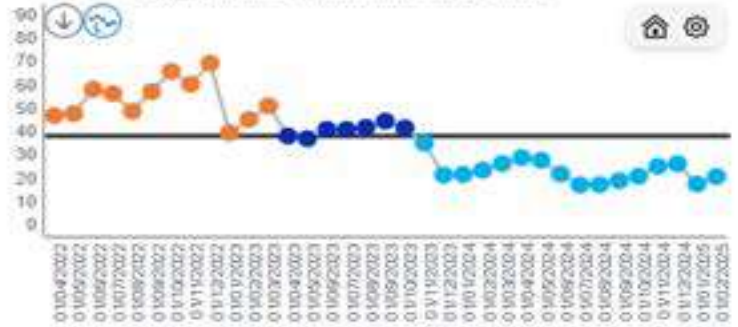
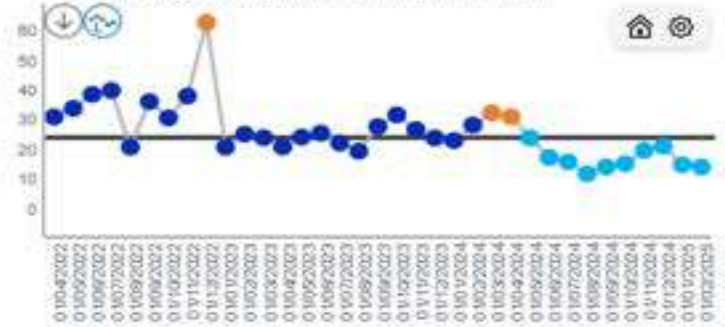
Best Clinical Outcomes

	Nov-2023	Dec-2023	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025
ED Triage Average Time To Streaming - Adults	35.01	21.30	21.59	23.43	26.28	28.82	27.70	21.79	17.11	17.20	18.90	20.80	25.10	26.17	17.46	20.65
ED Triage Average Time To Streaming - Children	26.89	24.09	23.20	28.44	32.54	31.26	24.10	17.50	16.00	12.00	14.30	15.40	19.90	21.29	15.04	14.31
% Patients seen within 15 minutes for initial assessment	37.27	50.80	51.02	47.02	45.54	42.43	47.70	54.14	59.99	64.80	59.80	58.90	52.90	51.61	62.71	61.18
Friends and Family Test - A&E - % responded Very Good/Good	61.60	62.90	67.70	65.20	62.40	62.90	60.30	66.10	75.00	75.90	53.10	69.80	71.20	60.50	71.00	77.70
Friends and Family Test - A&E - Response Rate %	4.00	3.00	5.50	4.20	3.80	5.10	6.10	6.60	5.70	6.50	0.30	5.90	5.60	5.90	7.30	1.00
Complaints by Theme - Admission / Discharge	8	12	14	13	12	20	14	17	17	22	18	16	17	18	14	18

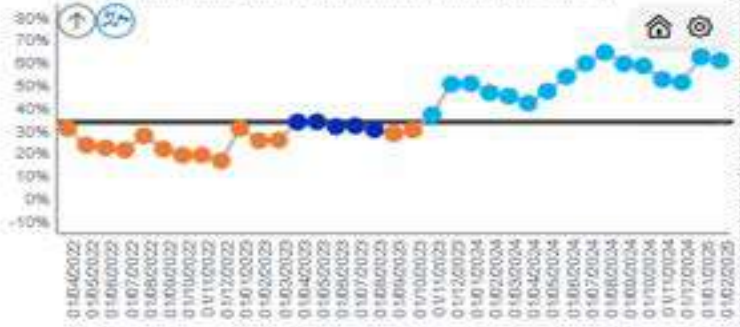
ED Triage Average Time to Streaming - Adults



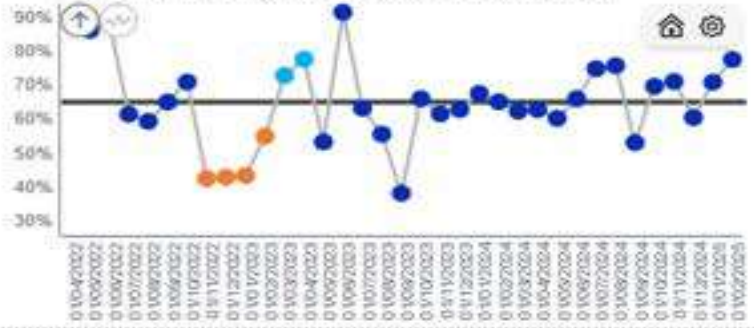
ED Triage Average Time to Streaming - Children



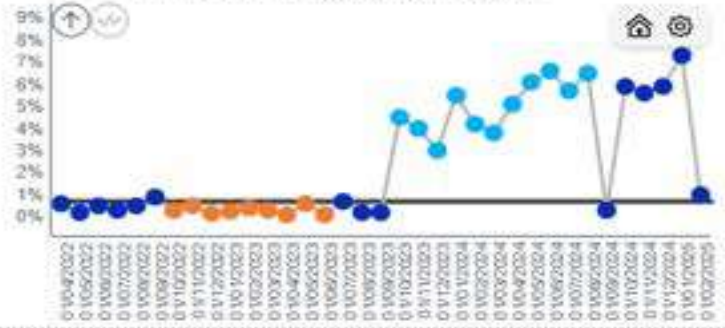
% Patients seen within 15 minutes for initial assessment



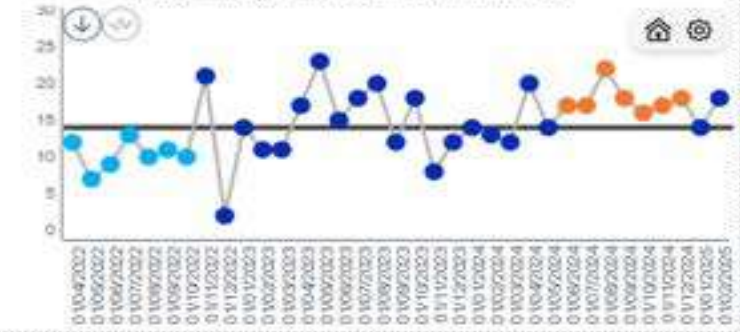
Freints and Family Test - % Responded Very Good/Good



Freints and Family Test - Response Rate %



Complaints by Theme - Admission / Discharge

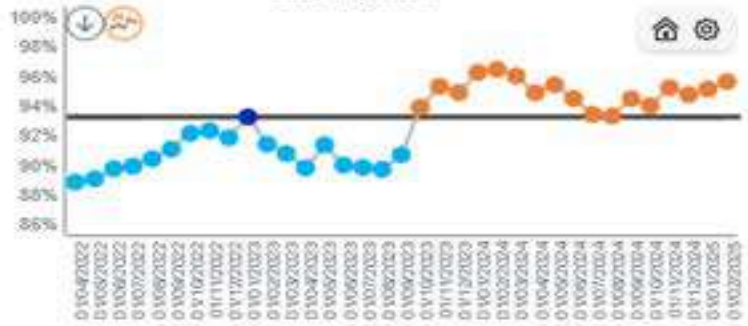


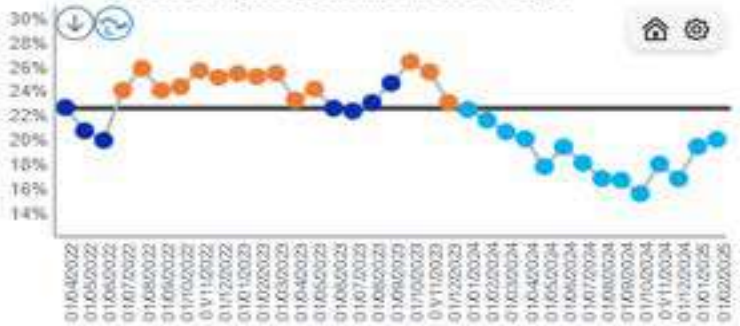
Quality - Effective - Right Care, Right Place, Right Time

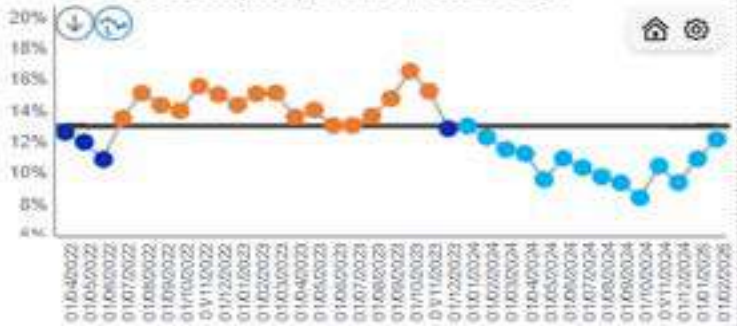
Page 1

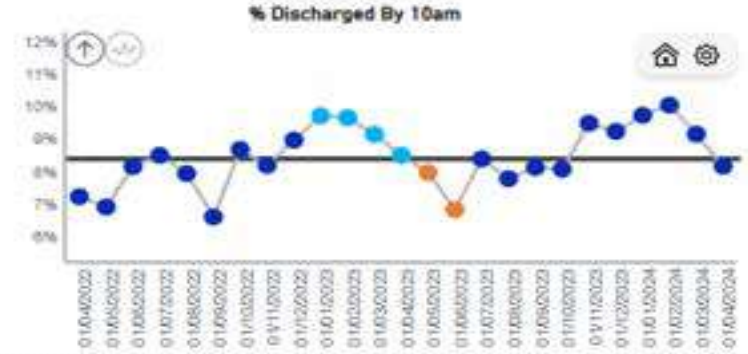
Best Clinical Outcomes

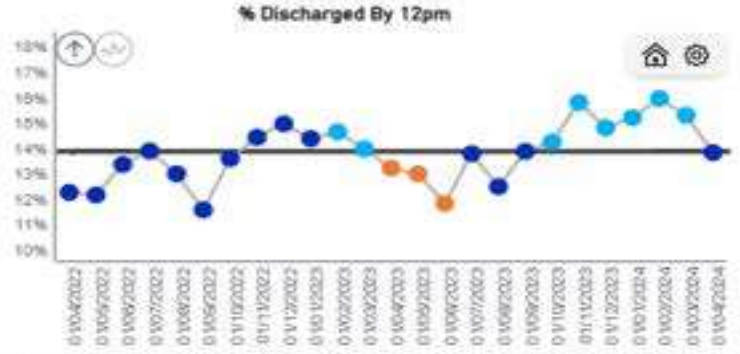
	Oct-2023	Nov-2023	Dec-2023	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025
Occupancy Rate %	93.96	95.37	94.96	96.31	96.52	96.09	94.95	95.49	94.55	93.48	93.37	94.54	94.08	95.29	94.81	95.20	95.69
% beds occupied by patients with LOS >14 days	26.48	25.66	23.15	22.56	21.70	20.73	20.16	17.88	19.50	18.18	16.92	16.78	15.66	18.09	16.88	19.53	20.11
% beds occupied by patients with LOS >21 days	16.53	15.24	12.83	13.01	12.29	11.50	11.24	9.57	10.94	10.34	9.75	9.36	8.40	10.45	9.37	10.90	12.16
% Discharged By 10am	8.09	9.51	9.25	9.75	10.06	9.17	8.18										
% Discharged By 12pm	14.29	15.85	14.85	15.25	16.00	15.34	13.87										
No criteria to reside	143	140	137	123	104	101	114	112	114	106	92	89	101	117	102	102	102

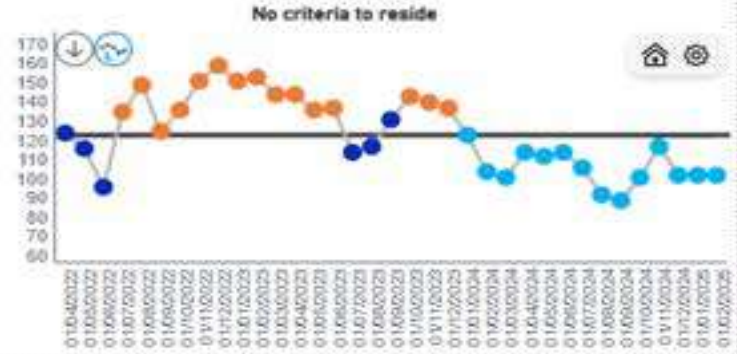












Diabetic foot

The Shrewsbury and Telford Hospital NHS Trust

Summary:
Shropshire, Telford and Wrekin (STW) ICB are an outlier for minor and major diabetes foot ulcers. We have a higher than national average of hospital spells for foot disease for people with diabetes (PWD).
Recent audit has shown we are a long way from delivering the National Institute for Health and Care Excellence (NICE) guidance.
People with diabetes should have foot assessment within 6 hours of admission. Only 10% of PWD have a compulsory foot assessment within 24 hrs.
People with diabetes foot ulcer should have MDFT referral within 24 hours of finding the wound. Only 42% of PWD with wounds were referred to the Multidisciplinary Foot Team (MDFT).
People at high risk of developing a hospital acquired foot problem should be issued with heel offloading. Only 13% of high risk PWD were issued heel offloading.

Recovery actions:

- Diabetes foot document included within the overall admission assessment document
- Easy to use document – Achilles heel. Education for nurses and Healthcare Assistants (HCAs) (LMS, Ward, Introduction of link workers) - complete
- Education for medics – new documents and quick referral posters – complete
- Update all inpatient foot documents. Accessible to all – complete
- Heel offloading available on ward – Heel boot available to order on wards – complete
- Hot clinics introduced for A&E and UCC for quick access to multidisciplinary team (MDT) clinic
- Quick access to outpatients with new diabetes foot complications – introduction of Hot phone
- Capacity to see PWD with acute problems in < 5 working days by changing ratio of new patient/follow up appointments
- Inhouse Diabetes Podiatry team (previously Shropcom who reduced contract, currently locum staff)
- Safety team will compile monthly reports on diabetes foot. This will be cross linked with treatment list. Requested SQL report to be shared

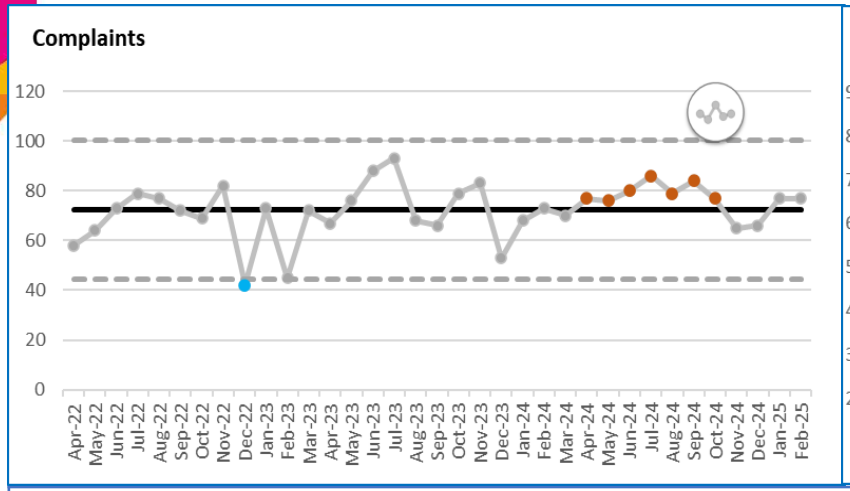
Anticipated impact and timescales for improvement:
Implementation of the new diabetes foot assessment. Majority of wards using new document, minority utilising last of old document. Education for both HCAs & nurses now on LMS.
Diabetes foot champions for every ward identified , targeted education
Annual integrated foot conference aimed at Acute Staff June 25
Hot clinics in A&E established.
Business Case agreed awaiting HR approval to go to TRACS.
Anticipated impact improvement in Diabetes foot pressure ulcers / hospital acquired diabetes foot ulcers.
Clinical strategy priority is reducing hospital spells for diabetes foot issued to 15 per 100k population and the relative number of diabetes lower limb amputations by 11 K per 100k population by 2025

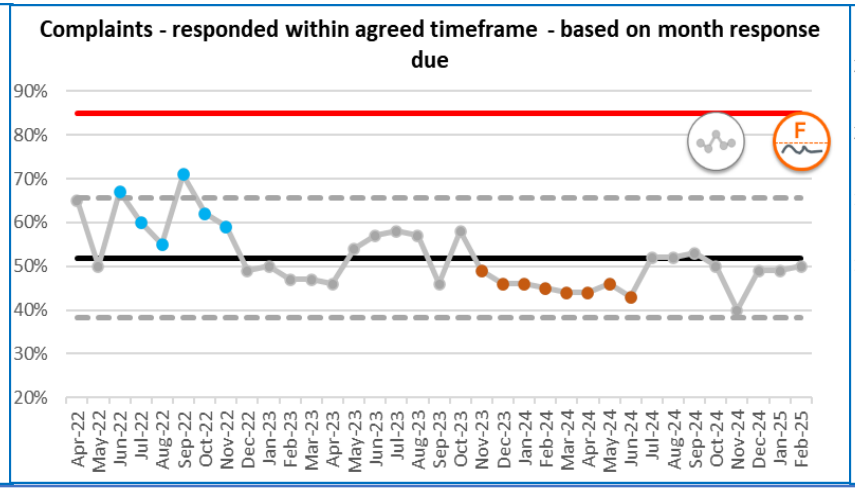
Recovery dependencies:

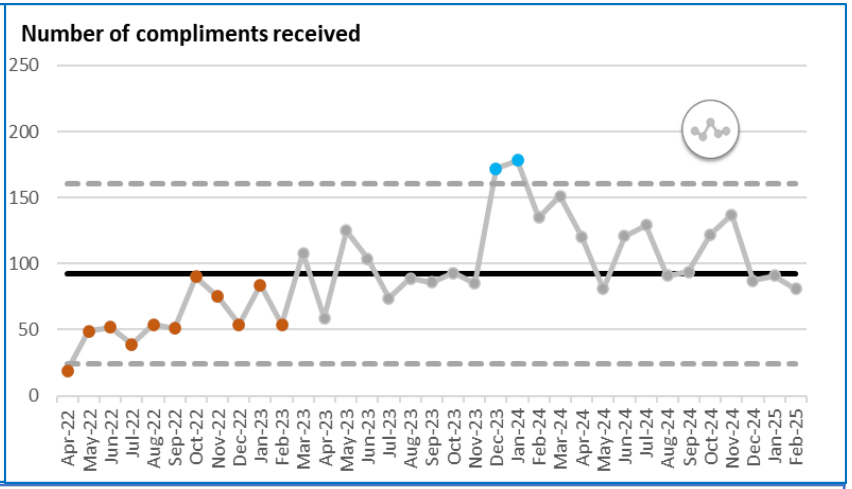
Business case for SaTH Diabetes Podiatry Team agreed
Ownership of new documentation and education for diabetes foot at ward and matron level
Diabetes foot screening must be undertaken in primary care, foot protection in community reducing clinical need in Acute service

Complaints and compliments

The Shrewsbury and Telford Hospital NHS Trust







Summary:
Numbers of new complaints were within expected variation in February. Work is ongoing to further reduce the backlog and the average time taken to respond to complaints further improvement is still needed, and work is ongoing with the divisions. The weekly meetings are showing good progress and ownership by the divisions, with early contact with complainants in cases where the patient has died to offer a meeting.

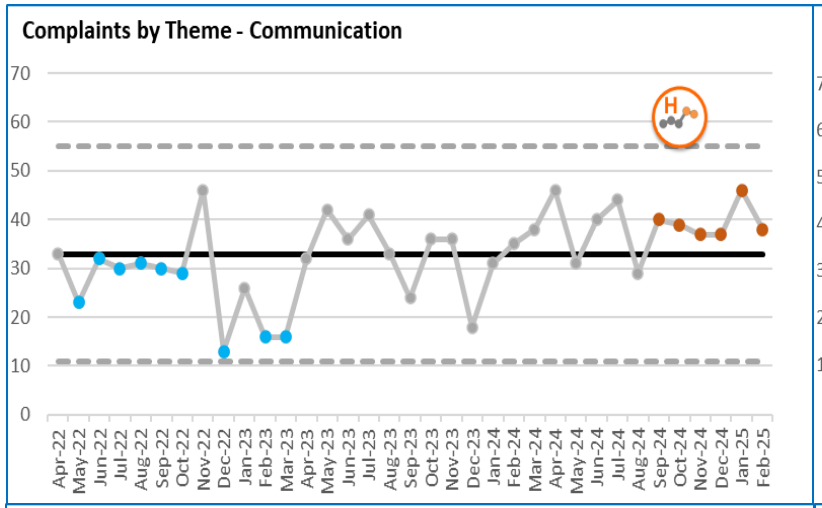
Recovery actions:
Dashboards now on Datix giving greater visibility of open cases for specialties.
Continue with weekly complaints review meetings with Divisional and Specialty Teams.
Embedded processes for bereavement cases, with divisional ownership.

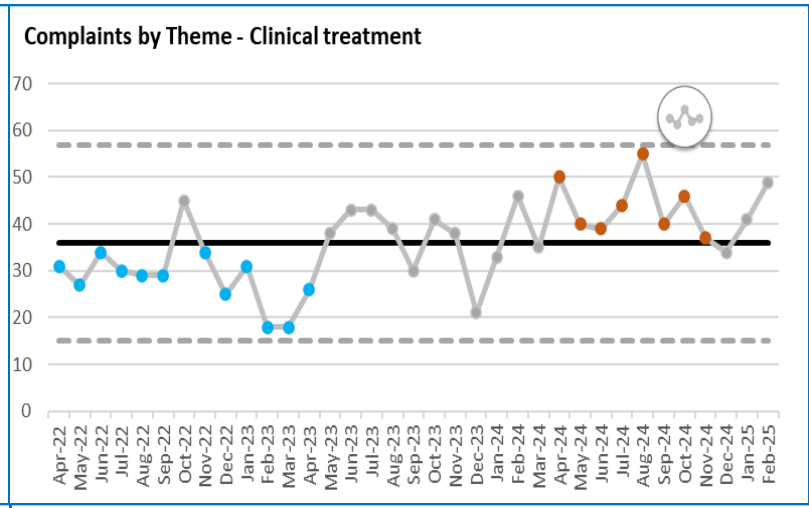
Anticipated impact and timescales for improvement:
Improvement in timeliness of responses.
Evidence of early involvement and support from Divisions/Specialities with complainants

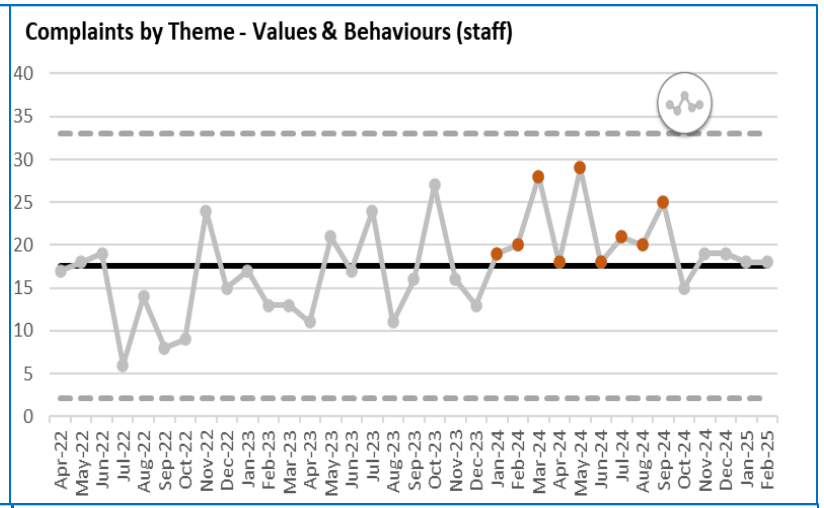
Recovery dependencies:	Capacity within Divisional teams due to high levels of clinical activity.

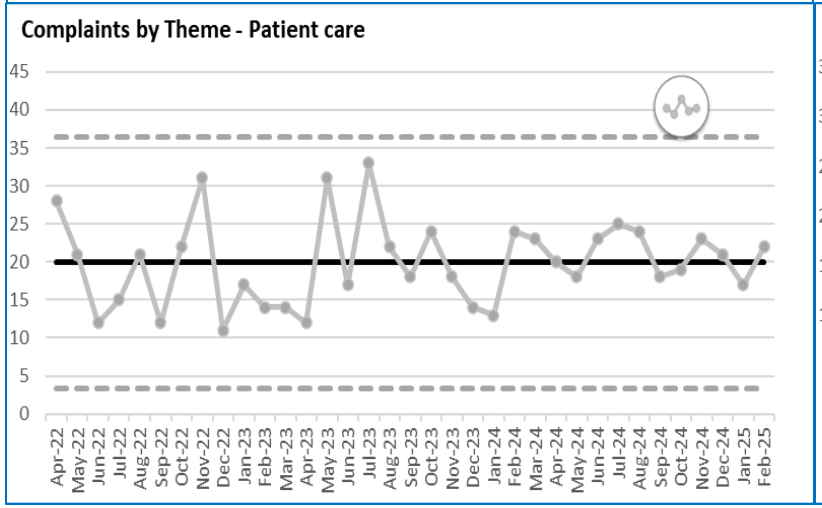
Complaints by theme – Top 6

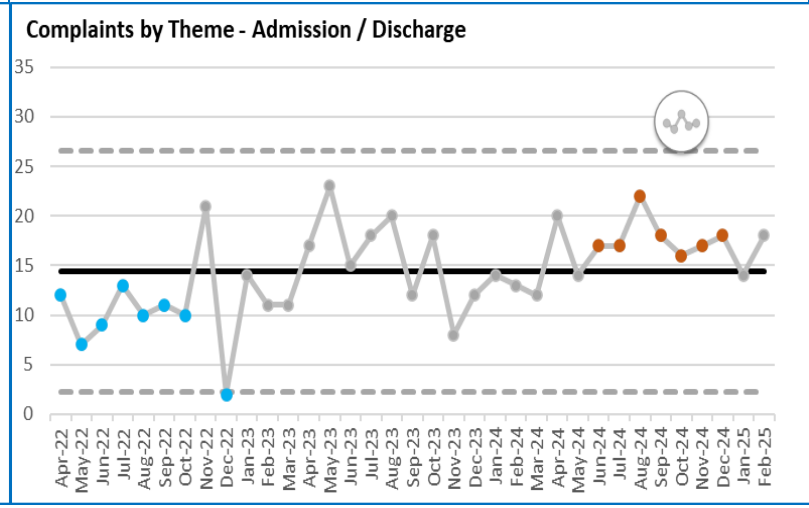
The Shrewsbury and Telford Hospital NHS Trust

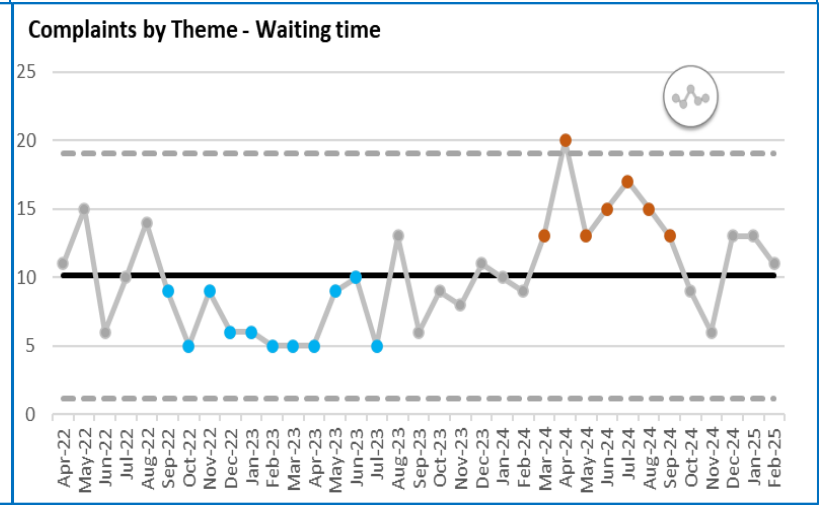












Quality - Patient Experience - Learning from Experience

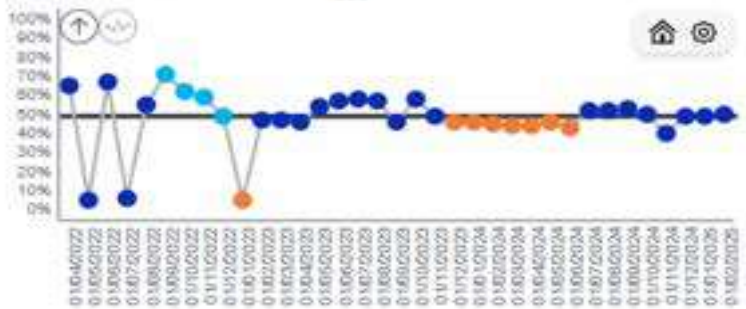
The Shrewsbury and Telford Hospital NHS

Partnering · Ambitious Caring · Trusted

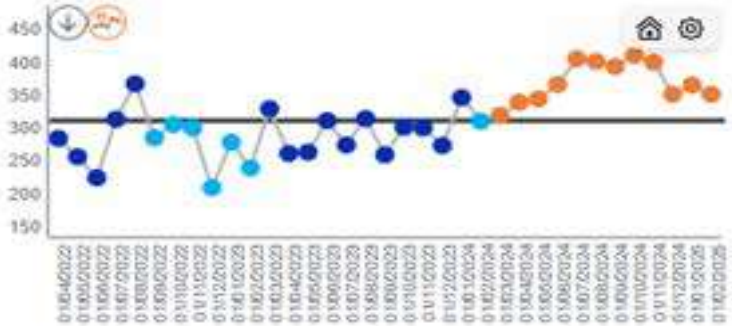
End of Life Care

	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025
Complaints - % Responded to within agreed timeframe based on month response due	46	45	44	44	46	43	52	52	53	50	40	49	49	50
PALS contacts	347	311	320	340	345	367	406	402	394	411	401	352	366	352
Complaints by Theme - Staff	53	61	70	70	67	63	79	55	73	57	67	59	74	66
Re-opened complaints upheld	1	0	0	0	0	0	0	0	0	0	1	0	0	1
Compliments Received	178	135	151	120	81	121	129	91	94	122	137	87	91	81
Friends and Family Test % recommenders	91.8	93.3	91.0	89.1	88.4	89.7	93.4	93.0	97.9	92.8	92.7	88.8	91.7	98.1

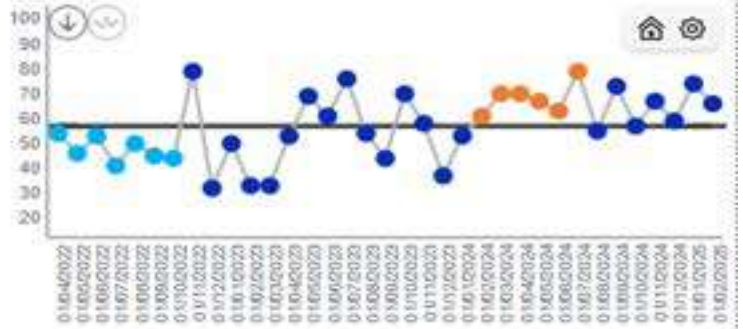
Complaints - % Responded to within agreed timeframe based on month response due



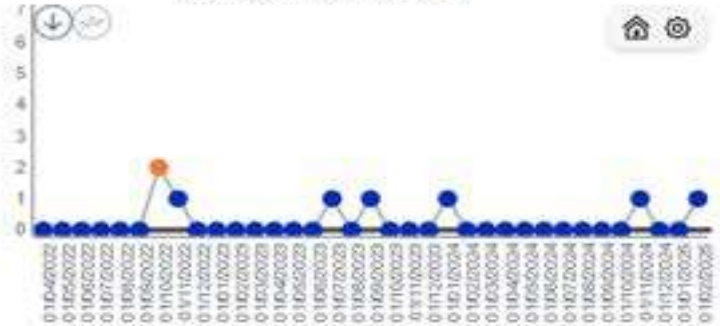
PALS contacts



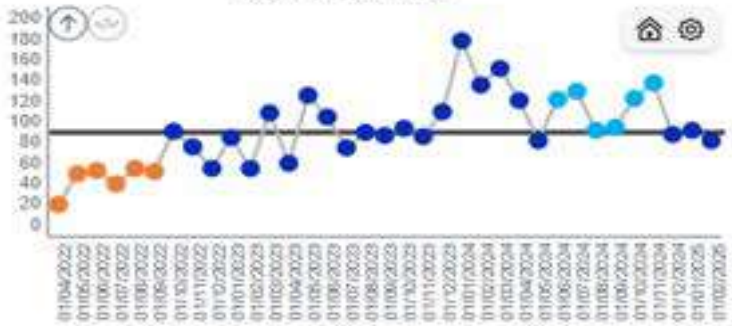
Complaints by Theme - Staff



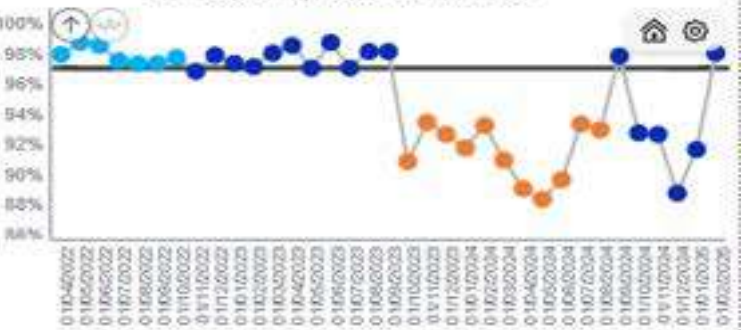
Re-opened complaints upheld



Compliments Received

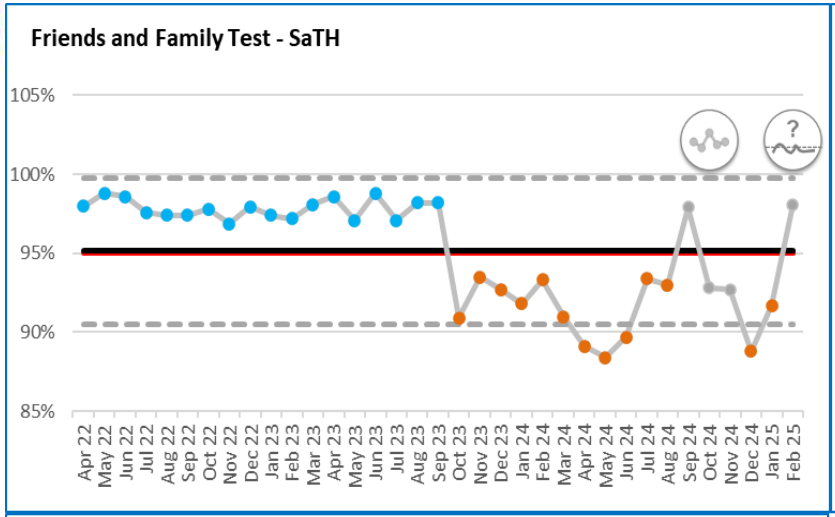


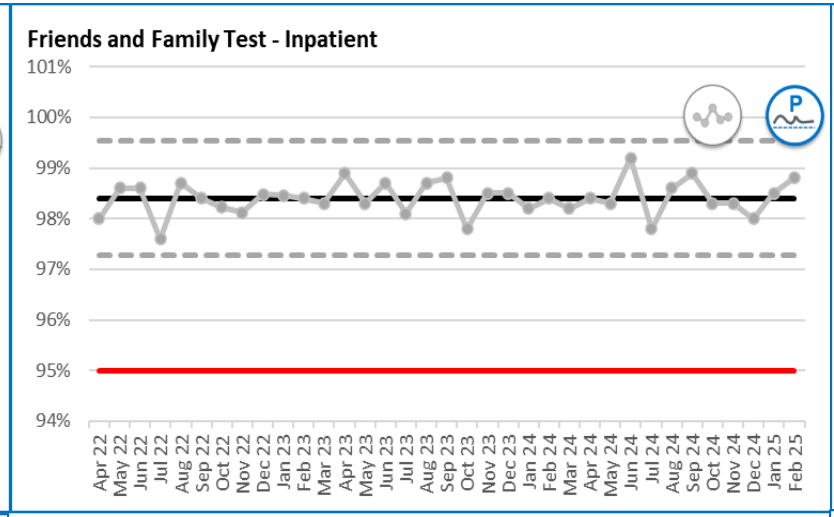
Freinds & Family Test % recommenders

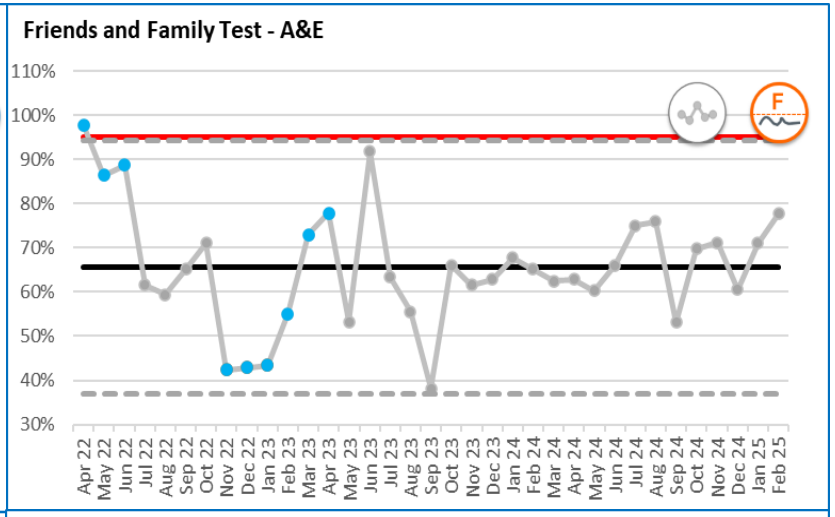


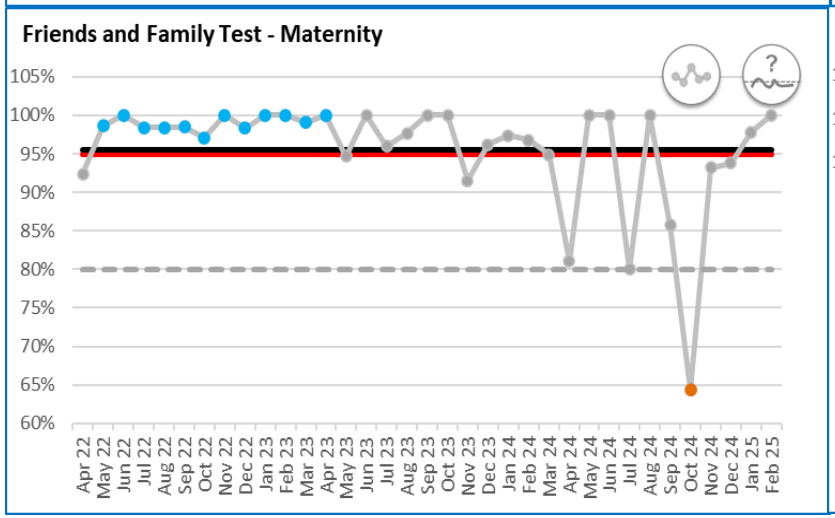
Friends and family test

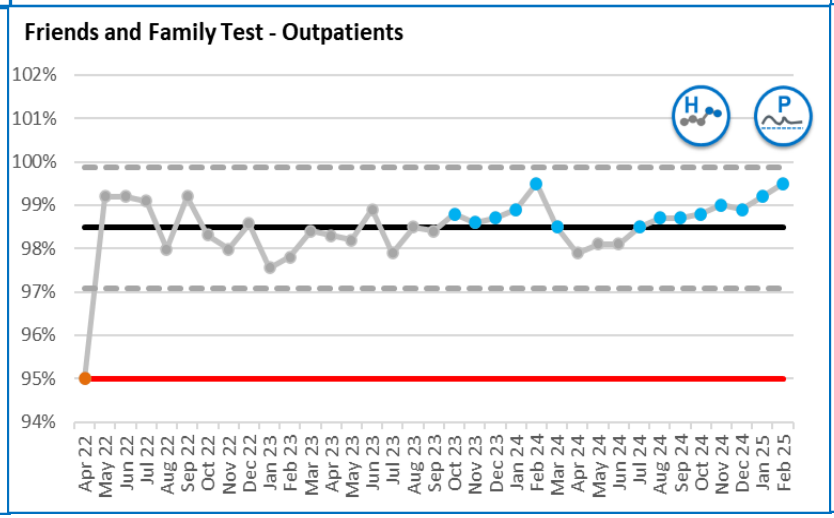
The Shrewsbury and Telford Hospital NHS Trust

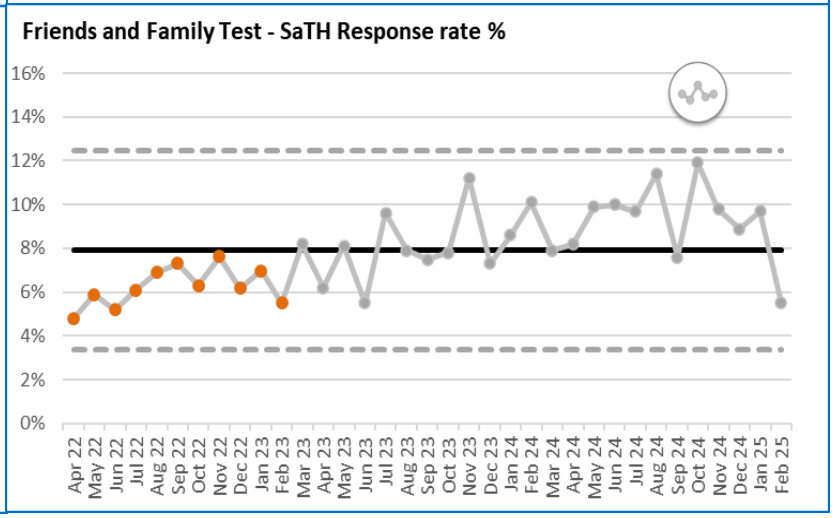






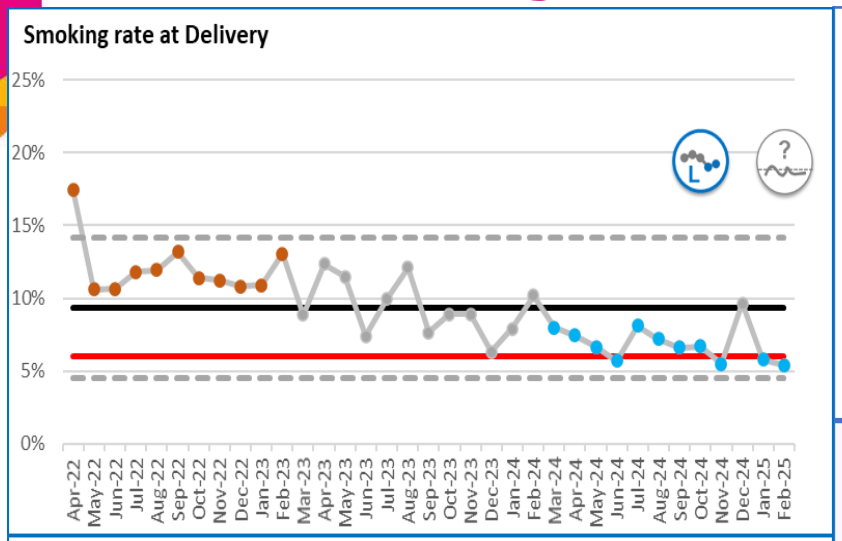


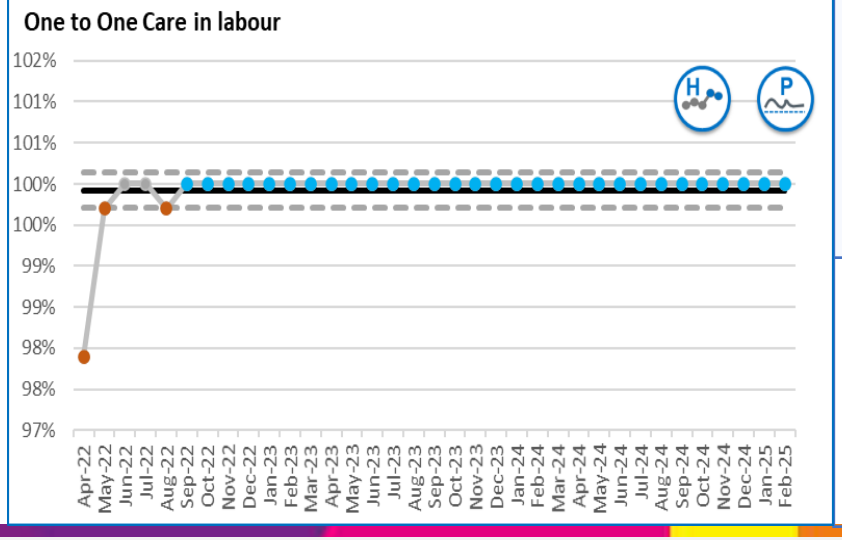




Maternity

The Shrewsbury and Telford Hospital NHS Trust





Summary:

Smoking at time of Delivery (SATOD) in February has seen a further decrease from 5.8% to 5.4%

The overall SATOD rate for 2024/25 remains at approximately 6.8%, which is a 2.5% decrease on the previous years figures, with just March data to collect.

Accurate recording of SATOD status is being closely monitored by the Healthy Pregnancy Support Service (HPSS) team to ensure correct data is being recorded.

Government target for this metric remains at 6%.

100% 1:1 care in labour is being achieved consistently in line with a comprehensive escalation policy and a 24/7 manager of the day service.

Recovery actions:

Look to further decrease SATOD through 2025.

Continue to work towards Government target for year end in March 2025.

The team are now able to refer family members for support to Telford Council or Shropshire Social prescribing service where Nicotine Replacement Therapy is now being offered.

Anticipated impact and timescales for improvement:

Continue to map and target areas of deprivation and provide support for pregnant women, whilst referring family members to local smoking cessation services.

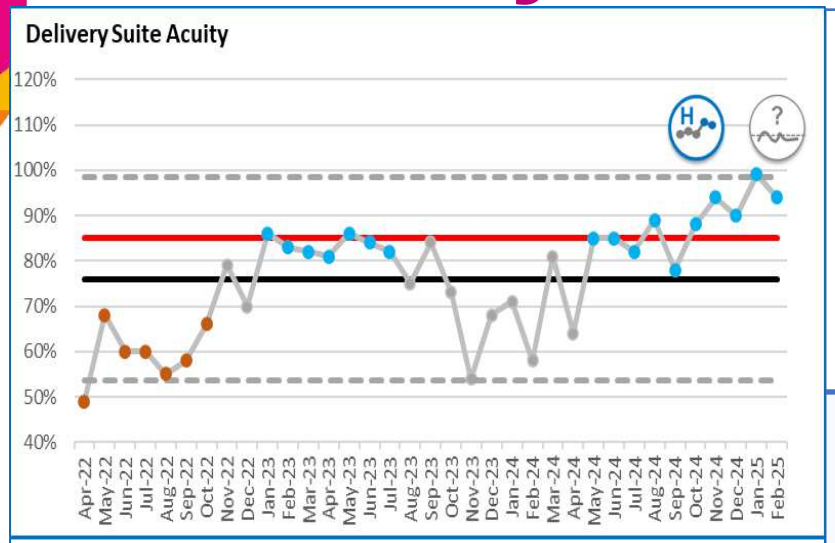
As per Saving Babies Lives version 3, all staff to discuss smoking cessation at every appointment and update smoking status. Carbon Monoxide monitoring to be completed at every antenatal appointment and offer re-referral to in house support service at any time.

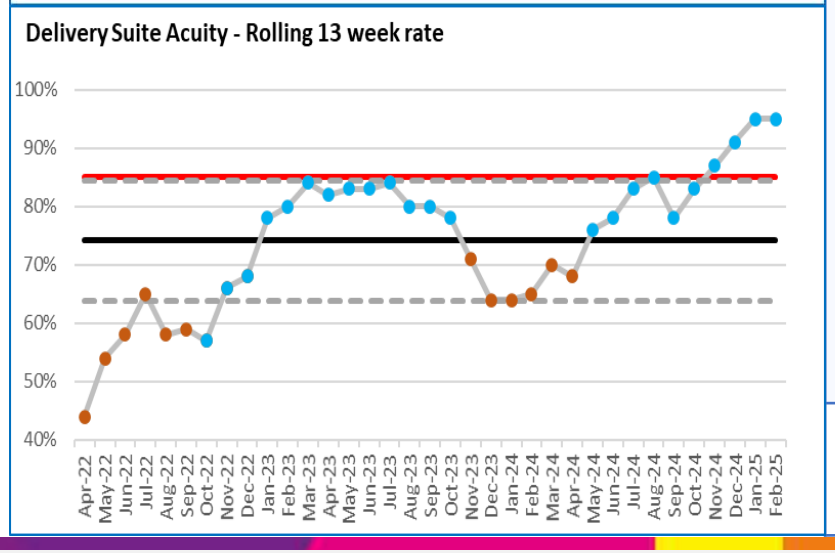
Recovery dependencies:

Local demographic has a large impact on SATOD rates despite intervention and support from the HPSS. The local demographic has higher than average deprivation, unemployment and complex social needs, which is linked to higher rates of tobacco dependence. 22 out of 106 ICB's (20%) are currently reaching the Government target. It is evident that this is a challenging target to reach for most Maternity services, however SaTH figures are now close to aligning with Government targets.

Maternity – delivery suite acuity

The Shrewsbury and Telford Hospital NHS Trust





Summary:
Delivery suite acuity has increased in February to 94% this is aligned to the National target of 85% and has been consistent for 6 months. The service continues to experience high levels of unavailability (>35wte against template) as a result of maternity leave/sick leave/supernumerary status of Band 5 midwives. This is in addition to short term sickness for seasonal bugs for staff and their dependants. In order to reduce the risk to the service, the specialist midwifery workforce has been reviewed with several being redeployed into the clinical workforce which reduces the risk to patient safety but increases the risk of non-delivery of the specialist workforce agenda. Ongoing recruitment pertaining to clinical roles continue, we are seeing an increase in external applications which is a positive sign and testament to the ongoing transformation work.

Recovery actions:
We continue to work through a comprehensive workforce plan which focuses on retention of current staff and proactive recruitment in conjunction with active management of attrition rates.

Proactive management of staffing deficits embedded via daily staffing meetings and the escalation policy, ensuring staff compliance with 1:1 care in labour and the coordinator maintains supernumerary status as per Clinical Negligence Scheme for Trusts (CNST).
100% 1:1 care in labour consistently being achieved.

Anticipated impact and timescales for improvement:
Continue to work towards maintaining 85% target for green acuity using proactive management of the clinical midwifery workforce.
High levels of unavailability continue to be anticipated which is mitigated by increasing clinical work for specialist midwives and senior leadership teams.
Several specialist roles have been paused to support the clinical workforce which has given a total of 16.8wte additional staffing resource.
The Head of Midwifery has stepped up to Interim Director of Midwifery role, Subsequently, resulting in a shortfall in Head of Midwifery hours.

Recovery dependencies:	The introduction of vacancy panels have hindered recruitment, as proactive management of attrition rates has been affected significantly.

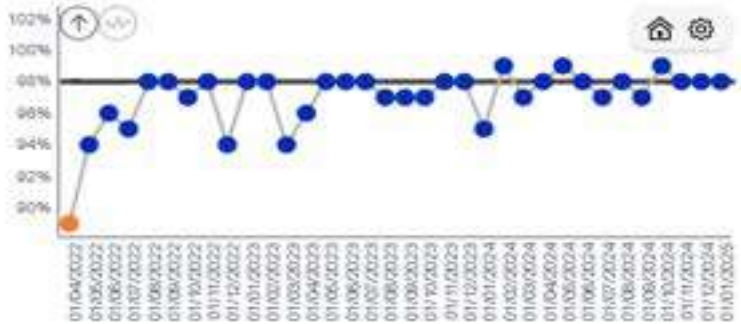
Quality - Patient Experience - End of Life Care

Page 2

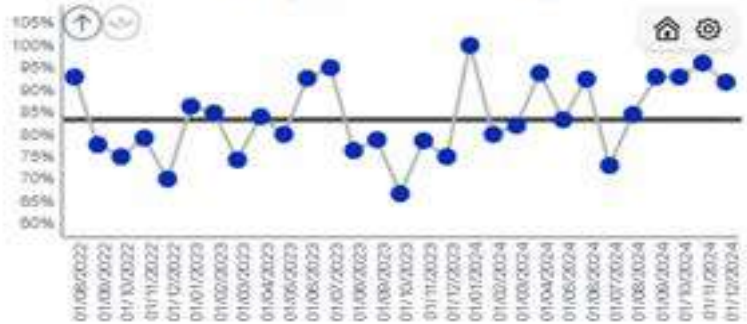
Learning from Experience

	Sep-2023	Oct-2023	Nov-2023	Dec-2023	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025
Palliative and End of Life Care - Audit Score % Score	97	97	98	98	95	99	97	98	99	98	97	98	97	99	98	98	98
% Overall rating of the PEoLC - Outstanding	78.8	66.7	78.6	75.0	100.0	80.0	82.0	93.8	83.3	92.4	73.0	84.5	92.9	92.9	96.0	91.7	
PPOC Discussion - total number	75	107	77	96	96	92	98	94	92	94	107	92	115	96	109	92	
PPOC Achieved - total number	61	96	72	91	86	82	86	88	86	78	97	86	103	87	101	89	
% Felt their loved one was comfortable in last days	65.0	76.5	92.6	92.0	82.8	72.8	72.4	88.2	60.6	78.6	69.2	64.7	70.6	68.8	92.0	58.3	
Palliative/End of Life Care - Nursing QA Audit	312	320	310	297	284	295	291	268	266	275	274	266	278	262	256	195	215

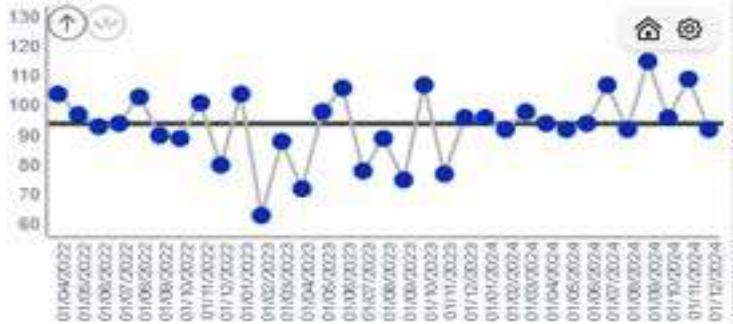
Palliative and End of Life Care - Audit Score % Score



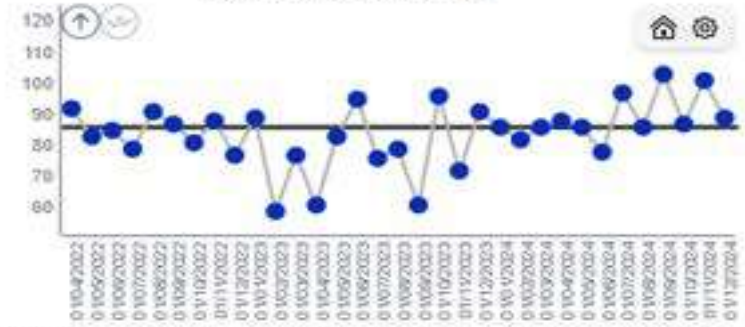
% Overall rating of the PEoLC - Outstanding



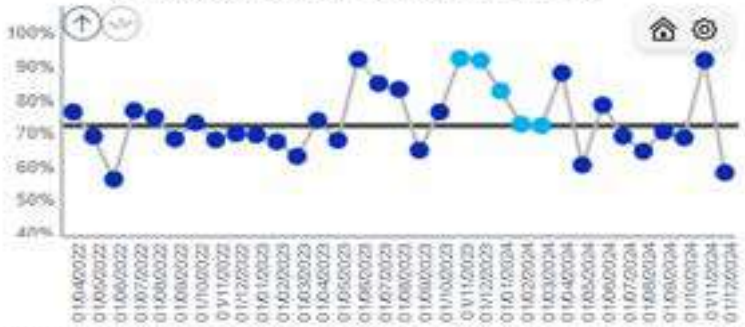
PPOC Discussion - total number



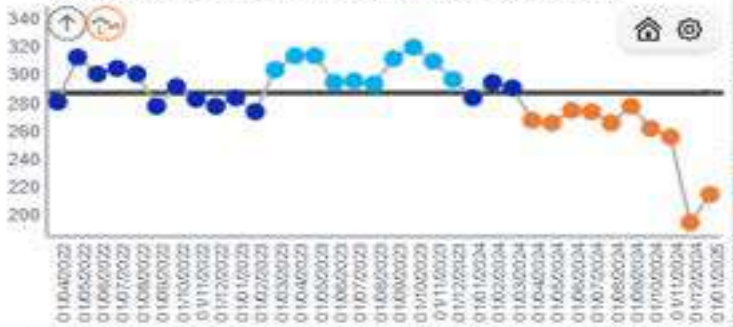
PPOC Achieved - total number



% Felt their loved one was comfortable in last days



Palliative/End of Life Care - Nursing Quality Assurance Audit

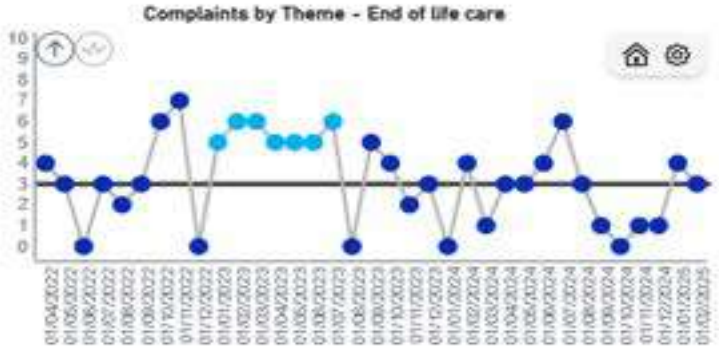


Quality - Patient Experience - End of Life Care

Page 1

Learning from Experience

	Oct-2023	Nov-2023	Dec-2023	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025
Bereavement feedback data - Total Number of responses	17	56	25	29	22	29	17	34	14	27	17	17	16	25	12		
Complaints by Theme - End of life care	4	2	3	0	4	1	3	3	4	6	3	1	0	1	1	4	3
End of Life Care Training	89.15	90.29	89.95	87.24	87.89	87.81	85.74	86.25	85.80	86.15	82.79	82.21	84.57	85.25	87.09	89.65	89.73



Our Vision: To provide excellent care for the communities we serve

End of life

The Shrewsbury and Telford Hospital NHS Trust

Summary:
Performance in relation to Palliative and End of Life Care (PEOLC) metrics remain good. Training is above the Trust target and patient feedback remains positive. Ongoing review and monitoring of the metrics takes place monthly via the Palliative and End of Life Care Steering Group and reports quarterly to the Quality Operational Committee.

Recovery actions/Ongoing Process for Monitoring:	**Anticipated impact and timescales for improvement:**
There is an overarching PEOLC improvement action plan and a PEOLC dashboard reviewed monthly at the PEOLC Steering Group enabling early identification of actions to maintain or improve compliance. PEOLC complaints are discussed at the Steering Group, themes relate to communication around end of life care continue. PEOLC ward support programme which supports wards with all aspects of PEOLC Small number of patients included in the Nursing Quality Assurance audits can affect the results of these audits. Action to ensure all matrons in ward areas caring for PEOLC patients are completing audits is ongoing.	Ongoing monitoring via PEOLC Steering Group to ensure improvements are sustained

Recovery dependencies:	N/A

Mental health training

The Shrewsbury and Telford Hospital NHS Trust

Summary:

- Introduction to the Mental Health Act (1983) training is available on LMS. This training provides an understanding of the Mental Health Act (1983), its application within an acute hospital context and an understanding of relevant considerations following detention under the Mental Health Act (1983), including giving of rights
- Restrictive Intervention Training- De-escalation, management and intervention training (DMI) competency lasts for 12 months before it expires. An update is required before the 12-month period usually at half the amount of training received- for example two-day DMI course for the enhanced care team would require a one-day update.
- There is a need to review how this training going forward is going be delivered, a scoping exercise is being undertaken and will be shared in Q4 2025 Areas that should maintain DMI competency include the Emergency Departments, The Enhanced Care Team and Ward 19. How this training is delivered to be addressed to ensure the Trust's requirements to comply with the legal considerations surrounding restrictive interventions including: Health & Safety and Risk assessment
- Mental Capacity Act 2005, Criminal Law Act 1967 (reasonable force, intent, potential), Human Rights Act 1998 and Duty of Care/Wilful Neglect. NICE guidance violence and aggression NICE guideline [NG10] (NICE, 2015) also states healthcare providers should train staff in de-escalation and specific areas in restraint
- The Mental Health Liaison team are developing a training package for staff which will cover mental health illnesses, presentations and symptoms, mental health triage and brief risk assessment. This will be available as e-learning modules and face to face depending on the area and need

Recovery actions:

- Mental Health Liaison (Midlands Partnership Foundation Trust - MPFT) progressing with development of training package
- De-escalation, Management and Interventions (de-escalation and clinical holding) training scoping exercise completed
- All Clinical Site Managers (CSM) trained in scrutiny and acceptance of Section Papers, refresher training (annually) August 2024 and September 2024
- Ongoing monitoring of compliance of Section Paper via monthly audits carried out by the Mental Health Administrator

Anticipated impact and timescales for improvement:

- Compliance with mental health triage- standards In line with Royal College of Emergency Medicine Mental Health Audit Standards for Individual Patients. Completion August 2025
- Scoping exercise for de-escalation, management and intervention completed by October 2024

Recovery dependencies:

- Joint working with Mental Health Liaison Team (Midlands Partnership Foundation Trust) to ensure targets are met
- Availability of funds for De-escalation, Management and Intervention Training
- Staff uptake of training offered

Learning disability and/or Autism (draft)

The Shrewsbury and Telford Hospital NHS Trust

Summary:
Improve the care and experience for inpatients with Learning Disabilities and/or Autism.

Recovery actions:
- Oliver McGowan training T1 is at 86.30%
- Working at a system level for the best model to deliver T2 training in 2025/26
- LD and Autism Patient Experience Group now meeting regularly
- Work ongoing to Embedding of the patient passport
- Stronger communication now in place for cases where MCA/BI requires collaborative working
- Oliver McGowan added to the mandatory training requirements for all locum and short-term medical staff
- E-Learning training added to the mandatory list for doctors during induction and reflected on LMS.
- Review of LD.A Policy
- Learning from incidents
- Strengthen the function of the LD and Autism Improvement Group
- Undertake LD Self Improvement Tool Assessment to inform action plan in 2025/26

Anticipated impact and timescales for improvement:
These are ongoing actions through 2025/26 and assessment in relation to progress will be made quarterly throughout the year

Recovery dependencies:

Availability of the Oliver McGowan training T2.

Responsiveness

Executive Lead:

Chief Operating Officer

Ned Hobbs

Integrated Performance Report

The Shrewsbury and Telford Hospital NHS Trust

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Trend
Key Performance	ED - 4 Hour Performance (SaTH Type 1 & 3) %		78% Mar'25	70.0%	51.1%	50.0%	48.6%	52.2%	54.8%	55.9%	52.4%	52.4%	50.9%	50.4%	52.4%	52.7%	53.1%	
	ED - 4 Hour Performance (All Types inc MIU) %		-	-	60.3%	60.2%	59.2%	61.9%	64.7%	65.0%	62.2%	61.5%	59.7%	58.7%	61.8%	61.5%	61.9%	
	ED - 12 Hour Trolley Breaches	R	0	0	844	578	629	547	560	548	587	1060	1502	1484	1316	1130	1390	
	Number of Ambulance Arrivals	R	-	-	3124	3089	3071	2963	3096	3404	3107	3203	3052	3103	3190	2945	3482	
	Ambulance Delays > 15 minutes	R	-	-	2536	2327	2391	2553	2675	2595	2624	2744	2646	2626	2645	2450	2859	
	Ambulance Delays > 15 minutes %	R	0%		81.2%	75.3%	77.9%	86.2%	86.4%	76.2%	84.5%	85.7%	86.7%	84.6%	82.9%	83.2%	82.1%	
	Ambulance Delays > 60 minutes %	R	0%		34.3%	31.6%	36.2%	30.3%	23.5%	17.7%	32.4%	36.4%	40.8%	46.9%	38.2%	34.5%	33.0%	
	ED activity (total excluding planned returns)		-	13218	13804	12983	13773	12940	12865	12401	12354	13067	12921	13308	11813	11533	13984	
	ED activity (type 1 excluding planned returns)		-	10921	10921	10412	10927	10489	10550	10150	10104	10603	10535	10433	9505	9158	11146	
	Total Emergency Admissions from A&E		-	-	3028	3050	3076	3054	3345	3281	3241	3469	3492	3445	3247	2899	3367	
	% Patients seen within 15 minutes for initial assessment		-		45.5%	42.4%	47.7%	54.1%	60.0%	64.8%	59.8%	58.9%	52.9%	51.6%	62.7%	61.2%	57.4%	
	Average time to initial assessment (mins)		15 Mins	15	28	28	27	21	17	10	18	18	24	23	17	19	19	
	Average time to initial assessment (mins) Adults		15 Mins	15	29	29	28	22	17	17	19	21	25	23	17	21	20	
	Average time to initial assessment (mins) Children		15 Mins	15	33	31	24	18	10	12	14	15	20	21	15	14	16	
	Mean Time in ED Non Admitted (mins)		-	215	374	386	335	302	269	259	288	292	310	325	320	307	314	
	Mean Time in ED admitted (mins)		-	500	1265	1175	1250	1148	939	889	1113	1105	1219	1337	1318	1252	1179	
	No. Of Patients who spend more than 12 Hours in ED		< 2023/24	165	2519	2588	2673	2208	2103	2080	2394	2494	2644	2741	2361	2146	2644	
	12 Hours in ED Performance %		< 2023/24	6%	18.25%	19.94%	19.50%	17.84%	16.25%	16.77%	19.36%	19.10%	20.50%	20.60%	19.95%	18.61%	18.91%	
	Bed Occupancy Rate - G&A (SitReps)		92%	-	93.0%	94.8%	95.6%	94.6%	93.6%	93.4%	94.5%	94.1%	95.3%	94.8%	94.2%	93.2%	95.7%	
	Diagnostic Activity Total			-	20125	20309	20617	19745	22698	21496	22212	23688	22369	22160	23202	22623	24212	
	Diagnostic 6 Week Wait Performance %		95% Mar'25	-	65.4%	71.0%	65.9%	61.4%	61.5%	57.5%	59.4%	58.1%	57.7%	53.6%	58.6%	61.7%	78.2%	
	Diagnostic 6+ Week Breaches		0	-	3318	4233	4627	5653	6323	7056	7509	7122	7771	8376	7524	4676	3437	
	Total Non Elective Activity - All		-	4756	5673	5515	5701	5380					Not Available					
	Total elective IPDC activity - All		-	7609	5909	5706	5564	5505					Not Available					
	Total outpatient attendances - All - SaTH		-	50303	49950	45943	38762	29237					Not Available					
	DNA rate - all ages		-	-	5.3%	5.4%	7.6%					Not Available						
	DNA rate - paeds		-	-	7.7%	8.8%	11.8%					Not Available						
	Number of episodes moved or discharged to PIFU		-	3300	1978	1896	1864	1693	2223	1964	2247	2592	2378	1978	2289	2090	2300	
	Number of episodes moved or discharged to PIFU %		-	6.6%	4.0%	4.1%	4.8%	5.8%					Not Available					
	Total virtual outpatient attendances - All - SaTH		-	12576	8370	6768	4212	2578					Not Available					
	Total virtual outpatient attendances % - All - SaTH		-		16.8%	14.7%	10.9%	8.8%					Not Available					
	RTT Incomplete 18 Week Performance		92%	-	50.2%	50.8%	51.4%	49.1%	49.6%	44.6%	42.3%	41.2%	48.5%	46.3%	49.2%	48.9%	48.1%	
	RTT Waiting list - Total size	R	-	-	41331	46317	49409	53280	55492	56163	53074	53214	53402	51652	49827	48383	46819	
	RTT Waiting list - English only		-	31679	36794	41406	44042	47563	49625	50364	47529	47713	47989	46254	44411	43218	41859	
	RTT 52+ Week Breaches (All)	R	0	-	2967	3584	3756	4656	4450	4614	4215	3666	3641	3557	3036	2493	1942	
	RTT 52+ Week Breaches - English only		-	286	2673	3210	3321	4131	3944	4088	3705	3118	3067	2971	2392	1987	1512	
	RTT 65+ Week Breaches (All)		0 Sep'24	-	447	786	921	1330	1184	1130	662	503	538	396	374	173	145	
	RTT 65+ Week Breaches - English only		0 Sep'24	0	378	708	824	1185	1025	948	508	327	350	204	166	84	66	
	RTT 78+ Week Breaches (All)	R	0	0	0	0	1	2	2	85	54	59	63	62	50	26	40	
	RTT 78+ Week Breaches - English only		0	0	0	0	0	0	1	49	49	8	19	13	4	0	14	
	RTT 104+ Week Breaches (All)	R	0	0	1	0	1	1	1	1	1	1	0	0	0	0	0	
	RTT 104+ Week Breaches - English only		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Cancer 62 Day Standard	R	70% Mar'25	68.1%	58.2%	59.5%	62.3%	56.9%	53.1%	53.3%	51.2%	55.4%	64.0%	63.3%	52.9%	54.2%	-	
	Cancer 31 Day First Treatment		96%	95.1%	91.6%	85.0%	91.6%	79.8%	81.8%	84.7%	85.5%	88.3%	89.6%	92.2%	88.5%	93.7%	-	
	Cancer 28 Day Faster Diagnosis - combined	R	77% Mar'25	77.5%	74.3%	73.6%	68.6%	67.0%	70.5%	67.6%	67.6%	70.4%	69.2%	66.7%	57.5%	65.1%	-	
	Theatre productivity			85%	76%	78%	79%	79%	78%	78%	77%	78%	80%	79%	80%	79%	78%	

Operational Summary

The Shrewsbury and Telford Hospital NHS Trust

SaTH ED 4-hour performance (type 1 & type 3) is showing common cause variation – no significant change, consistently failing target (53.2% against target of 70%). Ambulance arrival in month continues to show special cause concerning variation with 3268 patients arriving via ambulance in March, the highest in the last 12 months, and a 19.4% increase compared to February. SaTH Average time to initial assessment (IA) (mins) is showing special cause improving variation. Paediatric IA averaged 16.3 minutes in March. Adult IA averaged 19.9 minutes in March. The number of patients who spend more than 12 hours in ED remains common cause variation.

RTT - The Trust reported 4 x 78-week breaches at the end of March 2025 and 28 x 65-week breaches. The total waiting list size continues to reduce. Training continues with all teams to ensure that RTT clocks are not re-activated inappropriately on Careflow. Daily meetings are in place with all clinical centres to monitor and manage the risk of breaches and support additional mitigations. Additional capacity is being provided by ISP providers for ENT, maxillofacial, gynaecology, endoscopy and general surgery this includes both outpatient and surgical capacity. **Theatre Utilisation** in March was 79%.

Cancer - The combined backlog as at the end of March 2025 was 367 (decrease from 430 at the end of February). The validated February position for FDS was 65.1% (previous month was 57.5% and against a national target of 75%), 31-day standard was 93.7% (previous month was 88.5% against a national target of 96%) and 62-day standard was 54.7% (previous month was 52.9% against a national target of 85%). Predicted performance for March is expected to be 63% FDS, 93% for 31-day and 66% for 62-day.

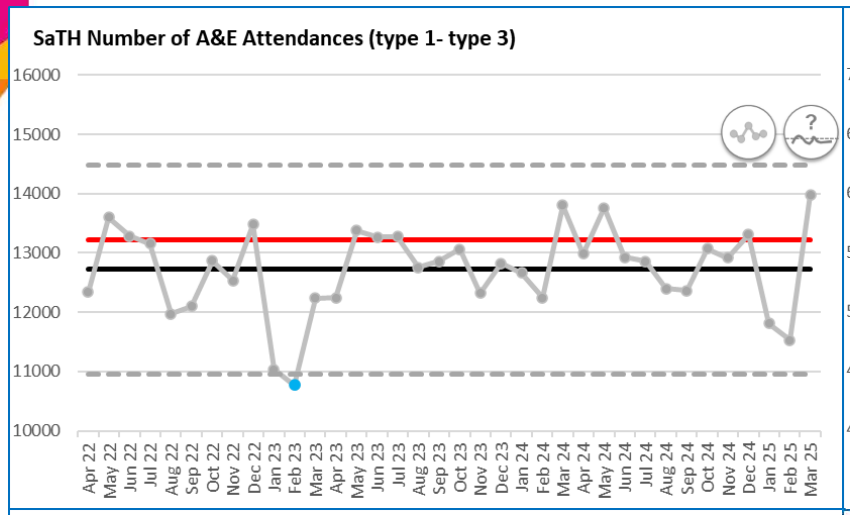
DM01 - The validated overall DM01 position for March was 78.2%, a significant improvement from 56.2% in January and 71.7% in February. Whilst significant progress has been made, radiology turnaround delays remain of concern. MRI TATs from referral to report are:- MRI TATs from referral to report are:- USC 4-6 weeks, urgent 9-10 weeks, and routine tests at 14-15 weeks. CT reporting times have improved ; USC 2 weeks, urgent 2 weeks and routine at 3-4 weeks (CTVC TATs for USC has remained at an improved position of 3-4 weeks). The backlog of all CT reporting was cleared by end January 2025. NOUS reporting times are; USC 2-3 weeks, urgent 4-5 weeks and routine at 15 weeks. Training posts and sickness in NOUS continue to restrict capacity, with reduced resilience during periods of sickness or annual leave.

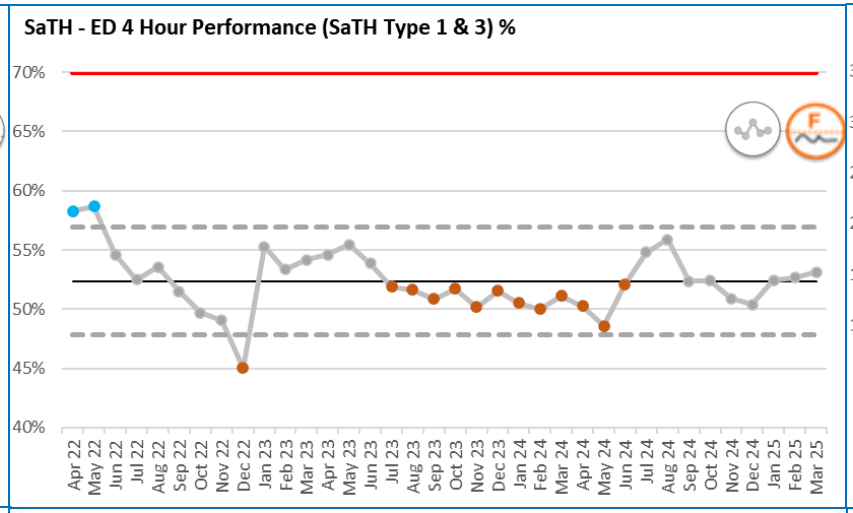
Key actions

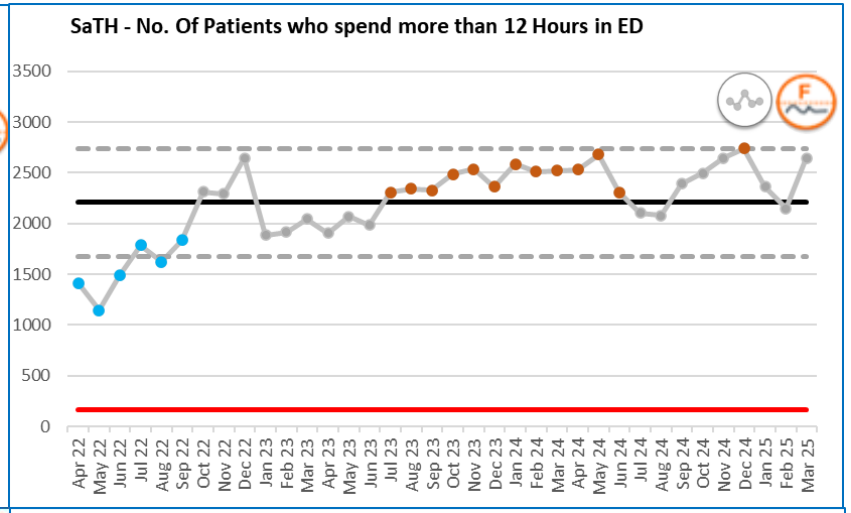
- Progression of actions within all Tier 1 workstreams
- Test of change in Minors, focussing on medical input and AMA, to improve flow
- Mobilising additional independent Sector provider activity and mutual aid for elective and cancer recovery
- Diagnostics recovery plan progressing, second MRI van on site from 18/2
- New theatre timetable has gone live on 31/3, 50% increase in overall and CYP allocation
- Outpatient productivity project has commenced to improve booking utilisation
- Elective recovery programme developed to focus on priority areas of transformation for 25/26
- MBI have commenced for a further 4 months focusing on validating patients over 18 weeks

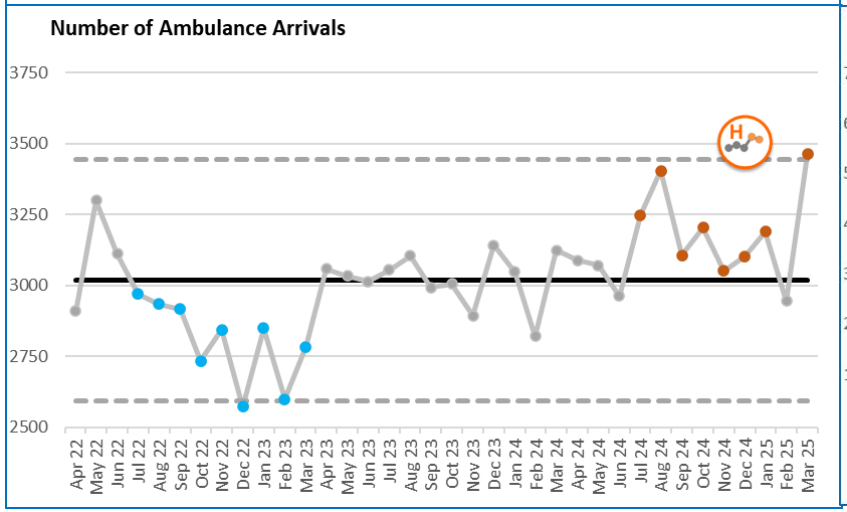
Operational – Emergency care

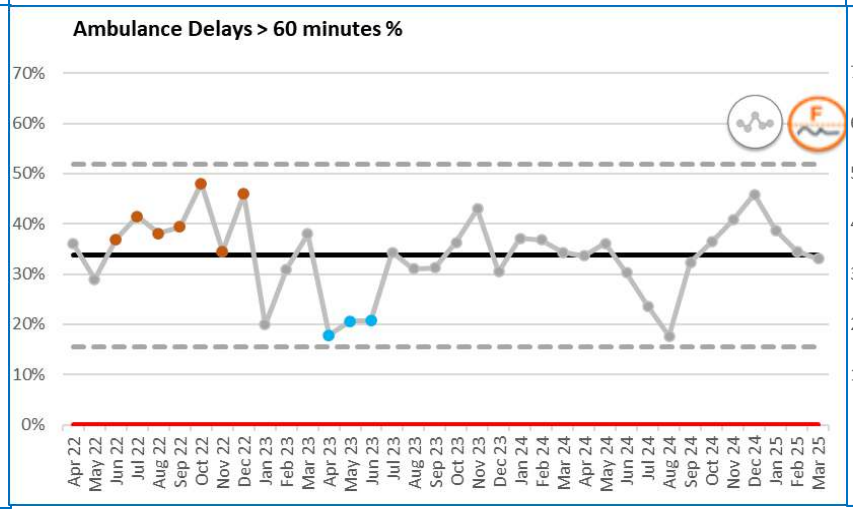
The Shrewsbury and Telford Hospital NHS Trust

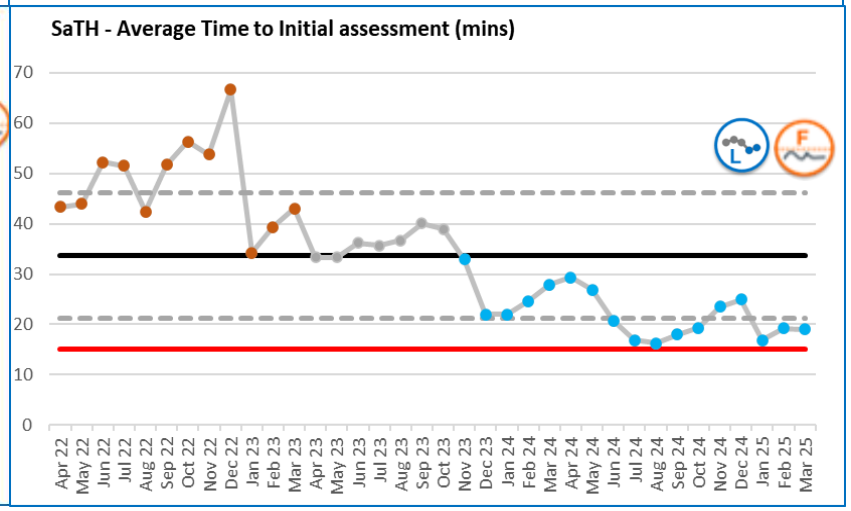












Operational – Emergency care

The Shrewsbury and Telford Hospital NHS Trust

Summary:

- SaTH number of A&E attendances (type 1 - type 3) is showing common cause variation – no significant change
- SaTH ED 4-hour performance (type 1 & type 3) % is showing common cause variation – no significant change, consistently failing target (53.2% against target of 70%)
- SaTH number of patients who spend more than 12 hours in ED is showing common cause variation
- Number of ambulance arrivals to SaTH has again moved to special cause concerning variation
- Ambulance delays in handover of patients to SaTH premises > 60 minutes (%) showing common cause variation, consistently failing target
- SaTH Average time to initial assessment (mins) continues to demonstrate special cause improving variation. Paediatric IA averaged 16.3 minutes in March. Adult IA averaged 19.9 minutes in March

Recovery actions:

- Ambulance handover: Revised Ambulance Offload to Assess model implemented to reduce handover delays to be expanded to 24/7
- 12 hour/4-hour performance: Implementation of additional domiciliary care supporting reduction in LoS; 25/26 increase streaming of patients to SDEC increasing 0-day LoS; UTC pathway optimisation following transition from private Provider to in house 01/04/25; implementation of 10 extra acute medicine beds at PRH August 23; implementation of two Modular wards on the RSH site by end of calendar year; system wide 25/26 schemes to be confirmed

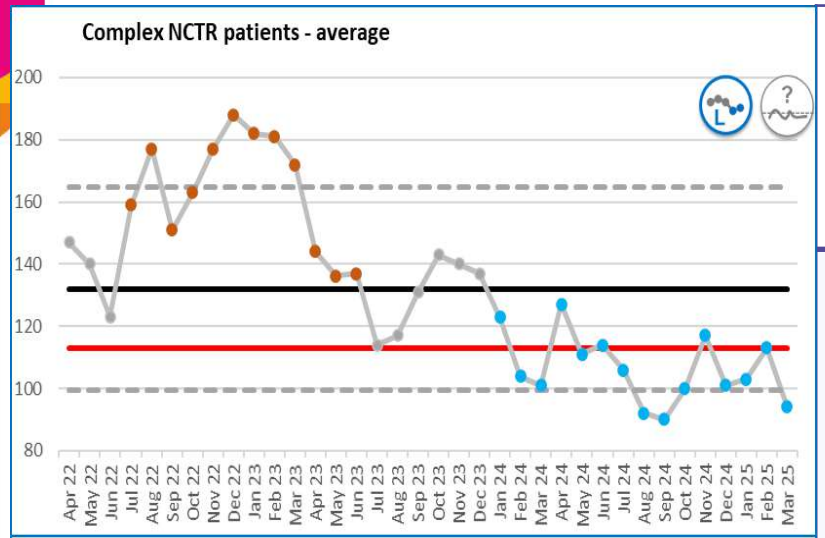
Anticipated impact and timescales for improvement:

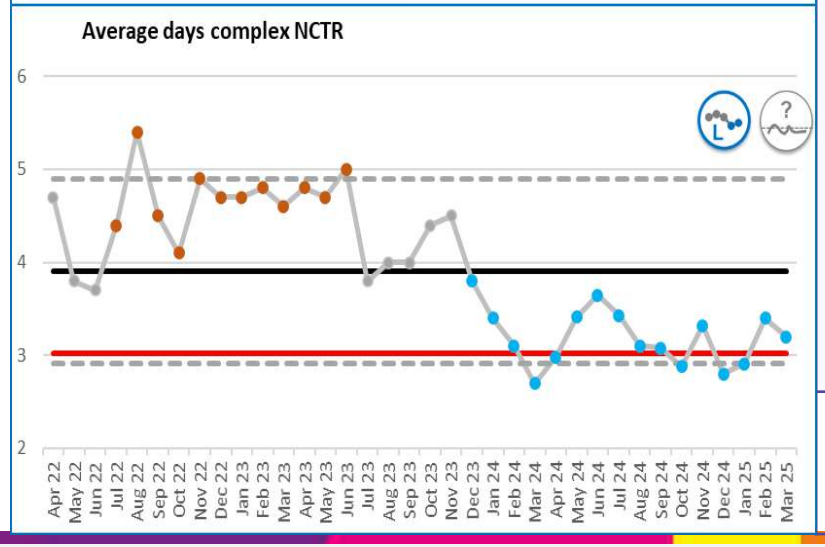
Progress reported monthly through UEC Flow improvement group to Performance Assurance Committee (PAC) and system UEC meeting.

Progress reported monthly through Emergency Care Transformation Assurance Committee (ECTAC) /MEDTAC and weekly cross Divisional metrics meeting.

Recovery dependencies:	System tier 1 workstreams – to reduce demand on A&E and reduce exit block.

Operational – Patient Flow





Summary:

- Number of complex no criteria to reside patients (average) for the month is demonstrating special cause improving variation
- Average days a patient is identified as no criteria to reside (complex) awaiting discharge is demonstrating special cause improving variation

- **Recovery actions:**
- Discharge lounge to open from 7 am to support early flow from wc 14/04/25
- Weekly focus on LoS of patients with criteria to reside
- Focus on accurate Estimated Discharge Date (EDD) to refer into Community Transfer Hub (CTH) 5 days prior to EDD to enable CTH to work up patient for discharge on EDD
- Improvement programme focusing on process for out of area patients to be repatriated to their nearest hospital
- Improvement programme preparing patients for home the night before
- Tracking of community beds and transport to reduce incomplete (failed) discharges
- Trust long length of stay weekly review meeting
- Continued focus on the IDT and therapy processes to reduce the length of time between NCTR and discharge
- Roll out of the deconditioning change model to all wards continues

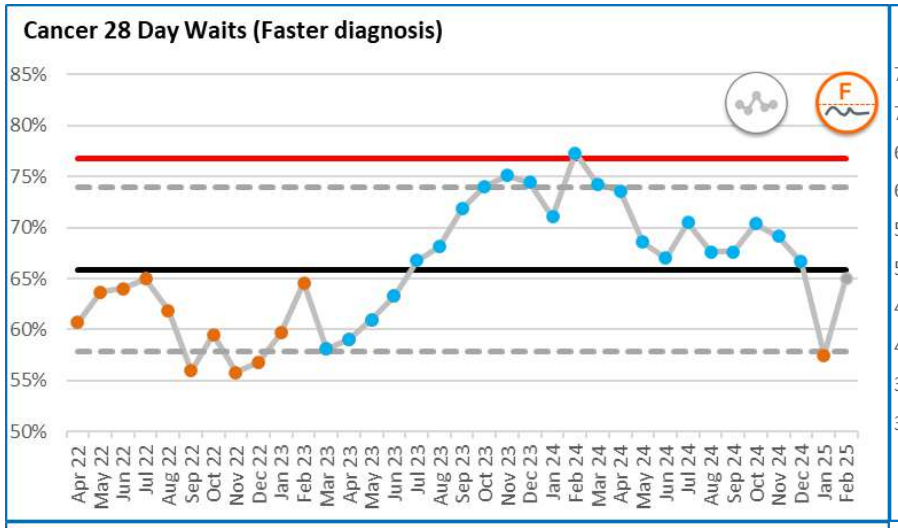
Anticipated impact and timescales for improvement:

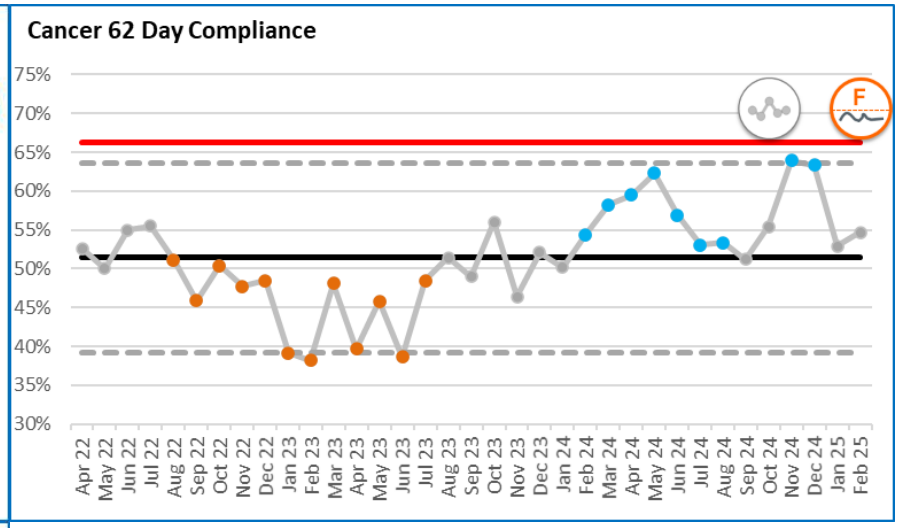
Progress reported monthly through UEC Flow improvement group to Performance Assurance Committee (PAC) and system UEC meeting.

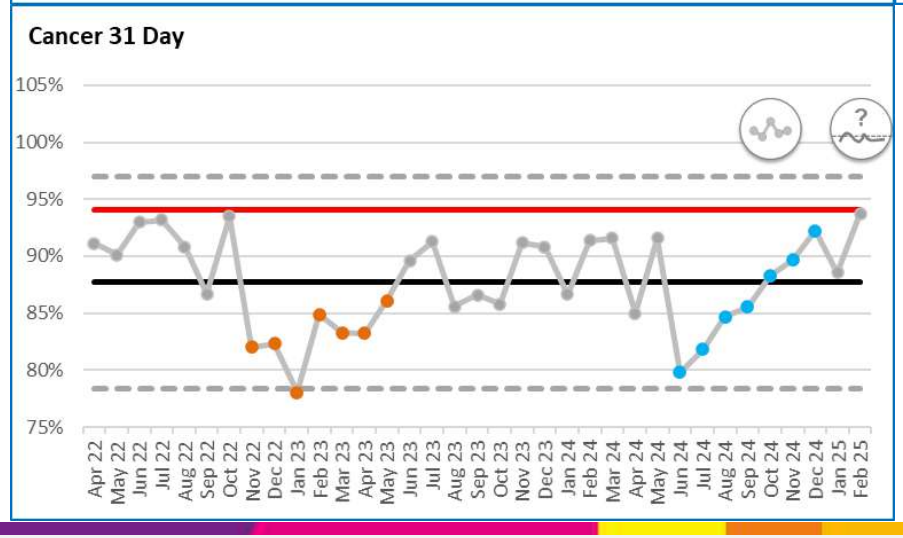
Recovery dependencies:	PW1, 2 and 3 capacity to support complex discharge pathways. Medical decision makers to support discharge decisions available on all wards throughout the day.

Operational – Cancer performance

The Shrewsbury and Telford Hospital NHS Trust







Operational – Cancer performance

The Shrewsbury and Telford Hospital NHS Trust

Summary:
The Trust is being monitored in Tier 1 for Cancer. The combined backlog as at the end of March 2025 was 367 (decrease from 430 at the end of February). The validated February position for FDS was 65.1% (previous month was 57.5% and against a national target of 75%), 31-day standard was 93.7% (previous month was 88.5% against a national target of 96%) and 62-day standard was 54.7% (previous month was 52.9% against a national target of 85%). Predicted performance for March is expected to be 63% FDS, 93% for 31-day and 66% for 62-day.

Recovery actions:

The Trust is in Tier 1 NHSE monitoring due to the deterioration in performance in all indicators since Q1 24/25. Delivery of the cancer standards remains a significant challenge, and we have underdelivered against forecast trajectories in 24/25. Recovery plans are in place and additional external non-recurrent funding from WMCA and NHSE has been received to support improvement in performance. Business plans have been submitted to BCRG to support sustainable services into 25/26. Additional cancer improvement expertise and senior leadership oversight has been sourced to support recovery and delivery of 25/26 plans.

Diagnostic recovery action to source additional capacity is supporting recovery and cancer patients are being prioritised appropriately. Capacity issues at tertiary centres for surgery and histology are resulting in additional delays for treatment. Delays for PET scans and molecular marker tests, both of which are not performed at SaTH, are also negatively impacting on the length of pathways. Clinical and operational workforce constraints continue within Oncology, Urology, Colorectal and Head & Neck. Oncology waiting time for patients with prostate cancer have reduced from 20-21 weeks in January to 2/3 weeks as at 31/3. Breast oncology waiting times also reduced from 10-12 weeks to 2/3 weeks during this same period. Attempts to recruit have been ongoing and the team have recently appointed two Medical Oncologists and Clinical Oncologist to support the team. Mutual aid and partnership working with neighbouring Centres is also being explored.

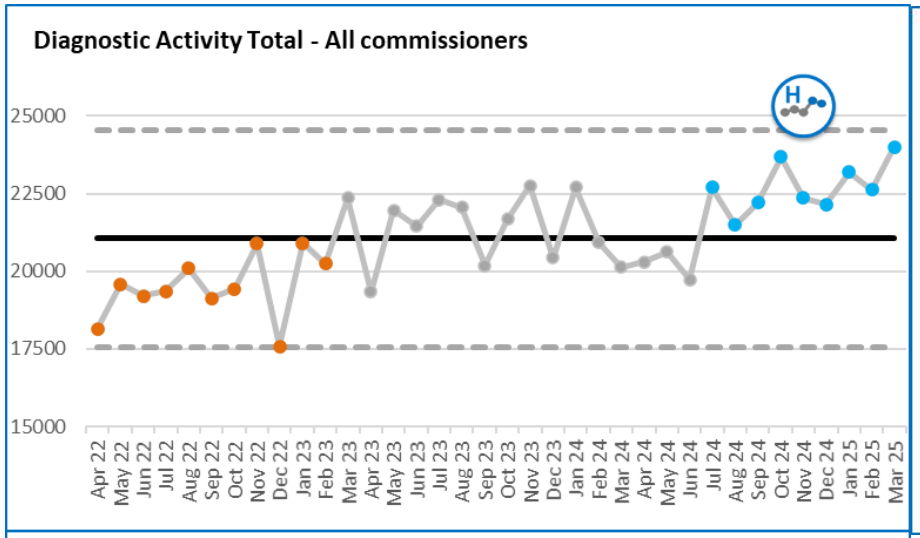
Anticipated impact and timescales for improvement:

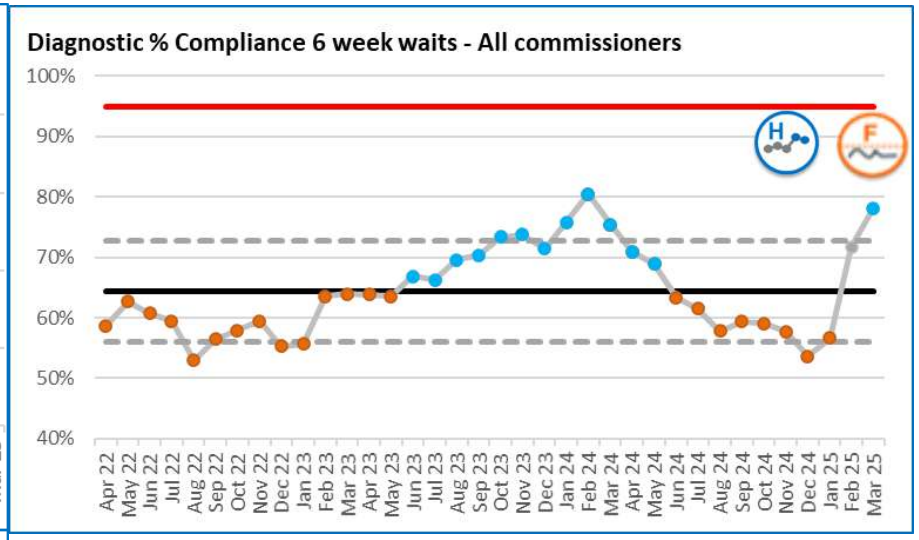
WMCA funding of approx. 1.7 million allocated to drive diagnostic cancer turnaround times for 25/26.

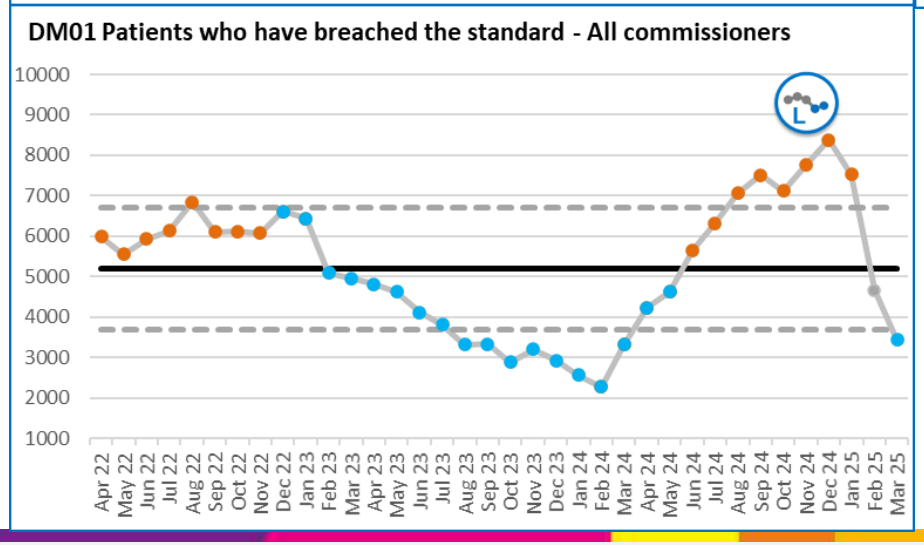
Recovery dependencies:	Transfer of Urgent Suspected Cancer referrals from Cancer Services to Patient Access Centre. Risks of delays to booking during changeover period and delays in patients being added to the PTL via Somerset Cancer Register.

Operational – Diagnostic waiting times

The Shrewsbury and Telford Hospital NHS Trust







Operational – Diagnostic waiting times

The Shrewsbury and Telford Hospital NHS Trust

Summary:
The validated DM01 imaging position for March was 81.9%.
Radiology turnaround delays are improving. MRI TATs from referral to report are:- USC 4-6 weeks, urgent 9-10 weeks, and routine tests at 14-15 weeks. CT reporting times have improved ; USC 2 weeks, urgent 2 weeks and routine at 3-4 weeks (CTVC TATs for USC has remained at an improved position of 3-4 weeks). The backlog of all CT reporting was cleared by end January 2025. NOUS reporting times are; USC 2-3 weeks, urgent 4-5 weeks and routine at 15 weeks. Training posts and sickness in NOUS continue to restrict capacity, with reduced resilience during periods of sickness or annual leave.

- Recruitment is ongoing and we are utilising insourcing to support NOUS and MRI
- Clinical prioritisation of radiology referrals is in place and reporting for the most urgent patients is being targeted alongside elective recovery of long waits
- Staff are deployed to prioritise acute and cancer pathways and the longest waiting patients, with a resultant impact on new urgent and routine capacity
- Two mobile MRI units are on site and continue to deliver activity to support recovery of the DM01 and Cancer performance.
- A NOUS recovery plan has been developed with additional WLI and insourcing support to support reduction of 13+ww and improve DM01 performance
- Insufficient capacity within endoscopy remains a concern. The sustainable endoscopy workforce business case was mobilised in June and requiring continued support of insourcing for the next 2 years pending recruitment and training lead time

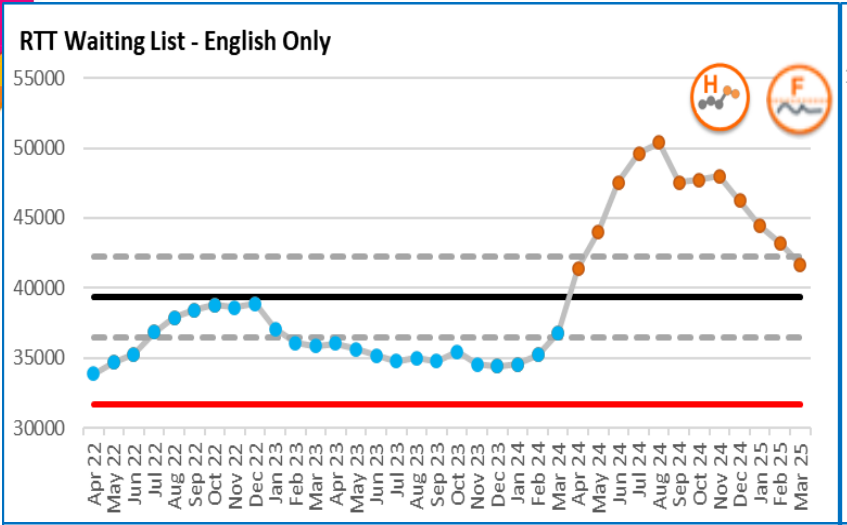
Recovery actions: Outsourced reporting continues to provide additional capacity supporting MRI and CT turnaround times. CT backlog has been cleared and focus in now on clearing the MRI backlog. Enhanced payments and WLIs are encouraging additional in-house reporting sessions across all modalities with backlogs being targeted. ERF funding has also been provided and will improve FDS performance levels over the next 6 months.
MRI performance remains challenged. Two mobile vans are now operational to increase scanning capacity. This includes reporting of images, waiting times are starting to reduce.
NOUS training posts have been increased from 2 to 4 from September 2024, a loan U/S machine has been secured to increase scanning capacity from March 2025. Process for avoiding RTT breaches is in place with daily calls attended by the operational teams. Daily calls are also in place between radiology and the gynaecology booking team to ensure all capacity is utilised for PMB USS.
The sustainable endoscopy business case has been approved and is a 3-year programme of work requiring support from an IS provider pending recruitment to substantive posts and lead time for training until endoscopy practitioners become independent.

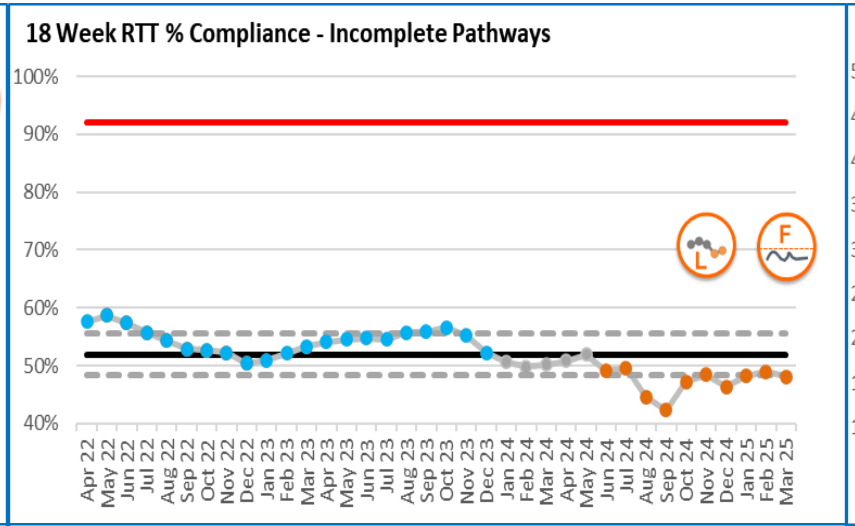
Anticipated impact and timescales for improvement:
Additional insourcing from '18 Weeks' to support endoscopy DM01 at weekends has been supported through the ERF. There is ongoing recruitment for radiologists, radiographers and sonographers.
A bank Consultant Radiographer has been recruited to cover vacancy and interviews for substantive replacement have been successful and awaiting confirmation of a start date..
Use of insourcing for USS and MRI is proving successful.

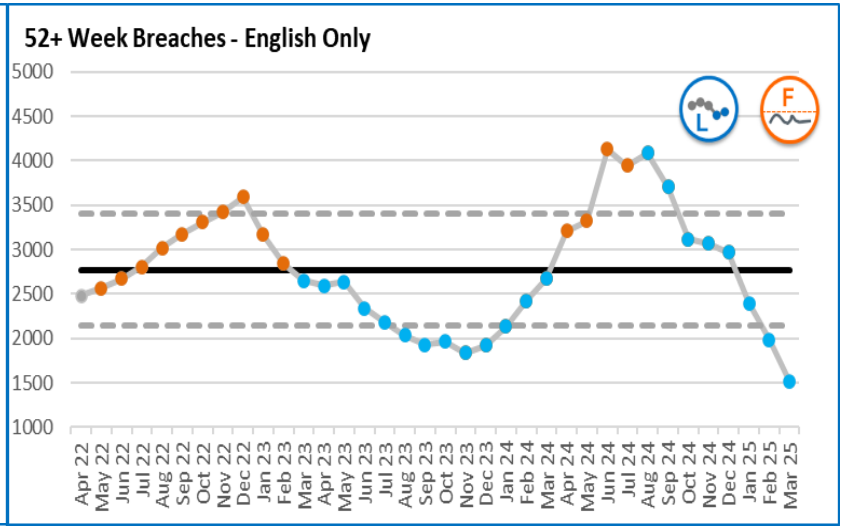
We are updating trajectories with interventions for recovery of DM01 for all modalities.

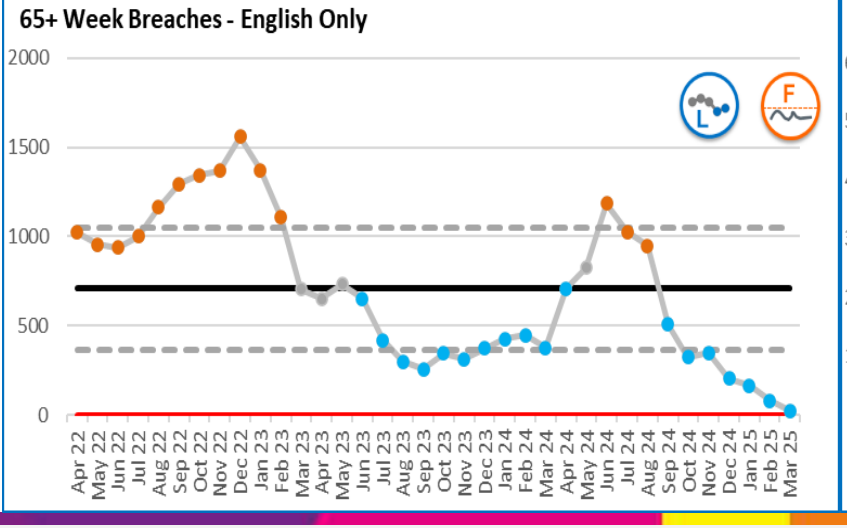
Operational – Referral to treatment (RTT)

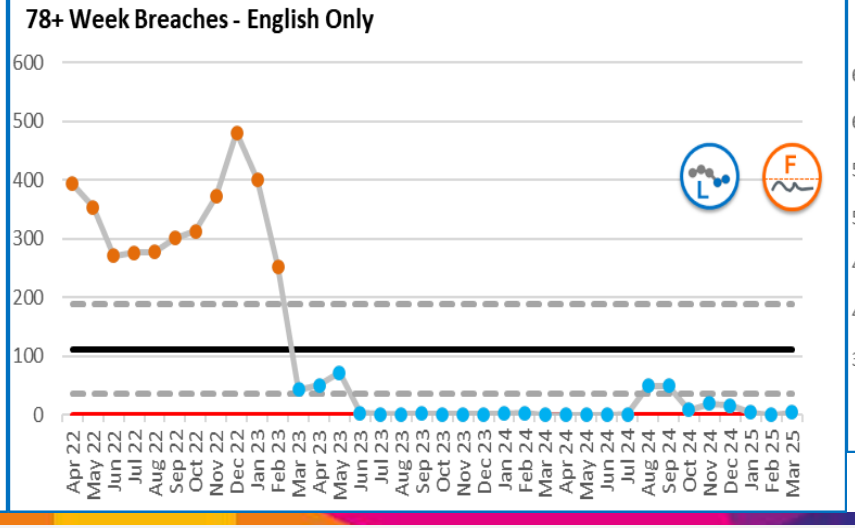
The Shrewsbury and Telford Hospital NHS Trust

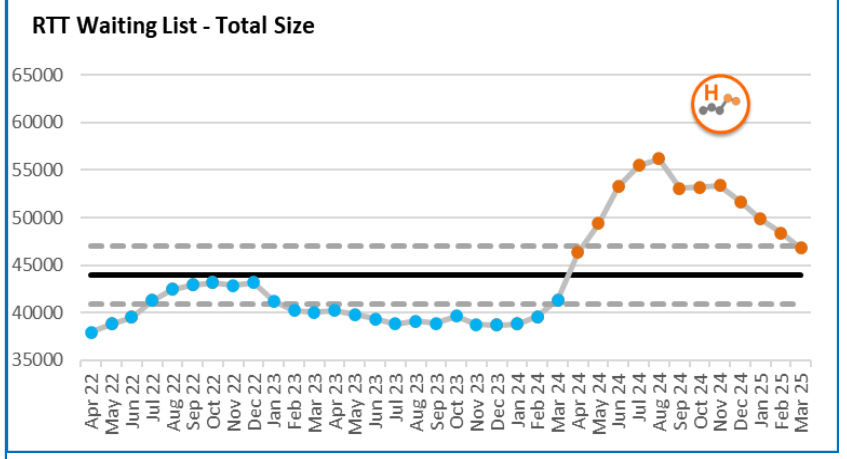












Note: includes Welsh unvalidated position

Operational – Referral to treatment (RTT)

The Shrewsbury and Telford Hospital NHS Trust

Summary:
SaTH remains in Tier 1 monitoring for elective recovery. The Trust reported 4 x Ophthalmology (Corneal Transplant) 78-week breaches at the end of March 2025 and 28 x 65-week breaches (English only). The total waiting list size continues to reduce. MBI have been retained for a further 4 months to support with validation of our patients waiting over 18weeks. Training continues with all teams to ensure that RTT clocks are not re-activated inappropriately on Careflow. Daily meetings are in place with all clinical Centres to monitor and manage the risk of unnecessary breaches and support additional mitigations. Additional capacity is being provided by ISP providers for ENT, maxillofacial, gynaecology, endoscopy and general surgery this includes both outpatient and surgical capacity. Demand & capacity models have been re-built in all specialities. Our Business Intelligence colleagues have built a breach forecasting tool to enable more accurate planning of the capacity needed by specialty to achieve our recovery of long waiting patients.

Recovery actions:
Operational governance: BI team have developed a forecasting tool to enable effective performance insight and planning. Daily and weekly performance monitoring meetings are in place. A methodology to enable a route to zero for long waiting patients has been operationalised. Plans have been developed to deliver the required 18 week and 52-week standards for 25/26.

Additional capacity: Independent sector providers continue to provide additional capacity in challenged specialties, including ENT, Max Fax, General Surgery and gynae.

Productivity: A new Theatre plan has been developed to open all elective theatres across sites, to increase capacity for certain specialties to support elective recovery. Paediatric theatre capacity has been increased by 50%. The planned start date for the new timetable is March 31st. Externally supported outpatient booking utilisation improvement programme due to commence March 2025.

Transformation: Design and development of planned care recovery framework focusing on three priorities: diagnostics, productivity and outpatient pathway transformation.

Anticipated impact and timescales for improvement:

The methodology to enable a 'route to zero' has been developed and a commitment to reach and sustain a zero position has been made for end of April 25.

Significant progress has been made:

- 65 weeks 1,000 in July to 28 in March and plan for zero in April
- Number of patients waiting > 52 weeks at the of March 25 is 2,065 which is a reduction of 311 patients in comparison to February 25

Recovery dependencies:	Continued capacity to validate the PTL, administrative staffing capacity, workforce of insourcing companies, (particularly in ENT maxillofacial, gynaecology, paediatrics) and theatre staffing.

Operational – 65-week cohort reduction

The Shrewsbury and Telford Hospital NHS Trust

This table demonstrates the work that is progressing to reduce the number of patients in the 65-week cohort to enable the Trust to deliver the target of zero patients waiting over 65 weeks for treatment. The Trust did not achieve the national 0 x 65-week target in March but is moving in the right direction and has committed to achieving zero by the end of June. Work continues to track progress at specialty level to identify areas where additional support is needed, and performance is monitored through daily meetings with the specialties. ENT and MaxFax capacity is of particular concern.

TOTAL COHORT (All Stages)	03/02/2025	10/02/2025	17/02/2025	24/02/2025	03/03/2025	10/03/2025	17/03/2025	24/03/2025	31/03/2025
ACTUAL TOTAL - 65+ Week Cohort	1,056	826	607	390	251	166	100	63	36
% Actual Movement	-40.7%	-41.8%	-42.5%	-52.8%	-58.6%	-57.4%	-60.2%	-62.0%	-42.9%
65+ Week Cohort - Split by Stage	03/02/2025	10/02/2025	17/02/2025	24/02/2025	03/03/2025	10/03/2025	17/03/2025	24/03/2025	31/03/2025
Milestone 1 *(awaiting 1st appt)*	152	85	43	31	22	14	8	0	0
Milestone 2/Other *(follow-up/diagnostic stages/validation)*	512	413	308	195	133	84	38	29	13
Milestone 3 *(awaiting admission)*	392	328	256	164	96	68	54	34	23
Milestone 1 Trajectory *(awaiting 1st appt)*	0	0	0	0	0	0	0	0	0
ACTUAL TOTAL (all) awaiting a first OPD appt (milestone 1)	152	85	43	31	22	14	8	0	0
Patients undated	6	2	1	0	0	1	1	0	0
Patients dated	146	83	42	31	22	13	7	0	0
Patients dated by month:									
Apr-24									
May-24									
Jun-24									
Jul-24									
Aug-24									
Sep-24									
Oct-24									
Nov-24									
Dec-24									
Jan-25									
Feb-25	128	60	16	6					
Mar-25	18	23	26	25	22	13	7	0	0
>1st April 2025	0	0	0	0	0	0	0	0	0

Operational – CYP cohort

The Shrewsbury and Telford Hospital NHS Trust

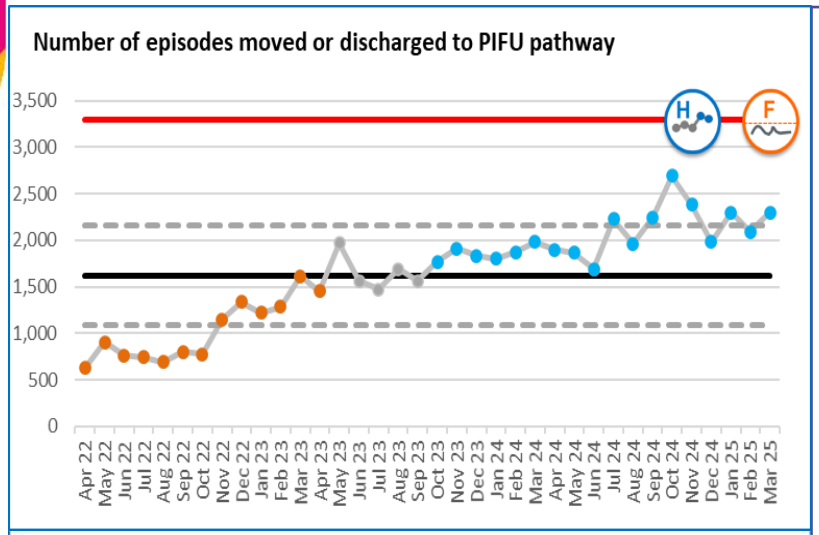
In addition to tracking overall patient cohorts, we also continue to work to reduce the number of children and young people cohort who have been waiting 52 weeks or more. We will not achieve 0 x 52w waits by 31st March 2025, but will by the end of Q1. Ensuring we can provide targeted support in booking these patients earlier in their pathways will prevent avoidable delays and ensure parity with adult recovery. Performance against the booking of these patients is monitored on a weekly basis and is also being tracked at a specialty level.

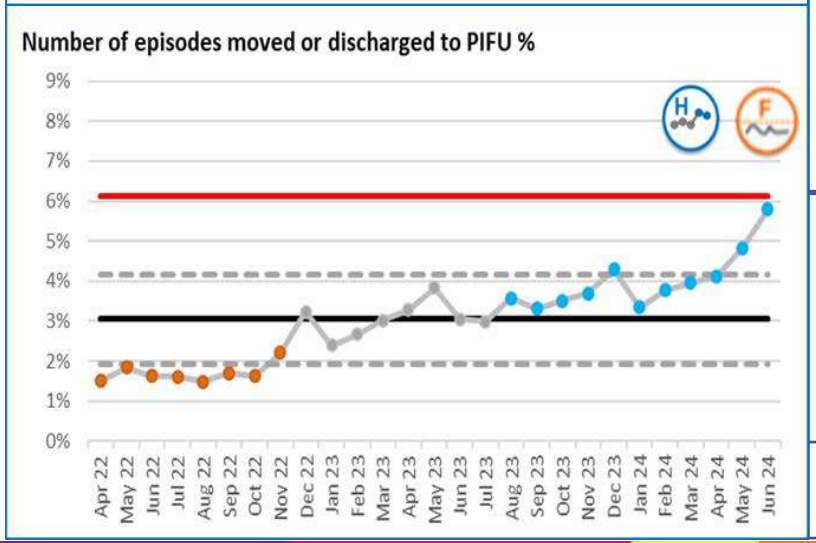
TOTAL COHORT (All Stages)	03/02/2025	10/02/2025	17/02/2025	24/02/2025	03/03/2025	10/03/2025	17/03/2025	24/03/2025	31/03/2025
ACTUAL TOTAL - 52+ Week CYP Cohort	629	501	411	353	300	231	193	139	121
% Actual Movement	-23.6%	-30.1%	-34.7%	-29.5%	-27.0%	-34.6%	-35.7%	-39.8%	-12.9%

52+ Week CYP Cohort - Split by Stage	03/02/2025	10/02/2025	17/02/2025	24/02/2025	03/03/2025	10/03/2025	17/03/2025	18/03/2025	31/03/2025
Milestone 1 *(awaiting 1st appt)*	372	238	178	141	113	90	60	41	32
Milestone 2/Other *(follow-up/diagnostic stages/validation)*	104	124	94	88	82	72	68	56	53
Milestone 3 *(awaiting admission)*	153	139	139	124	105	69	65	42	36
Milestone 1 Trajectory *(awaiting 1st appt)*									
ACTUAL TOTAL (all) awaiting a first OPD appt (milestone 1)	372	238	178	141	113	90	60	41	32
Patients undated	157	56	44	7	4	5	10	6	5
Patients dated	215	182	134	134	109	85	50	35	27
Patients dated by month:									
Apr-24									
May-24									
Jun-24									
Jul-24									
Aug-24									
Sep-24									
Oct-24									
Nov-24									
Dec-24									
Jan-25									
Feb-25	178	106	60	27					
Mar-25	37	76	74	107	109	85	50	35	27
>1st April 2025	0	0	0	0	0	0	0	0	0

Operational – PIFU

The Shrewsbury and Telford Hospital NHS Trust





Summary:

- The unvalidated Patient Initiated Follow-Up (PIFU) performance in March saw an increase to 5.7%. Although this is close to achieving the 6% target, it is falling short of the stretch target
- Careflow Task and Finish Group continues to meet on a bi-weekly basis, to resolve issues and assist towards providing more robust data for monitoring
- Clear guidance on the intranet for patients on a PIFU pathway, to support staff in selecting the correct RTT pathway code
- Clinician attendance at the GIRFT Action Plan Review meetings is allowing more direct clinical conversation and challenge
- Obstructive Sleep Apnoea service are developing a PIFU pathway with a technical solution within with Careflow having been confirmed. The Service now need a kick-off meeting where Clinical Outcome Forms and leaflets for patients will be put in place
- Cardiology went to Manchester but not able to use processes due to work force, the team are now looking to visit Lincoln
- Consultant connect to support cardiology AG
- Nephrology audit stopped due to OP Transformation change in scope but engagement with PIFU continues
- Respiratory join the big three for OP Transformation. PID to be developed for respiratory and cardiology, PID for ENT has been started

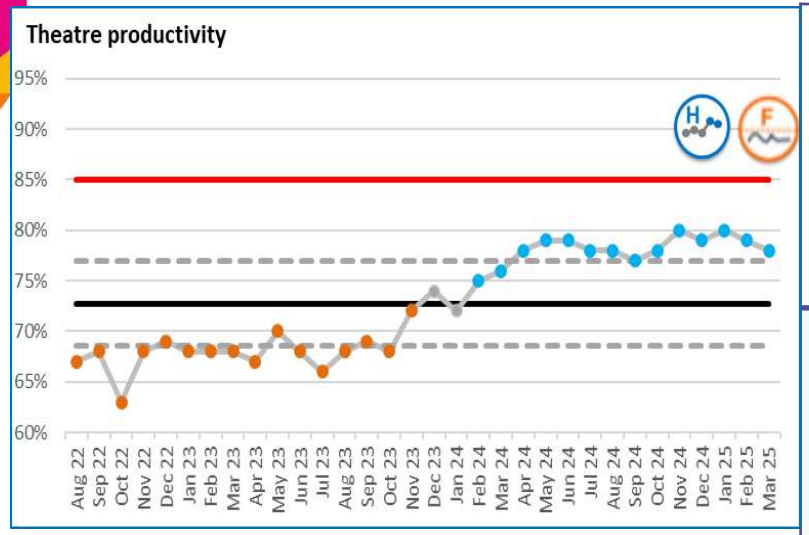
Recovery actions:

- Standard process is due for review
- Weekly challenge continues around progress made against Further Faster Handbooks
- Further conversations required with Cardiology Clinical Director regarding implementation of more PIFU within the department

Anticipated timescales for improvement:
Performance will continue to be monitored at weekly Outpatient Transformation meetings

Recovery dependencies: Due to data warehouse issues, SUS submissions are currently suspended.

Operational – Theatre productivity



Summary:
In March, theatre utilisation reached 79%. Meetings regarding theatre allocation, list planning, and lookback reviews are ongoing with the teams. A bi-weekly Theatre Task & Finish Group has been established to begin investigating areas for opportunity such as pre-op assessment, list allocation, scheduling, and theatre data. To help schedule patients further in advance, additional pre-op capacity has been added by increasing staffing levels. This initiative aims to reduce late cancellations, enhance theatre utilisation, and ultimately improve productivity.

Recovery actions:

- Work and regular updates continue with NHSE Regional Theatre Productivity Lead
- Ongoing discussions with Outpatient Network and specialty operational teams about insourced operating lists at PRH have resulted in better utilisation and a decrease in late changes, which previously had the potential to negatively impact capacity and utilisation
- A Theatre cancellations improvement initiative has begun and is currently in the early stages of analysing the causes of late procedure cancellations, which are impacting both patient experience and theatre productivity.
- Outpatient Network are supporting with additional weekend pre-operative assessment clinics to increase capacity
- Funding has been approved for a pre-operative assessment coordinator, enabling better patient communication and supporting optimisation in line with GIRFT recommendations

Anticipated timescales for improvement:
A new Theatre plan has been developed to open all elective theatres across sites, aiming to increase capacity for certain specialties to support elective recovery. The planned start date for this initiative is March 31st.

Opportunities to schedule additional lists across specialties, including paediatrics, to support elective recovery will continue.

Recovery dependencies:	Theatre staffing. Pre-operative assessment capacity. Theatre staffing

Well Led

Executive Lead:

Chief People Officer

Rhia Boyode

Integrated Performance Report

The Shrewsbury and Telford Hospital NHS Trust

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Trend
Well Led	WTE employed		-	7991	7114	7107	7117	7093	7057	7095	7152	7212	7219	7213	7259	7252	7192	
	Temporary/agency staffing		-	-	1010	887	880	851	862	824	769	794	789	732	752	786	780	
	Staff Turnover Rate (FTE) (excluding Junior Doctors)		0.8%	0.75%	1.1%	0.7%	0.9%	1.2%	1.0%	1.0%	0.8%	0.9%	1.0%	0.8%	0.8%	0.5%	1.2%	
	Vacancies - month end %		10%	<10%	2.1%	9.0%	8.9%	8.7%	9.5%	9.0%	9.0%	9.0%	9.1%	9.7%	9.2%	9.2%	10.0%	
	Sickness Absence rate		4%	4%	5.0%	5.1%	4.9%	5.0%	5.4%	5.2%	5.3%	5.8%	5.5%	6.0%	5.9%	5.56%	5.12%	
	Trust - Talent Conversation (Appraisal)		90%	90%	80.0%	78.4%	78.4%	78.3%	74.9%	77.4%	77.9%	83.6%	84.6%	85.0%	86.7%	85.3%	85.8%	
	Talent Conversations (Appraisal) – Medical Staff		90%	90%	94.1%	93.0%	93.2%	92.6%	91.5%	92.0%	93.0%	93.6%	93.1%	93.5%	96.4%	92.2%	90.7%	
	Trust Statutory and mandatory training compliance		90%	90%	92.5%	91.5%	91.5%	91.9%	92.0%	91.9%	92.1%	91.4%	91.5%	91.1%	94.1%	91.7%	91.3%	
	Trust MCA – DOLS and MHA		90%	90%	80.8%	79.7%	79.4%	80.2%	80.2%	79.9%	82.7%	83.9%	84.0%	83.2%	87.0%	85.4%	85.1%	
	Safeguarding Children - Level 2		90%	90%	95.2%	94.7%	89.2%	90.1%	94.9%	95.0%	95.0%	93.8%	93.8%	93.7%	96.0%	94.1%	94.5%	
	Safeguarding Adult - Level 2		90%	90%	94.8%	93.9%	87.9%	89.3%	94.5%	94.6%	95.2%	94.3%	94.3%	94.3%	96.7%	94.6%	94.4%	
	Safeguarding Children - Level 3		90%	90%	90.0%	88.4%	83.4%	88.4%	88.5%	88.1%	88.3%	89.6%	88.9%	90.1%	91.9%	89.6%	90.8%	
	Safeguarding Adult - Level 3		90%	90%	89.1%	87.3%	82.9%	90.4%	88.4%	87.2%	88.8%	89.6%	90.1%	89.8%	92.4%	90.4%	90.5%	
	Monthly agency expenditure (£'000)		-	479	1448	2400	1918	1952	1954	1700	1526	1751	1638	1404	1203	985	955	
Safe Staffing	Fill Rate % - All Staff - Day/Night			100%	96.5%	97.4%	96.8%	97.0%	96.6%	95.1%	94.5%	95.6%	95.7%	93.6%	94.4%	93.3%	93.3%	
	Fill Rate % - All Staff - Day			100%	95.4%	98.3%	95.5%	95.7%	95.7%	94.9%	94.0%	94.2%	93.9%	92.2%	93.1%	91.8%	92.5%	
	Fill Rate % - All Staff - Night			100%	97.9%	98.8%	98.4%	98.5%	97.7%	95.4%	95.1%	97.3%	97.8%	95.3%	95.9%	95.1%	94.3%	
	Fill Rate % - Registered Nurses/Midwives - Day/Night			100%	106.2%	106.8%	106.7%	106.0%	105.9%	104.4%	103.6%	104.2%	104.8%	104.9%	104.1%	101.3%	101.7%	
	Fill Rate % - Registered Nurses/Midwives - Day			100%	106.4%	107.8%	107.2%	106.2%	106.1%	104.5%	103.6%	103.1%	104.4%	104.9%	104.4%	101.0%	101.6%	
	Fill Rate % - Registered Nurses/Midwives - Night			100%	106.1%	105.6%	106.0%	105.6%	105.7%	104.2%	103.6%	105.5%	105.3%	104.8%	103.8%	101.6%	101.8%	
	Fill Rate % - Non-Registered Nurses/Midwives - Day/Night			100%	101.0%	101.0%	99.7%	100.3%	100.2%	98.9%	98.6%	99.1%	98.7%	94.1%	96.3%	98.5%	97.8%	
	Fill Rate % - Non-Registered Nurses/Midwives - Day			100%	99.7%	97.8%	96.4%	97.2%	98.3%	98.9%	98.2%	96.9%	95.4%	91.2%	93.1%	95.8%	95.8%	
	Fill Rate % - Non-Registered Nurses/Midwives - Night			100%	102.6%	104.9%	103.7%	103.9%	102.5%	98.9%	99.0%	101.9%	102.6%	97.5%	100.0%	101.7%	100.1%	
	Fill Rate % - Registered Nursing Associates - Day/Night			-	16.4%	23.0%	22.9%	22.4%	21.6%	19.8%	18.3%	24.7%	23.5%	19.5%	22.1%	18.6%	18.6%	
	Fill Rate % - Registered Nursing Associates - Day			-	17.8%	26.1%	27.2%	25.0%	25.3%	23.8%	21.4%	28.7%	26.5%	22.5%	25.4%	21.0%	24.7%	
	Fill Rate % - Registered Nursing Associates - Night			-	14.4%	18.6%	16.4%	18.7%	16.3%	14.2%	14.0%	19.0%	19.3%	15.4%	17.4%	15.3%	10.0%	
	CHPPD - Overall - National 11.99			11.99	8.7	8.9	9.0	9.5	9.1	9.0	8.7	9.8	8.8	8.6	8.7	8.6	8.5	
	CHPPD - Registered Nurses/Midwives - National 4.9			4.9	5.1	5.2	5.3	5.7	5.3	5.3	5.2	5.9	5.2	5.2	5.2	5.1	5.1	
	CHPPD - Non-Registered Nurses/Midwives - National 4.9			4.9	3.5	3.5	3.5	3.7	3.6	3.5	3.4	3.7	3.4	3.2	3.3	3.4	3.3	
	CHPPD - Registered Nursing Associates			-	0.1	0.2	0.2	0.2	0.2	0.2	0.1	0.2	0.2	0.2	0.2	0.1	0.1	

Workforce Executive Summary

The Shrewsbury and Telford Hospital NHS Trust

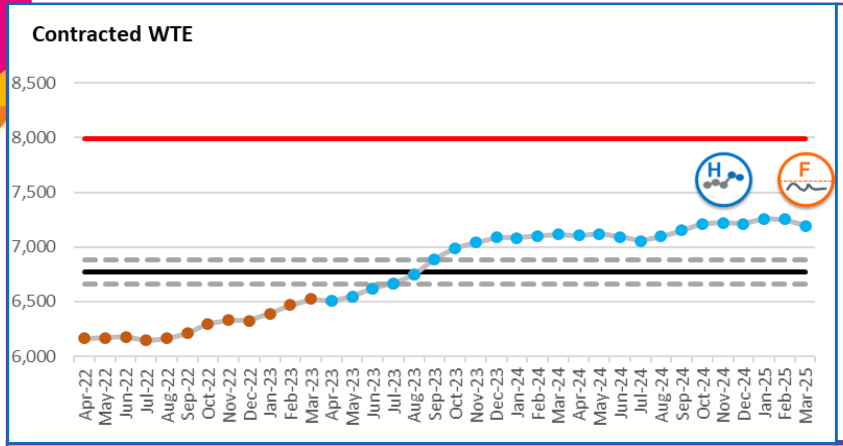
2024/25 Workforce Plan – At month 12 the total workforce outturn is 7973 WTE which is over planned levels by 460 WTE (set at the start of the year). Over the final 6 weeks of the plan, actions have been taken to ensure we meet a revised outturn ceiling of 7990 WTE including strengthening of vacancy controls, reducing agency workforce particularly across our nursing workforce which recorded the lowest levels this year.

Turnover – The rolling 12-month turnover rate for March remained at 10.6% equating to 713 WTE leavers. An in month turnover rate of 1.16% equates to 79 WTE leavers in March,. The turnover rate is expected to reduce over 25/26 as we have planned for a reduction to 10% by month 12.

Wellbeing of our staff – March sickness rate decreased to 5.12% (373 WTE) remaining above target by 0.62% (45 WTE). Sickness attributed to mental health continues to be the top reason for sickness making up 26% of calendar days lost in March equating to 96 WTE.

Agency and temporary staffing – Nursing agency is at the lowest levels seen in previous 5 years and we expect to reduce this further in 25/26 as we fill remaining vacancies following successful recruitment events. In the final week of March our combined agency and bank usage has decreased by 35 WTE. We have reduced medical agency by 42%, now reporting the lowest number for more than 5 years at 29 WTE. The medical workforce efficiency programme is a key enabler for 25/26 in terms of reducing temporary staffing costs through improving recruitment performance in our fragile and challenged specialties. Development of recruitment strategies linked to medical agency review panels will support addressing our higher use areas together with the expansion of electronic rostering across all medical specialties. The newly introduced digital workforce group has recommended several actions to support deployment of the system including new resourcing structure and investment in the system itself.

Workforce – Contracted WTE



Summary:
Contracted figure of 7,192 WTE in March, which is a decrease of 60 WTE in month.
Total workforce utilisation in March decreased by 66 WTE to 7972 WTE attributable the decrease in substantive, decrease in agency by 14 WTE; offset by an increase in bank by 8 WTE.

Agency use has ceased for the majority of inpatient areas. Where agency shifts are being requested, agency panels continue to monitor shifts being released to capped rate agencies. All nursing agency rates are now at capped rates including in specialist areas. Reductions in agency use reflects the rigor of the agency panels in reviewing requests.

Recovery actions:

- Attended the Telford Skills Show to engage with students from schools and colleges, along with general public
- Introduced BI reports to audit the quality and housekeeping of applicant records on ESR
- Student nurse and HCA advertising campaign event taking place in April
- Reviewing and relaunching safer recruitment training to ensure that recruitment practices are robust
- Vacancies continue to be rigorously monitored through weekly panel reviews
- Controls continue to be in place to provide rigour around increases to contractual working hours
- Manager Self Service (MSS) continues to be introduced in preparation for the new Future Workforce Solution. 64% of MSS is deployed and is on plan to achieve 70% deployment by the end of May
- Coding and validation exercise is currently being undertaken between ESR and Healthroster to ensure maximum efficiencies in interoperability between our systems is being achieved
- Leaver process is being promoted to assist in timely processing of ESR records and help ensure leavers are not booked against future shifts
- More than 7000 colleagues signed up to LOOP allowing our digital solutions to be utilised to support absence management

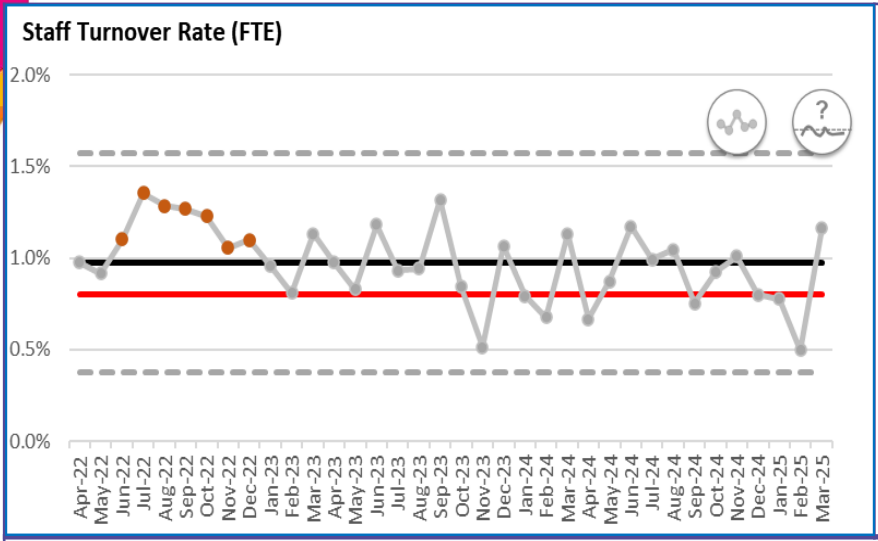
Anticipated impact and timescales for improvement:

There has been a significant shift in the number of nursing agency used which has resulted from successful recruitment filling known gaps (200 wte less than 12 months ago). Financial recovery schemes will continue to be implemented into 25/26 which will further support the position into Q1.

Recovery dependencies:	On-going focus on progressing workforce systems utilisation and leadership alongside system approach to working.

Workforce – Staff turnover rate

The Shrewsbury and Telford Hospital NHS Trust



Summary:

Our Turnover target for 2026 is 10%. The rolling 12-month turnover rate for March remained at 10.6% equating to 713 WTE leavers. An in month turnover rate of 1.16% equates to 79 WTE leavers in March. NHS Leaver turnover rate (those moving outside of the NHS) over the last 12 months is 6.9% equating to 463 WTE NHS leavers.

Staff groups where turnover is above 10.6% include Add Prof Scientific and Technic (12.3%); Additional Clinical Services (12.6%); Admin and Clerical (11.6%); Allied Health Professionals (12.7%).

We continue to see low numbers of those reporting 'unknown' as a reason for leaving. Work life balance remains the highest reason for leaving with 130 WTE leavers over the last 12 months and relocation the second highest reason with 123 WTE leavers.

Recovery actions to achieve our turnover target:

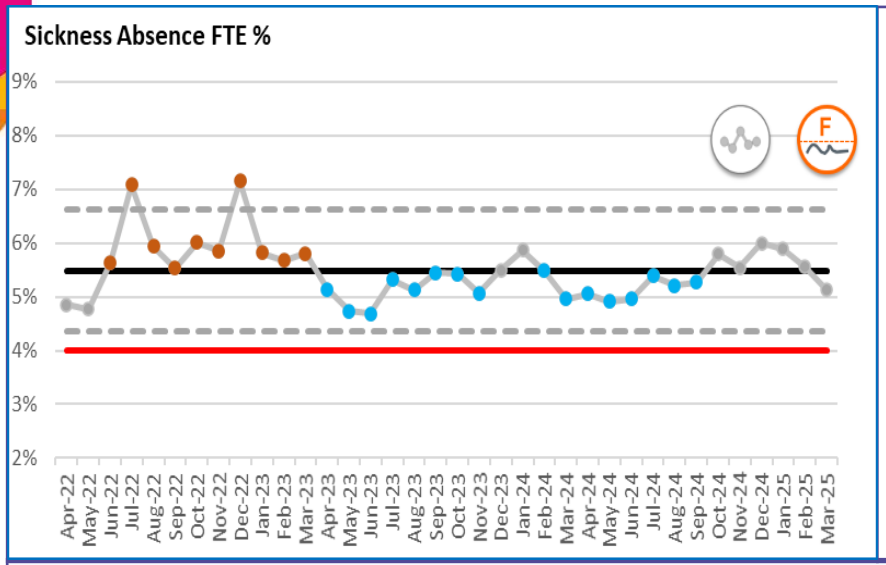
- Staff Networks all have Executive sponsors aligned
- Stay conversation framework available
- Targeted approach for areas identified through staff survey to have additional support aligned to cultural dashboard.
- Engagement with staff side colleagues given environment
- Leadership development programmes re-commenced
- Healthcare Support Worker Academy: Providing targeted training and career pathways for HCSWs; over 1000 HCSWs trained
- Quality Review being undertaken with ICS to assess the effectiveness of current retention initiatives, identify areas for improvement, and implement best practices to retain staff.
- The recognition programme for long service will commence in April, aiming to acknowledge and celebrate the dedication and contributions of long-serving employees

Anticipated impact and timescales for improvement:

The impact of actions taken will support retention levels which we expect to see by end of Q2 in 25/26.

Recovery dependencies:	On-going focus on culture and leadership alongside system approach to working. Engagement and support from our divisions.

Workforce – Sickness absence



Summary:
Our sickness target for 2026 is 4.5%. March sickness rate decreased to 5.12% (373 WTE) remaining above target by 0.62% (45 WTE). Sickness attributed to mental health continues to be the top reason for sickness making up 26% of calendar days lost in March equating to 96 WTE. 11% (40 WTE) of sickness was attributed to other known causes with other musculoskeletal (which does not include back problems) at 10% (37 WTE).

Target reduction of 4% total unavailability (31% to 27%) by the end of the year to support our cost improvement programme).

Additional Clinical Services has the highest sickness rate at 6.7%, Estates and Ancillary staff group has the second highest rate at 6.6% with Nursing and Midwifery at 5.3% and Admin and Clerical at 5.0%.

Recovery actions to achieve our target:

- Menopause support programme launched March 2025
- Review of HWB initiatives to streamline for our leaders and people
- Improvement plan continues to review ER approaches
- Trauma Informed leadership approach to be discussed
- On-going cultural work and support where identified
- Leadership development re-launched and working with specialist managers to further improve content
- Investment secured to develop leadership programme for colleagues with long term conditions
- Flu Campaign 2025/26 planning to commence
- Stage monitoring dashboard deployed to support timely sickness management support and interventions

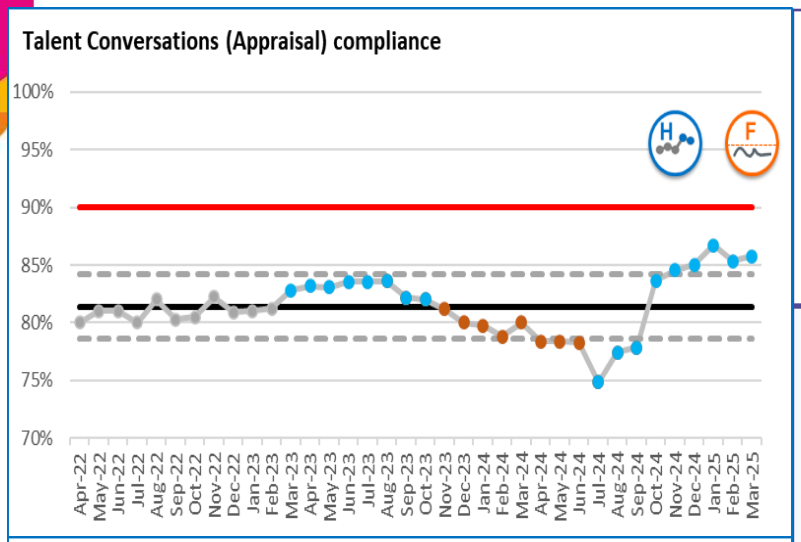
Anticipated impact and timescales for improvement:

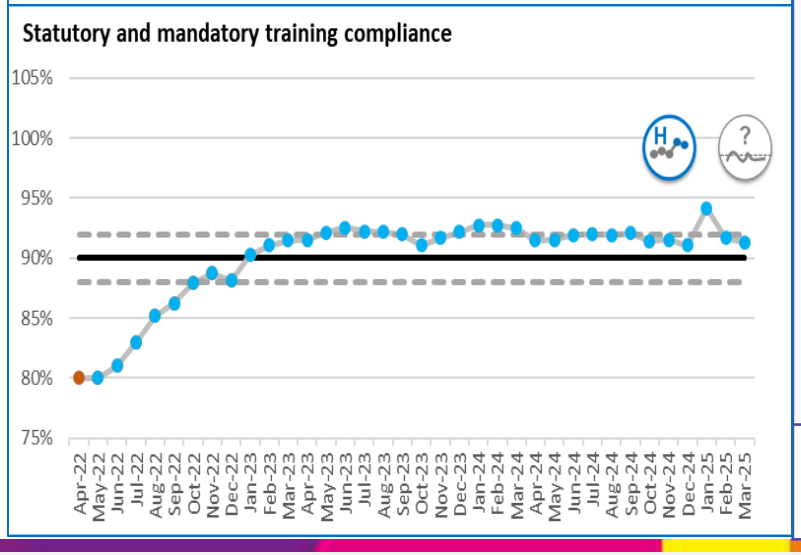
Key absence management schemes as part of financial recovery have been implemented and monitored monthly.

Recovery dependencies:	To ensure strong leadership behaviours, values to support desired culture during challenging times. Support from leaders to ensure proactive management of people and support provided. Risk that despite additional support sickness levels remain on the whole static.

Workforce – Talent Conversations & Training

The Shrewsbury and Telford Hospital NHS Trust





Summary:
Talent Conversations (Appraisals) target is 90%. Medical appraisals has declined over the past 2 months from 96.4% in January to 90.7% in March. For non-medical colleagues, talent conversations increased to 85.8%.
Our Mandatory and statutory training compliance target by 2026 is 93%, currently our target is 90%. The current rate is 91.3% which is above the 2024/25 target.

Recovery actions to achieve our 2026 target:

- Following the Trust decision to move to a new education delivery model we are currently working on our 2025/25 schedule to accommodate the changes. This includes working with our divisions and subject experts to understand any consequences, exceptions and mitigations. This will ensure education and development remains central to supporting and developing colleagues to deliver quality patient care. Plans on-going
- We also are reviewing frequency of our statutory and mandatory programmes aligned to the national review for core skills, more guidance received in month
- Talent conversations have slightly improved, new policy approved and launch Q1

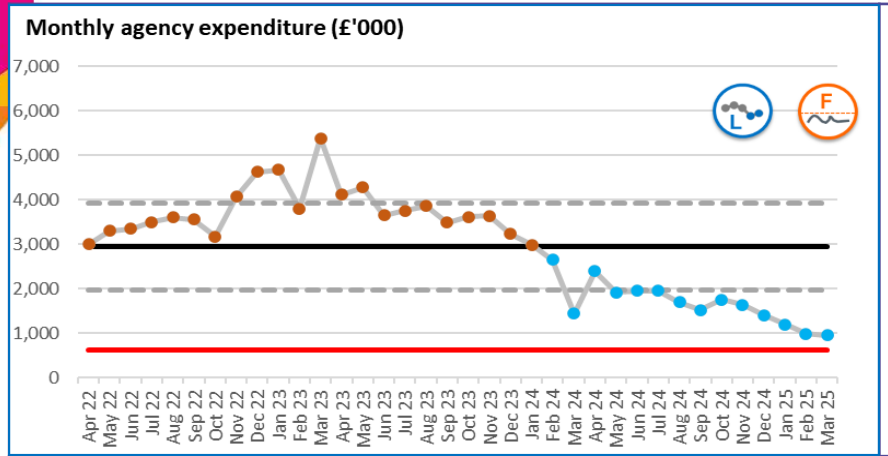
Anticipated impact and timescales for improvement:

Key priorities for People Plan 2024/25.

Recovery dependencies:	Investment in technology. Capacity to delivery new training delivery model.

Agency Expenditure – Monthly

The Shrewsbury and Telford Hospital NHS Trust



Summary:
March recorded the lowest levels of agency expenditure for the year. Agency pay expenditure has continued to reduce during FY24/25, reducing from £2.4m in April 2024 to a forecast £1.0m in March 2025. This is planned to reduce further during FY25/26 to £0.3m by March 2026 (after removing pay award costs).

Total nurse agency usage has continued to reduce and is at the lowest combined levels in last 12 months. The introduction of the NHSP National Bank has supported reductions across Theatre workforce. The programme of work to support improving price cap compliance has contributed to support cost reduction, with all nursing and AHP's now meeting the price cap compliance target.

- Rigor around WTE budgets continues requiring either approval through the budget setting round or triple lock approvals – increases in substantive WTE budget all funded or run rate reducing temporary medical staffing – three times a week approval panels jointly chaired by COO and MD/DMD
- Escalation of agency nursing requests beyond capped rates continue to be reviewed at twice daily approval panels with minimal numbers escalated above capped rate
- Currently reviewing process for nursing agency requests to be approved via a panel before releasing to capped rate agency
- Commenced working with NHSP National Bank to facilitate a migration of non-medical agency workers to join the NHSP bank which will further reduce agency use
- All substantive recruitment continues to be monitored through vacancy control panels at divisional level with executive attendance
- 100% compliant with no off-framework agency use and are working with agency providers to further reduce nursing agency capped rates which will drive further cost reductions over the coming months
- Use of NHSP Bank to reduce reliance on agency workers.
- Nurses continue to be automatically auto-enrolled on Trust Bank

Anticipated impact and timescales for improvement:

Continued reduction of agency nursing expected to end of year.

Recovery dependencies:	Escalation plan delivery and workforce unavailability going into winter.

Staffing - actuals vs plan

The Shrewsbury and Telford Hospital NHS Trust

Plan	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Substantive	7113	7116	7123	7119	7205	7199	7297	7272	7243	7212	7182	7151
Bank	687	687	687	651	619	585	552	518	484	450	415	318
Agency	321	313	306	275	247	218	189	160	131	102	73	44
Total	8,121	8,116	8,116	8,045	8,072	8,003	8,039	7,950	7,858	7,764	7,670	7,513
Actual	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Substantive	7107	7118	7093	7057	7095	7152	7211	7218	7213	7259	7227	7193
Bank	618	628	624	652	653	607	622	621	589	627	663	671
Agency	269	252	226	213	171	162	172	167	143	125	123	109
Total	7994	7999	7942	7922	7918	7921	8005	8006	7945	8011	8013	7973
Variance	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Substantive	-6	2	-30	-62	-110	-47	-86	-54	-30	47	45	42
Bank	-69	-59	-63	-1	34	22	70	103	105	177	248	353
Agency	-52	-61	-80	-64	-76	-56	-17	7	12	23	50	65
Total	-127	-117	-174	-127	-154	-82	-34	56	87	247	343	460

Summary:
Total staff usage of 7973 WTE in March which is 460 WTE behind the revised plan and a decrease of 43 WTE compared to February. The slippage to plan predominantly relates to continued use of escalation capacity with the revised plan taking in to account the additional 51 resident doctors and WTEs associated with income backed posts.
This year our primary focus has been on reducing our longstanding dependency on the agency workforce which is now at the lowest level this year.
The reductions in agency staffing reflects the impact of FRG agreed actions.

Continued actions:

- All recovery actions are clinically led
- A process for approving capped rate shifts to be escalated to agency has been introduced which will further provide further rigor around agency utilisation.
- The roster scorecard dashboard continues to support the monitoring of workforce utilisation and efficiency
- We continue to progress with work to increase the lead-time for our roster approvals from 6 weeks to 8 weeks
- Further agency controls
- Divisional WTE reduction plans being developed

Anticipated impact and timescales for improvement:
Actions being undertaken will have a continued improvement on the financial position and are monitored on a weekly / monthly basis.

Dependencies:
On-going focus on progressing workforce systems utilisation, culture and leadership alongside system approach to working.

Well Led - Finance

Executive Lead:

Director of Finance

Helen Troalen

Integrated Performance Report

The Shrewsbury and Telford Hospital NHS Trust

Domain	Description	Current Month Trajectory (RAG)	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Trend
Finance	End of month cash balance £'000	1,700	54,689	58,369	39,634	36,999	29,444	24,375	15,051	67,367	54,399	43,511	54,932	48,821	61,762	
	CIP Delivery £'000	12,046	3,506	850	869	1,915	2,125	2,367	2,799	3,390	3,585	2,833	3,654	4,287	5,659	
	Balanced £ Position £'000 (Cumulative)	(6,365)	(54,583)	(7,209)	(12,930)	(21,030)	(28,705)	(34,229)	(5,621)	(10,864)	(13,242)	(17,179)	(22,661)	(27,570)	(18,563)	
	Year to date capital expenditure £'000	88,331	18,423	741	1,734	3,278	5,424	7,364	8,403	10,153	16,157	22,352	26,936	39,110	69,194	

Finance Executive Summary

The Shrewsbury and Telford Hospital NHS Trust

The Trust submitted an updated finance plan to NHSE on 12th June which showed a deficit plan of £44.3m for the year which is in line with the financial parameters set by NHSE. In September, the Trust received additional funding to cover the planned deficit resetting the annual plan to breakeven. At the end of March (month twelve), the Trust has a deficit of £18.6m against that restated breakeven plan. The drivers of the variance remain largely consistent: temporary staffing premiums (£8.5m), endoscopy income (£4.0m) and non pay (£1.5m), the cost pressure resulting from the pay award increased in line with previous months (£3.6m year to date) and resident doctors at £1.0m. The previously reported variance associated with escalation costs has been eliminated following receipt of the surge funding support. The Trust has five main deliverables within the operating plan for 2024/25:

Delivery of the activity plan to secure the ERF and potentially additional income – there is no change in the reporting of income due to the data warehouse issues.

Delivery of the efficiency plan – The trust has an efficiency target of £44.7m (7.6%) in 2024/25. At the end of March, £34.3m has been delivered with shortfalls against the planned reduction of escalation capacity and income related schemes which currently cannot be validated. FRG actions delivered as per forecast at £3.5m which is £1.4m higher than month eleven with the main increase caused by a technical accounting adjustment.

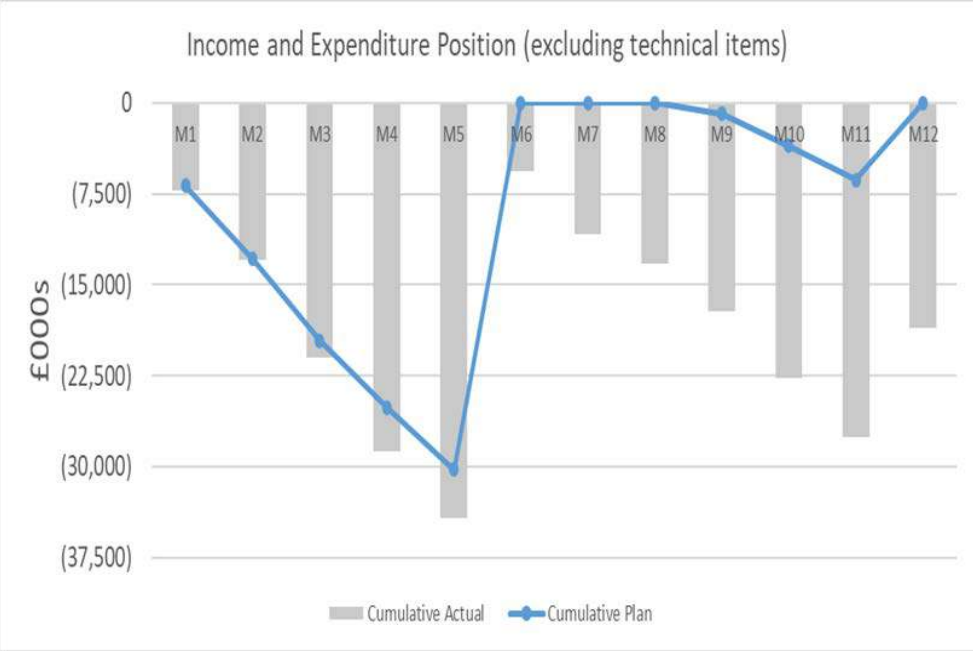
WTE reduction plan – At the end of March the actual wte is 461 WTE adverse to plan of which substantive (42) bank (353) and agency (65) are behind plan. It should be noted that the plan reflects additional income backed posts in year with the slippage being predominantly driven by escalation.

Delivery of the agency reduction plan – expenditure has continued to fall with total expenditure of £19.4m year to date with in month costs remaining below £1.0m for the second month. However, the expenditure is £4.3m above plan year to date which is driven by escalation costs and medical staffing linked to vacancy cover. There continues to be a strong focus on medical agency in the remaining few weeks of the year and beyond into FY25/26.

Delivery of the bed plan with reliance on system partners for out of hospital capacity – At the end of March, the planned reduction in escalation had been mobilised and decision taken not to open the Discharge Lounge overnight agreed. It should be noted that the operational plan was for the majority of escalation capacity to have ceased from the end of September which has not been achieved.

The Trust has set an operational capital programme of £16.8m and externally funded schemes of £52.5m in FY24/25, giving a total capital programme of £69.2m which was expended at month twelve, achieving a balanced year end position. The Trust held a cash balance at end of March 2025 of £61.8m.

Income and expenditure

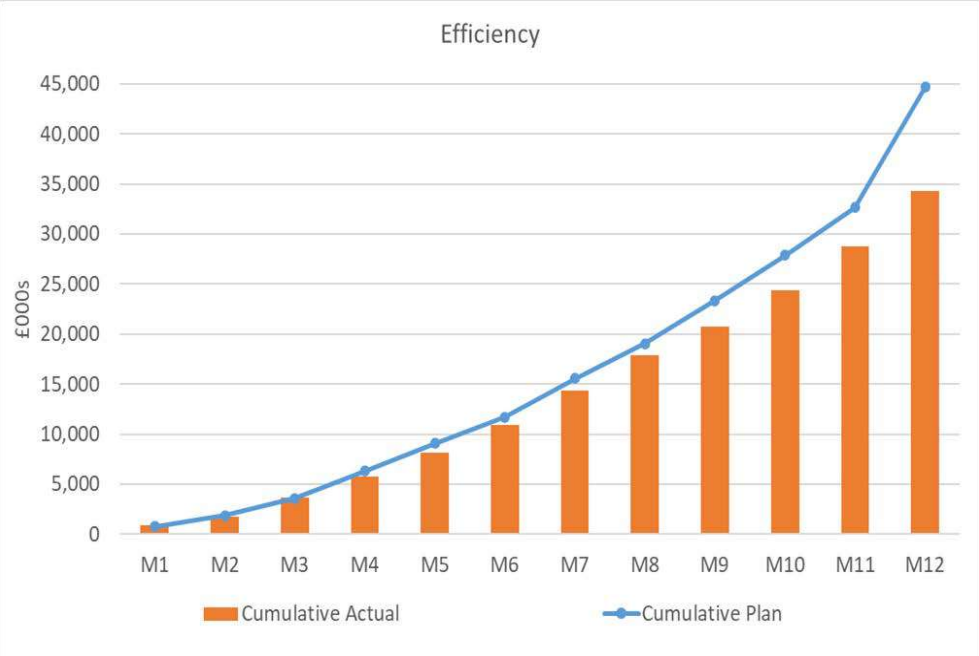


Summary:
The Trust submitted and had approved a financial plan deficit of £44.3m in FY24/25 which was in line with the stated NHSE policy at the time of planning. As a result of the STW plan for the year being within the NHSE agreed deficit, the Trust has received financial support to the value of the planned deficit. This has adjusted the annual plan to a breakeven position.

The Trust recorded a full year deficit of £18.6m against a revised breakeven plan. Of this deficit to plan £3.6m is the cost pressure associated with the pay award, £8.5m relates to agency and locum expenditure predominantly in medical staffing, £1.5m caused by non-pay variances, £1.0m due to the increase in resident doctors and £4.0m at risk endoscopy income. The cost pressure previously reported against escalation has been eliminated following the receipt of additional funding from the ICB.

Recovery actions:	**Anticipated impact and timescales for improvement:**
N/A	N/A
Recovery dependencies:	N/A

Efficiency



Summary:
The Trust has a total efficiency target for FY24/25 of £44.7m. This includes £41.0m of budget releasing savings and £3.7m of run rate reductions.

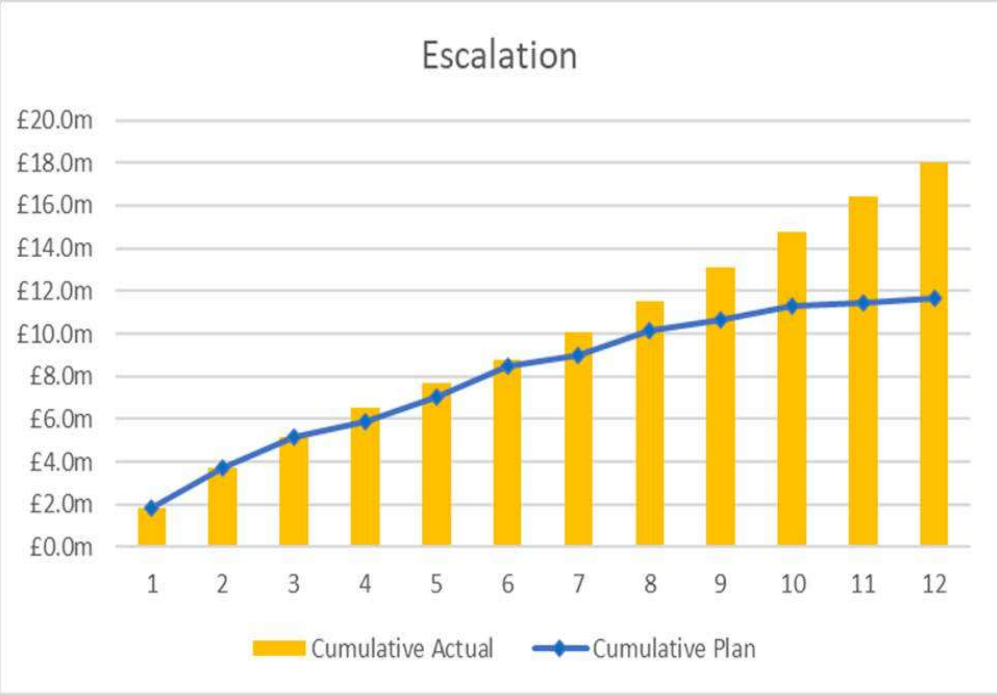
As at the end of March (month 12), the Trust has delivered £34.3m of efficiency savings for FY24/25 which is £10.4m adverse to the planned delivery.

The main drivers for this under delivery are escalation costs and income schemes which cannot be validated.

Recovery actions:	**Anticipated impact and timescales for improvement:**
N/A	N/A

Recovery dependencies:	N/A

Escalation



Summary:
Included within the operational plan bed model is a requirement for varying levels of escalation throughout the year including core beds as well as utilising unconventional capacity.

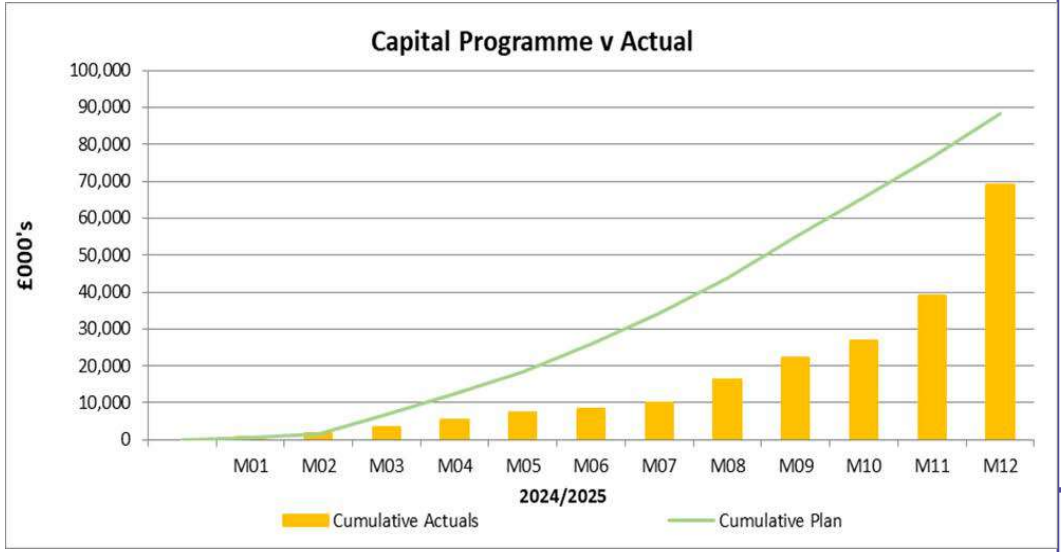
The requirement on a monthly basis is driven by changes in demand, offset by both internal and external interventions such as reduction length of stay and reductions in the number of patients with no criteria to reside, all of which is linked to the delivery of the 4 UEC transformation workstreams.

In March, the escalation costs remained at a similar level to February whereas the operational plan was for a significant reduction. This cost remain off plan year to date, however the cost pressure has been mitigated following receipt of the surge funding support.

Recovery actions:	**Anticipated impact and timescales for improvement:**
N/A	N/A

Recovery dependencies:	N/A

Capital Programme



Summary:
As required due to the NHSE business rules, the FY24/25 operational capital programme has been revised down by 10% to £16.8m.

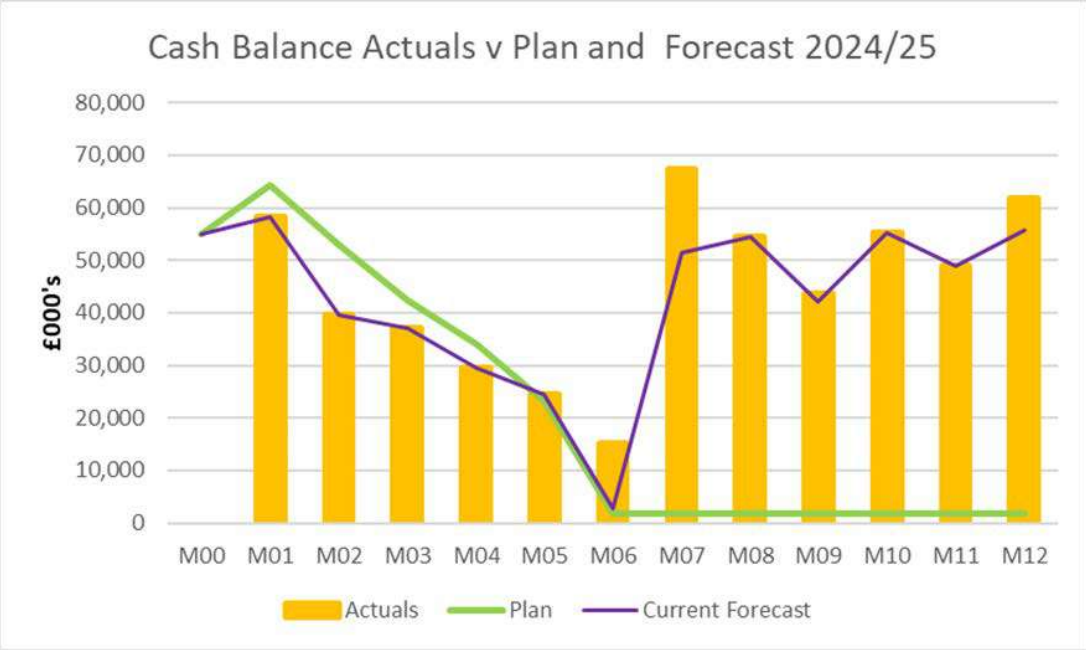
External allocations have remained at £52.5m. In addition, a Public Sector Decarbonisation Scheme grant of £8.1m in 2024/25 has also been approved to be spent on decarbonisation initiative on the Shrewsbury site, this has been fully expensed.

The total capital programme for FY24/25 is now £69.2m (excluding Salix).

During 2024/25 £69.2m of expenditure has been incurred. This is under the original plan due to rephasing of HTP with a reduction in FY24/25 and additional PDC allocations received not in the original plan.

Recovery actions:	**Anticipated impact and timescales for improvement:**
N/A	N/A
Recovery dependencies:	N/A

Cash



Summary:
The Trust undertakes monthly cashflow forecasting.

The cash balance brought forward into FY24/25 was £54.9m with a cash balance of £61.8m (ledger balance of £61.5m due to reconciling items) held at end of March 2025.

The graph illustrates actual cash held against the plan. The cash position is in excess of plan at end of March and is mainly due to receipt of additional income.

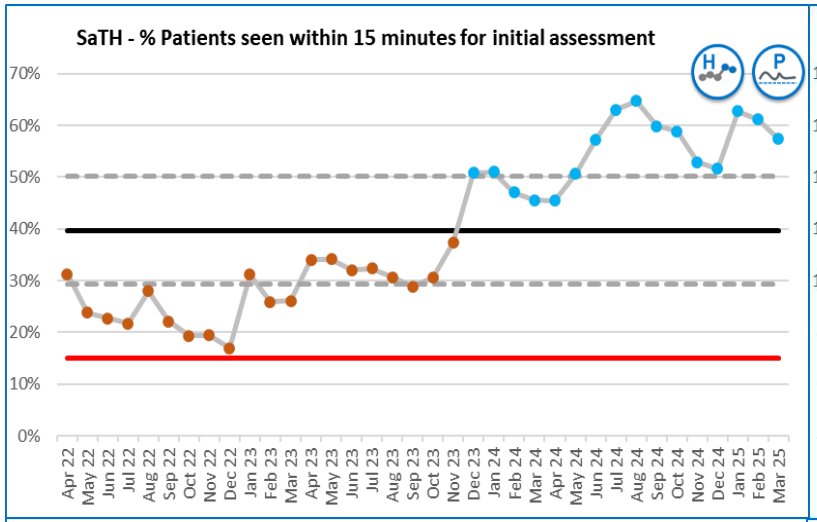
Recovery actions:	**Anticipated impact and timescales for improvement:**
N/A	N/A

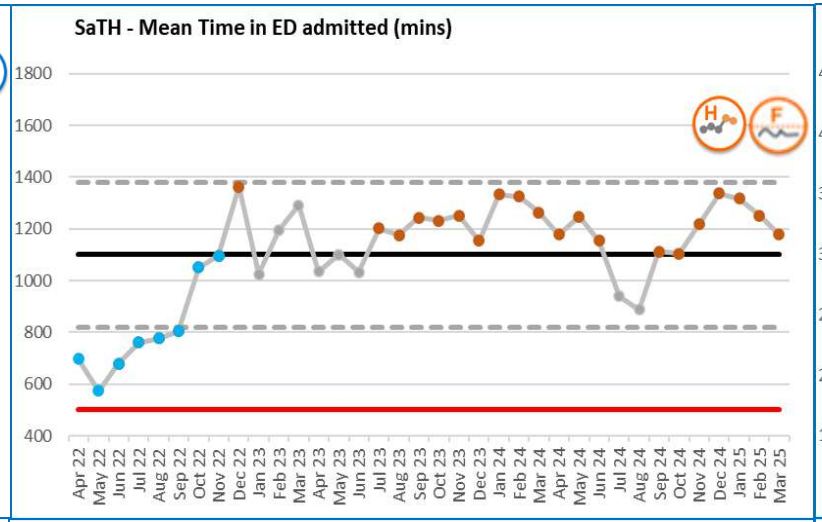
Recovery dependencies:	N/A

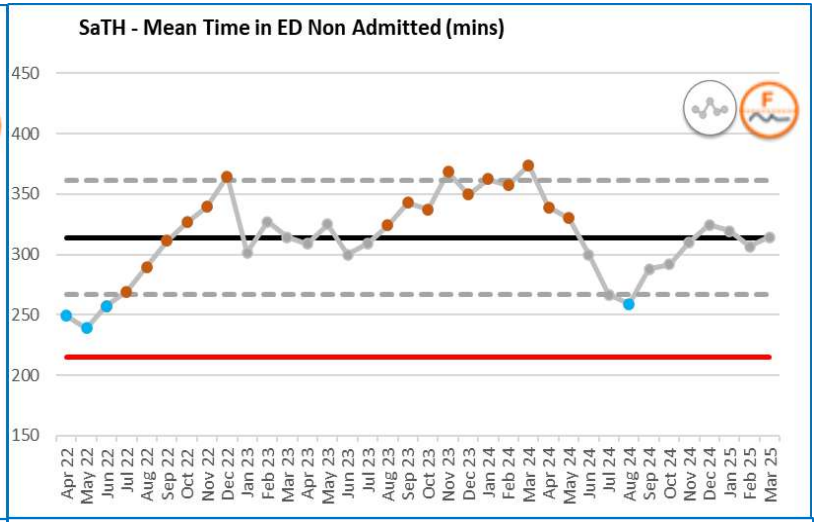
Appendices – Responsiveness and Well Led

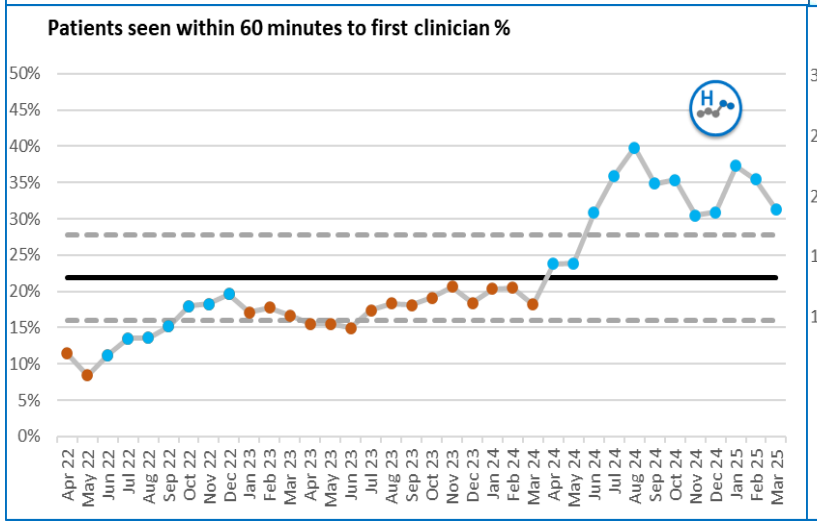
Appendix 1 – supporting detail on Responsiveness

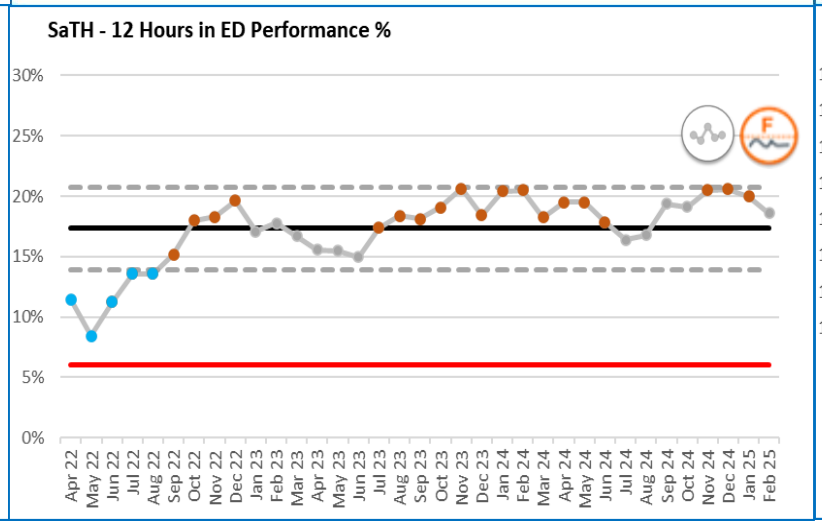
The Shrewsbury and Telford Hospital NHS Trust

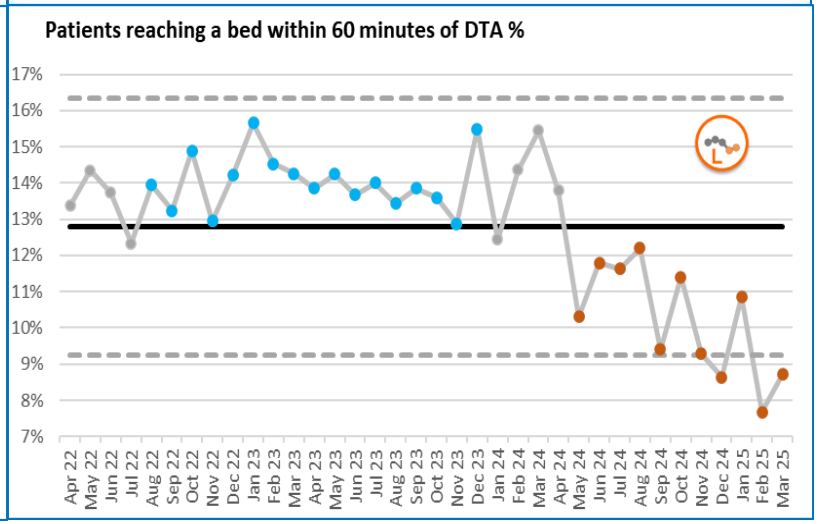






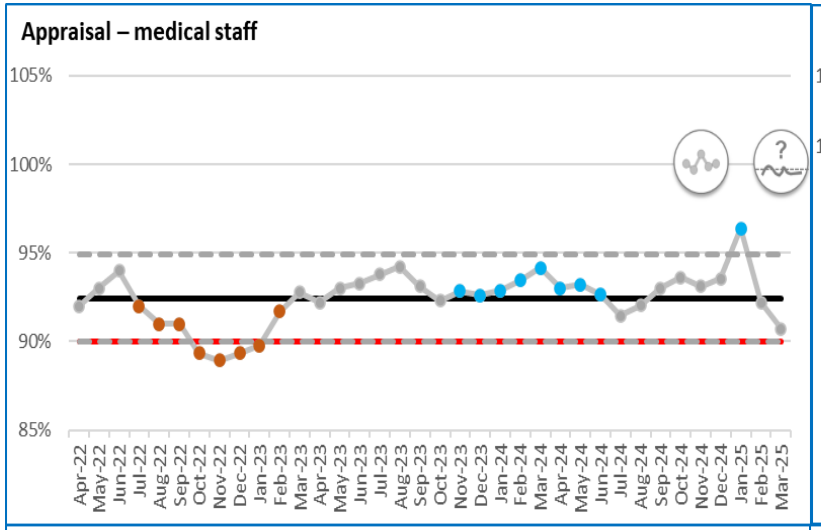


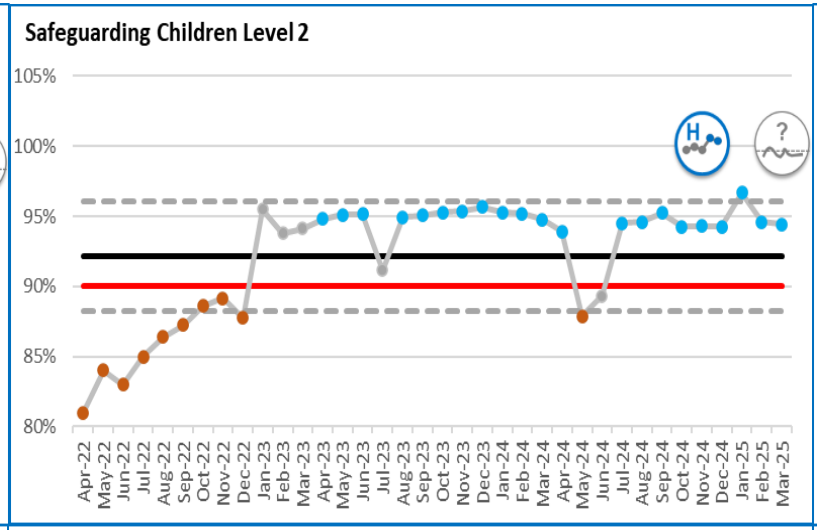


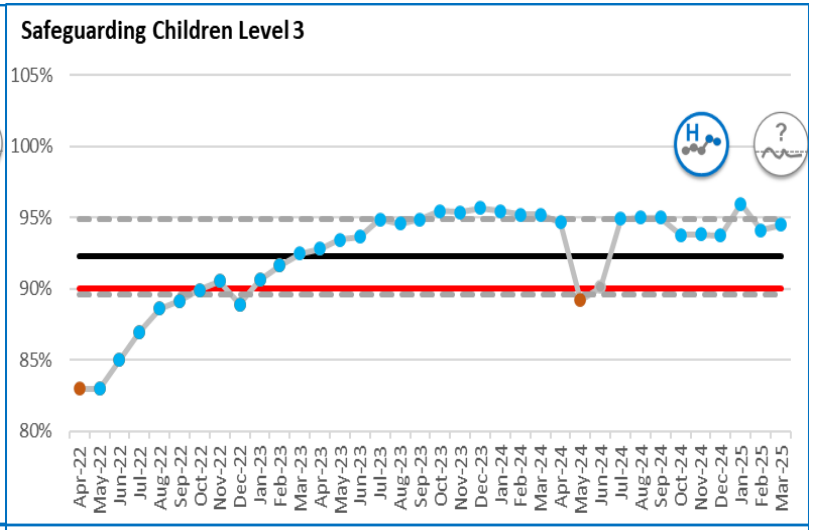


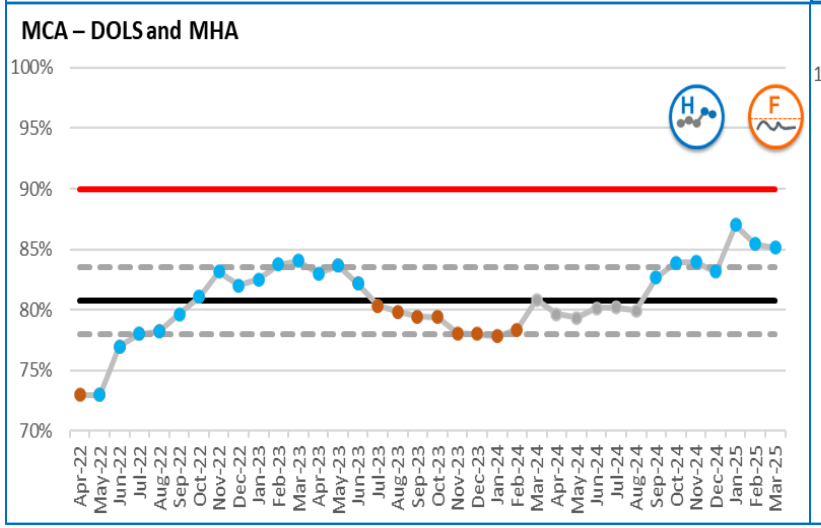
Appendix 2 – supporting detail on Well Led

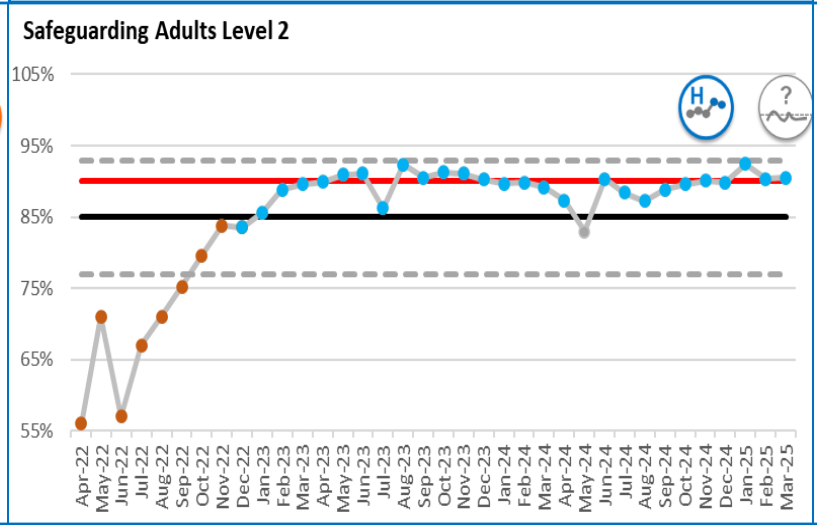
The Shrewsbury and Telford Hospital NHS Trust

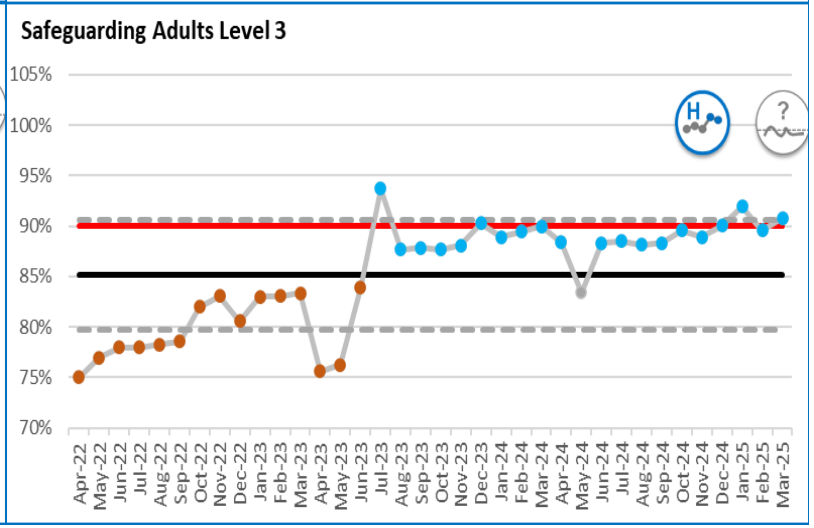












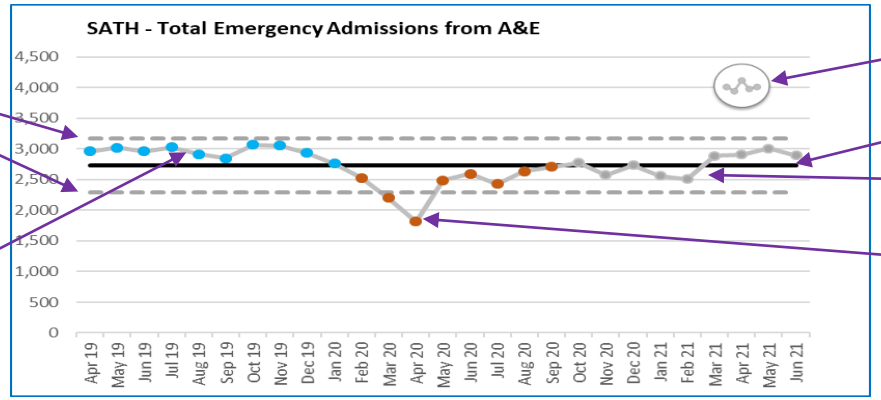
Appendix 3 – Understanding statistical control process charts in this report

The Shrewsbury and Telford Hospital NHS Trust

The charts included in this paper are generally moving range charts (XmR) that plot the performance over time and calculate the mean of the difference between consecutive points. The process limits are calculated based on the calculated mean.

Process limits – upper and lower

Special cause variation - 7 consecutive points above (or below) the mean



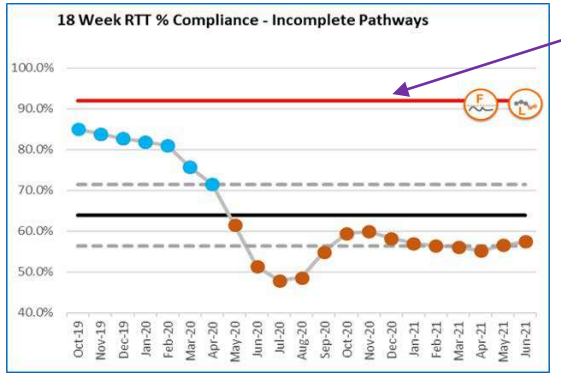
Icon showing most recent point type of variation

Mean or median line

Common cause variation

Special cause variation – data point outside of the process limit

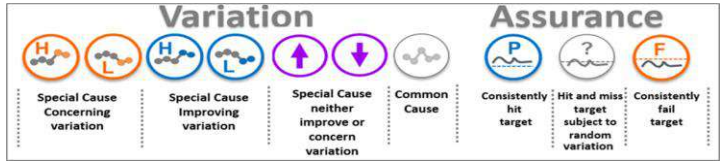
Where a target has been set the target line is superimposed on the SPC chart. It is not a function of the process.

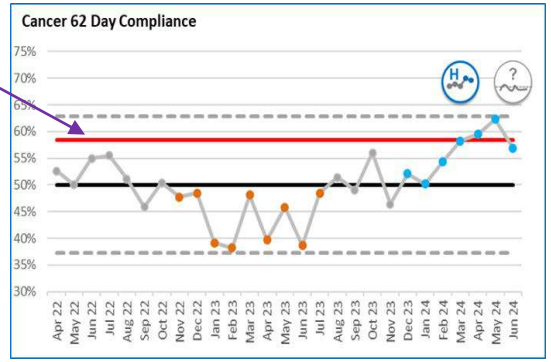


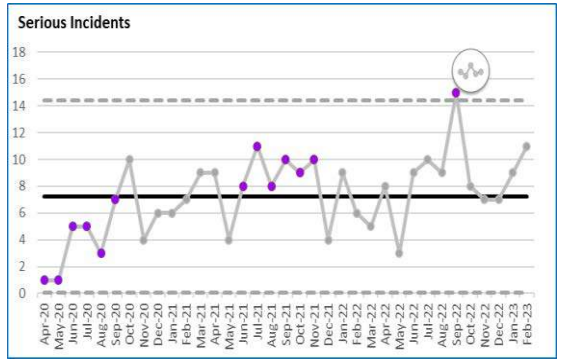
Target line – outside the process limits.

In this case, process is performing worse than the target and target will only be achieved when special cause is present, or process is re-designed

Target line – between the process limits and so will be hit and miss whether or not the target will be achieved







Appendix 4 – Abbreviations used in this report

The Shrewsbury and Telford Hospital NHS Trust

Term	Definition
2WW	Two week waits
A&E	Accident and Emergency
A&G	Advice and Guidance
AGP	Aerosol-Generating Procedure
AMA	Acute Medical Assessment
ANTT	Antiseptic Non-Touch Training
BAF	Board Assurance Framework
BP	Blood pressure
CAMHS	Child and Adolescence Mental Health Service
CCG	Clinical Commissioning Groups
CCU	Coronary Care Unit
C. difficile	Clostridium difficile
CHKS	Healthcare intelligence and quality improvement service.
CNST	Clinical Negligence Scheme for Trusts
COHA	Community Onset Hospital Acquired infections
COO	Chief Operating Officer
CQC	Care Quality Commission
CRL	Capital Resource Limit
CRR	Corporate Risk Register
C-sections	Caesarean Section
CSS	Clinical Support Services
CT	Computerised Tomography
CYPU	Children and Young Person Unit
DIPC	Director of Infection Prevention and Control
DMO1	Diagnostics Waiting Times and Activity
DOLS	Deprivation Of Liberty Safeguards
DoN	Director of Nursing
DSU	Day Surgery Unit

Term	Definition
DTA	Decision to Admit
E. Coli	Escherichia Coli
Ed.	Education
ED	Emergency Department
EQIA	Equality Impact Assessments
EPS	Enhanced Patient Supervision
ERF	Elective Recovery Fund
Exec	Executive
F&P	Finance and Performance
FNA	Fine Needle Aspirate
FTE	Full Time Equivalent
FYE	Full year effect
G2G	Getting too Good
GI	Gastro-intestinal
GP	General Practitioner
H1	April 2021-December 2021 inclusive
H2	December 2021-March 2022 inclusive
HCAI	Health Care Associated Infections
HCSW	Health Care Support Worker
HDU	High Dependency Unit
HMT	Her Majesty's Treasury
HoNs	Head of Nursing
HPP	Healthy Pregnancy Support Service
HSMR	Hospital Standardised Mortality Rate
HTP	Hospital Transformation Programme
ICB	Integrated Care Board
ICS	Integrated Care System
IPC	Infection Prevention Control

Appendix 4 – Abbreviations used in this report

The Shrewsbury and Telford Hospital NHS Trust

Term	Definition
IPCOG	Infection Prevention Control Operational Group
IPAC	Infection Prevention Control Assurance Committee
IPDC	Inpatients and day cases
IPR	Integrated Performance Review
ITU	Intensive Therapy Unit
ITU/HDU	Intensive Therapy Unit / High Dependency Unit
KPI	Key performance indicator
LFT	Lateral Flow Test
LMNS	Local maternity network
MADT	Making A Difference Together
MCA	Mental Capacity Act
MD	Medical Director
MEC	Medicine and Emergency Care
MFFD	Medically fit for discharge
MHA	Mental Health Act
MRI	Magnetic Resonance Imaging
MRSA	Methicillin- Sensitive Staphylococcus Aureus
MSK	Musculo-Skeletal
MSSA	Methicillin- Sensitive Staphylococcus Aureus
MTAC	Medical Technologies Advisory Committee
MVP	Maternity Voices Partnership
MUST	Malnutrition Universal Screening Tool
NEL	Non-Elective
NHSE	NHS England and NHS Improvement
NICE	National Institute for Clinical Excellence
NIQAM	Nurse Investigation Quality Assurance Meeting
OPD	Outpatient Department

Term	Definition
OPD	Outpatient Department
OPOG	Organisational performance operational group
OSCE	Objective Structural Clinical Examination
PAU	Paediatric Assessment Unit
PID	Project Initiation Document
PIFU	Patient Initiated follow up
PMB	Post-Menopausal Bleeding
PMO	Programme Management Office
POD	Point of Delivery
PPE	Personal Protective Equipment
PRH	Princess Royal Hospital
PTL	Patient Targeted List
PU	Pressure Ulcer
RALIG	Review Actions and Learning from Incidents Group
Q1	Quarter 1
QOC	Quality Operations Committee
QSAC	Quality and Safety Assurance Committee
QWW	Quality Ward Walk
R	Routine
RAMI	Risk Adjusted Mortality Rate
RCA	Route Cause Analysis
RJAH	Robert Jones and Agnes Hunt Hospital
RIU	Respiratory Isolation Unit
RN	Registered Nurse
RSH	Royal Shrewsbury Hospital
SAC	Surgery Anaesthetics and Cancer
SaTH	Shrewsbury and Telford Hospitals
SATOD	Smoking at the onset of delivery

Appendix 4 – Abbreviations used in this report

The Shrewsbury and Telford Hospital NHS Trust

Term	Definition
SDEC	Same Day Emergency Care
SI	Serious Incidents
SMT	Senior Management Team
SOC	Strategic Outline Case
SRO's	Senior Responsible Officer
STEP	Strive Towards Excellence Programme
T&O	Trauma and Orthopaedics
TOR	Terms of Reference
TVN	Tissue Viability Nurse
UEC	Urgent and Emergency Care service
US	Ultrasound
VIP	Visual Infusion Phlebitis
VTE	Venous Thromboembolism
WAS	Welsh Ambulance Service
W&C	Women and Children
WEB	Weekly Executive Briefing
WMAS	West Midlands Ambulance Service
WTE	Whole Time Equivalent
YTD	Year to Date

The Shrewsbury and Telford Hospital NHS Trust

Board of Director's Meeting: 8 May 2025

Agenda item		076/25		
Report Title		Public Participation Report Quarter 3&4 2024/25		
Executive Lead		Nigel Lee, Director of Strategy & Partnerships		
Report Author		Julia Clarke, Director of Public Participation		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe		Our patients and community	√	BAF9
Effective		Our people		
Caring		Our service delivery		**Trust Risk Register id:**
Responsive		Our governance		
Well Led	√	Our partners		
Consultation Communication		Public Assurance Forum – 14 April 2025		
Executive summary:		The Shrewsbury and Telford Hospital NHS Trust is committed to ensuring that the patient-public voice is at the centre of shaping our health services, both now and in the future. At the heart of our organisation and its future success are our patients, carers and local communities. We aim to provide the best care and experience we can, and to ensure that we do this, our local communities need to feel listened to, and that as an organisation we are responsive to their needs across Shropshire, Telford & Wrekin and Mid-Wales. Whilst we have a legal duty to engage with the public, we go far beyond this requirement. In the overview of the SaTH Care Quality Commission Inspection Report published in May 2024, the CQC found "*People who use services, the public and staff were highly engaged and involved to support high-quality sustainable services".* Under the banner of **#GetInvolved**, https://www.sath.nhs.uk/about-us/get-involved/get-involved-public-participation/ we aim to provide a range of opportunities for our communities to be involved with us. We reach out to engage with the public and the emphasis is on everything we do directly linking to our local communities.		
Recommendations for the Board:		The Board is asked to: **Note** the current activity from October 2024 to March 2025 across the Public Participation Team, and **Take assurance** from this work that our statutory duties are being met, as well as CQC Well-led requirements.		
Appendices:		Appendix 1: 6-month Public Participation Full Trust Board Report *(In the Board Supplementary Information Pack)*		

1.0 Public Participation Team

The Care Quality Commission rely on Key Lines of Enquiry (KLOEs), prompts and sources of evidence to answer the five key questions: is the service safe, effective, caring, responsive and well-led. One of the 8 Well-led KLOES is "*are the people who use the services, the public, staff and external partners engaged and involved to support high quality sustainable services*" and more specifically relating to public participation *"are people's views and experiences gathered and acted upon to shape and improve the services and culture? Does this include people in a range of equality groups?"*

The Public Participation Team consists of three main inter-related public-facing teams:

- Community Engagement including the Hospitals Transformation Programme (HTP)
- Volunteering
- SaTH Charity

Under the banner of Get Involved – Make a Difference the team https://www.sath.nhs.uk/about-us/get-involved/get-involved-public-participation/ there are lots of different ways to Get Involved and we've listened to feedback from our communities and made it easier to do. We reach out to engage with the public and the emphasis is on everything we do directly linking to our local communities.

The Public Participation Report (which is in the Board supplementary pack and contains rich information and assurance on the work of the team) contains a summary/highlights of the work across these three teams in slides 2-4, with the detail in the following slides.

2.0 Community Engagement including HTP (slides 5-20 in presentation)

2.1 The Community Engagement Team continues to engage with the public with a regular series of virtual and face-to-face meetings, health lectures and newsletter email updates. Activity is reported to the quarterly Public Assurance Forum which is co-chaired by a SaTH NED (Professor Trevor Purt) and a public member from Montgomery Health Forum (Cllr Joy Jones) and has a wide range of community, voluntary and statutory sector organisations as members; the Forum has the opportunity to discuss issues directly with our Divisional teams, who also attend. The papers are published on our website for full transparency and key items from the meetings in October and January are included in the accompanying pack (Slides 6 and 7).

2.2 Our community members (5189) and organisations (469) continue to increase. (Slide 8 details) and they have access to a wide range of ways to find out more about the Trust and to get involved. Some of the events we have attended/organised are detailed on Slide 9

2.3 Our engagement team has been making stronger links with a number of Seldom Heard Groups over the past six months focusing on Gypsy and Traveller outreach, veterans/Armed Forces and deaf/hard of hearing groups (Slides 11-12).

2.4 **HTP engagement (see slides 13- 20)** The Public Participation Department has also been leading the work to engage with our local communities around the Hospitals

Transformation Programme (HTP). Meetings are supported by the HTP team and chaired by the Director of Public Participation.

The team has organised a number of events including regular quarterly public focus groups (aligned to the clinical workstreams ie Medicine, Emergency Care & Surgery, Anaesthetics, Cancer & Critical Care and Women & Children's), as well as focus groups for patients with specific conditions eg mental health, dementia, children & young people and one looking specifically at the new main entrance. In early October we have held two face-to-face focus groups for the deaf (with support from BSL translators) and hard of hearing communities, one for our Veterans Community and two for GP Patient Participation Groups. All these have an extensive Q&A section to gain the views and comments from attendees. All focus groups presentations are published on our website along with the Q&As and action logs (after they've been reviewed by the attendees) to ensure full transparency. For more information please see our website: **HTP Focus Groups - SaTH**

2.5 We have also attended 42 events across the county and mid-Wales (noting there has been a pause due to going into pre-election in March) and a further 14 online events. The map below shows the spread of the face to face meetings and details are on slides 16-17 in the supplementary pack

2.6 We have been planning our engagement with our local communities for the next 6 months including the following focus groups:

- Communications and engagement for Urgent and Emergency Care (UEC) on Tuesday 3 June at 10:00am (hybrid meeting)
- Wayfinding for new healthcare facilities on Thursday 5 June at 10:00am (hybrid meeting)

2.7 Over the next 6 months we have planned 12 HTP drop in events across the areas we serve, in which the public can find out more about our plans. Drop-ins are planned in: Church Stretton, Shrewsbury, Wellington, Ironbridge, Wem, Oswestry, Welshpool, Ludlow, Bridgnorth, Market Drayton and Lydham.

2.8 Our next HTP About Health Event is taking place on Microsoft Teams on Tuesday 6 May at 6.30pm

2.9 A special event was held in March in which focus group members were invited to see the first area that has been developed as part of the Hospitals Transformation Programme – ED1. ED1 is the first development of our new Emergency Department at RSH and has our resuscitation area and part of our new Majors. Over 22 members of our focus groups and volunteers attended, with great feedback about the new facilities.

3.0 Volunteers (Slides 21-27)

3.1 We currently have 251 volunteers, who have given almost 14,000 hours of volunteer time across a wide range of activities. We have over 30 different role descriptions across all areas of the Trust including non-clinical support roles. Our volunteers have supported a number of "one off events" alongside their regular placements, including Exercise Spring (evacuation from ED) and the William Farr Academy to support medical training (See slide 22).

3.2 We have held a number of focus groups for our volunteers including an Autism Awareness session and a feedback session to support improvements of the new Outpatients entrance

3.3 Julia Clarke and Hannah Morris were invited by Helpforce (a national Charity supporting volunteering in health and social care) to attend a national Volunteer strategy launch event at the House of Commons. Over 80 leaders from across government, the NHS and voluntary and community sectors attended for the launch of a new report by Helpforce - "Unlocking the Power of Volunteering to support our NHS". Within the report SaTH's Volunteer to Career programme was highlighted as an area of good practice. (slide 23).

3.4 There have been some changes to the volunteer team over the past six months and we have welcomed three new members of staff to the team – two replacement posts, Volunteer Services Manager (Pete) and a Volunteer Facilitator (Jez), plus one post funded by the ICB Volunteer Project Lead – Patient discharges (Eve).

3.5 We celebrated one of our long-serving volunteers, Terry Seston, turning 90 in January. The news of Terry turning 90 spread and he was featured on the BBC news website and on Midlands Today News (slide 24). His wife Babs, who was also a volunteer until recently, will be also reaching 90 in May this year.

3.6 As part of the Trust's Annual Recognition Week we held a volunteer celebration event, with over 60 volunteers attending. Peter Hicking won the title of Volunteer of the Year at the Trust awards. Peter regularly contributes over 1000 hours a year to the Trust.

3.7 Following a successful bid proposal to the ICB, the Shrewsbury and Telford Hospital NHS Trust and Helpforce are working together to deliver a 6-month volunteer project, which should help to reduce hospital readmission through safe and timely discharge and follow-up community support. This project starts in April 2025, and includes implementing volunteer drivers to support patients getting home after discharge and providing telephone support for up to 72 hours post-discharge. (slides 26-28)

3.8 The Volunteer to Career (VtC) scheme continues to go from strength to strength. Over the past six months we have run a VtC cohort in Radiotherapy (RSH) and within Midwifery (PRH). Our volunteers within Radiotherapy contributed over 461 hours of volunteering and our Maternity volunteers have contributed over 893 hours (slide 29)

3.9 In partnership with the national charity Helpforce we are offering the opportunity to extend our Volunteer to Career programme to Veterans and their families. This will be a bespoke cohort and participants will have the chance to look at different roles in the NHS.

4.0 SaTH Charity (Slides 30-39)

4.1 SaTH Charity's Annual Report and audited accounts for 2023/24 were published on the Charity Commission website in January 2025. These show a 39% increase in income (from £359k in 2022/3 to £497k in 2023/4)

4.2 The income for 2024/25 is around £556k (final figure to be confirmed) which is an increase of almost 56% on the 2022/3 income of £357k, and reflects the increase in fundraising support from 0.2 wte to 1.6wte.

4.3 Income for the six months of Q3& Q4 2024/25 was £209,142 compared to £319,462 in the same period last year. Expenditure for the same period was £147,179 compared to £116,195 in 2023). Some examples of expenditure are shown on Slide 32.

4.4 A 5-year Charity Strategy (2025-2030) has been developed, and approved by the Charity's Corporate Trustees, and provides a clear direction of travel for the charity moving forward.

4.5 The SaTH Charity Policy has been reviewed and amended, and was approved by the Charity's Corporate Trustees in March 2025

4.6 Currently SaTH Charity has 949 supporters (slide 33):

Donors (875) - Provide financial support to the charity – this could be through a one-off donation, or multiple donations.
Fundraisers (74) - Organise events, and other initiatives, such as sponsorship for a marathon, to raise money and donations.

4.7 There are over 1000 members of staff who are now playing the staff lottery (from zero when it was started four years ago). Half the income is paid out in winnings to staff and half re-invested in the staff "Small Things Big Difference" Trust Fund.

4.8 Slides 34-37 show some of the ways our supporters have raised money for SaTH Charity, including our annual staff football tournament, a Halloween fundraising event by regular fundraiser Sally Jamison, support by Telford Rotary Club for our dementia fund, and The Works in Shrewsbury donating items for children at both our hospital sites. Slide 37 features the partnership purchase of a urodynamic machine with the League of Friends of the Shrewsbury and Telford Hospital, which will improve outcomes and patient discharges.

4.9 Slides 38-40 highlight some of the ways SaTH Charity has made a difference, including the redevelopment of Ward 32 Courtyard for Trauma and Orthopaedic patients (slide 37);

funding new internal signage to support patients and relatives navigate to clinics following the closure of the Outpatient entrance (slide 38); and through our "Small Things Big Difference" fund (aimed at supporting staff), the Charity has provided new furnishings for the restorative clinical supervision room (slide 39).

5.0 Q1&2 2025/26 Looking Forward (summarised slides 41-43)

5.1 Looking Forward highlights (slide 41)

- The Public Assurance Forum to meet on 14 April & 3 November 2025.
- Continue to support staff with any future service changes engagement.
- Supporting the HTP Engagement Programme, including quarterly focus groups for the public and patients.
- Continued attendance at community events to engage with the public and to reach out to seldom-heard groups with a focus on reducing health inequalities.
- 1-7 June is National Volunteer Week and we will be celebrating with our volunteers and staff with a special "Thank you" event on 4 June.
- Work with Helpforce to establish the Veterans to Career pilot and the Volunteer Discharge Project.
- We will be celebrating the NHS' 77th birthday, with our staff able to nominate colleagues for a SaTH Charity 'thank-you' daisy.
- We are working with Lingen Davies and the League of Friends of Shrewsbury and Telford Hospital NHS Trust to look at fundraising for clinical developments at PRH as part of our HTP vision for the future.
- We will be asking staff to select an option to bid for funding from NHS Charities Together for a staff wellbeing scheme.
- We have established links with a number of Rotary Clubs across the county and are looking to develop these further.

5.2 Dates for your diary (slide 43). Please contact sath.enagagement@nhs.net or visit our website for more information Public Participation - SaTH

6. Recommendations

The Board is asked to:

- **Note** the current activity from October to March across the Public Participation Team, and
- **Take assurance** from this work that our statutory duties are being met, as well as CQC Well-led requirements

Julia Clarke
Director of Public Participation
April 2025

Board of Directors' Meeting
8 May 2025

Agenda item		077/25		
Report Title		Infection Prevention and Control Report Q3 2024/25		
Executive Lead		Paula Gardner, Interim Chief Nursing Officer		
Report Author		Janette Pritchard, Lead Nurse IPC		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people		
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	443,923,444,722,814
Well Led	√	Our partners		
Consultation Communication		Infection Control Assurance Committee: 17 March 2025 Quality & Safety Assurance Committee: 25 March 2025		
Executive summary:		1.Increase in Clostridioides Difficile (C. diff) Cases • The Trust recorded 37 cases in Q3 (20 HOHA, 17 COHA) • The Trust is implementing targeted interventions through the C. diff workstreams and monitors progress via IPCOG and IPCAC. 2. Healthcare-Associated Infections (HCAIs) and Device-Related Bacteraemia • E. coli bacteraemia: 36 cases in Q3, with 5 linked to devices/interventions (CAUTI, PICC line, central line infections). • MSSA bacteraemia: 17 cases, with the Trust's rate higher than regional comparators. • Klebsiella and Pseudomonas Aeruginosa infections remained within target limits, highlight ongoing risks associated with invasive devices. 3. Outbreaks and Infection Control Challenges • 9 COVID-19 outbreaks in Q3 (up from 7 in Q2), 6 influenza outbreaks, and 1 Norovirus outbreak. • Challenges included delayed isolation due to limited side rooms, patients developing symptoms post-admission, and hand hygiene • 3 C. diff Periods of Increased Incidence (PIIs) were linked to contaminated equipment, overuse of gloves, and poor hand hygiene compliance, prompting focused education and weekly Quality Ward Walks (QWWs). These issues highlight the need for continued vigilance, targeted infection control measures, and improved staff education to mitigate infection risks.		
Recommendations for the Board:		The Board is asked to: **note** the issues highlighted, particularly with regard to the increasing rate of C. diff/MSSA Bacteraemia/EColi Bacteraemia		
Appendices (in Supplementary Information Pack):		Appendix 1: HCAI targets 2024/25 Appendix 2: HCAI graphs Appendix 3: Health and Social Care Act 2008 self-assessment tool Appendix 4: Funnel plots Appendix 5: Comparative data		

1.0 INTRODUCTION

This paper provides a report for Infection Prevention and Control (IPC) for Quarter 3 (October to December 2024) against the 2024/25 objectives for Infection Prevention and Control. An update on hospital acquired infections (HCAIs): - Methicillin Resistant *Staphylococcus aureus* (MRSA), Clostridioides Difficile (CDI), Methicillin-Sensitive Staphylococcus (MSSA), Escherichia Coli (E. Coli), Klebsiella and Pseudomonas Aeruginosa bacteraemia for October to December 2024 is provided as well as an update in relation to Covid-19. The report also outlines any recent IPC initiatives and relevant infection prevention incidents. The updated IPC Board Assurance Framework (BAF) is also included.

2.0 KEY QUALITY MEASURES PERFORMANCE

The HCAI targets (See Appendix 1)

2.1 MRSA Bacteraemia

The target for MRSA bacteraemia remains at zero cases for 2024/25. In Quarter 3, there was one MRSA bacteraemia case. This case was a Panton-Valentine leucocidin (PVL) MRSA.

2.2 Clostridioides Difficile

The IPC Doctor has reviewed CDI trends & has reported that general trends for reported cases of CDI have risen steadily since the end of 2022 across most Trusts within England. Our position, relative to other trusts within region, is generally favourable with the exception of a spike in cases in quarter 3 2023-24. SaTH is positioned mid-table (ranking of England trusts /100,000 bed days), and currently below the national average rate as outlined in the UKHSA quarterly data enclosed in Appendix 5 and comparative CDI data within England in Appendix 6. The reasons behind the steady increase are probably to do with the ramping up of clinical activity post COVID restrictions. There is also a possibility that the resulting backlog in chronic conditions has impacted on community related CDI. Nevertheless, in the IPC team (from RCA investigations and the 'Next Steps' conference) have identified numerous areas of practice and infrastructure that can and should be improved. These are now being implemented through the C diff workstreams. These are monitored via IPCOG monthly, where the overarching action plan will be presented as well, any escalations will be made to IPCAC.

The Trust trajectory for C diff cases in 2024/25 is no more than 98 cases. There was a total of 37 cases of C diff for Quarter 3 2024/25, (Table 2 Appendix 2). Of these, 20 of these cases were Hospital-Onset Healthcare Associated (HOHA) and the remaining 17 cases were Community-Onset Community associated (COHA). The Trust are unable to provide national submission data therefore we are unable to get 100,000 bed data so cannot compare to Q1 or Q2

2.3 E. coli Bacteraemia

The target for 2024/25 is no more than 146 cases. In Quarter 3 there were 36 cases attributed to the Trust, (Table 3, Appendix 2). Of these, 15 cases were HOHA, and the remaining 21 cases were COHA. 5 cases in Quarter 3 were considered to be device or intervention related with the sources related to: 2 cases CAUTI, 1 case PICC Line, 1 case Infected Central line and 1 with unknown source. A review of these cases has been undertaken by the IPC Doctor, to review the breakdown between community sources and hospital sources.

The COHA E. coli bacteraemia's account for between 55% & 70% of the totals in each quarter.

2.4 MSSA Bacteraemia

There is no nationally set target for MSSA, however, the Trust's MSSA bacteraemia rate is notably higher than that of other comparable acute trusts in the region (see Table 4, Appendix 2). The reasons for this discrepancy are currently unclear, but evidence suggests that a portion of these cases originate in patients from the community before they are admitted to the hospital. The IPC

doctor is currently conducting a review to analyse the distribution between community and hospital sources, as well as potential underlying factors contributing to the increase.

17 cases identified that were attributed to the Trust in Quarter 3. 8 of these cases were HOHA and the remaining 9 cases were COHA. All HOHA cases deemed to be device or intervention related have an RCA completed. In Quarter 3 this related to 2 of the 8 HOHA cases. In 1 case the source was unknown and the 2nd one the source was a line infection.

2.5 Klebsiella Bacteraemia

The target for 2024/25 is no more than 36 cases. In Quarter 3 2024/25 there were 14 cases of Klebsiella Bacteraemia attributed to the Trust, cases (Appendix 2 table 5). 9 of these cases were HOHA, and the remaining 5 cases were COHA. One post-48 case was related to a central line infection.

2.6 Pseudomonas Aeruginosa

The target for 2024/25 is no more than 19 cases. In Quarter 3 2024/25 there were 6 cases of Pseudomonas Aeruginosa attributed to the Trust, (Table 6, Appendix 3). 2 of these cases were HOHA and the remaining 4 cases were COHA. None of the post 48 cases were considered to be device related.

2.7 Root Cause Analysis Infections for MSSA and E. Coli Bacteraemia

In Q3, 17 MSSA were identified, 8 were HOHA, with 9 being COHA. Two cases required an RCA. Of the 36 E. coli bacteraemia cases, 21 were post 48, 15 were COHA. Two cases required an RCA. The learning identified relates to the recording of Blood Cultures in the notes. Improvements focused on sharing lessons in staff meetings, and medical governance meetings. This is monitored through divisional reports in IPCOG.

2.8 MRSA Elective and Emergency Screening

This report is now being produced and is available to Ward Managers to view their own ward activity. The data and presentation are being assessed for acceptability and ease of use by matrons and minor changes have been proposed to improve the identification of outstanding screens.

3.0 PERIODS OF INCREASED INCIDENCE/OUTBREAKS

In Quarter 3 there were 9 COVID outbreaks. This was an increase from the 7 outbreaks reported in Q2 of 24/25. There were also 6 Influenza outbreaks and 1 Norovirus outbreak. The most common issues identified during outbreak management are patients who are asymptomatic at the time of admission, patients developing symptoms once in the bay and creating contacts, who then tested positive, delayed isolation, due to the lack of side room availability, or lack of correct handover between areas.

There were 3 periods of Increased Incidents of C. diff on AMA, ward 27, and 23 at RSH. Learning identified included lack of hand hygiene for patients, contaminated sanitary equipment and overuse of gloves. This was supported by weekly QWWs and focused education on the ward to staff provided by the IPC nurses.

4.0 INCIDENTS RELATED TO INFECTION PREVENTION & CONTROL

There was 1 MRSA bacteraemia's in Quarter 3 (see section 2.1) attributed to ward 7 at PRH.
The case was deemed to be unavoidable.

5.0 IPC INITIATIVES

Quality Ward Walks (QWWs):

In Q3, matrons conducted 102 IPC Quality Ward Walks (QWWs), across 37 areas. Common issues included poor completion of the IPC screening pages in the admission booklets and completion of care plans, high and low dust, bedside table not clean and clutter free. The IPC team conducted

QWWs due to PIIs and outbreaks of respiratory and enteric infections. The issues most commonly identified issues are, incomplete ventilation and cleaning records, side room doors left open without a recorded risk-assessment, and hands not cleaned when required. These issues were addressed at the time and actions monitored through IPCOG.

After Action Review (AAR) Form for Clostridium difficile Infection (CDI):
The AAR form was introduced to address recurring findings in CDI investigations. However, feedback indicates that this form does not involve medical teams to the same extent as the previous RCA process and meetings. A review is underway to consider an alternative approach, which is expected to be finalised in Q4.

Link nurse meetings:
The Link nurse meetings have returned to Face-to-Face meetings with a focus for each meeting and learning activities for staff. The focus for the last meetings was PPE & Hand Hygiene audit.

Roadshow:
An IPC roadshow was conducted around the topic of admission screening

Emergency Department daily in-reach visits:
Following the dispatches TV programme daily supportive and educational visits were carried out by the IPC team to ED's on each site. Also, weekly QWWs completed by IPC team on Emergency departments on each site with facilities, estates and ED matron or senior nurse.

6.0 RISKS AND ACTIONS

The IPC Risk Register, overseen by the Director of Nursing, lists 5 active risks: all are rated "Extreme" decontamination assurance-Risk 443, isolation facilities- Risk 923, absence of deep clean program risk 444, Exceeding the target of HCAIs – Risk 722 and staffing in IPC team-Risk 814. There is one additional risk, "No staff trained in HCID PPE," is pending divisional action, with efforts underway to secure training.

7.0 IPC BOARD ASSURANCE FRAMEWORK

The Infection Prevention and Control Board Assurance Framework had an update published at the end of October 2024. The 10 domains remain, with a total of 54 lines of enquiry. This is reviewed and reported to the Trust Infection Prevention and Control Operational Group and Assurance Committee on a quarterly basis. The BAF has a total of 54 Key Lines of Enquiry. 41 of which are rated as Green, 13 are rated as Amber, and 0 rated as Red.

8.0 HEALTH AND SOCIAL CARE ACT COMPLIANCE UPDATE

The Health and Social Care Act (previously known as Hygiene Code) is reviewed quarterly by the IPC team and presented at the IPC Operational Group. Following the full review, the Trust is currently 97% compliant, being RAG rated 'Green' for 248 elements, 'Amber' for 19 and RAG rated 'Red' for 1.

The "red" element is in relation to follow of staff by occupational health as contact tracing is not include in the contract with Optima. This has been escalated to workforce as a risk.

The Trust self-assessment compliance against each of the 10 domains and the current gaps are shown the self-assessment Tool (see appendix 3)

9.0 CONCLUSION

This IPC report has provided a summary of the performance in relation to the key performance indicators for IPC in Quarter 3 of 2024/25.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors Meeting: 08 May 2025

Agenda item		078/25		
Report Title		**Freedom to Speak Up Annual Report 2024/25 inc Q4 figures**		
Executive Lead		Anna Milanec, Director of Governance		
Report Author		Helen Turner, Freedom to Speak Up (FTSU) Lead Guardian		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe		Our patients and community		
Effective		Our people	√	
Caring		Our service delivery		**Trust Risk Register id:**
Responsive		Our governance		
Well Led	√	Our partners		
Consultation Communication		N/A		
Executive summary:		At SaTH our FTSU vision is: "ALL staff from frontline workers to board level, feel psychologically safe to raise concerns - creating a Trust which is safe, transparent, kind and open, where staff at all levels are empowered and feel safe to 'Speak Up' and leaders 'Listen Up' and 'Follow Up'." This annual report includes the FTSU Q4 data and overall data for 2024/25 and provides a reflection on FTSU activity in 24/25. Since the appointment of a full time Guardian, 1085 contacts have been made to FTSU in 4 years.		
Recommendations to the Board:		The Board is asked to **note** and take assurance from FTSU's continued contribution to supporting our colleagues and improving our culture.		
Appendices (in supplementary Information Pack):		Appendix 1: FTSU Feedback		

1. National Context

The National Guardian's Office annual report 23/24 published in July 2024 stated that over 133,000 cases have been raised with Freedom to Speak Up Guardians since they were first established in 2016 claiming increasing trust in the Freedom to Speak Up guardian role. In 2023/24 there were 27.6% more cases recorded than the previous year

Quarter 3 2023/24 saw the highest number of cases (9,138) raised with Freedom to Speak Up guardians in a single quarter since they started collecting data in 2017.

Nationally, acute and acute community trusts report on average 40 cases quarterly. SaTH in 2023/24 and 2024/25 averaged 54 cases per quarter, on average for trusts whose CQC rating is 'requires improvement' 43 cases are raised per quarter.

According to the NGO annual report:

"There is a low relationship between the size of an organisation and the number of cases submitted, and organisations with a larger number of workers do not necessarily have more cases. There is more variability in how many cases the acute and acute & community trusts submit, while other sectors are more clustered together"

In 2024 the Dash review considered the operational effectiveness of the CQC following this, a further review was commissioned of six key organisations: CQC, the National Guardian's Office (NGO), Healthwatch England (HWE) and the Local Healthwatch (LHW) network, the Health Services Safety Investigations Body (HSSIB), the Patient Safety Commissioner (PSC), and NHS Resolution (quality and safety functions only). Its purpose is to determine if a different approach to patient safety oversight could strengthen the system and improve patient safety. The review was due to be published at the beginning of the year but at the time of writing, publication has been postponed to late April.

2. Assessment of Themes

In 2024/25, SaTH received 218 contacts through the FTSU mechanism an increase of one on the previous year, of these 193 are individual concerns.

	Number of Contacts	**Number of Concerns**
April 2024 – March 2025	218	193
April 2023 – March 2024	217	188
April 2022-March 2023	282	237
April 2021-March 2022	369	295

The previous year's contacts are contained in the table below to enable quarter and year on year comparison.

The NGO has not yet released the complete data set for the 24/25 period, so we are unable to benchmark the increase of concerns at SaTH against the national rise or decline.

Of the 218 contacts made, 105 were escalated, 83 signposted and 30 no further action was taken.

	Q1	Q2	Q3	Q4	Total	Increase	National Average Increase/Decrease
2024/25	67	48	56	47	**218**	0%	Not available
2023/24	47	52	68	50	**217**	↓23%	↑ 28%
2022/23	71	73	79	59	**282**	↓23%	↑ 25%
2021/22	100	113	90	66	**369**	↑21%	0%
2020/21	41	82	103	78	**302**	↑110%	↑ 26%

Table 1: Contacts made to FTSU in the last 5 years.

The NGO requires all Trusts to submit their data to the national portal following the close of a quarter and are submitted in the categories contained in Table 2. Please note we also record two additional categories which we are not required to report on; 'unknown/other' and 'policies, procedures and processes' and have added these to the table below.

Please note: In 2024/25 we changed our recording of data in line with NGO guidance, which asks us to record it as 'an element of', so one concern can have multiple elements of the categories below:

Category	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
	24/25	**24/25**	**24/25**	**24/25**	
Worker Safety or Wellbeing	49	34	35	30	148
Other inappropriate behaviours or attitudes	36	30	37	26	129
Policies, Procedures and Processes	31	14	24	25	94
Bullying and Harassment	6	10	15	8	37
Patient Safety	17	9	5	4	35
Unknown	3	1	6	2	12
Anonymous	0	1	0	2	3
Detriment	1	3	1	1	6

Table 2: NGO reporting category themes

To note:

1. Inappropriate behaviours and attitudes and bullying and harassment combined continues to be the most reported theme.
2. The biggest rise has been the reporting of worker safety and wellbeing in over 50% of the contacts made.

Themes	**20/21**	**21/22**	**22/23**	**23/24**	**24/25**
Worker Safety	13.0%	10.0%	22.0%	12.0%	33.0%
Inappropriate behaviours/attitudes	24.5%	37.0%	33.0%	36.0%	29.0%
Policies, Processes and Procedures	11.0%	21.0%	13.0%	27.0%	21.0%
Patient Safety	21.5%	15.0%	21.0%	12.0%	8.0%
Bullying and Harassment	13.0%	7.0%	11.0%	7.0%	8.0%
Unknown/Other	N/A	2.7%	6.7%	6.0%	3.0%
Anonymous	1.7%	1.4%	2.5%	2.8%	1.4%
Detriment	0.7%	0.5%	0.7%	0.0%	2.8%

Table 3: NGO reporting category themes proportional year on year comparator

Concerns Raised by Profession

Professional Group	Qtr1	Qtr2	Qtr3	Qtr4	Total
Nursing and midwifery registered	17	14	12	8	**51**
Administrative and clerical	12	10	15	10	**47**
Additional Clinical Services	23	7	7	9	**46**
Allied Health Professionals	6	2	7	9	**24**
Medical and dental	2	7	5	8	**22**
Estates and ancillary	4	2	6	0	**12**
Not known/Other	3	4	2	3	**12**
Healthcare scientists	0	2	2	0	**4**
Additional professional scientific and technical	0	0	0	0	**0**
Total	**67**	**48**	**56**	**47**	**218**

Table 4: Shows professional groups of people raising concerns 2024/25

Professional Group	20/21	21/22	22/23	23/24	24/25
Nursing and midwifery registered	34%	30%	28%	28%	23%
Administrative and clerical	24%	20%	19%	28%	22%
Additional clinical Services	9%	8%	8%	13%	21%
Allied health professionals	11%	19%	12%	10%	11%
Medical and dental	8%	7%	12%	7%	10%
Estates and ancillary	6%	8%	13%	7%	6%
Not known/Other	1%	2%	5%	5%	6%
Healthcare scientists	0%	0%	0.70%	2%	2%
Additional professional scientific and technical	0.30%	0%	0.70%	0.90%	0%

Table 5: Professional groups speaking up proportionally over the last 5 years

Points to note:

- Nurses and midwifery registered and administrative and clerical continue to be the professional groups who make the most contacts although this has decreased on previous years.
- Additional clinical services, most notably our HCA colleagues has seen the largest rise in 24/25.

Detriment

Six cases had an element of detriment, 3% of all cases, higher than previous years. The detriment reported was mainly about directly raising concerns to managers and corresponding repercussions.

Protected Characteristics

We have begun to monitor the protected characteristics of those reporting concerns, but more consistency is needed to get a true picture. The tables below show gender, ethnicity and whether the concern had an element of discrimination. All concerns that have an element of discrimination under the protected characteristics, where appropriate are monitored through the discrimination group.

Gender	
Female	71%
Male	27%
Unknown	2%

Table 6: Gender

Ethnicity	
White	74%
BME	21%
Unknown	5%

Table 7: Ethnicity

Number of concerns with an element of discrimination	
Race	13
Disability	4
Total	17

Table 8: Element of Discrimination

Open/Closed Cases

There has been much work done in 24/25 to conclude historic cases and all cases from 2021/22 are now closed. Of the concerns from 2022/23 and 2023/24 there are 13 contacts still open equating to 6 individual concerns, and we are working towards closing these concerns with stakeholders.

2024/2025

	Qtr1	Qtr2	Qtr3	Qtr4
Contacts	**24/25**	**24/25**	**24/25**	**24/25**
Open	3	10	3	20
Closed	64	38	53	27

Table 9: Open/Closed concerns for 2024/2025

Of the 37 open contacts in 2024/25 these equate to 32 open cases.

Divisional Contacts

Divisions	23/24	24/25
Medicine & Emergency Care	27%	41%
Surgery, Anaesthetics & Cancer	22%	19%
Corporate	25%	15%
Clinical Support Services	11%	15%
Women & Children's	12%	6%
Unknown/Other	3%	4%

Table 10: Contacts per Division 24/25

Medicine and Emergency Care proportionally continue to be the division where we receive most concerns from, however this has increased significantly since 23/24. Work is underway to understand the rise.

A more granular report will be provided to each division which will include information such as this, hotspots, any relevant feedback and staff survey raising concerns question scores.

Average number of days taken to close concerns

Since 2023/24 the FTSU team have now begun to monitor the average length of time from opening to closing of cases. Our 'framework for receiving a concern and escalating' has ambitious targets from the opening to closing of concerns.

- Worker Safety and Wellbeing/Patient Safety – 14 days

- Bullying and Harassment/Attitudes and Behaviours/Policies/Procedures and Processes – 30 days
- Unknown/Enquiry or Advice/Others – 60 days.

Measuring the average number of days will allow us to assess whether our targets are 'realistic'; the barriers to resolving concerns; what can be done Trust wide to remove the barriers; those barriers which maybe outside the control of the Trust.

To improve our responsiveness and learn how we can encourage colleagues to speak up and feel confident that their concerns will be addressed when they do, it is important that concerns are dealt with robustly and quickly.Therefore in 23/24 we began to measure the time it takes from closing to opening of a concern.

The following two tables show the percentage of concerns closed that fell within and outside the closure targets for 23/24 and 24/25. Whilst improvements have been made in closing within timeframes in 24/25, we are not where we want to be, in particular, concerns with worker safety and wellbeing at the heart of them.

We are undertaking a piece of work to understand the barriers to closing concerns within timeframes and will report on that in Q1.

April 2024-March 2025			
Nature of concern	**Red**	**Amber**	**Green**
Patient safety quality	36%	9%	55%
Worker safety or wellbeing	63%	16%	21%
Attitudes and behaviours	23%	17%	59%
Policies Procedures and Processes	18%	13%	70%
Bullying or harassment	5%	15%	80%

Table 11: Closure of themes 24/25

April 2023 - March 2024			
Nature of concern	**Red**	**Amber**	**Green**
Patient safety quality	60%	4%	36%
Worker safety or wellbeing	57%	14%	29%
Attitudes and behaviours	51%	13%	36%
Policies Procedures and Processes	39%	27%	34%
Bullying or harassment	35%	6%	59%

Table 12: Closure of themes 23/24

3. Key Achievements 24/25

In responding to both our local and national context, the following key achievements were made at SaTH in an effort to make speaking, listening and following up business as usual.

- 218 contacts were made through FTSU mechanism equating to 193 concerns
- Review of ambassador network with 42 ambassadors at various stages of recruitment/training, FTSU continuing to work to increase the number.
- 1000+ persons have attended the civility and respect session
- Presentations at international nurses; student nurses and student midwife inductions
- Presentations at student AHP learning days
- Attendance at weekly discrimination meeting

- October Speak Up Month activities
- Support and attendance at all staff network meetings
- Monthly meetings with all Divisional HRBPs in place.
- Regular contributor to STEP programme
- FTSUGs attended the national conference and local FTSU networks.
- Membership of PMA/PNA Steering Group
- Attendance at RALIG
- Attendance at Guardian of Safe Working and Junior Doctor Forum meetings.
- Attendance at Strategic People Group
- Quarterly update at Clinical Services staff side and management meeting.
- Attendance at STW ICB FTSU network.
- Measurement of closing/opening of concerns
- Quarterly update at Clinical Support Services/Staffside Division
- Substantial assurance for MIAA FTSU audit
- Increase in staff survey scores 20a and 20b for staff feeling safe to raise clinical concerns.

FTSU mandatory training compliance

In June 2022, the Trust mandated the three levels of FTSU speak up training, core, listen up and follow up. The table below show compliance rates for each of the three levels. In the last year working closely with education and HR/Divisional colleagues we have achieved over the 90% compliance core worker rate. However, we are still not at the Trust 90% compliance rate for the manager training and are raising with divisional colleagues for support to increase compliance. The CSS division has set a 100% target for their manager training.

	% Completion Q4 2023	% Completion Q4 2024	% Completion Q4 2025
FTSU – Core – Training for all Workers	76%	89.46%	92.99%
FTSU – Listen Up – Training for all Managers	62%	79%	81.19%
FTSU – Follow Up – Training for Senior Leaders	34%	59%	89%

Table 13: Culture dashboard scores

Key Performance Indicators

1. **Our Culture Dashboard achieves a 3% increase year on year in all themes.**

   In 24/25 the dashboard decreased by1% overall – individual scores underneath

	2021	2022	2023	2024
Compassion	62%	64%	66%	66%
Learning and Innovation	49%	52%	58%	58%
Health and Wellbeing	48%	51%	57%	57%
Vision and Values	51%	51%	57%	56%
Goals and Performance	58%	57%	62%	62%
Teamwork	72%	73%	75%	75%

Table 14: Culture dashboard scores

2. **Sickness absence rate is below 4%**
   End of Q4 – 5.4%

3. **People turnover is below threshold of 14.1%**
   End of Q4 – 10.64%

4. **Staff Survey response rate surpasses 45%**
   In 24/25 the staff survey response rate achieved 51%, a 6% increase on the year before.

5. **Staff Survey key questions for speaking up FTSU 20a, 20b and 25e and 25f increase.**
   Tables and commentary below

Staff Survey

In 24/25 the staff survey results for the two questions about staff raising clinical concerns and the organisational response improved, bucking the national trend, but SaTH saw a decline in the two questions raising concerns about anything in the organisation. Table 15 below shows the movement over the last 3 years for all four questions.

Table 16 also shows the professional groups scores. The downturn in feeling safe to raise concerns about anything is most significant from our Additional Clinical Services; Administration and Clerical and Estates and Ancillary teams. This may correlate with colleagues who are lower banded not feeling they have a voice, however in analysing the bottom 5 teams for this question, there was concerningly a divisional senior team who were included.

		2022 Organisation	2023 Organisation	2024 Organisation	2024 Movement	2024 National Score (2023)
20a	I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	64.7%	65.6%	68%	↑2.4%	71.53% (72.82%)
20b	I am confident that my organisation would address my concern (Agree/Strongly agree)	44.9%	49.1%	51%	↑1.9%	56.83% (56.87%)
25e	I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	49.5%	55.7%	54%	↓1.7%	61.82% (62.34%)
25f	If I spoke up about something that concerned me, I am confident my organisation would address my concern (Agree/Strongly agree).	35.6%	41.7%	41%	↓0.7%	49.52% (50.08%)

Table 15: Staff survey raising concern questions

	Additional Prof Scientific and Technical	Additional Clinical Services	Admin and Clerical	AHPs	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	National Average
20a (2023)	**67.7%** (66.2)	**71.8%** (67.7%)	**57.1%** (57%)	**76.7%** (70.2%)	**58.2%** (57.5%)	**67.5%** (66.9%)	**70%** (66.4%)	**76%** (72.5%)	**71.53%**
20b (2023)	**41.4%** (43.2%)	**53.6%** (51.7%)	**47.2%** (46.7%)	**47.2%** (47.7%)	**53.6%** (53.5%)	**43.9%** (43.9%)	**47%** (44%)	**54.7%** (50.8%)	**56.83%**
25e (2023)	**56.6%** (54.7%)	**53.9%** (58%)	**52.2%** (54.3%)	**54.9%** (56.4%)	**53.5%** (56.2%)	**52.5%** (53.8%)	**58.9%** (59.6%)	**54.1%** (54.7%)	**61.82%**
25f (2023)	**38.4%** (30.7%)	**42.7%** (46.2%)	**39.7%** (42.2%)	**35.7%** (33.8%)	**47.3%** (51.1%)	**33.3%** (34.6%)	**42.4%** (42.1%)	**41.8%** (40.1%)	**49.52%**

Table 16: Staff survey raising concern questions - professional groups

Conclusion and Next Steps.

In 2024/25 FTSU continued to contribute to supporting our colleagues and improving our culture. Our next steps will include a revised vision and strategy for 2026 onwards, a revised improvement plan and most importantly concentrating on the basics, alongside partners, getting it right when colleagues do raise concerns and giving them confidence in the system. We will also consider the gaps we have identified from the self-assessment tool which are, understanding detriment, the triangulation of issues with other sources and the consistency of management approach to setting the tone of a good speak up culture.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 8 May 2025

Agenda item		079/25			
Report Title		Guardian of Safe Working Hours Quarterly Report 01 Jan – 31 Mar 2025			
Executive Lead		Dr John Jones, Executive Medical Director and Responsible Officer			
Report Author		Dr Bridget Barrowclough, Guardian of Safe Working Hours			
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**	
Safe	√	Our patients and community	√	BAF1, BAF2, BAF3, BAF4, BAF8	
Effective	√	Our people	√		
Caring	√	Our service delivery	√	**Trust Risk Register id:**	
Responsive	√	Our governance			
Well Led	√	Our partners			
Consultation Communication					
Executive summary:		Engagement work taking place with Urology resident doctors to agree a compliant rota. Digital rostering does identify breaches in safe working hours that exception does not. Process being identified to highlight these breaches to divisions so that preventative action can be taken New exception reporting process has been released with a start date of September 2025. This may increase exception reporting and create a financial pressure.			
Recommendations for the Board:		The Board of Directors is asked to: **Note** the report.			
Appendices (In Supplementary Information Pack):		Appendix 1: Exception Reports Q4 Appendix 2: Locum Bookings by Department, Grade and Reason Appendix 3: Vacancy WTE for Resident and Locally Employed Doctors Appendix 4: Budgeted, Contracted, Vacancy (WTE) and Vacancy % of Budget M10-M12 (FY1-ST2) Appendix 5: Budgeted, Contracted, Vacancy (WTE) and Vacancy % of Budget M10-M12 (ST3-ST8) Appendix 6: Rostering Dashboard Q4			

1.0 Introduction

The safeguards around doctors working hours within Schedules 04-06 of the NHS Doctors and Dentists in Training (England) 2016 Contract and the role of the Guardian of Safe Working (GoSW) hours is recognised across the Trust.

In accordance with Schedule 06 Paragraph 11 of the NHS Doctors and Dentists in Training (England) 2016, this quarterly Board report includes data relevant to the safe working hours for resident doctors and locally employed doctors including, but not limited to, exception reports, vacancies and locum usage. Any issues identified and subsequent actions taken are summarised within the report. Serious escalations related to decisions or actions not addressed at department level are highlighted.

2.0 High level data for The Shrewsbury and Telford Hospital NHS Trust

Number of posts for resident doctors / dentists	372
Number of resident doctors / dentists on 2016 TCS:	276
Number of locally employed doctors:	204
Amount of time available in job plan for guardian:	2 PAs per week
Admin support provided to the Guardian:	0.2WTE
Amount of job-planned time for educational supervisors:	0.25 PAs per resident

3.0 Exception Reports

The GOSW report focuses on exception reports related to safe working hours.

A total of 27 hours and rest exceptions were raised across various specialties (Appendix 1), with 21 exceptions closed and 14 remaining outstanding by the 31 March 2025. The requirement to investigate and address issues raised delayed closure of reports in most cases with supervisor interaction delaying others.

The foundation years raised most reports.

3.1 Work Schedule Reviews

In line with Schedule 05, Paragraphs 22-38 of the 2016 Junior Doctor Contract, there were no formal work schedule reviews in Q4.

3.2 Fines

GOSW levied zero fines in Q4. The GOSW account therefore reports an ongoing total of £5,596.92 at the end of Q4.

4.0 Locum bookings

Appendix 2 summarises locum bookings by department, grade and reason and highlights the distribution of shifts across various departments, with a total of 3427 shifts filled by bank, 322 shifts filled by agency, and 31 unfilled shifts.

5.0 Vacancies

Appendix 3 summarises the breakdown between budgeted, contracted and vacancy whole time equivalent (WTE) for the grade ranges FY1-ST2 and ST3-8 in Q3. All data and comments are provided by Medical People Services (MPS).

6.0 Issues Arising & Actions Taken

6.1 Digital Rostering

Appendix 6 summarises the medical rostering dashboard for safe working hours for specialties live with the Health Roster (Medic on Duty) eRostering solution. In Q4, During the reporting period, there were a total of 13 exception episodes recorded across several specialties, resulting in 33 breaches. The highest number of episodes was seen in Trauma & Orthopaedics (T&O) with 7 episodes and 13 breaches, followed by Emergency Medicine, which also recorded 13 breaches across 3 episodes. Other specialties with recorded exceptions include General Surgery (1 episode, 4 breaches), ENT (1 episode, 2 breaches), and Oral & Maxillofacial Surgery (1 episode, 1 breach).

The underlying reason for the majority of these breaches continues to be doctors working additional bank hours beyond their safe working hour restrictions.

6.2 Exception reporting reform for resident doctors

On 31 March 2025 national agreement was reached on reforms for exception reporting for resident doctors introducing significant changes to how exception reports will be managed. In addition to the established fines for breaches of safe working hours and rest, Trusts will receive penalties for breaches related to the access and completion of reports and of data breaches or where detriment to a reporting doctor is identified.

Medical Peoples Services will action all reports removing the clinical supervisor from the process. The GoSW will retain oversight of all hours and rest reports and identify themes as previous. The DME will retain oversight of reports detailing missed educational opportunities only.

A new standardised reporting template will be provided enabling bench marking nationwide.

The monitoring of standards will be mandatory.
Further guidance, along with updates to the Terms and Conditions of Service (TCS), is anticipated in late April or early May 2025, and a corresponding implementation plan is currently in development.

MPS advise initial efforts to have been focused on staff briefings, reviewing existing capacity and resourcing risks, and compiling a verified list of all eligible resident and locally employed doctors. A full system cleanse has been completed, ensuring that all active exception reporting accounts align with current doctors in post. This foundational work will enhance the team's ability to meet the new 7-day access timescale outlined in the national framework.

Further updates will follow as implementation progresses.

Trusts are expected to implement all reforms by 12 September 2025.

In future, and as previously reported, live rostering throughout the Trust will be required to avoid penalties once the exception reporting reforms are established.

6.3 Urology update

The Trust recognised the safety concerns raised by the GoSW in November 2023 regarding the non-compliant NROC shift in urology. A proposal submitted to the SAC Division in December 2024 approved an additional Tier 2 post. MPS assured the GoSW that clear communication was provided to the doctors outlining the intention to convert work schedules to a full shift system with the introduction of resident long days and nights, and that this was

met without opposition. The new rota template including full shift patterns was presented to doctors on the 3 March 2025.

However, the department has also been working with MPS on a compliant NROC rota which aligns with other Trusts in the region. This rota design is strongly supported by their senior colleagues.

At the time of writing, the GoSW awaits a decision as to whether the current cohort of doctors can appeal the timeline for implementation of the full shift pattern.

6.4 Surgery

Doctors reported that requests were being made to them to commence morning shifts earlier than rostered. This concern has been discussed and addressed. This is a recurrent theme raised by doctors as they rotate in their foundation year.

6.5 Trauma & Orthopaedics

Concerns have been raised regarding the over running of theatre sessions resulting in an inability to work to rostered hours. Reports of doctors working over the 13-hour shift limit by remaining at the morning MDT and trauma meeting continue to be raised despite the GoSW receiving further assurance from the department that this practice would not continue. The GoSW will request a work schedule review.

7.0 Fatigue and Facilities Charter

In 2018 the Trust committed to the BMA Fatigue and Facilities Charter. It remains the responsibility of the GoSW to notify the Board of any conditions within the Charter that are not being met. Currently all conditions have been addressed.

8.0 Summary

This report highlights the persistent concerns previously raised in Urology regarding the NROC shifts. The GoSW supports the changes agreed to address this but is aware that discussions may be required to ensure all doctors are confident that required processes have been followed.

Following recent notification of the exception reporting reforms the GoSW awaits further guidance from NHS Employers regarding their role and responsibilities, and once again recommends the introduction of an e-rostering system throughout the Trust to enable oversight of all rotas at all times.

The Board is asked to **NOTE** this report.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 8 May 2025

Agenda item		080/25			
Report Title		Integrated Maternity and Neonatal Report			
Executive Lead		Paula Gardner, Interim Chief Nursing Officer			
Report Author		Kimberly Williams, Interim Director of Midwifery Jacqui Bolton, Interim Head of Midwifery Julie Plant, Divisional Director of Nursing – Women and Children's Services (Paediatrics, Neonatal, Gynaecology & Fertility)			
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**	
Safe	√	Our patients and community	√	BAF1, BAF4, BAF 3	
Effective	√	Our people	√		
Caring	√	Our service delivery	√	**Trust Risk Register id:**	
Responsive	√	Our governance	√	CRR 16, 18, 19, 23, 27, 7, 31	
Well Led	√	Our partners	√		
Consultation Communication		Directly to the Board of Directors			
Executive summary:		1. This Integrated Maternity and Neonatal Report includes the latest position in relation to: the delivery of actions from the Independent Maternity Review, the Maternity Transformation Programme, and NHS Resolution's CNST Maternity Incentive Scheme, the Neonatal Mortality Review action plan, and the NHS Staff Survey resultsf for 2024. 2. Specifically, the Board's attention is drawn to the exacting requirements for NHS Resolution's Maternity (and Perinatal Incentive Scheme (CNST) in section 5, and the specific wording to be included in the minutes of this meeting, which is summarised at section 7.3.			
Recommendations for the Board:		The Board of Directors is requested to: • Receive this report for information and assurance. • Confirm in the minutes of this meeting that it has received all the appended reports in section five and include the associated wording from sections 5.43 to 5.4.4 (inclusive) accordingly.			
Appendices:		All appendices are in the Board Supplementary Information Pack			

1.0 Introduction

1.1 This report provides information on the following:

1.2 The current progress with the delivery of actions arising from the Independent Maternity Review (IMR), chaired by Donna Ockenden.

1.3 The position in relation to the progress against the actions arising from the the invited review of Neonatal Mortality at the Trust conducted by the Royal College of Physicians.

1.4 A summary of progress with the Maternity and Neonatal Transformation Programme (MNTP), which is an IMR action requirement, including an update on the Cultural Improvement Plan.

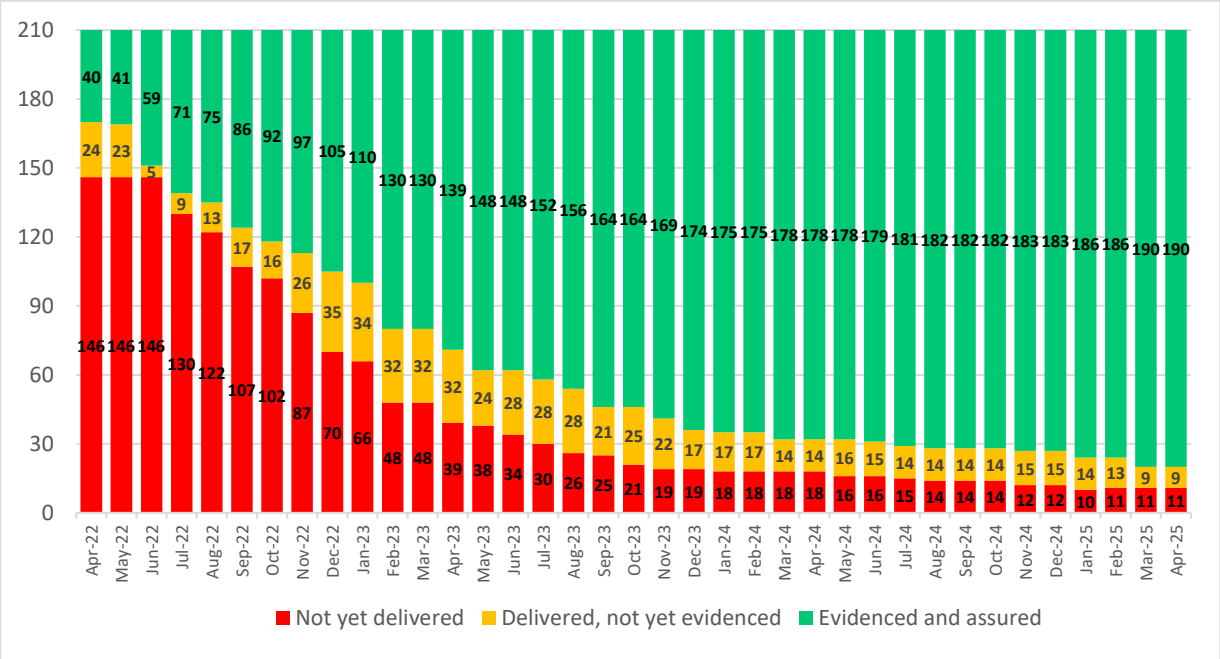
1.5 NHS Resolution's Maternity (and Perinatal) Incentive Scheme (Clinical Negligence Scheme for Trusts - CNST), along with suggested wording for recording in the minutes of today's meeting.

1.6 The results of the 2024 NHS Staff Survey for maternity and neonates

1.7 To support this paper, more detailed information and all appendices are provided in the Board Supplementary Information Pack. Further information on any of the topics covered is available on request.

2.0 The Ockenden Report Progress Report (Independent Maternity Review - IMR)

2.1 Progress against IMR actions are validated at the Maternity and Neonatal Transformation Assurance Committee (MNTAC), and progress is summarised at the Quality Safety and Assurance Committee (QSAC). **Appendix One** provides the summary Ockenden Report Action Plan at 8 April 2025. The overall trajectory and position are, as follows:



Delivery Status	Number (change since last report)	Percentage
Evidenced and Assured	190 (⇧4)	90.5%
Delivered, Not Yet Evidenced	9 (⇩4)	4.3%
Not Yet Delivered	11 (⇔)	5.2%
TOTAL	210	

**Rounded percentages

Progress Status	Number (change since last report)	Percentage
Completed fully (Evidenced and Assured)	190 (⇧4)	90.5%
On track	10 (⇩6)	4.8%
Off track	3 (⇧2)	1.4%
At Risk	0 (=)	0
De-scoped	7 (⇔)	3.3%
Total	210	100%

**Rounded percentages

2.2 Since March 2025, a further four actions have moved from **'Amber'** to **'Green'** delivery status.

2.3 In total, seven actions remain 'de-scoped,' currently. These relate to nationally led external actions (led by NHS England, CQC), and are not within the direct control of the Trust to deliver. These actions were reviewed at MNTAC in April and no progress against these was recorded. The Local Maternity and Neonatal System continues to oversee these actions. remain under review by the Trust at the Maternity and Neonatal Transformation Committee MNTAC quarterly, to check on any progress.

2.4 Since the April 2025 MNTAC meeting, NHSE has approved for the recently appointed Maternity and Neonatal Independent Senior Advocate for NHS Shropshire, Telford, and Wrekin – Liane Powell, to start collaborating with women, birthing people, and families. Subject to consent being obtained from the woman, birthing person or partner, Liane will start taking referrals in the following category areas either directly from the people affected or from the Trust:

- Any baby stillborn after 24 weeks of pregnancy
- Where a baby dies within 28 days of birth (neonatal death)
- Has a suspected or confirmed brain injury.
- Where the mother or birthing parent:
    - Died
    - Had a hysterectomy unexpectedly within six weeks of a birth.
    - Was unexpectedly admitted to critical care.

Liane has produced a set of detailed resources, which can be accessed via the following hyperlink: Maternity and Neonatal Independent Senior Advocate - NHS Shropshire, Telford and Wrekin.

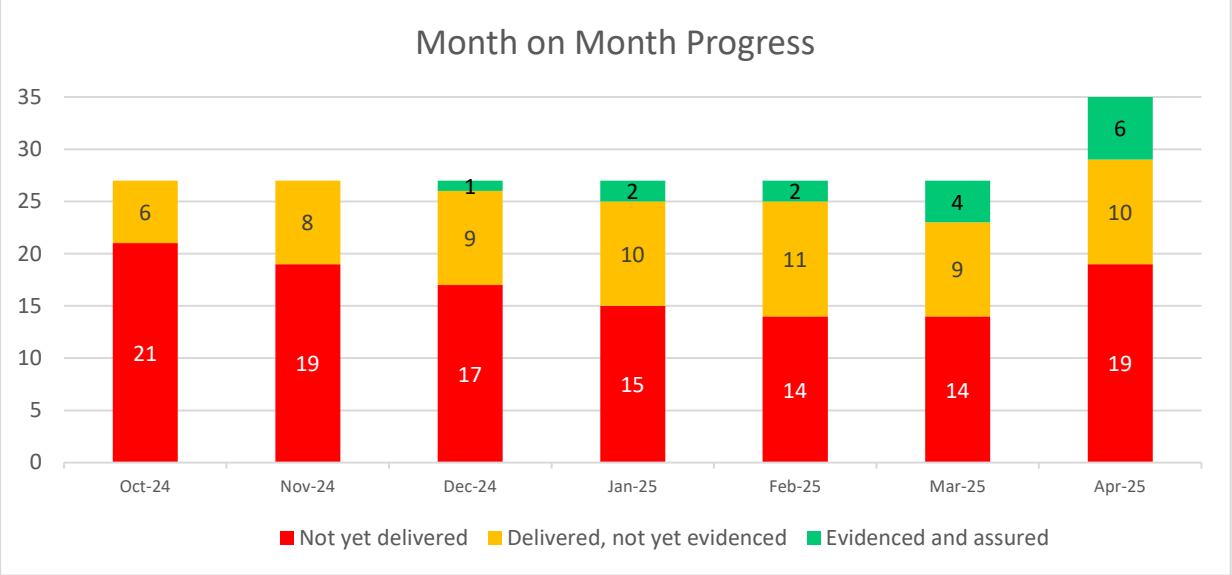
This means that the long-standing Immediate and Essential Actions IEA's 2.1 and 2.2 will soon change over to delivery status once their full conditions are met. This is all positive news for women, birthing people, and families.

2.5 Of specific note is the attraction and appointment of external neonatal nurses to the SaTH neonatal nursing establishment and the assurance of compliance with meeting the neonatal nurse qualified in specialty (QIS) trajectory.

2.6 All other actions within the Trust's gift to deliver are on track for their expected delivery dates.

3.0 Invited Review: The Shrewsbury and Telford Hospital NHS Trust Neonatology Service Review (2023/4)

3.1 Steady progress is being made to deliver the recommendations from the external invited review of the Trust's neonatal services, which was led by the Royal College of Physicians, and initially comprised 27 actions in total. However, one of the actions relates to employing several new roles, so this action has been split into separate sub-actions to enable each to be tracked separately, which means the total number of actions is now 35. **Appendix Two** provides the summary Neonatal External Mortality Review (NEMR) Action Plan at 8 April 2025. The overall trajectory and position are, as follows:



Delivery Status	Number	Percentage
Evidenced and Assured	6	17.1%
Delivered, Not Yet Evidenced	10	28.6%
Not Yet Delivered	19	54.3%
TOTAL *(Note: the total number of actions has been revised from 27 in April, as some actions have been broken down into more manageable sub-actions; hence the increase in number)*	35	100%

**Rounded percentages

Progress Status	Number	Percentage
Completed fully (Evidenced and Assured)	6	17.1%
On track	24	68.6%
Off track	2	5.7%
At Risk	0	0
Not Started	3	8.6%
Total	35	100%

**Rounded percentages

3.2 All other actions are on track for their expected delivery dates.

4.0 Maternity and Neonatal Transformation Plan (MNTP) Phase Two – High level progress report

4.1 It is a requirement of the Independent Maternity Review, for the Board of Directors to receive an update on the Maternity and Neonatal Transformation Plan at each of its meetings in public. The summary MNTP, which is now in its second phase, is attached at **Appendix Three**.

4.2 A review of the Cultural Improvement Plan was undertaken against the results of the 2024 Staff Survey (see section six for more information). Progress with this plan is expected to pick up in the next few months now that the previously suspended non-mandatory training activities can resume. There is nothing of exception from this to report at this time.

4.3 All other actions are progressing well.

5.0 NHS Resolution's Maternity (and Perinatal) Incentive Scheme (Clinical Negligence Scheme for Trusts - CNST)

5.1 The Board of Directors is familiar with the exacting annual declaration and submission process to meet the ten safety actions for CNST. Self-verification of the year six Maternity Incentive Scheme is currently embargoed with results due to be published soon, which is positive for the Trust.

5.2 Year seven of the scheme was launched in April 2025. Reporting will continue in line with the year seven technical guidance. The summary position is provided in the following table, with supporting appendices in the supplementary information pack. Further information is available on request, if needed.

Safety Action (SA)	Standard	Comments
SA1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 1 December 2024 to 30 November 2025 to the required standard?	Quarterly reports evidencing delivery against elements a), b) c) and d) will continue in line with Year 7 Technical Guidance. Quarter 4 Quarterly and Board reports are presented at **(Appendices Four and Five).**
SA2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Monthly compliance will continue to be monitored and presented to Maternity Governance, LMNS and QSAC. Aligned to Year 7 Technical Guidance
SA3	Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?	Quality Improvement project and quarterly reports with dissemination of learning will continue to be presented to LMNS, MNSC and QSAC in line with the technical guidance. Compliance will be monitored against elements a) and b).

SA4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	In keeping with Year 7 Technical Guidance, monitoring will continue against standards a) Obstetric workforce, b) Anaesthetic medical workforce, c) Neonatal medical workforce and d) Neonatal nursing workforce.
SA5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Bi-annual reports will be presented to Board of Directors' meeting during the reporting period evidencing achievement of standards a), b), c), d) and e). DoM bi-annual staffing report is presented at (**Appendix Six)**.
SA6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Provide assurance to the Trust Board and ICB that you are on trach with all six elements of SBLCB v3 through quarterly quality improvement discussions with the ICB.
SA7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	In keeping with Year 6 and aligned to Year 7 Technical Guidance. Reports and compliance will be presented to LMNS, Maternity Neonatal Safety Champions and QSAC
SA8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	In keeping with Year 7. Quarterly reports will be presented to LMNS, Maternity Neonatal Safety Champions and QSAC
SA9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	This Safety Action has multiple elements to evidence compliance: The Trust has fully embedded the Perinatal Quality Surveillance Model and must demonstrate work towards the revised Perinatal Quality Oversight Model. The Locally Agreed Safety Intelligence Dashboard has been presented to the Board each quarter during the reporting period. and is presented at **(Appendix Seven).** Trust's Claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is triangulated with other quality and safety metrics to inform targeted interventions aimed at improving patient safety and reflected in the Trust's Patient Safety Incident Response Plan **(Appendix Eight).** The Perinatal Leadership team meet (bi-monthly).

SA 10	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025.	Trust Board sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution. Trust Board sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible, with a SMART plan to address any challenges for the future. Trust Board sight of evidence of compliance with the statutory duty of candour.

5.3 All CNST progress reports are presented to the Quality, Safety and Assurance Committee (QSAC), and the Local Maternity and Neonatal System (LMNS).

5.4 The Board of Directors is required to record formally in the minutes of this meeting that:

5.4.1 (SA1) - It continues to receive quarterly Perinatal Mortality Review Team (PMRT) reports and Board reports, including details of deaths reviewed, any themes identified, and the consequent action plans. **(Appendices Four and Five).**

5.4.2 (SA5) – It has received the Director of Midwifery's bi-annual Safe Staffing report demonstrating an effective system of midwifery workforce planning to the required standard **(Appendix Six).**

5.4.3 (SA9) - Using the minimum dataset, the Perinatal Quality Surveillance Model is fully embedded, and a review has been undertaken by the Trust Board. The locally agreed dashboard is at **(Appendix Seven).**

5.4.4 (SA9) – the Trust's Claims scorecard has been reviewed alongside incident and complaint data has been triangulated with other quality and safety metrics to inform targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan **(Appendix Eight).**

6.0 NHS Staff Survey 2024

6.1 The results of the 2024 NHS Staff Survey were published in March 2025. Compared to the 2023 survey results, response rates improved in both maternity (31% to 46%) and neonatal services (58% to 80%), with the Women and Children Division's combined response percentage being 55% compared to the Trust overall average of 51%. These are encouraging results. Improvements were seen in the following areas:

6.2 Maternity improvements:

- We each have a voice that counts
- We are safe and healthy
- Morale

6.3 Neonates saw improvements across all 9 areas of the People Promise and Themes. Highest improvements were:

- We work flexibly
- We are a team
- We are always learning

6.4 Improvements across the wider W&C Division were in relation to the 'Focus upon Compassionate and Inclusive Culture' indicators:

- Fewer staff experiencing violence from patients, their families, or the public
- Increased confidence from staff that they will report incidents of violence
- Feeling that the Trust acts on concerns raised by patients and their families
- Staff have role clarity
- Improved Health and Wellbeing, better Work Life Balance, and lower levels of exhaustion
- Increased confidence from staff that patient care is the Trust's top priority

6.5 Improvements for 25/26 form part of the wider Divisional Cultural Improvement Plan, which is managed and monitored via the People and Culture Workstream of the Maternity and Neonatal Transformation Plan. These include:

- Continue to drive an increase completion rates in 2025
- Work with teams to understand their feedback
- Focus upon Compassionate and Inclusive Culture indicators
- Review Management and Leadership Development (all levels) and undertake a Training Needs Analysis
- Improve quality of Talent Conversations – staff feel objectives and development support their development.
- Continued focus on staff Health and Wellbeing
- Utilise existing staff recognition schemes and develop divisional schemes
- Review Workforce Race Equality Standards and Workforce Disability Equality Standard data to inform compassionate culture (e.g. Reasonable Adjustments)

7.0 Summary

7.1 Good progress continues to be made with actions from the Independent Maternity Review, The Maternity and Neonatal Transformation Plan and the Clinical Negligence Scheme for Trusts.

8.0 Recommendations

8.1 The Board of Directors is requested to:

8.2 Receive this report for information and assurance.

8.3 Confirm in the minutes of this meeting that it has received all the appended reports in section five and include the associated wording from sections 5.43 to 5.4.4 (inclusive) accordingly.

Kimberly Williams
Interim Director of Midwifery

Julie Plant
Divisional Director of Nursing

Jacqueline Bolton
Interim Head of Midwifery

April 2025

All appendices are in the Board Supplementary Information Pack

Appendix One:	Ockenden Report Action Plan at April 2025
Appendix Two:	Neonatal External Mortality Review (NEMR) Action Plan at April 2025
Appendix Three:	Summary Maternity and Neonatal Transformation Plan (MNTP) Phase Two at April 2025
Appendix Four:	CNST MIS Safety Action 1 Perinatal Mortality Review Tool Quarterly Report Q4
Appendix Five:	CNST MIS Safety Action 1 Perinatal Mortality Review Board Report Q4
Appendix Six:	Director of Midwifery Safe staffing Bi-annual report May 25
Appendix Seven:	Locally Agreed Dashboard - Safety Champions
Appendix Eight:	Triangulation of the Scorecard Q3 2024_5

Maternity & Neonatal Safety Champions - Key Issues Report

Report Date: 07/04/2025		**Report of:** Maternity and Neonatal Safety Champions Meeting
Date of last meeting: 03/04/2025		**Membership Numbers:** Quoracy met = yes
1	**Agenda**	• Chair's welcome and apologies, conflict of interests & minutes review • Action log and review of AAAA from February 2025 • Safety Champions Walkabout Oswestry MLU feedback • Neonatal review update • Maternity and neonatal quality dashboards and oversight reports • MLU update and maternity governance report including action plan for MNSI reports • Decision to delivery report • MBRRACE-UK perinatal mortality report • Neonatal staffing and BAPM report (SA4) • Scorecard triangulation (SA9) • Locally agreed safety intelligence dashboard (SA9) • Maternity services CQIM MSDS dashboard and AAA • Our Staff Said, We Listened Poster • MNVP updates including user survey, prioritisation action plan and 15 steps update • NNAP poster and Terms of reference review
2a	**Alert**	• None
2b	**Assurance**	• Champions received the MBRRACE-UK perinatal mortality report (relating to 2023) and noted trends in relation to still births and neonatal mortality with stabilized and adjusted data for still birth rate and extended perinatal mortality rate being around the average but neonatal mortality remaining more than 5% above average though lower than 2023 (1.05 compared with 1.39 per 1000 live births)
2c 2c	**Advise**	• Neonatologists have requested a review of the HTP floorplan and routes for movement of cots from delivery suite and maternity theatres to neonatal ICU area. This will be led with a focus on safety by deputy medical director. Champions have requested to have outcome of this presented at future meeting. • Visit to Oswestry MLU identified matters relating to access when ward clerk not present, complexity of pathways where we have different providers and healthcare systems in border areas. Large geographical area covered by on call community midwife. • Champions noted induction rate of approximately 50% is higher than peer average and requested more assurance on the indications for induction of labour notwithstanding the recognition that induction

		indications are in keeping with the recommendations from Saving Babies Lives report. • 10 category 2 caesarian sections exceeding the 75-minute target from decision. Champions have requested more detail on access to second theatre following review of decision to delivery report • The ICB Clinical Quality Lead and ICB Quality Improvement Lead have offered support to the maternity team with their current quality improvement projects. A meeting has already taken place to discuss the triage project (with a focus on reducing self-discharges) and a meeting is scheduled to take place on the 9th of May to discuss the Induction of Labour project.		
3	**Actions to be considered by the MTAC / QSAC / Trust Board**	• Report to be noted		
4	**Report compiled by**	*John Jones*	**Minutes available from**	*Charlotte Allmark*

Board of Directors' Meeting: 8 May 2025

Agenda item		082/25		
Report Title		Annual NHS Staff Survey results		
Executive Lead		Rhia Boyode, Chief People Officer		
Report Author		Dawn Thompson, Associate Director of Leadership & OD Sharon Parkes, Organisational Development Practitioner		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF3, BAF4
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Initial results shared with the People & OD Assurance Committee (PODAC) in February 2025.		
Executive summary:		The Board's attention is drawn to section 2 where the 2024 Staff Survey results show that four People Promises and the theme of Morale have improved, two have decreased and two have remained the same. Note that the scores for some of the People Promises have altered due to the weightings applied during the benchmarking process. Also to note, the 6% increase in staff completing the survey, which due to the increase in WTE, equates to our highest number of responses to date, which is of real significance, according to IQVIA. The Board is asked to acknowledge that several actions can take longer periods of time to embed before they are felt/ experienced by staff. NHSE suggests that the staff survey data provides rich and valuable data to support and inform continuous improvement and cultural change for longer term 3–5-year planning. This means that we may not achieve BAF3 as quickly as we would hope. We agreed on the timeline of actions at PODAC and we commit to achieving those actions, as well as the Divisional action plans listed in Appendix 1, and will continue to update the Board on progress.		
Recommendations for the Board:		The Board of Directors is asked to: **Note** this report, with regard to progress delivery against the People Strategy milestones.		
Appendices: (In Information pack)		Appendix 1: Trust and Divisional People Plan schemes. Appendix 2: Top Ten Priority Areas Appendix 3: Staff Survey Timeline Appendix 4: Copilot summary of Action Plans		

We each have a voice that counts

Annual Staff Survey Results 2024/25

1.0 Purpose

1.1 This paper is to provide assurance and outline the importance of the staff survey and in particular the Engagement measure and its pertinence in the workplace. The staff survey is aligned to the NHS People Promise and affords us the opportunity to listen and respond to our teams to deliver the best possible staff experience working here at SaTH.

1.2 The People Promise is a nationally led initiative, with the ambition that all staff working in the NHS will be able to recognise how the statements making up the promise apply to them.

1.3 Our People Promise Manager commenced in post in September 2024. Three key deliverables have been identified for the People Promise Exemplar (PPE) programme.

- Facilitating stay conversations with HCAs in hotspot areas of high turnover (particularly in the first 12 months)
- Improving reasonable adjustments for colleagues with long term health conditions (LTCs)
- Introducing regular (twice-monthly) staff health clinics. This post is due to cease mid-August and it is unlikely that further funding will be made available nationally. We will continue to align the programmes of work in the PPE as much as possible with existing meetings and communication streams to ensure it is part of 'business as usual'.

2.0 Situation

2.1 The Trust scores for four of the People Promises have improved from 2023 to 2024 (We are Compassionate and Inclusive, We each have a Voice that Counts, We are Always Learning, We Work Flexibly). We have seen decreases in two People Promises and one has remained the same. Morale has increased and Engagement has remained the same.

Table 1

2.2 A total of 8083 members of staff were eligible to respond to the survey, and 51% of staff completed the survey equating to 4085 respondents. This was a significant increase on last year's percentage (45%) and our highest in 10 years.

3.0 Background

3.1 IQVIA, on behalf of 65 Trusts, were commissioned to run the 2024 survey between October and November 2024, and we achieved a 51% response rate which was above the median for our sector benchmarking group (49%).

3.2 The full report can be found at NHS Staff Survey 2024 Benchmark Reports with the Interactive dashboards Results | Working to improve NHS staff experiences | NHS Staff Survey (nhsstaffsurveys.com).

3.3 Initial Staff Survey Data and further supportive information was shared under embargo rules to Senior Leaders in January 2025.

3.4 Organisational briefings took place on 19 and 20 March and Divisional briefings were held w/c 24 and 31 March.

4.0 High Level Results

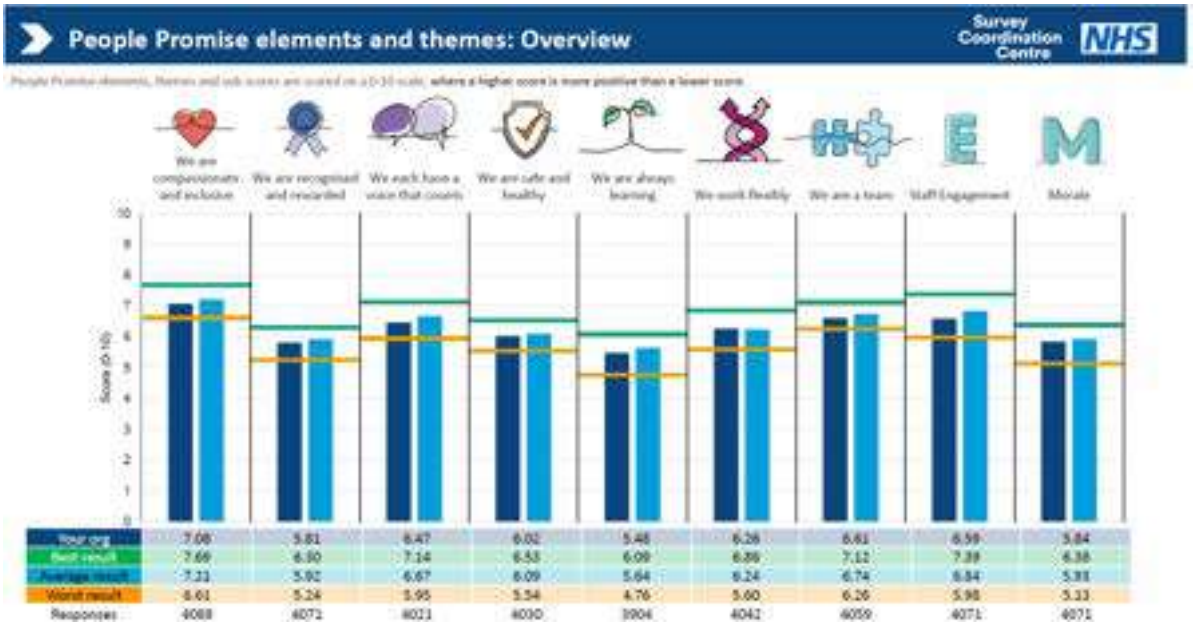
4.1 A total of 45 questions have improved their score with the total number of questions asked being 108 (excluding background information). There was one new question for 2024 which cannot be compared to last year:

- Q24f – I am able to access clinical supervision opportunities when I need to.

4.2 We are above the average for our sector in the sub-themes of Diversity and Equality, Development, Flexible working and Motivation.

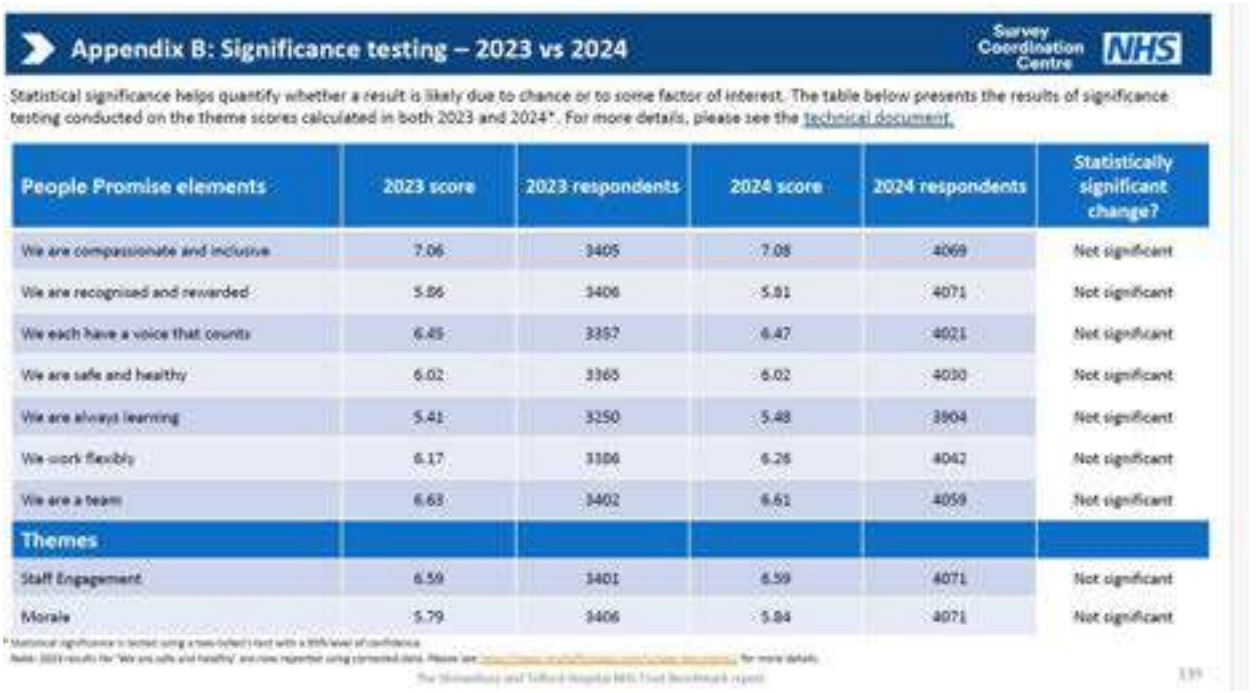
4.3 The tables below provide a high-level summary of the overall Trust scores for all seven People Promises and two themes. We are above our sector average for 'We Work Flexibly'.

Table 2 (shown below - taken from National Staff Survey Co-ordination Centre Benchmark Report)



4.4 Table 3 below shows that although we have seen some increases in our People Promise scores, and some decreases, the changes are not statistically significant. This means that the range within which scores have changed are so tight that the difference is minimal. With the exception of 'We Work Flexibly' we remain below our comparative organisations on all promises and themes.

Table 3 (taken from National Staff Survey Co-ordination Centre Benchmark Report)



Appendix B: Significance testing – 2023 vs 2024

Survey Coordination Centre NHS

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2023 and 2024*. For more details, please see the technical document.

People Promise elements	2023 score	2023 respondents	2024 score	2024 respondents	Statistically significant change?
We are compassionate and inclusive	7.06	3405	7.08	4069	Not significant
We are recognised and rewarded	5.86	3406	5.81	4071	Not significant
We each have a voice that counts	6.45	3357	6.47	4021	Not significant
We are safe and healthy	6.02	3365	6.02	4030	Not significant
We are always learning	5.41	3250	5.48	3904	Not significant
We work flexibly	6.17	3386	6.26	4042	Not significant
We are a team	6.63	3402	6.61	4059	Not significant
Themes					
Staff Engagement	6.59	3401	6.59	4071	Not significant
Morale	5.79	3406	5.84	4071	Not significant

4.5 The flagship programmes and the progress made since last year are shown below in Table 4.

Table 4 – Our flagship programmes

Programme	2021 People Promise Score	2022 People Promise Score	2023 People Promise Score	2024 People Promise Score
How it feels to work at SaTH – Civility, Respect and Inclusion	6.76	6.84	7.07	7.08
Our mindset to approaching flexible working	5.57	5.77	6.21	6.26
Reviewing appraisal process and talent conversations	4.87	5.06	5.37	5.48

4.6 Our Scores for 'We are Compassionate and Inclusive' have increased year on year since 2021 and we believe our culture work and the work we have done with Equality, Diversity and Inclusion is beginning to embed across the organisation. It is also worth noting that the average score for our sector has seen a decrease from 2023, whereas our score has increased on 2023.

4.7 It is encouraging to note that we are also higher than our comparators for the sub- theme of Diversity and Equality (8.10 compared to the sector average of 8.08). As a testament to this work, we were also invited to present at the NHSE Learning event in March, *The Power of Compassion for Inclusion: Leading Culture Change and Building Belonging | NHS England Events,* where over 200 organisations listened to our journey and have requested information on our flagships, culture dashboard, flexible working tool kit and other programmes of work.

4.8 Our scores for the sub-themes of compassionate culture and compassionate leadership have also seen further increases this year. The percentage of staff selecting agree/strongly agree to the question 'My immediate manager works together with me to come to an understanding of problems' has increased from 63.82% in 2023 to 65.22% in 2024.

4.9 Our score for the 'We work flexibly' People Promise has increased year on year since 2021, and we are above the average score for our sector this year at 6.26, compared to 6.24. The percentage of staff selecting agree/strongly agree to the question 'My organisation is committed to helping me balance my work and home life' has significantly improved from 45.75% in 2023 to 48.31% in 2024. The percentage of staff feeling able to approach their immediate manager to talk openly about flexible working has increased from 67.49% in 2023 to 70.06% in 2024 and is above the sector average of 69.74%.

4.10 We have been approached by a number of Trusts to share our Flexible Working programme, and we also delivered our Flexible Working Masterclass and Toolkit briefing to over 60 colleagues via NHS Futures, including those from:

- Birmingham Women's and Children's NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Mersey Care NHS Foundation Trust
- NHS Wales
- NHS West Yorkshire ICB

4.11 Our overall score for 'We are always learning' has seen a further increase since last year from 5.41 to 5.48 and a 0.59 increase since 2021 when our Talent programme began. The sub-theme of Development is higher than the sector average at 6.43 compared to 6.40, although has decreased from 6.48 in 2023.

4.12 The percentage of staff having an appraisal, (or Talent Conversation) has increased from 78.11% last year to 81.90%, and the percentage of staff feeling that it helped them improve how to do their job increased from 23.25% in 2023 to 24.87% in 2024, although we recognise that overall, this score is lower than we would like. We have recently made further improvements to the Talent Conversation document to ensure it meets the needs of colleagues at all levels of the organisation.

4.13 The Culture Dashboard seen in Table 5 below depicts the results for the last 4 years in 6 domains. The scores for each of the domains have remained the same as last year, with the exception of Vision and Values which has decreased by 1%.

4.14 We have identified a top 10 of priority areas, through the Culture Group, for 2024 survey results, to support with the right interventions that will be offered in collaboration with the key stakeholders and the senior teams from those departments or divisions. See Appendix 2.

Table 5 Culture Dashboard below

4.15 Our overall score for Engagement has remained the same since 2023 at 6.59, with the score for the sub-theme of Motivation being above the average for our sector. The score for the sub-theme of Involvement has seen further increases again this year from 6.70 in 2023 to 6.75. Similarly, Advocacy has increased from last year from 6.02 to 6.04, however it's important to recognise that our scores for recommending the organisation as a place to work and to receive care are noticeably lower than the sector. These scores are often linked to psychological safety and relationships with line managers, therefore focus in these areas will help to improve these results. Our score for Morale has increased on 2023 from 5.79 to 5.84.

4.16 We have seen a positive decrease in scores for staff experiencing discrimination from their manager or colleagues, from 8.46% in 2023 to 8.19%. For ethnic groups this score has reduced year on year since 2021 and has reduced from 18.33% in 2023 to 17.71%. This lower score is a positive trend. These measures are noted as success metrics within our EDI 6 High Impact Actions Plan, however 8% is still a concern.

4.17 The percentage of staff experiencing bullying, harassment or abuse from staff in the last 12 months has also decreased from last year, with ethnic groups showing a reduction from 28.46% in 2023 to 24.80%. These measures are noted as key success metrics for High Impact 6 in our EDI High Impact Actions Plan.

4.18 The percentage of staff selecting Yes to the question 'Has your employer made reasonable adjustments to enable you to carry out your work' has increased from 73.88% in 2023 to 81.01% in 2024. Reasonable adjustments is one of the key strands of work in the People Promise Exemplar programme, and in particular to improve engagement with colleagues with a long-term health condition. The engagement score for those with a long-term health condition has increased from 6.14 in 2023 to 6.18 in 2024.

We will continue our work in this area, with further improvements to the Health Passport, updates to our Employee Wellbeing and Attendance Management policy, and a new rapid access to treatment process alongside the new Reasonable Adjustments guidance.

4.19 Our overall score for 'We are Safe and Healthy' has remained the same as 2023 at 6.02. Our score for the sub-theme of Health and Safety Climate has increased from 5.30 in 2023 to 5.40 in 2024. The sub-themes of Burnout and Negative Experiences have seen decreases in scores this year. In all but one of the questions, our scores for the sub-theme of Burnout are showing that staff are experiencing burnout more often than the average of our comparators.

4.20 As part of our People Promise Exemplar programme, we have introduced staff health clinics, however due to issues with the partner organisation these are currently being reviewed. We will also be undertaking health and wellbeing roadshows to increase awareness of our extensive health and wellbeing offer. To address the expectations of stress management within Q2c in EDS22, we are reviewing the training and development of line managers to support them in creating the right environment for colleagues to be healthy and thrive at work.

4.21 Free text comments arrived on 7 March and the OD Team will be undertaking a thematic analysis for sharing with Divisions.

5.0 Bank staff Survey Results

5.1 The response rate for the Bank survey was 24% with 261 responses out of a possible 1078 eligible colleagues. This is a 1% decrease from last year and above our comparator organisations who finished on an 19% average response rate.

5.2 All of the 7 People Promise Themes have increased year on year. Morale has seen an increase from 2023, and Staff Engagement has decreased.

5.3 Of the 28 People Promise measures in the Bank staff survey, 22 measures were higher than 2023.

Summary of Results can be seen in Table 6 below.

Table 6 (taken from the IQVIA Management Report)

Summary of Scores

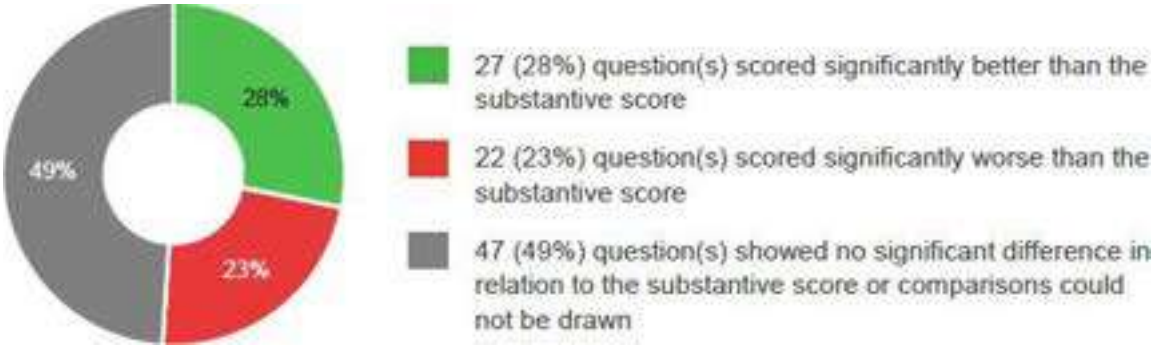
People Promise/Theme/Question	2023 Score	Significance	2024 Score	Significance	Sub. Score
Theme - Staff engagement	6.55	Not Significant	6.50	Not Significant	6.59
Theme - Morale	5.79	Not Significant	5.93	Not Significant	5.86
People Promise 1 - We are compassionate and inclusive	7.04	Not Significant	7.07	Not Significant	7.07
People Promise 2 - We are recognised and rewarded	5.79	Not Significant	5.91	Not Significant	5.81
People Promise 3 - We each have a voice that counts	6.17	Not Significant	6.27	Not Significant	6.46
People Promise 4 - We are safe and healthy	6.56	Not Significant	6.68	Significantly Better	6.05
People Promise 5 - We are always learning	5.91	Not Significant	5.95	Significantly Better	5.46
People Promise 6 - We work flexibly	6.51	Not Significant	6.52	Not Significant	6.28
People Promise 7 - We are a team	6.45	Not Significant	6.48	Not Significant	6.60

Bank Staff Survey Results

IQVIA 35

5.4 The below table 7 shows the comparison in scores compared to substantive staff:

Table 7 (taken from the IQVIA Management Report)



5.5 There are some key differences between the experiences of Bank staff compared to substantive staff:

- Bank staff score more positively in the ‘We are Safe and Healthy’ and ‘We are Always Learning’ People Promises.
- Bank staff are less positive to questions relating to their immediate manager and appraisals.
- Bank staff are less likely to feel involved in the workplace, in particular with proposed changes which affect them.

- Bank staff reported less positively when it comes to autonomy and control, they feel less likely to be able to make changes and improvements at work. They also report less positively to development opportunities.

6. Timescales for delivery

6.1 In January we agreed a timeline for delivery for all elements of the staff survey campaign. Appendix 3 provides an annual timeline to allow all colleagues to get involved in delivering the actions on the wider People Promise.

7.0 Conclusions

7.1 It is important to note that results were expected to be varied this year due to the significant increase in response rates. These are results that give an indication of a Trust which is continuing to improve experiences of staff. Even though many scores are still below sector comparison, our focus should be on continuing on the upward trend. In what is an incredibly challenging time, the results show we are responding well to current challenges.

7.2 The improvement in our scores across our flagship programmes demonstrates that our actions are beginning to embed across the organisation. Apart from We Work Flexibly, where we are above the sector average, we remain in the lower percentile for our sector. We will continue to focus on delivering the key changes identified from our staff feedback.

7.3 The People Promise priority actions are being reviewed in response to the 2024 results, building in actions to address operational pressures. These are taking place in Divisions currently and the full action plan can be seen in appendix 1.

7.4 Divisions continue to be provided with line manager training on the Learning Made Simple (LMS) system, and have been asked to review their results and discuss with their teams; a summary is shown in Table 9 below. There may be areas where teams can celebrate success and where things may be going well, and managers have been asked to agree local actions they feel their team could implement and others they feel may require a corporate-wide approach.

7.5 Although the divisional trends as outlined in Table 8 show a mixed picture, we are encouraged by the improvements that each Division has made, and in particular within Medicine and Emergency who have been faced with unprecedented internal and external pressures.

Table 8 (taken from an Excel spreadsheet)

NHS Staff Survey - Breakdown 2023 vs 2024																
People Promise & Theme	**Division**															
	CSS			MEC			SAC			W&C's			Corporate			
	2023	2024	Trend	2023	2024	Trend	2023	2024	Trend	2023	2024	Trend	2023	2024	Trend	
We are compassionate and inclusive	7.02	7.02	⇔	6.80	6.96	⇧	7.10	7.06	⇩	7.02	7.00	⇩	7.22	7.23	⇧	
We are recognised and rewarded	5.72	5.65	⇩	5.53	5.65	⇧	5.80	5.76	⇩	6.63	5.45	⇩	6.35	6.25	⇩	
We each have a voice that counts	6.21	6.25	⇧	6.24	6.40	⇧	6.52	6.47	⇩	6.46	6.49	⇧	6.65	6.62	⇩	
We are safe and healthy	5.90	5.86	⇩	5.40	5.49	⇧	6.14	6.11	⇩	5.80	5.90	⇧	6.58	6.59	⇧	
We are always learning	5.33	5.30	⇩	5.30	5.57	⇧	5.41	5.42	⇧	5.13	5.16	⇧	5.48	5.66	⇧	
We work flexibly	5.71	5.99	⇧	5.90	5.95	⇧	6.10	6.19	⇧	5.88	5.94	⇧	6.93	6.99	⇧	
We are a team	6.52	6.57	⇧	6.38	6.55	⇧	6.70	6.67	⇩	6.23	6.08	⇩	6.90	6.86	⇩	
Staff Engagement	6.28	6.31	⇧	6.44	6.52	⇧	6.63	6.60	⇩	6.68	6.69	⇧	6.78	6.74	⇩	
Morale	5.54	5.51	⇩	5.40	5.55	⇧	5.98	5.98	⇔	5.55	5.70	⇧	6.22	6.24	⇧	

7.6 A new, improved Staff Survey Dashboard of service and department level results has been developed to enable managers to access local results, encouraging departmental ownership and driving forward regular actions at a local level. See Table 9 below.

Table 9 – Visual of Power BI Results Dashboard

7.7 All management teams have been requested to review their results and consider how they will share the data with their teams – briefing packs have been provided by the OD team to help focus on key considerations and actions.

8.0 Risks

8.1 It is to be acknowledged that several actions can take longer periods of time to embed before they are felt/experienced by staff. NHSE suggests that the staff survey provides rich and valuable data to support and inform continuous improvement and cultural change for longer term 3–5-year planning. However, we need to action more rapid improvement to peoples' experience of working and delivering care here.

8.2 In addition, the financial pressures facing the Trust and the focus on unavailability may present challenges in taking improvement actions forward

and could impact on future results in morale and engagement and the overall development of our managers.

9.0 Recommendations

9.1 We recommend that in 2025-2026 all Divisions have an overarching Engagement and listening strategy and focus to deliver improved experience for both colleagues and patients. Research conducted by the Kings fund and NHS England suggest that focus on Employee engagement will improve both patient satisfaction and have a positive impact on sickness absence and agency spend.

9.2 It is recommended that senior and middle managers are key to the success of the survey and their role in embedding the NHS Leadership Way, the NHS People Promise with the ultimate goal of addressing the challenges set out in The NHS Long Term Workforce Plan. We therefore recommend that more managers are supported to attend our leadership programmes in order to develop themselves and understand the importance of their role and application of these skills in managing health and wellbeing, advocacy and engagement of their staff which ultimately impacts on patient care.

9.3 It is also recommended that Afina Team Journey is used where teams are fundamentally low in team effectiveness.

9.4 To ensure that managers are trained in the fundamental aspects of operational management, people management, finance, governance, assurance and safety, it is also recommended that all managers attend the STEP Management skills programme, and that attendance becomes mandatory.

9.5 It is further recommended that Divisions and managers:

- Monitor those who would **not recommend** the Trust as a place to work and those who are not satisfied with the standard of care provided. Break down the data to understand where these views are coming from.
- Monitor those areas who have lower scores in improvement questions.
- Ensure that **feedback from patients** is reviewed on a regular basis and is used to identify ways to **improve patient / service user care**. Record actions and decisions as well as monitoring any interventions or changes over time.
- Ensure leaders **clarify how concerns are handled** and demonstrate that they will be treated seriously. With all concerns ensure staff are directly informed of the actions the organisation has taken to address this concern.
- Ensure leaders are aware of staff experiencing **burnout, work-related stress** or **musculoskeletal** problems, seek to understand the underlying issues and provide early access to health and wellbeing support.
- Identify areas where staff are **not receiving a talent conversation (appraisal)**. Emphasise to line managers the importance and value of conducting such developmental reviews / appraisals.
- To identify managers for development and ensure they are released to attend leadership programmes.

9.6 Develop a Bank Corporate Action Plan to:

- Examine the data to identify any areas where bank staff are **not receiving appraisals** or annual reviews. Emphasise to line managers the importance and value of conducting such developmental reviews / appraisals.
- Consider setting up a staff group to dedicate time to discuss issues and strategies to **improve health and well-being amongst bank staff**. Ensure health and well-being initiatives are well publicised to bank staff.
- Promote a culture in which Bank staff feel their **opinions and skills are welcomed**, sought-after and valued, and that they are given opportunities to show initiative in their role.

10.0 Next steps

10.1 Division and areas to cascade information to teams and share any improvements and their action plans. This activity is to include but not limited to; review of internal and heat map data, holding engagement sessions to understand meaningful actions (using the year of listening narrative) and preparing priorities for 2025/2026 as outlined in Table 10 Staff Survey Divisional Next Steps (OD action highlighted in bold). High-level Action Plan can be seen in Appendix 1.

Table 10

10.2 From our own experience and from working with other Trusts, concentrating on a small number of focused actions is more effective than extensive action plans in achieving year-on-year improvements in survey results. This learning shows fewer and more focused actions for managers to focus on in the short time available is most effective in delivering year-on-year improvements. The NHS England People Experience team also advocate this approach, and this is also demonstrated by the improvements in the People Promise Scores for our Flagship programmes since 2021. On this basis, The People and OD Directorate will continue to focus on our flagship programmes, as highlighted in table 4, to support the 3 themes of We are Compassionate and Inclusive, We work flexibly, and We are always learning.

10.3 Using Copilot to summarise the Action Plan for Divisions in 2025-2026 as shown in Appendix 4, alongside working with their top ten priority areas, it has further been identified that the areas that are common amongst all the Divisions and will be the primary areas of focus are:

- Health & Wellbeing
- Leadership Development
- Staff Engagement

10.4 The OD team will continue with Engagement Masterclasses to support theme focus.

10.5 Divisions to follow annual timeline to meet Trust expectations and to cascade information to all their teams.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors Meeting
08 May 2025

Agenda item		083/25		
Report Title		**Board Assurance Framework – Draft Quarter 4, 2024/25**		
Executive Lead		Director of Governance – Anna Milanec		
Report Author		Head of Corporate Governance & Compliance – Deborah Bryce		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	All BAF risks
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Performance Assurance Committee - 23 April 2025 Finance Assurance Committee - 29 April 2025 Quality & Safety Assurance Committee - 29 April 2025 Audit & Risk Assurance Committee (via email in April)		
Executive summary:		The Board Assurance Framework (BAF) content has been thoroughly refreshed for quarter 4 of 2024/25 by the executive risk owners and their relevant senior team members. This quarter sees a proposed increase to the current total risk score of BAF risk 7a (maintaining cyber defences) from 15 to 20. The likelihood of this risk has increased in line with national threat levels and activity across the NHS. This risk is overseen by the Audit & Risk Assurance Committee.		
Recommendations to the Board:		The Board is asked to: a) Consider if the BAF content reflects the strategic risks within the organisation and if the risk scores are appropriate. b) Consider if there is evidence of successful management of the risks; if actions are being progressed in a timely manner; and if any further actions/mitigations are required. c) **Approve** the quarter 4 BAF.		
Appendices:		**Appendix 1**: Board Assurance Framework (draft) - quarter 4		

1.0 Introduction

1.1 The Board Assurance Framework (BAF) outlines the risks to achievement of the organisation's strategic objectives.

1.2 Work to review and refresh the BAF content for quarter 4 was undertaken during March 2025 to early April 2025.

1.3 The Board's attention is drawn to all BAF risks.

2.0 Significant changes to the BAF during quarter 4 2024/25

2.1 The draft BAF can be found within **Appendix 1.** New narrative since the previous quarter's BAF is shown in blue text.

2.2 It is proposed in quarter 4 to increase the current total risk score of BAF risk 7a from 5x3=15 to 5x4=20 - *Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation*. Board is asked to reflect on this risk score and increase it due to the ongoing national high level of threat and following the Board cyber training (to recognise the level of risk). The likelihood of this risk has increased from 'possible' to 'likely', in line with national threat levels and activity across the NHS.

2.3 It is proposed that new gaps in assurance, and associated actions, be added to BAF risk 2 in relation to Board reporting of regulatory training programmes and to BAF risk 9 in relation to limited assurance on cancer improvement delivery.

2.4 A new action is proposed to be added to BAF risk 13 (corporate governance) in relation to offering support to the Communications Team for a case to be developed for a new document library for easier policy access/search across the trust.

2.5 For BAF risk 5 (finance), three actions have been closed in quarter 4. There was also a full discussion at Finance Assurance Committee on 29 April 2025 on the total current risk score of BAF risk 5, following the early review of the risk at the beginning of the quarter. It was agreed to retain the total current risk score at 20 and not increase the impact score, as the Trust's forecast deficit has been delivered, along with the year-end position, and there is also an enhanced cash position.

3.0 Risks, actions and the Organisation's top risk(s)

3.1 The detail of each BAF risk and proposed actions aligned with gaps in control and assurance can be viewed within the draft BAF (**Appendix 1**).

3.2 Based on the draft current total risk scores for quarter 4, there are now four top risks with a current total risk score of 20; six risks with a score of 16; one with a score of 15 and three with a score of 12, as indicated within the BAF summary page.

3.3 BAF risk 7a (maintaining cyber defences) has been added to the top risks this quarter. The four top scoring risks, with a current total risk score of 20, are as follows:

The top scoring BAF risk(s) based on draft current total risk scores at quarter 4:

Risk No.	Risk title	Overseeing Committee	Current proposed risk score at quarter 4, 2024-25	Change in risk score since quarter 3 2024-25
BAF 5	The Trust does not operate within its available resources, leading to financial instability and continued regulatory action	Finance Assurance Committee	4x5 = 20	↔ No change
BAF 7a	Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation.	Audit & Risk Assurance Committee	5X4 = 20	↑ Proposed increase from 5X3=15 to 5X4=20
BAF 7b	The inability to implement modern digital systems impacts upon the delivery of patient care	Performance Assurance Committee	4x5 = 20	↔ No change
BAF 10	The Trust is unable to meet the required national urgent and emergency standards.	Performance Assurance & Quality & Safety Assurance Committees	4x5 = 20	↔ No change

Note: The BAF summary page outlines the other extreme risks scored at 15 or above.

3.4 Being aware of the proposed top scoring risk(s) should assist the Board to consider:

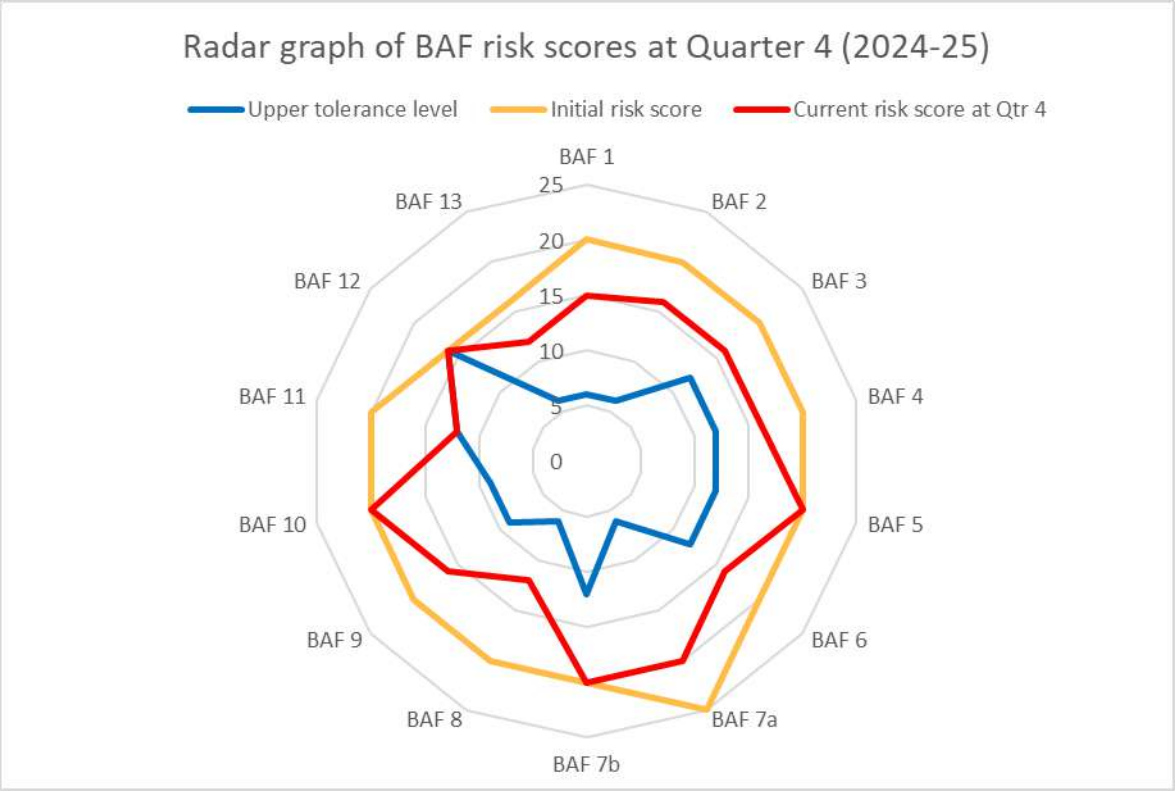
- If these risks reflect the perceived current top risks within the organisation.
- The priority of focus given to the risks and assurances received.
- The comparative scoring of all risks.

4.0 Visual representation of risk scores

4.1 The radar graph within the BAF (below) provides a visual representation of risk scores. It is intended that this graph will assist the Board to:

- identify the gap between the risk upper tolerance level and current risk score.
- help identify where the initial and current risk scores are the same (where the line on the graph overlaps), i.e., BAF risks 5, 7b, 10 and 12, and to consider if the controls are adequate for these risks or if further action and assurance is required.
- assist to continue to reflect upon the upper tolerance levels for BAF risks and whether these remain appropriate and achievable.

4.2 It is acknowledged that for BAF risks 11 and 12, the current total risk score has achieved (is at) the proposed upper tolerance level. All other BAF risks are above their upper tolerance levels.



5.0 Recommendations

The Board is asked to:

a) Consider if the BAF content reflects the strategic risks within the organisation and if the risk scores are appropriate.

b) Consider if there is evidence of successful management of the risks; if actions are being progressed in a timely manner; and if any further actions/mitigations are required.

c) **Approve** the quarter 4 BAF.

Appendix 1

The Shrewsbury and Telford Hospital NHS Trust

Board Assurance Framework (BAF) 2024/25 - draft quarter 4 (January-March 2025)

(Updated March/April 2025 - Version 1.2)

The Shrewsbury and Telford Hospital NHS Trust

Risk scoring framework

	Likelihood				
	1	2	3	4	5
Impact / consequence	Rare	Unlikely	Possible	Likely	Almost certain
5 Severe	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows*:

1 to 3	LOW risk
4 to 6	MODERATE risk
8 to 12	HIGH risk
15 - 25	EXTREME risk

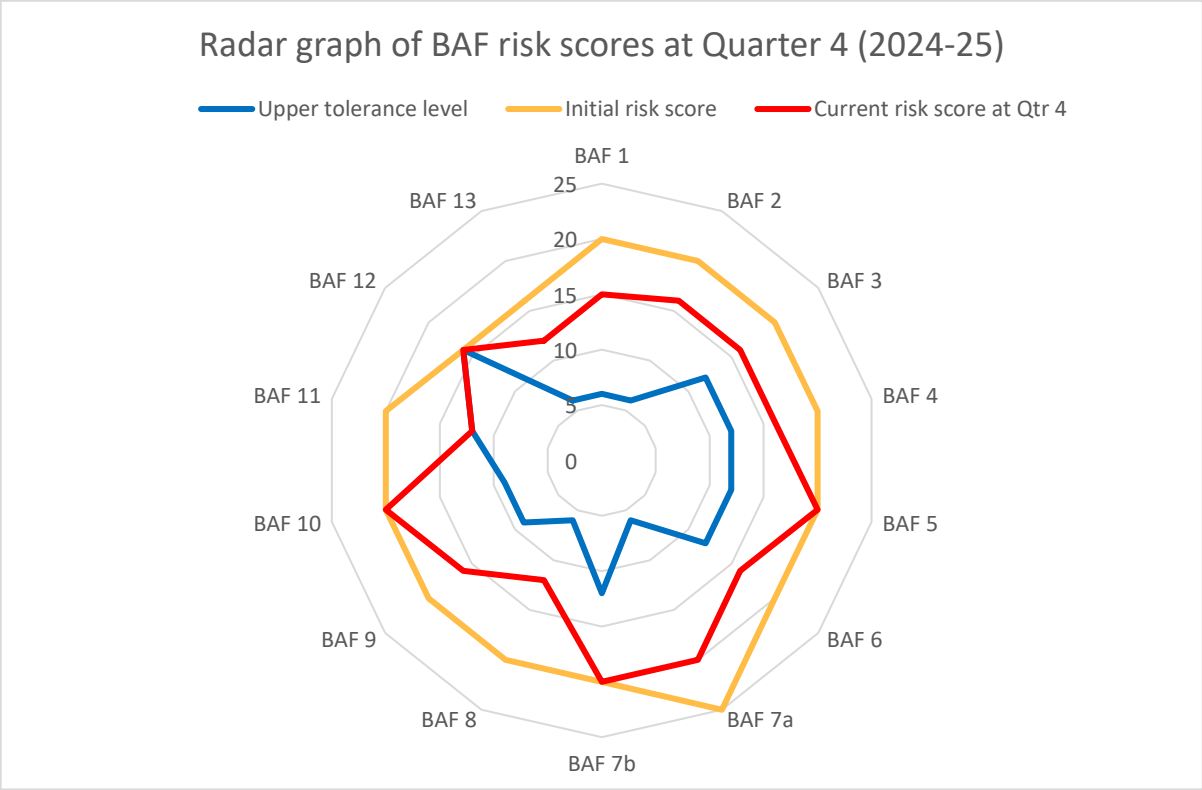
The Shrewsbury and Telford Hospital NHS Trust

											Current total risk score:	
Board Assurance Framework 2024/25 - Summary at Quarter 4 (January to March)		**Alignment to Trust Strategy - strategic themes/objectives**	**Initial (inherent) risk score**	**Upper tolerance level (and risk appetite)***	**Lead Executive**	**Lead Committee**	**Quarter 4 (2023-24)**	**Quarter 1 (2024-25)**	**Quarter 2 (2024-25)**	**Quarter 3 (2024-25)**	**Quarter 4 (2024-25)**	**Change in current risk score between Q2 and Q3, plus any further comments**
Ref:	**Risk title:**											
BAF 1	If the Trust is unable to maintain quality of care standards and clinical safety, outcomes will not be acceptable	Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless patient pathways.	5x4 = 20	6 (minimal)	Medical Director /Chief Nursing Officer	Quality & Safety Assurance Committee	5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15	↔ No change
BAF 2	The Trust is unable to consistently embed a safety culture with evidence of continuous quality improvement and patient experience.	Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless patient pathways. Make our organisation more sustainable.	5x4 = 20	6 (minimal)	Chief Nursing Officer/ Medical Director	Quality & Safety Assurance Committee	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	↔ No change
BAF 3	If the trust does not ensure staff are appropriately skilled, supported and valued this will impact on our ability to recruit/retain staff and deliver the required quality of care.	Make SaTH a great place to work. Deliver a better patient journey and experience. Make our organisation more sustainable.	5x4 = 20	12 (open)	Chief People Officer	People & OD Assurance Committee	4x3=12	4x3=12	4x3=12	4x4 = 16	4x4 = 16	↔ No change
BAF 4	A shortage of workforce capacity and capability leads to deterioration of staff experience, morale, and well-being.	Make SaTH a great place to work. Deliver a better patient journey and experience. Make our organisation more sustainable.	5x4 = 20	12 (open)	Chief People Officer	People & OD Assurance Committee	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	↔ No change
BAF 5	The Trust does not operate within its available resources, leading to financial instability and continued regulatory action	Make our organisation more sustainable.	4x5 = 20	12 (open)	Director of Finance	Finance Assurance Committee	4x5 = 20	4x5 = 20	4x5 = 20	4x5 = 20	4x5 = 20	↔ No change
BAF 6	Some parts of the Trust's buildings, infrastructure and environment may not be fit for purpose.	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	4x5 = 20	12 (open)	Assistant CEO	Performance Assurance Committee	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	↔ No change
BAF 7a	Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation.	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	5x5 = 25	6 (minimal)	Director of Strategy & Partnerships	Audit and Risk Assurance Committee	5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15	5x4 = 20	Recommendation to increase risk score. Board/ARAC are asked to reflect on this risk score and increase it due to the ongoing national high level of threat and following the Board cyber training.

Board Assurance Framework 2024/25 - Summary

											Current total risk score:	
Board Assurance Framework 2024/25 - Summary at Quarter 4 (January to March)		**Alignment to Trust Strategy - strategic themes/objectives**	**Initial (inherent) risk score**	**Upper tolerance level (and risk appetite)***	**Lead Executive**	**Lead Committee**	**Quarter 4 (2023-24)**	**Quarter 1 (2024-25)**	**Quarter 2 (2024-25)**	**Quarter 3 (2024-25)**	**Quarter 4 (2024-25)**	**Change in current risk score between Q2 and Q3, plus any further comments**
Ref:	**Risk title:**											
BAF 7b	The inability to implement modern digital systems impacts upon the delivery of patient care	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	**4x5 = 20**	**12 (open)**	Director of Strategy & Partnerships	Performance Assurance Committee	**4x4 = 16**	**4x4 = 16**	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	↔ No change
BAF 8	The Trust cannot fully and consistently meet statutory and / or regulatory healthcare standards.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**4x5 = 20**	**6 (minimal)**	Chief Nursing Officer	Quality & Safety Assurance Committee	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	↔ No change
BAF 9	The Trust is unable to meet the required national elective and cancer care standards.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**4x5 = 20**	**9 (cautious)**	Chief Operating Officer	Performance Assurance Committee and Quality & Safety Assurance Committee	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	↔ No change
BAF 10	The Trust is unable to meet the required national urgent and emergency standards.	Deliver a better patient journey and experience. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**4x5 = 20**	**9 (cautious)**	Chief Operating Officer	Performance Assurance Committee and Quality & Safety Assurance Committee	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	↔ No change
BAF 11	The current configuration and layout of acute services in Shrewsbury and Telford will not support future population needs and will present an increasing risk to the quality and continuity of services.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**5x4 = 20**	**12 (open)**	Director of Hospitals Transformation Programme	Hospitals Transformation Programme Assurance Committee	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	↔ No change
BAF 12	There is a risk of non-delivery of integrated pathways, led by the ICS and ICP.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**4x4 = 16**	**16 (eager)**	Director of Strategy & Partnerships and Chief Operating Officer	Quality & Safety Assurance Committee	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	↔ No change
BAF 13	The Trust is unable to ensure that robust corporate governance arrangements are in place resulting in poor processes, procedures and assurance	Improve the quality of care that we provide. Deliver a better patient journey and experience. Make our organisation more sustainable.	**4x4 = 16**	**6 (minimal)**	Director of Governance	Audit and Risk Assurance Committee	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	↔ No change

Visual representation of risk scores



Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite						
BAF 1: **If the Trust is unable to maintain quality of care standards and clinical safety, outcomes will be unacceptable.**			**Medical Director/ Chief Nursing Officer**	Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless patient pathways.	**SaTH has a MINIMAL risk appetite for risks that may compromise safety and the achievement of better outcomes and experience for patients. We are willing to consider actions which present a low risk to quality and safety priorities and objectives. We recognise, however, that we may have to tolerate a higher impact within the patient experience domain and greater levels of escalation.**			**Quality & Safety Assurance Committee**			
Risk opened: risk content refreshed 1 April 2023 (previous risk within 2021/22)			John Jones/ Paula Gardner								

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Inconsistencies in care • Inconsistencies and lack of clarity in governance arrangements • Lack of resources • Lack of clarity of standards and frameworks especially where practice may be different across sites • Incomplete training and competencies • Operational pressures • Workforce gaps in specific areas (including vacancies); Inability to recruit and retain the right numbers and skill mix of clinical staff • Clarity of and lack of consistency in the use of policies and procedures • Unable to off-load ambulances in a timely way because of lack of patient flow through the organisation • Lack of clarity of data and triangulation of data • Lack of capacity to plan service improvement work • Organisational culture **Consequence:** • Harm to patients • Delays in time-critical care • Inadequate care • Poor patient experience and increased complaints • Increased length of stay • Poor management of deteriorating patients • Reduced staff morale and recruitment and retention • Inconsistencies in governance arrangements • CQC prosecutions and enforcements if standards and frameworks are not in place. • Ambulance rapid handover could result in a greater volume of patients in ED than can be received and cared for • Reputational damage, financial loss and lack of confidence in the organisation • Increase in use of temporary and agency staff resulting in lack of continuity and financial pressures	5	4	20	• Getting To Good (G2G) workstreams: Levelling up Clinical Standards and Fundamentals in Care. • Targeted transformation programmes • Quality Strategy; Quality Priorities; Corporate Strategy; People Strategy; Digital Strategy; workforce planning • Clinical audit programme • Learning from Deaths Group review • Deteriorating Patient Group • Falls prevention strategy • Safeguarding Policy (including Mental Health and Learning Disabilities) • IPC Policy • Palliative and End of Life framework • Staff training • Identification and management of concerns about capability of healthcare professionals • Rapid review meetings/ RALIG both in place • Quality governance framework within Divisions • Exemplar programme (ward accreditation) • Monthly Nursing Metrics • Daily incident communications (Datix) • Nutrition and Hydration Group • Nursing Documentation Group in place • Trust Complaints Process and an independent complaints panel • Freedom to Speak Up Guardian and ambassador arrangements in place • Speciality Patient Experience Groups and the Patient and Carer Experience Panel. • Board Assurance Visits • Weekly clinical leaders forum • Patient Safety Specialist in post • SaTH Improvement Hub • Clinical Lead for Improvement in place • CQC action plan owned by Divisions • External representation at our quality meetings at QOC, RALIG and Safeguarding • Fortnightly catch ups and quarterly engagement meetings with CQC • MIAA follow-up reports • Patient and Carer Experience Panel (PACE) - Trust wide and speciality groups • Key Performance Metrics Monitoring Meeting (weekly) • Hospital Full Policy launched December 2023 • Dispatches action plan in place with associated dashboard and exception report which is shared with the executive team and ICB (and to be incorporated into CQC action plan), and is discussed bi- monthly with NHSE as part of the oversight framework meetings. • Assessing contingency arrangements in light of the fragility of Maxillo Facial consultants availability. • Review of pressure ulcer governance arrangements - new process being implemented April 2025.	**Reported to Board, committees and elsewhere:** Non-Executive led assurance committees: • Quality & Safety Assurance Committee, reporting to Board (2nd) • Mortality metrics reported to Board and Learning from Deaths Group considered by Board quarterly (2nd) • Quality metrics within Integrated Performance Report to Board (monthly)(2nd) • CQC Report, published May 2024 provides assurance that improvements are being made across the Trust (3rd) • Quality Account to QSAC/Board 2024 (2nd) • Incidents reports, themes, claims and complaints report to QSAC and public Board (2nd) • Staff Survey results to Board and quarterly pulse survey results considered at People & OD Committee (2nd) • Executive chaired assurance committees: Quality Operational Committee; IPC; Safeguarding; Nursing, Midwifery, AHP and Facilities Workforce; Maternity and Neonatal Transformation Assurance Committee (MNTAC); RALIG (review and learning from incidents); Emergency Care Transformation Assurance Committee (ETAC); Patient and Carer Experience Panel; Paediatric Transformation Assurance Committee (PTAC) - reports into QSAC (2nd) • Performance Management Review Meetings (PRM) with Divisions, executive led (2nd) • Operational groups: IPC; Safeguarding (children and adults); Quality Metrics; Falls; Nutrition and Hydration; Palliative End of Life Care Steering Group; Rapid Review; Getting to Good review meetings; Flow Improvement (1st) • Culture dashboard reported to Operational People Group (1st) • Externally led quality assurance visits and reports - e.g., NHSE, HEE (now NHSE), ODN's, ICB, and other regulators - paediatric visit, safeguarding and ED visit regarding ambulance offload delays 2022 (3rd) • Quarterly FTSU updates to Board (2nd) • External Peer reviews in neonatal, trauma and critical care in Q3 2023/24 (3rd). Progress in relation to action plans will be sought through PRM's. Report received in September 2024 and discussed at public Board November 2024. Recommendations accepted and action plan in place. Assurance provided through MNTAC for neonatal. • ICB quality peer review in ED - April (3rd) • Q4: Reset and Review meeting - national maternity team - awaiting results (3rd) •MIAA internal audit reviews 2023/24 (3rd) considered at Audit & Risk Assurance Committee: Infection Control (Substantial assurance); Mortality Governance (Substantial assurance); Duty of Candour (Substantial assurance); Pressure Ulcers (Substantial assurance); Quality Spot Checks (Limited assurance -has associated action plan); • ICB Insight Visits to both ED's following the broadcast of the Dispatches programme; Healthwatch Shropshire and Healthwatch Telford visit to ED's (3rd). • Director of Nursing and Medical Director presented information to Joint Health and Overview Scrutiny Committee (OSK) on 7 August 2024, alongside ICB CEO and Chief Nursing Officer (3rd). Also presented to Extraordinary Adult Safeguarding Board on 7 August 2024 (3rd). CEO, Chief Nursing Officer and Medical Director attended OSC again December 2024 and February 2025 (inc Chief Operating Officer). • A staffing review of establishment setting by the clinical workforce lead for the Safer Staffing Faculty from NHSE - May 2024 - which was positive (3rd) • Medical Regulatory Group established Q2 (2nd) • Q3-Q4: Pharmacy Aseptic Services - stage one compliance management (enhanced oversight following Environment Agency visit) (3rd).	5	3	15	**Gaps in control:** 1. National shortages in specific workforce, e.g. theatres, band 6 nurses in ED, endoscopy, doctors within critical care, care of the elderly, emergency medicine. 2. A number of patients with no criteria to reside and lack of alternatives to hospital admission, impacting on patient flow and pressures in the Emergency Department. 3. Prolonged timescale of electronic systems replacing dated and paper based systems. 4. Implementation of national Patient Safety Incident Response Framework (PSIRF) and development and roll-out of Patient Safety Strategy. 5. Standardisation of education for clinical ward leaders to ensure standardised approach across the organisation. 6. Lack of Policies and Procedures Group to sign-off clinical policies, plus no overarching Documentation Group. 7. Assurance framework to oversee smaller clinical regulator requirements (e.g., HTA, HFEA, UKAS and MHRA). **Gaps in assurance:**	Actions aligned to gaps: 1a.Workforce planning - see BAF risk 3 plus Workforce Strategy. 1b. Delivering the trajectories within the Workforce Strategy . Leads: Kara Blackwell (for nursing, midwifery and AHP) and Simon Balderstone. During 2023, 2024 and 2025. 2a. *See BAF risk 10.* 2b. *See BAF risk 10.* 3. Electronic Patient Record planned by end of 2025. New patient administration system (PAS) to be in place as per agreed implementation plan (see BAF risk 7b). Executive lead: Director of Strategy & Partnerships. 4. Develop a three year Quality & Safety Strategy by ~~Q4 2024/25~~ Q2 2025/26 which encompasses the key elements of the National Patient Safety Strategy. Executive Lead: Chief Nursing Officer. 5. Hold ward mangers away day in July to scope out development needs over the year (including nursing, midwives and AHP's) by Q2. Executive lead: Chief Nursing Officer. 6. Introduce refreshed Policy for Policies and Policy Approval Group in Q2 24/25. Executive Lead: Director of Governance (as per BAF risk 13). 7. Development of the framework and to report to QOC in Q3 24/25. Executive Lead: Executive Medical Director	1b. The majority of band 5 vacancies in ED and ward areas recruited to, but there will be requirements for specialist areas including theatres, ED band 6's and endoscopy. Q2: Work remains ongoing and ED is progressing well with RCN recruitment. There have been further appointments of Emergency Medicine Consultants. Q3: Appointment to ED band 6's, with long term agency staff being successful in applying to these roles. ED Consultant appointed during December 2024. 3. The new Careflow PAS and Careflow ED systems were implemented in Apr 24, and Vitals Paeds was successfully brought in during July 24. The remaining 24/25 digital programme includes Paeds Vitals Sepsis module (successfully in during Sep 24), Careflow Connect, Order Comms/Integrated Clinical environment and specialty systems such as Medilogik in Endoscopy. To note, these systems do require strong clinical leadership and extended involvement. The primary major clinical system gap remaining is EPMA – electronic prescribing and medicines administration system. The Trust has met with NHSE digital leaders to register this during October 24. We await further feedback. To note, this would be for implementation in 25/26, if funding received. Q3: New surgical electronic whiteboard in operation (SAU). 4 In progress. Working to align the Patient Safety Strategy to the Quality Strategy. Once complete, will go via Quality Operational Committee for approval. Q2: An outline of the key components of the Patient Safety Strategy was received at QSAC in September 2024, but there is further work to do to align this with the Quality Strategy which is being produced in January 2025. Q3: Now intend to develop a joint Quality and Safety Strategy. Q4: Plan to ensure consultation with stakeholders on the strategy in Q1, with revised draft end of Q1. 5. **Original action closed (Q2)**. Planning a set of half day away days/masterclasses for the ward manager programme. Q3: These are now paused until end of the financial year, due to financial challenges, and will commence in April 2025. Q4: Running the I Care Braver Leader Programme - two cohorts - one in April and one in Sept 2025 with band 7 ward managers. 6. The Trust's updated Policy for Policies was considered and agreed by the recently established Policy Approval Group on 16 October 2024 and is due to be considered by Executive Team, ahead of Board. Policy Approval Group commenced during August 2024, meeting monthly. 7. Q2: Medical Regulatory Group meetings in place and AAAA report was submitted to QSAC in September 2024. The group is meeting quarterly. Action closed Q4.			6

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee						
BAF 2: The Trust is unable to consistently embed a safety culture with evidence of continuous quality improvement and patient experience.			**Chief Nursing Officer/ Medical Director**	Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless patient pathways. Make our organisation more sustainable.	**SaTH has a MINIMAL risk appetite for risks that may compromise safety and the achievement of better outcomes and experience for patients. We are willing to consider actions which present a low risk to quality and safety priorities and objectives. We recognise, however, that we may have to tolerate a higher impact within the patient experience domain and greater levels of escalation.**			**Quality & Safety Assurance Committee**						
Risk opened: risk content fully revised Q2, 2023/24 (previous risk within 2021/22)			Paula Gardner/ John Jones											

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Inconsistent leadership to support a high quality compassionate care environment • Inconsistent embedding of learning when colleagues speak up • Inconsistent approach to ensure acceptable values and behaviours that create psychologically safe team working • Inconsistent organisational support to embed a continuous learning and improvement environment • Leaders inconsistently demonstrating basic good practice in respect of 1 to 1 meetings, health and wellbeing check ins and talent management conversations with colleagues. • Lack of prioritisation of learning and development for colleagues. • Discontent from resident doctors around a number of national issues including pay, training opportunities and regulation of Physician and Anaesthetic Associates. **Consequence:** • Increased harm • Poor patient experience • Increased complaints • Reputational damage • Lack of confidence in the organisation • Potential CQC prosecutions and enforcements • Our people are not routinely raising concerns/speaking up on patient safety and anything else that may affect great patient care • Our people do not work as a team and a safety culture is not embedded within the organisation • Poor communication and unable to learn from incidents • Lack of measure of safety culture within the organisation • Strain placed on relationships between resident doctors and Physician Associates	5	4	20	• Embedding NHS Impact within Getting To Good (G2G) workstreams • Freedom to Speak Up Guardian and ambassador arrangements • FTSU Vision and Strategy in place • New national FTSU 2022 policy update in place • FTSU on-line training is mandatory at SaTH - since June 2022. At February 2025: FTSU workers at 92.99%, FTSU managers at 81.19% and senior leaders at 89%. • Speciality Patient Experience Groups and the Patient and Carer Experience Panel. • Board Assurance visits • Patient Safety Specialist in post • SaTH improvement methodology courses • SaTH Improvement Hub • Trust Strategy 2022-2027 (includes continuous improvement culture) • Leadership programmes in place, including Galvanise programme for colleagues from ethnic minorities • Continuous improvement programme • Staff psychological wellbeing services in place • Staff Survey covers some key safety culture elements (was undertaken Oct to Nov 2023) • PSIRF Plan and Policy • Civility and Respect workshops in place in the Trust that are available for clinical and non-clinical teams (1,000 plus people have taken part in these workshops, at October 2023) • Head of Culture in place with Civility and Respect remit • Neutral evaluations/culture reviews take place within teams in certain areas • Internal cultural reviews taking place via OD Team, with subsequent cultural interventions put in place, where required, e.g. team workshops and signposting to leadership courses. • Board FTSU self-reflection tool: Board development session held 1 November 2023 • Review of all mandatory training has begun and SEMTRAG (SaTH Education Mandatory Training Group) established in Q4 - February 2024 • Two Family Liaison Officer posts put in place during Q4 (23/24), who will feedback following learning from incidents • Professional Nurse Advocacy and professional nurse advocacy roles in place to provide psychological restorative supervision • Action taken to improve temporary and permanent mess facilities at PRH for doctors • Regular meetings set up with senior medical leaders and tier two doctors.	**Reported to Board, committees and elsewhere:** • Reports to Quality & Safety Assurance Committee held monthly, reporting into Board (2nd) Patient Experience & Complaints Report to QSAC - quarterly (2nd) • ARAC - Audit & Risk Assurance Committee (2nd) - bi-annual FTSU reports • Culture dashboard (annually based on Staff Survey) and quarterly cultural report, reported to Strategic People Group (1st) • Updated FTSU Policy approved at June 2023 Board (2nd) • Quarterly FTSU updates to Board (Oct 2023) (2nd) • Patient Safety Incident Response Framework and policy to October Board (2nd) • Internal audit of FTSU arrangements (in-house) Sept 2022-May 2023 (2nd) • MIAA internal audit reviews 2024/25: Freedom to Speak Up (Substantial Assurance) (3rd). • Update to Strategic People Group on retention, featured Improvement Hub progress (Nov 2023) (2nd) • FTSU priorities shared and agreed at February 2024 Board meeting (2nd). And will be reviewed in Q1, 25/26. • CQC Report published May 2024 - refers to improving culture of high quality care and staff described as being committed to continually learning and improving services. Trust rated requires Improvement Overall, but rated 'Good' for Caring domain. 'Seen significant improvement since previous Well Led inspection of the Trust.' ' A positive shift in culture since the last inspection' (3rd) • *See BAF risk 1 regarding recent assurance visits* • Independent Patient Complaints Review Panel (2nd). • Culture reviews being reported to PODAC - December 2024 and onwards (2nd) • National trainee survey (3rd)	4	4	16	**Gaps in control:** 1. Delivery of the five components of NHS Impact: • Building a shared purpose and vision • Investing in people and culture • Developing leadership behaviours • Building improvement capability and capacity • Embedding improvement into management systems and processes 2. Embedding the new approach to patient safety 3. Evidence of continuous quality improvement culture 4. Colleagues having confidence and feeling safe and supported to raise patient safety concerns (FTSU and raising risks and incidents), and that they will be acted upon and learning embedded. 5. Clinical Lead for Improvement gap 6. Unprecedented continued overcrowding in ED's and its impact on normal culture **Gaps in assurance:** 7. Lack of information reported on longest complaints outstanding by division. 8. Board reporting of regulatory training programmes	**Actions aligned to gaps:** 1a. Deliver the Getting to Good (G2G) Plans for each of the NHS Impact five continuous improvement components during 2024/25. Executive lead: Director of People & OD. 1b. Embedding the Just Culture Framework and linking to workforce policies and procedures, during 2024-2026. Executive lead: Chief Nursing Officer, Medical Director and Chief People Officer. 2. Develop a three year Quality and Safety Strategy by Q2 2025/26. Executive Lead: Chief Nursing Officer 3a. Deliver Improvement Conference in May 2024. 3b. Review Staff Survey Results in January/February 2024 with Divisional action plans put into place by April 2024. Executive Leads: All 3c. Produce Improvement Hub Annual Report by May 2024. Executive Lead: Chief People Officer. 3d. Learning from patient complaints and reduction in common themes - ongoing. 3e. To implement and evaluate an observation methodology into the quality continuous improvement cycle – by March 2025. Executive lead: Chief Nursing Officer. 3f. Use the intelligence gained through triangulation of learning from incidents/complaints/learning from deaths and legal cases to develop a continuous cycle of themed improvement projects - by March 2025 and throughout 25/26. Executive lead: Chief Nursing Officer. 4. Review, refresh and implementation of new ambassador network by end of Q4. Executive Lead: Director of Governance. 5. Appoint Clinical Lead for Improvement during 24/25. Executive lead: Medical Director 6a. Deliver the actions identified in the culture work stream within UECTAC transformation programme during 24/25. 6b. UEC Board to deliver agreed 24/25 milestones. 7. Introduce reporting as part of patient experience and complaints report on the longest outstanding complaints by division, by end of Q2. Executive Lead: Chief Nursing Officer. 8. Review of terms of reference and business cycle of PODAC in relation to receiving regulatory training reports/surveys and meeting standards. By Q1 25/26. Executive Lead: Director of Governance.	1a. Reporting through Getting To Good Group on a monthly basis. Review of the five impact plans for 25/26 to take place during Q1. 1b. Improvement work is ongoing (Q3) as part of review of employment relations processes. A number of improvements have been made and a significant number of policies have been updated. 2. Strategy in draft form and requires further consultation. Q4: Plan to ensure consultation with stakeholders on the strategy in Q1, with revised draft end of Q1. 3a. Conference delivered May 2024. Action closed Q1. 3b. Staff Survey went live Oct-Nov 2023 with results published 7 March 2024. 45% response rate received to Staff Survey. Divisional plans due to be reported to PODAC in April. Divisional briefings being delivered March/April 2024. Action closed Q1. 3c. Improvement Hub Annual Report completed. Action closed Q1. 3d. Ongoing review of complaints and actions. Q2 update: IPR reports included as part of Strategic People Group in Q3 to support a more integrated approach and triangulation of quality, safety, finance and workforce data to inform people interventions. 3e. A standard method for observation is part of our improvement methodology with templates available on the SaTH Improvement intranet page. Observations take place. Action closed Q3. 3f. The Safety Intelligence Triangulation Group (as part of PSIRF) has a key role to play in identifying themes and trends and was established in September 2024. Undertaken 1st cycle of a trial proforma to cross reference learning and themes and known improvement work and links to risk register (2nd cycle of proforma undertaken January 2025 and group continues to meet). 4. FTSU month was held during October 2024 with a focus on recruitment of new ambassadors. Q4: Rolling programme - 42 ambassadors at various stages of recruitment/training. 5. Q1 & Q2: Awaiting confirmation of budget. Q3/Q4: Work is ongoing to identify a Clinical Lead for Improvement. 6a. Progressing workstream 2 - Staff Culture, Resilience & Wellbeing - this is monitored via the UECTAC using the reverse RAG (red, amber, green) methodology as per MTAC (Maternity Transformation Assurance Committee). Q3: Agreement with PODAC for any further cultural reviews commissioned across the Trust for PODAC to have oversight of reports and assurance of implementation of improvements. Medicine staff survey results 2024 showed improvement across all People Promise Domains. Progress continues to be monitored through UECTAC. 6b. *See action 6 progress in BAF risk 10.* Plus an action plan is in place following the Dispatches programme and is monitored by Executives and part of NHSE delivery meeting. The action plan is also received at UECTAC and onwards to QSAC. 7. Quarter 2 complaints reported January/February QOC/QSAC meeting. Reporting in place. Action closed, Q4.			6

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee						
BAF 3: If the trust does not ensure staff are appropriately skilled, supported and valued this will impact on our ability to recruit/retain staff and on the quality of care.			**Chief People Officer**	Make SaTH a great place to work. Deliver a better patient journey and experience. Make our organisation more sustainable.	**SaTH is OPEN to explore innovative solutions to future staffing requirements, our ability to retain staff and to ensure we are an employer of choice. We are prepared to invest in our people to create an innovative mix of skills. Responsibility for noncritical decisions may be devolved.**			**People & OD Assurance Committee**						
Risk opened: risk within 2021/22			Rhia Boyode (RB)											

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Failure to recruit and retain the right number of people at the right level, with the right skill mix. • Retirement remains as a leading reason for staff turnover • Staff fatigue burnout. Stress, anxiety, and depression remains a top reason for long term sickness • Lack of certainty around future ways of working and work environments • Shortage of key professionals and occupations in specific roles • Lack of succession planning to mitigate risks when key staff leave and encourage staff retention • Dissatisfaction with pay and reward • Work environment concerns in relation to belonging and staff experience relating to behaviours • Recruitment control processes in place to review current resources and skill mix • Failure to deliver training from December 2024 to March 2025 **Consequence:** • Staff dissatisfaction with the level of engagement, involvements and communication with team leaders and senior leadership leading to low morale • Poor levels of engagement and morale which are correlated with lower patient satisfaction and outcomes • High use of agency staff in medical and dental groups. • High levels of sickness and turnover. • Poor patient experience, outcomes and quality and safety. • Adverse publicity and/or reputational damage. • May lead to the financial unsustainability of some services. • Needing to reform our services	5	4	20	• People governance arrangements in place including Strategic People Group (monthly) • Dashboards reporting against People Strategy, action plans and KPI's • Inclusion Improvement Plan and Recruitment and Retention plan supporting it. • Regular meetings between the bank and rostering leads and operational leads to review performance and improvements. • Annual Staff Survey, pulse survey, workforce transformation ICB/ICS programmes such as HCSW and Talent programme, improve well and making a difference linked to the culture dashboard. • Enabling programmes in place with escalation/assurance to SPG/SLT/FPAC and QSAC committee through to People board where indicated. • Extensive Health & Wellbeing (HWB) programme including staff finance, support, physio, clinical psychology and therapy • Culture, respect and inclusion programmes • Leadership development framework • Working group in place engaging with workforce to create a plan new way of working alongside estate and digital plans to support. • Regular meetings with Consultant new starters with a member of the executive team, this is with the People and OD Director and for Nursing and Allied Health Professionals is with Director of Nursing • Developed a monthly recruitment dashboard to provide key metrics on both medical and non-medical recruitment activity. • Continued use of new roles such as Nursing Associate Top Up programme allowing development of Nursing Associates to become registered nurses. • Safer Recruitment and Selection workshops have been implemented to support appointing managers during the hiring process. • Developed operational integrated ICS Workforce Plan • Long-term NHS Workforce Plan • Vacancy and spending control panel • Review of mandatory and non-mandatory training in order to pause and move where possible and appropriate to a 9/12 month delivery model.	**Reported to Board, committees and elsewhere:** • Reports to People & OD Assurance Committee (PODAC) and Strategic People and Educational Group (SPG) (2nd) • Daily and weekly reports on workforce metrics, temporary staff usage, and agency spend considered (1st). • Annual Staff survey considered by Board along with updates (2nd) • People Strategy approved by Board 2024 (2nd) • Equality, Diversity & Inclusion Strategy approved by Board 2020 (2nd) • Quarterly/monthly People Pulse Surveys received (2nd) • Associated risk register entries reviewed and updated regularly at SPG (2nd) • Financial Governance Group - weekly (2nd) • Executive dashboard on agency expenditure - weekly (1st) • MIAA (internal audit): Staff Wellbeing & Engagement review to ARAC - Substantial assurance . • MIAA Rota Review Assignment Report to ARAC - limited assurance (3rd) • Medical Workforce Efficiency Taskforce Group (2nd) • People & OD Risk Register reported to PODAC and Strategic People Group (2nd) • Workforce Digital Group (2nd) • MIAA (internal audit) Bank and Agency Review Report (3rd) - Moderate assurance.	4	4	16	**Gaps in control:** 1. Systematic process throughout the Trust to support succession planning. 2. Embedded processes for medium- and long-term workforce planning mechanisms with links to transformation/Hospital Transformation Programme. 3. Recognition schemes. 4. Managing Working Time Directive breaches and management of rosters for medical staff. 5. Ongoing retention initiatives. 6. A plan to support staff to work in new ways, post pandemic, in accordance with the NHS People Plan. 7. Measurable objectives on equality, diversity and inclusion for Chair, CEO and Board members. 8. Availability of training/education during peak winter months. **Gaps in assurance:** 9. Employee relations practice in relation to harassment and discrimination.	**Actions aligned to gaps:** Executive Lead for actions: Chief People Officer. 1. To work with system colleagues to develop a system approach to talent management - during 24/25 and 25/26. 2. Harmonise key workforce datasets with system partners to support cohesive system level reporting and workforce planning during 24/25 and 25/26 3. Developing monthly recognition scheme delivered alongside our annual recognition programme during 24/25. 4. Visibility of all rosters and review consultant rosters during 24/25 and 25/26. 5. Ensure that each leader is confident to hold wellbeing and stay conversations to support, engage and retain colleagues during 24/25. 6. To review the NHS People Plan health and wellbeing strategy, to support, review and ensure inclusion within divisional people plans by March 2025. 7a. Board and executive team must have EDI objectives that are SMART and be assessed against these as part of the annual appraisal process, by March 2025. 7b. Board members should demonstrate how organisational data and lived experience have been used to improve culture, by March 2025. 7c. The Board must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework, by March 2025. 8. Complete quality and equality impact assessments for each education intervention being paused or moved to the 9/12 month model; to work with Director of Nursing and Medical Director to sign off and update regulators as appropriate - by 31 December 2024. 9. Ensuring policies and procedures in relation to employment are continually reviewed during 24/25.	1. As a system, initial conversations to support the High Potential leadership scheme and roll-out Galvanise leadership programme. Q4: Funding awarded from NHSE for High Potential Leadership Scheme (national roll-out) - hosted by MPFT - and STW have confirmed co-hort 3 will proceed. Given the ICB reduction in costs by 50% there is ongoing discussions with providers around priorities for 25/26 and beyond given our own internal cost efficiency programme. 2. As a system we have developed a systemwide dashboard on workforce planning which is in use across the system. Action complete, Q2. 3. Proposal to be taken to Executives in Q4 for monthly recognition approach. Slight delay in proposal due to financial position. Plans underway to launch a bi-monthly recognition programme during Q2, 25/26. 4. Until one roster system is implemented, the full benefits of having doctor working hour visibility will not be realised. Q4: Workforce Digital Group established as part of the Medical Workforce Efficiency Programme. Action plan developed. 5. Q2: Stay conversation framework to be rolled out in Q3 and Q4. People Advisory Team having a key focus on unavailability and additional training for managers. Q3: Stay conversation framework slightly off-track; mitigations in place. Unavailability and additional training - work ongoing. Q4: Training is now available on the LMS and training portal to support managers to have quality conversations; date to launch the framework is to be agreed. 6. Q2: Divisions have reviewed their People Plans for 24/25 and key programmes of work aligned to the People Promise Programme include supporting staff with long-term conditions and staff health clinics. Q3: EDS 22 (workforce domains) has been completed and will be reported to PODAC in February 2025. Staff health clinics continue to be delivered and will review model in Q4. Guidance on supporting staff with long term conditions has been developed. Q4: Divisions are finalising People Plans for 25/26 currently. 7a Objectives in place for current year. 7b Ongoing work. EDI Board development session held on 27 June 2024. WRES and WDES approved for publication in October 2024. Ongoing recognition such as Inclusion Week 23, September 2024. Q3: System-wide board development on EDI being commissioned for 25/26. 7c. Gender Pay Gap report approved by Board in February 2024. Annual EDI report received at March 2024 Board. Q3: Gender Pay Gap report presented to Strategic People Group and February PODAC. EDI Annual Report will be presented to ~~March~~ September 2025 Board (to align with AGM and annual report). 8. Trust-wide QEIA complete. Individual QEIA's being undertaken during December 2024. A new training schedule for 25/26 has been developed which will align to divisional needs throughout the year. Action closed, Q4. 9. Q3: Review of proposed legislation and potential changes to processes and policies complete. Q3: Policies being reviewed and updated as appropriate. Risk Assessment completed for new legislation and presented to PODAC in Q3 (Workers Protection Act 2024). Q4: A number of improvements have been made and a number of policies have been updated and work continues. Action closed, Q4.	3	2	12

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee					
BAF 4: A shortage of workforce capacity and capability leads to deterioration of staff experience, morale, and well-being.			**Chief People Officer**	Make SaTH a great place to work. Deliver a better patient journey and experience. Make our organisation more sustainable.	**SaTH is OPEN to explore innovative solutions to future staffing requirements, our ability to retain staff and to ensure we are an employer of choice. We are prepared to invest in our people to create an innovative mix of skills. Responsibility for noncritical decisions may be devolved.**			**People & OD Assurance Committee**					
Risk opened: risk within 2021/22			Rhia Boyode										

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Engagement in quality improvement initiatives due to competing demands on the team. • Redeployment of staff to support operational activity, reducing the opportunity of staff to be involved in improvement activity or take part in training. • Failure to address inequalities across all protected characteristic groups of staff in terms of promotion, career progression and over representation of staff from minority ethnic groups in formal HR processes. • Leadership styles that do not reflect the Trust values and behaviours framework • Colleagues not accessing appropriate learning and development, including statutory and mandatory training • Recruitment control processes in place to review current resources and skill mix **Consequence:** • The trust's reputation will be compromised impacting on recruitment and retention • Failure to embed and model the values and behaviours of the trust consistently and create confidence in speaking up culture and processes. • Leadership roles not reflecting diverse nature of community and any specific needs and cultural issues which may impact on staff, patient experience and outcomes • Turnover and sickness absence will remain above target • Potential incidents if staff are not up to date with mandatory training • Staff will not raise concerns reducing the opportunity to improve quality and staff and patient experience, and with attendant risks around staff motivation, morale and productivity. • Increasing agency costs if we are unable to recruit fully • Reforming our services	5	4	20	• Educator role for newly qualified nurses (visible role picking up pastoral and education needs) • Equip people to deliver quality improvement locally, to identify and embed organisational learning to provide a positive impact on quality of care • Board and workforce equality committee dashboards reporting against strategy, action plans/KPI's and inclusion plan • Workforce metrics, staff survey, pulse surveys, EDI (equality, diversity and inclusion) groups, staff networks, triangulation of data, coaching methodology, SaTH improvement methodology • Participation in WRES (workforce race equality standard), WDES (workforce disability equality standard), EDS (equality delivery system) frameworks and gender pay gap reporting • Minority ethnic staff leadership programmes • ICS BAME Programme • Values based recruitment approach • Agreed targeted recruitment campaigns and retention actions including exit interviews • Targeted interventions on statutory and mandatory training compliance, using Pareto analysis • Learning Made Simple reporting on statutory and mandatory training compliance • Target interventions on culture dashboard metrics, using Pareto analysis • External Executive Directorship Training • Civility Saves Lives programme roll out • SaTH education offer via education prospectus • SaTH 1 to 4 and STEP Leadership Programmes • Affina team journey interventions • Vacancy and spending control panel • Process to review training in place - SEMTRAG (SaTH Education Mandatory Training Group) established in February 2024	**Reported to Board, committees and elsewhere:** • Workforce metrics within Integrated Performance Report to Board (monthly) (2nd) • People & OD Assurance Committee (2nd) • Strategic People Group (SPG), monthly (2nd) • Education Group (1st) • System education/training meeting (1st) • Culture Group reporting and culture dashboard to Operational People Group (1st) • Retention Group reports into Operational People Gr+F8oup (1st) • Getting to Good progress reviewed/reported monthly (2nd) • Annual Staff Survey considered by Board (2nd) • Workforce data on leadership profile (1st) • Recruitment dashboard (1st) • Senior Leaders Committee - operational, monthly (2nd) • People Pulse Surveys reported to OPG quarterly (2nd) • EDI reporting into EDI Performance Group, which feeds into OPG (1st) • MIAA (internal audit) Staff Wellbeing & Engagement review to ARAC - substantial assurance (3rd) • MIAA Rota Review Assignment Report to ARAC - limited assurance (3rd) • People & OD Risk Register reported to PODAC and Strategic People Group (2nd) • MIAA (internal audit) Bank and Agency Review Report (3rd) - Moderate assurance.	4	4	16	**Gaps in control:** 1. Process for picking up and addressing wherever possible dissatisfaction in new starters before they decide to leave is in place 2. Developing workforce supply routes 3. New ways of working 4. Systematic process throughout the Trust to support succession planning. 5. EDI champions and local EDI objectives to create a diverse workforce, leadership and inclusive culture 6. High levels of mental health related sickness absence 7. Availability of training/education during peak winter months. **Gaps in assurance:** -	**Actions aligned to gaps:** Executive Lead for actions: Chief People Officer. 1. Continue to embed stay conversations and embed exit interview process during 24/25. 2. Further strengthen our widening participation approach during 24/25. 3a. Utilise technology advances to facilitate system interoperability and advances in robotic process automation from 24/25 through to 2030. 3b. Deploy Manager Self Service within the Electronic Staff Record by 25/26. 4. To work with system colleagues to develop a system approach to talent management - during 24/25 and 25/26. 5. Refresh and deliver EDI action plan and review against key workforce data to include review of newly published NHS EDI Improvement Plan, by March 2025, with report to Board at least annually in October. 6. Develop and embed our trauma informed leadership capabilities through our staff psychology offer during 24/25 and 25/26. *7. See BAF risk 3.*	1. Q2: Stay conversation framework to be rolled out in Q3 and Q4. People Advisory Team having a key focus on unavailability and additional training for managers. Q3: Stay conversation framework slightly off-track; mitigations in place. Unavailability and additional training. Q4: Training is now available on the LMS and training portal to support managers to have quality conversations; date to launch the framework is to be agreed. 2. Q2: In September we started Cohort 2 across both main sites for our Project Search Interns. Volunteer To Career Programmes continue with maternity and radiotherapy. Q3: Programmes continue including veterans scheme. Q4: extensive widening participation scheme which continues. Action closed Q4. 3a. Implemented ESR Go for medic on duty which provides a mechanism for automating staff contractual changes and taking information processed on ESR and updating Health Roster. ESR Business Intelligence alerting functionality being developed. Currently exploring robotic process automation opportunities and investment levels required. 3b. A trial of team based rostering has been launched on ward 23. Roll out programme of Manager Self Serve is in place. 4. As a system, initial conversations to support the High Potential leadership scheme and roll-out Galvanise leadership programme. Q4: Funding awarded from NHSE for High Potential Leadership Scheme (national roll-out) - hosted by MPFT - and STW have confirmed co-hort 3 will proceed. Given the ICB reduction in costs by 50% there is ongoing discussions with providers around priorities for 25/26 and beyond given our own internal cost efficiency programme. 5. EDI Champions training completed and ongoing support network in place. WRES and WDES approved for publication in October 2024 following receipt at Board. EDI improvement plan progress to be reported to Board in Q4. Q3: System-wide board development on EDI being commissioned for 25/26. Q4: EDI Annual Report will be presented to September 2025 Board (to align with AGM and annual report). 6. The team continues to support across the Trust and most recently following Dispatches in ED, however there is a risk to capacity due to ongoing vacancies within the team. Q3: further conversations with SLT planned for Q4 around culture development. Q4: Staff Survey Results received and divisions are working through their improvement action plans. Review of trust-wide approach, including culture, ongoing. Planned PODAC discussion on trauma-informed culture in Q1 to then inform further action and SLT discussion.			12

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee					
BAF 5: The Trust does not operate within its available resources, leading to financial instability and continued regulatory action.			**Director of Finance**	Make our organisation more sustainable	**SaTH is OPEN to pursue options which will benefit the efficiency and effectiveness of services whilst ensuring we minimise the possibility of financial loss and potential regulatory action to tolerable levels.* (*Note: In all circumstances, the Trust has no appetite for fraud and/or other financial crime risk)**			**Finance Assurance Committee (from Sept 2024)**					
Risk opened: risk within 2021/22			Helen Troalen										

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: •Overspend against operational budgets driven by operational pressures •Under-delivery of CIP • Capital constraints •Historic under-investment driving increased capital requirement •A failure to maintain financial sustainability due to non-planned cost pressures • Lack of available appropriate substantive workforce • Continuing to operate in a system with a commissioner deficit • Modular ward programme **Consequence:** •Short-term recovery inhibits service quality improvement. •Dwindling cash reserves. •External action being taken against the Trust (in segment 4 of National Oversight Framework) • Continue imposition of regulatory controls leading to the loss of local control. •Damage to the Trust's reputation and the Trust's continuing abilities to function • Inhibits ICS' ability to commission growth in services • Risk of increased cost	4	5	20	• Annual financial plan - revenue and capital plan. • Planning on a system wide basis with openness and transparency across the system. • Internal performance management system - budget holder to Board. • Monthly financial reporting system - nominal roll, budget statements, divisional committee, Operational Performance Oversight Group (OPOG), Performance Review Meetings (PRM). • Efficiency and Sustainability Group • Chief Executive-led Financial Recovery Group meets first and third Wednesday of the month • Annual revenue plan for 2024/25 that was developed with specialty input and within which activity, workforce and finance triangulate • Reviewing junior doctors rotas to ensure compliance • Internal (executive led) and system-wide vacancy control process. • Non-pay triple lock process to review mostly all non-pay expenditure over £10k • Strengthening governance via splitting the finance and performance elements within the assurance committees (but recognising the interdependencies between the two). • High levels of authority required to approve discretionary expenditure (non-pay) on Oracle - in practice since January 2025	**Reported to Board, committees and elsewhere:** • Monthly Trust-wide finance reports to Board of Directors, Finance Assurance Committee and Financial Recovery Group (2nd) • Sustainability and Efficiency (CIP) report to Innovation & Investment Committee and Senior Leadership Committee-Operational (2nd). • Annual financial plan, planning progress shared with Board for sign off (2nd) • Divisional Performance Review Meetings (PRM), Cascade, Executive messages into the organisation (2nd). •Monthly performance reviews with divisions (1st) • Routine monthly reporting including variance to plan and run rate analysis (1st) • Internal audit reports (MIAA): core financial controls and sustainability and efficiency processes (3rd) - Substantial assurance • Report to region (NHS Midlands) each month and position shared with local Integrated Care Board (2nd). • External audit of annual accounts (3rd) • Workforce plan reported to Operational People Group (1st) • Five Year Financial Plan presented to FPAC January 2023 (2nd) •Weekly Executive Meeting dashboard: beds, WTE and finances (2nd) • CIP follow-up review by MIAA - October 2023 (3rd) • Interim Budget setting paper for 24/25 to FPAC and Board 26/03/24 (2nd), with final budget approved by Board in August 2024 • Operational People Group now aligned into Operational Performance Oversight Group to enable better oversight • VFM opinion from external audit with no significant weaknesses identified (3rd).	4	5	20	**Gaps in control:** 1. Divisions recognise their financial responsibilities and engage well however, financial management, effective sustainability and efficiency planning compete with other high profile priorities across the Trust. 2. Identification and delivery of a £44.7 million cost improvement programme and adherence to cost control policies and processes 3. Inefficient reporting routines hampered by an outdated finance system and a misalignment between the finance system and the HR system. 4. Risk management process that takes into account quality and safety risk alongside financial risk on a daily basis leading to budget holders prioritising the quality and safety risk and incurring unbudgeted cost in relation to both medical and nursing staff. 5. Understanding how SaTH 5 year plan feeds into health system financial plan. **Gaps in assurance:** -	Actions aligned to gaps: 1a. Continue to engage divisions in a multi-year rolling programme of identifying cost improvements for 25/26 via a dedicated multi-disciplinary Financial Recovery Programme Office by December 2024. Executive lead: Director of Finance. 1b. Staff reduction targets with a monthly recruitment ceiling issued to divisions to achieve agreed exiting whole time plan by March 2025. Executive Leads: Chief Operating Officer/Director of People & OD/individual executives. 1c Monthly Operational Performance Oversight Group to be chaired by Director of finance with COO as Vice Chair to review financial and workforce performance with a regime of escalation for divisions not delivering to plan - ongoing. Lead Executive: Director of Finance. 2a. £37.7 million was identified by the time of the final operating plan submission on 12 June 2024, with only the £7 million stretch remaining unidentified. The priority is to de-risk and deliver the initial £37.7m, with attention turning to the remaining £7m after that - time scale TBC. Executive lead: Director of Finance. 2b. Set up an internal multi-disciplinary financial recovery task force with membership mirroring divisional leadership teams - by mid-July. Executive lead: Director of Finance 2c. Identify and recruit a financial improvement director by mid-July 2024. Executive lead: CEO 3a. Alignment of budgets between finance and HR systems to take place on a manual basis, with an initial focus on nursing ward areas and non-consultant medical staffing - September 2024. Executive lead: Director of Finance and Director of People and OD. 3b. Scoping exercise to link Electronic Staff Record (ESR) with finance budgets - ~~March~~ June 2025. Executive lead: Director of Finance and Director of People and OD. 4a. Introduce OPOG escalation measures internally to support divisions to ensure timely quality and safety decisions whilst considering budgetary impact . Executive lead: Director of Finance/Chief Operating Officer. 4b. System-wide management of escalation capacity to ensure the most cost effective service provision - timescale TBC. Executive lead: Director of Finance. 5. Sath have completed a medium term financial plan as part of the HTP business case, system-wide medium term financial plan required which is linked to a system-wide demand and capacity model - by Q4. Executive lead: Director of Finance	1a. Financial Recovery Programme Office in place since September 2024. Chief Executive chaired Financial Recovery Group - since August 2024. Fully identified CIP programme for 25/26. Action closed Q4. 1b. Revised whole time forecast for March 2025 was delivered. Action closed Q4. 1c. Operational Performance Oversight Group in place. Two divisions identified that are receiving additional support to develop a financial recovery plan, with the MEC division attending Finance Assurance Committee in March 2025. 2a. **Action complete (Q2)** 2b. **Action complete (Q2)** 2c. Action unsupported by NHSE. Action currently paused at Q2 3a. **Action complete (Q2)** 3b. Work ongoing into Q1 25/26. 4a. **Action complete (Q2)** 4b. ICB recognise the importance of system wide actions and deployed PWC Phase 2 work to support and this was complete by the end of March 2025. Agreed level of escalation funding included within 25/26 operational plan. Action closed Q4. 5. Work commissioned to develop a system-wide demand and capacity model has been completed, model continues to be updated by the ICB. Currently the ICB have not confirmed a date when this will be available. System wide medium-term financial plan using high level assumptions shared with respective organisational finance committees during September 2024. Further updated being shared with Finance Assurance Committee in April 2025 which includes the 2025/26 planning update.			12

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee					
BAF 6: Some parts of the Trust's buildings, infrastructure and environment may not be fit for purpose			**Assistant CEO**	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	**Recognising the current position with the Trust's estate, SaTH is OPEN to transforming its buildings/infrastructure to support better outcomes and experience for our patients and public. We will consider benefits and solutions which meet organisational requirements and ensure a safe environment.**			**Performance Assurance Committee (PAC) (from Sept 2024)**					
Risk opened: risk within 2021/22			Inese Robotham										

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Older buildings built with now outdated regulatory requirements • Restricted physical environment, unable to meet current capacity requirements • Backlog maintenance issues due to limited capital • Residual gaps in fire safety action plan • The Trust has identified reinforced autoclaved aerated concrete (RAAC) within specific areas within PRH and surveys continue across the Estate. **Consequence:** • Poorer patient outcomes and patient safety issues • Regulatory or legal action possible • Adverse publicity and reputational damage possible • Potential poor working conditions and environment affecting staff health, experience and engagement - increased sickness absence and recruitment.	4	5	20	• Board-approved (limited) Capital Programme including backlog maintenance plan and medical equipment budget in place addressing high risk backlog on a yearly basis, where funding allows. • Capacity & demand led capital programmes, aligned to Hospital Transformation Programme. • Capital Estates Plan 2021-2026 in place. • Updated Estates risk assessments and planned preventative maintenance of engineering infrastructure. • Staff survey measures staff levels of engagement and morale (in relation to working environment). • Minor and major works protocols and management plans in place for known risks, e.g. asbestos and RAAC. • RAAC business case developed, approved and national funding confirmed. • Fire action plans in place and being monitored. • Annual fire safety audits. • Standardised framework for large capital projects developed and implemented.	**Reported to Board, committees and elsewhere:** • Performance Assurance Committee (2nd) • Capital plan developed and overseen by Capital Planning Group (CPG), chaired by Director of Finance (2nd) • Annual estates report to Board (2nd) • Annual update backlog six facet survey that informs the capital plan (1st) • Regular updates of fire action plans at Fire Safety Group (1st) • Fire Safety Improvement Action Plan Oversight Group (2nd) • Fire safety updates reported to private Board regularly (2nd) • Operational estates governance and oversight in place including: Decontamination Group (2nd), Medical Gas Committee (2nd), F8 Ventilation Safety Committee (2nd), Water Safety Committee (2nd), Fire Safety Group (2nd), Asbestos Safety Committee (2nd). • Authorising Engineer's Annual Fire Safety Audit 2024 (3rd) - draft presented to Director of Finance and Director of Estates Nov 2024. And presented to March 2025 Board of Directors. • Independent structural engineers' review of RAAC (3rd) - Q3 2023/24. Along with completion of mitigations in these non-clinical areas. • Performance Review Meetings (PRM's) bi-monthly.	4	4	16	**Gaps in control:** 1. Energy infrastructure at its limit on the site 2. Lack of up-to-date Estates Strategy. 3. Awaiting confirmation of RAAC funding to enable long-term remedial works. 4. Aged nurse call systems require updating. **Gaps in assurance:** -	**Actions aligned to gaps:** 1a. Utilise Salix funding for replacement infrastructure and choose supplier by July 2024, and look for additional external funding opportunities - ongoing. Executive lead: Assistant CEO. 1b. Internal full business case to be developed and presented to the Board by September 2024. Executive lead: Assistant CEO 2. Develop and approve Estates Strategy by May 2025 ~~October 2024~~. Executive lead: Assistant CEO. 3. Proposal submitted to NHSE. Director of Estates regularly attends NHSE RAAC Board for update. Executive lead: Assistant CEO. 4a. Review temporary systems to cover risk by November 2024. Executive lead: Assistant CEO. 4b. Review longer-term plan to install new fixed nurse call systems, where appropriate by end of Q1 2025/26. Executive lead: Assistant CEO.	1a. Tender evaluation has been completed. Contractor selected and contract signed. Works commenced March 2025. 1b. Business case presented to Board and approved - Nov 2024. Action closed. 2. Estates Strategy in final draft form. Expected at Board in May 2025 for approval. 3. NHSE has approved and confirmed funding of £12.2m over two financial years. Contractors selected and approved. Project Board set up and enabling works have commenced. Project completion date is expected March 2026. 4a. Q3: Reviewed temporary systems resulting in procurement of more mobile units to ensure this is mitigated in the short term. Action closed. 4b. Q3: Considering the long term strategy for decanting patients to enable fixed nurse call systems to be installed. Q4: Decant space will not be available until the modular wards are built - December 2025 at the earliest.			12

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee					
BAF 7a: Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation.			**Director of Strategy & Partnerships**	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	**Whilst digital innovation will transform systems to support better outcomes, SaTH has a MINIMAL risk appetite in relation to cyber security and information governance compliance due to the impact on our patients and colleagues. Risk of loss or damage to information will be minimised through stringent security measures and business continuity planning.**			**Audit and Risk Assurance Committee**					
Risk 7a was partly included within BAF risk 7 in 2021/22 and was subsequently split out into risk 7a and 7b from 2022-23.			Nigel Lee										

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Lack of resource • Lack of capacity and capability • Continually changing threat landscape - technology and political unrest • Increasing prevalence of threats globally • Funding constraints to invest in digital tools to improve cyber security **Consequence:** • May lead to sub-optimal care, for example could lead to interruptions to vital IT applications which in turn could result in sub-optimal patient care. • May lead to inability to provide essential services for patients, work together with partners, and / or cease service provision • Potential financial penalties - e.g. ICO fines • Potential regulatory action - Network & Information System Regulations (note: this area is subject to further expansion) • Reputational damage and negative impact on public confidence • Temporary or permanent loss of data • Reinforces the need for dedicated resource and continued review of the capacity and capability required.	5	5	25	• Cyber Security Manager in place • Senior Information Risk Owner (SIRO) in place • Trust actively contributing to cyber security management at Integrated Care System (ICS) level • Business continuity plans in place • Cyber security tools in place to support access management, security compliance, single sign-on • Security compliance in place to monitor security patch compliance and compliance with Data Security & Protection Toolkit (DSPT) - DSPT is due to evolve further with a greater focus on cyber which will increase a lot of the controls in place • Information Governance (IG) strategy, policy and framework • Password and digital policies in place, with continual review • Network accounts checked and disabled after 90 days of inactivity if not used • CareCert updates reviewed for high severity alerts • Incident review processes and learning • Utilising NHS Digital provided services, including vulnerability management system, penetration testing, advanced threat protection and Bitsight (cyber security rating service) • Registered with National Cyber Security Centre for alerts and intelligence: Webcheck and Early Warning System • Regular cyber security communications for end users • Cyber element of Information Governance training in place as part of statutory and mandatory training for staff • Multi Factor Authentication (MFA) compliance for NHS mail • Deputy Cyber Security Manager in place from Q4.	**Reported to Board, committees and elsewhere:** • Information Governance Committee - (2nd) • MIAA internal audit of cyber security in 2021 (3rd) • MIAA internal audit of Data Security Protection Toolkit (annual - June 2023 - Substantial level of assurance provided in respect of the self-assessment. Moderate assurance level overall against the 10 National Data Guardian standards) (3rd) • Weekly Digital Services senior leadership team meetings where any issues escalated (1st) • Dedicated monthly risk review meeting (1st)+F8 • Active directory review report - NHS Digital/MTI (3rd) - report to Digital Services • Cyber update report to September 2024 Audit & Risk Assurance Committee meeting (2nd) • Internal audit (MIAA) of the Trust's DSPT self assessment - Substantial assurance (3rd) • Internal audit against the 10 National Data Guardian Standards - Moderate assurance (3rd) • MIAA Medical Devices review (second review) (3rd)	5	4	20	**Gaps in control:** 1. Some devices and systems will remain non-compliant with risk mitigation plans 2. Skilled resource and availability within ICS outside of core hours. 3. Cyber Security strategy to be developed. 4. Funding constraints. **Gaps in assurance:** 5. Medical device assurance report.	**Actions aligned to gaps:** 1. Risk mitigation plans in place - ongoing review. Long-term resolution plans required for non-compliant systems within Divisions - ongoing, funding dependent. Executive lead: Executive Lead: Director of Strategy & Partnerships 2. Continue our work as a health system partner during 23-24 and 24/25 as part of the work programme for the ICS Digital Delivery Group. 3. Develop Trust-level Cyber Security Strategy to support overarching Digital Strategy by Q2 25/26. Executive Lead: Director of Strategy & Partnerships 4a. Re-prioritisation of internal digital capital funding during 2024/25. 4b. Continue to explore external funding opportunities during 24/25. 5. Develop/support medical device security report by Q2 2024/25. Executive Lead: Director of Strategy & Partnerships, supported by Assistant CEO	1. Update report on cyber position provided to Audit & Risk Assurance Committee (ARAC) Q2 (September). Risk mitigations plans are in place and compliance continues to evolve and be kept up to date in line with national guidance. Some plans require prioritised and costed way forward - which may require some resolution in 2024/25, funding dependant (capital funding to be confirmed). Q4: Update scheduled for May 2025 ARAC. 2. In work programme for 2024/25 for the Digital Delivery Group. New Head of Digital (ICB) started end of September 2024. Q4: From December 2024, SaTH lead the ICS Cyber Operational Group. 3. The SaTH Cyber Security Strategy is currently under development, with a view for completion by July 2025. The intention is to ensure that the strategy is aligned with the National Cyber Strategy for Health and Social Care and the NHS England Data Security and Protection Toolkit. 4. Continue to monitor digital funding. Q4: Board of Directors cyber security training undertaken to support general understanding of cyber threats and specific focus on threats to health care organisations. Late 2024/25 capital funding secured February 2025. 5. Q1: Updated report completed in June 2024. Medical Device Security Working Group was established to follow up on relevant actions for high risk medical devices (task and finish group). (Q3:)Update provided to November 2024 ARAC providing an update on medical device audit actions and now making business as usual. Report as part of the 2024 audit programme is currently being finalised (December 2024). Q4: Report scheduled for April 2025 ARAC.			6

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee						
BAF 7b: The inability to implement modern digital systems impacts upon the delivery of patient care			**Director of Strategy & Partnerships**	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	**SaTH is OPEN to transform its digital systems to support better outcomes and experience for our patients and public. New technologies are viewed as a key enabler of operational delivery, productivity and efficiency (including clinical) following thorough assessment and testing.**			**Performance Assurance Committee (PAC) (from Sept 2024)**						
Risk 7b was partly included within BAF risk 7 in 2021/22 and was subsequently split out into risk 7a and 7b from 2022-23.			Nigel Lee											

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Lack of core digital project team resource - appropriate skillsets and experience and national shortage of digital technical personnel • Lack of clinical and operational capacity and capability within Trust • Large scale digital business change programme alongside other competing business change programmes such as financial improvement and UEC • Network replacement • Prescribing and Medicines Administration (EPMA - electronic prescribing and medicines administration) and Order Communications systems required to improve level of digital maturity. • Order Communication system is past the end of its useful life • Second phase of maternity system required - neonatal system upgrade - funding sought for increase in scope • Continuing national capital funding • Trust's Data Warehouse requires redevelopment and resourcing both in the short and medium term • Reduction in digital capital allocation (national, regional and local). **Consequence:** • Could lead to interruptions to vital IT applications which in turn could result in sub-optimal patient care. • Poor data quality • May lead to inability to provide essential services for patients, work together with partners, and / or cease service provision • Potential financial penalties - misreporting • Inability to provide national submission reports, which may affect income and activity • Potential regulatory action • Reputational damage and negative impact on public confidence • Potential negative impact on staff morale • Inability to operate in an integrated health and care system, e.g. shared care record (One Health and Care)	4	5	20	• Digital Transformation governance structure in place - Operational Readiness Groups which feeds into appropriate Programme Board. All digital projects report into Digital Oversight Group which reports into Senior Leadership Committee, reporting into Performance Assurance Committee/Trust Board • Business continuity plans in place and to be implemented for new systems • Managed service for hosting of patient administration system • Working closely with procurement to secure recruitment into vacant posts • Standardised network infrastructure platform • Exploring lessons learned from elsewhere • Functional Design and Process Design Groups in place - meetings involving trust staff • Chief Clinical Information Officer/Clinical Safety Officer in place along with Clinical Safety Committee (safety of software and reducing hazards for patient safety) • Chief Nursing Information Officer in place • Digital Nurses in place • Director of Digital Transformation/Lead in place - at SaTH • Head of Digital Innovation & Transformation in place within the ICB • Digital Design Authority Group meet frequently to review the design for systems and sign off to ensure fit for purpose • Business case developed for order communications and capital funding awarded for 2024/25 • Digital communications lead in place - until end March 2025 (temporary position)	**Reported to Board, committees and elsewhere:** • Weekly digital senior team meeting and bi-weekly digital design authority meeting for areas of escalation, along with monthly summary (1st) • Monthly programme reports to Programme Board which feed into Digital Oversight Group (2nd) • Bi-monthly update into Senior Leadership Committee (2nd) • Digital updates to Performance Assurance Committee (2nd) • Periodic Digital updates to Trust Board (Board report and/or Board seminar format) (2nd) • Report quarterly to NHS Digital and NHS Digital Programme Manager and Regional Digital Lead for Transformation sits on the Digital Oversight Group and receives monthly update (3rd) • Report to STW ICS Digital Delivery Committee with system updates to the ICB Strategy Committee (2nd) • Getting To Good (G2G) digital transformation workstream milestones reported to Board (2nd) • Daily Standup meetings, where appropriate (1st) • External assurance review by NHSE Digital System Support took place in January/February 2024 (3rd) - amber status (*successful delivery appears feasible but significant issues already exist requiring management attention. These appear resolvable at this stage and if addressed promptly, should not present a cost/schedule overrun*). • Continue to hold NHSE Digital Systems Support Meetings for post-EPR go-live assurance (3rd). • External assurance review by NHSE National Strategic Advisor for Digital - 3 October 2024 (3rd)	4	5	20	**Gaps in control:** 1. Requirement for key roles and increase in substantive capacity in the digital programme - still working with agencies and Procurement for the remainder of the programmes to fill posts. 2. Capacity within wider trust teams for digital system implementations. 3. EPMA, Badgernet neonatal and several other digital initiatives do not have a source of funding in 24/25 and no national capital funding identified for 25/26. 4. Ageing digital infrastructure and architecture. **Gaps in assurance:** -	**Actions aligned to gaps:** 1a. Work with agencies and procurement to appoint into vacant digital positions as they arise during 2024-25. Executive lead: Director of Strategy & Partnerships. 1b. Development of business case for substantive digital staff capacity from 25/26 - by March 2025. Executive Lead: Director of Strategy & Partnerships. 2a.A review of all digital initiatives and projects has been undertaken and continues to be reviewed during 24/25, aligned to the prioritisation of the service development capital allocation. 2b. The framework for the requirement for SRO, operational lead and clinical lead for each digital project has been described for 2024/25 and work is to be undertaken to review this with Divisions in 24/25. Executive lead: Director of Strategy & Partnerships. 3. Ongoing discussions with NHSE National and Regional Digital Team to explore external funding opportunities during 24/25 and 25/26. Executive Lead: Director of Strategy and Partnerships. 4a. Complete the digital maturity assessment and submit to NHSE annually. Executive Lead: Director of Strategy and Partnerships. 4b. Full review of Data Warehouse technical architecture and processes in order to set out short-term and medium-term options. Short-term by September 2024; medium-term by March 2025. Executive Lead: Director of Strategy and Partnerships.	1a. Digital positions continue to be appointed to, but it remains challenging to appoint to the specific technical expertise required for key programmes, which reflects the current market position. 1b. Business case agreed at Innovation & Investment Committee December 2024 which included phased increase in staffing until 1 April 2026. Ongoing work for 25/26 to optimise opportunities for digitally-enabled productivity and efficiency schemes. 2a.Q1: Fortnightly review of the digital programme through the Digital Design Authority and monthly update to SLC. Trust digital programme is discussed in more detail at the monthly executive-led Digital Oversight Group which includes representatives from all four clinical divisions and key corporate services. Q4: Planning session with all of the Divisions held in February 2025 and continuing into 25/26. 2b. Q1, Q2, Q3 & Q4 : In progress. 3. Q1: Additional external funding is pending for Laboratory Information Management System (LIMS). Women's and Children's Division are finalising funding for Badgernet Neonatal system 2025/26 (Q2). Divisions are prioritising their capital requests for 25/26. 4a. Action complete for 2024/25. 4b. Short-term review completed and plan set out for the resolution of technical issues - plan A has been endorsed by the Board and NHSE, and is in progress at Q3. In parallel, the development of the target operating model for the future model of the Data Warehouse is in progress. Interim solution for Data Warehouse remains in progress and expected to report as planned in Apr/May 25. Longer term solution in development with Federated Data Platform national team.			12

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee						
BAF 8: The Trust cannot fully and consistently meet statutory and / or regulatory healthcare standards.			**Chief Nursing Officer**	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**SaTH has a MINIMAL appetite to compromise legal and regulatory standards. We are only prepared to accept the possibility of very limited deviation from compliance during exceptional circumstances.**			**Quality & Safety Assurance Committee**						
Risk opened: risk within 2021/22			Paula Gardner											

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Poor processes, systems and culture • Operational challenges and pressures **Consequence:** • May lead to sub-optimal quality of care • Additional regulatory action • Damage to reputation and negative impact on public confidence • May lead to cultural issues, poor morale, and difficulties in recruitment • Financial penalties • At the end of Q3 2024/25 the Trust has five Section 31 conditions in place	4	5	20	• Getting To Good (G2G) workstream: Quality & Regulatory Compliance • Quality priorities • Quality & Safety Assurance Committee and Quality Operational Committee established to monitor position • Quality governance framework • Complaints process • Risk Management Policy and processes • Freedom to Speak Up arrangements • Exemplar programme (ward accreditation) • Monthly quality metrics • CQC action plan owned by Divisions • Palliative and End of Life Steering Group • Speciality Patient Experience Groups and the Patient and Carer Experience Panel. • Patient Safety Specialist in post • Board Assurance visits • Core Service CQC Self-Assessments and CQC quarterly engagement events with core services • CQC inspection report published May 2024 (3rd) • Regional Insight visit for first Ockenden Report which focused on immediate and essential actions.	**Reported to Board, committees and elsewhere:** • Reports received monthly at Quality Operational Committee (QOC) (2nd) • Quality & Safety Assurance Committee (QSAC) reports received (bi-monthly) and monthly via AAAA report to Board (2nd) • Quality, safety and performance metrics within Integrated Performance Report to Board (monthly) (2nd) • Regular reporting to QSAC, Quality Operational Committee and other divisional, specialist groups and committees (1st) • Compliance monitoring with CQC actions - QSAC (2nd) • RALIG meeting (1st) • Incident Review Oversight Group (1st) • Rapid Review process reporting (1st) • Patient & Carer Experience Group (1st) • Mortality Group (1st) • Deteriorating Patient Group (1st) • Infection Prevention and Control (IPC) Assurance Committee (2nd) • Safeguarding Assurance Committee (2nd) • Operational meetings for IPC, safeguarding, workforce and maternity (1st) • Bi-weekly informal meetings with CQC - chaired by Director of Nursing (2nd) • Quarterly engagement meetings with CQC (3rd) • CQC action plan owned by Divisions and confirm and challenge in place (1st) • System Oversight Assurance Group - chaired by the Region and CQC, Healthwatch, NMC, GMC and HEE/NHSE attend (3rd) • External audit did not identify any significant weaknesses in the Trust's arrangements in relation to: governance; economy, efficiency and effectiveness; and financial sustainability, in their 23/24 Auditor's Annual Report (3rd). • NHSE IPC inspection review undertaken March 2023 and rated 'green' (3rd) • Getting To Good Operational Delivery Group (1st) which feeds into QSAC and Board • External Peer reviews in neonatal, trauma and critical care in Q3 (see BAF risk 1) • CQC inspection undertaken on 10th and 11th October 2023, with Well Led undertaken 14th and 15th November. Improvement seen in a number of core services (CYP, maternity, palliative and end of life care good in all five domains). Improvement seen in medicine and PRH ED. Overall rating is Requires Improvement, with a Good for care rating. • MIAA internal audit reviews 2022/23 (3rd): End of life pathways - CQC action plan (Substantial assurance); management of Ockenden 1 report (Substantial assurance); •MIAA internal audit reviews 2023/24 (3rd): Infection Control (Substantial assurance); Mortality Governance (Substantial assurance); Duty of Candour (Substantial assurance); Pressure Ulcers (Substantial assurance); Quality Spot Checks (Limited assurance -has associated action plan); • MIAA internal audit reviews 2024/25 (3rd): Freedom to Speak Up (Substantial Assurance). • Full action plan quarterly to ICB Quality Surveillance Committee (3rd). • UEC action plan monthly to the Contract Monitoring Meeting (3rd).	4	3	12	**Gaps in control:** 1. Lack of whole system support for healthcare services (e.g. children and young peoples mental health and Urgent and Emergency Care - UEC). 2. 79 Must and should do actions from CQC Report from May 2024 **Gaps in assurance:**	**Actions aligned to gaps:** 1. System leadership required. 2. Deliver CQC action plan during 24/25	1. The Trust is working with the ICS. A Midland Partnership Foundation Trust and SaTH meeting was held in June 2024 for new ways of working for children and young people with mental health. Children and Young People mental health summit occurred in September 2023 - continue to await next steps. Q3: The Trust application to have two of the Section 31 conditions to be removed in relation to children with isolated mental health issues not being admitted to the Trust was accepted by the CQC and removed in December 2024. 2. Agreed governance through transformation programme and our existing governance structures in the trust. Full action plan quarterly to ICB Quality Surveillance Committee and UEC action plan monthly to the contract monitoring meeting. Q3: The Trust applied for the total removal of three of our Section 31 enforcement notices (risk assessments/care planning, CYP and mental health associated conditions (2)) - Q4: three of these were accepted and successfully removed (out of five). Q3: In 2020/21 we had 155 must and should do actions and we now have 79. Maternity have none. Medicine has improved from 48 to 22. Paediatrics and End of Life Care now have no must do actions following the CQC inspection last year (moved from inadequate to good services).			6

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee					
BAF 9: The Trust is unable to meet the required national elective and cancer care standards.			**Chief Operating Officer**	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**SaTH is CAUTIOUS and prefers not to take risks to the achievement of internal and external performance standards where there is likely to be adverse consequences.**			**Performance Assurance Committee (PAC) (performance impacts) and QSAC (patient/ quality/ safety related)**					
Risk opened: risk within 2021/22			Ned Hobbs										

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Delayed treatment times and backlog due to the Covid-19 pandemic • Workforce gaps - including nursing, medical, Allied Health Professionals, diagnostics and theatres • Bed capacity and urgent care demand • Insufficient capacity to meet demand • New Electronic Patient Record operational issues **Consequence:** • May lead to sub-optimal care • May lead to harm due to the unmet need • Financial activity impact • Regulatory action • Damage to reputation and negative impact on public confidence • ~~Taking longer to use Careflow system in elective pathway.~~	4	5	20	Performance controls below (refer to BAF 3 and 4 for workforce controls): • Getting To Good (G2G) Theatre Productivity workstream • ICS Planned Care Programme / Plan • Specialty level capacity and demand plans • Weekly/monthly monitoring of capacity/demand, and SaTH Internal Recovery Group • Departmental and Divisional monitoring of RTT, imaging and endoscopy • NHSE Diagnostic Task Group • NHSE weekly assurance meetings for cancer and RTT • Monthly Performance Review Meetings • Enhanced operational management structure with focus on elective and urgent care • Weekly validation process in place by external validation company • Mutual aid request to regional mutual aid hub • Outpatient Transformation Programme • Additional agency staff in place to manage elective workload whilst we undertake a review • New Interim Deputy COO for Planned Care commenced December 2024 • Substantive Deputy COO for Planned Care commenced February 2025. • Cancer Improvement Lead commenced March 2025. • Divisional Medical Director for Surgical Division appointed, to commence May 2025.	**Reported to Board, committees and elsewhere:** • G2G progress reviewed - reported to Board (2nd) • Performance metrics within Integrated Performance Report to Board (monthly) (2nd) • Weekly Trust Cancer performance meetings (1st) • Weekly Trust RTT performance meetings (1st) • Cancer Assurance Committee (2nd) • Standing monthly IPR reports to Quality & Safety Assurance Committee and Finance & Performance Assurance Committee (FPAC) (2nd) • Performance Highlight Report to FPAC, including RTT, Cancer, theatre productivity, outpatient transformation and UEC assurance (2nd) • Monthly reporting to Performance Review Meetings (2nd) • Shropshire Telford & Wrekin (STW) Planned Care Operational Committee reporting monthly (3rd) • Elective Recovery Board - Midland NHSE (3rd) • Weekly assurance meeting - 65 weeks, 62 day cancer backlog and 28 day faster diagnosis performance with NHSE and STW (3rd) • Cancer trajectories - 62 day backlog, and 28 day faster diagnosis to FPAC (2nd) • RTT - 65 week recovery trajectory to FPAC and 52 week trajectory for children and young people (2nd) • DMO1 (diagnostics)recovery trajectory to FPAC (2nd) • Weekly UEC assurance meeting (1st) • MIAA (internal audit) Waiting List Management Report Q4 23/24 - High assurance (3rd) • Cancer review by Intensive Support Team - no immediate concerns (3rd) • Number of English patients waiting over 65 weeks has reduced to 83 at the end of February 2025 - to be reported to March 2025 PAC (2nd).	4	4	16	**Gaps in control:** 1. Lack of resilient workforce capacity in radiology to meet clinical demands. 2. Shortage of theatre staff on both sites to meet capacity 3. Inadequate bed stock to maintain elective activity on both sites 4. Outpatient transformation standards still not being fully achieved **Gaps in assurance:** 5. Limited assurance on cancer improvement delivery.	**Actions aligned to gaps:** 1. Continue with year two of our Radiology workforce plan which includes undertaking recruitment including international recruitment; recruiting to support roles; continuing to develop the radiology workforce, using apprenticeships. 2. Ongoing recruitment and retention of Theatre staff by March 2025. Executive lead: Chief Operating Officer 3. Elective orthopaedics recommenced November 2024 with interim air handling solution following the closure of ward 5 due to inadequate air flow on the ward. Executive lead: Chief Operating Officer. 4. Deputy Medical Director to support the outpatient transformation clinical lead and divisional clinical leads to continue to implement outpatient transformation approaches including patient initiated follow up-by March 2025. Lead Executive: Chief Operating Officer. 5. Appointment of the Cancer Improvement Lead by Q4.	1. Ongoing work in place as part of our workforce plan. And, in addition, temporary scanning and reporting capacity deployed in 24/25. Evidence of reduced waiting times to scan and waiting times to report over Q4 24/25. 2. Elective Hub opened on 10 June 2024 which should assist with theatre staff recruitment and retention. Good progress in theatres recruitment during Q3. Six out of seven elective theatres internally staffed from Q4 at PRH. Seven out of seven planned by Summer 2025. New elective theatre timetable commencing 31 March 2025. Action closed. 3. Recommenced November 2024, and elective ring fence held throughout winter 24/25. Permanent air handling works planned for 25/26. 4. A gap analysis has been undertaken against *Going Further Faster* guidance and actions are included within the outpatient transformation plan. External support commenced Q4 24/25 to optimise outpatient clinic booking utilisation. 5. Cancer Improvement Lead commenced in post 19 March 2025. Action closed.			9

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee					
BAF 10: The Trust is unable to meet the required national urgent and emergency standards.			**Chief Operating Officer**	Deliver a better patient journey and experience. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**SaTH is CAUTIOUS and prefers not to take risks to the achievement of internal and external performance standards where there is likely to be adverse consequences.**			**Performance Assurance Committee (PAC) (performance impacts) and QSAC (patient/ quality/ safety related)**					
Risk opened: risk within 2021/22			Ned Hobbs										

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • lack of acute bed capacity and workforce. • Increase in complexity of demand and length of stay • Community capacity for pathway 2 & 3 insufficient to meet current needs for timely discharge • Primary and community health and care capacity not meeting pre-hospital demand **Consequence:** • Delays in treatment pathways including increase in acute length of stay • Urgent work impacting on elective capacity • Leads to sub-optimal care and poor patient experience • Regulatory action • Negative impact on reputation and public confidence. • Impact on ambulance handover delays and subsequent impact on ambulance availability within the community • Overcrowding and long lengths of stay in Emergency Department.	4	5	20	• Getting To Good (G2G) Urgent & Emergency Care (UEC)programme. • Work on System, Urgent and Emergency Care Plan • ICS UEC Committee • Capacity and demand analysis • Hospital Transformation Programme - addresses one of the biggest strategic challenges for the local health system by separating the emergency and planned care flows, and consolidating fragmented teams and pathways (including critical care) • Local Care Programme (LCP) - The system will build on existing good practice and develop more systematic, preventative, integrated interventions that will support the independence and wellbeing of residents in our local communities. The aim of the LCP is to avoid continued growth in acute UEC demand and capacity. • Multi-disciplinary check chase challenge put in place for discharges. • Taking forward the recommendations following the GIRFT visit in January 2024. • Weekly Metrics meeting with system partners chaired by the Chief Operating Officer • UEC project initiation document in place including implementation plan and Gaant chart • Re-introduced multi-disciplinary long length of stay meetings. • Transformation Lead Nurse for UEC appointed - commenced February 2025. • Deputy COO for UEC appointed - commenced March 2025.	**Reported to Board, committees and elsewhere:** • Performance Assurance Committee (monthly) (2nd) • Urgent and Emergency Care (UEC) metrics within Integrated Performance Report to Board (monthly) (2nd) • Urgent and Emergency Care Transformation Assurance Committee (underpinned by the UEC plan) - monthly (1st) • 'Tactical' and 'Strategic' system meetings, as triggered by escalation levels (2nd) • ICS UEC Committee - monthly (2nd) • Delivery meetings - system and regional for CEO's regarding A&E performance, ambulance offloads and CAT 2 response times- fortnightly (2nd) • Monthly reporting to the CQC (2nd). • Monthly CQC update report to Quality Operational Committee and Quality and Safety Assurance Committee (2nd). • Performance Review Meeting (PRM's) (2nd) • Weekly System Key Performance Metrics Meeting (2nd) • Internal Tier 1 meeting - weekly (2nd) • Tier 1 monthly meeting with national director of UEC (2nd) • External GIRFT and ECIST review of ambulance handover pathway - January 2025 (3rd) • External GIRFT and ECIST criteria to admit audit - commenced in Q4. (3rd)	4	5	20	**Gaps in control:** 1. Workforce challenges, including consultants, nurses, HCA's and middle grade doctors. 2. Inpatient bed capacity is not expected to meet demand. **Gaps in assurance:** -	**Actions aligned to gaps:** 1. Ongoing recruitment of substantive workforce in specific departments and staff groups, e.g. ED, medical and nursing staff, therapy staff, pharmacy staff and co-ordination with wider trust-wide recruitment schemes, e.g. RN and HCA recruitment, throughout 2024-25. Executive lead: Chief Operating Officer and Director of People & OD. 2. Improve/reduce length of stay for urgent and emergency pathways, in line with national standards. Executive Lead for actions: Chief Operating Officer: 2a. Reduce number of people in our hospitals who are over 14 and 21 days by March 2025. 2b. Improve the utilisation of virtual ward step down beds by March 2025, by incorporating it into the effective board round. 2c. Reconfigure services on the PRH site by June 2024. 2d. Create frailty assessment units on both sites by end June 2024. 2e. Reduce length of stay for no criteria to reside patients to three days by March 2025. 2f. Review SATH bed model ~~with PWC and ICS~~ to establish the acute bed requirement, by March 2025.	1. Recruitment ongoing and in progress. Work continues to recruit to national difficult to recruit positions within the medical workforce. 2. Work ongoing to achieve the timescales identified in the implementation plan for this overall action. 2a. Two modular inpatient wards due to open Q3 25/26 on RSH site. Reconfiguration of PRH estate to deliver additional inpatient capacity Q1 25/26. 2b. Special cause improvement shown over Q2 and Q3 in the number of virtual ward step down beds utilised. Shropshire Community Trust Urgent Care Practitioners commenced on both sites Q4, 24-25. 2c. Action complete, June 2024. 2d. Action complete; frailty unit opened July 2024. 2e. Special cause improvement shown over 24/25 in average days no criteria to reside. On track for March 2025. Action complete Q4. 2f. Initial action complete. Plan is 38 additional beds at RSH through modular wards (December 2025) and 10 additional acute medical beds at PRH (August 2025).			9

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee						
BAF 11: The current configuration and layout of acute services in Shrewsbury and Telford will not support future population needs and will present an increased risk to the quality and continuity of services.			**Director of Hospitals Transformation Programme (HTP)**	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**Recognising the current position with the Trust's estate, SaTH is OPEN to transforming its buildings/infrastructure to support better outcomes and experience for our patients and public. We will consider benefits and solutions which meet organisational requirements and ensure a safe environment.**			**HTP Assurance Committee**						
Risk opened: 1 April 2022			Matthew Neal											

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Emergency Department and multiple services (e.g. emergency surgery, critical care, acute medicine) operating at two sites (Princess Royal Hospital and Royal Shrewsbury Hospital) • Continued challenge in achieving national access performance standards • Insufficient shift to local services outside of the acute hospital setting - requirement to offset additional growth, in line with the Health and Care Models Transformation Programme. **Consequence:** • Unsustainable infrastructure • Unsustainable clinical services • Reduced patient satisfaction • Potential impact on quality and safety of patient care • Impacts financial sustainability and backlog maintenance not reduced • Reduced staff morale • Less efficient estate • Not achieving national access performance standards • Workforce position unsustainable if continue to duplicate services across two sites.	**5**	**4**	**20**	• Hospitals Transformation Programme (HTP) - the Trust has received national approval of its full business case for the programme. This has released the capital investment required for local services and the implementation of a new model of health care in the county, including the construction, has now begun. • The Trust has a contract with Integrated Health Partnerships in line with the full business case (FBC) approval. Major construction work on the site is underway (Q2). • System, Urgent and Emergency Care (UEC) Plan was produced for 2023/24 - led by ICS UEC Board supported by UEC Operational Group. This remains in place. • Now that the FBC has been approved, work has started to build detailed clinical pathways that support safe transfer and transformation of services from the current operating model to the new model of care. Priority is being afforded to urgent and emergency care pathways and work with ICS/UEC partners has begun. In parallel to the service transformation work being done in preparedness for the completion of the HTP build, clinical teams are reviewing options for accelerating any pathways that can be expedited prior to HTP 'go live' e.g. (1) elective surgical hub at PRH (opened 10 June 2024); (2) critical care model; (3) support to the ICS Health and Care Models Transformation Programme for community based pathways. • Development of the integrated ICS Workforce Plan. • Clinical Services Transformation Group established to produce clinical pathways in line with the clinical model. • Revised governance structure for the implementation of the clinical programme. • HTP Workforce Lead appointed. • Revised terms of reference for the Strategic People Group.	**Reported to Board, committees and elsewhere:** • SaTH Board (meets monthly - public/private) (2nd) • Shropshire Telford & Wrekin ICS Strategy Committee (monthly) (2nd) • HTP Assurance Committee (bi-monthly) (2nd) • HTP Programme Management Committee - SaTH executives (2nd) • HTP Programme Board (monthly), including system partners and ICS members (2nd) • UEC plan to ICS UEC Board - monthly (2nd) • Independent Reconfiguration Panel produced/published a report that made 13 recommendations in relation to HTP which agreed with the HTP delivery mechanism to deliver outcomes for the population of Shropshire, Telford & Wrekin - December 2024 (3rd) • Clinical Assurance Group (2nd) • Strategic People Group (2nd) • Health & Care Models Group - chaired by CEO, Shropshire Community Trust (2nd)	**4**	**3**	**12**	**Gaps in control:** 1. Elective surgery hub (first scheme) short form business case submitted to NHSI in June 2022 **Gaps in assurance:** 2. Personnel (HTP and Divisional), demand and capacity, dependency on system-wide programmes and governance to be expanded as part of full business case stage.	**Actions aligned to gaps:** 1. Implementation of the elective surgery hub build. Executive lead: Chief Operating Officer. By end of 2023/24. 2. HTP Director to hold regular meetings with ICB Chief Executive and Director of Finance to determine details of their strategy and the impact on HTP, to ensure co-production, throughout the HTP Programme. (The Director of Finance is also a core member of the HTP Programme Board.) Executive lead: Director of HTP. Ongoing - by 2027.	1. SaTH received formal confirmation on 22 August 2022 from the National Elective Recovery Targeted Investment Fund Team that the first scheme at Princess Royal Hospital (PRH) was approved (with conditions). The second scheme of the Elective Surgical Hub at PRH was approved by national panel on 27 September 2022. The elective surgery hub build has been underway at PRH site and opened on 10 June 2024, as per schedule. **Action closed Q1.** 2. Meetings are taking place. HTP Director is now a member of the newly constituted Health and Care Models Transformation Programme (HCMTP) to ensure HTP aligns with local care transformation programmes. Work has been ongoing to create stronger links between the two programmes and the ICB have presented their plans to HTP Assurance Committee. Action remains ongoing. The HTP revised governance structure has been approved (Q2) and is being implemented (at Q3). Q4: governance structure revised for clinical arm of the programme. HTP are monitoring the ongoing impact of the system-wide initiatives on bed requirements included within the FBC. Health and care models workshop planned with system-wide Senior Responsible Officers in Q1 25-26.			**12**

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee						
BAF 12: There is a risk of non-delivery of integrated pathways, led by the ICS and ICP.			**Director of Strategy & Partnerships and Chief Operating Officer**	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**SaTH is keen/EAGER to form collaborations and partnerships which will ultimately provide a clear benefit and improved outcomes for the people we serve. Guiding principles or rules will be in place that welcome considered risk taking in organisational actions and the pursuit of, for example, partnership and collaborative working priorities.**			**Quality & Safety Assurance Committee**						
Risk opened: 1 April 2022			Nigel Lee and Ned Hobbs											

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Lack of integrated model of service delivery locally • High non elective admissions • A shift required from acute to community setting for models of care • Challenges in the recruitment of key practitioner roles across health and care to the rapid response service in the Shropshire area • Lack of health prevention and early interventions • Insufficient current workforce capacity in clinical and corporate teams across the system to deliver new ways of working • Availability of systemwide digital specialist resource to implement effective remote monitoring, and enable timely sharing of robust data, and associated impact of achieving agreed trajectories for virtual ward mobilisation • Lack of cohesive approach to long-term condition management, e.g. diabetes **Consequence:** • Increased length of acute inpatient stay • Lack of bed capacity in acute setting impacting on patient flow and reduced delivery of elective activity • May reduce quality of patient care including risk due to ambulance handover delays • Increased demand for emergency department services and non-elective admissions to hospital • Lack of innovation and continuous improvement of services • Reduced staff experience and morale • Increased ambulance conveyances from one care setting to another • Increased emergency community nursing referrals • Increased acute diabetes presentations.	4	4	16	• Shropshire, Telford & Wrekin ICS Health and Care Models Transformation Programme in place • Five year programme plan in place - ICS Joint Forward Plan (updated annually). • Programme management in place with fortnightly PMO meetings - programme reported through ICS digital system (Inphase) • 'Deep dive' into each workstream on a regular basis • ICB Chief Medical Officer plan for group of speciality/condition based pathway improvements - priorities as at Q3 are: Diabetes, CVD and frailty (through Health and Care Models Transformation Group), MSK (through Planned Care Group).	**Reported to Board, committees and elsewhere:** • Reports to Shropshire Telford & Wrekin ICS Integrated Care Delivery Board and System Transformation Group (monthly) (2nd) • Report to place-based partnership Boards Shropshire Integrated Place Partnership Committee (SHIPP) and Telford and Wrekin Integrated Place Partnership Committee (TWIPP) (2nd) • Health and Care Models Transformation Programme Group - bi-monthly highlight reports presented covering actions and milestones (1st) • Relevant projects report to the ICS UEC Board - monthly (2nd) • UEC Board, HCMTP Group report to system Transformation and Digital Group (monthly) (2nd) • System Quality Risk Register reported to ICS Quality and Performance Committee (2nd)	4	4	16	**Gaps in control:** 1. Limited detail and limited delivery of the changes in improvement, as a relatively new programme 2. System agreement to the services "as is " services in and out of scope of the programme. 3. Reliance on physical acute beds rather than some 'virtual ward' capacity and delays within urgent and emergency care caused by lack of flow. 4. Lack of robust involvement and two-way communication with regard to integrated clinical pathways; there remains high health system quality and performance risk areas within: integrated/cohesive diabetes management, Children's and Young People's (CYP) mental health services transformation, safe and effective maternity care, effective acute paediatric pathway, and C'Difficile case numbers. **Gaps in assurance:** 5. Robust population health data intelligence.	**Actions aligned to gaps:** 1. Provide operational and clinical support to the Health and Care Models Transformation Programme (HCMTP) - ongoing. Lead Executive: Chief Operating Officer and Medical Director with support of HTP operational lead and clinical lead. 2. *Not a SaTH action to lead* 3. See actions within BAF risk 10. 4. Delivery of the ICS Clinical Strategy with six identified priority areas which SaTH takes part and supports. In addition, other streams of work are to be supported by: Paediatric Transformation Programme Assurance Committee (chaired by SaTH Medical Director); continued improvements within maternity via SaTH Maternity Transformation Committee co-ordinated by the Local Maternity & Neonatal System (LMNS), which is chaired by the ICB Medical Director; and development of CYP mental health programme to be led by Midlands Partnership University Foundation Trust reporting into the Provider Collaborative going forwards. Various leads for actions via various partner organisations, including SaTH's involvement. 5. *Not a SaTH action to lead but SATH Performance & Business Intelligence and Strategy & Partnerships leads take an active role in the ICS Population Health Management (PHM) group.*	1. Revised approach to Local Care Transformation programme proposed in summer 2024 and endorsed by System Transformation Group - with focus of LCTP on pathway development to offset demand and bed growth. During September and October, proposal refined to bring together HTP and LCTP in co-production of pathways for both improved outcomes and offsetting growth. November 2024 - the programme group meetings recommenced as Health and Care Models Transformation Programme. 2. SaTH taking part in this work with all partners. As part of system wide population health management led prioritisation, initial pathways for development will include Diabetes, Cardiovascular disease (CVD) and all age Mental health. Q3: Three initial priority pathways confirmed - Diabetes, CVD and Frailty. 3. UEC Programme for 25/26 will play an important part in development of community pathways. 4. SaTH taking part in this work with all partners. Clinical pathways to be reviewed and agreed. Joint SATH Director of Strategy/ICB Chief Strategy Officer role is supporting closer dialogue and prioritisation with all system partners including SATH. Q3: Three initial priority pathways confirmed as initial priority schemes for HCMTP - Diabetes, CVD and Frailty. Note: HTP operational and clinical leads are members of HCMTP Group. Mental health pathways in development as part of emerging mental health, learning disabilities and autism (MH LD&A) provider collaborative led by Midlands Partnership University Foundation Trust. Q4: SaTH Chair in Common now chairing System Transformation & Digital Group from March 2025. 5. October 2024 - Shropshire, Telford and Wrekin Integrated Care Partnership endorsed the revised system integrated care strategy which is underpinned by a population health management led joint strategic needs assessment. Q4: STW Population Health Dashboard developed by ICB, BI and Analytics Team. **Action closed Q4.**			16

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee						
BAF 13: The Trust is unable to ensure that robust corporate governance arrangements are in place resulting in poor processes, procedures and assurance			**Director of Governance**	Improve the quality of care that we provide. Deliver a better patient journey and experience. Make our organisation more sustainable.	**SaTH has a MINIMAL appetite to compromise legal and regulatory standards. We are only prepared to accept the possibility of very limited deviation from compliance during exceptional circumstances.**			**Audit & Risk Assurance Committee**						
Risk opened: 1 April 2023			Anna Milanec											

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Trust Policy Framework requires review • Poor processes and procedures • Culture • Governance improvement workload is high - started from a low base with embedded poor practices in some areas • As of September 2024, Interim CEO in place. (Substantive Chair in Common in place from 1 October 2024.) **Consequence:** • Lack of clear guidance for staff to follow and some out of date policies • Lack of openness and transparency • CQC 'Requires Improvement' Well Led rating • Incidents • Delay in completing internal audit recommendations • Potential ineffective committees, including late circulation of papers and breach of Standing Orders • Potential data breaches • Regulatory sanctions and/or fines • Following appointment of substantive Chair in Common and Interim CEO, there is the potential for governance changes, along with time to embed those changes	**4**	**4**	**16**	• Getting To Good (G2G) governance workstream • Trust Strategy • Board Assurance Framework (BAF) refreshed in 2022, with ongoing review • Board development programme in place • Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation in place and reviewed 2024 • Managing Conflicts of Interest Policy updated during 2023 • Declarations of interest made available within Electronic Staff Record from May 2023 • Register of Interests published on the Trust's website • Terms of reference refreshed for all assurance committees of the Board during 2023/24 and ongoing 24/25 • Review of effectiveness of FPAC and QSAC committees June/July 2023 • Committee effectiveness session held with Board in January 2023 • Scolding Review action plan • DSPT work underway and cyber security exercises planned at local and ICS level • Fit & Proper Person Policy updated following publication of new national framework • Fit & Proper reporting status established within the Electronic Staff Record (ESR) • Updated Undertakings with NHSE (September 2024 Board)	**Reported to Board, committees and elsewhere:** • SFI's, Standing Orders and Scheme of Reservation and Delegation to Audit & Risk Assurance Committee during November 2024 and Board January 2025 (2nd) • BAF considered quarterly at Board and its committees (2nd) • Managing Conflicts of Interest Policy approved at Audit Committee and Board during 2023 (2nd) • Refreshed terms of reference considered at all Board committees during 2023/24 and 2024/25 (2nd) • 2023/24 Annual Report to Board in June 2024 and published on the Trust's website (2nd) • Auditor's Annual Report 2023/24 published on Trust's website (3rd). External audit did not identify any significant weaknesses in the Trust's arrangements in relation to: governance; economy, efficiency and effectiveness; and financial sustainability, in their 23/24 Auditor's Annual Report (3rd). • Annual General Meeting held in public (face to face) - 30 September 2024 • Head of Internal Audit Opinion April 2024 providing Substantial Assurance that there is a good system of internal control (3rd) • Regular updates to Audit and Risk Assurance Committee on conflicts of interest compliance - achieved 80% by March 31st 2024 (2nd), with subsequent associated Counter Fraud Authority Standard achievement confirmed by internal audit (3rd). • Register of interests and gifts and hospitality reviewed by Audit & Risk Assurance Committee - November 2024 (2nd) • Policy Approval Group meeting, monthly (established August 2024) (2nd) • IG Committee met 2 December 2024 and terms of reference reviewed (2nd) • Executive led Financial Recovery Group and Task Force in place (2nd) • System Integrated Improvement Plan (SIIP) relating to governance is in place and currently on track - update received at Board (monthly) (2nd)	**4**	**3**	**12**	**Gaps in control:** 1. Trust Policy Framework (and document access). 2. Timely review of internal audit recommendations. 3. Outstanding subject access requests (SAR's), and subsequent complaints. **Gaps in assurance:** 4. Data Security & Protection Toolkit assurance. 5. BAF not aligned with the Trust's strategic 'themes'.	**Actions aligned to gaps:** 1a. Introduce refreshed Policy for Policies and Policy Approval Group in Q2 24/25. Lead Executive: Director of Governance. 1b. Case to be developed for new document library for easier policy access/search - offer support to Communications Team as part of case for new intranet - by Q1 25/26. Director of Governance. 2. Lead executives to review and action in a timely manner all internal audit recommendations. Lead Executives: All 3a. Fully staff the department, and train - by Q1. Lead Executive: Director of Governance. 3b. Senior manager put in place to support training and establishment of new processes within legal department. 3c. Procure a company to scan the medical records (by Q1) for SAR's to assist with backlog. Clear the backlog by Q4. 3d. Director of Governance to continue to liaise with the ICO - ongoing. 3e. Develop action plan for outstanding and overdue SAR's and monitor via ~~ARAC~~ Information Governance Committee from ~~February~~ April 2025. 4. Work towards DSPT/CAF (Cyber Assessment Framework) 'standards met' for 24/25 - evidence to be submitted by 30 June 2025. Lead Executive: Director of Governance. 5. Add strategic themes to BAF in Q1. Lead Executive: Director of Governance.	1. The Trust's Policy for Policies was considered and agreed by the newly established Policy Approval Group on 16 October 2024 and to be considered by Executive Team, ahead of Board. Policy Approval Group commenced during August 2024, meeting monthly. 2. Director of Governance now has access to the system where audit recommendations are held. To be raised with executives monthly. Ongoing. 3a. **Action complete and closed Q1.** b. Senior manager is in place and more efficient processes have been adopted. c. A company has been procured and scanning is ongoing. Q4: Backlog is substantially reduced. Work remains ongoing. d. Ongoing. 4. The Trust's current DSPT standards status at 30 June 2024 is 'not met standards'. - Updated action plan was submitted to NHSE at end of October 2024 which led to 'standards met' being achieved. Q4: Interim internal audit to be shortly advised via ARAC. 5. Completed Q1. **Action complete and closed Q1.**			**6**

Board of Directors' Meeting
8 May 2025

Agenda item		084/25		
Contract Title		**System Integrated Improvement Plan (SIIP) Report**		
Executive Lead		Jo Williams, Chief Executive Officer		
Report Author		Mary Aubrey, Programme Director for Getting to Good		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe		Our patients & community	√	BAF 1, BAF 2, BAF 4, BAF 5, BAF 10
Effective		Our people	√	
Caring		Our service delivery	√	**Trust Risk Register id:**
Responsive		Our governance	√	
Well Led		Our partners	√	
Consultation Communication		People and OD Assurance Committee, 07.04.2025 Performance Assurance Committee, 22.04.2025 Finance Assurance Committee, 23.04.2025 Quality & Safety Assurance Committee, 29.04.2025		
Executive summary:		1. A System Integrated Improvement Plan has been developed based on exit criteria that was agreed with NHS England. Delivery of the plan is designed to transition both the System and SaTH from segment 4 to segment 3 of the National Oversight Framework (NOF) by March 2026. 2. The report includes the latest position in relation to the delivery of tasks/actions against SaTH's section of the SIIP, which is detailed in Appendices 1–4. 3. The Board's attention is drawn to section 2 which details a number of key highlights against delivery of the System Integrated Improvement Plan.		
Recommendations:		The Board of Directors is asked to: **Receive** this report for information and take assurance from the updates provided. **Note** that this SIIP progress report and supporting evidence will be submitted to the STW ICB by 20 May 2025. **Approve** and sign off the STW ICS System PMO structure and approach (Appendix 5). This will then subsequently be submitted to the STW ICB Board in May 2025 requesting approval.		
Appendices		Appendix 1 - SaTH Governance, Leadership Plan Appendix 2 - SaTH Workforce Delivery Plan & Collaborative Decision-Making Leadership Plan Appendix 3 - SaTH Finance Recovery Plan Appendix 4 - SaTH Systemwide UEC Improvement Plan Appendix 5 - STW ICS System PMO structure and approach		

1. Introduction

The purpose of this paper is to provide the Board of Directors with an overview of progress against agreed exit criteria to enable the STW System and SaTH to transition from National Oversight Framework (NOF) segment 4 to segment 3 by the end of March 2026. The exit criteria will be delivered via a System Integrated Improvement Plan (SIIP) which has been developed in conjunction with NHSE colleagues.

2. Key highlights against delivery of SaTH's section of the System Integrated Improvement Plan

The Board's attention is drawn to a number of key highlights, which are detailed below:

Governance / Leadership

- **SaTH Metric 4.4.2:** STW System PMO proposals and alignment of resources associated were agreed at the STW CEO's meeting, with a view to implementation in Q1 2025/26 following the request for formal approval by SaTH and STW ICB respective Boards in May 2025.

Workforce and Leadership Collaborative

- **SaTH Metric 2.1:** SaTH workforce delivery plans for 2024/25 and 2025/26 are aligned to the overall system plans.
- **SaTH Metric 2.2**: Refreshed SaTH People and OD strategy aligned to the system strategy.
- **SaTH Metric 5.1:** Individual SaTH elements of the functioning Provider Collaborative (aligned to the priorities within the Strategic Commissioning Plan approved by Integrated Care Board) where open and honest conversations are brokered.
- **SaTH Metric 5.4:** SaTH's contribution to a clear system culture and leadership improvement programme and evidence of a positive shift in staff experience through pulse survey/NHS staff survey.

Finance

- **SaTH 1.1.9:** Work is underway to develop an overarching recovery plan that incorporates CIP planning and delivery, alongside developing a roadmap for financial sustainability from 2025/26 through to full implementation of HTP, that is aligned with Local Care Partnership (LCP) and benchmarking opportunities.
- **SaTH 1.3.5:** The Estates strategy has been amended to include the configuration of the modular wards, which has been circulated to staff, and comments have been considered.

UEC

- **SaTH 3.1.1.1** - UTC provision now delivered in house from 1 April 2025.
- **SaTH 3.1.1.3 & 3.1.1.4** – Implementing GP direct access specialty pathways across surgical services has moved to Amber, however work has commenced and will be driven forward by the new workstream established and chaired by Susanne Crossley, Deputy COO. The first meeting is w/c 28 May 2025 and will include representation from all divisions, Liz Slevin, ECIST, ShropDoc and WMAS.
- **SaTH 3.1.2.12** - All recruitment of additional Pathology posts has now been completed.
- **SaTH 3.1.5.2** - The training package for Clinical Frailty Scoring is now available on LMS.
- **SaTH 3.3.1** - The delivery of the UEC Quality Improvement Plan has moved to Amber as two Section 31 conditions remain in place, with 5 specific actions delivered but not yet evidenced.

The information in Appendices 1-4 provides a summary of the progress against delivery of the tasks/actions that were due up to and including 30 May 2025 against SaTH's section of the SIIP, which have been approved by the relevant Executive Director or nominated Deputy.

3. Recommendations

The Board of Directors is asked to:

Receive this report for information and take assurance from the updates provided.

Note that this SIIP progress report and supporting evidence will be submitted to the STW ICB by 20 May 25.

Approve and sign off the STW ICS System PMO structure and approach (Appendix 5). This will then subsequently be submitted to the STW ICB Board in May 2025 requesting approval.

Appendix 1. Summary of the progress against delivery of the SaTH Governance, Leadership Improvement Plan

The Shrewsbury and Telford Hospital NHS Trust

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 4.1.0	Continue to review current SATH internal governance structure to support oversight and assurance:	Anna Milanec	Already started	31/03/2026	Complete – Governance diagram in place which supports this. New HTP Assurance Committee established in 2024, along with Performance Assurance Committee and Finance Assurance Committee.	Completed and Evidenced by SaTH
SaTH 4.1.1	Following recent changes, review level 1 finance governance reporting structure (Link with SaTH1.1, SaTH1.2, SaTH1.3)	Debbie Bryce	01/12/2024	28/02/2025	The Finance and Assurance Committee (FAC) was established as a separate committee of the Board in September 2024. FAC terms of reference and associated groups currently under review. FAC effectiveness survey was undertaken in February 2025 and reported to the March FAC meeting.	Completed and Evidenced by SaTH
SaTH 4.1.2	Review level 1 Workforce governance reporting structure (Link with SaTH 2.1 and SaTH 2.2)	Debbie Bryce	01/12/2024	28/02/2025	PODAC terms of reference were reviewed and agreed by PODAC on 02/12/24 and approved by Board on 16/1/25. PODAC effectiveness survey was undertaken in February 2025 and will be considered on 7 April at the PODAC meeting.	Completed and Evidenced by SaTH
SaTH 4.1.3	Review level 1 UEC / performance governance reporting structure (link to SaTH 3.1 and 3.2)	Debbie Bryce	01/12/2024	28/02/2025	PAC was established as a separate committee of the Board in September 2024. Terms of reference currently under review for PAC and UECTAC. PAC effectiveness survey scheduled for July/Aug 2025 following discussion with the committee chair. UEC reporting into QSAC for quality and safety items was added to QSAC terms of reference which were considered at QSAC on 25 March 2025. UEC reports into PAC for performance elements.	Completed and Evidenced by SaTH
SaTH 4.1.4	Review level 1 HTP Committee governance framework in conjunction with above	Anna Milanec	01/12/2024	28/02/2025	(Anna's action). As a new committee of the Board, the terms of reference were agreed by Board in July 2024. Terms of reference are in date and are next due for review again in July 2025.	Completed and Evidenced by SaTH
SaTH 4.1.5	Review level 1 Quality & Safety Assurance governance framework in conjunction with above	Anna Milanec	01/01/2025	28/02/2025	QOC terms of reference approved by QSAC in February 2025. QSAC terms of reference annual review scheduled for March 2025 meeting. QSAC effectiveness survey undertaken February 2025 and considered at QSAC on 25 March 2025.	Completed and Evidenced by SaTH

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 4.1.6	Produce level 1 assurance mapping template	Anna Milanec	01/01/2025	28/02/2025	High level mapping template in place and presented to the Board in January 2025 as part of SIIP update.	Completed and Evidenced by SaTH
SaTH 4.1.7	Review, adjust and incorporate any gaps highlighted by assurance map	Anna Milanec	28/02/2025	31/03/2025	UECTAC reporting into QSAC for quality and safety elements has been added to QSAC terms of reference 25 March 2025 – agreed by QSAC and will be scheduled for May public Board approval.	Completed and Evidenced by SaTH
SaTH 4.1.8	SaTH Board to approve changes to internal level 1 governance structure as required	Anna Milanec	28/02/2025	31/03/2025	High level mapping template in place and presented to Board in January 2025 as part of SIIP update.	Completed and Evidenced by SaTH
SaTH 4.1.9	Review level 2 finance governance reporting structure - execs to approve changes	Anna Milanec / Debbie Bryce	01/02/2025	~~31/03/2025~~ 30/06/2025	Capital Planning Group terms of reference considered and approved by the Finance Assurance Committee on 25 March 2025. Financial Recovery Group (FRG) is in place and is part of the weekly CEO meeting. Terms of reference are being drafted for Financial Recovery Group for agreement on 4 June 2025 FRG. Then onward approval at the 17 June FAC meeting.	
SaTH 4.1.10	Review level 2 UEC / performance governance reporting structure - execs to approve changes	Anna Milanec / Debbie Bryce	01/02/2025	31/03/2025	UECTAC terms of reference were agreed August 2024 and are due for review August 2025. This reports into PAC and QSAC (addition to QSAC terms of reference agreed by QSAC 25 March 2025).	Completed and Evidenced by SaTH
SaTH 4.1.11	Review level 2 Workforce governance reporting structure - execs to approve changes	Anna Milanec / Debbie Bryce	01/02/2025	~~31/03/2025~~ 02/06/2025	Strategic People Group (SPG) terms of reference reviewed by corporate governance team in April 2025 and currently being reviewed by people team for agreement 6 May 2025 SPG meeting, then onward approval at the 2 June PODAC meeting.	
SaTH 4.1.12	Continually review / update as required committee / group TORs, agendas and workstreams to ensure they reflect focus on new / amended requirements	Anna Milanec / Debbie Bryce	Ongoing	31/03/2026	Business as usual work and processes embedded. Schedule of terms of reference reviews/agendas/workstreams in place and included within cycles of business for committees and groups.	Completed and Evidenced by SaTH
SaTH 4.1.13	Review monthly integrated performance reports to Board to ensure continued focus on essential elements	Inese Robotham	01/12/2024	31/03/2026	Once the Operational Plan is approved the KPIs for the main objectives will be aligned with the Operational Plan 2025/26. The KPIs have been drafted in preparation for this.	

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 4.1.14	Reporting from collaborative workstreams into SATH governance to commence	Anna Milanec	28/02/2025	30/01/2026		
SaTH 4.2.1	Agreement of SIIP approval and ongoing assurance arrangements within SaTH.	Jo Williams	Ongoing	14/11/2024	SaTH elements of the system performance & accountability framework have been developed and implemented. This was signed off at the Board of Directors meeting held on 14 November 2024 and discussed on 16 January 2025. (Board paper and minutes Evidence SaTH 4.2.1) (Assurance Committee, Key Issues Reports (4A's.)	Completed and Evidenced by SaTH
SaTH 4.2.2	SaTH elements of system performance & accountability framework documented and signed off by SATH board	Jo Williams/ Anna Milanec	01/11/2024	30/01/2025	SaTH elements of system performance & accountability framework was signed off by SATH Board of Directors in February 2025	Completed and Evidenced by SaTH
SaTH 4.2.3	Development of governance arrangements to deliver UEC performance, via a provider collaborative arrangement	Anna Milanec	Already started	31/03/2025	See 4.2.3	Completed and Evidenced by SaTH
SaTH 4.2.4	Review SATH SO's, SFI's, SORD to support the creation and operation of provider collaborative arrangements	Anna Milanec	Already started	31/03/2025	Review of SO's, SFI's and SoRD complete for 2024/25. Reviewed annually and approved by Board. Provisions in place for collaborative arrangements.	Completed and Evidenced by SaTH
SaTH 4.2.5	SaTH Board to consider and approve TOR / MOU / appropriate delegations to enable the creation and operation of provider collaborative arrangements	Anna Milanec	01/12/2024	31/03/2025	Provider collaborative arrangement need to be reviewed	Completed and Evidenced by SaTH
SaTH 4.3.1	SATH Risk Manager, James Webb, appointed the lead liaison role with ICS colleagues.	Anna Milanec	Already started	31/03/2025	Completed on 08/08/2024 – SaTH Risk Manager-liaising with ICS Colleagues'.	Completed and Evidenced by SaTH
SaTH 4.3.2	Engage with governance leads to develop risk management policies that all align with consistent risk language, scoring, risk management reporting procedures.	Anna Milanec	Already started	31/03/2025	Completed analysis of similarities across ShropCom, RJAH, SaTH and ICB Risk Management Policies on 16/01/2025	Completed and Evidenced by SaTH
SaTH 4.3.3	Engage with STW Provider Governance Leads to co-ordinate implementation of risk register accessible to all	Anna Milanec	Started	30/06/2025	Last correspondence was sent by James Webb to Alison Smith, Executive Lead, Governance and Engagement, on 16/01/2025	Completed and Evidenced by SaTH

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 4.3.4	Approve new Risk Management Policy by SATH Board	Anna Milanec	01/01/2025	~~31/0/2025~~ 31/07/2025	The new Risk Management Policy and Risk Management Strategy is under review	
SaTH 4.3.5	Review timing of each organisation's risk management strategy review	Anna Milanec	01/01/2025	01/04/2025	Completed on 19.03.2025	Completed and Evidenced by SaTH
SaTH 4.4.1	Engage with programme / governance leads to develop and implement proposals.	~~Nigel Lee~~ Ned Hobs	31/12/2024	28/02/2025	System PMO Steering Group established Jan 2025, with SaTH COO as member. Fortnightly meetings held.	Completed and Evidenced by SaTH
SaTH 4.4.2	SaTH elements of system PMO structure & approach documented and signed off by SATH board and ICB	~~Nigel Lee~~ Ned Hobs	01/11/2024	~~28/02/2025~~ 08/05/2025	The STW System PMO proposals and alignment of resources associated were agreed at the STW CEO's meeting, with a view to implementation in Q1 2025/26 following the request for formal approval by SaTH and STW ICB respective Boards in May 2025.	
SaTH 4.4.3	Continue to drive the delivery of a system PMO with all partners	~~Nigel Lee~~ Ned Hobs	01/11/2024	31/12/2026		

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

Appendix 2. Summary of the progress against delivery of the SaTH Workforce Delivery Plan, Leadership collaborative decision-making at both system and organisational levels (aligned to the priorities within the Strategic Commissioning Plan and System Culture and Leadership improvement programme

Metric 2.1: SaTH workforce delivery plans for 2024/25 and 2025/26 aligned to overall system plans and signed off by the Board of Directors

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
2.1.1	Identify baseline and outturn forecast	SB	04/11/2024	30/11/2024	Workforce plan submission (2nd submission to the ICB due 31 January 2025) - **Complete**	Completed and Evidenced by SaTH
2.1.2	Review known changes, service changes needed, and business cases approved from 24/25	BPs	01/12/2024	31/12/2024	2nd submission of the Workforce Plan to the ICB due 31 January 2025 This will include the submission of PODAC reports and IPR reports - **Complete**	Completed and Evidenced by SaTH
2.1.3	Outline any assumptions in terms of workforce metrics, turnover absence levels	SB	01/12/2024	31/12/2024	PODAC reports IPR reports **Complete**	Completed and Evidenced by SaTH
2.1.4	Populate Workforce Planning Template	RW	06/01/2025	31/01/2025	Workforce planning template is fully populated **Submitted as part of final operational plan March submission**	Completed and Evidenced by SaTH
2.1.5	Calculate the % Change by Staff Group	RW	06/01/2025	31/01/2025	Once the workforce plan is finalised for the 2nd submission this will be calculated as part of the template. **Submitted as part of final operational plan March submission**	Completed and Evidenced by SaTH
2.1.6	Challenge / Sense Check Data	RW	03/02/2025	28/02/2025	**Complete**	Completed and Evidenced by SaTH
2.1.7	Review Data with Stakeholders (Divisional teams etc.)	SB	03/02/2025	28/02/2025	Divisional planning meetings 3rd and 4th February 2025. **Presented at Senior Leadership Meeting**	Completed and Evidenced by SaTH
2.1.8	Populate Master Template and Triangulate with Finance and Operations	SB	03/02/2025	28/02/2025	**Submitted as part of final operational plan March submission**	Completed and Evidenced by SaTH

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
2.1.9	Final Sign Off - Board and NHSE	RB	03/03/2025	31/03/2025 30/04/2025	Due end March 2025 Feedback received from NHS E w/c 14/04/25. Operational plan was updated and resubmitted to ICB. Final submission 30th April 2025	
2.1.10	Set up and deliver workshop with People and OD team and Divisional reps to identify the priority areas needed that support delivery of our workforce plan	SB/EW	04/11/2024	30/11/2024	Operational Plan Stocktake meeting held 17th December 2024 **Complete**	Completed and Evidenced by SaTH
2.1.11	Develop set of actions and milestones that support each priority area with time frame and actions owners	SB/EW	02/12/2024	31/12/2024	Pro forma developed for divisional planning meetings scheduled 3rd and 4th February 2025. **Complete**	Completed and Evidenced by SaTH
2.1.12	Finalise plan with fully supported narrative describing the impact and benefit of delivery the plan	SB/EW	02/12/2024	31/12/2024 30/04/2025	First cut of plan drafted for review. Feedback received from NHS E w/c 14/04/25. Operational plan was updated and resubmitted to ICB. Final submission 30th April 2025.	
2.1.1	Capture risks to delivery of plan and any mitigations to reduce risk	SB/EW	02/12/2024	31/12/2024	Risks captured with mitigations aligned to People Strategy. Risk Register, BAF & PODAC Assurance reports	
2.1.14	Develop summary project plan showing high level timescale – Gantt chart	SB	02/12/2024	31/12/2024	Draft actions developed timelines drafted **Complete**	Completed and Evidenced by SaTH
2.1.15	Gain sign off from each provider and NHS England	RB	06/01/2025	~~31/01/2025~~ 31/03/2025 30/04/2025	Feedback received from NHS E w/c 14/04/25. Operational plan was updated and resubmitted to ICB. Final submission 30th April.	
2.1.16	Ensure actions and milestones monitoring is incorporated into fortnightly agenda of workforce planning and assurance group and Agency reduction group	SB	06/01/2025	~~31/01/2025~~ 31/03/2025	Due end January 2025. Need to gain approval by NHSE will need to extend timeframe to 31 March 2025 for final approval. Feedback received from NHS E w/c 14/04/25. Operational plan was updated and resubmitted to ICB. Final submission 30th April.	

Metric 2.2: Refreshed SaTH People and OD strategy aligned to the system strategy

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
2.2.1	Deliverable Completed -People Strategy has been refreshed and approved by Board this year (2024). Includes how we will deliver strategy and what this will do to improve our key KPIS	EW	01/10/2024	31/01/2025	People Strategy	Completed and Evidenced by SaTH
2.2.2	Monitor delivery of strategy via our Strategic People Group. Monthly highlight reports used to demonstrate progress against milestones outline within the priority areas within our Board approved strategy.	SB/EW	01/10/2024	31/01/2025	PODAC assurance paper Various reports are brought to Strategic People Group for assurance, challenge, decision and discussion all aligned to the People Strategy. Assurance and progress are reported/ escalated to PODAC. **Complete**	Completed and Evidenced by SaTH
2.2.3	Strategy sets out key actions and deliverables that are aligned to the NHS People Plan and are underpinned by the NHS People Promise and NHS Future HR and OD Report.	SB/EW	01/10/2024	31/01/2025	People Strategy **Complete**	Completed and Evidenced by SaTH
2.2.4	A set of metrics are outlined with target KPI's that support improvement in workforce retention, unavailability and staff engagement.	SB/EW	01/10/2024	31/01/2025	People Strategy IPR- monthly Culture Dashboard **Complete**	Completed and Evidenced by SaTH

SaTH Transition Criteria 5 Progress Report for Leadership: Demonstrate collaborative decision-making at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions for the whole population served by the system.

Metric 5.1: Individual SaTH elements of the functioning Provider Collaborative (aligned to the priorities within the Strategic Commissioning Plan approved by Integrated Care Board) where open and honest conversations are brokered.

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
5.1.3	Ensure individual SaTH contribution to delivery of Provider Collaborative elements of Workforce	RB	In progress	31/03/2026	Chief People Officer and deputy's roles working across SaTH and SCHT.	

Metric 5.4: SaTH's contribution to a clear system culture and leadership improvement programme and evidence of a positive shift in staff experience through pulse survey/NHS staff survey.

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
5.4.4	Analyse staff survey results and lead on development and delivery of associated action plan	EW	Jan 2025	Aug 2025	PODAC / Board Reports April-July 2025. Initial Staff survey results received. Shared internally development of plans in progress.	
5.4.5	Analyse pulse survey results and lead on development and delivery of associated action plan	EW	Jan 2025	Aug 2025	PODAC reports April 2025 Pulse survey results analysed and reported to Strategic People Group and PODAC. Inform strategy milestones to deliver our vision.	

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

Appendix 3. Summary of the progress against delivery of the SaTH Financial Recovery Plan

The Shrewsbury and Telford Hospital NHS Trust

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 1.1.1	MTFP planning assumptions matched to HTP with differences reconciled and base case modelled and updated in the system MTFP	JB	Complete	Complete	System MTFP and bridge document to HTP assumptions.	Completed and Evidenced by SaTH
SaTH 1.2.	24/25 Revenue Plan agreed by SaTH, ICS and NHSE and fully identified CIP plan	AW	Complete	Complete	FPR submission for 2024/25 and CIP updates to FIP showing plans identified.	Completed and Evidenced by SaTH
SaTH 1.1.2	Annual refresh of MTFP and 5 year high level financial plan (including triangulation)	AW	Commenced	Dec-25		
SaTH 1.1.3	Ongoing monitoring of underlying position against MTFP and HTP assumptions	AW	Ongoing	Mar-26		
SaTH 1.1.4	SaTH Demand and capacity model aligned to system model - 1 year model (Sept/Oct 24) 3-5 years (Mar 25).	AW	Sep-24	Mar-25	Completed - SaTH Demand and capacity model aligned to system model - 1 year model (Sept/Oct 24) 3-5 years.	Completed and Evidenced by SaTH
SaTH 1.1.5	Cashflow requirements matched to MTFP modelled. (Mar 25)	AW	Oct-24	Mar-25	Completed - Cashflow requirements matched to MTFP modelled.	Completed and Evidenced by SaTH
SaTH 1.1.6	Triangulation to activity, workforce and performance and updated for 25/26 operational planning guidance. (Dec 24-Jan 25).	KR	Dec-25	~~Jan 25~~ Mar 25	As a consequence of the DWH issues the 2025/26 integrated plan is using the 2024/25 plan as its baseline for all 3 elements of the plan. In addition to this any changes to each of the elements are amended accordingly, therefore the catchment internal plan will triangulate. Triangulation is ongoing and will be completed as part of the final planning submission in March 25. The Operational Activity Plan was signed off at the Board of Directors meeting held on 25 March 2025.	Completed and Evidenced by SaTH
SaTH 1.1.7	Long-Term financial plan model to include full impact of HTP - capital and revenue (complete) - updated to match the system LTFP. (Mar 2025).	SE	Oct-24	~~Mar 25~~ Apr 25	Partially completed - Long-Term financial plan model includes full impact of HTP. System medium term financial plan shared with further discussions at local finance committees in April 25.	Completed and Evidenced by SaTH

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 1.1.8	Signed off LTFP High Level Model 10 year - SaTH/ICS/NHSE	SE	Oct-24	~~Mar 25~~ ~~Apr 25~~ May 25	To be updated following sign off of FY25/26 financial plan.	
SaTH 1.1.9	Recovery plan trajectory based on Strategic Transformation Programmes including HTP, LCP and Benchmarking opportunities updated in SaTH and system MTFP model. (Mar 2025)	CMc	Oct-24	~~Mar 25~~ ~~Apr 25~~ May 25	Work is underway to develop an overarching recovery plan that incorporates CIP planning and delivery, alongside developing a roadmap for financial sustainability from 2025/26 through to full implementation of HTP that is aligned with LCP and benchmarking opportunities.	
SaTH 1.1.10	Triangulation to activity, workforce and performance and updated for 25/26 operational planning guidance	KR	Started	Mar-25	Completed as part of the operational plan submission for FY25/26 which was approved at Board on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.2.2	25/26 Revenue Plan agreed by SaTH, ICS and NHSE	AW	Commenced	Mar-25	The Revenue Plan was signed off at the Board of Directors meeting on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.2.3	25/26 Draft efficiency schemes high level	CMc	Commenced	Nov-24	Seven themes identified and shared with FIP. Formal presentation to internal Efficiency and Sustainability Group.	Completed and Evidenced by SaTH
SaTH 1.2.4	25/26 Draft efficiency schemes detail	CMc	Commenced	Jan-25	Draft efficiency schemes presented to Efficiency and Sustainability Group and Financial Recovery Group in January 2025.	Completed and Evidenced by SaTH
SaTH 1.2.5	25/26 Draft efficiency confirm & challenge with FRG	CMc	Commenced	Feb-25	CIP confirm & challenge sessions held with divisional and corporate teams as planned, good engagement in the process from all teams. Two service areas have been identified as requiring additional support from the recovery taskforce and PWC to further develop their plans to address the shortfall in their current planning. Outputs and escalation if required, further to this intervention, will be reported through to the executive led Financial Recovery Group.	Completed and Evidenced by SaTH
SaTH 1.2.6	25/26 Efficiency plan identified	CMc	Commenced	Mar-25	Efficiency plan for 25/26 identified. All evidence is filed on a newly implemented CIP tracker.	Completed and Evidenced by SaTH

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 1.2.7	25/26 Efficiency plan PIDs signed off by scheme leads and directors	CMc	Commenced	~~Mar 25~~ Apr 25	Efficiency planning has been undertaken via a programme management gateway process. Current gateways statuses are as follows: • Opportunity: £4.0m • Plans in Progress: £21.3m • Fully Developed: £8.3m • In Delivery: £7.7m While good progress has been made, a continued focus is required throughout April to ensure schemes transition trough the gateways to reach 'in delivery' status.	
SaTH 1.2.8	25/26 Efficiency plan QIA's developed by clinical leads	CMc	Commenced	~~Mar 25~~ Apr 25	A robust plan is now in place to ensure that PIDS cannot progress through to 'plans in progress' gateway without having a QIA completed by an appropriate clinical lead.	
SaTH 1.2.9	25/26 Efficiency plan QIA's signed off by DoN and MD	CMc	Commenced	~~Mar 25~~ Apr 25	A process has been established to ensure QIA's for PIDS that require DoN and MD sign is undertaken in a timely manner. As of 27/03/25 one scheme requires sign off and a review meeting to complete this action has been scheduled.	
SaTH 1.2.10	25/26 draft operational activity plan based on D&C work	RP	Commenced	Nov-24	Draft activity submission to system in December. 2024	Completed and Evidenced by SaTH
SaTH 1.2.11	25/26 monthly review of activity plan aligned to performance and financial requirements based on development of D&C model and interventions	RP	Commenced	~~Jan 25~~ Mar 25	As a consequence of the DWH issues the 2025/26 integrated plan is using the 2024/25 plan as its baseline for all 3 elements of the plan. In addition to this any changes to each of the elements are amended accordingly, therefore the catchment internal plan will triangulate. Triangulation is ongoing and will be completed as part of the final planning submission in March 25.	Completed and Evidenced by SaTH
SaTH 1.2.12	25/26 sign off operational activity plan	Ned Hobbs	Commenced	Mar-25	The 2025/26 Operational Activity Plan was signed off at the Board of Directors meeting on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.2.13	25/26 sign off workforce plan aligned to activity delivery	SB	Commenced	Mar-25	The 2025/26 Workforce Plan aligned to activity delivery was signed off at the Board of Directors meeting on 25th	Completed and Evidenced

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
					March 2025.	by SaTH
SaTH 1.2.14	25/26 triangulation of finance, activity and workforce	AW / KR	Commenced	Mar-25	Completed as part of the operational plan submission for FY25/26 which was approved at Board on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.2.15	25/26 draft cost pressures	AW	Commenced	Nov-24	High level cost pressures included within draft planning submission in December 2024. High level financial planning update to Finance Assurance Committee in December. Further discussions ongoing as part of the 2025/26 planning process.	Completed and Evidenced by SaTH
SaTH 1.2.16	25/26 cost pressures prioritization.	AW	Commenced	Nov-24	High level cost pressures included within draft planning submission in December 2024. High level financial planning update to Finance Assurance Committee in December. Further discussions ongoing as part of the 2025/26 planning process.	Completed and Evidenced by SaTH
SaTH 1.2.17	25/26 cost pressures internal confirm and challenge	AW	Commenced	Dec-24	High level cost pressures included within draft planning submission in December 2024. Further discussions ongoing as part of the 2025/26 planning process with Divisional C&C meetings to take place in February.	Completed and Evidenced by SaTH
SaTH 1.2.18	25/26 cost pressures system confirm and challenge	AW	Jan-25	Jan-25	25/26 cost pressures system confirm and challenge	Completed and Evidenced by SaTH
SaTH 1.2.19	25/26 organisational sign off draft plan submission	AW	Commenced	Feb-25	25/26 organisational sign off draft plan submission	Completed and Evidenced by SaTH
SaTH 1.2.20	25/26 organisational sign off final plan submission	AW	Commenced	Mar-25	25/26 organisational sign off final plan submission and was signed off at the Board of Directors meeting on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.2.21	25/26 budget setting – pay / non pay completed	AW	Commenced	Jan-25	25/26 budget setting – pay / non pay completed	Completed and Evidenced by SaTH
SaTH 1.2.22	25/26 budget sign off	AW	Commenced	Mar-25	25/26 budget was signed off at the Board of Directors meeting on 25th March 2025.	Completed and Evidenced by SaTH

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 1.2.23	In year monitoring of financial performance against plan assumptions identifying escalation actions where needed (oversight through OPOG, FRG and Finance Committee)	AW	Ongoing	~~Ongoing~~ Mar-26	PFR's, Finance Assurance Committee, Board and system finance reports.	
SaTH 1.2.24	Monitor ongoing demand & capacity actuals against plan assumptions identifying escalation actions where needed (oversight through OPOG and Performance Committee)	RP	Ongoing	~~Ongoing~~ Mar-26	Data warehouse reporting issues remain. Performance targets continue to be reported.	
SaTH 1.3.1	Sign off 3-Year Capital Plan - SaTH/ICS/NHSE	AW	Commenced	Mar-25	10-year Draft Capital Plan developed. 5-Year Capital Plan signed off at the Board of Directors meeting on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.3.2	10-Year first draft capital plan developed. (Complete)	AW	Complete	Mar 25	Complete – System submission of 10-year draft Capital Plan.	Completed and Evidenced by SaTH
SaTH 1.3.3	Capital MTFP update following capital allocations and guidance (Jan 25).	AW	Commenced	Jan-25	5-year capital plan submitted to CPG 5-Year Capital Plan signed off at the Board of Directors meeting on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.3.4	24/25 Capital Plan agreed by SaTH/ICS/NHSE (Complete).	AW	Complete	Complete	FPR submission for 2024/25	Completed and Evidenced by SaTH
SaTH 1.3.5	Update SaTH Estates Strategy	LW	Commenced	~~Nov-24~~ May 25	The Estates strategy has been reviewed and amended to include the configuration of the Modular wards which has been circulated to staff and comments have been taken into account. The next stage is to plan and manage the external communications.	
SaTH 1.3.6	Sign off of 25/26 capital plan by SaTH/ICS and NHSE (Mar 25).	AW	Commenced	Mar-25	5-Year Capital Plan signed off at the Board of Directors meeting on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.3.7	Support system delivery of 24/25 CDEL - application of the Capital prioritisation framework in action in year. Performance monitoring through CPOG.	AW	Apr-24	~~Mar-25~~ April 2025	This is on track for delivery. 2024/25 figures will be reported in April 2025.	Completed and Evidenced by SaTH

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 1.3.8	Support system delivery of 25/26 CDEL - application of the Capital prioritisation framework in action in year. Performance monitoring through CPOG.	AW	Apr-25	Mar-26		
SaTH 1.3.9	Capital prioritisation within available resource for 25/26 once funding limits following guidance is confirmed.	AW	Commenced	Mar-25	FY25/26 Capital Plan signed off at the Board of Directors meeting on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.3.10	Update the 25/26 Capital plan following the release of national capital guidance and sign-off by individual organisation and system governance and NHSE.	AW	Commenced	Mar-25	FY25/26 Capital Plan signed off at the Board of Directors meeting on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.3.11	Submission of agreed 25/26 capital plan into technical planning forms	AW	Jan-25	Mar-25	Submitted to NHSE as part of the planning submission.	Completed and Evidenced by SaTH
SaTH 1.4.1	Phase 1 I&I - External review assessment of Individual organisational self-assessment of NHSE grip and control checklist & HFMA Financial Sustainability checklist.	AW	Complete	Complete	Phase 1 PwC external review assessment report completed.	Completed and Evidenced by SaTH
SaTH 1.4.2	Delivery against Phase 1 I&I organisation specific intervention action plans (Enhance vacancy scrutiny panels, temporary staffing controls and de-risking cost efficiency schemes). Monitored weekly and reported to ICS.	AW	Commenced	Nov-25		
SaTH 1.4.3	Delivery of Phase 2 I&I scope in relation to controls (run-rate improvements) for Workforce, UEC and System PMO (high risk CIPs) - delivery of interventions post PWC Phase 2 completion by March 25.	AW	Commenced	Mar-25	Phase 2 PwC scope completed. Phase 3 PWC scope near to completion	Completed and Evidenced by SaTH
SaTH 1.4.4	Follow up review of I&I actions to ensure continued delivery	AW	Aug-25	Oct-25		
SaTH 1.4.5	External review of individual organisational assessment against NHSE grip and control checklist & HFMA Financial Sustainability checklist and efficacy of controls.	AW	Complete	Feb 25	Complete - Audit review of HFMA checklist and full review of NRST list reported to Board.	Completed and Evidenced by SaTH

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 1.4.6	Delivery of individual organisational internal audit report recommendations from prior years and pro-active management in year (Monthly review).	AW	Ongoing	Mar-26		
SaTH 1.4.7	Individual organisational tracking of timely completion of internal audit actions (Monthly).	AW	Ongoing	Mar-26		
SaTH 1.4.8	Delivery of individual organisational external audit report recommendations	AW	Ongoing	Mar-26		
SaTH 1.4.9	Individual organisational tracking of timely completion of external audit actions (Monthly)	AW	Ongoing	Mar-26		
SaTH 1.4.10	Internal Audit findings for all finance related audits to be rated moderate or substantial	AW	Ongoing	Mar-26		
SaTH 1.4.12	External audit including VFM to be rated moderate or substantial	AW	Ongoing	Mar-26		

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

3.1	**Deliver SaTH elements / benefits of the System led UEC Improvement Plan 24/25 and 25/26 plan (to be finalised when national guidance for 25/26 published)**

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 3.1.1	Deliver SaTH specific workstreams	Ned Hobbs	01/04/2024	31/03/2026		
SaTH 3.1.2	Actively engage with and make a marked contribution to system wide workstreams	Jo Williams Ned Hobbs	01/04/2024	31/03/2026		
3.1.1	**Lead workstream 1 – 4hr performance plan incorporating GIRFT actions**					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
SaTH 3.1.1.1	Review and recommission UTC provision to increase utilisation	Rebecca Houlston	01/10/2024	01/04/2025	UTC provision was transferred to SaTH on the 1st April 2025.	
SaTH 3.1.1.2	Implement admission avoidance clinics to reduce demand on ED	Gordon Wood	01/04/2024	30/11/2024	General medicine clinics implemented and running on Mondays and Fridays for internal referrals from ED. Booking process and utilisation provided as evidence	Completed and Evidenced by SaTH
SaTH 3.1.1.3	Implement further GP direct access speciality pathways across Women's and Children's services	Zain Siddiqui	12/05/2024	01/04/2025	Direct access in place for Gynae and EPS via GATU, further pathways are being reviewed as part of a new Direct Access / SDEC Pathways workstream within the Capacity and Flow Programme.	
SaTH 3.1.1.4	Implement GP direct access speciality pathways across surgical services	Andrena Weston	12/05/2024	01/04/2025	Direct access speciality pathways across surgical services as part of a new Direct Access / SDEC Pathways workstream within the Capacity and Flow Programme.	
SaTH 3.1.1.5	Improve productivity of Minors	Rebecca Race Rebecca	13/05/2024	01/01/2025	Minors 4-hour performance in March 2025 was at 83.7% (unvalidated position) and remains off track against the operational plan trajectory of 95%. An	

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
		Houlston Nat Rose Deb Archer			increase in attendances occurred in March 2025 across both hospital sites. Recovery actions are being implemented following a ED Flow Co/Clinical Flow Manager workshop	
SaTH 3.1.1.6	Review ED Medical staffing to ensure it aligns with the hourly demand with both ED departments	Rebecca Race	31/05/2024	31/12/2024	Briefing paper based on demand and capacity analysis completed by Chris Green – Head of Information ECIST, NHS England	Completed and Evidenced by SaTH
3.1.2	**Lead workstream 2 Acute Med & Admission and Referral Protocol (IPS) incorporating GIRFT actions**					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
SaTH 3.1.2.1	Improve response time to referrals on the AMU & Medical wards (currently 24 hours) by Cardio and Respiratory	Saskia Jones-Perrott	21/05/2024	30/04/2025		
SaTH 3.1.2.2	Review effectiveness of the Admission and Referral Protocol following relaunch	Steve McKew	24/05/2024	30/04/2025		
SaTH 3.1.2.3	Reconfiguration of bed base on PRH site to expand acute medical beds to align with demand	Laura Graham	01/11/2024	01/07/2025		
SaTH 3.1.2.4	Recruitment following reconfiguration of Cardiorespiratory to optimise diagnostics	Tom Phelps	31/05/2024	31/03/2025	Cardiorespiratory service has transferred to Clinical Support Services division and recruitment has continued and is ongoing to a number of different roles.	
SaTH 3.1.2.5	Therapies: Review the use of SPA time and the SOP updating if required	Emma Weaver	01/07/2024	30/11/2024	Staff survey completed on the use of SPA time.	Completed and Evidenced by SaTH
SaTH 3.1.2.6	Therapies: Review the impact of the E-job planning trial and agree next steps	Emma Weaver	01/07/2024	30/11/2024	Initial review completed next steps are to undertake a revalidation exercise and arrange a series of 1:1 meetings with staff to sense check if their job plans are where they need to be. To add individual objectives to the system including Trust, Therapy and Care Close to Home objectives.	Completed and Evidenced by SaTH

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 3.1.2.7	Therapies: Review Stroke Pathways considering the opportunities as outlined in the CQC report	Emma Weaver	01/07/2024	31/12/2024	Review of the Stroke pathway has informed the Business Case under consideration by Clinical Support Services division	Completed and Evidenced by SaTH
SaTH 3.1.2.8	Radiology: Gap analysis against proposed 12hr turnaround	Helen Williams	01/10/2024	~~31/10/2024~~ 28/02/2025	Analysis of "request to report" data completed. An exception report was presented and approved at UECTAC held on 23 January 2025.	Completed and Evidenced by SaTH
SaTH 3.1.2.9	Radiology: 12hr turnaround draft proposal including procedures and SOP	Helen Williams	01/10/2024	~~30/11/2024~~ 31/05/2025	Additional onsite observations completed by the Improvement Hub which will inform the procedures and SoP.	
SaTH 3.1.2.10	Pharmacy: Development of business case for Pharmacy staff in ED	Imran Hanif	28/10/2024	30/11/2024	Business Case presented to the Innovation and Investment Committee in December 2024.	Completed and Evidenced by SaTH
SaTH 3.1.2.11	Pharmacy - Procurement / Installation / Staff Training / Go live of automated cabinets at PRH emergency dept.	Imran Hanif	21/10/2024	~~31/03/2025~~ 31/06/2025	The RSH ED automated cabinets were in March 2025. A period of staff training is ongoing both face to face and via e-learning prior to hand over. The PRH ED automated cabinets are expected to be installed in May 2025.	
SaTH 3.1.2.12	Pathology - Recruitment of additional posts to extend out of hours provision	Adrian Vreede	01/11/2024	31/03/2025	Recruitment of 1 WTE Biomedical Scientists, 6 WTE Medical Laboratory Assistants 1 WTE Associate Practitioner completed	
3.1.3	**Working with system partners to deliver the System Discharge Alliance Plan to reduce No Criteria to Reside, and thus reducing escalation inpatient acute capacity (linking to reduced bed occupancy)**					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
SaTH 3.1.3.1	Continued engagement from surgery, medicine and ED with the Care Transfer Hub	Rebecca Houlston Angela Raynor Claire Evans	01/08/2024	31/03/2026		

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
3.1.4	**Working with system partners to deliver the alternatives to ED attendances / admissions and Care Coordination**					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
SaTH 3.1.4.1	Continued engagement from surgery, medicine and ED with the Integrated Care Coordination Centre	Rebecca Houlston Angela Raynor Claire Evans	01/08/2024	31/03/2026		
SaTH 3.1.4.2	Be a key stakeholder in the development of the STW integrated urgent care model	Ned Hobbs Jo Williams	01/10/2024	31/03/2026		
SaTH 3.1.4.3	Improving the data quality of ECDS to support identification of further alternative opportunities	Ned Hobbs	01/11/2024	31/03/2025		
3.1.5	**Working with system partners to deliver system frailty plan**					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
SaTH 3.1.5.2	Create and roll out a teaching package for ED and SDEC staff on Clinical Frailty Score	Angela Raynor	09/12/2024	31/03/2025	Training package is now available on LMS for staff to access.	
SaTH 3.1.5.4	Review Welsh documentation and link with Powys	Angela Raynor	10/02/2025	31/03/2025	Documentation has been reviewed, awaiting communication back from Powys.	
SaTH 3.1.5.5	Continued engagement from surgery, medicine and ED with the development of a fully integrated frailty pathway	Rebecca Houlston Angela Raynor Claire Evans	31/05/2024	31/03/2026		
3.2	**SaTH to chair UEC delivery group with effective regular membership from SaTH**					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 3.2.1	SaTH CEO to continue to be SRO for UEC and chair the UEC delivery group	Jo Williams	01/04/2024	N/A		Completed and Evidenced by SaTH
SaTH 3.2.2	Ongoing attendance from key leaders in regard to operational and clinical functions	Ned Hobbs Laurence Ginder	01/04/2024	N/A		
3.3	**Deliver UEC specific actions as per the Quality Improvement Plan including CQC must/should dos and post "Dispatches" actions**					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
SaTH 3.3.1	Deliver QIP in line with agreed timescales	Donna Hadley	05/01/2024	01/04/2025	Two UEC Section 31 conditions remain relating to 15-minute triage for adults and children and patients left without being seen. There are now 22 specific actions associated with these 2 UEC conditions. Currently 18 actions are "complete" with 13 evidenced and assured and 5 Delivered, not yet evidenced.	

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

APPENDIX 5

STW System PMO launch – 28 March 2025

The following provides STW CEOs with an update on the launch of the System PMO that was undertaken on 28 March 2025. The CEOs are asked to note progress and sign off the approach and alignment of associated resources.

In summary, a positive event with good engagement from all providers and agreement to the approach. An agreement on appropriate individuals to support System Transformation Programmes is identified below. Noting only three individuals (in red) required to be identified, with the key element of System PMO required support to Shared Services and Health models.

System wide programmes- alignment of resource

Note that this structure is provisional, will evolve over time and will require resources to be flexible to meet portfolio de mands.

	Workforce (including temporary spend)	UEC	Health Models (LCP)	Elective Reform (including Productivity	Shared Services* (including non-clinical reductions)	MSK Transformation	Financial Improvement Programme (including CHC)	System Improvement Programme
Exec Lead	Stacey Lea-Keegan	Jo Williams	Patricia Davies	Stacey Lea-Keegan	Patricia Davies	Stacey Lea-Keegan	Simon Whitehouse	Simon Whitehouse
SRO	Rhia Boyode	Gareth Wright	Nigel Lee	Maureen Wain	*Nigel Lee*	Mike Carr	Ian Bett	Julie Garside
System PMO Lead	**Jan Heath (ICB)**	**Poppy Horrocks (ICB) & Sam Farmer (SaTH)**	**Carole Peel (ShropCom) & TBC (ICB)**	**Raj Uppal (SaTH) & Geraldine Vaughan (RJAH)**	**(TBC SaTH and Shrop Com)**	**Raj Uppal (SaTH) & Geraldine Vaughan (RJAH)**	**Kate Owen (ICB) & Sanni Aujla (SaTH)**	**James Hosie (ICB) & Heather Weaver (ICB)**
Organisation leads ICB	Jan Heath	Poppy Horrocks Lynn Nicholls	Emma Pyrah Helen White Lorna Watkins Gill Harrell	Vicky Pike Sharon Clennell	Jan Heath	Lynn Nicholls	Natalie Wrighton, Shadina Dodds, Lynn Nicholls	Angie Parkes James Hosie
Organisation leads SATH	Hannes Kerr-Gold	Sam Farmer	Matt Mellors (*TBC*)	Raj Uppal	Sanni Aujla	Raj Uppal	Sanni Aujla	Matt Mellors
Organisation leads RJAH	Lee Osborne/Sally Davies	Geraldine Vaughan (*TBC*)	*TBC*	Lee Osborne/Sally Davies	Lee Osborne/Sally Davies	Geraldine Vaughan	Lee Osborne/Sally Davies	*TBC*
Organisation leads SCHT	Sarah Allan (*TBC*)	Carole Peel	Carole Peel	Alastair Campbell (*TBC*)	*TBC*	Alastair Campbell (*TBC*)	Maggie Durrant	Maggie Durrant

The session was undertaken in three parts:

1. Background, context, proposal and agreement of alignment of resources to System Transformation Programmes.
2. Agreement in use of tools and techniques and required processes to be undertaken.
3. Agreed actions and next steps.

The following notes provide details to the discussion and agreements made.

Meeting	STW ICS - System PMO launch event
Date	28th March 2025, 10:00 15:30
Attendees	1. Ian Bett, Chief Delivery Officer (STW ICB) 2. Natalie Wrighton (STW ICB) 3. Hannes Kerr-Gold (STW SaTH) 4. Matt Mellors (STW SaTH) 5. Sally Davies (STW RJAH) 6. Carole McInnes (STW SATH) 7. Sarah Lloyd (STW Shrop Com) 8. Craig McBeth (STW RJAH) 9. Maggie Durrant (STW SCHT) 10. Poppy Horrocks (STW ICB) 11. Carole Peel (STW SCHT) 12. Kate Owen (STW ICB) 13. Philip Cockayne (PwC) 14. Hadi Raza (PwC) 15. Dominic Allen (PwC) 16. Himesh Patel (PwC) 17. Rebecca Richmond-Smith (PwC)
Purpose	• Formally launch the STW System PMO structure. • Introduce all relevant stakeholders to the proposed structure, programmes, templates, tooling, and processes. • Invite stakeholders to ask any questions regarding the new structure and associated processes. • Invite stakeholders to raise any concerns which are to be addressed throughout implementation. • Agree next steps and associated follow-up actions.
Summary	**Session 1:** Ian Bett (IB) presented a set of slides outlining background to the implementation of a System PMO, the progress made to date, the FY25/26 strategic priorities (as agreed by the Strategic Transformation Group, or STG) and programmes, CEO, SRO and PMO alignment, and distribution of PMO resources. Stakeholders were invited to ask questions and share concerns regarding the changes being proposed: • There is a lack of clarity on the size and scale of programmes and the anticipated resource requirement (both from a PMO and programme resource (PPM) perspective), for example, for shared services and the Local Care Programme (LCP). Attendees requested that an indication of this is provided. • Further clarity regarding specific role descriptions was requested. PwC committed to sharing further details on this before their departure.

- There is currently some variation between individual roles and banding structures. This may present issues later (due to role specification and adherence to agenda for change. It was also acknowledged that some PMO and PPM resources may require additional training to ensure that they are sufficiently skilled to support their programmes. IB asked colleagues to appreciate that this will be addressed as roles and structures are formalised.
- Several individuals outlined on the programme alignment slide were not present in the meeting (Geraldine Vaughan, Raj Uppal). It was agreed that detailed comms would be shared with individuals who were not present.
- Co-locating on specific days, within the ICB's Wellington office, was discussed. It was acknowledged that this would be challenging given some individuals working arrangements and existing locations. It was agreed that one day per week, starting from w/c 31/03, was achievable. Individuals were encouraged to discuss and agree this with their line managers.
- Colleagues discussed how the transition away from accountability and towards acting as a 'critical friend' would require gradual change. Colleagues were asked to support this process, raise any concerns, and participate in the development of new ways for working.
- Colleagues expressed understandable nervousness in moving towards a new structure but were broadly supportive of the initiative. Colleagues were invited to discuss with colleagues, participate in group discussions, and establish both formal and informal forums to support collaborative working and work to address shared challenges.

Session 2

PwC presented the newly created templates, trackers, and reporting tools, and presented on new processes that would be required to deliver the proposed benefits.

Tools

- Colleagues outlined concerns regarding data sharing, whether the additional data requests are compliant with existing data sharing agreements and wanted to specifically understand how the data shared would be used. It was agreed that a Data Protection Impact Assessment (DPIA) should be completed to facilitate this process.
- Colleagues outlined concerns about potential duplication of effort arising from the use of additional systems (i.e. monday.com and Microsoft Accelerator). This point was acknowledged, although it was made clear that this process will not work unless the single version of the truth principle is adhered to.
- Colleagues asked how data integrity would be guaranteed within the tool, given the manual task of copying data between extracts and the tracker. Although this has been mitigated to a certain extent through data validation, residual risk remains. We also discussed how a nominated individual could be sufficiently upskilled to ensure this

process is more reliable. In the longer-term, the system could explore using advanced tooling (i.e. using VBAs and macros to scrape PID content).

- Further tool enhancements were also discussed, specifically the utilisation of reporting tools like Power BI. It was agreed that this would be considered as part of longer-term product development.
- Colleagues queried what would happen if there were issues with the tooling. In response, PwC outlined that although the tooling appears complicated, the underlying architecture is relatively straight-forward. In the first instance, colleagues should attempt to resolve issues themselves or with colleagues. PwC also committed to sharing details of the underlying structure and architecture with a member of the ICB Business Intelligence (BI) team to ensure someone with the requisite skills to diagnose any issues is available to the System.
- IB asked whether there are any opportunities to enhance the current reporting of key performance indicators (KPIs); i.e. through the inclusion of charts (as opposed to tables) and Statistical Process Control (SPC) charts. PwC indicated that this would not be possible for this iteration (due to time constraints) but should be considered under future product development. Others outlined that existing insight reports (i.e. UEC) could be appended to highlight reports in the absence of sufficient KPI reporting within the existing tooling.
- Colleagues queried best practice regarding the reporting of RAG status for milestones, and how this differs between PMOs. It was agreed that the standardisation of RAG indicators within the system would be defined and agreed in the short-term.

Process

- Colleagues questioned the cadence of reporting going forward. It was outlined that this will be dependent on the programme; some may be fortnightly, others may be monthly, and that this should be agreed with SROs to ensure compliance with existing governance arrangements. In principle, it was agreed that all programmes would be expected to report monthly, unless stated otherwise. Kate Owen (KO) also highlighted that the reporting cadence associated with some programmes would need to corroborate with NHS England (NHSE) reporting.
- Colleagues questioned where responsibility will lie for ensuring the information presented in the System PMO tracker is accurate. It was confirmed that this would be the responsibility of each organisation's "Head of PMO". It was also explained the Finance and BI representatives from each organisation would be expected to input into the accuracy of the information presented.
- The group discussed sign-off by SROs before material was to be populated in the System PMO tracker, and how this was to be secured. It was agreed that this would need to be determined on a case-by-case basis.
- The group outlined a sense of nervousness about the expectation that Strategic Transformation Group (STG) would receive the first suite of System PMO reports by the end of April, as the onboarding of

	programmes will take time. It was agreed that this will remain the ambition, although potential workarounds may need considering if information is not available.
Actions	**Action 1.1:** Ian Bett (IB) to provide a follow up session to individuals who could not attend due to leave. **Scheduled for 3 April 2025.** **Action 1.2:** PwC to share role specific role descriptions before departure. **Action 1.3:** System PMO aligned staff to reflect on co-locating request and liaise with Kate Owen to secure available space. Agreement of one day on site as a group in Wellington. **Action 1.4:** Kate Owen (KO) to conduct a data protection impact assessment (DPIA) regarding the production and utilisation of the System PMO tracker as a new information asset. KO to liaise with Ian Bett (IB) in the event of any emerging issues. **Action 1.5:** when the tool is populated, operational, and actively being utilised, group to consider product enhancements (i.e. automation, PID scraping, Power BI, etc.) to improve efficiency. **Action 1.6:** PwC to share further details of the underlying System PMO template and tracker with the ICB handover to ensure technical handover **Action 1.7:** System PMO aligned staff to discuss and agree reporting cadence with SROs and IB. **Action 1.8:** Further discussion needed on aligning system BI and **Action 1.9:** Agreement for monthly SteerCo to ensure evolution of system PMO and to address issues/risks as they arise. To include partners Executive leads and PMO leads. **First extended monthly SteerCo arranged for 24 April 2025.**
Next steps	• PMO and PPM staff to begin populating the System PMO trackers for all relevant programmes • Ian Bett (IB) to provide an update to System CEOs regarding the outcome of this launch event and proceed to secure CEO sign-off. • All PMO and PPM staff to work towards ensuring that programme-specific reports are ready by the STG scheduled for 18 April 2025.

Board of Directors' Meeting
8 May 2025

Agenda item		085/25		
Report Title		Safeguarding of Adults at Risk of Abuse Policy		
Executive Lead		Paula Gardner, Interim Chief Nursing Officer		
Report Author		Kathy George, Head of Adult Safeguarding, MCA & Prevent Lead		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Joint SaTH Safeguarding Operational Group, December 2024 Policy Approval Group, January 2025 Quality & Safety Assurance Committee, March 2025		
Executive summary:		The Board's attention is drawn to the following sections: • Section 4 .The inclusion of the Trust Modern Slavery Statement • Section 10. The inclusion of an additional reference: West Midlands Regional Adult Safeguarding Network; Framework for Responding to Organisational Failure or Abuse 2024 These are the only changes to the previous version of the policy; this is a routine policy review.		
Recommendations for the Board:		The Board of Directors is asked to: **approve** the policy		
Appendices:				

Safeguarding of Adults at Risk of Abuse Policy

Doc ID: CG15

Additionally refer to:

Procedure for Safeguarding Adults at Risk of abuse and neglect
CG14 - Mental Capacity and Best Interests Policy and Procedures
Policy and Procedure for the Deprivation of Liberty Safeguards (DoLS)
Managing Allegations against Staff in Positions of Trust Procedure (for those working with Adults with Care and Support Needs)
CG15a - Adult Safeguarding Supervision Framework
Prevent Policy
A Policy for the Management of Restrictive Interventions for Adults in an Acute Hospital Setting Policy
W4 - Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy

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Document Lead	Head of Adult Safeguarding		
Lead Director	Interim Chief Nursing Officer		
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Document Control Sheet

Document Lead/Contact:	Corporate Nursing Quality Assurance Lead
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Version history

Version	Date	Author	Status	Comment – include reference to Committee presentations and dates
V1	Oct 2020	Kathy George	Draft	Circulated for comment. Presented to Safeguarding Committee November 2020
V1.1	Nov 2020	Kathy George	Draft	Amended following comments. Recirculated and presented to Safeguarding Committee Dec 2020. Version agreed
V1.1	Dec 2020	Kathy George	Draft	Presented to Trust Safeguarding Assurance Committee for approval. Approved 17.12.2020
V1.2	Jan 2022	Kathy George	Annual Review	Circulated for comment. Presented to Safeguarding Operational Committee January 2022. Approved
V1.3	Dec 2022	Kathy George	Annual review	Presented to Safeguarding Operational Committee Dec 2022. No changes identified
V1.4	Nov 2023	Kathy George	Annual review	Presented to Safeguarding Operational Committee Nov 2023.
V1.5	Dec 2024	Kathy George	3 yearly formal review	Presented to and agreed at Joint Safeguarding Operational Group Committee. Inclusion of a Modern Slavery Statement and additional reference
V1.6	Jan 2025	Kathy George / Laura Perkins	Draft	Formatting carried out post PAG in preparation for presentation at QSAC and Board
V1.7	March 2025	Kathy George	Draft	Change of Job title from Director of people and OD to Chief people Officer for presentation to Board

Contents

Acknowledgement to University Hospitals Birmingham NHS Foundation Trust

1. Policy on A Page

1.1 Shrewsbury and Telford Hospital NHS Trust (SaTH) hereafter referred to as the Trust operates a zero-tolerance policy concerning the abuse of adults at risk. Any adult at risk of abuse, exploitation or neglect must be able to access support to enable them to live a life free from violence and abuse. The Care Act (2014) provides a framework to ensure all responsible agencies work together for the protection of vulnerable adults at risk of abuse.

1.2 The Trust will not tolerate any members of staff subjecting our patients to any type of abuse. This will be treated as gross misconduct.

1.3 The Trust aims to create a culture of openness, raising awareness of the kinds of abuse that might occur and where all staff act against abuse. The abuse of adults at risk constitutes a clear infringement of their rights and freedoms as citizens. The Trust is committed to ensuring people's individual rights and freedoms are protected and promoted through working to eliminate all forms of abuse.

1.4 The key objectives of this policy are.

- To set out the principles and framework for the safeguarding of adults at risk.
- To ensure all staff understand their roles and responsibilities in connection with safeguarding adults at risk.
- To ensure compliance with national and regional Policy and Guidance related to safeguarding adults at risk.

2. Scope

This policy applies to all areas of the Trust and all individuals employed by the Trust including contractors, volunteers, students, locums, bank and agency staff and staff employed on honorary contracts who are involved in Trust business on and off the premises.

3. Abbreviations and Definitions

Adult at Risk	An adult is any person aged 18 and over (UN Convention of the Rights of the Child, 1989) The Care Act 2014 identifies that an adult at risk is a person. (a) who has needs for care and support (whether or not the local authority is meeting any of those needs), (b) is experiencing, or is at risk of, abuse or neglect, **and** (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.
Abuse	Abuse is a violation of an individual's human and civil rights by any person or persons. This may present as single or repeated acts. The 10 main types of abuse as identified within the Care Act 2014 are: • Physical Abuse • Domestic Violence or Abuse • Sexual Abuse • Psychological or Emotional Abuse • Financial or Material Abuse • Modern Slavery • Neglect or acts of omission. • Self-neglect • Discriminatory • Organisational or institutional Abuse In addition, there is criminal exploitation which includes mate crime, cuckooing, county lines, and adult sexual exploitation. Forced Marriage and Honour Based Violence and Prevent For more information, please refer to the Trust procedures for Safeguarding Adults at Risk

4. Modern Slavery Statement

Under Section 54 of the Modern Slavery Act, we are committed to ensuring that employees of the Trust are not exploited, that they are safe, that they have the right to work and remain in the country, and that their employment standards and human rights are adhered to. The Trust expects the same from its suppliers and is committed to working with them to ensure any issues are identified and proactively managed. Some controls in place include:

- Employment checks of individuals and of agencies which supply temporary staff.
- Use of NHS General Terms and Conditions of Contract for Goods and Services which cover all suppliers to the Trust including medicines.
- Due diligence within our procurement and tendering processes to test that selected suppliers, and third parties are compliant with the legislation

5. Framework

5.1 This section describes the broad framework for the safeguarding of adults at risk of abuse throughout the Trust. Detailed instructions and definitions of types of abuse are provided in the associated procedural documents.

5.2 The Chief Nursing Officer will approve all procedural documents associated with the policy, and any amendments to such documents, and is responsible for ensuring that such documents are compliant with this policy.

The Framework for this policy is based on the West Midlands: Multi-agency policy and procedures for the protection of adults with care and support needs which detail the following responsibilities for NHS Hospital Trusts regarding the safeguarding of adults at risk. For details, please see references section below.

5.3 Information

- The Trust will ensure that awareness is raised within staff, patients and visitors through information via Trust intranet, internet and information leaflets about abuse of adults at risk, giving a clear message that it is everyone's responsibility and

- To have internal safeguarding adults' policy and procedure that clearly defines the responsibilities of all staff, and the actions that they should take when suspicions of abuse and neglect are raised. The internal procedure must link with regional multi-agency procedure.

5.4 Training

- In line with the Trust Safeguarding Training Needs Analysis, ensure that all staff/volunteers are trained to recognise abuse and how to use the procedures in place to support the person and to alert managers: (see Appendix A) and

- To train managers who may be responsible for making decisions about allegations of potential abuse.

5.5 Governance

- Trust recruitment has appropriate rigorous recruitment policies and practices for staff.

- Head of Adult Safeguarding ensures supervision and monitoring of staff working with adults at risk.
- Safeguarding team keep clear and accurate records of all incidents of abuse and provide information as required.

- Clinical staff as part of assessment process on admission identify any risks of abuse.

- All staff to share information in line with the Shropshire and Telford & Wrekin Safeguarding Partnerships Information Sharing agreement through the Head of Adult Safeguarding.

- All staff to participate in joint working with other agencies in investigations and actions to protect adults at risk of abuse through the Head of Adult Safeguarding.

- Adult Safeguarding Team to contribute to Safeguarding Adults assessments/enquiries through attendance at multi agency strategy meetings.

- Head of Adult Safeguarding to attend meetings of the Shropshire and Telford & Wrekin Safeguarding Partnerships

- Head of Adult Safeguarding to contribute to the annual safeguarding report to the Board of Directors.

- Head of Adult Safeguarding to ensure staff know they are protected in law if they report abuse and are concerned about their name being used (please refer to the Trust Freedom to Speak Up: Raising Concerns (Whistleblowing) policy)

5.6 All suspicions and allegations of abuse or inappropriate behaviour will be taken seriously by the Trust and responded to in line with the Managing Safeguarding Allegations against Staff in positions of Trust Procedure and the Disciplinary Policy and its associated procedures.

5.7 Safeguarding is everyone's business, and everyone matters, and all staff and volunteers have a responsibility for reporting any suspicions or concerns of abuse or inappropriate behaviour following the Procedures for Protecting Adults at Risk

5.8 Trust Safeguarding Committee

- The Trust Safeguarding Committee chaired by the Chief Nursing Officer ratifies all Policies relating to Safeguarding (both Adult and Children)

- The Chief Nursing Officer has established the Trust Safeguarding Operational Group to oversee the management and implementation of this policy across the Trust. The membership and roles and responsibilities of the Trust safeguarding operational Group are detailed in the terms of reference. The group includes representatives of staff working with the following patient groups who are considered to be especially vulnerable in this way.

- Adults with learning disabilities

- Frail older adults with dementia

5.9 Staff Support

- The Trust will ensure support is available to staff, who are involved in reporting an allegation of abuse. For staff who might themselves be survivors of abuse may require additional support. This support will be through their line manager, or more formal support may be sought from the Occupational Health department.

6. Duties

6.1 Chief Nursing Officer

The Chief Nursing Officer will.

- Sponsor the local safeguarding and control procedural documents.

- Be responsible to the Board of Directors for safeguarding adults at risk within the Trust.

- Provide an annual safeguarding report to the Board of Directors

- Appoint a nominated Head of Adult Safeguarding

6.2 Head of Adult Safeguarding

The Head of Adult Safeguarding will:

- Ensure all policy and procedural documents are current and reflect best practice.

- Provide specialist advice concerning the care of adults at risk of abuse.

- Ensure all clinical staff within the Trust have access to appropriate training in the safeguarding of adults at risk of abuse.

- Review cases where an adult at risk of abuse has not received appropriate care.

- Review all Trust Incident reports related to abuse or suspected abuse of adults at risk and ensure examples of good practice or required changes in practice are shared throughout the Trust via the Trust Safeguarding Operational Group which will report to the Trust Safeguarding Committee.

- Ensure an accurate record of adult protection cases within the Trust is maintained.

- Ensure that managers to whom safeguarding concerns are raised take appropriate action as to which route to take.
- Meet bi-monthly with the Chief Nursing Officer.

- Lead on the Prevent agenda.

- Lead on the education, training and implementation of the Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards.

6.3 The Head of Adult Safeguarding will ensure the following of the Trust Safeguarding Operational Group.

- The membership of this group is detailed in terms of reference which are approved by the Chief Nursing Officer. The Trust safeguarding operational group will be chaired by the Deputy Chief Nursing Officer and will.

- Meet on a bi- monthly basis

- Monitor, maintain and oversee the infrastructure in order to safeguard adults at risk of abuse.

- Support the development and delivery of training and the provision of best practice.

- Ensure the monitoring of incidents related to the safeguarding of adults at risk.

- Ensure the lessons learned for adverse incidents and near misses both within and external to the Trust are considered and relevant actions and changes are implemented across the organisation.

- Ensure that working practices are in line with legal and national requirements in relation to safeguarding adults at risk

- Provide a quarterly report to the Chief Nursing Officer through the Safeguarding Committee and an annual report to the Board of Directors.

- Provide expert adult safeguarding advice particularly in relation to adult protection, to the Chief Nursing Officer and thereby to the Executive team.

- Oversee and monitor the attainment and required standards of training and development for the safeguarding of adults; and

- Monitor and ensure the implementation of findings from Safeguarding Adult Reviews (SAR's) and Domestic Homicide Reviews (DHR's within the Trust and of Trust Complaints.

- **Named Doctor:**

  - Their role is to support other professionals in the Trust to recognise Adult Safeguarding concerns.

  - To promote good practice within the Trust.

  - To safeguard adults within the Organisation

  - To provide advice and expertise to staff.

  - To provide adult safeguarding supervision for medical staff

  - To participate in internal management, Safeguarding Adult and Domestic Homicide Reviews.

6.4 Chief People Officer

The Chief People Officer will:

- Develop HR policies and procedures which support adult safeguarding.

- Ensure appropriate background checks on prospective staff are rigorous in line with current policy and procedure and NHS Employment Checking Standards.

- Ensure HR and recruitment staff are appropriately trained and briefed on safeguarding adults at risk to be able to fulfil the responsibilities within their own role and to help others detect and report.

- Provide support and advice to staff involved in adult safeguarding procedures where staff members may be personally involved.

- Ensure the provision of Occupational Health services and staff support.

- Attend the Trust Safeguarding Committee and report on case management concerning staff who are at risk or are alleged to have placed an adult at risk, and any learning arising from that.

- Jointly attend multi-agency meetings with the Head of Adult Safeguarding where staff are involved.

6.5 Managers

Anyone who has responsibility for staff potentially involved in the safeguarding of adults must ensure.

- All staff have access to this policy and associated procedural documents.
- All staff adhere to and implement this policy and associated procedural documents.
- The appropriate staff, equipment and stationery are available to enable this policy to be followed; and
- Staff have necessary training to enable them to implement this policy provided by Trust Safeguarding team.

6.6 All Staff and Volunteers

All staff and volunteers will:

- Be vigilant to the possibility that adults at risk may be the victims of abuse.
- Adhere to the policy and associated procedural documents. In particular please see procedure for Safeguarding Adults at Risk.
- Attend or complete relevant training sessions and comply with Safeguarding Mandatory training.

7. Implementation and Monitoring

7.1 Implementation

- This policy and its associated procedures are available on the Trust Intranet and disseminated to staff through management and internal team structures within the Trust.

7.2 Monitoring

Monitoring of Implementation	Monitoring Lead	Reported to:	Monitoring process	Monitoring Frequency
Review all safeguarding adult contacts, including non -compliance with policy. This will include referral quality issues	Head of Adult Safeguarding	Trust Safeguarding Committee	Adult Safeguarding Activity report Trust database	Bi-monthly
Monitoring incident reports and complaints including trends and progress against action plans	Head of Adult Safeguarding	Trust Safeguarding Committee	All safeguarding cases are reported through the Trust incident reporting procedures. All complaints are monitored through IROG	Bi-monthly
Monitoring of new concerns raised against the Trust	Head of Adult Safeguarding	Trust Safeguarding Committee	Adult Safeguarding Activity report. Trust Database	Bi-monthly
Monitoring of new concerns raised by the Trust	Head of Adult Safeguarding	Trust Safeguarding Committee	Adult Safeguarding Activity report. Trust Database	Bi-monthly
Local arrangements for monitoring and identification of themes & trends and outcomes of adult safeguarding contacts	Head of Adult Safeguarding	Trust Safeguarding Committee	Adult Safeguarding Activity report Trust Database	Bi-monthly
Attendance/Compliance with the Local and National Adult Safeguarding Training Targets for Level 2 and 3	Head of Adult Safeguarding	Trust Safeguarding Committee	Training data Training Needs Analysis	Bi-monthly
Monitoring of adherence to Deprivation of Liberty Safeguards procedures	Head of Adult Safeguarding	Trust Safeguarding Committee	Adult Activity report	Bi-monthly
Monitoring and ensuring the implementation of findings from Safeguarding Adult and Domestic Homicide reviews within the Trust.	Head of Adult Safeguarding	Trust Safeguarding Committee	Presented to Trust Operational Group and Assurance Committee	Ad hoc

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8. Training

- A Training needs analysis and training implementation plan is in place to support this policy as per Appendix A.

9. EQIA Statement

An equality impact assessment has been undertaken on this policy. This policy applies to all persons equally and does not discriminate positively or negatively between protected characteristics.

10. References

Adult Safeguarding: Multi-agency policy and procedures for the protection of adults with care and support needs in the West Midlands
West-Mids-Policy-and-Procedures-Nov-2109.pdf [accessed 18.11.2024]

Care and Support Statutory Guidance (2022) Chapter 14
Care and support statutory guidance – GOV.UK [accessed 18.11.2024]

Department of Health (2011) Safeguarding Adults Role of Health Service Managers and their Boards
Safeguarding Adults: The Role of Health Service Managers & their Board
[accessed 18.11.2024]

Department of Health (2011) Building Partnerships Staying Safe – the health sector contribution to HM Governments Prevent Strategy Guidance for healthcare.
Building Partnerships, Staying Safe [accessed 18.11.2024]

The Care Act 2014 Care Act 2014 [accessed 18.11.2024]

Mental Capacity Act 2005 Mental Capacity Act 2005 [accessed 18.11.2024]

Safeguarding Adults: Roles and Competencies for Health Care Staff. Intercollegiate Document 2024. 2nd edition
Adult Safeguarding: Roles and Competencies for Health Care Staff | Publications | Royal College of Nursing [accessed 18.11.2024]

West Midlands Regional Adult Safeguarding Network; Framework for Responding to Organisational Failure or Abuse 2024 WM-Framework-for-Responding-to-Organisational-Failure-or-Abuse-v2.0_2024.pdf [accessed 11.2.2024]

Appendix A: Training Needs Analysis (December 2024)

Training	Frequency	Delivery Methods	Staff Groups	Trust Target
Level 1 All staff working in healthcare settings				
Level 1 Adult Safeguarding	On induction and 3 yearly	e-learning initially with Newsletter (refresh)	**All staff on induction**	100%
			3 yearly refresh for non - front facing staff. All health care staff including receptionists, administrative staff, caterers, domestic and transport staff, porters, maintenance staff, board level executives and non-executives	90%
Level 2 All staff working in healthcare who have regular contact with patients, their families or carers				
Level 2 Adult Safeguarding	3 yearly (min 3hrs per 3 years)	Training needs will be met through attendance at SSU training day	To include administrators for safeguarding teams and all front facing trust staff groups, including Chaplains Medical staff with no patient/front facing contact	90%
Level 3 All staff working in health care who are working with adults who are engaged in assessing, planning, delivering care and/or evaluating the needs of adults where there are safeguarding concerns (as appropriate to role).				
Level 3 Adult Safeguarding	3 yearly (8 hours over 3 years)	Through SSU training day **(With MS Teams Webinars Conferences and courses for the safeguarding specialist nurses Children and Maternity Safeguarding Leads)**	Nursing Associates (with PIN no) Band 5 clinical staff to include therapists Medical Staff with patient contact/front facing contact **Specialist Safeguarding Nurses** The Trust will also require the Safeguarding Trainer have level 3. Children and Maternity Safeguarding Leads	90%
Level 4: Specialist roles – named professionals, safeguarding leads (and equivalent roles directly advising staff on safeguarding).				
Level 4 Adult Safeguarding	3 yearly (24hrs over 3 years)	Accumulative independent training	Head of Adult Safeguarding Named Doctor for Adult Safeguarding	100%

Board of Directors' Meeting
8 May 2025

Agenda item		086/25		
Report Title		Patient Safety Incident Response Framework (PSIRF) Policy		
Executive Lead		Paula Gardner, Interim Chief Nursing Officer		
Report Author		Pete Jeffries, Assistant Director of Nursing, Quality Governance		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	All aspects of BAF
Effective		Our people		
Caring		Our service delivery		**Trust Risk Register id:**
Responsive		Our governance	√	
Well Led		Our partners		
Consultation Communication		Quality Operational Committee 21 January 2025 Policy Approval Group 26 February 2025 Quality and Safety Assurance Committee 25 March 2025		
Executive summary:		The Trust has now been working under the Patient Safety Incident Response Framework (PSIRF) since December 2023. It was agreed that the Patient Safety Incident Response Plan and Patient Safety Incident Policy would be reviewed and updated annually in the light of experience and learning from the previous 12 months. The documents have been reviewed in line with a learning workshop conducted with the Divisional Quality Governance Teams. Further review by the Patient Safety Specialists has suggested relatively minimal changes to the plan. Changes to the policy mainly revolve around updating terminology which does not alter the substance of the policy. Some slightly more detailed changes have been made as noted below: • Updates regarding the name and role of Incident Review and Oversight Group (IROG) – Page 12/13. • Updates relating to the Peer Review Group (PRG) which were introduced post the original Plan and Policy based on initial learning Page 12/13. • Changes to patient safety structures to incorporate the roles of Family Liaison Officers Page 9.		
Recommendations for the Board:		The Board is asked to: **Approve** the PSIRF Policy and associated Patient Safety Incident Response Plan.		
Appendices:				

Draft V2.3	The Shrewsbury and Telford Hospital NHS Trust

Patient Safety Incident Response Policy (including Patient Safety Incident Response Plan)

Doc ID: PSIRF2.3

Associated policies: Duty of Candour (CG10), Infection Prevention & Control Policy (IPC15), Health & Safety Management Policy (HS01)

Version:	V2.3 Draft for Board approval
V1 issued	October 2023
V1 approved by	Quality Operational Committee
V1 date approved	19th September 2023
V1 Ratified by:	Board
V1 Date ratified:	12th October 2023
Document Lead	Patient Safety Specialist
Lead Director	Chief Nursing Officer
Date issued:	October 2023
Review date:	December 2024
Target audience:	All Trust staff

Document Control

Document Lead/Contact:	Patient Safety Specialist
Version	V1.1
Status	Draft for QSAC approval
Date Equality Impact Assessment completed	See attached EQIA
Issue Date	October 2023
Review Date	December 2024
Distribution	Please refer to the intranet version for the latest version of this policy. Any printed copies may not necessarily be the most up to date
Key Words	Incident, adverse event, PSIRF01, patient safety incident response policy, patient, safety, event, adverse PSIRF, PSIRF policy, incident response, SI, serious incident, investigation.
Dissemination plan	Via SaTH Intranet and Document Library. Via various training courses and involvement events Divisional and speciality governance meetings Sharing via Trust Comms team

Version history

Version	Date	Author	Status	Comment – include reference to Committee presentations and dates
V1.0	October 2023	Peter Jeffries Patient Safety Specialist/ Sara Cormack Deputy patient Safety Specialist	Final	PSIRF Policy year one
V1.1	January 2025	Peter Jeffries Patient Safety Specialist/ Sara Cormack Deputy patient Safety Specialist	Draft for approval	Minor amends to meeting names (Rapid Review to IROG), addition of Peer Review Group (commissioning and approval). Minor edits to function and purpose of meetings. QOC approval – 21st January 2025Policy Approval Group – 26th February 2025 QSAC 25th March 2025

Contents

1. Purpose

1.1 This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out the approach Shrewsbury and Telford Hospital NHS Trust (hereby referred to as SaTH or the Trust) will take to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

1.2 The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management in the NHS.

1.3 This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents and safety issues.
- Supportive oversight focused on strengthening response system functioning and improvement.

2.Equality Impact Assessment Statement

2.1 An equality impact assessment has been undertaken on this policy. No negative or positive impacts have been identified on groups with protected characteristics.

3. Scope

3.1 This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across SaTH's two acute hospital sites, The Royal Shrewsbury Hospital (RSH) and The Princess Royal Hospital Telford (PRH), as well as a number of offsite and subcontracted services including, but not limited to:

- Community maternity services based at Bridgnorth, Ludlow, Market Drayton, Oswestry, Shrewsbury, Telford, and Whitchurch.
- Renal units at Ludlow Community Hospital and Hollinswood House Telford
- Home haemodialysis service
- Fertility services at Severn Fields
- Health harmony dermatology services
- Everlight radiology
- Virtual wards
- SaTH at home

3.2 Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a ‘person-focused’ approach where the actions or inactions of people, or ‘human error’, are stated as the cause of an incident.

3.3 There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims

handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

3.4 Response types that are outside the scope of this policy include:

- Complaints
- Human Resources (HR) investigations
- Professional standards investigations
- Coronial inquests
- Criminal investigations
- Claims management
- Financial investigations and audits
- Safeguarding concerns
- Information governance concerns
- Estates and facilities issues which do not impact on patient safety

3.5 Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

4. Our patient safety culture

4.1 SaTH is on a journey to promote an environment that fosters a positive safety and Just Culture and PSIRF forms a key component.

During the implementation of PSIRF phase two of the programme focused on diagnostic and discovery, an opportunity to review current systems and processes and through them how the Trust already responds to patient safety incidents for the purpose of learning and improvement.

4.2 Through this process, several strengths as well as areas of improvement were identified that will support the requirements and transition to PSIRF.

- The Trust template for formal investigations reflected the human factors system model of Systems Engineering Initiative for Patient Safety (SEIPS), to ensure all contributing factors are explored.
- Ongoing development of the Trust's Executive led incident review group to focus on systems learning and improvement and support.

Areas for improvement that were identified included:

- Effective ways to communicate shared learning from patient safety events, capturing all levels between Ward to Board.
- Engagement of staff when a patient safety event occurs, promoting a Just and Learning Culture and ensuring
- Development of HR systems and processes to support Just Culture.

4.3 Acting on this learning a separate but linked annual patient safety systems improvement plan will be developed to support the implementation of PSIRF and development of a proactive safety culture.

5. Patient safety partners

5.1 The NHS Patient Safety Strategy (July 2019) recognises the importance of involving patients, families, carers, advocates, and other lay people in improving the safety of NHS care, as well as the role that patients and carers can have as partners in their own safety.

This framework sets out how NHS organisations should involve patients in patient safety.

The framework is split into two parts:

- Involving patients in their own safety
- Patient Safety Partner (PSP) involvement in organisational safety

5.2 The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England to help improve patient safety across healthcare in the UK. It is a vital part of the new PSIRF that aims to allows members of the general public to advocate for the local population to influence and improve safety across our services. PSPs can be patients, carers, family members or other lay people, including NHS and Social Care staff from another organisations.

5.3 PSPs will each bring their own unique perspective and insight on patient safety as users of services across different parts of the NHS. They may also have experience of avoidable harm or healthcare related incidents and can therefore help inform the development of safety solutions that cross organisational boundaries. PSPs will also be pivotal in the development and continuous improvement of our policies and procedures relating to the involvement of patients, families, carers, and advocates who have been involved in patient safety incidents.

5.4 The recruitment process for our Trust PSPs is currently underway.

At SaTH we will use the insight of our PSPs to:

- Support us in reviewing incidents, investigations, and action plans by being a committee member at our Executive incident review group, (Response and Learning from Incidents Group (RALIG).
- Forming part of the teams reviewing our four initial patient safety priorities (as outlined in our Patient Safety Response Plan) ensuring the patient and family perspective is at the heart of our improvement work and providing critical challenge to our improvement plans.
- With the patient safety investigation team support review of patient and family feedback to inform continuous improvement of our investigation processes.
- Be involved with the ongoing annual review of our patient safety incident response as outlined in this policy.

6. Addressing health inequalities

6.1 The Trust recognises that the NHS has a core role to play in reducing inequalities in health by Iimproving access to services and tailoring those services around the needs of the local population in an inclusive way.

6.2 The Trust as a public authority is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics.

6.3 Within our patient safety response toolkit, we will directly address if there are any particular features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to any incident we will consider inequalities, and this will be inbuilt into our documentation and governance processes.

6.4 Our systems and processes underlying our patient safety incident response will support us to understand health inequalities in relation to patient safety by:

- A new monthly safety and quality intelligence triangulation group will review safety information to identify themes and trends, including information on health inequalities.
- Ongoing review and feedback from patient and families relating to incident responses will be assessed in terms of health inequalities.
- Our Patient Safety Partners and ongoing discussion of patient safety issues with our PACE panel will act as further sources of insight into disproportionate safety risk for any population group.
- Insight on health inequalities will inform our annual review of our patient safety incident response.

7. Engaging and involving patients, families and staff following a patient safety incident

7.1 SaTH recognises that patient safety incidents can have a significant impact on all those involved in them, including the patient, their families, advocates, and staff. Getting involvement with all parties right as part of our incident response is crucial, not only to provide answers to questions all involved may have in relation to the incident, but to support learning and continuous improvement of the services we provide. Learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place.

7.2 The voices of all those involved in an incident are an integral part of our PSIRF policy. We have developed procedures and guidance to support staff in how to discuss incidents with patients, families, advocates, and staff, as well as identifying any immediate support needs and signposting them to available support as required.

7.3 The overall framework for compassionate engagement of patients and families following and incident is outlined below, this forms the basis of the guidance we have produced for staff:

7.4 Duty of Candour is a general duty to be open and transparent with people using the services provided by the Trust, their family, carers, and advocates. It sets out specific requirements providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Legal Duty of Candour regulations will still apply for “notifiable safety incidents”.

8. Patient safety incident response planning

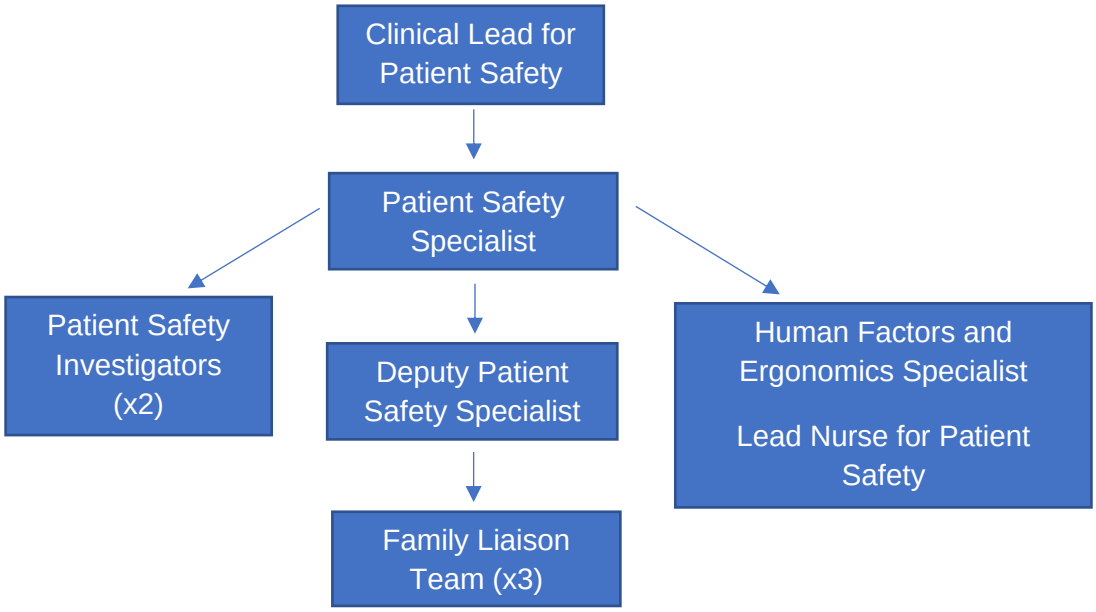
8.1 PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold. There are no further national rules or thresholds to determine what method of response should be used to support learning and improvement for each type of incident.

8.2 This change will result in some moderate harm and greater incidents receiving less review than they would previously. Conversely, some low and no harm incidents will receive more review due to the fact they will represent greater opportunity for learning and improvement in systems where the issues are not well understood.

8.3 With the implementation of the new PSIRF framework, SaTH are now able to balance effort and resources between learning through responding to incidents or exploring issues and improvement work. Responding proportionately to balance learning and improvement efforts requires a thorough understanding of the local patient safety incident profile and ongoing improvement work.

9. Resources and training to support patient safety incident response

9.1 The central patient safety team will take responsibility for investigating PSII's under the national priorities as outlined in our Patient Safety Incident Response Plan working closely with Divisional and clinical teams. The structure of the team is outlined below:



The central patient safety team will also take oversight of thematic work undertaken related to our PSIRF safety priorities.

9.2 Other safety learning responses (such as After Action Reviews (AARs) and Multidisciplinary Team Reviews (MDTs)) will be supported and facilitated by the Quality Governance Teams in each Division with further support from the central Patient Safety Team as required.

9.3 Initial training support has been delivered and is outlined below:

- Central Patient Safety Team, Quality Governance Teams, Corporate Nursing Quality team and Quality Leads from support services – *3 days training on systems investigations, compassionate engagement and oversight.*
- Divisional Leadership Teams – *two half days training on compassionate engagement and oversight.*
- Executive Director safety leads (Director of Nursing and Medical Director) - *two half days training on compassionate engagement and oversight and in line with PSIRF guidance level 1 for Boards National Patient Safety Syllabus training.*
- Non-Executive members of Quality and Safety Assurance Committee – *half day oversight training and in line with PSIRF guidance level 1 for Boards National Patient Safety Syllabus training.*
- Other members of Trust Board - *in line with PSIRF guidance level 1 for Boards National Patient Safety Syllabus training.*

9.4 Ongoing safety needs will be assessed as part of the annual cycle of PSIRF review and further training delivered based on that assessment.

10. Our Patient Safety Incident Response Plan

10.1 Our Patient Safety Incident Response Plan (PSIRP) sets out how SaTH intends to respond to patient safety incidents over a period of approximately 12 months from March 2025. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred, including the needs of those affected, the level of organisational knowledge of the risks involved in the incident, the learning potential of the incident, and the Trust's PSIRF plan to determine the most proportionate response to each incident.

10.2 Our PSIRP is attached to this policy as appendix 1

11. Reviewing our patient safety incident response policy and plan

11.1 Our Patient Safety Incident Response Plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date.

This review will be formed of three key components:

- Review of our ongoing patient safety profile informed by incidents, risks, complaints, learning from deaths information, external reports and patient, family and staff feedback.
- Review of improvement plans related to our Trust safety priorities.
- Feedback of ongoing review of both the positive and negative aspects of our PSIRF processes to inform ongoing improvement of our PSRIF implementation. This will be sourced from patient, family, and staff feedback.

11.2 These sources of information will be reviewed annually in conjunction with external and internal stakeholders and used to report to Quality Operational Committee (QOC) onto Quality and Safety Assurance Committee (QSAC) and to our Trust Board with recommendations for the refreshing of our Patient Safety Incident Response Plan and Patient Safety Incident Response Policy.

11.3 This is an important feature of PSIRF as with ongoing improvement work progressing in the Trust, our patient safety incident profile is likely to change and evolve.

This regular review process will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to months. Updated plans will be published on the Trust website, replacing the previous version.

12. Responding to patient safety incidents

12.1 Patient safety incident reporting arrangements

The main method for staff to report patient safety incidents is via the Trust Datix incident reporting system. This is a central Trust database of incidents and the learning and actions that have been implemented as a result of their review. This system allows managers and senior staff members in departments to have oversight of all incidents in their area and enables them to log how they have reviewed and responded to the incident as well as how they have provided feedback to the

staff who have raised their concerns. Datix also allows senior managers and executives oversight of patient safety incidents and is a vital source of data to identify areas of concern as well as good practice to help inform the Trust's overall safety profile.

12.2 Patient Safety Incidents can also be identified via a number of different routes including Learning from Deaths, Medical Examiner (ME) reviews, Structured Judgment Reviews (SJR), complaints, Multi-Disciplinary Team (MDT) discussions, Freedom to Speak Up (FTSU) concerns and audits. Once identified via these alternative routes, the incident is added to the Datix incident reporting system as a patient safety incident for full and transparent review, investigation, and learning.

12.3 The Trust is also required to fulfil a number of requirements to report or notify various organisations or regulatory bodies external to the Trust of specific incidents and adverse events. These include:

- **UKHSA**- UK Health Security Agency- all laboratories in England performing a primary diagnostic role must notify UKHSA on the confirmation of a notifiable organism.
- **SHOT**- Serious Hazards of Transfusion- must report adverse events of transfusion of blood and blood components.
- **HTARI-** Human Tissue Authority Reportable Incident- must report serious incidents and near-miss incidents that may affect the dignity of the deceased and damage public confidence.
- **HFEA-** Human Fertilisation and Embryology Authority- must report all incidents involving fertility treatment, including near misses to HFEA.
- **IRMER**- Ionising Radiation (Medical Exposure) Regulations- must report incidents involving accidental or unintended exposure to ionising radiation that the provider knows, or thinks are significant or clinically significant.
- **STEIS**- Strategic Executive Information system- system for reporting Serious Incidents (SI) to the appropriate Integrated Care System (ICS).
- **LFPSE-** Learning from Patient Safety Events- new national NHS service for the recording and analysis of patient safety events that occur in healthcare.
  NOTE: the functions of STEIS will likely be replaced by LFPSE during the time period covered by this policy. All Patient Safety Incident Investigations (PSIIs) will be reported on STEIS in the short term.
- **RIDDOR-** Reporting of Injuries, Diseases and Dangerous Occurrences Regulations- reporting of deaths and specified injuries to the Health & Safety Executive (HSE).
- **MHRA-** Medicines and Healthcare Products Regulatory Agency- must report suspected problems and adverse incidents with a medicine or medical device to the MHRA using the Yellow Card Scheme
- **CDOP-** Child Death Overview Panel– must be notified of all child deaths by the Head of Safeguarding Children.
- **Coroner**- deaths where no doctor is available to provide a cause of death, or other specific circumstances including deaths linked to medical treatment, surgery or anaesthetic, suspected suicides and deaths linked to drugs or medications (prescribed or illicit).
- **NHS screening programs** – any incidents in screening programmes must be reported to Public Health England (PHE) via a Screening Incident Assessment Form (SIAF) to allow them to assess and respond to each incident. The NHS Screening Programmes covered are:
  - NHS Breast Screening Programme
  - NHS Cervical Screening Programme
  - NHS Bowel Cancer Screening Programme
  - NHS Diabetic Eye Screening Programme

- NHS Abdominal Aortic Aneurysm Screening Programme
- NHS Foetal Anomaly Screening Programme
- NHS Infectious Diseases in Pregnancy Programme
- NHS Sickle Cell and Thalassaemia programme
- NHS Newborn Blood Spot Programme

13. Patient safety incident response decision-making

13.1 Because of the change of focus of which incidents need more detailed review under the new PSIRF, the Trust has introduced a new approach to the initial review of incidents. This new approach has introduced a daily triage of incidents by a senior member of the Patient Safety Team with admin support.

This new approach has a number of benefits, including:

- Enabling early corporate oversight of incidents that are likely to meet the criteria of national or Trust priorities to ensure the appropriate procedures are promptly initiated, including compassionate engagement of all those involved.
- Allowing incident reports that represent organisational risks rather than specific incidents, to be immediately closed with appropriate comments and retained for the purpose of data analysis an informing our safety profile and risk register.
- Ensuring all incidents with likely only local learning are directed to the most appropriate staff and clinical area to review, learn, and respond.
- Enabling the early identification of incidents that are most likely to require a learning response, and those that require Duty of Candour (DoC) to be completed. These incidents can then be escalated to the appropriate Quality Governance Team, clinical area, and divisional leadership team for compassionate engagement of those involved, completion of DoC if applicable and information gathering for discussion at the next Trust Incident Response Oversight Group (IROG).
- Better oversight of all Trust Patient Safety incidents is likely to allow emerging issues and themes to be identified more quickly by the Patient Safety Team.
- Quality control of the coding of incident reports including the locations and incident types will improve the quality of the data on Datix, and therefore improve the quality of the analysis performed on that data.
- Using a small pool of experienced, highly trained Patient Safety and Investigation Specialists to provide the initial review of incidents will likely improve standardisation of decision making, especially in conjunction with a clear process and implementation of a “Decision Tree” for decision making.

13.2 Once incidents have been identified by the triage team as potentially requiring a PSII or learning response, these will be reviewed by the appropriate Quality Governance Team in conjunction with the clinical area involved and all will require discussion at the Trusts Incident Review Oversight Group (IROG) meeting.

13.3 Any incidents that were triaged for local learning by the triage team but on review by the Quality Governance Team and clinical area have revealed additional concerns can also be escalated to IROG for discussion by these teams or other specialists involved in their review. Significant patient safety incidents that are identified via routes other than Datix (as described previously)

can also be bought to IROG for discussion by a representative of the team who identified the incident as requiring escalation.

13.4 The purpose of IROG is to identify any incidents that meet, or could potentially meet, the national criteria for a PSII, incidents that have the potential for significant new systems learning, and incidents that require further review to determine the above in line with the Trust PSIRF decision tree. IROG will be chaired by the Head of Clinical Governance (or their assigned deputy) and membership of the group will include a wide range of staff members and specialists which may include Safeguarding, Complaints, LfDs, the Improvement team, Specialist Nurses, Ward Managers, Matrons, Quality Governance Teams, Governance Leads, and the Patient Safety Team.

13.5 Incidents that are agreed as requiring a PSII or Learning Response will be escalated to Peer Review Group (PRG) Commissioning for discussion and agreement of key decisions including the scope of reviews, Investigating Officer or Learning Response Leads, terms of reference and target timeframes. Suggested Investigators and Learning Response Leads should have received the appropriate level of training and be independent from the areas and staff involved in the incident, ideally being from outside of the care group involved, as detailed in the national PSIRF guidance.

13.6 The recommendations agreed by IROG and PRG will then be discussed at the Trust's Review and Learning from Incidents Group (RALIG), chaired by the Trust Medical Director and/or the Chief Nursing Officer. At RALIG, recommendations will be discussed, challenged where appropriate and agreed before a final decision on the Trust's response to each incident is confirmed. Any differences of opinion regarding the response required to incidents, target timescales, or Investigator/Response Lead will be discussed at PRG and RALIG and a final decision ratified.

13.7 Membership of RALIG will include Deputy Medical Directors, Divisonal Directors of Nursing, Clinical Directors, Clinical Governance Leads, the Patient Safety Team, and representatives from the care groups and specialities whose cases are being discussed. Cases will be presented to RALIG by the senior leadership team for the area in which the incident occurred.

13.8 To ensure that there are sufficient resources to allocate to support responses to emergent issues that are not included in the initial PSIRF plan, one Trust priority has been left unallocated for this purpose. This will allow the Trust greater flexibility to react more promptly to newly identified system issues to ensure learning and improvement is completed more promptly.

14. Incidents with suspected criminal activity

14.1 In the event of the identification of incidents where there is confirmed or suspected criminal activity, the Trust will refer to the "**Investigating healthcare incidents where suspected criminal activity may have contributed to death or serious life-changing harm**" guidance provided by the Department for Health and Social Care.

15 Timeframes for learning responses

15.1 Under the new PSIRF framework there are no national target timeframes for completion of PSIIs or other learning responses. Instead, realistic, achievable timescales should be discussed and

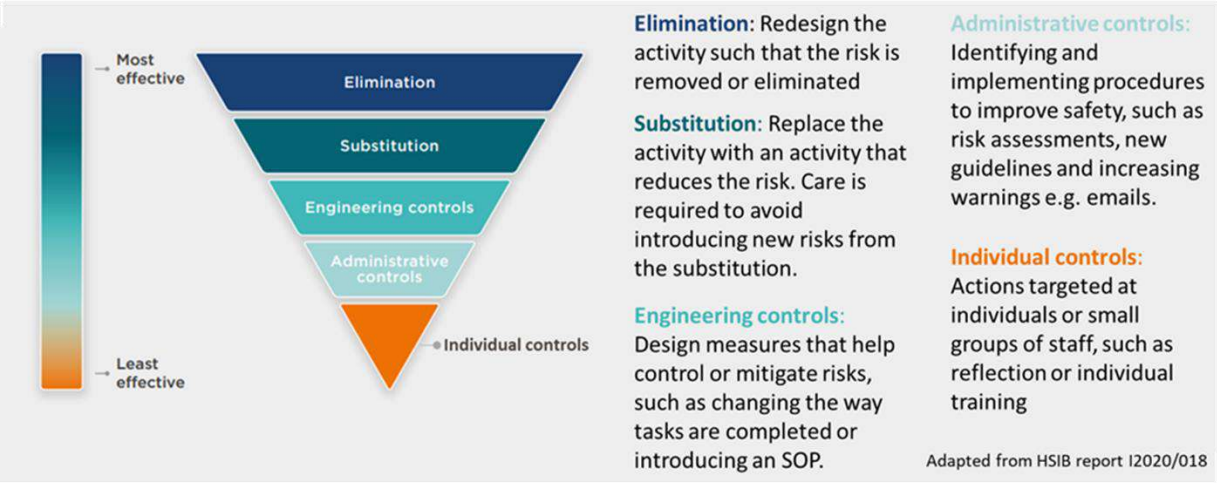
agreed by all those involved in the incident and its review, including the patient, their families, carers, and advocates where appropriate. These discussions should consider the complexity of the incident being reviewed, if it is an individual incident being reviewed or a cluster of similar incidents, the availability of those that need to be involved, and the current workload of the team that will be completing the review.

15.2 In some circumstances, particularly where demand for incident investigations and learning responses exceeds the Patient Safety Teams capacity, it may be appropriate to pause some PSIIs that are being completed for reasons other than those associated with national priorities. These incidents can then be restarted when capacity allows, but this approach and the delayed timescales must be discussed and agreed with all those involved in the incident and its review.

15.3 Target timescales for each PSII and learning response will be discussed at the Peer Review Group (PRG) Commissioning meeting, the conclusion of which will be put forward as a recommendation to RALIG. At RALIG, these timescales will be challenged where appropriate, and agreed before being communicated to all those involved. Any differences of opinion regarding these timescales will be discussed at RALIG and a final decision ratified.

16. Safety action development

16.1 Recommendations from PSIIs or other learning responses will be assessed against the hierarchy of risk controls to understand the likely impact in terms of reducing risk of harm. The hierarchy of interventions is outlined below:



16.2 Safety recommendations from PSII's and other learning responses will be reviewed as part of the ongoing annual review of PSIRF to understand how recommendations are being targeted and how recommendation making can be improved.

All safety actions identified for any level of learning response will be expected to:

- Have been developed in collaboration with the teams who undertake the clinical/non-clinical work to be impacted with a focus on the 'work as done' and the ability to effectively implement.
- Are SMART (**S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**imed).
- In line with 'measurable' have a defined measure of improvement (qualitative or quantitative) that can be tracked.

17. Safety improvement plans and monitoring improvement

17.1 Improvement plans will be reported and monitored at different levels depending on the nature of the scale, significance of learning and cross Divisional nature of the improvement plan.

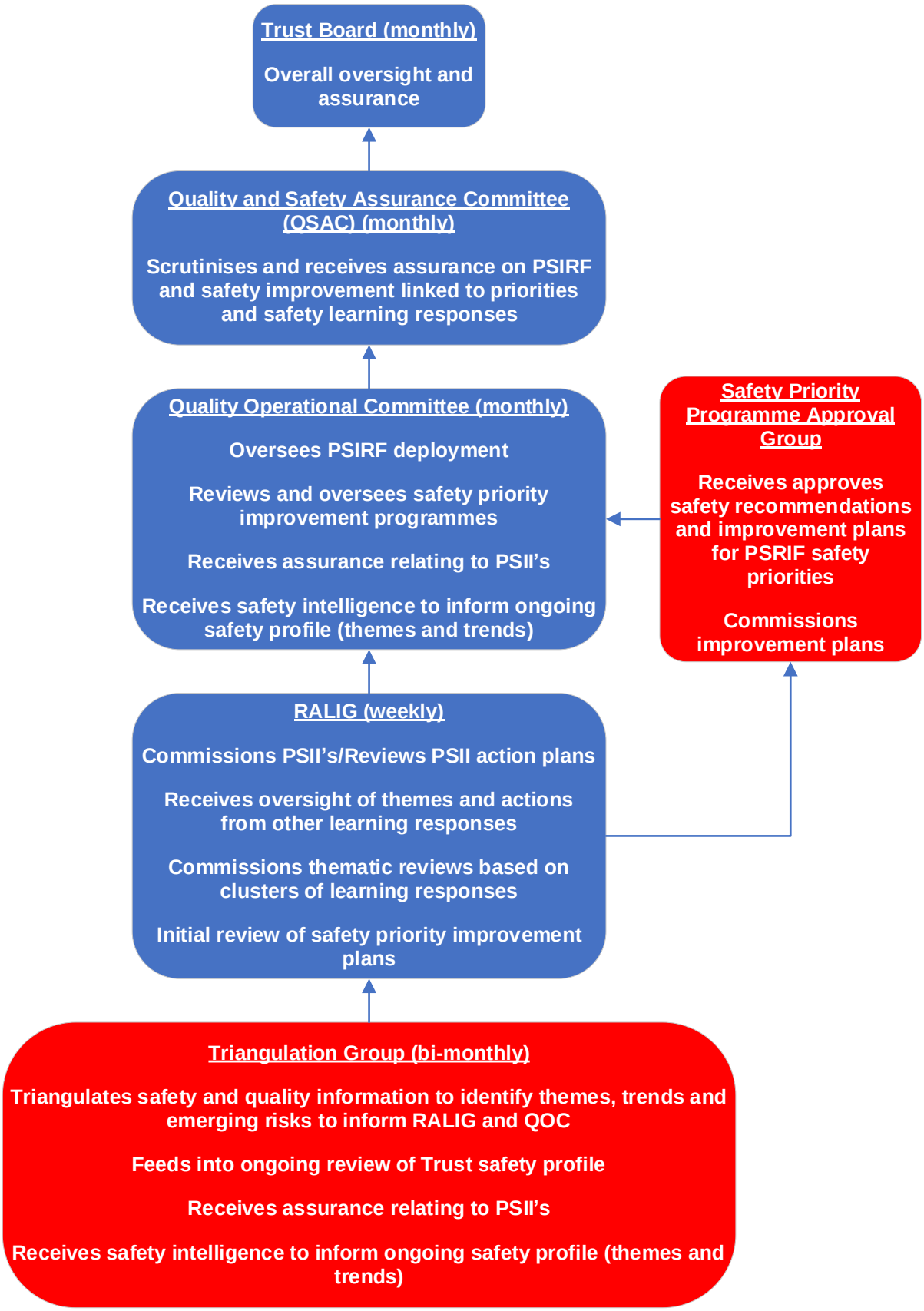
- Existing Corporate improvement plans that have a significant safety focus such as Maternity Transformation, Paediatric Transformation and the Emergency Care Transformation programme will continue to report to their respective steering committees to Quality Operational Committee, Quality and Safety Assurance Committee and for assurance to Trust Board.
- Specific PSIRF safety priority improvement plans will be scrutinised and approved by a dedicated Executive led Safety Programme Approval Group and then reported and monitored via Quality Operational Committee (QOC), Quality and Safety Assurance Committee (QSAC) and for assurance to Trust Board.
- Individual Patient Safety Incident Investigation improvement plans will be signed off at RALIG and will return for review based on a timescale agreed at RALIG. Reporting in summary and by exception will be undertaken via Quality Operational Committee, Quality and Safety Assurance Committee and for assurance to Trust Board.
- Learning response improvement plans will be reported and monitored Divisionally via local specialty/department governance meetings. If learning and associated recommendations and actions span Divisions actions plans will be brought to RALIG for discussion and scrutiny and agreement of arrangements for ongoing monitoring.

17.2 The role of key Trust committees and their oversight role for PSIRF is outlined in the oversight section below.

18. Oversight roles and responsibilities

18.1 Principles and structure for oversight

Working under PSIRF, organisations are advised to design oversight systems to allow an organisation to demonstrate improvement rather than compliance with centrally mandated measures. The high-level structure for oversight of PSIRF at SaTH is outlined in the diagram below:


Trust Board (monthly)
Overall oversight and assurance
Quality and Safety Assurance Committee (QSAC) (monthly)
Scrutinises and receives assurance on PSIRF and safety improvement linked to priorities and safety learning responses
Quality Operational Committee (monthly)
Oversees PSIRF deployment
Reviews and oversees safety priority improvement programmes
Receives assurance relating to PSII's
Receives safety intelligence to inform ongoing safety profile (themes and trends)
Safety Priority Programme Approval Group
Receives approves safety recommendations and improvement plans for PSRIF safety priorities
Commissions improvement plans
RALIG (weekly)
Commissions PSII's/Reviews PSII action plans
Receives oversight of themes and actions from other learning responses
Commissions thematic reviews based on clusters of learning responses
Initial review of safety priority improvement plans
Triangulation Group (bi-monthly)
Triangulates safety and quality information to identify themes, trends and emerging risks to inform RALIG and QOC
Feeds into ongoing review of Trust safety profile
Receives assurance relating to PSII's
Receives safety intelligence to inform ongoing safety profile (themes and trends)

19. Responsibilities

19.1 Alongside our NHS regional and local ICB structures and our regulator, the Care Quality Commission (CQC), we have specific organisational responsibilities with the Framework.

In order to meet these responsibilities, the Trust has designated the Chief Nursing Officer and Medical Director to support PSIRF as the executive leads.

19.2 *Ensuring that the organisation meets the national patient safety standards*

The Executive Medical Directors will oversee the development, review and approval of the Trust's policy and plan ensuring that they meet the expectations set out in the patient safety incident response standards. The policy and plan will promote the restorative just working culture that the Trust aspires to.

To achieve the development of the plan and policy the Trust will supported by internal resources within the Patient Safety team led by the Head of Clinical Governance and Clinical Lead for Patient Safety.

19.2 *Ensuring that PSIRF is central to overarching safety governance arrangements*

The Trust Board will receive assurance regarding the implementation of PSIRF, associated standards and implementation of improvement programmes linked to patient safety priorities via existing reporting mechanisms from the Quality Operational Committee (QOC) and Quality and Safety Assurance Committee (QSAC).

Divisions will have arrangements in place to manage the local response to patient safety incidents and ensure that escalation procedures as described in the patient safety incident response section of this policy are effective.

The Trust will source necessary training such as the Health Education England patient safety syllabus and other patient safety training across the organisation as appropriate to the roles and responsibilities of its staff in supporting an effective organisational response to incidents.

Updates will be made to this policy and associated plan as part of regular oversight.

19.3 *Quality assuring learning response outputs*

The Patient Safety Team will implement a central Peer Review Group (PRG) Approval to ensure that PSIIs and Learning Responses are conducted to the highest standards and support the executive sign off process. This process will also help to ensure that ongoing development and training needs are identified to support those completing learning responses.

20. Complaints and appeals

20.1 If a patient or family has the need to a complaint or appeal relating to a PSII or learning response that has been undertaken relating to an incident, in the first instance we will look to resolve these issues at a local level via the learning response lead (such as a Patient Safety Investigation Specialist for a Patient Safety Incident Investigation).

20.2 If the issue cannot be resolved at a local level, patients and families will be directed to the Trusts complaints procedures and process with signposting towards PALS and external advocacy services for support.

21. References

NHS England (2021) Core20PLUS5: An Approach to Reducing Health Inequalities

core20plus5-online-engage-survey-supporting-document-v1.pdf (england.nhs.uk)

NHS England (2022) Patient safety incident response standards

https://www.england.nhs.uk/long-read/patient-safety-incident-response-standards/

NHS England (2022) Safety action development guide

https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

Appendix 1: Patient Safety Incident Response Plan

V1.1	NHS The Shrewsbury and Telford Hospital NHS Trust

Patient safety incident response plan

Effective date: March 2025

Estimated refresh date: March 2026

	NAME	TITLE
Authors	**Peter Jeffries** **Sara Cormack**	**Patient Safety Specialist** **Deputy Patient Safety Specialist**

Contents

1. Introduction

This Patient Safety Incident Response Plan (PSIRP) sets out how The Shrewsbury and Telford Hospital NHS Trust (hereby referred to as SaTH or the Trust) intends to respond to patient safety incidents over a period of the first 12 months as we transfer to PSIRF and transition to new ways of working. The production of this plan is part of the introduction of the Patient Safety Incident Response Framework (PSIRF) which is a key component of the NHS patient safety strategy, which describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems.

PSIRF is based around four key principles which will inform and drive our approach to patient safety incidents as we go forward. These are:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approaches to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents.
4. Supportive oversight focused on strengthening response system functioning and quality improvement.

The plan is not a permanent rule that cannot be changed. SaTH will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. Our aim will be to maximise learning to inform improvements to our systems to reduce the risk of patient safety incidents occurring.

PSIRF is not just a small change to the current serious incident framework which guides how we respond to patient safety incidents but a radical shift and cultural change to how we approach safety. It will take time to embed and transition and will need to continually review what has worked (which we can build on) and where we must improve based on feedback from patients, families, and our staff. This PSIRF plan is underpinned by our Patient Safety Incident Response Policy.

As part of our policy, we will review and update our plan annually based on all we have learnt over the previous 12 months, so our PSIRF plan becomes part of an ongoing process of quality improvement supporting our overall patient safety plans and priorities.

A glossary of terms used in this plan can be found in Appendix 1.

2. Our services

SaTH is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford & Wrekin, and mid Wales.

Our main service locations are the Princess Royal Hospital (PRH) in Telford and the Royal Shrewsbury Hospital (RSH) in Shrewsbury, which together provide 99% of our activity.

Both hospitals provide a wide range of acute hospital services including accident & emergency, outpatients, diagnostics, inpatient medical care, and critical care. Together the hospitals have just over 700 beds.

Alongside our services at the Princess Royal and Royal Shrewsbury, SaTH also provide community and outreach services such as:

- Consultant-led outreach clinics
- Midwife-led units
- Renal dialysis outreach services
- Community services including Midwifery, Audiology and Therapies.

Currently, SaTH is in the process of implementing plans to transform acute hospital services across the region under the Hospital Transformation Programme (HTP). HTP plan to implement the reconfiguration of acute services agreed as part of the Future Fit public consultation, which will see PRH specialise in planned care and the RSH specialise in emergency care.

This new model of care was designed, led, and supported by clinicians, and is designed to enable multiple patient benefits. These benefits include fewer cancellations and delays for planned procedures, a more streamlined and effective emergency care service, fewer ambulance handover delays and the provision of a dedicated, modern Emergency Department.

Further information about the organisation and HTP can be found on the SaTH website.

Defining our patient safety incident profile

The definition of SaTH's patient safety incident profile is a collaborative process. To define the priorities to include in our initial patient safety response plan under the PSIRF framework, a number of key stakeholders were engaged through a variety of engagement methods. These included:

- Key stakeholders- through meetings, discussions and engagement events with those staff members directly involved in patient safety investigations, for example, the patient safety team, quality governance teams, medications safety officer, quality managers, complaints managers, medical examiners, learning from deaths teams and specialist nurses.
- Staff- through the incidents reported on the SaTH Datix incident management system and information obtained on staff concerns via dedicated staff surveys.
- Senior leaders across divisions- through a series of stakeholder events, regular agenda items on various meetings and 1:1 discussion.
- Patient groups- through a review of the thematic contents of complaints and Patient advice and liaison service (PALS) contacts, involvement in stakeholder events and discussions at Patient and Carer Experience Panel (PaCE Panel).
- Commissioners/ICS partner organisations- through partnership working with the ICS patient safety and quality leads and inclusion at stakeholder events.

SaTH also aims to incorporate a wider patient perspective into future PSIRF planning through the introduction of Patient Safety Partners (PSPs).

Several data sources were also utilised to define SaTH's patient safety incident profile. These included:

- Thematic analysis of two years of Datix incident report data (November 2020-October 2022).
- Thematic analysis of two years of complaints and PALS data (November 2020-October 2022).
- Thematic analysis of two years of Serious Incident (SI) investigation data November 2020- October 2022), including thematic analysis of the recommendations and actions identified by these investigations.
- Key themes identified from specialist safety & quality committees (e.g., deteriorating patient, falls, pressure ulcers).
- Output of stakeholder event discussions and workshops.

As part of the PSIRF guidance, a number of national priorities have been defined by the national team at NHS England. Local patient safety incidents that relate to these national priorities will require a specific, defined response to be detailed in SaTH's current PSIRF plan. Table 1 in the "*Defining our patient safety improvement profile*" section below details the full list of national priorities that require a response and defines the response that SaTH will undertake when these events occur.

SaTH's top local patient safety priorities (or Trust priorities) have been defined as the list of most significant patient safety risks identified through the data analysis and stakeholder engagement described above. Through this information gathering process, four initial Trust priorities have been identified as representing the most significant opportunities for learning and improvement in the SaTH healthcare system. Table 2 in the "*Defining our patient safety improvement profile*" section below details these Trust priorities.

The criteria SaTH have used to define our Trust Priorities for our initial PSIRP fall under two main categories: potential for harm that the incident type poses and the likelihood of reoccurrence of similar incidents. These were as follows:

- Potential for harm
    - People- physical, psychological, loss of trust (patients, family, caregivers, advocates)
    - Service delivery- impact on quality and delivery of healthcare services, impact on capacity.
    - Public confidence- including political attention and media coverage.

- Likelihood of occurrence
    - Persistence of the risk.
    - Frequency of incident occurrence.
    - Potential to escalate.

Defining our patient safety improvement profile

As outlined above SaTH has reviewed its current patient safety profile and has defined four initial key safety priorities. These priorities have been defined by:

In reviewing our safety profile, we have acknowledged a number of existing Trust programmes which are focused on, or have significant components relating to patient safety these include:

- Our 'Getting too Good' programme and existing quality priorities.
- The Emergency Care Transformation Programme
- The Maternity Transformation Programme
- The Paediatrics Transformation Programme
- The Hospital Transformation Programme
- Existing falls improvement programme
- Existing deteriorating patient programme
- Cultural improvement plans
- Infection Prevention and Control improvement plans

Our patient safety incident response plan: national requirements

Given that the Trust has finite resources for patient safety incident response, we intend to use those resources to maximise improvement. PSIRF allows us to use this resource to focus on improvement, rather than repeatedly responding to and investigating patient safety incidents based on thresholds and definitions of harm that can often be subjective. This is important as investigating numerous similar incidents will result in very limited new learning, whereas focusing on improving larger, often Trust wide systems, could yield much larger benefits for patients and staff.

Some patient safety events, such as Never Events and deaths thought more likely than not due to problems in care, will always require a specific type of response as defined by national policies or regulations, such as a Patient Safety Incident investigation (PSII), to learn and improve.

For other types of incidents which may affect certain groups of patients, for example children, a nationally defined response will also be required. These responses may include incidents being referred to, or reviewed by, a team or body outside of the organisation, depending on the nature of the event and the people involved. The Trust fully endorses this approach as it fits with our aim to learn and improve within a just and restorative culture.

Table 1 below outlines each defined national priority along with the nationally mandated responses to those incidents.

Table 1:

National Priority	Mandated response
Deaths clinically assessed as being more likely than not due to problems in care (incidents meeting the Learning from Deaths criteria)	Patient Safety Incident Investigation (PSII) led by SaTH
Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)	PSII led by the provider. Where the event did not occur in SaTH but they had involvement, SaTH will participate in the investigation, if required.
Incidents that meet the criteria set in the Never Event list 2018	PSII led by SaTH
Mental health-related homicides	Refer to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII. A PSII led by SaTH may be required, dependent on circumstances.
Maternity and neonatal incidents meeting Maternity and Newborn Safety Investigation (MNSI) criteria	Refer to the Maternity and Newborn Safety Investigation (MNSI) programme for independent PSII if accepted.
Child deaths	Refer for Child Death Overview Panel (CDOP) review. SaTH led PSII (or other learning response) may be required alongside the panel review dependent on circumstances and decision of the panel.

Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) including Structured Judgement Review (SJR). SaTH led PSII (or other learning response) may be required alongside LeDeR review dependent on circumstances.
Safeguarding incidents in which: Babies, children, and young people are on a child protection plan, looked after plan or are a victim of wilful neglect, domestic abuse, or violence. Adults (over 18 years old) in receipt of care and support needs by their Local Authority. The incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery, human trafficking, or domestic abuse/violence.	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.
Incidents in NHS screening programmes.	Refer to local Screening Quality Assurance Service for consideration of locally led learning response.
Deaths in custody (e.g., police custody, in prison, etc.) where health provision is delivered by the NHS	In prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare providers must fully support these investigations where required to do so.
Domestic homicide	A domestic homicide is identified by the police, usually in partnership with the Community Safety Partnership

	(CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel. The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs.

Our patient safety incident response plan: local focus

In line with PSIRF guidance local responses will conform broadly with the plan outlined below. We will maintain the flexibility to adjust our approach. The key decision-making assumptions that have informed both our plan and will inform our ongoing decision making are:

- The views of those affected, including patients and their families.
- Capacity available to undertake a learning response.
- What is known about the factors that lead to the incident(s)
- Whether improvement work is underway to address the identified contributory factors
- Whether there is evidence that improvement work is having the intended effect/benefit
- If an organisation and its ICB are satisfied risks are being appropriately managed.

SaTH considers that all of the incident types detailed in Table 2 and 3 have relevance across a number of our inpatient, outpatient, and community services.

Because of this, this document is an organisation wide PSIRF plan and there are no separate plans for individual services.

An outline of potential incident learning responses we will utilise is outlined under appendix 2.

Table 1:

Patient safety incident type or issue	Planned response	Anticipated improvement route
Hospital acquired pressure ulcers (HAPU)	Category 1- local review in line with current process for responding to local level Datix incident reports.	Create local safety actions and feed these into the overarching quality improvement strategy via

	Category 2 or above- as category 1, plus daily audit by Quality Matron team. Any category of HAPU where significant new learning is identified- IROG to consider commissioning Learning Response. Incidents falling under national priorities – PSII	pressure ulcer reduction group
Hospital acquired infections	MRSA bacteraemia/C-Diff and nosocomial Outbreaks- After Action Review	Co-production of safety improvement actions managed through the IPC (Infection Prevention and Control) improvement plan.
Transfusion incidents meeting SHOT (Serious Hazards of Transfusion) criteria	SHOT reportable incident- investigation as per SHOT requirements	Review at RALIG and Hospital Transfusion Committee (HTC)– develop local safety actions and feed these into the overarching quality improvement strategy
IRMER reportable incidents – Radiology incidents	IRMER reportable incident- specific IRMER review process in place. Includes both a review of the systems involved in the incidents and answers specific questions to meet the requirements of the CQC.	Review at RALIG and Radiology governance– develop local safety actions and feed these into the overarching quality improvement strategy
Assessment of incidents outside of the identified priorities (above and in table 3)	Proportionate response dependent upon the circumstances surrounding the patient safety event	Co-production of safety improvement actions managed on a local/organisational safety improvement plan.

Initial PSRIF safety priorities and responses:

Table 2:

	Incident Type	Description	Response type
1	Adult Deteriorating patient. (Note: Paediatric and maternity deterioration are subject to actions in the paediatric and maternity transformation programmes. Learning will be shared across these workstreams)	Actual or potential for patient harm due to delayed or non-recognition of deterioration despite clinical indicators, or incidents where deterioration is identified, but treatment is absent or significantly delayed.	For incidents falling under national priorities – PSII with learning incorporated into improvement plan. Dependent on capacity and if high likelihood of new learning for improvement plan – Learning Response The main priority for deteriorating patient priority is to use thematic systems work already undertaken to define a longer-term strategy and improvement plan (work already underway).
2	Falls	Adult, inpatient falls	For incidents falling under national priorities – PSII with learning incorporated into improvement plan. All inpatient falls- daily audit by Quality Matron team

			#NOF or significant head injury- hot debrief led by Quality Matron Team. Where potential for significant new learning agreed at IROG- Learning Response Many of the key causal factors behind falls are well understood. The key focus of this improvement stream will be to review our understanding of known issues that lead to harm and review current improvement strategies.
3	Missed radiology results (alerts and availability)	Potential for patient harm as a consequence of non-communication or action of diagnostic radiology results.	For incidents falling under national priorities – PSII with learning incorporated into improvement plan. The current systems issues leading to missed radiology results has been explored. The focus of this improvement stream will be twofold: • Short term risk reduction pending new electronic systems. • Safety review of procured IT

			systems to ensure risk mitigation and any new risks are understood to reduce the chances of harm.
4	Omitted doses of time critical medication	Time critical medicine is delayed leading to patient harm	For incidents falling under national priorities – PSII with learning incorporated into improvement plan. Incidents not falling under national definitions may be subject to a learning response based on their potential for new learning. The systems issues underlying missed doses are currently not well understood, therefore an overall thematic review of the system will be undertaken.

Local methods such as the national Perinatal Mortality Review Tool (PMRT) and Structured Judgement Review (SJR) tools and/or structured local proformas may be used for incidents which meet their review criteria. The completion of a narrative response on the Datix incident module is also appropriate.

Glossary

- **PSIRP** - Patient Safety Incident Response Plan

Our local plan details how we will achieve the PSIRF locally, including our list of current local priorities. These have been developed through a coproduction approach with the

divisions and specialist risk leads supported by analysis of local data and engagement with staff.

- **PSIRF** - Patient Safety Incident Response Framework

Building on years of evidence from previous investigations as well as the wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents. This framework prioritises support for those affected by incidents (including patients, families, advocates, and staff), effectively analysing incidents, and sustainably reducing future risk. This is the first year that SaTH will have implemented and be working under the PSIRF framework.

- **PSA** – Patient Safety Audit

A review of a series of cases of the same incident type using clinical audit methodology to identify opportunities to improve and more consistently achieve the required standards (e.g., in a policy or guideline) and/or outcomes.

- **PMRT** - Perinatal Mortality Review Tool

Developed through a collaboration led by MBRRACE-UK with user and parent involvement, the PMRT ensures systematic, multidisciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care.

- **SJR** - Structured Judgement Review

SJR is a systematic, evidence-based mortality review programme that can help drive improvement in the quality and safety of patient care. SJR was developed by the Royal College of Physicians as part of the National quality board national guidance on learning from deaths and blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about, and score, care for each phase.

- **Never Event**

Never Events are defined as incidents that are considered wholly preventable. This is because of the presence of guidance or safety recommendations that provide strong systemic protective barriers, available at a national level that should have been implemented by all healthcare providers.

- **Deaths thought more likely than not due to problems in care**

Incidents that meet the 'Learning from Deaths' (LfD) criteria. These are deaths that have been clinically assessed as more likely than not due to problems in care using a recognised method of case note review. These reviews must have been conducted by a clinical specialist not involved in the patient's care and conducted either as part of a local LfD plan or following reported concerns about care or service delivery.

Learning Response types

- **PSII - Patient Safety Incident Investigation**

PSIIs are undertaken to identify underlying system factors that contributed to an incident meeting the national criteria. These findings are then used to identify effective, sustainable improvements by combining learning across multiple PSIIs and other learning responses into incidents involving a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address the system factors identified by the investigation and help deliver safer care for our patients.

- **AAR – After Action Review**

A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these events to identify opportunities to improve and increase the instances where success occurs. AARs are usually used to review a single case or incident.

- **MDT (multi-disciplinary team) review**

Where an incident has been identified a period of time after it occurred (for instance via an audit or complaint) an MDT review approach may be used. It will follow a similar format to the After- Action Review but will acknowledge that there may be limits to the available information for learning given the time that has passed. MDTs are usually used for reviewing specific pathways or processes.

- **Hot Debrief**

Interactive, structured team dialogues that take place either immediately or very shortly after an incident. They can be used to capture immediate learning and inform further learning responses.

- **Thematic systems review**

Based on work undertaken to review the systems around the adult deteriorating patient we have developed a methodology for reviewing clinical systems to identify areas for improvement to reduce safety. We will build on this approach and continue to develop it. The key components of this approach are described below:

  - Review of key literature
  - Review of existing insights from incidents
  - Structured observations and discussions with staff of work systems based around the SEIPS framework

- **Learning Teams**

Learning teams allow staff who are involved in an incident to develop solutions to it. The process runs in parallel to the investigation and, rather than looking at the specific events that occurred, examines the process as a whole and identifies potential as well as actual hazards.

The learning team process consists of two facilitated group workshops attended by staff involved in the incident or others who undertake the same role. The first session maps out the process and identifies what could go wrong. This is followed by soak time – a period of reflection.

The second workshop brings the team back to explore solutions and develop a plan for fixing the process.

In line with the philosophy of PSIRF we will flexibly use the approaches outlined above in line with the nature of the incident which is being investigated and how it aligns with our PSIRP. Hybrid approaches mixing learning responses will be used as appropriate.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 8 May 2025

Agenda item		087/25			
Report Title		Budgetary Control Policy			
Executive Lead		Helen Troalen, Director of Finance			
Report Author		Eloise Oxenham, Financial Controller			
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**	
Safe		Our patients and community		BAF 5	
Effective		Our people			
Caring		Our service delivery		**Trust Risk Register id:**	
Responsive		Our governance	√	N/A	
Well Led		Our partners			
Consultation Communication		Policy Approval Group: 26 February 2025 Audit and Risk Assurance Committee: 14 April 2025			
Executive summary:		This paper updates the Board on the amended Budgetary Control Policy following review. The policy has been approved by Policy Approval Group and Audit and Risk Assurance Committee. The policy is a reserved policy, and thus requires Board approval.			
Recommendations for the Board:		The Board is asked to: **Approve** the amended Budgetary Control Policy.			
Appendices:		Appendix 1: Budgetary Control Policy			

1.0 Introduction

1.1 This paper updates the Board on the amended Budgetary Control Policy.

1.2 The Budgetary Control Policy has been reviewed and amended in accordance with the Standing Financial Instructions.

2.0 Key Amendments Made

2.1 Contract renewals – the following sections of the policy have been updated:

5.5.9 All contract renewals within budget can be approved in line with delegated authority, with contracts above £0.5m requiring approval by the Board. Contract awards will be reported retrospectively to Board through the quarterly contract award briefing. For contract renewals leading to a cost pressure (e.g. cost of renewal is above budgeted levels), the business case approval process is to be followed.

5.5.10 All in-year revenue allocations (new, in-year budget awards) to budget holders will be notified to Board. Revenue allocations linked to the approval of business cases will be approved in line with delegated authority with awards of £0.5m+ requiring Board approval. As per 5.5.9, if the in-year allocation is used to fund a contract award, or the business case results in the award of a new contract, then the Board will need to be notified.

2.2 Capital approvals – the following sections of the policy have been updated:

5.11.1 The Board, approves the capital programme at the beginning of the financial year. This approval covers all projects which may have an existing business case or for which a business case may be developed. Related business cases and contract awards are scrutinised and approved by the Capital Prioritisation Group (CPG) which includes three members of the Executive team. Any proposed changes to the capital programme will need to be authorised by the Board. As per 5.5.9, in-year contract awards linked to capital schemes will be reported retrospectively to Board through the quarterly contract award briefing. It is important to note the Board reserves the right to review previously authorised capital scheme decisions.

5.11.2 Due to potential breach of Trust, delegated capital limits and the need to ensure alignment with SaTH's strategic objectives, capital business cases requiring additional Public Dividend Capital (PDC) to fund them will require strict Board approval and increased delivery oversight. For Public Dividend Capital (PDC) funded capital programmes resulting from business cases authorised in-year, the allocation of capital required, and award of associated procurement contracts may be authorised by Board concurrently. This is linked to the timescales for notification of PDC award and drawdown.

5.11.3 For major programmes where the budget is above £10m or the programme covers multiple years the individual programme budget will require Board approval. The budgets for major capital programmes will be set prior to their commencement and will be updated periodically as required. Note, this may be

more frequent than an annual update for schemes with implementation periods spanning financial years. Any alterations to the approved programme budget will need to be approved by the Board of Directors. Associated contract awards will require approval by the DoF / CEO (CEO acting on behalf of the Board). As per 5.5.9, in-year contract awards linked to approved major programme budgets will be reported retrospectively to Board through the quarterly contract award briefing.

3.0 Policy Approval Group

3.1 The Budgetary Control Policy was considered by the Policy Approval Group on 26 February 2025. The Financial Controller presented the policy for comment and took questions as appropriate.

3.2 An Equality Impact Assessment was carried out as per the requirements of the Policy Approval Group, with the outcome being no positive or negative impact.

3.3 Various amendments were kindly highlighted by the Group and the Budgetary Control Policy has subsequently been updated.

4.0 Audit and Risk Assurance Committee

4.1 The Budgetary Control Policy was considered by the Audit and Risk Assurance Committee on 14 April 2025.

4.2 The Audit and Risk Assurance Committee approved the Budgetary Control Policy being sent to Board for final approval.

5.0 Conclusion or Recommendation

5.1 The Board is therefore asked to approve the Budgetary Control Policy.

Eloise Oxenham
Financial Controller
April 2025

The Shrewsbury and Telford Hospital NHS Trust

Appendix 1

BUDGETARY CONTROL POLICY

Additionally refer to: **Scheme of Reservation and Delegation**
Standing Orders
Standing Financial Instructions
Disciplinary Policy (W7)

Version:	V4
V3 Approved by	Policy Approval Group
V3 Date approved	March 2018
V3 Ratified by:	Sustainability Committee
V3 Date ratified:	March 2018
V4 Ratified by:	TBC
V4 Date ratified:	TBC
Document Lead	Deputy Director of Finance - Operational
Lead Director	Director of Finance
V4 Date issued:	TBC 2025
V4 Review date:	March 2027
Target audience:	Budget Managers & Budget Holders

Document Control Sheet

Document Lead/Contact	Deputy Director of Finance - Operational
Version	4.0
Status	Draft
Date Equality Impact Assessment completed	February 2025 – no positive/negative impact
Issue date	TBC
Review date	March 2027
Distribution	Executive Directors Divisional Directors Heads of Service Service Delivery Managers Budget Managers Centre Managers
Key words – including abbreviations if these would be reasonably expected to be used as search terms	Budget Finance Budgetary Control Policy
Dissemination plan	Via Divisional board meetings and finance leads

Version History

Version	Date	Author	Status	Comment – include reference to Committee presentations and dates
1.0	01.02.05	Assistant Director of Finance	Approved	First Draft
1.1	01.09.05	Assistant Director of Finance	Approved	Review Comments Amendments
2.0	01.09.07	Director of Finance	Draft	New Management Structure
2.1	25.09.07	Director of Finance	Approved	Finance Committee Review Comments Amendments
2.2	01.06.10	Deputy Director of Finance - Operational	Draft	Finance Committee Annual Review
3.0	01.03.18	Senior Finance Officer	Draft	Policy Approval Group – date to be confirmed
4.0	12.11.24	Deputy Director of Finance - Operational	Supported	Policy Approval Group – 26 February 2025

Contents

1 Policy on a Page

- A key control in achieving financial control as outlined in the Trust's Standing Orders and Standing Financial Instructions is to have a sound and embedded Budgetary Control Policy. It outlines the requirements of key individuals who have budgetary responsibilities within the organisation.

- Budget Holders are required to review their own procedures for financial management in the areas that they are responsible.

- The Policy includes details of delegated powers, the process for budget preparation, reporting procedures, virement of budgets to provide structure and support to both the Trust and Budget Holders.

- Failure to comply with the Budgetary Control Procedures may result in disciplinary action in accordance with the Trust's Disciplinary Policy.

- The Chief Executive is the accountable officer and reserves the right to suspend any aspect of this Policy to maintain the financial viability of the Trust.

2 Document Statement and Scope

This policy document is a key element of the Trust's internal control environment and describes, in detail, how the financial management responsibilities placed upon the Chief Executive and Director of Finance are discharged and implemented. Budget management is a key element of the Trust's overall performance management process. The Board of Directors have approved Standing Orders and Standing Financial Instructions which include instructions on financial management.

Budget Holders are required to regularly review procedures for financial management within their area(s) of responsibility to ensure that they meet the standards and comply with the directions and guidance contained within this policy document. This policy describes the responsibilities of Budget Holders in respect of maintaining sound financial management and the minimum procedures needed to ensure this. It also sets out the duties that Budget Holders must discharge to ensure the effective control of their financial activities.

This policy applies to all budget holders.

3 Overview

3.1 The Standing Financial Instructions *(SFIs)* of The Shrewsbury and Telford Hospital NHS Trust detail the financial responsibilities, policies, and procedures to be adopted by the Trust.

3.2 SFIs require that the Director of Finance will "devise and maintain systems of Budgetary Control". These Budgetary Control Procedures cover the directions described in the SFIs and therefore should be read in conjunction with the SFIs.

3.3 These Procedures, once adopted by the Board of Directors ("The Board"), form part of the SFIs and become binding on all Directors and employees of the Trust who have responsibilities connected with the budgetary control process.

3.4 **Failure to comply with the Budgetary Control Procedures may result in disciplinary action in accordance with the trust's Disciplinary Policy.** Any Director or employee involved in any way with the budgetary process, who is not clear as to the interpretation of these Procedures or who has specific difficulty in complying with them, should in the first instance seek the advice of their line manager. If unsure on who to refer to then contact the Director of Finance.

3.5 The Chief Executive is responsible for ensuring that all Directors and Budget Holders are provided with an up-to-date version of these procedures and that they are made aware of their responsibility to abide by their contents. Directors and Budget Holders are in turn responsible for ensuring that all employees to whom any powers are delegated are made aware of, read, and have continuous access to these procedures. All employees with delegated powers will be required to sign a statement that states that they have read and understood the procedures.

3.6 The Chief Executive is the accountable officer and reserves the right to suspend any aspect of this policy to maintain the financial viability of the Trust.

4 Definitions

4.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under those Acts, shall have the same meaning in these procedures.

Additionally:

a) "Trust" means The Shrewsbury and Telford Hospital NHS Trust;

b) "Board" means the Trust Chair, Executive and Non-Executive Directors of the Trust collectively as a body;

c) "Executive Team" means the executive leadership of The Shrewsbury and Telford Hospital NHS Trust who sit with the Board of Directors as executive directors.

d) "Budget" means a resource, expressed in numerical terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

e) "Chief Executive" means the accountable officer of the Trust;

f) "Director", for budgetary control purposes, means a designated member of the executive team;

g) "Budget Holder" means the individual with delegated authority to manage resources which have a financial impact (income and expenditure) for a specific area of the organisation;

h) "Operational Leads" means all managers that have authority in utilise resources. This will include both clinical and non-clinical leads in divisional / directorate management structures;

i) "Finance Lead" means the member of the Finance Department who is notionally linked to Operational Leads.

4.2 Wherever the title Chief Executive, Director of Finance, Operational Manager, Clinical Director, Budget Holder, Finance Manager/Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other Directors or employees who have been duly authorised to represent them.

4.3 Wherever the term *employee* is used, it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

5 Duties/Policy Details

5.1 Delegated Powers

5.1.1 The Trust is required to fulfil certain statutory financial duties, specifically:

- To at least break-even on the Income and Expenditure Account on a year to year basis.

5.1.2 The production and interpretation of timely and accurate budgetary control Information is an essential part of the management of the Trust. The balance between speed of production and increased accuracy of information is reviewed on a regular basis.

5.1.3 The preparation and maintenance of annual revenue budgets is undertaken with this objective in mind.

In exceptional circumstances where a deficit is planned it will require prior approval from the regulatory organisation overseeing the Trust's running. This will be reflected in the Trust's approved financial strategy for the year.

5.1.4 Employees of the Trust, and especially those involved with the budgetary process, have a responsibility to the Board for identifying all possible opportunities to use Trust resources more effectively and efficiently. All such opportunities should be brought to the attention of the appropriate Operational Lead who has budgetary control for the area for consideration and possible inclusion within the Operational Plans for the area.

5.1.5 The budgetary process requires adherence to timescales for the performance of routines and duties. As the timescales will change periodically, they are not included here. The Director of Finance is responsible for issuing and reviewing guidance on budgetary timetables. It is the responsibility of all Directors and Operational Leads concerned to adhere to such timetables and to inform the Director of Finance of any reasons preventing the achievement of a specific deadline.

5.1.6 The Chief Executive, in conjunction with the Director of Finance, will periodically re-assess all functions of the Trust that incur financial consequences and ensure that the responsibility for exercising budgetary control for each and every function is delegated to an appropriate Budget Holder.

5.1.7 Each Director and Operational Lead will, from time to time, acting on advice from nominated managers, review the range of delegated functions and make recommendations to the Director of Finance on a scheme for further delegating the budgetary responsibilities pertaining to those functions to appropriate Budget Holders. Account shall be taken of the scope and approximate value of resources and the seniority and management ability of a prospective Budget Holder.

5.1.8 The Board, acting upon the advice of the Director of Finance, will periodically review and approve the income and expenditure limits within which Budget Holders may operate. These limits will be laid down in the Scheme of Delegation.

5.2 Budgetary Responsibility

5.2.1 The Board is responsible for ensuring that financial performance is within the targets agreed by the Department of Health and Social Care and their regulatory organisations which the Trust reports to. In exercising this responsibility, it will be guided by the advice of the Chief Executive and Director of Finance.

5.2.2 The Director of Finance is responsible for ensuring that an adequate system of monitoring financial performance is in place so that the Trust can fulfil its responsibility for meeting its statutory financial duties.

5.2.3 The Director of Finance shall devise and ensure the maintenance of a suitable and adequate system of budgetary control. This will include ensuring that systems for invoicing and receipt of income, payroll, payment of invoices, recruitment and allocation of staff and stock control adequately match the needs of the budgetary control system.

5.2.4 The Director of Finance is responsible for ensuring that all budgetary control information is provided in a timely manner in the required format to all Directors and Budget Holders.

5.2.5 The Finance department team will check that all routines have been carried out in accordance with these instructions and that all appropriate persons have been properly informed of all pertinent matters.

5.2.6 The Director of Finance is responsible for ensuring that the sum total of all revenue budgets balances recurrently to income received on a year-to-year basis.

5.2.7 The Director of Finance reserves the right to have access to all Budget Holders and has the authority to require explanations on performance and spending/income trends within the remit of the Budget Holder. In normal circumstances, access will be through the relevant Operational Lead who has overall budgetary responsibility.

5.2.8 The Director of Finance will review, where necessary, the financial expertise of employees involved in the budgetary process and ensure that the appropriate guidance and training in respect of their budgetary duties is available.

5.3 Delegated Powers

5.3.1 All budget holders should be encouraged to demonstrate efficient and effective use of resources whilst considering the overall financial health and priorities of the Trust. Directors and Operational Leads should be able to give reasonable managerial freedom to proven efficient Budget Holders as well as ensuring greater control in those areas where budgetary performance has previously come into question or future difficulties anticipated.

5.3.2 The Chief Executive, acting on advice from the Director of Finance, will ensure that Divisions / Directorates are notified in writing of their budget with a clear definition of:

a) Functions / services for which the budget is provided;

b) Amount of the workforce and financial budget;

c) Planned levels of activity/service provision (if relevant);

d) Divisions / Directorates will be required to sign-off budgets at the commencement of each financial year.

e) Where appropriate the budget will also be supported by performance indicators and/or assumptions which will be used as cost drivers for monitoring and performance purposes

5.3.3 Divisions / Directorates performance against budget will be reviewed monthly by the Operational Lead and Finance Lead. Where any area shows a deficit position the Budget Holder, with the Finance Lead will be required to identify a mitigation plan detailing:

- Explanations for deterioration in financial performance
- Actions to be taken to achieve balance position
- Milestones and target dates for delivery

- Risks associated with delivery and how these will be mitigated

Progress against these plans will be monitored by Operational and Finance Leads.

The Finance Lead will inform the Director of Finance, via the Deputy Director of Finance - Operational of these plans and be kept informed on progress.

Should the plans and / or progress not provide sufficient assurance of delivery, this will be escalated to the respective Lead Director and Deputy Director of Finance - Operational who will provide a framework for the Divisions / Directorates to follow that delivers the required delivery assurance.

It is expected that within each Divisions / Directorates a budgetary reporting system will be in operation as deemed appropriate by the Operational and Finance Lead. Within this system it is also expected that a similar approach to the above will be taken should the financial performance of any individual budget holder not be in line with plan.

The Director of Finance may review and amend the financial authorisation status of any Budget Holder to deliver the required financial improvement.

5.3.4 The Director of Finance will maintain a register of all Budget Holders.

5.3.5 Budget Holders must restrict budgetary and spending activity to within the limits of delegated authority and purpose for each budget and may not further delegate any aspect without the approval of the appropriate Operational Lead. Standard limits for expenditure are set out in the Standing Financial Instructions.

5.3.6 Once a budget has been delegated only the budget holder can incur financial consequences against their respective budget. In exceptional circumstances where the Executive Team require, this can be overridden but the budget holder must be informed of the decision impacting their budget.

5.3.7 In normal circumstances no Director or Operational Lead may incur expenditure against a budget outside of their remit without the express agreement of the delegated Budget Holder for the budget concerned.

5.3.8 No purchase requisition or staffing request may be split in such a way as to circumvent spending limits attaching to a Budget Holder or budget heading.

5.3.9 All purchases and acquisition of services must be made in accordance with the delegated powers and the Financial Procedure Notes on Obtaining Goods, Works, and Services.

5.3.10 All staff appointments *(permanent and temporary)* must be made in accordance with the delegated powers and the Financial Procedure Notes on Payroll Procedures. Members of staff may only be appointed when provided for in the budgeted establishment and they remain within overall resources.

5.3.11 Where a Budget Holder has delegated power to vire between budget headings and staff establishments, no virement action should be exercised without consultation and agreement with their Finance Lead.

5.3.12 It is the responsibility of the Operational Leads to maintain an up to date and compliant schedule of approved signatories. This needs to be provided to the relevant Director who will ensure that the relevant details are provided to Payroll Services, Accounts Payable, Human Resources and Procurement. Deletions from

the list must be notified within one working day of the member of staff leaving the organisation/decision to make the amendment. Additions to the list must be notified prior to the designated signatory becoming effective.

5.4 Income and Service Level Agreements

5.4.1 Directors and Operational Leads, in conjunction with the Director of Finance, are responsible for ensuring that a proper system for recovering all patient-related and general service costs are recovered by income/recharges due under Service Level Agreement.

5.4.2 All Service Level Agreement costs and estimates *(including marginal costing)* must be approved by the Director of Finance before commitment. In-year marginal adjustments must be ratified by the Director of Finance.

5.4.3 The Director of Finance is responsible for ensuring that all NHS Service Level Agreement costs are reviewed within appropriate timescales and are in accordance with the rules set down by the NHS Executive for that purpose.

5.4.4 The Director of Finance is responsible for drawing-up and agreeing to the financial details contained within the NHS contracts which should, inter alias, agree to the total quantum of cost, and take account of activity, quality and other associated issues.

5.4.5 The Director of Finance will ensure that all income due to the Trust is properly invoiced within the requisite timescales and that there is an appropriate system for chasing late payments.

5.5 Budget Preparation

5.5.1 Prior to the commencement of a financial year and at a time designated by the Director of Finance, Directors and Operational Leads will assess budget proposals for the ensuing year. This will take place in conjunction with the appropriate consultation with Budget Holders. The budget proposals will normally be prepared in detail by the appropriate Finance Lead in format prescribed by the Director of Finance.

5.5.2 Budget proposals will take account of:

a) Proposed operational plans, cost improvement targets and guidelines laid down by the Board and governing bodies;

b) Expenditure/income trends in the current and previous years.

5.5.3 Budget proposals will be prepared in accordance with the latest known information e.g. pay awards, tariff changes, inflationary pressures, and will include for each detailed budget head:

a) The new year budget sum;

b) The value of pay award;

c) Additions for approved developments

d) Changes reflecting approved Executive team decisions;

e) Staff numbers in whole time equivalents

f) Demonstrate the recurrent and non-recurrent budgets

5.5.4 The budget proposal will be supported by sufficient narrative which explains the proposal, principles and key assumptions made. This could, where appropriate, include performance indicators.

5.5.5 Detailed working papers, setting out the calculations for each budget heading must be prepared and retained in an easily accessible format. These working papers will be kept within the Finance Department.

5.5.6 The Director of Finance will summarise the budget proposals in such a way as to demonstrate how the financial targets for the Trust can be achieved.

5.5.7 The Chief Executive will review the delegation of budgets and rules pertaining to the operation of individual budgets *(as indicated in paragraph 5.3),* prior to approved budgets being notified to Budget Holders.

5.5.8 The phasing of planned expenditure during the year in each budget is essential to maintaining in-year financial control. This is the responsibility of the Budget Holder, supported and advised by the Finance Lead. The emphasis of management activity is, therefore, focused upon looking forward, controlling planned expenditure, rather than working retrospectively as to why overspending has happened. Each budget has clearly defined phasing representing planned expenditure. This can take many forms, twelve equal monthly payments, month by month specific amounts, quarterly payments, or one single lump sum payment.

5.5.9 All contract renewals within budget can be approved in line with delegated authority. Contracts above £0.5m require approval by the Board. Contract awards under the Board approval limit of £0.5m will be reported retrospectively to Board through the quarterly contract award briefing. For contract renewals leading to a cost pressure (e.g. cost of renewal is above budgeted levels), the business case approval process is to be followed.

5.5.10 All in-year revenue allocations (new, in-year budget awards) to budget holders will be notified to Board. Revenue allocations linked to the approval of business cases will be approved in line with delegated authority with awards of £0.5m+ requiring Board approval. As per 5.5.9, if the in-year allocation is used to fund a contract award, or the business case results in the award of a new contract, then the Board will need to be notified.

5.6 The Role of the Finance Department and Finance Leads

5.6.1 Each budget limit must be agreed with the Budget Holder as being realistic and attainable. The budget will reflect all approved decisions where the funding source has been agreed.

The agreed budget will therefore be based on underlying principles used to establish the budget. For example, pay budgets will routinely be set based on substantive cost levels. Where staff with a premium cost are required e.g. agency, this will be agreed and set at an aggregate level, at least at Trust level, so that the aggregate budget accounts for these costs. The budget holder should be made aware of this and

control mechanisms are established at Divisions / Directorates and Trust levels to ensure that the overall level of premiums incurred do not exceed the planned and agreed levels.

5.6.2 The Director of Finance, will approve the framework within which budget setting takes place, and upon which performance management is based.

5.6.3 The Finance Lead will provide support to the Budget Holders and Operational Leads during the budget setting process.

5.6.4 The following arrangements apply:

a) The Finance Lead will work alongside the Operational and Clinical Teams in delivering these activities;

b) The Finance Leads are professionally responsible to the Director of Finance. The Finance Leads must work within the financial framework and provide sound professional accountancy and business advice to the Budget Holders.

5.6.5 The Finance Leads will:

a) During each financial year, maintain budget information regularly. They will calculate the financial effect of all proposed budgetary changes. All values will be expressed in terms of the cost/income in both the current year and a full financial year;

b) As relevant, discuss proposed changes with Budget Holders and where appropriate then obtain approval from the Operational Lead in order to transfer to/from budgets within their control;

c) Enact decisions made by the Executive Team based on approved business cases and annual financial plan impacting both in year and recurrently

d) Maintain a record of all budget sums together with the value of all approved changes to budget during the year. The total sum of all budgets within a Division / Directorate will be reconciled on a monthly basis;

e) Ensure that Budget Holders use the correct financial codes assigned to purchase requisitions, workforce forms and other source documents;

f) Regularly review the appropriate payroll records to ensure that all employees charged to the area are correctly coded and conform to the total staff establishment of each area. Details of the reviews will be discussed with the appropriate Budget Holders;

g) Ensure that changes to the budget including staff establishment are promptly communicated to all appropriate persons.

h) Maintain a record of the totals of all budget sums allocated to each Divisions / Directorates. All subsequent budget allocations/reductions must be recorded and notified as appropriate. The total sum of allocations must reconcile with the overall approvals to the Trust from the Executive on a monthly basis *(or more regularly);*

i) Monitor all actual expenditure and workforce against budgets;

j) Monitor compliance with the rules on budget virement;

k) Check excessive movements of expenditure between different budget sub-heads *(which is not virement)*

l) Provide advice and information to enable Budget Holders to manage their service.

m) Use their professional judgment to advise Budget Holders whether a financial decision, which may be within their delegated authority, should be escalated to more senior financial and operational leads including members of the Trust Executive.

5.6.7 Expenditure to be charged to Budget Holders, in conjunction with the Finance Leads must be understood and approved by the Budget Holder before the commitment of expenditure is entered into.

5.7 Reporting Procedures

5.7.1 The Finance Leads will produce monthly budget statements and associated reports/analysis in accordance with the timetable prescribed by the Director of Finance. The statement will include, where appropriate for each individual heading, details of:

a) The current financial position *(in-month/to date)*

b) Analysis of budget changes;

c) Trend analysis by month;

d) Workforce analysis;

e) Main issues arising in the month and forecast to occur in future months;

f) Projected end-of-year position;

g) Progress on rectification actions, where appropriate

h) Recommendations on actions required

5.7.2 The statements will conform to a reporting format agreed by the Director of Finance.

5.7.3 Budget values reported in the statements should take into account, wherever possible, all known adjustments to budget and all reasonably anticipated future adjustments.

5.7.4 Finance Leads should carefully assess income/expenditure within each report month and make appropriate accruals in order to allow for probable financial transactions not yet recorded in the accounting records.

5.7.5 After preparation of the statements, the Finance Leads will discuss any material issues in the resulting financial data with Operational Leads and Budget Holders.

5.7.6 The monthly submission in respect of each Divisions / Directorates will, where necessary, be accompanied by a request for a report outlining the cause of

significant variances, proposed remedial action, the results of earlier remedial action and anticipated outturn. The report should include details of major budget changes, transfers, anticipation of failure to meet financial targets and any other significant matters. It will be completed with consultation with the Divisions / Directorates.

5.7.7 The Director of Finance is responsible for collating all budget reports and preparing submissions, in the required format and timescale, to the Board and Executive team.

5.8 Investigation of Variances

5.8.1 Information on both material adverse and favourable variances from the budget plan, will be undertaken promptly. It should not be necessary to wait until a factor is included in a monthly report before investigative action is taken. When significant deviation from the planned budgetary trend appears likely, the Divisions / Directorates should notify the Finance Lead for either further investigation and/or to define the rectifying action.

5.8.2 All findings from material variances investigated by the Budget Holder in liaison with appropriate persons, are to be reported to the appropriate Finance Lead.

5.8.3 When variances become apparent at the time of the monthly report, these will be investigated in a timely manner based on their level of materiality.

5.9 Underspendings

5.9.1 Under normal budgetary conditions and within the limits of both the Divisions / Directorates and the Trust's financial position, the limits of virement will apply.

5.9.2 Wherever possible Budget Holders should be allowed to retain planned underspendings for alternative use providing that sound proposals can be put forward which will not jeopardise the Divisions / Directorates and/or Trust's overall commitment to achieving the financial plan on the income and expenditure account. Where agreed, the budget should be transferred to remove the budgetary variance and reflect the revised agreed plan.

5.9.3 Budget Holders are required to ensure, via their Finance Lead that anticipated material underspendings, whether planned or otherwise are notified to the Director of Finance at the earliest possible opportunity. Failure to make proposals in good time could result in under spendings not being available to the Budget Holder for future use.

5.9.4 Underspendings arising from:

a) unplanned or fortuitous circumstances;

b) failure to achieve contracted workload or agreed activity;

c) under demand for the budgeted level of service;

5.9.5 Should not be used or transferred without the prior agreement of the Chief Executive or Director of Finance. Normally, such underspendings will be transferred back to a general reserve for re-allocation by the Chief Executive or Director of Finance.

5.9.6 The Chief Executive, acting on advice from the Director of Finance, may approve a scheme or brokerage of underspendings between Budget Holders where transfer is not approved by the delegated powers.

5.9.7 Underspendings will not normally be carried forward from one year to another. Directors and Operational leads will be expected to provide a financial strategy to ensure that a balanced budget is achieved each year, within the Trust's overarching financial strategy.

5.10 Overspendings

5.10.1 The Board must safeguard its overall spending position with regard to delivery of the Trust's approved financial plan and will expect appropriate prompt action to be taken in order to minimise the serious consequences of potential overspending.

5.10.2 Where Budget Holders become aware that possible significant overspendings could arise, immediate action must be taken to rectify the situation. The Budget Holder should inform their Finance Lead, who will notify the Director of Finance. Delay that leads to a loss in opportunity to regulate overspending will be viewed as a serious breach of conduct.

5.10.3 Expenditure for which no budgetary provision has been made and which cannot be offset by delegated powers of transfer/virement, must not be incurred without the express permission of the Board. The Board have delegated this power to the Chief Executive or Director of Finance.

5.10.4 Where authority to transfer between budgets or budget headings has not been delegated, setting an underspending against a corresponding overspending is not permitted.

5.10.5 Overspendings will not normally be carried forward from one year to another. Directors and Operational Leads will be expected to provide a financial strategy to ensure that a balanced budget is achieved each year, within the Trust's overarching financial strategy.

5.11 Capital Budget Allocations & Management

5.11.1 The Board approves the capital programme at the beginning of the financial year. This approval covers all projects which may have an existing business case or for which a business case may be developed. Related business cases and contract awards are scrutinised and approved by the Capital Prioritisation Group (CPG) which includes three members of the Executive team. Any proposed changes to the capital programme will need to be authorised by the Board. As per 5.5.9, in-year contract awards linked to capital schemes will be reported retrospectively to Board through the quarterly contract award briefing. It is important to note the Board reserves the right to review previously authorised capital scheme decisions.

5.11.2 Due to potential breach of Trust delegated capital limits and the need to ensure alignment with SaTH's strategic objectives, capital business cases requiring additional Public Dividend Capital (PDC) to fund them will require strict Board

approval and increased delivery oversight. For Public Dividend Capital (PDC) funded capital programmes resulting from business cases authorised in-year, the allocation of capital required, and award of associated procurement contracts may be authorised by Board concurrently. This is linked to the timescales for notification of PDC award and drawdown.

5.11.3 For major programmes where the budget is above £10m or the programme covers multiple years the individual programme budget will require Board approval. The budgets for major capital programmes will be set prior to their commencement and will be updated periodically as required. Note, this may be more frequent than an annual update for schemes with implementation periods spanning financial years. Any alterations to the approved programme budget will need to be approved by the Board of Directors. Associated contract awards will require approval by the DoF / CEO (CEO acting on behalf of the Board). As per 5.5.9, in-year contract awards linked to approved major programme budgets will be reported retrospectively to Board through the quarterly contract award briefing.

5.12 Virement between Budgets

5.12.1 Divisions / Directorates must be able to respond to overspends or underspends if the variations are due to activity and workload, or as the result from external factors influencing expenditure. They, therefore, require defined powers to exercise virement up to a level appropriate to their virement limits as stated in 5.12.6 below. Virement is defined as a transfer of resources between two budgets and is in effect a downward revision in one budget off-setting an upward revision in another.

5.12.2 Divisions / Directorates may vire funds between the separate budgets within their control. A Division / Directorate may ask the Director of Finance to reduce a budget limit and raise another budget limit. This facility affords managers some level of flexibility during the year. Controls have been established to ensure that virement only takes place where agreement exists.

5.12.3 The need for virement is an acknowledgement that the planned budgets may require in-year revision. Authorisation has been delegated only to the Chief Executive or Director of Finance.

5.12.4 The Board has defined appropriate rules for virement between budgets. These rules are based upon an escalating basis of significance of the virement.

5.12.5 The following types of virement will generally not be supported unless a very strong case of need is made by the Budget Holder and agreed with their Finance Lead, who will then require authority from the Director of Finance:

- Virement between non-recurrent and recurrent resources;
- Virement between staff costs and operating expenses;
- Virement between capital and revenue.

5.12.6 Virement limits, which are based on the full year effect of the proposal, are aligned to the authorisation levels as set out in the Standing Financial Instructions. These proposals by budget holders need to be made in agreement with the respective finance lead. Where virement is in relation to increasing the pay establishment the

virement must be approved prior to appointment of the recruitment of the staff (substantive and/or temporary).

5.13 Reserves

5.13.1 The Director of Finance, on behalf of the Chief Executive, will endeavour to create such reserves as are deemed necessary to secure the ability of the Trust to meet its financial targets. Reserves may include sums to cover future pay awards, price inflation, unforeseen contingencies, non-recurrent spending and other specific items as yet not allocated to individual budgets.

5.13.2 The Director of Finance may exercise discretion to partly or wholly allocate reserves directly to the Divisions / Directorates or subsequent allocation to specific budgets.

6 Training Needs

6.1.1 This guidance is covered through budget holder training, however if staff have queries about its operation, they should contact their line manager in the first instance.

6.1.2 All budget holders are provided with training and on-going support from their respective finance lead to comply with this policy.

7 Review Process

7.1.1 This document will be reviewed in 3 years of approval date, or sooner if required. The document will also be reviewed in light changes to national policy, and feedback received.

8 Equality Impact Assessment (EQIA)

8.1.1 **An equality impact assessment has been undertaken on this document.** There are no positive or negative equality impacts resulting from this policy.

9 Standards of Business Conduct

9.1.1 Due consideration has been given to the Bribery Act 2010 in the formation of this policy document and no specific risks were identified. All budget holders and trust staff are expected to adhere to the Trust's Managing Conflicts of Interest Policy.

10 Process for Monitoring Compliance

Aspect of compliance or effectiveness being monitored	Monitoring Method	Responsibility for Monitoring	Frequency of Monitoring	Group or committee that will review the findings and monitor completion of any resulting action plan
Budget control is being achieved (outcomes)	Assessment of variances to budget	Board / Finance Assurance Committee	Monthly	Operational Performance Oversight Group
To review procedures for financial management within their area(s) of responsibility to ensure compliance with this policy	Documented evidence of procedures	Budget Holders	At least monthly	Operational Performance Oversight Group
Budget control is being achieved (outcomes)	Review of budget variances	Budget Holders	At least monthly	Operational Performance Oversight Group
The principles of sound budgetary control are being adhered to by budget holders	Finance Leads assessment of financial decisions and outcomes in budgetary reviews	Finance Leads	At least monthly	Operational Performance Oversight Group

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 08 May 2025

Agenda item		088/25		
Report Title		**Annual Review of QSAC Terms of Reference**		
Executive Lead		Anna Milanec, Director of Governance		
Report Author		Deborah Bryce, Head of Corporate Governance & Compliance		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe		Our patients and community		BAF13
Effective		Our people		
Caring		Our service delivery		**Trust Risk Register id:**
Responsive		Our governance	√	N/A
Well Led	√	Our partners		
Consultation Communication		Committee Chair. Quality & Safety Assurance Committee – 25 March 2025.		
Executive summary:		1. The Quality & Safety Assurance Committee's (QSAC) terms of reference have been subject to their annual review with updates proposed, as outlined within this paper. 2. The most significant update proposed is a change to meeting quorum from four to three members (from two to one executive director) within section 6.1 to reflect the quorum requirements of other committees of the Board.		
Recommendations to the Board:		The Board is asked to **approve** the updated Quality & Safety Assurance Committee terms of reference.		
Appendices:		Appendix 1: QSAC Terms of Reference – March 2025		

1.0 Introduction

1.1 The Quality & Safety Assurance Committee's terms of reference have been subject to their annual review and require approval by the Board as per the Trust's Standing Orders.

2.0 Proposed changes to the Quality & Safety Assurance Committee terms of reference

2.1 Updates to the terms of reference are proposed as follows:

a) Updates to titles of members in section 4.1, as follows:

- 'Director of Nursing' to 'Chief Nursing Officer'
- 'Medical Director' to 'Executive Medical Director'.

b) Proposed change to meeting quorum from four to three members (from two to one executive director) in section 6.1 to reflect the quorum requirements of other committees of the Board, i.e. Finance, Performance and People & OD assurance committees.

c) Addition of the following sentence in section 6.1: 'All efforts will be made to ensure that a designated deputy is in attendance if either the Chief Nursing Officer or Medical Director is absent.'

d) Change from 14 to 10 days in section 9.3 in the following sentence: 'Agenda papers shall be submitted at least 10 days prior to the meeting.'

e) The removal in section 10.8 (assurances from other committees) of the 'Nursing, Maternity and AHP Facilities Workforce Steering Group' now that the group's 4A's/key issues report is reporting into People & OD Assurance Committee. Also, the addition in this assurance section of: 'Urgent & Emergency Care Transformation Assurance Committee (quality and safety transformation programme issues)'

3.0 Recommendation

3.1 The Board is asked to **approve** the updated Quality & Safety Assurance Committee terms of reference.

Deborah Bryce
Head of Corporate Governance & Compliance
April 2025

Quality and Safety Assurance Committee

Terms of Reference

1 Constitution

1.1 The Board of Directors hereby resolves to establish a standing committee of the Board to be known as the Quality and Safety Assurance Committee ("the Committee").

1.2 The Committee has no executive powers, other than those specifically delegated in these Terms of Reference, or otherwise by the Board of Directors in its Scheme of Delegation.

1.3 As a Committee of the Board the Standing Orders of the Trust shall apply to the conduct of the working of the Quality and Safety Assurance Committee.

2 Authority

2.1 The Committee is authorised by the Board of Directors to investigate any activity within these terms of reference.

2.2 It is authorised to seek any information it deems relevant to fulfil its duties. All members of staff are directed to co-operate with any request made by the Committee.

2.3 The Committee is empowered by the Board of Directors to seek to obtain external professional advice and to invite external representatives or consultants with relevant experience and expertise to attend, if necessary, subject to Standing Financial instructions, Scheme of Delegation and approval of the Chief Executive and Trust Chair.

2.4 These Terms of Reference can be amended only with the approval of the Board of Directors.

3 Purpose

3.1 The purpose of the Committee is to seek and obtain evidence of assurance on the effectiveness of the Trust's clinical quality and safety governance structure, systems, and processes and the quality and safety of the services provided to achieve consistently high-quality effective care, ensure continuous improvement and to meet legal and regulatory obligations.

4 Committee Membership

4.1 The membership of the Committee shall be appointed by the Board of Directors and shall consist of not less than five members:

Committee Chair: a nominated Non-Executive Director
Two Further nominated Non-Executive Directors
Chief Nursing Officer (lead executive for the committee)
Executive Medical Director

4.2 The Non-Executive members and Committee Chair shall be appointed by the Board of Directors from amongst its independent Non-Executive Directors.

4.3 In the absence of the nominated Committee Chair, another Non-Executive Director member will chair the meeting.

4.4 Only members of the Committee shall attend the meetings, save for those stated in section 5. below.

5 Attendees

5.1 The following may attend, as necessary:

Deputy Director of Nursing
Director of Midwifery
Assistant Director of Nursing - Quality Governance
Deputy Medical Director
Head of Legal Services
Chief Operating Officer
Head of Risk
Chief Pharmacist
Lead subject experts: e.g. learning from deaths, patient experience, deteriorating patients and infection, prevention and control
Director of Governance, or nominated deputy
Committee Secretary
Senior Quality Lead - ICB

5.2 Meetings will be open to the Chief Executive and the Trust Chair to attend, along with other Non-Executive Directors.

5.3 It is for the Committee Chair to indicate whether other executive directors and/or other senior members of the Trust, attend, according to the requirements of each agenda. This will vary from meeting to meeting and will depend on whose area of responsibility an agenda item falls within. Directors / managers should be given sufficient notice that their presence is required so that they come fully prepared.

5.4 Other Trust Executive Directors and Trust officers will attend as required by the Committee to provide assurances and explanations to the Committee when discussing reports or other matters within the area of their responsibility.

5.5 Meetings are not open to members of the public.

5.6 Those in attendance do not count towards the quorum except where formal acting status is specifically in place for executive members.

6 Quorum

6.1 A quorum will be three members of the Committee of which there should be two Non-Executive Directors (including Associate Non-Executive Directors) and one Executive Director, one of which must be either the Medical Director or Chief Nursing Officer. A designated Deputy may act on behalf of an Executive Director in their absence, on the basis that one Executive Director is also present. All efforts will be made to ensure that a designated deputy is in attendance if either the Chief Nursing Officer or Medical Director is absent.

6.2 By exception, in the absence of Non-Executive Director committee member, a Non-Executive Director who is not a committee member, may count towards the quorum by the agreement of the Committee Chair and Trust Chair in advance.

6.3 No business shall be transacted by the Committee unless a quorum is present. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

6.4 At the discretion of the Chair of the Committee, business may be transacted through either: a tele/video-conference where an agenda has been issued in advance; or through the signing by at least three of all Committee members of a written resolution (including email) sent in advance to members outside of the meeting and recorded in the minutes of the next formal meeting.

7 Responsibilities of members

7.1 Identify agenda items for consideration by the Chair and the Committee Secretary at least 15 days before the meeting.
7.2 If unable to attend, send their apologies to the Chair and Committee Secretary with adequate notice prior to the meeting.
7.3 If appropriate, for 'attendees' of the meeting, seek the approval of the Chair to send a deputy to attend on their behalf.
7.4 When matters are discussed in confidence at the meeting, maintain such confidences.
7.5 At the start of the meeting, declare any relevant conflicts of interest/potential conflicts of interest in respect of specific agenda items in order that these can be considered by the committee/chair of the meeting in relation to participation in the agenda item.

8 Frequency of Meetings

8.1 The Committee shall normally meet ten times per year and not less than six times per year.

8.2 The Board or Committee Chair may request an additional meeting(s) if they consider that one is necessary to enable the Committee to discharge all its responsibilities.

9 Meeting administration

9.1 Meetings dates will be agreed by the committee members each year in advance. Notice of additional meetings will be given at least 14 days in advance unless members agree otherwise.

9.2 The agenda shall be determined by the Committee's agreed annual cycle of business/schedule, the Committee Chair, and the lead executive director.

9.3 Agenda papers shall be submitted at least 10 days prior to the meeting.

9.4 The agenda and papers will normally be circulated 7 days prior to the meeting, and at least 6 days prior.

9.5 The Committee Secretary, or their nominee, shall record the minutes of the meetings and provide relevant support for agenda setting, action logs and meeting invitations.

10 Duties of the Committee

The duties and responsibilities of the committee are as follows:

10.1 Strategies and Quality Account

10.1.1 To keep under review and recommend to the Board the quality, clinical and continuous improvement strategies.

10.1.2 To consider and recommend to Board, the contents of the Trust's annual Quality Account (in order for the trust to fulfill its obligations with regard to the Health Act 2009 and the Health and Social Care Act 2012)

10.1.3 To agree the quality priorities of the Trust following any necessary consultation, making recommendations to Board, and monitor progress of the quality priorities.

10.2 Patient Safety, compliance and regulation

10.2.1 To provide assurance to the Board that the Trust is meeting all CQC, regulatory and mandated care standards, guidelines, alerts and external review recommendations, and monitoring.

10.2.2 Ensure that a quality assurance framework is in place to support the governance arrangements required and consider if the quality and safety risk profile within the Board Assurance Framework should be amended in respect of any reports and significant risks received (internal or external).

10.2.3 Using the assurance framework, the Committee will review the risk and adequacy of assurance of patient safety. Ensuring that internal and external assurances are regularly reviewed, and the strength of assurances evaluated.

10.2.4 To receive assurance on patient safety incidents (PSIs) and mechanisms to maximise system-based learning and improvement.

10.2.5 To review and recommend to Board the Patient Safety Incident Response Framework. And provide assurance that the Patient Safety Incident Response priorities are being achieved, together with quality improvements, learning from incidents and associated transformation improvements, including identification of risks.

10.2.6 To gain assurance on Safeguarding including legislative compliance and completion of any action plans arising from matters of concern.

10.2.7 To receive assurances on medicines management/optimisation.

10.2.8 To gain assurance on compliance with Health and Safety requirements.

10.2.9 To receive and consider assurances in relation to infection, prevention and control (IPC).

10.2.10 To receive and consider assurances in relation to the Clinical Negligence Scheme for Trusts (CNST)

10.3 Incident Reporting and Investigation

10.3.1 To monitor the effectiveness of the Trust's systems for reporting and investigating Never Events, Patient Safety Incidents (PSIs), Near Misses and other incidents.

10.3.2 To receive assurance on the implementation of action plans and progress reports proposed by management in response to Never Events, PSIs, Near Misses and other incidents.

10.4 Patient Experience

10.4.1 To receive assurance from the Patient Experience Team and other relevant sources (e.g. Healthwatch) on all patient feedback, both of a positive and negative nature, and consider any gaps in assurance for any areas of concern.

10.4.2 To review the findings of patient and staff surveys (NHS, external organisations and local) considering any themes/trends as to impacts on patient experience and clinical quality, and gain assurance as to the implementation of the related action and improvement plans.

10.4.3 To receive assurance on the effectiveness of the Trust's systems for patient complaints, concerns, litigation handling and patient advocacy and review trends and themes.

10.4.5 To receive and consider the PALS, Compliments, Complaints and Patient Experience Annual Report, and any relevant reports from the Parliamentary and Health Service Ombudsman (PHSO), seeking assurance that any necessary action is being taken and monitored.

10.5 Clinical Effectiveness, performance and clinical governance

10.5.1 To receive assurances that the Trust has robust clinical governance processes that deliver safe, high quality and patient centered care based upon best practice metrics.

10.5.2 To provide assurance to the Board in relation to developing and sustaining an improvement culture including the promotion of best practice in patient care across the domains of quality and clinical effectiveness, patient safety and patient experience.

10.5.3 To review and consider the quality indicators within the Integrated Performance Report to ensure that assurance is received on all quality and safety of patient care matters.

10.5.4. To review assurances received on clinical practice and outcomes and be advised of the progress of any major quality initiatives in the Trust.

10.5.5 To receive assurances on the effectiveness of the Trust's arrangements for the systematic monitoring of mortality, and associated learning.

10.5.6 To review the assurance that the clinical audit programme is aligned with the key strategic and operational risks and review the Clinical Audit Annual Report and any associated action plans.

10.5.7 To receive assurances that the recommendations from external visits and national confidential enquiries are prioritised and progressed.

10.5.8 To identify quality improvement priorities in areas of poor performance or high risk, for example, by commissioning in-depth (deep dive) reviews of service areas.

10.6 Risk management

10.6.1 Identify and seek assurance on the management of significant quality and safety risks that are on the corporate risk register and ascertaining whether any risks should be incorporated onto the Board Assurance Framework and escalated to Board.

10.6.2 To review and oversee the strategic risks identified in the Board Assurance Framework that are assigned to the committee and make recommendations to Board on any changes required to the strategic risk profile.

10.7 Workforce Issues

10.7.1 To provide the Trust Board with assurance with respect to the safe staffing of wards and other facilities linked to the provision of clinically safe, high quality care 24 hours a day and seven days a week.

10.8 The Committee receives assurance from the following committees:
-Quality Operational Committee
-Infection, Prevention and Control Assurance Committee
-Patient & Carer Experience Panel
-Safeguarding Assurance Committee
-Clinical Audit Committee
-Maternity Transformation Assurance Committee
-Emergency Care Transformation Assurance Committee (ECTAC)/MEDTAC
- Paediatric Transformation Assurance Committee
- Getting to Good Group
- Urgent & Emergency Care Transformation Assurance Committee (quality and safety transformation programme issues)

11. Reporting

11.1 The Committee is accountable to the Board of Directors and the Committee Chair will report regularly on the Committee's proceedings in discharging its responsibilities and the effectiveness of systems and processes. The Committee Chair shall bring to the Board's attention, on behalf of the committee, significant matters that are under consideration and make necessary recommendations on any area within its remit where executive action or Board decision may be required.

11.2 The minutes of Committee meetings shall be formally recorded and made available to the Board of Directors.

11.3 The Committee will report to the Board at least annually on its work in support of the business of the Board and this report will be shared with the Audit & Risk Assurance Committee and the chair of the committee will attend ARAC at least once per year. This annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered and how they were addressed.

11.4 The Committee will refer to the Audit & Risk Assurance Committee any matters requiring review in that forum.

12. Monitoring Effectiveness

12.1 The Committee will conduct an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its duties, delivering its objectives and complying with its terms of reference.

13. Status of these Terms of Reference

13.1 The Committee's Terms of Reference, including membership, will be subject to annual review. Any proposed variations will require approval of the Board of Directors.

Agreed by Quality and Safety Assurance Committee on: 25 March 2025 (previously on 28 February 2024

Approved by the Board of Directors on: TBC (previously on 14 March 2024)