The Shrewsbury and Telford Hospital NHS Trust

BOARD OF DIRECTORS' MEETING IN PUBLIC
AGENDA

Date: 10 July 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	091/25	Welcome and apologies	Verbal	-	Chair in Common	For noting
	092/25	Patient Story	Enc	**3**	Interim Chief Nursing Officer	For noting
	093/25	Public Questions	Verbal	-	Chair in Common	For noting
	094/25	Quorum	Verbal	-	Chair in Common	For noting
	095/25	Declarations of conflicts of interest	Verbal	-	Chair in Common	For noting
	096/25	Minutes of the previous meeting held on 8 May 2025	Enc	**4**	Chair in Common	For approval
	097/25	Action log	Enc	**28**	Chair in Common	For approval
	098/25	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						
1015hrs	099/25	Report from the Chair in Common	Verbal	-	Chair in Common	For noting
	100/25	Report from the Chief Executive	Enc	**29**	Chief Executive	For noting
Reports from Assurance Committee Chairs						
1030hrs	101/25	Quality & Safety Assurance Committee Chair's Report (May & June 2025)	Enc	**36** **39**	Committee Chair	For assurance
	102/25	Performance Assurance Committee Chair's Report (May and June 2025))	Enc	**41** **44**	Committee Chair	For assurance
	103/25	Finance Assurance Committee Chair's Report (May and June 2025)	Enc	**47** **49**	Committee Chair	For assurance
SHORT BREAK						
1100hrs	104/25	People & OD Assurance Committee Chair's Report (June 2025)	Enc	**51**	Committee Chair	For assurance
	105/25	Audit & Risk Assurance Committee Chair's Report (May 2025)	Enc	**53**	Committee Chair	For assurance
Strategic, Quality & Performance Matters						
1115hrs	106/25	Integrated Performance Report	Enc	**55**	Chief Executive	For noting
Regulatory & Statutory Reporting						
1130hrs	107/25	Medical Examiner & Bereavement Service Report Q4 & Annual 2024/25	Enc	**135**	Executive Medical Director	For noting

	108/25	How we learn from deaths Annual Report 2024/25 (inc Q4)	Enc	**142**	Executive Medical Director	For noting
Assurance Framework						
1140hrs	109/25	Integrated Maternity & Neonatal Report	Enc	**150**	Interim Chief Nursing Officer	For assurance
	110/25	Board Maternity and Neonatal Safety Champions Report	Enc	**157**	Executive Medical Director	For assurance
	111/25	System Integrated Improvement Plan (SIIP) Report	Enc	**161**	Chief Executive	For assurance
	112/25	Risk Management Annual Report 2024/25 (inc Q4)	Enc	**163**	*Director of Governance	For assurance
Board Governance						
1215hrs	113/25	Fit and Proper Person Test (FPPT) Framework-Assessment Report 2025	Enc	**168**	*Director of Governance	For assurance
	114/25	Board Member Conflicts of Interests Report	Enc	**169**	*Director of Governance	For noting
Procedural Items						
1225hrs	115/25	Any other business – agreed by the Chair	Verbal	-	Chair in Common	For discussion
1230hrs	116/25	Date and time of next meeting: 0930hrs on **Thursday 11 Sept 2025**	Verbal	-	Chair in Common	Information
Close of meeting						

*Non-voting

ITEMS WITHIN THE BOARD INFORMATION PACK		
Reports / Appendices	**Lead**	**Page No.**
01 109/25 Integrated Maternity & Neonatal Report Appendices:	Int Chief Nursing Officer	
Appendix 1: Ockenden Report Action Plan		**2**
Appendix 2: Neonatal External Mortality Review (NEMR) Action Plan		**65**
Appendix 3: Summary Maternity & Neonatal Transformation Plan (MNTP) Ph2		**78**
Appendix 4: Year 7 CNST MIS Progress Report June 2025		**79**
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Appendix 6: Triangulation of NHSR Scorecard Q4 2025		**89**
Appendix 7: Minutes of Perinatal Quad Safety Champions Bi-monthly meeting		**110**
02 111/25 SIIP Report: Appendices 1-4	Chief Executive	**114**
03 QSAC Chair's Annual Report 2024/25	Int Chief Nursing Officer	**135**
04 F-PAC Chair's Annual Report 2024/25	Acting Director of Finance	**140**
05 ARAC Chair's Annual Report 2024/25	Director of Governance	**145**
06 PODAC Chair's Annual Report 2024/25	Chief People Officer	**150**

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 10 July 2025

Agenda item		092/25		
Report Title		Patient Story		
Executive Lead		Paula Gardner, Interim Chief Nursing Officer		
Report Author		Paula Gardner, Interim Chief Nursing 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				
Executive summary:		This month's Patient Story is from Louise, a patient in Oncology. Louise has had major surgery and is at present receiving chemotherapy . Louise and her husband will speak about their journey from diagnosis to treatment.		
Recommendations for the Board:		The Board is asked to **note** the patient story.		
Appendices:				

The Shrewsbury and Telford Hospital NHS Trust

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

Thursday 8 May 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 *(joined the meeting at 1015hrs)*
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 MBE	Non-Executive Director
Prof T Purt	Non-Executive Director / Vice Chair
Ms J Williams	Chief Executive
Mr A Winstanley	Acting Director of Finance
IN ATTENDANCE	
Mrs R Boyode	Chief People Officer
Ms T Cotterill	Interim Director of Financial Recovery and Transformation
Mr S Crowther	Associate Non-Executive Director
Prof H Fuller	Associate Non-Executive Director
Mr N Lee	Director of Strategy & Partnerships
Ms A Milanec	Director of Governance
Ms I Robotham	Assistant Chief Executive
Mr J Sargeant	Associate Non-Executive Director
Ms B Barnes	Board Secretariat (Minute Taker)
GUEST ATTENDANCE	
Ms H Turner	Lead Freedom to Speak Up Guardian *(Agenda Item 078/25)*
Mr M Dimmock	Head of Medical People Services *(Agenda Item 079/25)*
Ms K Williams and Ms J Bolton	Interim Director of Midwifery and Interim Head of Midwifery *(Agenda Item 080/25)*
Ms D Thompson and Ms S Parkes	Leadership & Organisational Development, People Directorate *(Agenda Item 082/25)*
APOLOGIES	
Ms H Troalen	Director of Finance

No.	ITEM	ACTION
PROCEDURAL ITEMS		
061/25	**Welcome and Apologies** The Chair in Common welcomed all those present, including observing colleagues and members of the public. Mr Morgan extended a particular welcome to Prof Heidi Fuller and Mr Jon Sargeant, who had recently joined the Board as Associate Non-Executive Directors; and Ms Tracey Cotterill, who had joined the Trust for six months to support with our financial recovery, in the role of Director of Financial Recovery and Transformation. Apologies were noted.	
062/25	**Staff Story** The Chief People Officer introduced a video featuring Liz, who works for Shropshire Community Health NHS Trust (SCHT) as a School Nurse with the 0-19 Service for Telford & Wrekin. Liz has participated in the Galvanise Leadership Programme, which is open to colleagues from Black, Asian and Ethnic Minority backgrounds. The Board was reminded that the Galvanise Programme forms part of the Trust's People Strategy and Leadership Development Framework. 37 participants have taken part in 'Galvanise' to date, including colleagues from SCHT who have joined the programme as part of our ongoing partnership and collaboration. Liz spoke of her positive experiences participating in Galvanise, and how she valued the opportunity to engage and share learning and development with colleagues from a variety of different roles. She also felt that Galvanise had increased her confidence and had equipped her with the skills to actively pursue career progression and growth. The Board noted that to date, 46% of participants have gained a promotion, with a further 30% actively seeking new roles. There had also been a positive impact on the 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 opportunities for career progression and growth. The Chair in Common thanked Liz for sharing her positive story with the Board. Mr Morgan also encouraged all Galvanise colleagues to engage with Executive members of the Board to explore potential opportunities for reverse mentoring, the benefits of which he was pleased to commend from personal experience in his previous Chief Executive role prior to joining SaTH/SCHT.	
063/25	**Public Questions Format**	

	The Board of Directors received a report from the Chair in Common detailing a change in the way that the Trust deals with questions from the public (and other stakeholders). This reflects 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', and the same process was being proposed to the Board of SCHT. Mr Morgan summarised the following key points, referring colleagues to Appendix 1 to the report, which set out the revised process in full: • Going forward, there will be a maximum of 30 minutes on the Board agenda for public questions, which will be taken after the patient/staff story. • It is proposed that questions for the Board are submitted in writing or via email to sath.trustboardsecretary@nhs.net, in the period between the papers being published on the Trust website (six days ahead of the meeting) and midday on the Tuesday before the meeting, to guarantee the question being dealt with at the Board meeting on Thursday of that week. • Whilst using a timeline associated with Board meetings, it is proposed that the parameters for questions be widened to relate to any matter within the powers and duties of the Trust. • The questions will be distributed upon receipt to the most appropriate executive(s), so that a verbal response can be provided at the Board meeting later that week. At the meeting, the Chair will read out the question and invite the appropriate executive to provide their response. • 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 permits, additional questions may be allowed from the same person. • Again, at the Chair's discretion and time-dependent, verbal questions may be permitted on the day, which will be taken after written questions. If any question (written or verbal) is considered to be more appropriate for a response through the Freedom of Information (FOI) route, it will be processed as such, and the questionner advised accordingly. • Both the questions and the answers will be included in the minutes of the meeting, which will be published on the Trust's website, and also directly in writing to the person(s) who asked them following the meeting. • Any questions received after the Tuesday midday deadline will be responded to by writing to the person directly and will be read	

	out at the subsequent Board meeting in public, along with the answer. • Full information on the public questions process and procedures is available on the 'Public Questions' page of theTrust's website. The Board of Directors noted the contents of the report, and supported the new process and procedures outlined.	
064/25	**Quorum** The meeting was declared quorate.	
065/25	**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.	
066/25	**Minutes of the previous meeting** The minutes of the meeting held on 13 March 2025 were accepted and approved by the Board of Directors as an accurate record, subject to the following minor amendment requested by Mr Hobbs to the penultimate sentence of agenda item 041/25, as follows: 'Mr Hobbs clarified that representatives of both Healthwatch groups were on the ~~System UEC Group~~ *Trust's Urgent and Emergency Care Transformation Assurance Committee, and that Healthwatch was represented on the Shropshire, Telford & Wrekin UEC Board.*'	
067/25	**Action Log** The Board of Directors reviewed the action log, and agreed the closure of Action No.8, noting that a paper had been taken to the Performance Assurance Committee (PAC) on 22 April 2025 covering non-elective length of stay and avoiding corridor care. This was covered in the PAC Chair's Report under agenda item 072/25 There were no further actions listed for review.	
068/25	**Matters arising from the previous minutes** 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		
069/25	**Report from the Chair in Common** The Chair in Common provided the Board with the following verbal update:	

	Local Elections: Mr Morgan noted that, following the recent local council elections, Shropshire now had a Liberal Democrat Council. He congratulated all those elected and provided commiserations to those who had not been successful. The Chief Executive referred to this further in her subsequent report. NHS reorganisation: • Mr Morgan shared with colleagues that the new national transitional leadership team were very keen to recognise and support Board accountability and leadership. • Following the recently announced plans to consolidate Integrated Care Boards (ICBs) across the country into clusters, a model ICB blueprint had recently been issued, including those functions which would be transferring to providers. The Trust would be engaging in discussions on the ICB reorganisation but is aware of its own very clear responsibilities for delivery, which would continue to be a key focus. • Further cost reduction work also continues with regard to roles in regional offices and ICBs. Finally, the Chair in Common thanked all colleagues across the Trust for the considerable work which had taken place on our 2025/26 planning. Following agreement by the national team, the focus now moves to delivery against the targets and objectives which have been set. The Board of Directors noted the report.	
070/25	**Report from the Chief Executive** The Board of Directors received the report from the Chief Executive. Taking the report as read, the Board's attention was drawn to the following key points: • Firstly, Ms Williams wished to thank all colleagues across the Trust 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. • There is now a bold, clear and comprehensive plan in place to deliver the operational and financial objectives agreed for 2025/26, to further enhance patient care and build a more sustainable future. • The Trust remains strongly focused on reducing long waiting times for patients. The 65-week elective wait backlog has continued to reduce, with full clearance on track for completion in quarter 1 2025. Since September 2024 the number of patients waiting over 52 weeks has also reduced from 4000 to 1500. In	

	parallel, our overall waiting list has reduced from 50,000 to 42,000, reflecting our sustained efforts to improve patient access and delivery, and the Trust has recently received national confirmation that we are the fifth most improved system in the country. • March and April 2025 continued to be extremely busy months for our Urgent and Emergency Care (UEC) pathways, with patients experiencing long waits in our Emergency Departments (EDs). Whilst recognising that this remains a very challenging period, our improvement work continues in critical areas, which includes 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. • The Trust has recently 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 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. • We have recently been advised that Ian Green OBE, currently Chair of Salisbury NHS Foundation Trust, has been appointed as the new STW ICB Chair, with his start date yet to be finalised. • As referenced in the report from the Chair in Common, we have recently welcomed Liberal Democrat Councillor Heather Kidd as the new Leader of Shropshire Council. Ms Williams advised the Board that she has sent a letter of congratulations to Cllr Kidd, in which she has emphasised the wish to continue to develop effective ways of working between our two organisations. • Finally, the Chief Executive was pleased to draw colleagues' attention to the previous day's announcement on the new Modular Ward at RSH. Work was due to start the following week, with a completion date of the end of November 2025, and would provide valuable additional service provision for our patients. The Board of Directors accepted and noted the report.	
REPORTS FROM ASSURANCE COMMITTEE CHAIRS		
071/25	**Quality & Safety Assurance Committee (QSAC) Report** The Board of Directors received the report from the Committee Chair, Ms Dunnett. Taking the report as read, discussion focused on the following points:	

	• Quality Oversight & Patient Experience: A number of positive actions had been identified in a comprehensive report received by the Committee. The report was commended as being very thorough, and included information from a number of evidence sources, both internal and external. • Palliative and End of Life Care (PEOLC): The Committee had undertaken a deep dive into this area following a deterioration in an indicator in the Trust Bereavement Survey in quarter 3 2024/25 in response to the question 'Was your relative comfortable'. It was confirmed that the fluctuating score for this question was due to a fluctuating number of 'don't knows', so in future both positive and negative scores would be reported, to provide a clearer picture. The report provided to the Committee 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. • Stroke Therapies and after-care: The Committee noted the challenges in recruiting to Therapies, particularly Occupational Therapists (OTs), which was recognised as a national issue. Temporary arrangements to support OT provision had recently been introduced. The impact of the service change on patients would be monitored and reported to the Quality Operational Committee (QOC) and escalated as needed. Other options across Shropshire were also currently being investigated. • Urgent & Emergency Care: No report had been received from the Urgent and Emergency Care Transformation Assurance Committee (UECTAC) due to the time between meetings, however the Committee did receive the System Integrated Improvement Plan, which would be brought within UECTAC governance. The Chief Executive added that she had subsequently taken the report to the NHSE fortnightly delivery group, who recognised the huge amount of work required. The Interim Chief Nursing Officer took the opportunity to thank and congratulate Donna Hadley, the Divisional Head of Nursing, for the marvellous job she had done on the report, noting that it could be used as a blueprint for other specialties. The Chair in Common commended the value of the patient experience content in the Committee report, observing that reports focused in that way supported better engagement with members of the communities who used our services. The Board of Directors accepted and noted the report.	
072/25	**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: • Equalities and Prevention work: The Committee 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 had been highly commended by the Regional Health Inequalities Team, and the work was showcased at the NHS England site visit held on 13 January 2025. • Digital Programme Update: The Committee heard that while SaTH has an ambitious digital programme, funding is very scarce nationally. Digital staffing resource is very challenging, with 50% committed to infrastructure maintenance and cyber security, meaning that any new requirements need to be carefully prioritised. The Chair in Common acknowledged that there was a lot to do in this area, with digital improvement encompassing productivity, costs and indeed every aspect of the Trust's business, and the Board looked forward to receiving updates over the coming months. • UEC performance: The Chief Operating Officer advised that NHSE had not accepted the original 2025/26 STW plan to improve performance on adult 4-hour and over 12-hour waits, and had required the System and SaTH to be more ambitious in its plans. This included an expectation that the System will increase alternatives to ED and that SaTH will do more to improve flow. The improvement plan had now been resubmitted, and we have received confirmation that it has been accepted. Mr Hobbs highlighted that a lot of work will be required to underpin how we will achieve the expected improvements. • Corridor care: Following a previous request from the Chair in Common for more detail to be brought to a future meeting on the actions being taken to avoid corridor care, the Committee received a report on Non-Elective Length of Stay (LoS) and its impact on corridor care in ED. The report showed that the Trust's average LoS for emergency admissions benchmarked in the top quartile (good), whilst its percentage of emergency admissions with a length of stay of 0-1 day was in the third quartile (room for improvement). To have a positive 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 five percentage points,	

	○ reducing complex LoS, with a reduction from 2.9 to 2 days from the time of a patient becoming medically fit for discharge to leaving the acute setting, ○ increasing SaTH inpatient bed numbers through the modular wards at RSH and through an additional 10 bed spaces at PRH, and ○ reducing numbers with No Criteria to Reside (NCTR) to 60 (from the current figure of 94). The Chair in Common thanked Ms Edwards for this update, commenting that it was good to see quantification of SaTH and the STW System working together on what we are trying to achieve. • Data Warehouse (DWH) Update: The Committee heard that the Trust was still on track for the DWH to become operational and to meet the timetable for submission of the 2024-25 data, however the work was intensive and relied on a small number of key people both within the digital team and within SaTH. Mr Lee confirmed that the first live submission was expected within the week, and he thanked all teams, particularly in Finance and IT, for their commitment over the last few weeks. • Patient Initiated Follow-Up (PIFU): The Committee received the Internal Audit report of a recent review of PIFU, following receipt of the report at the Audit & Risk Assurance Committee (ARAC). PAC would seek a follow-up report later in the year, and also wished to understand more about the impact of PIFU on patient care. The Board of Directors accepted and noted the report.	
073/25	**Finance Assurance Committee (FAC) Report** The Board of Directors received the report from the Committee Chair, Mr Miner. Taking the report as read, the Board's attention was drawn to the following points: • The Trust achieved its forecast outturn for 2024/25 of an £18.6m deficit, when taking into account the additional escalation support of £10.2m and noting the variations against budgets (mainly due to workforce costs). The Trust also delivered its forecast capital spend of £69.2m. • Mr Miner emphasised the critical focus required in the coming year on ensuring there was a timely forward look at numbers and costs, stressing that this would be of vital importance throughout 2025/26. Mr Miner also highlighted the development of enhanced reporting to embellish the controls necessary as an action of significance. • The Chair in Common invited the Interim Director of Financial Recovery & Transformation to provide any additional comments,	

	and Ms Cotterill advised the Board that a draft proposal had been submitted to the executive team the previous day, with a view to undertaking a deep dive across all specialties. She also highlighted the national focus at pace on corporate functions and future System working around shared services, with the Trust fully recognising the focus required on addressing the challenges ahead. The Chief Executive added that Executive colleagues have continued to be honest across the organisation. Divisional ownership has been very positive, and she clarified that corporate workforce plans were being reviewed the following week. The Board of Directors accepted and noted the report.	
074/25	**People & OD Assurance Committee (PODAC) Report** The Board of Directors received the report from Prof Purt, who had chaired the meeting in the absence of the regular Committee Chair, Mrs Boughey. The report was taken as read, and the Board's attention was drawn to the following points: • The Interim Chief Nursing Officer had attended the meeting for a number of relevant key reports, and the Chief Executive was present for the whole of the meeting. Some very useful and in-depth discussions had taken place, with the Committee focusing on workforce numbers at some length. • There was also discussion on clinical pathways and the need to align the HTP clinical plans/model and recruitment requirements. The Committee noted that an HTP clinical workshop was planned for early July 2025, and there was recognition that the workforce plan could not be undertaken in isolation. The critical importance was acknowledged of the input of Dr Jones and senior clinicians at the workshop, for clinical decisions to be taken on delivery, with the workforce plan then appropriately aligned. The Chair in Common added that these decisions could not be taken by the Trust in isolation, as there were potential System implications and dependencies. Referring to medical recruitment, the Chief Executive was pleased to note that the Trust has been fortunate in recently being able to recruit high calibre candidates into several consultant posts. A positive contribution to securing their recruitment was that the consultants were attracted by what we are aiming to achieve, and the Chair in Common observed that the 're-set' of SaTH was now starting to happen. Dr Jones also highlighted that one of the areas of HTP public consultation was an increase in recruitment, and it was encouraging to see this coming to fruition.	

	The Board of Directors accepted and noted the report.	
STRATEGIC, QUALITY AND PERFORMANCE MATTERS		
075/25	**Integrated Performance Report (IPR)** The Board of Directors received the report from the 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 February/March 2025. Whilst a number 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 Williams invited executive colleagues to provide the headlines from their sections. **Operational Summary** The Chief Operating Officer drew out the following points: • Planned Care: Mr Hobbs echoed the Chief Executive's earlier comments regarding the continued reduction in our 65-week elective wait backlog, with the Trust remaining committed to clearing all 65-week waits by the end of quarter 1 2025/26. The number of patients waiting over 52 weeks has also reduced from 4000 to 1500 since September 2024, and the total waiting list size continues to reduce. Additional capacity is being provided by independent sector providers for ENT, maxillofacial, gynaecology, endoscopy and general surgery. Referring to the children and young people (CYP) cohort, Ms Nicholson noted that there was continued work to reduce the number who have been waiting 52 weeks or more for treatment. Mr Hobbs provided assurance that, whilst the Trust would not achieve zero 52-week waits for this cohort by 31 March 2025, we will do so by the end of quarter 1 2025/26. He confirmed that the provision of 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 our CYP patients is monitored on a weekly basis and is also being tracked at specialty level. We recognise that we owe it to children and young people to ensure they are able to access treatment as soon as possible, mindful of the potential impact on their education and development. Finally, Mr Hobbs was pleased to advise that our PRH Surgical Hub has delivered a 50% increase in children's elective care since its opening last year. • Diagnostics: Performance has continued to show further improvement, with a validated overall DM01 position for March 2025 of 78.2%, a significant improvement from 56.2% in January and 71.7% in February. The number of over 6-week breaches	

reduced by 1239 (3437 in March 2025 v 4676 in February 2025), and the backlog of all CT reporting was cleared by the end of January 2025, with focus now on clearing the MRI backlog.

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

  Delivery of the cancer standards remains a significant challenge, and the Trust under-delivered against forecast trajectories in 2024/25. Recovery plans are in place and additional external non-recurrent funding from West Midlands Cancer Alliance (WMCA) and NHSE has been received to support improvement in performance. Additional cancer improvement expertise and senior leadership oversight has been sourced to support recovery and delivery of 2025/26 plans, and we are absolutely committed to improvement for our patients.

- Finally, Mr Hobbs wished to acknowledge the contribution of colleagues to our 2025/26 Operational Plan, which had now received national approval.

The Chair in Common welcomed the significant reduction in our waiting lists, and expressed his thanks to Mr Hobbs and colleagues, and all others around the Board table who have contributed to this improvement for our patients.

Patient Safety, Clinical Effectiveness & Patient Experience Summary

The Medical Director and Interm Chief Nursing Officer drew colleagues' attention to the following points:

- Smoking at time of Delivery (SATOD): A further decrease was seen in February 2025, from 5.8% to 5.4%. The government target for this metric is 6%, and the Trust is on track to meet this. Dr Jones commended the Healthy Pregnancy Support Service on this incredible achievement, emphasising the profound affect this will have on babies.

- Therapy stroke treatment: Dr Jones highlighted performance against national standards in therapy care for stroke patients as an area of concern. He noted that the recruitment challenges in recruiting to Therapies, and temporary arrangements to support

OT provision as a result, had been detailed in the previous QSAC report.

- Falls: The previously reported reconditioning work was continuing, including a review of bedtime routines. Ms Gardner advised that she had a second night shift planned, as a supportive measure, so that she could be present on the wards in the early hours of the morning to observe any issues first-hand. Senior leadership continued to support the further embedding of reconditioning into everyday practices.

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

- Complaints – Dementia Care: Mrs Boughey requested clarity on the figure of zero showing across the months on page 62 of the Board pack under 'Complaints by Theme – Dementia Care', querying whether the figure was genuinely zero or was due to this theme not being measured. Ms Gardner took this point away for clarification, and would provide an answer to Mrs Boughey offline. *(Response provided and included in Action Log as completed/recommend to close).*

Workforce Summary

There was nothing additional to report at this time.

Finance Summary

The Acting Director of Finance drew out the following points:

- Efficiency Plan delivery: £34.3m in efficiencies had been delivered at the end of March 2025, representing nearly double that of the previous financial year.

- Capital Programme delivery: The total capital programme for 2024/25 was £69.2m, which was expended at month 12, achieving a balanced year-end position. Mr Winstanley thanked all colleagues who were involved in this significant achievement, highlighting that this was the largest capital figure the Trust has ever had.

The Chair in Common commended the 2024/25 financial achievements relating to the efficiency programme and the capital programme, noting the key part played by our capital programme delivery. Mr Morgan expressed his congratulations on behalf of the Board to all those who had project-managed the capital schemes.

	The Board of Directors accepted and noted the Integrated Performance Report.	
076/25	**Public Participation Report Q3&4 2024/25** The Board of Directors received the report from the Director of Strategy and Partnerships, which was taken as read. Colleagues were also directed to the full Public Participation Report in the Board Supplementary Information Pack, containing further rich information and assurance on the work of the team. Mr Lee highlighted the excellent work being undertaken across the three main inter-related public-facing teams that form the overall Public Participation Team: • Community Engagement, including the Hospitals Transformation Programme (HTP): The 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 SaTH NED/Vice Chair, Prof Trevor Purt, and a public member from Montgomery Health Forum (Cllr Joy Jones). The Forum has a wide range of community, voluntary and statutory sector organisations as members, and provides an opportunity to discuss issues directly with our Divisional teams, who also attend. • Volunteers: We currently have 251 volunteers, who have given almost 14,000 hours of volunteer time across a wide range of activities. Our Volunteer to Career (VtC) scheme continues to go from strength to strength. In partnership with the national charity, Helpforce, we are offering the opportunity to extend our VtC programme to a bespoke cohort of veterans and their families, and participants will have the chance to look at different roles in the NHS. • SaTH Charity: We continue our focus on supporting the work of the Charity. Currently SaTH Charity has 949 supporters, comprising of 875 donors and 74 fundraisers. The Charity Annual Report and audited accounts for 2023/24, published on the Charity Commission website in January 2025, show a 39% incease in income (from £359k in 2022/23 to £497k in 2023/24). The income for 2024/25 is around £556k (final figure to be confirmed), which is an increase of almost 56% on the 2022/23 income. The full report includes highlights of some of the ways SaTH Charity has made a difference, including the redevelopment of Ward 32 Courtyard for Trauma and Orthopaedic patients, and funding new internal signage to support patients and relatives to navigate to clinics following the closure of the RSH Outpatient entrance.	

	The Chief Executive reiterated her thanks to our wide range of incredible volunteers for the significant support they provide to us, and she looked forward to joining a celebration tea-party for our volunteers in early June. Ms Williams also thanked Lingen Davies for their valuable support to the Trust. The Board of Directors accepted the report, noted the activity from October 2024 to March 2025 across the Public Participation Team, and took assurance from this work that the Trust's statutory duties, and CQC Well-Led requirements, continue to be met.	
REGULATORY AND STATUTORY REPORTING		
077/25	**Infection Prevention & Control (IPC) Report Q3 2024/25** The Board of Directors received the report from the Interim Chief Nursing Officer, providing a summary of performance in relation to the key performance indicators for IPC in quarter 3 of 2024/25. Colleagues were referred to the detailed information within the report on each infection, which was taken as read. Ms Gardner summarised the following quarter 3 key points: • Clostridioides Difficile (C.diff): There had been an increase in cases, with 37 cases recorded - 20 Hospital-Onset, Healthcare-Associated (HOHA), and 17 Community-Onset, Healthcare Associated (COHA). The Trust is implementing targeted interventions through the C.diff workstreams and monitors progress through the appropriate governance and assurance committees. • E.coli bacteraemia: there were 36 cases, with five linked to devices/interventions; and 17 cases of MSSA bacteraemia also linked to devices/interventions, with the Trust's rate higher than regional comparators. Klebsiella and Pseudomonas Aeruginosa infections remained within target limits, highlighting the ongoing risks associated with invasive devices. • Outbreaks and Infection Control Challenges: there were nine COVID-19 outbreaks (an increase from seven in quarter 2), six influenza outbreaks, and one norovirus outbreak. Challenges included delayed isolation due to limited side rooms, patients developing symptoms post-admission, and hand hygiene. Three 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). All these issues highlight the need for continued vigilance, targeted infection control measures, and improved staff education to mitigate infection risks. • Health and Social Care Act Compliance (previously known as Hygiene Code): this 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 'Red' for 1. The 'red' element is in relation to follow up of staff by occupational health as contact tracing is not included in the provider contract. This has been escalated to Workforce as a risk. The Board of Directors accepted the report and noted the issues highlighted, in particular with regard to the increasing rate of C.diff/MSSA Bacteraemia/EColi Bacteraemia.	
078/25	**Freedom to Speak Up (FTSU) Annual Report 2024/25** Ms Turner, FTSU Lead Guardian, joined the meeting to present the FTSU Annual Report. The Board of Directors noted that the report included quarter 4 data and overall data for 2024/25, as well as reflecting on FTSU activity throughout the year. The report was taken as read, and the Board's attention was drawn to the following points: • Closure targets: Whilst improvements have been made in closing concerns within the targets set, we are not where we want to be, in particular with regard to closing concerns with worker safety and wellbeing at the heart of them. A piece of work is being undertaken to understand the barriers to closing concerns within timeframes, which will be included in the Quarter 1 2025/26 report to Board. • Staff Survey results: The results of the 2024 NHS Staff Survey on the key questions for speaking up to FTSU were highlighted as follows: ○ There had been an improved response to the two questions about staff raising clinical concerns and the organisational response, bucking the national trend. ○ A decline was seen, however, in the two questions in relation to raising concerns about anything in the organisation. ○ The downturn in feeling safe to raise concerns about anything was most significant from our Additional Clinical Services, Administration and Clerical, and Estates and Ancillary teams. Whilst this may correlate with lower banded colleagues not feeling they have a voice, analysis of the bottom five teams for this question showed that, concerningly, a divisional senior team was included. The following responses were provided by Ms Turner to queries from Non-Executive Directors: • Administration and Clerical concerns: The majority tend to be concerns of an HR nature. FTSU continue to signpost and escalate as appropriate.	

	• Understanding detriment: FTSU do not routinely ask about detriment, but have plans to focus on this in the next 6-12 months. Findings will be included in future reports as appropriate. The Chief Executive shared with the Board the topics of concern on which she had met with staff, which included flexible working, working conditions at PRH and how we enable colleagues to undertake their jobs more easily/efficiently. Also, with regard to the role administration and clerical colleagues play in patient care, it was clear that digital enablement, and the Line Manager role, were an important part of the solution. The Chair in Common echoed Ms Williams' comment about the importance of all roles and the contribution everyone has to make to ensure that the Trust, as a large complex organisation, is able to function effectively. He acknowledged FTSU as an important part of our work, playing a key role in developing a culture where colleagues feel confident to raise concerns. Finally, in response to a query from Mr Morgan, Ms Turner was pleased to confirm that she continues to have direct access to the Board when required. The Board of Directors accepted and noted the report, and took assurance from FTSU's continued contribution to supporting our colleagues and improving our culture.	
079/25	**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, who was unable to join today's meeting. Mr Matt Dimmock, Head of Medical People Services, joined the meeting to support with any questions from the Board. The report was taken as read, and subsequent discussion covered the following key points: • Exception Reporting: Dr Jones advised the Board that national agreement was reached on 31 March 2025 on reforms for exception reporting for resident doctors, which will introduce significant changes to how exception reports are 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 data breaches, and where detriment to a reporting doctor is identified. Mr Dimmock added that Medical People 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 previously. The monitoring of standards will be mandatory and a new standardised reporting template will be provided to enable benchmarking nationwide. Further guidance, along with updates to the Terms and Conditions of Service	

	(TCS), was awaited, and a corresponding implementation plan was currently in development. Further updates will follow as implementation progresses, with trusts 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. • Urology concerns regarding the Non-Resident On-Call (NROC) shifts: The previously discussed conversion of work schedules to a full shift system, with the introduction of resident long days and nights, had been met without opposition, and the new rota template including full shift patterns was presented to doctors on 3 March 2025. However, the Department has also been working with Medical People Services 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 this report, the GoSW awaits a decision as to whether the current cohort of doctors can appeal the timeline for implementation of the full shift pattern. Finally, in response to a query from Ms Edwards on the main reasons for doctors working beyond their rota hours, Mr Dimmock advised that the fundamental issue was when doctors work bank shifts, as the Trust does not have a centralised rostering system, resulting in lack of visibility. It was confirmed that there are a number of plans to develop support to doctors in this respect, including comprehensive coverage as part of induction. The Board of Directors accepted and noted the report.	
ASSURANCE FRAMEWORK		
080/25	**Integrated Maternity & Neonatal Report** The Interim Chief Nursing Officer introduced and welcomed Ms Kim Williams, Interim Director of Midwifery and Ms Jacqui Bolton, Interim Head of Midwifery. As Ms Williams would be leaving the Trust shortly, and this would be her last report presentation at Board, Ms Gardner wished to publicly express her thanks to Kim for the impeccable way she has led the service during her tenure, to ensure that high quality care has been maintained for our patients. Colleagues were referred to the detail contained within the report, which was taken as read, together with the appendices in the Board Supplementary Information Pack which provided further comprehensive information. The Board's attention was drawn to the following key points: **The Ockenden Report (Independent Maternity Review) Progress Report:** 190 out of the total of 210 actions have now been	

	fully completed (evidenced and assured). In total, seven actions remain 'de-scoped' currently. These relate to national level external actions (led by NHS England and CQC), and are not within the direct control of the Trust to deliver. The summary action plan, as at 8 April 2025, was included as Appendix 1 in the Board Supplementary Information Pack. **Invited Neonatology Service Review (2023/24):** Steady progress was being made to deliver the recommendations from the external invited review of the Trust's neonatal services, led by the Royal College of Physicians. The review initially comprised of 27 actions in total, however one of the actions relates to employing several new roles, so this has been split into separate sub-actions to enable each to be tracked separately, which means the total number of actions is now 35. The summary Neonatal External Mortality Review (NEMR) Action Plan at 8 April 2025 was included as Appendix 2 in the 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 Supplementary Information Pack. The Board was also advised that a review of the Cultural Improvement Plan was undertaken against the results of the 2024 Staff Survey. Progress with this plan was expected to pick up in the next few months, now that the previously suspended non-mandatory training activities can resume. There was nothing of exception to report at this time. **NHS Resolution's Maternity (and Perinatal) Incentive Scheme (Clinical Negligence Scheme for Trusts – CNST)**: The results following the self-verification of the Year 6 Maternity Incentive Scheme are currently embargoed, but are due to be published soon, and are expected to be positive for the Trust. Year 7 of the scheme was launched in April 2025, and reporting would continue in line with the Year 7 technical guidance. The Board of Directors formally acknowledged that it had received and read all the reports detailed in section 5 of the report, 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 **Appendices 4 and 5** in the Board Supplementary Information Pack.	

	• (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. Included as **Appendix 6** 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 7** in the Board Supplementary Information Pack. • (SA9) – the Trust's Claims Scorecard has been reviewed alongside incident and complaint data, and has been triangulated with other quality and safety metrics to inform targeted interventions aimed at improving patient safety, and has been reflected in the Trust's Patient Safety Incident Response Plan. Included as **Appendix 8** in the Board Supplementary Information Pack. **NHS Staff Survey 2024:** Compared to the 2023 survey results, response rates improved in both Maternity (31% to 46%) and Neonatal services (58% to 80%), with a combined response percentage for the Women and Children's Division of 55% compared to the Trust overall average of 51%. The Board was referred to section 6 of the report for further detail on these encouraging results. **Insight Visit:** Finally, there had recently been a very positive insight visit into the service from ICB colleagues. There was acknowledgement from the ICB of the ongoing improvements being delivered to ensure patient safety and compassionate care, and ICB colleagues had also advised the service of areas where they could help further. 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. In closing this item, the Chair in Common endorsed Ms Gardner's earlier comments and added his thanks to Kim on behalf of the Board for the skill, enthusiasm and commitment she had shown during her time at the Trust. Colleagues wished Kim all the best in her new role, and looked forward to welcoming Jacqui to Board for future reports.	
081/25	**Board Maternity and Neonatal Safety Champions Report** The Board of Directors received the report from the Medical Director, which was taken as read and duly noted.	
082/25	**Annual NHS Staff Survey Results**	

(The meeting was paused during this item for colleagues to observe the two-minute national silence to mark the 80th anniversay of VE Day).

The Chief People Office introduced Ms Dawn Thompson and Ms Sharon Parkes to present the report, to provide assurance to the Board and outline the importance of the staff survey, in particular the engagement measure and its pertinence in the workplace.

The Board was referred to the detail within the report, which was taken as read, and particular attention was drawn to the following key points:

- Colleagues were reminded that the staff survey is aligned to the NHS People Promise, a nationally-led initiative, and affords the opportunity to listen and respond to our teams to deliver the best possible experience working at SaTH.

- The key findings from the 2024 survey show that the Trust scores for four of the People Promises have improved from 2023 *(We are Compassionate and Inclusive, We each have a Voice that Counts, We are Always Learning, We Work Flexibly).* There have been decreases in two People Promises *(We are Recognised and Rewarded, and We are a Team*) and one has remained the same *(We are Safe and Healthy).* The Morale score has increased and the Engagement score has remained the same.

- The People Promise priority actions are being reviewed in response to the 2024 results, building in actions to address operational pressures, and the Board was referred to the full action plan in Appendix 1 to the report.

- Although the Divisional trends show a mixed picture, the Board was encouraged to note the improvements that each Division has made, and in particular within Medicine and Emergency Care, who have been faced with unprecedented internal and external pressures.

- In conclusion, the 2024 results provide an indication of a Trust which is continuing to improve the experiences of staff. Even though many scores are still below sector comparison, our focus will be on continuing the upward trend. In what is an incredibly challenging time, the results show that the Trust is responding well to current challenges.

Finally, and building on a query from Ms Edwards on justification of the high scores, Mr Hobbs advised the Board of analysis which has been undertaken that correlates advocacy scores with waiting times across the country. He endorsed the importance of colleagues feeling that SaTH is a good place to work, and where patients feel safe to be treated.

	The Board of Directors accepted and noted the report, with particular regard to progress delivery against the People Strategy milestones.	
083/25	**Board Assurance Framework Q4 2024/25** The Board of Directors received the report from the Director of Governance. Taking the report as read, colleagues' attention was drawn to the following key points: • BAF risk 7a *(failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation)*: The likelihood of this risk had increased from 'possible' to 'likely', in line with national threat levels and activity across the NHS. It was therefore proposed to increase the current total risk score from 15 to 20. • BAF risk 13 *(corporate governance)*: The addition of a new action was proposed 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. • BAF risk 5 *(finance)*: Three actions were closed in quarter 4. The Board also noted that there was a full discussion at the Finance Assurance Committee (FAC) on 29 April 2025 on the total current score of this risk, 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. • The four top scoring risks, with a current total risk score of 20 at quarter 4, were BAF risks 5 *(finance),* 7a *(cyber defences),* 7b *(digital implementations)*, and 10 *(the Trust's ability to meet the required national urgent and emergency standards).* Ms Milanec proposed that a review of the BAF be undertaken with the Board, to include a review of the risks where the scores have not changed for the entire year, and whether they need to be amended. A session was agreed for inclusion in a future Board Seminar, with the date to be confirmed. 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 4 BAF.	
084/25	**System Integrated Improvement Plan (SIIP)** The Board of Directors received the report from the Chief Executive, providing 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. Colleagues noted that the SIIP had been developed in conjunction with NHSE colleagues. The Board noted and accepted the recommendations in the report, which would be submitted to the STW ICB by 20 May 2025 together with the supporting evidence. The submission would also include confirmation of Board sign-off of the STW ICS PMO structure and approach, as detailed in Appendix 5 to the report, for ICB approval.	
ITEMS FOR CONSENT (approval recommended from Board Committees)		
085/25	**Safeguarding Adults at Risk of Abuse Policy** The Board of Directors received the above policy for approval, which included two minor additions to the wording, following a routine review. The Board accepted the recommendation of QSAC following their earlier review, and **approved** the Safeguarding Adults at Risk of Abuse Policy.	
086/25	**Patient Safety Incident Response Framework (PSIRF) Policy** The Board of Directors received the above policy for approval following its annual review, noting that the changes mainly revolved around updating terminology, which had not altered the substance of the policy. The Board accepted the recommendation of QSAC following their earlier review, and **approved** the PSIRF Policy and associated Patient Safety Incident Response Plan.	
087/25	**Budgetary Control Policy** The Board of Directors received the above policy for approval following its review and amendment in accordance with the Trust's Standing Financial Instructions (SFIs). The Board accepted the recommendation of the Audit and Risk Assurance Committee (ARAC), and **approved** the Budgetary Control Policy.	
088/25	**QSAC Terms of Reference Annual Review** The Board of Directors received the QSAC Terms of Reference following their annual review, noting the minor updates as outlined in the paper. The Board **approved** the updated QSAC Terms of Reference, as per the Trust's Standing Orders.	
PROCEDURAL ITEMS		
089/25	**Any Other Business**	

	There were no further items of business.	
090/25	**Date and Time of Next Meeting** The next meeting of the Board of Directors in public was scheduled for Thursday 10 July 2025 from 0930hrs–1230hrs.	

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								
9	08/05/2025	075/25	IPR - Patient Safety/Experience Summary	Complaints – Dementia Care: Mrs Boughey requested clarity on the figure of zero showing across the months on page 62 of the Board pack under 'Complaints by Theme – Dementia Care', querying whether the figure was genuinely zero or was due to this theme not being measured. Interim CNO to clarify following meeting and provide response offline.	Interim CNO	15/05/2025	The following response has been provided by Ms Gardner to Mrs Boughey offline - "We capture dementia diagnoses in the demographic data (based on what is on Careflow) and then the subject codes will be used to capture what the issue is (eg lack of support, issues around nutrition and hydration etc). The subject and sub-subject codes will all be reviewed this year to ensure that they are giving the level of detail we need to properly analyse complaints. The dementia code on the system is one that is not really needed because we are capturing this through the demographics and it will be removed from reporting going forwards". *Recommend to close as response provided.*	Recommend to close
10								

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
10 July 2025

Agenda item		100/25		
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:		At the end of last month, NHS England published the 25/26 version of the Oversight Framework. This is usually an annual publication, but the extensive stakeholder engagement relating to the Government's long anticipated Ten Year Plan for health and care delayed this until last week. We hope that by the time this report is published, the Plan will also be available. On a lighter note, it was wonderful to spend an afternoon with our volunteers recently and to formally say 'thank you' for all that they do for the Trust and our patients – we couldn't be without them. Also, it was amazing to celebrate with some of our long serving colleagues who have worked for the NHS for 25, 40, or even, 50 years! It's incredible to think that some of our most experienced colleagues have been working for this national institution since 1975. A big thank you to them too.		
Recommendations for the Board:		The Board is asked to note the contents of the 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 public Board on 8 May 2025 from the Chief Executive's position, which includes an overall update, SaTH news and wider NHS updates.

2.0 OVERALL SaTH UPDATE

2.1 On Saturday 5 July 2025, we celebrated the 77th birthday of the NHS. I am filled with immense pride and gratitude to all our staff and volunteers. Your unwavering dedication, tireless efforts, and profound commitment to our patients continue to inspire and drive us forward, even in the face of daunting challenges. It is important to celebrate our successes; we must also acknowledge the ongoing challenges that we face.

The pressures on our Urgent and Emergency Care pathways, the continued need for transformation in our workforce, and the ambitious goals for reducing long-wait patient backlogs require our focused attention and collaborative efforts. I am confident that together, we will address these challenges with the same determination and resilience that has brought us this far. Our recovery and transformation plans are not just doable; they are driven by the incredible spirit and determination of our staff. We must plan to eliminate our deficit entirely and ensure that we have the right staff, with the right skills, in the right places to meet our patients' needs.

I encourage everyone to take a moment to reflect on the significance of our shared values in our daily work. These values underpin our interactions with colleagues and patients and form the foundation of our Trust's culture. As we celebrate the NHS birthday, let us remember that our collective efforts and unwavering commitment are the pillars that uphold this organisation. Together, we will continue to build a Trust that we can all be proud to work for, ensuring the highest standards of care for our patients and a supportive environment for each other.

Thank you for your hard work, commitment, and dedication.

2.2 I am pleased to share that, as at the end of month two, we have delivered our agreed financial plan. We remain focused on reducing long-wait patient backlogs and aim to eliminate patients waiting over 65-weeks by the end of June, in line with the national target. The number of patients waiting over 52 weeks has reduced by over 70% and the total elective waiting list has reduced by almost 20% in the last nine months.

Improvements continue across cancer and diagnostics services, for example 53.6% of patients waiting under 6 weeks for tests in December 2024, to 78.6% in April 2025. Our strong performance had led to fewer Tier 1 calls with NHSE. This reflects the hard work of our team, and I hope we can exit Tier 1 next Quarter.

2.3 Nearly 5,000 day-case patients have had surgery in the Planned Care Hub at PRH in its first year. The hub, which has just marked its first anniversary, delivers high-quality, high-volume surgery in a dedicated space, separate from emergency and winter pressures.

This is reducing the time patients are waiting for their procedures, improving health outcomes. Surgery waiting lists have reduced by 16% since the hub opened last summer and the number of operations taking place at the hub has increased by 34% per month since January 2025. The new LINAC bunker and linear accelerator at RSH is on track, with the first patient expected in Sept 2025.

2.4 May and June continued to be extremely busy months for our Urgent and Emergency Care (UEC) pathways, with patients experiencing long waits in our Emergency Departments. While 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 2025/2026 operational improvement plan.

2.5 On 3 June 2025 the CQC conducted an assurance visit to RSH ED and the Acute floor. During the feedback session, they noted significant improvements in the new areas. Despite being busy, the department felt calm, with friendly and welcoming staff, proud of their progress. They observed substantial improvements across the service. While we all acknowledge the ongoing work as part of our improvement programme, we recognise and appreciate the progress made by the teams under continuous pressure.

2.6 In the week commencing 30 June, we hosted our Values Week to acknowledge our commitment to our Values and their significance in our work for colleagues and patients. On Monday of that week, the first event was held to appreciate our long-serving colleagues. The Chair in Common and I attended the celebration of colleagues with 25, 40, and 50 years of service. A huge congratulations to our colleagues Jayne Smith and Sneta Devi, who have both reached the incredible 50-year milestone.

The following day we celebrated our second value ‘Ambitious,’ and we announced our first Moving to Excellence Award winners. We had an amazing response of 150 nominees across all our divisions and our corporate teams, and the judges had a tough job in selecting their winners. The awards shine a spotlight on colleagues and teams that are providing exceptional care for our patients, directly or indirectly, and those who are helping us to move to excellence by improving our performance and helping to deliver value for patients. Congratulations to everyone who took part and do not forget to nominate colleagues in the next launch in August 2025.

To close the week, we launched the Trust Celebratory Awards which reflect the huge diversity of what our colleagues do, day in and day out, to support and care for our local communities.

The awards celebrate the outstanding dedication and commitment of colleagues and teams, and the truly wonderful work they do every day across so many services in our hospitals and the wider community to support our patients and their families.

This is your opportunity to nominate and celebrate the outstanding dedication and

commitment of colleagues and teams. We have an array of new award categories, spanning how we are achieving our vision to provide excellent care for the communities we serve – and living and breathing our values Partnering, Ambitious, Caring and Trusted. This year the awards ceremony will be held on Friday 17 October 2025; the closing date for nominations is Friday 1 August 2025.

2.7 On 6 June 2025, staff from both SaTH and Shropshire Community Health NHS Trust (Shropcom) graduated from Galvanise, an ethnic minority leadership programme. The aims of the course are to support colleagues to progress their leadership careers, provide the two trusts with an opportunity to learn about cultures and backgrounds and ensure that ethnic minority colleagues have a space to come together and share their challenges and opportunities.

The eighteen graduates from teams including nursing, therapies, and corporate, came together last month to celebrate their graduation. Galvanise was established in 2023 by Dr Victoria Walton, a former junior doctor in training in SaTH. Galvanise equips colleagues with the skills, confidence, and knowledge to be ready for promotion opportunities, whilst allowing space for critical discussion via action learning groups and reflective practice, such as DiSC and Civility and Respect training sessions. To date 46% of participants have gained a promotion since taking part in the course and a further 30% are actively seeking promotion.

It was fantastic to celebrate our 2025 Galvanise cohort and see their energy and enthusiasm to lead change in their areas, to build a culture where everyone has a voice and feels they belong. Thank you to Rhia Boyode, Chief People Officer at SaTH and Shropcom, who dedicates much energy and commitment to the programme to ensure that our colleagues from ethnic backgrounds have the resources and support network to reach their potential.

2.8 The development of cancer services at the Princess Royal Hospital has been a long-held commitment for the Trust and will support us to deliver modern and high-quality care for our patients closer to home. We are working in partnership with Lingen Davies to improve cancer and urology investigation services and facilities at PRH by 2029, including supporting chemotherapy services. The development will have a real benefit to patients who currently have to travel from the Telford area to receive treatment, which is currently just under 40% of patients we see in our existing facilities at RSH. Growing our cancer service offer to both our hospitals will provide several benefits to our patients.

We are extremely grateful to Lingen Davies Cancer Support for working with us to fundraise £3.5m for this development as part of the “Sunflower Appeal”. Lingen Davies has been incredibly supportive of developments and investment in cancer services at SaTH for 45 years. We are proud of our ongoing links to ensure local people can access excellent cancer services locally. The investment forms part of our Hospitals Transformation Programme, which will see PRH specialise in planned care and RSH specialise in emergency care. This multi-million-pound investment will improve care for everyone through modern, purpose-built facilities and ensure more people get the care they need, at the right time and in the right place.

2.9 Congratulations to the Finance Team for winning three awards at the West Midlands HFMA conference: Team of the Year, Finance Excellence, and Outstanding Contribution. Fantastic achievement!

2.10 A £1million research study taking place at the Community Diagnostic Centre (CDC) in Telford has reached a major milestone in its aim to revolutionise the diagnosis of colorectal cancer.

The trial has now recruited more than five hundred patients from Shropshire, Telford, and Wrekin in its study, which will reduce the amount of time patients are waiting and worrying about a colorectal cancer diagnosis. The TRIOMIC study is developing a new test which aims to drastically reduce the number of patients who require an invasive colonoscopy. It will also take place away from a hospital setting at the CDC at Hollinswood House, Stafford Park.

More than five hundred symptomatic patients on the Colorectal Urgent Suspected Cancer pathway at SaTH have been recruited for the new test, which is quick and pain free, using the Oricol™ device by collecting rectal mucus samples. The samples are then assessed at laboratories for abnormal cells from cancer and significant polyps. If successful, eight out of ten patients will know that they have not got cancer within five days of the test, rather than having a 45-minute colonoscopy requiring full bowel preparation and a separate visit to hospital.

2.11 SaTH is currently subject to a West Mercia Police investigation called Operation Lincoln. The investigation started in 2020 and follows on from the Independent Review into Maternity Services, chaired by Donna Ockenden. The police are examining the care of mothers and babies who died or suffered serious harm in a maternity care setting between 1 October 2003 and the present day. West Mercia Police has informed us, and the families affected, that their investigation will now enter its next phase.

The primary focus of this phase is Corporate Manslaughter and whether there were failures at an organisational level at the Trust. As part of this process, the Operation Lincoln team will be interviewing some current and former staff members who have worked within maternity and neonatal services, or who have held relevant senior management positions in the organisation, as witnesses.

We are truly sorry for the harm caused to those families who rightfully expected a safe experience under our care, and who were let down by us. We know how important it is for the families and our communities to receive the answers they have waited for. We are fully cooperating with the police to support the integrity of their investigation. We are committed to providing a responsive maternity service for our communities and our staff that is open, kind, constantly learning and consistently improving.

Our maternity services remain fully open during the ongoing police investigation. Our teams are committed to providing the safest and best experience possible and we want to reassure women and their families they should not notice any disruption to their care during this time.

If you have any concerns or questions about your care, please speak to your midwife or consultant.

You can also contact our Patient and Advice Liaison Service (PALS):

· Royal Shrewsbury Hospital: 01742 261691

· Princess Royal Hospital: 01952 282888 ·

Or email: sath.pals@nhs.net

Further information for former service users:

Families who wish to discuss the maternity care they have received, can do so by contacting: sath.maternitycare@nhs.net

Families who wish to discuss the neonatal care their baby or babies have received, can do so by contacting: sath.neonatalcare@nhs.net

You can also contact our Patient and Advice Liaison Service (PALS)

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

3.1 The Integrated Care Board (ICS) Board meeting was held on Wednesday 25 June 2025. The papers can be accessed at ***NHS-STW-Integrated-Care-Board-Agenda-Papers.pdf***

The next meeting is due to be held on Wednesday 24 September 2025.

3.2 To mark World Day for Cultural Diversity 2025, the Shropshire, Telford, and Wrekin Integrated Care System has launched *Everyone Belongs Here* - a bold new campaign that celebrates the richness and diversity of our workforce and communities. Created collaboratively by colleagues across the NHS, local authorities and care partners, the campaign shares a clear message:

We're all different. We're all unique. Everyone belongs here. Discrimination in any form has no place in our services. *Everyone Belongs Here* is grounded in our shared values of respect, compassion, and inclusion. Whether you work in frontline care, support services or leadership, your voice, experiences, and identity matter.

4.0 NHS England (NHSE)

4.1 The next NHS Leadership event for ICB and trust Chief Executives with national and regional NHSE executives is scheduled in London on 10 July 2025.

4.2 We are anticipating the launch of the NHS 10 Year plan this week. As announced in

January 2025, the plan will set out how we will deliver the three big shifts: from hospital to community, from analogue to digital, and from sickness to prevention.

4.3 On 26 June 2025, NHSE published its oversight framework for 2025/26 which helps to build the foundations for the upcoming ten-year health plan, which includes a revised approach to the oversight of integrated care boards (ICBs), trusts, and foundation trusts. The framework reiterates the government's focus on granting high-performing providers and ICBs with additional freedoms, with a commitment to review the incentives available following publication of the ten-year health plan. One of the most significant changes is that in 2025/26 ICBs will not be issued with a formal rating or segment based on their performance across the framework's suite of metrics.

There will be no pause to segmentation for providers in 2025/26, with the publication of initial segments expected in July. This year, there will be an additional fifth segment to better identify those organisations most in need. Segmentation will be based on a stripped back list of short-term and operationally focused metrics, with a financial override that limits providers that are in a deficit or receiving deficit support to segment 3 or below. The framework also diverges from the proposals in the 2024 consultation for capability ratings and 'system considerations' to influence a provider's segment.

Provider capability ratings will inform NHSE's improvement response to ensure support is directed to those organisations that are unable to improve on their own. New guidance on NHSE's approach to provider capability assessments is expected in Q2 2025/26. The framework therefore reflects a move away from an emphasis on system working and collaboration and towards the tackling of provider organisations' operational challenges and financial balance. Details can be found at: ***NHS England » NHS Oversight Framework 2025/26***

5.0 RECOMMENDATION(S)

5.1 The Board is asked to note the contents of the report, and to take assurance where appropriate.

Jo Williams
Chief Executive
5 July 2025

The Shrewsbury and Telford Hospital NHS Trust

Quality & Safety Assurance Committee (QSAC) Key Issues Report		
Report Date: 28 May 2025		**Report of: Quality & Safety Assurance Committee - 27 May 2025**
Date of meeting:		27 May 2025
1	**Agenda**	The Committee considered the following for assurance: • Draft Quality Account 2024/25 • Urgent & Emergency Care Transformation Assurance Committee Report • Antibiotic Stewardship Group overview • Maternity Dashboard and key issues report • Quality Operational Committee key issues report • Quality indicators Integrated Performance Report • Incident Management Overview Report • Learning from Deaths Q4 Report • Medical Examiner and Bereavement Service Report (Q4) and Summary Annual Report 2024/25 • PALS, Complaints and Patient Experience Report (Q4) • Paediatric Transformation Assurance Committee Report • QSAC Chair's Annual Report
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• There was a never event in ophthalmology this month: a patient safety incident investigation has been commissioned.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• QSAC received the annual report from the paediatric transformation assurance committee (PTAC) and were pleased to hear: (a) there was a focus on the impact of actions and examples provided such as the improved use of the Paediatric Early Warning System (PEWS). (b) that the use of case studies demonstrated the complexity of the service and multi-agency collaboration, with positive challenge and learning for improved outcomes. (c) how the service had welcomed the increased visibility of their work within the Trust and were keen to make sure that this

		continued after the work was finished. QSAC thought it would be helpful to have a presentation on the work at a Board seminar. • Maternity acuity rates remained above target for the seventh month, with 97% this month. One to one care at delivery remained at 100% although unavailability remains high, and this has been effectively mitigated by specialist midwives working clinically. This new way of working has been positively received in the service. • The improvement seen in delays in caesarean sections continued with no category 1 delays this month and 3 category 2. No harm was identified. QSAC received the CNST assurance papers and noted that babies born <10th centile was just below the Perinatal Institutes (PI) national GAP average at 12.2% which is potentially linked to the fact that fewer women are smoking at the time of delivery because they have given it up during their time being cared for by the Trust. Smoking at the time of delivery (SaToD) was 6% this month, sustaining performance against the national target. Whilst progress has been made to narrow the gap between the national average and SaTH, further exploration of effectiveness and understanding of the co-dependencies is planned. • The Antibiotic Stewardship Group has reviewed its operation to increase clinical attendance and input. There are still areas where clinical input is needed and a number of suggestions to assist with this were discussed. This will be monitored via QOC. • The Medical Examiner and Bereavement Service Report highlighted the successful implementation of the statutory responsibilities which commenced during 2024/2025. Work is ongoing to improve the function of the service to respond to periods of high demand and ensure increased capacity to meet demand. The service has received positive feedback from external stakeholders and in Q4 96.5% of families felt that the service was helpful and compassionate.
2c	**Advise** *Areas that continue to be reported on and /or where some assurance has been noted/ further assurance sought.*	• The Interim Chief Nurse has invited the CQC to visit the newly opened majors area in RSH ED on 6 June. • The planned transition to support arrangements with UHNM for the maxillofacial surgery has been temporarily delayed. The current mitigations remain in place. The service remains fragile. • It has been agreed that the System Integrated Improvement Plan is to be reviewed at Performance Assurance Committee (PAC) and any issues relating to quality and safety will be escalated to QSAC. • The PALS, Complaints and Patient Experience Q4 report highlighted actions taken in response to complaints including the ongoing work to improve communication for those who raise concerns. The Trust continues to not meet its target for completing investigations into complaints. There is ongoing work to support

		staff to respond to concerns at the time, and to effectively communicate with patients and families. A business case has been submitted to use SMS text for feedback following the success of its use in ED. For PALS contacts, the largest number of concerns related to booking. • QSAC received the Learning from Deaths Q4 Report which reported the first meeting has taken place into the review of mortality in ED and key lines of enquiry identified. The Trust hope to reinstate statutory reporting in May for SHMI but maintain the position that Summary Hospital-level Mortality Indicator (SHMI) which is the same as expected does not provide assurance. • The number of structure judgement reviews (SJRs) was just below the Trust's own best practice target of 15% in Q4. Performance is impacted by several factors including clinical coding, availability of records and staff availability. Recruitment is in progress to maintain staffing levels. • The committee agreed the Annual Committee Report 2024-2025 for submission to the Board and noted the continued focus on the priorities of the committee. • The draft quality account was discussed and QSAC made some suggestions about including more information on outcomes where we have it and that members agreed to send in any more detailed comments. We also discussed the broad oversight and leadership of the quality priorities to ensure that priorities are not worked on in isolation and suggested there is an opportunity to consolidate this with the Moving to Excellence and CQC work.		
2d	**Actions *Significant*** *follow up actions*	• A deep dive into the diabetic foot service was agreed which will provide an update on the service since the podiatry service was brought in house.		
3	**Report compiled by**	*Sarah Dunnett, Non-Executive Director.*	**Minutes available from**	*Julie Wright Executive Support Team Leader*

Quality and Safety Assurance Committee, Key Issues Report		
Report Date: 25 June 2025		**Report on:** Quality and Safety Assurance Committee (QSAC)
Date of meeting: 24 June 2025		The NED Chair and all NED members were present. Deputy Chief Nurse, Medical Director, Interim Head of Midwifery, Chief Pharmacist, Divisional Director of Nursing (W&C), together with several Trust officers. The Senior Quality Lead for SaTH, STW ICB was also in attendance.
1	**Agenda**	The Committee considered the following: • Urgent & Emergency Care Transformation Assurance Committee (UECTAC) Report • CQC Quarterly Update Report • Quality Operational Committee Key Issues Report • Medication Safety Annual Report • Quality Indicators Integrated Performance (IPR) Report and Exception Report • Maternity & Neonatal Transformation Assurance Committee Key Issues Report • Maternity Dashboard and Key Issues Report • Levelling Up Report • Safeguarding Children and Young People Policy
2a	**Alert** *Matters of concern, gaps in assurance or key risks to escalate to the Board.*	• No alerts for escalation to the Board from this meeting.
2b	**Assure** *Positive assurances and highlights of note for the Board*	• QSAC received the Medication Safety Annual Report. This was an excellent report which provided an overview of the Trust's current performance, which is in line with other trusts, and actions to address where improvements were needed. The paper included details of a number of workstreams which were well thought out, and identified actions which used a systems approach to help improve outcomes for patients. Examples included: ○ improvements to the electronic reporting system to make it easier for staff to report incidents and the introduction of a specific category for controlled drugs to enhance monitoring. ○ A project, supported by final-year Keele University students, is auditing compliance with Trust prescribing standards while also identifying themes that will shape learning and inform a review of the current Trust standards. ○ Workstreams to improve administration of time-critical medication in ED and omitted doses. • Maternity acuity rates remained above target for the eighth month, with 96% this month. One-to-one care at delivery remained at 100% although unavailability remains high. Breast feeding rates were above target for first

		babies having breastmilk at first feed, and meant that all three breast feeding targets were met. The Neonatal Unit is now Baby Bliss Charter silver accredited, a programme which assesses against a number of criteria including audit compliance, and RAG rating. • QSAC received the CNST assurance papers, and the Trust is on track to meet 9 of the 10 safety actions. Safety action 7 is at risk. This relates to the need for the Maternity and Neonatal Voices Partnership (MNVP) to attend meetings. There is a risk that the MNVP structure, as it is currently set up, does not allow to have the lead as a quorate member of all required meetings outlined in the guidance as there is no cover in case of the lead's absence. This is affecting other systems. This has been discussed with the Local Maternity and Neonatal System (LMNS) and the ICB, and guidance is awaited from NHS England. We will continue to monitor progress with this. • The System Improvement Implementation Plan was reviewed. There is now GP direct access for gynae/early pregnancy patients which means faster access to specialist services for these patient groups. • The quarterly CQC update report was received. Mock CQC inspections, which include ICB colleagues, took place in medical wards and Urgent and Emergency care (UEC). In UEC, there were improvements in infection prevention and control (IPC) and the general environment across both sites, with improved Fit to Sit facilities providing a better patient experience as well as improved privacy and dignity. Staff were approachable, polite and providing attentive and compassionate care. Many members of staff spoke enthusiastically about the improvements in their areas and that they enjoyed working in ED. Mock inspections also took place in medical wards. • Completion of risk assessments had improved, with falls management (bed and trolley rail assessments) and patient safety checklists being consistently completed and food and drink being routinely offered. The management of pressure sores, a Trust priority, still requires improvement and forms part of the recommendations from the overarching report.		
2c	**Advise** *Areas that continue to be reported on, and / or where some assurance has been noted / further assurance sought.*	• The updated business case for TB service has been submitted to the ICB for approval. • The support arrangements with UHNM for the maxillofacial surgery service started on 9 June 2025. There are shadow arrangements in place to ensure a smooth transition. The service remains fragile. QSAC requested an update on the effectiveness of arrangements to be brought to the Committee. • QSAC received an update on ongoing work in relation to patient safety and clinical standards. An update on progress is to be presented at September QSAC. • There has been a significant reduction in incidents related to prolonged ambulance handovers. Harm reviews continue to be completed for these incidents. The importance of thematic analysis to align improvement efforts with the underlying causes of harm has been highlighted.		
2d	**Actions** *Significant follow-up actions*	• Work to be undertaken to align meetings to ensure timely receipt of papers at QSAC.		
	Report compiled by:	Ms Sarah Dunnett, Non-Executive Director	**Minutes available from:**	Ms Anna Milanec, Director of Governance

Performance Assurance Committee, Key Issues Report		
Report Date: 20 May 2025		**Report of:** Performance Assurance Committee (PAC)
Date of meeting: 20 May 2025		R Edwards (Chair) I Robotham, S Balderstone, J Wright, S Crossley, R Dhaliwal, S Dunnett, L Mitchell, A McGregor (part), J Cunningham (part) P Corbett (part)
1	**Agenda**	The Committee considered the following: • Performance Highlights • Integrated Performance Report • Review of Winter Plan • Workforce Plan and Performance Impact • N8 Pathology Network Update • Data Warehouse • Fire Safety Audit – Switchboard Actions • Climate Change Group Key Issues Report
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Cancer performance: there was variation in performance on the 3 targets in March: the 28 day Faster Diagnostic Standard was 62.5% compared with the planned target of 71.2%. The 62-day performance was 66.6% against a planned target 63.8%; and 31 day was 96.6% against a planned target of 96%. However, problems with radiotherapy capacity mean the 31-day target would be off-plan in 2025-2026. • The new LINAC will be in place in June 2025 and options for continuing to use the old LINAC are being considered. • Urgent and Emergency Care: In April, EC 4-hour performance for type 1 and type 3 was 47.1% against a planned target of 52%. Type 3 4-hour performance is driving the overall decline (see below, UTC). 12-hour performance was averaging 80.2% in April against an agreed target of 77.5%. Patients streamed to SDEC continues to improve with April at 37.9%. 0 Day LOS in medical SDEC also continues to show improvement with April at 31.3%. • Ambulance Handover Delays – 3,168 patients arrived via ambulance in April, the second highest number in the last 12 months – March 25 being the highest at 3,268. 68% of patients were handed over within 60 mins. The mean ambulance handover time was 1 hour 34 minutes which is below the planned target of 55 minutes. Regionally the Trust remains in the bottom quartile for both >60-minute handovers and average handover time. • Urgent Treatment Centre (UTC): following UTC being taken back in-house T3 performance has gone down. PAC heard that there had been recruitment to fill vacant posts, so performance should start to improve during May, but in addition there was a need for changes in the process to get maximum benefit from the change. PAC will receive a report on progress in August/September.

2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Elective Care: this shows a continuing reduction in long waits and the overall waiting list is decreasing and below (better than) the agreed trajectory, giving confidence that the progress is sustainable. The unvalidated Trust Position (including Welsh) for March is 0 x 104w breaches, 34 x 78w breach and 138 x 65w breaches. • Data Warehouse: PAC received a report on progress, with a verbal update regarding national submissions: all A&E records had been submitted successfully, all in-patient records likewise and Outpatient records were in the process of being submitted. The majority of tasks had been completed, following intensive work over the last 5 weeks. The end result is a workable DWH based on much better foundations than the previous DWH. • High intensity list: following the 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. • Elective Recovery: There will be a continued reliance on the Independent Sector Providers (ISP) going into the new financial year to sustain zero position on 65 weeks' waits and work towards 60% RTT for March 26. Following frank discussions with ISPs about costs SaTH have secured price reductions.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• Winter pressures: PAC received a report which reviewed the effectiveness of the 2024-2025 Winter Plan and indicated what would be needed in the 2025-2026 Winter Plan. PAC heard that the 2024-2025 plan had had limited positive impact on UEC performance despite a number of Trust and System interventions. To create a more robust plan for 2025-2026 SaTH are reviewing the 25/26 UEC Improvement Programme, working with the system and using the findings from the review of the 2024-2025 plan to get agreed measurable benefits for the schemes identified, ensuring that actions are directly positively impacting patient safety. • UEC attendances March and April 2025: PAC had asked about the reasons behind the increased ED attendances in March 2025. STW's Director of UEC Improvement reviewed the increased ED attendances, and increased ambulance conveyances over March and April 2025. He found that there was a statistically significant increase in Type 1 ED attendances over March and April - March and April are the two highest months of average ambulance arrivals per day on record. This correlated with higher See and Convey numbers and lower use of ShropDoc for "call before you convey" by WMAS. His report was to be discussed at the STW UEC meeting in May. • Cancer: as part of a large Cancer Improvement programme, SaTH is now using a methodology used successfully at RWT to identify delays and blockages in the cancer pathways. This has already identified delays inherent in the booking system. PAC will get a report on this in July 2025.

		• Pathology: PAC received a report outlining the Strategic Case for Change for aligning Pathology services at SaTH and Robert Jones and Agnes Hunt NHS Trust (RJAH) with the North Midlands and Cheshire Pathology Service (NMCPS) to formally form North 8 (N8). Alignment of Pathology services across the N8 Pathology Network may deliver financial benefits in the longer term by leveraging economies of scale, however it offers other more significant and advantageous gains such as improving robustness and sustainability of clinical services, harmonising equity across the Network, raising quality standards and providing opportunities for continuous improvement and learning. A recent key driver in terms of making progress and agreeing a direction of travel has been an NHSE mandatory requirement for Pathology Networks to reach a status of "Maturity" by March 2025. The preferred option, that NMCPS remains in its current form and enters into a collaboration with RJAH/SaTH while RJAH/SaTH continue to run their own pathology services but collaborate with NMCPS through a "Provider Collaborative" arrangement, was deemed to meet the "maturity" requirement but without the cost and complexity of creating a combined service. • Workforce Plan Update: the paper included graphs projecting staff cost reductions for substantive, bank and agency. It is expected that any additional cost from moves from outsourcing to in-house should be offset by reductions elsewhere. The planned substantive headcount reduction by March 2026 is significant (289), with bank reducing by 147 and agency by 67. PAC will monitor progress of these reductions and whether there is any impact on performance. • Switchboard at PRH: recommendations in the paper on the 2024 Fire Safety Audit at the March Trust Board concerning the location and function of the switchboard required further consideration from a fire safety and major incident/ business continuity aspect. The Senior Fire Safety Advisor, Telecoms Manager and Emergency Planning Manager met on 29.04.25 to consider the way forward. A paper to PAC considered short, medium and longer term actions. PAC will receive further paper in July when options, costs and deadlines have been established.		
2d	**Actions** ***Significant*** *follow up actions*	• Follow up report on PRH switchboard July 2025 • Report on Cancer Improvement Programme work on pathways July 2025 • Report on Winter Plan July 2025 • Reports on UTC and UEC August/September 2025		
3	**Report compiled by**	R Edwards (Chair) and Non-Executive Director	**Minutes availablefrom**	*Lisa Mitchell* Senior Governance Support Officer

Performance Assurance Committee, Key Issues Report		
Report Date: 17 June 2025		**Report of:** Performance Assurance Committee
Date of meeting: 17 June 2025		R Edwards (Chair) N Hobbs, I Robotham, S Dunnett, R Dhaliwal, S Balderstone, N Lee, L Wyatt, L Mitchell
1	**Agenda**	The Committee considered the following: • Performance Highlights (incl SIIP) • Integrated Performance Report • Workforce Plan and Performance Impact • Data Warehouse • Digital Update • Fire Enforcement Notice • Estates Strategy * (to be discussed further in July's meeting) • Estates & MES Plan
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Urgent and Emergency Care (UEC): May 4 hour performance for type 1 and type 3 attendances was 49.7% against a planned target of 50.2%. When SaTH took the Urgent Treatment Centre (UTC) back in house in April 2025 not all the workforce transferred, and low UTC (Type 3) 4-hour performance is still driving the adverse variance to plan but in May performance has improved by 4.5 percentage points compared to April. • Cancer: April cancer performance is 68.6% (28 day Faster Diagnostic Standard) ahead of the Trust's plan of 65.3% and against a national standard of 80%. SaTH's 62-day performance was 56.6% against the Trust's plan of 50.1% and a national target of 75%. The 62-day backlog is 335 patients over 62 days of which 90 are over 104 days (as of 10 June 2025). Although improving, SaTH's 28-day FDS and 62-day Cancer performance remains in the bottom quartile nationally. • Fire Enforcement Notices: Following their visit to SaTH in April 2025, Shropshire Fire and Rescue Service withdrew the existing Fire Enforcement Notice (255) on 27 May 2025, in response to finding that the vast majority of breaches described in it had been rectified. The residual areas of non-compliance have been incorporated in a new Enforcement Notice (348). This requires the Trust to complete a Fire Compartmentation Survey of the Ward Block at RSH. Once the Survey is completed, the Trust must formulate a plan of action to rectify any failings. The plan must be reviewed by, and in consultation with Shropshire Fire & Rescue Service by 31 July 2025. New methods of surveying using 360-degree cameras have enabled SaTH to get the survey done without decanting patients. The next step will be to decide what remedial work is required and how it can be done. A further report will come to PAC detailing the plan, cost and timescales.

2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Electives: total waiting list size, 52-week and 65-week performance all show significant improvement over the last 9 months. SaTH's national ranking for 52-week and 65-week performance is no longer in the bottom quartile, having lifted into the third quartile. National ranking for 18-weeks is expected to improve from next month. At month 2 SaTH is slightly ahead of plan for 18-weeks, 52-weeks and 65-weeks and total waiting list numbers. • Diagnostics: overall access (DM01 - non-urgent diagnostics) has improved in April to 78.6% and May to 79.8% against a system target of 85%. Some modalities are well above this and there are actions underway to improve access to other modalities. • Windows 11 Roll-out: SaTH's Digital Services Team presented the current project position to NHSE on 29 May 2025 and feedback from NHSE was very positive: they have no cause for concern and full confidence based on SaTH's current position. As of 9 June 2025, rollout was at 75.8% and at the date of the committee, this had already risen to over 80%. NHSE appreciated SaTH's clear approach regarding non-compliant applications, engagement with local departmental managers and information asset owners, and approach of assigning responsibility to divisions (asset owners) with digital support to achieve compliance. • Workforce: the staffing plan was on track and ahead of trajectory at month one and two but maintaining this progress will get more difficult from quarter two onwards. Agency numbers have reduced to 95 WTE but costs have increased. The reason for this is being assessed but seems to stem from SaTH needing to have particular high-cost consultant and AHP roles filled. Central co-ordination of trusts in the region has been successful in reducing agency cost for nurses and a similar coordinated approach is being used to bring down the cost of agency medical staff. •
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• SaTH Systemwide UEC Improvement Plan: PAC received the UEC SIIP and considered whether there were any quality and safety issues that needed to be referred to QSAC - there were not. PAC asked for actions to be updated where the due date for action had passed. • Workforce and Productivity: PAC heard that work is underway to compare the increases in staff numbers with productivity and outcomes at specialty level and was interested in a report on progress coming to one of the board committees (PAC or FAC). • Data Warehouse: PAC heard that the 2024-2025 data files had been submitted by the May deadline, but that the Outpatient data took longer to process and were not received in time, so for the moment they will not be visible to commissioners in the Flex or Freeze versions of data though they can be accessed in the Current version. SaTH has alerted stakeholders to this. The national SLAM upgrade failed initially, and negotiations are

		underway with the supplier as to what needs to be done to get it working. The resulting (continued) lack of costing data affects SaTH's ability to assess its productivity and efficiency and to benchmark. Resolution is expected soon. • PAC received the Estates Annual Report and noted the significant changes that have been implemented in terms of governance, compliance and management of the capital program. Estates had delivered its Headcount and CIP targets for last year, whilst also saving significant amounts in energy/revenue budgets and reducing carbon emissions. Advanced plans are in place for CIP and headcount for 2025/26. A significant risk for SaTH is the level of backlog maintenance but Estates have robust prioritisation to ensure the estate remains fit for purpose. The Estates Strategy will include measures to manage and reduce this risk. • PAC received the Estates Strategy and will return to it at the July meeting when members have had time to read and comment on it (whilst the paper had been submitted within the mandated timescales, issuing of the paper to PAC members had been delayed).		
2d	**Actions** ***Significant*** *follow up actions*	• PAC asked for a report to review a sample of patients on the PIFU pathway to gain assurance that the right patients are being put on this pathway and are gaining benefits. • A paper to come to PAC/FAC on work on productivity. This is being developed specialism by specialism and a higher-level paper on progress could come to one of the committees.		
3	**Report compiled by**	*Rosi Edwards (Chair) Non-Executive Director*	**Minutes availablefrom**	*Lisa Mitchell Senior Governance Support Officer*

The Shrewsbury and Telford Hospital NHS Trust

Finance Assurance Committee, Key Issues Report		
Report Date: 27 May 2025		**Report of:** Finance Assurance Committee (FAC)
Date of meeting: 27 May 2025		R Miner (c), S Crowther, J Sargeant, A Winstanley, P Gardner, T Cotterill, S Edmonds, C McInnes & L Mitchell
1	**Agenda**	The Committee considered the following: • STW Medium Term Financial Plan update • STW Finance Strategy • Financial Report & Forward Look M1 • Finance System Integrated Improvement Plan 4A Report • Quarterly Contract • System Operational Plan • Workforce Plan & Financial Impact • Capital Planning Key Issues Report
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Although the financial performance is on track for Month 1, it served to highlight the work required to ensure delivery of the workforce plan for the year as well as the related escalation and system risk share. • The efficiency plan accelerates in the second half of the year so monitoring progress, mitigating risks and finding further efficiencies will be ongoing. • Although we didn't have any representative from the workforce team, the workforce plan and financial impact report were considered in detail and feedback will be provided. The Committee recognises the "grip and control" measures being implemented, the need to track the right numbers and costs and the ongoing triangulation of the metrics.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• The financial performance is on track for Month 1 although there are both positive and adverse variances in the month (-ve on workforce but +ve on other costs). The performance is therefore a break even one notwithstanding the deficit support. • Cash balances at Month 1 are £46.8m. • There is an efficiency plan of £41.4m which is now subject to a robust efficiency programme albeit still being finessed. The programme considers both risk adjusted values and delivery; responsibilities and accountability; divisional shares and monitoring but importantly giving us a much better forward view so that actions can be implemented early. • Progress is being made with the System Integrated Improvement Plan to exit from "segment 4" to "segment 3" by March 2026. Financial performance represents the key risk. • Capital Planning Group 4A report was noted. • The quarterly contracts awards were noted with no concerns. • The Committee welcomed Jon Sergeant to his first FAC meeting and consider, based on his previous executive roles in the NHS his input will be invaluable.

2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• Keeping track of pay costs and escalation. • Monitoring of cash balances which may be influenced by the expected cash flow timing of the deficit support. It is expected that Q1 deficit support be linked to the region's confidence in our plans for which there has been so this is low risk. From Q2 onwards deficit support will be based on year-to-date delivery against plan with any slippage likely to result in the ceasing of deficit support. Monitoring performance of the efficiency plans which start to have a greater impact later in the year as noted above.		
2d	**Actions** ***Significant*** *follow up actions*	• Claire Skidmore, the CFO at STW, was not able to make the meeting and so the committee discussed some of the issues raised in the Medium-Term Financial Plan and Finance Strategy in more general terms. In particular it was considered that more work was required to determine the "who, what, how" aspects of the plan; a timeline; the HTP "triangulation" with STW; more details on activity; the starting point for year 2 (which does not appear to be the same as the end of year 1); more work on the drivers of the deficit; more work to understand the base case, upside and downside; more work on the drivers of the deficit.		
3	**Report compiled by**	*Richard Miner (Chair)* *Non-Executive Director*	**Minutes availablefrom**	*Lisa Mitchell* *Senior Governance Support Officer*

Finance Assurance Committee, Key Issues Report		
Report Date: 24 June 2025		**Report of:** Finance Assurance Committee
Date of meeting: 24 June 2025		R Miner (Chair), A Winstanley, S Crowther, S Edmonds, R Muskett, T Cotterill, C McInnes, S Balderstone (Part), L Mitchell
1	**Agenda**	The Committee considered the following: • Financial Report & Forward Look, M2 • Efficiency & Financial Recovery, M2 • Financial System Integrated Improvement Plan (SIIP) 4A Report • Workforce Plan & Financial Impact • Capital Planning Group Key Issues Report
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• There remain significant challenges in the medical division related to senior medical agency costs.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• The Trust maintained its budgeted break-even position at the end of May although the (funded) underlying position was a deficit of £5.47m (YTD: £10.9m). • The cash position was £35.1m, under budget but only due to timing differences. • The efficiency target of £4.96m out of an annual target of £41.4m (£29.9m of which is recurrent) is on track at M2. The plan accelerates towards the end of the year, but its risk rating and mitigation actions indicate the Trust is in a far better position than this time last year. • The capex position for the year of £145.9m (excluding Salix) is shaping up to be far more “linear” for the year than “back ended”. • Provided we can deliver the financial plan for the year then the System Integrated Improvement Plan (SIIP) can be achieved. • The Capital Planning Group (CPG) 4As were noted including that the modular build seems to be ahead of plan,
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• Divisions are much more aware of the challenges following delegation of budgets and are being monitored. • Workforce and governance issues around workforce plans probably still need to be finessed in order for the Trust to realise the full benefits of potential changes during the year. • We are still awaiting the availability of activity data.

2d	**Actions** ***Significant*** *follow up actions*	• The Financial Recovery Group (FRG) is still in operation with a far more strategic view (as opposed to “salami slicing”) and I will be attending and observing in the near future.		
3	**Report compiled by**	*Richard Miner (Chair, Non-Executive Director)*	**Minutes available from**	*Lisa Mitchell Senior Governance Support Officer (Minute taker)*

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People & OD Assurance Committee (PODAC) Key Issues Report		
Report Date: 25 June 2025		**Report of:** People & OD Assurance Committee – 02 June 2025
Date of meeting: 02 June 2025		PODAC members present at the 02 June 2025 meeting were: two Non-Executive Directors and an Associate Non-Executive Director and the Director of Strategy & Partnerships. Apologies were received from the Chief People Officer, but a deputy was in attendance. The Chief Executive Officer was also present for the meeting. T Boughey, Non-Executive Director chaired the meeting. The Chief Nursing Officer attended the meeting for the Nursing & Midwifery staffing report. The Chief Communications Officer attended the meeting for the people communications item.
1	**Agenda**	The Committee considered the following for assurance: • Summary Report Nursing and Midwifery Staffing (March 2025 data) • People & OD Assurance Report (including Culture) • Risk Report – People Risks • Workforce & Leadership System Integrated Improvement Plan (SIIP) Update • MIAA Audit Report – Bank and Agency Review 23-24 final update • HTP Update • Equality, Diversity & Inclusion quarterly update • Flu vaccine programme update • People communications • Assurance Committee Items (PAC / FAC/ ARAC) • PODAC Annual Committee Effectiveness Survey Results • Board Assurance Framework (BAF) Report – Quarter 4
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• The Committee received an update on the position regarding Clinical Support Workers. It was noted that work is underway to quantify the financial provision and impact for SaTH, and that assurance on the evaluation of Clinical Support Worker role profiles will be provided by August 2025. • The Committee sought assurance regarding the position on DBS checks. It was noted that requirements are currently under review and an update will be provided at the next meeting. • The Committee noted the details of the Trust's Workforce Plan submission, as part of the development of a system wide operating plan for 2025/26 and the position at April 2025. There has been a workforce reduction of 40 WTE since March, which is under the planned level by 83 WTE. • Hospitals Transformation Programme (HTP) — Specialty-level workforce plans and change management reports are in development. There is a risk that managers may not have sufficient capacity or focus to fully engage with HTP, so alignment with the reform agenda and the ongoing training is critical. Ensuring thorough and appropriate consultation remains a key priority.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• The Committee received a new format staffing report with March 2025 data. Combined vacancies for Band 5 Registered Nurses and Nurse Associates were reported at 79 WTE in March 2025, which is a reduction from 90 WTE in the previous month. Nurse Associate fill rates are low. There has been over recruitment of Registered Nurses to offset Nurse Associate vacancies. Recruitment days are on-track with recruitment planned in September 2025.

		The nurse sensitive indicators correlate with staffing levels. • Sickness absence has reduced to 5.12% (0.62% above target). • The Committee explored payroll overpayments for resident doctors and received assurance on the measures in place to address and rectify errors. There was a further discussion on the workforce plan in a private section of the meeting. • EDI objectives are in place for Board members. This will be extended to new members. • A member of the EDI Team has been invited to present at an NHSE presentation. • The flu vaccine uptake at SaTH for 2024–2025 was 49.6%, which represents a year-on-year increase from the previous two years. The 2% increase in the 2024-2025 season was achieved against a backdrop of decreasing flu vaccine uptake in NHS Trusts across England. Expenditure on the flu programme was managed tightly. A SaTH internal flu tracker was utilised. The flu vaccine programme is moving to the nursing portfolio next year. There is an emphasis now on next year's programme. • The Committee noted the BAF and linked it back to the discussion on the risk with Clinical Support Workers' role profile evaluation. The BAF risk scores will remain the same for now, with further review in July/August.		
2c	**Advise** *Areas that continue to be reported on and /or where some assurance has been noted/ further assurance sought.*	• The Chief Nursing Officer is undertaking some night shift visits to add to the richness of intelligence available on safe staffing. The Committee look forward to further information on this in due course. • A project plan is being developed to improve medical workforce efficiency by enhancing the digital health roster, with the aim of eliminating the need for multiple systems in the future. • The Committee recognised elements of the SIIP plan relevant to its terms of reference and noted the importance of this plan in supporting the Trust's exit from the regional support programme. • It was confirmed that reporting on the Disability Pay Gap will be a future requirement for the Trust. • The Committee noted that current Workforce Race Equality Standard (WRES) scores are not on a positive trajectory, and further work is needed to address this. • The Committee reviewed people communications, including the reform agenda and efforts to support cultural change across the organisation. It was highlighted that building a culture focused on patient needs through the Moving to Excellence programme remains essential. Additionally, embedding kindness and compassionate communication is important to support managers, with an emphasis on including real-life case studies. • The Committee considered areas of interconnectivity with other Board committees, including operational matters such as payroll overpayments and their link to the Audit and Risk Assurance Committee.		
2d	**Actions *Significant*** *follow up actions*	• The evaluation of Clinical Support Worker role profiles and the quantification of the associated financial provision and impact for SaTH. • The Committee reviewed its effectiveness following a February survey and agreed to submit an annual PODAC report to the Board.		
3	**Report compiled by**	*Deborah Bryce, Head of Corporate Governance & Compliance; and Teresa Boughey, Non-Executive Director.*	**Minutes available from**	*Deborah Bryce, Head of Corporate Governance & Compliance*

Audit and Risk Assurance Committee, Key Issues Report		
Report Date: 1 July 2025		**Report on:** Audit and Risk Assurance Committee
Date of meeting: 19 May 2025 23 June 2025		All NED members, except for Jon Sargeant (new member) were present for both meetings. Also present but not part of the quorum: Director of Governance, Acting Director of Finance, with representatives from the Trust's Internal Auditors MIAA, and the Trust's external auditors, KMPG, together with several Trust officers from the Governance Team.
1	**Agendas**	The Committee considered the following: • Internal Audit Report – DM01 Diagnostics Waiting Lists Review (*moderate assurance)* • Internal Audit Report – Quality Audit Review (*moderate assurance)* • Internal Audit Report – DRAFT Data Security & Protection Toolkit (DPST) / Cyber Assessment Framework (CAF) report • Quarterly No-Pay Controls Update Report • Losses and Special Payments Report • Procurement Waiver Report • Bi-annual Report of Register of Interests, Gifts, Hospitality and Sponsorship • Board Assurance Framework Report Q4 (circulated to members by email due to committee timings) • Annual Risk Management Report incorporating Q4 2024/25, and Triangulation Report • Draft Annual Governance Statement • End of financial year 2024/25 matters • Draft Annual Report and Accounts 2024/25, and associated items
2a	**Alert** *Matters of concern, gaps in assurance or key risks to escalate to the Board.*	• With respect to adherence to the mandated 80% NHS Counter Fraud Standard for declarations of interest, the Committee observed that the current compliance rate had recently declined to 76%. It was noted that this was likely to be related to an increase in Trust doctor numbers, and that this was being investigated. [At the time of writing and with induction support provided to new doctors, this figure had risen to +80% compliance.]
	Assurance *Positive assurances and highlights of note for the Board*	• The Committee took assurance from the contents of the Annual Risk Report 2024/25, which confirmed a decrease of forty-three overdue (for review) risks for the year, supporting the view that the risk culture at the organisation was continuing to slowly improve. • Regarding 'No PO, no pay' monitoring, the Committee took assurance that the compliance rate across 2024/25 was 77% - higher than anticipated – although the Committee stated that they would recommend a target compliance rate of 80%+ as a minimum, moving

		forward. • At the June meeting, the Committee received the annual Report and Accounts 2024/25 to recommend to the Board for approval. The Trust had received the external auditors' 'value for money' report which confirmed that they had not identified any significant weaknesses in the organisation's arrangements for achieving value for money, although a section 30 referral to the Secretary of State had been made given that the Trust breached its breakeven duty for 2024/25.		
2c	**Advise** *Areas that continue to be reported on, and / or where some assurance has been noted / further assurance sought.*	• The internal target of a write-off value of no more than 0.5% of the total cost of the drugs used during the period, had been achieved in six of the last 12 months. Across the 12-month period, the total value of drug write-offs equated to £283,271, representing 0.5% of total drugs issued across the Trust, totalling circa £57million. • The Committee received the draft Annual Governance Statement (part of the annual report) which included the following as risks to the organisation: I. Quality of care, including standards of performance and licence conditions. II. Access and waiting time performance. III. Financial performance. IV. Regulatory fire issues. V. Ongoing matters relating to the independent review of maternity services; and VI. The Political NHS Landscape.		
2d	**Actions** *Significant follow-up actions*	• Head of Risk Management to focus on next steps and prioritisation; the Committee to receive recommendations from him on which areas the Committee should be focusing on, so that it can provide him with support going forward. • Acting Director of Finance to consider implementing a higher compliance rate, of at least 80%, for 'No PO, no pay' monitoring.		
	Report compiled by:	Anna Milanec, Director of Governance Approved by Prof Trevor Purt, ARAC Chair	**Minutes available from:**	Mrs Beverley Barnes, Board Coordinator

Board of Directors' Meeting: 10 July 2025

Agenda item		106/25		
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 2025.06.17 Performance Assurance Committee 2025.06.17 Quality & Safety Assurance Committee 2025.06.24 Finance Assurance Committee 2025.06.24 Senior Leadership Committee 2025.07.03		
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 April/May 2025, a summary of 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 10 July 2025

Presenting Month 2 performance data

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The Shrewsbury and Telford Hospital NHS Trust

Performance against the 4-hour UEC standard in May 2025 showed a marginal improvement compared to April 2025 (49.7% v 47.1%); however, there was a slight increase in the monthly number of 12-hour trolley breaches (1379 in May 2025 v 1362 in April 2025). The percentage of patients seen within 15 minutes for initial assessment increased from 54.8% In April 2025 to 60.8% in May 2025.

The Trust has a break-even plan for 2025/26 (this includes deficit support of £45.1m). At the end of month two the Trust has delivered a break-even position against the break-even plan. The trust has an efficiency target of £41.4m in 2025/26. At the end of month two £4.96m has been delivered in line with the plan. In terms of WTE reduction, at the end of month two the actual head count is 36 WTE favourable to plan of which substantive and agency reductions are ahead of plan, however, bank usage exceeds planned levels. The Trust has set an operational capital programme of £22.5m (including IFRS 16 expenditure) and externally funded schemes of £123.4m in FY25/26, giving a total capital programme of £145.9m. The Trust held a cash balance at end of May 2025 of £35.11m (ledger balance of £35.13m due to reconciling items).

The Trust reported 0 x 78-week breaches at the end of May 2025 and 5 x 65-week breaches. 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 May 2025 was 375 (increase from 354 at the end of April). The validated April position for FDS was 68.6% (previous month was 62.5% against a national target of 80%), 31-day standard was 90.5% (previous month was 96.6% against a national target of 96%) and 62-day standard was 56.6% (previous month was 66.6% against a national target of 75%). Predicted performance for May 2025 is expected to be 72.8% FDS, 84.8% for 31-day and 62.2% for 62-day.

The validated overall DM01 position for May 2025 was 79.4%, a further improvement from 78.5% in April and the number of over 6-week breaches reduced by 405 (2577 in May2025 v 2982 in April 2025).

The Shrewsbury and Telford Hospital NHS Trust

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	Regulatory	National Standard 25/26	Current Month Trajectory (RAG)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Trend
Patient Safety & Effectiveness	Pressure Ulcers - Category 2		20% < 2024-25	16	20	17	21	19	21	18	24	32	28	36	15	33	26	
	Pressure Ulcers - Category 2 per 1000 Bed Days		20% < 2024-25	0.64	0.80	0.62	0.83	0.76	0.84	0.75	0.99	1.25	1.12	1.36	0.62	1.25	1.08	
	Pressure Ulcers - Category 3		10% < 2024-25	8	9	9	8	5	5	2	6	4	7	7	8	11	8	
	Pressure Ulcers - Category 3 per 1000 Bed Days		10% < 2024-25	0.36	0.36	0.33	0.32	0.20	0.20	0.08	0.25	0.16	0.28	0.26	0.33	0.42	0.33	
	Pressure Ulcers - Category 4		0	0	0	0	0	0	0	1	0	2	0	0	0	0	0	
	Falls - per 1000 Bed Days		5% < 2024-25	4.76	5.01	4.65	4.72	4.32	4.38	4.37	4.64	4.05	4.74	4.26	3.96	4.19	4.31	
	Falls - total		-	119	125	127	120	110	109	105	117	104	118	113	102	111	104	
	Falls - with Harm per 1000 Bed Days		5% < 2024-25	0.08	0.08	0.15	0.24	0.24	0.16	0.25	0.16	0.08	0.20	0.23	0.08	0.30	0.21	
	Falls - Resulting in Harm Moderate or Severe		0	0	2	4	6	6	4	6	4	2	5	6	2	8	5	
Patient Experience	Complaints		-	-	77	76	80	86	79	84	77	65	66	77	77	87	85	
	Complaints - responded within agreed timeframe - based on month response du		85%	85%	44.0%	46.0%	43.0%	52.0%	52.0%	53.0%	50.0%	40.0%	49.0%	49.0%	50.0%	48.0%	48.0%	
	Complaints by Theme - Access to Treatment or Drugs				3	3	5	4	3	4	1	3	1	3	1	7	2	
	Complaints by Theme - Admission / Discharge				20	14	17	17	22	18	16	17	18	14	18	20	25	
	Complaints by Theme - Appointment				10	20	10	11	6	11	7	11	5	9	9	15	11	
	Complaints by Theme - Clinical treatment				50	40	39	44	55	40	46	37	34	41	49	49	42	
	Complaints by Theme - Commissioning Decisions				0	0	0	0	0	0	0	0	0	0	0	0	0	
	Complaints by Theme - Communication				46	31	40	44	29	40	39	37	37	46	38	51	48	
	Complaints by Theme - Consent to treatment				3	5	0	2	1	3	2	1	3	3	1	2	2	
	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				3	3	4	6	3	1	0	1	1	4	3	4	2	
	Complaints by Theme - Facilities				11	2	8	6	5	6	4	7	7	7	3	9	7	
	Complaints by Theme - Mortuary				1	0	0	0	0	0	0	0	0	0	0	0	0	
	Complaints by Theme - Other				0	2	3	0	0	2	1	1	0	0	4	2	2	
	Complaints by Theme - Patient care				20	18	23	25	24	18	19	23	21	17	22	34	28	
	Complaints by Theme - Prescribing				3	5	3	8	5	7	0	8	2	4	1	2	4	
	Complaints by Theme - Privacy & Dignity				6	7	5	14	6	8	3	11	3	10	10	8	7	
	Complaints by Theme - Restraint				1	0	0	1	0	0	0	1	1	0	0	0	1	
	Complaints by Theme - Staff numbers				5	5	3	4	2	3	3	4	1	0	2	3	3	
	Complaints by Theme - Trust admin / procedure / records				17	9	10	10	12	20	3	4	2	2	6	4	3	
	Complaints by Theme - Values & Behaviours (staff)				18	29	18	21	20	25	15	19	19	18	18	17	24	
	Complaints by Theme - Waiting time				20	13	15	17	15	13	9	6	13	13	11	18	16	
	PALS - Count of concerns		-	-	340	374	367	406	402	394	411	401	285	352	366	362	330	
	Compliments		-	-	120	81	121	129	91	94	122	137	87	91	81	112	105	
	Friends and Family Test -SaTH		95%	95%	89.1%	88.4%	89.7%	93.4%	93.0%	97.9%	92.8%	92.7%	88.8%	91.7%	98.1%	97.6%	97.1%	
	Friends and Family Test - Inpatient		95%	95%	98.4%	98.3%	99.2%	97.8%	98.6%	98.9%	98.3%	98.3%	98.0%	98.5%	98.8%	97.5%	97.2%	
	Friends and Family Test - A&E		85%	85%	62.9%	60.3%	66.1%	75.0%	75.9%	53.1%	69.8%	71.2%	60.5%	71.0%	77.7%	77.0%	64.9%	
	Friends and Family Test - Maternity		95%	95%	81.0%	100.0%	100.0%	80.0%	100.0%	85.7%	64.3%	93.2%	93.8%	97.8%	100.0%	96.7%	95.5%	
	Friends and Family Test - Outpatients		95%	95%	97.9%	98.1%	98.1%	98.5%	98.7%	98.7%	98.8%	99.0%	98.9%	99.2%	99.5%	98.7%	99.0%	
	Friends and Family Test - SaTH Response rate %		-	-	8.2%	9.9%	10.0%	9.7%	11.4%	7.6%	11.9%	9.8%	8.9%	9.7%	5.5%	6.8%	5.2%	
	Friends and Family Test - Inpatient Response rate %		-	-	13.5%	16.7%	15.8%	16.1%	20.9%	19.5%	21.7%	16.5%	13.4%	12.9%	11.6%	16.8%	11.9%	
	Friends and Family Test - A&E Response rate %		-	-	5.1%	6.1%	6.6%	5.7%	6.5%	0.3%	5.9%	5.6%	5.9%	7.3%	1.0%	0.4%	0.6%	
	Friends and Family Test - Maternity (Birth) Response rate %		-	-	1.1%	27.3%	1.0%	3.0%	1.0%	2.1%	2.2%	0.9%	0.9%	1.0%	5.7%	6.9%	0.5%	

Integrated Performance Report

The Shrewsbury and Telford Hospital NHS Trust

Domain	Description	Regulatory	National Standard 25/26	Current Month Trajectory (RAG)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Trend
Patient Safety & Effectiveness	Trust SHMI (HED)		100	100	not available													
	Trust SHMI - Expected Deaths		-	-	not available													
	Trust SHMI - Observed Deaths		-	-	not available													
	SJRs Completed by Month				28	32	34	40	32	31	25	31	19	21	29	33	0	
	MRSA - HOHA				1	0	1	0	0	0	0	0	1	1	0	1	0	
	MRSA - COHA				0	0	1	0	0	0	0	0	0	0	0	0	0	
	MRSA - Total	R	0	0	1	0	2	0	0	0	0	0	1	1	0	1	0	
	MSSA - HOHA		-	-	3	3	4	3	1	2	3	3	2	2	3	2	2	
	C. difficile - HOHA				3	1	4	6	11	4	5	6	9	8	5	4	9	
	C. difficile - COHA				5	3	4	2	3	2	6	5	6	4	2	3	5	
	C. difficile - Total	R	98	8	8	4	8	8	14	6	11	11	15	12	7	7	14	
	E. coli - HOHA				3	8	2	2	5	5	3	4	8	6	6	2	4	
	E. coli - COHA				15	13	7	11	8	5	5	7	9	11	6	8	9	
	E. coli - Total	R	146	12	18	21	9	13	13	10	8	11	17	17	12	10	13	
	Klebsiella - HOHA				1	0	0	2	1	2	1	4	4	3	4	4	1	
	Klebsiella - COHA				0	3	1	3	0	3	1	2	2	4	2	1	5	
	Klebsiella - Total	R	36	3	1	3	1	5	1	5	2	6	6	7	6	5	6	
	Pseudomonas Aeruginosa - HOHA				0	0	0	1	1	1	1	0	1	1	0	1	0	
	Pseudomonas Aeruginosa - COHA				1	2	0	1	0	1	2	1	1	1	2	0	2	
	Pseudomonas Aeruginosa - Total	R	19	1	1	2	0	2	1	2	3	1	2	2	2	1	2	
	VTE Risk Assessment completion - SATH		95%	95%	-	-	-	-	-	-	-	-	-	-	-	-	-	
	Never Events		0	0	0	0	0	0	1	0	0	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		-	-	5	1	0	3	1	0	0	0	0	1	2	0	3	
	Serious Incidents - Closed in Month		-	-	6	2	4	2	3	2	1	0	1	0	1	0	0	
	Serious Incidents - Total Open at Month End		-	-	12	11	9	7	7	7	5	3	1	1	0	0	0	
	Mixed Sex Accommodation - breaches		10% < 2024-25	88	98	116	81	68	58	69	83	92	117	108	60	86	101	
	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%	64%	85%	85%	82%	89%	78%	88%	94%	90%	99%	94%	95%	97%	
	Smoking Rate at Delivery		6%	6%	7.4%	6.6%	5.7%	8.1%	7.2%	6.6%	6.7%	5.5%	9.6%	5.8%	5.4%	5.6%	5.6%	
	Therapy stroke treatment within 72 hours - Occupational Therapy		100%		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%		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								36.0%	37.3%	-	-	-	
	Therapy stroke assessment within 24 hours - Physiotherapy		100%		New metric introduced October 2024								34.2%	50.9%	-	-	-	
	Therapy stroke assessment within 72 hours - Speech & Language Therapy		100%		77.3%	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		45	50	44.6	40.5	40	46.6	replaced with Psychological							
	Therapy stroke treatment 45 mins per therapy per day - Physiotherapy		45		30	30	32	35	30	32.5	replaced with Motor therapy							
	Therapy stroke treatment 45 mins per therapy per day - Speech & Language Therapy		45		33.3	25.4	25.8	26.7	35	31.9	replaced with Comm/Swallowing							
	Therapy stroke treatment 3 hours per day - Motor Therapy		180		New metric introduced October 2024								31.6	30	-	-	-	
	Therapy stroke treatment 45 mins per day - Psychological Therapy		45		New metric introduced October 2024								34.7	30	-	-	-	
	Therapy stroke treatment 45 mins per day - Communication/Swallowing Therapy		45		New metric introduced October 2024								30	32.2	-	-	-	
	Stroke Patients Scanned - within 20 mins of clock start				New metric introduced October 2024								6.60%	5.20%	-	-	-	
	Stroke Patients Scanned - within 1 Hour of clock start				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				94.8%	93.2%	94.4%	95.8%	94.6%	98.7%	replaced with 20 mins metric							
	Readmissions within 28 days		-	-	1170	1100	552						Not Available					
	% readmission within 28 days		-	-	10.1%	9.5%	4.9%						Not Available					

Patient Safety, Clinical Effectiveness, Patient Experience Executive Summary

- C. diff cases remain above trajectory, revised C. diff improvement plan being implemented at division and Trust wide level
- Falls and falls with harm remain a focus for improvement, working with patient safety team
- New governance process and focus on ward level accountability and assurance, a pressure ulcer reviewing meeting now in place to ensure actions to improve are in place
- Overdue complaints and complaints response times remain a concern, divisional meetings are in place and Chief Nurse has addressed with Divisional Directors of Nursing

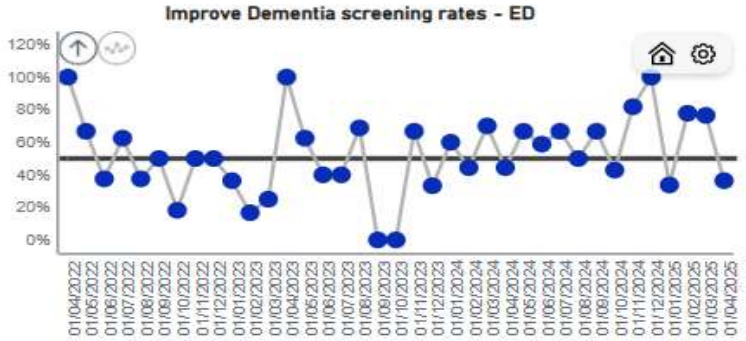
Quality - Safe - Deteriorating Patients - Fragility

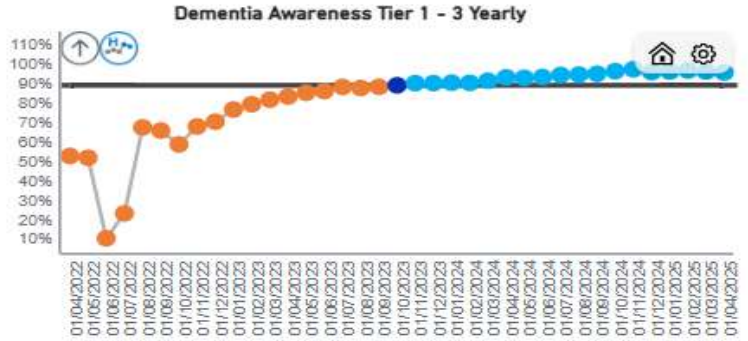
Partnering · Ambitious Caring · Trusted

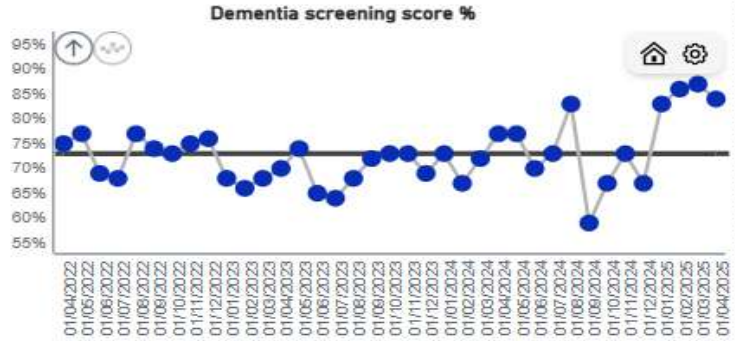
The Shrewsbury and Telford Hospital NHS Trust

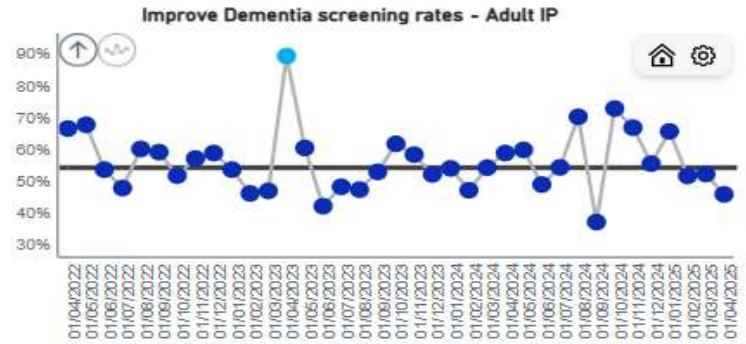
Falls | Deteriorating Patients - NEWS | Deteriorating Patients - PEWS | Medication - Omitted Doses

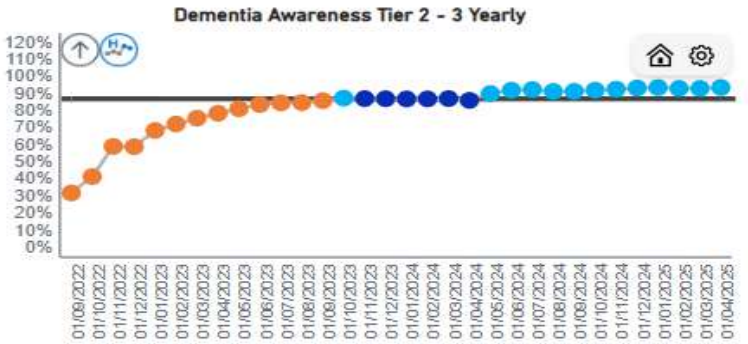
	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025
Improve Dementia screening rates - Patient had an AMT - ED	60.0	44.4	70.0	44.4	66.7	58.8	66.7	50.0	66.7	42.9	81.8	100.0	33.8	77.8	76.5	36.4
Improve Dementia screening rates - Patient had an AMT - Adult IP	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	52.4	46.0
Dementia Awareness Tier 1 3 Yearly	90.32	90.23	91.30	93.01	92.79	93.18	94.24	94.44	94.85	96.21	97.22	95.75	96.08	96.60	96.06	95.54
Dementia Awareness Tier 2 3 Yearly	86.85	86.87	87.07	86.02	90.03	91.95	92.37	91.26	91.35	91.95	92.59	93.25	93.51	93.02	92.99	93.53
Dementia Screening % Score	73	67	72	77	77	70	73	83	59	67	73	67	83	86	87	84
Dementia Screening Audited	263	267	277	251	249	255	264	262	273	251	246	189	207	202	200	245

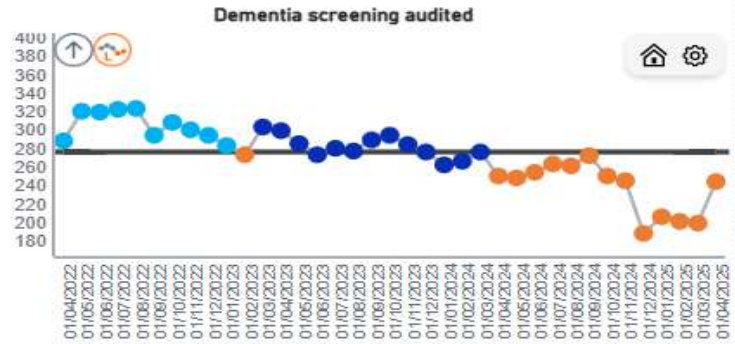






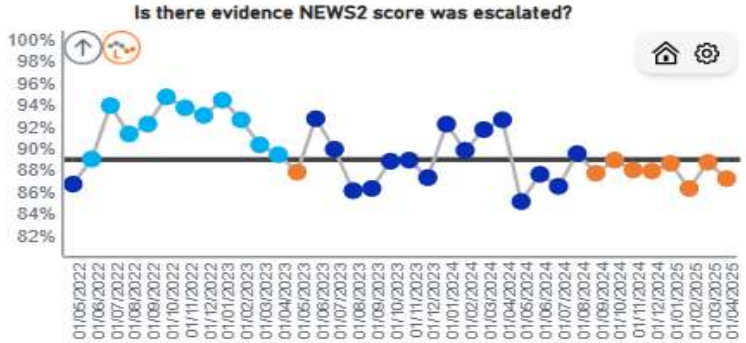


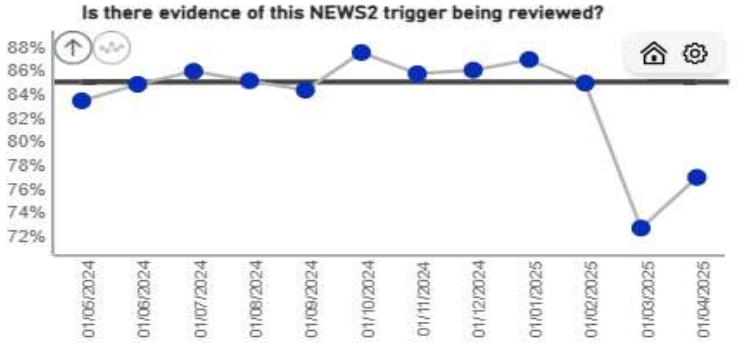


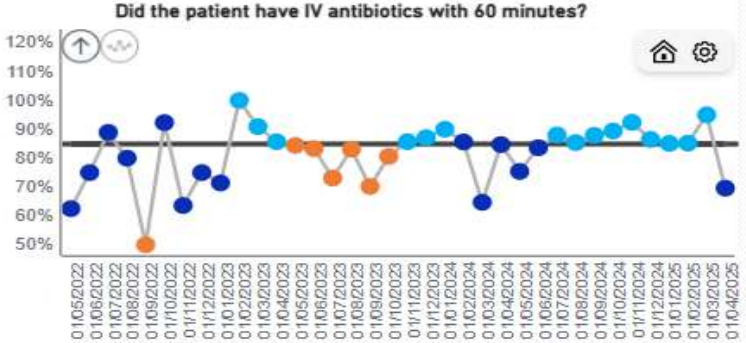


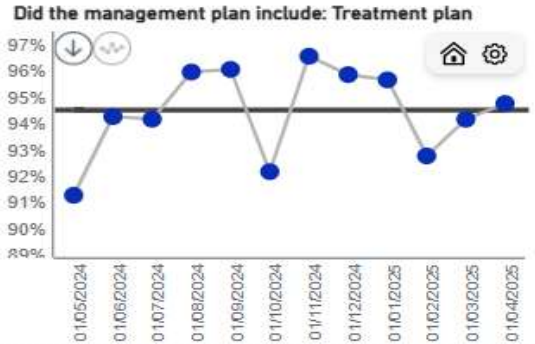
Quality - Safe - Deteriorating Patients - NEWS

	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	Mar-2025	Apr-2025
Is there evidence this NEWS2 score was escalated?	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	88.80	87.30
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	72.70	77.00
Did the patient have IV antibiotics within 60 mins of triggering risk of Sepsis	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	95.00	69.60
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	89.40	87.30
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	94.20	94.80
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	83.90	77.30
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	80.60	75.50









Deteriorating patients – NEWS2 & MEWS

The Shrewsbury and Telford Hospital NHS Trust

Summary: System oversight of deteriorating patient care is being delivered through seven interdependent workstreams: Dashboard, Recognition, Response, Individualised Treatment, Guidelines, Education, and Handover.
Data quality remains a key enabler, supporting performance monitoring against quality indicators and enabling localised action through ward-level engagement.
Metrics within adult inpatients (NEWS2) show strong adherence to escalation protocols in 2022, with periods exceeding 90%. However, this is offset by fluctuations in 2023 that indicate inconsistency that has since stabilised in 2025 between 86-88%. Meanwhile, the proportion of NEWS2 triggers formally reviewed remained stable at 84–86% through 2024 but fell sharply to 74% in March 2025, with only partial recovery to 78%. This pattern—reduced reviews and variable escalation—may reflect systemic pressures such as staffing constraints, workflow inefficiencies, or variable protocol adherence. These operational inconsistencies may have an impact on patient outcomes. Compliance with timely antibiotic administration (<60 mins) in suspected High risk sepsis cases shows a fluctuation between March and April 2025.
Sustained progress requires joined-up action across all workstreams, particularly in driving clinical engagement, standardising response models, and ensuring that data insights translate into measurable improvements.

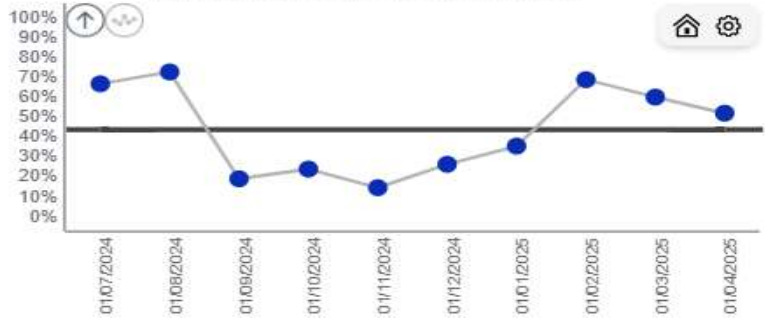
Recovery actions:	**Anticipated impact and timescales**
1. **Strengthening Clinical Quality & Care Coordination:** The deteriorating patient team is actively collaborating with the medical transformation workstreams 1 and 4, focusing on Clinical Quality, Outcomes, and Coordination of Care. Engagement 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 and supporting quality monitoring:** The newly developed report provides departments with deteriorating patient oversight this has now been be integrated within the ward dashboard and this tool will provide critical insights supporting effective strategies to improve compliance. In addition to this, development of the late observation dashboard is also underway, this is aimed at enhancing clinical understanding and thematic learning for clinical teams informing improvement	2. 12-18 months
3. **Workstream Development & Governance:** The DPG Programme Group meeting oversees the progress of the seven workstreams. Two workstreams are making significant progress, while the remaining five are in the initial stages of development, identifying leads to drive this work forward	3. 12-18 months
4. **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.	4. 6-12 months

Recovery dependencies:	Support via P&BI team 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 7 deteriorating patient group workstreams.

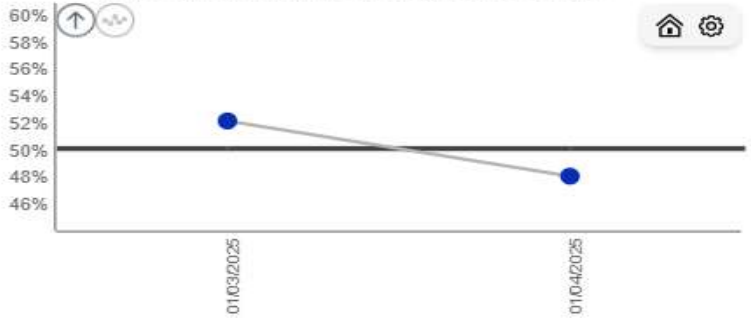
Quality - Safe - Deteriorating Patients - PEWS

	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-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	60.00	51.90
Is there evidence of this PEWS trigger being reviewed?									52.20	48.10
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	0.00	14.30
Did the PEWS management plan include: Investigation plan				45.50	38.10	77.80	77.80	93.30	81.80	75.00
Did the PEWS management plan include: Treatment plan				95.50	95.20	95.50	73.30	89.50	100.00	100.00
Did the PEWS management plan include: Escalation plan				13.60	19.00	54.50	46.70	21.10	35.70	46.20
Did the PEWS management plan include: Review plan				27.30	47.60	66.70	76.90	94.70	92.90	84.60

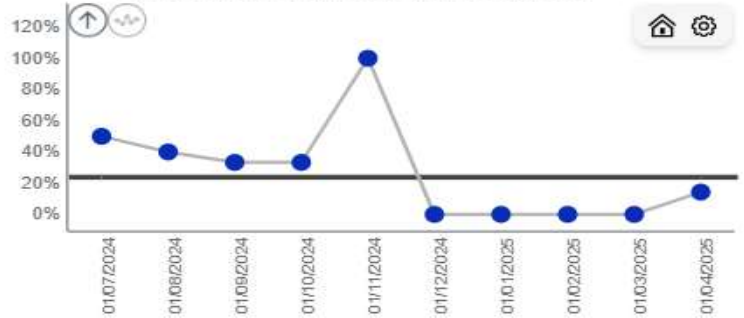
Is there evidence PEWS score was escalated?



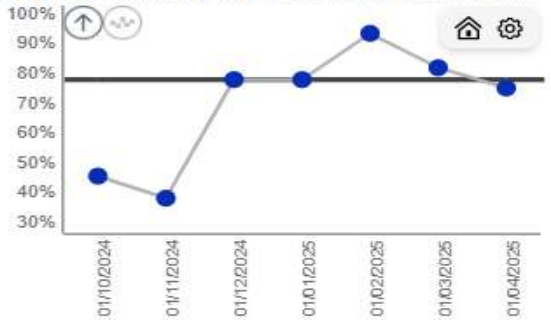
Is there evidence of this PEWS trigger being reviewed



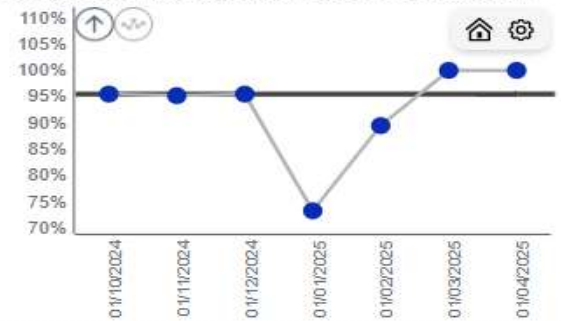
Did the CYP have IV antibiotics within 60 minutes?



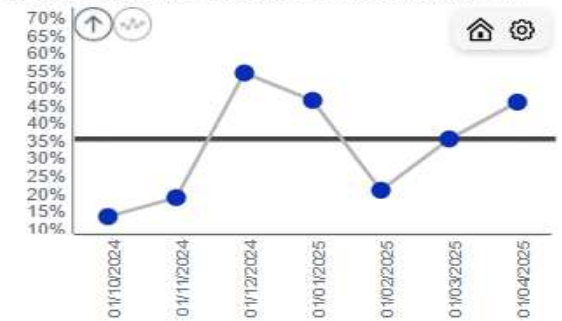
Did the PEWS management plan include: Investigation plan



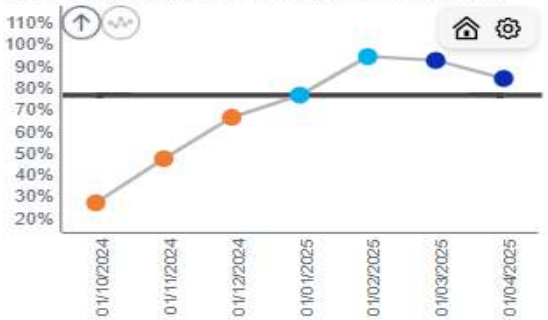
Did the PEWS management plan include: Treatment plan



Did the PEWS management plan include: Escalation plan



Did the PEWS management plan include: Review plan



Deteriorating patients – PEWS & NEWTT2

The Shrewsbury and Telford Hospital NHS Trust

Summary: Oversight of paediatric deteriorating patient care remains centred on improving data quality to support consistent escalation and timely intervention.
From July to December 2024, escalation adherence fell below 50% and remained low, despite fluctuations compliance fell again to 50% in April. These trends may be influenced by capacity constraints and the effectiveness of targeted improvement efforts.
Similarly, compliance with 60-minute IV antibiotic administration for children and young people (CYP) identified as high risk of Sepsis was persistently low (40%) between July and October 2024, before spiking briefly to 100% in November possibly due to a temporary intervention. This was followed by a sharp drop to below 10%, which persisted through to March, with slight improvement in April 2025, which may indicate that improvements have not been embedded.
These findings suggest possible inconsistent adherence, with protocols or reporting practices, operational challenges including workforce pressures, delayed recognition of deterioration and may indicate a need to look at how to sustain improvement, beyond isolated interventions.
Moving forward, strengthening escalation processes and ensuring timely antibiotic treatment for high-risk patients remain priorities. The intention is to work toward embedding these actions within PTAC and ensure operational oversight is focused on integrating system accountability into everyday clinical practice.

Recovery actions:

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 to enhance awareness of key metrics for deteriorating patient care

2. Data Consistency & Reporting Improvements

Ongoing efforts to standardise data collection and analysis across the trust, ensuring consistency in deteriorating patient & sepsis reporting

3. Strengthening Clinical Quality & Care Coordination

Work continues with neonatal and maternity teams to clarify systems and processes prior to the introduction of Badgernet for neonates and NEWTT2

4. 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

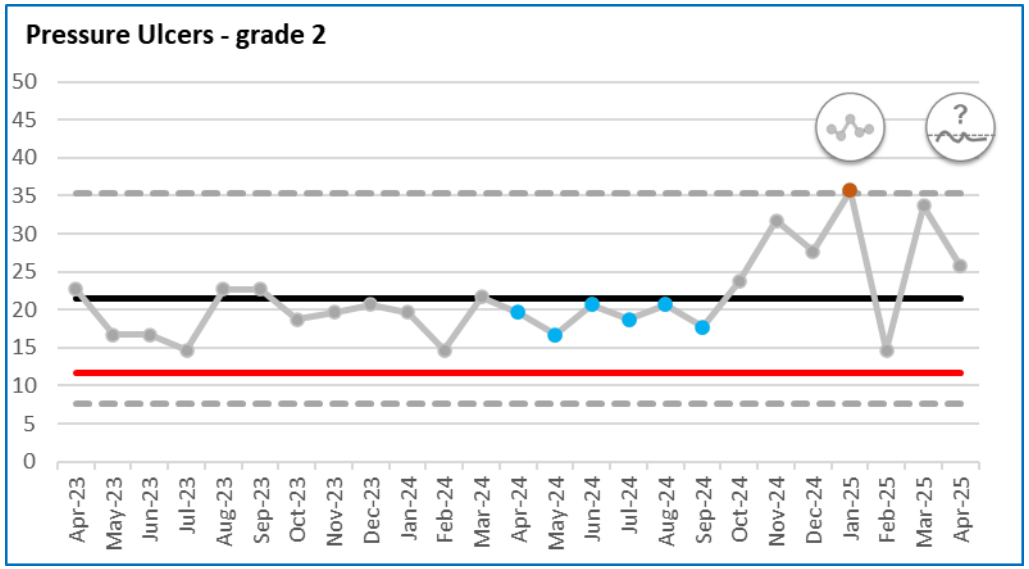
Anticipated impact and timescales for improvement:

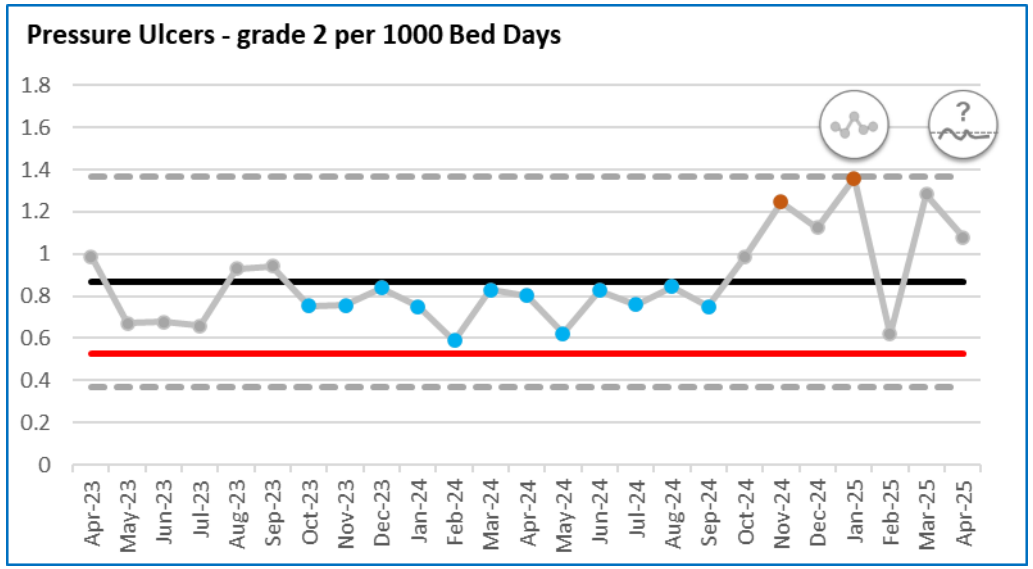
1. Full integration over 12 months
2. 12-18 months
3. 12-18 months
4. Initial improvements expected within 3–6 months, with full integration over 12 months
5. Initial improvement 6- 12 months

Recovery dependencies:	Support via Performance & Business Intelligence (P&BI) team, transformation project teams and engagement throughout the trust. Support via governance & clinical and operational teams to prioritise deteriorating patient with timely decisions made by DPG

Patient harm – pressure ulcers – Category 2

The Shrewsbury and Telford Hospital NHS Trust

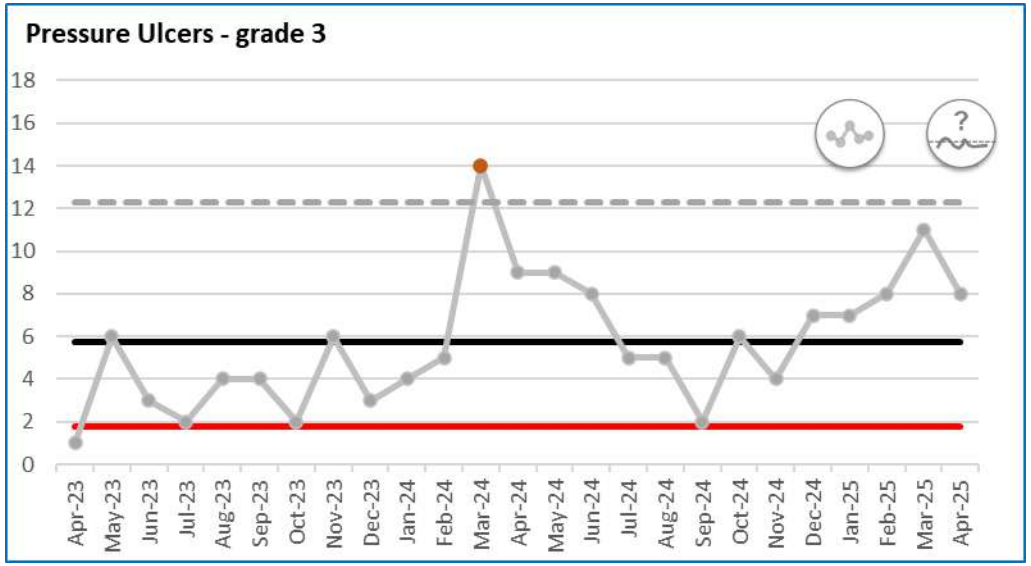


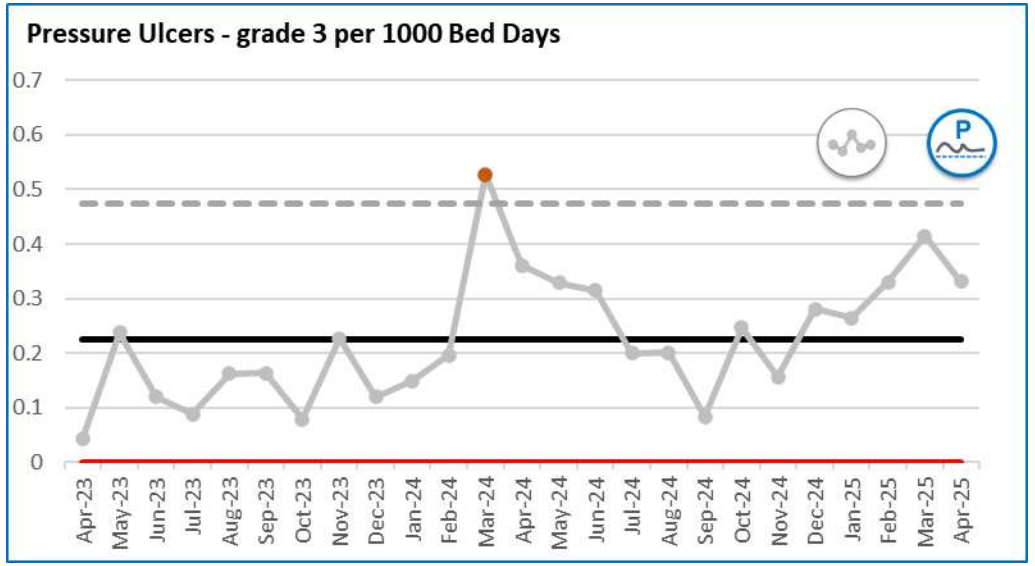


Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	18
Surgery, Anaesthetics and Cancer	8
Women's & Children's	1

Patient harm – pressure ulcers – Category 3

The Shrewsbury and Telford Hospital NHS Trust

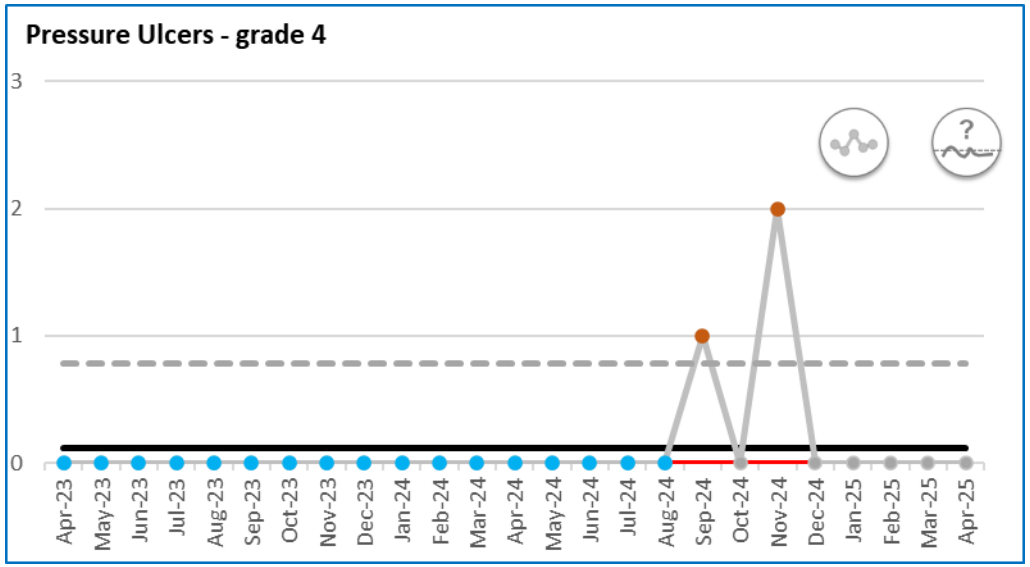




Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	2
Surgery, Anaesthetics and Cancer	4
Clinical Support Services	2

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:
During the month there has been a decrease in the amount of reported pressure ulcers from the previous month. 26 category 2 pressure ulcers reported this month against 33 in the previous month and 8 category 3 pressure ulcers reported against 11 reported in the previous month. There were no category 4 pressure ulcers reported in month.
Of these 34 incidents 22 were buttocks/sacrum, 8 on the heel/foot, 1 on the elbow, 1 on the ear, 1 on penis and 1 on hip.
With the increase in both acquired ulcers and severity of harm, the Trust did not 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. Of the 8 Cat 3 pressure ulcers reported, 1 on ward 27, and 1 on ward 4, 1 on ward 25, 2 on ward 37, 1 on ward 9 ward 23 had 2.
There were 29 DTIs reported in month.

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 May is being implemented linked into the monthly Trust Nursing Metrics meetings
- PURPOSE T- a nationally recommended pressure ulcer risk assessment 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)
- Off- loading boots available for all patient's risk assessed as required

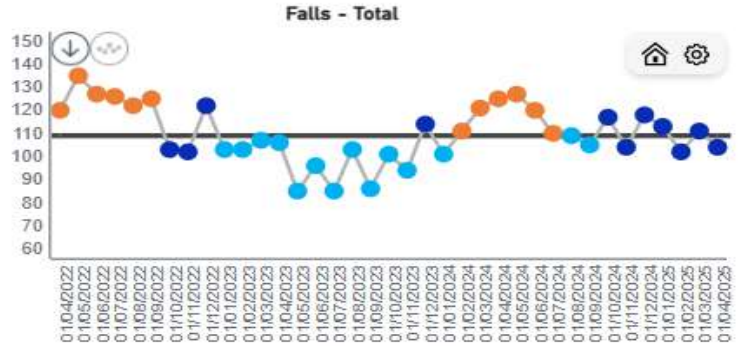
Anticipated impact and timescales for improvement:
Reduction in consistent themes in relation to pressure ulcers.

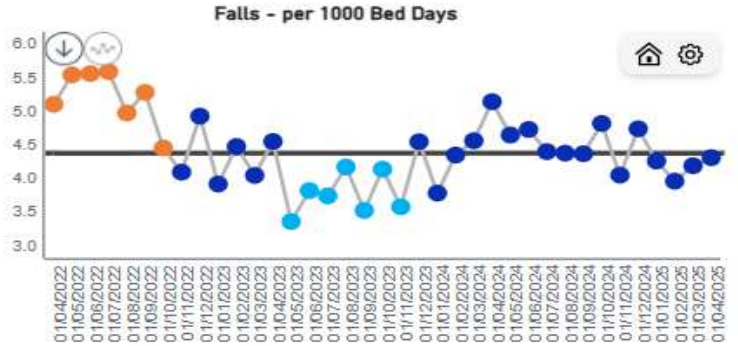
Recovery dependencies:	Ownership of action plans for pressure ulcer prevention at ward and matron level. Monthly review meetings for Category 2,3 and 4

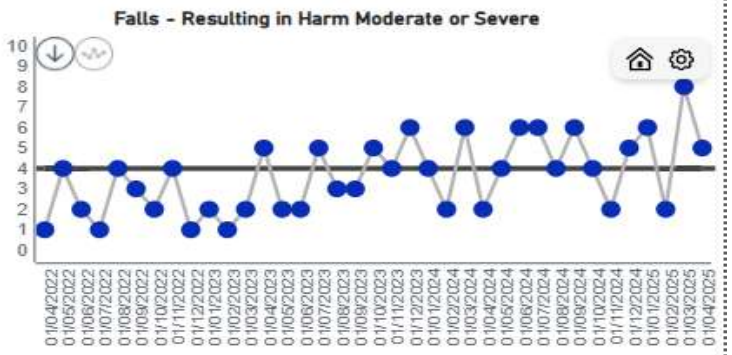
Quality - Safe - Falls

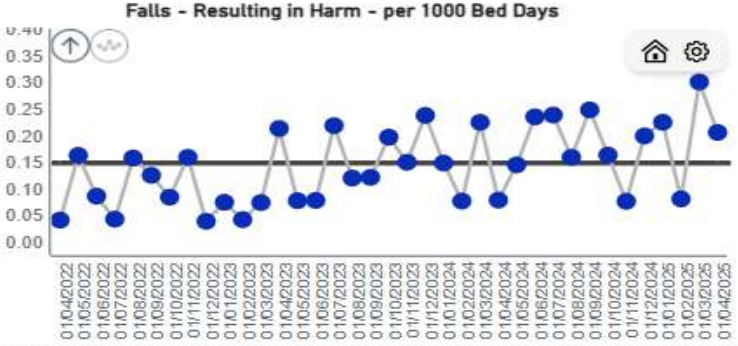
Deteriorating Patient - Fragility | Deteriorating Patients - NEWS | Deteriorating Patients - PEWS | Medication - Omitted Doses

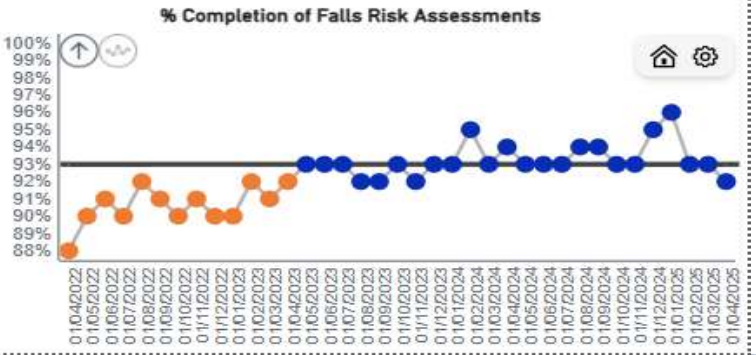
	Dec-2023	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025
Falls - Total	114	101	111	121	125	127	120	110	109	105	117	104	118	113	102	111	104
Falls - per 1000 Bed Days	4.55	3.78	4.35	4.56	5.14	4.65	4.73	4.40	4.38	4.37	4.82	4.05	4.74	4.26	3.96	4.19	4.31
Falls - Resulting in Harm Moderate or Severe	6	4	2	6	2	4	6	6	4	6	4	2	5	6	2	8	5
Falls - Resulting in Harm - per 1000 Bed Days	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	0.30	0.21
Falls Prevention Training Compliance % - 2 Yearly	88.50	88.05	88.82	89.12	89.40	90.74	91.20	91.79	91.99	92.28	92.59	92.77	92.84	93.36	90.03	88.75	86.04
% Completion of Falls Risk Assessments	93	93	95	93	94	93	93	93	94	94	93	93	95	96	93	93	92











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

Patient harm - falls

The Shrewsbury and Telford Hospital NHS Trust

Summary:
Falls per 1000 bed days in April 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 is estimated bed days, it is hoped that this will be rectified for the new reporting year April 2025. We reported a total falls in month of 104 which is a reduction to last month .
There continues to be falls with harm with 5 falls being seen in April 2025 that resulted in moderate harm or above. Common cause variation continues to be seen on the falls with harm and falls with harm per 1000 bed days charts.
Training compliance has dipped just below 90% at 86.04% and completion of risk assessments pre fall also remains above 92%.

Recovery actions:
Numerous falls projects in place with support from the improvement hub, these include, decaffeinated drinks project, Bedside vision checks, Reconditioning games and a review of bedtime routines is also in progress in conjunction with Patient Experience team

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 (June 25) due to secondment ending earlier than planned

Anticipated impact and timescales for improvement:
Monthly movement activities on wards with a timetable for the year planned.
Decaffeinated drinks project Ended March 31st – review of outcomes taking place .
Bedside vision checks – PSIRF project
Review of all falls continues with feedback presented to WM/Matron each month
Attendance at divisional falls meetings monthly
Lying and standing blood pressure awareness

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

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

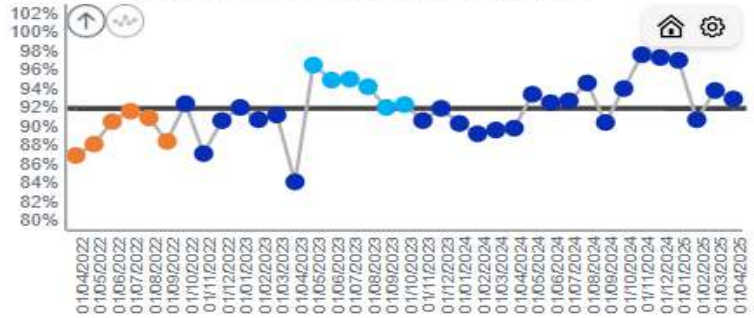
Partnering · Ambitious Caring · Trusted

NHS The Shrewsbury and Telford Hospital NHS Trust

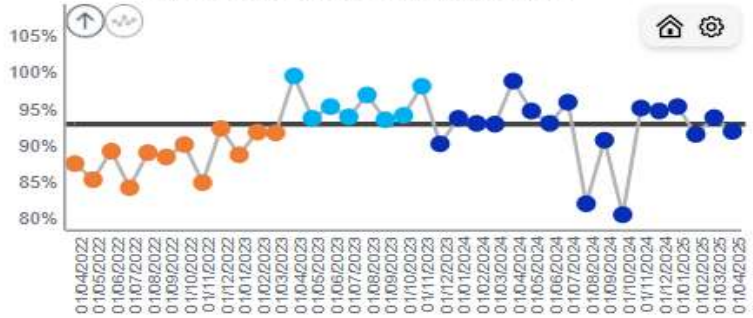
Falls | Deteriorating Patients - Fragility | Deteriorating Patient

	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	Mar-2025	Apr-2025
Has all prescribed medication been administered?	90.3	89.2	89.6	89.8	93.4	92.5	92.7	94.6	90.4	94.0	97.6	97.3	97.0	90.7	93.8	92.9
Was the reason for the omission documented?	93.8	93.1	93.0	98.9	94.8	93.1	96.0	82.1	90.8	80.6	95.2	94.8	95.4	91.6	93.9	92.0
Was appropriate action such as ordering medication, documented?	90.6	92.3	89.6	92.1	93.1	88.2	93.3	91.0	92.5	93.3	92.5	89.1	94.2	92.6	95.2	91.8

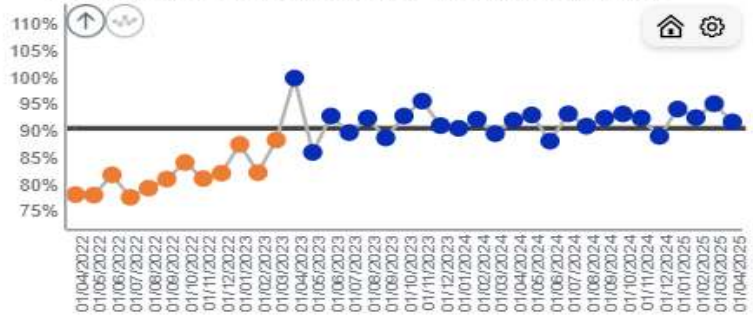
Has all prescribed medication been administered



Was the reason for the omission documented



Was appropriate action such as ordering medication, documented



Medication - Omitted doses

The Shrewsbury and Telford Hospital NHS Trust

Summary:
Omitted doses of medication is recognised nationally as a leading cause of patient harm within the NHS.
SaTH are an outlier in relation to implementation of Electronic Prescribing and Medication Administration (EPMA). EPMA is recognised to significantly improve prescribing and timely administration of medication with improved visibility of live data to measure compliance and incidents.
Due to SaTH using a paper-based prescribing and administration system, data relating to prescribing and administration incidents (including omitted doses) is difficult to obtain. Incidents reported into Datix is also recognised as unreliable as incidents of omitted doses of medication largely go unreported.

Performance indicators currently used to identify incidents of omitted doses include:
- Several snapshot audits completed by nursing matrons, quality matrons (via Exemplar) and pharmacy
- Incident reporting data via Datix
- Audits, observational sessions and planned staff focus groups (as part of the PSIRF Trust priority – Omitted doses of Time Critical Medication (TCM))

Recovery actions:
- Ongoing efforts to improve and increase incident reporting in relation to omitted doses of medication
- Observe and discuss processes relating to administration of medication during in-patient admission with clinical teams at the point of care
- Ongoing efforts to improve and standardise data collection and analysis in relation to omitted doses of medication
- Identify wider systems and organisational issues and themes to be incorporated into a thematic review and organisational improvement plan
- Implementation of EPMA
- Improvement work linked to timely prescribing and administration of medication in ED

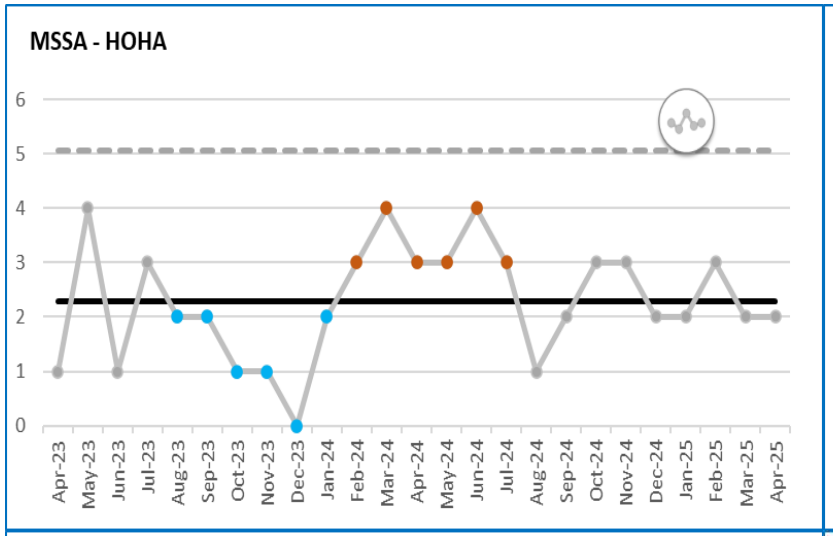
Anticipated impact and timescales for improvement:
In-line and aligned to the PSIRF Trust Priority – Omitted doses of time critical medication.

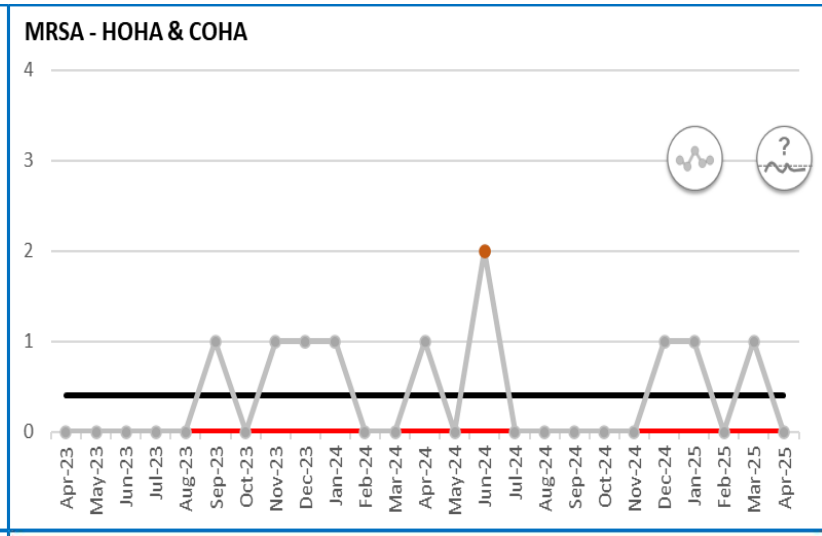
In line with full implementation of EPMA within the Trust.

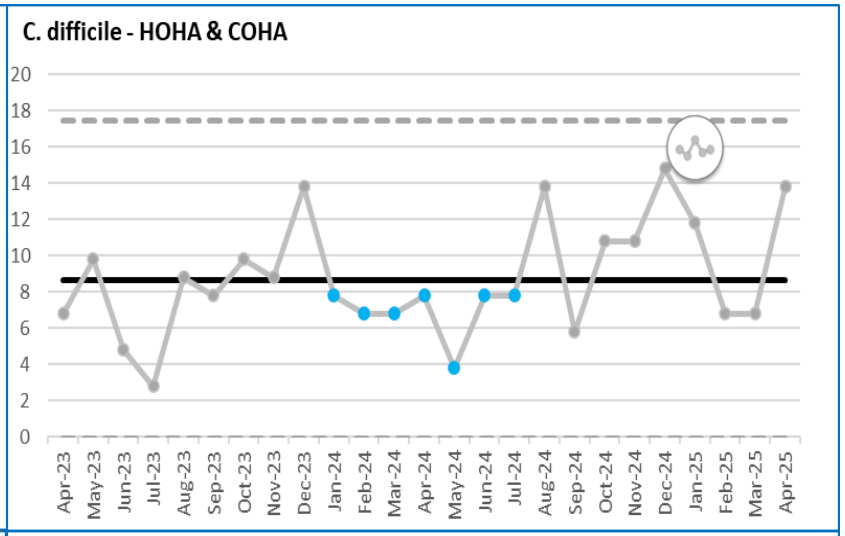
Recovery dependencies:

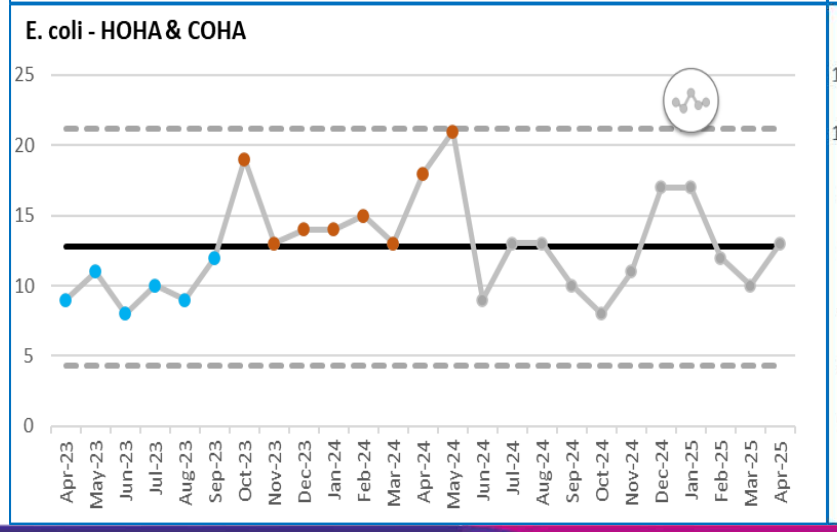
Infection prevention and control

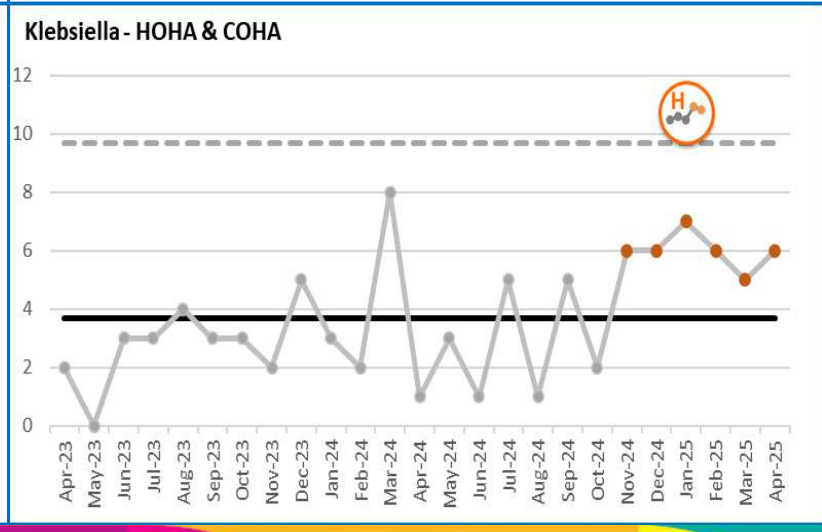
The Shrewsbury and Telford Hospital NHS Trust

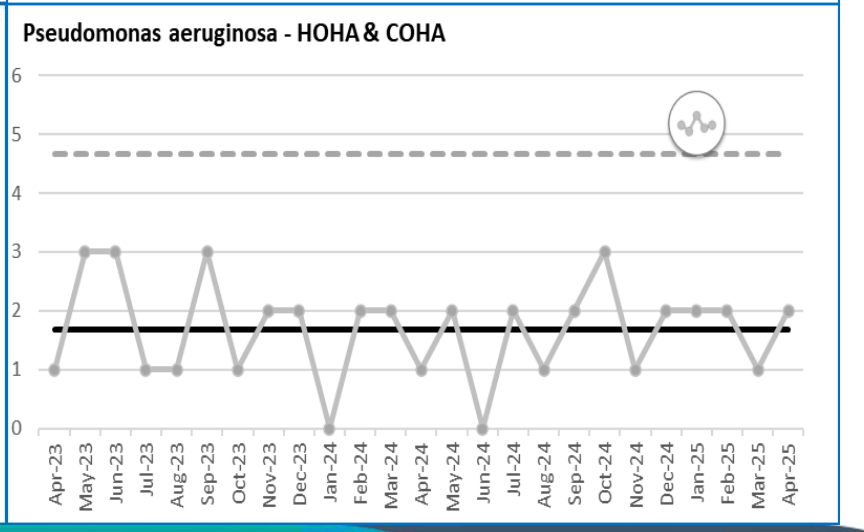












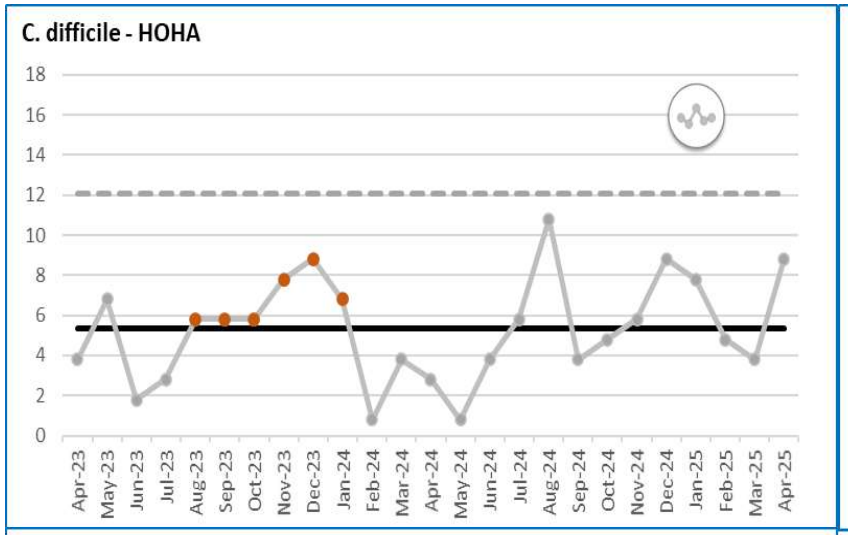
Partnering Ambitious Caring Trusted

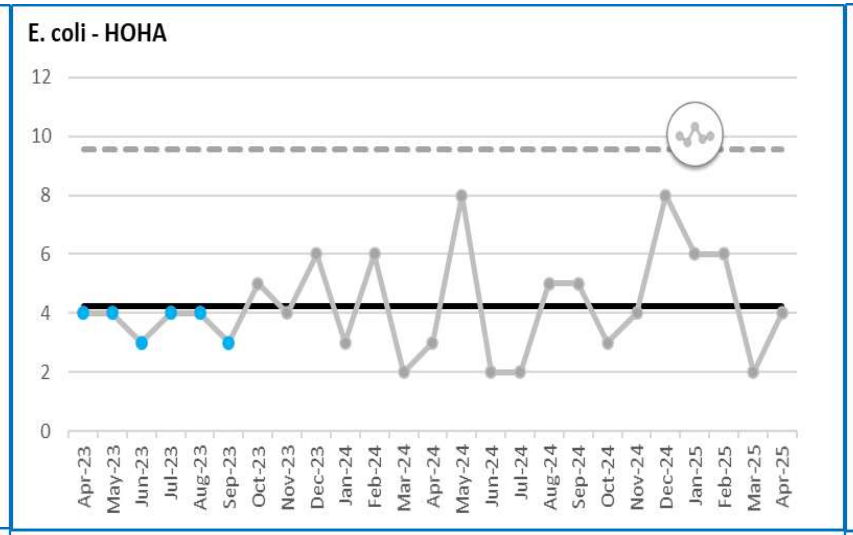
VETERAN AWARE

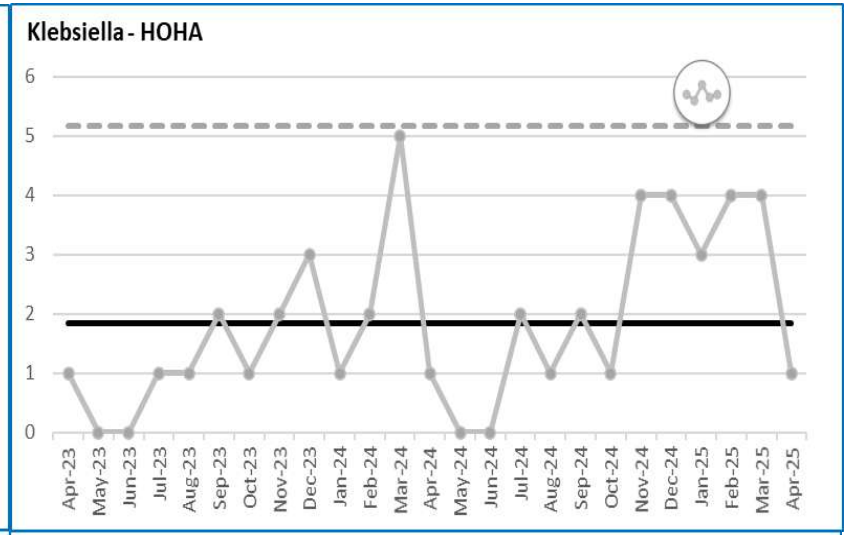
Our Vision: To provide excellent care for the communities we serve

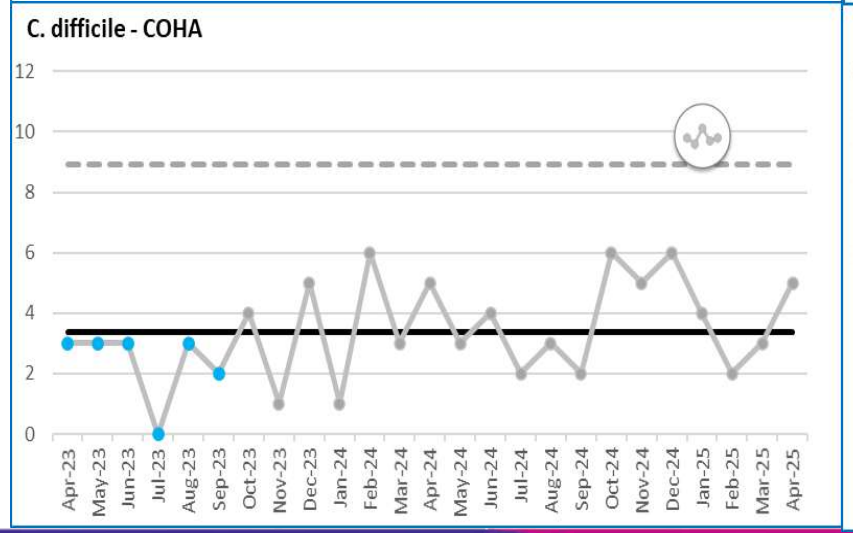
Infection prevention and control

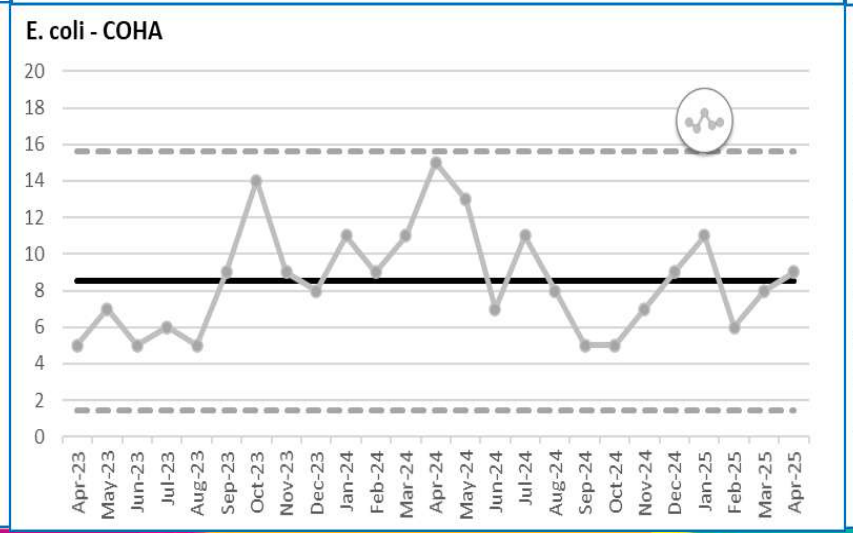
The Shrewsbury and Telford Hospital NHS Trust

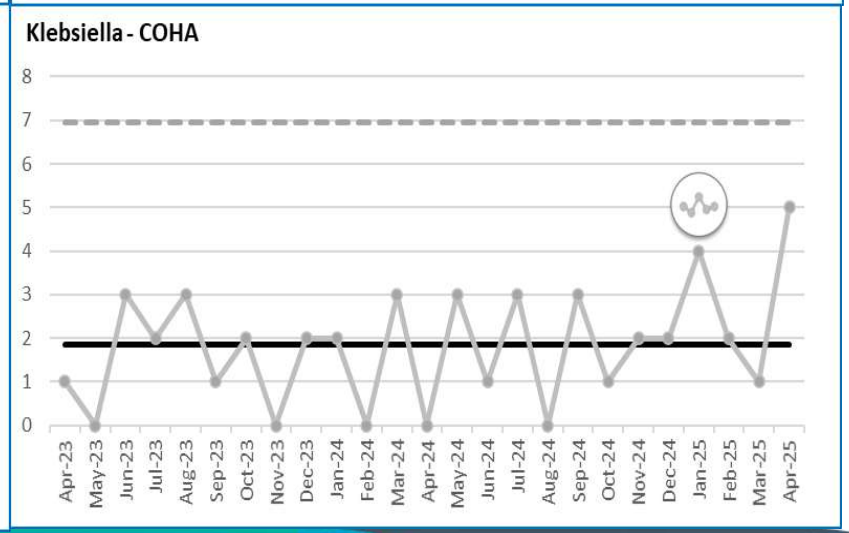












Infection prevention and control

The Shrewsbury and Telford Hospital NHS Trust

Summary:
In April 2025 there were the following bacteraemia:

•14 C. diff cases (9 HOHA, 5 COHA)
•0 MRSA Bacteraemia
•5 MSSA Bacteraemia (2 HOHA, 3 COHA)
•13 E. coli Bacteraemia (3 HOHA, 9 COHA)
•6 Klebsiella Bacteraemia (1 HOHA, 5 COHA)
•2 Pseudomonas Bacteraemia (2 COHA)

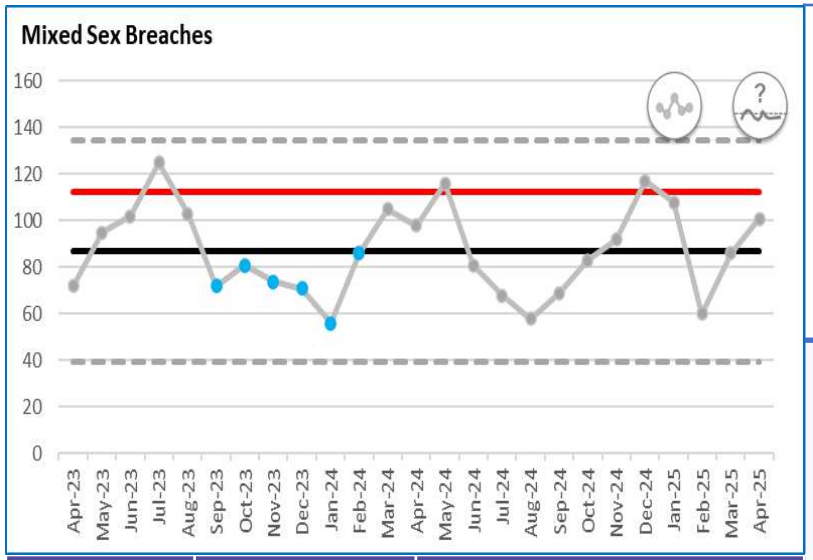
Recovery actions:
C. diff action plan was re written following an NHSE/ICB visit in April, this has been reviewed by both parties and agreement that it meets all national guidance. There is an expectation that the divisions will implement this and report back in the IPCOG reports.
The IPC team will develop the Divisional report template to include this section for ease of reporting.
The IPC team are visiting areas with Periods of Increased Incidence of C. diff regularly to identify issues and support the teams to make improvements.

C. diff, MRSA, E.coli and Klebsiella targets were breached for 2024/25.
We met the Pseudomonas target.
Although no target is set for MSSA bacteraemia, case numbers have increased year on year.
Actions to reduce these bacteraemia rates is ongoing and forms part of the IPC annual programme.

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



Location	Number of breaches	Additional Information
AMU (PRH)	10 breaches	Over 2 occasions in AMA
Ward 16 (PRH)	2 breaches	
AMA (RSH)	62 breaches	Over 19 occasions trolley area
ITU / HDU (RSH)	27 primary breaches	16 surgical, 11 medical/gastro

Summary:
Mixed sex accommodation breaches remained high in April, the reasons 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 RSH and AMA & SDEC at PRH overnight for patients requiring admission
The use of AMA/SDEC 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.

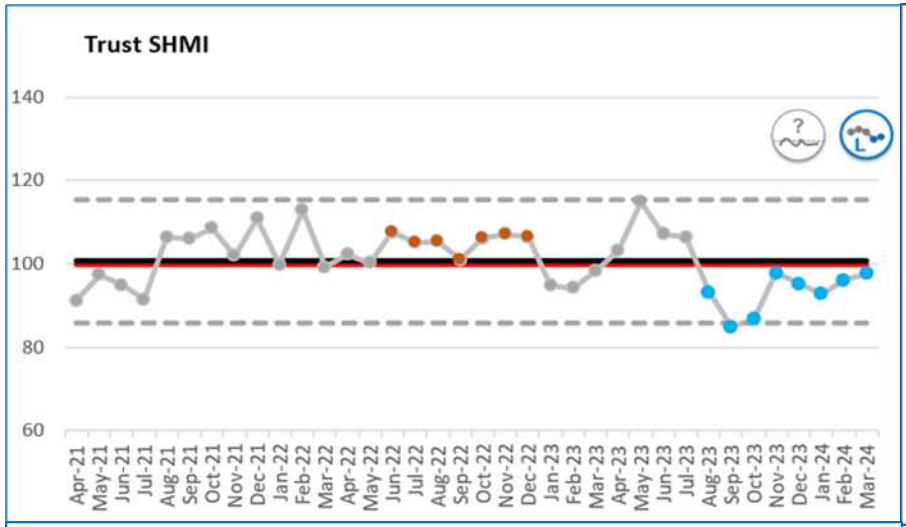
Recovery actions:
- Review of the Trust's application of the MSA Policy to ensure this is applied consistently across the Trust
- Improvement work in relation to patient flow, discharges earlier in the day (including increasing the number of discharges before midday and 5pm) and a reduction in patients 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 tried 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

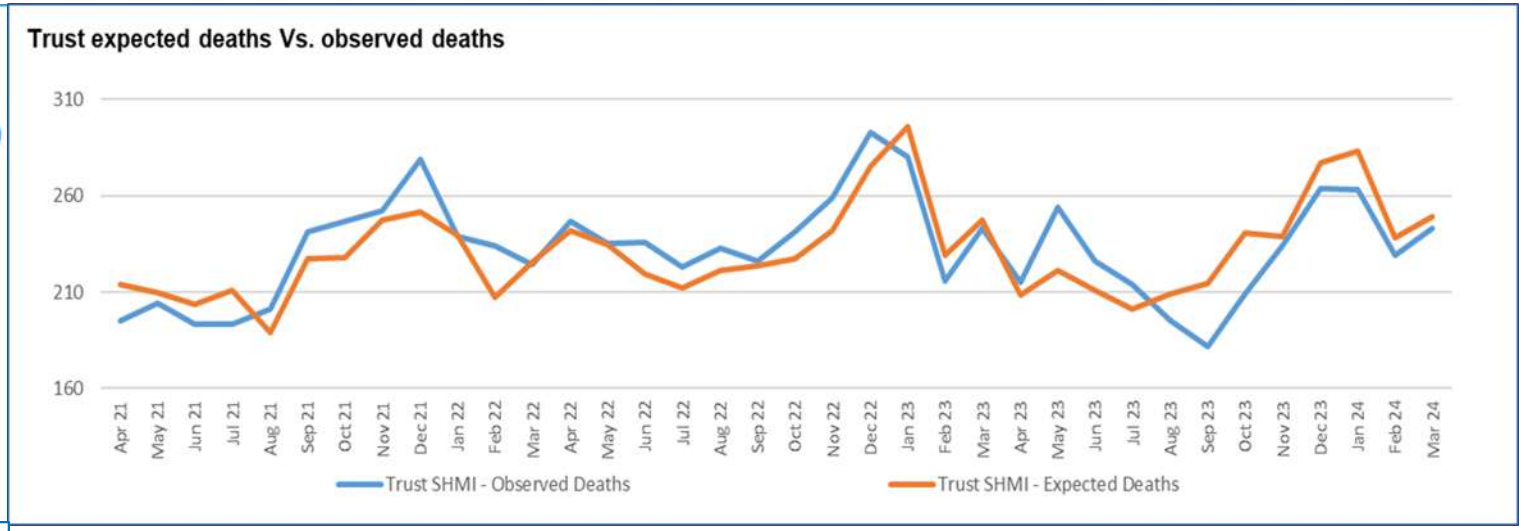
Anticipated impact and timescales for improvement:
- Beds available earlier in day
- Less patients attending ED with conditions which could be treated on alternative pathways
- Reduction in no criteria to reside patients in hospital
- Patients cared for in the most appropriate environment to meet their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

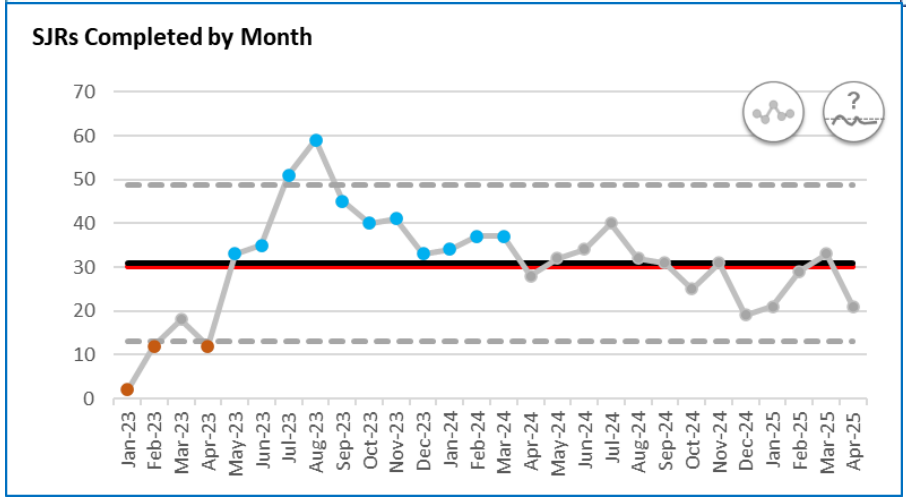
Recovery dependencies:	Patient flow improvement work. System wide work and alternative community pathways of care. Reduction in patients with no criteria to reside

Mortality outcome data

The Shrewsbury and Telford Hospital NHS Trust







Mortality outcome data

The Shrewsbury and Telford Hospital NHS Trust

Summary:

- Summary Hospital-level Mortality Indicator (SHMI) and Trust SHMI Observed versus Expected deaths is not available beyond March 2024 due to data acquisition problems in the Trust Data Warehouse therefore preventing the review of risk adjusted mortality in the Trust
- 21 SJRs were completed in April 2025, against the monthly local target of 30 (target aims to ensure that as an organisation ,15% of all deaths over the year are reviewed using this methodology). Identified learning is shared with divisional governance teams, clinical colleagues and with external stakeholders as appropriate and is discussed at the monthly Trust LfD Group with relevant improvement work
- The monthly SJR completion targets are anticipated to remain below the local target of 30 over the next few weeks following the retirement of one of the Corporate SJR Reviewers at the end of May (Medical Consultant) until the vacancy has been filled. This vacancy will impact the ability to maximise learning opportunities from the Learning from Deaths (LfD) agenda
- Just under 4% of all deaths in April 2025 had an SJR triggered from the ME Service on basis of significant concerns being raised by the bereaved. Themes raised by the bereaved in April include poor communication with families including around discharge plans and updates with patient's health, overall care on the ward and monitoring of patient, use of family members as an interpreter, management of care between hospitals.

Recovery actions:

- In the absence of risk adjusted mortality, internal crude mortality data continues to be reviewed as a standing agenda item in the monthly Trust LfD Group meeting
- Recruitment to the SJR Reviewer medical vacancy is currently being reviewed including alternative options for example senior nurse / MDT involvement
- Deaths where SJRs are triggered based on significant concerns being raised by the bereaved during ME Scrutiny, are triangulated through the weekly Mortality Triangulation Group and then reviewed through the most appropriate process including SJR, datix, and the formal complaint process, with learning shared as appropriate. This metric is monitored through the Learning from Deaths dashboard which is presented at the monthly Trust Learning from Deaths Group meeting

Anticipated impact and timescales for improvement:

- Statutory returns for data submissions recommenced in May although timescale for availability of reliable SHMI remains unknown. Advised that there is liaison between SaTH BI Team and CHKS to support data quality work to review impact on SHMI. Timescales outside of LfD remit.

Recovery dependencies:	Resolution of Data Warehouse challenges and subsequent availability of reliable Trust SHMI data. Recruitment to SJR reviewing team to maintain target number of SJRs per month and thereby maximise MDT learning opportunities across the Trust.

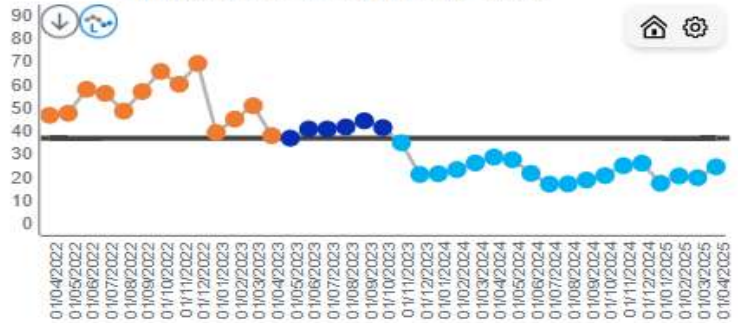
Quality - Effective - Right Care, Right Place, Right Time

Page 2

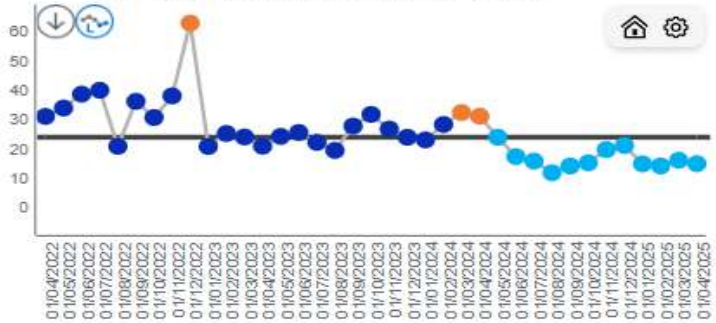
Best Clinical Outcomes

	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	Mar-2025	Apr-2025
ED Triage Average Time To Streaming - Adults	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	19.90	24.58
ED Triage Average Time To Streaming - Children	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	16.27	15.09
% Patients seen within 15 minutes for initial assessment	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	57.35	54.77
Friends and Family Test - A&E - % responded Very Good/Good	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	77.00	64.94
Friends and Family Test - A&E - Response Rate %	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	0.40	0.58
Complaints by Theme - Admission / Discharge	14	13	12	20	14	17	17	22	18	16	17	18	14	18	20	25

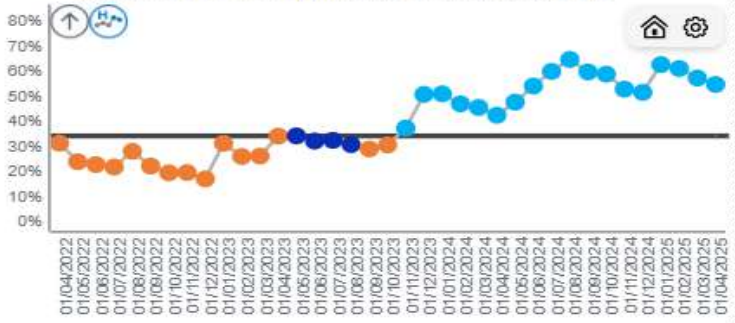
ED Triage Average Time to Streaming - Adults



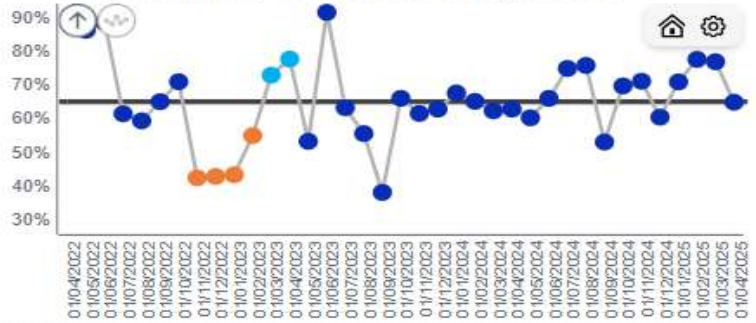
ED Triage Average TIme to Streaming - Children



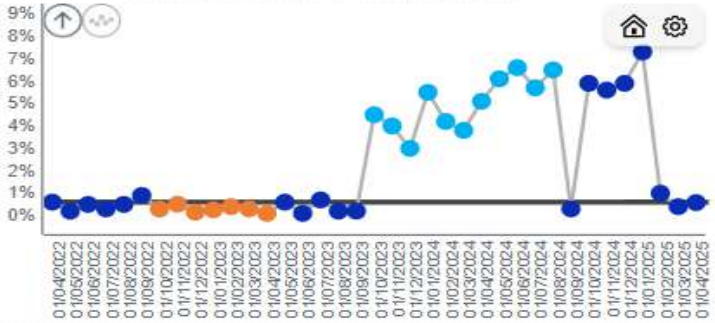
% Patients seen within 15 minutes for initial assessment



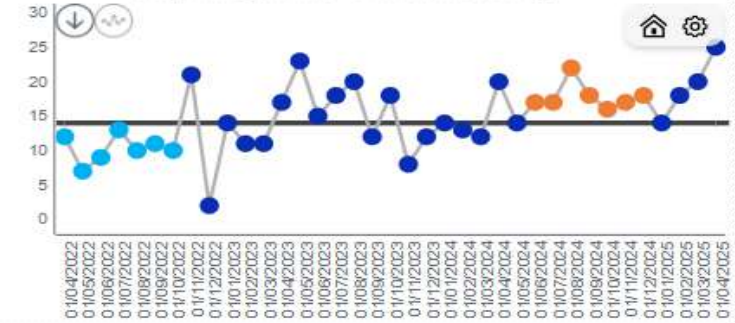
Freints and Family Test - % Responded Very Good/Good



Freints and Family Test - Response Rate %



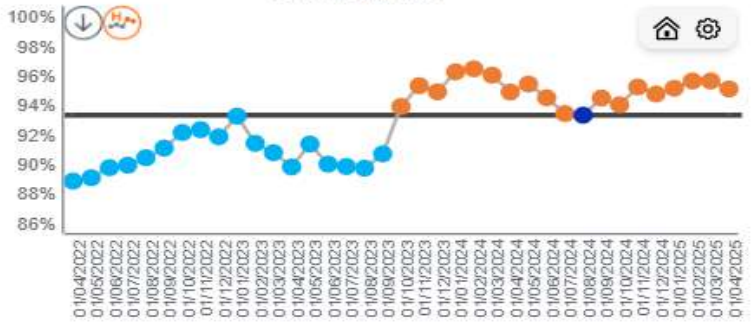
Complaints by Theme - Admission / Discharge



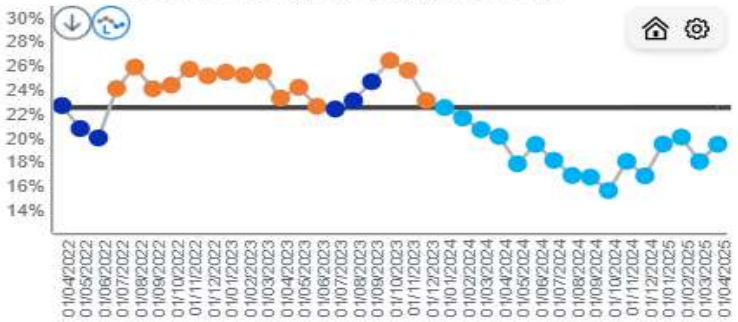
Quality - Effective - Right Care, Right Place, Right Time

	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	Mar-2025	Apr-2025
Occupancy Rate %	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	95.69	95.15
% beds occupied by patients with LOS >14 days	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	18.07	19.51
% beds occupied by patients with LOS >21 days	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	10.37	11.10
% Discharged By 10am	9.25	9.75	10.06	9.17	8.18												
% Discharged By 12pm	14.85	15.25	16.00	15.34	13.87												
No criteria to reside	137	123	104	101	114	112	114	106	92	89	101	117	102	108	105	105	105

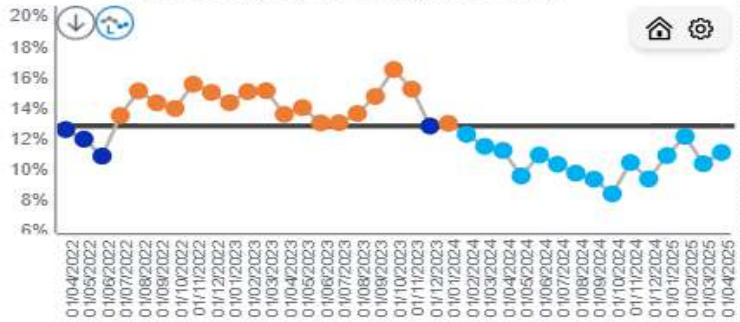
Occupancy Rate %



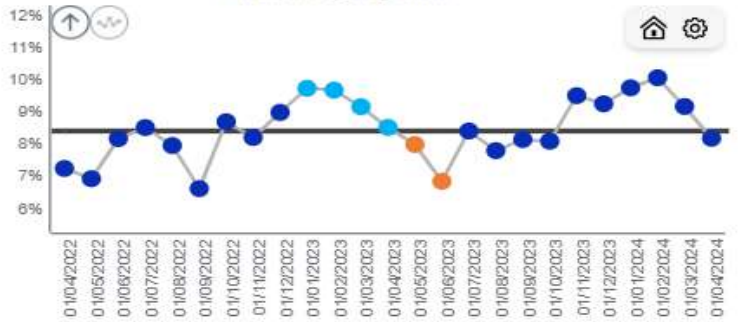
% beds occupied by patients with LOS >14 days



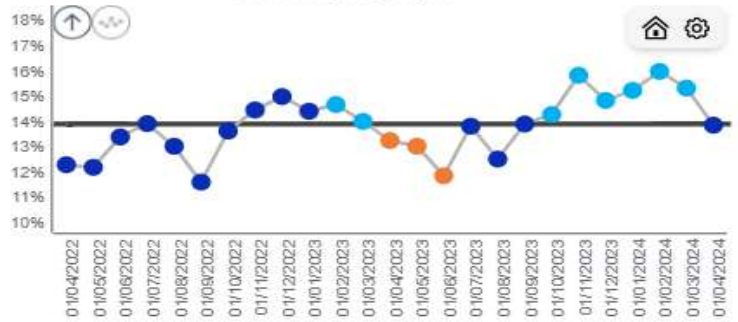
% beds occupied by patients with LOS >21 days



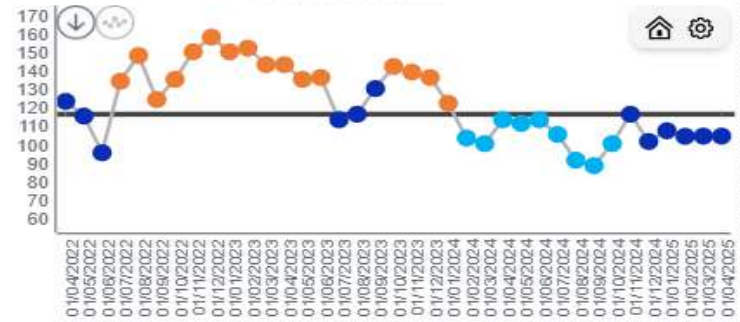
% Discharged By 10am



% Discharged By 12pm



No criteria to reside



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

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).
Audit 2024 revealed 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:

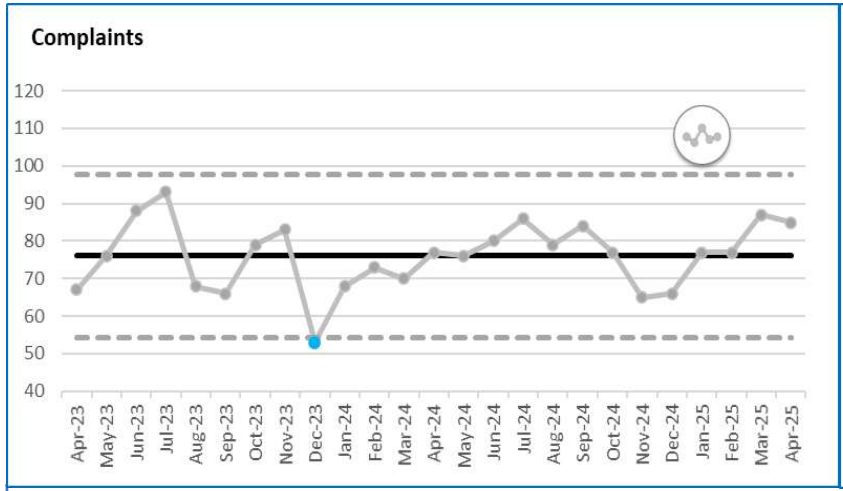
- Heel offloading available on ward – Heel boot available to order on wards – complete
- Hot clinics introduced for A&E and UCC for quick access to multidisciplinary team (MDT) clinic
- Quick access to outpatients with new diabetes foot complications – introduction of Hot phone complete
- Capacity to see PWD with acute problems in < 5 working days by changing ratio of new patient/follow up appointments
- Introduction of integrated orthopaedic prevention clinic for diabetes foot patients – complete
- Lift the sheet check the feet education campaign
- 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.
- Better preventative care offered in primary and community sectors including foot screening which is the cornerstone of diabetes care. (On hold with ICB)

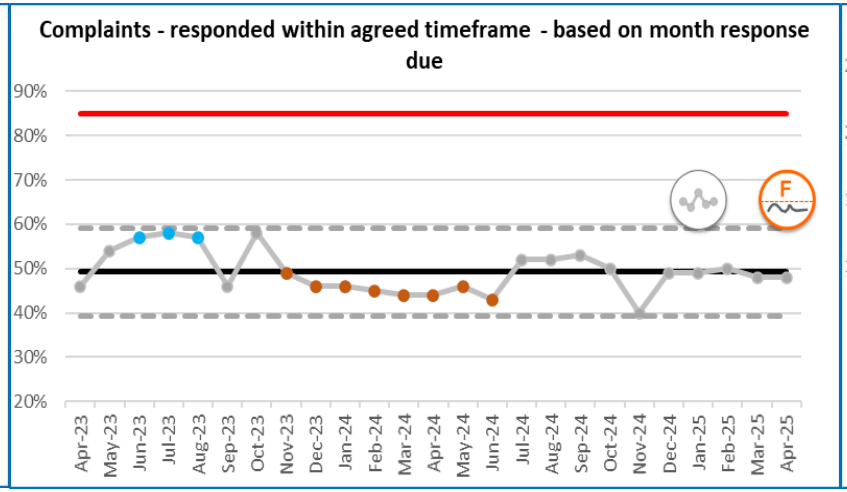
Anticipated impact and timescales for improvement:
Annual integrated wound conference aimed at Acute Staff June 25
Business Case agreed, HR approved – jobs advertised.
Reaudit of inpatient data to show anticipated improvement in statistics nearing NICE guidance standards July 2025.
Root Cause analysis of all diabetes foot amputations highlighting gaps in care and areas of improvement July 2025
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
Anticipated impact improvement in Diabetes foot pressure ulcers / hospital acquired diabetes foot ulcers

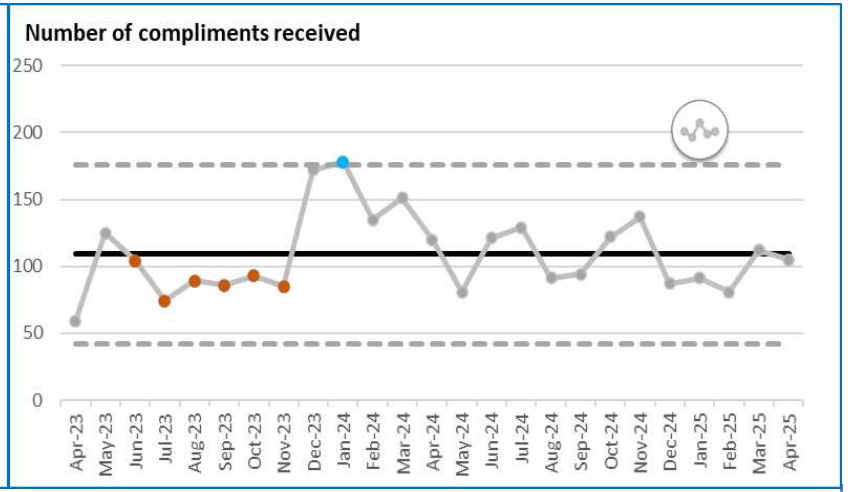
Recovery dependencies:	Business case for SaTH Diabetes Podiatry Team agreed Ownership of new documentation and education for diabetes foot at ward and matron level Diabetes foot screening must be undertaken in primary care, foot protection in community reducing clinical need in Acute service

Complaints and compliments

The Shrewsbury and Telford Hospital NHS Trust







Summary:
Numbers of new complaints were within expected variation in April. The Trust is still experiencing challenges in terms of responding in a timely way and the Complaints Team are working closely with clinical staff to support where they can. The weekly meetings continue, with clear ownership at specialty level and escalation as needed in the divisions.

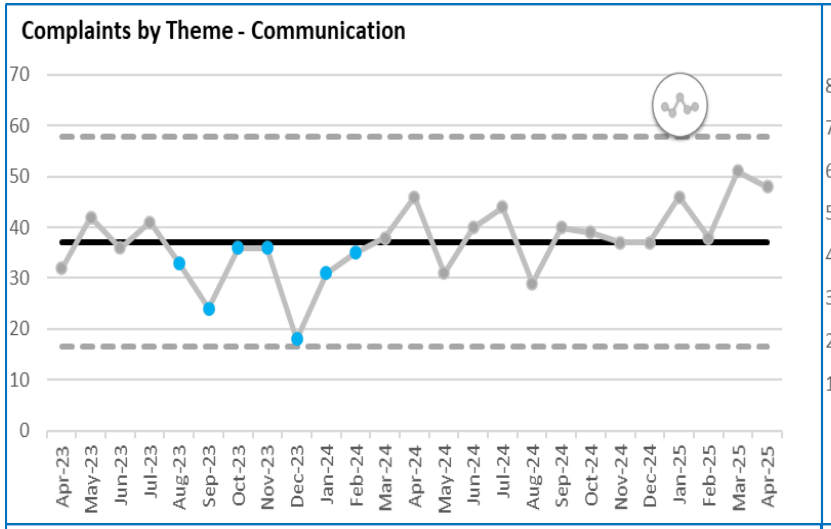
Recovery actions:
Dashboards on Datix give greater visibility of open cases for specialties.
Continue with weekly complaints review meetings with Divisional and Specialty Teams.
Embedded processes for bereavement cases, with divisional ownership.

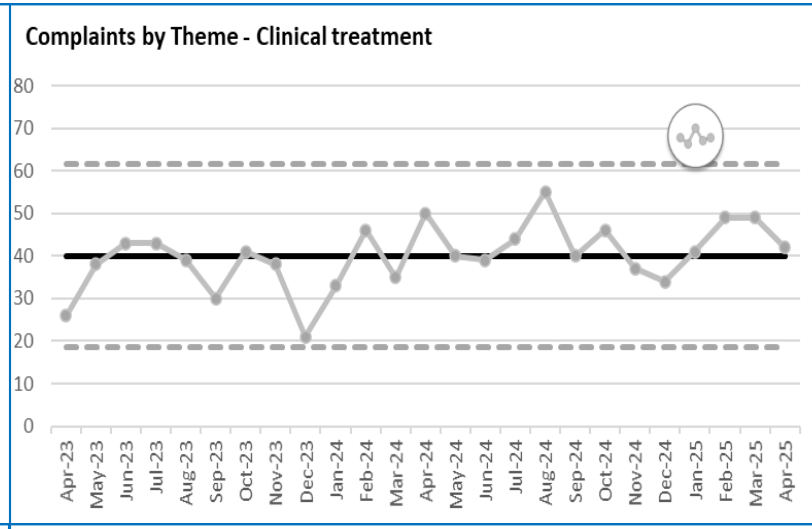
Anticipated impact and timescales for improvement:
Improvement in timeliness of responses.
Evidence of early involvement and support from Divisions/Specialities with complainants

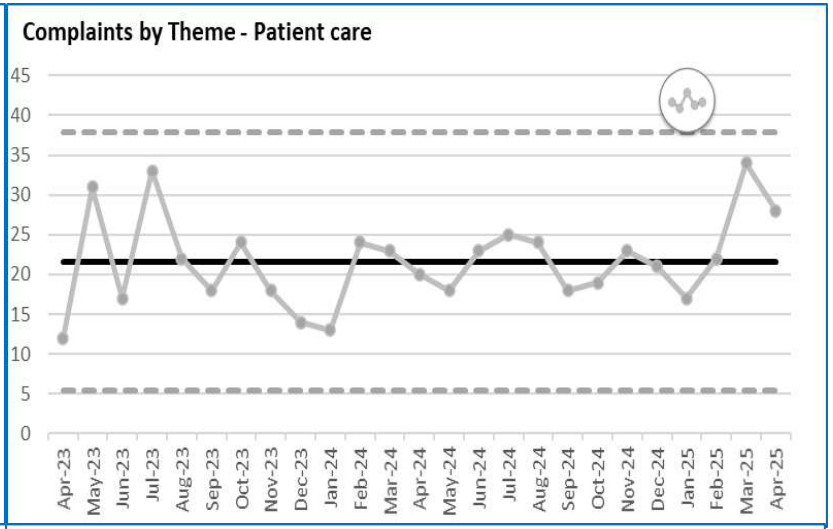
Recovery dependencies:	Capacity within Divisional teams due to high levels of clinical activity. Delays in accessing records to respond fully to complaints

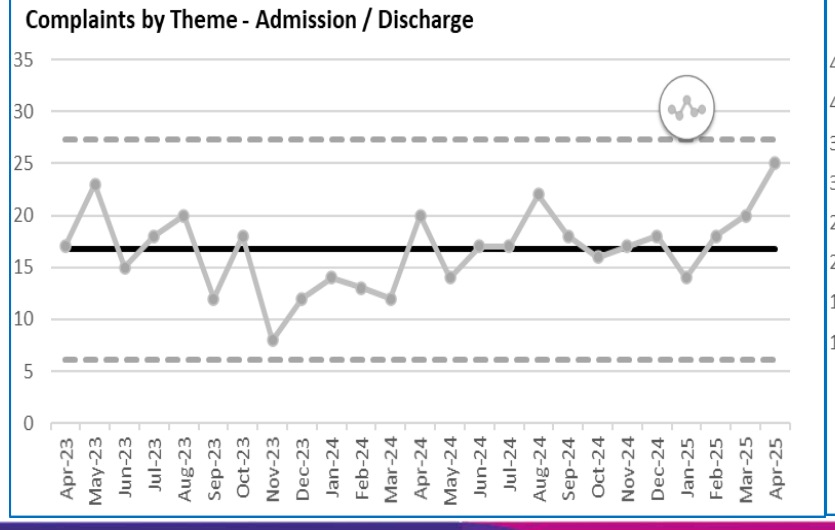
Complaints by theme – Top 6

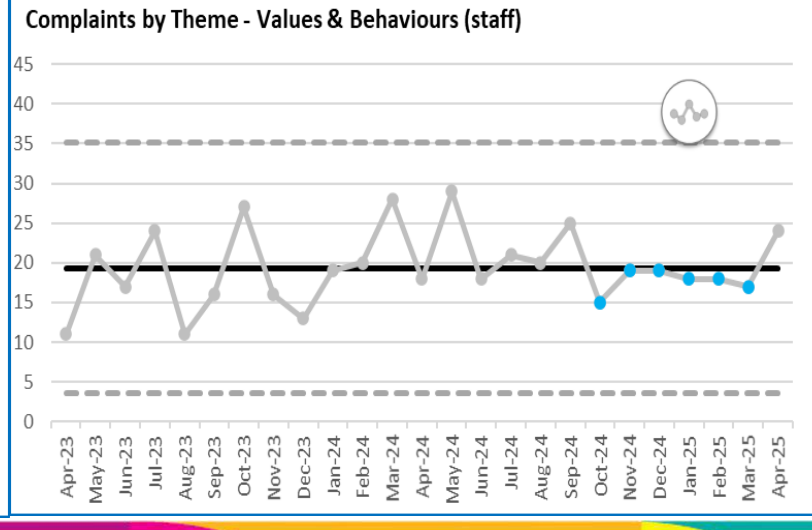
The Shrewsbury and Telford Hospital NHS Trust

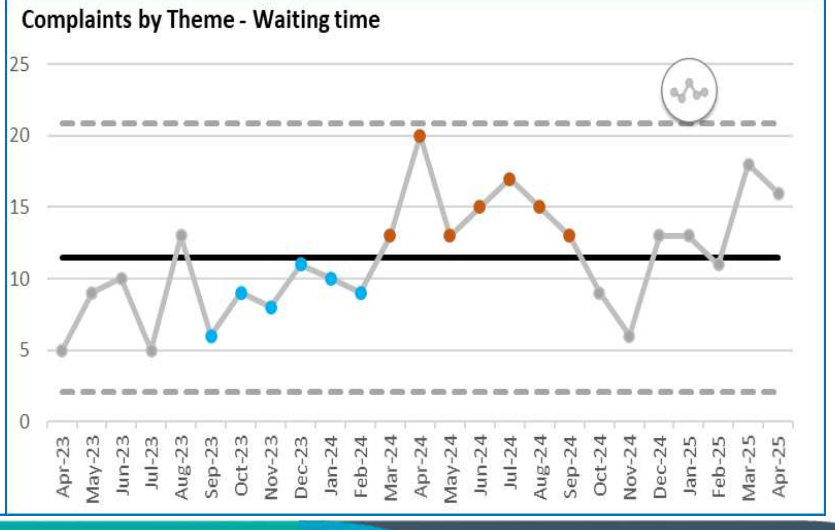












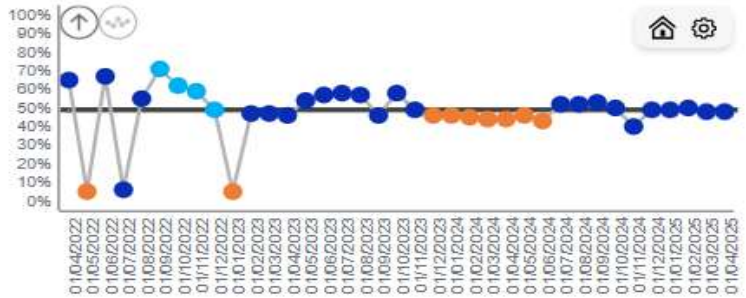
Quality - Patient Experience - Learning from Experience

The Shrewsbury and Telford Hospital NHS Trust
Partnering · Ambitious Caring · Trusted

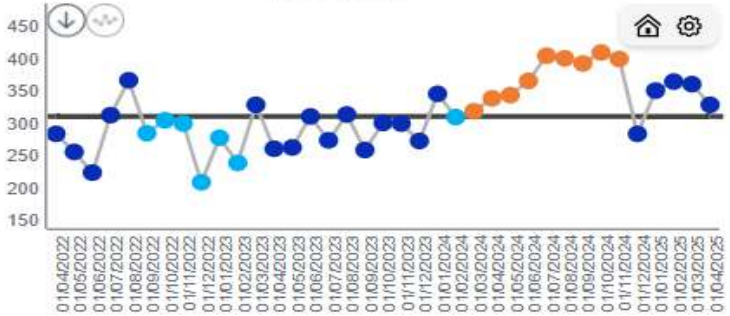
End of Life Care

	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025
Complaints - % Responded to within agreed timeframe based on month response due	44	44	46	43	52	52	53	50	40	49	49	50	48	48
PALS contacts	320	340	345	367	406	402	394	411	401	285	352	366	362	330
Complaints by Theme - Staff	70	70	67	63	79	55	73	57	67	59	74	66	76	79
Re-opened complaints upheld	0	0	0	0	0	0	0	0	1	0	0	1	0	0
Compliments Received	151	120	81	121	129	91	94	122	137	87	91	81	112	105
Friends and Family Test % recommenders	91.0	89.1	88.4	89.7	93.4	93.0	97.9	92.8	92.7	88.8	91.7	98.1	97.6	97.1

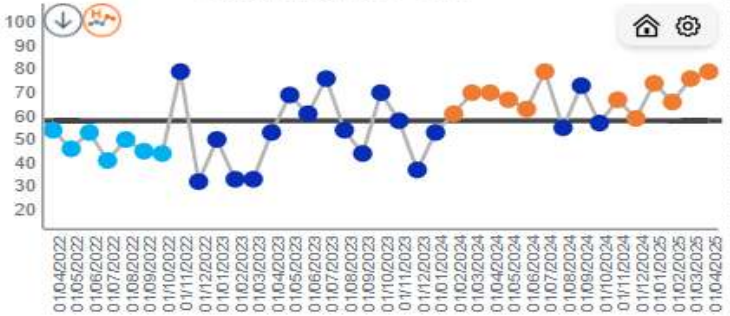
Complaints - % Responded to within agreed timeframe based on month response due



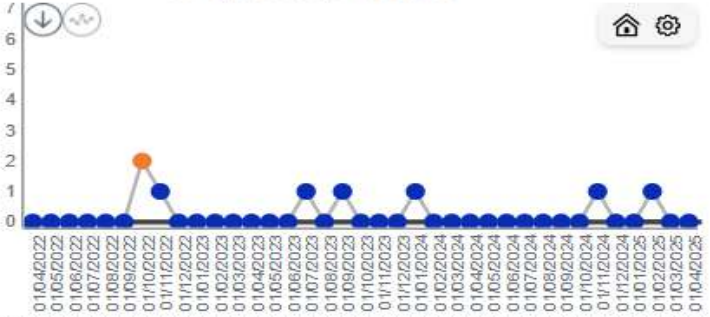
PALS contacts



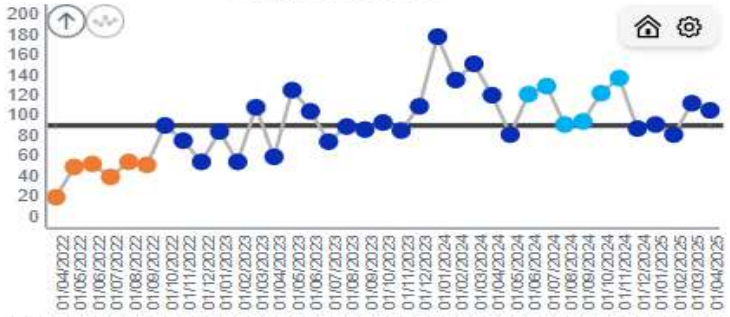
Complaints by Theme - Staff



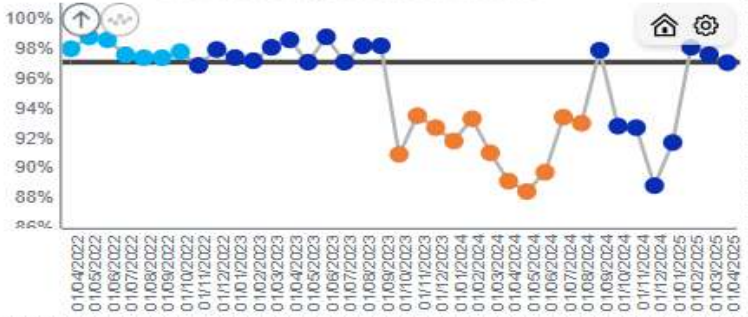
Re-opened complaints upheld



Compliments Received

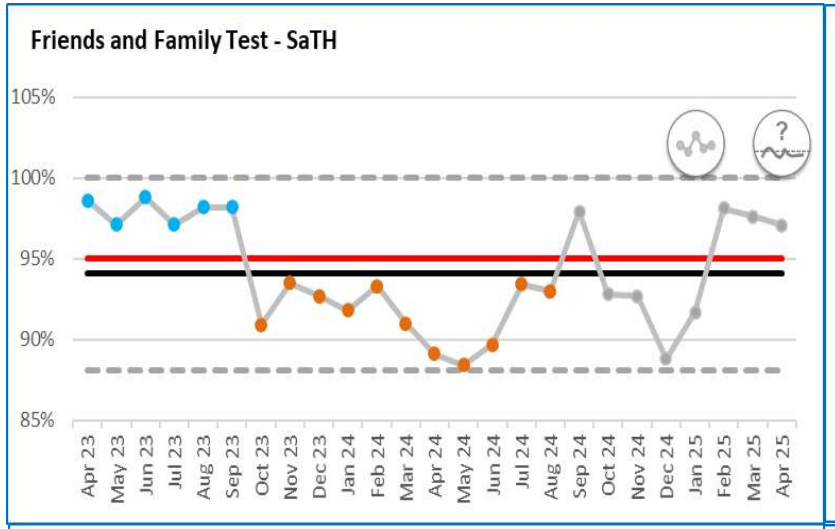


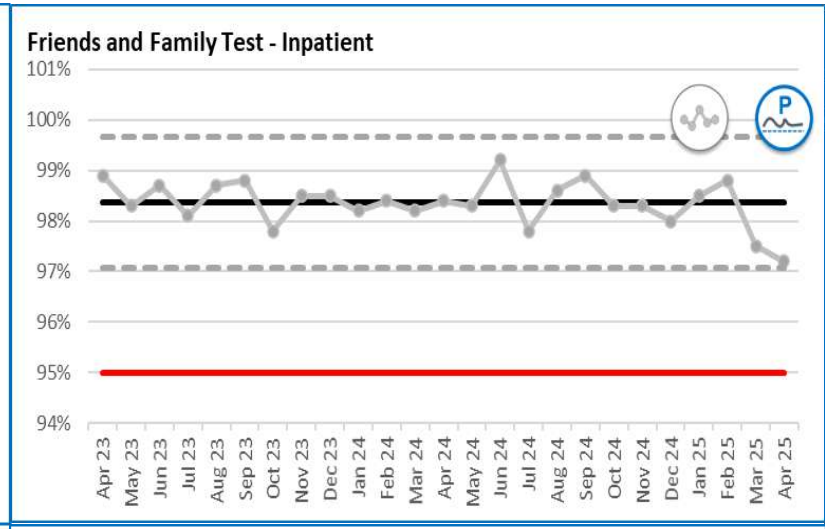
Freinds & Family Test % recommenders

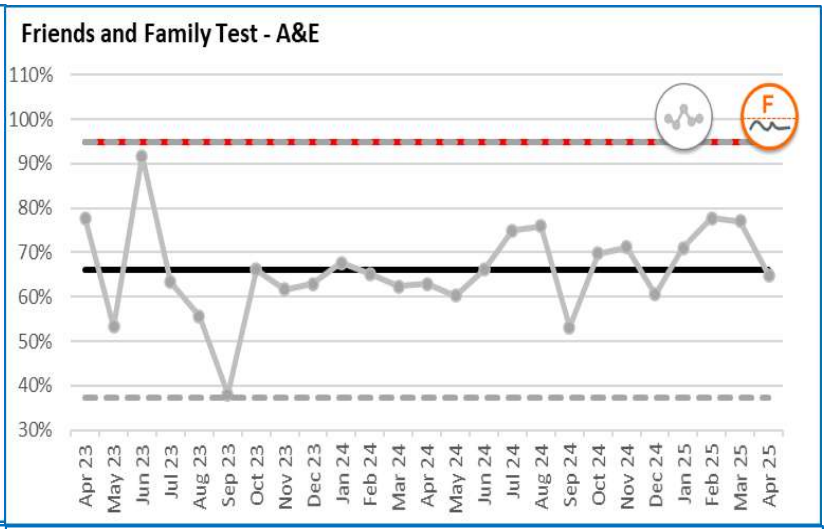


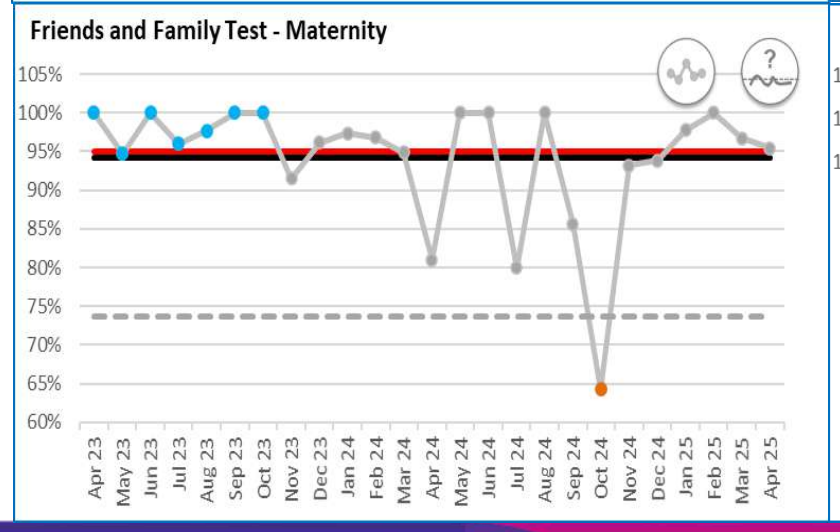
Friends and family test

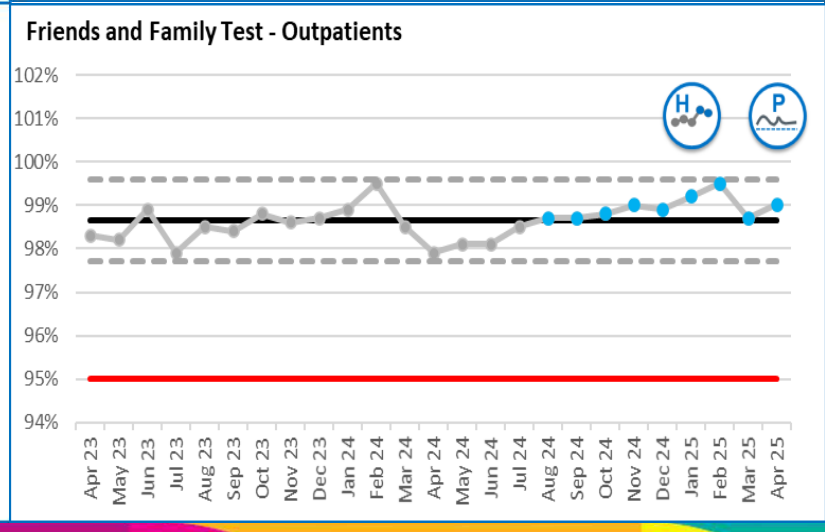
The Shrewsbury and Telford Hospital NHS Trust

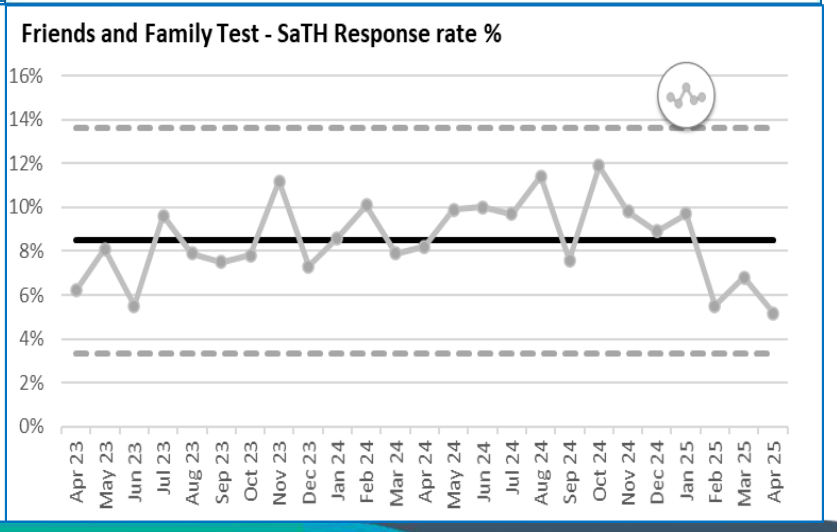




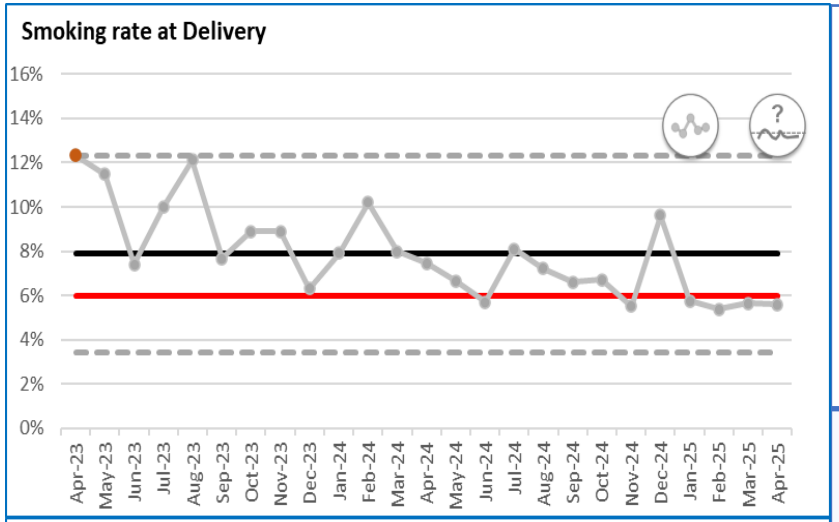


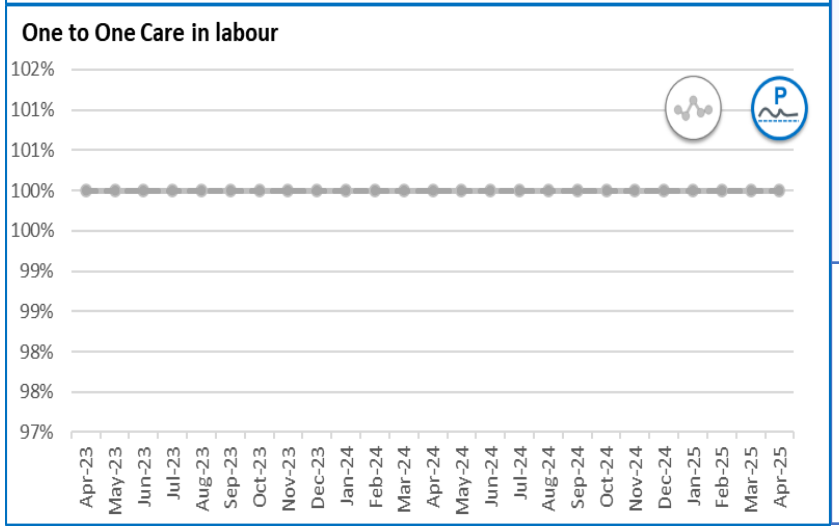






Maternity





Summary:
Smoking at time of Delivery (SATOD) was maintained below Government target of 6% for Q4. Quarter 1 has started with a 5.6% SATOD rate in April, which exceeds Government expectation.
The overall SATOD rate for YTD 2024/25 was 6.7% which is a 2.6% decrease on the previous years figure making this the lowest ever SATOD rates seen in the local Maternity population. Accurate recording of SATOD status is being closely monitored by the Healthy Pregnancy Support Service (HPSS) team to ensure accurate data is being recorded.

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.

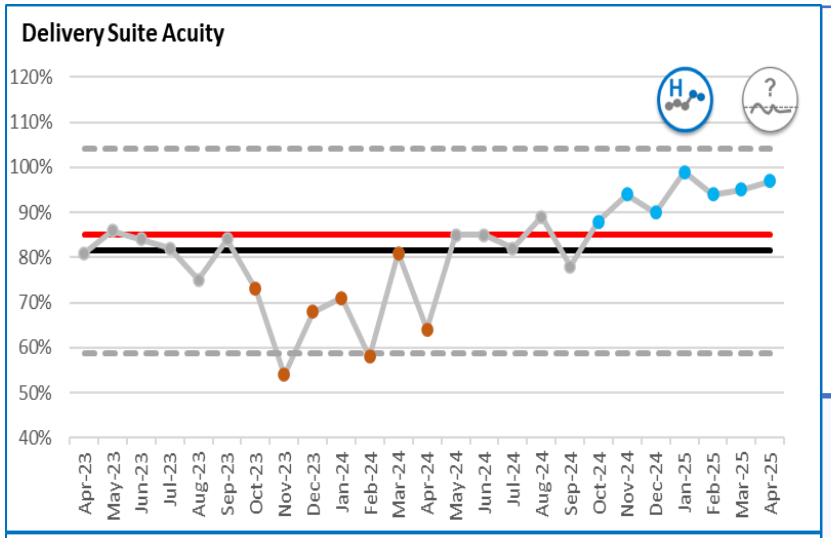
Recovery actions:
Continue to further decrease SATOD throughout 2025.
Continue to work towards and possibly exceed Government target of 6%.
The team are now able to refer family members for support to Telford Council or Shropshire Social prescribing service where Nicotine Replacement Therapy is now being offered.

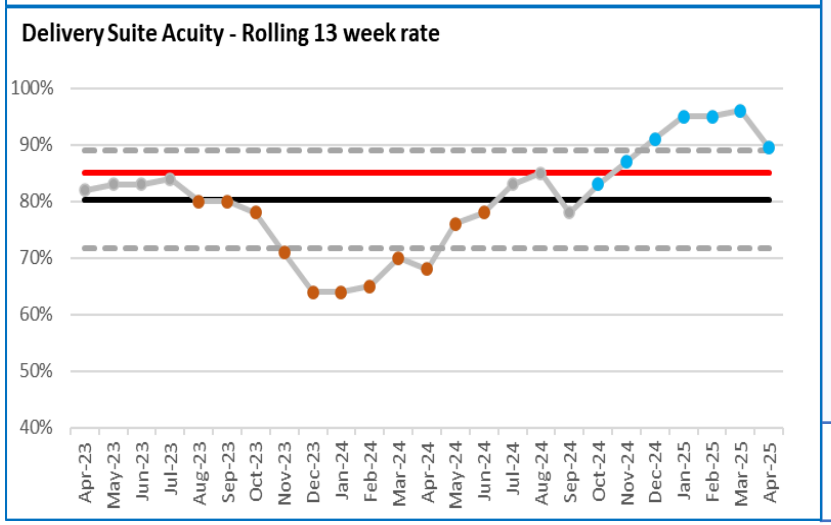
Anticipated impact and timescales for improvement:
Continue to map and target areas of deprivation and provide support for pregnant women, whilst referring family members to local smoking cessation services.
As per Saving Babies Lives version 3, all staff to discuss smoking cessation very brief advice (VBA) 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 continues to be maintained above the National target above 85% and has been consistently above 90% for the last seven months with April acuity of 97%. The service continues to experience high levels of unavailability (>33 wte against template) as a result of parenting leave and sickness. The midwifery workforce lead continues to maintain oversight with proactive monitoring around sickness absence and a robust recruitment and retention process. The high unavailability has been mitigated with recruitment over the establishment and when required clinical support from Specialist midwives. Specialist Midwives maintain a level of clinical contact which is in accordance with their individual roles.

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. Specialist roles continue to support the clinical workforce.

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

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The Shrewsbury and Telford Hospital NHS Trust

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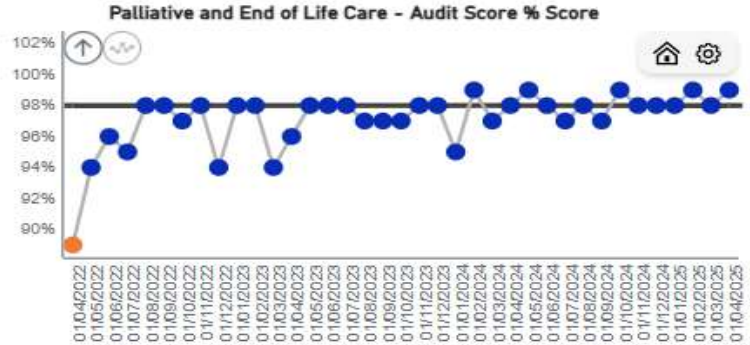
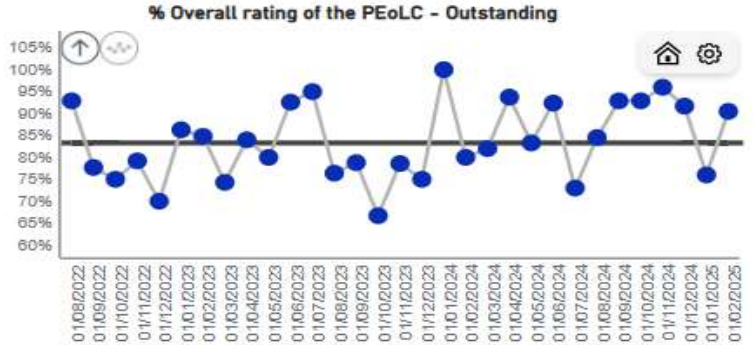
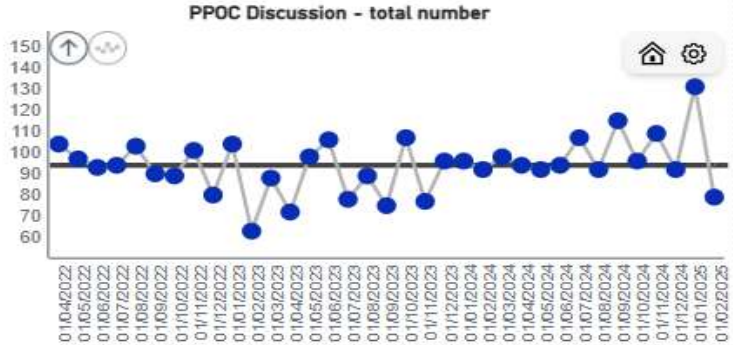
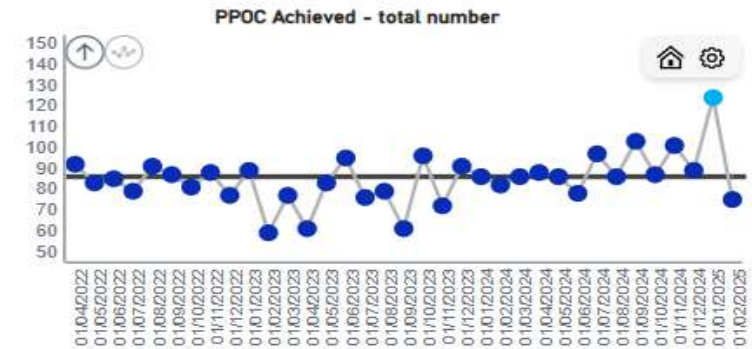
Learning from Experience

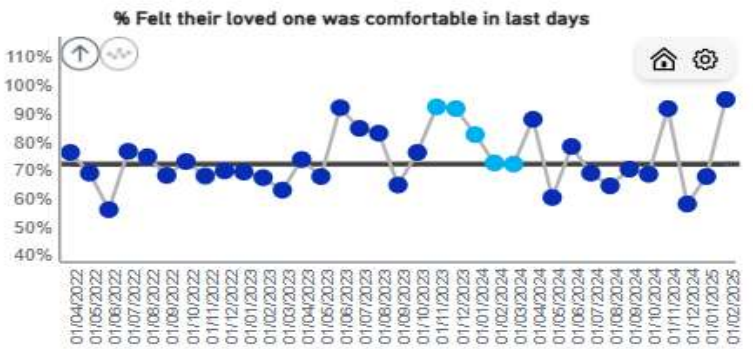
	Dec-2023	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025
Palliative and End of Life Care - Audit Score % Score	98	95	99	97	98	99	98	97	98	97	99	98	98	98	99	98	99
% Overall rating of the PEoLC - Outstanding	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	76.0	90.5		
PPOC Discussion - total number	96	96	92	98	94	92	94	107	92	115	96	109	92	131	79		
PPOC Achieved - total number	91	86	82	86	88	86	78	97	86	103	87	101	89	124	75		
% Felt their loved one was comfortable in last days	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	68.0	95.2		
Palliative/End of Life Care - Nursing QA Audit	297	284	295	291	268	266	275	274	266	278	262	256	195	215	207	207	253

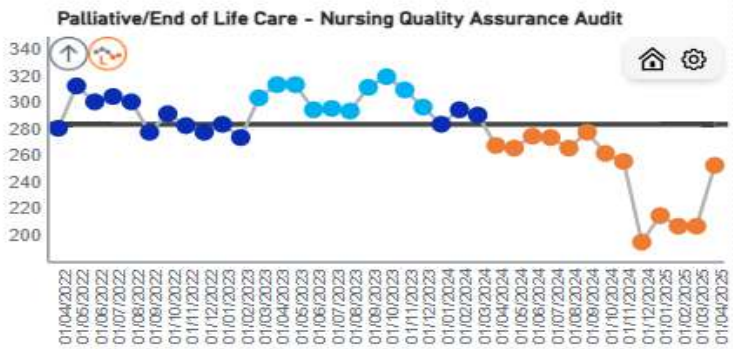










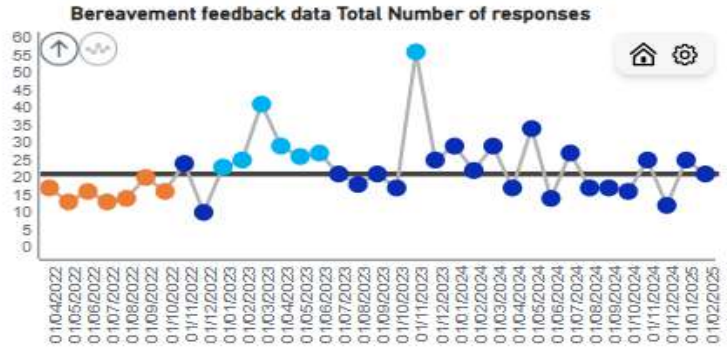


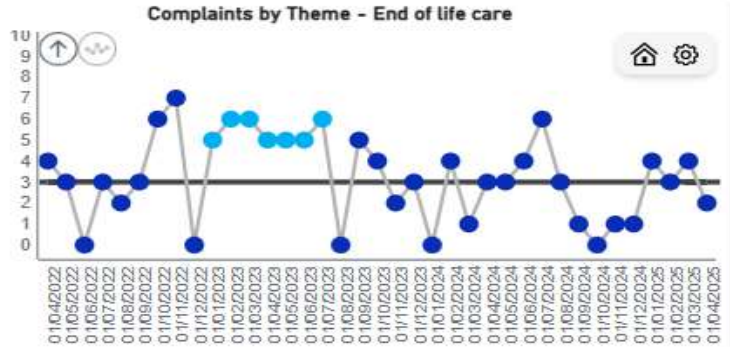
Quality - Patient Experience - End of Life Care

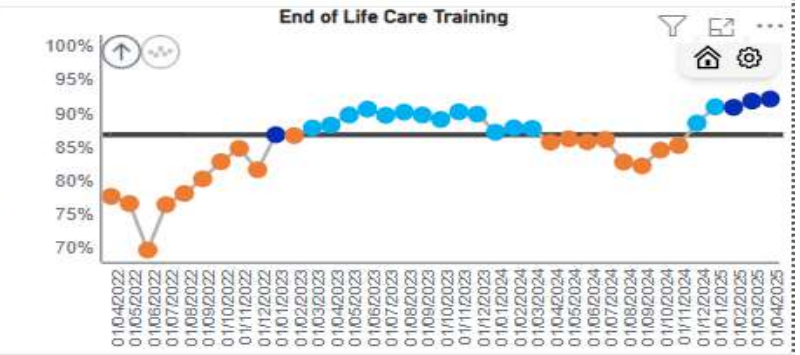
Page 1

Learning from Experience

	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	Mar-2025	Apr-2025
Bereavement feedback data - Total Number of responses	25	29	22	29	17	34	14	27	17	17	16	25	12	25	21		
Complaints by Theme - End of life care	3	0	4	1	3	3	4	6	3	1	0	1	1	4	3	4	2
End of Life Care Training	89.95	87.24	87.89	87.81	85.74	86.25	85.80	86.15	82.79	82.21	84.57	85.25	88.61	91.03	90.95	91.89	92.20







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 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 effect 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.

The Shrewsbury and Telford Hospital NHS Trust

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)	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Trend
Responsiveness	ED - 4 Hour Performance (SaTH Type 1 & 3) %		78% Mar'26	50.2%	48.6%	52.2%	54.8%	55.9%	52.4%	52.4%	50.9%	50.4%	52.4%	52.7%	53.1%	47.1%	49.7%	
	ED - 4 Hour Performance (All Types inc MIU) %		-	-	59.2%	61.9%	64.7%	65.0%	62.2%	61.5%	59.7%	58.7%	61.8%	61.5%	61.9%	56.9%	59.4%	
	ED - 12 Hour Trolley Breaches	R	0	0	829	647	560	546	587	1060	1562	1494	1316	1130	1390	1362	1379	
	Number of Ambulance Arrivals	R	-	-	3071	2963	3096	3404	3107	3203	3052	3103	3190	2945	3462	3309	3496	
	Average ambulance handover time (ED and non-ED)		-	-	01:14:13	01:04:33	00:51:46	00:40:50	01:03:14	01:18:25	01:34:56	01:59:52	01:37:56	01:13:21	01:13:07	01:34:14	00:56:45	
	Ambulance Delays > 15 minutes	R	-	-	2391	2553	2675	2595	2624	2744	2646	2626	2645	2478	2872	2812	2772	
	Ambulance Delays > 15 minutes %	R	0%		77.9%	86.2%	82.4%	76.2%	84.5%	85.7%	86.7%	84.6%	82.9%	84.1%	83.0%	85.0%	79.3%	
	Ambulance Delays > 60 minutes %	R	0%		36.2%	30.3%	23.6%	17.7%	32.4%	36.4%	40.8%	45.9%	38.7%	34.5%	33.0%	38.4%	25.7%	
	ED activity (total excluding planned returns)		-	13886	13773	12940	12865	12401	12364	13067	12921	13308	11813	11533	13984	13251	13858	
	ED activity (type 1 excluding planned returns)		-	11245	10927	10489	10550	10150	10104	10603	10535	10433	9505	9158	11146	10749	11110	
	Total Emergency Admissions from A&E		-	-	3076	3054	3345	3281	3241	3469	3492	3445	3247	2899	3363	3142	3345	
	% Patients seen within 15 minutes for initial assessment		-		47.7%	54.1%	60.0%	64.8%	59.8%	58.9%	52.9%	51.6%	62.7%	61.2%	57.4%	54.8%	60.8%	
	Average time to initial assessment (mins)		15 Mins	15	26.9	20.8	16.9	16.3	18.0	19.3	23.5	25.0	16.9	19.2	19.0	22.5	17.6	
	Average time to initial assessment (mins) Adults		15 Mins	15	27.7	21.8	17.1	17.2	18.9	20.8	25.1	26.2	17.5	20.7	19.9	24.6	18.4	
	Average time to initial assessment (mins) Children		15 Mins	15	24.1	17.5	16.0	12.0	14.3	15.4	19.9	21.3	15.0	14.3	16.3	15.1	14.7	
	Mean Time in ED Non Admitted (mins)		-	215	335	302	269	259	288	292	310	325	320	307	314	345	321	
	Mean Time in ED admitted (mins)		-	500	1250	1148	939	889	1113	1106	1219	1337	1318	1252	1179	1332	1174	
	Percentages of attendances in A&E over 12 hours - Type 1		-	22.27%	24.11%	21.60%	19.84%	20.18%	23.37%	23.16%	24.76%	25.88%	24.46%	23.12%	23.25%	23.86%	23.4%	
	No. Of Patients who spend more than 12 Hours in ED - Type 1		-	2504	2635	2266	2093	2048	2361	2456	2608	2700	2325	2117	2591	2565	2604	
	Bed Occupancy Rate - G&A (SitReps)		92%	-	95.5%	94.6%	93.5%	93.4%	94.5%	94.1%	95.3%	94.8%	95.2%	95.7%	95.7%	95.2%	94.4%	
	Diagnostic Activity Total - All commissioners			-	20617	19745	22698	21496	22212	23688	22369	22160	23202	22623	24212	24021	24580	
	Diagnostic Total Waiting List - All commissioners			-	14898	15450	16440	16714	18482	17403	18374	18055	17493	16509	15738	13866	12511	
	Diagnostic 6 Week Wait Performance %		99% Mar'26	-	68.9%	63.4%	61.5%	57.8%	59.4%	59.1%	57.7%	53.6%	56.6%	71.7%	78.2%	78.5%	79.4%	
	Diagnostic 6+ Week Breaches		0	-	4627	5653	6323	7056	7509	7122	7771	8376	7524	4676	3437	2982	2577	
	Total Non Elective Activity - All		-	5372	5701	5380						Not Available						
	Total elective IPDC activity - All		-	6519	5564	5505						Not Available						
	Total outpatient attendances - All - SaTH		-	50214	51329	47327						Not Available						
	Number of episodes moved or discharged to PIFU		-	2735	1864	1693	2223	1964	2247	2692	2378	1978	2299	2090	2300	2196	2203	
	RTT Incomplete 18 Week Performance		65% Mar'26	50.63%	51.4%	49.1%	49.6%	44.6%	42.3%	47.3%	48.5%	46.3%	48.2%	48.9%	48.1%	49.6%	53.0%	
	RTT Waiting list - Total size	R	-	-	49409	53280	55492	56163	53074	53214	53402	51652	49827	48383	46775	46242	44005	
	RTT Waiting list - English only		-	41317	44042	47563	49625	50364	47529	47713	47989	46254	44411	43218	41669	41238	39042	
	RTT 52+ Week Breaches (All)	R	0	-	3756	4656	4450	4614	4215	3666	3641	3557	3036	2493	1933	1778	1570	
	RTT 52+ Week Breaches - English only		-	1594	3321	4131	3944	4088	3705	3118	3067	2971	2392	1987	1512	1312	1170	
	RTT 65+ Week Breaches (All)		-	-	921	1330	1184	1130	662	503	538	396	374	173	115	166	130	
	RTT 65+ Week Breaches - English only		0	28	824	1185	1025	948	508	327	350	204	166	84	26	18	5	
	RTT 78+ Week Breaches (All)	R	0	0	1	2	2	65	64	59	83	62	50	25	29	34	26	
	RTT 78+ Week Breaches - English only		0	0	0	0	1	49	49	8	19	16	4	0	4	1	0	
	RTT 104+ Week Breaches (All)	R	0	0	1	1	1	1	1	1	0	0	0	0	1	4	3	
	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	75% Mar'26	50.1%	62.3%	56.9%	53.1%	53.3%	51.2%	55.4%	64.0%	63.3%	52.9%	54.7%	66.6%	56.6%	-	
	Cancer 31 Day First Treatment		96%	90.0%	91.6%	79.8%	81.8%	84.7%	85.5%	88.3%	89.6%	92.2%	88.5%	93.7%	96.6%	90.5%	-	
	Cancer 28 Day Faster Diagnosis - combined	R	80% Mar'26	65.3%	68.6%	67.0%	70.5%	67.6%	67.6%	70.4%	69.2%	66.7%	57.5%	65.1%	62.5%	68.6%	-	
	Theatre productivity			85%	79%	79%	78%	78%	77%	78%	80%	79%	80%	79%	78%	79%	79%	

Operational Summary

The Shrewsbury and Telford Hospital NHS Trust

SaTH ED 4-hour performance (type 1 & type 3) is showing common cause variation. Ambulance arrival in month continues has moved from common cause concerning variation to special cause concerning variation. SaTH Average time to initial assessment (IA) (mins) is showing special cause improving variation. Paediatric IA averaged 15 mins in May. Adult IA averaged 18 minutes in May. The number of patients who spend more than 12 hours in ED remains in special cause concerning variation.

RTT - The Trust reported 0 x 78-week breaches at the end of May 2025 and 5 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 May was 79%.

Cancer - The Trust is being monitored in Tier 1 for Cancer. The combined backlog as at the end of May 2025 was 375 (increase from 354 at the end of April). The validated Apr position for FDS was 68.6% (previous month was 62.5% and against a national target of 80%), 31-day standard was 90.5% (previous month was 96.6% against a national target of 96%) and 62-day standard was 56.6% (previous month was 66.6% against a national target of 75%). Predicted performance for May is expected to be 72.8% FDS, 84.8% for 31-day and 62.2% for 62-day.

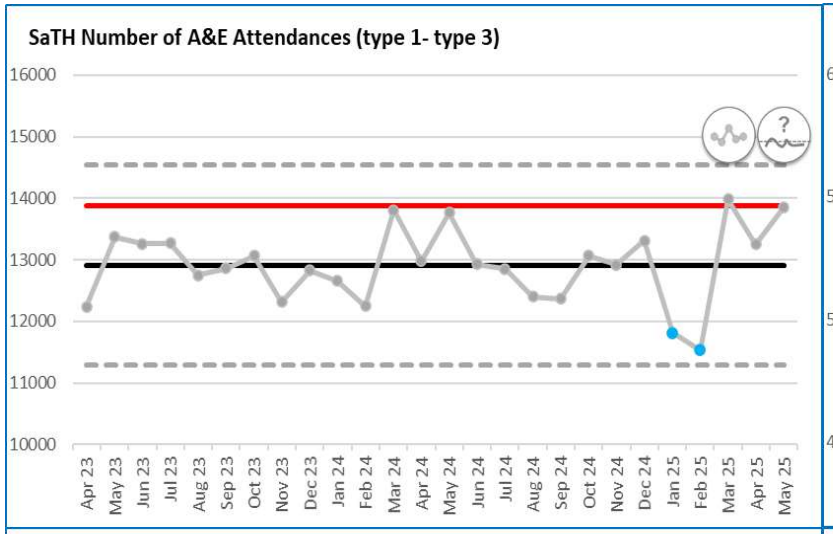
DM01 - The submitted DM01 position for May was 79.4%. Radiology turnaround delays are being maintained. MRI TATs from referral to report are:- USC 4-6 weeks, urgent 9-10 weeks, and routine tests at 13-14 weeks. CT reporting times have improved ; USC 2 weeks, urgent 2 weeks and routine at 3-4 weeks (CTVC TATs for USC has remained at an improved position of 3-4 weeks). NOUS reporting times are; USC 2-3 weeks, urgent 8 weeks and routine at 10 weeks. Sickness and retirement in NOUS and Radiologist workforce continue to restrict capacity, with reduced resilience during periods of sickness or annual leave.

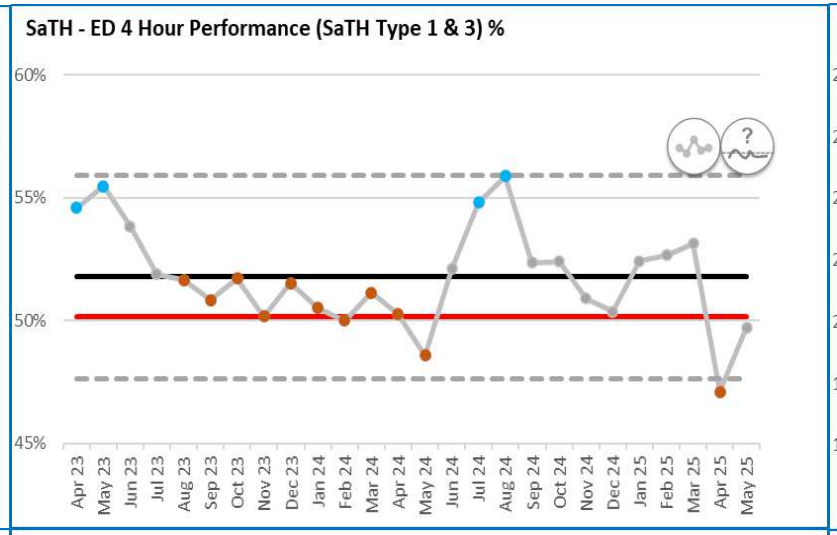
Key actions

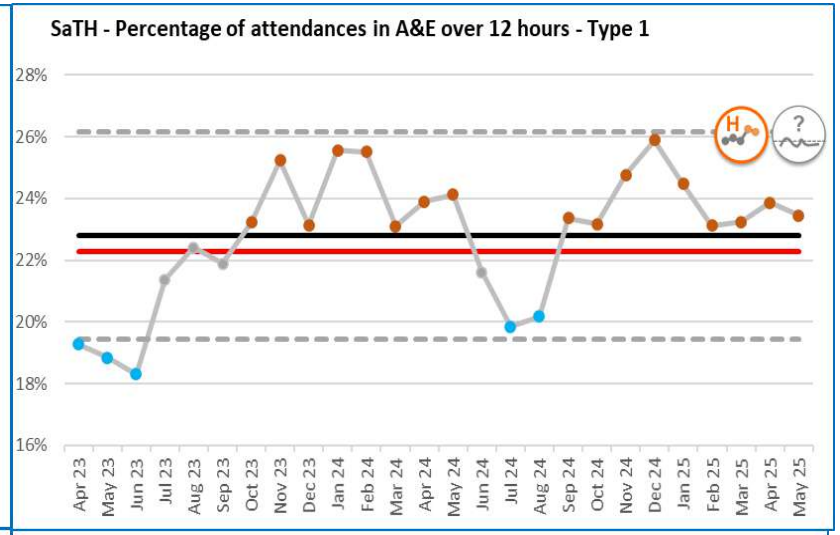
- Progression of actions within all Tier 1 workstreams
- Test of change in Minors, focussing on medical input and AMA, to improve flow
- Mobilising additional independent Sector provider activity and mutual aid for elective and cancer recovery
- Phase one cancer improvement plan launched
- Outpatient productivity project continues seeing improved booking utilisation whilst now moving onto utilisation of our outpatient estate
- Elective recovery programme developed to focus on priority areas of transformation for 25/26
- Validation sprint in process – leading trust in Midlands region

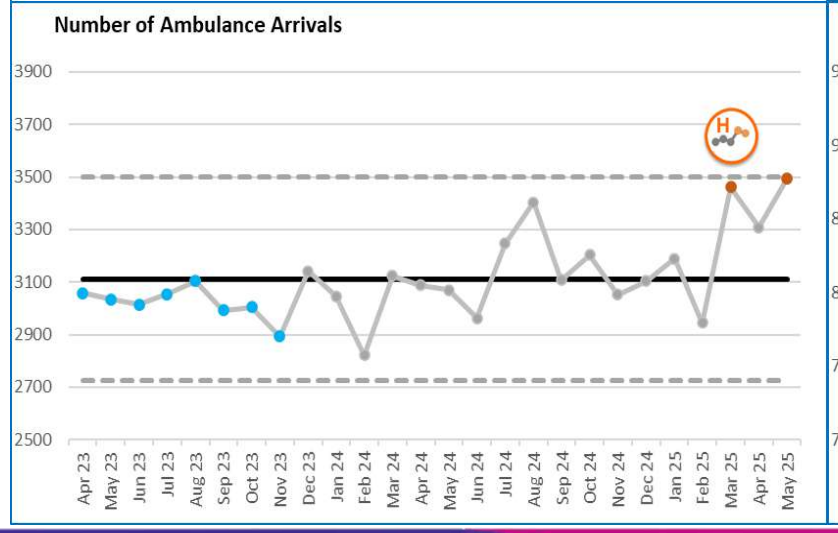
Operational – Emergency Care

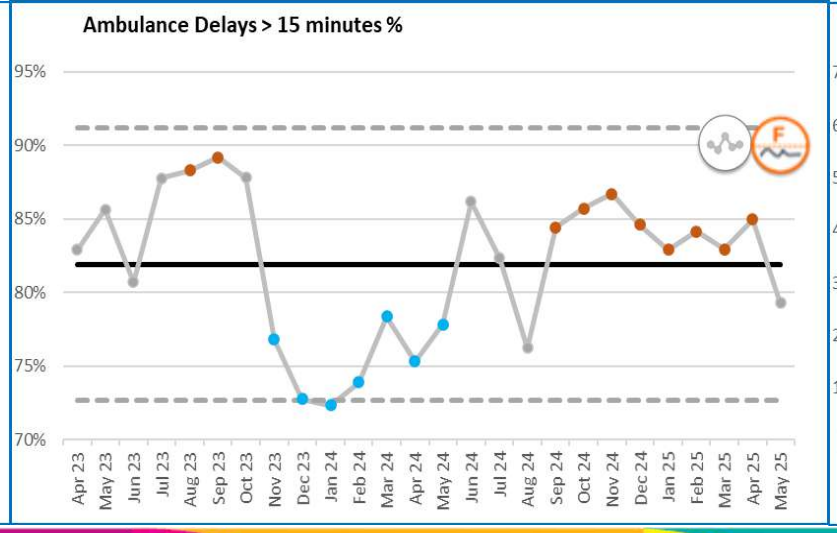
The Shrewsbury and Telford Hospital NHS Trust

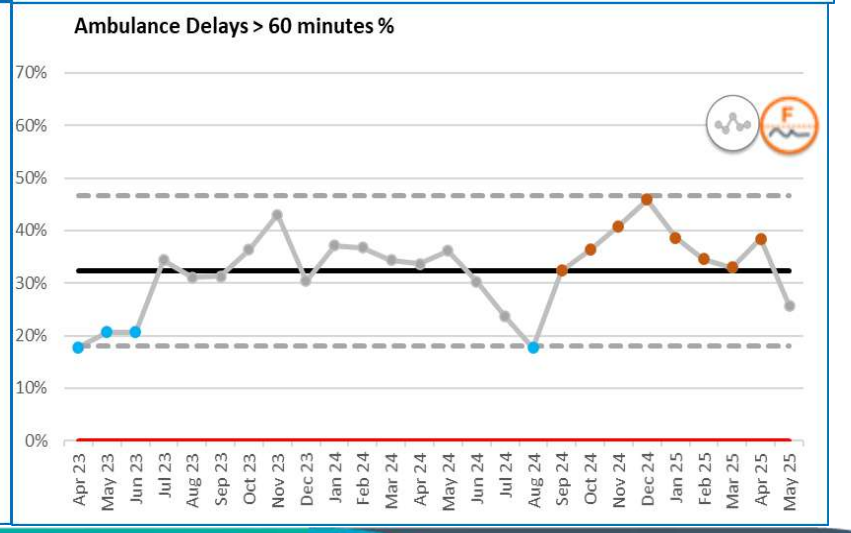












Operational – Emergency Care

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 – driven by improvement of Type 3 performance by 4.5%
- SaTH number of patients who spend more than 12 hours in ED is showing special cause concerning variation
- Number of ambulance arrivals to SaTH has again moved from common cause variation to special cause concerning variation
- Ambulance delays in handover of patients to SaTH premises > 60 minutes (%) has moved to common cause variation
- SaTH Average time to initial assessment (mins) continues to demonstrate special cause improving variation**.** Paediatric IA averaged 15 mins in May. Adult IA averaged 18 minutes in May

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; Test of change wc 9th June supported by ECIST and GIRFT; implementation of 10 extra acute medicine beds at PRH August 25; 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:

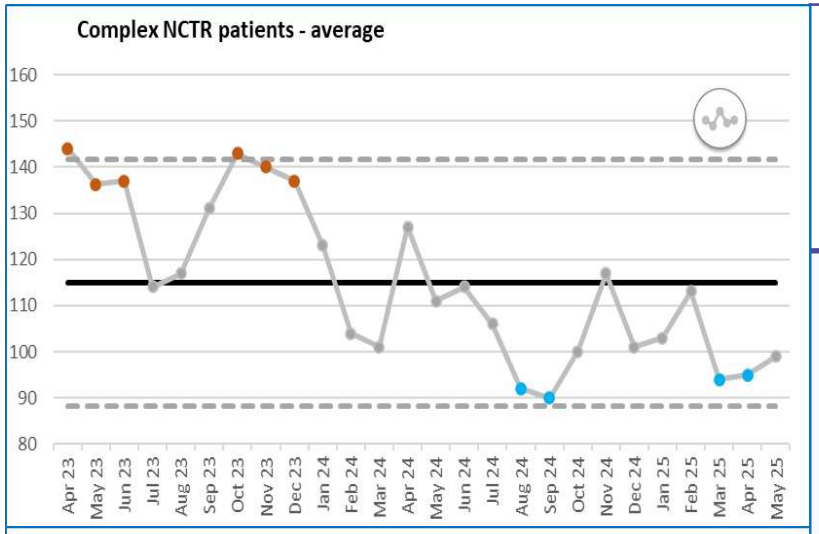
Progress reported monthly through UEC Flow improvement group to Performance Assurance Committee (PAC) and system UEC meeting.

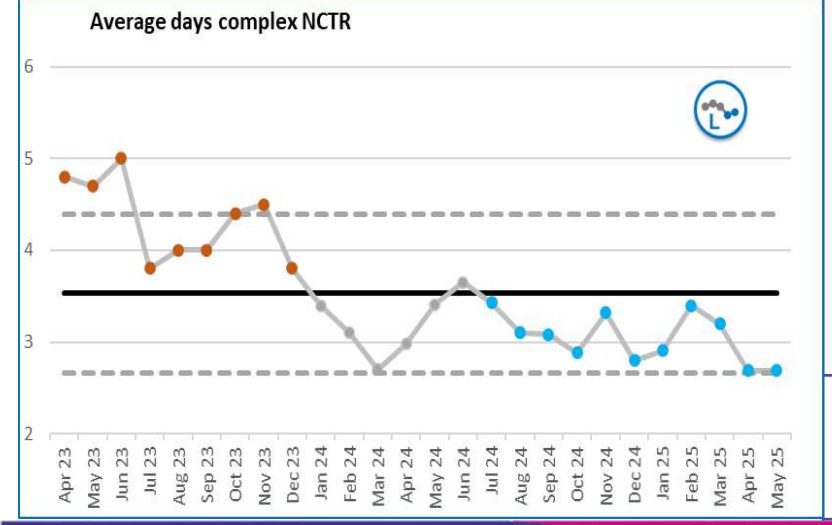
Progress reported monthly through Urgent and Emergency Care Transformation Committee (UECTAC) and weekly cross Divisional metrics meeting.

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

Operational – Patient Flow

The Shrewsbury and Telford Hospital NHS Trust





Summary:

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

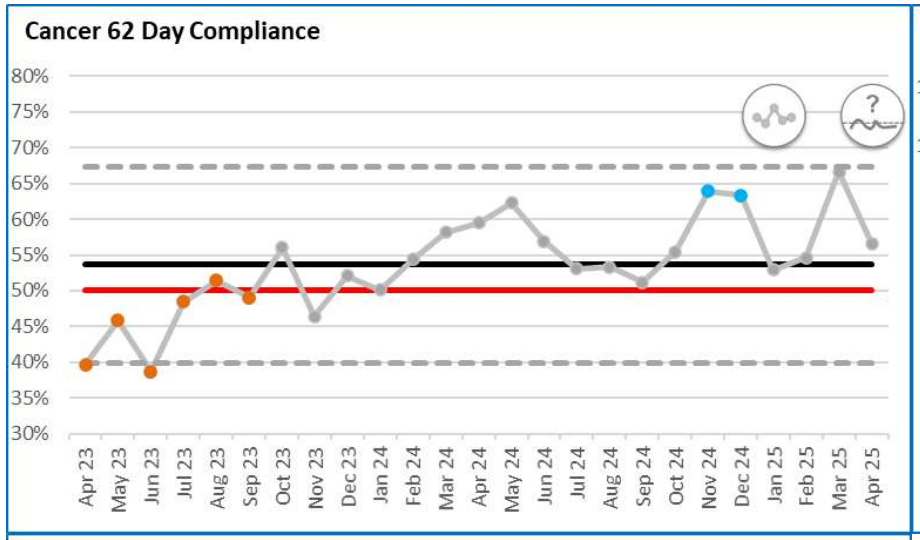
- **Recovery actions:**
- Weekly focus on LoS of patients with criteria to reside
- Focus on accurate Estimated Discharge Date (EDD) to refer into Community Transfer Hub (CTH) 5 days prior to EDD to enable CTH to work up patient for discharge on EDD
- Improvement programme focusing on process for out 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

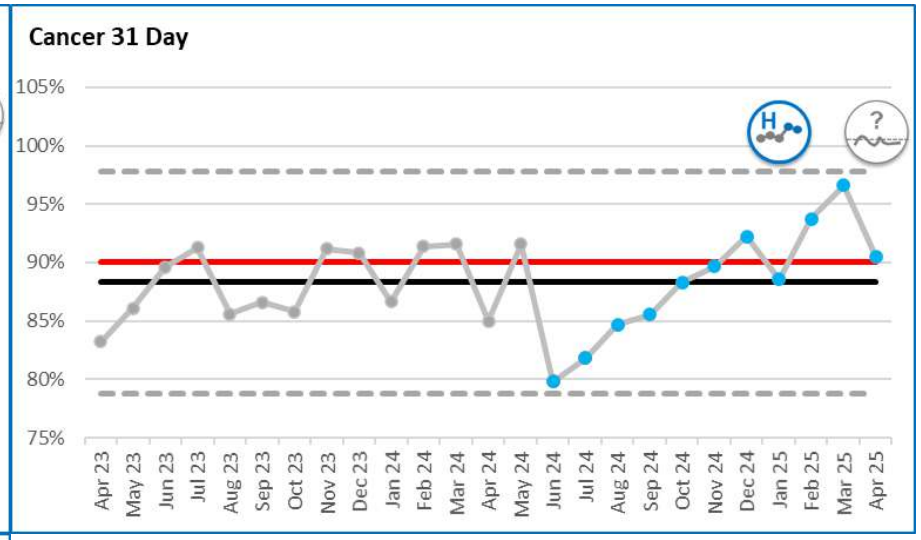
Anticipated impact and timescales for improvement:

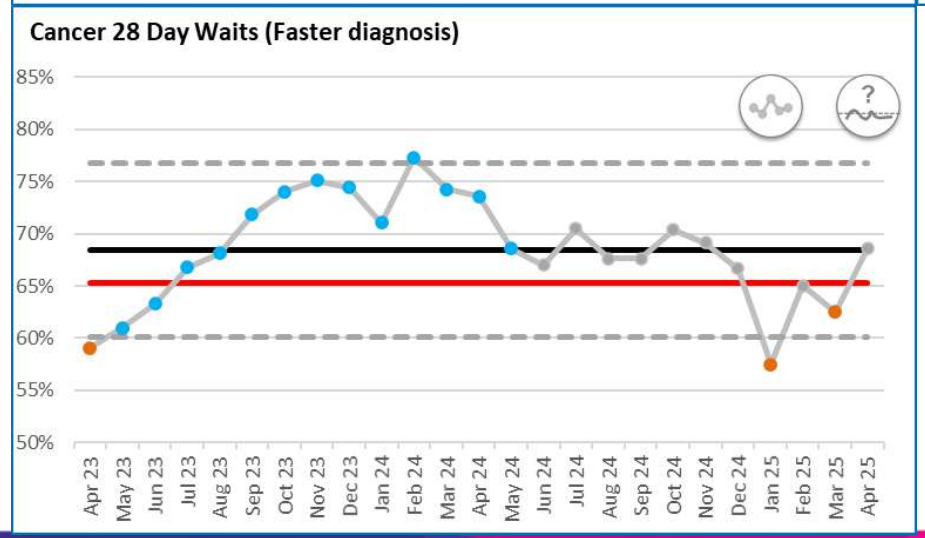
Progress reported monthly through UEC Flow improvement group to Performance Assurance Committee (PAC) and system UEC meeting.

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







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 May 2025 was 375 (increase from 354 at the end of April). The validated Apr position for FDS was 68.6% (previous month was 62.5% and against a national target of 80%), 31-day standard was 90.5% (previous month was 96.6% against a national target of 96%) and 62-day standard was 56.6% (previous month was 66.6% against a national target of 75%). Predicted performance for May is expected to be 72.8% FDS, 84.8% for 31-day and 62.2% for 62-day.

Recovery actions:
The Trust remains in Tier 1 NHSE monitoring due to the under delivery against forecast trajectories in 24/25.

Additional cancer improvement expertise and senior leadership oversight is in place to drive recovery. A cancer improvement plan has been launched to support recovery and delivery of the 25/26 plan. Phase one of the plan is focussed on three workstreams: cancer governance, cancer diagnostic turnaround times and three high priority tumour sites Lower GI, Urology and Gynaecology. Early signs of improvement are clear with FDS performance improving and overachieving on 25/26 plan. In addition, external non-recurrent funding from WMCA and NHSE has been received to support improvement in performance in 25/26.

Clinical and operational workforce constraints continue most notably in Oncology and Max Fax pathways. Whilst oncology outpatient waiting times have improved, time to radiotherapy is currently a challenge. 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. The fragility of the Max Fax pathway remains a risk, and several actions are being taken to mitigate, including partnership working with neighbouring Trust and insourcing additional capacity.

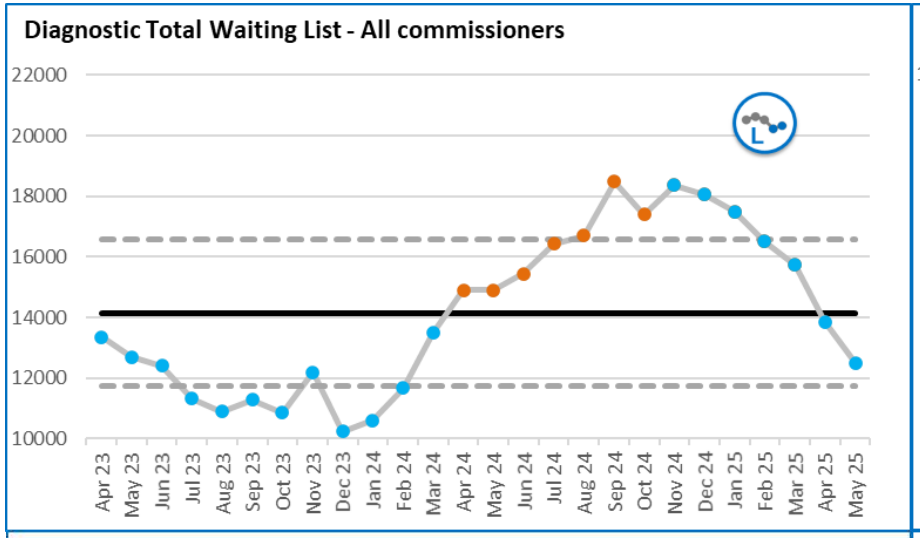
Anticipated impact and timescales for improvement:

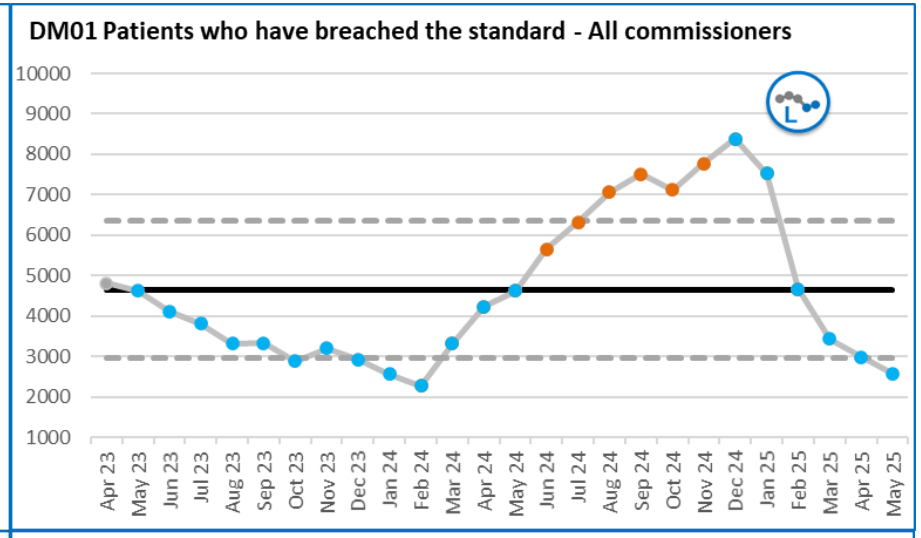
WMCA funding of approx. 1.7 million allocated to drive diagnostic cancer turnaround times for 25/26.

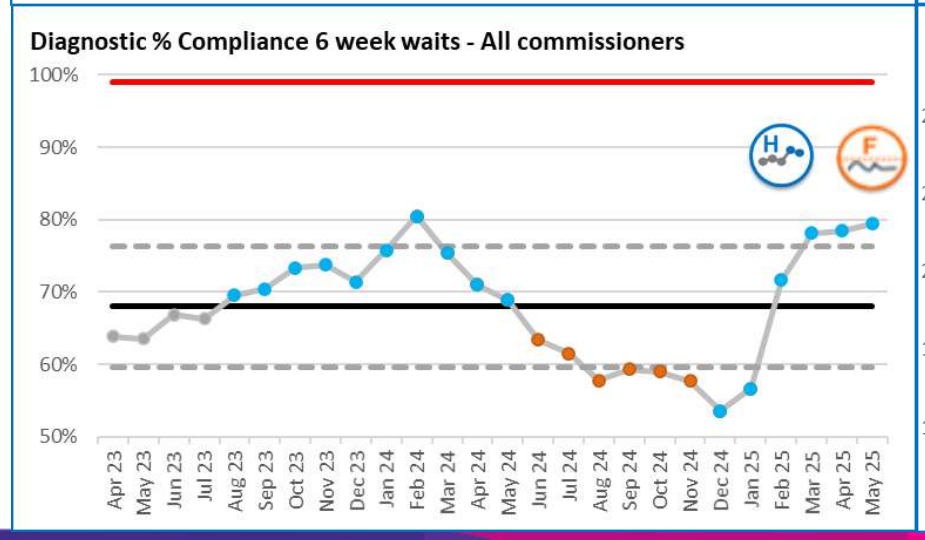
Recovery dependencies:	Transfer of Urgent Suspected Cancer referrals from Cancer Services to Patient Access Centre. Risks of delays to booking during changeover period and delays in patients being added to the PTL via Somerset Cancer Register.

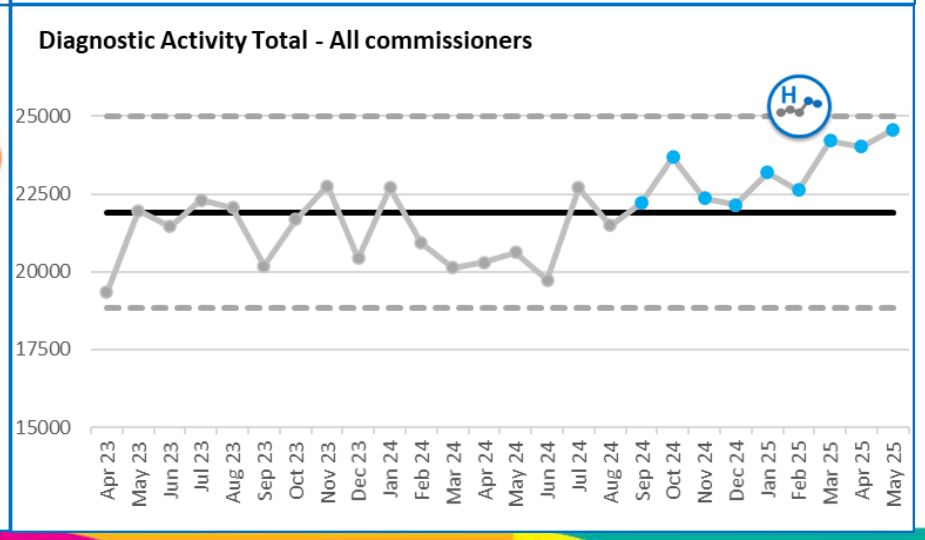
Operational – Diagnostic waiting times

The Shrewsbury and Telford Hospital NHS Trust









Operational – Diagnostic waiting times

The Shrewsbury and Telford Hospital NHS Trust

Summary:
The submitted DM01 position for May was 79.4%.
Radiology turnaround delays are being maintained. MRI TATs from referral to report are:- USC 4-6 weeks, urgent 9-10 weeks, and routine tests at 13-14 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). NOUS reporting times are; USC 2-3 weeks, urgent 8 weeks and routine at 10 weeks. Sickness and retirement in NOUS and Radiologist workforce 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 Cancer performance.
- A NOUS recovery plan has been developed with additional WLI and insourcing support to support reduction of 13+ww and continued improvement of 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. Enhanced payments and WLIs are encouraging additional in-house reporting sessions across all modalities.
MRI performance remains challenged. Two mobile vans are operational to increase scanning capacity and support with cancer performance. This includes reporting of images, waiting times are reducing.
NOUS training posts have been increased from 2 to 4. 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.

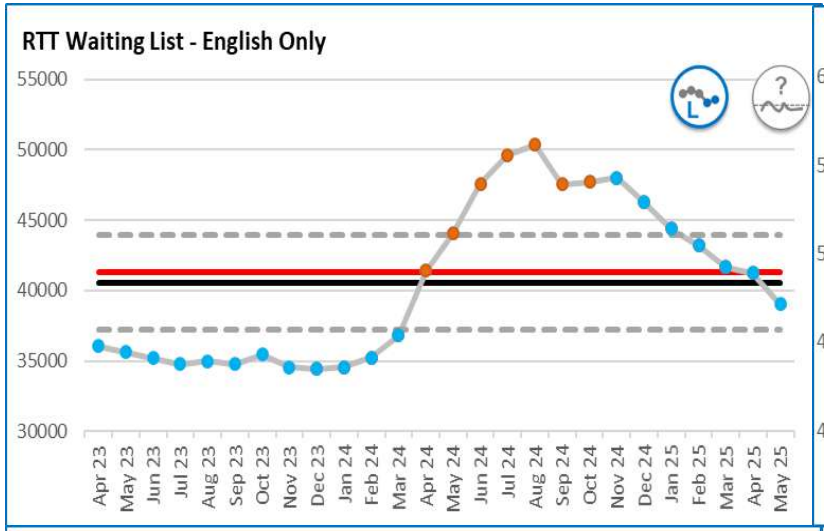
Anticipated impact and timescales for improvement:
Additional insourcing from '18 Weeks' to support endoscopy DM 01 at weekends has been supported through the ERF. There is ongoing recruitment for radiologists, radiographers and sonographers.

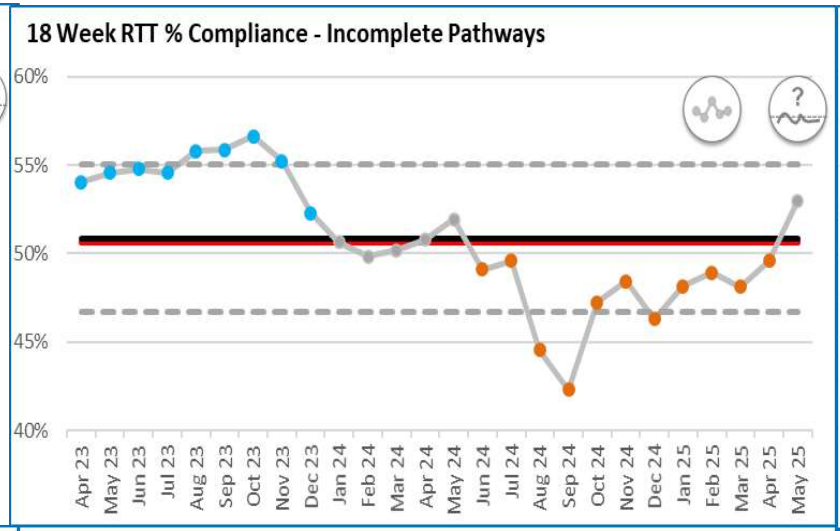
Use of insourcing for USS and MRI is proving successful.

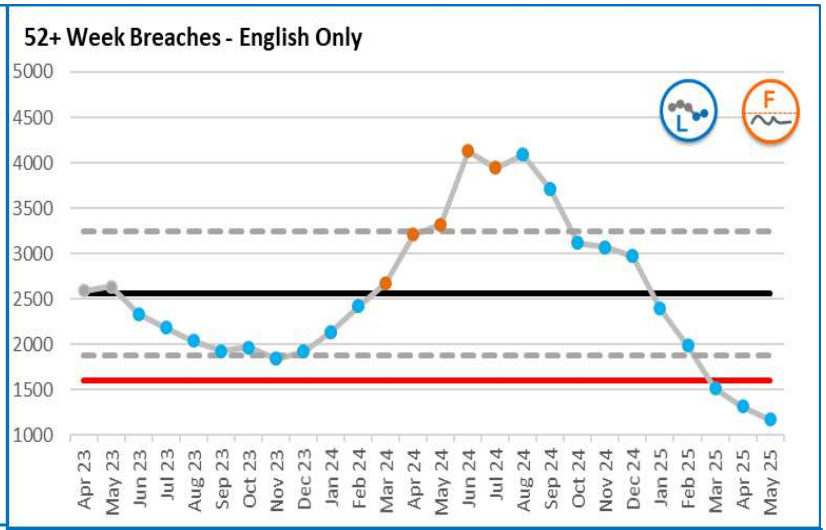
We are updating trajectories with interventions for recovery of DM01 for all modalities.

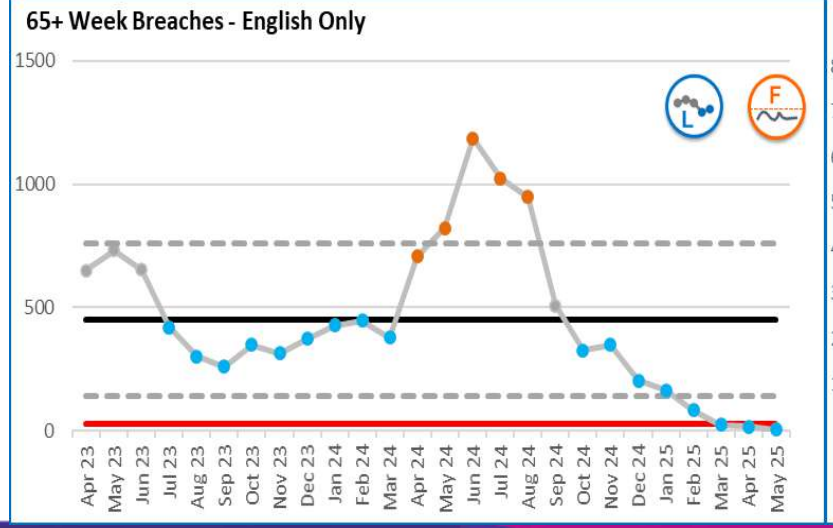
Operational – Referral to treatment (RTT)

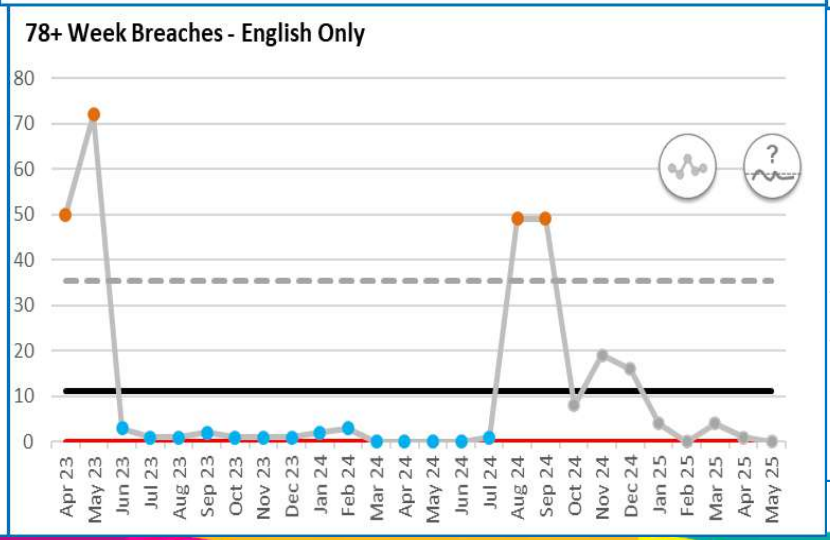
The Shrewsbury and Telford Hospital NHS Trust

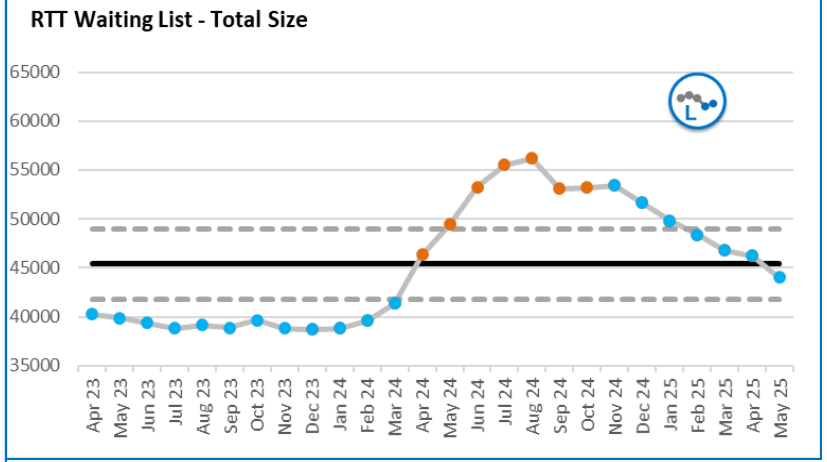












Note: includes Welsh unvalidated position

Operational – Referral to treatment (RTT)

The Shrewsbury and Telford Hospital NHS Trust

Summary:
SaTH remains in Tier 1 monitoring for elective recovery. However, the frequency has reduced from weekly meetings to bi-weekly. The Trust reported 0 x 78-week breaches at the end of May 2025 and 5 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 outpatient capacity and surgical capacity. Demand & capacity models have been re-built in all specialities. The teams are actively using the 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: The teams are actively using the breach forecasting tool to enable more accurate planning of the capacity needed by specialty to achieve our recovery of long waiting patients. 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, Gastro and gynae.
Productivity: The Planned Care Improvement Programme has been launched for both outpatients and Inpatients. The Programme will deliver significant benefits to patient flow and efficiency through four core pillars. Success will be measured by improved high-level Key Performance Indicators (KPIs), with supporting secondary metrics in each workstream. Utilising Quality Improvement (QI) methodologies, the PCIP will prioritise and execute key improvement actions, focusing on safety, patient experience, and measurable outcomes.

Anticipated impact and timescales for improvement:

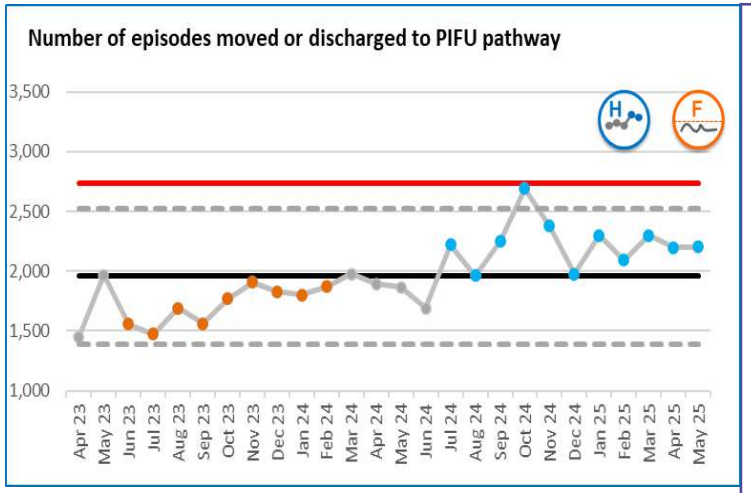
The methodology to enable a 'route to zero' has been developed and a commitment to reach and sustain a zero position has been made for end of June 25.

Significant progress has been made:

- 65 weeks 1,000 in July 2024 to 18 in April and plan for zero in June
- Number of patients waiting > 52 weeks as of the 2nd June 25 is 1,229 which is a reduction of 140 patients in comparison to 27th April 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 – PIFU



Summary:

The unvalidated Patient Initiated Follow-Up (PIFU) performance in May was a 5.4% 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

SaTH Outpatient Pathway Transformation Programme has been launched. There are 3 work streams:

- Outpatient Productivity (Foureyes)
- Outpatient Pathway
- Transformation Outpatient Advice and Guidance

SaTH recognise that the provision of outpatient services could be more productive. The following improvement opportunities have been identified:

- Opportunities to reduce waiting times for planned care by optimising processes and improving resource allocation through digital tools
- Opportunities to improve the quality of planned care by supporting the use of evidence-based practices, providing clinicians with timely access to patient information, and facilitating better coordination of care through digital systems
- Opportunities to improve data and digitalisation

It is anticipated that the above programme of work will have a positive effect on PIFU performance

Recovery actions:

Conversations with Respiratory clinical and operational leads have taken place, with their performance report has been completed, with plans to utilised the PIFU pathway.

Further conversations required with Cardiology Clinical Director regarding implementation of more PIFU within the department.

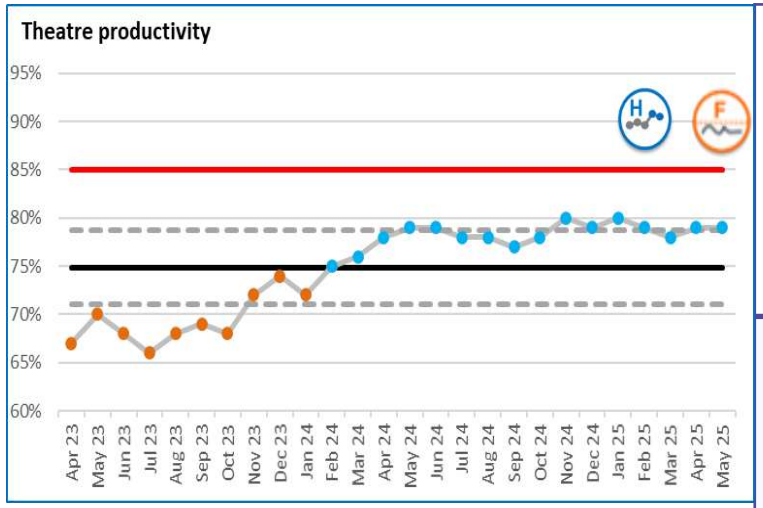
Anticipated timescales for improvement:

Performance will continue to be monitored at bi-weekly Outpatient Transformation meetings

Recovery dependencies:	Due to data warehouse

Operational – Theatre Productivity

The Shrewsbury and Telford Hospital NHS Trust



18.05.2025

Summary:
In May, theatre utilisation remained consistent at 79%. Regular meetings are ongoing with clinical and operational teams to review and improve theatre allocation, surgical list planning, and retrospective (lookback) reviews. These discussions aim to ensure efficient use of resources and address any bottlenecks. The bi-weekly Theatre Task & Finish Group continues to focus on three key areas to drive further improvements 1. Pre-operative assessment capacity, 2. List Allocation & Scheduling (6-4-2), 3. Elective Hub productivity, with root cause analysis and improved data supporting. Elective theatre activity remains robust, maintaining patient levels more than 40% higher than the same period last year, reflecting improvement and increased surgical output.

Recovery actions:

- Ongoing collaboration and regular progress updates are being maintained with the NHSE Regional Theatre Productivity Lead to ensure alignment with regional objectives and best practices for improving theatre efficiency
- A series of upcoming meetings are scheduled with colleagues from other clinical specialties currently utilising the elective hub. These discussions will focus on optimising list management practices to meet the 'GIRFT standard'—ensuring productivity is maximised whilst maintaining and quality
- The business case for a selected digital tool aimed at enhancing the pre-operative assessment process is in the final stages of preparation. Funding has already been identified, and submission for approval is anticipated shortly
- Engagement is ongoing with the Business Intelligence (BI) team to determine how they can best support the next phases of both the Theatre Task and Finish Group initiatives and the broader Elective Hub improvement workstreams with progress being made on a more insightful theatre data dashboard

Anticipated timescales for improvement:
30.06.25 - Planning meetings to finalise High Flow (GIRFT standard) lists across Trauma & Orthopaedics (T&O), ENT, and Gynaecology should be completed, with initial list dates identified.
30.06.25 - Preliminary plans and actions aimed at enhancing productivity within Ophthalmology are expected to be in place. Throughout June, additional list scheduling across multiple specialties will continue, with critical areas such as cancer services and paediatrics targeted. This is intended to meet specific specialty demand and support ongoing recovery.

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

The Shrewsbury and Telford Hospital NHS Trust

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)	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Trend
Well Led	WTE employed		-	7560	7117	7093	7057	7095	7152	7212	7219	7213	7259	7252	7192	7229	7227	
	Temporary/agency staffing		-	-	880	851	862	824	769	794	789	732	752	786	780	705	722	
	Staff Turnover Rate (FTE) (excluding Junior		0.8%	0.75%	0.9%	1.2%	1.0%	1.0%	0.8%	0.9%	1.0%	0.8%	0.8%	0.5%	1.2%	0.6%	0.9%	
	Vacancies - month end %		10%	<10%	8.9%	8.7%	9.5%	9.0%	9.0%	9.0%	9.1%	9.7%	9.2%	9.2%	10.0%	4.5%	4.4%	
	Sickness Absence rate		4%	4%	4.9%	5.0%	5.4%	5.2%	5.3%	5.8%	5.6%	6.0%	5.9%	5.6%	5.1%	4.95%	4.65%	
	Trust - Talent Conversation (Appraisal)		90%	90%	78.4%	78.3%	74.9%	77.4%	77.9%	83.6%	84.6%	85.0%	86.7%	85.3%	85.8%	85.5%	86.0%	
	Talent Conversations (Appraisal) – Medical Staff		90%	90%	93.2%	92.6%	91.5%	92.0%	93.0%	93.6%	93.1%	93.5%	96.4%	92.2%	90.7%	92.5%	93.8%	
	Trust Statutory and mandatory training compliance		90%	90%	91.5%	91.9%	92.0%	91.9%	92.1%	91.4%	91.5%	91.1%	94.1%	91.7%	91.3%	92.9%	93.1%	
	Trust MCA – DOLS and MHA		90%	90%	79.4%	80.2%	80.2%	79.9%	82.7%	83.9%	84.0%	83.2%	87.0%	85.4%	85.1%	85.0%	85.0%	
	Safeguarding Children - Level 2		90%	90%	89.2%	90.1%	94.9%	95.0%	95.0%	93.8%	93.8%	93.7%	96.0%	94.1%	94.5%	96.0%	96.4%	
	Safeguarding Adult - Level 2		90%	90%	87.9%	89.3%	94.5%	94.6%	95.2%	94.3%	94.3%	94.3%	96.7%	94.6%	94.4%	95.8%	95.9%	
	Safeguarding Children - Level 3		90%	90%	83.4%	88.4%	88.5%	88.1%	88.3%	89.6%	88.9%	90.1%	91.9%	89.6%	90.8%	89.2%	89.8%	
	Safeguarding Adult - Level 3		90%	90%	82.9%	90.4%	88.4%	87.2%	88.8%	89.6%	90.1%	89.8%	92.4%	90.4%	90.5%	90.0%	91.0%	
	Monthly agency expenditure (£'000)		-	1,032	1918	1952	1954	1700	1526	1751	1638	1404	1203	985	955	1063	684	
Safe Staffing	Fill Rate % - All Staff - Day/Night			100%	96.8%	97.0%	96.6%	95.1%	94.5%	95.6%	95.7%	93.6%	94.4%	93.3%	93.3%	93.9%	93.5%	
	Fill Rate % - All Staff - Day			100%	95.5%	95.7%	95.7%	94.9%	94.0%	94.2%	93.9%	92.2%	93.1%	91.8%	92.5%	92.7%	91.8%	
	Fill Rate % - All Staff - Night			100%	98.4%	98.5%	97.7%	95.4%	95.1%	97.3%	97.8%	95.3%	95.9%	95.1%	94.3%	95.3%	95.7%	
	Fill Rate % - Registered Nurses/Midwives - Day/Night			100%	106.7%	106.0%	105.9%	104.4%	103.6%	104.2%	104.8%	104.9%	104.1%	101.3%	101.7%	101.4%	99.3%	
	Fill Rate % - Registered Nurses/Midwives - Day			100%	107.2%	106.2%	106.1%	104.5%	103.6%	103.1%	104.4%	104.9%	104.4%	101.0%	101.6%	100.8%	98.1%	
	Fill Rate % - Registered Nurses/Midwives - Night			100%	106.0%	105.6%	105.7%	104.2%	103.6%	105.5%	105.3%	104.8%	103.8%	101.6%	101.8%	102.1%	100.7%	
	Fill Rate % - Non-Registered Nurses/Midwives - Day/Night			100%	99.7%	100.3%	100.2%	98.9%	98.6%	99.1%	98.7%	94.1%	96.3%	98.5%	97.8%	98.5%	100.2%	
	Fill Rate % - Non-Registered Nurses/Midwives - Day			100%	96.4%	97.2%	98.3%	98.9%	98.2%	96.9%	95.4%	91.2%	93.1%	95.8%	95.8%	96.2%	97.3%	
	Fill Rate % - Non-Registered Nurses/Midwives - Night			100%	103.7%	103.9%	102.5%	98.9%	99.0%	101.9%	102.6%	97.5%	100.0%	101.7%	100.1%	101.1%	103.7%	
	Fill Rate % - Registered Nursing Associates - Day/Night			-	22.9%	22.4%	21.6%	19.8%	18.3%	24.7%	23.5%	19.5%	22.1%	18.6%	18.6%	24.9%	24.5%	
	Fill Rate % - Registered Nursing Associates - Day			-	27.2%	25.0%	25.3%	23.8%	21.4%	28.7%	26.5%	22.5%	25.4%	21.0%	24.7%	30.8%	30.5%	
	Fill Rate % - Registered Nursing Associates - Night			-	16.4%	18.7%	16.3%	14.2%	14.0%	19.0%	19.3%	15.4%	17.4%	15.3%	10.0%	16.6%	15.4%	
	CHPPD - Overall - National 11.99			11.99	9.0	9.5	9.1	9.0	8.7	9.8	8.8	8.6	8.7	8.6	8.5	8.6	8.7	
	CHPPD - Registered Nurses/Midwives - National 4.9			4.9	5.3	5.7	5.3	5.3	5.2	5.9	5.2	5.2	5.2	5.1	5.1	5.1	5.1	
	CHPPD - Non-Registered Nurses/Midwives - National 4.9			4.9	3.5	3.7	3.6	3.5	3.4	3.7	3.4	3.2	3.3	3.4	3.3	3.3	3.4	
	CHPPD - Registered Nursing Associates			-	0.2	0.2	0.2	0.2	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.2	0.2	

Workforce Executive Summary

The Shrewsbury and Telford Hospital NHS Trust

2024/25 Workforce Plan – At Month 2 our total workforce position is under plan by 36 WTE. The substantive position has reduced supported by our vacancy control process and is under plan by 46 WTE. This is being off-set by our bank workforce used to cover gaps particularly across our nursing workforce. Agency usage has decreased marginally this month now at 94 WTE and is on track against our reduction trajectory.

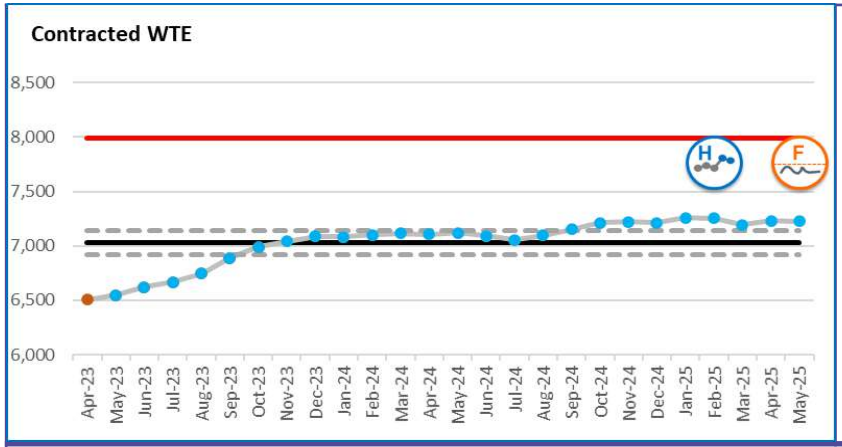
Turnover – The rolling 12-month turnover rate for May increased by 0.1% to 10.7% equating to 720 WTE leavers. An in month turnover rate of 0.92% equates to 63 WTE leavers in May. The turnover rate is expected to reduce over 25/26 as we have planned for a reduction to 10% by month 12.

Wellbeing of our staff – May sickness rate decreased to 4.65% (339 WTE) remaining above target by 0.15% (11 WTE). Sickness attributed to mental health continues to be the top reason for sickness making up 25% of calendar days lost in May equating to 85 WTE.

Agency and temporary staffing – As per our plan we have seen agency reductions as we continue to transfer to bank usage for inpatient nursing teams. To support reductions needed in Bank and Agency the following actions are being taken:

- Measures to prevent retrospective bookings and tighter controls over our workforce management. There are now revised processes that ensure appropriate sign off is made for all scenarios including acting up arrangements, fixed term extensions, the use of bank in non-clinical areas, retire and return arrangements, secondments etc.
- Preventing overtime and converting it to bank. Overtime and additional pay have reduced from March with overtime reducing from 17 WTE in April to 12 WTE in May.
- Substantive recruitment to fill gaps across nursing teams.
- Delivering the medical workforce efficiency programme including delivering targeted recruitment to hard-to-fill roles, with a primary focus on consultant-level positions, by developing and implementing strategic recruitment plans.

Workforce – Contracted WTE



Summary:
Substantive figure of 7,227 WTE in May, which is a decrease of 2 WTE in month.
Total workforce utilisation in May increased by 15 WTE to 7949 WTE attributable an increase in the use of temporary staff; increase in bank by 18 WTE; decrease in agency by 1 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.

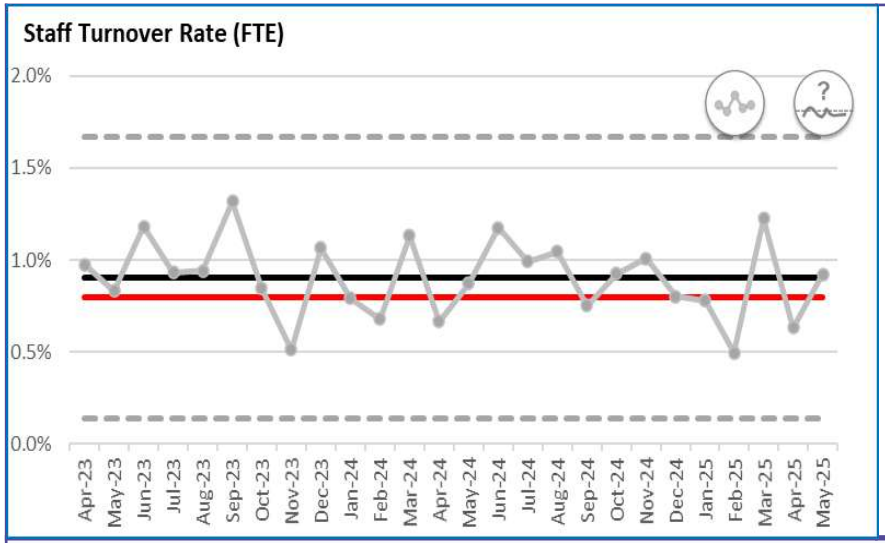
- Apprentice ODP campaign successfully recruited 6 Apprentice ODPs following a targeted recruitment campaign and event day
- Unavailability and leave rostering for August is being addressed through the unavailability project, with the People Advisory Team leading actions related to the unavailability PID
- Annual rota template reviews are progressing, with a focus on ensuring timely delivery of rosters for the August intake. Rosters for Anaesthetics, General Surgery, Women's & Children, Ophthalmology, and Emergency Medicine have already been published
- Vacancy Control and Reform plans are ongoing to meet 2025/26 requirements, including reviewing paused posts and planning for organisational change
- Establishment reviews (Non-Medical) commenced in June, with meetings underway to understand medical workforce changes
- Premium pay spend reduction remains a key focus, with strategic planning and transformation initiatives in place
- Workforce planning for HTP continues, including workshops in divisions and the identification of Change Agents. Training for leaders managing change is also being developed
- Transformation plans for maternity, neonates, and paediatrics are active, with ongoing programme work and cultural transformation initiatives
- Manager Self Service (MSS) adoption increase; 78% of departments now managing or on target to manage assignments via MSS

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



Summary:
Our Turnover target for 2026 is 10%. The rolling 12-month turnover rate for May increased by 0.1% to 10.7% equating to 720 WTE. An in month turnover rate of 0.92% equates to 63 WTE leavers in May. NHS Leaver turnover rate (those moving outside of the NHS) over the last 12 months is 6.8% equating to 463 WTE NHS leavers.
Staff groups where turnover is above 10.7% include Additional Clinical Services (13.0%); Add Prof Scientific and Technic (12.7%); Admin and Clerical (11.7%);Healthcare Scientists (11.7%); Allied Health Professionals (11.1%).

Relocation is currently the highest reason for leaving with 137 WTE leavers with work life balance as the second highest reason with 129 WTE leavers over the last 12 months.

Recovery actions to achieve our turnover target:

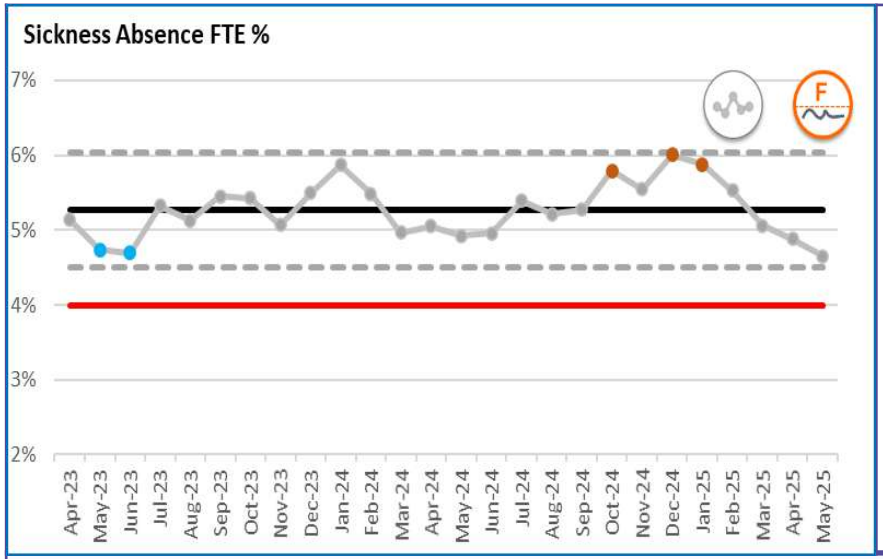
- Review of leadership development STEP underway to ensure content reflects operational, clinical leadership and financial needs. To support improving culture and how it feels to work at SATH
- Workforce planning on-going and alignment to HTP alongside immediate needs to support improved planning and use of resources/ investment in education
- Improvement in culture in both Emergency Departments required, Psychology has also been supporting across both sites
- Flexible working campaigns and redesign
- Provide clarity for our future and manage MOC well across the Trust
- Proactively address poor behaviour and any instances of harassment that may occur consistently across the Trust

Anticipated impact and timescales for improvement:

Part of our 2025/26 programmes of work.

Recovery dependencies:	Estate and Digital are key enablers to improve environment and agility to work differently. Resilience of colleagues given uncertain landscape and leading well. Targeted attendance on leadership programmes.

Workforce – Sickness absence



Summary:
Our sickness target for 2026 is 4.5%. May sickness rate decreased to 4.65% (339 WTE) remaining above target by 0.15% (11 WTE). Sickness attributed to mental health continues to be the top reason for sickness making up 25% of calendar days lost in May equating to 85 WTE. 13% (44 WTE) of sickness was attributed to other known causes with other musculoskeletal (which does not include back problems) at 12% (42 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 6.8%, Estates and Ancillary staff group has the second highest rate at 6.1% with Nursing and Midwifery at 5.9%.

Recovery actions to achieve our target:

- Regular HWB walks and general engagement walks
- Specific training and briefings to support new policy implementation
- Psychology are trailing a new approach to appointments to minimise the waits and offer shorter interventions
- Regular engagement with colleagues and review of our plan for 2025/26
- Promotion of key engagement events ongoing such as Men's Health

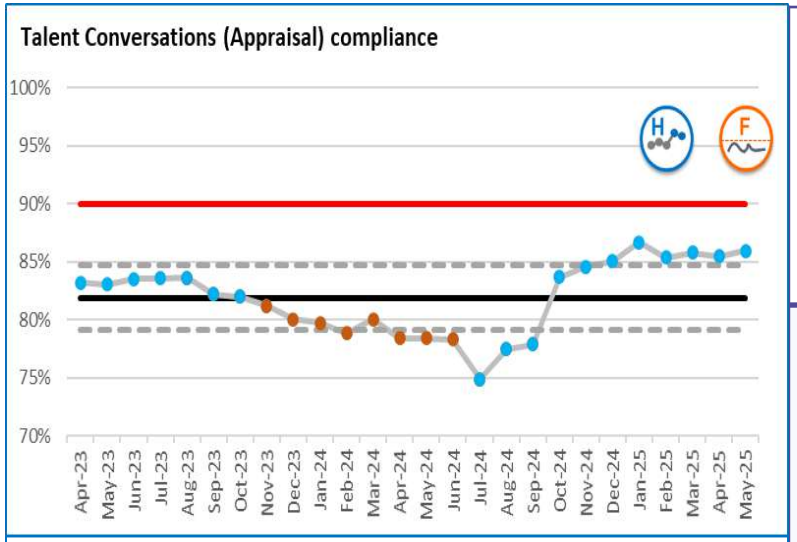
Anticipated impact and timescales for improvement:

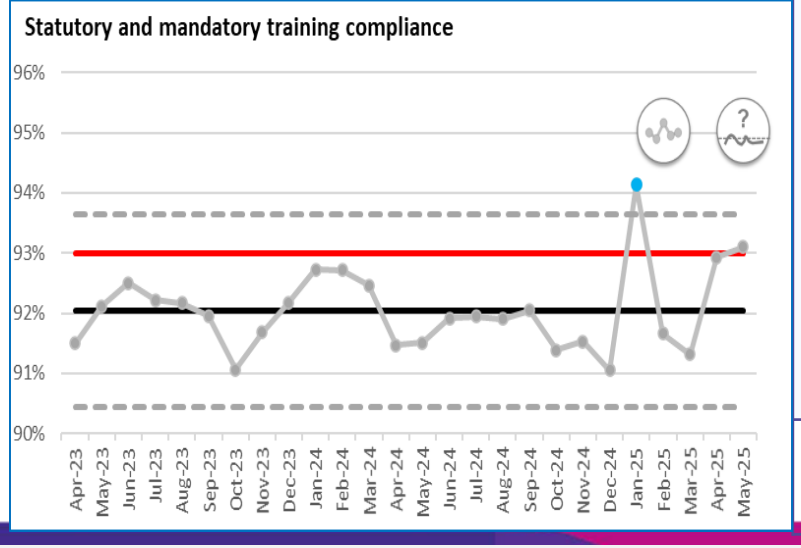
Key absence management schemes as part of financial recovery have been implemented and monitored monthly.

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.

Workforce – Talent Conversations & Training

The Shrewsbury and Telford Hospital NHS Trust





Summary:

Talent Conversations (Appraisals) target is 90%. For Medical appraisals, after a decline from 96.4% in January through February and March, has improved to 93.8% in May. For non-medical colleagues, talent conversations increased to 86.0% in May.

Our Mandatory and statutory training compliance target by 2026 is 93%, currently our target is 90%. The current rate is 93.1% which is above target.

Recovery actions to achieve our 2026 target:

- National mandatory learning policy framework to be adopted by 30 September 2025
- Annual Education report produced
- Local annual plan to quantify mandatory learning and evidence of improved outcomes as part of business planning 2026/27
- Support to continue investment in career management portal to support resources available for colleagues

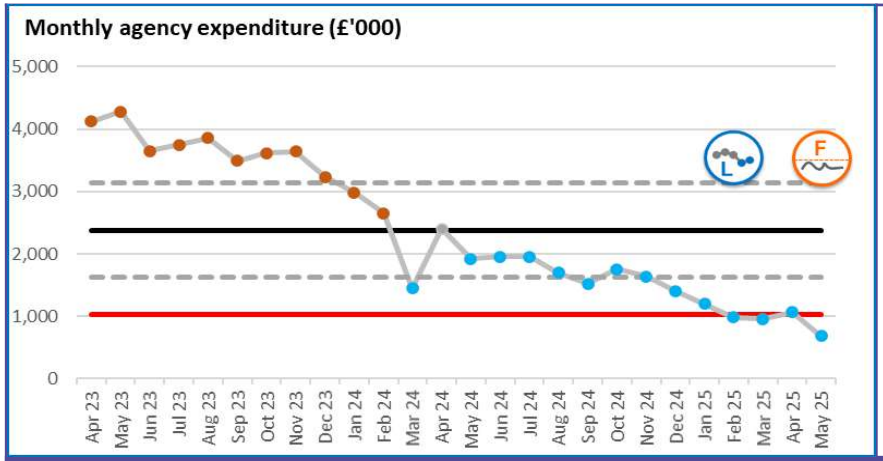
Anticipated impact and timescales for improvement:

Key priorities for People Plan 2025/26 and beyond.

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

Agency Expenditure – Monthly

The Shrewsbury and Telford Hospital NHS Trust



Summary:
Delivery of the agency reduction plan – expenditure has marginally reduced in month compared to April is now below the planned levels of expenditure. There continues to be a strong focus on medical agency in FY25/26. Reduction in sickness absence levels have supported reduced demand and all nursing agency used is now price cap compliant. All agency workers are engaged via framework agencies.

- Rigor around WTE budgets continues, with vacancy control and reform plans in place to meet 2025/26 requirements. This includes reviewing paused posts and planning for change, with executive-level oversight
- Nursing and AHP agency requests are being tightly managed. 100% compliance with no above-cap agency usage, and no shifts escalated above capped rates
- Plans continue to address agency use on Ward 27 including mitigation for maternity leave cover and new B5 starters
- ED agency use: Streamlining templates to reduce reliance on agency nurses; ongoing efforts to fill Band 6 and Band 5 vacancies, including interviews and cross-site coordination
- Working with Acute Floor to ensure Agency staff are aware of their options going forward
- NHSP National Bank: Engagement has begun with Pharmacy to support the migration of AHP agency workers to the NHSP bank, aiming to reduce agency reliance
- Supporting SCHT with Agency rate compliance
- Nurses, AHPs and HCAs 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-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Substantive	7,259	7,272	7,268	7,318	7,422	7,447	7,422	7,393	7,359	7,326	7,293	7,245
Bank	641	603	598	593	588	533	529	557	553	549	545	542
Agency	118	110	102	95	78	73	69	69	66	62	59	55
Total	8,017	7,984	7,967	8,005	8,089	8,053	8,020	8,019	7,979	7,938	7,897	7,841
Actual	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
Substantive	7,229	7226										
Bank	610	628										
Agency	95	94										
Total	7,934	7,948										
Variance	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
Substantive	-30	-46										
Bank	-31	25										
Agency	-23	-16										
Total	-83	-36										

Summary:
Total staff usage of 7948 WTE in May is 36 WTE under plan however this is an increase from the April position of 14 WTE. Substantive and agency levels have reduced this month which is encouraging however our bank usage has increased across most clinical divisions and corporate areas. Our focus is now on addressing the usage and filling gaps in our workforce particularly for nursing and medical teams

Continued actions:

- Deliver targeted recruitment to hard-to-fill roles, with a primary focus on consultant-level positions, by developing and implementing a strategic recruitment plan. This includes streamlining time-to-hire processes to address long-term workforce challenges effectively
- Deliver reduction in temporary staffing usage through refreshed governance processes
- Rollout of medical rostering for sickness, leave, and unavailability across all areas
- Rollout of electronic medical rostering to areas not currently using digital solutions
- Deliver business case for the procurement of Activity Manager
- Create and deliver a flightpath plan for reducing agency rates of pay to align with the WM Cluster Rate Card. - All Divisions are required to finalise and agree their respective flight path plans by 20 June 2025

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.

The Shrewsbury and Telford Hospital NHS Trust

Finance

Executive Lead:

Acting Director of Finance
Adam Winstanley

Integrated Performance Report

The Shrewsbury and Telford Hospital NHS Trust

Domain	Description	Current Month Trajectory (RAG)	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Trend
Finance	End of month cash balance £'000	49,568	39,634	36,999	29,444	24,375	15,051	67,367	54,399	43,511	54,932	48,821	61,762	45,006	35,131	
	CIP Delivery £'000	2,578	869	1,915	2,125	2,367	2,799	3,390	3,585	2,833	3,654	4,287	5,659	2,392	2,568	
	Balanced £ Position £'000 (Cumulative)	0	(12,930)	(21,030)	(28,705)	(34,229)	(5,621)	(10,864)	(13,242)	(17,179)	(22,661)	(27,570)	(18,563)	5	1	
	Year to date capital expenditure £'000	10,686	1,734	3,278	5,424	7,364	8,403	10,153	16,157	22,352	26,936	39,110	69,194	2,044	12,632	

Finance Executive Summary

The Shrewsbury and Telford Hospital NHS Trust

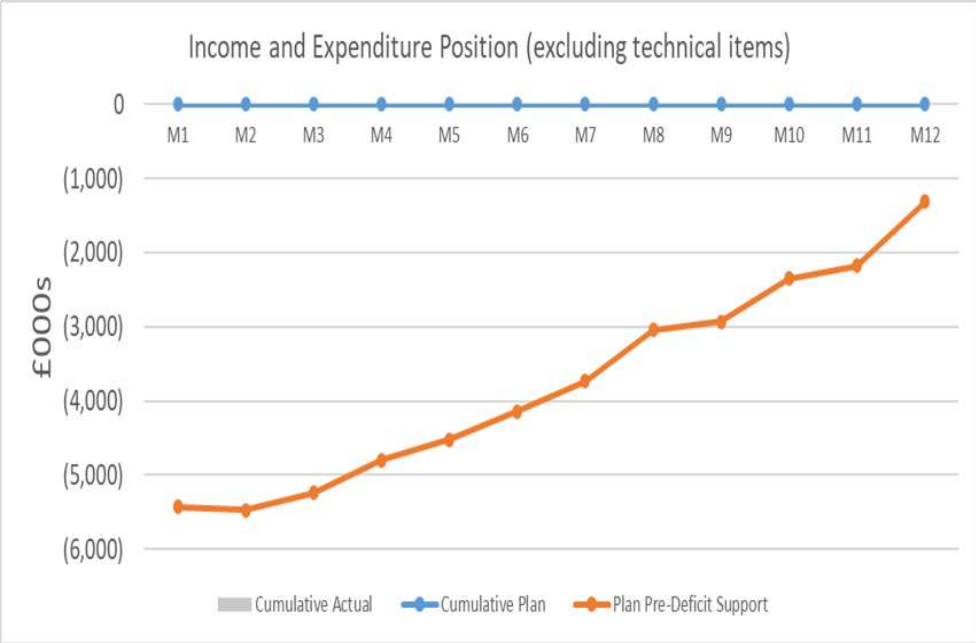
The Trust submitted a finance plan to NHSE on 30th April which showed a breakeven plan with deficit support of £45.15m for the year. At the end of May (month two), the Trust has delivered a breakeven position against the breakeven plan. However, there have been some variances in the cost categories with income favourable to plan and pay and non-pay adverse to plan. The drivers of the variances are; additional capacity (£0.34m), additional income backed posts (£0.23m) which are offset by an over achievement in income. There has also been an increase in pass through devices (£0.25m) which is also offset by an over achievement in income. There has been a benefit in financing costs resulting from the Trusts' cash position (£0.28m).
The Trust has five main deliverables within the operating plan for FY25/26:

- 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 at present, however the Trust is actively making CDS submissions through to SUS
- Delivery of the efficiency plan – The trust has an efficiency target of £41.40m in FY25/26. At the end of May, £4.96m has been delivered in line with plan
- WTE reduction plan – At the end of May the actual WTE is 36 WTE favourable to plan of which substantive and agency are ahead of plan however, bank usage exceeds planned levels
- Delivery of the agency reduction plan – expenditure has marginally reduced in month compared to April is now below the planned levels of expenditure. There continues to be a strong focus on medical agency in FY25/26
- Delivery of escalation within a core capacity funding envelope (£14.00m) – at the end of month two there has been an overspend of £0.34m against plan

The Trust has set an operational capital programme of £22.53m (including IFRS 16 expenditure) and externally funded schemes of £123.39m in FY25/26, giving a total capital programme of £145.92m.

The Trust held a cash balance at end of May 2025 of £35.11m (ledger balance of £35.13m due to reconciling items).

Income and expenditure – year to date

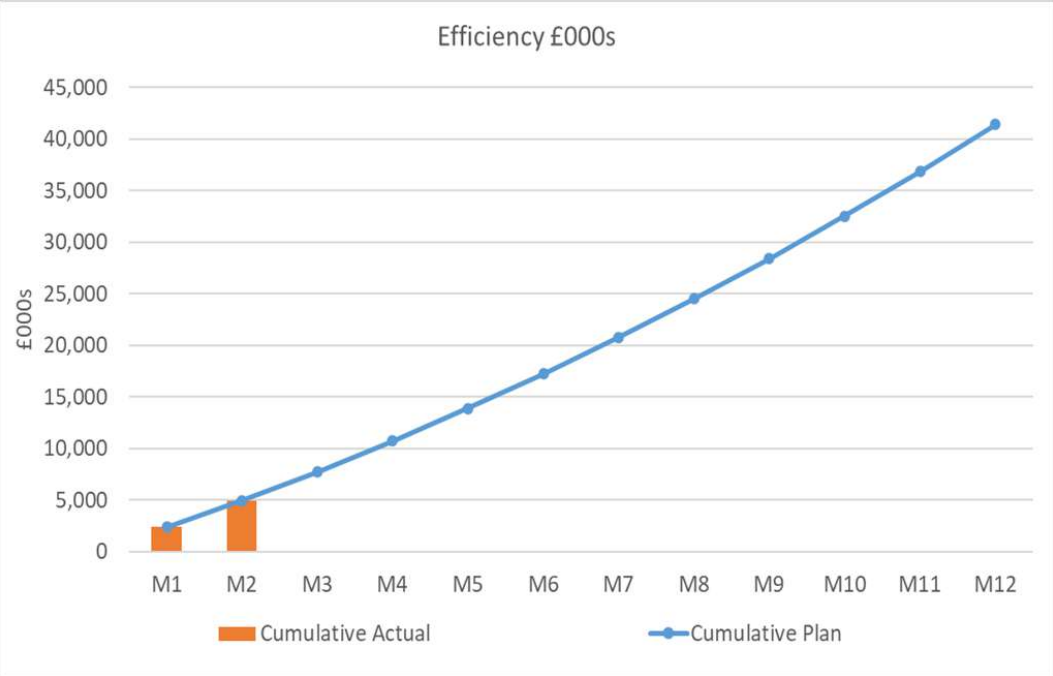


Summary:
The Trust submitted and had approved a breakeven plan in FY25/26 following the Trust receiving financial support to the value £45.15m.

The Trust recorded a breakeven position in month and year to date, in line with plan, this position is supported by £5.47m of deficit support funding in the month and £10.90m year to date. Whilst the Trust has reported a position in line with the plan, there have been movements in the different cost categories with an overspend on pay and non-pay being offset with an underspend on financing costs and an over delivery of income against planned levels.

Recovery actions: N/A	**Anticipated impact and timescales for improvement:** N/A
Recovery dependencies:	Risk remains in relation to the use of additional capacity but we expect this to be managed between now and year end.

Efficiency



Summary:
The Trust has a total efficiency target for FY25/26 of £41.40m.

As at the end of May (month two), the Trust has delivered £4.96m of efficiency savings for FY25/26 which is in line with the planned delivery.

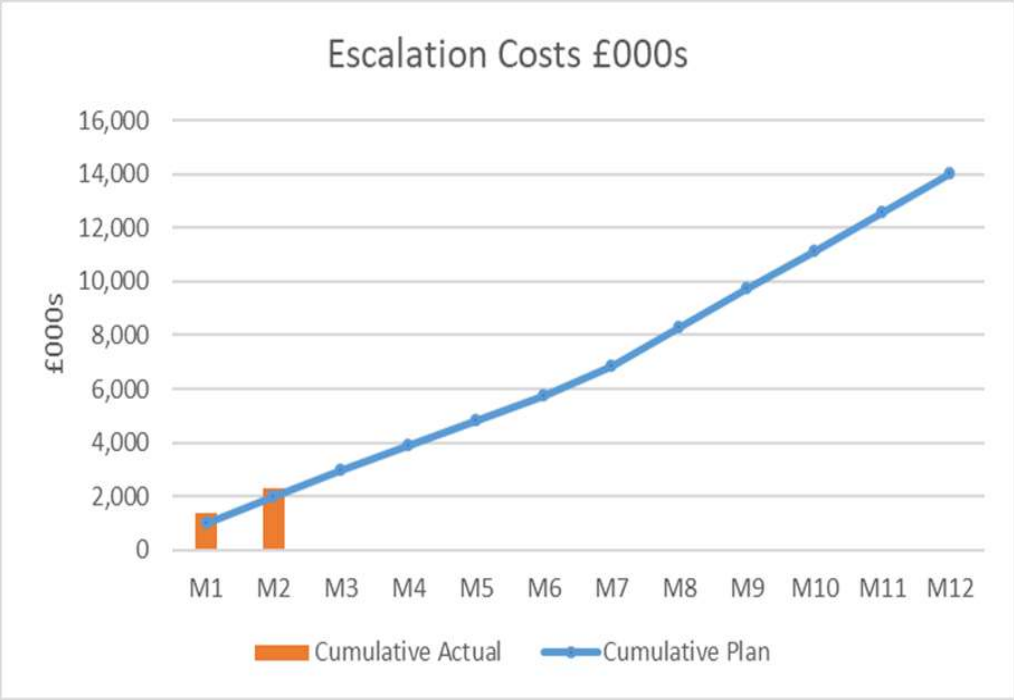
Of the £41.40m target £19.48m is identified as low risk, £21.05m is classed as medium risk and £0.87m high risk.

All of the £41.40m has plans against it, with £40.17m fully developed and £1.15m in progress. There is a further £0.09m that has been identified.

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

Recovery dependencies:	Delivery of actions against project initiation documents (PIDs)

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.

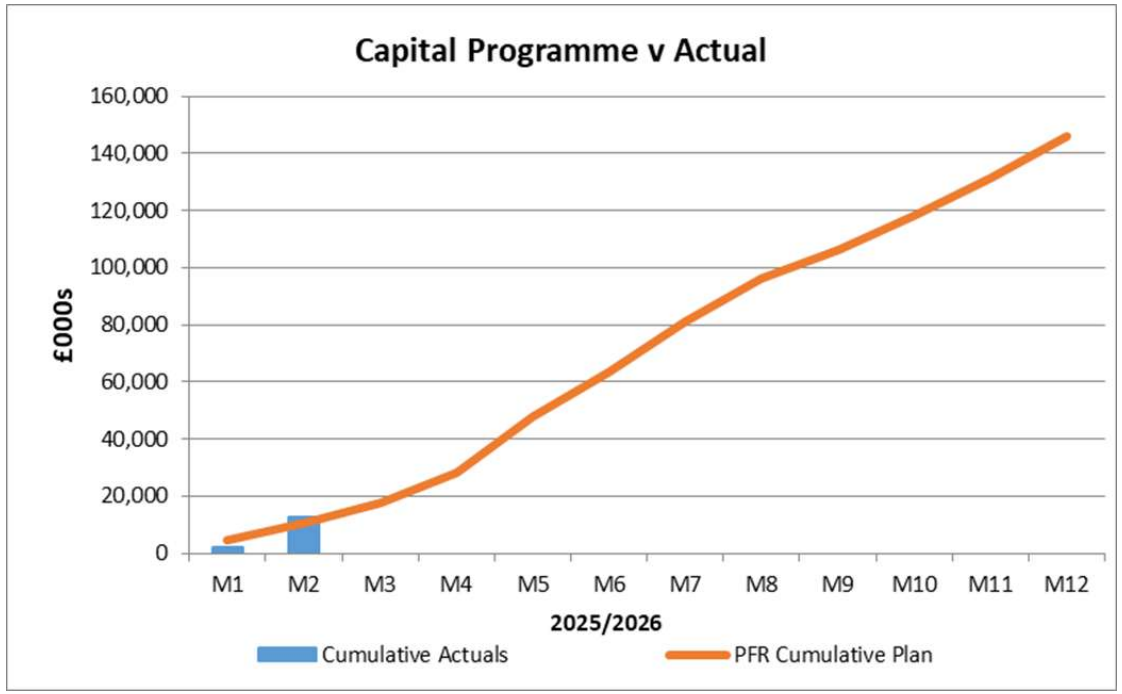
The requirement on a monthly basis is driven by changes in demand, offset by both internal and external interventions such as reduction length of stay and reductions in the number of patients with no criteria to reside, all of which is linked to the delivery of the 4 UEC transformation workstreams.

In May escalation costs (£0.93m) reduced compared to April and are below the planned levels for the month however, they are still above the year to date levels included within the operational plan. YTD plan is £1.97m and actual is £2.31m.

Recovery actions:	**Anticipated impact and timescales for improvement:**
SaTH is working in conjunction with the ICB, other system to reduce the need for expensive escalation capacity. This is directly overseen by the UEC Transformation Board.	Increased delivery expected over the coming months, linked to further improvement in UEC metrics.

Recovery dependencies:	Delivery of escalation reduction is linked to 5 workstreams from UEC transformation programme and managed through UEC board.

Capital Programme



Summary:
The Trust has received a System Capital Allocation of £22.53m for FY25/26. This allocation is inclusive of IFRS 16 capital expenditure.

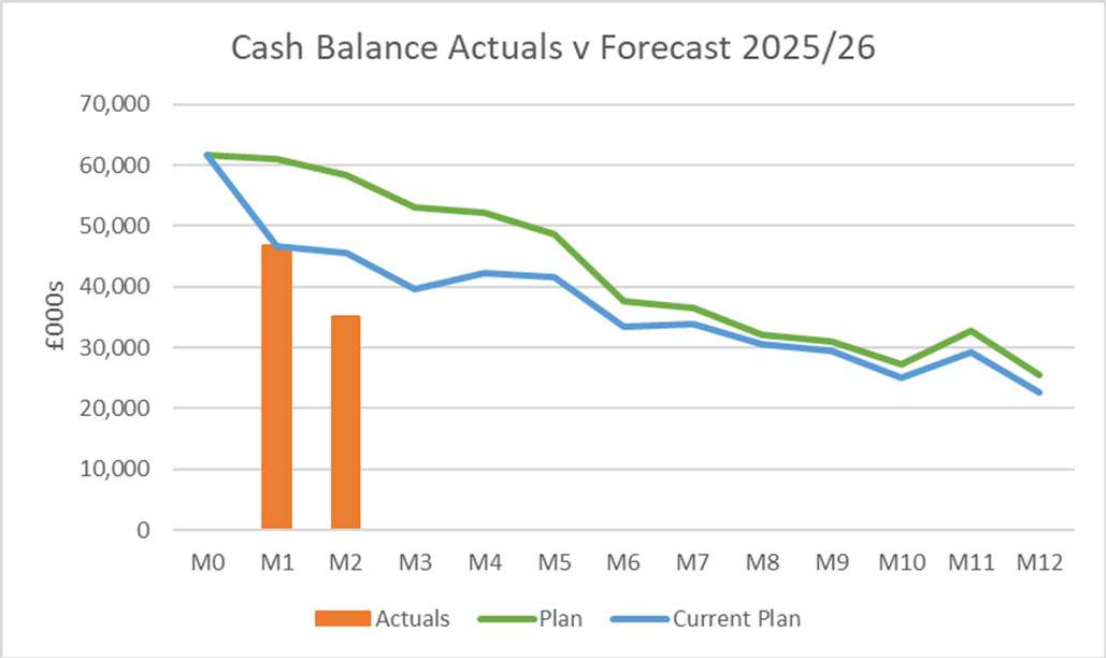
External allocations have been included in the Capital Plan of £123.39m (including £99.30m relating to HTP), giving an overall Capital Programme of £145.92m (excluding Salix).

In addition, the second year of Public Sector Decarbonisation Scheme grant of £8.10m will be received in FY25/26 to be spent on decarbonisation initiative on the Shrewsbury site.

At M2 FY25/26, £0.16m of expenditure relating to System Allocation has been expended and £12.47m of external expenditure has been incurred, giving total expenditure of £12.63m.

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

Cash and cash equivalents



Summary:
The Trust undertakes monthly cashflow forecasting.

The cash balance brought forward into FY25/26 was £61.76m with a cash balance of £35.11m (ledger balance of £35.13m due to reconciling items) held at end of May 2025.

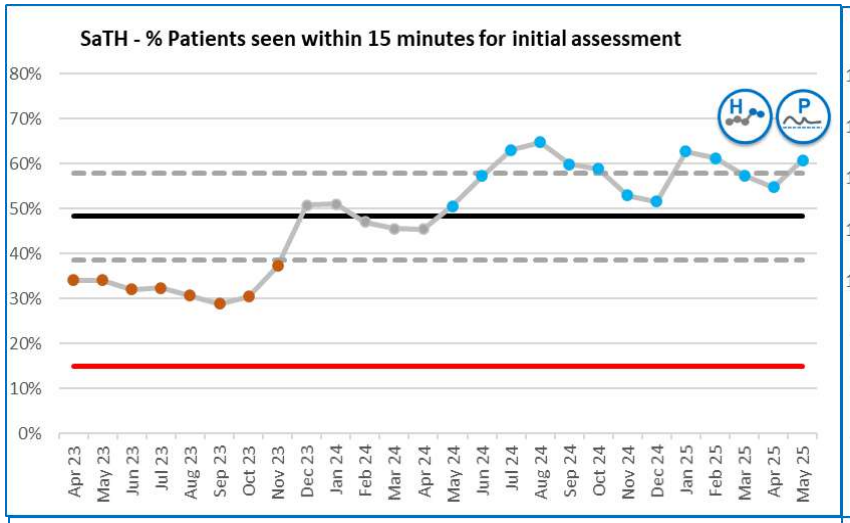
The graph illustrates actual cash held against the plan. The lower cash balance against plan is mostly due to a higher outflow relating to capital creditors for previous financial year.

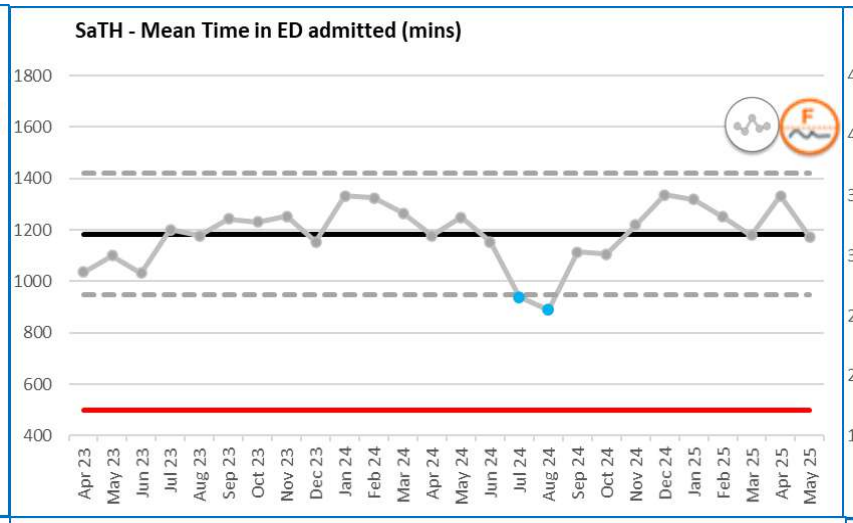
Recovery actions: N/A	**Anticipated impact and timescales for improvement:** N/A
Recovery dependencies:	N/A

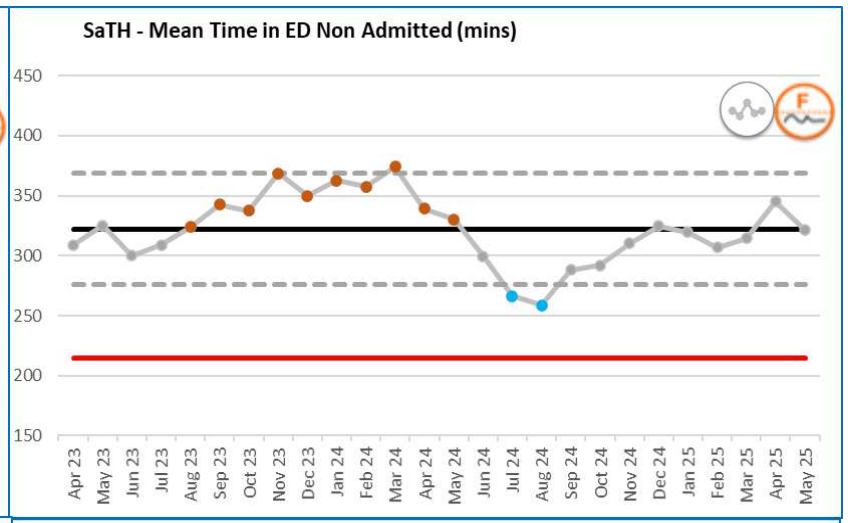
Appendices – Responsiveness And Well Led

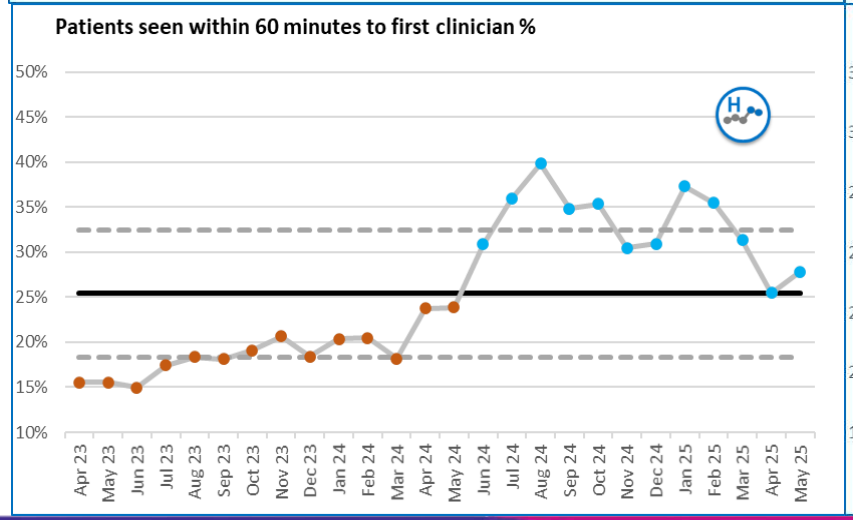
Appendix 1 – supporting detail on Responsiveness

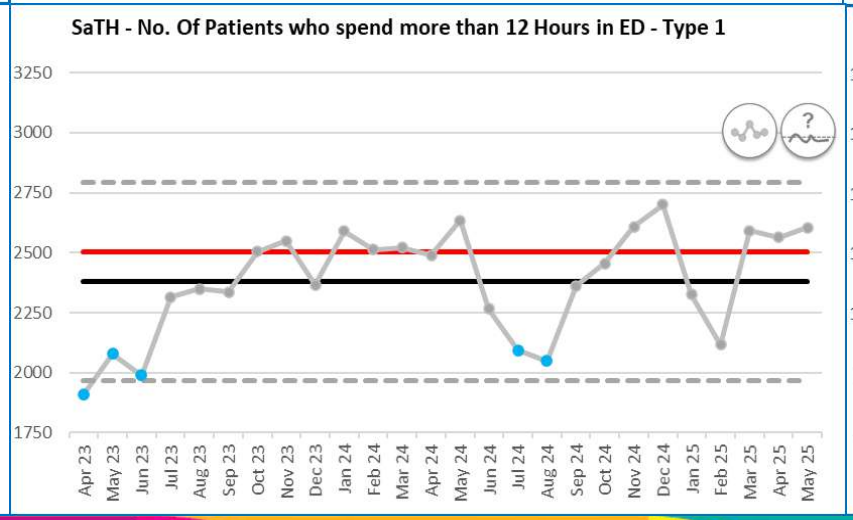
The Shrewsbury and Telford Hospital NHS Trust

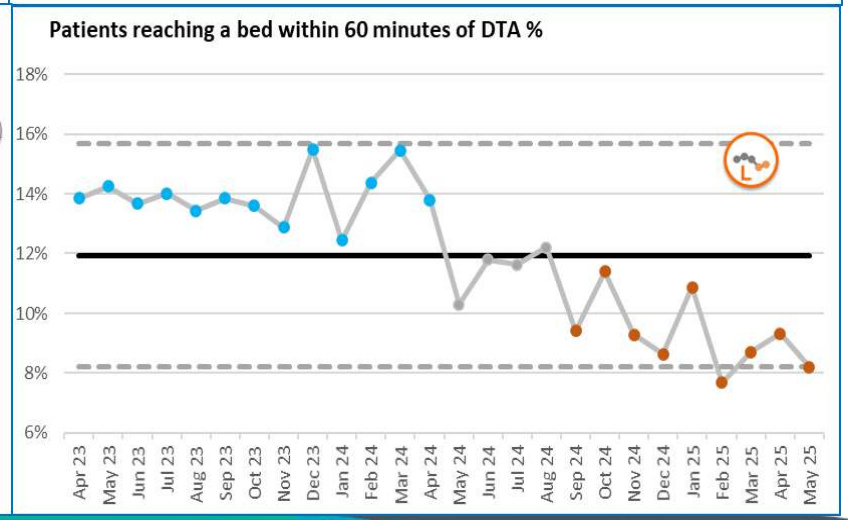






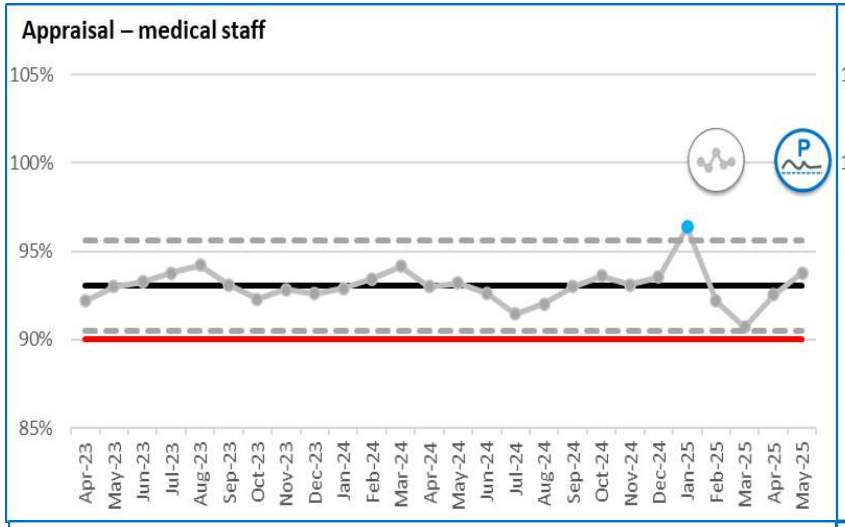


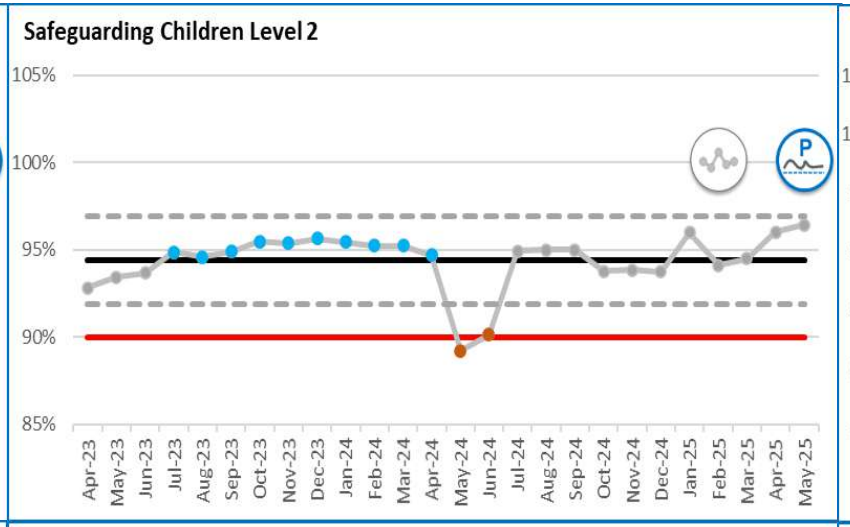


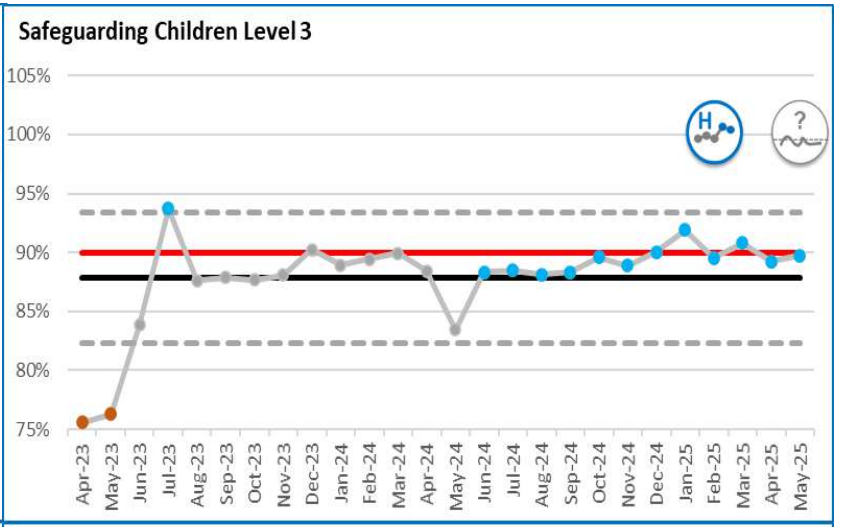


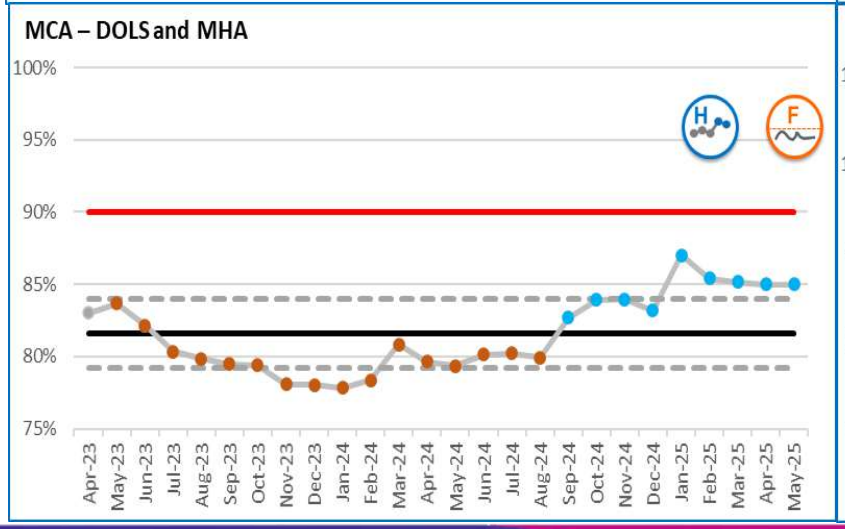
Appendix 2 – supporting detail on Well Led

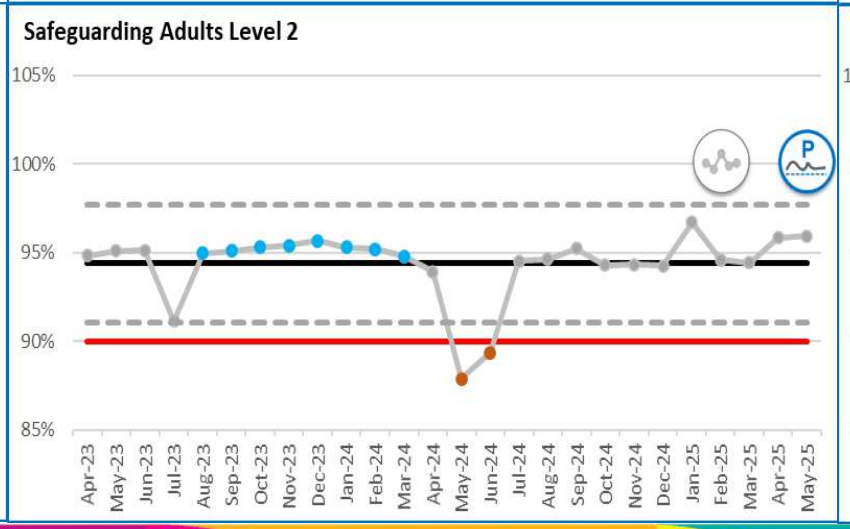
The Shrewsbury and Telford Hospital NHS Trust

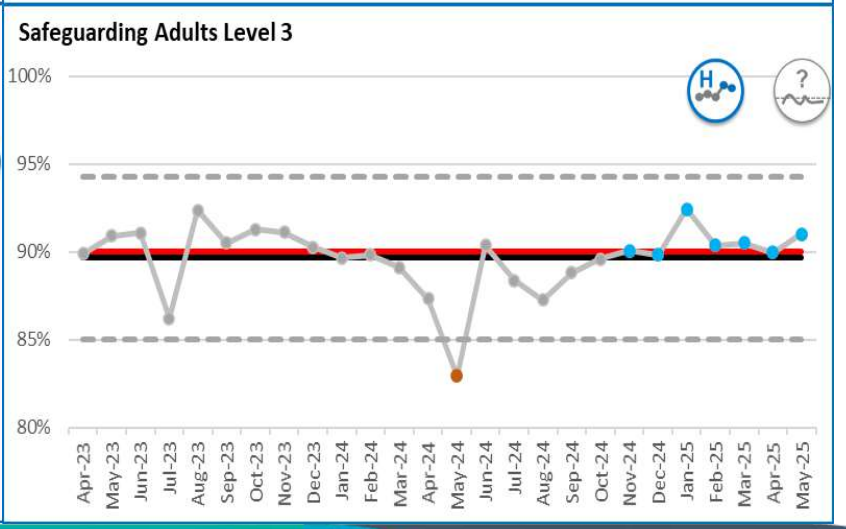










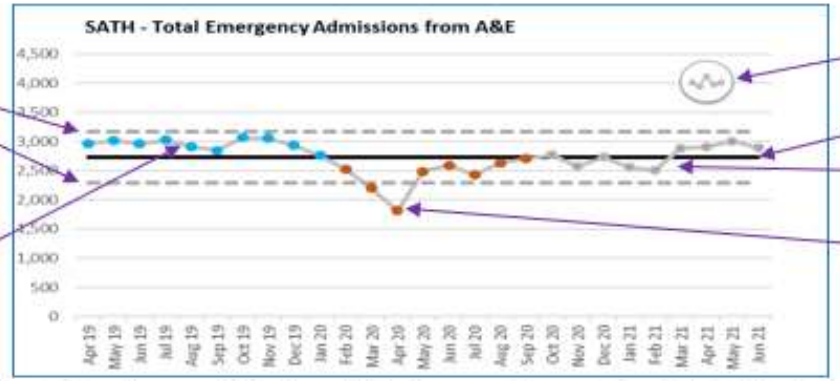


Appendix 3 – Understanding statistical control process charts in this report

The 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



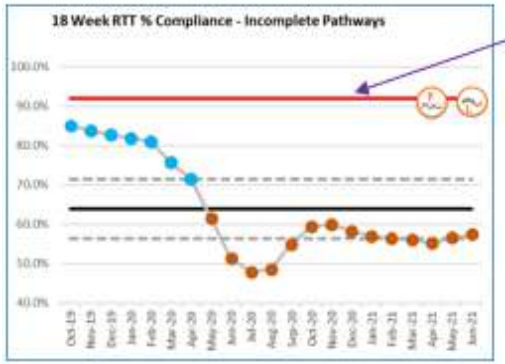
Icon showing most recent point type of variation

Mean or median line

Common cause variation

Special cause variation – data point outside of the process limit

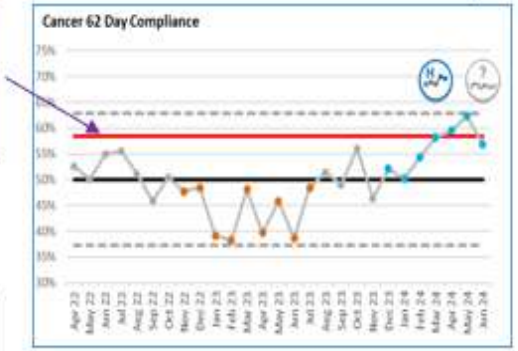
Where a target has been set the target line is superimposed on the SPC chart. It is not a function of the process.

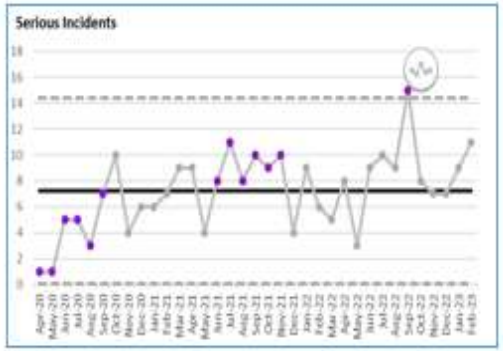


Target line – outside the process limits.

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

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

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

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

Board of Directors' Meeting 10 July 2025

Agenda item	107/25			
Report Title	Medical Examiner & Bereavement Service Report Quarter 4 January 2025 – March 2025 & Summary Annual Report 2024-2025			
Executive Lead	Dr John Jones, Executive Medical Director			
Report Authors	Dr Suresh Ramadoss, Trust Lead Medical Examiner Lindsay Barker, Head of Medical Examiner & Bereavement Services			
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	Trust Learning from Deaths Group, 1st May 2025 Quality Operational Committee, 20th May 2025 Quality & Safety Assurance Committee, 27th May 2025 Trust Board, 10th July 2025			
Executive summary:	The Board's attention is drawn to: • Q4 saw an increase of 102 hospital deaths compared to Q3. • In early February 2025, the National Medical Examiner reported to all ME services across England, that in the first 4 weeks of January 2025, the number of deaths registered nationally was around 9.5% higher than the equivalent period in 2024. • Performance with issuing MCCDs during Q4 was challenged with 62% being beyond the target timeframe (3 calendar days). The mean number of calendar days from date of death to registering was four.			
Recommendations for the Board:	The Board is asked to note the report.			
Appendices:	None			

1.0 Introduction

To provide assurance that SaTH, as the host site of the Medical Examiner Service for Shropshire, Telford, and Wrekin (ST&W), is providing an effective, well led, and compassionate service which is meeting its statutory function.

This report has been specifically prepared for Board recognising that more detailed reports are presented to and scrutinised by the Quality Operational Committee (QOC) and the Quality and Safety Assurance Committee (QSAC).

2.0 Summary of Hospital Deaths

2.1 There were 2114 hospital deaths reported to the Medical Examiner Service within the Trust during the year 2024-25 (Figure 1), which was an increase of 24 deaths from what was reported in 2023/24. There were 624 deaths in Q4 which was an increase of 102 deaths from what was recorded in Q3.

2.2 At the start of February 2025, the National Medical Examiner updated all ME Services in England that in the first 4 weeks of January 2025, the number of deaths registered was around 9.5% higher than the equivalent period in 2024, demonstrating that the increase in deaths in SaTH during this period was aligned to the national picture.

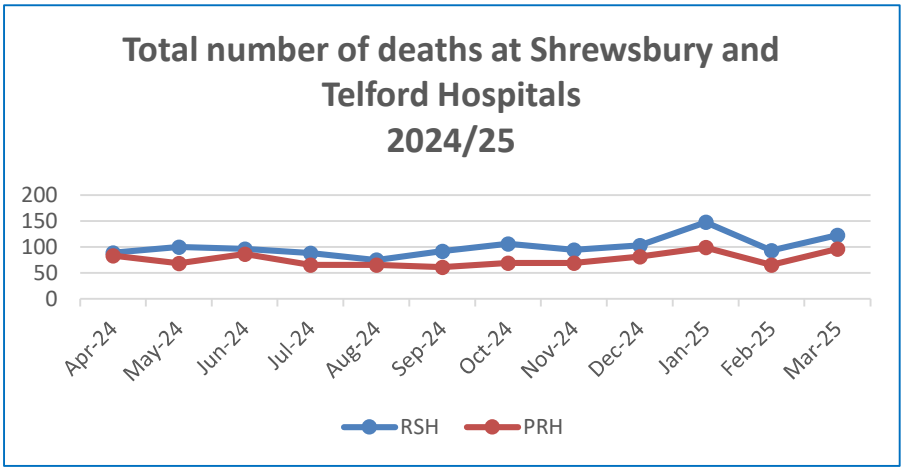


Figure 1 – Total number of deaths at SATH 12-month overview

3.0 Medical Examiner Scrutiny of SaTH & STW Deaths

3.1 Throughout 2024/25 the Medical Examiner service has scrutinised 2094 hospital deaths, 98.5% of the total number of deaths.

During Q4 the ME service received 629 hospital deaths for scrutiny. Of these 629 reviews, 99% of bereaved relatives received a phone call from the Medical Examiner service to discuss the care, treatment, and cause of death.

3.2 During Q4 the ME service received 844 community referrals. Throughout 2024/25, the ME service has undertaken reviews in a total of 2181 deaths from community providers across ST&W, which has been a gradual increase as the service approached the statutory commencement in September 2024.

3.3 Throughout 2024/25 the Medical Examiner Service has reviewed 4275 deaths from across the health system of Shropshire, Telford, and Wrekin. During Q4 the ME service received 1473 referrals which is the highest level of demand the service has seen since its inception in 2019.

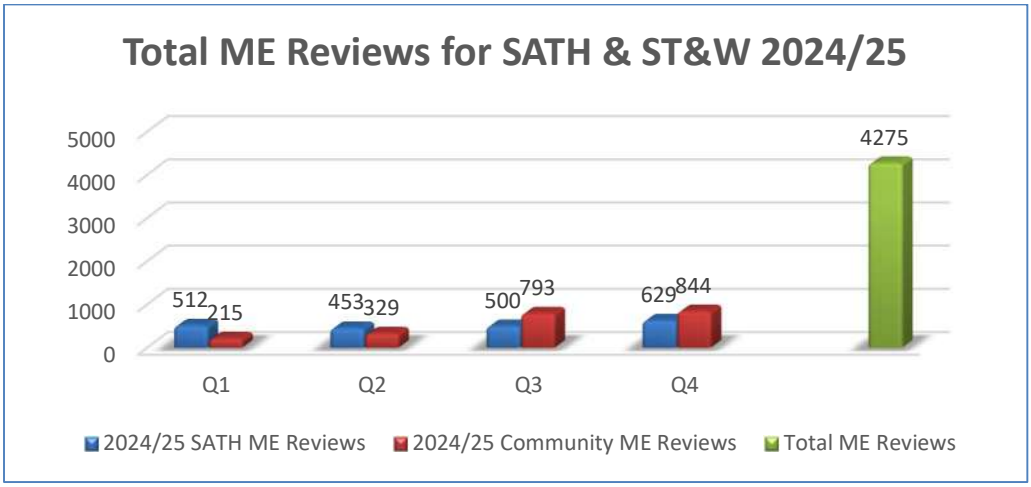


Figure 2 – Total ME reviews for SaTH & ST&W 2024/25

4.0 Medical Certificates of Cause of Death (MCCD)

4.1 Of the 629 hospital deaths reviewed by the ME service, 566 MCCDs were requested following Medical Examiner review and completed by the hospital attending practitioner.

Of the 566 MCCDs written, 514 had no coroner involvement, which demonstrates the reduction being seen in coroner involvement in deaths with known causes of death. The performance target for these to be written remains set to 3 calendar days to meet the previous 5-day registration target.

321 of the 514 MCCDs (62%) were written beyond three calendar days during quarter four, with 180 of these being in January. This is a further significant increase from what was seen in Q3. Performance did improve during February, but due to an increase in the number of deaths across the system in March, this rose again when the system saw further pressures.

The challenges with meeting this performance target during Q4 was multifaceted. This was related to a rise in demand from community clinicians, sick leave in the Medical Examiner team along with annual and study leave, equating to thirty-seven sessions lost. Another complexity that compounded the issue was the delay of notification of deaths from community clinicians, in some cases of up to 3 weeks between the date of their patient's death and date of referral to the ME. This therefore diverted ME capacity away from hospital cases to community cases as bereaved relatives were waiting to register the death and proceed with funeral arrangements, which extended the time of ME review for SaTH deaths.

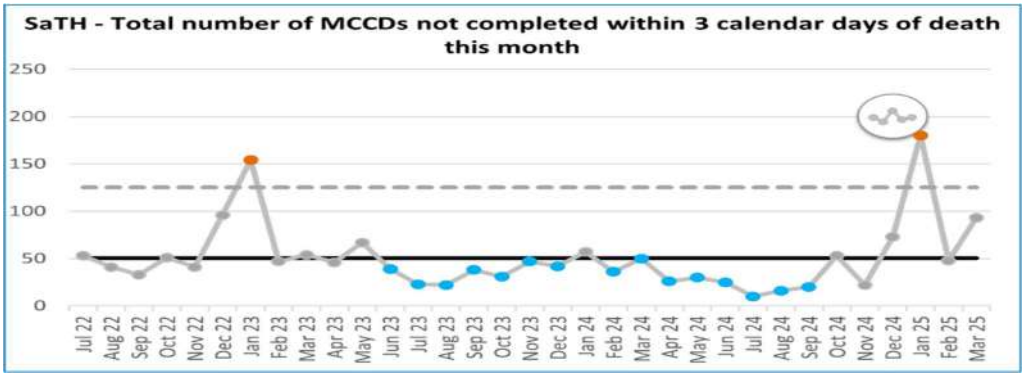


Figure 3 – Number of MCCDs not completed within three calendar days of death.

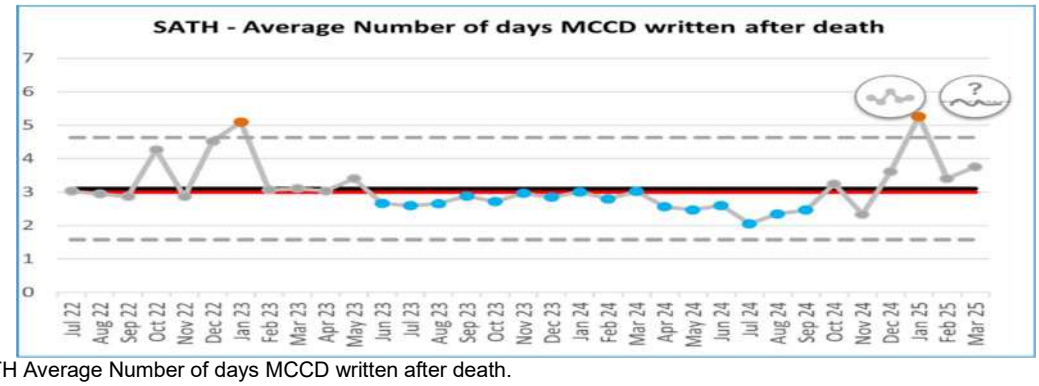


Figure 4 – SaTH Average Number of days MCCD written after death.

The above SPC chart demonstrates the pressures the service faced throughout Q4. The mean number of calendar days from date of death to releasing MCCDs for hospital deaths for registration was 4 days which is outside of the desired performance the service is striving to achieve and is a correlation with the aforementioned factors effecting capacity.

Throughout this period additional ME sessions were authorised to help deal with the demand the service was facing and the Medical Examiner Officers worked tirelessly to ensure all cases were prepared promptly to minimise the delays where possible.

The performance of issuing MCCDs has remained under close review whilst the service continued to balance the demand between hospital and community deaths. Formal demand and capacity planning has started to fully understand the pressures facing the service and work with Performance Team colleagues continues.

4.2 MCCDs for community deaths

MCCDs for 829 of the 844 community cases were authorised by the ME service during this quarter. The ME did not authorise the causes of deaths in fifteen cases and requested the attending practitioner refer their patient's death to the coroner. The mean number of calendar days from receipt of community referral to sending the MCCD to the registrar is 6.4 during Q4 and this was reported to NHSE as part of the quarterly data submission. Throughout 2024/25 the ME service has authorised 2136 community MCCDs.

5.0 Structured Judgement Review (SJR) & Potential Learning

5.1 Throughout 2024/25 the ME service has recommended 164 cases be considered for SJR. Figure 5 shows the categories for which the Medical Examiner has recommended an SJR review take place.

Cases that were recommended for SJR by the Medical Examiner have been discussed at SaTH's mortality triangulation group meetings, which are held weekly. The Medical Examiner service attends this meeting to continue to advocate for the bereaved and the recommendations made by the ME service. This information is also submitted to NHSE as part of the quarterly return.

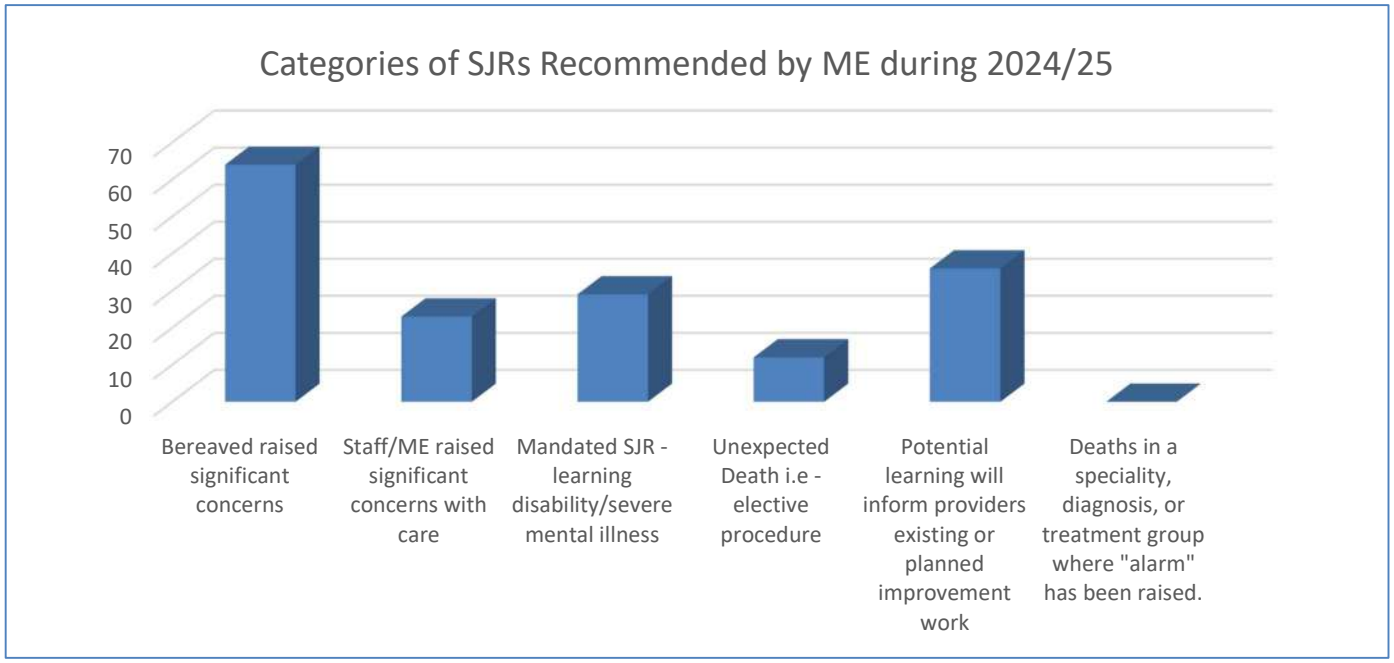


Figure 5 – Categories of SJRs recommended.

5.2 Deaths identified by Medical Examiner for potential learning.

Medical Examiners raised potential learning in ninety-nine deaths during Q4, with all these cases being referred to the relevant clinical divisions and specialties for review through their governance processes to ensure learning is shared. Throughout 2024/25 the ME has identified potential learning in 366 cases.

Whilst supporting the bereaved relatives during Q4, the Medical Examiner advised the next of kin in forty-seven cases to contact PALS to raise the concerns that were expressed during their interaction with the ME which is an increase of thirty-five cases in comparison to Q3. This is a significant increase in comparison to the same period of 2023/24 where eighteen families were signposted to PALS.

6.0 Coroner Referrals

6.1 Across both hospital sites the Medical Examiner facilitated 110 referrals to the coroner during Q4. This is an increase from what was referred in Q3 by twenty-eight referrals. Of the 110 cases referred, one case was a paediatric death which was reported to the coroner by the Medical Examiner and resulted in an MCCD being issued.

Of the 110 referrals made for the deaths on both hospital sites, the coroner did not action forty-nine of the cases by deciding the cases did not meet their duty to engage and issued a CN1A confirming their intention not to engage. The Medical Examiner therefore authorised these deaths. The coroner took sixty-one of the cases to investigation by authorising either an investigation, a post-mortem or proceeded to an inquest.

6.2 Throughout 2024/25, there have been 373 referrals made to the coroner, 13% of the overall deaths. Of this, 6% resulted in no action taken and 7% were taken for investigation.

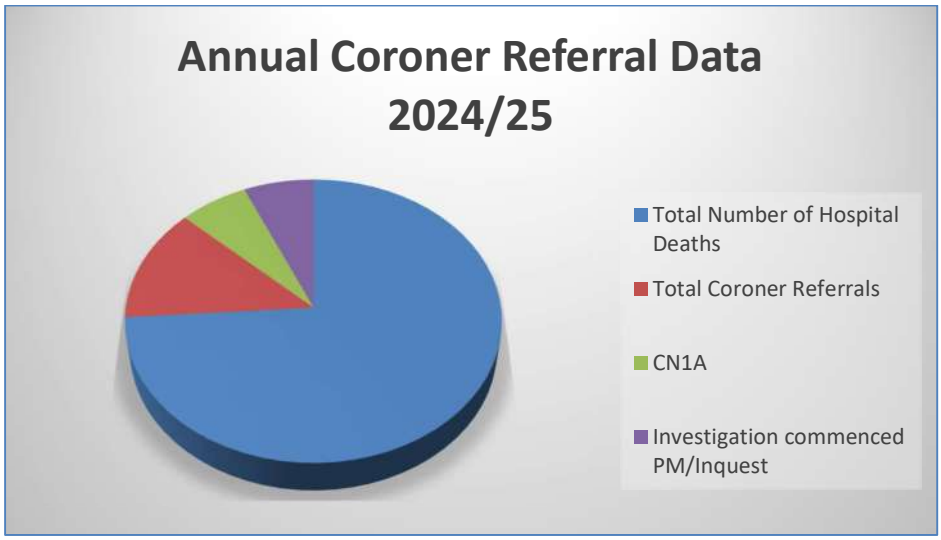


Figure 6 – Annual Coroner Referral Data 2024/25.

7.0 Urgent body release/faith requests

7.1 Over the course of 2024/25 there have been thirteen requests for urgent release of the deceased, all of which have been SaTH deaths and have not been made by community clinicians. The Bereavement and ME service met their obligations in supporting the bereaved in all thirteen cases.

8.0 Service Highlights

8.1 The Medical Examiner system became a statutory function during this annual reporting period and is a significant achievement and change in the death certification reforms. SaTH is the host site for the ME service for Shropshire, Telford & Wrekin and can demonstrate, through robust evidence, that it has expanded its function to ensure all deaths in the county, that do not meet the criteria for coroner notification, are referred to the ME service and proportionate scrutiny is carried out and support provided to the bereaved.

8.2 Throughout 2024/25 the ME service has supported 4275 families across ST&W in the initial stages of their grief, by explaining the medical nature of their relative's death and listening to their concerns and worries and in some cases the praise they had for the medical professionals who cared for their loved one.

8.3 The expansion of the Medical Examiner service was a formal project as part of the Getting to Good Programme, and through providing robust evidence of milestones

achieved, and providing regular programme updates and assurance, the project was officially closed in March 2025, having successfully delivered all key milestones.

8.4 The ME service at SaTH has partnered with external stakeholders across the system to ensure a robust service is embedded, so that learning that is identified can be shared and acted upon. The ME service have far reaching links with external partners, including the Welsh ME service.

9.0 Feedback

The service received thank you cards & flowers during Q4 from bereaved relatives, thanking the service for its kindness, compassion and dealing promptly with their relative's death. Positive feedback was received by the Coroner for Shropshire about the ME service and has praised the positive working relationship that exists between our services and the professionalism of the Medical Examiner Officers and the supportive style that the service has. During Q4 96.5% of bereaved relatives felt the ME service was beneficial and helpful.

10.0 Risks

10.1 The increase in demand to the ME service during Q4 was heavily felt and the quality of ME referral and MCCDs being received by community clinicians created significant administrative burden on the service. The delays by some community clinicians referring their patient's deaths created issues with the flow of the demand as more ME capacity was diverted to community cases than hospital cases in the early part of Q4. This has been addressed with individual providers at the point of receipt of referral and remains under constant review. Ensuring a balance between managing community referrals along with hospital deaths has continued to be a priority to ensure the impact to mortuary capacity is limited and delays to the bereaved kept to a minimum where possible.

11.0 Summary

1.1 The commencement of the statutory ME system has allowed all the preparatory work that was undertaken in the months and years leading up to it, to be fully realised. The project to formally oversee the expansion of the service to all clinical stakeholders across ST&W officially recognised the significant achievement that had been undertaken in developing and implementing the service which ensures SaTH has a statutory function in place and is delivering its obligations in a timely, efficient, and compassionate manner and mirrors the wider ambition of collaboration with our system partners.

Board of Directors' Meeting 10 July 2025

Agenda item	108/25			
Report Title	How We Learn from Deaths Quarter 4 / Annual Summary 2024-2025 Report			
Executive Lead	Dr John Jones, Executive Medical Director			
Report Authors	Dr Dewi Eden, Trust Clinical Lead for Learning from Deaths Fiona Richards, Head of Learning from Deaths & Clinical Standards			
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	√	1078
Well Led	√	Our partners		
Consultation Communication	Trust Learning from Deaths Group, 1st May 2025 Quality Operational Committee, 20th May 2025 Quality & Safety Assurance Committee, 27th May 2025			
Executive summary:	• A summary of crude mortality data within the Trust for 2024-2025 including Q4 is included in the report - broadly in line with 2023-2024. • The reporting of statutory returns for data submission within the Trust has recommenced in May 2025. The impact on the Trust SHMI and other key performance metrics within the Learning from Deaths agenda will be reviewed once this work has been completed satisfactorily. • A detailed prospective review of mortality within the ED has been commissioned with key lines of enquiry agreed with oversight by the Medical Director. The lines of enquiry may evolve as the review progresses. • One Regulation 28 Report to Prevent Future Deaths, has been received by the Trust from His Majesty's Coroner (HMC) during Q4, the first since 2021. • An SJR was completed for just under 15% of all deaths that were recorded during 2024-2025. • Key negative and positive learning identified through the Learning from Deaths agenda with details of related improvement activity summarised in the report.			
Recommendations for the Board:	The Board is asked to note the report and the improvements made during Q4.			

1.0 Introduction

1.1 This report using data to 12 May 2025, provides an update for Learning from Deaths (LfD) for the full year 2024-2025 as well as a summary for the quarter 4 (Q4) period.

1.2 This is a summary report specifically prepared for Board recognising that more detailed reports are scrutinised by the Quality Operational Committee (QOC) and the Quality and Safety Assurance Committee (QSAC).

2.0 Summary of Hospital Deaths: Crude Mortality - Internal Performance Monitoring

2.1 There were 2114 deaths reported to the Medical Examiner (ME) during 2024-2025 compared to 2090 recorded during 2023-2024. 1713 of these deaths were recorded as inpatient deaths and 401 were reported as having occurred in the Emergency Department (ED). Of the 624 deaths that were reported during Q4, 501 were recorded as inpatient deaths and 123 recorded as having occurred in the ED. This figure represents an overall increase (inpatient and ED) of 102 deaths from Q3 and an increase of 57 deaths from Q4 in 2023-24.

2.2 During Q4, January and March 2025 demonstrated increases in both inpatient and ED mortality with a notable spike seen in January. This was in line with the increase of deaths registered nationally in the first 4 weeks of January as informed through the National ME.

Over the full year 2024-2025, the total number of inpatient deaths and deaths within the ED are comparable to 2023-2024.

3.0 Data Warehouse Challenges

3.1 Performance reporting of various metrics within the Learning from Deaths agenda remain negatively impacted by the Data Warehouse challenges which have affected national submissions related to Secondary Uses Service (SUS) and Service Level Agreement Monitoring (SLAM) within the Trust. This includes Summary Hospital-level Mortality Indicator (SHMI), Crude Mortality Rate (CMR) depth of coding and palliative care coding. Local improvement work to monitor 30-day mortality relating to attendances in the ED, including those where a delay has been experienced is also impacted until the issue is resolved. The risk that an inability to monitor these metrics poses has been incorporated into a wider Trust risk relating to this issue.

3.2 The LfD team understand that national submissions recommenced in May 2025 and it is anticipated that the impact on the Trust SHMI and other key performance metrics within the Learning from Deaths agenda will be reviewed once this work has been completed satisfactorily.

4.0 Mortality within the Emergency Department (ED)

4.1 A detailed review of mortality within the ED has been commissioned, informed by a multi-disciplinary group chaired by the Deputy Medical Director. This will build on previous retrospective and collaborative work undertaken within the Trust which was reported to Board in December 2023.

4.2 A review of patient safety themes relating to mortality within the Emergency Department has been undertaken and a dataset proposed to inform a prospective clinical audit in the ED with commencement planned for Autumn 2025. A review of ReSPECT within the ED, to include system partners as required and a review of frailty within ED is being facilitated by key stakeholders.

5.0 Structured Judgement Reviews (SJRs) Performance

5.1 At the time of writing this report, SJRs were completed for just under 15% of all deaths that occurred during 2024-25 and for just under 10% of deaths that occurred during Q4. Q4 performance will increase when SJRs in progress have been completed. This figure is in addition to deaths that have been reviewed through other methods including datix investigations, coronial processes and the Formal Complaints process. 77% of the SJRs undertaken were completed within 8-weeks of the patient's death.

5.2 The majority of SJRs (61%) completed in the Trust during 2024-2025 were triggered through random selection, with 22% from the ME Service, 13% arising from the weekly Mortality Triangulation Group (MTG) and 4% through online mortality screening undertaken by clinical colleagues.

5.3 During 2024-25, there has been a slight increase in the number of SJRs where the overall care rating was either 'good' or 'excellent' compared to 2023-2024 (63.9% vs 59.1%) and a decrease in those where the overall care rating was 'poor' or 'very poor' (14.4% vs 15.74%).

5.4 There have been 8 patient safety incidents arising out of the 356 SJRs completed during 2024-2025. These were reported to the Learn From Patient Safety Events (LFPSE) Service, formerly called the National Reporting and Learning System (NRLS), following submission of an SJR datix and management through the Trust Incident Response Oversight Group (IROG) forum where level of harm is agreed.

5.5 During 2024-2025, there were 64 SJRs triggered by the ME on the basis of concerns raised by the bereaved which includes an additional 8 cases from August, September and October 2024 which were identified through data validation work in Q4 and were not included in previous Board reports.

Significant concerns raised by bereaved families or carers for patients who died during Q4 include those relating to pressure care, mental capacity assessment, communication issues including around transfer between hospital sites, discharge arrangements, pain management, falls including provision of physiotherapy, EoL care, including decision making around commencement of EoL pathway, use of naso-gastric tubes, delays in the ED, concerns around general medical care, nursing issues including the provision of compassionate care, medication issues, and missed opportunities to identify deterioration including within primary care.

6.0 Learning to Improvement

6.1 Both positive and negative learning identified through the completion of SJRs, as well as the wider Learning from Deaths processes is shared with key internal and external stakeholders to inform quality improvement initiatives across the Trust. These include the Palliative and End-of-Life Care (PEoLC) team, Medicine Safety Officer (MSO), Quality Matrons, Divisional Quality Governance Teams, clinical colleagues, specialist

clinical staff, and system partners, for example Shropshire, Telford and Wrekin Integrated Care Board (STW ICB) and West Midlands Ambulance Service (WMAS). Individual learning is usually managed at Divisional level.

6.2 Positive learning identified in Q4 includes staff attitudes, collaboration between specialist teams with good examples of multi-disciplinary working and communication, prompt medical assessments, expert advice being sought internally and externally as required, EoL care, and good documentation including medical care plans and escalations, evidence of senior review, family involvement with and completion of Mental Capacity and Best Interests forms, safety checks in ED, and good nursing assessments.

Learning from Excellence is celebrated and promoted through the wider Learning from Deaths agenda including the Trust Learning from Deaths Group, Divisional Morbidity and Mortality or Governance meetings and individual feedback.

6.3 Key negative learning within the LfD agenda during Q4 including SJRs where the overall care was rated as poor or very poor includes: issues relating to delays with initial assessments / triage, corridor care and transfer to ward beds in ED, delays waiting for ambulances, recognition, escalation and management of deterioration and sepsis including the assessment of new confusion, delays with specialty referrals including problems incurred with the stroke service being on different site, medication issues including administration of time-critical medications, nutritional issues for example delays providing nutritional support including Total Parenteral Nutrition (TPN), electrolyte and metabolic management, as well as recognition of poor nutritional state, fluid balance monitoring, delayed recognition of deterioration and commencement of end-of-life (EoL) care, delayed completion of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) plans leading to potentially inappropriate active management, resuscitation or admission to hospital which may have been prevented, delays in the completion, reporting and review of laboratory and imaging investigations resulting in delayed diagnosis and treatment plans, and lack of senior review following admission to a ward.

6.4 The qualitative narrative provided within completed SJRs is challenging to analyse to ensure themes and trends are appropriately identified and can be utilised for quality improvement work within the Trust. The Learning from Deaths team are continuing to develop and refine the thematic analysis of learning specifically related to 'Problems in Care' (PIC) categories identified within SJRs as well as MTG so it can be positively impactful across the quality and safety improvement agenda within the Trust.

6.5 Specific quality improvement work underway within the Trust which address aspects of learning identified through the LfD agenda includes:

ReSPECT: Focused work coordinated by Trust ReSPECT Lead incorporating a revised ReSPECT audit process, a guide developed to help clinicians fill in the ReSPECT form ensuring that the patient remains at the centre of discussions and planning – a trial is in progress on wards 15 and 16, specific communication strategies to promote the ReSPECT process as not just a 'do not attempt resuscitation' (DNAR) decision but also one that addresses plans for treatment when reversible causes of deterioration have occurred for example anaphylaxis and choking, system working to promote effective use of ReSPECT forms, patient representative involvement with improvement work and a Trust ReSPECT intranet page.

PEoLC: Six training sessions for PEoLC Champions confirmed and available for staff to book between May and November 2025, the Bereavement Feedback questionnaire has been updated and improvements made in how anonymised results are reported to ward areas, positive feedback dissemination to clinical areas, the Palliative Care Consultant establishment has been recruited to in full and 2 consultants started in the Trust during Q4, and the Swan Care Plan has been updated which has a more concise layout. Within this the Abbey pain scale has been replaced with Pain Assessment in Advanced Dementia (PAINAD) scale where patients are unable to verbalise pain, symptom early warning scores have been introduced replacing comfort observations, and changes have been made to the spiritualistic / holistic care page.

MEC Division: a Trial is underway on ward 35 supported by Pharmacy, MSO and relevant Quality Governance teams to introduce a new system for transcribing medication, with a focus on prescribing and compliance to the Trust prescribing standards, improvement work relating to the incorrect calculation of new confusion on NEWS score planned – actions to be developed from current patient safety investigations.

Deteriorating Patient: a Deteriorating Patient Programme Group has been established and 6 workstreams of improvement work agreed and monitored through the Deteriorating Patient Group. These are:

1. Education to support the recognition of deterioration in a patient's condition.
2. Guidelines
3. Development of a Deteriorating Patient Dashboard providing ward, divisional and trust-wide performance data which will inform quality improvement work.
4. 'Ceilings of Care' – trials have already been undertaken in some ward areas including a treatment escalation plan (TEP), and a deteriorating patient sticker.
5. Handover – reviewing the multiple handovers that occur for example, ward to ward, nurse to nurse, shift handover, and 'on call to day' team.
6. 'Response' – for example escalation response times, personnel who respond to escalation of concerns, bleep issues.

7.0 Maternal Mortality

7.1 During 2024-2025, there was 1 maternal death reported by SaTH to 'Mothers and Babies: Reducing the Risk through Audits and Confidential Enquiries' (MBRRACE-UK). This death occurred outside of the Trust and was referenced in the Q1 2024-2025 iteration of this report.

7.2 The MBRRACE-UK Saving Lives, Improving Mothers' Care 2020-2022 report was published in October 2024. This was discussed at the Maternity Governance meeting in January 2025. Key points from the report are:

- The maternal death rate in the UK is the highest it has been for 20 years at 13.56/100,000 maternities.
- The leading cause of death is thrombosis and thromboembolism, followed by Covid and heart disease.
- Deaths from mental health related causes account for nearly 34% of late maternal deaths (6 weeks to 1 year after pregnancy).
- There are national recommendations and learning specifically relating to thrombosis and thromboembolism, cancer, ectopic pregnancy and women who are recent migrants and have language difficulties.

8.0 Paediatric Mortality

8.1 There have been 33 paediatric deaths across the Shropshire, Telford and Wrekin Integrated Care System (STW ICS) notified through the Child Death Overview Panel (CDOP) during 2024-2025. This figure includes 9 deaths that occurred within SaTH; 5 neonatal deaths, 3 deaths that occurred in the ED and 1 death that occurred on the paediatric ward. Neonatal mortality is detailed at section 9. All child deaths are reviewed within the CDOP statutory process.

8.2 Positive learning identified through the CDOP panel and received during Q4 includes: good neonatal counselling to parents of an extremely premature baby, parental involvement in the conversation regarding the reorientation of care to comfort care, good support provided to families by Hope House, good support provided by the Bereavement Midwives to families, parents very grateful for the support provided by the neonatal team and ward staff, referrals to Children's Social Care was done at an early opportunity in pregnancy for support, blessing for babies took place as per the parents' wishes, family members were able to be present during palliation of babies.

8.3 Learning for improvement identified through the CDOP panel and received during Q4 includes: the communication between different specialties and external agencies was delayed in one case – this did not impact on the outcome for the baby, care being provided on a ward with other mothers whilst babies are in the neonatal unit, areas for improvement with both nursing and medical documentation – this did not impact on the outcome for the baby.

9.0 Perinatal Mortality

9.1 During 2024-2025, there were a total of 5 neonatal deaths where the baby was born and died at SaTH. Of these, 4 babies were over and 1 baby was under 22 weeks gestation. One of these deaths occurred during Q4. Three of the neonatal deaths were not notified to the Medical Examiner Service as these occurred prior to the introduction of the statutory service in September 2024. Death certification would therefore be managed at specialty level. During the year there were an additional 3 neonatal deaths where the baby was born at SaTH but died elsewhere.

9.2 There have been 9 stillbirths over 24 weeks gestation during 2024-2025, 2 of these occurred during Q4. There have been 3 late fetal losses between 22+0 and 23+6 weeks of pregnancy during the year, none of which occurred during Q4. Both stillbirths and late fetal losses fall outside of the remit of the ME Service and therefore are not included with the overall Trust mortality data given within this report.

9.3 Learning points from a completed PMRT review during Q4 relate to: the availability of patient information leaflets in different languages, the requirement for interpreters for all booked appointments for women who are non-English speaking, women who contact maternity triage with abdominal pain must be advised to attend for examination to rule out pre-term labour, when a woman attends for review, the team are to ensure the medical history is reviewed and management plans updated accordingly, if women are unable to attend appointments due to problems with transport, this can be arranged through the management team, requirements for referral to the pre-term prevention clinic, antenatal supply of aspirin at booking for all women recognised as high risk for fetal growth restriction and / or pre-eclampsia, referral requirements for women with

moderate to severe anxiety and or depression, red-flag symptoms for mental health conditions.

9.4 The action plan relating to invited external expert review completed in Q3 2023-24 in relation to the 'above average' mortality within SaTH highlighted in the MBBRACE-UK reports for 2021 and 2022, continues to be monitored through the Maternity and Neonatal Transformation Assurance Committee and as such, reported directly to Board by the Division.

9.5 The MBRRACE-UK Perinatal Mortality Surveillance: UK Perinatal Deaths of Babies Born in 2022 was published in July 2024 and relates to stillbirths and neonatal deaths (after 24 weeks) in the UK during 2022. The report was discussed at the Maternity Governance forum in January and the quarterly Maternity and Neonatal Mortality and Morbidity meeting in February 2025. SaTH specific data was shared in the Q1 2024-2025 iteration of this report. Key points to note:

- This report is the 10th Perinatal Mortality Surveillance report and focuses mainly on births from 24 weeks completed weeks gestation in the UK in 2022.
- The report summarises the UK position.
- Stillbirths have decreased but neonatal deaths have increased.
- Inequalities in mortality rates by deprivation and ethnicity remain.
- The most common cause of stillbirth was placental.
- The most common cause of neonatal death was congenital anomalies followed by neurological causes.
- When stillbirths and neonatal deaths are combined, congenital anomalies contributed to 17% of deaths.

9.6 The MBRRACE-UK perinatal mortality report: 2023 births in SaTH, focus on stillbirths - Trust specific data was published in February 2025. The full report will be published in the summer 2025. The key points of note are:

- The stabilised and adjusted stillbirth rate for SaTH is around the average for similar Trusts and Health Boards.
- The stabilised and adjusted extended perinatal mortality rate is around average for similar Trusts and Health Boards. This is an improvement from the 2022 data.
- There were no trends identified which were thought to contribute to the outcome, on review of the stillbirths that occurred in 2023. Incidental learning was identified and guidelines updated accordingly.

9.7 It should be noted that the inclusion criteria for neonatal deaths within published MBRRACE-UK reports is based on the date of birth of the baby rather than the date of death and on a calendar year rather than the financial year that all the other mortality data contained within this report refers to.

10.0 Deaths of Patients with a Confirmed Learning Disability or Autism or a Serious Mental Health Illness (SMI)

10.1 There have been 17 deaths of patients who died within the Trust during 2024-2025 with a learning disability or autism, 4 of which occurred in Q4. Three of the 17 cases were patients with an address in Wales and as such they did not meet the criteria for referral to LeDeR. Deaths of patients who live in Wales are shared with NHS Wales for a local review to be undertaken as per their local process.

10.2 There 11 deaths of patients with an SMI during 2024-2025, 2 of which occurred during Q4. One additional case has been flagged for a specialist mental health review although the diagnosis available does not meet the SMI criteria.

10.3 All deaths of patients with a confirmed learning disability, autism or a diagnosed SMI are reviewed through the SJR process unless an alternate review is underway for example a patient safety datix investigation. Local learning identified in the SJR informs the wider LeDeR review for patients with a learning disability or autism.

10.4 Positive learning and learning for improvement identified for this group of patients has been incorporated into section 6 of this report.

11.0 Deaths Deemed More Likely Than Not Due to Problems in Healthcare

11.1 During the full year 2024-2025, there have been 7 deaths reported to the Board which have been deemed more likely than not due to problems in healthcare and therefore were considered to be potentially avoidable. These deaths have been reported within previous iterations of this report. None of these occurred in Q4.

12.0 Regulation 28 – Reports to Prevent Future Deaths

12.1 One Regulation 28 Report has been received by the Trust from His Majesty's Coroner (HMC) in Q4. This is the first Regulation 28 to have been received since 2021.

12.2 Concerns identified by HMC focused on communication with patients around potential side effects of new medication, which is started in hospital, including information about actions to be taken if a patient believes they are having an adverse reaction. These concerns also included how this information is documented so that other staff are aware of the information that has or has not been provided.

12.3 A multi-disciplinary working group has been set up to address the concerns raised and ensure appropriate actions are developed, implemented and embedded. Actions to include:

- Changes to the medication counselling Standard Operating Procedure (SOP) require all counselling to be documented.
- Referral to community-based services to be documented.
- New patient medication leaflet has been designed and will be available by September 2025.
- Senior doctor training will include safe prescribing, incorporating the case as a training example.

13.0 Risk Register

13.1 There is one Trust-wide risk which impacts on the Learning from Deaths agenda. This relates to the current challenges with the Data Warehouse as detailed at section 3 of this report.

Dr Dewi Eden, Trust Clinical Lead for Learning from Deaths
Fiona Richards, Head of Learning from Deaths & Clinical Standards
April 2025

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 10 July 2025

Agenda item		109/25		
Report Title		Integrated Maternity and Neonatal Report		
Executive Lead		Paula Gardner, Interim Chief Nursing Officer		
Report Author		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. 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. • Record formally in the minutes of this meeting that it has received Appendices listed in the table under section 5.2 (Appendices Five to Seven), which accompany this report in the supplementary information pack.		
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.

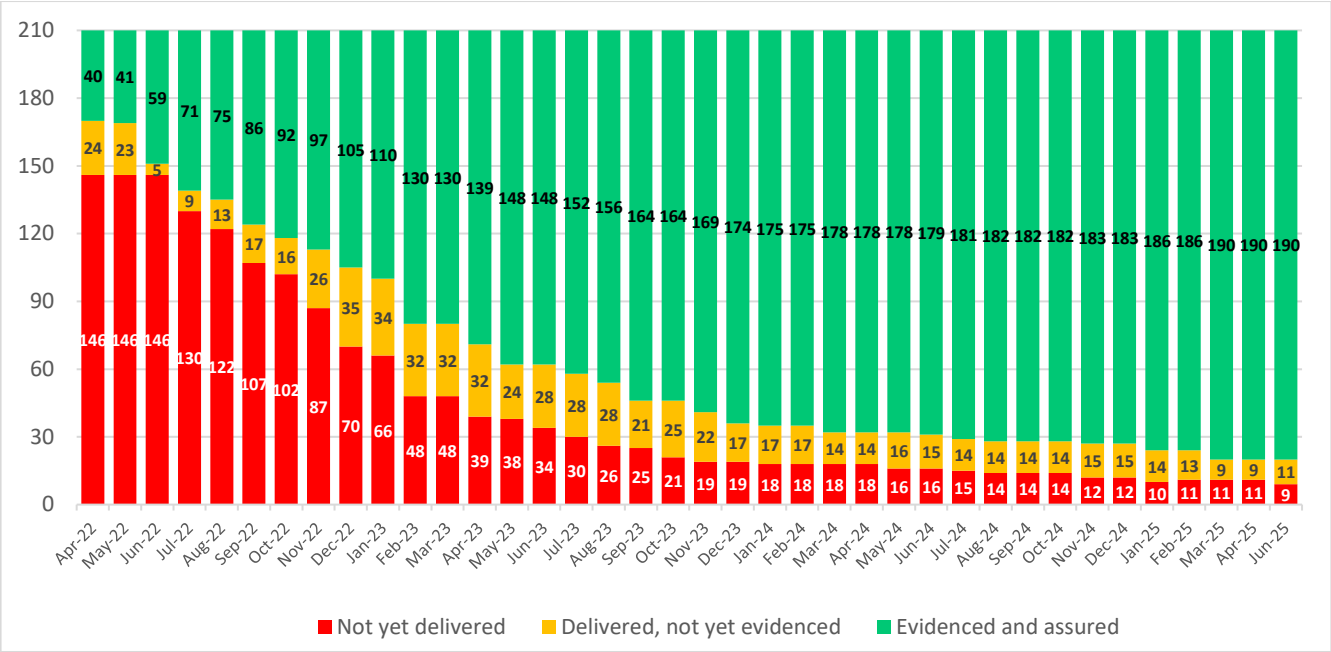
1.4 A summary of progress with the Maternity and Neonatal Transformation Programme (MNTP), which is an IMR action requirement, including an update on the Cultural Improvement Plan.

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

1.6 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 is 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 10 June 2025. The overall trajectory and position are, as follows:



Delivery Status	Number (change since last report)	Percentage
Evidenced and Assured	190 (⇔)	90.5%
Delivered, Not Yet Evidenced	11 (⇧4)	5.2%
Not Yet Delivered	9 (⇩2)	4.3%
TOTAL	210	

**Rounded percentages

Progress Status	Number (change since last report)	Percentage
Completed fully (Evidenced and Assured)	190 (⇔)	90.5%
On track	13 (⇧3)	6.2%
Off track	0 (⇩3)	0
At Risk	0 (⇔)	0
De-scoped	7 (⇔)	3.3%
Total	210	100%

**Rounded percentages

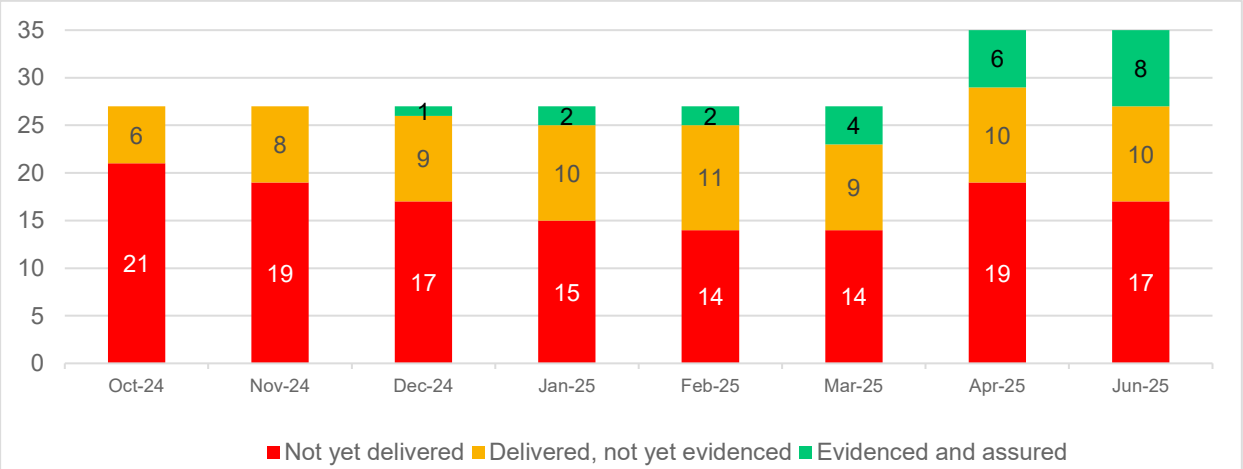
2.2 Since March 2025, three actions have moved from **off-track** to **on track**. Currently, no actions are at risk or off track.

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, which remain under review by the Trust at the Maternity and Neonatal Transformation Committee MNTAC quarterly, to check on any progress.

2.4 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 Continued 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. **Appendix Two** provides the summary Neonatal External Mortality Review (NEMR) Action Plan at 10 June 2025. The overall trajectory and position are, as follows:



Delivery Status	Number	Percentage
Evidenced and Assured	8 (⇧2)	22.9%
Delivered, Not Yet Evidenced	10 (⇔)	28.6%
Not Yet Delivered	17 (⇩2)	48.6%
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)	8 (⇧2)	22.9%
On track	23 (⇩2)	65.7%
Off track	2 (⇔)	5.7%
At Risk	0	0
Not Started	2 (⇩1)	8.6%
Total	35	100%

**Rounded percentages

3.2 The two actions off-track currently relate to the service's 'Golden hour' provision. A Golden Hour checklist has been implemented within the service for preterm babies, but compliance has not yet been sufficient for this action to be proposed for 'evidenced and assured' Green Status. Additionally, the service has been collaborating with the reviewers to introduce guidelines for adopting the Golden hour for term babies, for which there is no national guidance available. Both of these actions have been reviewed with the LMNS and the network, and updates will be provided back to MNTAC, along with revised timeframes to get them back 'on track'.

3.3 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 All actions are progressing well.

4.3 A refreshed action plan for the Three-Year Delivery plan has been received from the LMNS, and a gap analysis is underway to compare this with the previous version in order to ensure that nothing is missed.

4.4 Progress continues to be made with the cultural improvement plan. This includes widening its scope to look more broadly at the culture within and across the Women and Children's Division. This is all within existing resources. One notable change is that self-rostering has been introduced in the neonatal unit, and this is having a positive impact on staff. This Division is considering if this can be achieved in its other services.

4.5 The Board of Directors is advised that the neonatal service has achieved Bliss Baby Charter silver status, which improves family centred care. In addition, Stage 2

accreditation for the Baby Friendly initiative has been achieved, and the service is working towards the Stage 3 standards.

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 was validated and accepted by NHS Resolution, which means the Trust met the requirements to receive the incentive scheme premium in full.

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 and further details 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 continue in line with Year 7 Technical Guidance. Quarter 1 Quarterly and Board reports are expected to be presented in Sep-25.
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. No risks to delivery have been identified.
SA3	Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of mothers 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?	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). The second DoM Staffing report for the reporting period is expected to be presented in Nov-25 (Last reported May 2025).
SA6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	This standard was achieved in full last year. Compliance is being benchmarked against the recently published SBLCB version 3.2, along with quarterly quality improvement discussions with the ICB.

SA7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	Reports and compliance will be presented to LMNS, Maternity Neonatal Safety Champions and QSAC. A risk to the delivery of this action has been identified, relating to the requirement for the MNVP lead to be a quorate member of internal meetings. Further details are available in section 4.7.2 of the Year 7 CNST Progress CNST Report June 2025, which is provided in the supplementary reading pack at **Appendix Four.**
SA8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Quarterly reports will continue 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 Dashboard Safety Champions is presented to the Board each quarter during the reporting period. and is presented at **(Appendix Five).** The 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 Six).** The Perinatal Quadrumvirate Leadership team meet (bi-monthly), and the minuted minutes of the May-25 meeting are at **(Appendix Seven)**
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.	This safety action relates principally to the work of the divisional governance team, supported by the legal team. As with Safety Action 1, the need to report appropriately to the (HSIB) and the NHS Resolution Early Notification Scheme (ENS) is ongoing, hence this action will not be

SA 10 Cont.		evidenced as delivered/complete until the end of the reporting period. Family information on the role of HSIB/NHSR ENS and Duty of candour is monitored weekly, and an audit will be produced to evidence compliance following the reporting deadline which is in keeping with Year 4 of the scheme.

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, it has received Appendices listed in the table under section 5.2 (Appendices) Five to Eight that accompany this report.

6.0 Summary

6.1 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.

7.0 Recommendations

7.1 The Board of Directors is requested to:

7.2 Receive this report for information and assurance.

7.3 Record formally in the minutes of this meeting that it has received Appendices listed in the table under section 5.2 (Appendices Five to Seven), which accompany this report in the supplementary information pack.

Jacqueline Bolton
Interim Head of Midwifery

Julie Plant
Divisional Director of Nursing

July 2025

All appendices are in the Board Supplementary Information Pack

Appendix One:	Ockenden Report Action Plan at June 2025
Appendix Two:	Neonatal External Mortality Review Action Plan at June 2025
Appendix Three:	Summary Maternity and Neonatal Transformation Plan (MNTP) Phase Two at April 2025
Appendix Four:	Year 7 CNST MIS Progress Report June 2025
Appendix Five:	Locally agreed dashboard Safety Champions Q1 2025 June meeting (1)
Appendix Six:	Triangulation of NHSR Scorecard Q4 2025 June Governance
Appendix Seven:	Minutes of Perinatal Quadrumvirate Safety Champions Bimonthly mtg May 2025

Maternity & Neonatal Safety Champions - Key Issues Report

Report Date: 09/05/2025		**Report of:** Maternity and Neonatal Safety Champions Meeting
Date of last meeting: 01/05/2025		**Membership Numbers:** Quoracy met = yes
1	**Agenda**	• Chair's welcome and apologies, conflict of interest and minutes reviewed. • Action log and review of AAAA from April 2025 • Neonatal Review update • Maternal and Neonatal quality dashboards and oversight reports • MTP/Ockenden Report Action Plan and Assurance Report • MLU update • Decision to delivery report • Education and training report • ATAIN quarterly report • PMRT quarterly report • Neonatal staffing and BAPM report • Locally agreed safety intelligence dashboard • Maternity services CQIM MSDS dashboard and AAA • Maternity CQC Survey Report and related action plans • Maternity safe staffing report and DoM safe staffing report • Maternity governance report • MNVP - Maternity and Neonatal Service User Feedback – themes and actions • MNVP Neonatal families/bereavement/BAME/high depravation – Prioritisation action plan
2a	**Alert**	
2b	**Assurance**	• The MNSC group were assured that although the reporting of third and fourth degree tears was 2.6%, above the national target of 2%, this is within the limits of normal variation, the YTD figure is 1.9%.
2c	**Advise**	• Feedback has been requested and will be sent by the Medical Director to the Royal College of Physicians, who carried out the invited neonatal review, on progress in implementing the • recommendations. The neonatologists request for a review of the HTP floorplan for the new neonatal unit has been started with input from the patient safety team. Learning from regional units who do not have co-located units is

		being sought so we can learn from the operational experience of other units. The review will report to the HTP Clinical Advisory Group with the outcome fed back to the MNSC group also. • The group noted that the Trust performed 'About the same' as other Trusts in all 10 sections of the 2024 CQC Maternity Services Survey Action Plan. There was no statistically significant change from last year. In one question we were 'somewhat worse than expected'; Were you offered a choice about where to have your baby? • Maternity and Neonatal Independent Senior Advocate (MNISA) approved by NHSE on 11 April 2025 to begin working directly with women, birthing people and families. Associated webpage, contact forms and promotional materials live. Soft launch via NHS STW social media channels week commencing 14 April 2025. • MNVP – engagement events have started and themes are emerging that will feed into the service to improve the care provided to patients.		
3	**Actions to be considered by the MTAC / QSAC / Trust Board**			
4	**Report compiled by**	Dr Stephen McKew (Deputy Medical Director)	**Minutes available from**	Charlotte Allmark (PA to Deputy Medical Directors and Associate Medical Director)

Maternity & Neonatal Safety Champions - Key Issues Report

Report Date: 09/06/2025		**Report of:** Maternity and Neonatal Safety Champions Meeting
Date of last meeting: 05/05/2025		**Membership Numbers:** Quoracy met = yes
1	**Agenda**	• Chair's welcome and apologies, conflict of interest and minutes reviewed. • Action log and review of AAAA from May 2025 • Feedback from Safety Champions Walkabout – Wrekin MLU • Neonatal Review update • Maternal and Neonatal quality dashboards and oversight reports • MLU update • Decision to Delivery report • Saving Babies Lives Report • Transitional Care Audit Quarterly Report • Locally Agreed Safety Intelligence Dashboard • Maternity Services CQIM MSDS Dashboard and AAA • Maternity Safe Staffing Report • Maternity Governance Report including MNSIs and action plans • MNVP - Maternity and Neonatal Service User Feedback – themes and actions • MNVP Neonatal families/bereavement/BAME/high depravation – Prioritisation action plan • Home Birth Service • Neonatal Badgernet • Cross-border Maternity Care • Safety Champions Walkabout Feedback – Review of access to Oswestry MLU
2a	**Alert**	• None
2b	**Assurance**	• There has been a notable reduction in the number of delays for Category 2 caesarean sections following work around developing the standard operating procedure and introducing the use of 2222 for category 2 caesarean sections.
2c	**Advise**	• Champions discussed staff and family engagement on Wrekin MLU walk about. No significant safety concerns. Observations fed back to management. • Discussion on complexity of cross-border arrangements for maternity care discussed. Further information requested.

		• Champions requested more information on causes for babies of small gestational age now that smoking rates have fallen significantly. • Requested neonatal metrics are now on locally agreed dashboard. • Champions received an update on work being carried out by MNVP and challenges created by number of hours available to role.		
3	**Actions to be considered by the MTAC / QSAC / Trust Board**	• To note that there has been an escalation to ICB regarding time available to MNVP to support quoracy in meetings for CNST.		
4	**Report compiled by**	Dr John Jones (Executive Medical Director)	**Minutes available from**	Charlotte Allmark (PA to Deputy Medical Directors and Associate Medical Director)

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
10 July 2025

Agenda item		111/25		
Contract Title		**System Integrated Improvement Plan (SIIP)**		
Executive Lead		Jo Williams, Chief Executive Officer		
Report Author		Mary Aubrey, Programme Director		
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, 02.06.2025 Performance Assurance Committee, 24.06.2025 Finance Assurance Committee, 24.06.2025 Quality & Safety Assurance Committee, 24.06.2025		
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 by March 2026. 2. The report includes the latest position in relation to the delivery of tasks/actions against SaTH's section of the System Integrated Improvement Plan (SIIP), which are 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 15 July 2025.		
Appendices (in Board Information Pack)		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		

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 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 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 4.19:** The Financial Recovery Group (FRG) is established and forms part of the weekly CEO meeting. Its Terms of Reference have been drafted and are under review
- **SaTH Metric 4.21:** Strategic People Group terms of reference approved by SPG on 3 June 2025.
- **SaTH Metric 4.4.3:** The Trust continues to actively support the development and delivery of a system PMO within the Shropshire, Telford and Wrekin (STW) Integrated Care System.

Workforce and Leadership Collaborative

- **SaTH Metric 2.1:** SaTH workforce delivery plans for 2024/25 and 2025/26 aligned to system plans
- All workforce actions have been delivered against the System Integrated Improvement Plan.

Finance

- **SaTH Metric 1.2.15**: NHS Planning guidance was delayed and was released on 30th January 2025.
- **SaTH Metric 1.1.3:** The financial position across the system and at SaTH remains a risk especially in relation to escalation, premium rate staffing and efficiency.
- **SaTH Metric 1.3.5:** The final draft of the Estates Strategy has been produced to include the configuration of the Modular wards. Following engagement with stakeholders during March and April 25, and in light of ongoing contributions from staff, we are aiming for Board sign-off in September 25.
- **SaTH Metric 1.2.5**: Financial Recovery Director appointed and Financial Recovery Group in place to support efficiency delivery and financial recovery.
- The increasing alignment between financial and workforce governance is vital.
- Reducing reliance on agency is making good progress with similar efforts underway for bank staff.

- **UEC**
  - **SaTH Metric 3.1.1.1:** Trajectory developed to increase percentage of SaTH attendances treated as Type 3 to 25% by 31/03/2026 with supporting working group formed
  - **SaTH Metric 3.1.1.3**: Direct access is now in place for Gynaecology and Early Pregnancy Assessment via Gynaecology Assessment and Treatment Unit (GATU), enabling faster access to specialist care. Further pathways are under review.
  - **SaTH Metric 3.1.1.5 & 3.1.2:** Improvement Week concluded in May 2025 and rolled out at PRH in June 2025, introducing direct streaming to Minors from Initial Assessment and reinforcing the Admission and Referral Protocol, which GIRFT will observe on site
  - **SaTH Metrics 3.1.29:** A draft 12-hour radiology turnaround proposal, including procedures and SOPs, has been developed. Onsite observations by the Improvement Hub will inform the final version
  - **SaTH Metric 3.2.55**: Integration of frailty pathway is progressing.

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 June 2025 against SaTH's section of the System Integrated Improvement Plan which have been approved by the relevant Executive Director.

3. Recommendations

The Board of Directors is asked to:

Receive this report for information and assurance that progress is being made.

Note that this SIIP progress report and supporting evidence will be submitted to the STW ICB by 15 July 25.

Board of Directors' Meeting
10 July 2025

Agenda item		112/25		
Report Title		Risk Management Annual Report 2024/25		
Executive Lead		Anna Milanec, Director of Governance		
Report Author		James Webb, Head of Risk Management		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe		Our patients and community		N/A
Effective	√	Our people		
Caring		Our service delivery		**Trust Risk Register id:**
Responsive		Our governance	√	All
Well Led	√	Our partners		
Consultation Communication		Monthly report to Senior Leadership Committee, Operational Monthly report to Executive Team Quarterly report to Audit and Risk Assurance Committee		
Executive summary:		This report presents the Annual Risk Management Report for 2024/25, highlighting progress in managing risks and enhancing the risk culture at SaTH. It outlines key achievements, ongoing initiatives, and future steps for risk management within the organisation. • **Risk Management Progress:** The report notes a reduction in overdue risks and actions, with more risks closed than opened during the reporting period. • **Training and Culture Improvement:** Over 200 staff members received risk management training, reflecting an ongoing commitment to enhancing the organisation's risk culture. • **Risk Assessment and Monitoring:** Divisions regularly review risks categorized by severity, ensuring that risks are actively managed. The Corporate Risk Register tracks extreme risks and identifies themes for further analysis whilst the Board Assurance Framework highlights and reports again strategic themes.		
Recommendations for the Committee:		The Board is asked to: **Take assurance** from this report as to the progress made during the last financial year. **To note** that the timing of this report will be brought forward next year to align with end of year matters, and the production timetable of the annual report and accounts.		
Appendices:		N/A		

1.0 Introduction:

The Risk Management Group (the Group) has a reporting line into the Board's Audit and Risk Assurance Committee (ARAC) and provides a quarterly report to the meeting, presented by the Head of Risk Management.

The Group revised its terms of reference in February 2025, with the support of the ARAC, to enhance the challenge and maturity of the risk assurance framework.

Currently, the Trust is reviewing its Risk Management Policy (to broadly align with other providers in the system, whilst recognising the additional challenges that the Trust has faced) and Risk Management Strategy.

An Anti-Fraud, Bribery and Corruption Policy is published on the intranet and applies to all employees, and others who work for or on behalf of the Trust. Internal control systems are intended to minimise the opportunity for fraud or misappropriation of assets. Members of the national NHS Counter Fraud Authority (NHSCFA) team recently interviewed the Head of Risk Management, who was advised that the Trust stood out as an exemplar due to the processes and documentation that had been put in place at the organisation for the prevention of fraud, bribery and corruption. In addition, NHSCFA have offered to provide more support to the Head of Risk Management to strengthen the link between risk management and fraud.

Internal audit plays a vital role in advising the Trust that arrangements in relation to governance, risk and internal control are in place and operating effectively. Response to internal audit activity should lead to the strengthening of the internal control environment.

The annual 'Internal Audit Plan' is informed by the Trust's Strategic Risks, together with discussions with individual Executive Directors and ARAC members.

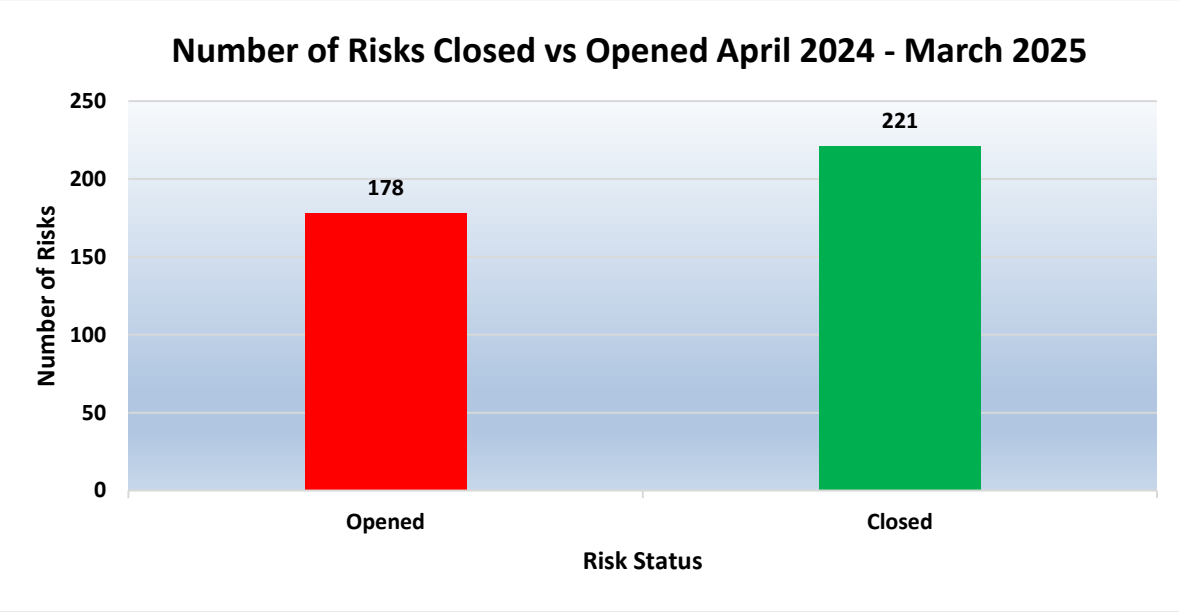
A review (requested by the Director of Governance) by the Trust's independent internal auditors in 2023/24 provided eight recommendations to strengthen the divisional risk assurance framework. These recommendations were all complete by the first half of 2024/25.

An online training package, developed in-house, provides risk management awareness, and helps to develop skills for those who work in the organisation. However, there is still a tendency within the organisation for individuals to be more risk averse than the Board-agreed risk appetite may suggest. This could be due to the Trust's historic challenges, or a belief that others might hold about the organisation and its capabilities. There is a question as to whether the current risk-averse culture may be impacting the organisation; there is limited awareness that, in some situations, accepting a certain level of risk could support the organisation in achieving its objectives.

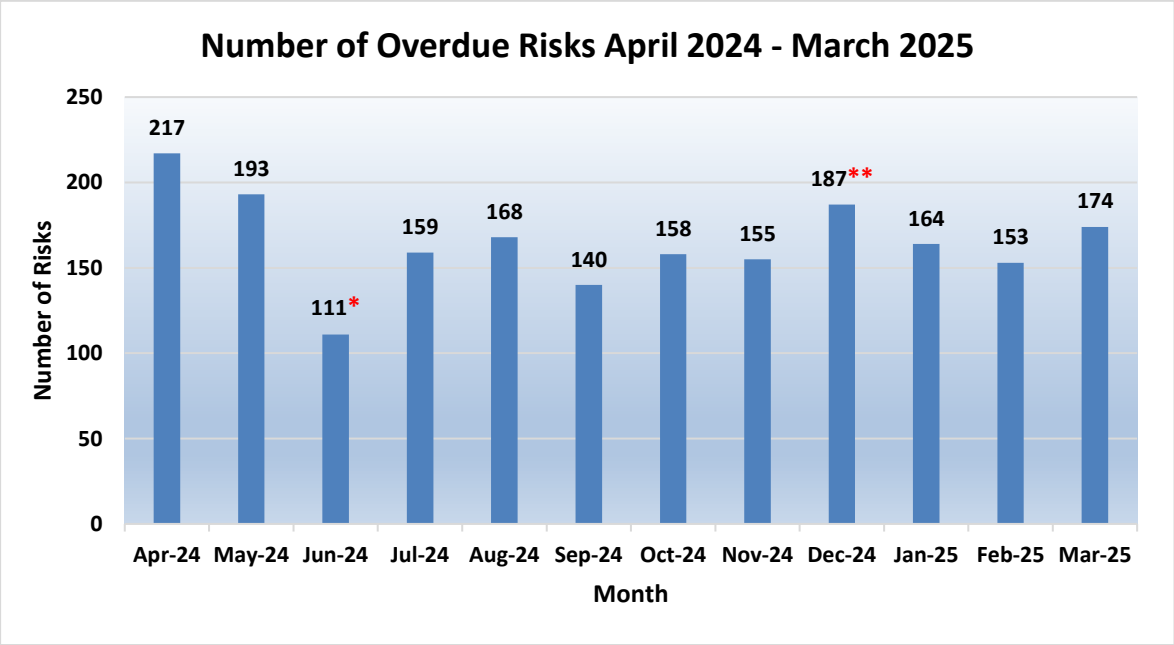
Operational matters

Divisions review their extreme risks (scored ≥15) on a monthly basis, high risks (scored 9-12) are reviewed every two months and moderate risks (scored 4-6) and low risks (scored 1-4) are reviewed every quarter as part of their Divisional meetings. New extreme risks are also presented at the Risk Management Group (RMG), where they are made active.

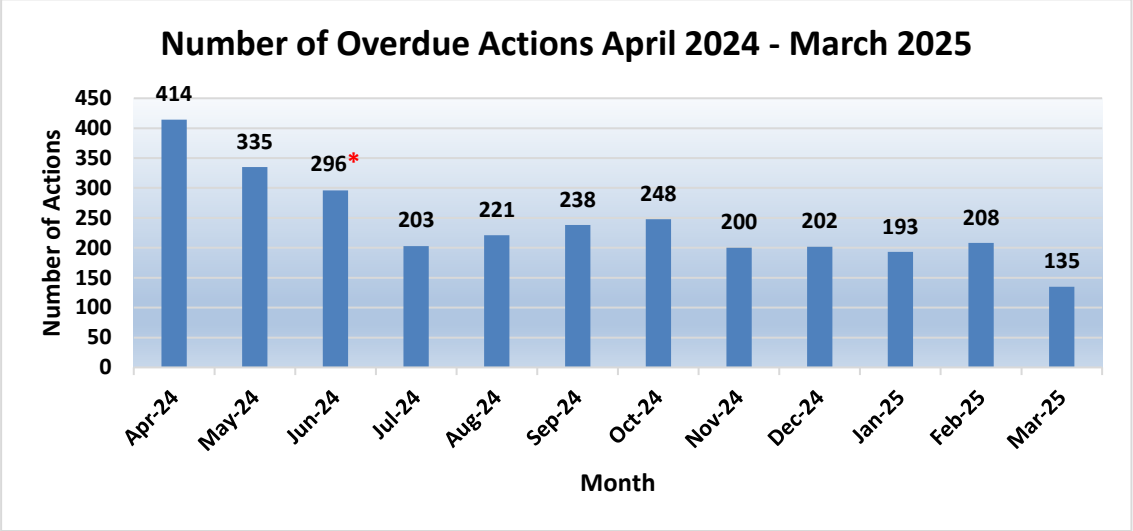
From 01 April 2024 – 31 March 2025, more risks on the Trust's risk register were closed than were opened - see graph below:



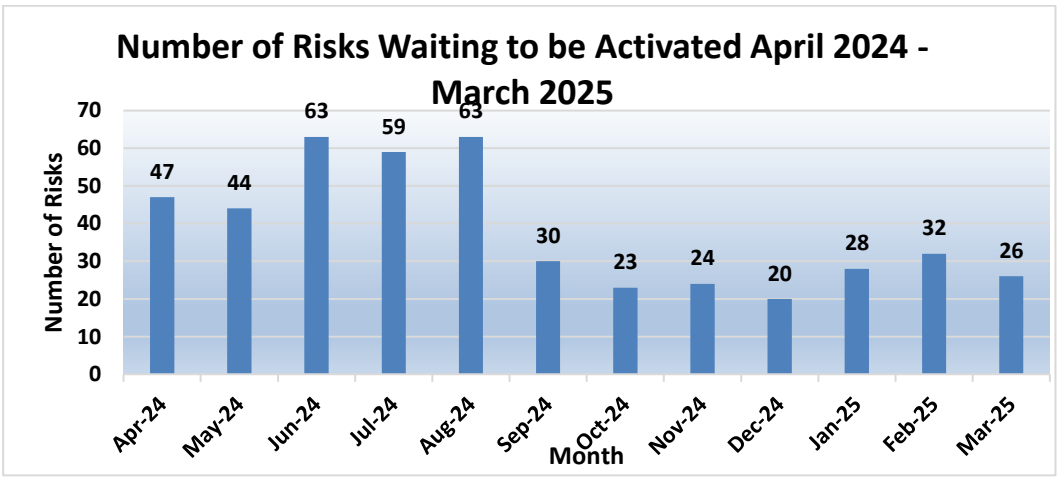
The rate of overdue risks decreased from 217 at the beginning of the year to 174 at end year (difference of 43) – see graph below:



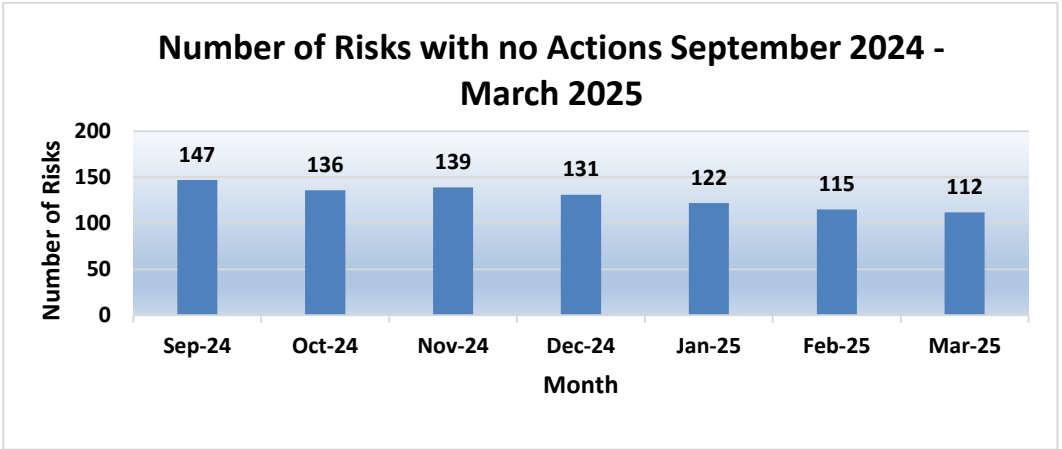
The rate of overdue actions decreased from 414 at the beginning of the year to 135 at end year (difference of 279) – see graph below:



The rate of risks waiting to be activated decreased from 47 at the beginning of the year to 26 at end year at end year (difference of 21) – see graph below:



The rate of risks with no actions was reduced from 147 in September 2024 to 112 at end year at end year (difference of 35) – see graph below:



Total corporate risk register activity during the financial year:

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 10 July 2025

Agenda item		113/25		
Report Title		**Fit & Proper Person Test (FPPT) Framework for Board Members**		
Executive Lead		Anna Milanec, Director of Governance/Company Secretary – on behalf of the Chair in Common		
Report Author		Beverley Barnes, Board Coordinator		
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		Direct to the Board of Directors		
Executive summary:		The national Fit and Proper Person Test (FPPT) Framework (launched by NHS England in September 2023) sits in the wider context of good governance, leadership and Board development, and is intended to strengthen individual accountability for Board members, thus enhancing the quality of leadership within the NHS. The Chair in Common has overall accountability for adherence to the Framework, which applies to all voting and non-voting executive and non-executive members of the Board. In addition to the Framework requirement for all new Board members to demonstrate that they have met all the required criteria prior to appointment, there is also an ongoing requirement for individual assessments to be completed on currently serving Board members each year. This report provides confirmation that all necessary individual annual checks have been completed, and the evidence reviewed confirms that all serving members of the Board are fit and proper. The requirements for the annual 2025 FPPT assessment have therefore been fully satisfied, and an overall summary has been submitted to the regional NHSE team in line with the Framework guidance.		
Recommendations for the Board:		The Board of Directors is asked to **note** the report.		
Appendices:		N/A		

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 10 July 2025

Agenda item		114/25			
Report Title		Board Member Conflicts of Interests Report			
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		Audit & Risk Assurance Committee – 19 May 2025			
Executive summary:		1.1 The Trust's Standing Orders outline that the registers of interests should be published at least annually. 1.2 The registers of interests (including gifts and hospitality) were reviewed by Audit & Risk Assurance Committee (ARAC) on 19 May 2025 (for the position at 30 April 2025) and were approved for publication on the Trust's website. ARAC reviews these registers every six months. 1.3 This report includes the Board member interests only. It is intended that the Board member interests are published on the Trust's website alonside the other registers of interests.			
Recommendations to the Board:		The Board is asked to consider and note the Board member interests.			
Appendices:		**Appendix 1**: Board member interests			

Board member interests - 30 April 2025

The Shrewsbury and Telford Hospital NHS Trust

First Name	Last Name	Position Title	Interest Category	Interest Situation	Interest Description	Date From	Date To	Comments
Teresa	Boughey	Non-Executive Director Trust Board	Financial interests	Loyalty interests	WR Partners have been historic clients of my business Jungle HR Ltd	19/03/2025		
Teresa	Boughey	Non-Executive Director Trust Board	Non-financial personal interests	Loyalty interests	My Son is a Volunteer at the Trust (as part of his DofE Gold Programme)	01/11/2023		
Teresa	Boughey	Non-Executive Director Trust Board	Non-financial professional interest	Outside employment	NED at Middlemarch Environmental Limited	20/02/2024		
Teresa	Boughey	Non-Executive Director Trust Board	Financial interests	Shareholdings and other ownership interests	Director - Inclusion 247 Ltd	19/09/2019		
Teresa	Boughey	Non-Executive Director Trust Board	Financial interests	Shareholdings and other ownership interests	Director - Jungle HR Ltd	08/08/2008		
Teresa	Boughey	Non-Executive Director Trust Board	Non-financial professional interest	Loyalty interests	Trustee of SaTH Charity	01/09/2019		
Teresa	Boughey	Non-Executive Director Trust Board	Non-financial professional interest	Loyalty interests	Advisory Board Member at Royal Holloway University School of Business and Management	03/09/2019		
Teresa	Boughey	Non-Executive Director Trust Board	Non-financial professional interest	Loyalty interests	Business Board Member of the All-Party Parliamentary Group for Women and Enterprise, and Chair of the ESG Workstream	01/01/2017		
Teresa	Boughey	Non-Executive Director Trust Board	Financial interests	Shareholdings and other ownership interests	QIAGEN is a client of Jungle HR Ltd	01/01/2017		
Teresa	Boughey	Non-Executive Director Trust Board	Non-financial personal interests	Loyalty interests	Daughter works at Robert Jones & Agnes Hunt Hospital	01/09/2019		
Rhia	Boyode	Chief People Officer	I have no interests to declare			16/01/2024		
Simon	Crowther	Associate Non-Executive Director	I have no interests to declare			28/02/2024		
Rajinder	Dhaliwal	Non-Executive Director Trust Board	I have no interests to declare			28/07/2023		
Sarah	Dunnett	Non-Executive Director Trust Board	Financial interests	Outside employment	I am employed by Niche Health and Social Care Consulting, an Employee Owned Trust, who supply health and social care investigations, healthcare analytics and assurance projects.	20/02/2024		I work 80% FTE and have declared this employment at SaTH to Niche.
Diana (Rosi)	Edwards	Non-Executive Director Trust Board	Non-financial personal interests	Loyalty interests	Daughter Sarah Edwards is now Member of Parliament for Tamworth in Staffordshire. She was re-elected in July 2024 and is now on the Business & Trade Select Committee.	19/10/2023		SaTH has links to University of North Midlands NHS Trust, which provides services to people in Tamworth. It may be that in campaigning my daughter will want to comment on the way services are provided in South East Staffordshire.
Diana (Rosi)	Edwards	Non-Executive Director Trust Board	Non-financial professional interest	Loyalty interests	As a NED I sit on the meeting of the Board acting as Corporate Trustee for the SaTH charity, so it seems I am an agent of the Trustees	01/02/2023		I was appointed as a full NED in February 2023 but did not realise until a board training session on 30 May that this might present a conflict of interest.

First Name	Last Name	Position Title	Interest Category	Interest Situation	Interest Description	Date From	Date To	Comments
Diana (Rosi)	Edwards	Non-Executive Director Trust Board	Non-financial personal interests	Loyalty interests	Branch Secretary of Billesley Branch Labour Party since November 2022. This branch is part of Selly Oak Constituency in Birmingham, with two Labour Councillors. The MP is also Labour. The role is largely administrative and low key. I can see little prospect of a conflict of interest arising with my work at SaTH, given the location of the branch/CLP.	31/05/2023		
Diana (Rosi)	Edwards	Non-Executive Director Trust Board	Non-financial professional interest	Loyalty interests	Honorary President, Birmingham Health, Safety and Environment Association. This is a charity, operating since the 1930s, which aims to improve the management of health and safety at work through companies sharing good practice. I have held this role since November 2016.	31/05/2023		
Heidi	Fuller	Associate Non-Executive Director	Non-financial personal interests	Loyalty interests	I am under the care of the Haematology Unit at SATH.	01/04/2025		
Heidi	Fuller	Associate Non-Executive Director	Financial interests	Outside employment	I am employed by Keele University with whom SATH have arrangements in place including to host Keele students on clinical placement. My husband is also employed by Keele University.	01/04/2025		
Paula	Gardner	Executive Director of Nursing	I have no interests to declare			02/01/2025		
Edward	Hobbs	Chief Operating Officer	Indirect interests	Loyalty interests	My father is a Governor for Oxford Health NHS Foundation Trust	01/05/2019	01/03/2025	
Edward	Hobbs	Chief Operating Officer	Indirect interests	Loyalty interests	My wife is Education Quality Advisor for Special Educational Needs & Disabilities at Shropshire Council	01/09/2024		
Edward	Hobbs	Chief Operating Officer	Indirect interests	Loyalty interests	My Sister-in-law is Deputy Group Director of Nursing at Sandwell & West Birmingham NHS Trust	01/01/2024		
John	Jones	Executive Medical Director	Indirect interests	Outside employment	I am a GMC associate providing services to the GMC in their role as the national regulator for medical education, training and professional conduct and capability.	01/04/2013		This involves reading and commenting on matters of relevance to the GMC's role as well as attendance at virtual meetings and on in person visits to healthcare providers and universities and to GMC premises. It also involves being part of decision-making panels for regulatory work. This work involves occasional overnight stays in hotels, travel and meals which are either payed for directly by the GMC or via invoicing for costs incurred. There are also fees of up to £325/full day.
John	Jones	Executive Medical Director	Indirect interests	Shareholdings and other ownership interests	Director Dr J I W Jones ltd	20/06/2023		
Nigel	Lee	Director of Strategy and Partnerships	Non-financial professional interest	Loyalty interests	Trustee - Learning Community Trust, Hadley, Telford. Member of Trust Board and Chair of Audit & Risk Committee.	01/01/2023		Situation category does not fit well. This is a voluntary unpaid role, with no specific allegiance or loyalty involved. Declaration confirmed as part of recruitment to substantive role at SATH. Reviewed; no change 18/03/25.

First Name	Last Name	Position Title	Interest Category	Interest Situation	Interest Description	Date From	Date To	Comments
Nigel	Lee	Director of Strategy and Partnerships	Non-financial professional interest	Loyalty interests	Agent of SATH Charity	30/05/2024		In addition to trustee role, also Executive Director responsible for Public Participation /Charity directorate Reviewed; no change 18/03/25.
Nigel	Lee	Director of Strategy and Partnerships	Non-financial professional interest	Loyalty interests	Substantive part-time executive Chief Strategy Officer for Shropshire Telford & Wrekin Integrated Care Board. Role leads on: Integrated Care Strategy, Joint Forward Plan, strategy development and integrated pathways, health inequalities and Greener NHS.	23/07/2023		Substantive role confirmed wef 1st July 2024 Reviewed; no change 18/03/25.
Anna	Milanec	Director of Governance	I have no interests to declare			01/04/2023	31/03/2024	
Richard	Miner	Non-Executive Director Trust Board	Financial interests	Outside employment	Non-Executive Director of Tictrac Limited, a wholly owned subsidiary of Dialogue Health Technologies Inc of Canada which itself is a wholly owned subsidiary of Canadian listed company, Sun Life Financial Inc.	29/11/2024		Tictrac runs a consumer web portal related to the identification of health risks. The role is a corporate governance one.
Richard	Miner	Non-Executive Director Trust Board	Financial interests	Outside employment	I am a shareholder and director in Enterprise FD Limited, a company providing financial consultancy services. Clients include those which may benefit from contracts with sections of the NHS.	01/04/2018		
Richard	Miner	Non-Executive Director Trust Board	Non-financial personal interests	Outside employment	I am the (paid) managing trustee of Dinwoodie Charitable Company, that provides financial support to NHS organisations. I do not benefit financially from these grants but my interactions with senior clinicians and senior health service personnel may enhance my professional standing.	01/04/2022		
Richard	Miner	Non-Executive Director Trust Board	Indirect interests	Loyalty interests	My spouse is a community midwife with another NHS Trust.	01/06/1999		
Andrew	Morgan	Chair in Common	Financial interests	Outside employment	Chair in Common, Shrop Com	01/10/2024		
Andrew	Morgan	Chair in Common	Financial Interests	Outside employment	Attendee at ICB Board	01/10/2024		
Wendy	Nicholson	Non-Executive Director Trust Board	Financial interests	Outside employment	I am employed as a ANED at UHNM NHS trust	07/10/2024		I would however like to declare the following: my partner is employed as a specialist nurse at other NHS Trust. I am visiting lecturer at University of Keele. I am Judge for Nursing Times Award
Trevor	Purt	Non-Executive Director Trust Board	Non-financial personal interests	Outside employment	Agent of the Sath Charity - Corporate trustees	01/04/2024	31/03/2025	
Trevor	Purt	Non-Executive Director Trust Board	Financial interests	Outside employment	West Mercia Police - member of the Joint Audit and Standards Committee	01/06/2024	31/05/2026	
Trevor	Purt	Non-Executive Director Trust Board	Financial interests	Outside employment	Institute of Osteopathy Lay Council Member	01/10/2023	30/09/2026	
Trevor	Purt	Non-Executive Director Trust Board	Indirect interests	Outside employment	Wife - NED / SID Shropshire community Trust Wife - Chair of ICB Strategy committee	01/04/2022	31/03/2025	
Trevor	Purt	Non-Executive Director Trust Board	Non-financial professional interest	Outside employment	Board member - Rural Health Scientific Advisory Board Lincoln University	01/04/2022	31/03/2025	
Inese	Robotham	Assistant Chief Executive	I have no interests to declare			01/08/2023		

First Name	Last Name	Position Title	Interest Category	Interest Situation	Interest Description	Date From	Date To	Comments
Jonathan	Sargeant	Associate Non-Executive Director	Financial interests	Outside employment	Part Time employment 2 days a week	01/02/2025		£28600. Project work for Donacaster Place (SY ICB and Doncaster and Bassetlaw NHS Trust)
Helen	Troalen	Director of Finance	Indirect interests	Loyalty interests	Husband of a close friend works for CCLA Investment Management Ltd.	01/10/1999		The Trust's charity holds a contract with CCLA Investment Management Ltd. The conflict can be managed.
Helen	Troalen	Director of Finance	Indirect interests	Loyalty interests	Close friendship with a regional director at Siemens.	01/09/2006		Siemens are a supplier of pathology and imaging equipment to the NHS. The Trust holds contracts with this company. The interest can be adequately managed.
Helen	Troalen	Director of Finance	Financial interests	Outside employment	Company director - Vadebeam Limited - a family business owned by my parents.	01/08/2006		Vadebeam Ltd is a property company that owns and lets commercial units in Warwickshire. There is no potential interest.
Joanne	Williams	Chief Executive Officer	Non-financial personal interests	Loyalty interests	Trustee of 'Versus Arthritis' Charity	01/12/2022		
Joanne	Williams	Chief Executive Officer	Indirect interests	Loyalty interests	Spouse, deputy COO of University Hospital of Birmingham NHS FT	01/01/2017		