The Shrewsbury and Telford Hospital NHS Trust

BOARD OF DIRECTORS' MEETING IN PUBLIC
AGENDA

Date: 13 November 2025
Time: 0930hrs – 1230hrs
Venue: Shropshire Education & Conference Centre
Chair: Trust Vice Chair – Prof Trevor Purt

Time	Item no.	Item	Paper / Verbal	Page	Lead	Action
Procedural Items						
0930hrs	144/25	Welcome and apologies	Verbal	-	Vice Chair	For noting
	145/25	Patient/Staff Story	Enc	**4**	Interim Chief Nursing Officer	For noting
	146/25	Public Questions	Verbal	-	Vice Chair	For noting
	147/25	Quorum	Verbal	-	Vice Chair	For noting
	148/25	Declarations of conflicts of interest	Verbal	-	Vice Chair	For noting
	149/25	Minutes of the previous meeting held on 11 September 2025, and Boards in Common meeting (to agree Group model) held on 23 September 2025	Encs	**7**	Vice Chair	For approval
	150/25	Action log	Enc	**34**	Vice Chair	For approval
	151/25	Matters arising from the previous minutes (not covered elsewhere on the agenda or action log)	Verbal	-	Vice Chair	For discussion
Report on behalf of the Group Chair, and Group Chief Executive Report						
1010hrs	152/25	Report on behalf of the Group Chair	Verbal	-	Vice Chair	For noting
	153/25	Report from the Group Chief Executive	Enc	**35**	Group Chief Executive	For noting
Reports from Assurance Committee Chairs						
1020hrs	154/25	Audit & Risk Assurance Committee Chair's Report (September 2025)	Enc	**40**	Committee Chair	For assurance
	155/25	Quality & Safety Assurance Committee Chair's Report (September and October 2025)	Enc	**43** **46**	Committee Chair	For assurance
	156/25	Performance Assurance Committee Chair's Report (September and October 2025))	Enc	**50** **53**	Committee Chair	For assurance
SHORT BREAK						
1045hrs	157/25	Finance Assurance Committee Chair's Report (September and October 2025)	Enc	**56** **58**	Committee Chair	For assurance
	158/25	People & OD Assurance Committee Chair's Report (October 2025)	Enc	**60**	Committee Chair	For assurance
	159/25	HTP Director SRO Update (September 2025)	Enc	**62**	Committee Chair	For assurance
Strategic, Quality & Performance Matters						
1100hrs	160/25	Integrated Performance Report	Enc	**74**	Group Chief Executive	For noting

Operational Reporting						
1110hrs	161/25	Bi-Annual Public Participation Report *(full report in Information Pack)*	Enc	**155**	*Dir of Strategy & Partnerships	For noting
Assurance Framework						
1115hrs	162/25	STW System Winter Plan 2025/26	Enc	**160**	Chief Operating Officer	For noting
	163/25	System Integrated Improvement Plan (SIIP) Report	Enc	**183**	Group Chief Executive	For assurance
	164/25	Integrated Maternity & Neonatal Report	Enc	**186**	Interim Chief Nursing Officer	For assurance
	165/25	Board Maternity & Neonatal Safety Champions Reports: a. Summary report of activities July-September 2025 b. October Report	Encs	**194** **196**	Executive Medical Director	For assurance
	166/25	Board Assurance Framework Draft Q2 2025/26	Enc	**198**	*Director of Governance	For approval
	167/25	Risk Management Report Q1 2025/26	Enc	**221**	*Director of Governance	For assurance
Regulatory and Statutory Reporting						
1140hrs	168/25	***Item deferred to a future meeting***	Enc	**234**	Interim Chief Nursing Officer	For noting
	169/25	Bi-Annual Nurse Staffing Review	Enc	**245**	Interim Chief Nursing Officer	For noting
	170/25	Medical Examiner / Bereavement Service Report Q1 2025/26	Enc	**257**	Executive Medical Director	For noting
	171/25	How we learn from deaths Report Q1 2025/26	Enc	**264**	Executive Medical Director	For noting
	172/25	Progress on 10-point Plan to improve Resident Doctors' working lives	Enc	**271**	Executive Medical Director	For assurance
	173/25	FTSU Report Quarters 1&2 2025/26	Enc	**278**	*Director of Governance	For noting
	174/25	Emergency preparedness, resilience and response (EPRR) assurance process Annual Report	Enc	**291**	Chief Operating Officer	For agreement
Items for Consent - approval recommended from Board Committees						
1220hrs	175/25	Safeguarding Children & Young People Policy	Enc	**301**	Int Chief Nursing Officer	For consent
Procedural Items						
1225hrs	176/25	Any other business – agreed by the Chair	Verbal	-	Vice Chair	For discussion
1230hrs	177/25	Date and time of next meeting: 0930hrs on **Thurs 15 January 2026**	Verbal	-	Vice Chair	Information
Close of meeting						

*Non-voting

(Information Pack items listed overleaf)

ITEMS WITHIN THE BOARD INFORMATION PACK		
Reports / Appendices	**Lead**	**Page No.**
01 161/25: Bi-Annual Public Participation Report *(full report)*	Dir of Strat & Partnerships	**2**
02 163/25 SIIP Report: *Appendices 1-4*	Group Chief Executive	**51**
03 164/25 Integrated Maternity & Neonatal Report Appendices:	Int Chief Nursing Officer	
Appendix 1: Ockenden Report Action Plan		**69**
Appendix 2: Neonatal External Mortality Review (NEMR) Action Plan		**132**
Appendix 3: Summary Maternity & Neonatal Transformation Plan (MNTP) Ph2		**143**
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Appendix 12: CNST SA7 LMNS Programme Board agenda and evidence of escalation with action plan for MNVP		**214**
04 169/25 Bi-Annual Nurse Staffing Report: *Appendices 1&2*	Int Chief Nursing Officer	**217**
05 174/25 EPRR Report: *Appendices B&C*	Chief Operating Officer	**235**
06 Security Annual Report 2024/25	Chief Operating Officer	**257**

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 13 November 2025

Agenda item		145/25		
Report Title		Digital Story – Have Empathy For Each Other, Not Just Patients		
Executive Lead		Interim Chief Nursing Officer		
Report Author		Interim People Director Lead for Patient Experience		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF1, BAF2, BAF3, BAF4
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance		
Well Led	√	Our partners	√	
Consultation Communication				
Executive summary:		The Board's attention is drawn to listening to the storyteller outline their experience through the digital story, and the actions taken in response to the feedback being shared.		
Recommendations for the Board:		The Board is asked to: **Note** there is a clear correlation between staff culture and patient experience. Fostering a positive and supportive environment is critical to ensuring the wellbeing and satisfaction of everyone associated with the organisation, including patients, staff, volunteers, and visitors. By prioritising a culture that values kindness, civility, and respect, the organisation can create the conditions necessary for high-quality care and a safe, reassuring atmosphere. This approach not only strengthens team cohesion and morale but also enhances the overall experience for all who interact with our services.		
Appendices:		Appendix 1: Digital Story – Have Empathy For Each Other, Not Just Patients		

1.0 Background

1.1 The person sharing their story shared her personal experience as a patient in the gynaecology department, describing both the positive aspects of her hysteroscopy procedure and the subsequent discomfort caused by overhearing staff conflict, which ultimately affected her willingness to engage with the department for follow-up care.

2.0 Patient Experience in Gynaecology Department

2.1 The storyteller describes her initial experience with the hysteroscopy procedure as very positive, highlighting the welcoming environment, effective pain management, and the presence of a supportive advocate, which made her feel relaxed and well cared for after the procedure.

2.2 While recovering in the department, the storyteller overheard a heated exchange among staff members, including a distressing comment about another patient and raised voices, which made her feel uncomfortable and distracted from her own recovery and questions. The uncomfortable environment and repeated staff apologies led her to feel anxious and reluctant to contact the department for follow-up, resulting in her not receiving further treatment.

3.0 Effects of Staff Conflict on Patient Perception

3.1 The storyteller observed that the conflict she witnessed stemmed from communication between different departments, which made her aware of possible systemic issues and led her to question whether similar conflicts might occur elsewhere in the trust. She recounted previous experiences where staff members disagreed or expressed frustration with each other in front of patients, noting that while these actions may be motivated by patient advocacy, they contribute to a negative and uncomfortable atmosphere.

3.2 The storyteller emphasised that such conflicts could undermine patients' sense of safety and trust in the hospital, as they may feel exposed to internal issues and less confident in the cohesiveness of their care. She stressed that patients want to see staff working together harmoniously, acknowledging that while this can be challenging due to different working practices and pressures, it is crucial for a positive patient experience. She advocated for extending empathy beyond patients to include colleagues, arguing that a supportive environment among staff would contribute to a safer and more reassuring environment for patients.

4.0 Link Between Staff Culture and Patient Care

4.1 This story highlights the close connection between staff culture and patient experience. When staff feel valued, respected, and psychologically safe, they are better able to provide compassionate, coordinated care. Conversely, visible conflict or tension can unintentionally affect how safe and reassured patients feel during their care.

4.2 It is equally important to consider how working within such an environment may have felt for the staff involved. Teams under pressure, or where communication and relationships are strained, may experience frustration, low morale, and emotional fatigue — all of which can impact wellbeing and, ultimately, the quality of care delivered.

4.3 Understanding the staff experience behind the incident is therefore a key part of learning and improvement. By seeking the perspectives of those involved, the organisation can identify underlying causes, such as workload, communication challenges, or cultural factors, and support teams to strengthen how they work together.

5.0 Conclusion

5.1 The Clinical Director has contacted the person sharing her story, and action has been taken to arrange a follow-up with the Gynaecology Team to address any continuing healthcare needs the storyteller may have.

5.2 As a listening and learning organisation, we are committed to using stories such as this to inform our culture improvement work — creating the right conditions for staff to feel heard, safe, and supported. Embedding kindness, civility, and respect across teams is essential to sustaining a culture where both staff and patients can thrive.

The Shrewsbury and Telford Hospital NHS Trust

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

Thursday 11 September 2025
Held in Shrewsbury Education & Conference Centre

MINUTES

Name	Title
MEMBERS	
Mr A Morgan	Chair in Common
Mrs T Boughey	Non-Executive Director
Mr R Dhaliwal	Non-Executive Director
Ms S Dunnett	Non-Executive Director
Ms R Edwards	Non-Executive Director
Ms P Gardner	Interim Chief Nursing Officer
Mr N Hobbs	Chief Operating Officer
Mr R Miner	Non-Executive Director
Ms W Nicholson MBE	Non-Executive Director
Prof T Purt	Non-Executive Director / Vice Chair
Dr J Rowlands	Deputy Medical Director *(representing the Medical Director)*
Ms J Williams	Chief Executive in Common
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
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 Coordinator (Minute Taker)
GUEST ATTENDANCE	
Ms J Bolton	Acting Head of Midwifery *(agenda item 133/25)*
Dr R Hollands	Guardian of Safe Working *(agenda item 138/25)*
APOLOGIES	
Dr J Jones	Medical Director
Prof H Fuller	Associate Non-Executive Director

No.	ITEM	ACTION
PROCEDURAL ITEMS		
117/25	**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 Dr Jenni Rowlands, Deputy Medical Director, who was representing the Medical Director at today's meeting. Apologies were noted.	
118/25	**Patient Story** The Interim Chief Nursing Officer welcomed and introduced Oliver and his Mum, Hayley, who had kindly agreed to share their story of Oliver's cancer treatment. Oliver and Hayley particularly wished to recognise and thank Becky, the Trust's Teenage Cancer Liaison Nurse Specialist, for the support she had provided throughout Oliver's treatment. Becky had been present at every treatment session with Oliver, was always available at the end of the phone for support and guidance, and she had also put Oliver in touch with other young people who were going through the same challenges. Hayley advised that, apart from one occasion, Oliver's experience throughout his whole treatment journey had been positive. Referring to the one negative exception, Ms Gardner advised, with apologies, that this had been a lesson for the Trust to learn from. When arriving at hospital with a high temperature, rather than being admitted to Oncology Assessment as he should have been, Oliver had been left to sit all night in a chair in Acute Medical Assessment (AMA) at a time when he was immunocompromised. The Chair in Common thanked Oliver and Hayley for taking time out of their day to share their story, and Becky and colleagues for their caring and dedicated commitment to our patients. Emphasising that, as a Board, it was important to hear first-hand of our patients' experiences, Mr Morgan also wished to apologise on behalf of the Trust for Oliver's negative experience described above. Finally, Mr Morgan congratulated the family on the positive way they were giving back to the community through their fund raising for the Teenage Cancer Trust, which had reached around £10k to date. He also wanted to record his appreciation of the actions of Oliver's barber who initially drew Oliver's attention to the lump on the back of his neck. The Board wished Oliver a healthy and successful future.	
119/25	**Public Questions**	

	The Chair in Common thanked members of the public who had submitted questions in advance of today's meeting. The questions, and the responses provided verbally at the meeting by the appropriate Executive Director, are included at the end of these minutes, together with further verbal questions and comments received on the day from observing members of the public.	
120/25	**Quorum** The meeting was declared quorate.	
121/25	**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.	
122/25	**Minutes of the previous meeting** The minutes of the meeting held on 10 July 2025 were accepted and approved by the Board of Directors as an accurate record, subject to the following minor amendment to agenda item 106/25, IPR Finance Summary: '…. *the Acting Director of Finance was pleased to advise the Board that the Trust's* ~~***capital***~~ ***cash*** *position for June 2025 was back in line with plan'.*	
123/25	**Action Log** The Board of Directors reviewed the action log, and agreed the closure of Action No.10, noting that most Board members had now self-declared on ESR that they act as an 'Agent of the Corporate Trustee to the SaTH Charity'. The Chair in Common asked the few members of the Board who had not yet done so to input their declarations as soon as possible. There were no further actions listed for review.	
124/25	**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 IN COMMON		
125/25	**Report from the Chair in Common** The Chair in Common provided the Board with the following verbal update: • SaTH and SCHT integration: Since the Board last met, the recruitment process for the Chief Executive in Common/Group CEO Designate of SaTH and SCHT had been concluded. Mr Morgan wished to formally recognise and congratulate Jo Williams on her richly deserved appointment, and looks forward	

	to working with Jo on the continued development of a Group model between the two Trusts. Mr Morgan confirmed that we have now reached the Board sign off stage of the Group model Case for Change, and a meeting of both Boards in Common is scheduled for 23 September 2025, to be held in public, which will be solely focused on a final review and approval of the Case for Change. We continue to engage with NHSE who remain very supportive of our proposal, and the Chair in Common thanked Mr Lee of SaTH and Ms Lloyd of SCHT for their work on the Case for Change to date. • Provider Capability Self-Assessment: All Trusts have been asked to carry out a provider capability review, and work is taking place to complete this in readiness for submission to NHSE by 22 October 2025. • Neighbourhood Health: The outcome of applications for NHSE's national neighbourhood health pilot have recently been announced, and STW have been successful in securing participation in one of the pilot schemes. Further information will be shared with colleagues in due course. • SaTH Annual General Meeting: The Chair in Common reminded colleagues and observing members of the public that the Trust AGM will take place on 25 September 2025 at 1400hrs. The Board of Directors **noted** the report.	
126/25	**Report from the Chief Executive in Common** The Board of Directors received the report from the Chief Executive in Common. Taking the report as read, Ms Williams summarised some of the key points, and provided further updates since the report had been produced: • University Status: Ms Williams was delighted to announce that we have shared with our teams today that the Trust has been awarded university status in partnership with Keele University. Colleagues from Keele particularly wished to recognise Dr Rowlands' highly valuable contribution throughout the extensive joint work that has taken place leading up to today's announcement. As our statutory instrument will need to change, we will require a new name and branding for the organisation, and engagement work on this will start shortly. The Chair in Common reassured colleagues that there was no intention of committing vast sums of money to the necessary statutory changes, whilst recognising the important step that university status represents in our aspiration to become the service provider that our community	

deserves.

- Operational and Financial Performance: Ms Williams was pleased to share that as at the end of month four the Trust has delivered our agreed financial plan, with £11.3m of efficiencies delivered by July 2025 compared with £5.76m in July 2024. Whilst real progress has been made in many areas, we know we still have much to do, and are mindful of the scale of the continued challenge ahead. However, we are also proud of the work our teams have delivered so far, and colleagues were referred to section 2.1 of the report for details of the Trust's latest key improvements and achievements.

- Withdrawal of Fire Enforcement Notice: Ms Williams advised the Board that Shropshire Fire & Rescue Service confirmed on 1 August 2025 that, further to the follow up fire safety audit carried out on 31 July 2025, they considered that the requirements detailed in the Enforcement Notice dated 23 May 2025 have been complied with. The withdrawal of the notice means that steps have been taken to remedy the specified failure to comply with the Regulatory Reform (Fire Safety) Order 2005.

- Research Trial: The team at the Community Diagnostic Centre (CDC) had recently hosted Lord Prior (former Member of Parliament, former chairman of NHSE and chairman of University College Hospital). Lord Prior's visit focused on the TRIOMIC trial, which the team are delivering in partnership with Origin Sciences, to completely transform the colorectal cancer diagnosis pathway. Ms Williams congratulated all those who have worked hard to bring this trial to fruition, adding that the amount of research taking place in the organisation is a tangible example of one of our key Trust values, of 'ambitious'.

- Consultant appointments: Ms Williams advised that information will be brought to the next Public Board meeting on the quality of consultant appointments the Trust has made over the last year. Mr Morgan added that he has been impressed by the applicant numbers and the high calibre of candidates, including many who wish to relocate to spend their careers at the Trust.

- Resident Doctors: Ms Edwards asked about progress to address the required facilities detailed in the recently published NHSE 10-point plan to improve the working lives of resident doctors. Ms Williams acknowledged that whilst the Trust does not yet have a firm plan, she accepted the need to focus on this, equally recognising that appropriate facilities are important for all our staff. She confirmed that Dr Jones, as the executive lead for this work, would provide a progress report to Board in the coming months. Mrs Boughey, as Chair of the Charitable Funds Committee, added that the Committee would be pleased to consider a funding request for improved facilities once details were finalised.

	Commenting on how valuable and rewarding it was to receive unsolicited positive feedback, Mr Morgan took the opportunity to highlight the comments made in a recent social media post by a colleague following their attendance at a resident doctors' induction session, posting that this was the best event of its type they had ever experienced. The Board of Directors accepted and **noted** the report.	
REPORTS FROM ASSURANCE COMMITTEE CHAIRS		
127/25	**Quality & Safety Assurance Committee (QSAC) Report** The Board of Directors received the report from the Committee Chair, Ms Dunnett, which was taken as read. Highlights from the report included the following: • IPC Annual Report: The Committee noted that system risks persist due to increased demand, static estate capacity, and rising national infection trends. Priorities aligned to risks and themes have been identified for 2025/26. This includes a business case which is in train for steam cleaning to mitigate the risk of not currently being able to decant wards to undertake deep cleaning, noting that the estate capacity issues will be mitigated by new modular ward and estate development plans. • Clinical Negligence Scheme for Trusts (CNST): The Committee noted the identification of a new risk for safety action 1 relating to the requirement for an external member of the PMRT panel to be present at 50% of reviews. *This was covered further under agenda item 133/25, Integrated Maternity and Neonatal Report.* Safety action 7, relating to the MNVP lead attendance at internal meetings, also remained at risk at the time of the meeting, however Ms Gardner confirmed that she was currently awaiting written confirmation of an output from NHSE about how this can be overcome. The Board of Directors accepted and **took assurance** from the report.	
128/25	**Performance Assurance Committee (PAC) Report** The Board of Directors received the report from the Committee Chair, Ms Edwards, which was taken as read. At the request of the Chair in Common, the Chief Operating Officer provided the Board with the Trust's latest performance updates, which covered the following highlights: • The Trust achieved a major milestone against our operational metrics in quarter 2, with our de-escalation due to improved performance, from NHSE Tier 1 oversight to Tier 2 for Cancer and Diagnostics, and Tier 3 for Elective performance.	

	• Our total waiting list size continues to reduce.The total elective referral to treatment (RTT) waiting list (English and Welsh) has reduced by over 27% in the last year. • The largest improvement has been seen in the number of patients waiting 52+ weeks for treatment, which has reduced by 90% in the last 10 months. • Further significant improvements have been seen in Diagnostics. DM01 performance for June 2025 stood at 82.3% of patients waiting less than six weeks, representing the Trust's best performance in five years. • There was also improvement in our 28-day Faster Diagnosis Standard in July, currently over 75%, ahead of 73.9% plan. • There have been a record number of planned procedures through our operating theatres/procedure suites, standing at 1,727 in July 2025. • There were early signs of encouragement in UEC in July 2025, with an improvement in 12-hour waits to 78.4%, and an average ambulance handover reduction to 42 minutes, although these were both acknowledged as still far too high. The Chair in Common expressed the Board's huge thanks and congratulations to Mr Hobbs and his team for these achievements, fully recognising that we still have much more to do. The Board of Directors accepted and **took assurance** from the report.	
129/25	**Finance Assurance Committee (FAC) Report** The Board of Directors received the report from the Committee Chair, Mr Miner, which was taken as read. Highlights from the report included the following: • Financial performance: The Trust achieved its budgeted break-even position at the end of Month 4 2025/26, and the forecast to the end of the year remains break-even (including £45m of deficit support). The ongoing monitoring and achievement of our budgeted performance at Month 5 was recognised as crucial, as financial support from NHSE is dependent upon this achievement. Without this support it was noted that the impact on the organisation could be severe. • Workforce reductions: The Trust is currently adverse to planned levels of WTE which, together with CIP performance, remains critical to the overall achievement of our 2025/26 financial plan.	

	Our workforce performance remains under close scrutiny by the Committee and the Executive Team. • Cash balances: The Board was advised that assurance is being increased on cash management through the establishment of a Cash Committee. • Financial governance: NHSE have recently issued guidance to providers, highlighting the need for strong financial governance and for Boards to maintain a focus on challenge, accountability and run rates. Mr Miner observed, in the context of this guidance, that the Board is making decent progress in their scrutiny and focus on the above. The Chair in Common thanked Mr Miner, Executive and Non-Executive colleagues for their focus on our financial governance. He shared feedback from a recent NHSE Chairs' meeting of the stated national expectation that organisations manage within their allocated resources. In the interests of professional pride, the above statutory expectation, and a determination to not repeat the past, Mr Morgan stressed how essential a sustained focus was on our financial governance throughout the remainder of 2025/26. The Board of Directors accepted and **took** assurance from the report.	
130/25	**People & OD Assurance Committee (PODAC) Report** The Board of Directors received the report from the Committee Chair, Mrs Boughey, which was taken as read. Highlights from the report included the following: • Joint People Strategy: Mrs Boughey had presented this discussion document to the Committee, which had been reviewed and agreed. The Executive will now reflect on the feedback from PODAC and take forward plans as appropriate. The Board noted that planning is also underway for the establishment of a joint People & OD Committee, and further details will be provided in due course. • Mutually Agreed Resignation Scheme (MARS): the Committee acknowledged the need to be mindful of staff views throughout the process. Whilst recognising that the scheme could be viewed negatively, from a positive perspective some colleagues have provided feedback that it provides an enabler for them to make life decisions. In response to a query from Ms Dunnett on how we are enabling colleagues to air any issues, Mrs Boughey confirmed that a large number of sessions have been delivered, in partnership with FTSU, to provide guidance on moving through change, in recognition that this is a new experience for our staff. She also	

	highlighted the role and responsibilities of managers in helping their staff navigate change. The Board of Directors accepted and **took** assurance from the report.	
STRATEGIC, QUALITY AND PERFORMANCE MATTERS		
131/25	**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 to the end of June/July 2025. Recognising that a number of the key issues had been covered in the earlier Committee reports, and taking the report as read, Ms Williams invited executive colleagues to provide the headlines from their sections. **Patient Safety, Clinical Effectiveness & Patient Experience Summary** The Deputy Medical Director and Interim Chief Nursing Officer drew colleagues' attention to the following points: • Deteriorating Patients – Paediatric Early Warning System (PEWS): Ms Gardner wished to draw the Board's attention, with apologies, to an error within this slide (page 58 of the Board pack). The slide contains reference to two patients not receiving antibiotics within 60 minutes, however Ms Gardner provided assurance that this was a reporting error and both patients did, in fact, receive appropriate treatment. • Infection Prevention and Control (IPC): The Board's attention was also drawn to an error on page 70 of the Board pack within the table detailing Measures and Annual Targets, where two figures had been inadvertently transposed. The 2025/26 annual target for C diff infections should read 98 and for MRSA Bacteraemia it should read 0, rather than the other way round. Flu vaccinations: Ms Gardner advised that the staff flu vaccination compliance rate last year was 49%, and despite NHSE seeking a 5% increase in take-up this year, we have set ourselves a stretch compliance target of 60%. National guidance is awaited on additional precautionary measures to reduce the spread of respiratory infections this winter, to protect patients, visitors and colleagues. In the meantime, Ms Gardner provided assurance that the Trust has processes in place, which will be invoked as necessary. There has been no national guidance on Covid vaccinations. Ms Gardner brought the attention of the Board to a medication funding issue, which is currently awaiting ICB approval, and the	

potential consequences for either infection reduction or spread, dependent upon the funding outcome.

- Complaints and Compliments: Mr Miner referred to the significant increase in complaints in a number of different areas, including Gynaecology, Renal and Orthopaedics, and an increase in complaints relating to staff attitude, communication and treatment. Ms Gardner acknowledged this concerning increase, recognising that it evidences a need for customer care training.

  In response to a query from Mrs Boughey on the reasons for the spike in complaints relating to clinical treatment, Ms Gardner clarified that this covers a wide range of issues, and she proposed looking at this topic in more detail at QSAC.

- Friends and family test: Ms Nicholson noted that the Trust is struggling to get back to earlier response percentages, and Ms Gardner agreed to refer this observation to the Medical Director. Mr Lee additionally reassured the Board of the continued rollout of the SaTH Patient Engagement Portal, acknowledging that whilst it will not solve all issues, it is intended to facilitate easier and timely patient feedback.

- Mortality outcome data: Dr Rowlands highlighted that there were no Trust Summary Hospital-level Mortality Indicator (SHMI) updates, or benchmarking against the Caspe Healthcare Knowledge System (CHKS) Peer Group, available at present, due to the current Data Warehouse challenges. She provided assurance, however, on other triangulation mechanisms which are in use by the Trust, including Structured Judgement Reviews (SJRs), the Patient Safety Incident Response Framework (PSIRF) and other nationally available statistical information.

Operational Summary

Noting that key operational issues and highlights had been covered in earlier reports, the Chief Operating Officer additionally advised the Board that NHSE have recently published details of their Elective Capital Incentive Scheme. As one of the most improved Trusts nationally, we are eligible to receive enhanced funding, for which we are cautiously optimistic.

Workforce Summary

The Chief People Officer advised the Board that, as mental health continues to be the main reason for staff sickness absence, she would shortly be meeting with clinical psychology colleagues to learn from their expertise and advice, and will report back through PODAC.

Finance Summary

	Adding to the earlier financial reporting, the Acting Director of Finance drew the Board's attention to a cost pressure of £0.51m associated with the latest industrial action, which has been mitigated by bringing forward an expected CIP scheme in non-pay. The cost pressure of £0.61m associated with this year's pay award has been mitigated by a technical adjustment in pay, and work is underway to review where further adjustments can be made. The Board of Directors accepted and **noted** the Integrated Performance Report.	
132/25	**Estates Strategy** The Board of Directors received the report from the Assistant Chief Executive, presenting the final draft of the Estates Strategy 2025/2030. The document sets out the Trust's vision and direction for developing and managing our physical and operational estate over the next five years and beyond, in alignment with the Trust's Strategy (2022-2027), wider System priorities and national policy and guidance. Taking the report as read, Ms Robotham wished to particularly thank Performance Assurance Committee colleagues for their valuable scrutiny and challenge during development of the document. Key points from subsequent Board discussion are summarised as follows: • Group model: Prof Purt highlighted the early requirement to consider how the estates strategy will reflect the SaTH and SCHT Group model, noting that SCHT operates across 73 sites and their estates function is mostly outsourced. Ms Williams confirmed that work on this has started, and includes considerations relating to shared services integration. Ms Cotterill provided additional context on the number of workstreams which are currently running across the ICS, including facilities and estates. Mr Lee added, from an ICB perspective, that an update was being provided to colleagues the following day on the ICS Infrastructure Strategy, and some of the content could be useful when considering our future Group model estates strategy, in addition to potential inter-relationships with Local Authorities. • Measurement of success: Mr Miner stated that he would like to see more focus on measurement of what we wish to achieve, particularly around key strategic aim 4 – embedding sustainability models and approaches into our estate management. Ms Robotham clarified that clear sustainability measures feature in the Trust's separate Green Plan, which she offered to discuss with Mr Miner offline.	

	• Lease and rent expenditure: Mr Dhaliwal sought assurance on whether there is a plan to reduce the amount spent on leases and rent. Ms Robotham confirmed the intention to carry out further extensive work on this, which would include any opportunities created by break clauses in contracts. • Finally, Ms Williams wished to recognise the excellent leadership of Mr Lee Wyatt, Director of Estates, noting the positive feedback that Lee has received from external contractors, and the great asset that he is to our organisation. Mr Morgan asked for the appreciation of the Board to be relayed to Lee following this excellent feedback, and he also thanked Prof Purt and committee colleagues for their ongoing HTP work. The Board of Directors: • **Noted** the contents of the Estates Strategy, particularly the detail under the six strategic aims, and • **Approved** the final draft for publication (subject to the above comments).	
ASSURANCE FRAMEWORK		
133/25	**Integrated Maternity & Neonatal Report** Ms Gardner introduced Ms Jacqui Bolton, Acting Head of Midwifery, to present the report, which detailed the latest position in relation to the delivery of actions from the Independent Maternity Review (Ockenden Review), the Maternity Transformation Programme, NHS Resolution's CNST Maternity Incentive Scheme, and the invited Neonatal Mortality Review action plan. Colleagues were referred to the detail contained within the main report, together with the appendices in the Board Supplementary Information Pack which provided further comprehensive information. Highlights from the report included the following: **The Ockenden Report (Independent Maternity Review) Progress Report:** The summary action plan, as at 12 August 2025, is included as **Appendix 1** in the Board Supplementary Information Pack. 192 out of the total of 210 actions have now been fully completed (evidenced and assured), with the remaining 11 on track for their delivery dates. Seven actions remain 'de-scoped', relating to nationally-led external actions (led by NHS England and the CQC), which are not within the direct control of the Trust to deliver. The Local Maternity and Neonatal System (LMNS) continues to oversee these actions, which remain under quarterly review by the Trust at the Maternity and Neonatal Transformation Assurance Committee (MNTAC). **Invited Neonatology Service Review (2023/24):** Progress continues with delivery of the recommendations from the external	

	invited review led by the Royal College of Physicians. The summary action plan, as at 12 August 2025, is included as **Appendix 2** in the Board Supplementary Information Pack. All actions are on track for their expected delivery dates, with the exception of an action relating to the service's 'golden hour' provision. This remains off-track until a realistic timeline can be provided for compliance with the 'golden hour' audit. This action forms part of ongoing work in collaboration with the LMNS, and guidance is currently awaited from Network members as to how compliance is achieved in other units to help guide improvements. Additionally, an action regarding the National Perinatal Mortality Review Tool (PMRT) has been identified at risk. Although the process has been improved internally, with outputs and learnings from PMRT complying with the review recommendation, the requirement for neonatal externality remains challenging to achieve reliably. An agreement is in place within the Network to allow for sufficient provision of externality, and time has been allocated within job plans to provide this externality to other Trusts. Delivery of CNST Safety Action 1 (requiring externality to be achieved in 50% of PMRTs) has been added as an evidence requirement before this action can be proposed for 'Evidenced and Assured' status. **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, is included as **Appendix 3** in the Board Supplementary Information Pack. All actions are progressing well, and progress continues to be made with the cultural improvement plan. **NHS Resolution's Maternity (and Perinatal) Incentive Scheme (Clinical Negligence Scheme for Trusts – CNST)**: Reporting continues in line with the Year 7 technical guidance, and the Trust is currently on track for 8 of the 10 Safety Actions. Of the two actions at risk, the first relates to the requirement for neonatal externality at 50% of PMRTs, as described above, and the second relates to a requirement for the Maternity and Neonatal Voices Partnership (MNVP) lead to be a quorate member of internal meetings, as referenced in the earlier QSAC report. The Board of Directors formally acknowledged that it had received and read all the reports listed in the table under section 5.2 of the paper, and confirmed as follows: • SA7 – *'Listen to women, parents and families using maternity and neonatal services and co-produce services with users'* – Reports and compliance continue to be presented to the LMNS, Maternity & Neonatal Safety Champions and QSAC. As covered above, a risk to the delivery of this action has been identified, with written confirmation of a solution awaited from NHSE. Further details are available in section 3 of the Year 7 CNST	

	Progress Report August 2025, which is provided in the Board Supplementary Information Pack as **Appendix 4.** • 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 standards?'* – Quarterly reports evidencing delivery continue in line with Year 7 technical guidance. Quarter 1 reports are provided as **Appendix 5** in the Board Supplementary Information Pack. • (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, as follows: ○ The Trust has fully embedded the Perinatal Quality Surveillance Model and must demonstrate work towards the revised Perinatal Quality Oversight Model. ○ The Safety Champions Locally Agreed Dashboard is presented to the Board each quarter during the reporting period, and is presented as **Appendix 6** in the Board Supplementary Information Pack. ○ The Trust's Claims Scorecard is reviewed alongside incident and complaint data and discussed by the Maternity and Neonatal Board Safety Champions at a Trust level (Board or Directorate) meeting. ○ The Perinatal Quadrumvirate Leadership team meet (bi-monthly), and the minutes of the June 2025 meeting are presented as **Appendix 7** in the Board Supplementary Information Pack. 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.	
134/25	**SaTH Winter Plan 2025/26** The Board of Directors received the report from the Chief Operating Officer, and Mr Hobbs firstly wished to put on record his thanks to Susanne Crossley, Deputy Chief Operating Officer (UEC), for her work in leading on the robust 2025/26 Winter Plan being presented today. Colleagues were referred to the comprehensive detail in the report, which included the SaTH 2025/26 Winter Plan document, the Winter Bed Modelling Summary, the SaTH 2025/26 Winter Board Assurance Statement, and a supporting Quality, Equality and Impact Assessment (QEIA). Mr Hobbs highlighted the requirement for the Board to approve both the SaTH 2025/26 Winter Plan and the NHSE 2025/26 Winter	

Board Assurance Statement, both of which had been reviewed beforehand by the Performance Assurance Committee.

The Board was advised that, since submission of this report, NHSE colleagues have undertaken a STW Winter Planning assurance review and they were supportive of the Plan.

Subsequent discussion focused on the following points:

- The Board recognised that a successful Winter period will, critically, be based on our ability to intervene in a timely manner.

- Ms Williams advised that it has been emphasised to all System partners that we will need their support, and they have been asked to fully consider this when undertaking their own winter planning. Recognising also the need for engagement and consistent messaging to our GP colleagues, Ms Williams advised that three GPs sit on the UEC Board, which was proving very useful in terms of engagement. She added that Dr Jones is also working with SCHT on how medical support can be extended.

- Prof Purt sought the reassurance of also having sight of our System partners' plans, and it was agreed that the System Winter Plan would be brought to Board once it had been signed off by all organisations and approved by the ICB Board.

- Assurance was provided, in response to a request for clarity from Ms Nicholson on joined up communication plans to our communities, that the ICB communications lead sits on the UEC Board, and mapping has been taking place on all available communication avenues and their utilisation to maximum effect.

- In response to a query from Mr Crowther on the level of Executive confidence in our organisational 'readiness' for the Winter period, Mr Hobbs provided assurance that the Winter Planning Group has been established since late Spring 2025 so there has been extensive preparation. He also referred to the baseline and surge scenarios covered in the report, confirming that the thresholds can be tracked on a daily and weekly basis, and post-December it is thought that the Trust will have sufficient resilience to manage baseline and surge scenarios.

- Responding to a further request from Mr Crowther for assurance on how the Trust will achieve timely financial grip and control of the different scenarios which may need to be faced, Mr Hobbs confirmed that Finance colleagues have been a key part of the working group since it was established, and there has been extensive discussion and planning on the financial consequences of levels of mitigation.

The Board of Directors **approved** the SaTH Winter Plan 2025/26 and the SaTH Winter Board Assurance Statement 2025/26, and

	agreed that the System Winter Plan should be brought to Board once approved.	
135/25	**Mortuary Report** The Board of Directors received the report from the Chief Operating Officer, which notes the Trust's assurance position relating to the 20 recommendations for NHS Trusts to review from the Independent Inquiry of the Fuller Case Phase 2 report. Assurance was provided that the Trust is fully compliant with 16 out of the 20 standards; partially compliant with three of the standards but with actions underway to achieve compliance; and one where we are not yet assured but have an agreed plan to achieve compliance as soon as possible. The Chair in Common clarified that, whilst the report has been through Board governance, the information which is presented today is to provide appropriate assurance without going into sensitive detail in the public domain. The Board of Directors **noted** the report and the Trust's assurance position relating to the 20 recommendations from the Independent Inquiry Phase 2 report.	
136/25	**System Integrated Improvement Plan (SIIP) Report** The Board of Directors received the report from the Chief Executive in Common, providing an overview of progress against agreed exit criteria, developed in conjunction with NHSE colleagues, to enable the STW System and SaTH to transition from National Oversight Framework (NOF) segment 4 to segment 3 by March 2026. Ms Williams reminded colleagues of the importance of this critical live document, which brings together comprehensive and triangulated evidence to support our exit from RSP. This will be a critical milestone for the organisation and Ms Williams wished to thank Mary Aubrey for her detailed ongoing work on this. The Board noted the report and **took assurance** from the updates provided, which would be submitted to the STW ICB by 6 September 2025 together with supporting evidence.	
137/25	**Board Assurance Framework – Draft Q1 2025/26** The Board of Directors received the report from the Director of Governance, which was taken as read. Colleagues noted that the only change being recommended at this time was a reversal of the impact and likelihood ratings of BAF risk 5, from 4X5=20 to 5X4=20, as detailed in the report. The Board of Directors: • Considered that the BAF content reflected the strategic risks within the organisation, with appropriate risk scores,	

	• Supported the reversal in total current risk score of BAF risk 5, as agreed by the Finance Assurance and Audit & Risk Assurance Committees, and • **Approved** the Quarter 1 BAF.	
REGULATORY AND STATUTORY REPORTING		
138/25	**Guardian of Safe Working (GoSW) Hours Report (April-June 2025)** The Deputy Medical Director welcomed and introduced Dr Robin Hollands, who will be taking up the post of Guardian of Safe Working Hours from 22 September 2025, following the retirement of Dr Bridget Barrowclough. Dr Rowlands reminded colleagues of the requirement that the GoSW Hours provides their report independently, direct to the Board. The Chair in Common welcomed Dr Hollands to this important role on behalf of the Board, and provided a commitment that the safe working hours of our resident doctors is taken very seriously at Board level. Mr Morgan invited Dr Hollands to engage directly with himself and Ms Williams should he require assistance at any time. Dr Rowlands reminded colleagues that the Trust is progressing towards full compliance with national reforms to the Exception Reporting process for resident doctors. This was due to be implemented on 12 September 2025, however the rollout has now been delayed until February 2026, and the current exception reporting process will continue in the meantime. Finally, on behalf of the Medical Director, Dr Rowlands wished to formally recognise and thank Dr Barrowclough for the outstanding support and significant contribution she has provided to the safe working hours of our resident doctors throughout her tenure. Echoing the above comments, the Board of Directors **noted** the report, wished Dr Hollands well in his new role, and sent very best wishes to Dr Barrowclough for a fulfilling and enjoyable retirement.	
ITEMS FOR CONSENT – approval recommended by Board Committees		
139/25	**Remuneration Committee Terms of Reference** The Director of Governance advised that the annual review of the Remuneration Committee's terms of reference had been undertaken, drawing the Board's attention to the proposed minor amendments detailed in the report. The Board of Directors **approved** the terms of reference of the Remuneration Committee.	
140/25	**Group Transition Committee Terms of Reference**	

	The Director of Governance presented the terms of reference of the newly established Group Transition Committee. Ms Milanec confirmed that the ToR was approved by the SCHT Board at its meeting in public on 7 August 2025. It was also approved in private session by the SaTH Board in August, however for transparency purposes and public information, it was also being presented at this meeting to complete the necessary governance requirements. Ms Robotham highlighted that the committee membership continued to show two separate Chief Executives, and it was agreed that this would be corrected to read 'Chief Executive in Common' The Board of Directors **noted** the terms of reference of the Group Transition Committee, and **approved** the amendment detailed above.	
141/25	**Audit & Risk Assurance Committee Terms of Reference** The Director of Governance advised that the annual review of the Audit & Risk Assurance Committee's terms of reference had been undertaken, drawing the Board's attention to the minor amendments and one addition detailed in the report. The Board of Directors **approved** the terms of reference of the Audit & Risk Assurance Committee.	
PROCEDURAL ITEMS		
142/25	**Any Other Business** Mr Lee was pleased to advise the Board that SaTH has been shortlisted as a finalist in the Health Technical News Awards. The nomination recognises the work that has been taking place with NHSE and other partners to update our systems, making them more reliable and better prepared for the future. Mr Lee particularly highlighted the close technical collaboration that has taken place between our internal Data Warehouse team and the NHS Federated Data Platform developers. The Board endorsed Mr Lee's thanks and recognition of all our teams involved in these important and innovative developments. There were no further items of business, and the meeting was declared closed.	
143/25	**Date and Time of Next Meeting** The next regular meeting of the Board of Directors in public was scheduled for Thursday 13 November 2025 from 0930hrs–1230hrs.	

(Public Q&As from the meeting follow below):

Public Q&As *(agenda item 119/25)*

Q1 – submitted by Stacey Harris:

Hand hygiene compliance appears to be particularly poor amongst the Trust's medical staff (a disappointing 53% compliance reported in Board papers). What steps are being taken to ensure this is resolved?

A – provided by Paula Gardner, Interim Chief Nursing Officer:

The IPC Team delivers 15-minute mandatory training sessions for consultants and registrars (two sessions per month). Doctors also receive hand hygiene training at induction, which is repeated annually.

Hand hygiene and dress code compliance have been escalated to the Medical Director. From an IPC perspective, investment in targeted training and sustained engagement from senior medical leaders is required to improve compliance.

The Medical Director has attended FY1 doctors' induction to explain the importance of hand hygiene and compliance with the uniform policy and has also reminded colleagues when acting as guest editor of the Chief Executive's weekly staff message.

Q2 – submitted by Marilyn Gaunt:

The Patient Satisfaction results reported in Board papers suggest there may be specific equalities issues involved in patient experience (e.g. around sexual orientation, ethnicity and disability). My belief is that these issues are far more likely to be accidental than arising from prejudice or discrimination. Can the Trust ensure steps are taken to support staff in meeting the needs of a diverse patient group effectively and with sensitivity?

A - provided by Paula Gardner, Interim Chief Nursing Officer:

People identifying as gay women/lesbian demonstrated a drop in satisfaction by 6.5%, however cisgender patients also reported a decrease in satisfaction by 5.9%.

Most of the feedback providing demographic data has been captured through 'SMS FFT' (NHS Friends and Family Test via Short Messaging Service – SMS) within the Emergency Departments, rather than giving an overview of patient experience within the Trust. SMS FFT has been included in the Trust's financial plan for 2025/26 to support a wider SMS FFT roll out across inpatient, outpatient, and maternity areas, which will provide us with greater data collection and insight into any demographic variations.

Actions being taken by the Trust to increase awareness and address inequalities:

- *We have established EDI Leads across the Trust, within Workforce, Maternity, and Nursing and Allied Health Professionals (AHPs) to lead on this agenda.*
- *EDI Champions have also been established across the Trust.*
- *The Trust has an EDI Advocate Group which incorporates patient partners in identifying and addressing barriers.*
- *We undertake EDS2022 (Equality Delivery System 2022), a national framework developed by NHS England to help NHS organisations to assess and improve their services and work environments to promote equality and tackle health inequalities.*

- *We have established a Learning Disability and Autism Patient Experience Group, working with people with lived experience and key stakeholders, to drive improvement work.*
- *Training has been delivered on: Cultural Competency, Active Bystander, in addition to further training made available on faith and belief, and disability such as BSL awareness and accredited courses.*
- *The Trust has engaged with local LGBTQIA+ community groups to listen and learn from their experiences of care.*
- *Digital stories are captured incorporating a wide range of people from different demographics, supporting increased awareness and learning. These stories are used within facilitated discussions, with a number being heard at Board.*

Q3 – submitted by Gill George:

The system winter plan (reported in Board papers) includes: 'Expanding Urgent Community Response (UCR) to midnight (7 days/week)' and 'Providing an appropriate UCR Medical Model'.

Can you elaborate on what the UCR service will consist of? What consideration has been given to developing Urgent Care services in a wider range of locations? (The development of Urgent Care Centres to replace our existing Minor Injuries Units is a long-held aspiration of Shropshire's rural communities. You may be unaware that Future Fit/Hospital Transformation Programme previously promised ***seven*** *Urgent Care Centres to meet the needs of the population of Shropshire, Telford and Wrekin).*

A - provided by Ned Hobbs, Chief Operating Officer:

The Urgent Community Response (UCR) Service (or Rapid Response), delivered by clinical practitioners from Shropshire Community Health Trust, supports patients to receive timely care in their own homes, helping to avoid unnecessary hospital admissions, ie meeting their needs in the community.

The expansion will see an extension of the UCR service operational hours to midnight across the whole county, rather than finishing at 8pm as currently, enabling the care of more people to be safely managed in their own homes.

Through the system UEC Improvement workstream the impact of the expansion will be evaluated and monitored to help inform and shape the future of urgent care provision.

Q4 – submitted by Dylan Harrison:

Board papers report: 'Health Hero Integrated Care successfully launched Category 3 portal access in collaboration with WMAS on 27 August 2025. The remaining components of the Care Coordination Centre and the GP Out of Hours Service are scheduled to go live on 1 October 2025'.

Was this service previously offered by ShropDoc? Can you provide a little more detail eg on triage, which patient groups are considered appropriate for Health Hero to manage, and how safety and efficacy are to be monitored? This is presumably an ICB decision?

A – provided by Ned Hobbs, Chief Operating Officer:

This service is part of the Integrated Care Board's (ICB's) contract with ShropDoc and has previously been delivered by them.

When a member of the public calls 999 for an ambulance, the call is triaged, and the patient is placed into one of five categories. Category 1 is for life-threatening emergencies such as cardiac arrest, while Category 2 includes serious conditions like suspected strokes.

Patients in Category 3 may not require immediate hospital intervention/care and can be supported by alternative providers. In these cases, the Ambulance Service refers cases to providers in each area within the West Midlands. These cases are clinically reviewed by either a GP or an Advanced Care Practitioner (ACP), who assesses the patient and, where appropriate, guides patients to alternative care pathways such as the Urgent Community Response Team.

This model has been adopted by many NHS organisations to support both ambulance services and healthcare trusts and is part of a decision made by the ICB.

Q5 – submitted by Sue Campbell:

The system financial plan in recent ICB papers shows target efficiency savings for SaTH of 6.4% in 2025/26, 5.8% in 2026/27, and 5.8% in 2027/28 (with the long-term plan projecting further efficiencies over a 10-year period). SaTH's Board papers report access to deficit funding this financial year, which will mitigate the impact. However, access to deficit funding in the future is likely to be harder.

What is the projected impact of this extraordinary and unprecedented level of cost cutting? Has SaTH discussed the possible consequences of these efficiencies with local political representatives (our two local authorities, and MPs in Shropshire, Telford and Wrekin)?

A – provided by Adam Winstanley, Acting Director of Finance:

Efficiency requirements are a core part of operational planning each year, however given the underlying deficit and a commitment to achieve a breakeven position in the STW ICS Medium Term Financial Plan in FY27/28, the targets are challenging over the next few years. In order to deliver these targets, we have a strong focus on productivity within our efficiency programme which will have no negative impact on the care we provide.

All efficiency schemes are only implemented following the completion of a Quality Impact Assessment (QIA) and Equality Impact Assessment (EQIA), which are signed off by the Chief Nursing Officer and Medical Director, to ensure there will be no negative impact on quality and safety.

Whilst no formal discussions have taken place with local political representatives specifically in relation to the efficiency challenge, regular updates are provided in relation to delivery against the operational plan, which include efficiency delivery.

Q6 – submitted by Linda Senior:

a. *Ward 36 at PRH and Ward 18 at RSH – the Rehabilitation and Recovery Units – are to be closed. Those beds have been provided by ShropCom but have of course relieved pressure on acute beds. How many beds will be lost through the closure of the RRUs?*

b. *What involvement does SaTH have in developing services that will meet the needs of these patients in the future? How many beds will there be in the modular wards at RSH, and for which patient groups; also, what consideration has there been of the impact on Telford and Wrekin patients and their family and friends as the focus of inpatient care switches to RSH?*

A - provided by Ned Hobbs, Chief Operating Officer:

a. *ShropCom will see a reduction in their beds by 46 following the Rehabilitation and Recovery Unit closures.*

b. *As part of the system-wide Urgent and Emergency Care (UEC) Improvement Programme we are focused on developing services that best meet the needs of our local population in a community setting. This work involves close collaboration between SaTH, ShropCom, the ICB, and Local Authorities.*

At RSH, 56 additional beds will be introduced through new modular wards, due to open later this calendar year. These include:

- *8 additional beds for Colorectal services*
- *10 additional beds for Gastroenterology*
- *20 new beds for General Medicine*
- *18 new beds for flexible deployment over winter*

Plans are also being developed for the Princess Royal Hospital, to ensure that service improvements benefit patients across both hospital sites.

Q7 – submitted by Marilyn Gaunt:

A local paper has reported that 150 jobs will be lost at SaTH. Can you provide more detail (eg the reasons for this, the designation of those staff, and any potential impact on patient care)?

A – provided by Rhia Boyode, Chief People Officer:

Following an announcement several months ago by the Secretary of State for Health, many organisations have been presented with job loss requirements. Importantly, there have been no cuts to frontline healthcare workers. Where opportunities have been identified to reduce costs, it will support reinvesting to expand essential clinical services.

Any potential cost-saving measures involving workforce reductions are thoroughly reviewed, and quality impact assessments are conducted to understand any possible impact on patients before making final decisions. Supporting our workforce through these changes is key to our plan. Whether it's a shift in how they work, the roles they take on, or if they leave the organisation, our goal is to ensure staff are supported, treated fairly, and given every opportunity to be consulted and engaged in the process.

In our efforts to improve workforce planning we are focusing on boosting efficiency through technology, revamping service functionality, and eliminating duplication or inefficiency. This way, we are only reducing our workforce when it truly makes sense.

Q8 – submitted by Julia Davies:

I would like to know what plans SaTH have to support Bridgnorth Hospital MIU and X-Ray department when the 111 service keep sending people to Bridgnorth at weekends, when there is only a Nurse Practitioner, who is not able to offer X-Ray and who has then to refer people back to SaTH, and they then have to wait all over again, often having travelled from the north of the county.

A - provided by Ned Hobbs, Chief Operating Officer:

Bridgnorth Hospital MIU, and the other MIUs, are services run by Shropshire Community Health Trust. But SaTH are currently working in partnership with ShropCom to develop plans to enhance the provision of X-Ray to the MIUs, such that a greater number of patients can receive their scan locally, without needing to attend SaTH Emergency Departments. The Board will be kept updated as plans with ShropCom are finalised.

Due to additional time available under this agenda item following the responses provided to written questions, the Chair in Common invited verbal questions from observing members of the public, as follows:

Question received from David Tooley: *What is the Trust's reaction to the recently published Government NHS league table announcement and SaTH's position within it?*

A - provided by the Chair in Common: *SaTH is in segment 5 of the national league table by virtue of the Trust being in the NHSE Recovery Support Programme (RSP). Our league position stands at 113 out of 134, which is not where we want to be, but colleagues may recall that this represents a significant improvement on our previous position. Clearly, we have more to do and whilst we continue to make progress on elective care and finances, the main pressure continues to be within UEC.*

The Chair in Common thanked those who have made positive comments in the media on SaTH's improving performance and emphasised that it is the Trust's firm intention to continue our upward trajectory, so that no-one associates this Trust with being at the bottom of league tables.

Comment from David Sandbach: *The consensus, speaking with fellow community members, is that your Board is on the cusp of transforming SaTH into a successful organisation. Whilst the Trust's current improved national league position remains low, the robust 2025-26 Winter Plan is a positive indication for marked improvements in UEC performance by April 2026.*

The Chair in Common responded that no one around the Board table is deluded about the challenges ahead, but we are determined that the people of STW will receive the best possible care, from staff working in a successful and fulfilling environment.

Shropshire Community Health NHS Trust

The Shrewsbury and Telford Hospital NHS Trust

Board in Common Meeting

The Shrewsbury and Telford Hospital NHS Trust (SaTH) and Shropshire Community Health NHS Trust (SCHT)

Tuesday 23 September 2025 at 1015hrs (held at SECC, RSH, Shrewsbury)

MINUTES

MEMBERS	
Name	**Role**
Mr Andrew Morgan	Chair in Common, SaTH & SCHT
Ms Jo Williams	Chief Executive in Common, SaTH & SCHT
Mrs Rhia Boyode	Chief People Officer, SaTH & SCHT
Mr Harmesh Darbhanga	SCHT, Non-Executive Director
Mr Raj Dhaliwal	SaTH, Non-Executive Director *(via Teams)*
Ms Rosi Edwards	SaTH, Non-Executive Director
Dr Mahadeva Ganesh	SCHT, Medical Director
Ms Kara Blackwell	SaTH, Deputy Chief Nurse *(representing Int.Chief Nursing Officer)*
Ms Clair Hobbs	SCHT, Director of Nursing, Quality & Clinical Delivery
Mr Ned Hobbs	SaTH, Chief Operating Officer
Ms Claire Horsfield	SCHT, Director of Operations & Chief AHP
Dr John Jones	SaTH, Medical Director
Mr Nigel Lee	SaTH, Director of Strategy & Partnerships
Ms Sarah Lloyd	SCHT, Director of Finance, Digital & Estates
Ms Tina Long	SCHT, Non-Executive Director / Vice Chair
Ms Wendy Nicholson MBE	SaTH, Non-Executive Director
Mrs Cathy Purt	SCHT, Non-Executive Director
Prof Trevor Purt	SaTH, Non-Executive Director / Vice Chair
Mr Adam Winstanley	SaTH, Acting Director of Finance
IN ATTENDANCE	
Ms Tracey Cotterill	SaTH, Interim Director of Financial Recovery & Transformation
Mr Simon Crowther	SaTH, Associate Non-Executive Director *(via Teams)*
Ms Anna Milanec	SaTH, Director of Governance
Ms Shelley Ramtuhul	SCHT, Director of Governance
Ms Inese Robotham	SaTH, Assistant Chief Executive
Mr Jon Sargeant	SaTH, Associate Non-Executive Director *(via Teams)*
Ms Beverley Barnes	SaTH, Board Coordinator (Minute Taker)
APOLOGIES	
Ms Jill Barker	SCHT, Non-Executive Director
Mrs Teresa Boughey	SaTH, Non-Executive Director
Ms Sarah Dunnett	SaTH, Non-Executive Director
Prof Heidi Fuller	SaTH, Associate Non-Executive Director
Ms Paula Gardner	SaTH, Interim Chief Nursing Officer
Mr Richard Miner	SaTH, Non-Executive Director

001/25	**Welcome** The Chair in Common welcomed all colleagues and observing members of the public and formally noted that representatives from both Shropshire Community Health NHS Trust and The Shrewsbury and Telford Hospital NHS Trust are attending this meeting, taking place in public session. The purpose of the meeting was to consider a proposal to establish a Group model between the two Trusts.
002/25	**Apologies & Quorum** Apologies were noted, and it was confirmed that the designated quorum from each Board was in place, with any decisions made severally by both organisations, in accordance with their Standing Orders.
003/25	**Declarations of Interest** It was confirmed that the Register of Interests for each Board could be found on their respective websites. For the purposes of the two Boards meeting in common, a potential non-pecuniary interest has been recognised and noted for all members.
004/25	**Public Questions** The Chair in Common invited verbal questions from observing members of the public. One question was received, asking what advice people should follow, given recent international and national news headlines on the suggestion that had been made about the risk of autism in babies from mothers taking paracetamol during pregnancy. Dr Jones, SaTH Medical Director, wished to reassure the public that the media comments were speculative and medically unfounded. He advised anyone with questions or concerns to seek support and advice through the formal healthcare channels available to them in this country, either from their GP, another appropriate healthcare professional, or the extensive NHS information which is available online to support families.
005/25	**Case for Change** Mr Morgan and Ms Williams introduced this item by summarising the requirement for both Boards to: • review the Case for Change, • propose any further amendments, and • subject to those amendments, approve the Case for Change and the establishment of a Group model. Mr Morgan confirmed that today's meeting was the culmination of extensive engagement with staff, system partners, external stakeholders and NHS England, and was borne out by the overwhelming feedback that our two Trusts are 'better together' whilst committed to full engagement with all our partners for the benefit of the communities we serve. He added that NHSE has made it very clear that, whilst happy to provide guidance and support, this was a decision for both Boards to take and it did not require national approval.

Ms Williams thanked Mr Nigel Lee and Ms Sarah Lloyd for leading this joint work; all partners and stakeholders who have contributed their time to providing feedback; and colleagues across both Trusts whose palpable positive feedback has confirmed that our teams want to work together and take this next step. She noted that this also provided an important catalyst for delivering the NHS 10 Year Plan.

A comprehensive presentation followed from Mr Lee, detailing the case for establishing a Group model, which covered the key areas of:

- benefits from working closer together for our patients, staff and communities,
- our guiding principles,
- issues and risks,
- staff and stakeholder engagement,
- culture and engagement plan, and
- the next steps required following approval.

Accepting that both Boards, individually and collectively, had reviewed the Case for Change document prior to today's meeting, the Chair in Common invited any further comments, questions or observations following Mr Lee's presentation, as detailed below:

- Adequacy of document content on level of staff engagement: The Chief People Officer confirmed that Staff Side colleagues from both organisations had been involved in all engagement, as had staff across both Trusts, however she agreed to review the sufficiency of content with Mr Lee and Ms Lloyd, with a view to adding a few further lines to the document as necessary.

- Group model v formal merger: Mr Lee clarified that both options were carefully considered, which is one of the reasons why there has been extensive collaboration. The conclusion was reached that moving to a shared leadership model as a Group at this time would provide the benefits we want to achieve. From talking to other organisations operating as an established Group, we know that many have taken the decision to continue to operate as a Group as they feel the model provides the right balance without the distraction of undergoing a formal merger.

  The Chair in Common added that, whilst not precluding this option in the future, it was felt that a merger at this time would hold us back from our aim of doing things differently and better, particularly in view of the considerable cost and length of time involved in a legal merger.

- Impact on colleagues: Ms Williams wished to recognise and acknowledge, when talking about this change, that those who will be most affected are colleagues around this Board table. Mr Morgan echoed this comment and gave his assurance that, as we move forward, colleagues will be treated with appropriate respect and dignity.

- Progression momentum: The need to move forward to a Group model as quickly as practicable was recognised by all, and the Chair in Common observed that we would be letting our colleagues, as well as our patients, down if momentum was not maintained.

Following review of the Case for Change document, each Board of Directors:

	• **Approved** the Case for Change on behalf of their respective Trusts, subject to any final updates reflecting comments above where necessary, and • **Approved** the establishment of a Group between the two Trusts.
006/25	**Closing Comments** The Chair in Common, adding his thanks to Mr Lee and Ms Lloyd for the extensive work that had been undertaken to reach this stage, also highlighted that a lot of work was still required, including the NHSE assurance process, in which several Board colleagues would be involved. Mr Morgan also stressed the importance of continued drive and focus on the operational and financial challenges and priorities which each provider needs to deliver during 2025/26 and beyond. Finally, referring to the need to promote and reinforce the establishment of the Group, the Chair in Common advised that colleagues would see a movement to the use of the Group Chair and Group Chief Executive titles in future communications and engagements. These would replace the 'In Common' titles which many people found confusing. Mr Morgan thanked Board colleagues for their in-person and virtual attendance at today's important meeting, which was declared closed.

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

Log number	Date of meeting	Agenda item	Item	Action	Lead Officer	Deadline	Comment/ Feedback from Lead Officer	Action
2025								
				There were no Board actions arising from the meeting of 11/09/25, and the closure of all previous actions had been agreed.				
11								

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
13 November 2025

Agenda item		153/25		
Report Title		Chief Executive's Report		
Executive Lead		Jo Williams, Group Chief Executive, The Shrewsbury and Telford Hospital NHS Trust and Shropshire Community Health NHS Trust		
Report Author		Jo Williams, as above		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	all strategic risks
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	-
Well Led	√	Our partners	√	
Consultation Communication		N/A		
Executive summary:		Operational pressure on the Trust and other providers has begun to ramp up as we change season from late summer to autumn, anticipating the approach of winter. Therefore, we have included a copy of the Shropshire, Telford and Wrekin ICS-wide winter plan, which includes SaTH plans, as an item on the agenda today. (162/25) Whilst the Trust and sites remain busy, some of our colleagues have gone well beyond what is expected of them, and I was delighted that the Trust was able to invite so many of them to be recognised in our annual staff awards ceremony, which took place on Friday 17 October 2025. Enormous thanks also go to our event sponsors for the evening - ModuleCo, Vinci Building, Dyke Yaxley, Group Nexus, and One Retail. Inside this meeting pack, we include our updated operational performance data for the last month and assurance reports from our monthly Board Committees.		
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 meeting on 11 September 2025 from the Group Chief Executive's position, including an overall update, SaTH news and wider NHS updates.

2.0 OVERALL SaTH UPDATE

2.1 I would like to express my sincere appreciation to all our staff for their dedication in delivering care to our patients. As demand for our services has continued at elevated levels throughout the summer and into autumn, we are actively implementing our winter plan to ensure we are well-prepared to manage the ongoing and anticipated increase in demand during the winter period.

2.2 The Trust continues to work hard to improve its financial position and take steps to deliver sustainable, high-quality, responsive care within available funding. In September 2025, the Trust reported a deficit of £1.3m against a breakeven plan predominantly driven by premium staffing costs and unavailability with additional actions being undertaken. We have delivered £18.3m against our Cost Improvement Programme (CIP) efficiencies to date which is 44% of our annual target by September 2025 (month 6). This is compared with £10.9m in September 2024

2.3 The Board papers for this meeting include a comprehensive Integrated Performance Report, outlining our performance against the plans agreed with NHS England. We remain committed to driving improvement across all key areas. Over the last month we have seen our Diagnostics performance improve significantly - DM01 performance for September stands at 85.33% of patients waiting less than six weeks. This is our best performance for five years and the Trust is now in the top performing half of the country. We have seen an overall reduction in our elective waiting list by 30% in the last year. We have also seen a reduction in the number of patients waiting 52 weeks by over 95% in the last year, and SaTH is now in the top performing half of the country. 18-week Referral to Treatment performance is our highest performance for four years, and we lifted out of the bottom quartile nationally. We are progressing as planned with a range of UEC initiatives, supported by substantial investments to expand inpatient bed capacity and assessment spaces at both hospitals.

2.4 The Trust is proud to continue to celebrate the outstanding commitment of long-serving staff through its regular 'long service' award ceremonies. In October 2025, The Shrewsbury and Telford Hospital NHS Trust held a celebration to mark the contribution of their members of staff who have completed 25, and an incredible 40 years of service. Over thirty-five members of staff with more than 1,100 years' experience between them, who work at both Royal Shrewsbury Hospital (RSH) and Princess Royal Hospital (PRH) gathered with members of the hospitals' executive team to celebrate their long service achievements.

I was pleased to attend the ceremony and was struck by the dedication of both clinical and non-clinical colleagues who received awards – I offer my congratulations to them all.

2.5 The NHS workforce is now more diverse than ever, which we value greatly. In October 2025, we marked Black History Month with the theme 'Standing Firm in Power and Pride'. While progress has been made towards being an anti-racism organisation, further efforts are needed to enhance the experiences of Black and other global majority colleagues at the Trust.

2.6 The Trust was contacted in mid-September by Baroness Valerie Amos, Chair of the Independent National Maternity and Neonatal Investigation, to confirm that the Trust would

be part of the review, together with 13 other Trusts. However, shortly afterwards the Trust was contacted again to advise that, due to the ongoing West Mercia Police investigation, it had been decided that the Trust would be removed from the review.

2.7 Additional industrial action has been scheduled for resident doctors over 5 days/nights in November 2025 (14th-19th), with the possibility of further action again before Christmas. Efforts are ongoing across the system to sustain all activities and reduce any impact on patients.

2.8 Congratulations to all individuals who were nominated, as well as the finalists and winners at the staff awards in October. Appreciation is also extended to the sponsors ModuleCo, Vinci Building, Dyke Yaxley, Group Nexus, and One Retail for supporting the event on Friday evening. Thanks are given to everyone involved in organising the evening and to all staff for their contributions to patients, local communities, and colleagues.

2.8 The Board is asked to note the following consultant appointments made since the last report:

Division	Post Type	Start Date
Clinical Support Services	NHS Locum Consultant - Oncology	03/09/2025
Clinical Support Services	NHS Locum Consultant - Oncology	03/09/2025
Clinical Support Services	Consultant - Pathology	01/10/2025
Clinical Support Services	Consultant - Pathology	20/10/2025

Division	Post Type	Start Date
Medicine and Emergency Care	NHS Locum Consultant – Gen Medicine	14/10/2025
Medicine and Emergency Care	NHS Locum Consultant – Gen Medicine	19/09/2025

Division	Post Type	Start Date
Surgery, Anaesthetics and Cancer	NHS Locum Consultant-Ophthalmology	04/09/2025
Surgery, Anaesthetics and Cancer	NHS Locum Consultant-Ophthalmology	15/09/2025
Surgery, Anaesthetics and Cancer	Consultant- Gastroenterology	17/10/2025
Surgery, Anaesthetics and Cancer	Consultant- Gastroenterology	01/10/2025
Surgery, Anaesthetics and Cancer	Consultant - Anaesthetics	08/09/2025

Division	Post Type	Start Date
Women and Children's	Consultant - Paediatric Neonatal	02/10/2025
Women and Children's	NHS Locum Consultant - Obstetrics and Gynaecology	29/09/2025
Women and Children's	NHS Locum Consultant - Obstetrics and Gynaecology	29/09/2025

In addition to these appointments, we currently have 19 consultants under offer as follows; the team are diligently working on their pre-employment checks.

- 1 consultant in CSS
- 6 consultants in MECC
- 6 consultants in SACC
- 6 consultants under offer in W&C

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

3.1 The next public board meeting is being held on Wednesday 26 November 2025.

4.0 NHSE

4.1 On 24 October 2025 NHS England (NHSE) and the Department of Health and Social Care (DHSC) jointly published a Medium-Term Planning Framework covering the financial years 2026/27 to 2028/29 - 'Medium term planning framework - delivering change together 2026/27 to 2028/29'.

It emphasises collaboration, innovation, and sustainability to meet evolving population needs and financial pressures. It builds on recent reforms and lessons learned from the pandemic, aiming to deliver better outcomes for patients, staff, and communities.

Strategic Priorities

- **Prevention and early intervention**: A shift toward proactive care, with increased investment in public health and community services.
- **Integrated care systems (ICSs)**: Strengthening collaboration across NHS organisations, local authorities, and voluntary sectors to deliver joined-up care.
- **Workforce transformation**: Addressing staffing challenges through recruitment, retention, and new roles, with a focus on wellbeing and flexible career pathways.
- **Digital and data innovation**: Expanding digital infrastructure and data sharing to improve decision-making, patient experience, and operational efficiency.
- **Financial sustainability**: Emphasising value for money and productivity, with clear expectations for cost control and resource optimisation.

Planning Expectations

- **Three-year operational plans**: NHS organisations are expected to develop aligned plans that reflect national priorities and local needs.
- **Performance metrics**: Targets include reducing waiting times, improving access to mental health services, and increasing cancer screening rates.
- **Equity and inclusion**: Tackling health inequalities is a core requirement, with a focus on underserved populations and inclusive service design.

Collaborative Delivery

- The framework encourages **co-production with patients and communities**, ensuring services are shaped by those who use them.
- It also promotes **cross-sector partnerships**, particularly in areas like housing, education, and employment, to address wider determinants of health

NHS Providers have developed a helpful summary of the document **on-the-day-briefing-medium-term-planning-framework-2026-2029.pdf**

Over the coming weeks, NHSE intends to distribute a series of documents to complement the guidance, including financial materials such as capital allocation documentation.

5.0 **RECOMMENDATION(S)**

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

5.2 Note the contents of the report.

Jo Williams

Group Chief Executive
The Shrewsbury and Telford Hospital NHS Trust
Shropshire Community Health NHS Trust

The Shrewsbury and Telford Hospital NHS Trust

Audit and Risk Assurance Committee, Key Issues Report		
Report Date: 6 October 2025		**Report on:** Audit and Risk Assurance Committee
Date of meeting: 1 September 2025		All NED and Associate NED members were present. Also present but not part of the quorum: Director of Governance, Director of Financial Recovery and Transition (on behalf of the Acting Director of Finance), NHSE Improvement Director, together with representatives from the Trust's Internal Auditors MIAA, the Trust's external auditors KMPG, together with several Trust officers from the Governance and Risk Teams.
1	**Agendas**	The Committee considered the following: • External Auditor's 2024/25 Annual Report • Internal Audit – revised internal audit plan • Internal Audit – Progress Report • Internal Audit Report – Fit & Proper Persons (*substantial assurance)* • Internal Audit Report – PSIRF (*substantial assurance)* • Internal Audit Report – Follow Up Report – Medical Devices • Internal Audit Report – Follow Up Report – DM01 Diagnostics • Anti-Fraud Progress Report • Losses and Special Payments Report • Procurement Waivers Report • Non-pay controls report (quarterly) • Contract Award Report (quarterly) • APRR Draft Audit Standards • Security Report (Annual) • Risk Management Report Q1 2025/26 • Board Assurance Report Q1 2025/26 • Cyber security Report
2a	**Alert** *Matters of concern, gaps in assurance or key risks to escalate to the Board.*	• The Committee noted that some 'high risk' internal audit recommendations had still not been completed, despite original deadlines being extended. • The Committee, once again, noted the high number of contract waivers that had been executed (May – September 2025; 20 competition waivers and 6 full breach waivers) since the last report. However, a Non-Pay Oversight Group was due to launch imminently to mitigate and reduce the number of waivers used.
	Assurance *Positive assurances and highlights of note for the Board*	• The External Auditor's Annual Report – into their findings of the 2024/25 external audit of the Trust – was received by the Committee, noting another year's unqualified opinion on the financial statements, commenting that this was a phenomenal outcome for a Trust as large as SaTH. • Two internal audits had been completed since the previous meeting, both providing substantial assurance:

		• Fit and Proper Persons (process). • Patient Safety Incident Response Framework • During presentation of the Trust's Annual Security Report, it was noted that whilst there had been an increase in the number of incidents across the Trust's sites over the last three years, the incidence of moderate or severe harm had not increased. In addition, feedback received on the security teams themselves, was 'overwhelmingly' positive. • Both the BAF and Risk Management reports for Q1 2025/6 were presented, with the score on BAF risk 5 being reallocated from 4x5 to 5x4 scoring, for recommendation to the Board. Meanwhile, it was noted that 144 risks on the risk register had been closed during Q1, resulting in 363 risks remaining on the Trust's risk register.
2c	**Advise** *Areas that continue to be reported on, and / or where some assurance has been noted / further assurance sought.*	• The Chair advised the Committee that an extensive procurement process had been undertaken regarding the appointment of Internal Auditors, as the last contract had ended, in line with the contractual arrangements. *Following the robust procurement process, the Board accepted the Committee's recommendation that Mersey Internal Audit Agency (MIAA) be awarded the initial 3-year contract, at its meeting on 10 July 2025.* • As part of the award for the new Internal Audit Contract, it had been agreed that the draft workplan that had been put in place by MIAA under the previous contract, be reviewed and updated as part of the new contract. This had been done, with additional proposals being suggested as part of the three-year Internal Audit workplan. The Committee approved the plan, noting a possible deferment of the proposed Safe Care Tool audit, which would be further discussed with the Interim Chief Nursing Officer after the meeting. • The Internal Auditor advised of a Trust finance request for them to undertake a re-assessment review of the NHSE Grip and Control List, which was being undertaken by the team. It was agreed that this be undertaken, and, if the Safe care Tool audit deferred (as the point above), that those audit days be given over to the new request – the Committee approved this course of action. • The draft annual EPRR (Emergency Preparedness, Resilience & Response) core standards self-assessment was presented to the Committee (as a Check and Challenge review tool). The core standards had been self-assessed as "Substantially Compliant," with 58 out of 62 of the standards having been rated as fully compliant. Whilst appreciating the additional work that had been undertaken throughout the year which had led to this position, the Committee agreed with the self-assessment but asked that the Committee be advised when formal confirmation of the level of assessment had been received from NHSE (due mid-late November 2025) so that the Committee can be assured of the outcome. • The potential security risks across the sites were highlighted in the Trust's Annual Security Report where it was noted that additional mitigations were in place across most areas – although it was noted that whilst high risk areas had strengthened security measures in place, lack of swipe card access into every area of the Trust had not yet been completed for low-risk areas. The impact of HTP, and the new build at the RSH site was also considered, noting that the additional building areas would need a security appraisal before being opened.

		• The Committee was advised that the UK national cyber threat remained high, with on-going work taking place by the in-house cyber team, whilst being supported by regular, real-time threat updates from NHSE and other third parties. In addition, the committee noted that the Data Security & Protection Toolkit (DSPT) had been significantly updated with a definite focus on cyber security. The DSPT internal audit report would be presented to the next Committee meeting, providing details of the Trust's current position.		
2d	**Actions** *Significant follow-up actions*	• Executive Directors responsible for incomplete audit recommendation actions to provide emailed explanations as to reasons for the delays in implementation, ahead of the next Committee meeting. • Anti-Fraud and Risk Management to work together to produce a plan, with timelines, addressing CFA recommendations, to be brought back to the Committee for review. • Updated Committee Terms of Reference, to be provided to Board with the Committee's recommendation for approval.		
	Report compiled by:	Anna Milanec, Director of Governance Approved by Prof Trevor Purt, ARAC Chair	**Minutes available from:**	Mrs Beverley Barnes, Board Coordinator

The Shrewsbury and Telford Hospital NHS Trust

Quality and Safety Assurance Committee, Key Issues Report		
Report Date: 01.10.2025		**Report of:** Quality & Safety Assurance Committee (QSAC)
Date of meeting: 30.09.2025		All NED and Executive Director members, and regular Trust Officer attendees, were present.
1	**Agenda**	The Committee considered the following: • UEC System Integrated Improvement Plan (SIIP) Key Issues Summary Report • Urgent & Emergency Care Transformation Assurance Committee (UECTAC) Report • Quality Operational Committee Key Issues Report • Quality Indicators Integrated Performance (IPR) Report and Exception Report • Report: Learning from deaths (Q1) • Medical Examiner's Report (Q1) • Safeguarding Assurance Committee Report Q1 • PALS, Complaints, Patient Experience, and PACE Report (Q1) • Medical Regulatory Group • Maternity & Neonatal Transformation Assurance Committee - items for escalation • Maternity Dashboard - items for escalation • Maternity Services CQIM MSDS Dashboard and AAA • Maternity Neonatal Safety Champions Report • Safeguarding Children and Young People Policy • Nursing and Midwifery Staffing Bi-annual report • Report into the benefits of the diabetic podiatry service being brought into SaTH
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Medication incident (Insulin administered in non-insulin syringe) formally identified as a Never Event due to the use of wrong syringe). A patient safety incident investigation (PSII) review has been commissioned to identify learning from this. • The Committee heard that the Information Governance Committee which is where subject access requests (SAR) are monitored has not met since December 2024. To provide assurance, the medical director is going to map out the committees which are vital for assurance to QSAC and thus to the board.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• QSAC received the CNST assurance papers, and the Trust is on track to meet 8 of the 10 safety actions. The risk for safety action 1 has reduced as there has been an increase in independent panel members in the network to provide externality at PMRTs. With the requirement for independent review for 50% of PMRT reviews, currently the trust is at 70% where an external panel member was present. Safety action 7 remains at risk. Region have responded to a request for clarity and the Trust has to formally notify the LMNS about the risk of the MNVP representative not being able to attend all required meetings for the

		safety action. This has now formally been escalated through the PQSM at the LMNS, ICB and regional levels. An action plan is in development to satisfy this requirement and achieve compliance. • The Trust's implementation of the medical examiner process into the community was praised by Dr Claire Fuller, Primary Care National Director of NHSE. The Trust is performing well regionally for issuing certificates in a timely way. The service is also best performing regionally for attending and certifying death when requested by the coroner in cases when there is no attending practitioner. • There has been continued improvement in reducing the number of delays for Category 2 caesarean sections. The committee suggested that this successful piece of improvement work was shared more widely across the Trust. • Maternity acuity rates in delivery remained above target for the eleventh month, with 95% in August. One to one care at delivery remained at 100% although unavailability remains high. The maternity dashboard is to be reviewed in line with the review of the national dashboard. Induction of labour rates remain high. • QSAC received the Nursing and Midwifery Staffing Bi-annual report. The report provided assurance that staffing was being monitored, and where there was unavailability there was no connection with incidents. The report provided evidence of responding to clinical risks, and professional judgement to ensure sufficient staff were available to respond to increased need.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• There was a deep dive on the diabetic podiatry service which described the need for the STW system to work collaboratively to improve outcomes for people with diabetes. 15-25% with a diabetic foot ulcer will require amputation with NHSE estimating that 85% are preventable with costs to the NHS of 1 billion a year. • A number of actions for the system were described which could improve outcomes for people: ➢ Primary care screening is vital to identify those at higher risk. ➢ Equitable access to community services to dress and treat diabetic foot ulcers. • The diabetic podiatry service in SaTH has driven improvements. Education of ward staff has improved referral to the service and means more patients are seen quicker. Compulsory foot assessment has increased from 10% in June 2024 to 60% July 2025. Heel offloading being provided in house has improved patient care with associated cost saving. • There are capacity issues at SaTH which could be addressed by: ➢ 5-day week orthotic offer (currently 4 days a week) ➢ Room availability 5 days a week at Telford (currently 4) ➢ recruitment of a casting technician

		➢ sufficient consultants who can provide diabetic foot clinic as currently not sufficient to provide cover leave with cover currently provided by a GP locum agency ➢ a diabetic nurse specialist in the foot clinic ➢ reducing waiting time for vascular imaging and reporting. • While there have been connections made in the system, this work needs to be accelerated and supported to make a difference for our people. A number of actions were agreed, and support offered, which QSAC will monitor. • The absence of Summary Hospital- level Mortality Indicator data continues with no date provided of when this will be available. The prospective review of mortality in ED is continuing to look at harms related to long waits in ED. The impact of the actions relating to ED waits and getting people to the most appropriate setting to receive care and thus reduce the risks will continue to be monitored closely by QSAC. • The PALS, Complaints, Patient Experience and PACE report for Q1 identified some positive feedback of care. The report also included examples where actions had led to improvements for example medicines on discharge. The Trust continues to not meet targets for closing complaints. A number of initiatives are being taken to help respond to concerns sooner. There is an opportunity to work with the People's Promise initiative to reduce duplication and maximise impact of this work in improving people's care experience. There has been an increase in the number of complaints this quarter. • The extension of Badgernet for the neonatal service has been pushed back. While there are commercial reasons, the neonatal service needs to provide clarity on their requirements to move this forward. • QSAC approved the Safeguarding Children and Young People policy. • The Safeguarding Assurance Committee Report Q1 described challenges in delivering safeguarding training. Where areas are below target, there are targeted actions in place to increase compliance. There is no evidence of this impacting reporting alerts and concerns. There is a review of the safeguarding team in train to look at capacity.		
2d	**Actions** ***Significant*** *follow up actions*	• None		
3	**Report compiled by**	*Ms Sarah Dunnett* *Chair of Quality and Safety Assurance Committee*	**Minutes available from**	*Julie Wright* *Committee Support*

The Shrewsbury and Telford Hospital NHS Trust

Quality and Safety Assurance Committee, Key Issues Report		
Report Date: 28.10.2025		**Report of:** Quality & Safety Assurance Committee (QSAC)
Date of meeting: 28.10.2025		All NED and Executive Director members, and regular Trust Officer attendees, were present.
1	**Agenda**	The Committee considered the following: • Themes for Complaints (Clinical Care) • Clinical Audit Plan – Bi-annual Progress Report • Legal Report • Urgent & Emergency Care Transformation Assurance Committee (UECTAC) Report • Quality Operational Committee Key Issues Report • Quality Indicators Integrated Performance (IPR) Report and Exception Report • Board Assurance Framework (BAF) Q2 • The Royal Wolverhampton NHS Trust - elective work update (from May) • Maternity & Neonatal Transformation Assurance Committee • Maternity Dashboard and key issues report • Equality issues with delays in C-Sections & decision to delivery in category 1 & 2 caesarean sections • Maternity Neonatal Safety Champions Report • ED mortality audit and fit-to-sit case update
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• The Trust has received a Prevention Future Death Report before an inquest has concluded, which is unusual as the Trust has not had the opportunity to present learning and actions taken to the Coroner. Further details have been requested. The Trust must respond to the Coroner by December 2025.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• QSAC received the CNST assurance papers, and the Trust is now on track to meet 9 of the 10 safety actions. The risk for safety action 1 has reduced as there has been an increase in independent panel members in the network to provide externality at PMRTs. With the requirement for independent review and an external panel member for 50% of PMRT reviews, currently the trust is at 70% with an external member of the panel present. Safety action 7 remains at risk. Region have responded to a request for clarity and the Trust has to formally notify the LMNS about the risk of the MNVP representative not being able to attend all required meetings for the safety action. This has now formally been escalated through the PQSM at the LMNS, ICB and regional levels. An action plan has been developed which will satisfy this requirement and achieve compliance.

		• Maternity acuity rates in delivery remained above target for the eleventh month, with 97% in September. One to one care at delivery remained at 100% although unavailability remains high. • There has been continued improvement in reducing the number of delays for Category 2 caesarean sections. QSAC received a deep-dive into whether there were differences of delays in C-Sections impacting people from different backgrounds. As the numbers of delays is small, there are fluctuations in each quarter, however women ethnic minority groups are over-represented. With the increased reporting on different outcomes in maternity and neonate papers, QSAC have requested a report on what actions are being taken to reduce the difference and improve outcomes for women with protected characteristics. • QSAC were pleased to hear that the Trust's EDI midwife has won a national award for her work, named EDI Midwife of the Year. • QSAC received a survey on women's experience of maternity care where there had been an artificial rupture of membranes (ARM) in the last three years. The response was small (15) and not representative of the demographics. Findings included that the data shows that delays in ARM are a clear source of anxiety and dissatisfaction for most service users. Nearly half, 46.7% (7 of 15) felt worried or unhappy, and another 40% (6 of 15) were left uncertain about how to feel, leaving only a small 13.3% (2 of 15) who felt okay with the wait. This indicates that delays not only disrupt clinical timeline but also undermine confidence and emotional wellbeing. • Overall, the responses from service users about satisfaction with their care shows a split in perception. Nearly half of service users 46.7% (7 of 15) were happy with their care. The proportion who was "not so happy" or "not at all happy" points to inconsistency in how care is delivered. These findings highlight the need to standardise and strengthen key aspects, especially communication, responsiveness to concerns, and timely interventions to raise overall satisfaction and ensure more service users leave feeling genuinely supported. • QSAC received the Clinical Audit Plan- Bi-annual Progress Report. Due to reductions in the team, the clinical audit team can now only support mandatory audits (such as national and NICE). The report provided assurance that the Trust was participating in all mandatory audits. 88% of audits on the clinical audit forward plan are progressing in accordance with the Trust clinical audit process and progress has deviated from process for 12%: this has been escalated to the audit owners. There was a delay in starting the Ockenden maternity notes audit, however, this will be completed by December. The audit for x-ray following NG tube placement showed 100% compliance. • 38 (29%) audits identified inadequate compliance (<80% overall compliance) with standards audited, with 11 of these demonstrating significant non-compliance (overall compliance of <50%). Actions have been identified.

		Themes were: ➢ Inadequate patient education and provision of written information ➢ Inadequate/unnecessary diagnostic investigations ➢ Non-compliance with drug prescribing/administration standards ➢ Low compliance with training requirements ➢ Inadequate completion of documentation
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• In response to the complaints report last month, and a question at Board, a paper was presented on the number of complaints which are recorded as clinical. The category was broad with 386 complaints in 33 subcategories. The largest number of complaints are for ED, and a sample of complaints, and learning was included. It has been identified that there is an overuse of the 'other' category when coding complaints, and this is being reviewed by the Complaints Team, with plans for changes to the sub-categories for the next financial year to further refine reporting. • While Summary Hospital- level Mortality Indicator data is now available there remains caution about the quality of the data. • The prospective review of mortality in ED is continuing to look at harms related to long waits in ED there was an update with MD meeting with the lead for the research on mortality in ED. A further meeting is planned with the potential for a research project. • The Trust will likely exceed the targets for C-Diff this year. Plans continue to enable deep cleaning to commence at RSH with a two week window to use ward 18 to facilitate this, but this is reliant on being able to recruit a team to deliver this. At PRH, alternative approaches are being considered. • Flu vaccination rates for staff remain behind target, with reluctance from some staff groups identified. • The committee noted the updates to the Board Assurance Framework. For the risks overseen by QSAC (1,2,8,9,10 and 12). There was a proposal to reduce the BAF risk2 (safety culture) from 16 to 12. The committee did not agree with the proposal and agreed that the risk should remain at 16. QSAC recognised that there had been improvements and a great deal of work but felt that there was a need to observe progress for longer. The proposal to reduce the rating for risk 9, elective care and cancer, was agreed. It is proposed this quarter to reduce the current total risk score of BAF risk 9 from 4x4=16 to 4x3=12 as cancer 28-day faster diagnosis standard and 62-day RTT performance is now out of the bottom quartile, and elective 52-week performance is now in the top performing half of the country. The committee agreed that the current ratings for the other risk (1,8,10 and 12) were appropriate and no changes to other risk ratings were made. Risk 10 (Urgent and emergency care standards) remains at 20 and therefore one of the highest risks for the Trust. Two mitigating actions, one for BAF risk 2 and one for BAF risk 10, have been closed this quarter.

2d	**Actions** ***Significant*** *follow up actions*	• None		
3	**Report compiled by**	*Ms Sarah Dunnett* *Chair of Quality and Safety Assurance Committee*	**Minutes available from**	*Julie Wright* *Committee Support*

Performance Assurance Committee, Key Issues Report		
Report Date: 23 September 2025		**Report of:** Performance Assurance Committee
Date of meeting: 23 September 2025		R Edwards, S Dunnett, N Hobbs, I Robotham, N Lee, R Dhaliwal, F Blakeman, C Bickley, R Boyode, T Cotterill, I Tomkiss (part)
1	**Agenda**	The Committee considered the following: • Performance Highlights • UEC System Integrated Improvement Plan (SIIP) • Integrated Performance Report • Productivity Deep Dive & Medical Productivity & Capacity Project • Type 3, 4-hour performance update • UEC Improvement Programme Update • Workforce Plan and Performance Impact • Update on withdrawal of Enforcement Notice 348 • Update on PRH Switchboard • Hospital of the Future • Neighbourhoods • Review of Committee's ToRs
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• PAC received a report on the Urgent and Emergency Care Improvement Programme and noted the combination of measures being taken. PAC observed that the average for over 12 hour waits in July was 1120 minutes, (nearly 19 hours) and were informed that patients can be in ED waiting 24-48 hours for a bed. Those waiting longest tend to be older people. PAC wanted these long waits to be more visible in the data so that we can monitor whether measures taken, including the interventions approved at September Board, are reducing the number and length of long waits. • Workforce: PAC heard that at month 4 the total workforce (worked) was over plan by 43 WTE, driven by above planned levels of bank usage stemming from industrial action, covering vacancies and providing additional capacity. PAC noted the need to invest in additional staff (eg for UEC plans and where there are gaps in medical specialties) in the next few months but also the need to manage staff numbers and costs so that we stay within budget.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Elective care: the report to PAC covered July, but PAC heard that performance had improved further in August, with 52-week performance now in the top half of trusts in the country. Cancer: FDS and 62-day performance is out of the bottom quartile. PAC heard that performance is ahead of plan and improvements are sustainable, while still allowing SaTH to reduce insourcing. • PAC received a report on Service Review Deep Dives and the Medical Productivity & Capacity Project and noted the way the data was used collaboratively with the specialties involved, using appreciative inquiry to explore opportunities for improvement. The

		team are aware of potential data limitations, but SaTH has the benefit of holding all the required data within the productivity dashboard, with 97% job plan compliance, one of the key elements for determining capacity. • Productivity in Outpatients: PAC heard that this programme is supported by an external agency and is already seeing an increase in clinic utilisation, with further actions to follow. • Theatre productivity: PAC heard of regular meetings with clinical and operational teams to review and improve theatre allocation, surgical list planning and retrospective reviews. This resulted in operations on 1731 cases in July, representing a further increase on June's record monthly total since 2017. • Fire Enforcement Notice: following withdrawal of Enforcement Notice 255 on 27 May 2025 the Trust was issued with Enforcement Notice 348 over outstanding areas of non-compliance, regarding concerns about Fire Stopping and Compartmentation of the Ward Block at The Royal Shrewsbury Hospital (RSH). Shropshire Fire and Rescue Service undertook a review of the compartmentation survey and the Trust's action plan on 31 July and confirmed that The Trust had complied with Enforcement Notice 348, which was withdrawn on 01 August 2025 and subsequently removed from the national register. To ensure that good progress is maintained, the Trust and Shropshire Fire Service have agreed that the action plan will be reviewed quarterly through meetings with the Fire Service, Head of Capital and Trust Fire Safety Manager. It is estimated that the full programme of works will take circa twelve to fifteen months. Reports on progress will come to PAC.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• PAC received a report on the Urgent Treatment Centre (UTC) Type 3 performance and noted that between April-August 2025 it had not recovered to pre-1st April levels. Performance had improved further in September which is likely to be back up to pre-change level. Recruitment to ensure adequate levels of staffing continues and the longer-term aim is to extend the conditions covered by UTC to improve the way the UEC operates. • Switchboard action update: PAC received a report describing a short-term fix to provide remote visibility of the alarm monitoring panels at RSH, due to be installed by the end of October at the latest, while options for improving the current monitoring system are discussed with the supplier. Longer term, SaTH will work with system partners through a newly created STW Telephony task and finish group to review options for a joint system-wide monitoring system. • PAC received two reports: one on "Hospital of the future: hospital as a service, not a building" and the other on Neighbourhood Health Service models of care. These reports provided PAC with a view of how some care could be moved out of the physical hospital, combining an increase in virtual care with renewed approaches to system integration; and with an update on systemwide progress in relation to the development of Neighbourhood Health Service models of care in line with the NHS 10 Year Plan, related NHSE guidance and areas for consideration within SaTH.

		• NHSE have said that they will prioritise working with Places that want to explore using the full range of approaches set out in the 10 Year Health Plan such as working on new financial flows to incentivise achievement of key population outcomes; supporting GPs to work at scale; developing neighbourhood and multi-neighbourhood providers. STW's Place-level application for Shropshire has been successful, so there will be innovative work on this in future.		
2d	**Actions** ***Significant*** *follow up actions*	• N Hobbs and T Cotterill to agree a way to triangulate and report the financial risks and impacts within the UEC transformation programme. • N Hobbs to present data on long waits in ED, so that PAC can see trends and progress and also the impact on those with protected characteristics.		
3	**Report compiledby**	*R Edwards, Non-Executive Director/Chair*	**Minutes available from**	*Lisa Mitchell, Senior Governance Support Officer*

The Shrewsbury and Telford Hospital NHS Trust

Performance Assurance Committee, Key Issues Report		
Report Date: 21 October 2025		**Report of:** Performance Assurance Committee
Date of meeting: 21 October 2025		R Edwards(Chair), R Dhaliwal, N Hobbs, I Robotham, S Dunnett, N Lee, A Winstanley, L Mitchell, L Bibby(observer) S Balderstone(part), J Cunningham (part) A Milanec (part)
1	**Agenda**	The Committee considered the following: • Performance Highlights • Typing Backlog Update • PIFU Pathway Update • UEC System Integrated Improvement Plan • Integrated Performance Report • West Midlands Imaging Network OBC • Workforce Plan and Performance Impact • Strategy & Partnerships – Health Inequalities • Digital Programme Update • Climate Change 4A Report • Solar Car Canopy update • Board Assurance Framework • Committee Effectiveness Annual Review • Cycle of Reportin
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Urgent and Emergency Care: all 3 headline UEC metrics (4 hour and 12 hour waits and ambulance handover delays) continue to place the Trust in the bottom decile nationally, as has been the case for over 3 years. PAC now receive graphs breaking down the long waits with a view to observing whether measures being taken have an impact in reducing the number and length of very long waits. Information will also be provided in future to identify any relationship between long waits and people with protected characteristics. • PAC received the mid-year review of the UEC 25/26 Operational Plan which was required by NHSE. This has a revised trajectory to get back to plan from January 2026 - the changes with the biggest impact will start to take effect in December 2025 (RSH modular wards, extra capacity at PRH).
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• UEC: PAC observed that the number of ambulance conveyances had reduced and was informed that this was down to the new service HealthHero taking over management of the category three 999 call stack on 1st September, resulting in a 10% reduction in ambulance conveyances compared with the previous month. HealthHero commenced the contract for GP out of hours and care coordination centre functions from 1st October. • Elective, cancer performance and diagnostics: PAC noted the steady continuing improvement, such that SaTH has met the Trust's RTT 18 weeks commitment for March 2026 in month 6 and has risen out of the bottom quartile nationally, while 52-week and 65-week RTT performance is in the top half nationally.

		• PIFU pathway: PAC received a paper on Patient Initiated Follow-Up which reported on qualitative feedback gathered from 28 patients. It was found that many didn't know they were on the pathway, while some believed they had been discharged without follow-up options. Once PIFU had been explained, most patients appreciated the benefits. The results will be fed back into divisions to ensure better communication when a patient is put on the PIFU pathway. The next phase will involve integrating PIFU patients into Dr Dr, a digital patient engagement portal. • Climate Change Group: PAC heard that The Trust were successful in the NHS Waste Awards: Silver award for the 'Best reduction in Clinical waste, and Gold for Mark Leighton in the Waste Champion of the Year. The Green Plan will be uploaded by the 31st of October in line with • the NHS Guidance. SaTH's bid for £35,000 funding for operational EV chargers for SaTH vehicles, • in line with Trust EV Strategy, was successful and they will be installed at RSH, PRH and Sentinel works. SaTH also secure funding for two solar car park canopies at RSH and PRH, which should be in place by March 2026.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• BAF: in the light of the continued improvement in elective and cancer performance, PAC agreed to a reduction in the score for BAF risk 9 from 4x4 to 4x3. PAC also suggested a new risk be developed regarding SaTH's moves towards a group model. • West Midlands Imaging Network (WMIN): PAC received a report on the Convergency Digital Imaging Platform (CDIP) which outlined the benefits of joining WMIN's CDIP in order to replace the current Picture Archiving and Communication Systems and Radiology Information Systems, which are due for replacement in September 2027. The alternative would be to go it alone. PAC could see the benefits of regional and cross site imaging and information sharing and reporting and supported the idea in principle, while noting that more information on costs and benefits would be required and provided. This report will also go to FAC as the majority of information provided at this stage is financial. • Digital Programme Update: PAC discussed the paper which had already been to October's board. PAC noted the number of unplanned and unfunded demands made on the Digital Team, including support for setting up systems access for the new GP out-of-hours provider HealthHero Integrated Care and noted the constraints imposed by the need to reduce headcount. PAC considered that the digital programme was so important to SaTH in terms of productivity and as one of the "3 shifts" that ensuring we have the right staffing is vital. • Health Inequalities: PAC heard that funding for the Alcohol Care Team was no longer provided by the ICB, despite the improvements it had made to patient care, so treatment pathways have reverted to the previous provision. PAC asked for a paper describing how the system and SaTH would now be providing care for patients and families affected by alcohol dependency/alcohol misuse.

2d	**Actions** ***Significant*** *follow up actions*	• Report on care pathways for patients with alcohol dependency to come to January 2026 PAC.		
3	**Report compiled by**	*R Edwards, Chair, Non-Executive Director*	**Minutes available from**	*Lisa Mitchell Senior Governance Support Officer*

Finance Assurance Committee, Key Issues Report		
Report Date: 30 September 2025		**Report of:** Finance Assurance Committee
Date of meeting: 30 September 2025		R Miner(Chair), S Crowther, J Sargeant, P Gardner, A Winstanley, T Cotterill, C McInnes, R Musket, S Edmonds, S Balderstone, L Mitchell, In attendance, J Williams & R Winter (NHSE)
1	**Agenda**	The Committee considered the following: • Financial Report & Forward Look, including cash flow, M5 • Efficiency & Financial Recovery Report M5 • Finance System Integrated Improvement Plan (SIIP) 4A Report • Deep Dive – Productivity • National Planning Framework • Workforce Plan and Financial Impact • Capital Planning Group 4A Report (CPG) • Operational Performance Oversight Group 4A Report (OPOG) • Financial Recovery Group (FRG) ToR
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Despite the assurance of a break-even position at M5, cost pressures continue to build particularly around workforce costs, where the plan is lagging, and can be seen particularly in divisional performance. There are grip and control actions but FAC wants the executive to apply maximum pressure to ensure it is delivered and FAC wants to monitor. • Linked to the above point and in order to achieve break-even for the year means closing the gap of a current unmitigated risk of £9.7m. • FAC notes the impact and resources necessary to carry out all of the monitoring and pressure this places on colleagues' time.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• M5 has seen the Trust break even again notwithstanding that this has been after deficit support for the month of £4.53m and £25.47m YTD. • Cash balances at the end of August were £51.4m with a projected year end cash balance in excess of £10m. • Additional governance processes continue to be applied including the cash committee and the proposed divisional financial performance management framework. • Progress continues on the financial recovery and efficiency work (CIP) where the Trust is on track having so far realised £14.45m out of £41.4m, a small element of which is included in the above gap (the plan is not linear) and is still expected to be achieved by year end. • The Terms of Reference for the Financial Recovery Group (FRG) were approved, noting the reporting through to FAC. • The report from the capital planning group indicates the Trust will have achieved full spend by the year end. A full forecasting exercise is taking place with NHSE to confirm year end forecast ahead of month 8. • The national planning process, with an agreed timetable, has commenced. • Further progress has been made on the system integrated improvement plan including noting the estates strategy as approved by the Board.

2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• FAC has asked for further clarification on run rates and trend lines to better understand the normalised/underlying run rates including the effect of income backed costs. • FAC will continue to monitor the deep-dive productivity work which has started.		
2d	**Actions** ***Significant*** *follow up actions*	• Executive feedback and measures, impact and timing to deal with the current unmitigated £9.7m of risk.		
3	**Report compiled by**	*R Miner, Non-Executive Director/Chair*	**Minutes available from**	*Lisa Mitchell, Senior Governance Support Officer*

Finance Assurance Committee, Key Issues Report		
Report Date: 28 October 2025		**Report of:** Finance Assurance Committee
Date of meeting: 28 October 2025		R Miner (Chair), A Winstanley, P Gardner, S Crowther, J Sargeant, L Mitchell, S Edmonds, C McInnes, R Boyode(part), I Robotham (part), R Muskett, L Wyatt (part), R Dixon(part), Bryce, (part), F Blakeman (observer, part). Apologies: S Balderstone, T Cotterill
1	**Agenda**	The Committee considered the following: • Finance Report, M6 • SIIP • Run Rate Deep Dive M6 • Efficiency & Financial Recovery Report • Grip & Control Checklist and HFMA Sustainability Framework • Service Review Programme – Key Messages • Modular Theatre Options Appraisal • West Midlands Imaging Network OBC • Workforce Plan & Financial Impact • ToR for Integrated Planning Meeting • Integrated draft Operating Plan 26-27 • RAAC Update • EDF Energy Tariff Validation • Capital Planning Group 4A Report (CPG) • Operational Performance Oversight Group 4A Report (OPOG) • Board Assurance Framework • FAC Cycle of Reporting review
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• There was a reported deficit of £1.27m (in month and year to date) against a break-even plan after deficit support of £4.14m for the month. Deficit support to date amounts to £30.85m meaning the level of support to the year-end reduces and there is even greater pressure on performance. The incremental effect of the pay award and the premium payments for temporary staffing are the main causes of the deficit to plan. • In September we reported the need to "bridge a gap" of £9.7m to achieve break-even by the end of the year. This has now been mitigated down to £2.4m but is dependent upon the achievement of additional savings on bank expenditure of £4m.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Cash currently stands at £40.3m • Efficiency savings of £18.3m against a target to date of £17.3m have been achieved so far and there is still a strong expectation of achieving the full £41.4m by the end of the year. • The Committee approved the Outline Business Case for the Convergency Digital Imaging Platform (CDIP) and the expected financial impact for SaTH which appears better than if we did it alone. The expectation is that the full business case will be developed across the network and be presented back to FAC in the future for approval. • The Committee approved the Integrated Planning Group Terms of Reference.

		• The Committee noted the progress of the draft Integrated Plan 26-27 which we started early but there remains a lot to do. • RAAC costs have increased but there is a good chance of full recovery from NHSE. • The Committee approved maintaining the Trust's electricity supply on standard tariff which provides a small price advantage. • The Committee noted the reports from the Capital Planning Group and the Operational Performance Oversight Group including uncertainties over power capacity for the modular theatres for which a business case is being developed. • Progress continues on the System Integrated Improvement Plan • The Committee noted the FAC cycle of reporting and a number of small additions required.		
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• BAF Risk 5 (available resources, instability) has been agreed to remain at 20 and remains under regular review.		
2d	**Actions *Significant*** *follow up actions*	• As a consequence of run rate analysis presented at the meeting, the Committee is asking for further assurance around underlying run rates and to satisfy itself that the underlying cost base is reducing. • The Committee recognises the current workload and challenges of hitting financial targets by the year end particularly the pressure from workforce costs including current NHSE observations on bank costs and the need to balance safety considerations (staff ratios, fill rates, roles not filled etc) and proposes a more detailed Board discussion.		
3	**Report compiled by**	Richard Miner (Chair) Non-Executive Director	**Minutes available from**	Lisa Mitchell Senior Governance Support Officer

The Shrewsbury and Telford Hospital NHS Trust

People & OD Assurance Committee (PODAC) Key Issues Report		
Report Date: 27 October 2025		**Report of:** People & OD Assurance Committee held on 06 October 2025
Date of meeting: 06 October 2025		PODAC members present at the 06 October 2025 meeting were: Chief People Officer, Director of Strategy & Partnerships, three Non-Executive Directors and an Associate Non-Executive Director. The Chief Nursing Officer and Deputy Medical Director attended the meeting.
1	**Agenda**	The Committee considered the following assurance items: • Chief People Officer Update • Culture update reports • Summary Report Nursing and Midwifery Staffing • Nursing & Midwifery job evaluation project • Graduation guarantee for newly qualified nurses and midwives • Integrated Performance Report • HTP and Neighbourhood Report • Strategic Resourcing Report - Workforce Plan and Medical Workforce Efficiency Programme • Risk Report – People Risks • Audiology Staff Survey discussion • Proposal to Change Disclosure and Barring Service (DBS) Checks Policy • Disciplinary Policy • Board Assurance Framework – Quarter 2 • Assurance Committee Items (PAC / FAC/ ARAC).
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• The Trust has been written to by staff side who have rejected the first offer to Clinical Support Workers. The Trust is reflecting on its position and regrouping in October with a view to settling for individuals to receive a back pay payment by December. The Trust is working within NHSE guidelines regarding this and looking to be consistent with Shropshire Community Trust. • The Committee noted that whilst we are within plan, bank is an area of risk for the Trust. NHSE have written to us on this and we welcome their support in this area. It is encouraging to see some of the KPI metrics progress, although some are still not at target. The national framework of KPI's is currently being reviewed to see where we align as an acute trust.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• The Committee received an update on culture including the four key steps. The Committee noted that we are looking at an appreciation of our baseline of culture across the two organisations and the plans to co-create the framework for the future, underpinned by being embedded and sustainable for the future, and will receive further updates and assurance in this area. • The Trust has secured £326,000k from NHSE Recovery Support Programme funding for recovery and workforce planning. • In relation to nursing and midwifery staffing, there was recognition of the work being done on staff unavailability. The Committee was satisfied that fill rates are being regularly reviewed. • The Committee heard that further recruitment events are planned for

		registered nurses. • The updated Disciplinary Policy was approved, which is delegated to the Committee from the Board. • The Committee agreed the Quarter 2 Board Assurance Framework including a reduction to the risk score of BAF risk 3 from 16 to 12, as turnover has remained stable and is below target. • The Committee received and welcomed a presentation from the audiology service on the Staff Survey. The Committee members recognised the need to consider the unintended consequences of our trust-wide messages, for example, the impact on the audiology team meeting cancellation from a decision to defer trust-wide training last winter.		
2c	**Advise** *Areas that continue to be reported on and /or where some assurance has been noted/ further assurance sought.*	• There is an intention to hold a People Committee in common with Shropshire Community Trust and further discussion on culture will occur there, along with System Transformation Committee. • The Committee heard about Hospitals Transformation Programme (HTP) progress and noted the link with transformation and neighbourhood work. The committee will continue to receive updates in this area.		
2d	**Actions *Significant*** *follow up actions*	• It was agreed to bring the DBS checks policy changes back to a future meeting for further discussion and members agreed to feedback any further comments to the Chief People Officer on the policy outside of the meeting.		
3	**Report compiled by:**	*Deborah Bryce, Head of Corporate Governance and Compliance and Teresa Boughey, Non-Executive Director*	**Minutes available from:**	*Deborah Bryce, Head of Corporate Governance and Compliance*

The Shrewsbury and Telford Hospital NHS Trust

Hospitals Transformation Programme

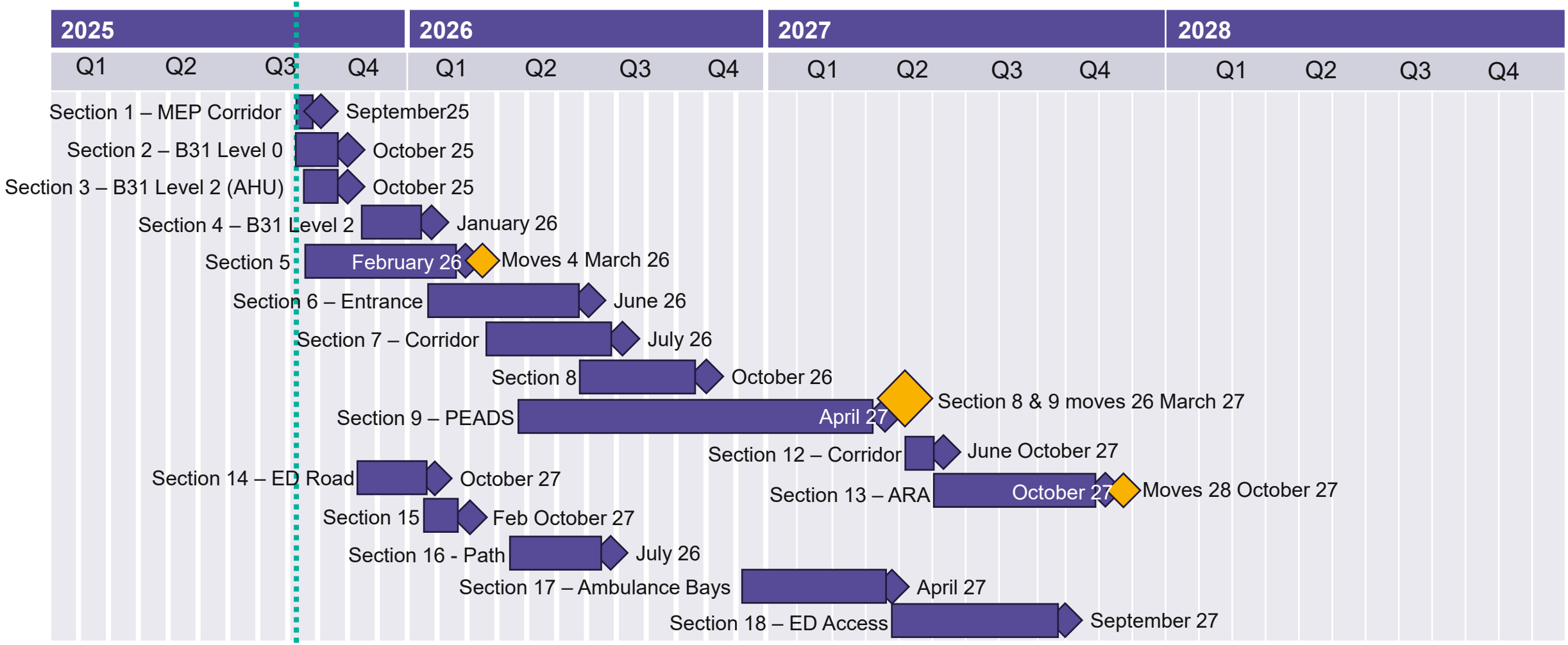
SRO Update October 2025

Integrated Care System
Shropshire, Telford and Wrekin

ED2 Critical Path Overview

Integrated Care System
Shropshire, Telford and Wrekin

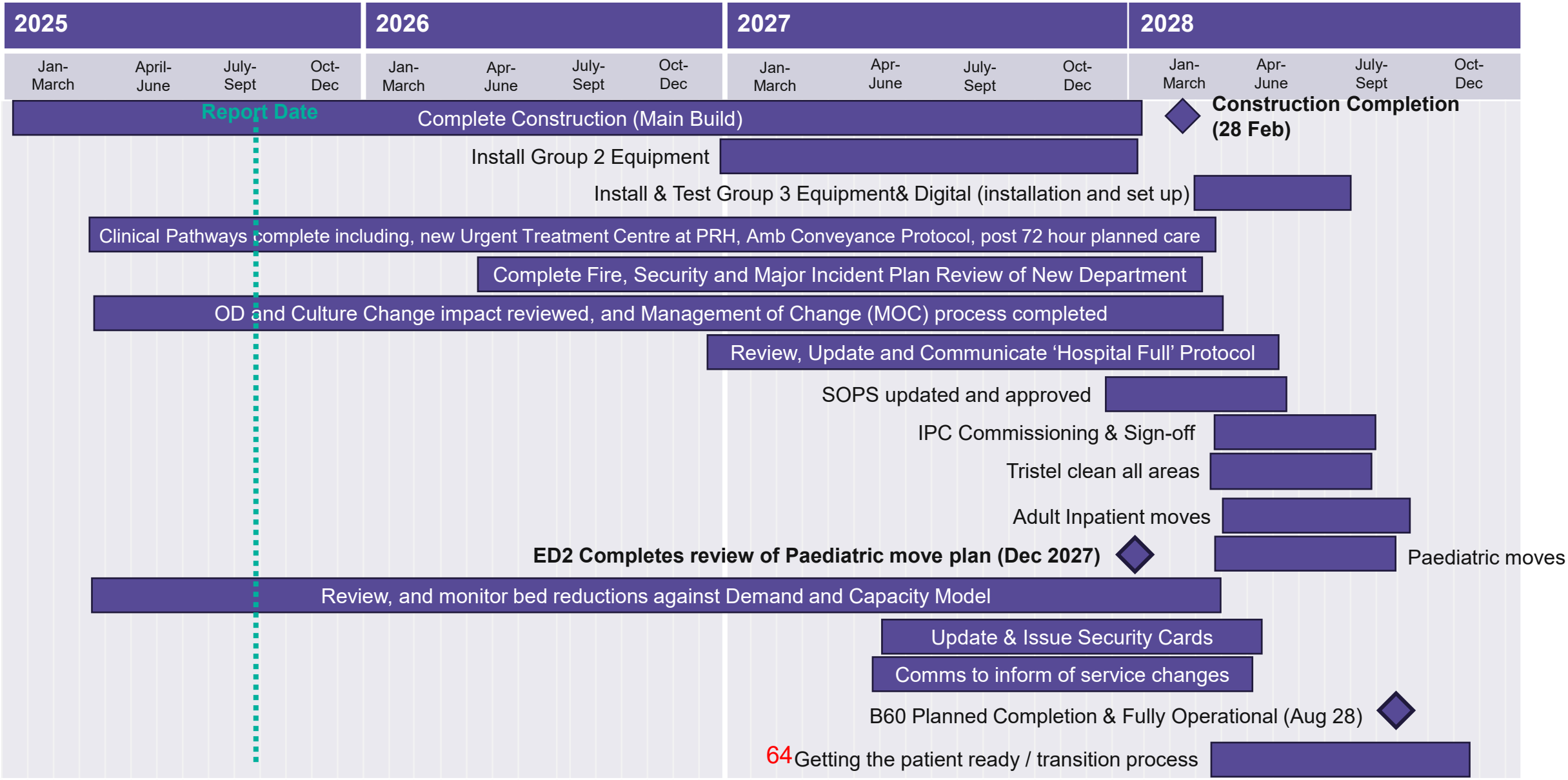
NHS
The Shrewsbury and Telford Hospital
NHS Trust



B60 Critical Path Overview

Integrated Care System
Shropshire, Telford and Wrekin

NHS
The Shrewsbury and Telford Hospital
NHS Trust



NHS
The Shrewsbury and Telford Hospital
NHS Trust

Construction and Estates

Executive Lead :

Matthew Neal

Integrated Care System
Shropshire, Telford and Wrekin

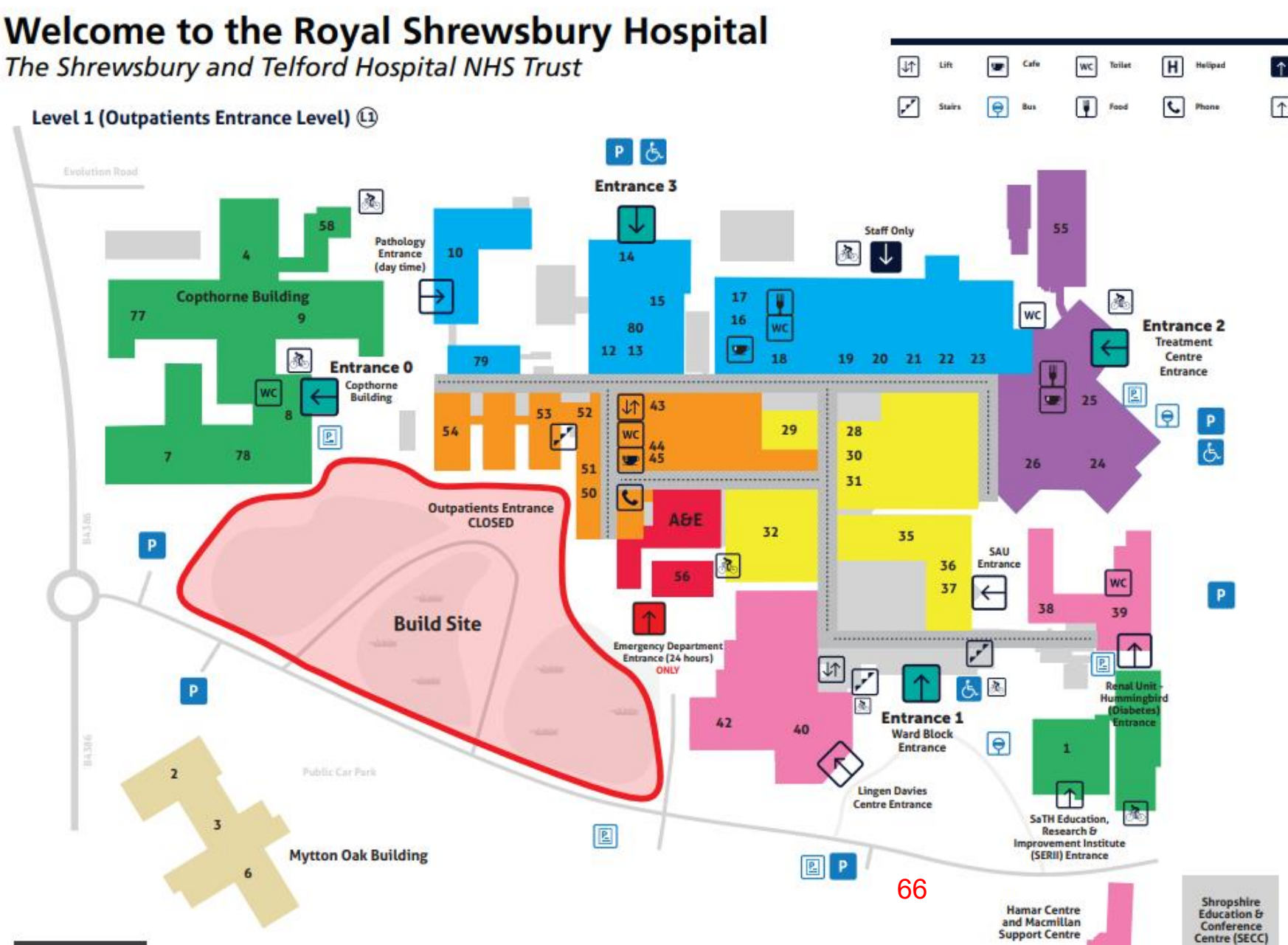
Construction area

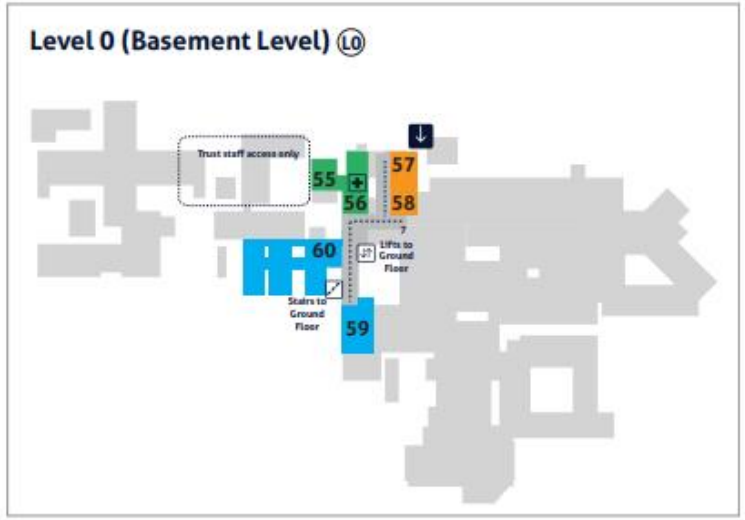
Integrated Care System

NHS The Shrewsbury and

Welcome to the Royal Shrewsbury Hospital

The Shrewsbury and Telford Hospital NHS Trust





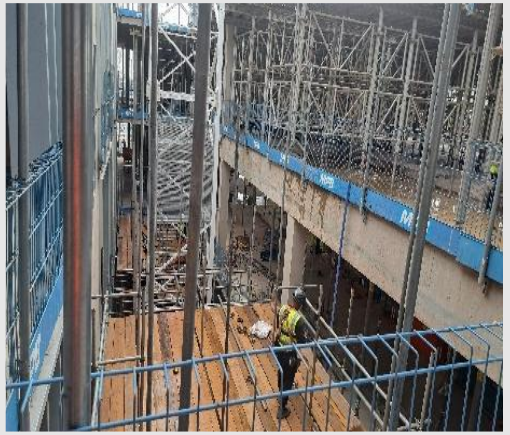
Latest Drone Image

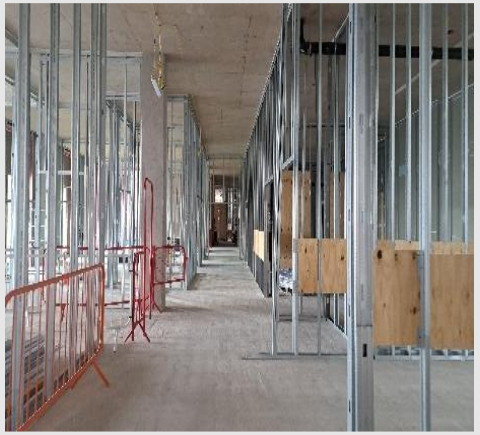
Integrated Care System
Shropshire, Telford and Wrekin

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Construction Progress

- Concrete frame now complete in three areas.
- Ground floor slab of area 4 now completed.
- External walls and windows being installed.
- Noise, vibration and dust being regularly monitored and working with staff and clinics to keep distribution to a minimum.
- Works on Level 1 of Block 31 have commenced to install new ventilation system.
- Drainage connections from B60 to main Hospital Drainage system now complete.





The Shrewsbury and Telford Hospital NHS Trust

Comms and Engagement

Executive Lead : Inese Robotham

Integrated Care System
Shropshire, Telford and Wrekin

Community Engagement

IHP have been in discussions with a number of local community opportunities including:

- T-Level placement students from Shrewsbury Colleges group have returned this month for their second-year placements.
- IHP have supported numerous activities with schools across the Marches careers hub and have various upcoming activities with schools over the next term. There is another meeting with them at the end of October, on supporting the new government modern work experience programme for schools. This follows on to IHP's support with schools across Shropshire, Herefordshire, Telford and the marches.
- IHP are supporting local care children with SEMH through Witherslack Group and New Reflexions provisions. This includes working closely with the centres on ways to engage with the children to build their confidence and trust. The next activity is in October with Witherslack Group where members from IHP will be creating mood boards for green spaces with the children, with the aim to recreate their visions at their children's home.
- IHP have held a meeting with Shropshire Mental Health Support Charity to look for ways to support.
- IHP supported Hadley Youth Club with a donation of cooking equipment for the children.
- IHP supported a local community running group in Telford in need of additional pedestrian crowd barriers to support their community fun day.
- IHP have spoken with Powys County Council and Powys Association of Voluntary Organisations, regarding their support for care experienced young people. After initial discussions, we are just waiting on their employer support form to complete.

Communications Update (1)

- Proactive engagement with communities and stakeholders – multiple events taking place each month across STW
- The Transforming PRH Hub was officially opened in collaboration with partner charities and stakeholders, providing a dedicated space at PRH to engage with patients and staff regarding the programme – HTP will have a dedicated day within the hub on the first Monday of every month
- Quarterly focus groups continue – the next groups will take place in December and focus on the Critical Care sky gardens, in partnership with Rotary
- Engagement with JHOSC members resulted in an agreement to regularly share briefings and updates, thereby strengthening community involvement – follow up public meeting in October
- Collaboration continues with the Workforce Lead to support the work of Change Agents and to develop a broader internal campaign "**HTP and me**"
- Update of HTP information public – to be signed off end of November. To be distributed to libraires, GPs, community meeting places. For Winter engagement the team will be visiting libraries across Shropshire, Telford and Wrekin and mid Wales

- **Recent coverage**
  - Next phase of Emergency Department refurbishment now open – SaTH
  - Transforming PRH Hub opens at Princess Royal Hospital – SaTH

Communications Update (2)

Integrated Care System
Shropshire, Telford and Wrekin

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Hoarding designs now in situ

Artwork competition winner

Recent and upcoming engagement activity

- Bridgnorth Befriending group – HTP update – 1 October
- Telford Visually Impaired group – HTP update – 2 October
- Lydham market, Friday 3 October, 10am–1pm
- Oakengates drop-in – 9 October
- SaTH Leadership Conference – 13 October
- Montgomery Health Day – 14 October
- Rotary Club of Ironbridge – 23 October
- Launch of High Vis Health – 23 October
- Neighbours' drop-in – 23 October

- Public Assurance Forum – 4 November
- About Health event – 5 November
- Rotary club MoU signing and PR – 6 November
- HTP Focus Group – 2 December
- Sky Garden focus group – 5 December

TBC – first cohort of Community Training Centre begin (expected end of Nov/beginning of Dec)

Board of Directors' Meeting: 13 November 2025

Agenda item		160/25		
Report Title		Integrated Performance Report		
Executive Lead		Jo Williams, Joint Chief Executive		
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 2025.10.22 Performance Assurance Committee 2025.10.22 Finance Assurance Committee 2025.10.28 Senior Leadership Committee 2025.11.06		
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 August/September 2025, summarises planned recovery actions, correlated impact, and timescales for improvement.		
Recommendations for the Board:		The Board is asked to **note** the contents of the report.		
Appendices:		Appendix 1: Integrated Performance Report		

The Shrewsbury and Telford Hospital NHS Trust

Integrated Performance Report

Board of Directors Meeting 13 November 2025

Presenting Month 6 performance data

Contents

Executive Summary

The Shrewsbury and Telford Hospital NHS Trust

Performance against the 4-hour UEC standard in September 2025 showed marginal improvement compared to August 2025 (53.7% v 52.1%), however, remains below the improvement trajectory. The number of 12-hour breaches increased from 1300 in August 2025 to 1495 in September 2025. The percentage of patients seen within 15 minutes for initial assessment reduced from 72.3% in August 2025 to 65.1% in September 2025.

The Trust has a break-even plan for 2025/26 (this includes deficit support of £45.1m). At the end of month six the Trust has delivered a deficit position of £1.27m against the break-even plan. The trust has an efficiency target of £41.4m in 2025/26. At the end of month six £18.30m has been delivered which is £1.00m more than plan. In terms of WTE reduction, at the end of month six compared to the numbers reported in August (actual worked) there has been a 61 WTE substantive increase, partially offset by a reduction in worked bank of 59 WTE. The Trust has set an operational capital programme of £22.53m (including IFRS 16 expenditure) and externally funded schemes of £128.70m in FY25/26, giving a total capital programme of £151.23m. The Trust held a cash balance at end of September 2025 of £40.30m.

The Trust continues being monitored in Tier 3 for Electives. For English patients the Trust reported 0 x 104-week breaches, 0 x 78-week breaches, 0 x 65-week breaches and 0 x 52 weeks for Children and Young People at the end of September 2025. The total waiting list size continues to reduce . 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. Theatre utilisation in September 2025 remained steady at 81%.

Confirmed August cancer performance is 75.9% (28-day FDS) vs the local plan of 72.9% and a national standard of 75%, the highest for 18 months. 62-day performance was 68.8% (against a local target 61.3% and a national target 85%) and 31 day was 91.6% (national target 96%). The 62-day combined backlog was 241 at the end of September 2025 (decrease of 32 compared to August 2025).

The Trust has been deescalated in the past month and is now being monitored in Tier 2 for Diagnostics. The submitted DM01 position for September 2025 was 85.3%, a further improvement of 3.5%. The number of 6-week breaches decreased from 2086 to 1692 respectively.

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

Patient Safety, Clinical Effectiveness, Patient Experience Executive Summary

The Shrewsbury and Telford Hospital NHS Trust

SHMI Mortality Data: New SHMI figures are available up to March 2025, but data quality concerns remain due to unresolved data warehouse issues, so the figures should not yet be considered fully reliable. Assurance on data quality is still pending from the performance team.

Antibiotics for Children: Manual audits show that none out 22 notes reviewed did patients need antibiotics so nature of audit process being reviewed to provide more assurance on IPR as direct data from vitals includes the patients that do not require antibiotics. The narrative will be strengthened to clarify this in future reports.

Pressure Ulcers: Ongoing high levels of category 3 pressure ulcers are noted, with interventions including increased capacity for pressure-relieving mattresses and associated equipment. Contract capacity has been increased by 20%, but harm levels remain a concern.

Complaints: Data on complaints is included in the IPR. Work is ongoing to improve both the timeliness and quality of complaint responses, with divisions addressing backlogs and focusing on response quality.

Infections: Hospital acquired infections, notably C. difficile likely to exceed target. General approach to reducing infections as a long-term aim being addressed with emphasis on flu vaccination in October

Integrated Performance Report

The Shrewsbury and Telford Hospital NHS Trust

Domain	Description	Regulatory	National Standard 25/26	Current Month Trajectory (RAG)	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Trend
Patient Safety & Effectiveness	Pressure Ulcers - Category 2		20% < 2024-25	17	21	18	24	32	28	36	15	34	26	27	28	26	21	
	Pressure Ulcers - Category 2 per 1000 Bed Days		20% < 2024-25	0.67	0.84	0.75	0.99	1.25	1.12	1.36	0.62	1.28	1.08	1.00	1.17	1.15	0.93	
	Pressure Ulcers - Category 3		10% < 2024-25	5	5	2	6	4	7	7	8	11	8	1	4	4	9	
	Pressure Ulcers - Category 3 per 1000 Bed Days		10% < 2024-25	0.10	0.20	0.08	0.25	0.16	0.28	0.26	0.33	0.42	0.33	0.04	0.17	0.18	0.40	
	Pressure Ulcers - Category 4		0	0	0	1	0	2	0	0	0	0	0	1	0	0	0	
	Falls - per 1000 Bed Days		5% < 2024-25	4.16	4.38	4.37	4.64	4.05	4.74	4.26	3.96	4.19	4.31	3.78	3.98	5.22	4.24	
	Falls - total		-	104	109	105	117	104	118	113	102	111	104	104	95	118	106	
	Falls - with Harm per 1000 Bed Days		5% < 2024-25	0.15	0.16	0.25	0.16	0.08	0.20	0.23	0.08	0.30	0.21	0.07	0.21	0.27	0.12	
	Falls - Resulting in Harm Moderate or Severe		0	0	4	6	4	2	5	6	2	8	5	2	5	6	3	
Patient Experience	Complaints		-	-	79	84	77	65	66	77	77	87	85	91	114	127	106	
	Complaints - responded within agreed timeframe - based on month response du		85%	85%	52.0%	53.0%	50.0%	40.0%	49.0%	49.0%	50.0%	48.0%	48.0%	42.0%	44.0%	49.0%	49.0%	
	Complaints by Theme - Access to Treatment or Drugs				3	4	1	3	1	3	1	7	2	0	4	5	6	
	Complaints by Theme - Admission / Discharge				22	18	16	17	18	14	18	20	25	16	18	25	27	
	Complaints by Theme - Appointment				6	11	7	11	5	9	9	15	11	16	24	19	21	
	Complaints by Theme - Clinical treatment				55	40	46	37	34	41	49	49	42	47	72	71	63	
	Complaints by Theme - Commissioning Decisions				0	0	0	0	0	0	0	0	0	0	0	0	0	
	Complaints by Theme - Communication				29	40	39	37	37	46	38	51	48	40	62	60	60	
	Complaints by Theme - Consent to treatment				1	3	2	1	3	3	1	2	2	2	2	0	1	
	Complaints by Theme - Dementia Care				0	0	0	0	0	0	0	0	0	0	0	0	0	
	Complaints by Theme - End of life care				3	1	0	1	1	4	3	4	2	2	5	0	6	
	Complaints by Theme - Facilities				5	6	4	7	7	7	3	9	7	4	5	7	13	
	Complaints by Theme - Mortuary				0	0	0	0	0	0	0	0	0	0	0	0	0	
	Complaints by Theme - Other				0	2	1	1	0	0	4	2	2	0	2	2	1	
	Complaints by Theme - Patient care				24	18	19	23	21	17	22	34	28	21	27	18	29	
	Complaints by Theme - Prescribing				5	7	0	8	2	4	1	2	4	6	7	9	6	
	Complaints by Theme - Privacy & Dignity				6	8	3	11	3	10	10	8	7	11	16	7	15	
	Complaints by Theme - Restraint				0	0	0	1	1	0	0	0	1	1	0	1	0	
	Complaints by Theme - Staff numbers				2	3	3	4	1	0	2	3	3	0	0	2	0	
	Complaints by Theme - Trust admin / procedure / records				12	20	3	4	2	2	6	4	3	7	10	11	15	
	Complaints by Theme - Values & Behaviours (staff)				20	25	15	19	19	18	18	17	24	27	37	41	31	
	Complaints by Theme - Waiting time				15	13	9	6	13	13	11	18	16	15	17	19	16	
	PALS - Count of concerns		-	-	402	394	411	401	285	352	366	362	330	365	351	375	318	
	Compliments		-	-	91	94	122	137	87	91	81	112	105	93	110	81	109	
	Friends and Family Test -SaTH		95%	95%	93.0%	97.9%	92.8%	92.7%	88.8%	91.7%	98.1%	97.6%	97.1%	93.2%	96.8%	88.3%	92.4%	
	Friends and Family Test - Inpatient		95%	95%	98.6%	98.9%	98.3%	98.3%	98.0%	98.5%	98.8%	97.5%	97.2%	91.4%	97.4%	96.9%	96.4%	
	Friends and Family Test - A&E		85%	85%	75.9%	53.1%	69.8%	71.2%	60.5%	71.0%	77.7%	77.0%	64.9%	51.7%	57.6%	63.0%	33.3%	
	Friends and Family Test - Maternity		95%	95%	100.0%	85.7%	64.3%	93.2%	93.8%	97.8%	100.0%	96.7%	95.5%	88.6%	98.4%	100.0%	100.0%	
	Friends and Family Test - Outpatients		95%	95%	98.7%	98.7%	98.8%	99.0%	98.9%	99.2%	99.5%	98.7%	99.0%	99.0%	97.6%	94.0%	92.9%	
	Friends and Family Test - SaTH Response rate %		-	-	11.4%	7.6%	11.9%	9.8%	8.9%	9.7%	5.5%	6.8%	5.2%	5.3%	4.8%	1.3%	1.2%	
	Friends and Family Test - Inpatient Response rate %		-	-	20.9%	19.5%	21.7%	16.5%	13.4%	12.9%	11.6%	16.8%	11.9%	12.8%	11.5%	2.2%	2.9%	
	Friends and Family Test - A&E Response rate %		-	-	6.5%	0.3%	5.9%	5.6%	5.9%	7.3%	1.0%	0.4%	0.6%	0.4%	0.3%	0.7%	0.1%	
	Friends and Family Test - Maternity (Birth) Response rate %		-	-	1.0%	2.1%	2.2%	0.9%	0.9%	1.0%	5.7%	6.9%	0.5%	6.6%	2.1%	0.7%	0.2%	

Integrated Performance Report

The Shrewsbury and Telford Hospital NHS Trust

Domain	Description	Regulation	National Standard 25/26	Current Month Trajectory (RAG)	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Trend
Patient Safety & Effectiveness	Trust SHMI (HED)		100	100	89	92	85	92	86	106	96	103	-	-	-	-	-	
	Trust SHMI - Expected Deaths		-	-	226	234	264	253	280	282	242	252	-	-	-	-	-	
	Trust SHMI - Observed Deaths		-	-	202	216	225	232	240	299	231	260	-	-	-	-	-	
	SJRs Completed by Month				32	31	25	30	19	21	25	31	20	33	20	17	15	
	MRSA - HOHA				0	0	0	0	1	1	0	1	0	0	0	0	0	
	MRSA - COHA				0	0	0	0	0	0	0	0	0	0	0	0	0	
	MRSA - Total	R	0	0	0	0	0	0	1	1	0	1	0	0	0	0	0	
	MSSA - HOHA		-	-	1	2	3	3	2	2	3	2	2	3	1	2	2	
	C. difficile - HOHA				11	4	5	6	9	8	5	4	9	2	6	5	10	
	C. difficile - COHA				3	2	6	5	6	4	2	3	5	2	6	5	3	
	C. difficile - Total	R	98	8	14	6	11	11	15	12	7	7	14	4	12	10	13	
	E. coli - HOHA				5	5	3	4	8	6	6	2	3	2	3	2	8	
	E. coli - COHA				8	5	5	7	9	11	6	8	9	14	9	10	10	
	E. coli - Total	R	146	12	13	10	8	11	17	17	12	10	12	16	12	12	18	
	Klebsiella - HOHA				1	2	1	4	4	3	4	4	1	4	0	2	1	
	Klebsiella - COHA				0	3	1	2	2	4	2	1	5	2	1	1	5	
	Klebsiella - Total	R	36	3	1	5	2	6	6	7	6	5	6	6	1	3	6	
	Pseudomonas Aeruginosa - HOHA				1	1	1	0	1	1	0	1	0	0	1	0	0	
	Pseudomonas Aeruginosa - COHA				0	1	2	1	1	1	2	0	2	0	0	3	1	
	Pseudomonas Aeruginosa - Total	R	16	1	1	2	3	1	2	2	2	1	2	0	1	3	1	
	VTE Risk Assessment completion - SATH		95%	95%	76.0%	74.9%	75.2%	75.5%	74.8%	76.2%	75.6%	74.3%	75.6%	75.0%	75.5%	77.5%	-	
	Never Events		0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	
	Psii		-	-	1	0	0	0	0	1	2	2	4	1	0	1	0	
	Mixed Sex Accommodation - breaches		10% < 2024-25	52	58	69	83	92	117	108	60	86	101	87	65	52	38	
	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%	89%	78%	88%	94%	90%	99%	94%	95%	97%	96%	96%	99%	95%	
	Smoking Rate at Delivery		6%	6%	7.2%	6.6%	6.7%	5.5%	9.6%	5.8%	5.4%	5.6%	5.6%	4.0%	5.9%	5.0%	4.4%	

Quality - Safe - Deteriorating Patients - Fragility

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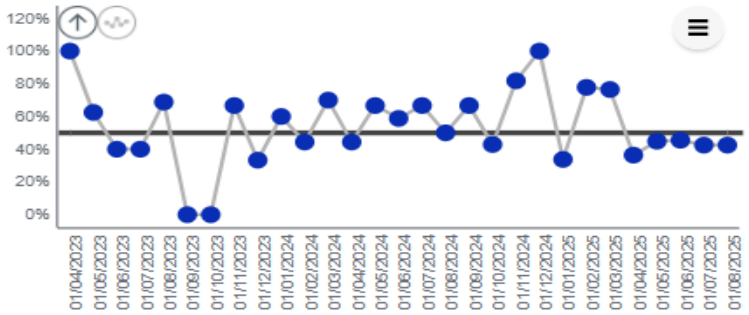
NHS The Shrewsbury and Telford Hospital NHS Trust

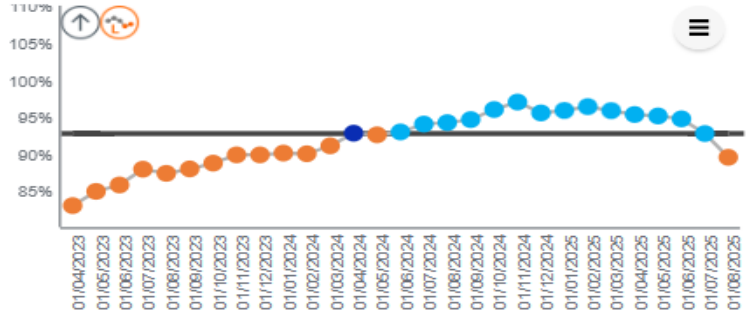
Falls | Deteriorating Patients - NEWS | Deteriorating Patients - PEWS | Medication - Omitted Doses

	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025
Improve Dementia screening rates - Patient had an AMT - ED	66.7	58.8	66.7	50.0	66.7	42.9	81.8	100.0	33.8	77.8	76.5	36.4	44.9	45.5	42.5	42.5
Improve Dementia screening rates - Patient had an AMT - Adult IP	60.0	49.1	54.5	70.4	37.3	73.0	67.0	55.7	58.2	44.6	53.7	47.1	44.7	43.2	48.1	53.1
Dementia Awareness Tier 1 3 Yearly	92.79	93.18	94.24	94.44	94.85	96.21	97.22	95.75	96.08	96.60	96.06	95.54	95.34	94.95	92.96	89.75
Dementia Awareness Tier 2 3 Yearly	90.03	91.95	92.37	91.26	91.35	91.95	92.59	93.25	93.51	93.02	92.99	93.53	93.19	91.93	92.86	93.00
Dementia Screening % Score	77	70	73	83	59	67	73	67	83	86	87	84	86	92	95	93
Dementia Screening Audited	249	255	264	262	273	251	246	189	207	202	200	245	248	234	250	245

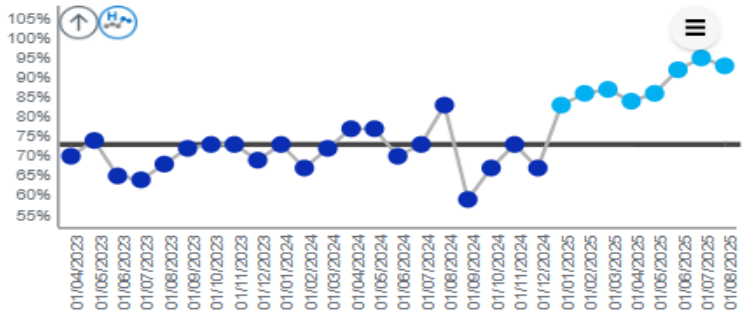
Improve Dementia screening rates - ED



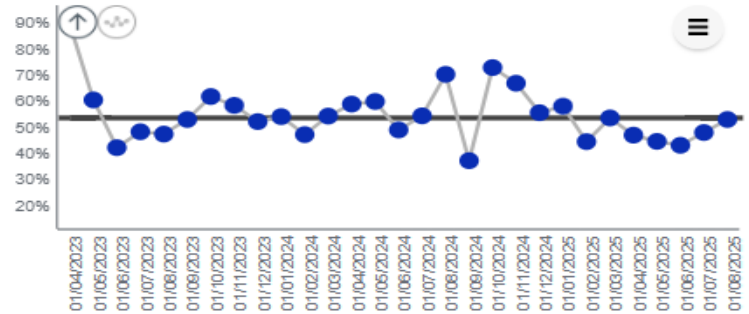
Dementia Awareness Tier 1 - 3 Yearly



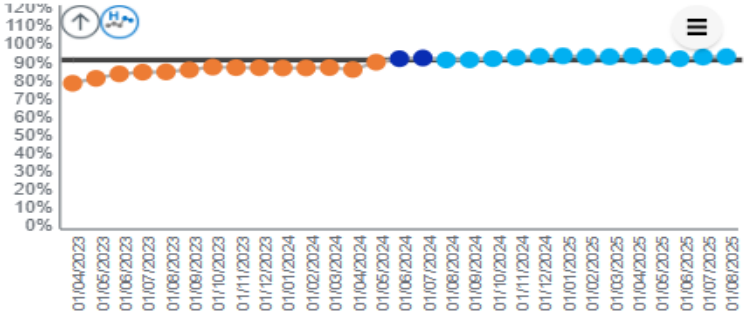
Dementia screening score %



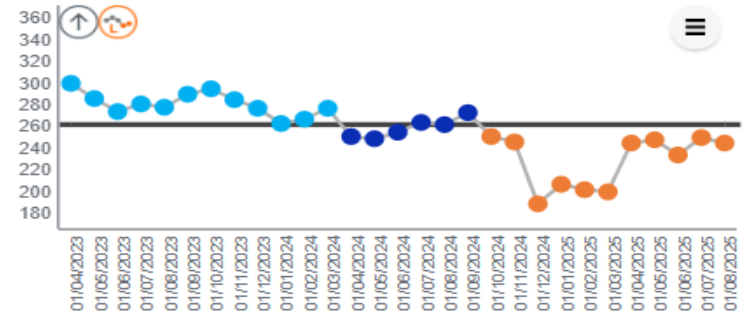
Improve Dementia screening rates - Adult IP



Dementia Awareness Tier 2 - 3 Yearly



Dementia screening audited

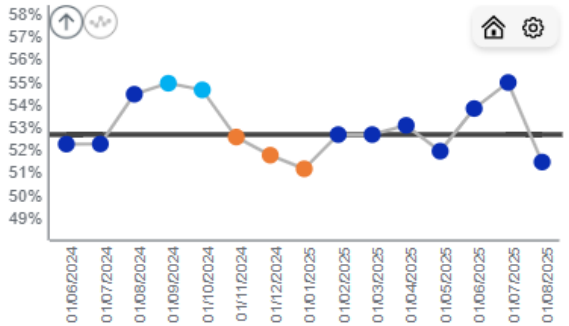


Quality - Safe - Deteriorating Patients - NEWS

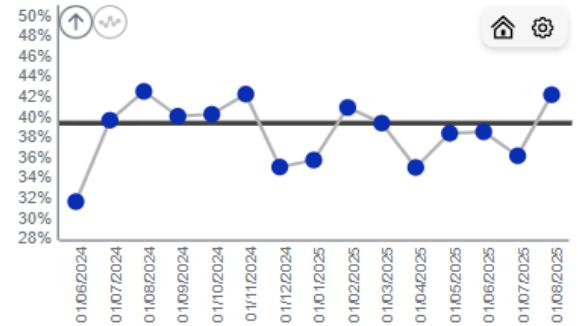
Falls | Deteriorating Patients - Fragility | Deteriorating Patients - PEWS | Medication - Omitted Doses

	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	May-2025	Jun-2025	Jul-2025	Aug-2025
% Compliance Deterioration Risk - All Wards				52.28	52.29	54.48	54.96	54.67	52.59	51.79	51.19	52.70	52.70	53.11	51.97	53.85	55.00	51.49
% Compliance Deterioration Risk - ED				31.64	39.66	42.51	40.06	40.26	42.24	35.05	35.74	40.92	39.38	35.01	38.38	38.52	36.16	42.18
% Compliance Evidence that Deterioration Risk (NEWS2 trigger) Escalated	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	90.90	87.30	86.10	89.60
% Compliance Evidence that Deterioration Risk (NEWS2 trigger) 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	83.10	81.80	77.80	83.90
% Compliance of review within recommended timeframe				91.70	93.70	95.20	94.30	95.00	95.30	95.40	93.60	96.30	96.20	92.20	95.00	92.00	88.20	94.90
% Compliance reviewed by recommended seniority				96.80	97.50	97.90	97.90	98.40	98.90	96.80	98.60	98.40	96.40	97.50	96.60	97.60	99.50	98.50
% Compliance those stratified high-risk of Sepsis, received antibiotics within 1hr	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	90.90	100.00	100.00	100.00

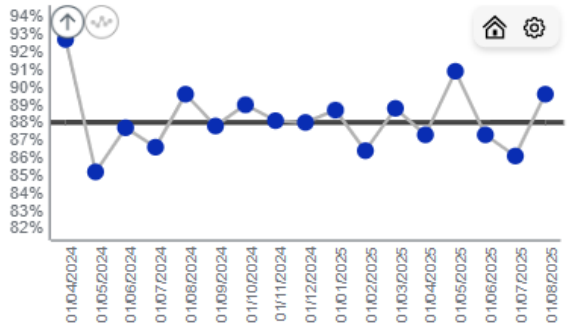
% Observation compliance for patients at risk of deterioration



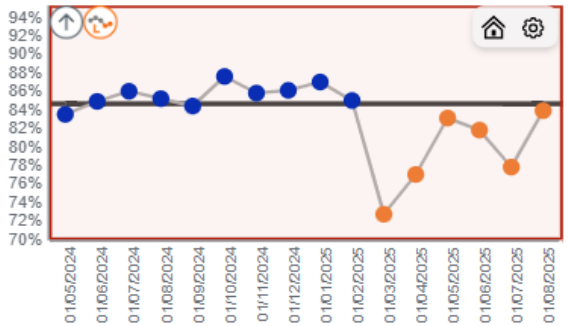
% Observation compliance for patients at risk of deterioration- ED



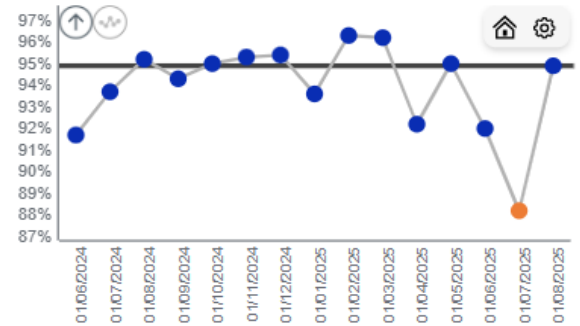
% Compliance Evidence that Deterioration Risk escalated



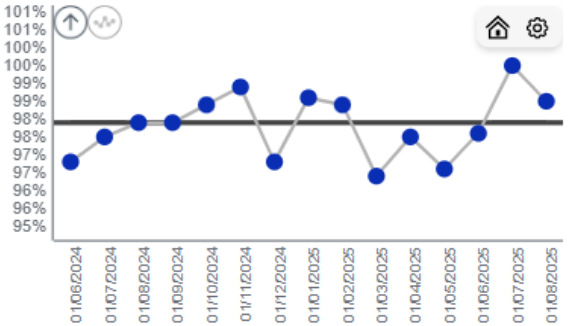
% Compliance Evidence that Deterioration Risk reviewed



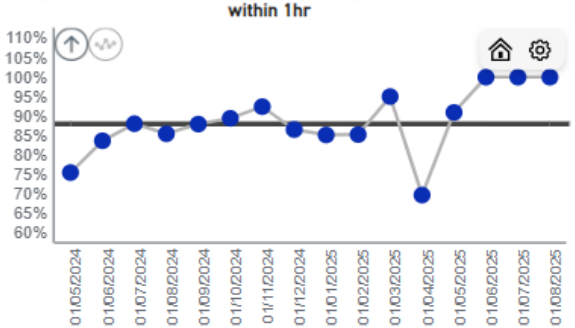
% Compliance of review within recommended timeframe



% Compliance reviewed by recommended seniority



% Compliance those stratified high-risk of Sepsis, received antibiotics within 1hr



Deteriorating patients – NEWS2

The Shrewsbury and Telford Hospital NHS Trust

Summary: In August, **270 'deterioration risk' patients** were audited; (having triggered either **≥5 or 3 in a single criterion on NEWS2)**.
Of these, **242 patients (89.6%) had documented evidence of escalation**, whilst **28 patients (10.4%)** did not. Among those without documentation, **15 (53.6%) had a justifiable reason for deviation** (e.g., managed under an individual escalation plan), however **13 (46.4 %) had no documented justifiable reason** for deviation.
Of the 255 patients who required a review, **213 (83.5%) met the standard**. Of the 42 not reviewed (16.5%), **11 (26.1%) were following an escalation plan (**but this was not captured by the auditor), **5 patients (11.9%) received verbal advice,** and whilst not the standard this demonstrates deterioration risk resulted in an action. For the remaining patients, reviews were conducted later during ward rounds, several patients had persistently high scores which in fact demonstrated an improving trend or their subsequent observations improved. One patient who had been triggering high EWS for >6 hrs, passed away later in the day, ME review reports documentation was good, and that the patient was approaching palliation but waiting on clinicians formalising the decision. Among the 213 reviewed patients:

- **187 (87.79%) were reviewed within the recommended timeframe**,(going forward this data will exclude those where the time was not documented, capturing these as non-compliant, and informing quality improvement work).
- **10 (4.6%) were reviewed outside the timeframe**
- **16 (7.5%) had no documented review time**
- **196 (92.0%) patients were reviewed by the appropriate designation**, while in **13 (6.1%)** cases **seniority was not recorded**,(going forward this data will exclude those where the designation of the reviewer was not documented and capture these as non-compliant, thereby informing quality improvement work). Of those audited, **67 patients (26.3%) were identified as high-risk for sepsis**, of these, **2 patients were eligible for antibiotics within 1 hour** and received them, resulting in **100% compliance, which demonstrates 3 consecutive months of 100% in this metric.** The remaining patients were either deemed not septic, already receiving IV antibiotics, or reviewed in line with antibiotic guidelines.

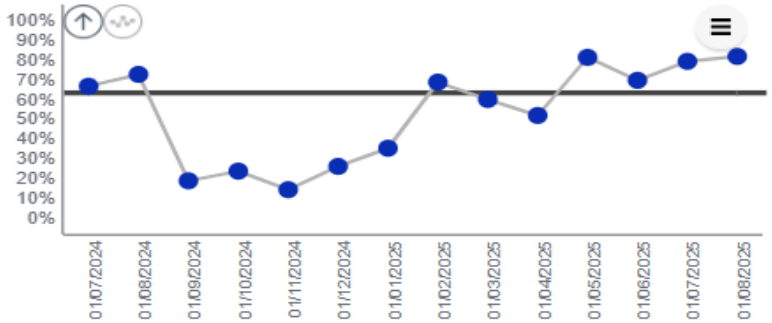
Recovery Actions:	**Anticipated impact and timescales.**
• **Escalation Documentation:** Audit tool refinement to capture decision making supporting individualised treatment, work with handover, SHOP model and individualised treatment workstreams to enhance ward education on documenting rationale for deviation; continue monthly spot checks encourage department level oversight of documentation quality. • **Review Compliance:** Provide policy clarification to ensure all escalations result in documented review; work in collaboration with clinical teams and data teams to provide ward/divisional level feedback on performance in this area. • **Timeliness of Review:** Missing times now accurately captured as non-compliant thereby improving data quality and confidence, work with teams via workstreams providing education on documenting time; with care flow connect digital timestamp options being explored. • **Reviewer Seniority**: Individualised Treatment workstream to incorporate learning and support development of systems and processes to strengthen timely decision-making, incorporating into Individualised Escalation Plans workstream promoting consultant oversight and shared learning in Safety Huddles. • **Sepsis Recognition and Management :** Maintain sepsis oversight on key metrics, share success story and ongoing assurance to governance teams	1. 3 months 2. 6-12 months 3. 6 months 4. 3 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. Engagement with the deteriorating patient group workstreams.

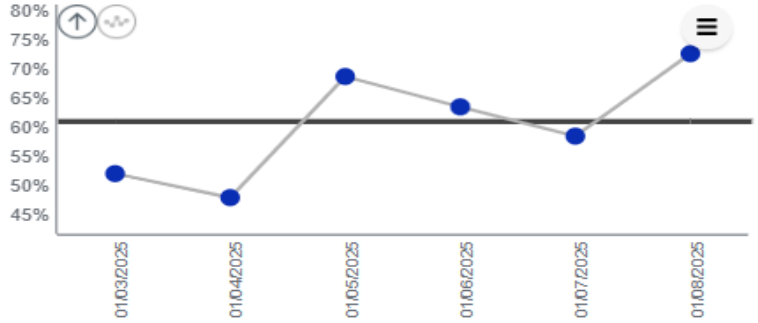
Quality - Safe - Deteriorating Patients - PEWS

	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-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	81.30	69.70	79.30	81.80
Is there evidence of this PEWS trigger being reviewed?									52.20	48.10	68.80	63.60	58.60	72.70
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	25.00	0.00	0.00	0.00
Did the PEWS management plan include: Investigation plan				45.50	38.10	77.80	77.80	93.30	81.80	75.00	62.50	78.60	63.60	91.70
Did the PEWS management plan include: Treatment plan				95.50	95.20	95.50	73.30	89.50	100.00	100.00	87.00	90.50	94.10	100.00
Did the PEWS management plan include: Escalation plan				13.60	19.00	54.50	46.70	21.10	35.70	46.20	30.40	23.80	11.80	33.30
Did the PEWS management plan include: Review plan				27.30	47.60	66.70	76.90	94.70	92.90	84.60	87.00	95.20	94.10	100.00

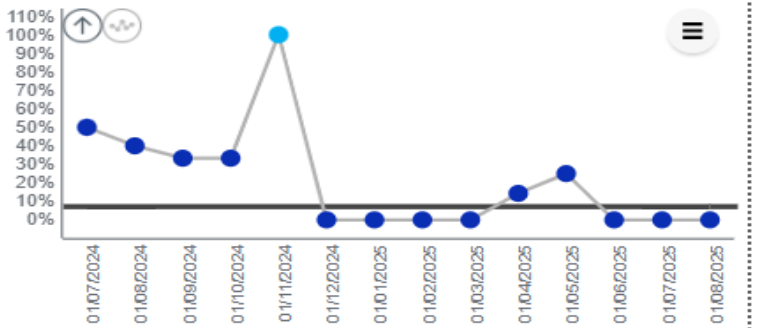
Is there evidence PEWS score was escalated?



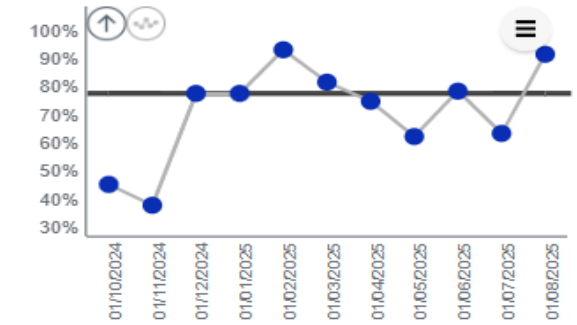
Is there evidence of this PEWS trigger being reviewed



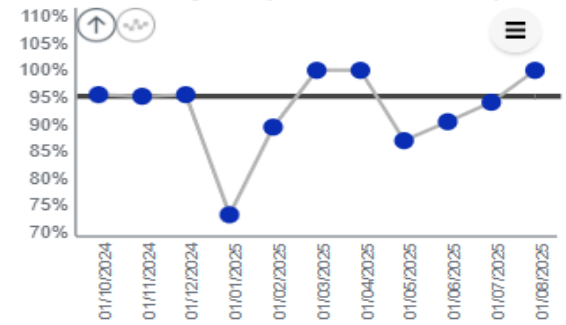
Did the CYP have IV antibiotics within 60 minutes?



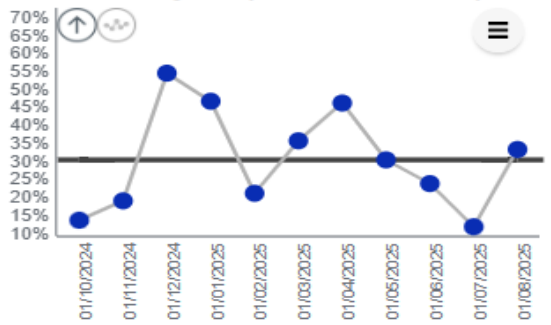
Did the PEWS management plan include: Investigation plan



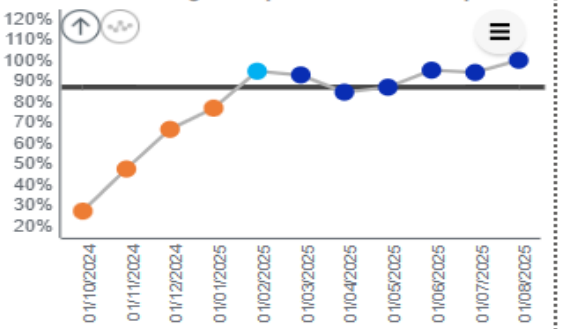
Did the PEWS management plan include: Treatment plan



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: In August, 22 patients were audited. Of those requiring escalation, 81.8% (18 CYP) had documented evidence of escalation. However, 18.1% (4 CYP) were not escalated but 25% (1 patient) had a valid reason with documentation and justification, 3 CYP lacked evidence indicating gaps in record-keeping but the audit review demonstrated these patients did not require escalation and no harm occurred.

A slight decline was observed in review compliance, with 72.72 % (16 CYP) of patients reviewed in August, compared to 81.25% in July. Among the 27.27% (6 patients) not reviewed, 33.26 % (2 CYP) were given verbal advice or were following a document medical plan. 66.6% (4 CYP) had no documented reason for not being reviewed.

Regarding sepsis, 95.5% of CYP were screened for sepsis at initial assessment which is an increase from 93.75% in July. 54.54% (12 patients) showed high-risk indicators. 16.6% (2 patients) have been de-escalated, as they were deemed not septic but were being treated for alternative diagnoses. 83.4% (10 patients) were eligible for IV antibiotics, however, audit review showed 2 CYP were discharged home, 1 CYP was receiving treatment for viral infections, 1 CYP was receiving oral antibiotics, 2 CYP were pre/ post-surgery, 1 CYP was post immunisation administration, and 2 CYP were admitted due to Mental Health. Therefore, no patients required IV antibiotics, resulting in a compliance of 100%. On reviewing the audits improvement is required in de-escalating sepsis when required, documentation following reviews, and escalation of PEWS.

Recovery actions:

Escalation Compliance: Documentation of escalation has reduced to 81.8%, this is supported by the paediatric PEF team, simulation training, and audit feedback via newsletters and huddles.

From **Review Compliance: Review compliance has reduced at 72.72%,** the increased use of PEW parameter stickers on ward rounds would reduce the number of reviews required when CYP trigger the standard PEW scores, illness or oxygen requirement will create an elevated score. These CYP require individualised PEWS triggers decided by the Tier 2 or consultant. Reminders to be sent out via email, within huddles and newsletters.

IV Antibiotic Compliance: Antibiotics given within 1 hour is 100% compliance due to no CYP requiring treatment within the audit.

Documentation: De-escalation of sepsis triggers via vitals and documenting reviews remains the biggest challenge within Paediatrics with majority of children presenting to the department triggering sepsis due to children's physiology and response to illness. Targeted education during Doctor induction completed by the consultant alongside deteriorating patients teaching during new nurse induction. Tier 2 medics/ACP have received refresher training on de-escalation of sepsis with a reminder to document reviews

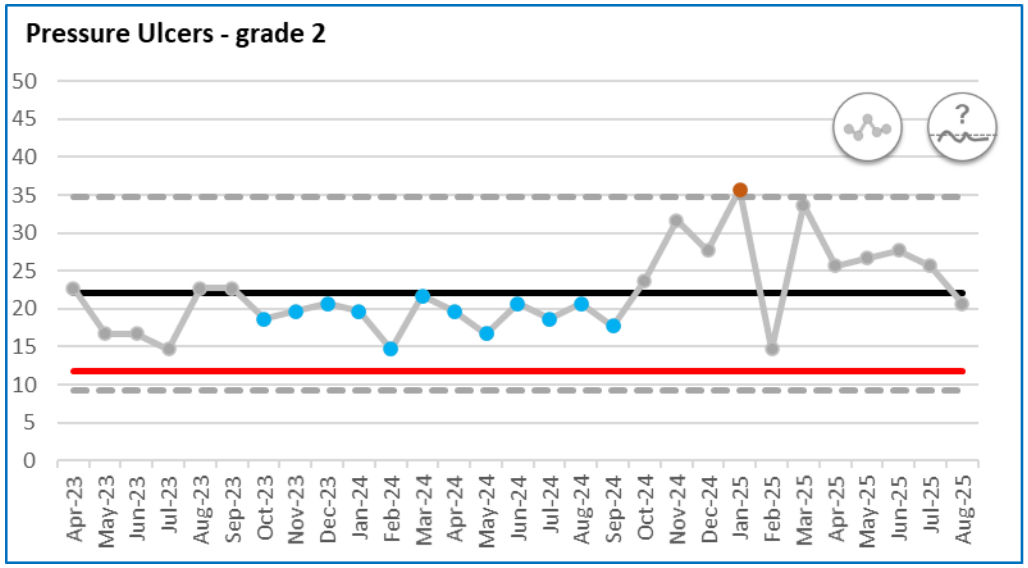
Anticipated impact and timescales for improvement:

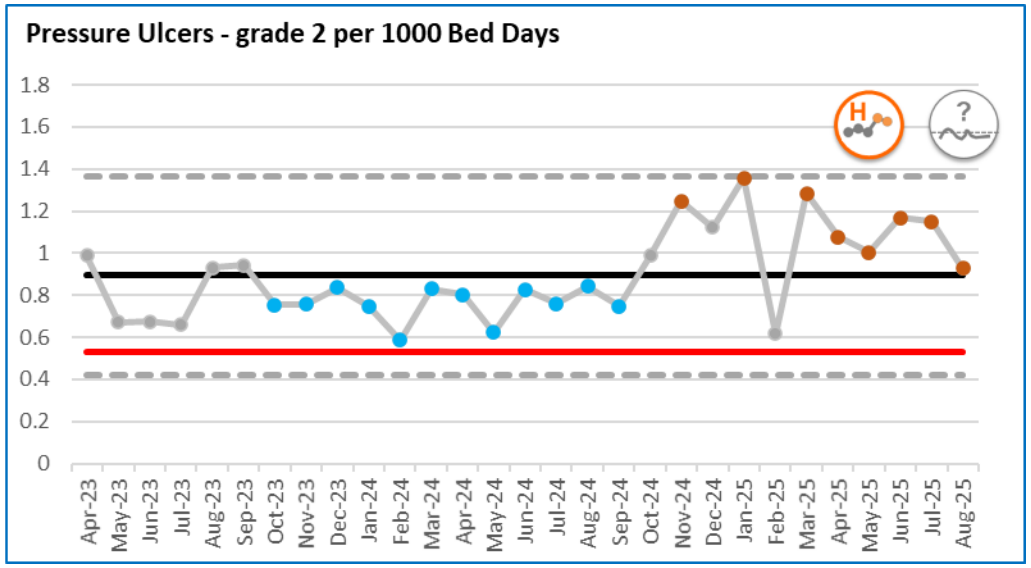
1. 12-18 months
2. 12-18 months
3. 6 months

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

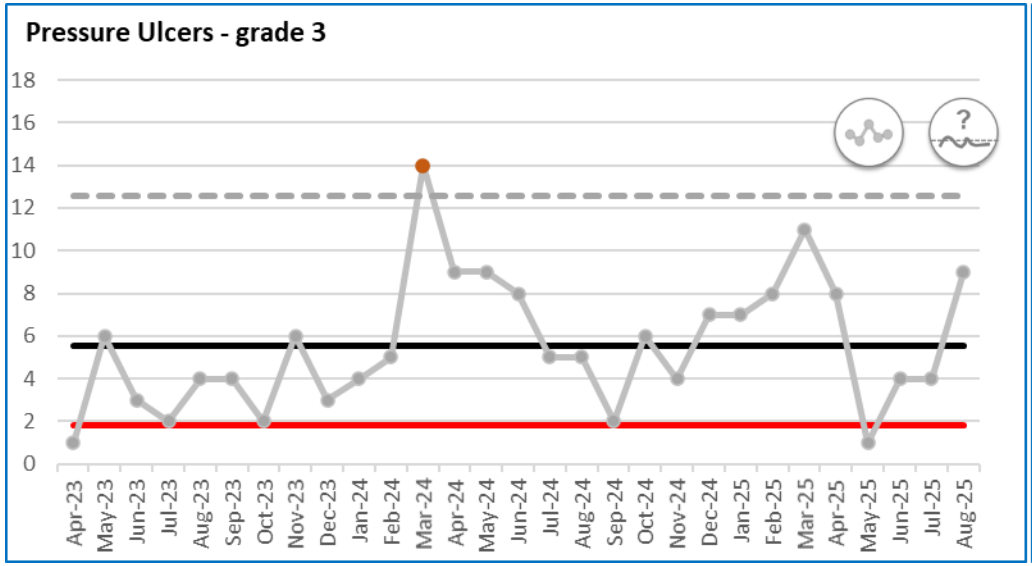


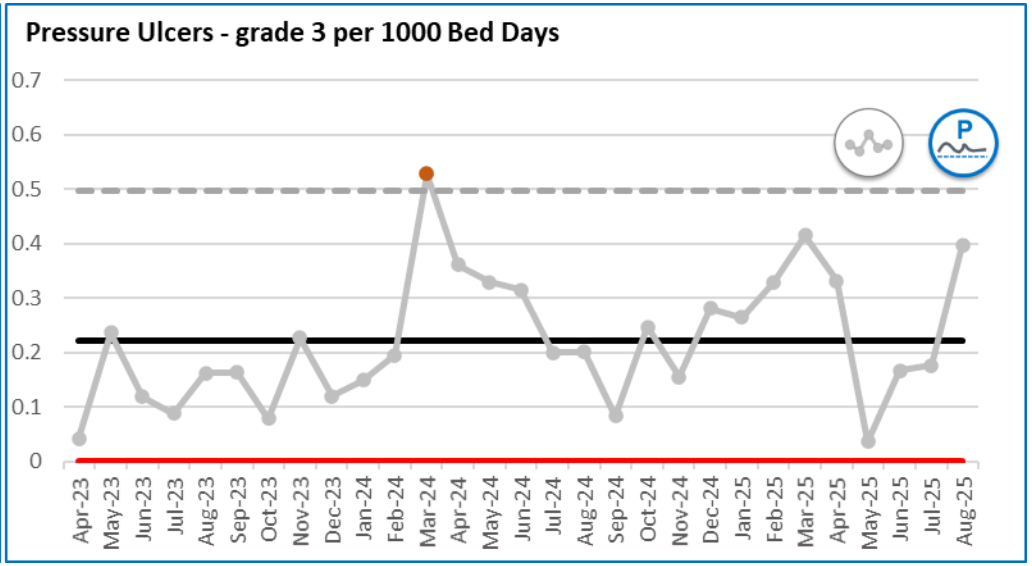


Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	16
Surgery, Anaesthetics and Cancer	5
Women's & Children's	0
Clinical Support Services	0

Patient harm – pressure ulcers – Category 3

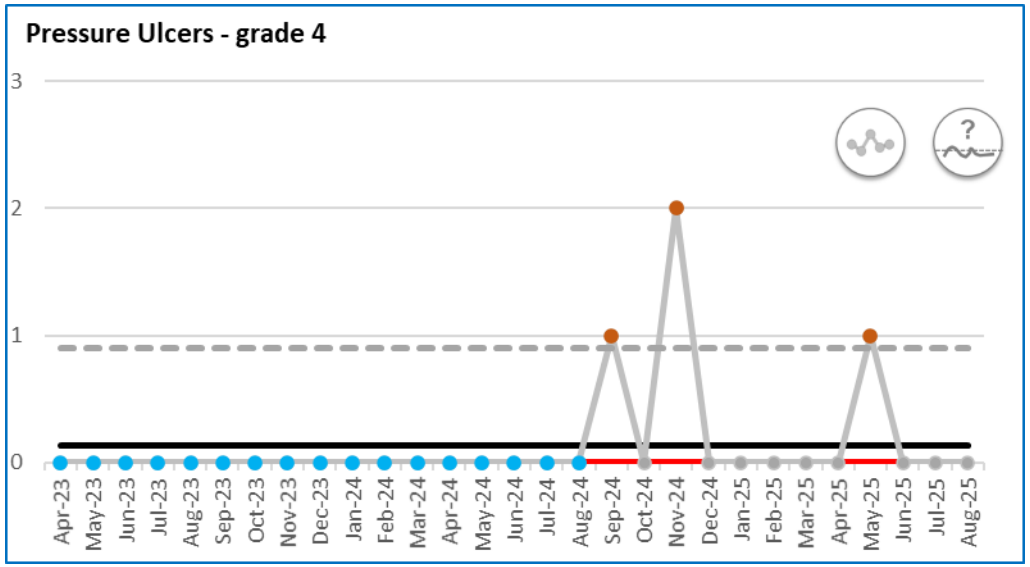
The Shrewsbury and Telford Hospital NHS Trust





Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	7
Surgery, Anaesthetics and Cancer	2
Women's & Children's	0
Clinical Support Services	0

Patient harm – pressure ulcers – Category 4



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

Patient harm – pressure ulcers

The Shrewsbury and Telford Hospital NHS Trust

Summary:
The number of Category 2 injuries has decreased by 5 this month. The number of category 3 pressure ulcers has increased in month. The 9 category 3 pressure ulcers in month were attributed to ward 28, ward 26, ward 24, ward 25, ward 35 x2, ward 17, ITU and ward 11. Of these, 6 were on buttocks/sacrum, 1 on spine, 1 bilateral heels and 1 device related on nose. Following the review meeting there was a lack of off-loading devices in place, gaps in daily skin assessments, patient repositioning schedule and position changed was not highlighted. Core care plan was also not always completed
3 of the cat 3s, on review showed there was evidence that all actions of the aSSKINg care bundle were taken, and pressure ulcer preventative measures were maximised as much as possible as due to the complex co-morbidities and the overall conditional status of these patients, their skin was incredibly vulnerable to injury despite all actions being in place to prevent. These patients from ward 17, 28 and ITU.
There have been no category 4 pressure ulcers this month.
There have been 3 category 2 devices related pressure ulcers, and 1 category 3 devices related pressure ulcer (the category 3 was one of the 3 patients in the narrative above).
There were 23 reported Deep Tissue Injuries this month which is an increase of 3 from last month.
These figures are correct at the time of validation by the Tissue Viability Service.

Recovery actions:

- Hospital acquired C3 and 4 injuries are reviewed by the Tissue Viability Team and ward manager/matron within 1 week. All category 2 pressure ulcers are reviewed by ward managers. All injuries are reviewed in line with the gold standard care of the aSSKINg care bundle to identify areas of learning and to ensure no requirement for after action review
- All injuries sustained in trust are checked against the decision support tool for safeguarding concerns and are escalated if required with the local authority in conjunction with the Trust safeguarding team
- All injuries sustained in Trust are presented at the monthly Pressure Ulcer Review Meeting where areas for learning and actions taken to embed are discussed
- Business case completed for all patients to have a hybrid pressure relieving mattress on admission

Current actions in place/ongoing are:

- Trial of NIV face mask to reduce device related pressure ulcers
- Introduction of upgraded alternating air mattress with associated staff education to improve device use and availability
- Increase on the amount of alternating air mattress in the contract to meet the demand of patients requiring one
- Offloading boot availability at ward level to reduce delays in placement
- Utilisation of ward Education Facilitators and the Quality facilitators in education regarding pressure ulcer documentation and associated nursing actions
- Ward manager focus on Tissue Viability Documentation completion and follow through of associated actions

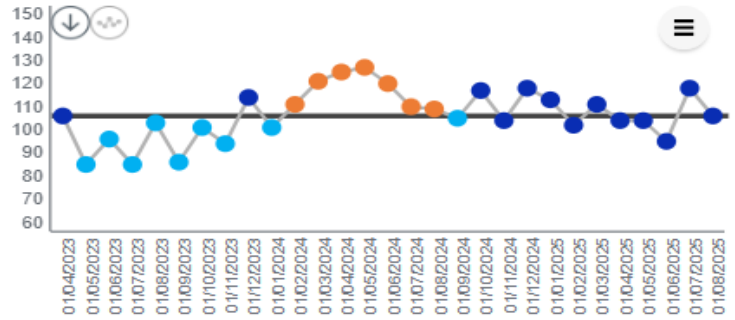
Anticipated impact and timescales for improvement:
Reduction in consistent themes in relation to pressure ulcers.

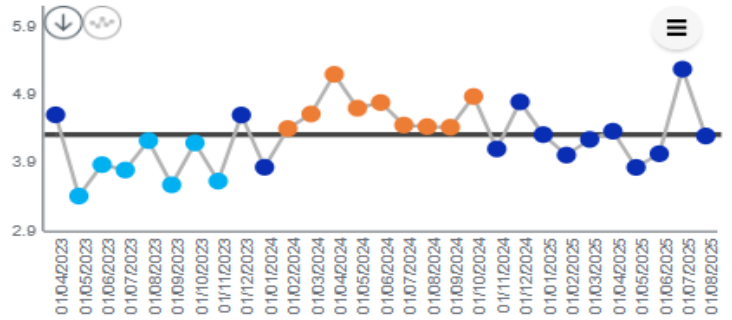
Recovery dependencies:	Ownership of action plans for pressure ulcer prevention at ward and matron level. Monthly review meetings for Category 2,3 and 4

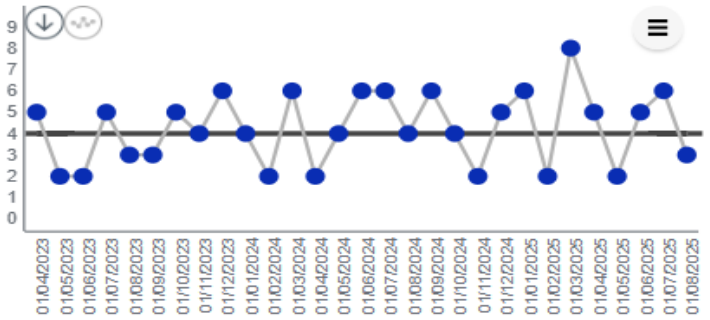
Quality - Safe - Falls

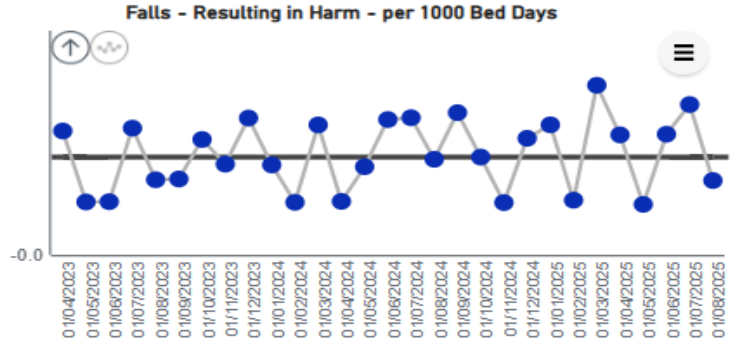
Deteriorating Patient - Fragility | Deteriorating Patients - NEWS | Deteriorating Patients - PEWS | Medication - Omitted Doses

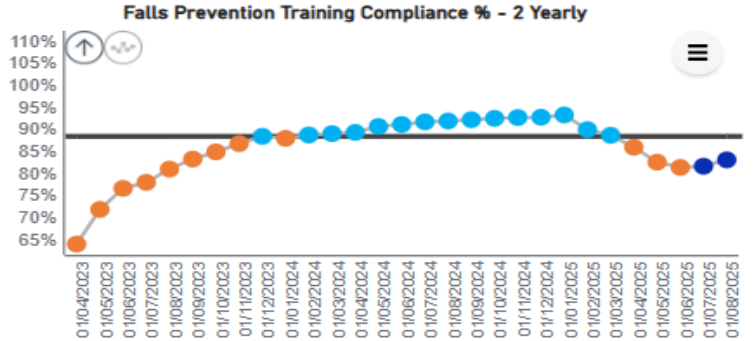
	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025
Falls - Total	125	127	120	110	109	105	117	104	118	113	102	111	104	104	95	118	106
Falls - per 1000 Bed Days	5.14	4.65	4.73	4.40	4.38	4.37	4.82	4.05	4.74	4.26	3.96	4.19	4.31	3.78	3.98	5.22	4.24
Falls - Resulting in Harm Moderate or Severe	2	4	6	6	4	6	4	2	5	6	2	8	5	2	5	6	3
Falls - Resulting in Harm - per 1000 Bed Days	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	0.07	0.21	0.27	0.12
Falls Prevention Training Compliance % - 2 Yearly	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	82.66	81.46	81.73	83.18
% Completion of Falls Risk Assessments	94	93	93	93	94	94	93	93	95	96	93	93	92	92	91	90	92

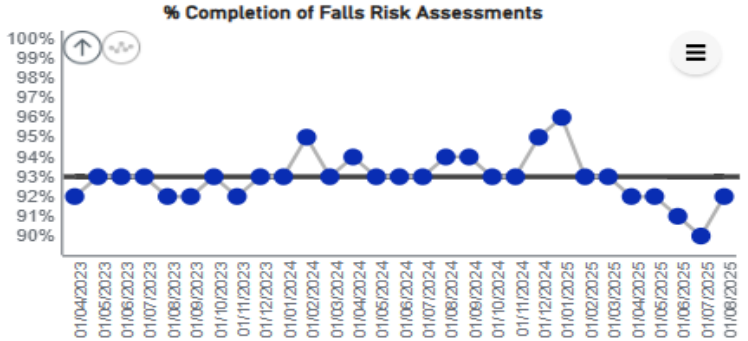












Our Vision: To provide excellent care for the communities we serve

Patient harm - falls

The Shrewsbury and Telford Hospital NHS Trust

Summary:
Falls in August showed a decrease from 118 falls in July to 106 in August. 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.
There was a decrease in falls with harm in August to 3, against 6 in July 2025 that resulted in moderate harm or above. The injuries sustained were fractured wrist (ward 21PN), fractured shoulder (ward 17) and fractured scapula (ward 23). On review all risk assessments was correct and in place, lying and standing blood pressure had been completed where applicable and post falls documentation was correct. Common cause variation continues to be seen on the falls with harm and falls with harm per 1000 bed days charts.
Training compliance has increased again his month at 83.18% and completion of risk assessments pre fall also increased again 92%.

Recovery actions:

Current falls projects being progressed is a pilot of BMAT (Bedside Mobility Assessment Tool), a patient early mobilisation tool which will also help with hospital associated deconditioning.
The Quality team review each patient fall to check process pre/post fall. There were 3 falls with harm in August 2025. Pre-fall patients had all been correctly risk assessed and appropriate plans in place including medication review. For 2 of the falls no lying and standing BP reading had been recorded pre-fall. Post fall a lying and standing BP reading was recorded, with no deficit found. For 1 of the falls, neuro-observations were not in line with RCP recommendations.
Ward Managers and Matrons review each fall on their wards with support from the Quality team. Letters are sent to the individual nurse who completed the post fall documentation where elements pre/post fall may have been missed.
Completion of lying and standing BP is an issue and there will be a focus back on raising awareness and improving compliance. Training for this forms part of the 2 yearly falls update.
Zimmer frame/mobility audit to take place in November. This will capture if the correct equipment is in place at the time of the fall.

Anticipated impact and timescales for improvement:
Beside mobility assessment – BMAT to commence with a pilot on 2 wards across the trust February 2026.
Review of all falls continues with feedback presented to WM/Matron each month and letter sent to nurse caring for the patient at the time of fall.
Attendance at divisional falls meetings monthly

Lying and standing blood pressure awareness. This is checked monthly through documentation audits by the Quality team.

Recovery dependencies:	Support to further embed reconditioning into everyday practices from ward teams by embedding mobilisation dependant on risk assessment Appointment of Falls Prevention Practitioner

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. Next audit September 2025.

Anticipated impact and timescales for improvement:

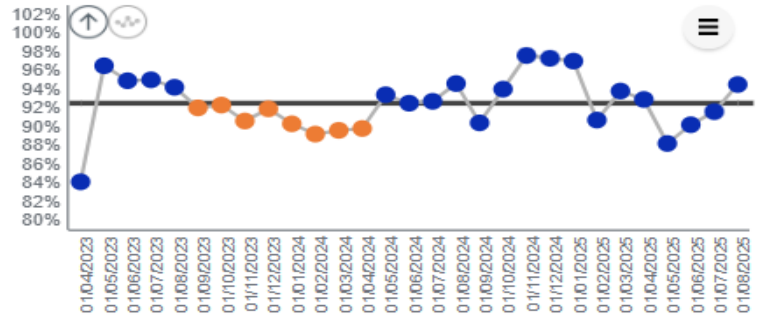
Recovery dependencies:

Quality - Safe - Medication - Omitted Doses

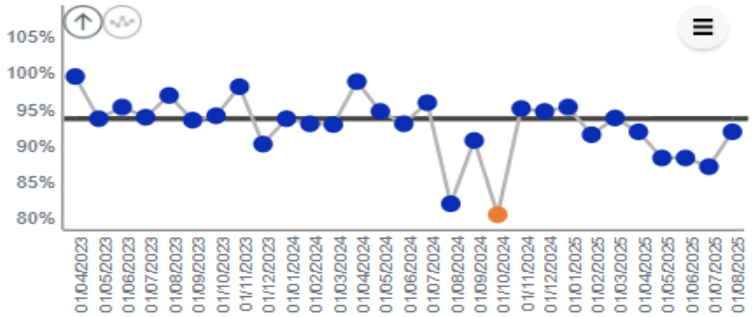
Falls | Deteriorating Patients - Fragility | Deteriorating Patient

	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025
Has all prescribed medication been administered?	93.4	92.5	92.7	94.6	90.4	94.0	97.6	97.3	97.0	90.7	93.8	92.9	88.2	90.2	91.6	94.5
Was the reason for the omission documented?	94.8	93.1	96.0	82.1	90.8	80.6	95.2	94.8	95.4	91.6	93.9	92.0	88.4	88.4	87.2	92.0
Was appropriate action such as ordering medication, documented?	93.1	88.2	93.3	91.0	92.5	93.3	92.5	89.1	94.2	92.6	95.2	91.8	92.5	93.8		

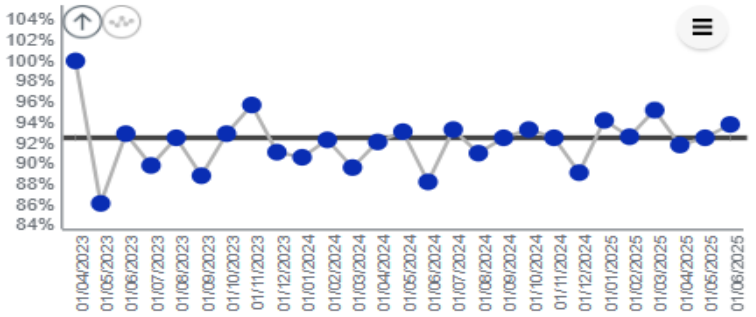
Has all prescribed medication been administered



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

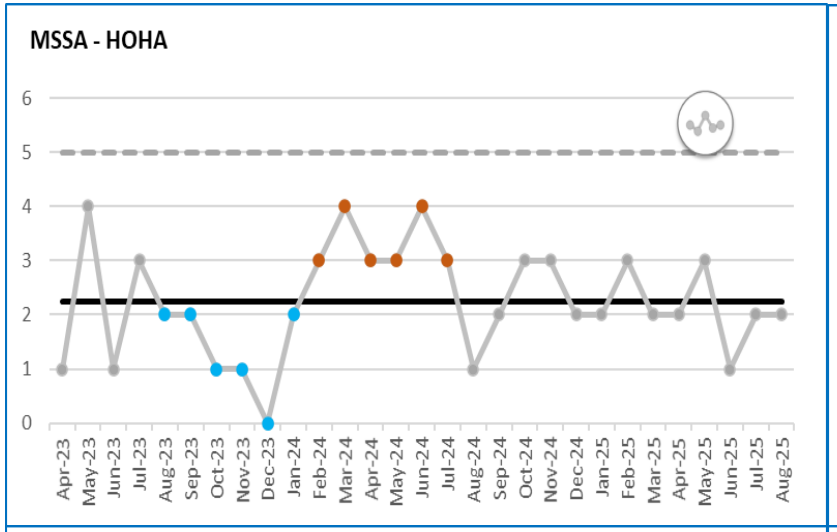
Anticipated impact and timescales for improvement:
In-line and aligned to the PSIRF Trust Priority – Omitted doses of time critical medication.

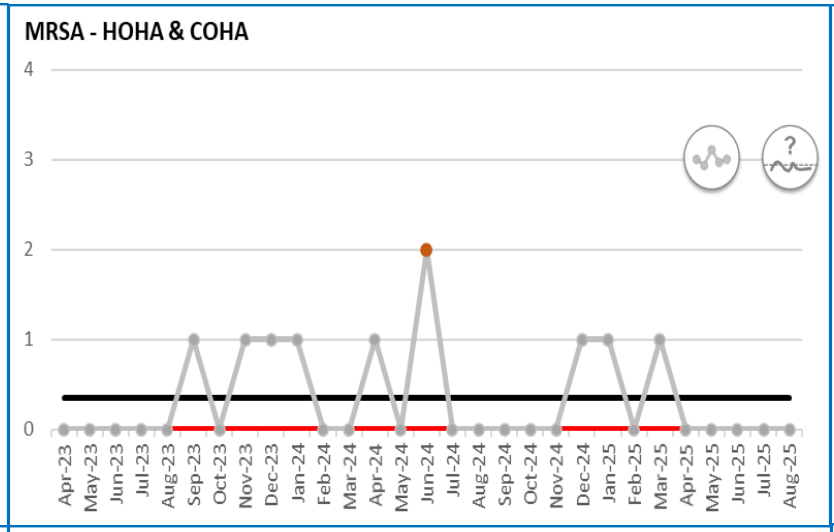
In line with full implementation of EPMA within the Trust.

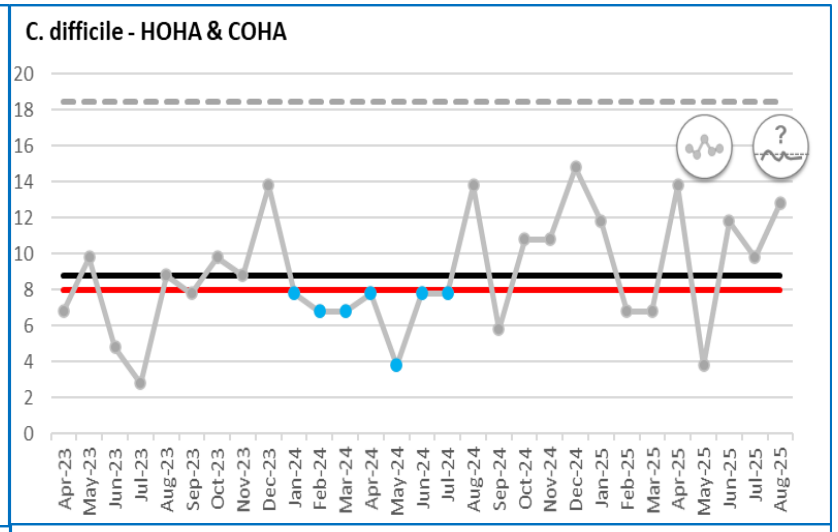
Recovery dependencies:

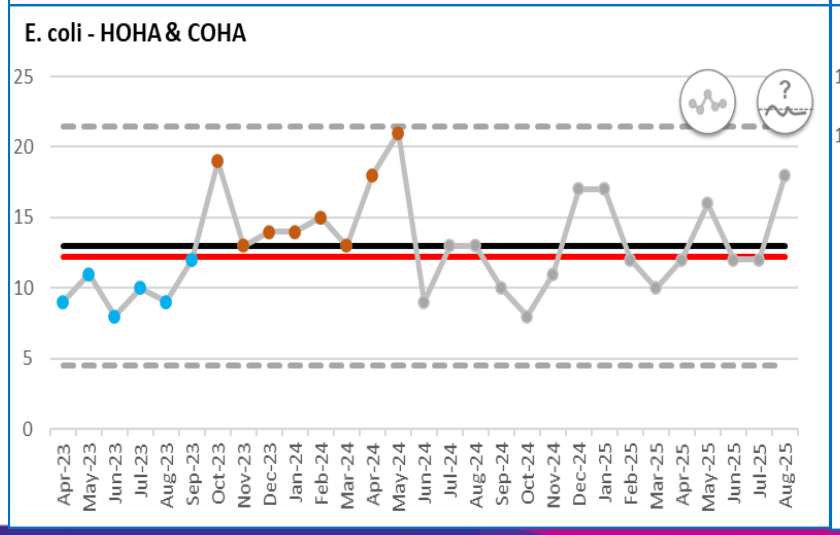
Infection prevention and control

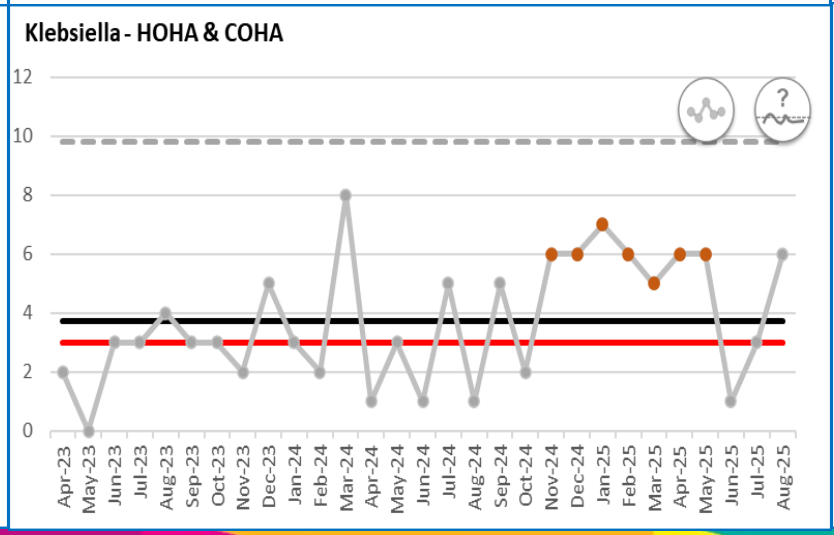
The Shrewsbury and Telford Hospital NHS Trust

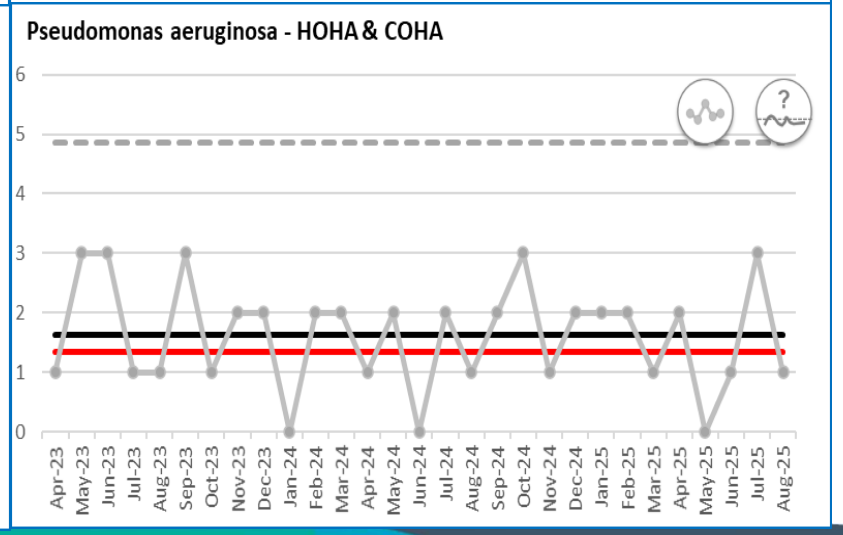












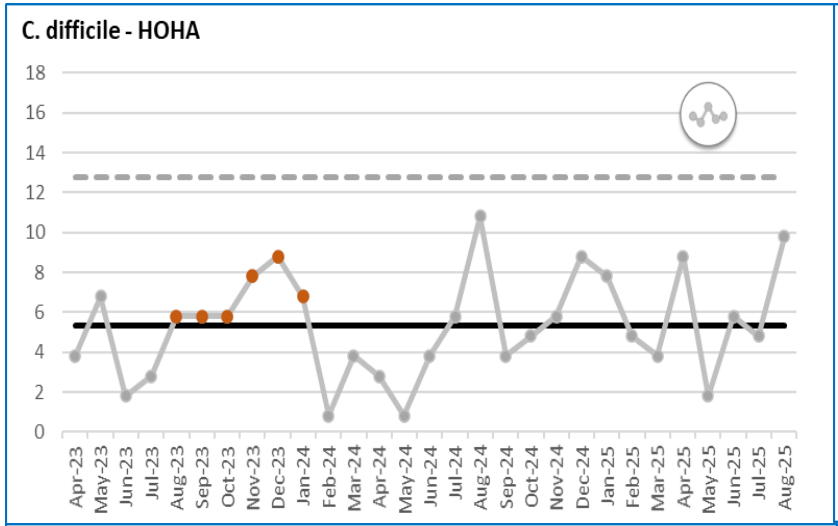
PACT Partnering Ambitious Caring Trusted

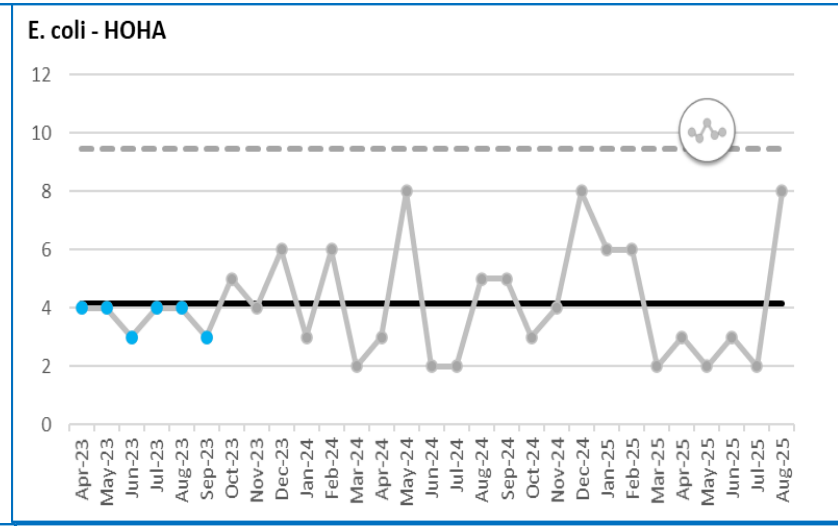
VETERAN AWARE

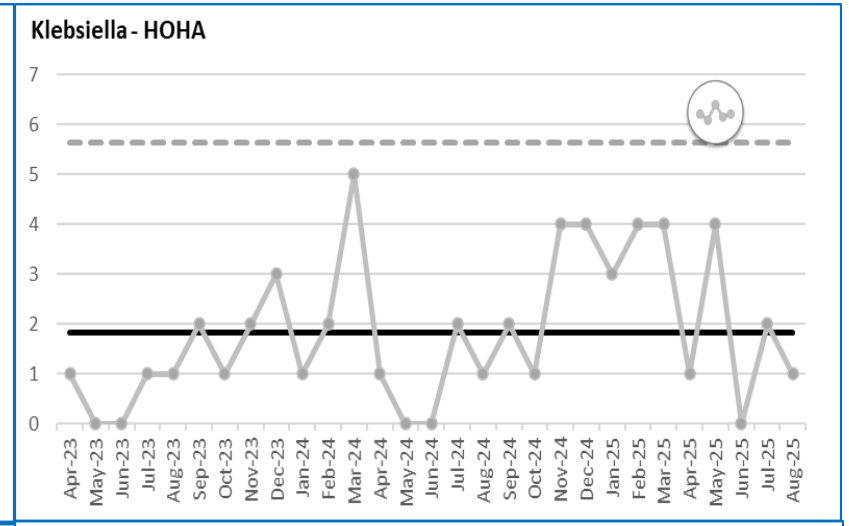
Our Vision: To provide excellent care for the communities we serve

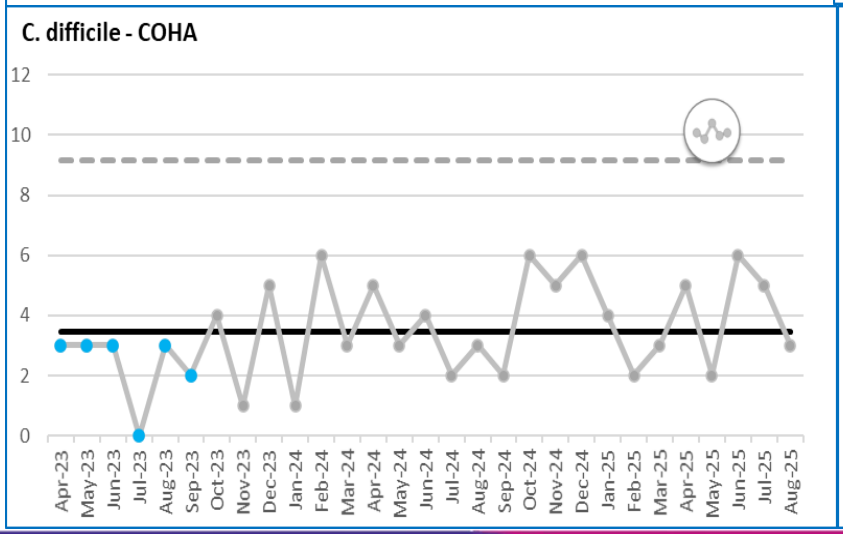
Infection prevention and control

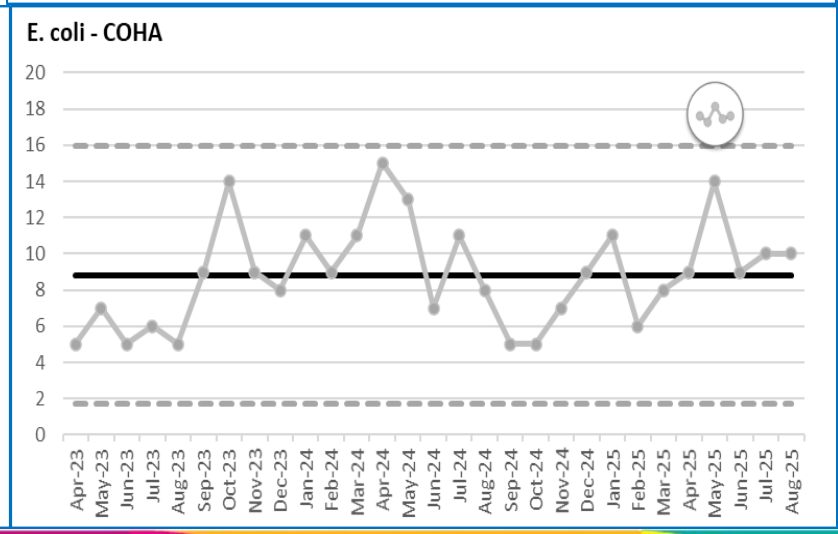
The Shrewsbury and Telford Hospital NHS Trust

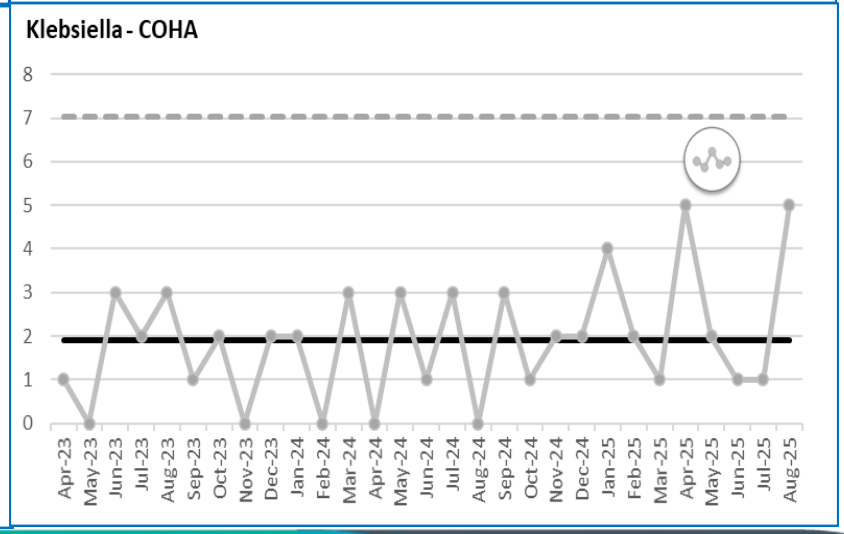












Infection prevention and control

The Shrewsbury and Telford Hospital NHS Trust

Summary:
In August 2025 there were the following bacteraemia:

- 13 C. diff cases (10 HOHA, 3 COHA)
- 0 MRSA Bacteraemia
- 7 MSSA Bacteraemia (2 HOHA, 5 COHA)
- 18 E. coli Bacteraemia (8 HOHA, 10 COHA)
- 6 Klebsiella Bacteraemia (1 HOHA, 5 COHA)
- 1 Pseudomonas Bacteraemia (0 HOHA, 1 COHA)

Measure	Apr-25	May-25	Jun-25	Jul-25	Aug-25	YTD 25/26	Annual Target 25/26
C diff Infections	14	4	12	10	13	53	98
MRSA Bacteraemia	0	0	0	0	0	0	0
MSSA Bacteraemia	5	5	3	5	7	25	NA
E. Coli Bacteraemia	12	16	12	12	18	70	146
Klebsiella Bacteraemia	6	6	1	3	6	22	36
Pseudomonas aeruginosa Bacteraemia	2	0	1	3	1	7	16

5

Recovery actions:

- C diff action plan in place & there is an expectation that the divisions will implement this & report back to IPCOG. We are still struggling to provide a case rate, rather than pure case number due to issues with bed day data, however we do know that this year there are an increase in inpatient bed spaces, increased patient numbers may account for the increase in C. diff cases in part.
- The IPC Team are visiting areas with Period of Increased Incidence of C diff and other organisms regularly to identify issues & support the teams to make improvements
- Actions to reduce bacteraemia rates are ongoing & forms part of IPC annual programme, it is positive to see that we have report 0 MRSA bacteraemia this year.
- We have continued to see more COHA cases than HOHA in gram negative bacteraemia, from 01/04/25-30/09/25, 73% of GNB have been COHA cases. The most common source of infection being UTI's without a catheter.
- Work is ongoing with the quality team and education team on management of urinary catheters.

Anticipated impact and timescales for improvement:

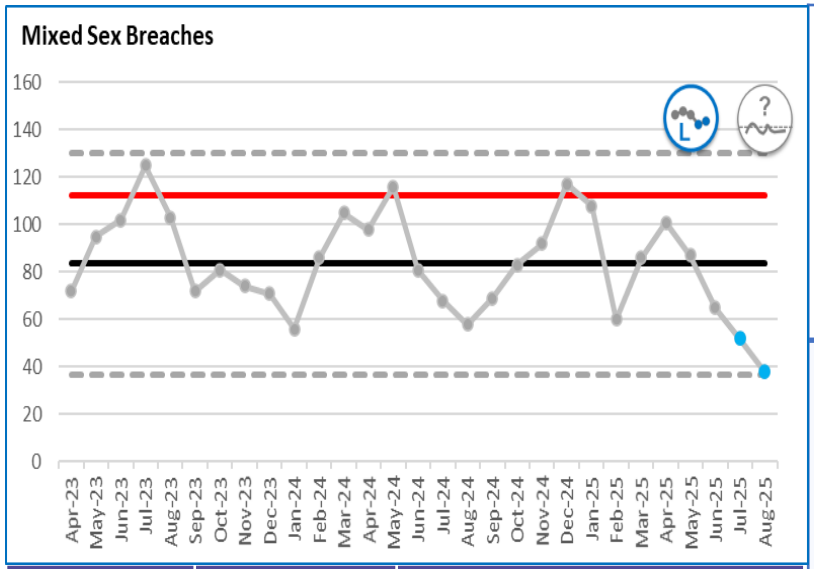
Anticipated improvements include a reduction in catheter-associated infections, improved patient outcomes, and greater adherence to best practice.
Initial changes should be seen within 1–3 months through targeted education, with measurable improvements expected over 3–6 months and sustained outcomes by 12 months.

Audit results to be escalated to Deputy Chief Nurse, to agree next steps.

Recovery dependencies:	Input from education /clear escalation processes & criteria for catheter insertion., review & removal. Staff engagement & compliance /support from ward managers & matrons.

Mixed sex accommodation breaches

The Shrewsbury and Telford Hospital NHS Trust



Summary:
There was a further decrease in August in Mixed sex breaches, there has been a month-on-month reduction since April 2025. Bed availability across the Trust and 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 overnight for patients requiring admission remains a challenge.
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.

Location	Number of breaches	Additional Information
ITU / HDU (PRH)	4 breaches	2 medical, 1 ENT, 1 gynae
AMA (RSH)	7 breaches	trolley area
ITU / HDU (RSH)	27 primary breaches	10 medical, 17 surgical

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 try to prioritise step down patients from ITU when this is possible
- All actions in place to ensure patients comfort and dignity is maintained when AMA/SDEC is used

Anticipated impact and timescales for improvement:

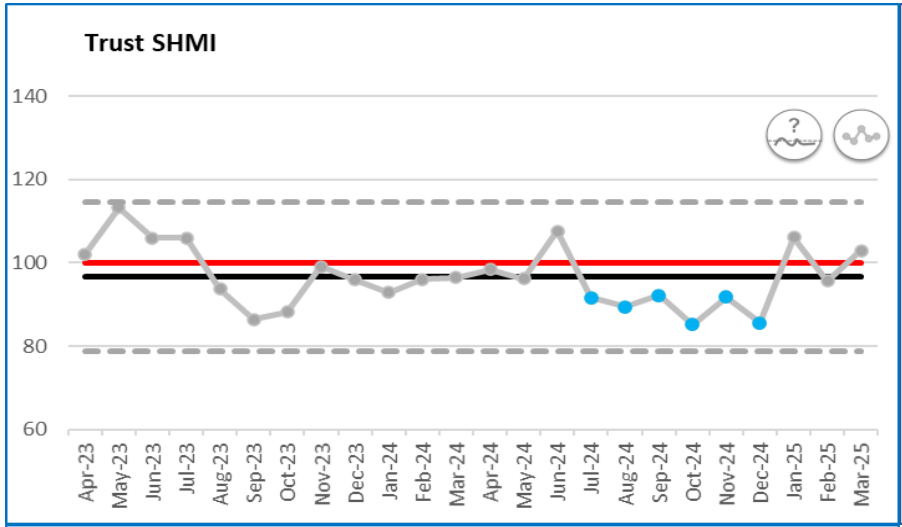
- Beds available earlier in day
- Less patients attending ED with conditions which could be treated on alternative pathways
- Reduction in no criteria to reside patients in hospital
- Patients cared for in the most appropriate environment to meet their needs

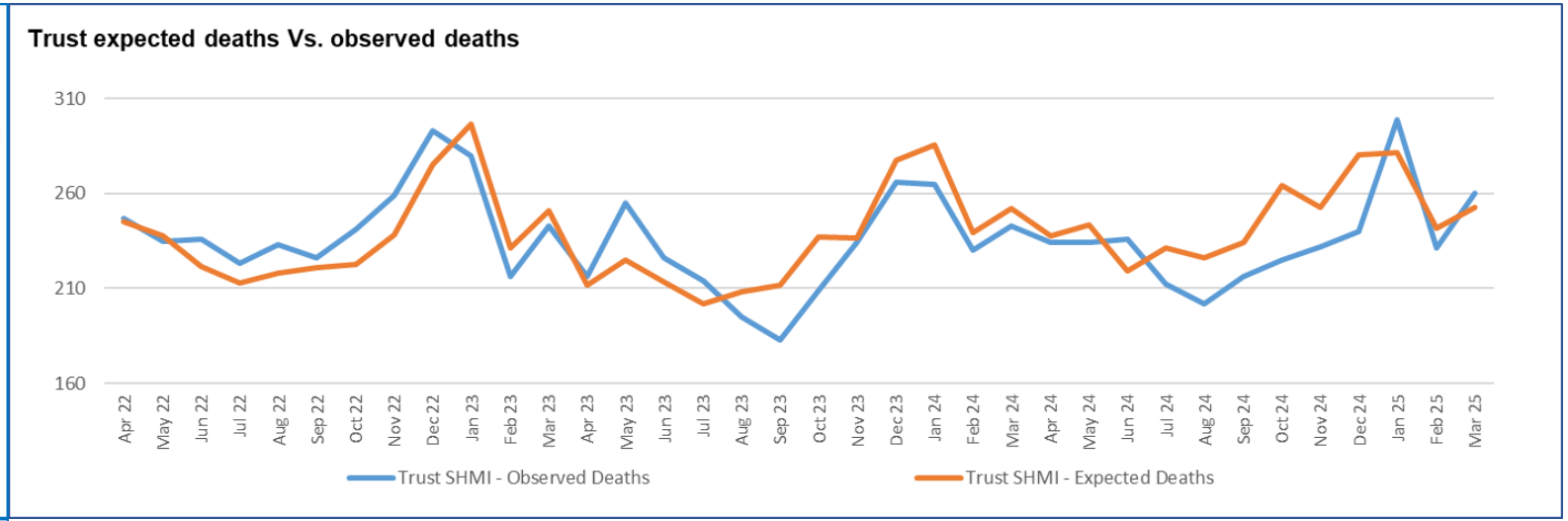
Recovery dependencies:

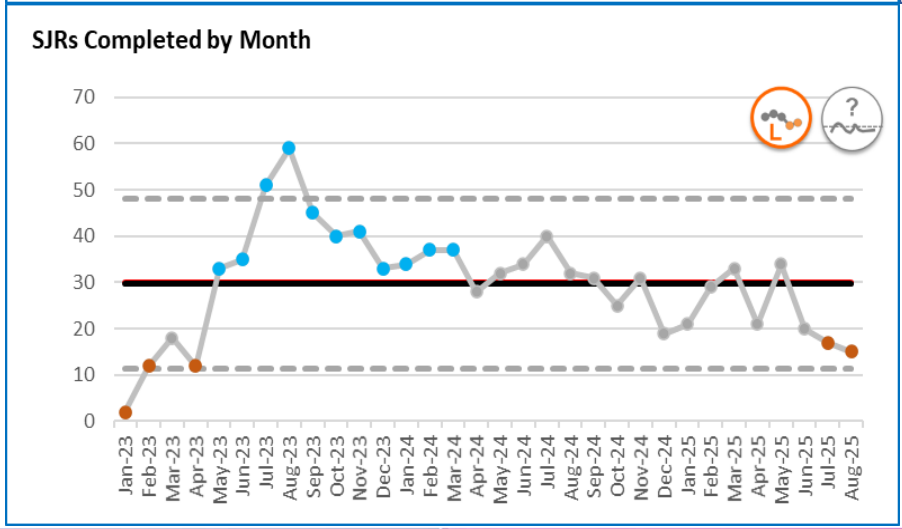
Patient flow improvement work.
System wide work and alternative community pathways of care.
Reduction in patients with no criteria to reside

Mortality outcome data

The Shrewsbury and Telford Hospital NHS Trust







Mortality outcome data

The Shrewsbury and Telford Hospital NHS Trust

Summary:

- Trust SHMI updates and benchmarking against the CHKS Peer Group continue to be unavailable. Despite Commissioning Data Set (CDS) submissions to Secondary Uses Service (SUS) recommencing in May, issues within the Data Warehouse persist preventing both the SHMI and wider metrics within the Learning from Deaths agenda being available within the Learning from Deaths Dashboard.
- Since the end of May 2025, the SJR medical reviewer substantive workforce has reduced by a third, following the retirement of one of the SJR reviewers. This has had a significant impact on the number of SJRs being completed by month - during Aug, only 12 SJRs were completed reducing the learning opportunities identified and the ability to identify themes and trends.

Recovery actions:

- In the continued absence of risk adjusted mortality (SHMI), internal crude mortality data continues to be reviewed as a standing agenda item in the monthly Trust LfD Group meeting
- Digital and Business Intelligence (BI) Teams are working through potential data quality issues within the CDS submissions, which could affect external reporting being produced by Hospital Episode Statistics (HES) data. This includes published SHMI data
- The Performance team are currently exploring the potential to replicate some of the metrics incorporated into the Learning from Deaths dashboard which have not been available since April 2024, through the internal Data Warehouse
- CHKS Representative liaising with the trust Digital and BI teams to support recovery
- Recruitment to the SJR Reviewer medical vacancy has been completed with 1PA split between two new Consultant SJR Reviewers. Both reviewers have commenced in post and will undertake SJRs following appropriate training

Anticipated impact and timescales for improvement:

- Whilst the Learning from Deaths team have been notified that no major issues with inpatient data have been identified to date, the published SHMI may be impacted by potential data quality issues within the CDS submissions. No timescales as yet have been provided to complete this work
- Awaiting timescales for confirmation that the internal data warehouse can be utilised to replicate some of the wider Learning from Deaths metrics in the Dashboard

Recovery dependencies:	Resolution of Data Warehouse challenges and subsequent availability of reliable Trust SHMI data and wider Learning from Deaths metrics.

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

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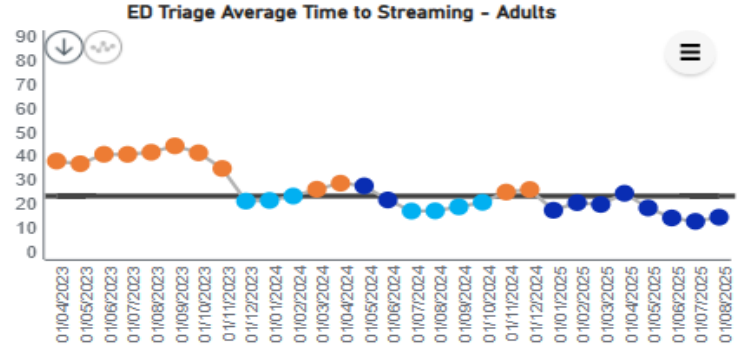
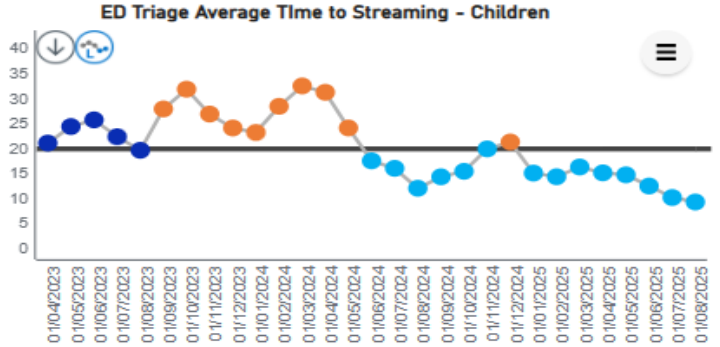
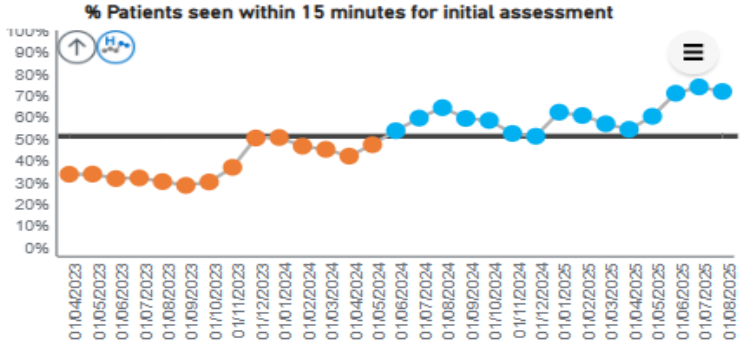
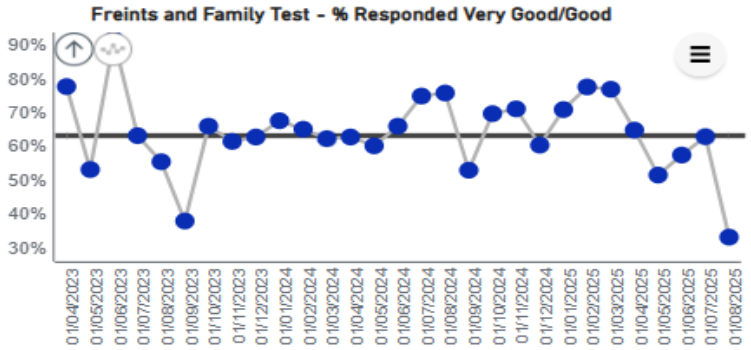
Best Clinical Outcomes

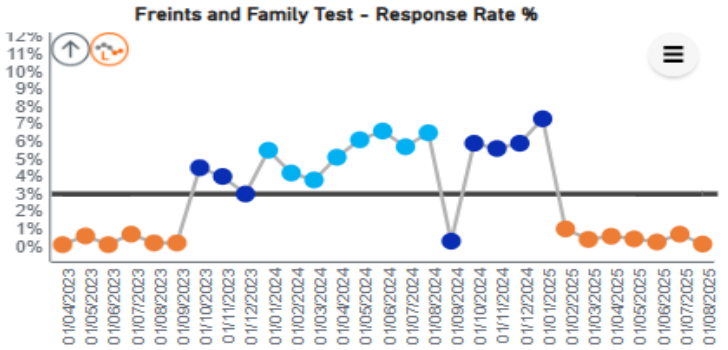
	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025
ED Triage Average Time To Streaming - Adults	27.70	21.79	17.11	17.20	18.90	20.80	25.10	26.17	17.46	20.65	19.90	24.58	18.42	14.22	12.78	14.52
ED Triage Average Time To Streaming - Children	24.10	17.50	16.00	12.00	14.30	15.40	19.90	21.29	15.04	14.31	16.27	15.09	14.69	12.45	10.14	9.24
% Patients seen within 15 minutes for initial assessment	47.70	54.14	59.99	64.80	59.80	58.90	52.90	51.61	62.71	61.18	57.35	54.77	60.80	71.44	74.37	72.25
Friends and Family Test - A&E - % responded Very Good/Good	60.30	66.10	75.00	75.90	53.10	69.80	71.20	60.50	71.00	77.70	77.00	64.94	51.67	57.58	63.00	33.33
Friends and Family Test - A&E - Response Rate %	6.10	6.60	5.70	6.50	0.30	5.90	5.60	5.90	7.30	1.00	0.40	0.58	0.43	0.25	0.70	0.14
Complaints by Theme - Admission / Discharge	14	17	17	22	18	16	17	18	14	18	20	25	16	18	25	27

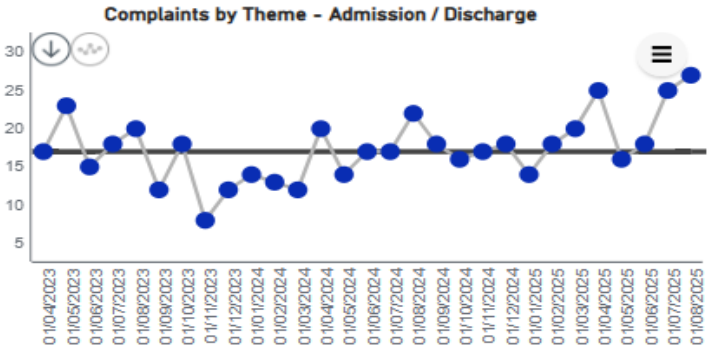












Our Vision: To provide excellent care for the communities we serve

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

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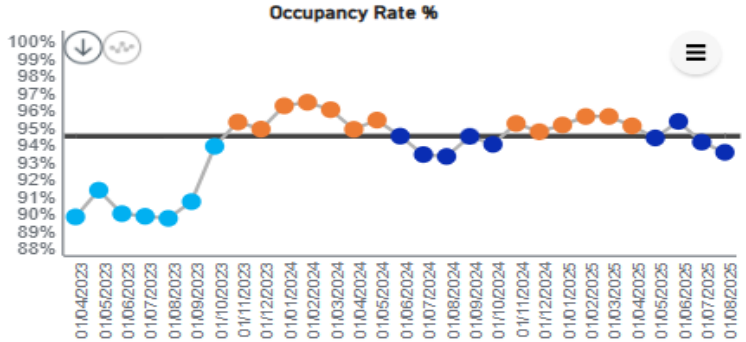
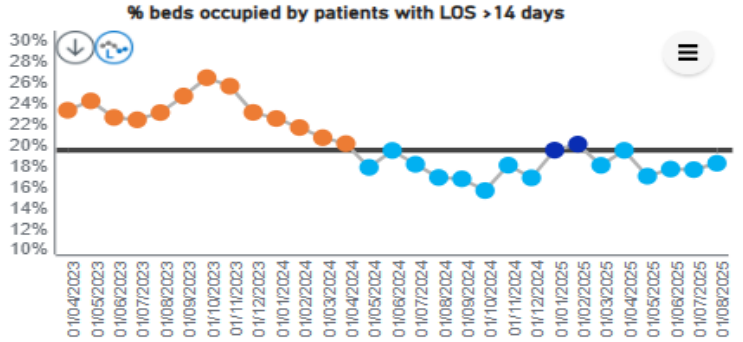
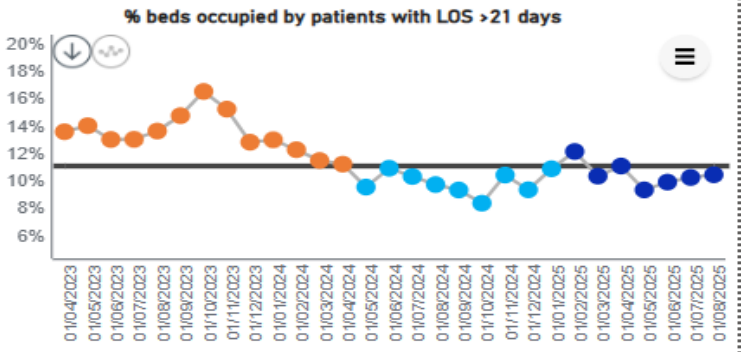
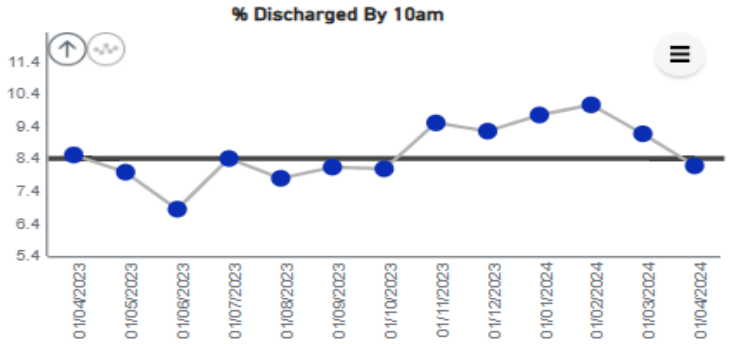
Best Clinical Outcomes

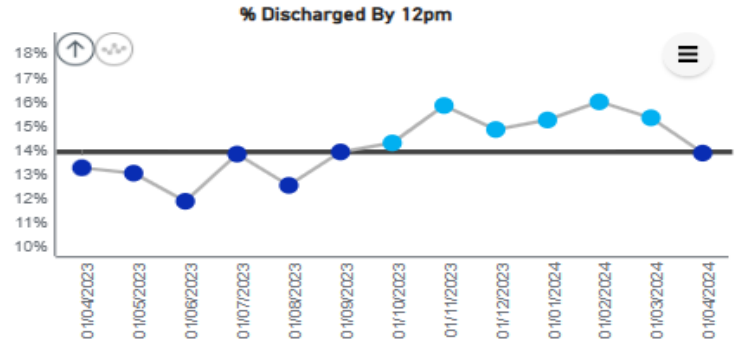
	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025
Occupancy Rate %	94.95	95.49	94.55	93.48	93.37	94.54	94.08	95.29	94.81	95.20	95.69	95.69	95.15	94.45	95.41	94.21	93.61
% beds occupied by patients with LOS >14 days	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	17.04	17.72	17.67	18.28
% beds occupied by patients with LOS >21 days	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	9.36	9.93	10.26	10.47
% Discharged By 10am	8.18																
% Discharged By 12pm	13.87																
No criteria to reside	114	112	114	106	92	89	101	117	102	104	113	94	95	99	100	101	99

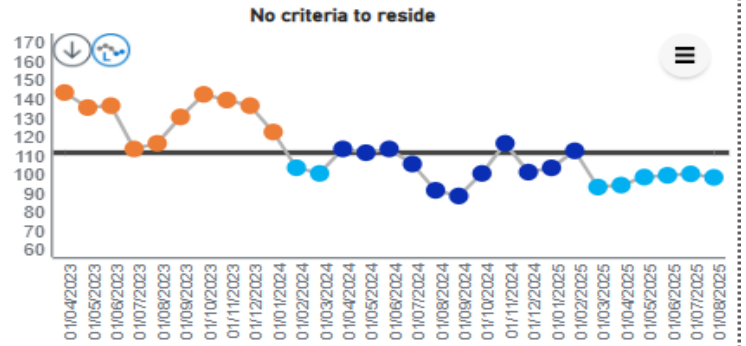












Diabetic foot

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 2025 revealed People with diabetes should have foot assessment within 6 hours of admission. 60% (improved from 10% 2024) 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. 67% (Improvement from 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 53% (improved from 13%) of high risk PWD were issued heel offloading.
Current wait time from referral to appointment is 1.28. More than 70% of new ulcers should receive first expert assessment within 0-13 days by 2026.

Recovery actions:

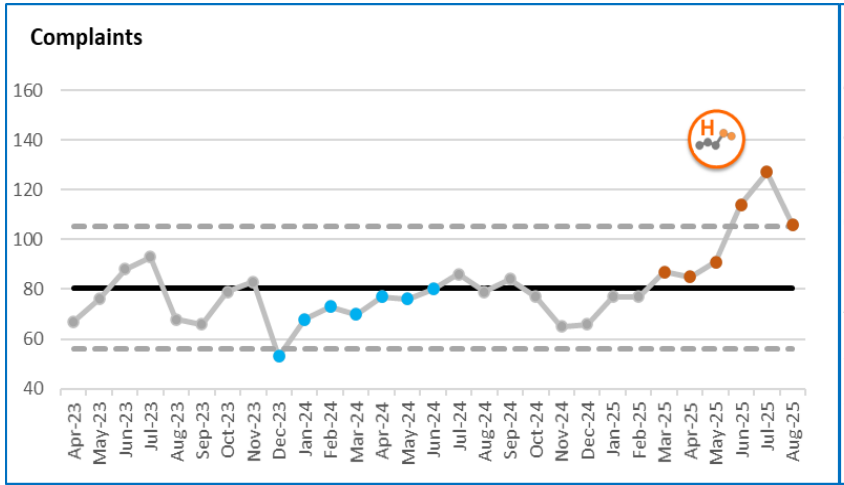
- Heel offloading available on ward – Heel boot available to order on wards – complete
- Hot clinics introduced for A&E and UCC for quick access to multidisciplinary team (MDT) clinic
- Quick access to outpatients with new diabetes foot complication's introduction of Hot phone complete
- Capacity to 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 & annual wound conference introduced
- Inhouse Diabetes Podiatry team (starts Nov 2025)
- 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)

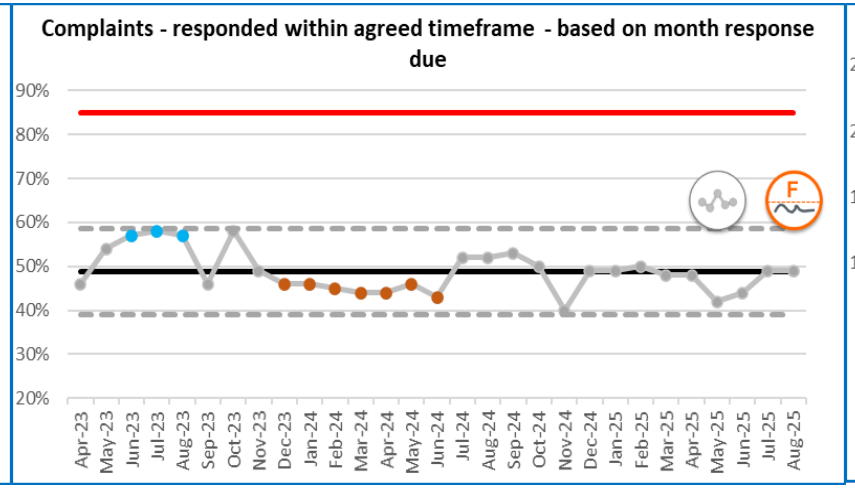
Anticipated impact and timescales for improvement:
Business Case agreed. Vacancies filled complete
Reaudit of inpatient data to show anticipated improvement in statistics nearing NICE guidance standards July 2025. Complete
Root Cause analysis of all diabetes foot amputations highlighting gaps in care and areas of improvement Sept 2025.
Audit of diabetes foot wound categorisation and reporting Sept 25
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

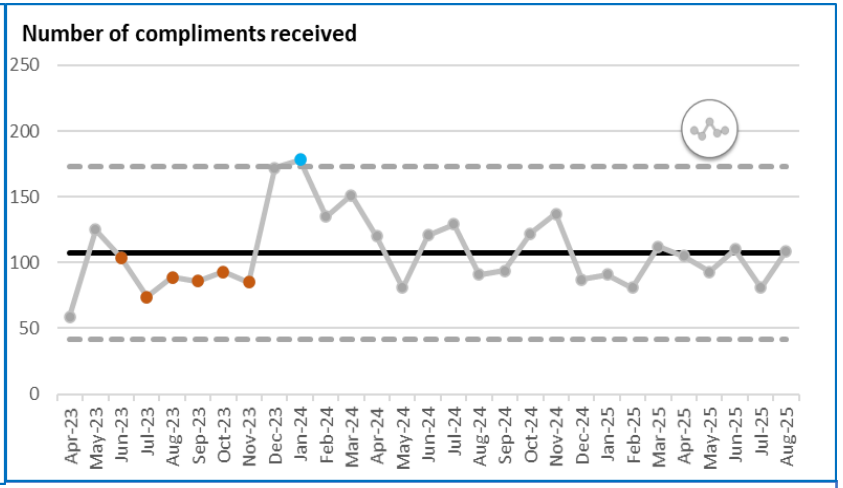
Recovery dependencies:	Business case for SaTH Diabetes Podiatry Team agreed Ownership of new documentation and education for diabetes foot at ward and matron level Diabetes foot screening must be undertaken in primary care, foot protection in community reducing clinical need in Acute service

Complaints and compliments

The Shrewsbury and Telford Hospital NHS Trust







Summary:
Numbers of new complaints dropped in August 2025 but remained above expected levels. As with previous months there are higher numbers in the emergency and acute areas. Other areas of concern are linked to known capacity issues. Work is ongoing to improve response rates.

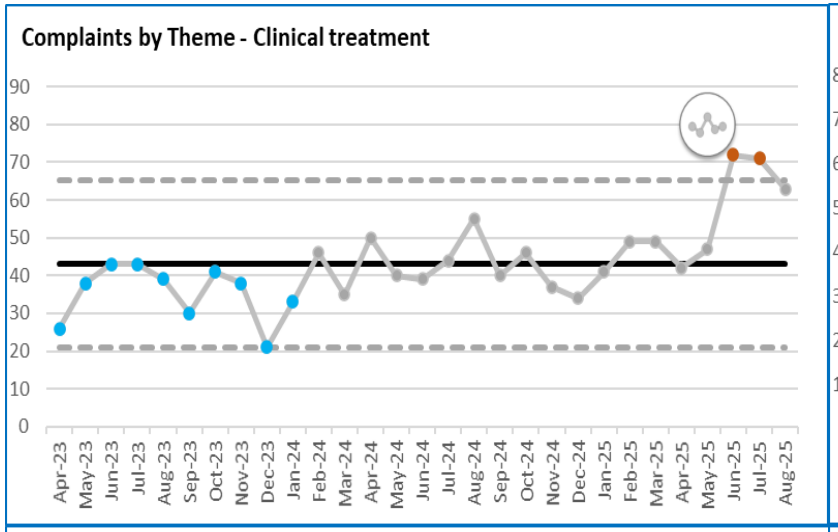
Recovery actions:
Dashboards on Datix give greater visibility of open cases for specialties.
Continue with weekly complaints review meetings with Divisional and Specialty Teams.

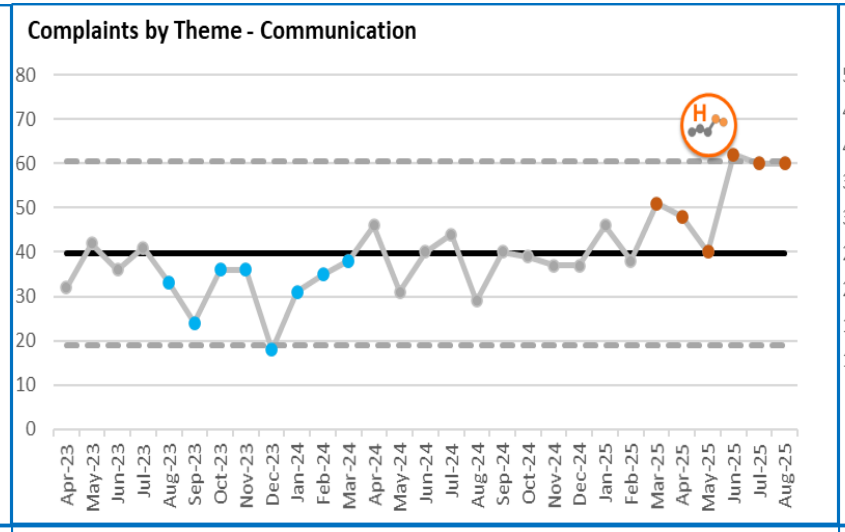
Anticipated impact and timescales for improvement:
Improvement in timeliness of responses.
Evidence of early involvement and support from Divisions/Specialities with complainants

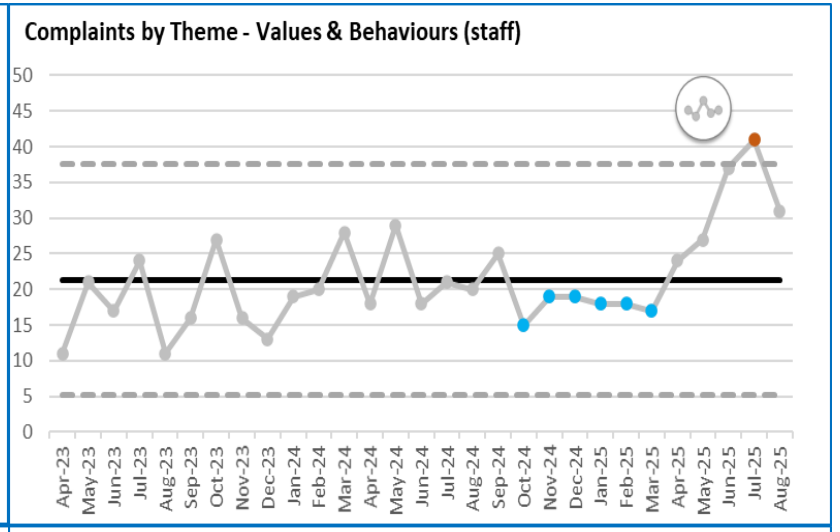
Recovery dependencies:	Capacity within Divisional teams due to high levels of clinical activity and recent increases in complaints. Delays in accessing records to respond fully to complaints

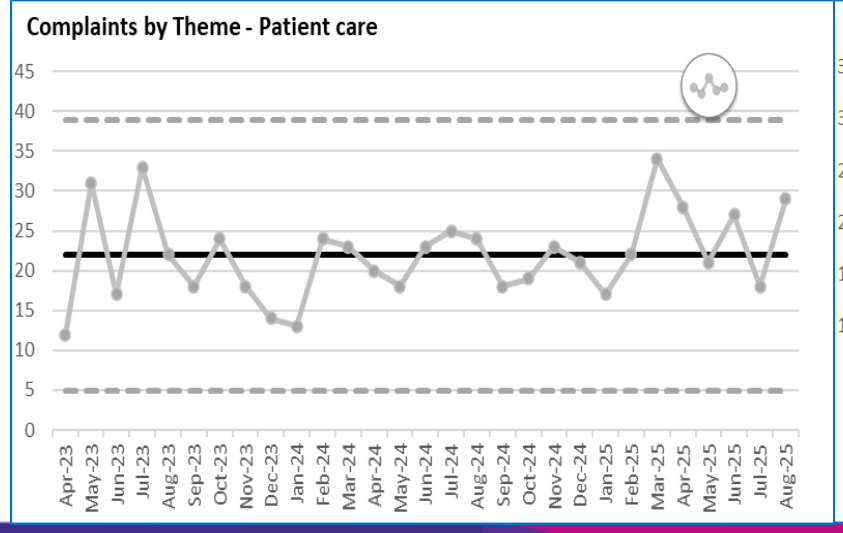
Complaints by theme – Top 6

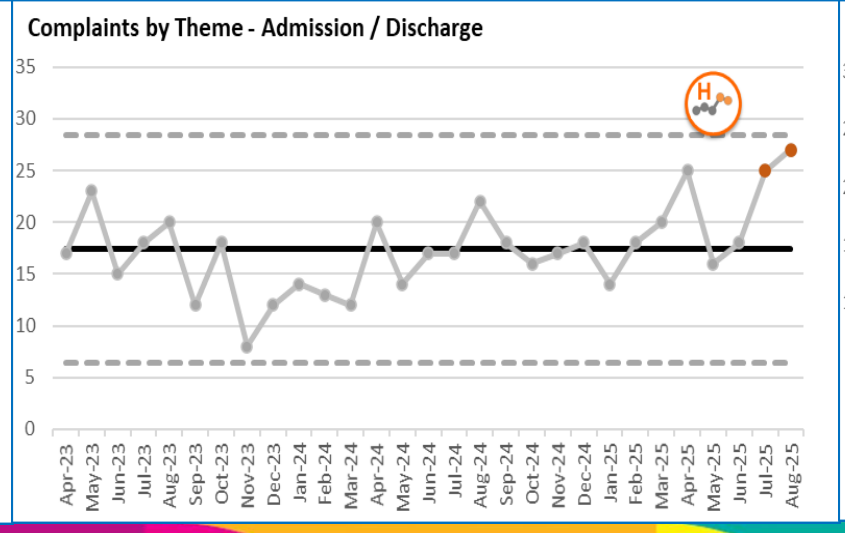
The Shrewsbury and Telford Hospital NHS Trust

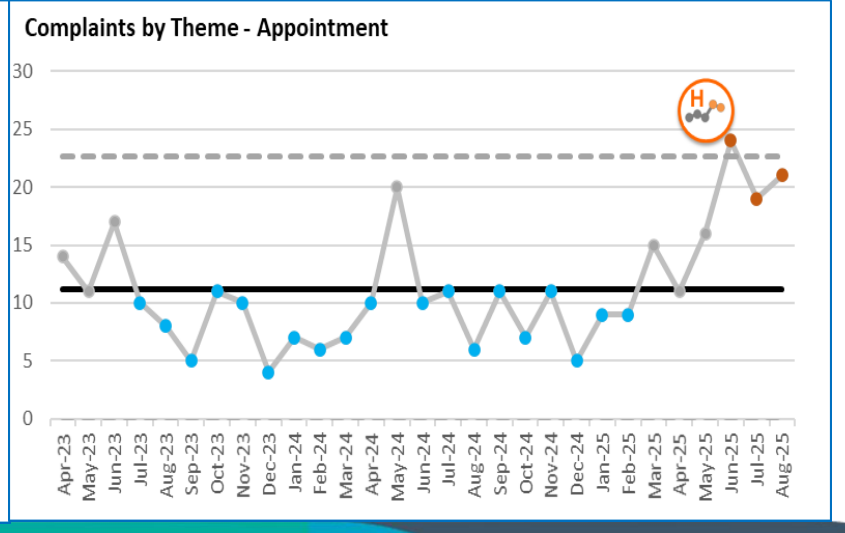












Partnering Ambitious Caring Trusted

VETERAN AWARE

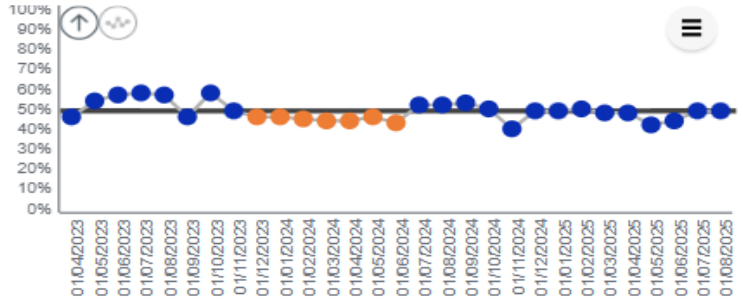
Our Vision: To provide excellent care for the communities we serve

Quality - Patient Experience - Learning from Experience

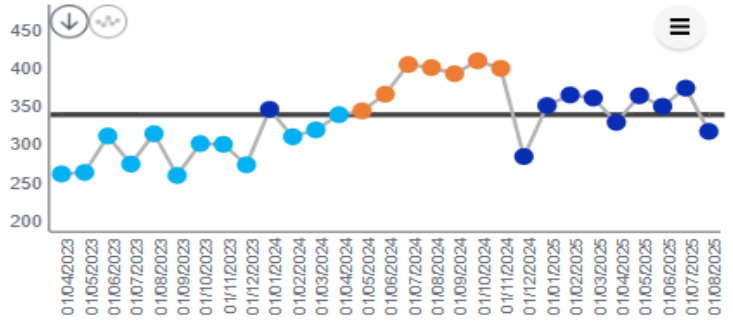
End of Life Care

	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025
Complaints - % Responded to within agreed timeframe based on month response due	52	52	53	50	40	49	49	50	48	48	42	44	49	49
PALS contacts	406	402	394	411	401	285	352	366	362	330	365	351	375	318
Complaints by Theme - Staff	79	55	73	57	67	59	74	66	76	79	78	115	108	106
Re-opened complaints upheld	0	0	0	0	1	0	0	1	0	0	0	0	1	0
Compliments Received	129	91	94	122	137	87	91	81	112	105	93	110	81	109
Friends and Family Test % recommenders	93.4	93.0	97.9	92.8	92.7	88.8	91.7	98.1	97.6	97.1	93.2	96.8	88.3	92.4

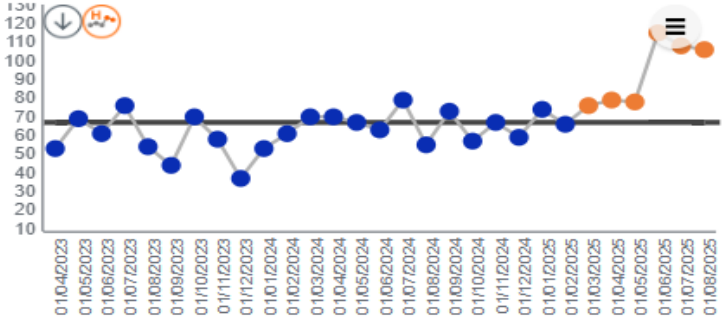
Complaints - % Responded to within agreed timeframe based on month response due



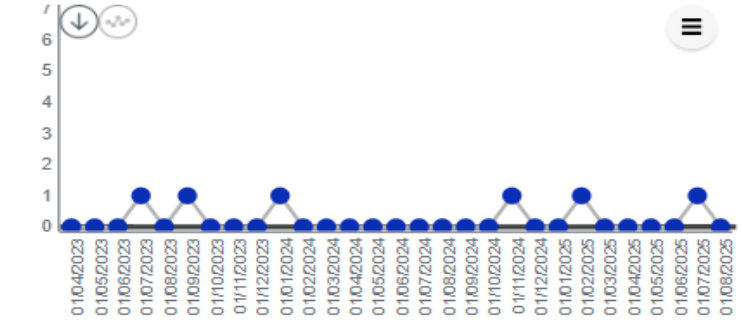
PALS contacts



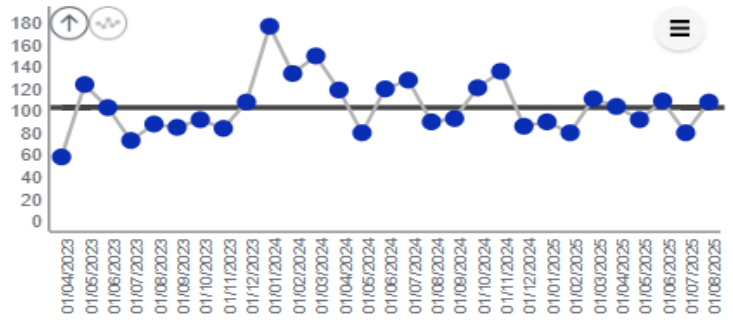
Complaints by Theme - Staff



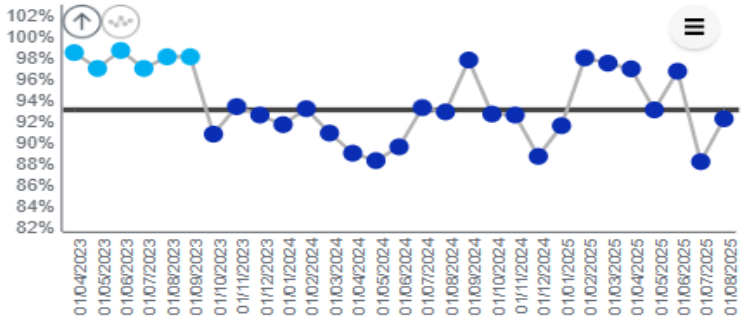
Re-opened complaints upheld



Compliments Received



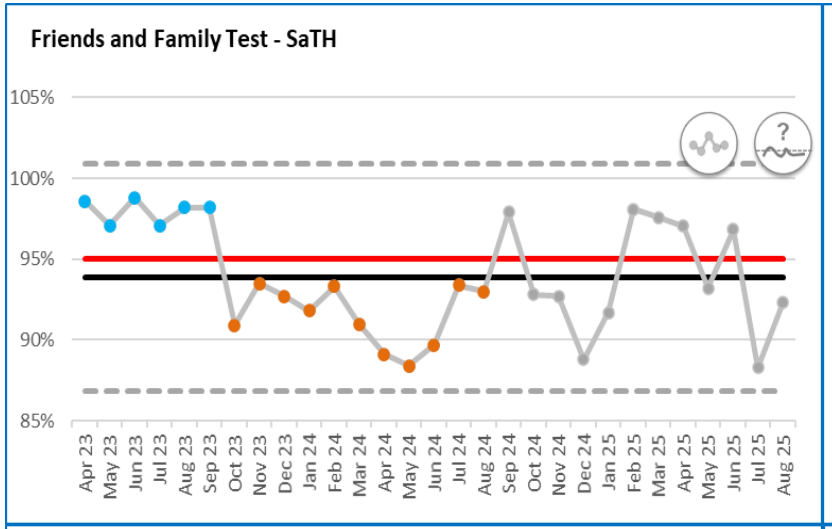
Freinds & Family Test % recommenders

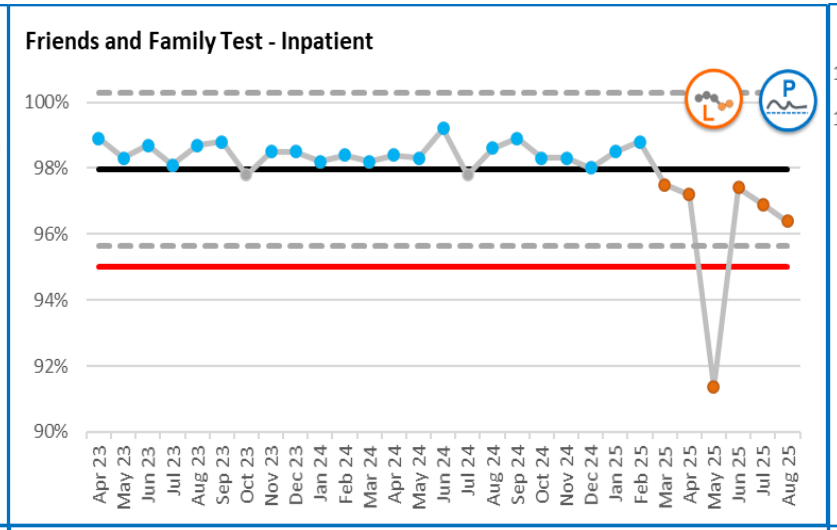


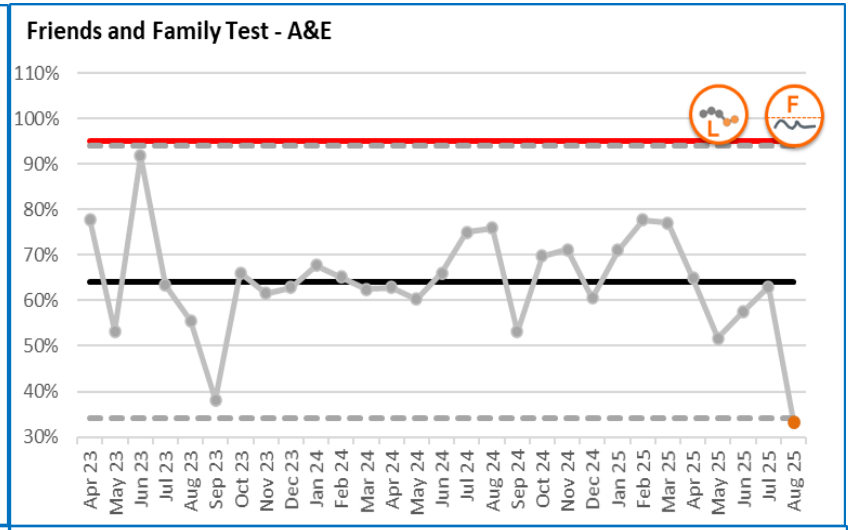
Our Vision: To provide excellent care for the communities we serve

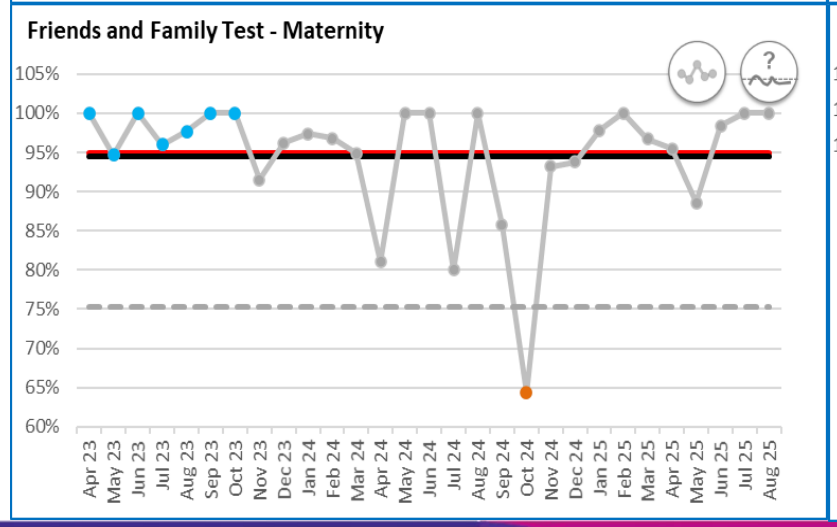
Friends and family test

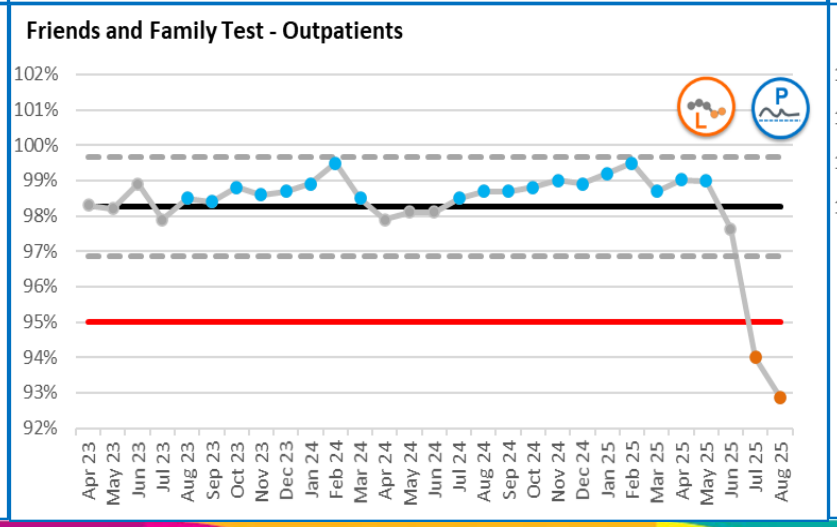
The Shrewsbury and Telford Hospital NHS Trust

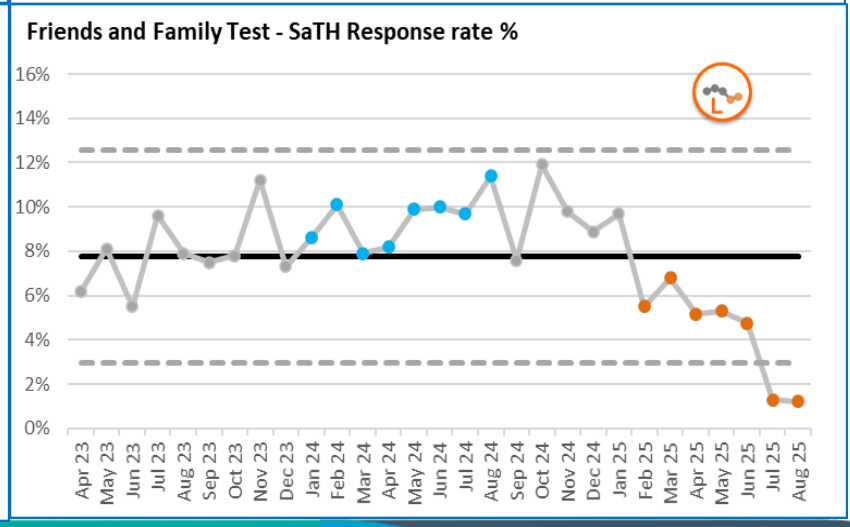




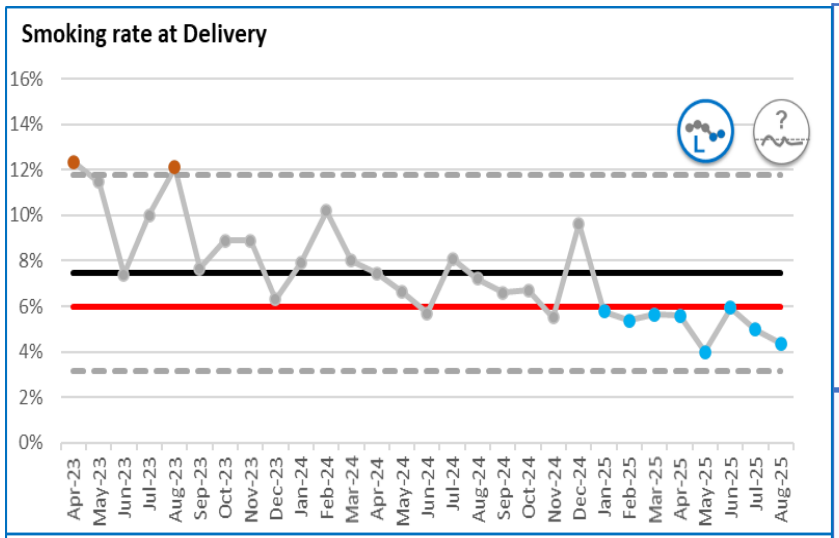


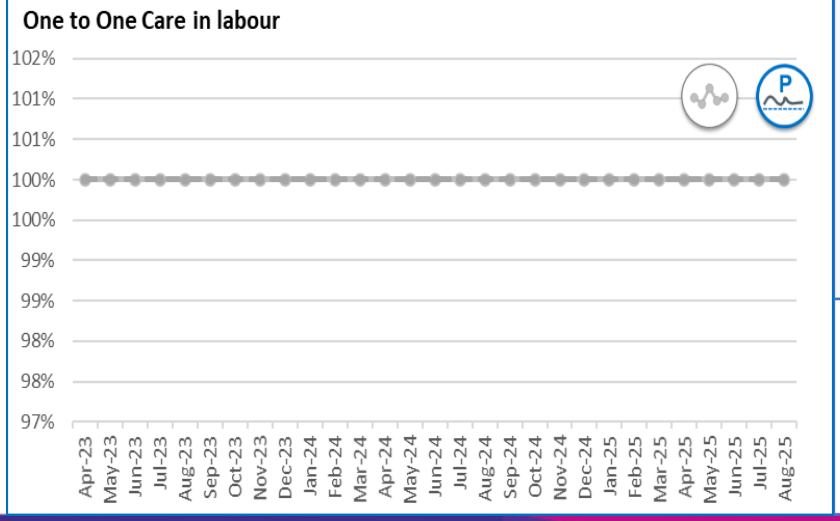






Maternity





Summary:
August data is reporting a 4.4% SATOD rate, which is well below the Government target of 6% and shows a further decline in rates for the Trust. The overall Trust SATOD rate for the financial year so far is 5%.
The overall SATOD rate for 2024/25 was 6.7% So far this year, the Trust is therefore exceeding Government targets. 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.

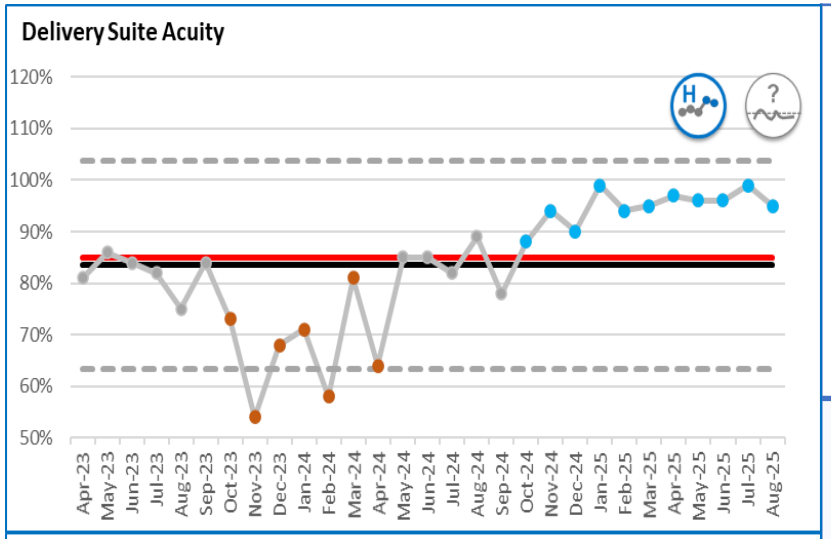
Recovery actions:
Continue to further decrease SATOD throughout 2025.
Continue to work towards and exceed or maintain Government target of 6%.
The team are now referring family members for quit support to Telford Council or Shropshire Social prescribing service where Nicotine Replacement Therapy is now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

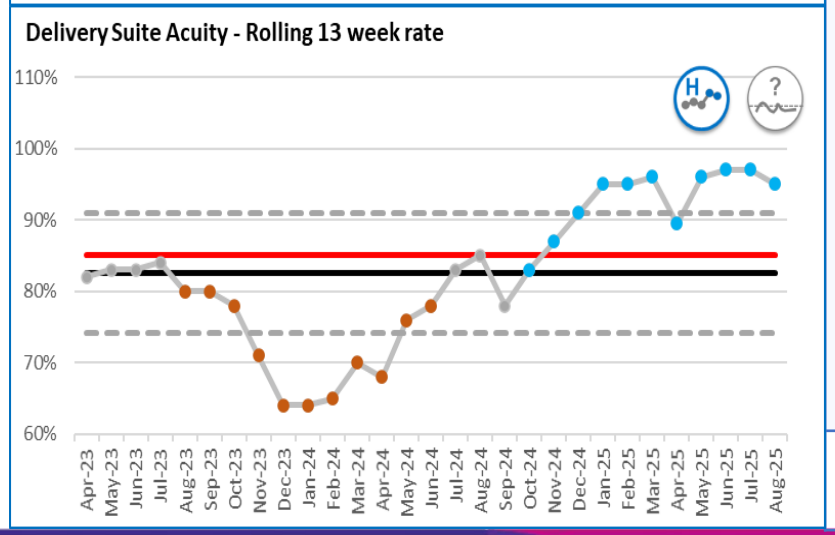
Anticipated impact and timescales for improvement:
Continue to map and target areas of deprivation and provide support for pregnant women, whilst referring family members to local smoking cessation services.
As per Saving Babies Lives version 3, all staff to discuss smoking cessation very brief advice (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:
The local demographic has higher than average deprivation, unemployment and complex social needs, which is linked to higher rates of tobacco dependence. However, SaTH figures are now reaching Government targets which demonstrates the value of the HPSS model and the health improvements they are supporting for local families.

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 July acuity of 99%. The service continues to experience higher 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 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.

Levels of unavailability continue to be anticipated which is mitigated with 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.

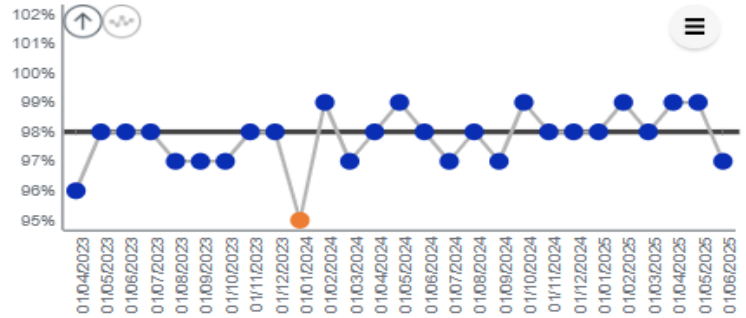
Quality - Patient Experience - End of Life Care

Page 2

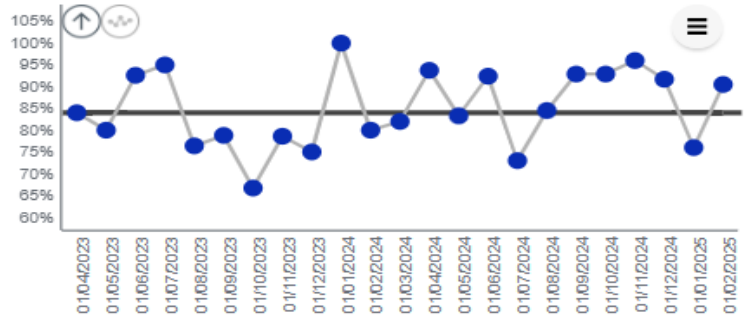
Learning from Experience

	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	May-2025	Jun-2025	Jul-2025	Aug-2025
Palliative and End of Life Care - Audit Score % Score	98	99	98	97	98	97	99	98	98	98	99	98	99	99	97		
% Overall rating of the PEoLC - Outstanding	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	94	92	94	107	92	115	96	109	92	131	79						
PPOC Achieved - total number	88	86	78	97	86	103	87	101	89	124	75						
% Felt their loved one was comfortable in last days	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	268	266	275	274	266	278	262	256	195	215	207	207	253	262	244	264	261

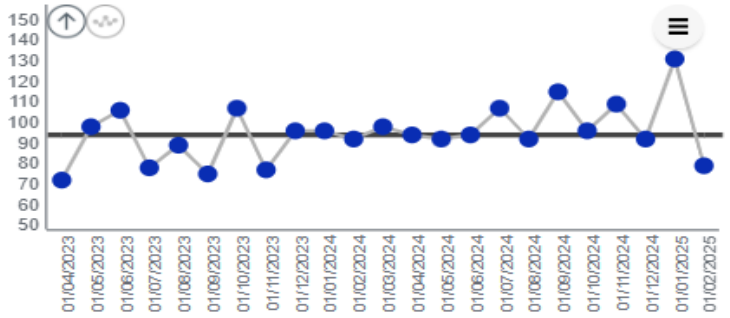
Palliative and End of Life Care - Audit Score % Score



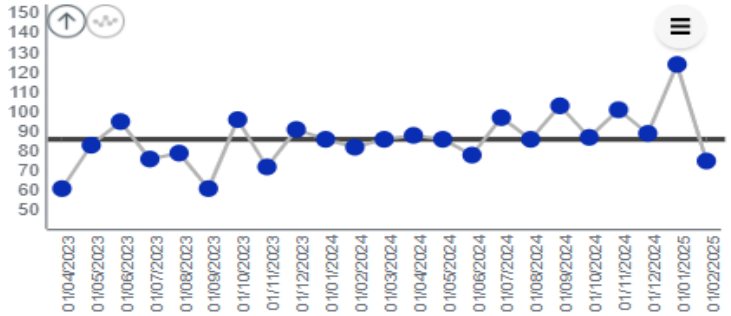
% Overall rating of the PEoLC - Outstanding



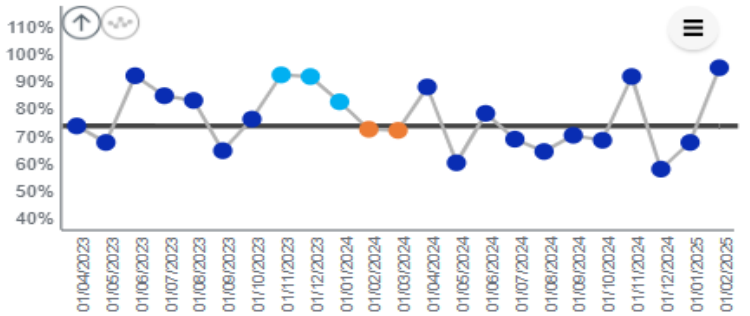
PPOC Discussion - total number



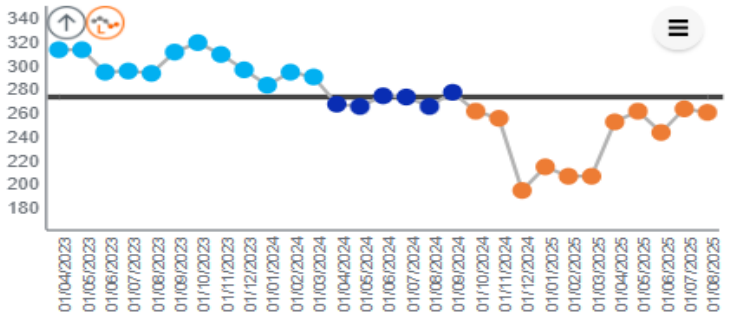
PPOC Achieved - total number



% Felt their loved one was comfortable in last days



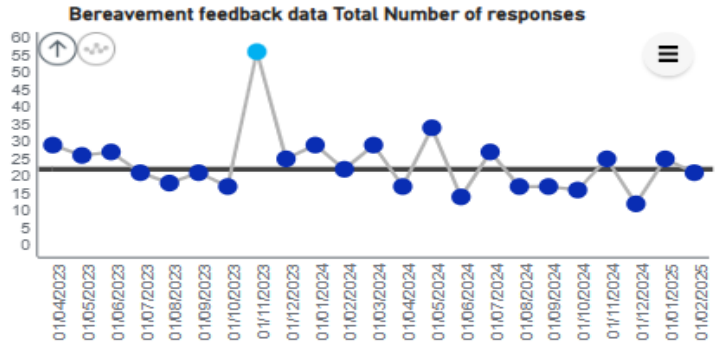
Palliative/End of Life Care - Nursing Quality Assurance Audit

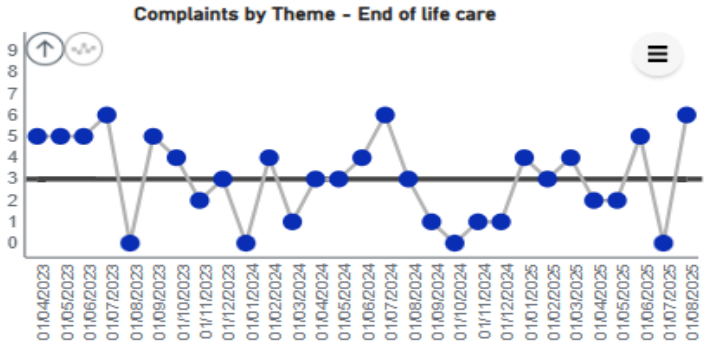


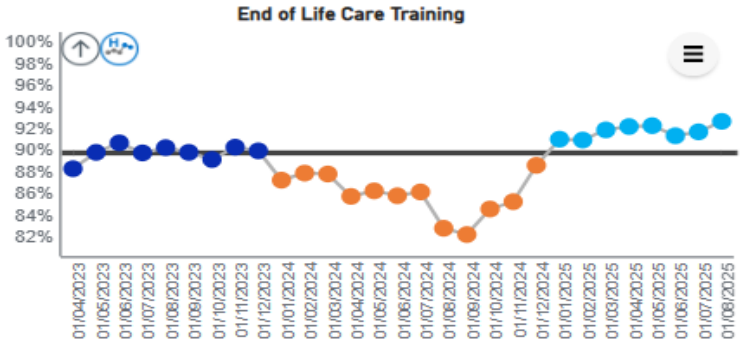
Our Vision: To provide excellent care for the communities we serve

Quality - Patient Experience - End of Life Care

	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	May-2025	Jun-2025	Jul-2025	Aug-2025
Bereavement feedback data - Total Number of responses	17	34	14	27	17	17	16	25	12	25	21						
Complaints by Theme - End of life care	3	3	4	6	3	1	0	1	1	4	3	4	2	2	5	0	6
End of Life Care Training	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	92.28	91.35	91.71	92.68







End of life

Summary:
Performance in relation to Palliative and End of Life Care (PEOLC) metrics remain good. Training is above Trust targets 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 relating to communication around end-of-life care continue. PEOLC ward support programme which supports wards with all aspects of PEOLC. Small number of patients included in the Nursing Quality Assurance audits can affect the results of these audits. Action to ensure all matrons in ward areas caring for PEOLC patients are completing audits is ongoing.	Ongoing monitoring via PEOLC Steering Group to ensure improvements are sustained

Recovery dependencies:	N/A

Mental health training

The Shrewsbury and Telford Hospital NHS Trust

Summary:

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

Recovery actions:

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

Anticipated impact and timescales for improvement:

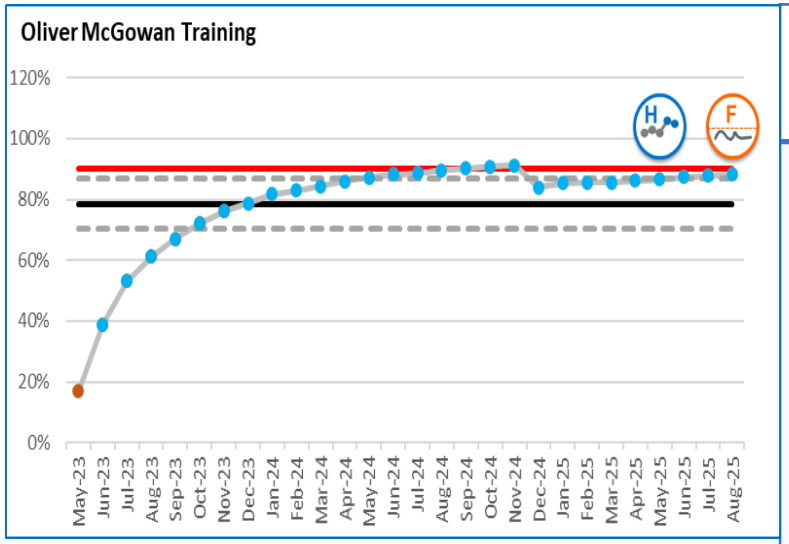
- Compliance with mental health triage- standards In line with Royal College of Emergency Medicine Mental Health Audit Standards for Individual Patients. Completion August 2025
- Scoping exercise for de-escalation, management and intervention completed by October 2024

Recovery dependencies:

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

Learning disability and/or Autism

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 e-learning training is at 86.30%
- Working at a system level for the best model to deliver T1 and 2 training in 2025/26
- LD awareness training sessions recommencing with priority cohort identified
- LD and Autism Patient Experience Group now meeting regularly
- Work ongoing to embed the patient passport and raise awareness of reasonable adjustments
- 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
- Full review and update of the LD policy underway including care pathways.
- LD Self Improvement Tool completed, and action plan formulated
- Targeted improvement work underway within ED
- Learning from incidents
- Strengthen the function of the LD and Autism Improvement Group

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 Tier 1 and 2 training sessions.

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)	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Trend
Responsiveness	ED - 4 Hour Performance (SaTH Type 1 & 3) %		78% Mar'26	55.4%	52.4%	52.4%	50.9%	50.4%	52.4%	52.6%	52.5%	47.0%	49.5%	53.0%	52.9%	52.1%	53.7%	
	ED - 4 Hour Performance (All Types inc MIU) %		-	-	62.2%	61.5%	59.7%	58.7%	61.8%	61.5%	61.4%	56.8%	59.2%	62.3%	62.9%	61.1%	63.4%	
	ED - 4 Hour Performance (SaTH Type 1) %		-	46.5%	43.2%	43.7%	41.9%	39.7%	42.6%	42.0%	43.6%	41.2%	42.5%	45.8%	45.7%	45.9%	45.8%	
	ED - 4 Hour Performance (SaTH Type 3) %		-	93.4%	92.7%	90.1%	89.8%	90.0%	91.7%	93.2%	90.2%	74.8%	79.3%	83.4%	86.0%	81.1%	87.8%	
	ED - 12 Hour Trolley Breaches	R	0	0	587	1060	1562	1494	1316	1130	1390	1362	1379	1334	1407	1300	1495	
	Number of Ambulance Arrivals	R	-	-	3094	3191	3050	3096	3186	2937	3451	3301	3489	3335	3484	3392	3041	
	Average ambulance handover time (ED and non-ED)		-	-	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	01:06:14	00:45:38	00:50:09	01:25:24	
	Ambulance handovers > 15 minutes	R	-	-	2538	2639	2576	2567	2562	2390	2799	2748	2692	2544	2509	2557	2489	
	Ambulance handovers > 15 minutes %	R	0%		82.0%	82.7%	84.5%	82.9%	80.4%	81.4%	81.1%	83.2%	77.2%	76.3%	72.0%	75.4%	81.8%	
	Ambulance handovers > 45 minutes				New Metric April '25									1227	884	932	1335	
	Ambulance handovers > 45 minutes %		0%		New Metric April '25									36.8%	25.4%	26.7%	43.9%	
	Ambulance handovers > 60 minutes %	R	0%		32.5%	36.0%	41.1%	46.5%	38.8%	34.7%	33.2%	38.5%	25.8%	29.5%	19.9%	20.7%	37.9%	
	ED activity (total excluding planned returns)		-	12729	12364	13067	12921	13308	11813	11533	13984	13251	13858	13552	13577	13242	12966	
	ED activity (type 1 excluding planned returns)		-	10308	10078	10615	10503	10478	9446	9131	11119	10931	11150	10883	11091	10809	10459	
	Total Emergency Admissions from A&E		-	-	3241	3469	3492	3445	3247	2899	3363	3142	3345	3266	3323	3381	3301	
	% Patients seen within 15 minutes for initial assessment		-		59.8%	58.9%	52.9%	51.6%	62.7%	61.2%	57.3%	54.7%	60.8%	71.4%	74.4%	72.3%	65.1%	
	Average time to initial assessment (mins)		15 Mins	15	18.0	19.6	23.8	25.4	16.9	19.5	19.9	23.0	17.6	13.8	12.3	13.6	16.3	
	Average time to initial assessment (mins) Adults		15 Mins	15	18.9	20.8	25.1	26.2	17.5	21.0	21.2	25.3	18.5	14.2	12.8	14.5	16.5	
	Average time to initial assessment (mins) Children		15 Mins	15	14.3	15.4	19.9	21.3	15.0	14.3	16.3	15.1	14.7	12.4	10.1	9.2	15.6	
	Mean Time in ED Non Admitted (mins)		-	215	288	292	310	325	320	307	314	345	321	304	291	292	293	
	Mean Time in ED admitted (mins)		-	500	1113	1106	1219	1337	1318	1252	1179	1332	1174	1189	1120	1091	1230	
	Percentages of attendances in A&E over 12 hours - Type 1		-	19.43%	23.43%	23.14%	24.83%	25.77%	24.61%	23.18%	23.30%	23.47%	23.35%	21.87%	21.57%	22.02%	23.6%	
	No. Of Patients who spend more than 12 Hours in ED - Type 1		-	2002	2361	2456	2608	2700	2325	2117	2591	2565	2604	2380	2392	2380	2464	
	Bed Occupancy Rate - G&A (SitReps)		92%	-	94.5%	94.1%	95.3%	94.8%	95.2%	95.7%	95.7%	95.2%	94.4%	95.4%	94.2%	93.6%	93.8%	
	Diagnostic Activity Total - All commissioners			-	22212	23688	22369	22160	23202	22623	24212	24021	24580	23930	25161	23367	24860	
	Diagnostic Total Waiting List - All commissioners			-	18482	17403	18374	18055	17493	16509	15738	13866	12511	11453	12013	11471	11634	
	Diagnostic 6 Week Wait Performance %		99% Mar'26	-	59.4%	59.1%	57.7%	53.6%	56.6%	71.7%	78.2%	78.5%	79.4%	82.2%	83.2%	81.8%	85.5%	
	Diagnostic 6+ Week Breaches		0	-	7509	7122	7771	8376	7524	4676	3437	2982	2577	2039	2016	2086	1692	
	Number of episodes moved or discharged to PIFU		-	2586	2247	2692	2378	1978	2299	2090	2300	2196	2203	2633	2627	2288	2523	
	RTT Incomplete 18 Week Performance		65% Mar'26	54.07%	42.3%	47.3%	48.5%	46.3%	48.2%	48.9%	48.1%	49.6%	53.0%	54.9%	56.4%	58.8%	62.3%	
	RTT Waiting list - Total size	R	-	-	53074	53214	53402	51652	49827	48383	46775	46242	44005	42449	39438	37137	36050	
	RTT Waiting list - English only		-	41297	47529	47713	47989	46254	44411	43218	41669	41238	39042	37630	34742	32670	31652	
	RTT 52+ Week Breaches (All)	R	0	-	4215	3666	3641	3557	3036	2493	1933	1778	1592	1103	734	586	374	
	RTT 52+ Week Breaches - English only		-	1125	3705	3118	3067	2971	2392	1987	1512	1312	1170	718	444	305	125	
	RTT 65+ Week Breaches (All)		-	-	662	503	538	396	374	173	115	166	139	114	98	97	105	
	RTT 65+ Week Breaches - English only		0	0	508	327	350	204	166	84	26	18	5	0	3	0	0	
	RTT 78+ Week Breaches (All)	R	0	0	64	59	83	62	50	25	29	34	30	33	27	35	19	
	RTT 78+ Week Breaches - English only		0	0	49	8	19	16	4	0	4	1	0	0	0	0	0	
	RTT 104+ Week Breaches (All)	R	0	0	1	1	0	0	0	0	1	4	3	1	1	1	1	
	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	61.3%	51.2%	55.4%	64.0%	63.3%	52.9%	54.7%	66.6%	56.6%	63.1%	62.6%	66.6%	68.8%	-	
	Cancer 31 Day First Treatment		96%	92.9%	85.5%	88.3%	89.6%	92.2%	88.5%	93.7%	96.6%	90.5%	88.2%	87.9%	94.7%	91.6%	-	
	Cancer 28 Day Faster Diagnosis - combined	R	80% Mar'26	72.9%	67.6%	70.4%	69.2%	66.7%	57.5%	65.1%	62.5%	68.6%	71.4%	72.5%	75.5%	75.9%	-	
	Theatre productivity			85%	77%	78%	80%	79%	80%	79%	78%	79%	79%	80%	81%	81%	81%	

Operational Summary

The Shrewsbury and Telford Hospital NHS Trust

SaTH ED 4-hour performance (type 1 & type 3) is showing common cause variation. Type 1 performance in September is 45.8%, and Type 3 87.8%. Average ambulance handover time shows common cause variation in September with 60.8% within 60 mins. The number of Type 1 patients who spend more than 12 hours in ED shows common cause natural variation.

RTT - The unvalidated Trust Position for September English is 0 x 104 weeks, 0 x 78 weeks 0 x 65 weeks and 0x 52 weeks for CYP. The unvalidated Trust position for Welsh is 1 x 104 weeks, 19 x 78 weeks and 86 x 65 weeks. 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 September remained steady at 81%.

Cancer - The combined backlog as at the end of September 2025 was 241 (decrease of 32 compared to the end of August). The confirmed August cancer performance is 75.9% (28-day FDS) vs the local plan of 72.9% and a national standard of 75%, the highest for 18 months. 62-day performance was 68.8% against a (local target 61.3% and a national target 85%) and 31 day was 91.6% (national target 96%). The Trust are currently delivering above plan for all cancer metrics for September.

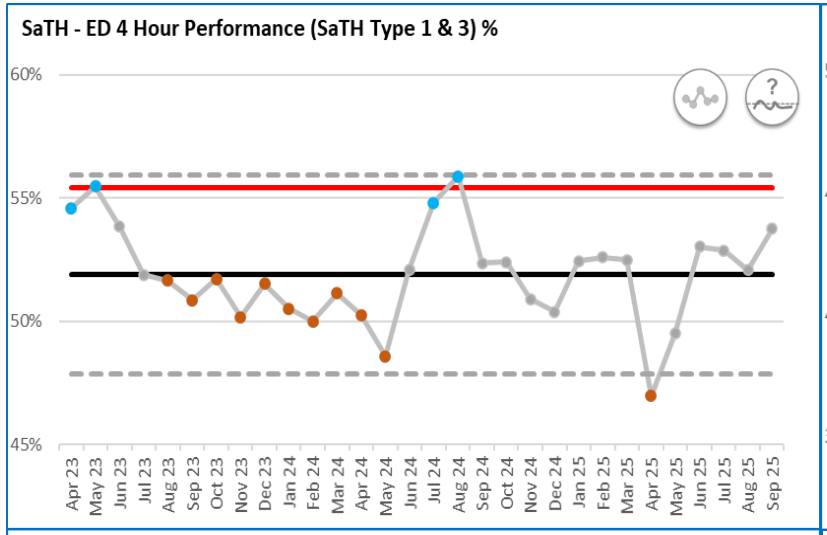
DM01 - The submitted DM01 position for September was 85.3%, an improvement of 3.5%. Radiology turnaround times are being maintained. TATs from referral to report for USC are:- CT 1-2 weeks, MRI 1-2 weeks and NOUS 1-2 weeks.

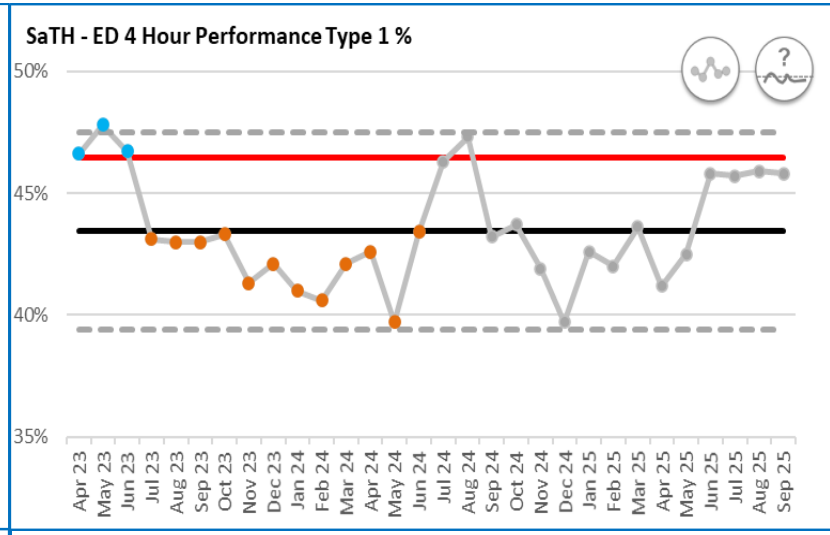
Key actions

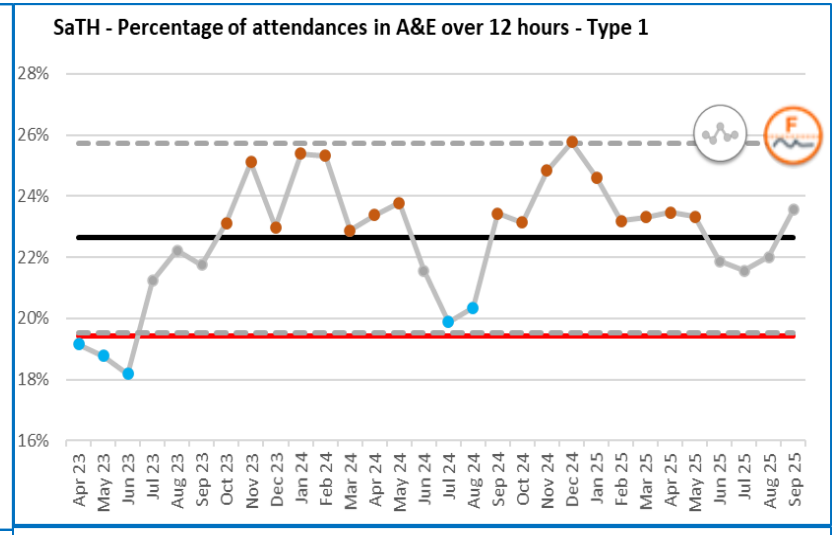
- Test of change in Minors, focussing on medical input and AMA, to improve flow
- Mobilising additional independent Sector provider activity and mutual aid for elective and cancer recovery
- Outpatient productivity project concluded with a 3-4% increase in booking utilisation seen across chosen specialties
- Elective recovery programme continues to deliver at a high level of performance
- Validation sprint in process – leading trust in Midlands region

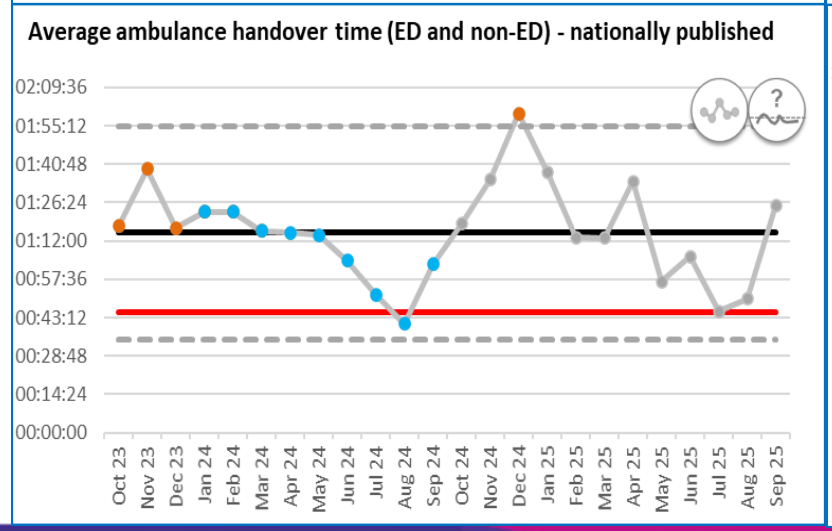
Operational – Emergency Care

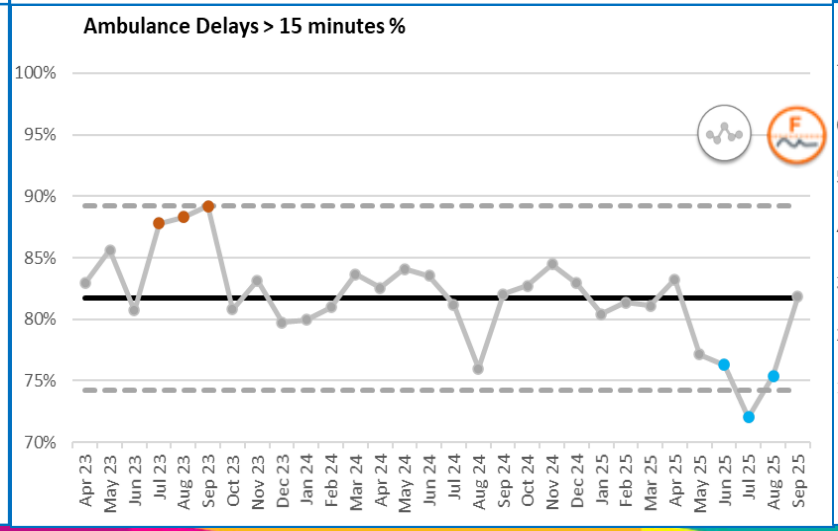
The Shrewsbury and Telford Hospital NHS Trust

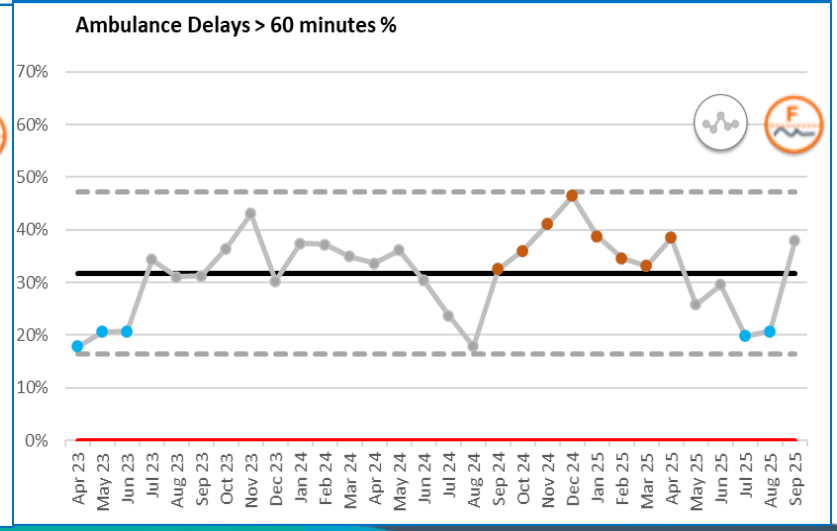












Operational – Emergency Care

The Shrewsbury and Telford Hospital NHS Trust

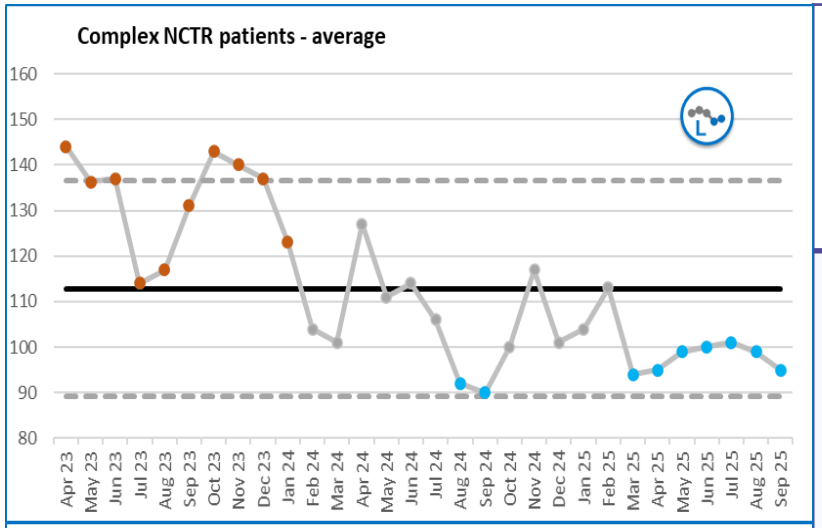
Summary:

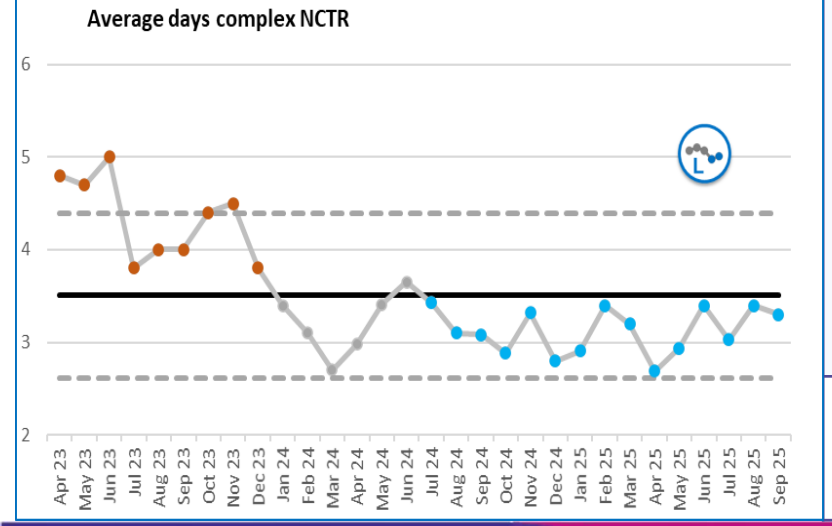
- SaTH ED 4-hour performance (type 1 & type 3) % is showing common cause variation in September 25
- SaTH number of patients who spend more than 12 hours in ED is showing common cause natural variation
- Number of ambulance arrivals to SaTH is showing common cause natural variation, with ambulance conveyances decreasing in September
- Average Ambulance handover of patients to SaTH premises shows common cause variation in September with 60.8% within 60 mins

Recovery actions:	**Anticipated impact and timescales for improvement:**
• 25/26 plan agreed to reach 55 minutes mean ambulance handover performance by March 2026 • Health Hero Cat 3 Validation from w/b 25/08/25 to support reduction in conveyances • 12 hour/4-hour performance: Implementation of additional domiciliary care supporting reduction in length of stay (LoS); 25/26 increase streaming of patients to SDEC increasing 0-day LoS; UTC pathway optimisation; implementation UEC recovery plan PRH providing +9 Inpatient Beds, +23 Assessment Spaces and +8 Assessment Unit Beds; implementation of two Modular wards on the RSH site by end of calendar year; system wide 25/26 schemes including integrated community front door; expanded UCR to midnight; additional discharge planning capacity	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





Summary:

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

- **Recovery actions:**

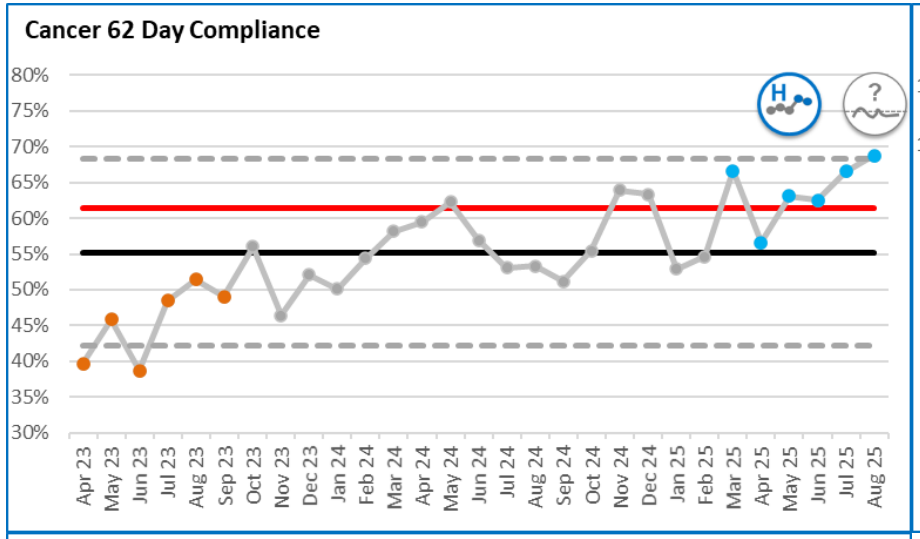
- Focus on accurate Estimated Discharge Date (EDD) to refer into Community Transfer Hub (CTH) 5 days prior to EDD to enable CTH to work up patient for discharge on EDD
- Improvement programme focusing on process for out of area patients to be repatriated to their nearest hospital
- Improvement programme 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
- Rolling schedule of Deep dives by MEC Matrons with
- TOC with centralised patient flow co-ordinators ongoing until mid November.
- Daily monitoring of out of area patients

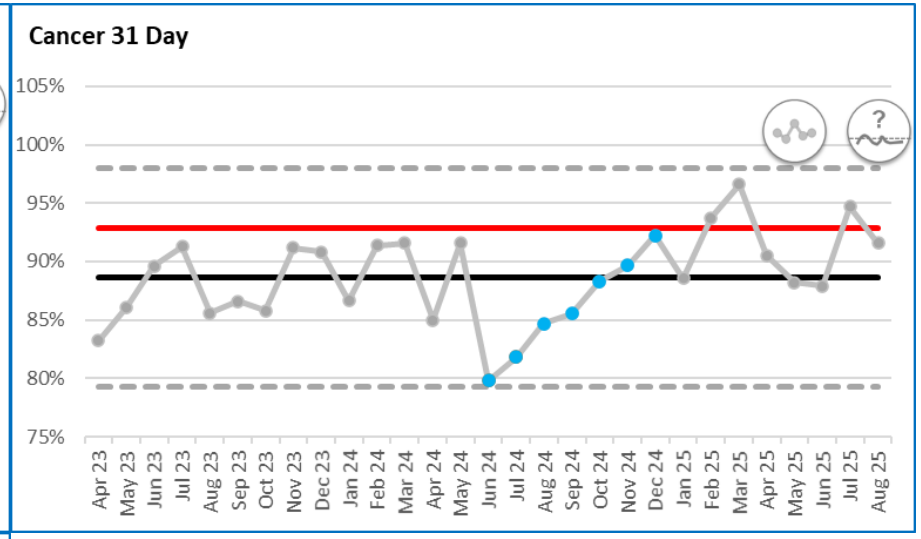
Anticipated impact and timescales for improvement:

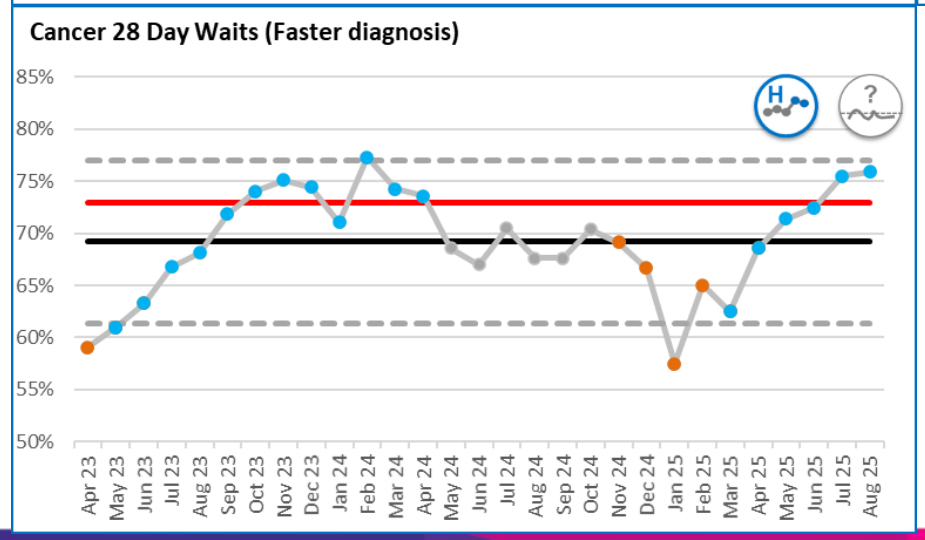
Progress reported monthly through UEC Flow improvement group to Performance Assurance Committee (PAC) and system UEC meeting.

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 combined backlog as at the end of September 2025 was 241 (decrease of 32 compared to the end of August). Confirmed August cancer performance is 75.9% (28-day FDS) vs the local plan of 72.9% and a national standard of 75%, the highest for 18 months. 62-day performance was 68.8% against a (local target 61.3% and a national target 85%) and 31 day was 91.6% (national target 96%). The Trust are currently above plan against all cancer metrics for September.

Recovery actions:
The Trust is now in Tier 2 NHSE monitoring for cancer due to improved performance.

Additional cancer improvement expertise and senior leadership oversight is in place to drive improvement against the cancer waiting times standards. Recruitment has been successful to the cancer clinical lead role; a full triumvirate leadership team is now in place. Our cancer improvement plan is driving the required improvement to deliver the 25/26 plan. Phase one of the plan remains focussed on three workstreams: cancer governance, cancer imaging turnaround times and three high priority tumour sites Lower GI, Urology and Gynaecology. Improvement is clear. We have lifted ourselves out of the bottom quartile nationally for 28-day faster diagnosis standard and 62-day cancer standard, having been bottom decile in both last year. Our 28-day FDS performance in August was best for over 18 months, our 62-day RTT performance was the best performance since the combined measure began, and we have the lowest number of over 62-day patients for four years. Phase two of the cancer improvement plan is in progress and is focussed on delivering highest opportunity improvements relating to reducing pathway length and increasing performance to over 70% against the 62-day target.

Clinical and operational workforce constraints continue most notably in Oncology and Max Fax pathways. Whilst oncology outpatient waiting times and radiotherapy waiting times have improved the fragility of the Max Fax pathway remains a risk. Mitigations are in place, including partnership working with a neighbouring Trust and insourcing additional capacity.

Anticipated impact and timescales for improvement:

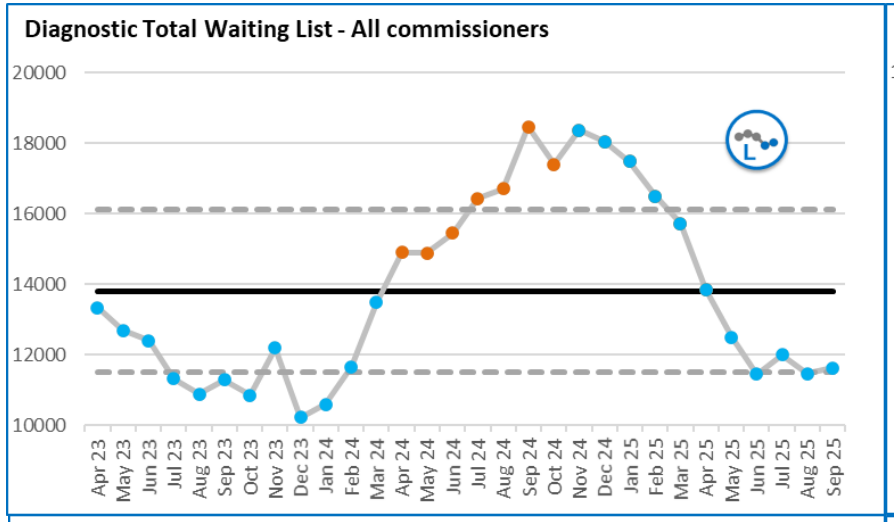
Phase one improvement plan to deliver operational plan as at end of Q2.

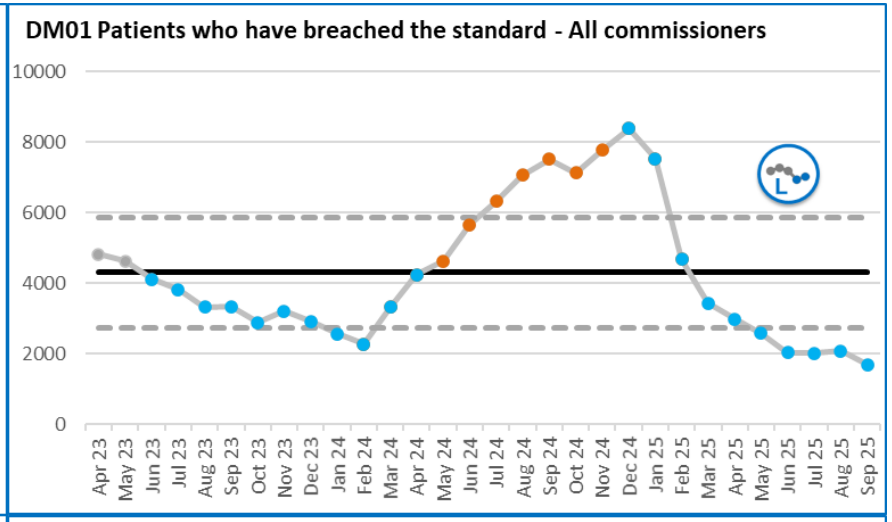
Phase two improvement plan to deliver operational plan as at end of Q4.

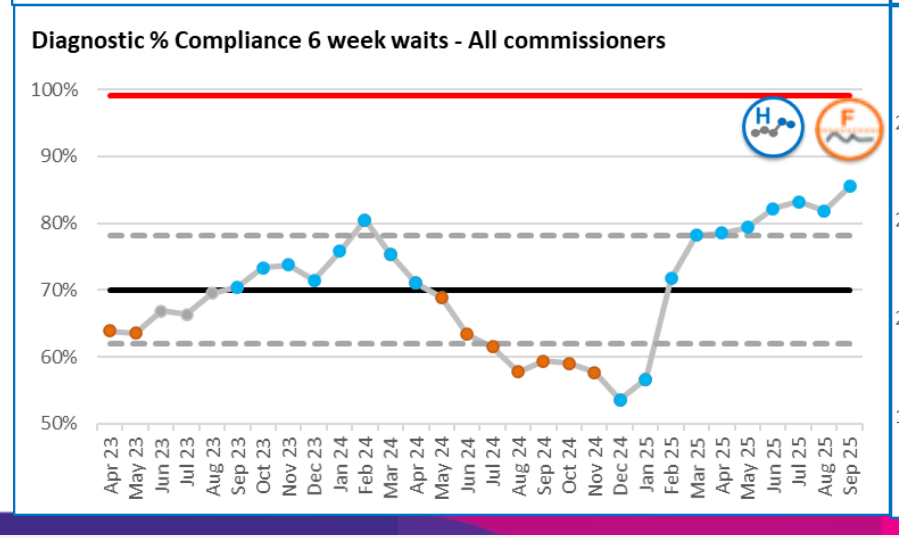
Recovery dependencies:	WMCA funding of approx. 1.7 million allocated to drive diagnostic cancer turnaround times for 25/26. Radiotherapy recovery plan.

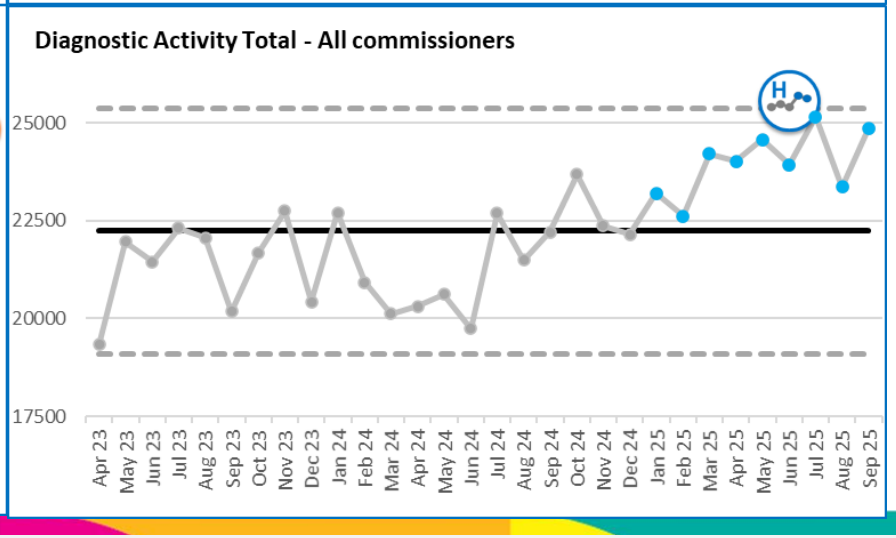
Operational – Diagnostic waiting times

The Shrewsbury and Telford Hospital NHS Trust









Operational – Diagnostic waiting times

The Shrewsbury and Telford Hospital NHS Trust

Summary:
The submitted DM01 position for September was 85.3%, an improvement of 3.5%.
Radiology turnaround times are being maintained. TATs from referral to report for USC are:- CT 1-2 weeks, MRI 1-2 weeks and NOUS 1-2 weeks. Radiologist workforce continue to restrict capacity for reporting, with reduced resilience during periods of sickness or annual leave, however we now have another outsourcing provider for reporting to provide more flexibility.

- 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
- A mobile MRI unit is on site and continues 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. It is anticipated that there will be 0 13+ww in NOUS by the end of September
- DM01 performance for MRI and NOUS has exceeded 90% since July
- 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

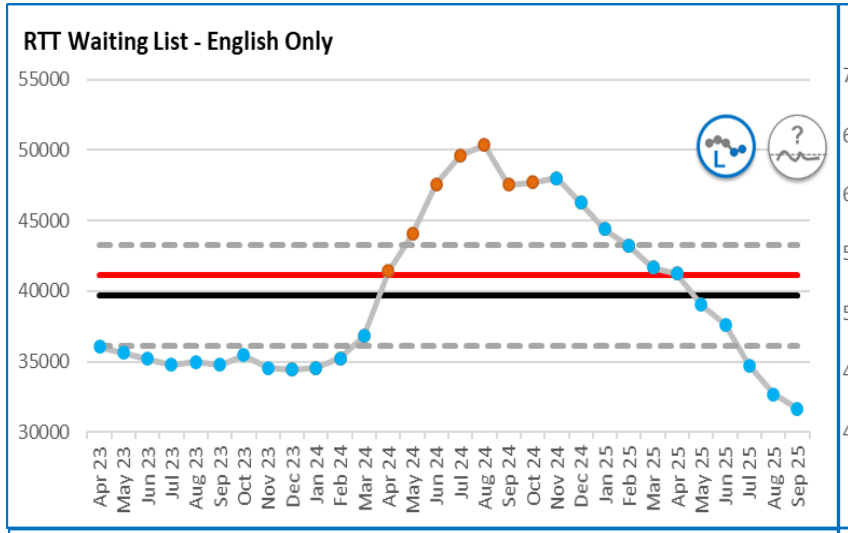
Recovery actions: Outsourced reporting continues to provide additional capacity supporting MRI and CT turnaround times. Enhanced payments and WLIs are encouraging additional in-house reporting sessions across all modalities.
MRI performance has improved significantly, with a small number of Cardiac scans remaining outstanding over 13 weeks. A mobile van is operational to increase scanning capacity and support with cancer performance, which has improved significantly since March for MRI.
NOUS training posts have been increased from 2 to 4. An additional NOUS scanning room has been operational since 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.

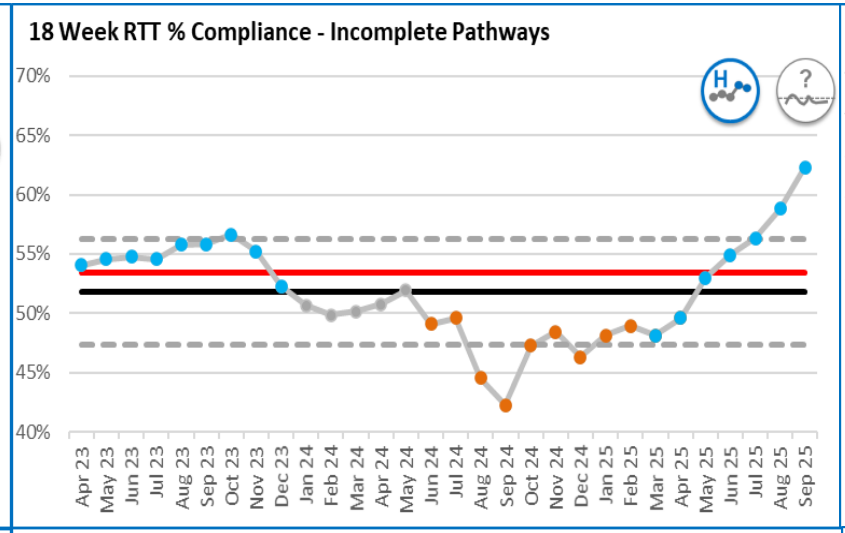
Anticipated impact and timescales for improvement:
Additional insourcing from '18 Weeks' to support endoscopy DM 01 at weekends has been supported through the ERF. It There is ongoing recruitment for radiologists, radiographers and sonographers.

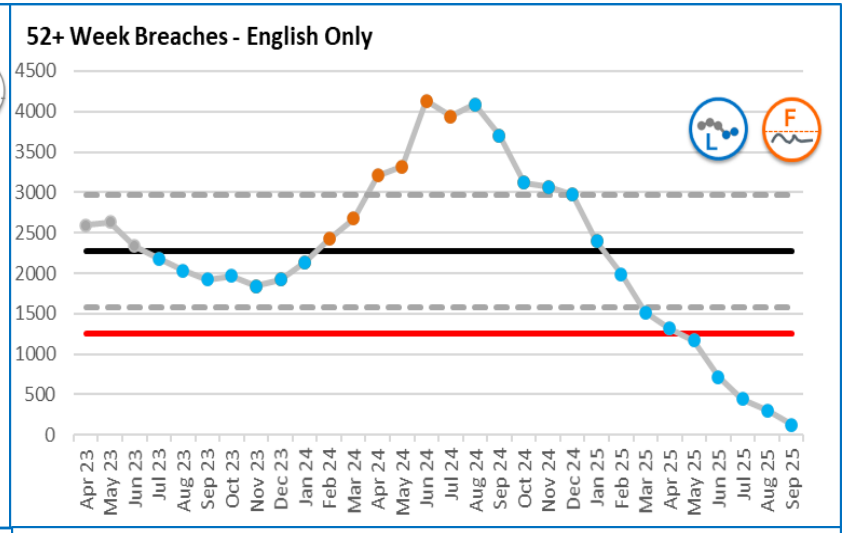
Use of insourcing for USS and MRI is proving successful with DM01 continuing to improve towards the target of 99%

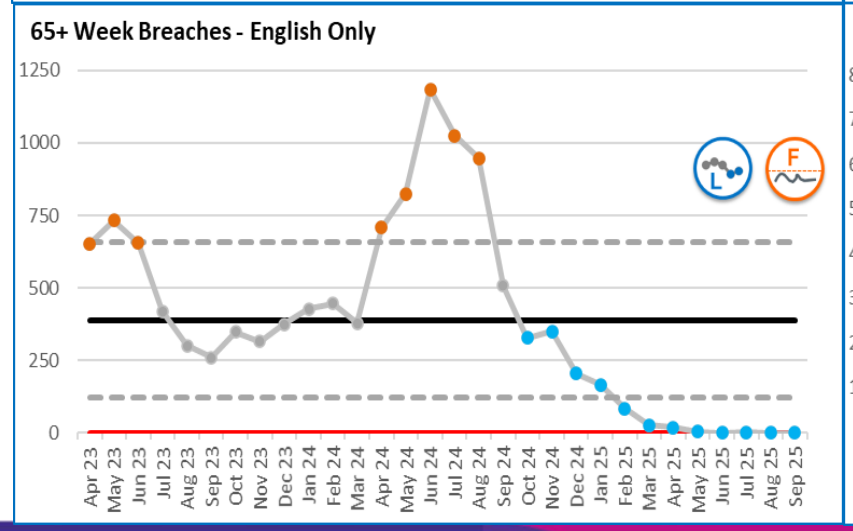
Operational – Referral to treatment (RTT)

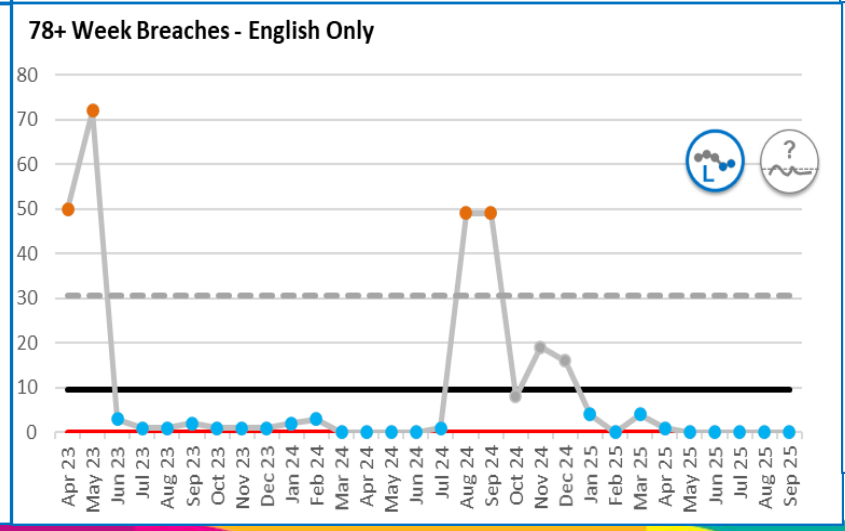
The Shrewsbury and Telford Hospital NHS Trust

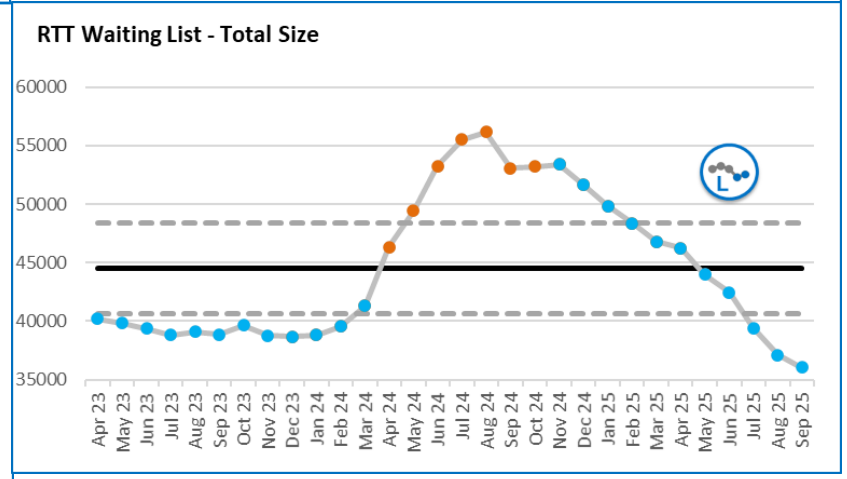












Note: includes unvalidated Welsh position

Operational – Referral to treatment (RTT)

The Shrewsbury and Telford Hospital NHS Trust

Summary:
The unvalidated Trust Position for September: English is 0 x 104 weeks, 0 x 78 weeks 0 x 65 weeks and 0x 52 weeks for CYP. The unvalidated Trust Position for Welsh is 1 x 104 weeks, 19 x 78 weeks 86 x 65 weeks.

The Trust is currently ahead of plan across all RTT metrics. Through the support given and work completed by Four Eyes Consultancy supporting the Trust's outpatient transformation programme we have realised a 3-4% improvement in outpatient booking rate which is an extra c.300 appointments per week within core templates across the Trust. Introducing broadcasting messaging has had a marked impact on the booking team and has reduced workload through the targeted measure and supported this improvement. Work is now taking place on ensuring clinic templates are standardised. In addition to this we have seen a marked increase in the number of patients being treated in theatres which is having a positive effect across all RTT standards.
A full review into the insourcing contracts the Trust has in place was conducted with an aim to reduce costs and increase activity. This has led to a signed off forecast for the year that is in line with the delivery plan for 25/26. A change in focus from elective IP to outpatient activity has supported the achievement of the 60% RTT target.

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 reduce waiting times for 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 (PCIP) continues for both outpatients and Inpatients. For eyes have further been engaged to support our next phase with clinic optimisation this will focus on clinic template optimisation and the implementation of key digital tools. This programme complements the work already underway across the organisation, helping to accelerate progress, remove operational barriers, and embed sustainable changes that improve patient access and service efficiency.

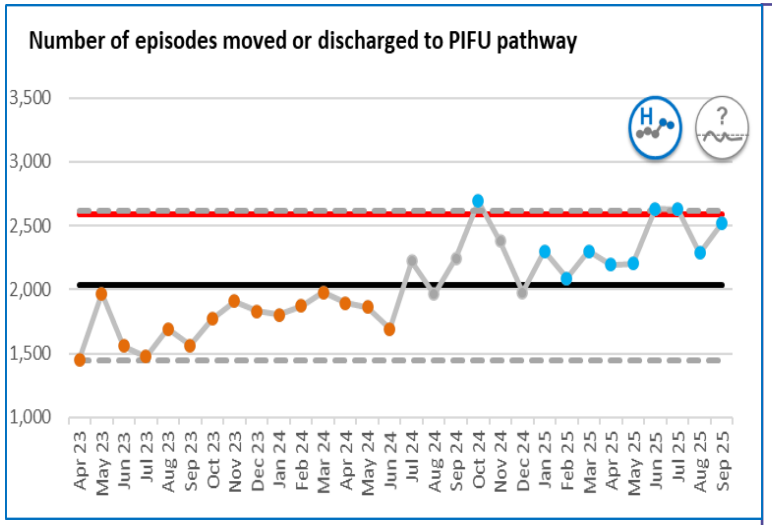
Anticipated impact and timescales for improvement:
The methodology to enable a 'route to zero' has been developed and a commitment to sustain a zero position for 65 weeks has been made and in addition reduce waiting times for CYP.

The total waiting list size for the Trust continues to decrease through a combination of treating more patients and focused validation with support from MBI.

The number of patients waiting > 52 weeks as of the 19th October 2025 is 113.

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 September increased to 5.7% which is below the 6% target.
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 (supported by Foureyes)
•Outpatient Pathway
•Transformation Outpatient Advice and Guidance Cardiology are part of a pilot using consultant Connect with a roll out plan in place for further specialties.

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:

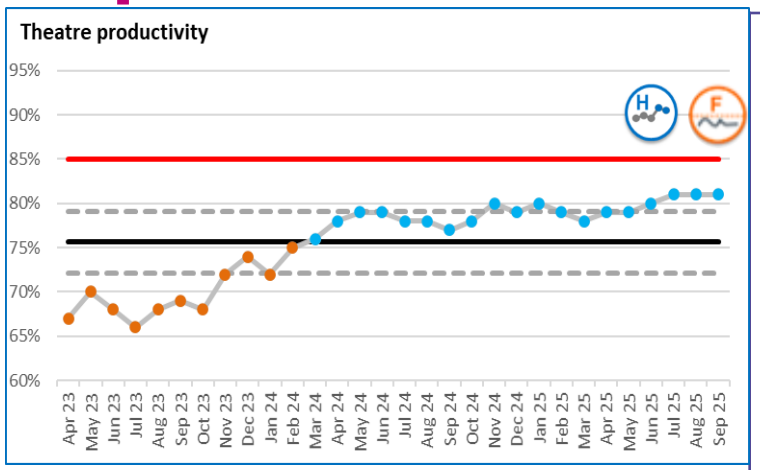
Conversations with Respiratory, Cardiology and Gynaecology clinical and operational leads have taken place, with their performance report has been completed, with plans to utilised the PIFU pathway.
Further conversations required with Cardiology Clinical Director regarding implementation of more PIFU within the department.
We are looking to implement (PEP)Dr Doctor to support the PIFU pathway and encourage engagement.

Anticipated timescales for improvement:

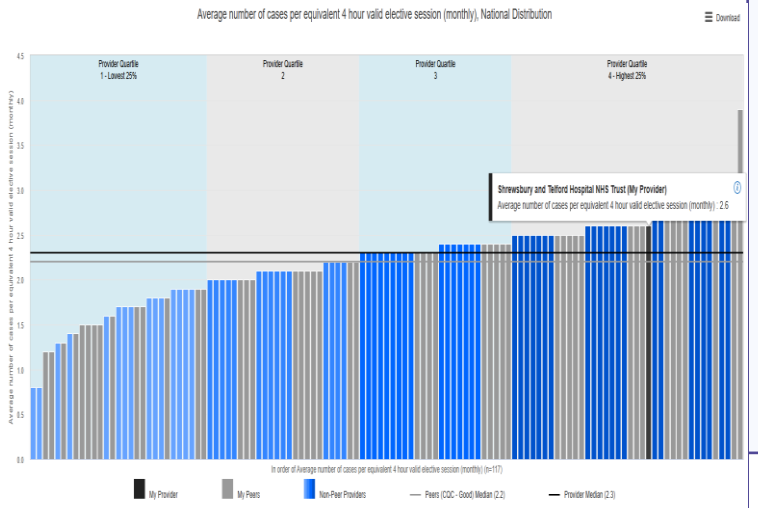
Performance will continue to be monitored at bi-weekly Outpatient Transformation meetings

Operational – Theatre Productivity

The Shrewsbury and Telford Hospital NHS Trust



New MHS monthly benchmarking data – August ’25 Cases per list 2.6 – shows impact of recent work on high volume lists.



September Summary:

Theatre Utilisation remained steady at **81%**. Ongoing collaboration between clinical and operational teams continues to improve theatre allocation, planning, and retrospective reviews.

1570 elective cases completed - slightly higher than August and the 4th highest monthly total since 2017,despite a further reduction in insourced lists from a high of 96 sessions in March to 13 in September.

Late Cancellations fell to its lowest monthly level of 8.0% driven by efforts to book operating lists further in advance to ensure potential blocks can be investigated. Targeted actions are being implemented, supported by enhanced weekly trend data from BI.

Theatre Task & Finish Group is focused on:

1. Expanding pre-op assessment capacity to support earlier booking
2. Improving list allocation and 6-4-2 scheduling
3. Boosting Elective Hub productivity using root cause analysis and improved data

New work underway following BI report of mean / average times per procedure per surgeon.

Recovery Actions:

- Continued collaboration with the NHSE Regional Theatre Productivity Lead ensures alignment with regional goals and best practices to boost theatre efficiency
- Upcoming meetings are scheduled with colleagues from various clinical specialties with senior clinical support using the elective hub and high flow lists to refine list management practices
- Business case for a digital tool to enhance pre-operative assessments has been approved, with IT support agreed
- Theatre templates are under review to facilitate the opening of a robotic theatre at PRH
- Arthroplasty sessions have been temporarily paused, with resources reallocated to other specialties to minimise reliance on weekend insourced lists

Anticipated timescales for improvement:

SOP detailing process for high-flow theatre lists to be distributed in October after governance agreement.

Initial plans and measures to improve productivity in Ophthalmology are expected to be implemented with senior clinical support.

Throughout October, the Trust will continue to expand list scheduling across multiple specialties. This initiative is strategically focused on addressing specific specialty demands and accelerating recovery efforts.

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)	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Trend
Well Led	WTE employed		-	7671	7152	7212	7219	7213	7259	7252	7192	7229	7227	7225	7213	7222	7380	
	Temporary/agency staffing		-	-	769	794	789	732	752	786	780	705	722	738	783	749	679	
	Staff Turnover Rate (FTE) (excluding Junior		0.8%	0.75%	0.8%	0.9%	1.0%	0.8%	0.8%	0.5%	1.2%	0.6%	0.9%	0.7%	0.6%	0.8%	0.7%	
	Vacancies - month end %		10%	<10%	9.0%	9.0%	9.1%	9.7%	9.2%	9.2%	10.0%	4.5%	4.4%	5.7%	5.9%	6.1%	6.1%	
	Sickness Absence rate		-	4.5%	5.3%	5.8%	5.5%	6.0%	5.9%	5.5%	5.0%	4.8%	4.6%	4.7%	4.9%	4.66%	4.90%	
	Trust - Talent Conversation (Appraisal)		90%	90%	77.9%	83.6%	84.6%	85.0%	86.7%	85.3%	85.8%	85.5%	86.0%	86.1%	86.6%	86.1%	86.4%	
	Talent Conversations (Appraisal) – Medical Staff		90%	90%	93.0%	93.6%	93.1%	93.5%	96.4%	92.2%	90.7%	92.5%	93.8%	93.5%	93.3%	94.4%	95.3%	
	Trust Statutory and mandatory training compliance		90%	90%	92.1%	91.4%	91.5%	91.1%	94.1%	91.7%	91.3%	92.9%	93.1%	93.2%	93.4%	93.2%	93.1%	
	Trust MCA – DOLS and MHA		90%	90%	82.7%	83.9%	84.0%	83.2%	87.0%	85.4%	85.1%	85.0%	85.0%	85.2%	86.0%	85.8%	85.3%	
	Safeguarding Children - Level 2		90%	90%	95.0%	93.8%	93.8%	93.7%	96.0%	94.1%	94.5%	96.0%	96.4%	96.6%	96.4%	96.2%	95.8%	
	Safeguarding Adult - Level 2		90%	90%	95.2%	94.3%	94.3%	94.3%	96.7%	94.6%	94.4%	95.8%	95.9%	95.9%	96.0%	95.7%	95.5%	
	Safeguarding Children - Level 3		90%	90%	88.3%	89.6%	88.9%	90.1%	91.9%	89.6%	90.8%	89.2%	89.8%	90.5%	90.8%	90.3%	88.2%	
	Safeguarding Adult - Level 3		90%	90%	88.8%	89.6%	90.1%	89.8%	92.4%	90.4%	90.5%	90.0%	91.0%	91.7%	92.1%	91.5%	90.5%	
	Monthly agency expenditure (£'000)		-	787	1526	1751	1638	1404	1203	985	955	1063	684	817	873	921	820	
Safe Staffing	Fill Rate % - All Staff - Day/Night			100%	94.5%	95.6%	95.7%	93.6%	94.4%	93.3%	93.3%	93.9%	93.5%	95.0%	95.2%	94.0%	95.4%	
	Fill Rate % - All Staff - Day			100%	94.0%	94.2%	93.9%	92.2%	93.1%	91.8%	92.5%	92.7%	91.8%	93.7%	93.7%	93.0%	94.3%	
	Fill Rate % - All Staff - Night			100%	95.1%	97.3%	97.8%	95.3%	95.9%	95.1%	94.3%	95.3%	95.7%	96.6%	97.0%	95.1%	96.7%	
	Fill Rate % - Registered Nurses/Midwives - Day/Night			100%	103.6%	104.2%	104.8%	104.9%	104.1%	101.3%	101.7%	101.4%	99.3%	101.5%	102.3%	101.1%	100.4%	
	Fill Rate % - Registered Nurses/Midwives - Day			100%	103.6%	103.1%	104.4%	104.9%	104.4%	101.0%	101.6%	100.8%	98.1%	100.0%	101.0%	99.8%	99.1%	
	Fill Rate % - Registered Nurses/Midwives - Night			100%	103.6%	105.5%	105.3%	104.8%	103.8%	101.6%	101.8%	102.1%	100.7%	103.1%	103.7%	102.5%	101.9%	
	Fill Rate % - Non-Registered Nurses/Midwives - Day/Night			100%	98.6%	99.1%	98.7%	94.1%	96.3%	98.5%	97.8%	98.5%	100.2%	99.8%	100.7%	100.4%	103.3%	
	Fill Rate % - Non-Registered Nurses/Midwives - Day			100%	98.2%	96.9%	95.4%	91.2%	93.1%	95.8%	95.8%	96.2%	97.3%	98.8%	98.6%	99.2%	102.2%	
	Fill Rate % - Non-Registered Nurses/Midwives - Night			100%	99.0%	101.9%	102.6%	97.5%	100.0%	101.7%	100.1%	101.1%	103.7%	101.1%	103.3%	101.9%	104.5%	
	Fill Rate % - Registered Nursing Associates - Day/Night			-	18.3%	24.7%	23.5%	19.5%	22.1%	18.6%	18.6%	24.9%	24.5%	27.8%	25.4%	22.4%	25.7%	
	Fill Rate % - Registered Nursing Associates - Day			-	21.4%	28.7%	26.5%	22.5%	25.4%	21.0%	24.7%	30.8%	30.5%	33.4%	30.5%	29.2%	32.3%	
	Fill Rate % - Registered Nursing Associates - Night			-	14.0%	19.0%	19.3%	15.4%	17.4%	15.3%	10.0%	16.6%	15.4%	19.6%	18.4%	13.1%	16.1%	
	CHPPD - Overall - National 11.99			11.99	8.7	9.8	8.8	8.6	8.7	8.6	8.5	8.6	8.7	9.1	8.8	8.8	8.7	
	CHPPD - Registered Nurses/Midwives - National 4.9			4.9	5.2	5.9	5.2	5.2	5.2	5.1	5.1	5.1	5.1	5.4	5.2	5.2	5.0	
	CHPPD - Non-Registered Nurses/Midwives - National 4.9			4.9	3.4	3.7	3.4	3.2	3.3	3.4	3.3	3.3	3.4	3.5	3.4	3.4	3.5	
	CHPPD - Registered Nursing Associates			-	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	

Workforce Executive Summary

The Shrewsbury and Telford Hospital NHS Trust

2024/25 Workforce Plan – At month 6 the total workforce is 3 WTE (worked) under planned levels with bank workforce over planned levels by 67 WTE. This is offsetting the level of substantive under planned levels. The pay cost is however greater due to the premium costs associated with medical workforce and a limited number of departments that have enhanced pay arrangements (non -medical. The substantive worked position for September was 70 WTE under plan with gaps being covered by bank which was 67 WTE over planned levels. There was a reduction in both bank and agency from month 5. Substantive workforce grew by 61 WTE from August to September with the increase seen across all clinical divisions, following recruitment into investment business cases. Across non-clinical / corporate areas the bank levels reduced by 16 WTE.

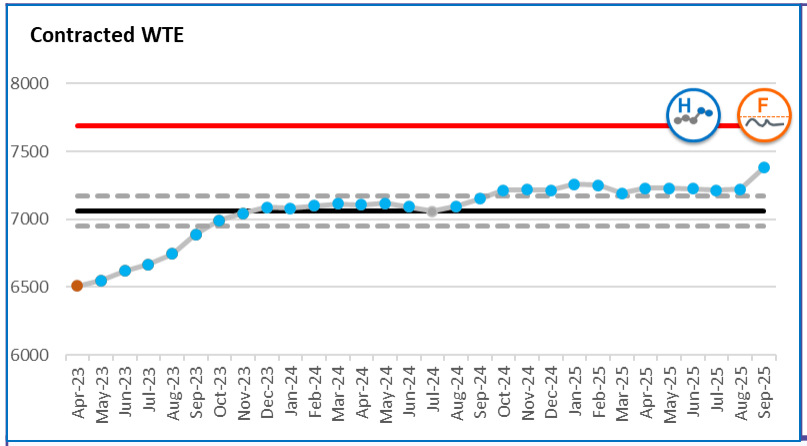
Turnover – The rolling 12-month turnover rate for September remains at 9.7% equating to 660 WTE. An in month turnover rate of 0.7% equates to 47 WTE leavers in September. NHS Leaver turnover rate (those moving outside of the NHS) over the last 12 months is 6.2% equating to 421 WTE NHS leavers.

Wellbeing of our staff – September sickness rate increased to 4.90% (362 WTE) remaining above target by 0.40% (29 WTE). Sickness attributed to mental health continues to be the top reason for sickness making up 27% of calendar days lost in September equating to 99 WTE. Our Chief People Officer will lead a round table event on mental health for colleagues, featuring clinical psychologists and occupational health experts.

Agency and temporary staffing - Both Medicine and Surgical divisions reduced their bank usage this month, Women's and Children's remained at similar levels and Clinical support increased by 2WTE. Agency usage levels have decreased to within 6 WTE of planned levels, this is following successful recruitment across nursing and medical workforce. We have launched our new consultant induction course. For the first time in many years, some of our most challenged specialties are now filling their vacancies which is reducing our temporary workforce position. The main reasons driving bank usage is filling gaps in substantive vacancies, covering sickness absence and maternity leave. The level of non-clinical bank usage reduced this month by 16WTE. This level is expected to continue to reduce following the introduction of the new non- clinical bank approval process.

Workforce – Contracted WTE

The Shrewsbury and Telford Hospital NHS Trust



Summary:

Substantive figure of 7,380 WTE in September, which is an increase of 158 WTE in month.
Total workforce utilisation in September increased by 25 WTE to 8059 WTE attributable an increase in substantive staff.
Use of temporary staff temporary staff has decreased with bank use decreasing by 59 WTE and agency decreasing by 11 WTE.

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

Recovery actions to achieve our target:

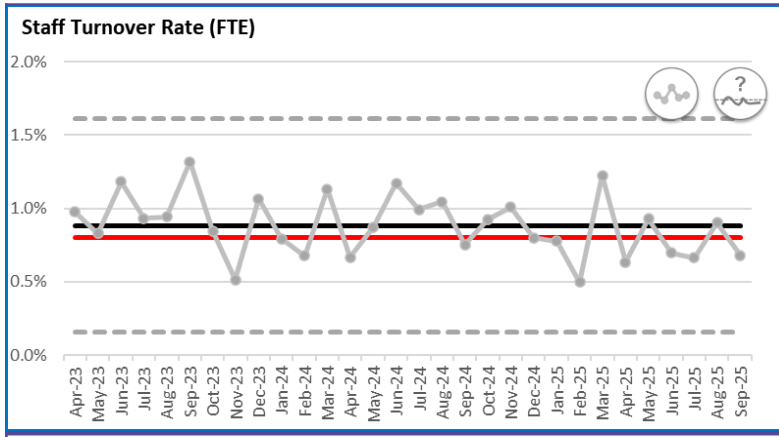
- 67 Registered Nurse applications are being shortlisted for interviews in November
- Recruitment event for HCAs and Housekeepers filled all required vacancies for new wards; 45 offers made
- Recruitment support for new Acute Floor, Ward 25 Medicine, Frailty, and Ward 36—over 112 FTE to be recruited
- Working with RNIB to gain “Visibly Better Employer” accreditation for recruitment processes
- Exploring Indeed’s Talent Scout function for advanced sourcing and screening (launching January 2026)
- Committed to Guaranteed Interview scheme for Care Leavers as part of NHS Universal Family Programme
- Assessing Group Employer function on Trac for enhanced collaboration and shared job boards with Shropcomm
- HTP workshops are underway to complete divisional workforce planning by the end of October
- Workforce planning is being driven by Demand & Capacity reviews, ensuring staffing aligns with service needs and future growth across divisions
- 92% of departments are live or on track for Manager Self Service (MSS) by 2025/26
- ESR: Contract awarded to Infosys for future workforce solution

Anticipated impact and timescales for improvement:

Following recent review of our 300 WTE target reductions all divisional teams have identified the full reductions and are now developing implementation plans. Our contracted employment levels are expected to reduce in line with plan and will be seen in the second half of the year.

Recovery dependencies:	On-going focus on progressing workforce systems utilisation and leadership alongside system approach to working. Utilisation and Deployment of our workforce systems are key digital enablers.

Workforce – Staff turnover rate



Summary:
Our Turnover target for 2026 is 10%. The rolling 12-month turnover rate for September remains at 9.7% equating to 660 WTE. An in month turnover rate of 0.7% equates to 47 WTE leavers in September. NHS Leaver turnover rate (those moving outside of the NHS) over the last 12 months is 6.2% equating to 421 WTE NHS leavers.
Staff groups with highest turnover rates are: Additional Clinical Services (12.6%); Add Prof Scientific and Technic (12.0%); Healthcare Scientists (10.7%); Admin and Clerical (10.2%).
Nursing and Midwifery has the lowest turnover rate at 7.1%.
Work life balance is currently the highest reason for leaving with 115 WTE leavers with relocation as the second highest reason with 113 WTE leavers over the last 12 months.

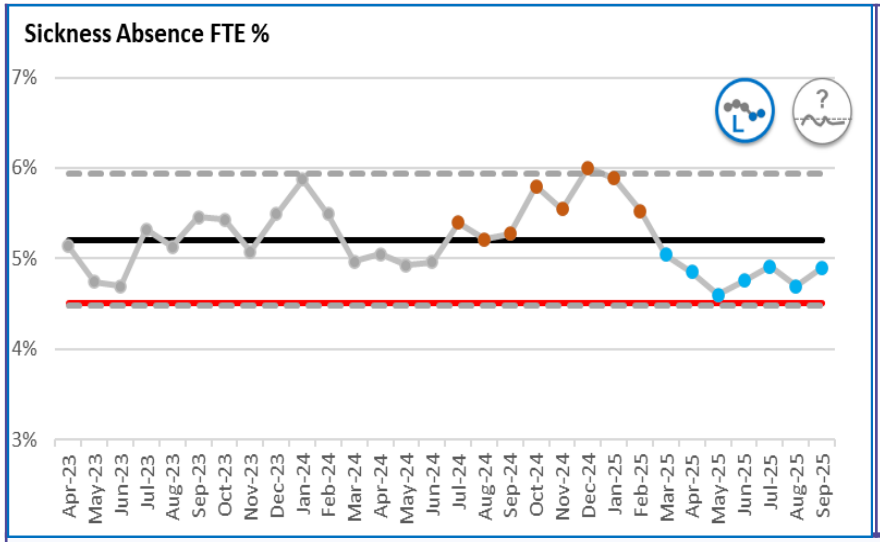
Recovery actions to achieve our target:

- MARS Scheme: individuals approved for MARS to leave between September – December 2025
- Staff Engagement: NSS 2025 has launched and active campaign to support colleagues to share feedback
- Redeployment Improvements: The redeployment process is being enhanced in collaboration with the recruitment team to better support staff transitions including movements from other Trusts
- Workforce Realignment and change: The Trust is reshaping its workforce to support service transformation and investment delivery
- Cultural Transformation: Plans to support transition to Group underway to support cultural transformation
- Leadership Summit: Held in October to support compassionate leadership through change and system transformation
- Psychological Support: The Staff Psychology Service is delivering reflective practice, trauma-informed sessions, and mental health support to help reduce stress-related turnover
- Leadership Programmes: Continue to deliver and launch of Galvanise cohort 4

Anticipated impact and timescales for improvement:
Turnover is expected to increase towards end of this year in line with our workforce plans as we see departures through mutual agreed resignations and through the conclusion of management of changes across teams later in the year.

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%. September sickness rate increased to 4.90% (362 WTE) remaining above target by 0.40% (29 WTE). Sickness attributed to mental health continues to be the top reason for sickness making up 27% of calendar days lost in September equating to 99 WTE. 13% (47 WTE) of sickness was attributed to musculoskeletal (which does not include back problems) with other known causes at 10% (35 WTE).

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

Estates and Ancillary has the highest sickness rate at 7.5%, Additional Clinical Services staff group has the second highest rate at 5.8% with Nursing and Midwifery at 5.3%.

Recovery actions to achieve our target:

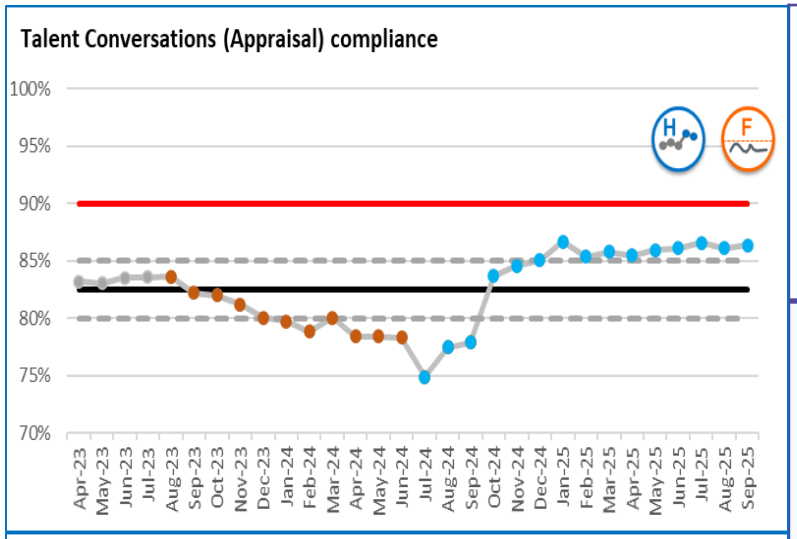
- New Attendance and Wellbeing Policy active for 6 months, full transition to this policy in place during October 2025
- Management of Change Masterclasses: Supporting staff through change to reduce stress-related absence continue
- Sickness Management Trial: Piloting new approaches for Medical & Dental staff
- Staff Psychology Support: Offering mental health and trauma-informed sessions to reduce absence
- Wellbeing Initiatives: Delivering roadshows, wellbeing walks, and targeted support to boost resilience
- Cultural Transformation: NSS 2025 formally launched
- Divisional Engagement Plans: Helping teams address wellbeing and retention challenges
- Prevention: Review of local needs, Equality Delivery System 22 to ensure clear focus for HWB and prevention
- Review of all long term sickness to ensure robust support to managers and colleagues

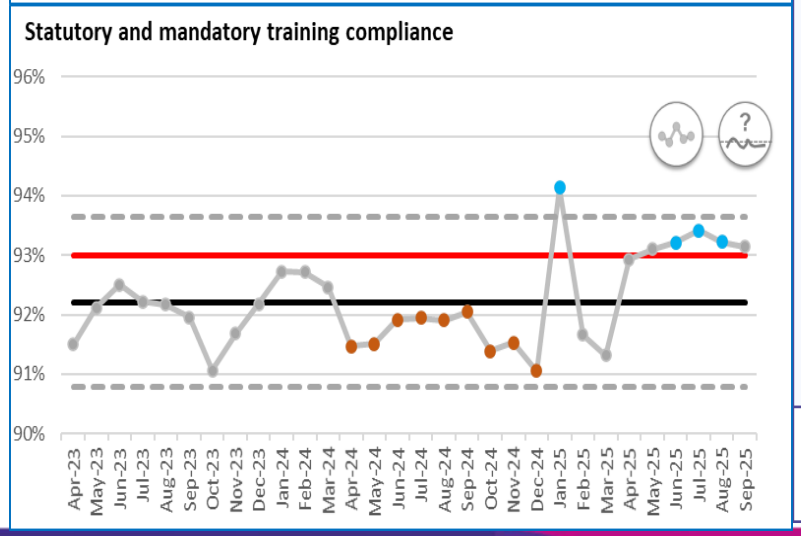
Anticipated impact and timescales for improvement:
Expected reductions in absence levels throughout the year in line with plan with a level of increase over winter months after which we expect a 1% reduction.

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, remained stable June into July at 93.5%. For non-medical colleagues, talent conversations increased to 86.6% in July.

Our Mandatory and statutory training compliance target by 2026 is 93%, currently our target is 90%. The current rate is 93.4% which is above target.

Recovery actions to achieve our 2026 target:

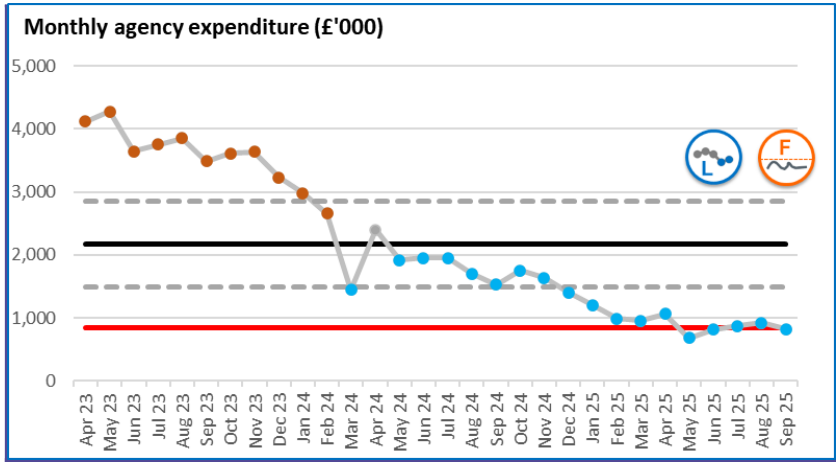
- National mandatory learning policy framework implementation
- Review of NHS Ten-year plan and support development of Joint People Strategy. Investment in clinical educators, expansion in widening participation opportunities, entry routes into the NHS to support a unified, inclusive and high performing leadership culture
- Continue to build and work with Keele University, Telford College and Shrewsbury College to develop opportunities to support development of future workforce and workforce skills

Anticipated impact and timescales for improvement:

Expected steady increase in training compliance as next quarter and on track to meet target.

Recovery dependencies:	Investment in AI and technology digital tools. Capacity and capability to deliver new training delivery model.

Agency Expenditure – Monthly



Summary:
Agency expenditure has decreased this month and is 6 WTE above planned levels. There are 28 medical agency workers currently engaged with the majority covering vacancies. Recruitment plans for hard to fill medical specialities are being developed with initiatives being recommended to aid recruitment efforts. Rates of pay for both agency and bank doctors have been agreed for implementation in September (Agency) and October (Bank) which will aid reductions in temporary staffing spend

Recovery actions to achieve our target:

- 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
- New rates for agency medical now in place which is expected to reduce spend
- Additional Nursing Shifts: Extra shifts are being requested to support increased bed capacity and the opening of the discharge lounge at night
- Admin Bank Requests: Supporting rollout of a new procedure with updated communications to streamline admin bank requests.
- Regional Price Cap Compliance: The Trust is actively supporting the region to meet PCC targets and is currently reporting zero above-cap agency usage
- Bank Attendance: Focused efforts are underway to reduce cancellations, including sending letters to frequent cancellers
- Agency Cost Management: Strategic planning continues to reduce premium pay spend and improve workforce efficiency
- Workforce Deployment: Enhanced rostering and unavailability tracking are helping optimise staffing and reduce reliance on agency cover

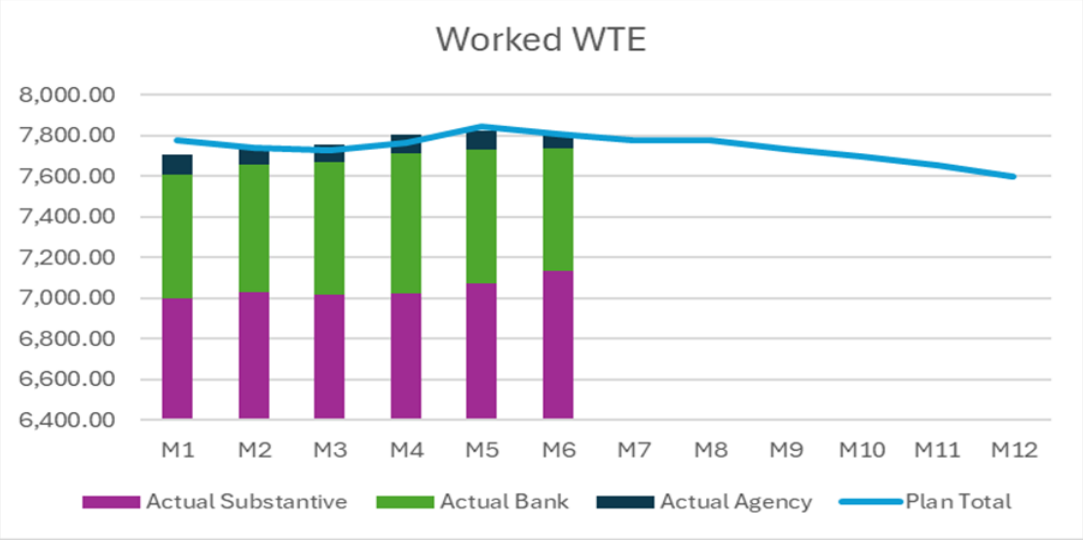
Anticipated impact and timescales for improvement:

Continued reduction of agency nursing expected to end of year. At month 5 agency is now over plan, with recruitment trajectories in place the end of year position is expected to reduce further in line with plan.

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

Staffing - actuals vs plan

Plan	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Substantive	7,259	7,272	7,268	7,318	7,422	7,447	7,422	7,393	7,374	7,356	7,323	7,275
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	**8,018**	**7,985**	**7,968**	**8,006**	**8,088**	**8,053**	**8,020**	**8,019**	**7,978**	**7,937**	**7,897**	**7,842**
Actual												
Substantive	7,229	7,226	7,225	7,216	7,222	7,380						
Bank	610	628	652	692	659	600						
Agency	95	94	86	91	91	79						
Total	**7,934**	**7,948**	**7,963**	**7,963**	**7,971**	**8,059**	**0**	**0**	**0**	**0**	**0**	**0**
Variance												
Substantive	30	46	43	102	200	67						
Bank	31	-25	-54	-99	-71	-67						
Agency	23	16	16	4	-13	-6						
Total	**84**	**37**	**5**	**7**	**117**	**-6**	**0**	**0**	**0**	**0**	**0**	**0**



Summary:
Total staff usage of 8059 WTE in September is 6WTE (Contracted) below plan and a increase from the August position of 88WTE. Substantive levels have increased this month following recruitment into key investments as part of operational plan. The bank usage has reduced this month. 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 for nonclinical bank
- 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

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)	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Trend
Finance	End of month cash balance £'000	49,599	15,051	67,367	54,399	43,511	54,932	48,821	61,762	45,006	35,131	41,161	44,343	51,400	40,294	
	CIP Delivery £'000	3,358	2,799	3,390	3,585	2,833	3,654	4,287	5,659	2,392	2,568	2,742	3,579	3,166	3,843	
	Balanced £ Position £'000 (Cumulative)	0	(5,621)	(10,864)	(13,242)	(17,179)	(22,661)	(27,570)	(18,563)	5	1	10	8	4	(1,274)	
	Year to date capital expenditure £'000	63,543	8,403	10,153	16,157	22,352	26,936	39,110	69,194	2,044	12,632	19,759	24,803	32,363	41,608	

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 September (month six), the Trust has delivered a deficit position of £1.27m against the breakeven plan. 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 costs associated with UEC (£1.12m) and income backed posts (£0.63m) offset by income. There has also been a cost pressure associated with the industrial action (£0.51m) in July which was mitigated by bringing forward an expected CIP scheme in non-pay. The cost pressure associated with the pay award (£0.83m) had been mitigated in previous, however, this can no longer be mitigated and is a cost pressure along with the premium payments associated with temporary staffing (£3.40m). An increase in pass through devices has also been seen which is offset by an over achievement in income and a benefit in financing costs (£0.60m) resulting from the Trusts' cash position.

The Trust has five main deliverables within the operating plan for FY25/26:

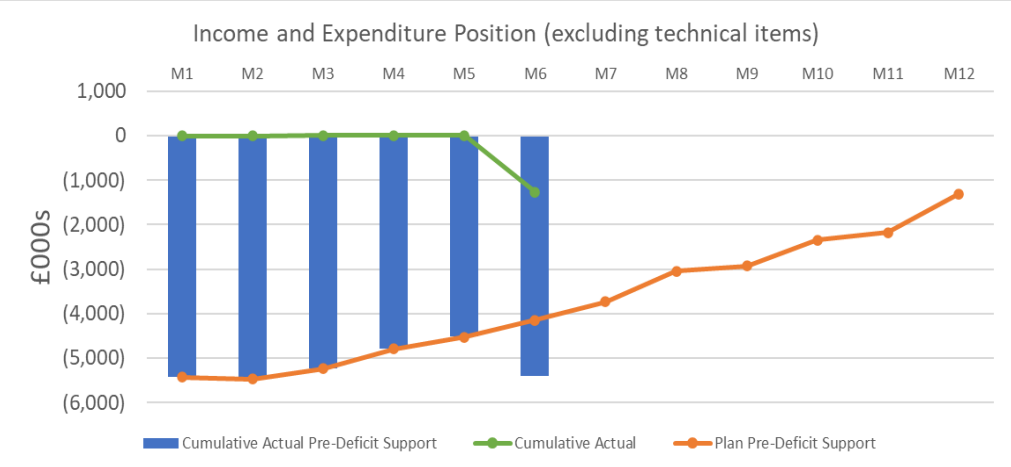
- Delivery of the activity plan to secure the ERF and potentially additional income – there is no change in the reporting of income due to the data warehouse issues at present, however the Trust is actively making CDS submissions through to SUS and there are ongoing conversations within the system around redistribution of variable ERF funding
- Delivery of the efficiency plan – The Trust has an efficiency target of £41.40m in FY25/26. At the end of September, £18.30m has been delivered which is £1.00m more than plan
- WTE reduction plan – At the end of September against the numbers reported in August (actual worked) there has been a 61 WTE substantive increase, partially offset by a reduction in worked bank of 59 WTE
- Delivery of the agency reduction plan – expenditure has decreased in month compared to August and remains below the planned levels of expenditure. There continues to be a strong focus on medical agency in FY25/26
- Delivery of additional capacity (escalation) within a core capacity funding envelope (£14.00m) – at the end of month six there has been an overspend of £1.12m against plan

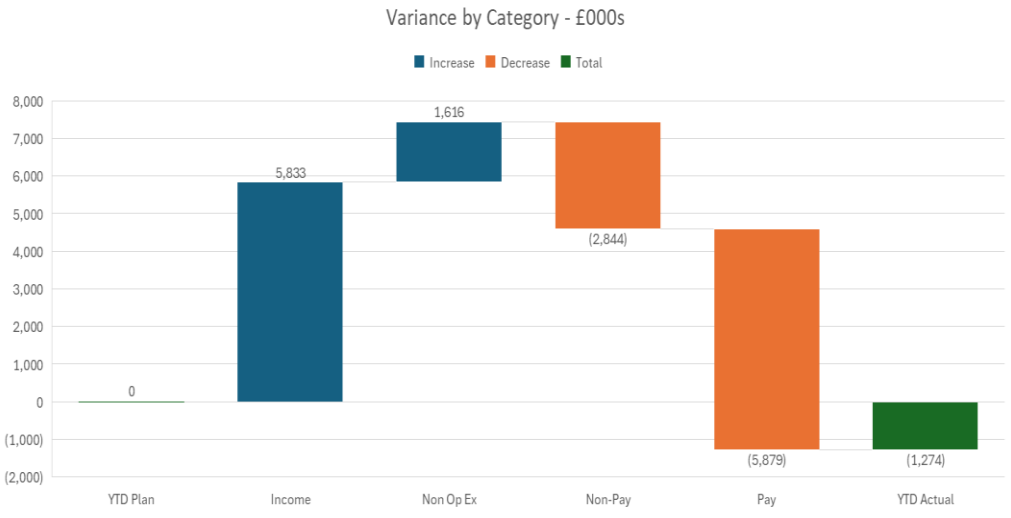
The Trust has set an operational capital programme of £22.53m (including IFRS 16 expenditure) and externally funded schemes of £128.70m in FY25/26, giving a total capital programme of £151.23m.

The Trust held a cash balance at end of September 2025 of £40.30m.

Additional grip and control actions have been pipelined during August, including additional non pay controls with oversight from Executives and a Cash Committee.

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 plan is breakeven in each respective month of the FY25/26.

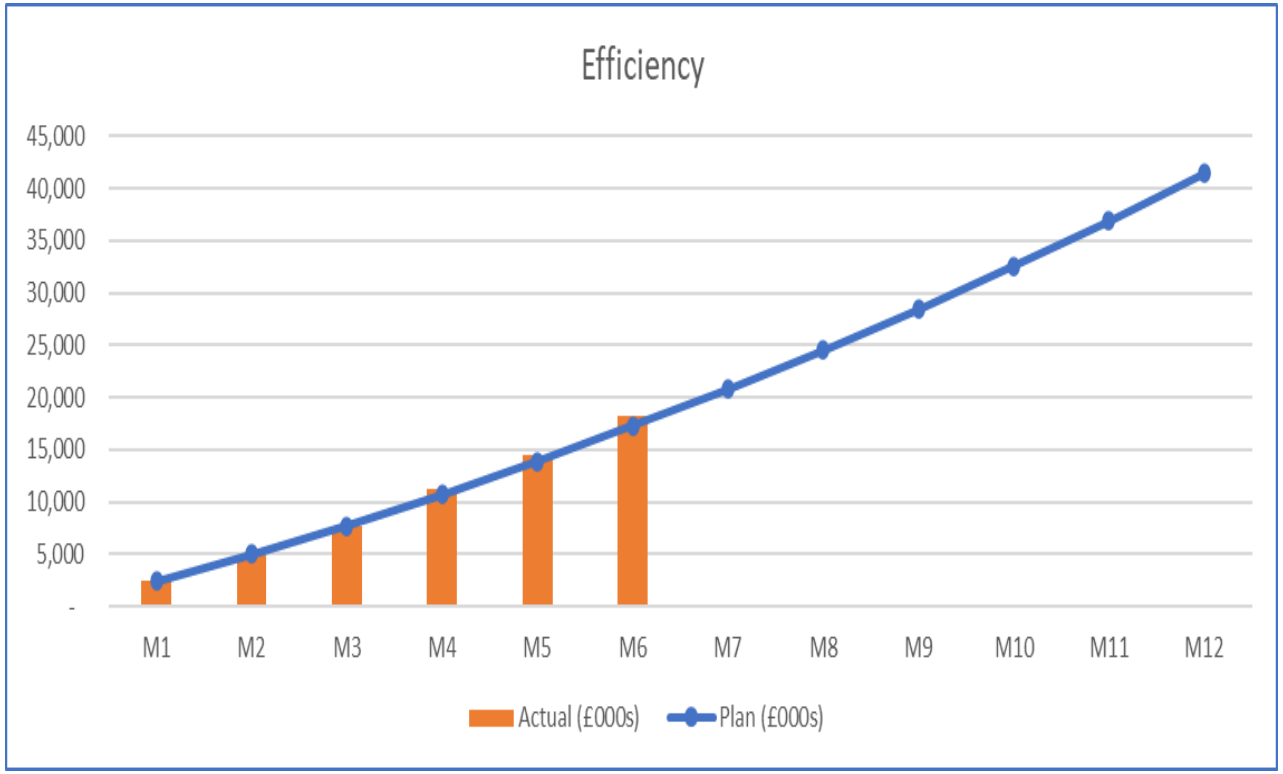
The Trust recorded a deficit in month and year to date of £1.27m, this position is supported by £4.14m of deficit support funding in the month and £30.85m year to date. There have been movements in the different cost categories with an overspend in pay and non-pay being offset with an underspend on financing costs and an over delivery of income against planned levels.

Recovery actions:
Actions are being managed through the Financial Recovery Group and include:
- Additional productivity opportunities
- Review of temporary staffing expenditure
- Acceleration of 2026/27 efficiency opportunities

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



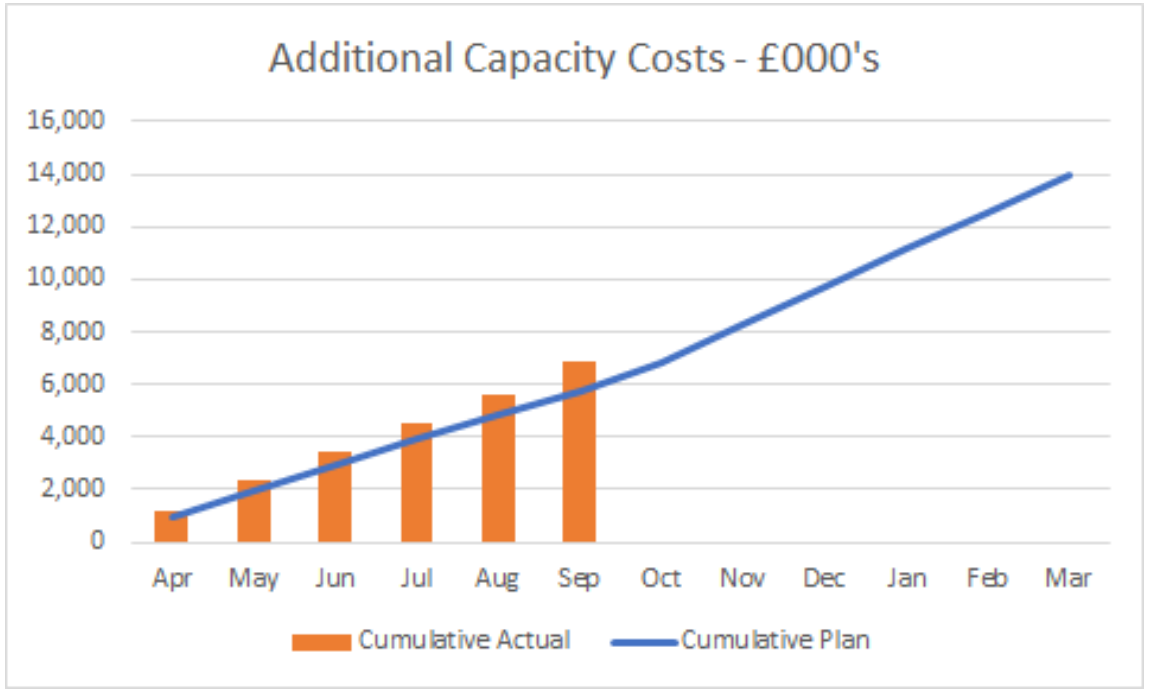
Summary:
The Trust has a total efficiency target for FY25/26 of £41.44m.
As at the end of September (month six), the Trust has delivered £18.30m of efficiency savings for FY25/26 which is £1.00m above the planned delivery. The YTD over-performance relates to early recognition of the CNST scheme to offset the impact of industrial action and additional productivity savings.

At M6 the Trust is forecasting to meet its target CIP by the end of the year. Risk has been built into these forecasts and there are mitigations in place where high risks have been identified.

Recovery actions:	**Anticipated impact and timescales for improvement:**
Continue to develop mitigation plans potential under-delivery in high-risk schemes.	N/A

Dependencies:	Delivery of actions against PIDs.

Additional capacity



Summary:

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

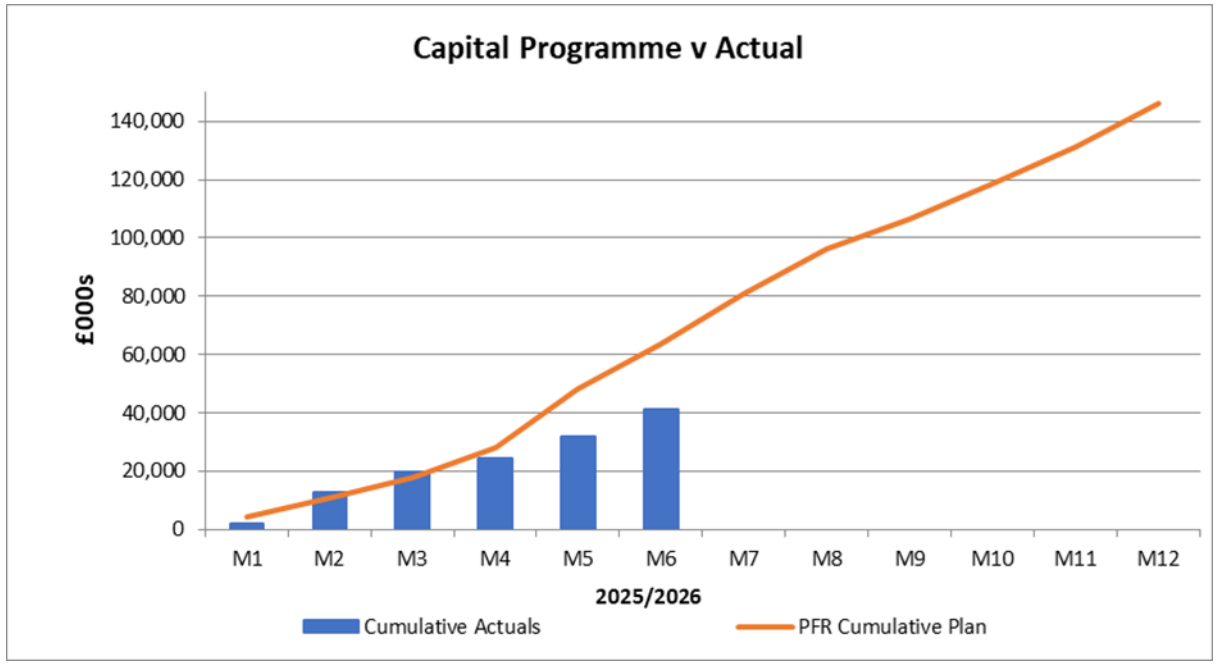
The requirement on a monthly basis is driven by changes in demand, offset by both internal and external interventions such as reduced length of stay and reductions in the number of patients with no criteria to reside, all of which is linked to the delivery of the 4 UEC transformation workstreams.

In September additional capacity costs increased compared with August and remain above the planned levels both in month and year to date with year-to-date costs at £6.87m against a plan of £5.75m.

Recovery actions:	**Anticipated impact and timescales for improvement:**
SaTH is working in conjunction with the ICB, other system to reduce the need for expensive additional 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 additional capacity reduction is linked to 5 workstreams from UEC transformation programme and managed through UEC board.

Capital



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

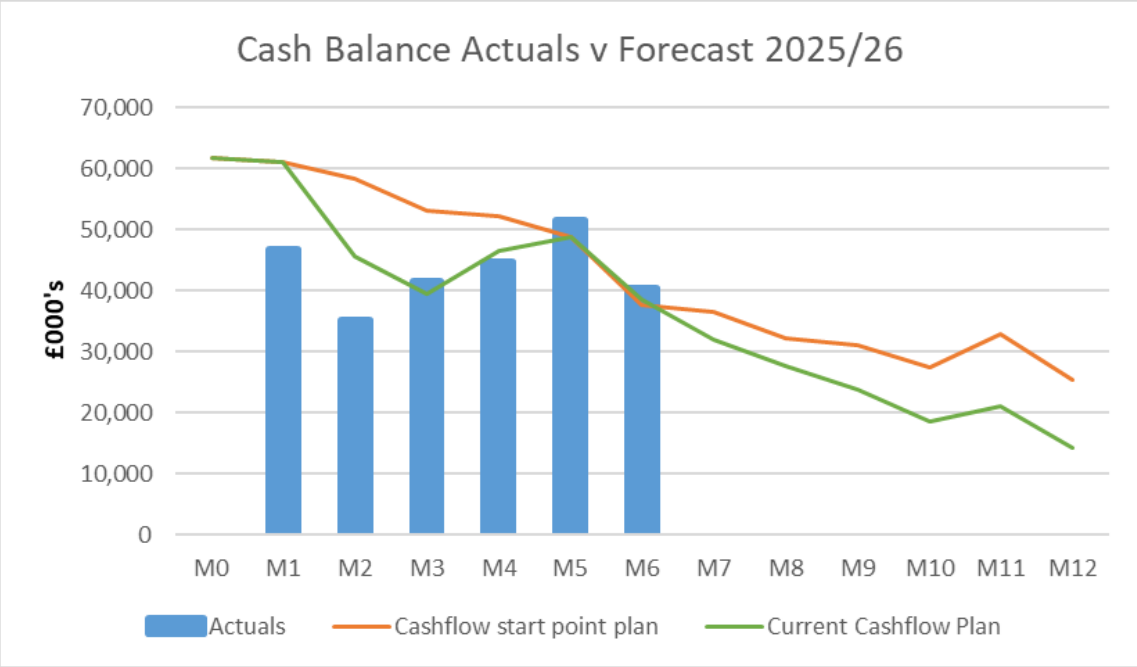
External allocations have increased to £128.70m following receipt of additional £0.72m for HTP and £0.44m for Solar Canopy at PRH giving an overall Capital Programme of £151.23m (excluding Salix).

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

At month six FY25/26, £5.00m of expenditure (excluding IFRS 16) relating to System Allocation has been expended and £36.12m of external expenditure has been incurred, giving total expenditure of £41.12m.

Recovery actions:	**Anticipated impact and timescales for improvement:**
It is anticipated the programme will recover by year end, however a reforecast exercise is being undertaken as part of a national exercise to provide assurance, with meetings scheduled in December and January with key stakeholders to review actual spend against delivery plans.	N/A
Recovery dependencies:	N/A

Cash and Cash Equivalents



Summary:
The Trust undertakes monthly cashflow forecasting. The plan represents the Trust's internal start point cashflow, this is then re-forecast each month to give a current cashflow plan which reflects actual performance to date.

The cash balance brought forward into FY25/26 was £61.76m with a cash and ledger balance of £40.30m held at end of month six.

The graph illustrates overall actual cash held against the plan. At month six, actual cash balances were broadly in line with forecast.

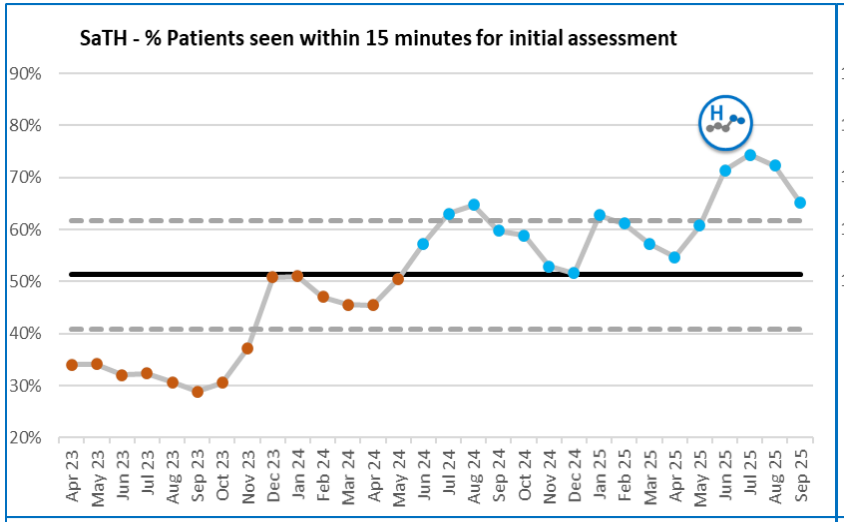
As at the end of August a Bi-Weekly Cash Committee has been introduced, for which a weekly operational cash group also takes place as a workstream. The Cash Committee has been established to provide oversight, scrutiny, and assurance on the Trust's cash position, cashflow forecasting, and short- to medium-term liquidity management.

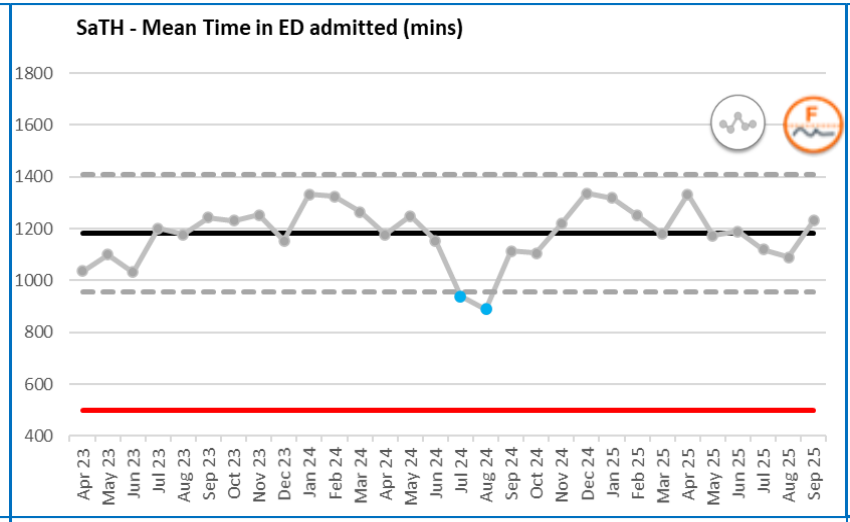
Recovery actions: N/A	**Anticipated impact and timescales for improvement:** N/A
Recovery dependencies:	N/A

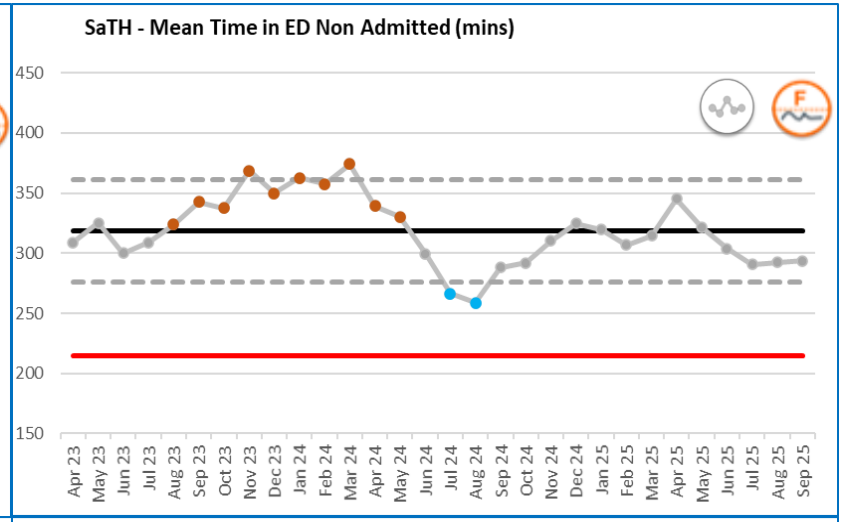
Appendices – Responsiveness And Well Led

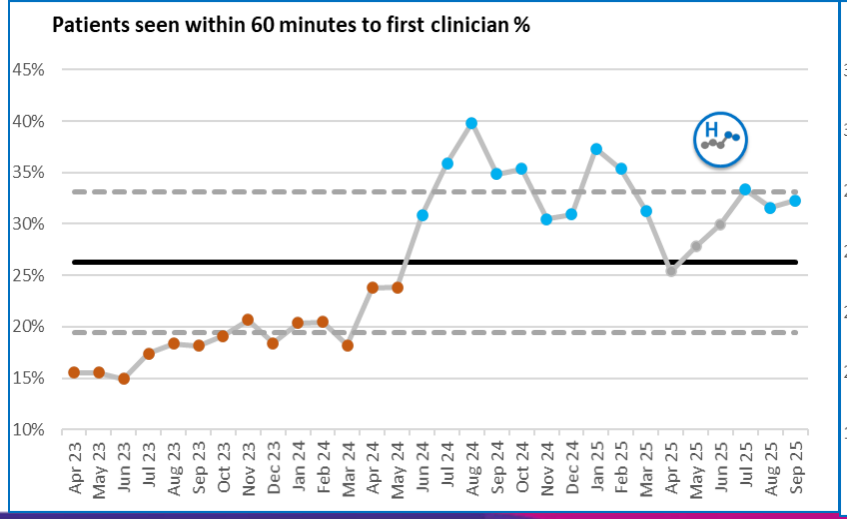
Appendix 1 – supporting detail on Responsiveness

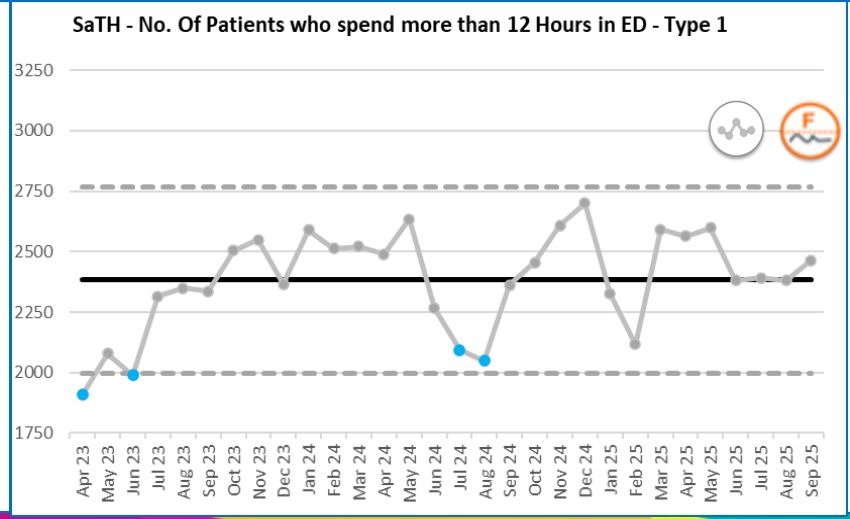
The Shrewsbury and Telford Hospital NHS Trust

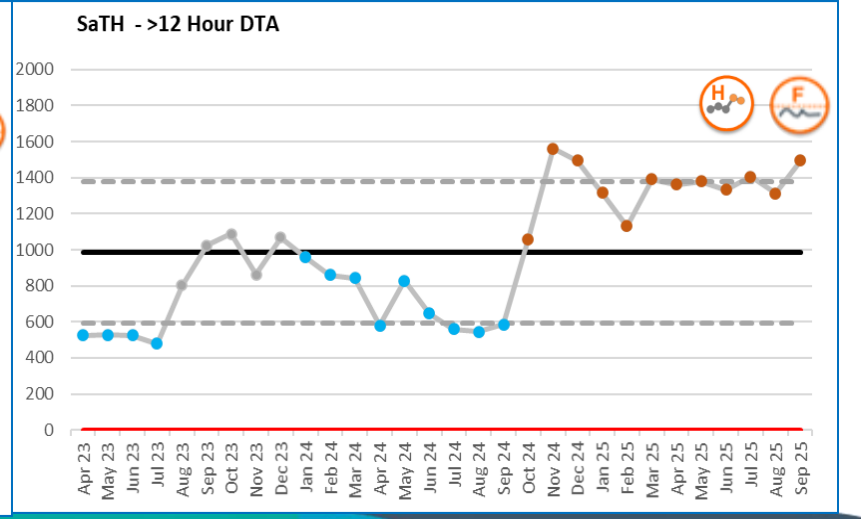






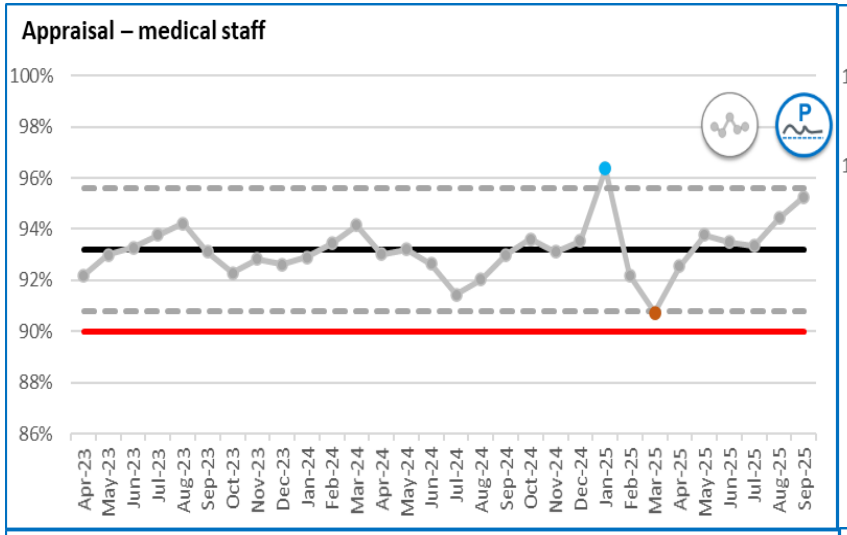


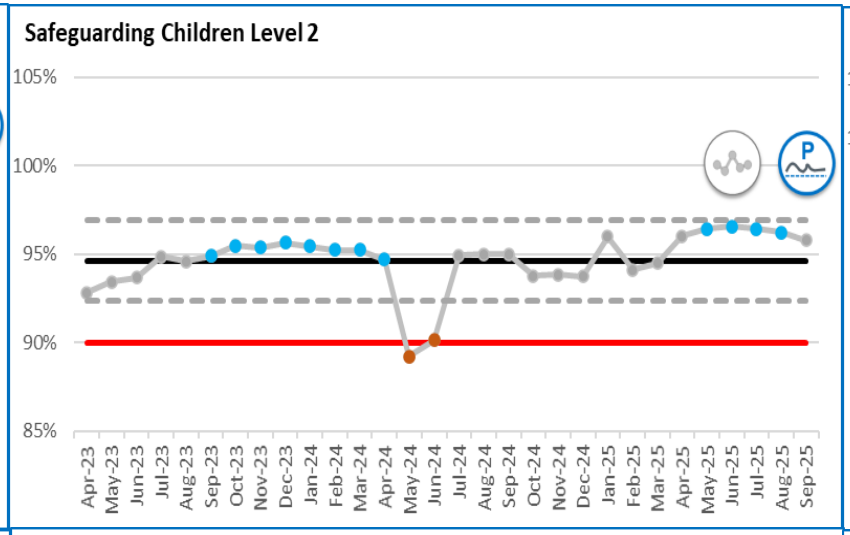


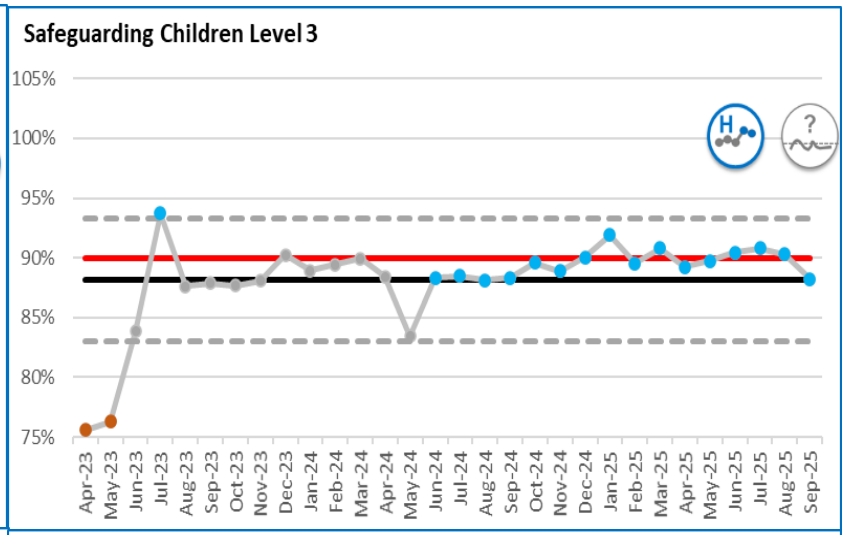


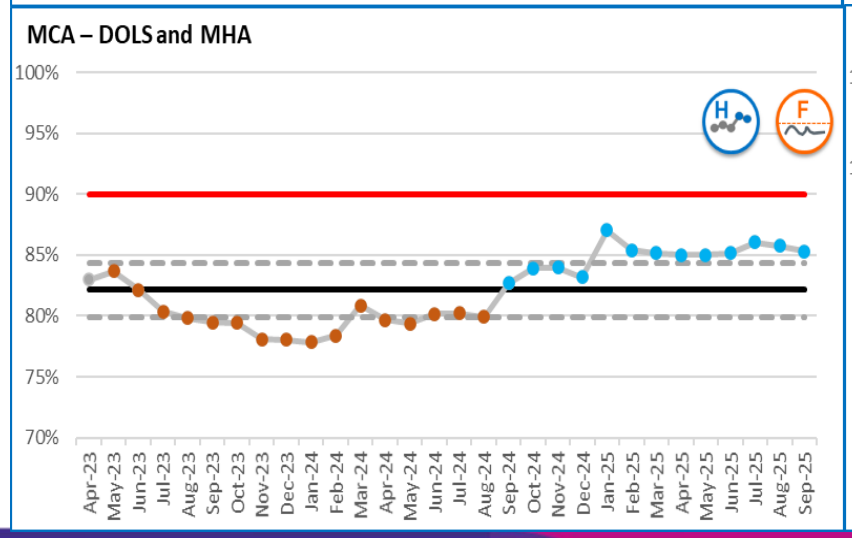
Appendix 2 – supporting detail on Well Led

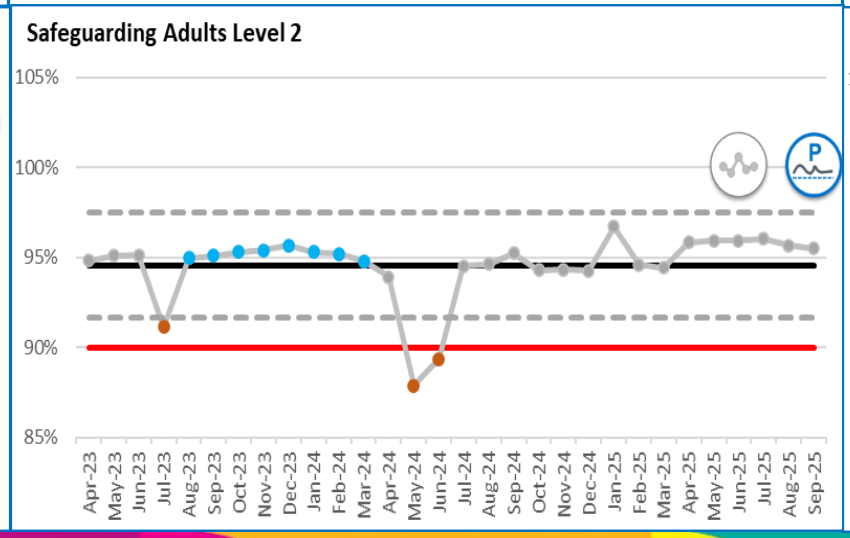
The Shrewsbury and Telford Hospital NHS Trust

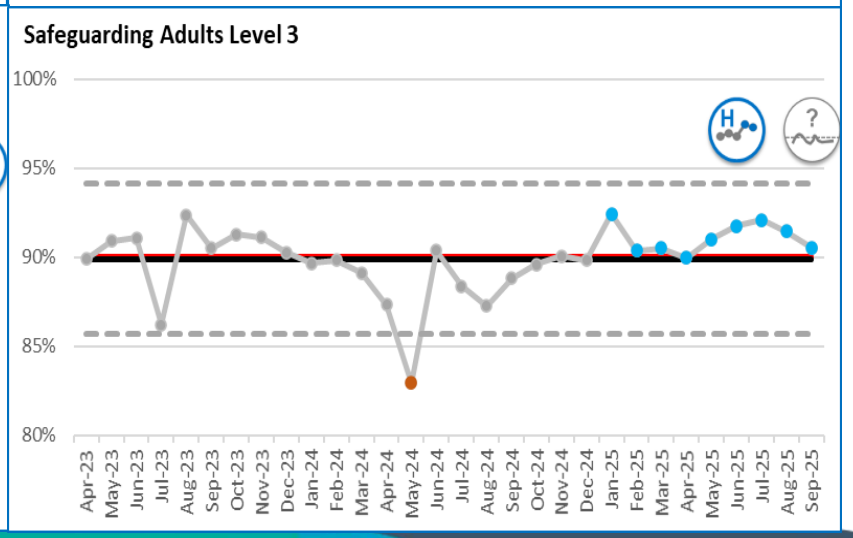










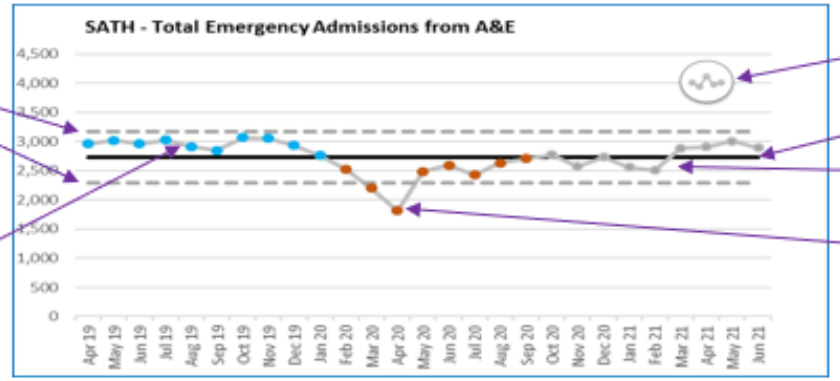


Appendix 3 – Understanding statistical control process charts in this report

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



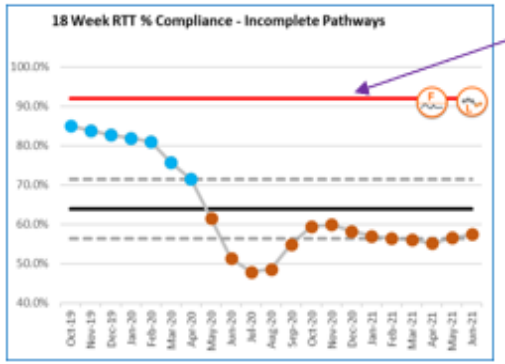
Icon showing most recent point type of variation

Mean or median line

Common cause variation

Special cause variation – data point outside of the process limit

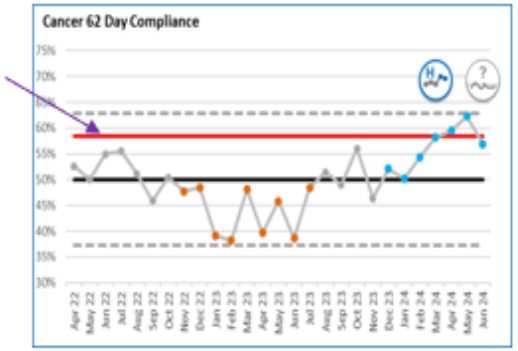
Where a target has been set the target line is superimposed on the SPC chart. It is not a function of the process.

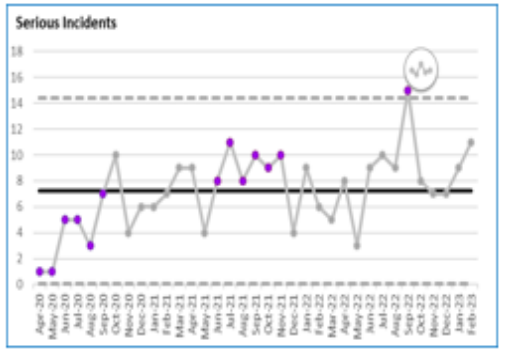


Target line – outside the process limits.

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 Director's meeting: 13 November 2025

Agenda item		161/25		
Report Title		Quarter 1&2 Public Participation Report		
Executive Lead		Nigel Lee, Director of Strategy & Partnership		
Report Author		Julia Clarke, Director of Public Participation		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe		Our patients and community	√	BAF9
Effective		Our people		
Caring		Our service delivery		**Trust Risk Register id:**
Responsive		Our governance		
Well Led	√	Our partners		
Consultation Communication				
Executive summary:		The Shrewsbury and Telford Hospital NHS Trust is committed to ensuring that the patient-public voice is at the centre of shaping our health services, both now and in the future. At the heart of our organisation and its future success are our patients, carers and local communities. We aim to provide the best care and experience we can, and to ensure that we do this, our local communities need to feel listened to, and that as an organisation we are responsive to their needs across Shropshire, Telford & Wrekin and Mid-Wales. Whilst we have a legal duty to engage with the public, we go far beyond this requirement. In the overview of the SaTH Care Quality Commission Inspection Report published in May 2024, the CQC found "*People who use services, the public and staff were highly engaged and involved to support high-quality sustainable services*" Under the banner of **#GetInvolved**, https://www.sath.nhs.uk/about-us/get-involved/get-involved-public-participation/ we aim to provide a range of opportunities for our communities to be involved with us. We reach out to engage with the public and the emphasis is on everything we do directly linking to our local communities.		
Recommendations for the Board:		The Board of Directors is asked to: **Note** the current activity from April 2025 to September 2025 across the Public Participation Team and **Take assurance** from this work that our statutory duties are being met as well as CQC Well-led requirements		
Appendices:		Appendix 1: 6-month Public Participation Trust Board Report (in supplementary information pack)		

1.0 Public Participation Team

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

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

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

Under the banner of Get Involved – Make a Difference the team https://www.sath.nhs.uk/about-us/get-involved/get-involved-public-participation/ there are lots of different ways to Get Involved and we've listened to feedback from our communities and made it easier to do. We reach out to engage with the public and the emphasis is on everything we do directly linking to our local communities. We are also currently working with staff, public and volunteers to develop our Community Engagement and Volunteers 5-year Strategies for approval in May 2026.

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

2.0 Community Engagement including HTP (slides 8-25 in presentation)

2.1 The Community Engagement Team continues to engage with the public with a regular series of virtual and face-to-face meetings, health lectures and newsletter email updates. Activity is reported to the quarterly Public Assurance Forum which is co-chaired by a SaTH NED (Professor Trevor Purt) and a public member from Montgomery Health Forum (Cllr Joy Jones) and has a wide range of community, voluntary and statutory sector organisations as members, who have the opportunity to discuss issues directly with our Divisional teams, who also attend. The papers are published on our website for full transparency and key items from the meetings in April and July are included in the accompanying pack (Slides 9 and 10).

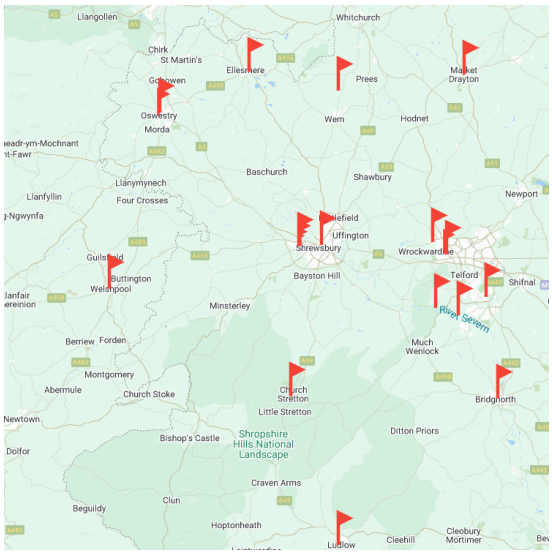
2.2 Our community members (5337) and organisations (472) continue to increase (Slide 11 details) and they have access to a wide range of ways to find out more about the Trust and to get involved. Some of the events we have attended/organised, especially relating to engaging with our Seldom Heard Communities are detailed on Slide 12

2.3 Our engagement team has focused their engagement this year on four core areas – Dementia, Diabetes, Respiratory and Cardiovascular, which align well to the national priority cohorts of patients as part of the National Neighbourhood Health programme. Slides 13-16 outline the engagement we have undertaken and the impact of our engagement.

2.4 **HTP engagement (see slides 17- 25)** The Public Participation Department has been leading the work to engage with our local communities around the Hospitals Transformation Programme (HTP).

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

2.5 We have also attended 31 events across the county and mid-Wales (noting there has been a pause due to going into the pre-election period in March). The map below shows the spread of the face to face meetings and details of all meetings we attended are on slides 19-21 in the supplementary pack



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

- HTP Public Focus group – 2 December 2025 (Hybrid meeting)
- Public focus group on the Critical Care Sky Garden with Shrewsbury Severn Rotary Club – 5 December 2025 (Hybrid meeting)

2.7 Our last HTP About Health Event took place on Tuesday 4 November at 6.30pm on MS Teams

2.8 On the 5 September 2025 the Transforming PRH Hub was opened near the main entrance of PRH, providing a space for the charities that are supporting developments at PRH to share information about their activities, as well as a place to share information about HTP

2.9 Slides 23-24 outline our "You Said, We Did" following feedback from our local communities at events and focus groups in relation to HTP.

3.0 Volunteers (Slides 26-34)

3.1 We currently have 214 volunteers, who have given over 12,500 hours of volunteer time over the past 6 months. We have over 30 different role descriptions across all areas on the Trust including non-clinical support roles. Our volunteers have supported an number of "one off events" alongside their regular placements, including Exercise Jupiter and the vertical evacuation event at SERII. We have new members of staff join the volunteer team and on average we are taking 3.2 weeks to carry out the relevant recruitment checks and training for new volunteers (slide 27).

3.2 In collaboration with the National Charity Helpforce, we have been able to highlight the amazing work of our volunteers has gained local and national media attention with the inspirational stories of Alisha-Mai Stevens, Claire Ashton and Robert Turner. (slide 28)

3.3 We have developed several new volunteer roles, including a digital volunteer role and an appointment reminder service. Following a meeting with the Duke of Edinburgh Charity we are soon to become an Approved Activity Provider for volunteering (Slide 29-30)

3.4 Following joint funding by SaTH Charity and the League of Friends we have been able to purchase a volunteer buggy. The buggy is to support patients with mobility issues to get to outpatient clinics from the treatment centre. (Slide 31)

3.5 Slides 32-34 highlight the successful volunteer driver project that has been introduced following a successful bid proposal to the ICB. We have worked with National Charity, Helpforce to deliver this project, which has seen our 14 volunteer drivers undertaken 462 since June to take patients home following discharge from hospital or following an outpatient's appointment. 90.5% of patients were collected within 30 minutes of the requesting being made and the service has been extended to support maternity and renal patients recently. Our data also shows that 44.8% of patients who utilised our service were in the 1st and 2nd quintiles for deprivation.

4.0 SaTH Charity (Slides 35- 46)

4.1 Income for the 6 months of Q1 & Q2 2025/26 was £217,683 compared to £349,982 in the same period last year (please note that in May and August 2024 we received 3 legacies totalling £212,489 which is why the income is significantly higher). Expenditure for the same period was £342,919 compared to £178,986 in 2024. Some examples of expenditure are shown on Slide 37.

4.2 Currently SaTH Charity has 1152 supporters (slide 38):
Donors (1057) - Provide financial support to the charity – this could be through a one-off donation, or multiple donations.
Fundraisers (95) -Organise events, and other initiatives, such as a sponsorship for a marathon, to raise money and donations.

4.3 SaTH Charity was delighted to announce the opening of a dedicated Transforming PRH Hub, in collaboration with the League of Friends of the Shrewsbury and Telford Hospital and Lingen Davies charities. The Hub officially opened its doors on 5 September at the main entrance of Princess Royal (PRH), with local partners in attendance, including local MP Shaun Davies. The hub will serve as a central

information point for patients, visitors and staff to find out more about the work happening to transform PRH and how they can get involved. (Slide 39)

4.4 Slides 40-41 highlight some of the ways SaTH Charity have made a difference, including, the purchasing a fourth robotic scope which can be used for upper gastrointestinal surgery (slide 40) and a new fluoroscopy stretcher for Cardiology (slide 41)

4.5 On the NHS birthday (5 July 2025) we celebrated with our staff with our annual thank you daisies and cards. Over 270 members of staff were nominated and the daisies and cards with their nominations were handed out at RSH and PRH

4.6 Slides 43 - 45 shows some of the ways our supporters have raised money for SaTH Charity, including our annual staff football tournament and fundraisers running the Manchester Marathon and the Shrewsbury Half Marathon. Slide 44 celebrates the Swan Fund celebrating a milestone birthday, turning 10 years old and raising over £100,000.

4.7 In partnership with The League of Friends, we have funded £245,000 for crucial equipment to support urology patients. The purchase of the equipment will help reduce waiting times, improve patients comfort and allow a greater number of operations to take place (slide 46).

5.0 Q3&4 Looking Forward (summarised slides 47-49)

5.1 Looking Forward highlights (slide 47)

- The Public Assurance Forum to meet on 19th January 2026
- Continue to support staff with any future service changes engagement
- Supporting the HTP Engagement programme, including the quarterly focus group for the public and patients.
- Continued attendance at community events to engage with the public
- Continuing to support staff wellbeing through Charity Small Things Big Difference Fund
- Support fundraising for the Hospitals Transformation Programme
- Develop our 5-year strategy for Volunteers and Community Engagement with our staff, volunteers and local communities
- Continue to grow and support our volunteers and the opportunities we provide to them

5.2 Dates for your diary (slides 49). Please contact sath.enagagement@nhs.net or visit our website for more information Public Participation - SaTH

6. Recommendations

The Board of Directors is asked to:

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

Julia Clarke Director of Public Participation
November 2025

Board of Directors' Meeting: 13 November 2025

Agenda item	162/25				
Report Title	STW System Winter Plan 2025/26				
Executive Lead	Ned Hobbs, Chief Operating Officer				
Report Author	Gareth Wright, Head of Clinical Operations UEC & EPRR, NHS STW				
CQC Domain:	**Link to Strategic Goal:**			**Link to BAF / risk:**	
Safe	√	Our patients and community	√	BAF9, BAF10, BAF12	
Effective	√	Our people	√		
Caring	√	Our service delivery	√	**Trust Risk Register id:**	
Responsive	√	Our governance	√	N/A	
Well Led	√	Our partners	√		
Consultation Communication	N/A				
Executive summary:	The SaTH Winter Plan 2025/26 was approved at the Trust's September Public Board meeting and is now being implemented. It builds on lessons from last winter and is aligned with the STW System UEC Improvement Plan. The STW Winter Plan (Appendix 1) has been developed earlier and more comprehensively this year, with positive feedback from NHSE Midlands following their assurance visit in September. The STW Winter Plan was approved in September at ICB Board and is shared with SaTH Board for information. Please note, the performance data included in the STW Winter Plan is up to and including August 2025. More recent performance data is available via the SaTH Integrated Performance Report. The risks are:- • Operational pressures: Sustained crowding in EDs, particularly impacting 4-hour and 12-hour standards, and ambulance handover delays, entering the winter period. • Delivery risks: Potential delays in implementing high-impact winter plan schemes due to estates or workforce constraints, and the risk that improvement workstreams may not deliver the intended impact by December. • Delivery of the Urgent Treatment Centre extended hours is being reviewed given workforce constraints. • System resilience: Workforce fatigue, winter illness, and the need for robust command and control to manage concurrent pressures. • Patient behaviour: Insufficient public awareness of alternatives to EDs, which is being addressed through a targeted winter communications campaign. We are currently:- • Supporting delivery of the STW-wide Winter Plan through implementation of the approved SaTH Winter Plan and SaTH UEC Recovery Plan (approved September 2025), with both plans forming a unified system response to seasonal pressures. • Sharing the STW System Winter Plan with the Board, at Board's request, to reaffirm strategic alignment and provide assurance that the system is better prepared than in previous years, with improved modelling, earlier planning, and more focused interventions.				
Recommendations for the Board:	The Board of Directors is asked to **note** the report, particularly as highlighted above.				
Appendices:	Appendix 1: STW Winter Plan 2025/26				

1. ICB 25-09.201 – Winter Plan 2025-26

Meeting Name: NHS Shropshire, Telford and Wrekin Integrated Care Board
Meeting Date: Wednesday 24 September 2025
Report Presented by: Ian Bett, Chief Delivery Officer, NHS STW
Report Approved by: Ian Bett, Chief Delivery Officer, NHS STW
Report Prepared by: Gareth Wright, Head of Clinical Operations UEC & EPRR, NHS STW
Action Required: For Discussion and Approval

1.1. Purpose

1.1.1 The purpose of this report is to update the Board on our planning for winter to date, and if content, to seek approval of our Winter Plan.

1.2. Executive Summary

1.2.1. The System UEC Improvement Plan 2025/26 is broadly on track. There are twin aims to support delivery of our operational plan and ensure preparedness for winter on a better footing than previous years. Against the primary performance metrics specified by NHSE committed to in our operational plan, we have achieved significant improvement on the ambulance performance required. We have made progress, but have more to do in order to reduce the time our patients are in our emergency departments. We expect to be back on plan in Q3 following delivery of our programme of improvement work.

1.2.2. Winter planning has gone further and been much earlier this year than last, both locally and nationally, and NHSE direction has been more proscriptive. We submitted our initial winter plan on 1 Aug to NHSE Midlands, who have conducted an assurance visit to our system on 4 Sep, which will be followed by an exercise to test system plans on 17 Sep. Following completion of that process, ICB and Trust Boards have been asked to complete board assurance statements no later than 30 Sep. Our proposed submission is covered in this report.

1.2.3. Detailed work that is progressing includes aligning provider plans with our system-wide approach; refining modelling of the impact upon our performance measures and capacity in the acute hospitals; and having selected where to apply our system interventions to greatest effect, moving them forward at pace.

1.2.4. The effects we intend to achieve are: to decompress our emergency departments; shift more urgent care out of hospitals to the community; maintaining a ‘home first’ principle for our patients; and minimise delays at each stage of the pathway. This is an ambitious agenda, but we have good grounds for optimism from the delivery of our programme of work that we will enter winter this year from a much stronger start position than previous years.

1.3. Recommendations

1.3.1 The Board is invited to:

- Note the progress of the system UEC improvement programme and delivery of our operational plan.
- Approve the system winter plan, to mitigate additional seasonal pressure, and safely maintain quality of care.
- Agree the submission of our Winter Board Assurance Statement to NHSE no later than 30 Sep, subject to finalisation by the Chair and CEO.

1.4. Conflicts of Interest

1.4.1. No conflicts of interest related to this report.

1.5. Links to the System Board Assurance Framework (SBAF)

1.5.1. Strategic Objective 3 includes: Improving Health and Care – Urgent & Emergency Care.
1.5.2. Strategic Risk No.2b: Failure to deliver the System and ICB Revenue and Capital Resource Limit Plans; due to Escalation costs not reducing as planned due to UEC pressure and links to discharge.

1.6. Alignment to Integrated Care Board

1.6.1. Improve quality of care and patient experience in the UEC pathway. Enhance productivity and value for money.

1.7. Key Considerations

1.7.1. **Quality and Safety:** Achieving the best we can for patient care and outcomes under extreme operational pressure.
1.7.2. **Financial Implications:** UEC Improvement Programme is required to contribute to the System Financial Plan 2025/26, by reducing cost of Escalation capacity and process improvements in Community pathways.
1.7.3. **Workforce Implications:** UEC Improvement Programme is required to contribute to the System Workforce Plan 2025/26, by reducing reliance upon temporary staffing.
1.7.4. **Risks and Mitigations:** Risks to programme delivery are being managed by the UEC Delivery Group; accountable to the System Transformation Group.
1.7.5. **Engagement:** Extensive winter communications plan across broad media sources.
1.7.6. **Supporting Data and Analysis:** Data used in the report is from NHS STW Business Intelligence.
1.7.7. **Legal, Regulatory, and Equality:** Addressing health inequalities will continue to be a deliverable within the UEC programme 2025/26.

1.8. Impact Assessments

1.8.1. **Has a Data Protection Impact Assessment been undertaken?** No

1.8.2. **Has an Integrated Impact Assessment been undertaken?** No, but an Equality & Quality Impact Assessment has been reviewed by our Quality and Inequalities teams, and continues iteration.

1.9. Attachments

1.9.1. Appendix 1 - STW Winter Plan 2025-26 summary.
1.9.2. Appendix 2 - STW Winter funded mitigation schemes.
1.9.3. Appendix 3 - System bed model 2025-26.
1.9.4. Appendix 4 - Board Assurance Statement evidence and rationale.
1.9.5. Appendix 5 - NHSE Winter Planning Board Assurance Statement – ICB. This is for approval at this meeting.

2. Winter Planning 2025-26

2.1. Introduction

2.1.1. This report follows on from the presentation delivered to the Board on 30 Apr 25, which updated on delivery last winter and reflected upon UEC improvement achievements in 2024/25. The Board was apprised of our intended approach for 2025/26 as Year 2 of our improvement programme, having learned from the experience of last year. Our winter planning for this year to date was briefed to the Board Development Session on 30 Jul 25, to enable submission of our initial Winter Plan to NHS England on 1 Aug 25.

2.1.2. Performance against the trajectories we have committed to is being much closer monitored this year. Improvements made within our UEC pathway have directly contributed to this and will do more. Our programme of work includes planning across the system to mitigate the predicted increased demands over the coming winter months. We have high impact schemes that will come to fruition, which will enable us to enter winter on a stronger footing than in previous years.

2.2. Background

2.2.1. **National direction – UEC Plan 2025/26**. Ahead of release of the 10 Year Health Plan for England, NHSE published the UEC Plan 2025/26 on 6 Jun 25. A wide-ranging document, which:

2.2.1.1. Confirms **priority focus upon key metrics** that we are closely monitoring in our Operational plan: patients waiting for 4 hours and 12 hours in our emergency departments; Category 2[1] ambulance response; and confirmation of a new standard for ambulance handover delays to be a maximum handover time of 45 minutes.

2.2.1.2. Provides **direction on preparing for winter**; principally seeking to learn from previous years, with two priority actions:

[1] Patients who are categorised as Category 2 – such as those with a stroke, heart attack, sepsis or major trauma – are to receive an ambulance response within 30 minutes.

'Focus as a whole system on achieving improvements that will have the biggest impact on urgent and emergency care services this winter.'

'Develop and test winter plans, making sure they achieve a significant increase in urgent care services provided outside hospital compared to last winter.'

2.2.2. **NHSE Midlands direction**. An NHSE Midlands letter was received on 18 Jun, 'Winter 2025/26 Expectations for Planning, Preparedness, and Assurance', which informed the Board update on 30 Jul. We have submitted a winter Key Lines of Enquiry return to the regional team, our initial winter plan on 1 Aug; and hosted senior leadership from the Midlands Region team on a winter assurance visit to our system on 4 Sep. At the time of writing, formal feedback on the latter is awaited, but comments on the day were very positive; welcoming our progress and level of ambition, recognising that delivery is now key.

2.2.3. **NHSE Winter Board Assurance Statements**. On 14 Jul, the National Director of UEC & Operations, Sarah-Jane Marsh, wrote to ICB and Trust CEOs with supplementary guidance. Two specific expectations of all ICBs and Trusts, new this year, are:

- Stress test draft winter plans by participating in an **NHS England-hosted exercise** in September, to be arranged by Regional teams. The latter has been set for 17 Sep, which post-dates the finalisation of this report, so any significant outputs from that event will be covered during discussion.

- By 30 Sep, we are to submit a **Board Assurance Statement** direct to the NHSE national UEC team. The proposed statement is attached to this report, with the current status of actions leading to being able to recommend assurance to the Board are at Appendix 4. If content, the Board is asked to provide approval for submission.

2.2.4. **Improvement acknowledged by NHSE**. We are in Year 2 of our system plan to meet the Undertakings we committed to in May 24, including for operational delivery. What has been well received during our time in the national Recovery Support Programme (RSP), is that as a system, we have had a single, unified plan for improvement and delivery, and stuck to it. Tangible confirmation of achievement is:

2.2.4.1. A certificate of **compliance with the Undertakings** (not just UEC) has been issued by NHSE Midlands, on 18 Jul 25.

2.2.4.2. NHSE Midlands are reviewing whether the conditions have been met for the ICB to **transition out of RSP**. We have provided comprehensive evidence to demonstrate fulfilment of what we committed to do. At the time of writing the decision upon that is **awaited.**

2.3. System approach to winter 2025-26

2.3.1. **Transition from winter 2024/25**. It is generally expected that winter pressures ease after the turn of the financial year, but a conflation of factors contributed to a challenging exit from winter and start to Q1 in our system:

- **High attendances**. Ambulance conveyances to our hospitals were unusually high in March and April, with a weekly average 9.1% higher than in Dec 24 to Feb 25; and 5.8% higher than Mar/Apr 24. Overall front door attendances at our EDs were also 8.9% higher over the same period; with Type 1 at 2.3% higher.

- Taking the SaTH **Urgent Treatment Centres (UTCs)** contract back in-house resulted in a temporary reduction in activity through the UTCs and the performance achieved. The UTCs and our community Minor Injuries Units when working well, typically achieve over 90% compliance with the 4 Hour standard, which contributes strongly to our overall system performance as well as flow. Low activity through the UTCs displaces activity into our EDs.

- The start of the transition period for our **GP Out of Hours / Care Coordination Centre** provider contract; and the ending of additional capacity within it that had been funded by the national Recovery Support Programme. The effect has been to reduce options to signpost activity away from our hospitals; and in particular to reduce the ambulance service 'call before convey' for an alternative.

- **Ending of System-funded winter schemes** that contributed to flow, notably additional patient transport for discharges and transfers. This affected early outflow from our hospitals; proving the value of the intervention.

2.3.2. **Performance against Plan**. These factors increased and sustained crowding in our EDs, with a concomitant impact upon our primary performance metrics. But we remain largely on track or close to our operational plan. Our improvement programme is responsive to supporting course-correction, and our winter planning has been informed accordingly.

2.3.2.1. **4 Hour standard**. Notwithstanding these adverse pressures, our system performance overall has largely tracked, albeit fallen slightly short of the trajectory we have committed to, as shown in Figure 1 below. Importantly, the ED Type 1 performance has been closer to plan, which is generally harder to achieve than the Type 3 contribution by the UTCs, which will continue improve. The principal contributory factor to adverse 4 Hour performance is crowding in the EDs, with too many patients to be seen by too few clinicians with too few clinical spaces to see them in. It is our main effort to decompress the EDs, and several of our high impact enduring changes – as well as winter-specific schemes – are focused upon this effect.

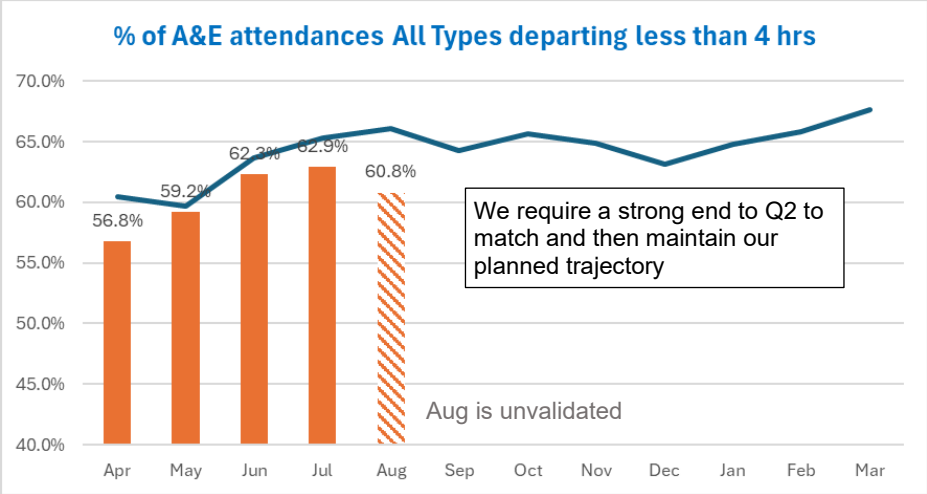


Figure 1: System 4 Hour performance against trajectory

2.3.2.2. **12 Hour waits in EDs**. This remains our area of most significant challenge, as shown in Figure 2. It is a direct result of the crowding in our EDs, which in turn is a product of too many arrivals and insufficient exit flow; not just admissions, discharge or transfer. Progress in the department slows, quality of care is diminished, and safety can be compromised. Corridor care becomes an unwelcome pressure. Approximately 60% of our 12-hour waits are for inpatient beds, with circa 20% routed to ambulatory or short stay settings; and the remainder are either discharged or transferred to other locations (such as a community bed). Additional bed capacity is due to be available on our acute sites in Q3, and several of our other schemes due to come online achieve a bed *equivalence* by providing alternatives to hospital attendance and admission, as well as facilitating more timely discharge and reducing the incidence of readmissions.

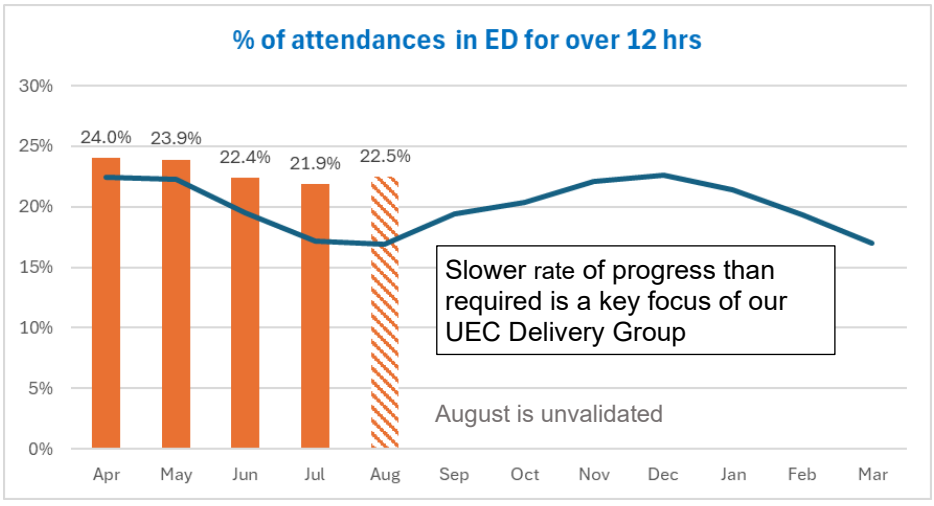


Figure 2: SaTH 12 Hour performance against trajectory

2.3.2.3. **Ambulance handover**. We have committed to an ambitious trajectory that is a 17% improvement on what we achieved each month last year. A new standard was introduced over Q4 of last year, to achieve handover within 45 mins (absolute, rather than

average). This has been confirmed in the NHSE UEC Plan, and although not in the planning round so we do not have a trajectory for it, we have committed to month-on-month improvement. August has been our most compliant month this year to date with 66.2%. Handover performance has a close connection with our financial plan, with potential penalty costs to contribute to WMAS capacity being a topical sticking point in agreeing the WMAS contract being brokered by Black Country ICB as lead commissioner. Figure 3 shows the challenging start in April but subsequent months being closer to our trajectory.

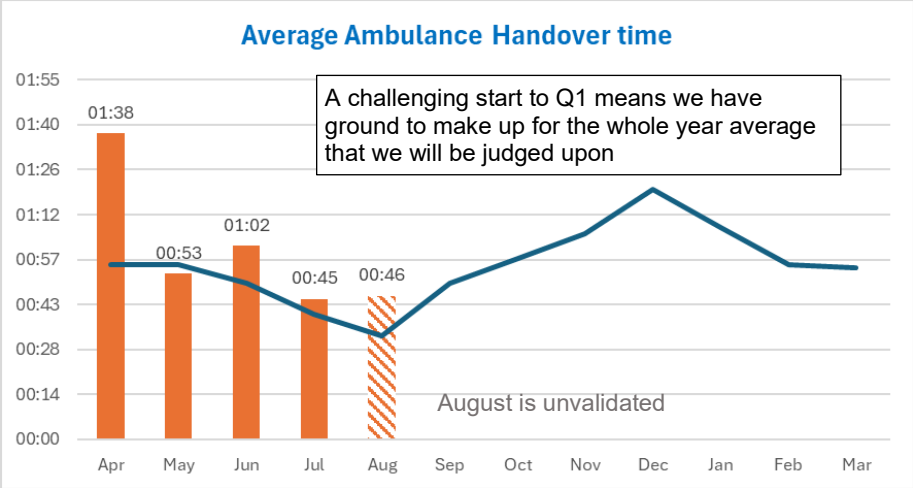


Figure 3: SaTH Ambulance handover performance against trajectory

2.3.2.4. **Ambulance Category 2 response**. This is a system metric that is a shared endeavour with WMAS, being partly a function of the resource deployed by our ambulance service colleagues and timely release of crews following handover at our hospitals, as well as finding alternatives to conveyance in the first place. In 2024/25 our system was one of the top 5 most improved nationally. Figure 4 shows the achievement this year to date.

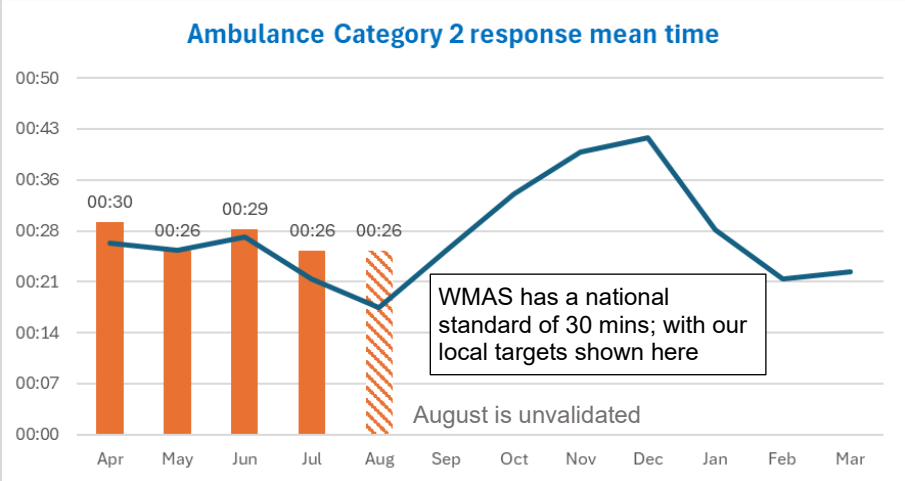


Figure 4: System Ambulance Cat 2 response against Plan

2.3.3. **Learning from Winter 2024-25**.

2.3.3.1. **System review and learning**. The UEC Delivery Group received a review of our System winter plan 2024/25 on 27 May 25. In summary, our ability to respond was insufficient to counter the progressive pressure that built throughout Nov & Dec 24, culminating in declaring a system-wide critical incident on 3 Jan 25. It was recognised the significant response from system partners to ensure the incident only lasted for 48 hours. Winter pressures extended into April in terms of demand upon our pathway, which we have made provision for in our planning this year.

2.3.3.2. **NHSE Midlands**. The review of the experience across the Midlands region over winter acknowledged and confirmed the themes we had identified. A key observation made in the NHSE Midlands feedback was:

'*STW has proven it can recover under pressure. The next step is to avoid getting there in the first place*'.

2.3.4. **What we are doing differently.** Considering what has already been covered in this report, our approach has been modified based upon experience, including:

- Nationally and locally, **planning** has started much earlier.
- Our UEC Improvement **programme will complete *ahead of* winter**, not at the tail end of it, in the way intended last year.
- **Provider-specific improvement** programmes are more realistic; and complementary to the overarching system programme.
- We are **involving primary care** to better effect.
- Working with our Local Authorities on our **domiciliary care** provision.

2.3.5. **System-level interventions** will be more focused at the time and places to achieve most impact, rather than spread too thinly.

2.3.6. **Why we will be in a better place this year**. We require a more robust UEC pathway all-year round, with the ability to adjust for seasonal variations. That has been the focus of our Improvement programme. There are high impact changes being made – none of which we had last year – that are not winter-specific and therefore enduring. All these changes will contribute to our main point of effort, which is to decompress our EDs, by reducing attendance and increasing outflow. This includes an integrated out of hospital model for the services delivered by SCHT; reinvesting funds released from repurposing the Rehabilitation & Recovery Units at our acute sites. The principal changes are:

Enduring scheme	Output intended	Timeframe
Expansion of Urgent Community Response (UCR) to midnight, 7 days a week	ED Attendance avoidance	Nov/Dec
UCR Medical Model via GP cover and oversight	Safer, timelier community-based decision-making	Nov/Dec
Integrated Community services at the Front Door of our Emergency Departments	Redirection of patients into community service alternatives	Sep
2-Hour Domiciliary Care Bridging	ED Admission avoidance by supported discharge	Nov/Dec
Additional Discharge Planning capacity (5 to 8pm, 7 days a week)	Maintain discharge flow beyond core hours	Nov
Care Transfer Hub (CTH) System Manager	Enhanced operational leadership and joint working	Oct
Additional Weekend Therapy cover for CTH	7-day therapy input for frail / complex patients	Nov
Care Coordination Centre / GP Out of Hours delivery under new contractor	Alternatives to ED, including reduced Ambulance conveyances	Oct
SaTH UTCs brought back in-house	Higher productivity is being incrementally achieved	In place
A modular build comprising 56 additional beds at RSH	38 additional inpatient beds available year-round, plus 18 Winter Flex inpatient beds	Nov/Dec
Reconfiguration of acute medicine beds and assessment areas at PRH (subject to Board approval 11 Sep 25).	Increase outflow options and capacity from ED	Oct/Nov

2.4. Winter Plan 2025-26

2.4.1. **Development of our Plan**. Winter planning has been a workstream in our Improvement programme, enacted from 1 Apr. The UEC Delivery Group has directed the programme, received monthly updates and made decisions on our approach. Our proposed plan has been reviewed and agreed at appropriate waypoints by the system UEC Clinical Advisory Group, the Commissioning Working Group, the System Transformation & Digital

Committee ahead of Board on 30 Jul. The sequence of governance checks and balances enabled us to meet the NHSE submission deadline.

2.4.2. **Winter Plan summary**. Appendix 1 is the system winter plan, on a page. It consists of five phases with specific effects intended to match expectation of pressure and response. The phases are summarised in the table below:

Phase	Time period	Effect intended	Summary
1	Jul – Oct 25	**Deliver our programmes**	High impact changes (paragraph 2.3.5 above) will come online at varying points and coordinated to best effect.
2	Ahead of the festive fortnight	**Reduce rising pressure**	Intensive system effort to offset rise in demand and create capacity needed to get through the bank holiday period; which effectively has two 4-day weekends.
3	Early new year	**Recovery**	Having used the capacity, priority is to decompress and rebuild our reserve.
4	Feb – Mar 26	**Sustain our response**	Avoid being over-matched by pressure and set conditions for a strong Mar 26.
5	Mar – Apr	**Transition from winter**	Taper off the winter schemes and start 2026/27 well.

2.4.3. **Command & control**. Against the backdrop of the national and local NHSE / ICB reset, ICBs are required to deliver winter, and we will do so seeking any opportunities to work closer with our ICB cluster colleagues in the Staffordshire & Stoke-on-Trent ICB. Command & control will be exercised through our System Coordination Centre, which is well established and regularly tested in responding to pressures and the unforeseen. Managing the concurrency of UEC pathway winter pressures alongside an EPRR incident is being worked through.

2.4.4. **Applying system interventions**. We will have a tiered response framework this winter, which was welcomed and assured during the NHSE Midlands visit on 4 Sep:

2.4.4.1. **Enduring**. This will be our baseline increase in capacity, comprising what we have now, improved by the high impact changes detailed in paragraph 2.3.5 above. Redistribution of resources to rebalance activity into our Neighbourhoods.

2.4.4.2. **Seasonal**. This will comprise the interventions that we plan and proactively apply in a place and time of our choosing – such as a multi-agency discharge events, a GP at the ED front door, additional capacity in primary care, more patient transport.

2.4.4.3. **Responsive**. If our pre-planned interventions are judged insufficient to mitigate pressure, we will enact focused additional measures to de-escalate and avoid reaching a tipping point that would require an incident-level response. This might include extending opening hours of services; additional clinical decision-making capacity; and enhanced control by senior leadership.

2.4.5. **Allocation of ICB winter funding**. There is no general national funding again this year to resource the response required to winter pressures. We have a system budget of £740k, which is comparable to last year. Where to apply this funding to deliver the effects we require has been informed by review of what worked and what was less impactful last winter. There have been tests of change for the efficacy of schemes, such as transport capacity to be ringfenced for specific purposes. The ability to plan more deliberately is a direct benefit of starting our planning process earlier this year.

2.4.5.1. **Impact areas**. The UEC Delivery Group on 26 Aug agreed the schemes we will fund this year. This is summarised in Appendix 2. It was agreed that we would expect greatest impact from allocating system winter funding to:

- ED attendance and re-attendance avoidance by **Primary Care**, both our general practice and community pharmacy capacity.
- **Patient discharge transport** and enabling earlier facilitated discharge.
- **Communicating** with our patients to reassure, inform and empower their decision-making.
- Provide a capacity **reserve for de-escalation**, under a response scenario as outlined at paragraph 2.4.4.3 above.
- And that we should de-prioritise previous year schemes that have limited proof of delivery

2.4.5.2. **Distribution of funding**. At the time of this report, providers of the selected schemes are being given authority to proceed. We await a decision on a bid we have submitted for additional funding from a national Respiratory Transformation Programme scheme. If successful, it would enable primary care seasonal respiratory intervention on a broader basis that we can currently fund as a system. Assurance that we are using our system funding appropriately continues to be by the Commissioning Working Group.

2.4.6. **Winter-specific planning**. There are specific seasonal sub-plans that are well advanced, including:

- **Vaccination programme**, executive lead CMO supported by CNO; being developed by the Directors of Public Health for our population, and by provider leads for staff immunisation and inpatients.

- **Infection Prevention & Control**, executive lead is CNO; we will receive health intelligence input from UKHSA, and response plans by providers.

- Our **Workforce** is under the most pressure of any time of the year with staff fatigue, burnout, winter illness and the imperative to take leave all factors that will be carefully managed.

2.4.7. **Bed demand & capacity**. Our baseline bed model is derived from our Operational Plan 2025/26. This is supplemented by the impacts of our change programme activities (including SaTH modular build) and our winter-specific schemes. We continue to refine modelling of the impacts that could be realised; along with what can be achieved at an appropriate confidence level.

2.4.7.1. **Winter scenario impact effects** are based upon actual experience last year, with two levels 'surge' (1 or 1.5% increase in demand and bed closures) and 'super surge' (2 to 5% increase, depending which metric is affected). Whereas these percentages are not particularly high, such is the nature of current demand upon finely balanced service capacity, they have a cumulative effect over a succession of days if the pressure cannot be eased. Our ability to turn over beds is more significant than absolute numbers.

2.4.7.2. **Assessment**. There are plus and minus shifts intended as we rebalance our bed base, as well as measures that will provide bed equivalence in our high impact schemes. Taking all of this into account, a summary of our demand and capacity is at Appendix 3. Our most challenging month is expected to be December, both in terms of peak demand as well as a number of our change programmes rebalancing capacity and service delivery. Every effort will be made to bring forward, deconflict and coordinate provider changes with system support.

2.4.7.3. Use of **Temporary Escalation Spaces (TES)** will be minimised this winter. TES comprise the use of unfunded or unconventional care spaces, which may include one or more additional patients in inpatient wards, or 'corridor care' in an emergency department. The latter, above all, will not form part of our escalation processes this year.

2.4.8. **System partner key contributions**. Our role as the ICB is to plan and deliver 'a better winter for our patients and staff', as directed in the NHSE UEC Plan 2025/26 published on 6 Jun 25. Key contributions that our system partners are accountable for include:

2.4.8.1. **SaTH** will deliver the process improvements within their agreed Improvement programme; and reconfigure the acute bed base for greater optimisation of flow through the hospitals.

2.4.8.2. **ShropComm** will deliver the closure of the Rehabilitation & Recovery Units in order to release resources to reinvest in the Integrated Out of Hospital model. The outcome will be a significant shift of patient activity away from hospital into community settings.

2.4.8.3. **RJAH** will continue to focus on elective activity and backlog reduction. Over the festive fortnight, fallow capacity will be made available to SaTH to continue elective programme delivery during the forthcoming bed reconfiguration; and ease pressure upon the acute sites at this most demanding point in winter.

2.4.8.4. **MPFT** will maintain resilience in its community and inpatient mental health services in support of the overall system ambition to drive down unnecessary demand on primary care and acute services.

2.4.8.5. **WMAS** will maintain ambulance resource availability in accordance with their demand & capacity plan for winter. And bear down upon unnecessary conveyance to hospital, making appropriate use of the 'call before convey' options for lower acuity patients. Close contact is maintained daily between our Ops teams to manage pressure.

2.4.8.6. **Health Hero**, our provider of single point of access and GP out of hours services with effect from 1 Oct, will collaborate with our system partners to identify and provide alternative to hospital pathway referrals for our patients.

2.4.9. **Risks to Quality and delivery**. Key risks being managed in our preparedness, all under ICB leadership and command & control interventions are:

- **High impact schemes** being delayed in implementation; for example, estates delays and workforce consultation. There will also be sequencing and concurrency issues to be carefully managed as we make changes to the services we are delivering.

- **UEC Improvement programme** workstreams not delivering the impact envisaged by the start of November; for example, more patients being discharged home, has a dependency upon reducing delay-related deconditioning in our hospitals.

- **Insufficient information to inform patient decisions** to select the right service for their needs, other than our EDs. This is the principal focus of our system winter communications campaign, which is in development.

- **The unforeseen** is a daily challenge on the UEC pathway; for example, across the NHSE Midlands region last year there was an earlier onset at higher levels than predicted of Flu.

2.4.10. **Towards Board Assurance of our Plan**. New to this year, although consistent with the direction of travel for more defined accountability, is the requirement for CEOs and Chairs of ICBs and Trusts to complete and submit a Board Assurance Statement (BAS) to the NHSE national team, no later than 30 Sep.

2.4.10.1. A **proposed BAS** is enclosed for ICB Board consideration, with a summary of evidence and rationale for recommending assurance at Appendix 4 of this report.

2.4.10.2. Although the ICB assurance is not an aggregation of our **provider Trusts' statements**, we have been monitoring progress through the system Planning & Performance Group and by the ICB Board meeting on 24 Sep all should have been reviewed by Trust Boards, as follows:

Trust	Board date	Notes
RJAH	3 Sep	BAS was reviewed and supported
SCHT	4 Sep	BAS was approved and will be aligned with SaTH by CEO in Common
SaTH	11 Sep	Not taken place at the time of writing this report
MPFT	11 Sep	Jointly comprises the assurance for Staffordshire & Stoke-on-Trent

2.5. Recommendation

2.5.1. Winter will never be a straightforward period of pressure for our system. But we have come far in setting the conditions for a more resilient UEC pathway, that is more able to absorb and recover from peaks of demand. Provided we successfully deliver the interconnected programmes of work that we have in progress, we should enter winter in a significantly better position than previous years. This will provide our basis to maintain safety and the quality of care that our patients deserve.

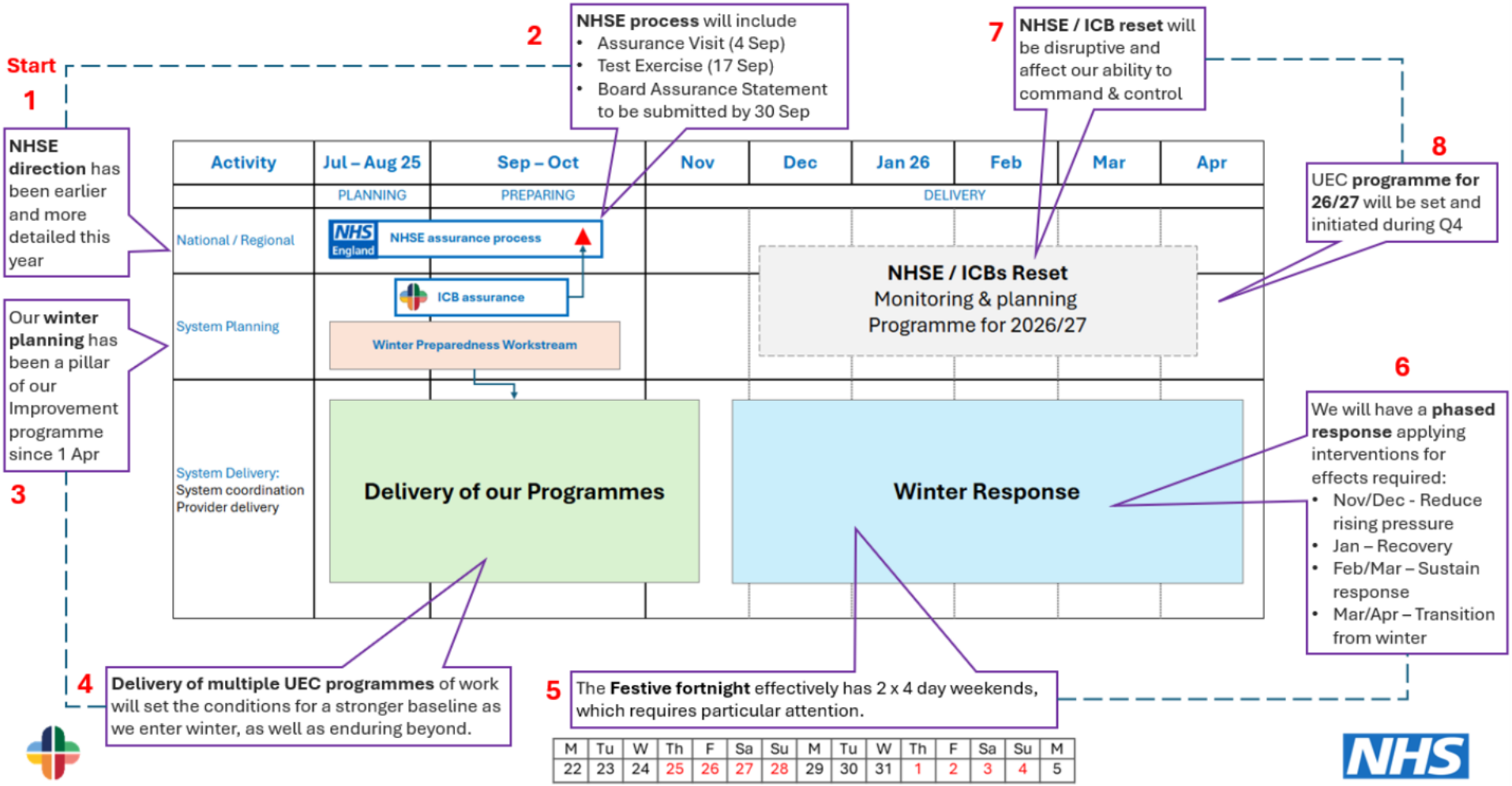
2.5.2. On this basis, the Board is recommended to:

- Note the progress of the system UEC improvement programme and delivery of our operational plan.
- Approve the system winter plan, to mitigate additional seasonal pressure, and safely maintain quality of care.
- Agree the submission of our Winter Board Assurance Statement to NHSE no later than 30 Sep, subject to finalisation by the Chair and CEO.

Appendices:

1. STW Winter Plan 2025-26 summary.
2. STW Winter funded mitigation schemes.
3. System bed model 2025-26.
4. Board Assurance Statement evidence and rationale.

Elements of our Winter Plan 2025/26



System Winter schemes to be funded by ICB 2025/26

Time limited interventions for the winter period.

Scheme	Summary	Outcome expected	Effects intended
Extended Hours of UTC opening	By opening from 0800-midnight daily, we can reduce the number of patients handed back to ED; as well as easing pressure upon general practices.	*Typically 15-20 patients seen in each UTC rather than ED*	ED decompression Reduce pressure on primary care
Primary Care management of rising risk patients	Identify rising risk patients, optimise care, and support, linking with Virtual Ward and acute physicians if necessary. Funding bid pending for Respiratory Transformation Programme.	*Patients de-risked from COPD exacerbation in the community*	ED attendance avoidance
British Red Cross ED support scheme	To provide emotional and practical support to our patients, their families and carers.	*Support to 300-600 patients, subject to final model agreed*	Admission avoidance and ED decompression
System-level Communications	We need to keep our patients informed of their options including Pharmacy First and NHS 111.	*'Think Which Service' broad spectrum campaign*	Influence public and patients
Patient transport capacity	Complete work to ensure we are making best use of what we have, supplementing if the need is proven.	*Additional 1,600 patient journeys for discharges*	Earlier in the day discharge
Enhance our Discharge Medicines Service	Increase the volume of referrals and targeted support to community pharmacies to increase completion rates.	*Bed days saved from approx 15-20 beds equivalence*	Re-admission avoidance
Reserve capacity to meet peaks of demand	A range of pre-planned interventions is needed, within agreed lead times. This may include additional GP capacity in acute settings.	*Focused interventions to deliver double digit impacts*	Ease system pressure at points of greatest need on our pathway

ICB 25-09.201 - Appendix 3 – System bed model 2025-26

The System Operational Plan 2025/26 provides progressive mitigation of the bed position at SaTH by a range of improvement programme schemes. Added here are the expected impacts of the high impact change programmes and System funded winter schemes (Appendix 2). The mitigations will offset our anticipated adverse bed position. December is our month of highest anticipated pressure, concurrent with enacting changes such as the modular build at RSH becoming available to use.

Physical beds required	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Baseline	709	741	721	719	699	683	688	718	740	710	733	684
Surge	709	741	721	719	699	683	711	750	786	754	769	707
Super surge	709	741	721	719	699	683	727	774	818	786	795	723
Beds available												
Overnight G&A available - core	768	768	768	768	768	768	768	796	796	796	796	796
Planned Escalation beds	17	17	17	17	17	17	17	17	45	45	45	45
Total beds	**785**	**785**	**785**	**785**	**785**	**785**	**785**	**841**	**841**	**841**	**841**	**841**
NEL acute beds (including SaTH schemes)	**662**	**662**	**662**	**662**	**662**	**662**	**662**	**735**	**745**	**763**	**763**	**763**
Occupancy assumption	98%	98%	98%	98%	96%	96%	96%	96%	96%	96%	96%	96%
Beds available	**649**	**649**	**649**	**649**	**636**	**636**	**636**	**706**	**715**	**732**	**732**	**732**
Bed gap (after IPC closures)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Baseline	-68	-101	-88	-77	-73	-55	-69	-19	-33	3	-6	33
Surge	-68	-101	-88	-77	-73	-55	-92	-51	-79	-41	-43	10
Super surge	-68	-101	-88	-77	-73	-55	-108	-75	-112	-74	-69	-6
System bed mitigations include												
Out of Hospital activity shifts								8	17	18	17	17
System winter mitigation schemes							6	9	13	14	14	14
Residual bed gap	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Baseline	-68	-101	-88	-77	-73	-55	-63	-2	-3	35	25	64
Surge	-68	-101	-88	-77	-73	-55	-86	-34	-49	-9	-12	41
Super surge	-68	-101	-88	-77	-73	-55	-102	-58	-82	-42	-38	25

ICB 25-09.201 - Appendix 4 – Board Assurance Statement evidence and rationale

By 30 Sep, we are to submit a Board Assurance Statement directly to the NHSE national UEC team. The current status of actions leading to being able to recommend assurance to the Board are detailed here.

Section A: Board Assurance Statement

Assurance statement	Assurance recommended (Yes / No)	Evidence / rationale
Governance		
The Board has assured the ICB Winter Plan for 2025/26.	Yes	Summarised in this report. Our Plan has been reviewed and assured by NHSE Midlands on a winter assurance visit to our System on 4 Sep.
A robust quality and equality impact assessment (QEIA) informed development of the ICB's plan, and this has been reviewed by the Board.	Yes	This has been extensively reviewed with input and iteration between the ICB UEC, Quality and Inequalities team. It will be reviewed on behalf of the Board at the Quality & Performance Committee on 25 Sep.
The ICB's plan was developed with appropriate levels of engagement across all system partners, including primary care, 111 providers, community, acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.	Yes	Our Plan has been developed under direction of the UEC Delivery Group, at which all partners are represented, including NHSE Midlands, our Local Authority colleagues and Partners in Care. Engagement with the ambulance service is led by our UEC Improvement Director (formerly of WMAS).
The Board has tested the plan during a regionally led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	A delegation of 9 senior leaders from the ICB and partners across our system will participate in the NHSE-led winter exercise on 17 Sep. The outcome intended is to identify any gaps in our preparedness, to incorporate ahead of the winter period.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Our Chief Delivery Officer is the accountable executive supported by the Deputy Director of Operations in Urgent and Emergency Care.
Plan content and delivery		
The Board is assured that the ICB's plan addresses the key actions outlined in Section B.	Yes	Detailed in the section below

Assurance statement	Assurance recommended (Yes / No)	Evidence / rationale
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	This is built into our Plan, and will be assured on behalf of the Board at the Quality & Performance Committee on 25 Sep.
The Board is assured there will be an appropriately skilled and resourced system control centre in place over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.	Yes	Our SCC operates 7 days each week and is the principal daily command & control mechanism to direct and coordinate system-wide response to pressures. Closer alignment will be sought with our Staffordshire & Stoke-on-Trent system cluster partners to ensure any staffing issues are mitigated. Clinical leadership to provide on call support where required from across all system partners.
Section B: 25/26 Winter Plan checklist		
Prevention		
1. Vaccination programmes across all of the priority areas are designed to reduce complacency, build confidence, and maximise convenience. Priority programmes include childhood vaccinations, RSV vaccination for pregnant women and older adults (with all of those in the 75-79 cohort to be offered a vaccination by 31 August 2025) and the annual winter flu and covid vaccination campaigns.	Yes	System partnership group has been established (12 Aug) working together to improve all vaccination uptake across STW. Under leadership of Directors of Public Health. All NHS providers, ICB and Local Authorities are included. Will meet fortnightly from the 9th September. Key output is the STW Vaccination Improvement Plan delivery. Our Flu vaccination campaign delivery started 1 Sep for these groups and will run through to 31 Mar 26. Delivered through GP practices, community pharmacies and hospital trusts.
2. In addition to the above, patients under the age of 65 with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses should receive targeted care to encourage them to have their vaccinations, along with a pre-winter health check, and access to antivirals to ensure continuing care in the community.	Yes	Patients aged 18 years to under 65 years in clinical risk groups (as defined by the Green Book, Influenza chapter 19 e.g. chronic respiratory disease, cardiac disease, diabetes, immunosuppressed) are eligible to receive a flu vaccination as per JCVI guidance. This will start from 1 Oct for these groups.

Assurance statement	Assurance recommended (Yes / No)	Evidence / rationale
3. Patients at high risk of admission have plans in place to support their urgent care needs at home or in the community, whenever possible.	Yes	Our GPs work tirelessly to identify and have plans in place for individual patients. We will have improved options available to support fulfilment of urgent care needs at home with expansion of our Urgent Community Response, backed up by resilient medical oversight. Alternative to hospital pathway referrals will be more available through our care coordination centre / GP out of hours provider from 1 Oct.
Capacity		
4. The profile of likely winter-related patient demand across the system is modelled and understood, and individual organisations have plans that connect together to ensure patients' needs are met, including at times of peak pressure.	Yes	Our demand & capacity model for the system includes baseline, surge & super surge scenarios. This incorporates our individual provider elements. This will be stress tested through the NHSE winter exercise process. Our understanding of likely demand will be refined upon receipt of the UK Health Security Agency scenario assessments, expected late September.
5. Seven-day discharge profiles have been shared with local authorities and social care providers, and standards agreed for P1 and P3 discharges.	Yes	These profiles have been built into our Improvement programme throughout. Our Integrated Out of Hospital Model being implemented by ShropComm includes additional discharge planning capacity, 7 days each week. Robust planning on going to mitigate bank holidays over festive period.
6. Action has been taken in response to the Elective Care Demand Management letter, issued in May 2025, and ongoing monitoring is in place.	Yes	Key point is to maintain elective activity with minimal disruption because of high pressure from the non-elective pathway. We are well placed to achieve this. SaTH is significantly ahead of trajectory on elective waiting time standards. Over the festive period RJAH fallow capacity will be made available to SaTH to continue elective (principally elective orthopaedic) programme delivery including during the bed-base reconfiguration; and ease pressure upon the acute sites at this most demanding point in time.
Leadership		
7. On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	Our ICB on-call cohort will be provided with additional training in October following the NHSE winter exercise to cover the anticipated differences in regional command & control posture this winter, as well as more specific guidance on our intra-system changes to managing pressures.

Assurance statement	Assurance recommended (Yes / No)	Evidence / rationale
		We will work closely with our providers to check – and rebalance if necessary – the overall experience and competencies of the collective on-call on a given day across our system. Key point will be to ensure that we have sufficient clinical leadership.
8. Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	This is well established in our system, using the SHREWD system that aggregates up to NHSE regional level. Additionally, we are reviewing our escalation triggers to reflect the changes in capacity and out of hospital model we are implementing.

Board of Directors' Meeting: 13 November 2025

Agenda item		163/25		
Contract Title		**System Integrated Improvement Plan (SIIP)**		
Executive Lead		Jo Williams, Group Chief Executive		
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, Performance Assurance Committee, Finance Assurance Committee, Quality & Safety Assurance Committee,		
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 the 2025/26 tasks/actions against SaTH's section of the System Integrated Improvement Plan (SIIP) which is detailed in Appendix 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: **Take assurance** from the updates provided. **Note** that this SIIP progress report and supporting evidence for those 2024/25 actions RAG rated blue as completed and evidence will be presented and reviewed by the ICB and NHSE as part of a planned schedule of review meetings from November to December 2025.		
Appendices		Appendix 1 - SaTH Governance, Leadership Plan 2025-26 Appendix 2 - SaTH Workforce Delivery Plan & Collaborative Decision-Making Leadership Plan 2025-26 Appendix 3 - SaTH Finance Recovery Plan 2025-26 Appendix 4 - SaTH Systemwide UEC Improvement Plan 2025-26		

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 4.1.9:** Financial Recovery Group (FRG) is in place and is part of the weekly CEO meeting. Terms of reference were agreed at 3 September 2025 Financial Recovery Group (FRG) and approved at the Finance Assurance Committee on 30 September 2025.
- **SaTH Metric 4.4.3:** The new Risk Management Policy and Risk Management Strategy remain under review. Both are scheduled for Audit & Risk Assurance Committee on 24 November, prior to January 2026 Board.
- **SaTH Metric 4.4.4:** SaTH Board skills audit has been undertaken on 31 October 2025.
- **SaTH Metric 4.**4.8: The Boards' decision on 23 September 2025 to establish a Group enables progression toward appointing the Joint Leadership Team. Remuneration Committees are reviewing the process and timeline.
- **SaTH Metric 4.4.9:** A joint Board of Director development day was held on 23 October 2025. Next one scheduled during February 2026.

Workforce and Leadership Collaborative

- All actions within the SIIP Workforce and Leadership Collaborative Plan have been completed and a meeting has been scheduled to review all of the actions RAG rated Blue, completed and evidenced, demonstrating strong alignment with system priorities and robust assurance through PODAC and Board reporting. All actions are on track with the delivery of the 2025-26 SIIP Workforce and Leadership Collaborative Plan

Finance

- **SaTH Metric 1.2.23:** £1.3m off plan at month 6. Risk identified as well as additional mitigations. Closely monitored through Finance Assurance Committee (FAC).
- **SaTH Metric 1.4.5:** External assessment against the NHSE Grip and Control Checklist and HFMA Financial Sustainability Checklist was completed in 2024–25, with a refresh underway for 2025–26. Internal Audit will review the updated controls in Q3.
- **SaTH Metric 1.4.4:** Follow-up review of Income and Investment (I&I) actions to ensure continued delivery has been completed and is monitored through the Financial Recovery Group (FRG).

- **UEC**

  - **SaTH Metric 3.1.1:** MEC Transformation Programme workstream 1 has refreshed focus towards 4 hour, 12 hour and ambulance offload performance. Breach validation work previously completed by the Division has been utilised to inform a plan for improvement which will commence with a process review of timely discharging of patients from ED with a view to mitigating 4 hour breaches who are flagged as leaving the department before 5 hours
  - **SaTH Metric 3.1.1.4**: Frailty SDEC at PRH is on track to launch in December 2025. A location for Frailty SDEC at RSH is being determined. Workshop for Frailty held in September to help determine a future state in terms of flow and ca
  - **SaTH Metric 3.1.1, 3.1.1.5 & 3.1.1.7:** A new working group will be established in October 2025 to include minors, wait to be seen, 4 type 3 performance, and Fit to Sit.

The information in Appendix 1 - 4 provides a summary of the progress against delivery of the tasks/actions that were due up to and including 31 October 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:

- **Take assurance** from the progress being made.
- **Note** that this SIIP progress report and supporting evidence for those 2024/25 actions RAG rated blue as completed and evidence will be presented and reviewed by the ICB and NHSE as part of a planned schedule of review meetings from November to December 2025.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
13 November 2025

Agenda item		164/25		
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:		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, NHS Resolution's CNST Maternity Incentive Scheme and the Neonatal Mortality Review action plan.		
Recommendations for the Board:		The Board of Directors is requested to: • Receive this report for information and assurance.		
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 invited review of Neonatal Mortality at the Trust conducted by the Royal College of Physicians.

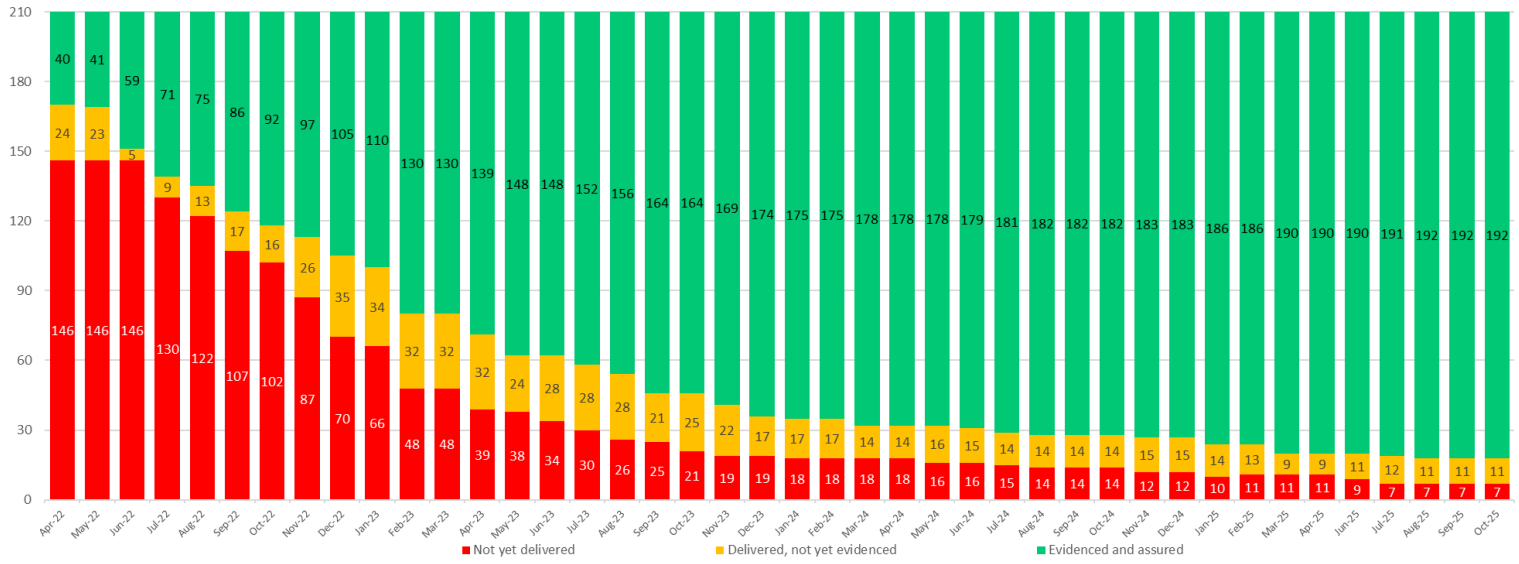
1.4 A summary of progress with the Maternity and Neonatal Transformation Programme (MNTP), which is an IMR action requirement, including an update on the Cultural Improvement Plan.

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 are validated at the Maternity and Neonatal Transformation Assurance Committee (MNTAC), and progress is summarised at the Quality Safety and Assurance Committee (QSAC). **Appendix One** provides the summary Ockenden Report Action Plan at 14 October 2025. The overall trajectory and position are, as follows:



Delivery Status	Number (change since last report)	Percentage
Evidenced and Assured	192 (⇔)	91.5%
Delivered, Not Yet Evidenced	11 (⇔)	5.2%
Not Yet Delivered	7 (⇔)	3.3%
TOTAL	210	

**Rounded percentages

Progress Status	Number (change since last report)	Percentage
Completed fully (Evidenced and Assured)	192 (⇔)	91.5%
On track	11 (⇔)	5.2%
Off track	0 (⇔)	0
At Risk	0 (⇔)	0
De-scoped	7 (⇔)	3.3%
Total	210	100%

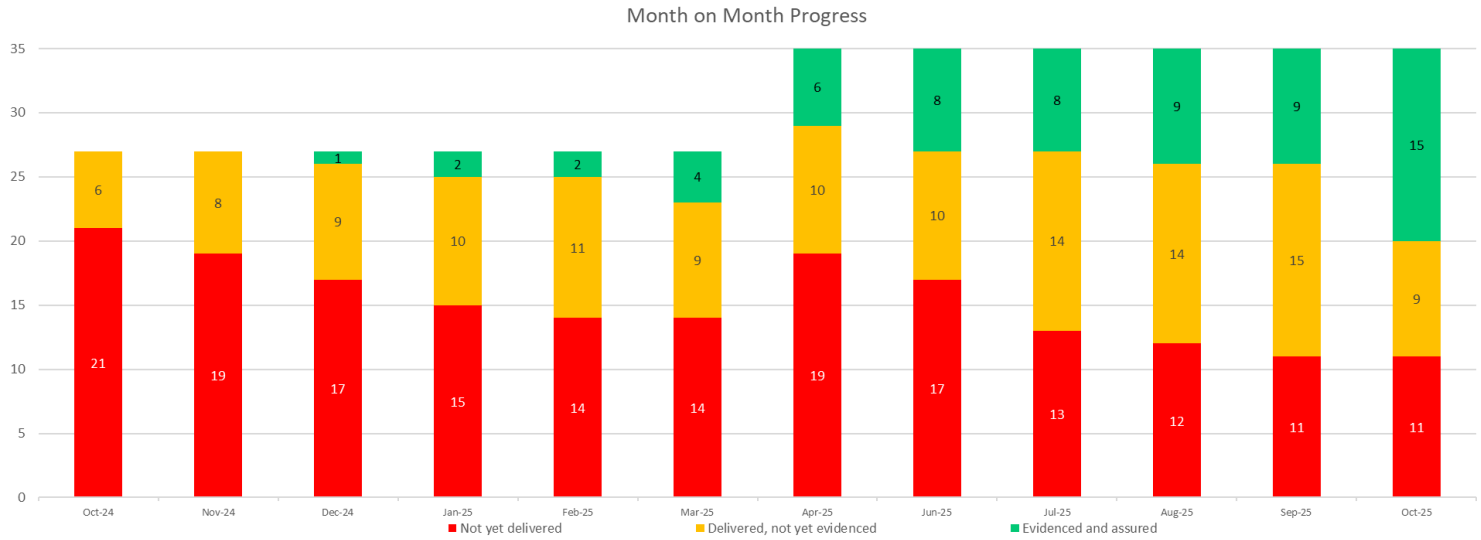
**Rounded percentages

2.2 In total, seven actions remain 'de-scoped,' currently. These relate to nationally led external actions (NHS England, CQC) and are not within the direct control of the Trust. Trust feedback on these actions has been received and presented at August's MNTAC. The narrative provided by NHSE was not sufficient to allow for any status changes according to the methodology in use within the programme. Examples of evidence requirements have been provided to the national team so those actions can be proposed for a status change in due course. 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. The next quarterly review is now due in January 2026.

2.3 Progress against all other actions within the Trust's gift to deliver continues. They are currently on track for their expected delivery dates, pending evidence that they have been appropriately embedded.

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 as of 14 October 2025. The overall trajectory and position are, as follows:



Delivery Status	Number	Percentage
Evidenced and Assured	15 (⇧6)	42.9%
Delivered, Not Yet Evidenced	9 (⇩5)	25.%
Not Yet Delivered	11 (⇩1)	31.4%
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)	15 (⇧6)	42.9%
On track	16(⇩6)	45.7%
Off track	1 (⇔)	2.9%
At Risk	1 (⇔)	2.9
Not Started	2 (⇔)	5.7%
Total	35	100%

**Rounded percentages

3.2 An action relating to the Golden Hour (bundle of evidence-based care to optimise neonatal outcomes) provision on the service remains off track until a realistic timeline can be provided for compliance with the golden hour audit. This action forms part of ongoing work in collaboration with the LMNS as part of their Quality and Safety Workstream. Guidance from Network members as to how compliance is achieved in other units to help guide improvements has been sought. It has been noted that units only have a checklist for preterm infants, and no unit has a checklist for term infants. Therefore, these findings have been shared with the reviewing team, and as a result, an admission checklist, in line with other trusts, is being designed.

3.3 In addition, an action regarding the National PMRT has been identified at risk. While the process has been improved internally, with outputs and learnings from PMRT complying with the recommendation from the review, the requirement for neonatal externality remains challenging to achieve reliably. An agreement is in

place within the Network to allow for sufficient provision of externality, and time has been allocated within job plans to provide this externality to other Trusts. Delivery of CNST Safety Action 1 (which requires externality to be achieved in 50% of PMRTs) has been added as an evidence requirement before this action can be proposed for 'Evidenced and Assured'. All other actions are on track for their expected delivery dates. To date and for the reporting period for CNST, we have had two PMRT cases that have been held that did not meet the requirements of external representation, however, we have led on seven cases, giving our to date figure of 71% evidence with external representation.

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 has now been completed, ensuring nothing has been missed in the run up to the March 2026 deadline for implementation.

4.4 Progress continues to be made with the cultural improvement review. This includes widening its scope to look more broadly at the culture within and across the Women and Children's Division. The team is currently focused on driving Staff Survey completion.

4.5 Significant progress has been made in neonatal services' nurse recruitment to ensure safe staffing and also to recruit to the BAPM recommended quality posts. Of the 9 identified specialist nurse posts, 7 are fully recruited and have commenced in post, 1 post will be recruited by December, and work is underway to develop the final post jointly with maternity services. In regard to the 70% target for neonatal nurses who are qualified in specialty (QIS), the current compliance is 56% which is the highest rate which has been achieved by the Unit to date. The trajectory for full QIS compliance is January 2027.

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

5.1 Year seven of the scheme was launched in April 2025. Reporting will continue in line with the year seven technical guidance. The service continues to make good progress to evidence all actions and the risk to delivery of Safety Action 7 has now been deescalated.

5.2 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 2 Quarterly and Board reports are provided at **Appendix Five** of the supplementary reading pack. A risk has been identified against this action relating to the requirement for neonatal externality at 50% of PMRTs (see section 3.3) Further details are available in section 3.1.2 of the Year 7 CNST Progress CNST Report October 2025, which is provided in the supplementary reading pack at **Appendix Four.**
SA2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Confirmation of compliance with July's data has now been received and is provided for evidence to Board as **Appendix Nine.**
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, c) Neonatal medical workforce and d) Neonatal nursing workforce. Evidence of compliance against standard b) Anaesthetic medical workforce is provided as **Appendix Eleven.**
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 Q1 and Q2 presented as part of this IMNR paper to board **Appendix Nine**
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 evidence continue to be presented to LMNS, Maternity Neonatal Safety Champions and QSAC. A risk to the delivery of this action, relating to the requirement for the MNVP lead to be a quorate member of internal meetings, has now been deescalated **Appendix Twelve**

		Further details are available in section 3.7.2 of the Year 7 CNST Progress CNST Report October 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 continue to 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 provided in the supplementary reading pack **Appendix Six.** 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 **Appendix Seven** The Perinatal Quadrumvirate Leadership team meet (bi-monthly), and the minutes of the September meeting are at **Appendix Eight**
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 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 and Safety 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 Twelve 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 Twelve accompanying this report in the supplementary information pack.

Jacqueline Bolton
Interim Head of Midwifery

Julie Plant
Divisional Director of Nursing

October 2025

All appendices are in the Board Supplementary Information Pack

Appendix One:	Ockenden Report Action Plan as of October 2025
Appendix Two:	Neonatal External Mortality Review Action Plan as of October 2025
Appendix Three:	Summary Maternity and Neonatal Transformation Plan (MNTP) Phase Two at October 2025
Appendix Four:	Year 7 CNST MIS Progress Report October 2025
Appendix Five:	PMRT Board Report and Quarterly Report – Q2 2025
Appendix Six:	Safety Champions Locally Agreed Dashboard – Q2 2025 - September Meeting
Appendix Seven:	Safety Action 9 Triangulation of the Scorecard Q1 September 2025
Appendix Eight:	Perinatal Quadrumvirate Meeting Minutes – September Meeting
Appendix Nine:	Maternity 6 monthly Safe Staffing Report Q1 and Q2 2025
Appendix Ten:	Safety Action 2 Scorecard Year 7 Final
Appendix Eleven:	Safety Action 4 - Obstetric Anaesthesia Compliance Paper
Appendix Twelve:	Safety Action 7 LMNS Programme Board Agenda evidence of escalation with action plan for MNVP

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
13 November 2025

Agenda item		165/25a		
Report Title		Summary of Maternity and Neonatal Safety Champion Activities July to September 2025		
Executive Lead		Dr John Jones, Executive Medical Director		
Report Author		Dr John Jones, Executive Board Safety Champion		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF1, BAF2, BAF 3, BAF 4, BAF 7 and BAF 8
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Individual MNSC reports have been discussed at QSAC.		
Executive summary:		1. Safety Champions have received reports in line with the requirements of the maternity incentive scheme 2. Walkabout has taken place at RSH midwife led unit, 3. Posters have been updated to reflect "Our staff said, we listended" 4. Availability of maternity and neonatal voices partnership representative 5. Attendance of new maternity and neonatal independent advocate 6. Specific focus has been placed on: a. Time to category 2 caesarian section b. Updates on invited review into neonatal mortality c. Interventions during golden hour of neonatal care d. Induction of labour indications e. Timeline for neonatal badgernet f. Neonatal pneumothoraces g. Plans for neonatal transfers from delivery suite/obstetric theatres in after HTP		
Recommendations for the Board:		The Board of Directors is requested to: • Receive this report for information and assurance		
Appendices:		none		

1.0 Introduction

1.1 The maternity and neonatal safety champions group meets monthly and is attended by the non-executive and executive board safety champions

2.0 Background and context

2.1 This report summarises the meetings held in July, August and September. This is because the July and August reports should have been received at September's public board meeting, but the internal governance process was delayed as there was no QSAC meeting in August.

3.0 Summary of activities

3.1 Safety champions continue to receive and question reports including maternal and neonatal quality dashboards, Maternity and Neonatal transformation programme / Ockenden assurance reports, CNST updates, Maternity staffing, Neonatal staffing and British Association of Perinatal Medicine (BAPM) reports, maternity governance reports and maternity and neonatal service user feedback.

3.2 Safety champions receive updates on the nature and content of perinatal quad meetings (i.e. meetings with divisional clinical leadership).

3.3 Safety champions have also received updates on activity in Wrekin MLU, Claims scorecard, Maternity CQIM MSDS dashboard.

3.4 Safety champions requested and received reports on decision to delivery.

3.5 Safety champions welcomed the attendance and contribution of new maternity and neonatal independent safety advocate (MNISA) and our maternity and neonatal voice partnership (MNVP) lead.

3.6 Safety champions continued bimonthly walkabouts, with Shrewsbury MLU being visited.

3.7 Safety Champions review and update posters on "Our staff said, we listened"

4.0 Key Issues

4.1 Champions received a report relating to delays to category 2 caesarean sections (target < 75 minutes) and noted dramatic improvement following improvement work

4.2 New ICB appointed MNVP lead welcomed as 0.6 WTE but more time would be required to attend all meetings relating to maternity and neonatal care which means quoracy not always possible. This has been raised with ICB in relation to providing evidence for CNST.

4.3 Champions have been updated on work being carried out to understand why some babies receive antibiotics outside of the 1-hour standard from delivery

4.4 Champions heard how induction of labour rates are significantly higher than is considered the standard for the UK but assurance that indications for intervention are clear and consistent with meeting Saving Babies Lives version 3 which identifies need for acting on concerns in pregnancy

4.5 Champions have expressed concern about length of time it is taking to install neonatal badgernet electronic record. Monthly updates requested.

4.6 Champions heard how changes being made to chest drain equipment to assess impact on risk of pneumothoraces following a rise in incidence.

5.0 Action required of the Board of Directors

5.1 The Board of Directors is requested to receive this report for information and assurance

5.2 Decide if any further information and/or assurance is required.

John Jones
Executive Medical Director

Maternity & Neonatal Safety Champions - Key Issues Report

Report Date: 2 October 2025		**Report of:** Maternity and Neonatal Safety Champions Meeting
Date of last meeting: 02/10/2025		**Membership Numbers:** Quoracy met
1	**Agenda**	• Chair's welcome and apologies, conflict of interest and minutes reviewed. • Action log and review of AAAA from September 2025 • Safety Champions Walkabout Feedback • Maternity Quality Dashboard and Oversight Report (AAA) • Neonatal Quality Dashboard and Oversight Report (AAA) • MTP/Ockenden Report Action Plan and Assurance Report • Perinatal Quad Meeting Minutes – Quarterly • CNST Update with Appendices – Monthly Staffing Report, Locally Agreed Safety Intelligence Dashboard, Scorecard Triangulation • Neonatal Staffing & BAPM Report • Our Staff Said, We Listened Poster and Safety Champions Poster • Maternity Governance Report (including MNSIs and Action Plans) • Maternity & Neonatal Service User Feedback
2a	**Alert**	• None
2b	**Assurance**	• There have been notable reductions in the number of category 2 caesarean sections with longer than 75 minutes from decision • The significant reduction in rates of smoking at time of delivery has been maintained • A continued increase in bookings before 10 weeks was highlighted. • There continues to be a gradual increase in QIS accreditation in neonatal staff (56%) supported by good retention figures • The Neonatal Quality Dashboard shows an apparent reduction in parents seen by senior staff within 24 hours of admission. This is most likely due to a data quality issue as practice has not changed. This will be reviewed, and an update will be provided next month.
2c	**Advise**	• Safety champions carried out a walkabout on the neonatal unit and met several families all of whom were complimentary about care, staff who described positive interprofessional working relationships and a unit that appeared calm, tidy and well organised • The supernumerary status of the nurse in charge has been impacted by high acuity and staff sickness.

		• The group heard a highly detailed presentation by the Lead Midwife for Saving Babies Lives and Preterm Prevention which clearly explained the contributing factors to small for gestational age babies. • The group were provided an update around SOPs for discharges and home visits. • The group heard about antibiotics in the golden hour after birth and will seek updates at future meetings. • The group received an update on access to the neonatal unit and some technological approaches that will need to inform HTP plans.		
3	**Actions to be considered by the MTAC / QSAC / Trust Board**	• Note the report		
4	**Report compiled by**	Dr John Jones (Medical Director)	**Minutes available from**	Sabrina Kitcher (EA to Medical Director)

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors meeting: 13 November 2025

Agenda item		166/25		
Report Title		**Board Assurance Framework – Draft Quarter 2, 2025/26**		
Executive Lead		Director of Governance – Anna Milanec		
Report Author		Head of Corporate Governance & Compliance – Deborah Bryce		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	All BAF risks
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Executive risk leads. The following committees of the Board during October 2025: ARAC (via email), PODAC, PAC, FAC and QSAC.		
Executive summary:		The Board Assurance Framework (BAF) content has been reviewed and refreshed for quarter 2 of 2025/26 by the executive risk owners and their relevant senior team members. There are proposed total current risk score reductions this quarter to BAF risks 3 and 9.		
Recommendations to the Board:		The Board is asked to: a) Consider if the BAF content reflects the strategic risks within the organisation and if the risk scores are appropriate. b) Consider if there is evidence of successful management of the risks; if actions are being progressed in a timely manner; and if any further actions/mitigations are required. c) **Approve** the quarter 2 BAF.		
Appendices:		**Appendix 1**: Board Assurance Framework (draft V1.2) – Quarter 2 2025/26		

1.0 Introduction

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

1.2 Work to review and refresh the BAF content for quarter 2 was undertaken during September 2025 to early October 2025.

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

1.4 The following committees of the Board have considered the draft BAF in October 2025: Audit & Risk Assurance Committee (ARAC) (via email due to meeting scheduling/timings); People & OD Assurance Committee (PODAC); Performance Assurance Committee (PAC); Finance Assurance Committee (FAC); and Quality & Safety Assurance Committee (QSAC).

1.5 There was a discussion at Quality & Safety Assurance Committee on 28 October regarding the potential to reduce the total current risk score of BAF risk 2 (safety culture). However, it was agreed that the score of BAF risk 2 should remain at 16, with further review in future.

2.0 Significant changes to the BAF during quarter 2 2025/26

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

2.2 It is proposed this quarter to reduce the current total risk score of BAF risk 3 from 4x4=16 to 4x3=12, as turnover has remained stable and is below target.

2.3 It is also proposed this quarter to reduce the current total risk score of BAF risk 9 from 4x4=16 to 4x3=12 as cancer 28-day faster diagnosis standard and 62-day RTT performance is now out of the bottom quartile, and elective 52-week performance is now in the top performing half of the country.

2.4 There is a slight change proposed to the risk description of BAF risk 12 to remove reference to the ICP and include reference to the ICB.

2.5 The lead executive for BAF risks 7a and 7b has changed from the Director of Strategy and Partnerships to the Acting Director of Finance.

2.6 There have been some changes to action timescales within the BAF, along with some actions that have been closed this quarter, as shown in blue text within the BAF.

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

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

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

3.3 The four top scoring risks, with a current total risk score of 20, are as follows:

The top scoring BAF risk(s) based on draft current total risk scores at quarter 2:

Risk No.	Risk title	Overseeing Committee	Current proposed risk score at quarter 2, 2025-26	Change in risk score since the previous quarter
BAF 5	The Trust does not operate within its available resources, leading to financial instability and continued regulatory action	Finance Assurance Committee	4x5 = 20	↔ No change
BAF 7a	Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation.	Audit & Risk Assurance Committee	5X4 = 20	↔ No change
BAF 7b	The inability to implement modern digital systems impacts upon the delivery of patient care	Performance Assurance Committee	4x5 = 20	↔ No change
BAF 10	The Trust is unable to meet the required national urgent and emergency standards.	Performance Assurance & Quality & Safety Assurance Committees	4x5 = 20	↔ No change

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

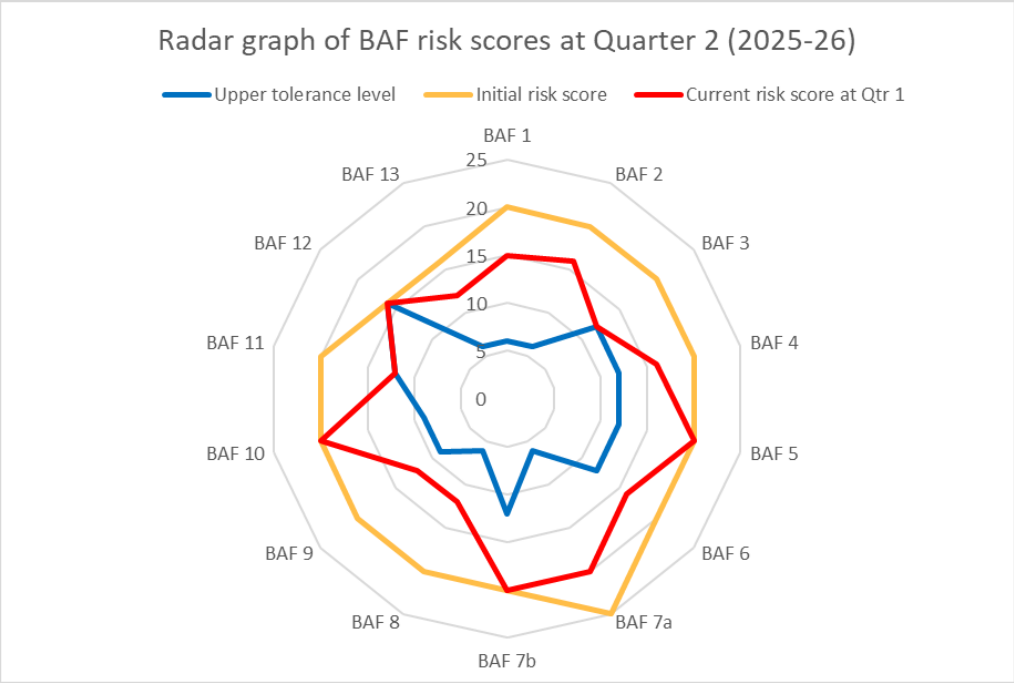
3.4 Being aware of the proposed top scoring risk(s) should assist the Board to consider:

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

4.0 Visual representation of risk scores

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

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



4.2 It is acknowledged that for BAF risks 3, 11 and 12, the current total risk score has achieved (is at) the proposed upper tolerance level. All other BAF risks remain above their upper tolerance levels.

5.0 Recommendations

The Board is asked to:

a) Consider if the BAF content reflects the strategic risks within the organisation and if the risk scores are appropriate.
b) Consider if there is evidence of successful management of the risks; if actions are being progressed in a timely manner; and if any further actions/mitigations are required.
c) **Approve** the quarter 2 BAF.

Deborah Bryce
Head of Corporate Governance & Compliance
November 2025

Appendix 1

The Shrewsbury and Telford Hospital NHS Trust

Board Assurance Framework (BAF) 2025/26 - draft quarter 2 (July-Sept 2025)

(Updated Sept/Oct 2025 - Version 1.2)

The Shrewsbury and Telford Hospital NHS Trust

Risk scoring framework

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

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

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

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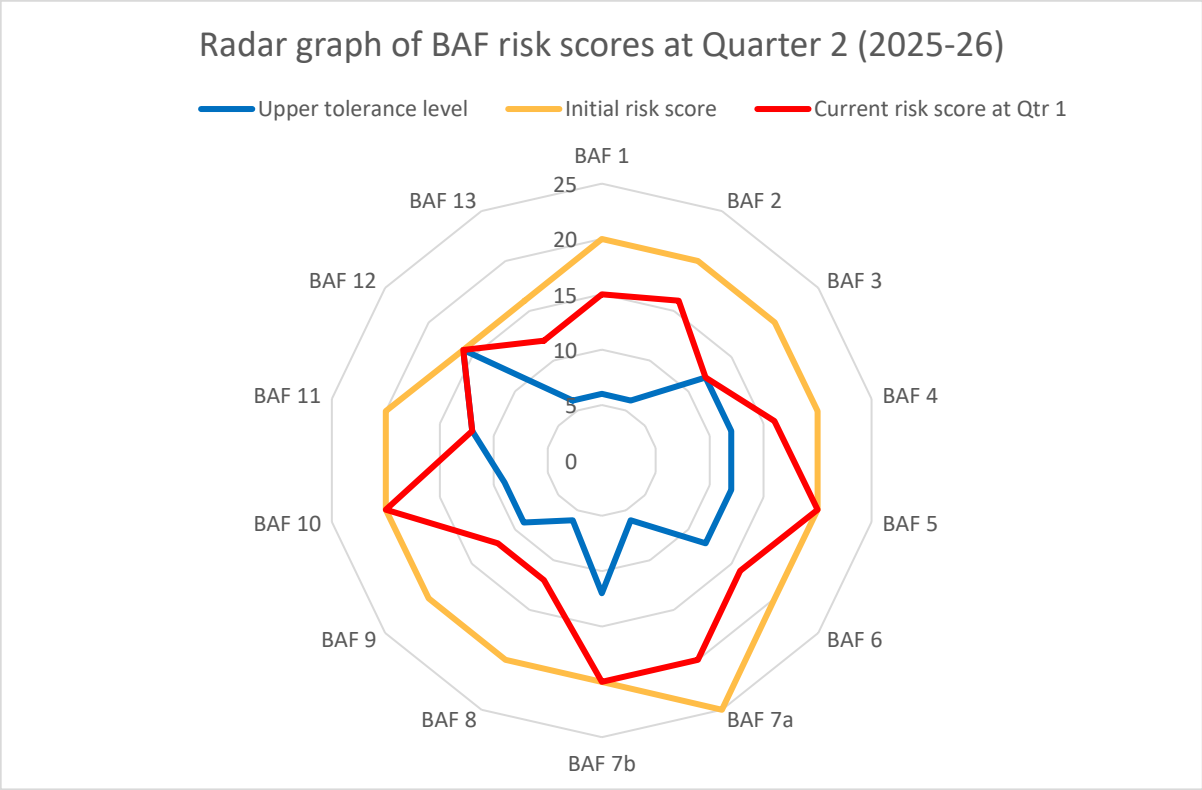
NHS Trust

							Current total risk score in previous quarters (lxL):				Current total risk score (lxL):	
Board Assurance Framework 2025/26 - Summary at Quarter 2 (July to September)		**Alignment to Trust Strategy - strategic themes/objectives**	**Initial (inherent) risk score**	**Upper tolerance level (and risk appetite)**	**Lead Executive**	**Lead Committee**	**Quarter 2 (2024-25)**	**Quarter 3 (2024-25)**	**Quarter 4 (2024-25)**	**Quarter 1 (2025-26)**	**Quarter 2 (2025-26)**	**Change in current risk score since previous quarter, plus any further comments**
Ref:	**Risk title:**											
BAF 1	If the Trust is unable to maintain quality of care standards and clinical safety, outcomes will not be acceptable	Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless patient pathways.	**5x4 = 20**	**6 (minimal)**	Medical Director /Chief Nursing Officer	Quality & Safety Assurance Committee	**5x3 = 15**	**5x3 = 15**	**5x3 = 15**	**5x3 = 15**	**5x3 = 15**	↔ No change
BAF 2	The Trust is unable to consistently embed a safety culture with evidence of continuous quality improvement and patient experience.	Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless patient pathways. Make our organisation more sustainable.	**5x4 = 20**	**6 (minimal)**	Chief Nursing Officer/ Medical Director	Quality & Safety Assurance Committee	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	↔ No change
BAF 3	If the trust does not ensure staff are appropriately skilled, supported and valued this will impact on our ability to recruit/retain staff and deliver the required quality of care.	Make SaTH a great place to work. Deliver a better patient journey and experience. Make our organisation more sustainable.	**5x4 = 20**	**12 (open)**	Chief People Officer	People & OD Assurance Committee	**4x3=12**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x3 = 12**	↓ Reduction in total current risk score from 16 to 12 as turnover has remained stable and is below target.
BAF 4	A shortage of workforce capacity and capability leads to deterioration of staff experience, morale, and well-being.	Make SaTH a great place to work. Deliver a better patient journey and experience. Make our organisation more sustainable.	**5x4 = 20**	**12 (open)**	Chief People Officer	People & OD Assurance Committee	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	↔ No change
BAF 5	The Trust does not operate within its available resources, leading to financial instability and continued regulatory action	Make our organisation more sustainable.	**4x5 = 20**	**12 (open)**	Acting Director of Finance	Finance Assurance Committee	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	**5x4 = 20**	**5x4 = 20**	↔ No change
BAF 6	Some parts of the Trust's buildings, infrastructure and environment may not be fit for purpose.	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	**4x5 = 20**	**12 (open)**	Assistant CEO	Performance Assurance Committee	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	↔ No change
BAF 7a	Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation.	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	**5x5 = 25**	**6 (minimal)**	~~Director of Strategy & Partnerships~~ Acting Director of Finance	Audit and Risk Assurance Committee	**5x3 = 15**	**5x3 = 15**	**5x4 = 20**	**5x4 = 20**	**5x4 = 20**	↔ No change
BAF 7b	The inability to implement modern digital systems impacts upon the delivery of patient care	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	**4x5 = 20**	**12 (open)**	~~Director of Strategy & Partnerships~~ Acting Director of Finance	Performance Assurance Committee	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	↔ No change

Board Assurance Framework 2025/26 - Summary

							Current total risk score in previous quarters (IxL):				Current total risk score (IxL):	
Board Assurance Framework 2025/26 - Summary at Quarter 2 (July to September)		**Alignment to Trust Strategy - strategic themes/objectives**	**Initial (inherent) risk score**	**Upper tolerance level (and risk appetite)**	**Lead Executive**	**Lead Committee**	**Quarter 2 (2024-25)**	**Quarter 3 (2024-25)**	**Quarter 4 (2024-25)**	**Quarter 1 (2025-26)**	**Quarter 2 (2025-26)**	**Change in current risk score since previous quarter, plus any further comments**
Ref:	**Risk title:**											
BAF 8	The Trust cannot fully and consistently meet statutory and / or regulatory healthcare standards.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**4x5 = 20**	**6 (minimal)**	Chief Nursing Officer	Quality & Safety Assurance Committee	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	↔ No change
BAF 9	The Trust is unable to meet the required national elective and cancer care standards.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**4x5 = 20**	**9 (cautious)**	Chief Operating Officer	Performance Assurance Committee and Quality & Safety Assurance Committee	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x3 = 12**	↓ Reduction in total current risk score from 16 to 12 as cancer 28 day faster diagnosis standard and 62 day RTT performance is now out of the bottom quartile, and elective 52 week performance is now in the top performing half of the country.
BAF 10	The Trust is unable to meet the required national urgent and emergency standards.	Deliver a better patient journey and experience. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**4x5 = 20**	**9 (cautious)**	Chief Operating Officer	Performance Assurance Committee and Quality & Safety Assurance Committee	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	↔ No change
BAF 11	The current configuration and layout of acute services in Shrewsbury and Telford will not support future population needs and will present an increasing risk to the quality and continuity of services.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**5x4 = 20**	**12 (open)**	Director of Hospitals Transformation Programme	Hospitals Transformation Programme Assurance Committee	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	↔ No change
BAF 12	There is a risk of non-delivery of integrated pathways, led by the ICB and ICS ~~and ICP~~.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**4x4 = 16**	**16 (eager)**	Director of Strategy & Partnerships and Chief Operating Officer	Quality & Safety Assurance Committee	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	↔ No change
BAF 13	The Trust is unable to ensure that robust corporate governance arrangements are in place resulting in poor processes, procedures and assurance	Improve the quality of care that we provide. Deliver a better patient journey and experience. Make our organisation more sustainable.	**4x4 = 16**	**6 (minimal)**	Director of Governance	Audit and Risk Assurance Committee	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	↔ No change

Visual representation of risk scores



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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Inconsistencies in care • Inconsistencies and lack of clarity in governance arrangements • Lack of resources • Lack of clarity of standards and frameworks especially where practice may be different across sites • Incomplete training and competencies • Operational pressures • Workforce gaps in specific areas (including vacancies); Inability to recruit and retain the right numbers and skill mix of clinical staff • Clarity of and lack of consistency in the use of policies and procedures • Unable to off-load ambulances in a timely way because of lack of patient flow through the organisation • Lack of clarity of data and triangulation of data • Lack of capacity to plan service improvement work • Organisational culture **Consequence:** • Increased avoidable harm to patients • Delays in time-critical care • Inadequate care • Poor patient experience and increased complaints • Increased length of stay • Poor management of deteriorating patients • Reduced staff morale and recruitment and retention • Inconsistencies in governance arrangements • CQC prosecutions and enforcements if standards and frameworks are not in place. • Ambulance rapid handover could result in a greater volume of patients in ED than can be received and cared for • Reputational damage, financial loss and lack of confidence in the organisation	5	4	20	• Moving to Excellence programme. • Targeted transformation programmes • Quality and Safety Strategy under development; Quality Priorities for 25/26 in place; Corporate Strategy; People Strategy; Digital Strategy; workforce planning • Clinical audit programme • Governance structure in place. • Safeguarding Policy (including Mental Health and Learning Disabilities), IPC Policy and PSIRF policy in place. • Palliative and End of Life strategy • Staff training • Daily incident communications (Datix)and Incident Review Overview Group (IROG) RALIG both in place • Trust Complaints Process and an independent complaints panel • Freedom to Speak Up Guardian and ambassador arrangements in place • Board Assurance Visits • SaTH Improvement Hub and Clinical Lead for Improvement in place • CQC action plan owned by Divisions • External representation at our quality meetings at QOC, RALIG and Safeguarding • Fortnightly catch ups and quarterly engagement meetings with CQC • MIAA follow-up reports • Hospital Full Policy in place • Dispatches action plan in place • Contingency arrangements in place with UHNM for emergency Maxillo Facial work. Elective and cancer service contingency arrangements being developed with Royal Wolverhampton. • Footprint for the space available for assessing acutely unwell medical patients is being increased in both hospitals as part of the Winter Plan - during December/Q3.	**Reported to Board, committees and elsewhere:** Non-Executive led assurance committees: • Quality & Safety Assurance Committee, reporting to Board (2nd) • Mortality metrics reported to Board and Learning from Deaths Group considered by Board quarterly (2nd) • Quality metrics within Integrated Performance Report to Board (monthly)(2nd) • CQC Report, published May 2024 provides assurance that improvements are being made across the Trust (3rd) • Quality Account to QSAC/Board 2025 (2nd) • Incidents reports, themes, claims and complaints report to QSAC and public Board (2nd) • Staff Survey results to Board and quarterly pulse survey results considered at People & OD Committee (2nd) • Executive chaired assurance committees which report into QSAC (2nd) • Performance Management Review Meetings (PRM) with Divisions, executive led (2nd) • Operational groups in place (2nd) • Culture dashboard reported to Operational People Group (1st) • Externally led quality assurance visits and reports (3rd) • Quarterly FTSU updates to Board (2nd) • External Peer reviews with action plans produced, as required (3rd) • Q4: Reset and Review meeting - national maternity team - awaiting results (3rd) • MIAA internal audit reviews 2024/25 (3rd): PSIRF (Substantial assurance) • Medical Regulatory Group established Q2 24/25 (2nd) • Q3-Q4: Pharmacy Aseptic Services - stage one compliance management (enhanced oversight following Environment Agency visit) (3rd) • National Maternity Review - Q3/Q4.	5	3	15	**Gaps in control:** 1. National shortages in specific workforce, e.g. theatres, endoscopy, doctors within critical care, care of the elderly, emergency medicine. 2. A number of patients with no criteria to reside and lack of alternatives to hospital admission, impacting on patient flow and pressures in the Emergency Department. 3. Prolonged timescale of electronic systems replacing dated and paper based systems. 4. Implementation of national Patient Safety Incident Response Framework (PSIRF) and now to work on the outcomes of PSIRF. Development and roll-out of Patient Safety & Quality Strategy. 5. Standardisation of education for clinical ward leaders to ensure standardised approach across the organisation. 6. Lack of Policies and Procedures Group to sign-off clinical policies, plus no overarching Documentation Group. 7. Notice served on inpatient neurology service by RWT which came to an end on 19 June 2025. **Gaps in assurance:** 8. Multiple different programmes of work and groups focusing on improving quality with the risk of loss of oversight of the overarching themes.	Actions aligned to gaps: 1a.Workforce planning - see BAF risk 3 plus Workforce Strategy. 1b. Delivering the trajectories within the Workforce Strategy (timescale: ongoing) . Leads: Kara Blackwell (for nursing, midwifery and AHP) and Simon Balderstone. During 2023, 2024 and 2025. 2. See BAF risk 10. 3. Electronic Patient Record planned by end of 2025. New patient administration system (PAS) to be in place as per agreed implementation plan (see BAF risk 7b). Executive lead: Director of Strategy & Partnerships. 4. Develop a three year Quality & Safety Strategy by Q3 2025/26 which encompasses the key elements of the National Patient Safety Strategy. Executive Lead: Chief Nursing Officer. 5. Roll out of I Care Braver Leader Programme by Q2. Executive lead: Chief Nursing Officer. 6. Agree refreshed Policy for Policies Q3 25/26. Executive Lead: Director of Governance (as per BAF risk 13). 7. Work with regional and extra-regional partners with support from NHSE and ICB leadership to develop short term and longer term mitigation. By August 2025 (short-term) and April 2026 (longer-term). Executive lead: Executive Medical Director. 8. Deputy Chief Nurse and Deputy Medical Director to work together to review the function of each group including Learning from Deaths and Deteriorating Patients Groups to consolidate working arrangements and nature of the reports to Board - by October 2025. Executive lead: Executive Medical Director/Chief Nursing Officer.	1b. Q1: Ongoing recruitment to all nursing and AHP roles, including theatre staff. Continuing with our student nurse associate programme. Regular trust-wide recruitment days in place for the year. Recruitment via fixed-term contracts for maternity leave to help manage unavailability gaps is progressing. Also working with Shrop Comm to work on joint appointments and vacancies. Recruitment of further permanent gastroenterologists and further completion of training for clinical nurse practitioners within colonoscopy. Q2: Improved consultant recruitment in critical care, emergency medicine and gastroenterology such that we are almost recruited to template. 3. Following the successful implementation of the Careflow PAS and Careflow ED in early 2024, together with other clinical systems and core technologies, the EPR programme continues in 2025/26. Endoscopy Medilogik went live in June 2025, and work is in progress to upgrade Badgernet Neonatal. Order Comms ICE for radiology is in progress (noting that this also covers RJAH and General Practice) albeit with a supplier capacity risk. Funding has now been confirmed for the next phase of Winpath Laboratory Information Management System (LIMS) in collaboration with UHNM. Teams are finalising the business case and plan for EPMA with expectation that this begins in late Q2/early Q3. To note, these systems do require strong clinical and operational leadership alongside technical expertise, with projects needing medium term involvement. 4 In progress. Working to align the Patient Safety Strategy to the Quality Strategy. Plan to ensure consultation with stakeholders on the strategy in Q1 and Q2, with revised draft end of Q3 and then onward to QSAC and Board. 5. Q4: Running the I Care Braver Leader Programme - two cohorts - one in April and one in Sept 2025 with band 7 ward managers. Q1: Scoping the requirements for a Band 6 programme and a Matrons programme to deliver in Q3 and Q4. Q2: Matrons programme being delivered in October 2025; band 6 programme will be during 26/27 6. The Trust's Policy for Policies was considered and agreed by the Policy Approval Group on 16 October 2024 and to be considered by Executive Team, ahead of Board. Policy Approval Group commenced during August 2024, meeting monthly. 7. Telephone support via a specialist private provider and some short-term interim support from a locum Neurologist in place. 8. Single Group being created to consolidate the outputs from learning from deaths, medical examiner and incidents during Q3.			6

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Inconsistent leadership to support a high quality compassionate care environment • Inconsistent embedding of learning when colleagues speak up • Inconsistent approach to ensure acceptable values and behaviours that create psychologically safe team working • Inconsistent organisational support to embed a continuous learning and improvement environment • Leaders inconsistently demonstrating basic good practice in respect of 1 to 1 meetings, health and wellbeing check ins and talent management conversations with colleagues. • Lack of prioritisation of learning and development for colleagues. • Discontent from resident doctors around a number of national issues including pay, training opportunities and regulation of Physician and Anaesthetic Associates. **Consequence:** • Increased avoidable harm • Poor patient experience • Increased complaints • Reputational damage • Lack of confidence in the organisation • Potential CQC prosecutions and enforcements • Our people are not routinely raising concerns/speaking up on patient safety and anything else that may affect great patient care • Our people do not work as a team and a safety culture is not embedded within the organisation • Poor communication and unable to learn from incidents • Lack of measure of safety culture within the organisation • Strain placed on relationships between resident doctors and Physician Associates • People normalise poor practice.	5	4	20	• Embedding NHS Impact • Freedom to Speak Up Guardian and ambassador arrangements • FTSU Vision and Strategy in place, FTSU policy and training in place • Speciality Patient Experience Groups and the Patient and Carer Experience Panel. • Board Assurance visits • PSIRF structure and plan/policy in place • SaTH Improvement Hub and improvement methodology courses in place • Trust Strategy 2022-2027 (includes continuous improvement culture) • Leadership programmes in place, including Galvanise programme for colleagues from ethnic minorities • Staff psychological wellbeing services in place • Staff Survey covers some key safety culture elements (was undertaken Oct to Nov 2024) • Civility and Respect workshops in place in the Trust that are available for clinical and non-clinical teams. Plus EDI training in place. • Board FTSU self-reflection tool • Professional Nurse Advocacy and professional nurse advocacy roles in place to provide psychological restorative supervision • Regular meetings set up with senior medical leaders and tier two doctors • Incorporation of Ten Point Plan to improve resident doctors working lives during Q3 • SaTH is part of phase 2 of the introduction of Martha's Law • Sexual Safety Charter in place and Sexual Misconduct Policy.	**Reported to Board, committees and elsewhere:** • Reports to Quality & Safety Assurance Committee held monthly, reporting into Board (2nd) • Patient Experience & Complaints Report to QSAC - quarterly (2nd) • ARAC - Audit & Risk Assurance Committee (2nd) - bi-annual FTSU reports • Culture dashboard (annually based on Staff Survey), reported to Strategic People Group (1st) • Quarterly FTSU updates to Board (2nd) • Patient Safety Incident Response Framework and policy to Board (2nd) • MIAA internal audit reviews 2024/25: Freedom to Speak Up (Substantial Assurance) to ARAC August 2024; PSIRF (Substantial Assurance) 2024/25 to September 2025 ARAC (3rd). • CQC Report published May 2024 (3rd) • Independent Patient Complaints Review Panel (2nd). • Culture reviews being reported to PODAC - December 2024 and onwards (2nd) • National trainee survey (3rd) • National Patient Surveys (3rd) - to QSAC from Oct 2025 • Medical Director and Chief Nurse attending PODAC to provide assurance around meeting standards in care and training of regulated professionals (2nd)	4	4	16	**Gaps in control:** 1. Developing a shared purpose, vision and values across the Group Model to support culture. 2. Embedding the new approach to patient safety. 3. Evidence of continuous quality improvement culture. 4. Colleagues having confidence and feeling safe and supported to raise patient safety concerns (FTSU and raising risks and incidents), and that they will be acted upon and learning embedded. 5. Clinical Lead for Improvement gap. 6. Unprecedented continued overcrowding in ED's and its impact on normal culture. **Gaps in assurance:** 7. Board reporting of regulatory training programmes	**Actions aligned to gaps:** 1. Report on culture engagement work through Moving To Excellence, PRM's, Strategic People Group and PODAC. Develop culture and engagement framework to support delivery of the Joint People Strategy - by Q3, 25-26. Executive Lead: Chief People Officer/ Chief Nursing Officer 2. Develop a three year Quality and Safety Strategy by ~~Q2~~ Q3 2025/26. Executive Lead: Chief Nursing Officer 3a. Learning from patient complaints and reduction in common themes - ongoing. Executive Lead: Chief Nursing Officer 3b. Use the intelligence gained through triangulation of learning from incidents/complaints/learning from deaths and legal cases to develop a continuous cycle of themed improvement projects throughout 25/26. Executive lead: Chief Nursing Officer. 4. Continue with implementation of new ambassador network during 2025/26. Executive Lead: Director of Governance. 5. Appoint Clinical Lead for Improvement during 25/26. Executive lead: Medical Director/Chief Operating Officer. 6a. Deliver the actions identified in the culture work stream within UECTAC transformation programme during 25/26. 6b. UEC Board to deliver agreed 25/26 milestones. 6c. Review of approach towards cultural change within ED - by December 2025. Executive lead: Medical Director/COO/Chief Nursing Officer 7. Review of terms of reference and business cycle of People & OD Assurance Committee (PODAC) in relation to receiving regulatory training reports/surveys and meeting standards. By Q1 25/26. Executive Lead: Director of Governance.	1. Draft framework has been developed and socialised. Early engagement has commenced with colleagues across the two Trusts and patients, families and volunteers. 2. In progress. Working to align the Patient Safety Strategy to the Quality Strategy. Plan to ensure consultation with stakeholders on the strategy in Q1 and Q2, with revised draft end of Q3 and then onward to QSAC and Board. 3a. Q1: all learning is logged on Datix and shared with the divisions through monthly reporting. Q2: Working With Families work underway led by the Programme Director. 3b. The Safety Intelligence Triangulation Group (as part of PSIRF) has a key role to play in identifying themes and trends and was established in September 2024. Q1: The safety intelligence triangulation group is working well. It is planned that there will be a new Patient Safety Committee chaired by the Deputy Medical Director - to be discussed at QSAC in September 2025. The Safety Intelligence Triangulation Group will feed into this committee with the focus on themes and trends, linking into improvement programmes across the Trust. 4. Q2: Rolling programme - currently there are 68 ambassadors at various stages of recruitment/training. Speak Up Week is 13th-17th October 2025 - The theme this year is "Follow Up in Action" - focusing on the crucial next step in the speaking up journey acting on what we hear. 5. Q2: Clinical Lead for Improvement started early September 2025. **Action closed Q2.** 6a. Progressing workstream 2 - Staff Culture, Resilience & Wellbeing - this is monitored via the UECTAC using the reverse RAG (red, amber, green) methodology as per MNTAC (Maternity and Neonatal Transformation Assurance Committee). Medicine staff survey results 2024 showed improvement across all People Promise Domains. Progress continues to be monitored through UECTAC. 6b. *See BAF risk 10.* 7. PODAC business cycle has been updated to include annual regulatory training report. Training already included in PODAC terms of reference. **Action closed Q1.**			6

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Failure to recruit and retain the right number of people at the right level, with the right skill mix. • Retirement remains as a leading reason for staff turnover • Staff fatigue burnout. Stress, anxiety, and depression remains a top reason for long term sickness • Lack of certainty around future ways of working and work environments • Shortage of key professionals and occupations in specific roles • Lack of succession planning to mitigate risks when key staff leave and encourage staff retention • Dissatisfaction with pay and reward • Work environment concerns in relation to belonging and staff experience relating to behaviours • Recruitment control processes in place to review current resources and skill mix **Consequence:** • Staff dissatisfaction with the level of engagement, involvements and communication with team leaders and senior leadership leading to low morale • Poor levels of engagement and morale which are correlated with lower patient satisfaction and outcomes • High use of agency staff in medical and dental groups. • High levels of sickness and turnover. • Poor patient experience, outcomes and quality and safety. • Adverse publicity and/or reputational damage. • May lead to the financial unsustainability of some services. • Needing to reform our services	5	4	20	• People governance arrangements in place including Strategic People Group (monthly) • Dashboards reporting against People Strategy, action plans and KPI's • Inclusion Improvement Plan and Recruitment and Retention plan supporting it. • Regular meetings between the bank and rostering leads and operational leads to review performance and improvements. • Annual Staff Survey, pulse survey, workforce transformation ICB/ICS programmes such as HCSW and Talent programme, improve well and making a difference linked to the culture dashboard. • Enabling programmes in place with escalation/assurance to SPG/SLT/PAC/FAC and QSAC committee through to People board where indicated. • Extensive Health & Wellbeing (HWB) programme including staff finance, support, physio, clinical psychology and therapy • Culture, respect and inclusion programmes • Leadership development framework • Working group in place engaging with workforce to create a plan new way of working alongside estate and digital plans to support. • Regular meetings with Consultant new starters with a member of the executive team, this is with the People and OD Director and for Nursing and Allied Health Professionals is with Chief Nursing Officer • Developed a monthly recruitment dashboard to provide key metrics on both medical and non-medical recruitment activity. • Continued use of new roles such as Nursing Associate Top Up programme allowing development of Nursing Associates to become registered nurses. • Safer Recruitment and Selection workshops have been implemented to support appointing managers during the hiring process. • Developed operational integrated ICS Workforce Plan • Long-term NHS Workforce Plan • Vacancy and spending control panel • Training and delivery model aligned to operational demand and capacity. • Medical workforce efficiency programme in place	**Reported to Board, committees and elsewhere:** • Reports to People & OD Assurance Committee (PODAC) and Strategic People and Educational Group (SPG) (2nd) • Daily and weekly reports on workforce metrics, temporary staff usage, and agency spend considered (1st). • Annual Staff Survey considered by Board along with updates (2nd) • People Strategy approved by Board 2024 (2nd) • Equality, Diversity & Inclusion Strategy approved by Board 2020 (2nd) • Quarterly/monthly People Pulse Surveys received (2nd) • Associated risk register entries reviewed and updated regularly at SPG (2nd) • Financial Recovery Group - fortnightly (2nd) • Executive dashboard on agency expenditure - weekly (1st) • MIAA (internal audit): 2023/24 Staff Wellbeing & Engagement review to ARAC February 2024 - Substantial assurance . • Medical Workforce Efficiency Taskforce Group (2nd) • People & OD Risk Register reported to PODAC and Strategic People Group (2nd) • Workforce Digital Group (2nd) • MIAA (internal audit) 2024/25 Bank and Agency Review Report (3rd) to ARAC November 2024 - Moderate assurance.	4	3	12	**Gaps in control:** 1. Systematic process throughout the Trust to support succession planning. 2. Recognition schemes. 3. Managing Working Time Directive breaches and management of rosters for medical staff. 4. Ongoing retention initiatives. 5. A plan to support staff to work in new ways, post pandemic, in accordance with the NHS People Plan. 6. Measurable objectives on equality, diversity and inclusion for Chair, CEO and Board members. **Gaps in assurance:** -	**Actions aligned to gaps:** Executive Lead for actions: Chief People Officer. 1. To work with system colleagues to develop a system approach to talent management - during 25/26. 2. Developing monthly recognition scheme delivered alongside our annual recognition programme during 24/25. 3. Visibility of all rosters and review consultant rosters during 24/25 and 25/26. 4. Ensure that each leader is confident to hold wellbeing and stay conversations to support, engage and retain colleagues during 25/26. 5. To review the NHS People Plan health and wellbeing strategy, to support, review and ensure inclusion within divisional people plans. Workforce plans for HTP and operational planning required by Q3. 6a. Board and executive team must have EDI objectives that are SMART and be assessed against these as part of the annual appraisal process, by March 2025. 6b. Board members should demonstrate how organisational data and lived experience have been used to improve culture, by March 2026. 6c. The Board must review relevant data to establish EDI areas of concern/celebration and prioritise actions, by March 2026.	1. Leadership development and talent is shared across Shrop Comm and SaTH. In addition, we are exploring shared services which will have a wider footprint across the system for leadership development and delivery. Q2: The Task & Finish Groups are now being established for joint working. 2. Proposal to be taken to Executives in Q4 for monthly recognition approach. Slight delay in proposal due to financial position. Plans underway to launch a bi-monthly recognition programme during Q2, 25/26. Action complete Q1 25-26. 3. Until one roster system is implemented, the full benefits of having doctor working hour visibility will not be realised. Q4: Workforce Digital Group established as part of the Medical Workforce Efficiency Programme. Action plan developed and continue to deliver against this at Q1 and Q2. 4. Q4: Training is now available on the LMS and training portal to support managers to have quality conversations; date to launch the framework is to be agreed. Q1: Review of retention interventions as part of the corporate service review for People & OD. 5. Q1: Divisions actively developing their workforce plans to support delivery of operational plan which is a key part of their local people plans. Q2: Workforce plans have been refreshed in light of exit programmes. Divisions are moving forward with reform and organisational change which will contribute to the planning for 2026/27. 6a Q1: Objectives need to be reviewed and finalised for Board members for current year (25/26) and remain outstanding. 6b Q1: Active executive sponsorship for each of the staff networks. Also involved in system-wide development of communications campaign We All Belong. Active engagement with our patients, families and volunteers as part of the Culture and Engagement Framework to support development and improvement of services. 6c. Q1: EDI WRES and WDES data has been submitted to inform future planning. The report was discussed at Strategic People Group in July 2025 and was received by PODAC in August 2025.	3	2	12

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Engagement in quality improvement initiatives due to competing demands on the team. • Redeployment of staff to support operational activity, reducing the opportunity of staff to be involved in improvement activity or take part in training. • Failure to address inequalities across all protected characteristic groups of staff in terms of promotion, career progression and over representation of staff from minority ethnic groups in formal HR processes. • Leadership styles that do not reflect the Trust values and behaviours framework • Colleagues not accessing appropriate learning and development, including statutory and mandatory training • Recruitment control processes in place to review current resources and skill mix **Consequence:** • The trust's reputation will be compromised impacting on recruitment and retention • Failure to embed and model the values and behaviours of the trust consistently and create confidence in speaking up culture and processes. • Leadership roles not reflecting diverse nature of community and any specific needs and cultural issues which may impact on staff, patient experience and outcomes • Turnover and sickness absence will remain above target • Potential incidents if staff are not up to date with mandatory training • Staff will not raise concerns reducing the opportunity to improve quality and staff and patient experience, and with attendant risks around staff motivation, morale and productivity. • Increasing agency costs if we are unable to recruit fully • Reforming our services	5	4	20	• Educator role for newly qualified nurses (visible role picking up pastoral and education needs) • Equip people to deliver quality improvement locally, to identify and embed organisational learning to provide a positive impact on quality of care • Board and workforce equality committee dashboards reporting against strategy, action plans/KPI's and inclusion plan • Workforce metrics, staff survey, pulse surveys, EDI (equality, diversity and inclusion) groups, staff networks, triangulation of data, coaching methodology, SaTH improvement methodology • Participation in WRES (workforce race equality standard), WDES (workforce disability equality standard), EDS (equality delivery system) frameworks and gender pay gap reporting • Minority ethnic staff leadership programmes • Values based recruitment approach • Agreed targeted recruitment campaigns and retention actions including exit interviews • Learning Made Simple reporting on statutory and mandatory training compliance • Target interventions on culture dashboard metrics, using Pareto analysis • External Executive Directorship Training • Civility Saves Lives programme roll out • SaTH education offer via education prospectus • SaTH 1 to 4 and STEP Leadership Programmes • Affina team journey interventions • Vacancy and spending control panel • Process to review training in place - SEMTRAG (SaTH Education Mandatory Training Group) established in February 2024 • Non-Clinical Bank Review Panel in place since end of August 2025	**Reported to Board, committees and elsewhere:** • Workforce metrics within Integrated Performance Report to Board (monthly) (2nd) • People & OD Assurance Committee - meets bi-monthly (2nd) • Strategic People Group (SPG), monthly (2nd) • Education Group (1st) • System education/training meeting (1st) • Culture Group reporting and culture dashboard to Operational People Group (1st) • Moving To Excellence progress reviewed/reported monthly (2nd) • Annual Staff Survey considered by Board (2nd) • Workforce data on leadership profile (1st) • Recruitment dashboard (1st) • Senior Leaders Committee - operational, monthly (2nd) • People Pulse Surveys reported to OPG quarterly (2nd) • EDI reporting into EDI Performance Group, which feeds into OPG (1st) • MIAA (internal audit) 2023/24 Staff Wellbeing & Engagement review to ARAC February 2024 - substantial assurance (3rd) • People & OD Risk Register reported to PODAC and Strategic People Group (2nd) • MIAA (internal audit) 2024/25 Bank and Agency Review Report to ARAC November 2024 (3rd) - Moderate assurance. • Medical workforce efficiency programme reported to FRG, Finance Assurance Committee and Strategic People Group (2nd)	4	4	16	**Gaps in control:** 1. Process for picking up and addressing wherever possible dissatisfaction in new starters before they decide to leave is in place 2. Developing workforce supply routes 3. New ways of working 4. Systematic process throughout the Trust to support succession planning. 5. EDI champions and local EDI objectives to create a diverse workforce, leadership and inclusive culture 6. High levels of mental health related sickness absence **Gaps in assurance:** -	**Actions aligned to gaps:** Executive Lead for actions: Chief People Officer. 1. Review our retention interventions during 25/26. 2. Continue to embed our widening participation approach during 25/26 3a. Utilise technology advances to facilitate system interoperability and advances in robotic process automation from 24/25 through to 2030. 3b. Deploy Manager Self Service within the Electronic Staff Record by 25/26. 4. To work with system colleagues to develop a system approach to talent management - during 2025/26. 5. Refresh and deliver EDI action plan and review against key workforce data. by March 2026, with report to Board at least annually. 6. Develop and embed our trauma informed leadership capabilities through our staff psychology offer during 2025/26.	1. The development of the Joint People Strategy is underway and review of People and OD service structures and priorities. Discussion document on draft Joint People Strategy received by PODAC August 2025. 2. Q1: Graduations of our DFN Project Search interns (a national charity that enables young adults who have a learning disability or autism spectrum condition to secure meaningful permanent employment) across both PRH and RSH sites and plans complete for the next cohort starting in September 2025. 3a. Implemented ESR Go for medic on duty which provides a mechanism for automating staff contractual changes and taking information processed on ESR and updating Health Roster. ESR Business Intelligence alerting functionality is developed. Currently exploring robotic process automation opportunities and investment levels required. Q1: Submitted an application to NHSE to trial robotic process automation which was not accepted, although the organisation is exploring other opportunities for this. 3b. A trial of team based rostering was completed on ward 23 during 24/25 . Roll out programme of Manager Self Serve is in place and is 80% complete at Q2. 4. Leadership development and talent is shared across Shrop Comm and SaTH. In addition, we are exploring shared services which will have a wider footprint across the system for leadership development and delivery. Q2: The Task & Finish Groups are now being established for joint working. 5. Q1: EDI WRES and WDES data has been submitted to inform future planning. The report was discussed at Strategic People Group in July 2025 and was received by PODAC in August 2025. 6. Q1: Leadership development programmes have been reviewed to incorporate trauma informed leadership as part of these programmes. Engagement conversations held with patient advocate groups which is supporting the formulation of the joint people strategy and priorities.Q2: Change Agent training being delivered across the organisation and psychology are part of these programmes.			12

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Overspend against operational budgets driven by operational pressures • Capital constraints • Historic under-investment driving increased capital requirement • A failure to maintain financial sustainability due to non-planned cost pressures • Lack of available appropriate substantive workforce • Continuing to operate in a system with a commissioner deficit • Increasing demand placing pressure - inadequate estate available to accommodate need. Inefficient deployment of resources to bridge gap. • Aged infrastructure requiring increased maintenance and potential loss of capacity • Significant CIP plans of 6.4% required to deliver the annual plan • High sickness levels placing additional pressure on service costs. **Consequence:** • Short-term recovery inhibits service quality improvement. • Dwindling cash reserves. • External action being taken against the Trust (in segment 5 of National Oversight Framework) • Continue imposition of regulatory controls leading to the loss of local control. • Damage to the Trust's reputation and the Trust's continuing abilities to function • Inhibits ICS' ability to commission growth in services • Risk of increased cost	4	5	20	• Annual financial plan - revenue and capital plan. • Planning on a system wide basis with openness and transparency across the system. • Internal performance management system - budget holder to Board. • Monthly financial reporting system - nominal roll, budget statements, divisional committee, Operational Performance Oversight Group (OPOG), Performance Review Meetings (PRM). • Chief Executive-led Financial Recovery Group meets first and third Wednesday of the month • Service Review Deep Dives in place to identify opportunity for improving efficiency. • Triangulation of operational, financial and workforce data into a dashboard to provide greater visibility of service performance. • Service Line Reporting to assess service viability and ensure appropriate funding in place. • Annual revenue plan for 2025/26 that was developed with specialty input and within which activity, workforce and finance triangulate • Reviewing medical doctors rotas to ensure compliance • Internal (executive led) and system-wide vacancy control process. • Strengthening governance via splitting the finance and performance elements within the assurance committees (but recognising the interdependencies between the two). • High levels of authority required to approve discretionary expenditure (non-pay) on Oracle - in practice since January 2025	**Reported to Board, committees and elsewhere:** • Monthly Trust-wide finance reports to Board of Directors, Finance Assurance Committee and Financial Recovery Group (2nd) • Sustainability and Efficiency (CIP) report to Innovation & Investment Committee and Senior Leadership Committee-Operational (2nd). • Annual financial plan, planning progress shared with Board for sign off (2nd) • Divisional Performance Review Meetings (PRM), Cascade, Executive messages into the organisation (2nd). •Monthly performance reviews with divisions (1st) • Routine monthly reporting including variance to plan and run rate analysis (1st) • Internal audit reports (MIAA): core financial controls and sustainability and efficiency processes (3rd) - Substantial assurance • Report to region (NHS Midlands) each month and position shared with local Integrated Care Board (2nd). • External audit of annual accounts (3rd) • Workforce plan reported to Operational People Group (1st) • Weekly Executive Dashboard: beds, nursing WTE and finances (2nd) • Interim Budget setting paper for 25/26 to FAC and Board (25th Feb 2025 to FAC and 13th Mar 2025 to Board) (2nd), with final budget approved by Board (on 25th Mar 2025) • Operational People Group now aligned into Operational Performance Oversight Group to enable better oversight • VFM opinion from external audit with no significant weaknesses identified (3rd).	5	4	20	**Gaps in control:** 1. Divisions recognise their financial responsibilities and engage well however, financial management, effective sustainability and efficiency planning compete with other high profile priorities across the Trust. 2. Comprehensive identification and delivery of a £41.4 million cost improvement programme and adherence to cost control policies and processes 3. Inefficient reporting routines hampered by an outdated finance system and a misalignment between the finance system and the HR system. 4. Risk management process that takes into account quality and safety risk alongside financial risk on a daily basis leading to budget holders prioritising the quality and safety risk and incurring unbudgeted cost in relation to both medical and nursing staff. 5.-Understanding how system partners medium term plans impact SaTH - ensuring that CIPs do not push cost around the system and that interdependencies are clear. 6. Lack of activity data means it is challenging to triangulate spend with changes in activity. **Gaps in assurance:** 7. Ability to accurately report contract income position.	Actions aligned to gaps: 1a. Continue to engage divisions in a multi-year rolling programme of identifying cost improvements for 2026/27 via a dedicated multi-disciplinary Financial Recovery Programme Office by December 2025. This is in addition to identifying any mitigations in relation to the 25/26 programme. Executive lead: Director of Finance. 1b. Staff reduction targets with a monthly recruitment ceiling issued to divisions to achieve agreed exiting whole time plan by March 2026. Executive Leads: Chief Operating Officer/Director of People & OD/individual executives. 1c Monthly Operational Performance Oversight Group to be chaired by Director of finance with COO as Vice Chair to review financial and workforce performance with a regime of escalation for divisions not delivering to plan - ongoing. Lead Executive: Director of Finance. 2a. £41.4 million was identified by the time of the final operating plan submission on 30 April 2025. The priority is to de-risk, identify mitigating alternative schemes and deliver the £41.4m - timescale end of Q2. Executive lead: Director of Finance. 2b. Identify and recruit a financial improvement director by end of April 2025. Executive lead: CEO 3. Scoping exercise to link Electronic Staff Record (ESR) with finance budgets - ~~Q2~~ Q3 2025. Executive lead: Director of Finance and Director of People and OD. 4a. Revised escalation measures to be introduced to support divisions to ensure timely quality and safety decisions whilst considering budgetary impact - by end July 2025 . Executive lead: Director of Finance/Chief Operating Officer. 4b. System-wide actions in relation to the UEC pathway, managed by the UEC Transformation Board in order to mitigate the risk of additional capacity-timescale ongoing. Executive Lead: Chief Operating Officer. 5. Sath have completed a medium term financial plan as part of the HTP business case, system-wide medium term financial plan required which is linked to a system-wide demand and capacity model - by-end of Q2 25/26. Executive lead: Director of Finance. 6a. Re-introduce activity data to divisional reporting packs at PRM and OPOG. end of Q3 ~~Q2~~ 25/26. Executive lead: Director of Finance and Assistant CEO. 6b. Devolve Clinical Income to divisions - end of Q3 ~~Q2~~ 25/26. Executive lead: Director of Finance. *7. See BAF risk 7b, action 4b regarding Data Warehouse.*	1a. Financial Recovery Taskforce supported by the Financial Recovery Programme Office in place since September 2024. Chief Executive chaired Financial Recovery Group - since August 2024. Fully identified CIP programme for 25/26. 1b. Whole time reduction monitored on a monthly basis and reported to both Finance Assurance Committee and People & OD Assurance Committee. 1c. Operational Performance Oversight Group in place. Divisions will be escalated as necessary. Q2: Escalation framework to be presented to Finance Assurance Committee in September 2025. 2a. Full efficiency programme identified. De-risking continues to be monitored via Financial Recovery Group and Finance Assurance Committee. 2b. Action complete Q1. 3. Work ongoing during 2025/26. 4a. Review of monthly meetings taking place and escalation process to be implemented by ~~end of July 2025~~ Q2 2025/26 following divisional forecasting at the end of Q1. 4b. Previous escalation capacity included as core capacity in the 25/26 operational plan. Further additional capacity planned ahead of winter with the Winter Plan agreed at Board in September 2025. 5. Work commissioned to develop a system-wide demand and capacity model has been completed, model continues to be updated by the ICB and has been shared with system partners. System wide medium-term financial plan using high level assumptions shared with respective organisational finance committees during Q1 25/26. As part of the national phase 1 work, underlying positions and medium-term financial plans will be submitted to NHSE during Q2. Q2: Underlying positions submitted on a monthly basis through the Provider Finance Returns. 6a and 6b. Q1: Investigating the most appropriate approach to devolving income and reporting income and activity at division, specialty and Point Of Delivery level. Q2: interim solution of ICB sharing relevant data agreed pending longer-term solution.			12

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Older buildings built with now outdated regulatory requirements • Restricted physical environment, unable to meet current capacity requirements • Backlog maintenance issues due to limited capital • Residual gaps in fire safety action plan • The Trust has identified reinforced autoclaved aerated concrete (RAAC) within specific areas within PRH and surveys continue across the Estate. **Consequence:** • Poorer patient outcomes and patient safety issues • Regulatory or legal action possible • Adverse publicity and reputational damage possible • Potential poor working conditions and environment affecting staff health, experience and engagement - increased sickness absence and recruitment.	4	5	20	• Board-approved (limited) Capital Programme including backlog maintenance plan and medical equipment budget in place addressing high risk backlog on a yearly basis, where funding allows. • Capacity & demand led capital programmes, aligned to Hospital Transformation Programme. • Capital Estates Plan 2021-2026 in place - in Capital Planning Group for review (subject to funding each year). • Estates Strategy 2025-2030 • Updated Estates risk assessments and planned preventative maintenance of engineering infrastructure. • Staff survey measures staff levels of engagement and morale (in relation to working environment). • Minor and major works protocols and management plans in place for known risks, e.g. asbestos and RAAC. • RAAC national funding received and removal project in progress. • Fire action plans in place and being monitored. • Annual fire safety audits. • Standardised framework for large capital projects developed and implemented.	**Reported to Board, committees and elsewhere:** • Performance Assurance Committee (2nd) • Capital plan developed and overseen by Capital Planning Group (CPG), chaired by Director of Finance (2nd) • Annual estates report to Board (2nd) • Annual update backlog six facet survey that informs the capital plan (1st) • Regular updates of fire action plans at Fire Safety Group (1st) • Fire Safety Improvement Action Plan Oversight Group (2nd) • Fire safety updates reported to private Board regularly (2nd) • Operational estates governance and oversight in place including: Decontamination Group (2nd), Medical Gas Committee (2nd), Ventilation Safety Committee (2nd), Water Safety Committee (2nd), Fire Safety Group (2nd), Asbestos Safety Committee (2nd). • Authorising Engineer's Annual Fire Safety Audit 2024 (3rd) - report presented to Assistant Chief Executive and Director of Estates November 2024. And presented to March 2025 Board of Directors. • RAAC Project Group in place (monthly) for the duration of the programme, chaired by Assistant Chief Executive (2nd). • Performance Review Meetings (PRM's) bi-monthly (2nd). • Estates Strategy 2025-2030 to Performance Assurance Committee June and July 2025 and to Board September 2025. • Fire Enforcement Notice 348 removed July 2025. Plan in place for associated fire stopping works in ward block RSH.	4	4	16	**Gaps in control:** 1. Energy infrastructure at its limit on the site 2. Lack of up-to-date Estates Strategy. 3. Awaiting confirmation of RAAC funding to enable long-term remedial works. 4. Aged nurse call systems require updating. **Gaps in assurance:** -	**Actions aligned to gaps:** 1. Utilise Salix funding for replacement infrastructure - supplier identified and project has commenced. Public Dividend Capital (PDC) Fund allocation of approximately £7m (proportion of which relates to energy infrastructure). Continuous exploration for additional external funding opportunities - ongoing. Executive lead: Director of HTP (SRO). 2. Develop and approve Estates Strategy by end of Q2 2025. Executive lead: Assistant CEO. 3. RAAC removal project at PRH has commenced with expected end date of April 2026. Executive lead: Assistant CEO. 4. Develop plan for new fixed nurse call systems, where appropriate by end of Q1 2025/26 (plan) and conclude the works by end of Q4 25/26. Executive lead: Assistant CEO.	1. Contractor selected and contract signed. Works commenced March 2025. Two year programme underway. 2. Draft Estates Strategy submitted to Performance Assurance Committee in June 2025 and returned in July 2025. Estates Strategy 2025-2030 approved by Board on 11 September 2025. **Action closed Q2.** 3. NHSE has approved and confirmed funding of £12.2m over two financial years. Contractors selected and approved. Project Group set up and full works have commenced. Project completion date is expected April 2026. 4. Q1: Received PDC Estates Safety Programme funding covering high risk nurse call systems. Developing a plan with clinical teams to install in this financial year.			12

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee						
BAF 7a: Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation.			**Acting Director of Finance**	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	**Whilst digital innovation will transform systems to support better outcomes, SaTH has a MINIMAL risk appetite in relation to cyber security and information governance compliance due to the impact on our patients and colleagues. Risk of loss or damage to information will be minimised through stringent security measures and business continuity planning.**			**Audit and Risk Assurance Committee**						
Risk 7a was partly included within BAF risk 7 in 2021/22 and was subsequently split out into risk 7a and 7b from 2022-23.			Adam Winstanley (from 01 Sept 2025)											

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Lack of resource • Lack of capacity and capability • Continually changing threat landscape - technology and political unrest • Increasing prevalence of threats globally • Funding constraints to invest in digital tools to improve cyber security • Continued national development of cyber strategy, policy and compliance & mitigation framework **Consequence:** • May lead to sub-optimal care, for example could lead to interruptions to vital IT applications which in turn could result in sub-optimal patient care. • May lead to inability to provide essential services for patients, work together with partners, and / or cease service provision • Potential financial penalties - e.g. ICO fines • Potential regulatory action - Network & Information System Regulations (note: this area is subject to further expansion) • Reputational damage and negative impact on public confidence • Temporary or permanent loss of data • Reinforces the need for dedicated resource and continued review of the capacity and capability required. • Limited or non-compliance with national framework	5	5	25	• Governance resource in place including Cyber Security Manager, Deputy and SIRO • Trust actively contributing to cyber security management at Integrated Care System (ICS) level • Business continuity plans in place • Cyber security tools in place to support access management, security compliance, single sign-on, password and digital policies, CareCert updates reviewed for high severity alerts, Multi-Factor Authentification compliance for NHS mail, Phishing test cycles. • Security compliance in place to monitor security patch compliance and compliance with Cyber Assurance Framework (CAF) aligned DSPT • Information Governance (IG) strategy, policy and framework • Incident review processes and learning - national and local • Utilising NHS Digital provided services, including vulnerability management system, penetration testing, advanced threat protection and Bitsight (cyber security rating service) • Registered with National Cyber Security Centre for alerts and intelligence: Webcheck and Early Warning System • Regular cyber security communications for end users • Cyber element of Information Governance training in place as part of statutory and mandatory training for staff • Monthly meeting with regional NHSE cyber security lead.	**Reported to Board, committees and elsewhere:** • Information Governance Committee - (2nd) • MIAA internal audit of cyber security - Sept 2025 (3rd) • Annual MIAA internal audit of cyber security, reporting to Audit & Risk Assurance Committee (3rd) • MIAA Technical Review Medical Devices 2024/25 - Moderate Assurance (3rd) • Weekly Digital Services senior leadership team meetings where any issues escalated (1st) • Dedicated monthly risk review meeting (1st) • Active directory review report - NHS Digital/MTI (3rd) - report to Digital Services • Bi-annual cyber update reports to Audit & Risk Assurance Committee meeting (2nd) • Monthly meetings held between SaTH Digital Services and NHSE Regional Cyber Security Team since 2024/25 to provide ongoing updates in relation to remediation planning and ongoing risk / impact • STW Digital Delivery Group (exec lead) - meets monthly (2nd)	5	4	20	**Gaps in control:** 1. Some devices and systems will remain non-compliant with risk mitigation plans 2. Skilled resource and availability within ICS outside of core hours 3. Cyber Security strategy to be developed. 4. Funding constraints. **Gaps in assurance:** 5. Continued joint working between digital services and MES.	**Actions aligned to gaps:** 1. Risk mitigation plans in place - ongoing review. Long-term resolution plans required for non-compliant systems within Divisions - ongoing, funding dependent. Executive lead: Executive Lead: Acting Director of Finance 2. Continue our work as a health system partner during 25/26 and 26/27 as part of the work programme for the ICS Digital Delivery Group. 3. Develop Trust-level Cyber Security Strategy to support overarching Digital Strategy by ~~Q2~~Q4 25/26. Executive Lead: Acting Director of Finance 4a. Re-prioritisation of internal digital capital funding during 2025/26. 4b. Continue to explore external funding opportunities during 2025/26. 5. Establish a Medical Devices Security Working Group by Q3. Executive Lead: Acting Director of Finance, supported by Assistant CEO.	1. Risk mitigations plans are in place and compliance continues to evolve and be kept up to date in line with national guidance. Q1: Digital services have reviewed cyber plans for 25/26 as part of the digital delivery programme. Cyber update received at September 2025 Audit and Risk Assurance Committee (ARAC). 2. Q4: From December 2024, ICS Cyber Operational Group established, focusing on Cyber and Infrastructure Optimisation. Q2: STW ICS Digital Cyber Strategy has commenced. 3. The SaTH Cyber Security Strategy is currently under development, with a view for completion by December 2025 following alignment with new Cyber Assurance Framework aligned DSPT. The intention is to ensure that the strategy is aligned with the National Cyber Strategy for Health and Social Care and the NHS England CAF aligned Data Security and Protection Toolkit. Q2: Development of SaTH Cyber Strategy has now paused pending delivery of the ICS Cyber Strategy. 4. Continue to monitor digital funding and prioritise in accordance with the national policy, recognising the constraints on capital funding. 5. Group in the process of being set up with both digital and medical device colleagues and will be chaired by digital colleagues. First meeting scheduled for October 2025.			6

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee						
BAF 7b: The inability to implement modern digital systems impacts upon the delivery of patient care			Acting Director of Finance	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	**SaTH is OPEN to transform its digital systems to support better outcomes and experience for our patients and public. New technologies are viewed as a key enabler of operational delivery, productivity and efficiency (including clinical) following thorough assessment and testing.**			**Performance Assurance Committee**						
Risk 7b was partly included within BAF risk 7 in 2021/22 and was subsequently split out into risk 7a and 7b from 2022-23.			Adam Winstanley (from 01 Sept 2025)											

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Lack of core digital project team resource - appropriate skillsets and experience and national shortage of digital technical personnel • Lack of clinical and operational capacity and capability within Trust • Large scale digital business change programme alongside other competing business change programmes such as financial improvement and UEC • Network replacement • Prescribing and Medicines Administration (EPMA - electronic prescribing and medicines administration) and Order Communications systems required to improve level of digital maturity. • Order Communication system is past the end of its useful life • Second phase of maternity system required - neonatal system upgrade - funding sought for increase in scope • Trust's Data Warehouse requires redevelopment and resourcing both in the short and medium term, with alignment to the national federated data platform. • Reduction in digital capital allocation (national, regional and local). **Consequence:** • Could lead to interruptions to vital IT applications which in turn could result in sub-optimal patient care. • Poor data quality • May lead to inability to provide essential services for patients, work together with partners, and / or cease service provision • Potential financial penalties - misreporting • Inability to provide national submission reports, which may affect income and activity • Potential regulatory action • Reputational damage and negative impact on public confidence • Potential negative impact on staff morale • Inability to operate in an integrated health and care system, e.g. shared care record (One Health and Care) Inability to adopt modern technologies such as artificial intelligence (AI), robotic process automation (RPA), etc.	4	5	20	• Digital Transformation governance structure in place - Operational Readiness Groups which feeds into appropriate Programme Board. All digital projects report into Digital Oversight Group which reports into Senior Leadership Committee, reporting into Performance Assurance Committee/Trust Board • Business continuity plans in place and to be implemented for new systems • Working closely with procurement to secure recruitment into specialised posts and to continue to recruit substantive vacant posts • Standardised network infrastructure platform • Governance resource in place: Chief Clinical Information Officer and Chief Nursing Information Officer provide Clinical Safety Officer functions. Clinical Safety & Hazard Group in place monthly (safety of software and reducing hazards for patient safety), Chief Information Officer/Director of Digital Transformation in place - at SaTH, Head of Digital Innovation & Transformation in place within the ICB • Digital Design Authority Group and the Clinical Design Authority / Medical Records Committee meet frequently to review the design for systems and sign off to ensure fit for purpose	**Reported to Board, committees and elsewhere:** • Weekly digital senior team meeting and bi-weekly digital design authority meeting for areas of escalation, along with monthly summary (1st) • Monthly programme reports to Programme Board which feed into Digital Oversight Group (2nd) • Bi-monthly update into Senior Leadership Committee (2nd) • Digital updates to Performance Assurance Committee (2nd) • Periodic Digital updates to Trust Board (Board report and/or Board seminar format) (2nd) • Report to STW ICS Digital Delivery Committee with system updates to the ICB Strategy and Prevention Committee (2nd)	4	5	20	**Gaps in control:** 1. Requirement for key roles and increase in substantive capacity in the digital programme. 2. Capacity within wider trust teams for digital system implementations. 3. EPMA and several other digital initiatives do not have a source of full funding in 25/26 and limited national/regional capital funding identified for 25/26. 4. Ageing digital infrastructure and architecture. **Gaps in assurance:** -	**Actions aligned to gaps:** 1. Continue to recruit into substantive vacant posts that were approved as part of 25/26 operational plan. Executive lead: Acting Director of Finance. 2a.A review of all digital initiatives and projects has been undertaken and continues to be reviewed during 25/26, aligned to the prioritisation of the service development capital allocation and recovery programmes. Executive lead: Acting Director of Finance. 2b. The framework for the requirement for SRO, operational lead and clinical lead for each digitally enabled project has been described for 2025/26 and work is to be undertaken to review this with corporate leads and Divisions in 25/26. Executive lead: Acting Director of Finance. 3. Ongoing discussions with NHSE National and Regional Digital Team to explore external funding opportunities during 25/26 and 26/27. Executive Lead: Acting Director of Finance. 4a. Complete the digital maturity assessment for 25/26 and submit to NHSE annually. Executive Lead: Acting Director of Finance. 4b. Develop programme for substantive solution for Data Warehouse supported by national federated data platform (FDP) team by March 2026. Executive Lead: Acting Director of Finance.	1. Digital positions continue to be appointed to, but it remains challenging to appoint to the specific technical expertise required for key programmes, which reflects the current market position. 2a.Trust digital programme is discussed in more detail at the monthly executive-led Digital Oversight Group which includes representatives from all four clinical divisions and key corporate services. Q1: Regular planning, review and prioritisation sessions with all divisions will continue through 25/26. Q2: Digital update due at October 2025 Board. 2b. Q1 and Q2: In progress. 3. Q1 25/26: Additional external funding has been successfully secured for Laboratory Information Management System (LIMS) and Electronic Order Communications and Results Reporting (OCRR). Women's and Children's Division have finalised funding for Badgernet Neonatal system 2025/26. Divisions have prioritised their capital requests for 25/26; opportunities for use of AI/RPA are being reviewed across the Trust and will require the development of business cases. 4a. Q2: Submission made for 2025/26. Results due to be published Q3. 4b. Q1: Successful live automation of the Trust's SUS returns through the Federated Data Platform (FDP). Second phase to fully transition functionality into the FDP with the national team has commenced.			12

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Poor processes, systems and culture • Operational challenges and pressures **Consequence:** • May lead to sub-optimal quality of care • Additional regulatory action • Damage to reputation and negative impact on public confidence • May lead to cultural issues, poor morale, and difficulties in recruitment • Financial penalties • At the end of Q2 2025/26 the Trust has two Section 31 conditions in place	4	5	20	• Moving To Excellence Programme • Quality priorities 25/26 • Quality & Safety Assurance Committee and Quality Operational Committee established to monitor position • Quality governance framework • Complaints process • Risk Management Policy and processes • Freedom to Speak Up arrangements • Exemplar programme (ward accreditation) • Monthly quality metrics • CQC action plan owned by Divisions • Palliative and End of Life Steering Group • Speciality Patient Experience Groups and the Patient and Carer Experience Panel. • Patient Safety Specialist in post • Board Assurance visits • Core Service CQC Self-Assessments and CQC quarterly engagement events with core services • CQC inspection report published May 2024 (3rd)	**Reported to Board, committees and elsewhere:** • Reports received monthly at Quality Operational Committee (QOC) (2nd) • Quality & Safety Assurance Committee (QSAC) reports received (bi-monthly) and monthly via AAAA report to Board (2nd) • Quality, safety and performance metrics within Integrated Performance Report to Board (monthly) (2nd) • Regular reporting to QSAC, Quality Operational Committee and other divisional, specialist groups and committees (1st) • Compliance monitoring with CQC actions - QSAC (2nd) • RALIG meeting (1st) • Incident Review Oversight Group (1st) • Rapid Review process reporting (1st) • Patient & Carer Experience Group (1st) • Mortality Group (1st) • Deteriorating Patient Group (1st) • Infection Prevention and Control (IPC) Assurance Committee (2nd) • Safeguarding Assurance Committee (2nd) • Operational meetings for IPC, safeguarding, workforce and maternity (1st) • Bi-weekly informal meetings with CQC - chaired by Director of Nursing (2nd) • Quarterly engagement meetings with CQC (3rd) • CQC action plan owned by Divisions and confirm and challenge in place (1st) • System Oversight Assurance Group - chaired by the Region and CQC, Healthwatch, NMC, GMC and HEE/NHSE attend (3rd) • NHSE IPC inspection for C'Diff undertaken April 2025 - actio plan updated and reorted via IPCAC and QSAC (3rd) • Moving To Excellence Operational Delivery Group (1st) which feeds into QSAC and Board • External Peer reviews in neonatal, trauma and critical care in Q3 • MIAA internal audit reviews 2024/25 (3rd): Freedom to Speak Up (Substantial Assurance). • UEC Transformation Assurance Committee, reporting to QSAC (2nd)	4	3	12	**Gaps in control:** 1. Lack of whole system support for healthcare services (e.g. children and young peoples mental health and Urgent and Emergency Care - UEC). 2. 79 Must and should do actions from CQC Report from May 2024 *3.* Under stage one compliance management for aseptic services. **Gaps in assurance:** 4. Board reporting on assurance on delivery of research requirements and aspirations	**Actions aligned to gaps:** 1. System leadership required. 2. Deliver CQC action plan during 24/25 and 25/26 3. Deliver action plan which relates to training, equipment and work environment during 25/26: Lead: Chief Pharmacist 4. Develop research assurance reporting by Q3. Lead: Executive Medical Director	1. The Trust is working with the ICS. A Midland Partnership Foundation Trust and SaTH meeting was held in June 2024 for new ways of working for children and young people with mental health. Children and Young People mental health summit occurred in September 2023. 2. Agreed governance through transformation programme and our existing governance structures in the trust. Full action plan quarterly to ICB Quality Surveillance Committee and UEC action plan monthly to the contract monitoring meeting. Q2 25/26: we have applied for one Section 31 condition to be removed and are awaiting the outcome from the CQC. 4. Q2 25/26: SaTH has received confirmation that it has been awarded University Hospital Status in recognition of its research and education work.			6

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Delayed treatment times and backlog • Workforce gaps - including nursing, medical, Allied Health Professionals, diagnostics and theatres • Bed capacity and urgent care demand • Insufficient capacity to meet demand • New Electronic Patient Record operational issues Insufficient productivity in Planned Care **Consequence:** • May lead to sub-optimal care • May lead to harm due to the unmet need • Financial activity impact • Regulatory action • Damage to reputation and negative impact on public confidence	4	5	20	Performance controls below (refer to BAF 3 and 4 for workforce controls): • Trust Planned Care Transformation Programme • Specialty level capacity and demand plans • Weekly/monthly monitoring of capacity/demand and performance • Departmental and Divisional monitoring of RTT, imaging and endoscopy • NHSE Diagnostic Task Group • NHSE fortnightly tier 1 assurance meetings for cancer and RTT • Monthly Performance Review Meetings • Enhanced operational management structure with focus on elective and urgent care • Validation of waiting list to address data quality issues and ensure accuracy of waiting times • Outpatient Transformation Programme • Associate COO for elective recovery commenced December 2024 • Substantive Deputy COO for Planned Care commenced February 2025. • Cancer Improvement Lead commenced March 2025. • Divisional Medical Director for Surgical Division commenced May 2025. Substantive Director of Operations for W&C commenced April 2025 Additional elective activity delivered by insourcing providers	**Reported to Board, committees and elsewhere:** • Performance metrics within Integrated Performance Report to Board (monthly) (2nd) • Weekly Trust Cancer performance meetings (1st) • Weekly Trust RTT performance meetings (1st) • Standing monthly IPR reports to Quality & Safety Assurance Committee and Performance Assurance Committee (PAC) (2nd) • Performance Highlight Report to PAC, including RTT, Cancer, theatre productivity, outpatient transformation and UEC assurance (2nd) • Monthly reporting to Performance Review Meetings (2nd) • Shropshire Telford & Wrekin (STW) Planned Care Delivery Group reporting monthly (3rd) • Elective Recovery Board - Midland NHSE (3rd) • 'Tier' assurance meetings - 65 weeks, 62 day cancer backlog and 28 day faster diagnosis performance with NHSE and STW (3rd) • Cancer trajectories 25/26 - 62 day backlog, and 28 day faster diagnosis to PAC (2nd) • RTT 25/26 - 65 week recovery trajectory to PAC and 52 week trajectory for children and young people (2nd) • DMO1 (diagnostics)recovery trajectory 25/26 to PAC (2nd) • MIAA (internal audit) DM01 Diagnostics Audit 24/25 (Moderate assurance) (3rd) • 18 week, 52 week and total waiting list size - all ahead of plan Q1, 25/26 • Planned Care Transformation Assurance Comittee - meets monthly - commenced April 2025 (2nd) • Improvement in performance reported to Performance Assurance Committee - September 2025 (2nd): Elective care: De-escalated from NHSE Tier 1 (highest level of performance management) to Tier 3; Reduced number of people on waiting list by almost 30% in the last year; Eradicated 65 week waits; Biggest improvement - reduced 52 week waits by 90%; Best 18 week RTT performance in Aug 2025 for 4 years. Cancer: Improved performance in cancer 28 day Faster Diagnostic Standard (FDS), with July performance the best for 18 months and exited bottom quartile nationally; Improved performance in cancer 62-day Referral To Treatment with July performance the joint best month for over 3 years, and exited bottom quartile nationally; De-escalated out of NHSE Tier 1 oversight to Tier 2. Diagnostics - Best diagnostic 6 week wait (DM01) performance in five years in July 2025; De-escalated out of NHSE Tier 1 oversight to Tier 2.	4	3	12	**Gaps in control:** 1. Diagnostics turnaround times to enable elective and cancer treatment 2. Productivity - opportunity to better optimise core capacity for treating elective and cancer patients 3. Outpatients - opportunity to improve referral and demand management approaches and optimise outpatient capacity 4. Digital - introduce digital enablers to elective care and treatment **Gaps in assurance:** 5. Further development of demand and capacity, development of leadership in planned care management, clinical capacity challenges	**Actions aligned to gaps**: (executive lead for actions: Chief Operating Officer) 1a. Develop and monitor diagnostics improvement workstream by March 2026 1b. Design and introduce cancer diagnostics dashboard to allow real time visibility of cancer imaging performance by May 2025. 2a. Implement GIRFT best practice productivity interventions and drive improvement in productivity in theatres and outpatients to 97% session utilisation by March 2026. 3a. Implement high impact evidence-based interventions: a) Redesigning referral pathways; b) Transforming outpatients; c) Reducing unwarranted variation - by March 2026. 3b. Reduce waiting times for planned care by optimising processes and improving outpatient booked utilisation by 4% by September 2025. 4. Introduce digital workstream to identify and implement digital tools to enable improved planned care delivery, by March 2026. 5. Complete demand and capacity modelling as part of planned care right sizing exercise by March 2026, leading to a reduction in clinical capacity issues. Development of leadership capability as part of national programme delivered by NHS Impact.	1a. Diagnostics workstream set up and reporting monthly to Planned Care Transformation Committee. 1b. Cancer diagnostics dashboard created and implemented, May 2025. 2. Theatre productivity improvement workstream in place reporting to Planned Care Transformation Committee with established action plan to deliver theatre utilisation ambitions. 3a. Outpatient transformation workstream in place reporting to Planned Care Transformation Committee with established action plan to deliver outpatient improvement ambitions. 3b. Four Eyes outpatient utilisation project: Q2: phase one completed to improve booked utilisation identified. Phase two commenced to optimise clinic templates during Q2. 4. Digital workstream set up to oversee implementation of digital tools and benefits realisation. Initial five key priority systems identified: Patient Engagement Portal AI Scribe Medical Form Digitalisation Pre-op SDEC Digital. 5. SaTH is part of Cohort 1 for leadership training delivery with NHS Impact commenced Aug 2025. Currently 55 band 6-8a signed up to scheme. Demand and Capacity modelling is to be undertaken in conjunction with a proposal from Four Eyes.			9

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • lack of acute bed capacity and workforce. • Increase in complexity of demand and length of stay • Community capacity for pathway 2 & 3 insufficient to meet current needs for timely discharge • Primary and community health and care capacity not meeting pre-hospital demand • Insufficient effectiveness of SaTH UEC pathways **Consequence:** • Delays in treatment pathways including increase in acute length of stay • Urgent work impacting on elective capacity • Leads to sub-optimal care and poor patient experience • Regulatory action • Negative impact on reputation and public confidence. • Impact on ambulance handover delays and subsequent impact on ambulance availability within the community • Overcrowding and long lengths of stay in Emergency Department, with increased associated risk of harm.	4	5	20	• Revised SaTH 25/26 Urgent & Emergency Care (UEC)improvement programme. • Confirmed System 25/26 Urgent and Emergency Care Improvement Plan • STW UEC Delivery Group • Capacity and demand analysis • Hospital Transformation Programme - addresses one of the biggest strategic challenges for the local health system by separating the emergency and planned care flows, and consolidating fragmented teams and pathways (including critical care) • UEC project initiation document in place including implementation plan and Gaant chart • Transformation Lead Nurse for UEC appointed - commenced February 2025 • Deputy COO for UEC appointed - commenced March 2025 • STW UEC Improvement Director commenced April 2025 • Substantive Director of Operations for Medicine & Emergency Care commenced September 2025.	**Reported to Board, committees and elsewhere:** • Performance Assurance Committee (monthly) (2nd) • Urgent and Emergency Care (UEC) metrics within Integrated Performance Report to Board (monthly) (2nd) • Urgent and Emergency Care Transformation Assurance Committee (underpinned by the UEC plan) - monthly (1st) • 'Tactical' and 'Strategic' system meetings, as triggered by escalation levels (2nd) • STW UEC Delivery Group - monthly (2nd) • NHSE Delivery meetings - system and regional for CEO's regarding A&E performance, ambulance offloads and CAT 2 response times- fortnightly (2nd) • Monthly reporting to the CQC (2nd). • Monthly CQC update report to Quality Operational Committee and Quality and Safety Assurance Committee (2nd). • Performance Review Meeting (PRM's) (2nd) • Weekly System Key Performance Metrics Meeting (2nd) • NHSE Tier 1 monthly meeting with national director of UEC (2nd) • External GIRFT and ECIST review of ambulance handover pathway - January 2025 (3rd) • External GIRFT and ECIST criteria to admit audit - completed Q1 25/26. (3rd)	4	5	20	**Gaps in control:** 1. Inpatient bed capacity. 2. Proportion of urgent and emergency care patients streamed to the Urgent Treatment Centre (UTC). 3. Proportion of emergency care patients managed through same day emergency care pathways. 4. SaTH interface with system-wide Urgent & Emergency Care (UEC) improvement programme. **Gaps in assurance:** -	**Actions aligned to gaps:** Executive Lead for actions: Chief Operating Officer. 1. Develop workstream for SaTH bed base which will encompass project milestones detailing PRH acute bed base and RSH capacity increases alongside the exploration of further capacity, if feasible, by ~~November~~ December 2025 2. To improve Type 3 performance and the volume of patients streamed to the Urgent Treatment Centre by Q4, 25/26. 3a. Establish Same Day Emergency Care (SDEC) Workstream through the UEC Improvement Programme. 3b. Review of clinical space to deliver SDEC services, by September 2025. 4. To explore opportunities for future collaboration with system partners to improve urgent and emergency care during 25/26.	1. Q2: Workstream commenced in July 2025 as part of the UEC Improvement Programme. 56 additional inpatient beds at RSH through two new modular wards. 40 additional (trolley and bed) assessment spaces at PRH. Both planned December 2025. 2. Q1: Type 3 Task and Finish Group meeting monthly to address gaps in service and operational challenges following the transferred services in March 2025. Test of change w/c 9/6/25; learning and outputs from the week being reviewed and implemented. Q2: September 2025 was best month for Type 3 four hour performance since SaTH took over the running of the UTC's. 3a. Q1: To commence July 2025 and to increase the percentage of patients streamed to SDEC areas by 5%, Q4, 25-26. 3b. **Action Complete Q2**. RSH SDEC will move to current Acute Medical Assessment (AMA) location. PRH SDEC will expand into current AMA location. 4. Q1: System approval for funding of interventions for Shropshire Community Trust: extension of urgent community response service; implementation of the integrated front door team; and extension of the service provided by the care transfer hub. Q2: New GP Out of Hours care co-ordination centre provider (Health Hero) commences 1 October 2025.			9

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Emergency Department and multiple services (e.g. emergency surgery, critical care, acute medicine) operating at two sites (Princess Royal Hospital and Royal Shrewsbury Hospital) • Continued challenge in achieving national access performance standards • Insufficient shift to local services outside of the acute hospital setting - requirement to offset additional growth, in line with the Health and Care Models Transformation Programme. **Consequence:** • Unsustainable infrastructure • Unsustainable clinical services • Reduced patient satisfaction • Potential impact on quality and safety of patient care • Impacts financial sustainability and backlog maintenance not reduced • Reduced staff morale • Less efficient estate • Not achieving national access performance standards • Workforce position unsustainable if continue to duplicate services across two sites.	5	4	20	• Hospitals Transformation Programme (HTP) - the Trust received national approval of its full business case for the programme and work commenced 2024 and remains on track for delivery. This capital investment will deliver a new model of health care in the county. • System, Urgent and Emergency Care (UEC) Plan in place for 2025/26 - led by ICS UEC Board. • Work remains on track to build detailed clinical pathways that support safe transfer and transformation of services from the current operating model to the new model of care. Priority is being afforded to urgent and emergency care pathways and work with ICS/UEC partners has begun. In parallel to the service transformation work being done in preparedness for the completion of the HTP build, clinical teams are reviewing options for accelerating any pathways that can be expedited prior to HTP 'go live'. • Development of the integrated ICS Workforce Plan. • Clinical Services Transformation Group is now operational to produce clinical pathways in line with the clinical model. • Revised governance structure for the implementation of the clinical programme. • HTP Workforce Lead appointed. • Revised terms of reference for the Strategic People Group. • Workforce programme established for 2025-2028. • A dedicated HTP master programme action plan is in place and being reported against.	**Reported to Board, committees and elsewhere:** • SaTH Board (meets monthly - public/private) (2nd) • Shropshire Telford & Wrekin ICS Strategy Committee (monthly) (2nd) • HTP Assurance Committee (bi-monthly) (2nd) • HTP Programme Management Committee - SaTH executives (2nd) • HTP Oversight Group (monthly), including system partners and ICS members, chaired by ICS Chief Finance Officer (2nd) • UEC plan to ICS UEC Board - monthly (2nd) • Independent Reconfiguration Panel produced/published a report that made 13 recommendations in relation to HTP which agreed with the HTP delivery mechanism to deliver outcomes for the population of Shropshire, Telford & Wrekin and mid-Wales - December 2024 (3rd) • Clinical Assurance Group (2nd) • Strategic People Group (2nd), reporting to People & OD Assurance Committee. • STW Neighbourhood Implementation Group - chaired by ICS Chief Medical Officer (2nd) • Clinical Services Transformation Group (2nd) • Formal HTP Finance Committee (2nd) • NHSE monthly meeting (3rd)	4	3	12	**Gaps in control:** - **Gaps in assurance:** 1. Dependency on system-wide programmes to deliver the clinical model.	**Actions aligned to gaps:** 1. HTP Director to hold regular meetings with ICB to determine details of their strategy and the impact on the delivery of the clinical model, to ensure co-production, throughout the HTP Programme. Executive lead: Director of HTP. Ongoing - by 2027.	1. HTP Director is a member of the newly constituted Health and Care Models Transformation Programme (HCMTP) to ensure HTP aligns with local care transformation programmes. Work has been ongoing to create stronger links between the two programmes. The HTP revised governance structure was approved (Q2, 24-25) and was implemented at Q3, 24-25. Governance structure revised for clinical arm of the programme. HTP are monitoring the ongoing impact of the system-wide initiatives on bed requirements included within the FBC. Q1: system-wide workshop held on 16 May 2025 with all system partners to understand all of the work being undertaken to support the community model. Follow-up meeting planned for 24 June 2025 with senior responsible officers for all of the programmes. Q2: STW Neighbourhood Implementation Group now supersedes Health & Care Transformation Programme, focussing more on neighbourhoods.			12

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Lack of integrated model of service delivery locally • High non elective admissions • A shift required from acute to community setting for models of care • Challenges in the recruitment of key practitioner roles across health and care to the rapid response service in the Shropshire area • Lack of health prevention and early interventions • Insufficient current workforce capacity in clinical and corporate teams across the system to deliver new ways of working • Availability of systemwide digital specialist resource to implement effective remote monitoring, and enable timely sharing of robust data, and associated impact of achieving agreed trajectories for virtual ward mobilisation • Lack of cohesive approach to long-term condition management, e.g. diabetes **Consequence:** • Increased length of acute inpatient stay • Lack of bed capacity in acute setting impacting on patient flow and reduced delivery of elective activity • May reduce quality of patient care including risk due to ambulance handover delays • Increased demand for emergency department services and non-elective admissions to hospital • Lack of innovation and continuous improvement of services • Reduced staff experience and morale • Increased ambulance conveyances from one care setting to another • Increased emergency community nursing referrals • Increased acute diabetes presentations.	4	4	16	• Shropshire, Telford & Wrekin ICS Neighbourhood Health Implementation Programme ~~Health and Care Models Transformation Programme~~ in place • Five year programme plan in place - ICS Joint Forward Plan (updated annually). • Programme management in place with fortnightly PMO meetings - PMO resource combined across ICS with new standardised reporting tools. • 'Deep dive' into each workstream on a regular basis • UEC programme for 25/26 with link to neighbourhood health - overseen by STW UEC Board • Planned Care programme for 25/26 linked to primary care referral management • ICB Chief Medical Officer plan for group of speciality/condition based pathway improvements - priorities remain as : Diabetes, CVD and frailty (through Health and Care Models Transformation Group), MSK (through Planned Care Group). System Transformation and Digital Committee mechanism in place and all of the major programme boards report into this - chaired by Chair in Common	**Reported to Board, committees and elsewhere:** • Reports to Shropshire Telford & Wrekin ICS Integrated Care Delivery Board and System Transformation and Digital Committee, chaired by SaTH/SCHT Chair in Common (monthly) (2nd) • Report to place-based partnership Boards Shropshire Integrated Place Partnership Committee (SHIPP) and Telford and Wrekin Integrated Place Partnership Committee (TWIPP) (2nd) • Neighbourhood Health Implementation Programme - bi-monthly highlight reports presented covering actions and milestones (1st) • Relevant projects report to the ICS UEC Board - monthly (2nd) • UEC Board, NHIP Group report to System Transformation and Digital Committee (monthly) (2nd) • System Quality Risk Register reported to ICS Quality and Performance Committee (2nd) • Planned Care Assurance Committee at SaTH (monthly), which reports into SaTH Performance Assurance Committee and ICS Planned Care Delivery Group.	4	4	16	**Gaps in control:** 1. Limited detail and limited delivery of the changes in improvement. 2. System agreement to the services "as is " services in and out of scope of the programme. 3. Reliance on physical acute beds rather than community UEC capacity ~~some 'virtual ward' capacity~~ and delays within urgent and emergency care caused by lack of flow. 4. Lack of robust involvement and two-way communication with regard to integrated clinical pathways; there remains high health system quality and performance risk areas within: integrated/cohesive diabetes management, Children's and Young People's (CYP) mental health services transformation, safe and effective maternity care, effective acute paediatric pathway, and C'Difficile case numbers. **Gaps in assurance:** -	**Actions aligned to gaps:** 1. Provide operational and clinical support to the Neighbourhood Health Implementation Programme - ongoing. Lead Executive: Chief Operating Officer and Medical Director with support of HTP operational lead and clinical lead. 2. *Not a SaTH action to lead* 3. See actions within BAF risk 10. 4. Delivery of the ICS Clinical Strategy with six identified priority areas which SaTH takes part and supports. In addition, other streams of work are to be supported by: Paediatric Transformation Programme Assurance Committee (chaired by SaTH Medical Director); continued improvements within maternity via SaTH Maternity Transformation Committee co-ordinated by the Local Maternity & Neonatal System (LMNS), which is chaired by the ICB Medical Director; and development of CYP mental health programme to be led by Midlands Partnership University Foundation Trust reporting into the Provider Collaborative going forwards. Various leads for actions via various partner organisations, including SaTH's involvement.	1. From June 2025 ICB Chief Medical Officer takes chair of Neighbourhood Health Implementation Programme Group. This Group has full representation across ICS partners. Programme aligned to NHSE neighbourhood health guidelines. Sept 2025: Focus is on updating the delivery plan and workstreams to take account of national neighbourhood health guidance. 2. SaTH taking part in this work with all partners. As part of system wide population health management led prioritisation, initial pathways for development will include Diabetes, Cardiovascular disease (CVD) and all age Mental health. Q3: Three initial priority pathways confirmed - Diabetes, CVD and Frailty (urgent care perspective) and MSK (planned care perspective). Q2: action closed - Population Health Management priorities agreed. 3. UEC Programme for 25/26 will play an important part in development of community UEC pathways (in accordance with NHSE neighbourhood health guidelines). Q2: STW investment in non-bed based community UEC capacity confirmed with implementation plans in Q3 25/26. 4. Q2: SaTH continues to play a major role in both STW place-based partnerships and the ICS Neighbourhood Health Implementation Programme Group which are the primary mechanisms for system-wide integrated pathway development. SaTH and Shrop Comm Boards have approved plans to form a shared leadership Group Model with a key objective of accelerating transformation of neighbourhood health services, including clinical pathways.			16

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Trust Policy Framework requires further embedding • Potential poor processes and procedures • Improved culture still not fully embedded • Governance improvement workload is high - started from a low base with embedded poor practices in some areas • Change in organisational governance arrangements from establishing a new Group Model **Consequence:** • Lack of clear guidance for staff to follow and some out of date policies • Potential lack of openness and transparency • CQC 'Requires Improvement' Well Led rating • Incidents • Potential ineffective committees, including late circulation of papers and breach of Standing Orders • Potential data breaches • Regulatory sanctions and/or fines • High workload involved to work together and align systems, processes and teams.	4	4	16	• Moving To Excellence programme • Trust Strategy • Board Assurance Framework (BAF) with ongoing review • Board development programme in place • Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation in place and reviewed Autumn 2024 • Managing Conflicts of Interest Policy updated during 2023 • Declarations of interest made available within Electronic Staff Record from May 2023 • Register of Interests published on the Trust's website, bi-annually • Terms of reference refreshed for all assurance committees of the Board during 2024/25 and ongoing during 25/26 • Review of effectiveness of FAC, QSAC and PODAC committees February 2025 • Fit & Proper Person Policy updated (Oct 2023) following publication of new national framework • Fit & Proper reporting status established within the Electronic Staff Record (ESR) • A number of NHSE reviews currently ongoing (due Q2 2025/26)	**Reported to Board, committees and elsewhere:** • SFI's, Standing Orders and Scheme of Reservation and Delegation to Audit & Risk Assurance Committee during November 2024 and Board January 2025 (2nd) • BAF considered quarterly at Board and its committees (2nd) • Managing Conflicts of Interest Policy approved at Audit Committee and Board during 2023 (2nd) • Refreshed terms of reference considered at all Board committees during 2024/25 and 2025/26 (2nd) • 2024/25 Annual Report to Board in June 2025 and subsequently published on the Trust's website following submission (2nd) • Auditor's Annual Report 2024/25 (3rd). External audit did not identify any significant weaknesses in the Trust's arrangements in relation to: governance; economy, efficiency and effectiveness; and financial sustainability, in their 2024/25 Auditor's Annual Report (3rd). • Annual General Meeting held in public (face to face) - scheduled 25 September 2025 • Head of Internal Audit Opinion April 2025 providing Substantial Assurance that there is a good system of internal control (3rd) • Regular updates to Audit and Risk Assurance Committee on conflicts of interest compliance - achieved 80% by March 31st 2024 and into 2024/25 (2nd), with subsequent associated Counter Fraud Authority Standard achievement confirmed by internal audit May 2025 (3rd). • Register of interests and gifts and hospitality reviewed by Audit & Risk Assurance Committee - May 2025 (2nd) • Policy Approval Group meeting, monthly (established August 2024) (2nd) • Executive led Financial Recovery Group and Task Force in place (2nd) • System Integrated Improvement Plan (SIIP) relating to governance is in place and currently on track - update received at Board (monthly) (2nd) • MIAA Fit and Proper Persons Report (Substantial Assurance) 2025/26 (3rd) • Group Transition Committee established - terms of reference to September 2025 Board (2nd)	4	3	12	**Gaps in control:** 1. Trust Policy Framework (and document access). 2. Outstanding subject access requests (SAR's), and subsequent complaints. **Gaps in assurance:** 3. Data Security & Protection Toolkit assurance.	**Actions aligned to gaps:** 1a. Agree refreshed Policy for Policies Q3 25/26. Lead Executive: Director of Governance. 1b. Case to be developed for new document library for easier policy access/search - offer support to Communications Team as part of case for new intranet - by Q1 25/26. Director of Governance. 2a. Senior manager put in place to support training and establishment of new processes within legal department. 2b. Procure a company to scan the medical records (by Q1) for SAR's to assist with backlog. Clear the backlog by Q4. 2c. Data Protection Officer to continue to liaise with the ICO - ongoing. 2d. Develop action plan for outstanding and overdue SAR's and monitor via-Information Governance Committee from April 2025 onwards. 3. Work towards DSPT/CAF (Cyber Assessment Framework) standards for 24/25 - evidence to be submitted by 30 June 2025. Lead Executive: Director of Governance.	1a. The Trust's Policy for Policies was considered and agreed by the Policy Approval Group on 16 October 2024 and to be considered by Executive Team, ahead of Board. Policy Approval Group commenced during August 2024, meeting monthly. 1b. Q1: Support offered. Q2: Communications Team have developed a new intranet specification (under consultation in Sept 2025). 2a. Senior manager is in place and more efficient processes have been adopted. Action closed Q2 25-26. 2b. Company procured. Q4: Backlog is substantially reduced. Q2: work is now business as usual. Action closed. 2c. Q2: Action complete in relation to SAR's. 2d. Action plan in place and continues to be monitored by management. 3. The Trust's current DSPT standards status at 30 June 2025 is 'not met standards'. - Updated action plan was submitted to NHSE following this but not yet accepted.			6

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 13 November 2025

Agenda item		167/25			
Report Title		Risk Management Report Q1 2025/26			
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	√	N/A	
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 quarterly Risk Management Report for Q1 2025/26, highlighting progress in managing risks and enhancing the risk culture at SaTH. The Board's attention is drawn to: • **Effectiveness of Risk Mitigation:** the controls and actions of 40 extreme risks (scored ≥15) have either resulted in a reduced risk score or overall risk closure throughout Q1 • **Risk Management Progress:** The report notes a reduction in overdue risks and actions, with 144 risks closed in Q1, bringing the number of active risks at the end of June 2025 to 363 (including risks opened in Q1) • **Training and Culture Improvement:** Staff members are still receiving risk management training, reflecting an ongoing commitment to enhancing the organisation's risk culture.			
Recommendations for the Board:		The Board is asked to: **Note** the current risk position, and **take assurance** from the mitigation in place to ensure that Risk Management is practiced across the Trust consistently.			
Appendices:		Appendix 1: Divisional risk profile from April, May and June 2025 (Q1 2025/26) with severity breakdown. Appendix 2: Summary of the Corporate Risk Position on 11 August 2025. Appendix 3: Corporate Risk Register on 11 August 2025.			

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. An annual risk management report was presented at the May 2025 ARAC.

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, the 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.

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.

The table below shows the operational risk position by approval status over Quarter 1 2025/26.

Rows 1, 2 and 3 capture all open risks. Row 4 captures the number of risks recommended as accepted. Row 5 captures the number of accepted and closed risks. Row 6 captures the number of overdue risk reviews for open risks. Row 7 captures the number of overdue actions for review.

Trust Wide Risk Position by Approval Status	Apr 2025 Total	May 2025 Total	Jun 2025 Total	Jul 2025 Total
1. Total number of **Active Risks** *(Risk has been acknowledged and agreed by the risk owner, the centre / divisional governance meeting / committee / specialist subject group)*	**463**	**439**	**381**	**363**
2. Total number of **Newly Identified Risks** *(Default approval status once risk is populated in Datix and has not been reviewed by anyone other than the risk reporting officer)*	**14**	**6**	**15**	**18**
3. Total number of **New Risks awaiting Divisional/Directorate review and approval** *(Not currently 'active' - are awaiting authorisation from member of the Leadership's Team, and/or joint team decision made during a speciality/ divisional/ committee/specialist subject group meeting)*	**8**	**4**	**6**	**6**
4. Total number of **Overdue Risk Reviews** for **Open risks**	**113**	**112**	**140**	**82**
5. Total number of **Overdue Actions Reviews**	**167**	**151**	**171**	**132**

See Appendix 2 for Divisional risk profile from April, May and June 2025 (Q1 2025/26) with severity breakdown. N.B. The total numbers in Appendix 2 are points 1, 2 and 3 in the table above added up per month. In addition, the data is live so will change throughout the month.

2.0 Summary of Corporate Risk Position:

The Trust has created a Corporate Risk Register that categorises all high-level risks scoring ≥15 risk activity into the five CQC domains and aligns them to the eight categories of risk (corporate goals) – see Appendix 3. This breakdown has allowed for a thematic analysis of the risk position (we will be looking at creating a target risk score that will align with the risk appetite score). See Appendix 3 for the detail of the Corporate Risk Register on 11 August 2025.

3.0 Effectiveness of Risk Mitigation

The table below demonstrates how the controls and actions of 40 extreme risks (scored ≥15) have either resulted in a reduced risk score or overall risk closure throughout April, May and June 2025 (Q1 2025/26).

Month	Risk	Risk Status	Actions Taken to Mitigate / Close Extreme Risk *(at 06/08/2025)*
April 2025	825 'Infection, Prevention Control (IPC) in Ambulance Receiving Area) (ARA) at both sites'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 20 to 12 because both sites have ringfenced cubicles for immunocompromised patients.
	87 'Midwifery Staffing Challenges'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 16 to 12 because, since October 2024, Positive Acuity has been 88-95%, and in January 2025 it was 99%. Risk to be re-reviewed following an Establishment Review by Interim Director of Midwifery and Deputy Head of Midwifery.
	1115 'Capacity of Safeguarding Children Team'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 20 to 12 because there have been no issues/incidents reported around service provision since risk was opened in November 2024. There is cover via the Lead nurse 0.8 WTE and a Band 7 Safeguarding Children Nurse. There is also senior cover and support via the Head of Nursing for Adults and the Lead for Midwifery. The service provision for Hospital Transformation Plan (HTP) will see based on one site when services relocate making cover further robust.
	747 'Apley Restaurant RAAC Structural Damage'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 16 to 12 *(at 06/08/2025 scored 8)* because scheme was approved by Board, works ongoing, demolition and removal works started on site.
	1133 'Generator fuel shortage. Non-compliance with HTM0 6. Potential loss of backup power generators'	Closed	PRH fuel supplier (Sertas Energy previously) a new contract with LCM Environmental is now in place and LCM Environmental can provide fuel on a 24-hour turnaround should the need arise.
	1063 'Failure of W&C UPS Batteries'	Closed	Tender process and purchase order placed with supplier. Work started March 2025.
	443 'Decontamination Assurance for Medical Devices'	Closed	Standard Operating Procedure (SOPs) developed by the clinical leads, endorsed at Decontamination Group and signed off at Infection Prevention and Control (IPC) Assurance Committee. Staff Training.

			Trust Decontamination Policy reviewed and ratified. Authorising engineer audit for all areas where decontamination completed. Business case developed for Clinical Decontamination lead. Decontamination Policy been approved by Policy Approval Group.
	826 ‘Cars parked on pavements and grassed areas forcing staff and public onto road at PRH and RSH’	Closed	New cameras and pay machines installed. Traffic Management processes in place.
	993 ‘52-week Harm Review on NON-cancer Pathways’	Closed	Monthly admin validation discussed at weekly Referral to Treatment assurance meetings (RTT). Assurance sought that a harm review has been undertaken initially for all high-risk patients. Consultant lead for each speciality reviews all the referrals in line with national policy and prioritises these on the waiting list.
	996 ‘52-week Harm Review on NON-cancer Pathways’	Closed	Monitored by the People and OD Assurance Committee and the Board through the IPR.
	998 ‘Inadequate patient handling equipment on site at RSH and PRH affecting each hospital’s ability to deliver safe post-falls care’	Closed	Moving and Handling team have received equipment and are in process of rollout.
	1058 ‘Modular Wards - Risk to Delivery Timescales and Risk of Increased Costs’	Closed	Modular wards contract with Catfoss terminated.
	790 ‘Bed Rail Entrapment’	Closed	Bed rail improvement programme delivered.
	1117 ‘High Volume of Urology Typing, Resulting in delays’	Risk closed and merged into Risk 1094 ‘Secretarial staffing shortages unable to meet trauma typing demand’.	
	1069 ‘Lack of secretarial workforce resulting in delay in typing turnaround in Haematology’	Risk closed and merged into Risk 1094 ‘Secretarial staffing shortages unable to meet trauma typing demand’.	

Month	Risk	Risk Status	Actions Taken to Mitigate / Close Extreme Risk *(at 06/08/2025)*
May 2025	618 'There is a lack of clinical capacity to deliver Diabetes and Endocrine new and follow up appointments'	Risk closed and merged into Risk 1185 'Fragility of Diabetes and Endocrinology Workforce'.	
	1021 'There is a lack of clinical capacity to deliver diabetic Foot Clinics and diabetic outpatients MDT'	Risk closed and merged into Risk 1185 'Fragility of Diabetes and Endocrinology Workforce'.	
	730 'Capacity for stress echo testing does not meet demand'	Risk closed and merged into Risk 698 'Capacity for Cardiorespiratory Holter reporting'	
	648 'Lack of Gastroenterology Governance Lead'	Closed	There are staff acting up as well as governance leads.
	701 'Delay in treatment for paediatric torsions resulting in loss of testes'	Closed	Consultant on call working on site is present. Patient can be transferred to either site.
	630 'The RO plant at PRH is located in a position where failure would result in a loss of service for a minimum of 28 days'	Closed	Business continuity is in place.
	631 'Lack of office space for Doctors on Ward 25'	Closed	Use ward office and other areas instead.
	769 'Limited capacity to treat patient requiring simple and video urodynamics'	Closed	Clinical validation of the waiting list undertaken. Harm proformas to be completed for the longest waiting patients. Joint business case between gynae and urology written to purchase a new urodynamics machine and associated kit.
	628 'NUTRITION: Insufficient Specialist nursing team'	Closed	Flexible working to adhere to mental wellbeing of staff.
	629 'INFUSION: Insufficient Specialist nursing team'	Closed	Workforce template reviewed to have infusion team staffed safely.

	220 ‘Key nursing shortages across the Eye service resulting in inability to provide appropriate volumes and levels of care’	Closed	Patients are prioritised according to need. Recruitment is business as usual.
	249 ‘Specialist workforce constraints - EMR interventional Endoscopy’	Closed	Risk and action closed job plans review undertaken on annual basis in line with national guidance. Patients are prioritised according to need.
	626 ‘Lack of handwashing sinks on Ward 25’	Closed	Handwashing training has been completed for all staff. PPE available in appropriate places.
	767 ‘Urological services currently dispersed across multiple clinics and cross site’	Closed	Identified as a ‘Getting it Right First Time’ (GIRFT) recommendation to develop a Urology Investigation Unit (4 & 5 & 8). Business case discussed.
Month	**Risk**	**Risk Status**	**Actions Taken to Mitigate / Close Extreme Risk *(at 06/08/2025)***
	761 ‘Lack of available capacity for outpatient appointments in Oncology which is causing risk of patient harm’	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 16 to 9 because Outpatient capacity has increased.
	194 ‘Oncology workforce crisis Urology, lung, breast & colorectal tumour sites’	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 16 to 9 because all job packs use the new more aesthetic template and are re-advertised when posts close. Collaboration with medical recruitment.
	728 ‘Urology Cystoscopy Suite’	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 15 to 8 because there is limited impact on patients and no harm identified. Walk arounds undertaken for hybrid Urological Investigation Unit (UIU) - clinic 12 identified as suitable following IPC and estates sign off if a clinic room is converted to a procedure room.
	1135 ‘Potential delay to loading of blood culture bottles whilst the Microbiology department	Score reduced to ≤15 - risk removed from	Score reduced from 15 to 10 because new Medical Laboratory Assistants (MLAs) have now been recruited and are in post for Blood Sciences and can load blood cultures outside of routine Microbiology opening hours. Training is ongoing and MLA out of hours rota has been implemented in part.

June 2025	is in business continuity measures'	Corporate Risk Register	
	801 'Withdrawal of orthopaedic input from diabetes foot clinic'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 15 to 12 because of input from Robert Jones and Agnes Hunt Orthopaedic Hospital to support with preventative measures to support with Tendon release. Total contact casting clinic for a limited amount of patients has been set up.
	578 'Insufficient number of consultants being able to cover the ITU Rota - Workforce Wellbeing'	Closed	Additional staffing plus changes to the rota structure have mitigated this risk.
	1047 'ENT Waiting List – Lack of sufficient theatre capacity for patients'	Closed	New theatre timetable has been implemented with ENT receiving further capacity.
	633 'Increased risk of unsupervised oxygen cylinders on RSH hospital corridors'	Closed	Incidents on corridor have been monitored and discussed at COO huddle and, separately, UEC patient safety huddles to ensure immediate review to prevent recurrence.
	464 'Medications not being stored correctly in PRH ED in accordance with Trust policy'	Closed	BD Pyxis unit ordered - Go Live date was 18/06/2025.
	231 'Risk of patient harm, including mortality for Renal patients due to shortages of Consultant interventional radiologists'	Closed	Renal consultants with vascular speciality support can provide intervention in the majority of cases. Collaboration with colleagues in radiology to monitor the situation.
	61 'There is a risk of patient harm due to Cardiac CT capacity not meeting required demand'	Closed	Patients are prioritised in terms of clinical need, and the waiting list is reviewed daily. Collaboration with colleagues in radiology to identify options to establish capacity. Waiting List Initiative (WLI) undertaken.

Appendices

Appendix 1 - Divisional risk profile from April, May and June 2025 (Q1 2025/26) (and July 2025) with severity breakdown:

Open Risks by Division and Level of risk	April 2025 LOW (1-3)	May 2025 LOW (1-3)	June 2025 LOW (1-3)	July 2025 LOW (1-3)	April 2025 MODERATE (4-6)	May 2025 MODERATE (4-6)	June 2025 MODERATE (4-6)	July 2025 MODERATE (4-6)	April 2025 HIGH (8-12)	May 2025 HIGH (8-12)	June 2025 HIGH (8-12)	July 2025 HIGH (8-12)	April 2025 EXTREME (15-25)	May 2025 EXTREME (15-25)	June 2025 EXTREME (15-25)	July 2025 EXTREME (15-25)	April 2025 Total	May 2025 Total	June 2025 Total	July 2025 Total	Difference Month on Month
SA&C	0	0	0	0	0	9	9	10	87	74	52	52	43	35	22	22	139	118	83	84	⇑
M&E	0	1	0	0	5	4	3	3	51	49	51	37	30	29	26	21	86	83	80	61	⇓
W&C	0	0	0	0	3	3	3	3	47	44	43	43	13	13	15	16	63	60	61	62	⇑
CSS	0	0	0	0	9	10	10	9	30	42	45	45	32	37	37	42	71	89	92	96	⇑
CORP	5	3	2	2	37	30	20	20	60	45	45	45	25	18	19	17	127	96	86	84	⇓
Total	5⇔	4⇓	2⇓	2⇔	63⇑	56⇓	45⇓	45⇔	275⇓	254⇓	236⇓	222⇓	143⇓	132⇓	119⇓	118⇓	486	446	402	387	⇓

Appendix 2 – Summary of Corporate Risk Register Position at 11/08/2025

Theme	CQC Domain(s)	BAF ID	Initial Risk Score	Current Risk Score (with controls in place)
Risk to the quality of care provided to patients	Safe	BAF 1 BAF 2 BAF 8	20	16
Poor patient experience	Caring	BAF 1 BAF 2 BAF 8	20	16
Overcrowding in ED	Safe / Responsive	BAF 1 BAF 2 BAF 8 BAF 10 BAF 11	20	18
Increased pressure on health services	Safe / Responsive	BAF 1 BAF 2 BAF 9 BAF 10 BAF 11 BAF 12	20	16
Insufficient staffing capacity / skills	Effective / safe	BAF 3 BAF 4 BAF 5	20	16
Inability to meet regulatory and legislative performance requirements	Well Led	BAF 8 BAF 13	16	18
Inappropriate use of expired, outdated or substandard equipment or lack of appropriate equipment	Safe / Responsive	BAF 6 BAF 7b	20	16
Increasing Cyber Threat	Responsive / Well Led	BAF 7A	25	16
Poor / ageing estate	Safe / Responsive	BAF 6 BAF 11	20	16

CORPORATE RISK REGISTER 11 August 2025

Categories of risk - corporate goals
Our Patients and Community: we deliver safe and excellent care, first time, every time.
Our Patients and Community: we work closely with our patients and communities to develop new models of care that will transform our services.
Our People: our staff are highly skilled, motivated, engaged, and live our values. SATH is recognised as a great place to work.
Our People: Our high performing and continuously improving teams constantly strive to improve services which we deliver.
Our Service Delivery: Our services are efficient, effective, sustainable, and deliver value for money
Our Service Delivery: We deliver our services utilising safe, high quality estate and up to date digital systems and infrastructure.
Our Governance: We are a learning organisation that sets ambitious goals and targets, operates in an open environment and delivers what is planned
Our Partners: We have outstanding relationships with our partners, working together to deliver best practice, integrated care for our communities

Risk scores	Consequence				
Likelihood	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Severe (5)
Almost certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Possible (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare (1)	1	2	3	4	5

CQC Domain		Title	Owner	Risk Description	Caused by (operational, not strategic, causes)	Resulting in (consequence)	Initial risk score: *Likelihood*	Initial risk score: consequence	Initial risk score: Score	Controls already in place	Current risk score (with current controls in place): Likelihood	Current risk score (with current controls in place): consequence	Current risk score (with current controls in place): Score	Controls to be put in place	BAF ID	Operational Risk Register ID	
Safe	1	**Risk to the quality of care provided to patients**	**DON /MD**	Quality of care experienced by patients may be below the standard tolerated by the organisation	Increased demand to healthcare services: EDs overcrowded with long waits to be seen, and insufficient flow: Insufficient support from neighbouring authorities / providers re complex care, which affects flow: Challenging substantive workforce numbers: Use of agency: Use of ageing or outdated equipment: Loss of partner services which supported the Trust, e.g. stroke rehabilitation for stroke patients at Bridgnorth: Escalation into poor environments e.g. corridors: Poor medicines management: Delays in transferring wardable patients out of ITU: Variations in the recognition, escalation and management of sepsis risk: Inability to recruit in line with requirement of consultants and speciality level doctors: Potential unavailability of financial resources	Potential for increased safety patient incidents: Poorer experience of patients, their families, and our communities; Patients waiting longer to be seen via referrals: Slow or inaccurate diagnostic test results: Compromised recovery which may result in long term social care placement: Failure to recognise the deteriorating patient in a timely manner: Delayed diagnosis by duplicate electronic records (radiology)	5	4	20	Policies and SOPs in place, including for use of escalation areas; Use of bank staff, agency staff in particular areas; Continued recruitment of specific roles; Introduction of new clinical roles and ways of working being introduced; Visiting third party (royal colleges, etc) peer reviews and reporting; Collaborative working with neighbouring providers where possible; Hospital flow protocols in place; Improved quality governance framework in place Quality Improvement Plan in place, tracked by SOAG / NHSE	4	4	16	Increase collaborative working with partners over services; Further the work relating to HTP to introduce better care models: Continue to introduce new staff grades, and roles: Continue to review, update and implement new policies, and procedures in compliance with regulatory requirements	BAF 1 BAF 2 BAF 8	**CSS:** 645 (15), 949 (20), 963 (20), 535 (15), 845 (15), 861 (15), 1010 (16), 698 (20), 652 (15), 1181 (20), 1222 (16), 1223 (16), 1224 (15) **M&E:** 884 (20), 917 (15), 612 (15), 195 (16), 564 (16), 881 (16), 778 (15), 1141 (15), 1167 (16), 793 (15), 1172 (15), 1174 (16) **SA&C:** 454 (16), 804 (20), 1030 (20), 912 (16), 969 (16), 1074 (15), 1173 (16), **929 (20-25 - TBC)** **W&C:** 720 (15), 875 (16), 1007 (20), 1126 (15), 1140 (16), 1092 (15) **Corp:** 347 (16), 904 (15), 1131 (15)	CSS M&E SA&C W&C Corp
Caring	2	**Poor patient experience**	**DON /MD**	Patients may experience delays in provision of timely care, in a suitable environment	Inability to provide timely and efficient care due to poor flow through the hospitals; Increased waiting times for elective surgery: Escalation into poor environments e.g. corridors.	Delayed clinical diagnosis and outcomes: Insufficient elective theatre capacity: ED's overcrowded with long waits to be seen; Not all escalation areas are suitable for all types of patient care, e.g. same sex.	5	4	20	Hospital flow protocols in place; Use of bank staff, agency staff in particular areas; Leadership/ manager development opportunities available; Ward environment improvement project in place; Quality governance framework in place; Quality Improvement Plan in place, tracked by SOAG / NHSE; collaborative working in place with neighbouring providers where possible	4	4	16	Continue to explore new methods of working, including increased use of technology: Continue to introduce new staff grades, and roles: Project re doctor rotas to be completed: Continue to work to attract apprentice type roles: Continue to attract skills of recently retired clinical colleagues	BAF 1 BAF 2 BAF 8	**CSS:** 845 (15), 861 (15), 652 (20), 665 (20), 1181 (20) **M&E:** 195 (16), 612 (15), 1141 (15), 1167 (16), 793 (15) **SACC:** 1030 (20), 912 (16), 986 (20), 969 (16), 1173 (16), **929 (20-25 - TBC)** **W&C:** 720 (15), 875 (16), 1007 (20), 1140 (16), 1092 (15) **Corp:** 347 (16), 904 (15), 1131 (15)	CSS M&E SA&C W&C Corp

main		Title	Owner	Risk Description	Caused by	Resulting in (consequence)	Initial risk score			Controls already in place	Current risk score (with current controls in place)			Controls to be put in place	BAF ID	Operational Risk Register ID	
Safe / Responsive	3	**Overcrowding in ED**	**COO**	Increased demand on healthcare services, and lack of flow/discharges through 'back door'	Inability to discharge patients (no criteria to reside): Increasing demands upon secondary care, particularly urgent and emergency care: Challenging staffing situation and skill mix: Patients being inappropriately signposted to A&Es rather than to speciality pathways: Bed gap:	Unable to maintain clinical assessment of patients in line with policy: Flow through hospitals affected: Long ambulance waits and offloads - which may lead to offloading critically unwell patients straight into resus and starting high level care in the back of ambulances: Deteriorating patients: Unable to comply with national performance standards, e.g. ambulance offloads: Some level 2 patients admitted to respiratory wards rather than ITU/HDU/RSU	5	4	20	Incident Command Centre in place, both locally and within the ICS to coordinate support across the area; Business Continuity Plans in place for significantly increased pressures; Regular site safety calls in place 24/7: Scheduled system calls and regular engagement with partners; Policies and SOPs in place, including for use of escalation areas and hospital flow protocols; Use of bank staff, agency staff in particular areas; Use of daily multi disciplinary meetings	4	4	18	Continue to work with national policy and seek best practice principles from elsewhere to trial, where resources allow; Increase collaborative working with partners re services, pathways, e.g. virtual ward, etc.;	BAF 1 BAF 2 BAF 8 BAF 10 BAF 11	**M&E:** **917 (15), 612 (15), 195 (16), 177 (20), 881 (16), 878 (25), 793 (15)** **SACC:** **804 (20)**	CSS M&E SA&C W&C Corp
Safe / Responsive	4	**Increased pressure on health services**	**COO**	Increased demand for secondary care, together with poor restoration of services after COVID has affected delivery of inpatient and outpatient care.	Lack of resources in the STW ICS to deliver 7 day services: Delays in provision of tier 4 CAHMS / specialist eating disorder specialist services: Insufficient theatre space for provision of PEGS on both sites: Challenging staffing situation and skill mix:	Lack of radiology for research trials; National shortages of critical medicines: Potential patient harm and poor experience Patients may experience lack of timely intervention in their care: Flow through hospitals affected; Long ambulance waits and offloads; Longer inpatient hospital stays (NCTR)	5	4	20	Incident Command Centre in place, both locally and within the ICS to coordinate support across the patch; Business Continuity Plans in place for significantly increased pressures; Policies and SOPs in place, including for use of escalation areas and hospital flow protocols; Daily nurse staffing review to make best use of available resource:	4	4	16	Continue to work with national policy and seek best practice principles from elsewhere to trial, where resources allow; Increase collaborative working with partners re services, pathways, virtual ward, etc.;	BAF 1 BAF 2 BAF 9 BAF 10 BAF 11 BAF 12	**CSS:** **659 (16), 698 (20)** **M&E:** **195 (16), 612 (15), 778 (15)** **SACC:** **804 (20)** **W&C:** **720 (15), 875 (16)** **Corp:** **347 (16)**	CSS M&E SA&C W&C Corp
Effective / safe	5	**Insufficient staffing capacity / skills**	**DPOD**	National shortage of healthcare staffing and increased vacancies may affect the delivery of services and the standard of patient care provided	Lack of national investment into health care: Ageing workforce: NHS pension rates decreased over last few years - NHS less attractive for long term career; Potential unavailability of financial resources	Increased patient harm: Increase in patient safety incidents: Non compliance with core standards: Inability to complete pre-assessments on some high risk endoscopy patients: Failure to learn from incidents: Decline in staff wellbeing: Increase in patient complaints: Failure to respond to complaint / incident response: Staff wellbeing affected by additional workforce stress: Delays in diagnosis: Gaps in consultant rotas potentially causing delay to consultant statutory training: Unable to meet national clinical standards: Therapy services do not comply with national staffing requirements for paediatric inpatients:	5	4	20	Daily nurse staffing review to make best use of available resource: Patients managed in line with clinical need as par as possible: Increased use of bank staff: Use of agency only in specific areas: Learning and Development offer within the organisation: Choice of leadership skill development in place: Ongoing recruitment campaigns subject to front line requirements Workforce Strategy: Rotas adjusted to cover gaps; Collaborative working with the ICS; Where appropriate, patients given self management advice within the confines of remote care (virtual ward)	4	4	16	Continue to explore new methods of working, including increased use of technology: Continue to introduce new staff grades, and roles: Project re doctor rotas to be completed: Continue to attract apprentice type roles: Continue to attract skills of recently retired colleagues.	BAF 3 BAF 4 BAF 5	**CSS:** **659 (16), 845 (15), 1010 (16), 1112 (20), 665 (20), 1111 (15), 1137 (15), 1160 (20), 1151 (16), 1223 (16)** **M&E:** **884 (20), 128 (16), 1017 (15), 882 (15), 1172 (15), 1174 (16), 1185 (20), 1238 (16)** **SACC:** **927 (16), 906 (16), 537 (20), 804 (20), 1139 (16), 1121 (16), 1094 (20), 929 (20-25 - TBC)** **WAC:** **875 (16), 1159 (16), 1195 (20), 1140 (16)** **Corp:** **774 (15), 1206 (15)**	CSS M&E SA&C W&C Corp
Well Led	6	**Inability to meet regulatory and legislative performance requirements**	**DG**		Increasing demand on healthcare services: Insufficient staffing / leadership capacity: Poor or faulty equipment: Poor governance processes in place, policies out of date Increasing demands from regulators	Increased patient harm: Increased regulatory intervention: Regulatory fines; Legal action taken against the Trust: Financial risk due to potential regulatory fines Failure to learn from incidents	4	4	16	Ward to board governance framework in place: Policies and procedures, reflecting updates national guidance and regulations: Mandated intensive support with NHSE in place through the Recovery Support Programme. Regular communication with CQC	4	4	18	Continue to fully engage with NHSE as part of the Recovery Support Programme; Continue to engage with CQC; Continue to engage with other third party regulators, Royal Colleges, Unions, etc.	BAF 8 BAF 13	**CSS:** **954 (16), 535 (15), 682 (15)** **M&E:** **128 (16), 917 (15), 757 (20), 1174 (16), 878 (25)** **SACC:** **986 (20), 1173 (16)** **W&C:** **1007 (20)**	CSS M&E SA&C W&C Corp
Safe / Responsive	7	**Inappropriate use of expired, outdated or substandard equipment or lack of appropriate equipment**	**FD** (estates) **DS&P** (digital)		Insufficient space (estate) for some services: Escalation areas may not be fully equipped for patient care - may lack usual equipment compliance requirements; Infection control issues in some areas: No electronic system in place which is capable of monitoring whether Radiology Reports have been read or acted on: Write over / duplicate records software can be produced (radiology): Pharmacy Laura software not compatible with widows 7 or above.	Harm to patients / staff: Longer waiting times for patient / poor experience: Diagnosis delays: Poor staff morale: Risk of fire or similar outcome: Non-compliance with healthcare standards: Delays in treatment / referrals: Loss of staff or patient data;	4	5	20	Trust policies and procedures in place regarding use of hazardous equipment; Business continuity plans in place; Training provided for use of specialised equipment; Digital Strategy and work-streams in place for large scale digital upgrading. Increasing numbers of information asset owners (IAOs) being registered to ensure oversight of digital programmes.	4	4	16	Continue to ensure that policies are in place and updated to avoid consequences; Continue to communicate health and safety messages;	BAF 6 BAF 7B	**CSS:** **963 (20), 955 (16), 645 (15), 861 (15), 848 (15), 72 (15), 1222 (16), 1224 (15)** **SACC:** **1030 (20), 912 (16), 1075 (15), 1074 (15)** **W&C:** **700 (15)** **Corp:** **645 (15), 1102 (15)**	CSS M&E SA&C W&C Corp

main		Title	Owner	Risk Description	Caused by	Resulting in (consequence)	Initial risk score			Controls already in place	Current risk score (with current controls in place)			Controls to be put in place	BAF ID	Operational Risk Register ID	
Responsive / Well Led	8	**Increasing Cyber Threat**	**DG (SIRO)**	Increasing risk in the potential for a cyber attack, particularly relating to ongoing political unrest	Out of date/ unsupported software and / or systems: Poor maintenance and lack of investment into old systems: Potential non-compliance with Cyber Essentials and Digital CareCert requirements: Lack of technically qualified subject experts:	IT systems lost or compromised: Potential significant data breach: ICO fines or action taken: Reputational damage: Financial loss:	5	5	25	Digital Services have invested in a system to monitor Security Patch compliance, unsupported/out of date software and NHS Digital CareCert compliance in near-real time: NHS Digital High Severity Alerts are acted upon as a priority to minimize exposure: Regular cyber awareness communications are distributed to staff to increase awareness and understanding of cyber related matters; SaTH continues to work toward full compliance with cyber essentials and NHS Digitals Data Security and Protection toolkit, both of which have comprehensive requirements with regards to cyber security Use of other NHS Digital and National Cyber Security Centre Services such as Vulnerability Management, BitSight, WebCheck and Early Warning System to ensure issues are picked up and responded to quickly.	3	5	16	Ongoing work continues. (Specific details have not been included here in order to protect the systems, but details are available on datix.)	BAF 7A	**CSS:** **864 (16)** **Corp:** **499 (15)**	**CSS** **M&E** **SA&C** **W&C** **Corp**
Safe / Responsive	9	**Poor / ageing estate**	**FD**	Some areas of the organisation's estate require upgrading, attention, or reconfiguring	Current estate means some services are fragmented and located in more than one location: Insufficient space for some services: Potential unavailability of capital resources Use of RAAC in 1980's: Copthorne Lift 54 years old and unreliable: Obsolete nurse call system at PRH ED: Door access control systems are not in use in all clinical areas:	Inability to develop teams and transfer skills: Patients have fragmented pathway: Inefficiencies in flow: Risk of increased lone working: Low staff morale: Potential disruption to service delivery by closure of hazardous areas: Financial risk: Reputational Risk: Harm to patients and staff: IPC issues: Health and Safety issues: Loss of critical services supplies: Unable to acquire regulatory certificates and licences: Reverse Osmosis System at PRH poorly located, and risk of closure of service for 28 days if area flooded, etc. Unauthorised access to clinical areas: Increasing demand for care leads to lack of appropriate office space.	4	5	20	Appointment of Interim Director of Estates: Online reporting system in place for estate concerns and issues to be reported in real time; Business cases in place for various projects / capital spending; Staff receive focussed IPC training in specific areas where this is appropriate, according to the issue; More home working for admin staff where the service allows; Patients transferred to alternative accommodation where appropriate and available; Timely, Trust-wide communications cascade in place for urgent messaging to staff for arising issues, and for communications with the public / patients; Governance processes in place for monitoring ongoing incidents	4	4	16	Continuous oversight of capital plan to endeavour for improvements to be made in a timely manner; Progress HTP, thus enabling relocation of some services to a single site;	BAF 6 BAF 11	**CSS:** **682 (15)** **M&E:** **793 (15)** **W&C:** **1034 (16)** **Corp:** **1039 (16)**	**CSS** **M&E** **SA&C** **W&C** **Corp**

Board of Directors' Meeting: 13 November 2025

The Shrewsbury and Telford Hospital NHS Trust

Agenda item		169/25		
Report Title		Bi-annual Nurse Staffing Review		
Executive Lead		Paula Gardner, Interim Chief Nursing Officer		
Report Author		Steph Young, Lead Nurse Workforce, Kara Blackwell, Deputy Chief Nurse		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF 1
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	327, 247, 220, 192, 1547, 130, 129, 128, 111, 581, 549
Well Led	√	Our partners		
Consultation Communication		Nursing, Midwifery and AHP Workforce Group		
Executive summary:		All NHS Trusts are required to undertake a formal nursing and midwifery inpatient establishment review, bi-annually, using evidence-based tools, professional judgement, and clinical outcomes. This report provides the Board with the outcomes of the review and a summary of the nurse staffing position from an assurance and risk perspective. Key points include: • CHPPD reported via Model Hospital for the Trust are in Quartile 2 and in line with peer and provider median • RN fill rates remain over 100% for Days and Nights, Registrant fill rates in February were 89% for days and 92% for nights • Registered Nurse to Patient ratios are far better than the recommended minimum of no more than 1 RN to 8 Patients • No changes in establishments are recommended as part of this census; establishment changes approved by the Board in January 2025 following the previous census were not enacted until March 2025, after updates to finance budgets were made, so data reported in this report provides a comparator to 2024-2025 budgets		
Recommendations for the Board:		The Board is asked to **note** the content of the nurse staffing review report and the actions being taken at ward and service level.		
Appendices: (in Information Pack)		Appendix 1: Bi-annual Nurse Staffing Review January/February 2025 Appendix 2: Workforce Safeguards Gap Analysis		

Bi-annual Nurse Staffing Review

1.0 Introduction

Having the right nurse staffing levels is fundamental to providing safe and high-quality patient care, as well as creating a positive work practice environment for staff. Demonstrating safe staffing is one of the essential standards that all health care providers must comply with to meet Care Quality Commission (CQC) regulation, Nursing and Midwifery Council (NMC) recommendations and national policy on safe staffing.

The National Quality Board (2016) guidance and Developing Workforce Safeguards (2018) sets out expectations for Nursing and Midwifery staffing levels to assist local Trust Board decisions in ensuring the right staff, with the right skills are in place at the right time. It identifies that Trusts must ensure there is a systematic approach to determining staffing numbers and skills required to maintain safety of patients in their care, and that best practice principles and processes of safe staffing are used.

This report provides an overview of the evidence-based establishment review undertaken in January/February 2025, using the Safer Nursing Care Tool (SNCT), triangulated with professional judgement and nurse sensitive indicator outcomes to make recommendations for our nursing establishments on adult inpatient wards, acute assessment areas, Emergency Departments and Paediatric ward.

It provides an overview of staffing capacity and compliance with the National Quality Board (NBQ, 2016) standards and Developing Workforce Safeguards (2018).

Cumulative oversight of the care hours per patient day (CHPPD) over the last six months is provided and comparison to peer via the Model Hospital.

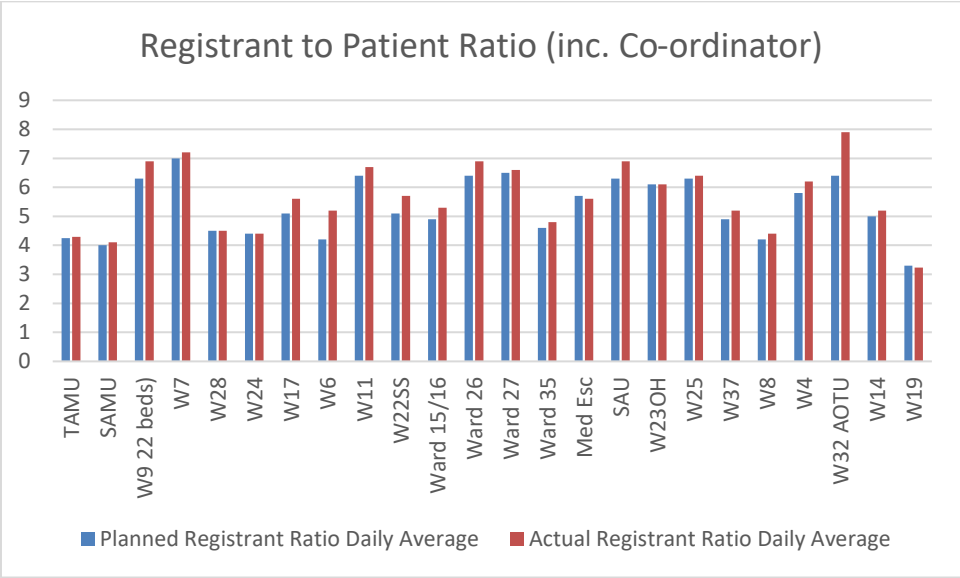
2.0 RIGHT STAFF

2.1 Nurse to Patient Ratios

It is well documented that ensuring adequate Registered Nurse (RN) staffing levels on acute medical and surgical wards in line with national recommendations has many benefits including improved recruitment and retention, reduction in staff stress and thus sickness levels, improved patient outcomes including mortality and improved levels of patient care (Royal College of Nursing, 2021; Rafferty et al 2007).

Nurse to patient ratios are a useful benchmark for assessing the average amount of patients each nurse is caring for, but do not accurately reflect the needs of the individual patients, as acuity and dependency needs may vary at different points and as such nurse-to-patient ratios must account for these factors. Nevertheless, the Royal College of Nursing (RCN) ‘Mandatory Nurse Staffing Levels’ (2012) and NICE ‘Safe Staffing for nursing in adult inpatient wards in acute hospitals’ (2014) suggest acute wards must have a planned Registered Nurse (RN) to patient ratio of **no more than 1: 8** during the day. There is no current guidance for nights.

Patient to registrant ratio



The above graph shows the average RN:Patient Ratio at Shrewsbury and Telford Hospital (SaTH) during the months of January and February 2025 for the 30 days of SNCT census collection. Nurse associates have been included in ratio calculations as a registrant, as the role will contribute to most aspects of care. Nurse associate roles have developed since NICE guidance was published and are part of the nursing team. All areas have a planned daytime ratio that is better than a 1:8 Nurse/Patient.

Comparison of January/February 2025 with September/October 2024 shows that average daytime ratios for RN to Patients are slightly better for Medicine and Emergency Care and Women and Children's (Ward 14) when compared to the previous census, with a ratio of 1:5.3 (previously 1:5.5) and 1:3.5 (previously 1:4.5) respectively. In Surgery, Anaesthetics and Cancer Division there was a slight increase in the number of patients cared for by an RN with ratio of 1:5.5 compared with 1:5.1 previously. Overall, the data shows that for all three divisions with inpatient wards the nurse to patient ratios are far better that the NICE (2021) recommendations of no more than 1 RN to 8 patients.

Table 1: Average RN: Patient Ratio

Division	Sept/Oct 2024 **Registrant: Patient Ratio** (Daytime Average)	Sept/Oct 2024 **Registrant: Patient Ratio** (Overall Average)	Jan/Feb2025 **Registrant: Patient Ratio** (Daytime Average)	Jan/Feb 2025 **Registrant: Patient Ratio** (Overall Average)
Medicine & Emergency Care	1:5.5	1:5.8	1:5.3	1:5.9
Surgery, Anaesthetics & Cancer	1:5.1	1:5.7	1:5.5	1:6.2
W&C (ward 14)	1:4.5	1:5.2	1:3.5	1:5.2

2.2 Setting Evidence Based Establishments

Boards should ensure there is sufficient and sustainable staffing capacity and capability to always provide safe and effective care to patients, across all care settings in the NHS provider organisation. They should ensure there is an annual strategic staffing review, with evidence that this was developed using a triangulated approach (i.e. the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans (NQB 2013 and 2016).

The Chief Nurse has agreed the process for setting nursing establishments. The process includes several important components:

- Using the Safer Nursing Care Tools (SNCT) to assess acuity and dependency, daily for 30 days across all adult wards, acute assessment units, Children and Young Person's inpatient wards and the Emergency Departments. The assessment is undertaken by staff trained in the use of the tool.
- The SNCT is repeated twice per year to ensure validity. To note, for this year (January to December 2025) the census will be complete twice, January/February 2025 and June and July 2024. Establishment changes that were agreed from last year's SNCT census were not enacted until March 2025, on rosters after updates to finance budgets made, so data reported in this paper provides a comparator to 2024-2025 budgets.
- A multi-professional meeting with the ward manager/unit manager, matron, Divisional Director of Nursing, Corporate Lead Nurse for Workforce and Deputy Chief Nurse as well as Finance and Workforce to triangulate the SNCT data with nursing quality indicator outcomes, and professional judgement is applied to assess staffing adequacy, and agree establishments to ensure the right staff, with the right skills are in the right place at the right time.

Staffing establishments take account of the need to allow nurses and care staff the time to undertake continuous professional development, and to fulfil mentorship and supervision roles. Core principles in determining the nursing establishments have been identified, namely:

- The ward manager role is supervisory, and they use their time to direct care, undertake front line clinical leadership, focus on discharges and support unfilled shifts. At SaTH, all wards have a supervisory ward manager (implemented as part of the last full establishment review in 2022).
- The Carter report recommends 25% uplift, however, 22.5% is the minimum headroom allowed with the Safer Nursing Care Tool, and it recommends a minimum of 27% for the Emergency Departments. At SaTH the headroom uplift is 24%; 20.5% is allocated in ward/department budgets and recruited against with 3.5% of this held centrally for maternity leave.

The establishment reviews are approved at Board and will then be fed into the annual operational planning cycle and budgets.

All nursing staff completing the SNCT census have undertaken SNCT training delivered by the Lead Nurse for Workforce, as have the nursing staff who undertake the validation of the SNCT data submitted at ward level.

2.3 Nursing Establishment Review January/February 2025

2.3.1 Safer Nursing Care Tool Data Results

The Safer Nursing Care Tools (SNCT) calculates clinical staffing requirements based on patients' needs (acuity and dependency) which, together with professional judgement, guides chief nurses in their safe staffing decisions. The levels of acuity within the tool range from Level 0 to Level 3. Level 3 acuity is only delivered in the Emergency Departments and Critical.

The review was undertaken across the adult inpatient wards, Emergency Departments and Paediatrics. The data from this census is not reviewed in isolation as data from previous years census is reviewed in the establishment review meetings. No new wards have been opened, from the last census undertake, but a number of wards have opened escalation beds to support flow and reduce risk in the emergency departments. It was noted that the majority of areas where escalation beds were used were mostly open for the whole-time census data collected. Therefore, the total number of beds in open in an area have been included in calculating census data.

Data was collected for adult inpatient wards and paediatric wards over a 30-day period. A Professional Judgement Framework within the SNCT was also used by the ward managers and matrons to inform their professional judgement used as part of the triangulation for the staffing reviews.

The emergency departments data collection is completed over a 12-day period and records acuity twice a day providing data on the 24 hours period. Full details of the Nursing establishment review are outlined in Appendix 1.

For the purpose of the bi-annual staffing reviews, a benchmark of RN: HCA ratio of 65:35 has been utilised within the SNCT for adult inpatient wards. It should be noted that the gold standard would be a mix of 70% RN to 30% HCA. However, where a ward has a usual higher dependency rather than acuity need, it is accepted the ratio may need change. Current acuity/dependency scoring across medicine and surgery show a higher dependency (1b) of patients in January/February 2025 in line with censuses completed in 2024, and as such templates currently reflect a ratio with higher levels of HCA.

SNCT guidance requires a review of data from a minimum of two census periods before making changes to establishments/budgets. At the time of the January/February 2025 census being undertaken the recommended changes in establishment from the previous SNCT undertaken in September/October 2024 which were approved by the Trust Board in January 2025 were in the process of being implemented, so the January/February 2025 census does not include these changes.

2.3.2 Adult Inpatient Wards SNCT %

The overall average percentage data for all adult wards for the last four SNCT periods completed in 2024/2025 is shown below. The main acuity of patients is stable requiring ward care (Level 0) or stable and dependent (Level 1B), with 44.55% and 45.45% respectively in January/February 2025.

Table 4 – average acuity by census (%)

	Empty Beds	Patient Acuity Level 0	Patient Acuity Level 1a	Patient Acuity Level 1b	Patient Acuity Level 1c	Patient Acuity Level 1d	Patient Acuity Level 2	Patient Acuity Level 3
Jan/Feb 2025	2.74	44.55	5.59	45.45	0.51	0.01	1.14	0
Sept/Oct 2024	2.72	43.6	6.52	45.83	0.87	0.82	1.31	0
Jun/Jul 2024	1.93	43.65	5.96	44.97	1.4	1.18	1.61	0
Jan/Feb 2024	1.69	43.95	8.44	44.62	0.56	0.04	1.69	0.00

2.3.2 Paediatrics

Ward 19 acuity by census period is shown below:

Ward 19	Empty Bed (%)	Patient Acuity Level 0 (%)	Patient Acuity Level 1a (%)	Patient Acuity Level 1b (%)	Patient Acuity Level 2 (%)	Patient Acuity Level 3 (%)
Jan/Feb 2025	15.5	82.4	5.4	12.0	0.2	0
Sept/Oct 2024	17.27	62.12	6.97	13.33	0.3	0
Jun/Jul 2024	13.93	72.12	5.45	8.18	0.3	0
Jan/Feb 2024	3.98	84.3	3.6	7.7	0.2	0.1

During 2024, the department operated on a reduced bed base due to vacancies and recruitment challenges. This led to frequent agency use to maintain safe staffing. A robust workforce plan has led to a significant increase in substantive employment of Registered Children's Nurses, and it is expected by September 2025, there will be no registered nurse vacancies in this area.

At the last establishment meeting, it was agreed to implement a seasonal staffing model as analysis work done by the team noted a consistent variation over several years of activity between summer and winter months and as it was thought efficiencies could be made by aligning a summer and winter template with seasonal variations in activity. The recommended SNCT was below the current budget and template, the establishment template for the paediatric areas was changed to a seasonal template, as there were significantly more acute admissions over the winter months meaning patient care and experience would benefit from additional staff support. The Summer template was enacted from 11th May 2025, and the current audit reflects the previous (pre-seasonal) budget which did not align at the time the adults were completed to the new staffing model. Financially the budgets for paediatric services have been stratified to clarify staffing needs across:

- Ward 19
- Paediatric Oncology and Haematology Unit
- Children's Assessment Unit
- Paediatric day case
- Paediatric Day Surgery (which is undertaken in the Elective Hub)

With improved recruitment and revised templates, agency staffing ceased from the end of March 2025.

2.3.4 Emergency Department Establishment Review February 2025

The current SNCT tool for ED expects that patients will have been admitted or discharged within 12 hours so there is no current provision in the tool for patients in the department for greater than 12 hours. The SNCT ED tool is currently under review by the national team given the need to consider patients who are in the ED department more than 12 hours as this is occurring nationally. Conversation with regional Safer Staffing Fellows highlights the same issues with capturing the workload associated with 12 hours plus patients and no current national guidance is currently given as to how this workload is captured/equated.

ED acuity by census period:

	Patient Acuity Level 0	Patient Acuity Level 1a	Patient Acuity Level 1b	Patient Acuity Level 1c	Patient Acuity Level 2	Patient Acuity Level 3
RSH Feb 2024	51.9	19.7	22.2	6.6	1.6	0
RSH Jul 2024	50.3	19.3	20.3	8.3	1.5	0.4
RSH Oct 2024	53.9	20.6	20.1	4.6	0.6	0.1
RSH Feb 2025	57.2	12.1	25.2	3.9	0.9	0.9
PRH Feb 2024	55	20.6	11.2	11.4	1.7	0
PRH Jul 2024	60	13.1	13.6	10.9	2.1	0.2
PRH Oct 2024	59.3	22.9	13.5	3.7	0.7	0
PRH Feb 2025	63.4	15.7	15.1	4.4	1.0	0.2

The outputs of the SNCT tool show that without taking professional judgement into consideration the current budgeted establishments are well above the SNCT recommendations but do not reflect the workload in the department and challenges with delivering care.

Layering on the additional work of patients waiting in the emergency department for admission it is recognised that 30-40 patients waiting for admission are held in the emergency departments. The departments can often site at 200% occupancy which disables the ED from working effectively.

Key quality metrics for ED are reported below target i.e. triage within 15 minutes, ambulance handover. During a previous census period the acuity of the additional patients was analysed, and it was noted the patients required a higher level of nursing support than the patients having ED care where the majority are stable. The environment is challenging to care for the additional patients and still operate normally. Cohorting of confused and risk of falls patients has been difficult with an increased requirements and request for staff to support patients requiring 1:1. This was not undertaken in the current census on the advice of the National Clinical Lead for Workforce.

Waiting rooms can have high number of patients that need observations. At PRH, during peak times in the department will the nursing team work differently and deploy a nurse from the fit to sit area to the waiting room to ensure patients have timely observations and care. Additional patients can be managed on corridors and support is sought regularly from wards to provide nurse and HCA when corridor care is being delivered.

No changes to the templates are recommended at this time however it is recognised that the department will need to adapt and work differently.

2.3.5 Staffing, Quality and Safety Indicators

Nurse Sensitive Indicators

Quality data and nurse sensitive indicators are reviewed and triangulated at the establishment review meetings. 6 months of data was considered looking for trend and also triangulation of data during census completeion to review impacts/harm due to reduced staffing levels. All patient safety incident investigations will review staffing to understand whether this may have been a route cause, none of the incident reported noted any concerns regards staffing.

From Febrary 2025 there was a significant increase across wards with delays in obervations. This coincided with the system that records observations having been updated and the time allowed for a late observation reduced. This change impacted on performamnce in relation to this metrics. The managers have noted the need for improvements but the reduction in compliaince has not been related to lower fill rates as it was across all areas.

Quality Metrics dashboard February 2025

1st February to 28th February 2025																
	Quality Indicators															
Location	Complaints	Medication Errors	Nursing medication - administration	MRSA	MSSA	cDiff	Falls - Total	Falls with Harm	Pressure Ulcer Category 1 - Hospital	Pressure Ulcer Category 2 - Hospital	Pressure Ulcer Category 3U (unstage	Pressure Ulcer Category 4 - Hospital	Serious Incidents (SIs) - reported to STEIS	Patient Safety Incident Investigations	Staffing issues - Datix raised
AMA - Acute Medical Assessment (off AMU RSH)	0	2	2	0	0	0	3	0	0	0	0	0	0	0	0
Accident & Emergency Department (PRH)	12	2	1	0	1	0	3	0	0	0	0	0	0	0	3
Accident & Emergency Department (RSH)	7	6	3	0	0	1	3	0	0	1	1	0	0	0	0
Acute Medical Unit (AMU) (PRH)	0	6	5	0	0	0	2	0	0	0	0	0	0	0	0
Acute Medical Unit (AMU) (RSH)	0	5	1	0	0	0	3	1	0	0	0	0	0	0	0
Acute Orthopaedic Trauma Unit (AOTU) (RSH)	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
ITU/HDU (PRH)	1	2	2	0	0	0	0	0	0	1	0	0	0	0	0
ITU/HDU (RSH)	0	1	1	0	0	0	0	0	0	0	1	0	0	0	0
Medical Escalation (PRH)	0	8	4	0	0	0	5	0	1	0	0	0	0	0	0
Ward 10 - Short Stay (PRH)	0	0	0	0	0	0	2	1	0	0	0	0	0	0	2
Ward 11 Nephrology (PRH)	0	2	0	0	1	1	3	0	0	0	0	0	0	0	1
Ward 14 - Gynaecology	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ward 15 - Stroke Unit (PRH)	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0
Ward 15/16 Stroke Unit (PRH) Structure	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ward 16 - Acute Stroke Unit (PRH)	3	1	0	0	0	0	1	0	0	0	1	0	0	0	0
Ward 17 - Respiratory (PRH)	0	0	0	0	0	0	3	0	0	1	0	0	0	0	0
Ward 19	0	6	4	0	0	0	0	0	0	0	0	0	0	0	1
Ward 22 - Short Stay (RSH)	7	0	0	0	0	0	7	0	0	0	0	0	0	0	0
Ward 23OC	1	2	0	0	1	1	3	0	0	0	0	0	0	0	0
Ward 24 - Respiratory (RSH)	2	3	1	0	0	1	3	0	0	0	0	0	0	0	1
Ward 25	2	2	2	0	0	1	11	0	0	1	0	0	0	0	1
Ward 26 - Endo/Medicine (RSH)	0	1	1	0	0	0	7	0	0	2	0	0	0	0	4
Ward 27 (RSH)	1	0	0	0	0	1	4	0	0	3	0	0	0	0	5
Ward 28 Medicine & Frailty (RSH)	2	1	0	0	0	0	4	0	0	0	0	0	0	0	2
Ward 34 SAU & 33SS	0	2	1	0	0	0	3	0	0	0	0	0	0	0	0
Ward 35 Nephrology (RSH)	2	0	0	0	0	0	1	0	0	0	0	0	0	0	2
Ward 37 - Surgical (RSH)	2	2	1	0	0	0	5	0	1	1	0	0	0	0	1
Ward 4 - Trauma & Orthopaedics (PRH)	3	1	0	0	0	1	1	0	0	0	0	0	0	0	0
Ward 5 - Elective Orthopaedic (PRH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ward 6 - Coronary Care Unit (PRH)	2	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Ward 7 - Endo/Cardio (PRH)	3	0	0	0	0	0	4	0	0	0	0	0	0	0	2
Ward 8 H&N	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0
Ward 9 - Frail and Complex (PRH)	0	0	0	0	0	0	2	0	0	3	0	0	0	0	1

None of the wards or matrons highlighted staffing issues impacting the development of pressure ulcers or falls during this census period.

Staffing Incidents

In February 2025, there were 61 Datix submitted for staffing for the areas under review. Of these, 58 reported a lack of suitable staff (nursing & midwifery), 2 related to a missed breaks/leaving late, and 1 related to temporary staffing availability.

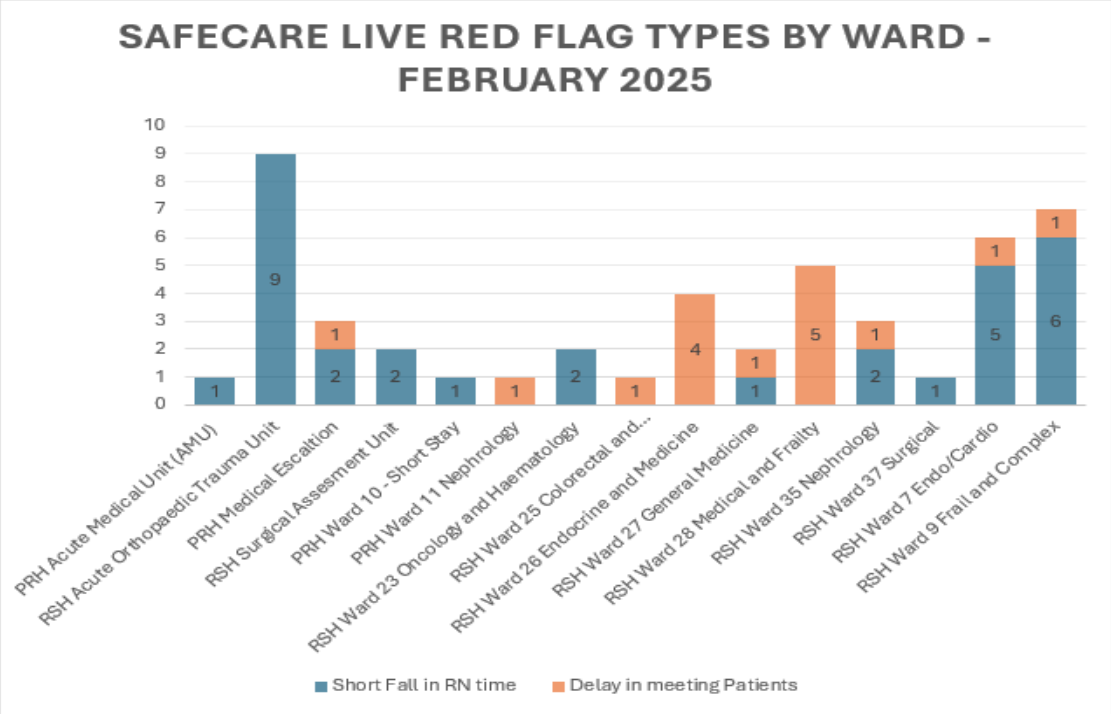
Incidents were reported as no or low harm events only. Themes included delays in care, staff moved to support other departments, missing skills due to short notice staff unavailability and theatre cancellations due to staff unavailability.

Triangulation of staffing and incidents is undertaken by Matrons and monthly metrics reports feed into the metrics meetings where any issues are noted.

Ward Managers have reported working an increased number of clinical shifts to fill staffing gaps, but these hours are not consistently recorded on the roster. The practice has led to an under reporting of actual clinical input and may obscure the true staffing picture. Managers have been asked to record the clinical hours worked so this is reflected in the staffing rosters. From May 2025, the monthly staffing paper included a record of Ward Manager management time and clinical shifts covered. The expectation is that Ward Managers operate in a supervisory capacity focusing on patient experience, and the quality and safety of care. However, in taking on direct patient care responsibilities for full shifts their ability to complete non-clinical duties may be compromised, impacting strategic oversight, staff development and service improvement work. The situation is being actively monitored to assess frequency and duration of clinical cover by manager and impact on managerial responsibilities and consideration if any further actions required to protect management time.

Nursing Red Flags

Over the past 12 months, the Trust has reintroduced Safecare Live, an electronic staffing management system that enables the monitoring of staffing levels in relation to patient acuity and need. Ward staff can raise 'red flags' on the system to highlight staffing concerns that may impact safety or quality of care. These alert triggers are followed up by the Matron, with the system supporting the documentation of actions, mitigations or escalation to capture decision making in relation to concerns. The use of Safecare live supports the oversight of staffing concerns. A validation process is also completed monthly to ensure all red flags have been reviewed and any incidents requiring further investigation are reported via Datix. Red flag events are reviewed at the monthly Quality Metrics meetings, chaired by the Deputy Chief Nurse. These reviews feed into the monthly Safe Staffing report and Workforce Steering Group, supporting strategic workforce planning.



A total of 48 red flags were recorded in relation to staffing concerns in February 2025. All red flags were reviewed by Matrons to determine if any harm occurred to patients. None of the reported redflags were linked to incidents reported as moderate or severe harm.

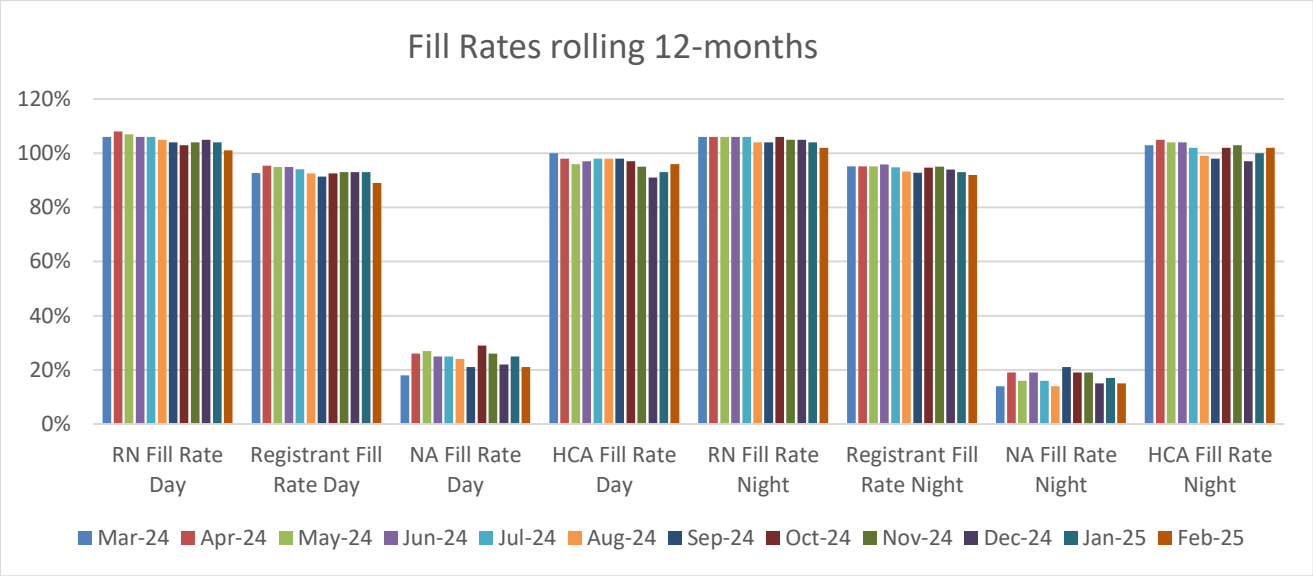
2.3.6 Comparison with Peers

Fill rates

Acute Trusts are required to collate and report staffing fill rates for external data submission to NHSE every month. Fill rates are calculated by comparing planned (rostered) hours against actual hours worked for Registered nurses (RN), Nurse Associates (NA) and healthcare care assistant (HCA).

The summary position for the last 12 months is shown below. Registered Nurse fill rates have been maintained over 100%. However, there was a slight reduction for January and February 2025 due to the cessation of agency use across many ward areas.

Trust Safe staffing fill rate (Nstf_Fill)



As part of the workforce strategy, a plan was agreed to recruit registered nurses to compensate for Nurse Associate (NA) vacancies, so it is with intent that the RN fill rates are high as the Trust continues to implement a 'grow your own' strategy for Nursing Associates, with a five-year trajectory to meet the demand for staff. A combined RN and NA fill rate is calculated to reflect the true registrant staffing position. Registrant fill rates have been consistently maintained above 90% at 93% days and 94% for nights. However, it is noted the February 2025 marked the drop below 90%, reported at 89% on days.

Healthcare Support Worker fill rates have been maintained and consistently above 90%, though slightly reducing following the switch-off of agency HCSW in April 2024. Fill rates may exceed 100% when escalation beds are open, ward functions temporarily change, or enhanced care support (ECS) staff are deployed to support patient care when' continual observation (in-arms reach) is required From May 2025, the monthly staffing report separately reviews ECS hours and to ensure core staffing levels remain satisfactory.

Apart from February 2025, day and night fill rates for registrants and non-registered staff are RAG rated green overall, indicating satisfactory staffing levels across wards. Despite overall green rating, individual wards have experienced fill rates below 75% of planned on occasion. These instances trigger immediate review by the Matron, mitigating actions such as redeployment or escalation and monitoring of quality metrics to ensure no harm results from reduced staffing. Good staffing governance sees these incidents reviewed and triangulated. Where required Datix reporting will highlight issues, none of the incidences over the last six months have resulted in significant harm events and as noted in section 2.3.5 of this report.

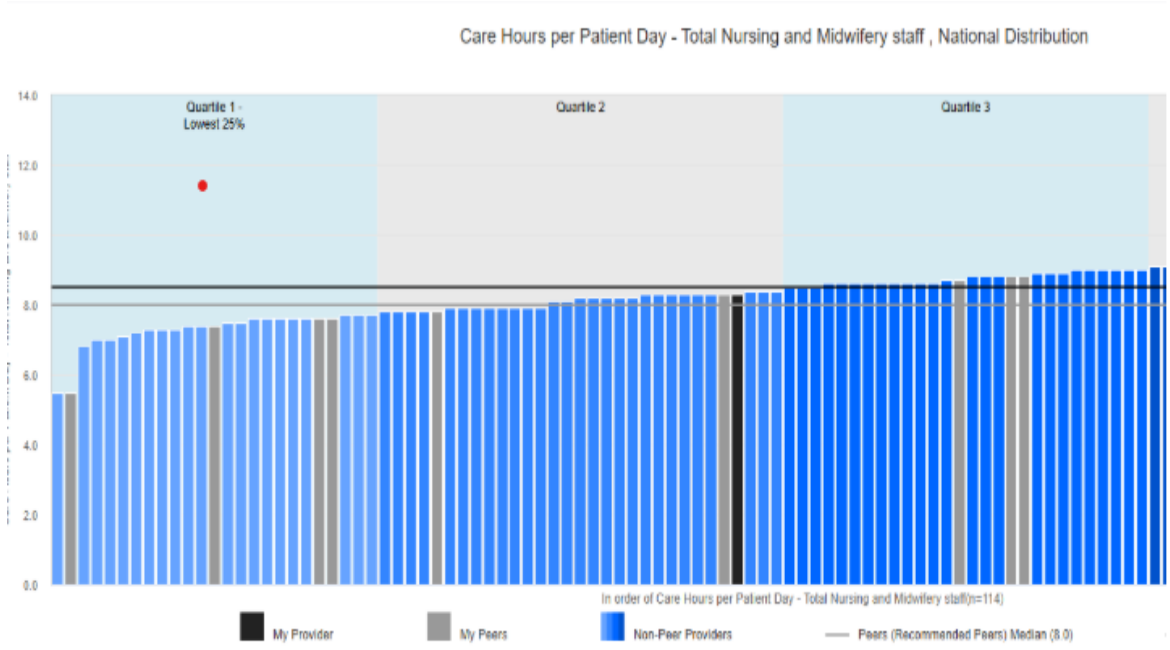
Datix are reviewed and no significant harm events have been linked with these occasions of reduced staffing.

2.3.7 Care Hours per Patient Day (CHPPD) – Model Hospital Comparison

Care Hours per Patient Day (CHPPD) is a useful means of benchmarking against other NHS Trusts via the Model Hospital website. CHPPD is calculated by dividing the total numbers of nursing hours on a ward or unit by the number of patients in beds at the midnight census. This calculation provides the average number of care hours available for each patient on the ward or unit.

Care Hours Per Patient Day for Total Nursing, Midwifery and AHP staff (CHPPD) reported for January 2025 is reported as 8.3 in Quartile 2. When benchmarked against other peer Trusts and nationally, Shrewsbury and Telford Hospital NHS Trust (SaTH) is in line with the peer median of 8.0 and provider median of 8.5. It has been noted over the last 6 months the CHPPD has reduced slightly which has reflected decisions to cease agency, high levels of unavailability and ongoing recruitment.

CHPPD national distribution



[Source Model Hospital CHPPD (March 2025 data, accessed 2nd June 2025)]

Results available on Model Hospital have been compared with peer data. By itself, CHPPD does not reflect the total amount of care provided on a ward nor does it directly show whether care is safe, effective or responsive. It should therefore be considered alongside measures of quality and safety and was considered as a metric in the establishment review meetings. Generic categories for peer comparison does provide some limitations as it does not recognise.

3.0 Recommendations

- No planned changes were proposed following this review as the agreed changes made at the last establishment review and agreed by the Trust Board in January 2025 were only enacted after the census period was undertaken, the impact of changes in staffing levels will be monitored.

- Continue the recruitment and retention work to sustain reduced vacancies across the Trust.
- Eliminate agency nurse usage across all the remaining clinical areas in Trust.
- Undertake an exercise in EDs, Assessment areas (SAU, SDEC, CAU) to map staffing against daily activity, acuity, and peaks in service demand.
- Continue the work to provide assurances in relation to 'Developing Workforce Safeguards' through delivery of the action plan to address the remaining gaps (Appendix 2)
- Complete 2nd set of Establishment review Meetings for 2025 based on the June/July SNCT census which will also including departments not included in the SNCT census such as outpatients and renal services, and make recommendations to the Board around safe staffing establishments in the next bi-annual staffing review report.

4.0 Conclusion

The Chief Nurse working with the Medical Director continue to provide assurance that safe nursing staffing is in place by undertaking the bi-annual nurse staffing reviews to ensure our wards and departments are staffed safely and to help identify further opportunities for increased efficient and reduced costs.

The review paper has provided an overview of the establishment review process and has provided assurance in relation to systems and process in place for the establishment review, as well as our establishments, fill rates and CHPPD.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
13 November 2025

Agenda item	170/25			
Report Title	Medical Examiner & Bereavement Service Report Quarter 1 April – June 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, 7 August 2025 Quality Operational Committee, 19 August 2025 Quality & Safety Assurance Committee, 30 September 2025			
Executive summary:	The Board's attention is drawn to: • Collectively 1208 cases have undergone ME review from across the system during this period. • Throughout Q1 the ME service has recommended 40 SaTH deaths be considered for SJR and identified potential learning in 87 cases. • 76 referrals for hospital deaths were made to the coroner. • The ME service was represented by the Medical Director at an ICS event in August, attended by Dr Claire Fuller, Primary Care Medical Director for NHSE, focusing on the implementation of the ME service, concluding this had been a good example of effective collaboration across the system. • Regional ME analysis of SaTH's ME service data submission indicates the service is performing very well amongst its peers in the Midlands.			
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, timely, 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 509 hospital deaths reported to the Medical Examiner Service during quarter one (figure 1), which was a reduction of 115 deaths from what was reported in quarter four. Two of these deaths were neonatal cases.

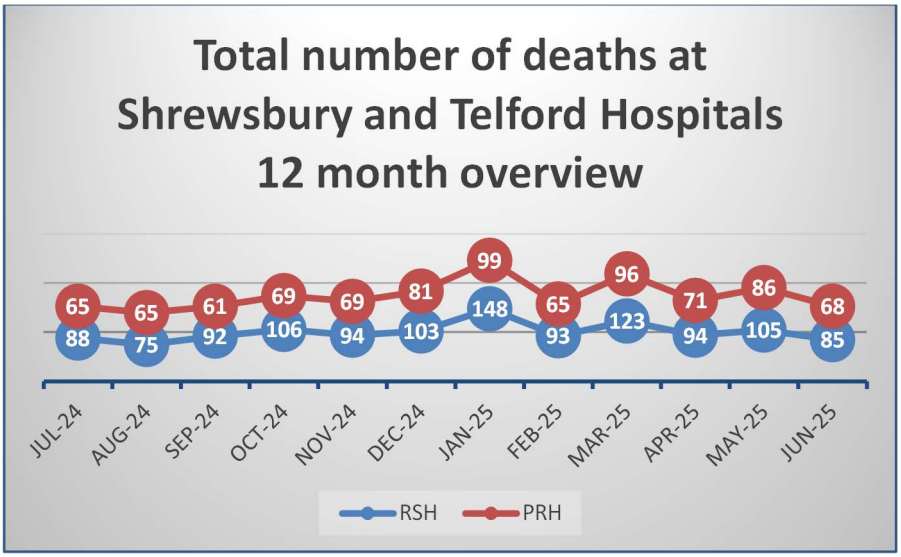


Figure 1 – Total number of deaths at SATH 12-month overview

2.2 The ME service is required to report the above data to NHSE as part of the ME quarterly data return, along with performance data on time to undertake ME review, releasing MCCDs to Registration Services, number of coroner referrals and learning identified. The service is also obliged to report on any themes or trends identified for service providers, however during this reporting period, the ME service has not detected any themes for escalation.

3.0 Medical Examiner Scrutiny of SaTH & STW Deaths

3.1 During Q1 the ME service reviewed 526 hospital deaths and authorised the release of the medical certificate of cause of death in 470.

3.2 Of these 526 reviews, 99% of bereaved relatives received a phone call from the Medical Examiner service to discuss the care, treatment, and cause of death. The ME service can provide assurance through the data collected that it is consistently reporting excellent compliance with ensuring that, where there is next of kin known to the service, they receive a call from an ME and support and compassion is provided to them in the earliest stages of their grief.

3.3 During Q1 the ME service received 682 referrals from across our community care providers, with deaths reported by GP services providing a significant proportion of that demand.

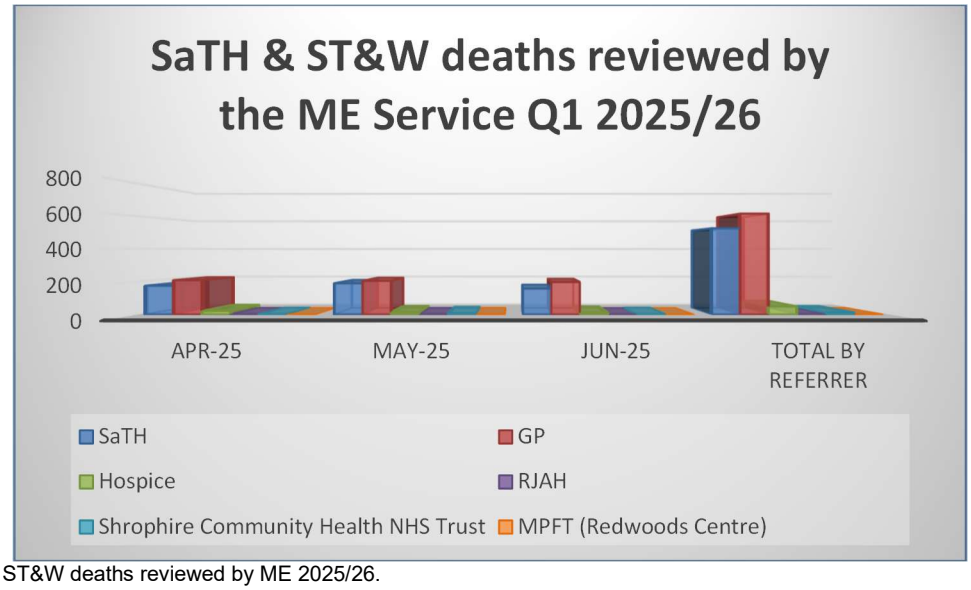


Figure 2– SaTH & ST&W deaths reviewed by ME 2025/26.

At the time of writing, the service is now in its tenth month of being statutory and is starting to see an improvement in the time it is taking for community clinicians to refer their patient's death, with the mean number of days being 2.5 from date of death. In cases where we do see prolonged notification times, we act promptly in working on these cases to limit the distress for the bereaved and support the GP practices with their working procedures to ensure prompt notification of future cases.

4.0 Medical Certificates of Cause of Death (MCCD)

4.1 Of the 526 hospital deaths reviewed by the ME service, causes of death in 470 cases were approved by the Medical Examiner and MCCDs authorised for release to progress for registration of death.

Of the 470 MCCDs written, 433 had no coroner involvement, which continues to demonstrate 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.

136 of the 433 MCCDs (31%) were written beyond three calendar days during quarter one, which is a significant reduction from what was reported during quarter four where 62% of MCCDs were written beyond 3 calendar days.

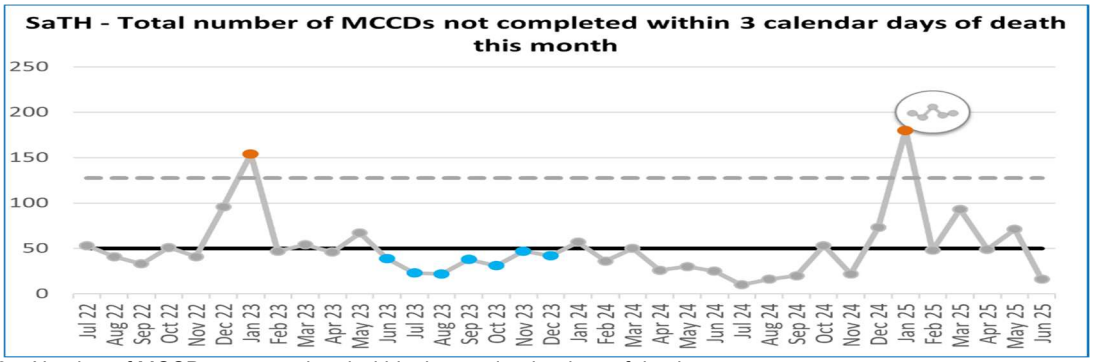


Figure 3 – Number of MCCDs not completed within three calendar days of death.

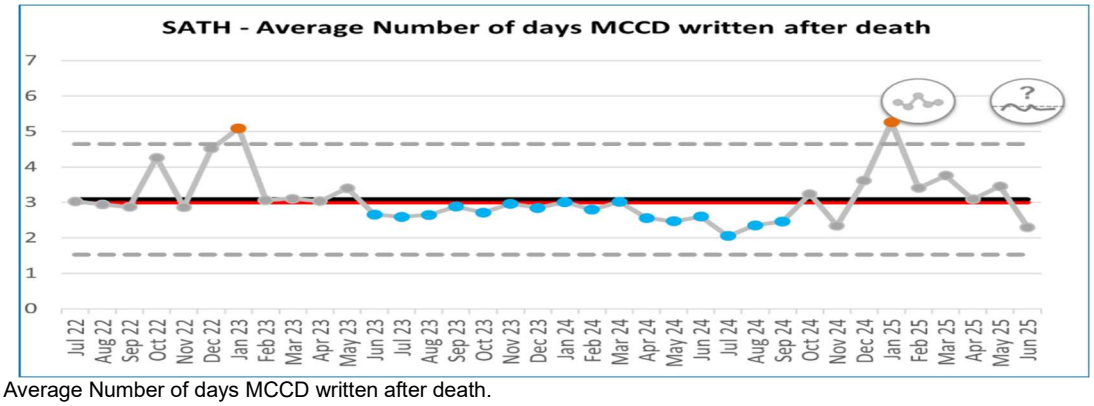


Figure 4 – SaTH Average Number of days MCCD written after death.

The above SPC chart demonstrates the improved performance in respect of issuing MCCDs timelier this quarter. It is important to note the 3 bank holidays during this period, which does impact the timeliness of death certification. In April 49 certificates were over 3 calendar days, increasing to 71 in May with a significant drop seen in June with just 16 over 3 calendar days. The peak in May is due to having more non-operational days during that month and June's performance is aligned with the reduction in deaths. It is worthy to note that the above SPC shows visual representation of how the commencement of the statutory service and the increase in demand has extended the timeframe of MCCD completion, with the service routinely working at between 2-3 days prior to September 2024, with post statutory commencement working at 3-4 days at times of peak demand.

4.2 MCCDs for community deaths

MCCDs for 675 of the 682 community cases were approved by the ME service during this quarter. The ME did not authorise the causes of deaths in 7 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 3.2 during quarter one which is a significant improvement from what was seen during quarter four and indicative of improved notification times. This was reported to NHSE as part of the quarterly data submission.

5.0 Structured Judgement Review (SJR) & Potential Learning

5.1 The Medical Examiner recommended SJRs in 40 of the hospital deaths reviewed in quarter one (figure 5). The peak seen in May of SJRs recommended is in line with the increased number of deaths during that month.

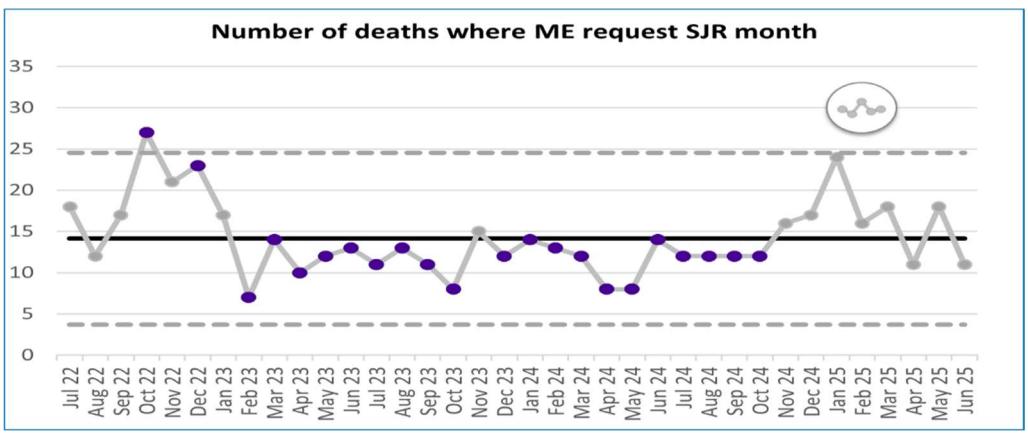


Figure 5 – Number of SJRs recommended following Medical Examiner Review

Figure 6 below shows the categories for which the Medical Examiner has recommended an SJR review take place. Concerns being raised by the bereaved has reduced slightly from quarter four but represents half of the SJRs that were recommended.

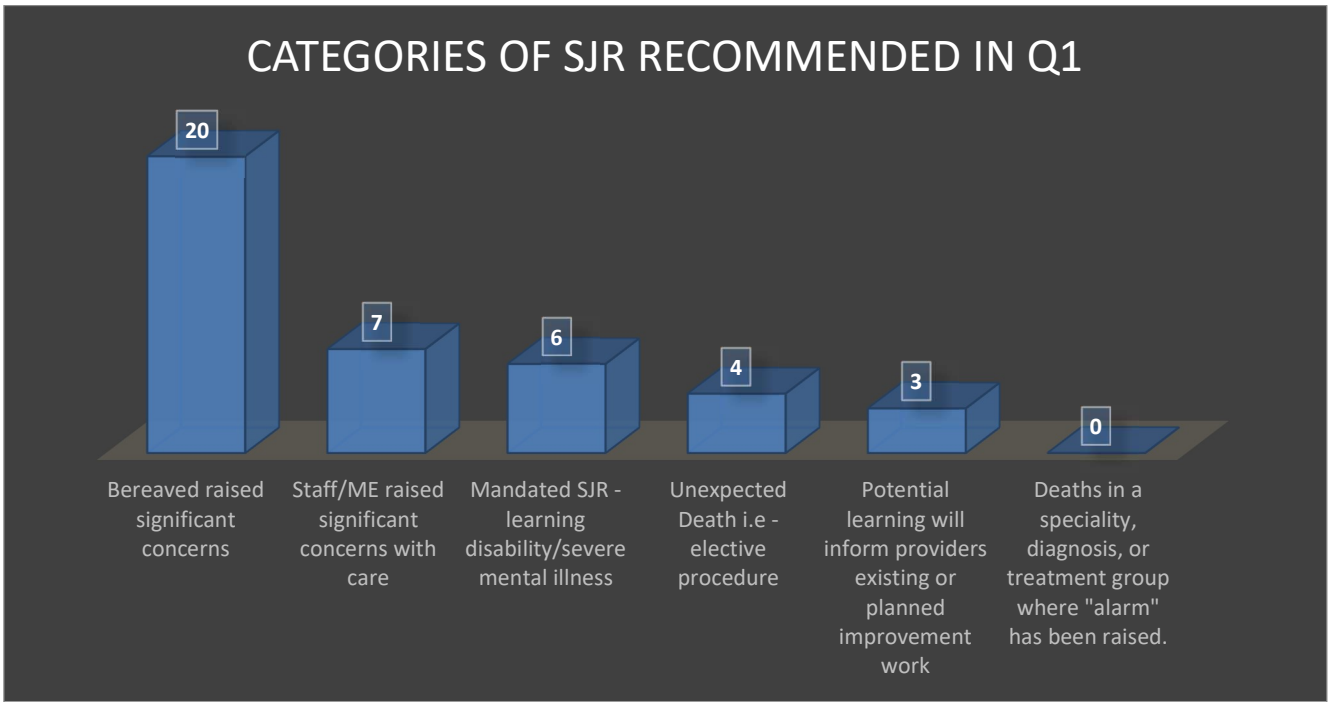


Figure 6 – Categories of SJRs recommended.

The 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.

5.2 Deaths identified by Medical Examiner for potential learning.

Medical Examiners raised potential learning in 87 deaths during quarter one, a reduction of 12 from the previous quarter, with all these cases being referred to the relevant clinical divisions and specialties for review through their governance processes to ensure learning is shared.

Whilst supporting the bereaved relatives during quarter one the Medical Examiner advised the next of kin in 32 cases to contact PALS to raise the concerns that were expressed during their interaction with the ME which is a reduction of 15 cases in comparison to quarter four.

6.0 Coroner Referrals

6.1 Across both hospital sites 76 deaths were referred to the coroner during quarter one, a reduction of 35 from the previous quarter. Of the 76 cases referred, one case was a neonatal death which was reported to the coroner by the Neonatal Consultant, with the coroner authorising a postmortem for this case.

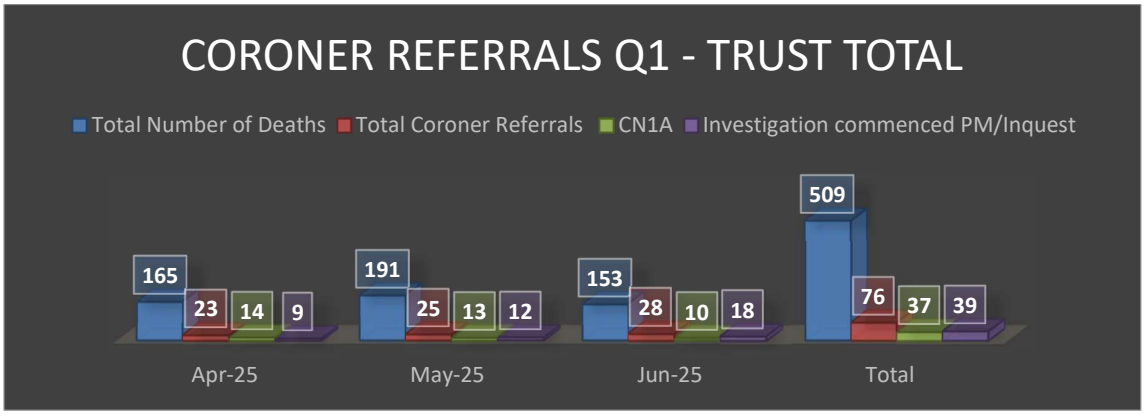


Figure 7 – Coroner referral outcomes for Q1.

The above chart provides the outcomes of those cases with coroner interaction.

During this quarter there were two requests by the coroner for a CN1B for deaths in the community, which for clarity, is requested in only exceptional circumstances when there is no attending practitioner available to certify a death in a timely manner, however the death does not require investigation by the coroner. In these circumstances the coroner will request an ME MCCD by issuing a CN1B to the service.

7.0 Urgent body release/faith requests

7.1 There have been two requests for urgent body release for faith purposes in quarter one for hospital deaths. These cases were managed during core working hours and ME review was facilitated promptly. A further two requests for urgent ME review for faith purposes were received for community deaths during the reporting period. These cases were out of hours over the course of the weekend and so the standard operating procedure for out of hours ME has now been tested and the operating process was followed successfully.

8.0 Service Highlights

8.1 Performance with issuing MCCDs within 3 calendar days has improved during this quarter, along with the turnaround times for ME review of hospital and community cases. Seasonal reduction in demand has supported the service with achieving improved KPIs, along with an improvement from community providers in notifying the ME service of their patient's deaths.

8.2 Some ME capacity has been achieved by re-introducing clinicians to undertaking the reporting of their patients' deaths to the coroner directly, creating capacity for some MEs to achieve an additional review in their session. Greater delegation from MEs to MEOs in making calls to next of kin in appropriate cases has also supported our efficiency improvements this quarter.

9.0 Feedback

9.1 Feedback received about the Medical Examiner (ME) Office has been overwhelmingly positive, with responses gathered primarily through the Bereavement Survey and direct comments from healthcare professionals and next of kin. According to the survey, 95% of bereaved respondents felt that the cause of death was explained clearly by the ME, and 97% found their interaction with the service helpful.

Many described the conversations as very supportive and empathetic, with one individual noting it helped them process their loss. Positive feedback was also received from a GP surgery, who stated that all the staff at the ME service are always extremely helpful when challenges arise, and that their support is genuinely appreciated. In addition, a Medical Examiner Officer received direct feedback from a next of kin, who described their call as very helpful and said that the essential information provided made the process smoother during a difficult time.

9.2 The ME service was represented by the Medical Director at a recent ICS event, attended by Dr Claire Fuller, Primary Care Medical Director for NHSE, focusing on the implementation of the ME service at SaTH, concluding this had been a good example of effective collaboration across the system. It was recognised that the service had been successfully implemented, that the ME workforce represented a diverse clinical background from both primary and secondary care, and that the service was providing support to clinicians to ensure comprehensive and accurate death certification.

9.3 The service has received feedback from the Regional Medical Examiner on quarter one's performance in respect of 6 key elements of the ME service's work, such as, number of days from death to sending MCCD to registrar (4 days), ME review turnaround times (2 days), number of coroner referrals made after ME scrutiny (7.4%), number of ME MCCDs (0.20%), percentage of cases where next of kin interaction has taken place (98%) and the percentage of urgent body release cases achieved (100%). It is encouraging to report that the ME service is performing very well in all key areas amongst its peers across the region, particularly in its performance in liaising with the bereaved, and specifically in the number of ME MCCDs issued, which should only be in exceptional circumstances. This particular element demonstrates how collaboratively the service is working with its community partners and the close partnership that exists between the ME and bereavement service.

10.0 Summary

10.1 Quarter one of 2025 has seen a reduction in the number of hospital deaths reported, broadly in line with figures from Q1 2024. Despite this reduction, the Medical Examiner team has maintained a strong focus on improving timeliness, communication, and quality of case reviews. Significant progress has been made in reducing the time from referral to registration of the MCCD. The ME team is now consistently reviewing deaths within three days of referral, reflecting improved efficiency and responsiveness. There has been a positive increase in advice and guidance activity, with more GPs contacting the ME service for assistance in the completion of MCCDs. This reflects growing confidence in the support the ME team can provide. Compliance with the ME referral form process has improved, helping to streamline case review and reduce delays. Constructive communication has been shared with GP practices to address issues and encourage best practice. While delayed referrals from GP practices remain a concern, the ME team continues to challenge the reasons for delay and has proactively issued targeted communications to address this. The service is now actively contributing to Learning from Deaths at the Integrated Care Board level. This represents a significant step toward more collaborative, system-wide learning, and quality improvement.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
13 November 2025

Agenda item	171/25			
Report Title	How We Learn from Deaths Report Quarter 1 2025-2026			
Executive Lead	Dr John Jones, Executive Medical Director			
Report Authors	Dr Roger Slater, Senior Clinical Lead for Learning from Deaths Dr Dewi Eden, 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, 7 August 2025 Quality Operational Committee, 19 August 2025 Quality & Safety Assurance Committee, 30 September 2025			
Executive summary:	• There has been a reduction in both adult inpatient deaths and deaths that occur in the Emergency Department across the Trust in Q1. • Commissioning Data Sets (CDS) submissions recommenced in May 2025 however ongoing issues within the Data Warehouse continue to prevent the ability to report various performance metrics relevant to the Learning from Deaths agenda. The Digital and Business Intelligence teams are reviewing potential data quality issues within the submissions which could impact external reporting being produced by Hospital Episode Statistics (HES) data, including the Summary Hospital-level Mortality Indicator (SHMI). • During Q1 there has been a decrease in the percentage of completed SJRs where the overall care has been rated good or excellent and a corresponding increase in those where the care was rated as poor or very poor. Themes do align to several areas of identified improvement work including increasing acute bed base and care of the deteriorating patient. • The key learning themes identified through the Learning from Deaths agenda during Q1 are detailed within the report.			
Recommendations for the Board:	The Board is asked to **note** the report and the improvements made during Q1.			

1.0 Introduction

1.1 This report provides an update for Learning from Deaths for quarter 1 (Q1) 2025-26.

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).

1.3 A single integrated learning report covering updates from the Deteriorating Patient improvement workstreams, the Patient Safety Team, the Medical Examiner and Bereavement Service, and Learning from Deaths, is planned for the next quarterly report to the Board of Directors which is due for presentation in January 2026. This integrated report is being developed with oversight from the Trust Patient Safety Committee which is chaired by the Deputy Medical Director.

2.0 Deaths across the Trust in Q1

2.1 A decrease in the total number of deaths in the Trust has been observed in Q1 2025-26 following the spike seen in Q4 2024-25 which was in line with the national picture. This decrease has been in both inpatient deaths and deaths in the Emergency Department (ED). The proportion of deaths at each hospital site in the Trust is broadly consistent with previous quarters.

2.2 The distribution of deaths across the divisions within the Trust this quarter has been altered by the transfer of Oncology and Haematology specialities from the Surgery and Cancer Care (SACC) Division to the Clinical Support Services (CSS) Division. As such there has been a small reduction in deaths within SACC as deaths within these specialities are now allocated to CSS.

2.3 There have been no maternal deaths that have occurred within the Trust or reported by SaTH to 'Mothers and Babies: Reducing the Risk through Audits and Confidential Enquiries' (MBRRACE-UK) during Q1.

2.4 There have been 6 child deaths across the Shropshire, Telford and Wrekin Integrated Care System (STW ICS) notified through the Child Death Overview Panel (CDOP) during Q1. This figure includes 4 neonatal deaths over 22 weeks gestation which met the criteria for MBRRACE reporting by SaTH. One of these neonatal deaths occurred at SaTH.

2.5 There have been no neonatal deaths under 22 weeks gestation during Q1 which met the criteria for MBRRACE reporting as a neonatal death by SaTH. There has been one death under 22 weeks gestation which was referred to the Coroner. This death was recorded by the Medical Examiner Service and is included in the Trust inpatient mortality data for the quarter.

2.6 There has been 1 stillbirth over 24 weeks gestation and no late fetal losses between 22+0 and 23+6 weeks of pregnancy. Stillbirths and late fetal losses fall outside of the remit of the ME Service nationally and therefore are not included with the overall Trust mortality data given within this report.

3.0 Summary Hospital-level Mortality Indicator (SHMI):

3.1 Due to the current challenges within the Data Warehouse, no further Trust SHMI updates or benchmarking against the CHKS Peer Group are available for Q1.

3.2 Commissioning Data Set (CDS) submissions recommenced in May 2025, however potential data quality issues are currently being reviewed within the Digital and Business

Intelligence teams which could affect external reporting being produced by Hospital Episode Statistics (HES) data. This includes published SHMI data.

4.0 Mortality within the Emergency Department (ED):

4.1 A review of mortality within the ED is in progress with an audit of patients who die in the department due to commence in Q3, with the expectation that the work will take at least 12 months. This has been commissioned internally to review the higher mortality rate in the ED within SaTH in comparison to other similar Trusts based on the CHKS Peer Group which has been reported in previous iterations of this report. The Executive Medical Director has met with Professor Simon Jones who was 1st author of the 2022 Royal Emergency Medicine Journal paper on "Association between delays to patient admission from the emergency department and all-cause 30-day mortality".

5.0 Learning for improvement: Adult Deaths

5.1 Potential learning identified through the statutory and independent scrutiny of all non-coronial causes of deaths by the Medical Examiner (ME) Service, is shared with the Trust for deaths that occur as an inpatient or in the ED but also for deaths that occur in the community where the ME Service identify that the learning is relevant for the Trust. This includes feedback that is shared with the ME Service from bereaved relatives and carers.

5.2 Cases where learning has been identified by the ME Service are discussed at the Trust Mortality Triangulation Group (MTG) meeting where the most appropriate review process including SJR methodology is confirmed. Duplication of review is avoided where possible.

5.3 The Learning from Deaths team work closely with both the Divisional Quality Governance Teams and the Patient Safety Team to ensure that processes to manage learning align with the wider PSIRF framework.

5.4 At the time of writing this report 8.8% (45) of the deaths in Q1 have been reviewed using the SJR methodology. Seventy-three SJRs have been completed in the quarter, which includes deaths from previous quarters. Of these, 68.5% were completed within 8-weeks from the date of death, 87.7% were completed within 12 weeks, 96% within 18 weeks and 100% completed within 40 weeks from the date of death. Completing reviews as soon as possible after the death ensures that the learning identified is both relevant and actionable to improve the quality of care provided to patients within the Trust.

5.5 During Q1, 64% of all SJRs completed in Q1 were identified through random selection, with 25% triggered through Medical Examiner Scrutiny, 10% through the weekly Trust Mortality Triangulation Group (MTG) and 1% through online mortality screening undertaken by clinical teams. Facilitating a high percentage of random selection aims to identify learning across the full range of care provision to ensure that themes and trends are more representative of normal practice in the organisation, rather than being skewed by a focus on cases where concerns have been raised.

5.6 There has been a slight decrease in the percentage of SJRs where the overall care was rated as good or excellent from 65.7% overall during 2024/25, 63.9% in Q4 2024/25 to 56.1% in Q1 2025-26, with a corresponding increase in the percentage of cases where the care was rated as poor or very poor, from 11.8% overall in 2024/25, 14.4% in Q4 2024/25 to 19.2% in Q1 2025-26. Case selection is unlikely to account for this deterioration as the percentage of SJRs triggered randomly has increased in the quarter, against those triggered through Medical Examiner Scrutiny, the Mortality Triangulation Group or Mortality Screening where SJRs are usually triggered following concerns with

care being raised. A number of the concerns identified can be linked to delayed transfers of care which are subject to intervention on acute bed base in Winter 2025/6.

5.7 Learning identified in Q1 through SJRs and MTG including feedback from the bereaved relates to:

- Readmission issues including potential failed discharges.
- Patients being treated in an inappropriate place for example sitting in a chair with no bed, or in a corridor.
- Delayed specialty transfer or issues identified with the pathway of care.
- Communication issues with the bereaved, including where family members were concerned that the patient had been sent home without discussion with the family, inconsistent messaging around end-of-life care and where there was delayed contact with a relative or carer.
- Recognition and escalation of deterioration and management of sepsis including failure to administer antibiotics within an hour, and documenting evidence of escalation for deterioration, failing to act on abnormal blood results prior to cardiac arrest.
- Delayed / missed diagnoses including, because of ambulance offload waits, delays with diagnostic investigations, missed fracture on admission, missed diagnoses and subsequent failure to act including following abnormal blood results.
- Medical and nursing documentation issues including documentation of escalation following deterioration of patients.
- Medication issues including delayed administration, drug interactions, reversal agent required, omitted medication without appropriate documentation, sub-optimal prescribing and administration, continuation of medication where side effects have been experienced without evidence within the documentation that the risks versus benefits had been considered and delayed end-of-life medication.
- Fluid balance monitoring including for patients with kidney disease with fluid balance charts being poorly completed including for patients who required their fluid intake to be restricted. Intravenous fluids not being prescribed in line with the electrolyte imbalance algorithm.
- Nutritional concerns including failure to initiate Total Parenteral Nutrition whilst a patient in Fit to Sit area of ED, nutritional assessment and Malnutrition Universal Screening Tool (MUST) score not being completed or miscalculated especially in vulnerable patients and then a subsequent failure to refer appropriately to the dietician.
- Management of constipation and stool charts being poorly completed.
- Missed opportunities for early recognition of dying, advanced care planning, discussions relating to Treatment Escalation Plans (TEP) especially when planning for care provision over weekends, and Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) documentation. There is an ongoing programme of work led by the Trust ReSPECT Lead to target improvement in this area.
- Completion of neurological assessments.

5.8 Improvements arising from the LfD agenda during Q1:

5.8.1 The Learning from Deaths team work closely with the Trust Medicines Safety Officer to share relevant learning and inform improvement work. The following examples demonstrate the effectiveness of this collaborative approach which is also informed by triangulation with other sources of learning within the Trust:

- A new ‘Identification and Management of Allergies and Anaphylaxis Policy has been approved in the Trust as it had been identified that there was no overarching allergy policy in the Trust, that the anaphylaxis algorithms required updating, and that there were issues around reporting and recording of new allergies and food allergens and the supply of adrenaline.
- Following learning identified relating to safe medication administration, a review of the e-Learning training package for prescribing and medicine administration has been undertaken and a ‘One-Minute Brief’ has been issued for the prescribing of once weekly medications. Changes have also been made to Datix incident reporting of medication issues and a ‘Systems’ approach to relevant incident review has been incorporated into the medication incident guideline, which has now been implemented.
- Changes have been made to the Datix incident reporting system to encourage notification and data collation of opioid toxicity and use of reversal agents in the Trust. Implementation of the Electronic Prescribing and Medicines Administration (ePMA) within the Trust will facilitate further improvement activity in this area.

5.8.2 Specific learning directly identified through SJR completion or the wider LfD agenda is being incorporated into multi-disciplinary non-medical training facilitated by the Practice Education Team. This involves the use of anonymised learning around documentation, nutrition and fluid management, patient assessment and ReSPECT discussions, also incorporating learning identified from the family perspective.

An example of this is where the experiences of a patient who was a tetraplegic were reviewed and, using a collaborative approach between the Tracheostomy Practitioner and the Practice Education (non-medical) team, targeted training has been provided to the clinical area as well as with individuals who were directly involved along the patient’s journey within the hospital. This learning has also been included in both tracheostomy and simulation training scenarios as well as being incorporated into the ‘tabletop ward’, an educational tool to develop managerial skills in nurses. Identified learning has also been incorporated into wider work relating to long term spinal patients which is being undertaken by the Quality Governance Team.

5.9 Positive learning identified through the Learning from Deaths agenda:

It is not uncommon for positive learning identified through SJRs to relate to similar issues where negative learning has also been identified. Whilst this can appear contradictory, it highlights the complexity of care provision within the acute care sector and the value of learning from both good care as well as care provided which did not meet the standards we would hope to achieve for our patients.

Areas of positive practice identified in Q1 include good care noted in ED and on the wards; examples of good documentation including body mapping, Mental Capacity Act (MCA), Best Interests (BI) and Deprivation of Liberty (DoLs) form completion, good nursing documentation, and evidence of regular and timely medical / Consultant reviews; good clinical monitoring including completion of food charts, fluid balance charts, comfort charts, observations and good escalation of deterioration to medical staff; early diagnostic investigations; early discussions around treatment escalation plans and involvement of the family; good pain management; robust cross-site and weekend cover from the Advanced Oncology Nurse; good communication with relatives and carers and within teams and good end-of-life care including early recognition of the need to consider end-of-life care, good ReSPECT planning and the provision of compassionate end-of-life care.

6.0 Learning for Improvement: Maternal, Paediatric and Perinatal Deaths

6.1 The last MBRRACE-UK Saving Lives, Improving Mothers' Care 2020-2022 report was published in October 2024. The key points from this report were summarised in the Q4 / Annual Summary 2024-25 iteration of this report. SaTH continue to work to reduce inequalities in care provision, working with the Local Maternity and Neonatal System (LMNS) on their equality audit for the childbearing population

6.2 All child deaths are reviewed within the CDOP statutory process.

6.3 Positive learning identified through the CDOP panel during Q1 includes:

- Good palliative and end-of-life (EoL) care provided to a patient with a metastatic germ cell tumour.
- Good support provided to the parents of a child who had been brought into the ED in cardiac arrest.
- Good bereavement support provided to a family of a patient with Burketts Lymphoma.
- All Road Traffic Accidents reviewed demonstrated good actions being taken by the local council to improve road safety.
- Appropriate treatment plan for a child with complex needs in the community including a tracheostomy.
- Recognition and escalation of the deteriorating child on ward 19.
- Well managed cases where the child had life limiting conditions.
- Advanced Care Plans completed and updated.
- Good communication with parents through the CDOP process.

6.4 Learning for improvement identified through the CDOP panel and presented to Learning from Deaths during Q1 includes:

- Unsafe sleeping environments were present in several cases - regional learning was identified to remind all healthcare professionals of the importance of discussing safe sleeping at every contact.
- Learning for the ambulance service regarding call handler advice given.

6.5 Learning points from a completed Perinatal Mortality Review Tool (PMRT) during Q1 relate to:

- Women presenting with a stillbirth must receive a thorough multi-disciplinary review, be carefully monitored and rapidly escalated involving high dependency monitoring if required.
- Anti-D prophylaxis and Kleihauer is not required for any sensitising events where the fetus is known to be Rhesus (RhD) negative through cell-free fetal deoxyribonucleic acid (cffDNA) testing.
- A positive Kleihauer-Betke test indicates the presence of fetal red blood cells in the mother's blood, and is suggestive of a feto-maternal haemorrhage, which requires escalating.
- An antenatal check and cardiotocography (CTG), if appropriate, and an obstetric review must be completed on the day of a patient's discharge.

6.6 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.

6.7 The MBRRACE-UK Perinatal Mortality Surveillance: UK Perinatal Deaths of Babies Born in 2023 was published in May 2025 and relates to stillbirths and neonatal deaths (after 24 weeks) in the UK during 2023. This report will progress through Divisional Governance forums and updates will be provided in future iterations of this report as appropriate.

7.0 Deaths of Patients with a Confirmed Learning Disability (LD), Autism or a Serious Mental Illness (SMI)

7.1 There have been 8 deaths identified of patients who died within the Trust during Q1 with a learning disability or autism. Two of these were patients with an address in Wales and as such 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. A LeDeR referral has been completed for the remaining 6 cases.

7.2 There have been 2 deaths identified of patients with an SMI during Q1.

7.3 The Lead for Health Inequalities and Equality, Diversity and Inclusion (EDI) in SaTH has taken responsibility for LD and Autism improvements within the Trust from Q1. A comprehensive action plan has been developed which incorporates improvements identified through the completion of the Reducing Deaths for Adults with a Learning Disability Self Improvement Tool, along with learning from LeDeR and previous serious incidents. That plan is currently being cited through the appropriate governance channels and progress will be monitored via Safeguarding Assurance Committee.

7.4 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. A specialist LD nurse and Mental Health nurse now provides specialist input with this process. Learning is incorporated into section 5.

8.0 Deaths Deemed More Likely Than Not Due to Problems in Healthcare:

8.1 There are no deaths that have been confirmed as potentially avoidable in Q1.

9.0 Regulation 28 – Reports to Prevent Future Deaths

9.1 No Regulation 28 Reports have been received by the Trust during Q1.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 13 November 2025

Agenda item	172/25			
Report Title	Progress on 10 Point Plan to improve resident doctors working lives			
Executive Lead	Dr John Jones, Executive Medical Director			
Report Authors	Sam Hooper, Senior Business Manager to the Medical Director			
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:	On 29 August 2025 NHSE set out a 10 Point Plan to improve resident doctors' working lives with clear timelines for progress within 12 weeks The Trust has met or partially met the majority of the actions required and the Group Chief Executive and Executive Medical Director have met resident doctors to seek feedback on progress to date The Trust is ranked highly in relation to other Trusts in the region for its progress in meeting the actions			
Recommendations for the Board:	The Board is asked to **take assurance** that the Trust is responding in a timely way to the requirements of the 10-point plan.			
Appendices:	Appendix 1: Action Plan			

1.0 Introduction

1.1 On 29 August 2025 NHS England launched a 10-point plan to improve resident doctors working lives. This was to address issues including payroll errors, poor rota management, lack of access to rest facilities and hot food, and the unnecessary repeating of training. This was consistent with our commitment to staff under the 10-year health plan for England. NHS England have set out 10 ways that we should improve resident doctors' working conditions over 12 weeks.

1.2 As a Trust we are required to ensure meaningful progress has been made and this will be formally incorporated into the new NHS Oversight Framework. We are also expected to develop a Board Assurance Framework to provide oversight of this work. The outcomes should be included in their annual reports to demonstrate accountability and progress.

1.3 Every NHS organisation is required to act across all 10 areas within the 12 weeks. Progress must be reported to their boards and, where actions are not met, a formal explanation and corrective measures should be provided.

2.0 Key Milestones

2.1 Since the launch of the 10-Point Plan there have been some key milestones that have been required to be met.

- Baseline submission of 10-point plan – completed 9.9.2025
- CEO attended a meeting with the resident doctor committee to discuss the 10-point plan and gain feedback and discuss next steps – completed 24.9.2025
- Appointment of Senior Leader for Resident Doctor Experience (SLRDE) – completed 09.09.2025
- Appointment of Resident Doctor Peer Lead (RDPL) – completed 09.09.2025
- Next submission re: progress from 12-week baseline submission – not yet due.

3.0 Summary of 10-Point plan

1. Trusts should take action to improve the working environment and wellbeing of resident doctors
2. Resident doctors must receive work schedules and rota information in line with the Code of Practice
3. Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing
4. All NHS trust boards should appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to trust boards.
5. Resident doctors should never experience payroll errors due to rotations
6. No resident doctor will unnecessarily repeat statutory and mandatory training when rotating

7. Resident doctors must be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours
8. Resident doctors should receive reimbursement of course related expenses as soon as possible
9. We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery
10. We will minimise the practical impact upon resident doctors of having to move employers when they rotate

4.0 Progress to date (see Appendix 1)

4.1 A Task and Finish Group has been set up chaired by the Director of Medical Education with all key stakeholders involved to address the work needed to be carried out.

4.2 One of the standards NHS England, DHSC and BMA are responsible for:

- We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery (Point 9)

4.3 One of the standards NHS England are responsible for:

- We will minimise the practical impact upon resident doctors of having to move employers when they rotate (Point 10)

4.4 We have met 3 of the standards which are:

- Resident doctors must receive work schedules and rota information in line with the Code of Practice (Point 2)
- All NHS trust boards should appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to trust boards (Point 4)
- No resident doctor will unnecessarily repeat statutory and mandatory training when rotating (Point 6)

4.5 We have partially met 4 standards which are:

- Trusts should take action to improve the working environment and wellbeing of resident doctors (Point 1)
- Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing (Point 3)
- Resident doctors should never experience payroll errors due to rotations
- (Point 5)
- Resident doctors must be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours (Point 7)

4.6 We are planning to introduce 1 standard which is:

- Resident doctors should receive reimbursement of course related expenses as soon as possible (Point 8)

5.0 Conclusion

5.1 We are making good progress of meeting the requirements of the 10 Point Plan to improve resident doctors working lives.

5.2 We are ready to implement the reimbursement for course related expenses within 4-6 weeks of claims being submitted (Point 8) as soon as NHS England update the regional policies conveying their requirements.

5.3 The areas which sit within NHS England's areas of responsibility (Points 9 and 10) we are waiting for the requirements to be conveyed further but feel confident that we can be responsive to make the adjustments necessary.

5.4 We are committed to achieving the targets and are on track and are also looking to excel in the areas which we have already achieved.

Appendix 1 – 10 Point Plan to improve resident doctors lives Action Plan

No	Action Area	Action	Comments	Owner	Due by	Benchmark	Progress Status
1	Improve workplace wellbeing for our resident doctors	Trusts are expected to take meaningful steps to improve the working environment for resident doctors. Issues will vary by location, so trusts can adapt implementation to reflect local needs and operational realities in these and other areas and where possible:- **Provide designated on-call parking spaces** **The autonomy to complete portfolio and self-directed learning from an appropriate location for them** **Access to mess facilities, rest areas and lockers in all hospitals, including new builds** **A 24/7 out-of-hours menu offering hot meals and cold snacks for staff.** Within the next **12 weeks every trust should**: Conduct a self-assessment of the feasibility of improving priority areas and develop action plans to address any gaps. This audit and subsequent plans must be approved by the trust's people committee or equivalent body. Trusts will be expected to provide updates for national reporting on progress.	**Parking:-** Purple Parking Zone at RSH - this might extend to PRH once estate allows. Access to park and ride Flexible parking options for those that might only want to park ad-hoc	Facilities	21/11/2025	standard partially met	On Track
			Food:- Hot and cold food available 24/7 on both sites. Access to vending machines on both sites - food can also be ordered in the daytime for collection out of hours. 24 hour shop access at PRH.	Facilities / GOSW	21/11/2025	standard partially met	On Track
			Doctors Mess:- Access to mess facilities are currently available on both hospital sites. There is also an active mess committee on both hospital sites. A new PRH mess is due to open June 2026.	All	21/11/2025	standard partially met	On Track
			Lockers:- Lockers are available in the Doctors Mess on both hospital sites (RSH 36 lockers / 35 appear to be in use on the 21 October 2025 / PRH 16 lockers, 10 appear to be in use on the 20th October 2025). Only available for less than half of residents. In Line with HTP there are plans for additional changing areas with lockers to be developed. PRH - Computer "drop in" suite has 10 PCs and 2 laptops for resident doctors to use. RSH - Computer "drop in" suite has 25 PCs and there are 15 PCs within the library. We also have 2 bookable computer suites providing access to an additional 25 PCs.	All	21/11/2025	standard partially met	On Track
			Rest:- Sleep pods available on both sites. (Mess/W&Cs). The new Mess at PRH will also have access to an adjoining office, discussions are taking place to ringfence this space as a dedicated rest area within the new Mess footprint. MPS have approved a Too tired to drive SOP - the document details how residents can book accommodation following an on-call/night shift if they are too tired to drive home.	MPS/GOSW	21/11/2025	standard partially met	On Track

			Self-directed learning time Ability for residents to work from home for portfolio if required	Medical Education / Educational Leads	21/11/2025	standard partially met	On Track
			Positive Feedback Mechanisms:- Greatix Moving to Excellence Awards Star Cards Annual Trust Awards	Executive Team / COO	21/11/2025	standard partially met	On Track
			Promotion of the Safe Learning Environment Charter Follow the charter at SATH - Postgraduate Clinical Tutor to lead on promoting this.	PG Clinical Tutor	21/11/2025	Planning to introduce	
			Sexual Safety/Harassment training Awareness Sexual Safety covered at resident doctors inductions - this is delivered by the PG Clinical Tutor. FTSU and GOSW also have a slot on the resident doctors induction. The trust has a Sexual Safety lead in place (Danielle Alexander). The trust has signed up to and has launched the Sexual Safety Charter. The PG Education Team provide training on sexual safety for trainers and run CPD events on this topic. The PG and UG teams have provided bystander training in conjunction with Keele University. Foundation Training Programme Directors have recently attended an NHSE event to support the delivery of sexual safety training for resident doctors.	All / Sexual Safety Lead	21/11/2025	standard partially met	On Track
2	**Resident doctors should receive work schedules and rota information as per the requirements of the Rota Code of Practice**	Trusts must use this information to ensure that resident doctors receive their work schedules at least **8 weeks** in advance and detailed rotas no later than 6 weeks before the rotation begins. Where these standards are not met corrective action must be taken. Performance data must be submitted by trusts, and NHS England will monitor and report on national compliance across all stages of the process.	Delivered as BAU service for MPS however accessibility of central reporting for performance limited SOP for work schedules - including responsibilities and timescales for educational leads and escalation process Report performance for August, September, October and December rotations. Report performance through quarterly GOSW and annual reports. Signed off SOP.	MPS	21/11/2025	Standard met	Complete
3	**Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing**	**Within 12 weeks, NHS England will**: conduct a review of how annual leave is currently agreed and managed for our resident doctors. This review will identify areas for improvement and lead to clear recommendations to ensure a more consistent, transparent and supportive approach across all trusts.	Good annual leave practice covered at Induction Current review of the annual leave policy for doctors is underway.	Executive Team	21/11/2025	standard partially met	On Track
4	**All NHS trust boards must appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to the board**	**Within 6 weeks, trusts should**: appoint a senior named lead for resident doctors' issues (where one is not already in place), and a resident doctor peer representative, to report to the board.	Dr John Jones - Executive Board Lead The trust a Non Executive Director who supports Education The Chief Registrar is the peer representative junior doctor (Dr Aung Naing) Executive lead and Resident Lead are attending the West/East Midlands Launch events in October/November 2025.	Executive Team	13/10/2025	Standard met	Complete
5	**Resident doctors should never experience payroll errors due to rotations**	**Within the next 12 weeks**, every trust should: Participate in the current roll out of the national payroll improvement programme and ensure that payroll errors as a result of rotations are reduced by a minimum of 90% by March 2026. All organisations are required to establish a board-level governance framework to monitor and report payroll accuracy and begin national reporting as required.	Medical People Services have implemented a new policy Medical People Services undertake monthly pay audits for all doctors Medical People Services also undertake retrospective pay audits approaching changeover	MPS / Payroll	21/11/2025	standard partially met	On Track
6	**No resident doctor will unnecessarily repeat statutory and mandatory training when rotating**	**Within the next 12 weeks** if they are not already doing so, every trust should: Comply with agreements set out in the MoU signed by all trusts in May 2025 by ensuring acceptance of prior training. By April 2026, NHS England will: reform the entire approach to statutory and mandatory training with a revised framework as outlined in the 10 Year Health Plan for England.	Tom George , Head of Education and Infrastructure is leading on the programme of work. SaTH adheres to agreements set out in the MoU and People Policy Framework. A paper on this was submitted to Strategic People Group in May 2025 - confirmed by Tom George. Paper submitted to SPG by Tom George. StatMand Rationalisation Update Paper - ; Appendix 1 StatMand Update April25.pptx ; Appendix 3 - Mandatory Learning Policy	Head of Education / Medical Education	21/11/2025	Standard met	Complete

7	**Resident doctors should be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours**	A new national Framework Agreement for Exception Reporting was agreed on 31 March 2025 and will be rolled out for implementation in due course. The changes agreed simplify the reporting process for resident doctors, ensure they are being fairly compensated for the additional hours they are required to work, and will support the safety of their working hours.	An exception reporting reform task and finish group has been established. Training slides have been developed and a process is in place to ensure all new resident doctors receive a login to the RLDatix system within 7 days of commencement. Training slides will be updated upon receipt of further information from NHS Employers.	MPS	21/11/2025	**standard partially met**	On Track
8	**Resident doctors should receive reimbursement for course-related expenses within 4 to 6 weeks of submitting their claims**	**Within the next 12 weeks** every trust should: Review their current processes to ensure they can reimburse resident doctors upon submission of valid receipts for all approved study leave-related expenses, including travel and subsistence.	From 1 October 2025, NHSE have enabled an option in Accent Leave Manager to allow resident doctors to claim expenses early. Once a resident doctor has an **approved** application for study leave, including any estimated expenses on Accent Leave Manager they can submit a claim before attending the event/course for reimbursement. This option only applies to expenses the doctor can provide a valid receipt for - this is usually the course/conference fee, public transport e.g., train travel and accommodation. This does not apply to expenses for mileage or subsistence which can only be claimed after a doctor has attended the study leave activity. Early reimbursements can only be processed when the necessary approvals are in place on Accent (NHSE system to manage study leave). Local arrangement with payroll has been agreed. Resident doctors have been communicated with directly about this change from NHSE on 30th September 2025. The cut-off date for residents claiming expenses is 10th of the month to be paid in that	Medical Education/Payroll	21/11/2025	**Planning to introduce**	On Track
9	**We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery**	A review of how rotations are managed is now underway and is being led by the Department for Health and Social Care (DHSC) in conjunction with the British Medical Association (BMA). NHS England is working closely with the BMA to fully understand trainees' concerns and to find constructive and workable solutions to address their needs as a matter of priority. **Within 12 weeks,** NHS England will: develop and launch suggested pilots of reformed rotational changes, while continuing to look at wider reform.	Reduced disruption and improved continuity for resident doctors.	DHSC/BMA/NHS England	21/11/2025		
10	**We will minimise the practical impact upon resident doctors of having to move employers when they rotate, by expanding the Lead Employer model**	NHS England is committed to extending the Lead Employer model to cover all resident doctors and dentists in training. This change will eliminate the need for trainees to change employers with each rotation, reducing duplication and administrative errors while improving continuity, efficiency, and the overall training experience. **By October 2025,** NHS England will: develop a comprehensive and financially sustainable roadmap, underpinned by a robust business case. This will include detailed recommendations on costing and funding, service catalogue requirements, and pricing models for national implementation. The roadmap will provide a clear framework	Improved efficiency and reduced administrative burden for rotating doctors.	NHS England	21/11/2025		

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 13 November 2025

Agenda item		173/25		
Report Title		Freedom to Speak Up (FTSU) Report Quarter 1 and 2 2025-26		
Executive Lead		Anna Milanec, Director of Governance		
Report Author		Chan Kaur, FTSU Guardian		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe		Our patients and community		
Effective		Our people		
Caring		Our service delivery		**Trust Risk Register id:**
Responsive		Our governance	√	
Well Led	√	Our partners		
Consultation Communication		N/A		
Executive summary:		The Freedom to Speak Up Guardian role continues to be a key part of helping staff raise concerns that affect how well they can do their jobs whether that's about patient safety, team relationships, or workplace culture. The role of the FTSU Guardian is rewarding, but it also comes with real challenges. To keep making a meaningful difference, Guardians need the Board's ongoing support. That means promoting a culture where concerns are not only heard but are listened to and acted upon with clear outcomes and learning. This will help to build and maintain the trust of our staff across the organisation and ensure the Guardian role remains a meaningful part of our commitment to creating an open and honest safety culture with a strong emphasis on empowerment and promoting staff health and wellbeing.		
Recommendations to the Board:		The Board is asked to receive and note the FTSU activity report for Q1 and Q2 2025/26.		
Appendices:		Appendix 1: Feedback		

Introduction

Due to exceptional circumstances, the Board did not receive a Freedom to Speak Up (FTSU) update report in Quarter 1. This paper therefore provides a consolidated overview of FTSU activity across Quarters 1 and 2 of 2025/26.

It should be noted that external reporting to the NGO/NHSE did continue in line with deadlines throughout the period.

The data indicates an increase in engagement, with 130 contacts received in the first half of the year—representing a 13% rise compared to the same period in 2024/25.

Whether this indicates increased confidence in speaking up or some other motivation for the increase, the reasoning for utilising FTSU needs to be understood. The additional data from the 2025 NHS Staff Survey will be able to help us investigate this further and futher analysis will be provide to the Board once the data becomes available.

Assessment of issues including themes and trends

In 2025/26, 130 contacts were received in the first two quarters, exceeding the combined Q1–Q2 total of 115 from the previous year.

This reflects a 13% increase in early year engagement compared to the same period in 2024/25.

The previous 6 year's contacts are contained in the table below to enable quarter and year on year comparison.

	Q1	Q2	Q3	Q4	Total	Local Increase/ Decrease	National Increase
2025/26	79	51	NA	NA	**130 (Q1, Q2)**		
2024/25	67	48	56	47	**218**	0.5	NA
2023/24	47	52	68	50	**217**	↓23%	↑27.6%
2022/23	72	73	76	59	**282**	↓23%	↑25%
2021/22	100	113	90	66	**369**	↑21%	0%
2020/21	41	82	103	78	**302**	↑110%	↑26%

Table 1: Contacts made to FTSU since reporting began

Contacts versus concerns is contained in the table below for Q1 and Q2.

Qtr. 1 April - June 25	
Number of Contacts	79
Number of Concerns	63

Qtr. 2 July - September 25	
Number of Contacts	51
Number of Concerns	44

The NGO (National Guardian's Office) requires all Trusts to submit their data to the national portal following the close of a quarter and to be submitted in the following categories. At SaTH we also record an additional category of policies, procedures, and processes which is also included in the table below.

Please note: In line with NGO guidance, we record our data using the 'element of' approach. This means that a single concern may include multiple elements from the categories listed below. As such, the total number of elements may exceed the total number of concerns raised.

Category	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26
Bullying and Harassment	10	15	15	5
Patient Safety	9	5	29	12
Worker Safety or Wellbeing	34	35	66	39
Inappropriate attitudes and behaviours	30	37	52	24
Policies, Processes and Procedures	14	24	38	33
Unknown	1	6	1	0
Other	1	4	0	5
Anonymously	1	0	1	0
Detriment	3	1	1	0

Table 2: NGO reporting category themes

Worker safety and wellbeing remained the most reported category in both quarters, accounting for nearly one-third of all concerns. Patient safety concerns increased in Q1 and remained high in Q2 than previous quarters. Inappropriate attitudes and behaviours and policies, processes and procedures were consistently high, indicating ongoing cultural challenges. Bullying and harassment dropped in Q2 from Q1.

Concerns raised by profession

Professional Group	Qtr3 (24/25)	Qtr4 (24/25)	Qtr1 (25/26)	Qtr2 (25/26)
Nursing and midwifery registered	12	8	23	5
Administrative and clerical	15	10	18	20
Estates and ancillary	6	9	3	4
Additional Clinical Services	7	9	11	7
Medical and dental	5	8	9	4
Allied Health Professionals	7	0	8	8
Not known/Other	2	3	2	2
Students	0	0	2	0
Healthcare scientists	2	0	1	0
Additional professional scientific and technical	0	0	2	1
Total	**56**	**47**	**79**	**51**

Table 3: Shows professional groups of people raising concerns

In Q1 2025/26, there was a significant increase in Nursing and Midwifery staff reporting

concerns, 40% of those came from ED, on both sites, which continues a trend of high numbers of concerns coming from our Emergency Departments. The other concerns were from a mix of areas and were about staffing, confidentiality, responding to Datix's, and aggression from patients.

Breakdown of the most common themes in Qtr1 and Qtr2:

Recent feedback from colleagues has highlighted several recurring concerns across the organisation. Issues around team dynamics and professionalism were frequently mentioned, with the repeated nature of these comments suggesting persistent behavioural challenges in areas that may benefit from targeted intervention.

There is ongoing confusion and inconsistency in the application of internal processes and policies. This has been particularly evident in areas such as flexible working arrangements, annual leave, and attending medical appointments, where staff have reported varied experiences and unclear guidance.

Anxiety around job security and organisational restructuring remains a repeated theme. Staff have expressed concern about potential role changes and reductions, contributing to a sense of uncertainty and unease across teams.

Concerns about staffing levels and workload pressures were also raised. These issues are seen as having a direct impact on both patient care and staff wellbeing, with some feedback linking them to increased stress and potential safety risks.

Departmental culture continues to be a challenge in some areas, with comments referencing leadership style, team morale, and overall engagement. These factors may be influencing satisfaction.

Practical matters such as parking access and the condition of facilities were also noted as affecting the day to day working environment. While these may seem minor, they contribute to the overall experience of staff and can influence morale.

In addition to these themes, staff have sought advice, information, and general guidance on a range of organisational matters, indicating a need for clearer communication and more accessible support.

Actions taken to address concerns raised in Qtr1 and Qtr2

1. Concerns around attitude and behaviours, including repeated reports, were escalated to HR and remain open for further investigation.
2. Departmental culture and ED related patient safety issues were escalated and are currently under review.
3. Staffing matters were addressed through both escalation to senior colleagues and signposting, with a mix of open and closed cases.
4. Workload concerns were escalated to HR and remain open, and others were signposted for support.
5. Flexible working and pay scale issues were signposted and are still being supported.
6. Process related matters were managed through a combination of escalation and signposting, with ongoing follow-up.
7. Facilities concerns were either signposted or didn't require further action, and all have been closed.
8. Parking concerns were signposted and remain open.

9. Advice related queries were mostly closed with no action taken by FTSU, though one remains open; others were resolved through signposting.
10. Some colleagues were signposted to support services but chose not to escalate due to concerns about confidentiality, these cases are now closed.
11. Several individuals requested no action, using the space to share concerns and explore options informally.

Reports of Discrimination

Number of concerns with an element of discrimination		
	Qtr1	Qtr2
Disability	4	1
Race	4	0
Sexual Orientation	2	0
Religion	1	0
Total	11	1

This data provides valuable insight into the nature of concerns being raised and supports ongoing efforts to address issues of discrimination within the Trust.

Escalation and signposting

In 2024/25, we began recording the outcomes of concerns raised through the FTSU process to better understand how issues are managed and resolved.

	Qtr1	Qtr2
Escalated	35	24
Signposted	29	23
No action	15	4

Signposting involves directing colleagues to appropriate support channels, most commonly HR or their line manager. A recurring theme in Quarter 2 was that many colleagues contacted FTSU because they were unsure where to take their concern. This pattern highlights the continued importance of FTSU in helping staff navigate internal support structures and ensuring concerns are appropriately addressed.

NB: FTSU encourages all individuals to seek support through line managers and other lines of escalation first before escalating through FTSU. It is noted here as there can be frustration from managers/supervisors that colleagues use FTSU to circumnavigate the line management process.

Staff Contract

In 2024/25 we started recording the contractual status of colleagues who accessed the FTSU service. This change was introduced to help identify any patterns or gaps in accessibility.

The data for Q1 and Q2 is shown below:

Contract Type	Number	
	Qtr1	Qtr2
Substantive	74	42
Not Known	3	6
Other	1	1
Bank	1	2
Locum	0	0

Table 4: Contract Type

Detriment

In Quarter 1, there was one reported case of detriment associated with speaking up. This case remains under ongoing review, with appropriate steps being taken.

No reports of detriment were reported in Quarter 2.

Contacts Per Division

Divisions	Q3	Q4	Q1	Q2
Medicine and Emergency Care	20 (36%)	14(30%)	38(48%)	9 (18%)
Surgery, Anaesthetics and Cancer	7 (12.5%)	13(28%)	7(9%)	10(20%)
Corporate	9 (16%)	7(15%)	16 (20%)	15(29%)
Clinical Support Services	11 (20%)	9 (19%)	10(13%)	8 (16%)
Women and Children's	5 (9%)	3(6%)	5 (6%)	6(12%)
Unknown/Other	4 (7%)	1(2%)	3 (4%)	3(6%)
Total	**56**	**47**	**79**	**51**

Table 5: Contacts by Division shown by number and proportionality.

Medicine and Emergency Care saw a sharp decline in contacts from Q1 to Q2, dropping from nearly half of all contacts to just 18%. Surgery Anaesthetics and Cancer, Women and Children's, Corporate and Clinical Support Services all experienced increases. Divisional figures are submitted monthly to be included in their monthly ER reports for information and triangulation.

Open/Closed Contacts

Significant progress has been made between 2024 and 2025 to resolve historic cases, one concern remains open from 2022/23; it is currently in the final stages of resolution, with a feedback meeting scheduled for December. For the 2023/24 period, six individual concerns remain open, and we are actively working with stakeholders to close these concerns.

2024/2025

	Qtr1	Qtr2	Qtr3	Qtr4
Contacts	**24/25**	**24/25**	**24/25**	**24/25**
Open	1	4	3	10
Closed	66	44	53	37

2025/2026

	Qtr1	Qtr2	Qtr3	Qtr4
Contacts	**25/26**	**25/26**	**25/26**	**25/26**
Open	37	29	NA	NA
Closed	42	22	NA	NA

Please note: *We will only close a concern once the colleague has confirmed they are satisfied that their issue has been addressed or that they no longer require further follow up support.*

Breakdown of open concerns in Qtr1 2025/26

- Worker Safety and Wellbeing; There are currently 16 open contacts which equates to 10 individual concerns. HR related issues linked to flexible working, pay scales, have been signposted. Workload concerns have been escalated to HR for support.
- Policies, Processes, and Procedures; There are 6 individual concerns with 2 escalated for further support and 4 signposted.
- Attitudes and Behaviours; There are 6 open contacts which equates to 4 concerns. Of these, 3 have been escalated and 1 signposted.
- Patient Safety: 8 open contacts which equates to 1 concern. This concern has been escalated and is currently being addressed.
- Detriment Case Review: A review of a detriment case is currently ongoing.

Breakdown of open concerns in Qtr2 2025/26

- Attitudes and Behaviours: 5 open concerns, 3 escalated and 2 signposted. Issues included poor behaviours and one concern about departmental culture.
- Policies, Procedures and Processes: 18 open contacts covering 12 concerns, 4 escalated and 8 signposted. Themes included job cuts and changes, flexible working, and suggestions for improving clinical systems.
- Bullying or Harassment: 2 open contacts, 1 escalated and 1 signposted, both related to inappropriate behaviours.
- Worker Safety and Wellbeing: 4 open concerns 2 escalated and 2 signposted. Key issues raised were parking, workload pressures, and staffing levels

All concerns are being monitored, with signposted cases awaiting feedback from colleagues.

Number of days taken to close concerns in Qtr1 and Qtr2

Since 2023/24, the FTSU team have tracked how long it takes to close concerns, using set targets: 14 days for safety-related issues, 30 days for behaviours and processes, and 60 days for advice or unknown matters. This helps assess whether targets are realistic, identify barriers, and improve responsiveness.

Note: All Qtr1 open cases are in red as they are over the set target days.

Qtr1	Closed			Open
Nature of concern	Red	Amber	Green	Red
Patient safety quality	25%	0%	50%	25%
Worker safety or wellbeing	10%	14%	29%	47%
Attitudes and behaviors	8%	8%	50%	34%
Policies Procedures and Processes	0%	16%	53%	31%
Bullying or harassment	0%	0%	100%	0%

Qtr2	Closed			Open		
Nature of concern	Red	Amber	Green	Red	Amber	Green
Patient safety quality	0%	50%	50%	0%	0%	0%
Worker safety or wellbeing	14%	14%	14%	58%	0%	0%
Attitudes and behaviors	0%	10%	40%	10%	30%	10%
Policies Procedures and Processes	0%	5%	26%	32%	11%	26%
Bullying or harassment	0%	0%	0%	0%	50%	50%

Delays in Closing Concerns

Several factors continue to impact the timely resolution of concerns raised through the FTSU route:

- Extended timeframes for progressing concerns through internal processes
- Lack of feedback to colleagues who have spoken up regarding actions taken
- Feedback that does not align with workplace realities
- Limited sharing of outcomes following signposting to other teams or services from colleagues using the FTSU service.
- Colleagues report feeling heard, but no meaningful action has followed
- Actions taken, but no improvement in behaviours/situations.

We are working with senior leaders and HR to ensure feedback received through the FTSU route is shared and acted upon. Our focus is on reducing delays and ensuring concerns are addressed promptly and meaningfully. While there have been improvements in meeting closure timeframes during 2025/26, further progress is needed.

Speak up Week Activity

- During Speak Up Week, the organisation embraced the theme Freedom to Speak Up: Follow Up in Action, reinforcing the importance of listening and acting on concerns raised by staff.

- FTSU Executive Lead met with FTSU Ambassadors to thank them for their vital contributions and discuss the impact of their role.
- A visibility walkaround with the CEO
- FTSU Guardian presented at Cascade to raise awareness and emphasise the importance of following up with action ensuring that speaking up leads to meaningful change.
- Throughout the week, we continued promoting the FTSU Ambassador recruitment drive, spotlighting the value of this voluntary role in signposting colleagues to the service and supporting those who may face barriers to speaking up.
- These activities supported not only the importance of the role but the shared responsibility to not only listen, but to follow up with action showing that every voice is valued, and every concern deserves a considered response.

National Picture

The National Guardian's Office is scheduled to close in 2026. From the 2026/27 period onward, NHS England will assume responsibility for providing national oversight and guidance to Freedom to Speak Up Guardians. Until that transition happens, the NGO will remain the central source of support and contact for all guardians.

NHS England and the Department of Health and Social Care have announced that the Freedom to Speak Up Guardian position will continue to be included in the NHS Standard Contract for 2026/27. This decision offers reassurance about the long-term stability of the guardian role.

Improvements

FTSU exists so that concerns reported lead to improvements, in all future reports, a case study will be included from concerns raised:

Case Study - Year 2 Internal Medical Trainee raised concerns about racism.

When she started at the Trust, she witnessed colleagues making racist comments. She addressed the comments, however the colleagues were ignorant as to why their words had been unacceptable and implied that she had been overreacting.

This made her feel nervous about starting her position at SaTH. After speaking with her supervisor, she was directed to a FTSU ambassador, who in turn connected her with the FTSU Guardian.

The Guardian escalated the concern to the employee's manager who spoke with the employee involved, who apologised for the way the situation was handled. She felt supported throughout the process and was provided with regular updates.

She said: "Speaking up is so important as it protects us all. When staff feel safe and respected, this in turn gives them confidence which leads to better patient care. Above all I was made to feel my voice mattered and that I was welcome in this organisation as a black Muslim female. FTSU works to make everybody feel respected and safe, regardless of their race, religion,

sexual orientation."

Mandatory Training

In June 2022, Shrewsbury and Telford Hospital were one of the first Trust's in the country to mandate FTSU online training. The FTSU team are working with the Education Team to increase compliance of all FTSU training modules to 90%.

On 30th September 2025 the compliance rate for all modules stands at:

FTSU Online Training	% Completion Q4 2025	% Completion Q2 2025
FTSU – Core – Training for all Workers	92.99%	94.07%
FTSU – Listen Up – Training for all Managers	81.19%	83.25%
FTSU – Follow Up – Training for Senior Leaders	89%	*84%

*Figure correct at 1 October 2025. The % decrease is caused by changes in Board member numbers.

Key Performance Indicators at Q2

1. **Cultural Dashboard in all themes.**

   In 24/25 the dashboard decreased by1% overall in Vision and Values the rest remained the same – individual scores underneath.

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

2. **Sickness absence rate is below 4%**
   Up to September 2025 – 4.9%

3. **People turnover is below threshold of 14.1%**
   Up to September 2025 – 9.72%

4. **Staff Survey response rate at its's highest level to date**
   In 2024, we received the highest response rate to date at 51%, with 4085 completions.

5. **Staff Survey key questions for FTSU 20a, 20b, 25a and 25f.**
   Q20a I would feel secure raising concerns about unsafe clinical practice - increased

from 2023 to 2024 (65.75% to 68.48%)
Q20b I am confident that my organisation would address my concern - increased from 2023 to 2024 (49.09% to 51.01%)
Q25e, I feel safe to speak up about anything that concerns me in this organisation - decreased in 2024 (55.74% in 2023 to 54.08% in 2024)
Q25f If I spoke up about something that concerned me, I am confident my organisation would address my concern - slight decrease in 2024 (41.53% to 41.09% in 2024).

Results in 2024 showed a mixed picture with some increases and some decreases in scores, commentary took place in the Q4/annual report at the June Board.

SaTH Feedback

NGO guidance expects that all those who have raised concerns to the FTSUG and ambassadors are to be asked the following questions:

1. Given your experience would you speak up again to the FTSU Guardian? Yes/No/Maybe/Don't Know

2. Please explain your response

The feedback given in Appendix 1 indicates that the majority of those who raised concerns were happy with the outcome. However, there is clearly more work to be done as can be seen from some of the responses.

NHSE FTSU Review

A review of the Trust's FTSU service has recently been carried out by NHSE. This was one of a series of thematic reviews undertaken to assess the Trust's cultural and leadership maturity.

A terms of reference for the review was agreed with the Trust, and focussed on the effectiveness of the current framework, including an assessment of governance arrangements, leadership visibility, whether the framework allows colleagues to raise concerns and speak up without fear of reprisal, and whether the structure aligns with that required by the NGO and NHSE policy.

The outcome report of the review is due shortly, and we will work closely with NHSE colleagues should there be any recommendations arising which will help further strengthen our processes and improve outcomes for our staff.

Appendix 1
Responses to Feedback Questions

Would You Speak Up Again	Please Explain Your Answer
Yes	I must admit that I was very hesitant to speak up about the treatment I was facing at work, mostly because I felt I might be blowing things out of proportion. But after speaking with FTSUG, she reassured me and made me feel safe. She provided me with the support I desperately needed at the time and put my wishes at the centre of every action. Above all, she has assured me that even though I do not feel prepared to escalate my concerns at this time, it is okay to tell my story whenever I am ready and to use my experience to support others. I am very grateful to have felt as empowered as I did with the support of FTSUG and the FTSU service
Yes	The trust encourages staff to speak up, as I have previously spoken up
Yes	Thank you for the brilliant support you gave to me. Thanks to you and your service I have a workable solution
Yes	I am now utilising the flexible working policy many thanks for all your help.
Yes	It is important that we speak up especially if it affects our family life. We have to be sensitive in each other journey in life. People working in our institution are hard workers and they do it for their families. It is important that we protect what matters to them so that they will be feel valued
Yes	I felt comfortable with the process and would do it again if ever required.
Yes	In speaking up I was given the support I needed to enable me to address a number of issues within my department. Advice was impartial and non-judgemental.
Yes	Was grateful for the safe space to talk about my concerns
Yes	Ther independent investigation was completed and everyone including myself have decided to move on thank you for your advice.
Yes	Thanks for checking in while this was being addressed, everything is much better thank you
Maybe	Would depend on the scenario and the reasons
Maybe	I do not know if I would speak up again. However, I appreciate that we have a FTSU channel, and I also appreciate the support that you gave me when I raised the issue I had. The reason for my answer being that I do not feel that the issue I raised was really met with any care about me as an individual person from the people who make decisions within the trust when you raised it with them.

No	“I spoke up about a culture in a team and our working practices, it was very difficult, and it took 4.5 years to come to a solution. Following the outcome, I was relieved of my managerial duties and was told “you will never manage in this Trust again.” I believe the reason for this was because I spoke up and although I had made an error following process this was used as an excuse to relieve me of my duties. I find this shocking when I have seen colleagues do much worse. At SaTH there is a culture in middle management that is impenetrable and holds back those trying to change the culture and instil good working practices. Although I have suffered detriment because of speaking up I am not prepared to have this escalated and looked at because of fear of further repercussions. I know now that further advancement at SaTH is out of my reach because of the culture that prevails.”
No	As I feel that the higher managers don’t care and that we are just a number and easily replaceable. I feel that after nearly 17 years working for SATH I feel disillusioned and very disappointed, and I would not recommend this a place to work for anyone if asked.
Yes	Really helpful, kind and supportive
Yes	I have found the service really helpful. It was a difficult situation in that the patient did not want to raise their concern, but I felt it needed to be raised. I wanted to remain anonymous. The Guardian was brilliant at keeping the situation confidential. I was able to raise the concern on behalf of the patient without it leading to any animosity. The situation was looked into, and answers were found.
Yes	It was easy to contact someone and explain my concerns. I was given good advice and sign posting and received regular follow up contact.

Board of Directors' Meeting: 13 November 2025

Agenda item		174/25		
Report Title		Emergency Preparedness, Resilience and Response (EPRR) Assurance Process Annual Report		
Executive Lead		Ned Hobbs (Chief Operating Officer & Accountable Emergency Officer)		
Report Author		Emma-Jane Beattie (Emergency Planning, Resilience and Response Manager)		
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		In line with the requirements for the Core Standards for Emergency Preparedness Resilience and Response (EPRR), The Shrewsbury and Telford Hospitals NHS Trust engaged in an internal and external confirm and challenge process with NHS England and Shropshire and Telford and Wrekin Integrated Care Board (STW ICB) which took place on 20 October 2025.		
Executive summary:		1. This is the Annual EPRR report of 2025/26 presented to the Trust Board detailing the outcome of the NHSE assessment of Core Standards for EPRR in line with the annual assurance process. 2. SaTH are reporting a status of **Substantial Compliance** in relation to the EPRR core standards 2025/2026, with a self-assessment against this year's standards indicating that the Trust is Fully Compliant with 57 out of the 62 Core Standards applicable to Acute Trusts, giving a score of 91.9%. The Trust is further reporting partial compliance for 5 out of the 62 Core Standards and has put in place an action plan to address these through the EPRR Work Programme.		
Recommendations for the Board:		The Board is asked to **agree** the status in regard with the proposed Self- Assessment of **"Substantial Compliance"** (91.9%) in Appendix A against the NHSE Core Standards for EPRR.		
Appendices: (*in Information Pack)		Appendix A – Core Standards – Self Assessment *Appendix B – NHSE Core Standards Evidence Log *Appendix C – Letter to NHSE outlining SaTH's post EPRR Confirm and Challenge Annual Assurance Position.		

1.0 Introduction

In July 2025, NHSE confirmed that there would be changes to the Annual Confirm and Challenge process this year, whereby, if Trusts were assessed as “Fully Compliant” with any of the 62 Standards, additional evidence would not be required.

However, where Trusts proposed to move up from last year’s position, evidence was requested and was subsequently submitted to the NHS Futures Platform.

The Trust proposed, and it was accepted by STW ICB and NHSE, that the following standards would be moved from **Partial to Full** compliance this year:

Core Standard	Rational for moving from partial to full compliance	Comments from NHSE and STWICB
CS05 EPRR Resource	The EPRR Team now consists of an Emergency Planning Manager, an Emergency Planning and Business Continuity Officer and a Resilience and Emergencies Practitioner Degree Apprentice has been appointed.	Full Compliance Accepted. The trust received some observational comments which will be incorporated into plans as they are updated.
CS19 Excess Fatalities	The Trust has developed a stand alone Excess Deaths Plan. West Mercia Local Resilience Forum and partners (including SaTH) have developed a Mass Fatalities Plan this year. Pathology Business Continuity Plan covers additional body storage solutions.	Challenge Accepted by STW ICB and NHSE.
CS22 EPRR Training	Despite the Training pause and continued operational demands, the EPRR Training and Exercising Programme has continued. The EPRR Team have developed and will continue to develop online training modules during 2025/26.	Additional evidence was submitted (LMS Screenshots) and the challenge was accepted by STW ICB and NHSE.
CS33 Warning and Informing	SaTH Communications Team have developed this plan.	This was tested during Exercise Jupiter and the learning and Post Exercise Report will be shared in due course to evidence that the Strategic Commander, the Incident Command Centre (Tactical Commanders) and the Communications Team

		rehearsed this plan during the exercise. This was one of the Learning outcomes of the exercise which can be found in the Joining Instructions and slides uploaded onto NHSE Futures.
CS34 Incident Communications Plan	SaTH Communications Team have developed this plan and the document was provided as evidence.	Additional evidence was requested of who the named media spokespersons were, commentary was received from the organisation that all Executives are trained spokespersons. Self-declarations were submitted to NHSE Futures as Evidence.
CS35 Communication with Partners and Stakeholders	SaTH Communications Team have developed this plan.	Observational comments were received from STW ICB and NHSE and will be incorporated into the plan reviews.
CS36 Media Strategy	SaTH Communications Team have developed this plan.	This has been signed off, the Trust will remove the refence to DRAFT in the Title. This has been uploaded to NHSE Futures as Evidence.
CS43 Information Sharing	The Trust has Information Governance Arrangements in place and an LRF Information Sharing Protocol is in place (developed in 204/25).	

The NHSE Core Standards for EPRR that the Trust proposes to Self- Assess as **Partially** Compliant are as follows:

Core Standard	Rational for moving from partial to full compliance	Action to be taken
CS21 Trained on Call Staff	As a result of operational demands, Tactical Commanders are not always able to attend training and exercises.	Strategic, Tactical and Operational Commanders have been offered further training opportunities which have

		been endorsed by the COO/ AEO.
CS24 Responder Training	As a result of operational demands, Tactical Commanders are not always able to attend training and exercises.	Strategic, Tactical and Operational Commanders have been offered further training opportunities which have been endorsed by the COO/ AEO.
CS37 LHRP Engagement	NHSE require the COO/ AEO or a Trust Board member to attend at least 1 LHRP meeting per year. The DCOO has been given delegated authority to attend on behalf of the COO/ AEO.	COO/ AEO/ deputy will ensure attendance at these meetings.
CS43 Information Sharing	NHSE have requested further evidence to support this standard. arrangements.	The EPRR Team will work with the Information Governance Team and the Local Resilience Forum Information Sharing Group to further develop and formalise Information Sharing arrangements. Exercise Tollard (24th February 2025) tested the system wide information sharing and vulnerable people agreements (this was led by Shropshire and Telford & Wrekin Local Authorities).
CS49 Data Protection and Security Toolkit	SaTH are working through an improvement programme during 2025-26.	The EPRR Team will work with the Digital and IG Team to support the assessment process.

Colleagues from across the Trust have supported in the development of contingency plans and have committed to attending relevant meetings, training and exercising opportunities to support in the fulfilment the gaps outlined above (CS21, CS24, CS49, CS27).

2.0 Core Standards for Emergency Preparedness, Resilience and Response Annual Assurance Process.

In accordance with the requirements laid out in the EPRR 2025-2026 Assurance Process Letter (15.07.2025), the overall level of compliance is based on the percentage of standards that the Trust is Fully Compliant with.

The Trust submitted 61 pieces of evidence in support of the submission on 30.08.2025 which were rigorously scrutinised by NHSE and several areas for improvement were identified. Following the Confirm and Challenge Process which took place on 20.10.2025, SaTH was assessed as Substantially Compliant as follows:

Post Confirm and Challenge Scores 2025/26:

	Fully Compliant	Partially Compliant	Non-Compliant	Compliance
2025/2026	57	5	0	91%
2024/2025	51	11	0	82%
2022/2023	29	33	0	47%

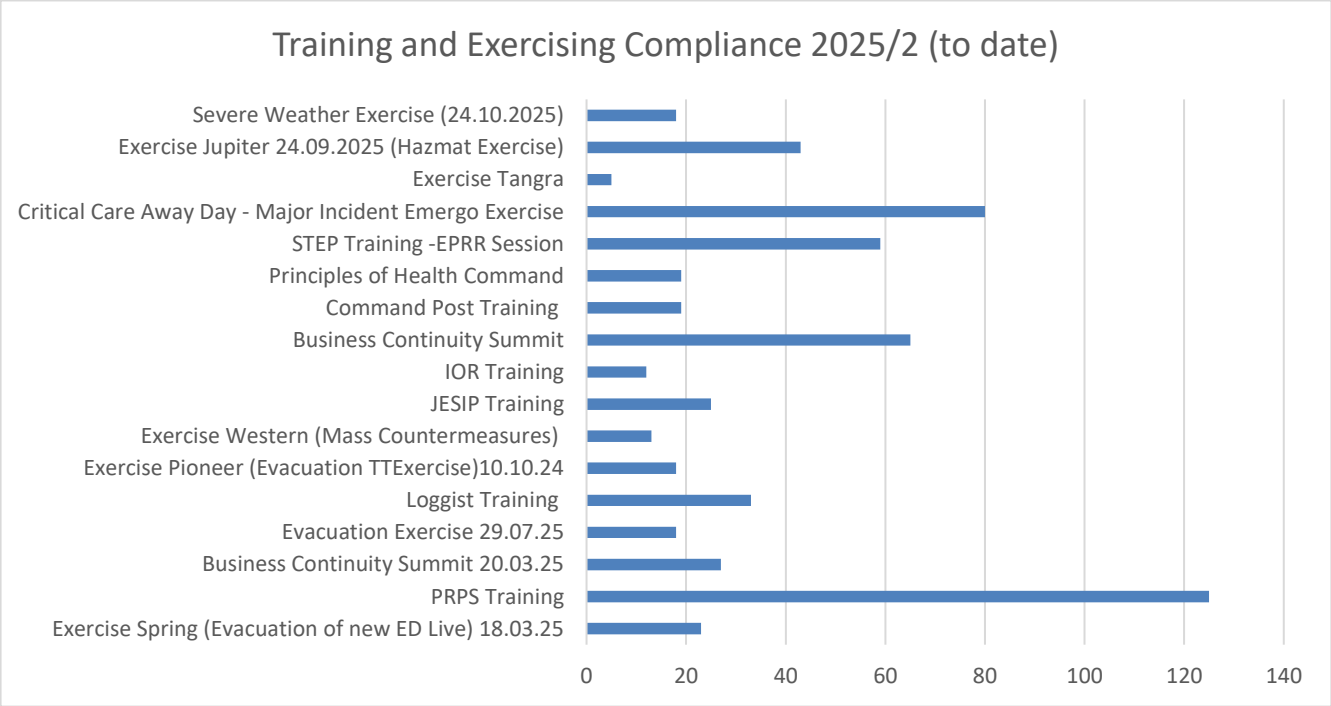
The EPRR team have developed and adhered to a robust and comprehensive work and improvement plan during 2026/27 to maintain the position of Substantial Compliance into 2026/27.

3.0 2025/26 Deep Dive

NHSE confirmed that there was **no** Deep Dive Assessment as part of the NHSE Core Standards process in 2025.

4.0 Training and Exercising Compliance

In line with Core Standard #3: EPRR Trust Board Reports, the annual report must include details of Training and Exercising that the trust has carried out during 2025/2026. The details of this can be found below:



5.0 EPRR Resource

The Trust maintains resources to support on call mechanisms and incident response in line with NHSE Core Standard for EPRR 05.

During 2024/2025, the Trust re-structured the On Call system (through a formal Management of Change process), whereby a cadre of Flow Matrons were appointed and the role of the Senior Manager on Call role was changed to a Tactical Commander Role, whereby their responsibilities are to respond to Major, Critical and Business Continuity incidents whilst the Operational Commanders are responsible for Capacity and Flow.

The Trust's Incident Response workforce resource is as follows:

Role	Number of Trained Staff
Executives on Call (Strategic Commanders)	15
Tactical Commanders	26 (reduced from 46 prior to the Management of Change process)
Operational Commanders	5
PRPS Train the Trainers	7
PRPS Wearers	125
Loggists	33

6.0 The impact of Industrial Action and Critical, Major and Business Continuity Incidents

5.1 The ability for both Operational Teams and Clinical Teams to fully commit time and resources to the EPRR Work Programme has been adversely affected by planning for and responding to ongoing Industrial Action (Resident Doctors and Consultants).

The Trust has also declared and responded to several Critical and Business Continuity Incidents during 2024/25 which continues to limit capacity for EPRR activities. Since the previous report these are outlined below.

Date Incident Declared	Date Incident Stood Down	Reason for Incident Declaration
26.09.2024	NA	Flood PRH ED
27.09.2024	NA	Car Vs Hummingbird
16.10.2024	NA	BC Standby- ITU UPS Failure
16.10.2024	NA	CI Standby- Capacity
21.10.2024	NA	Powys Train Collison
18.11.2024	NA	Blackstart Exercise
03.01.2025	04.01.2025	CI Capacity
22.03.2025	23.03.2025	Business Continuity Incident - IT and telephone failure
11.05.2025	11	Critical Incident - Bleep Downtime
03.06.2025	12.06.2025	Business Continuity Incident Bleep Downtime
23.06.2025	24.06.2025	Critical Incident - Flooding/ Burst Water Main at PRH

7.0 Business Continuity Policy and Major Incident Policy

The summary of the development of the Trust's Departmental BCP's can be found below from 01/01/2024-20/10/2025.

Monitoring & Evaluation Dashboard @ 30/06/2025			
Key Performance Indicators	**Target 2025**	**Achieved 2025**	**% Achieved 2025**
Target for BCPs submission for review	104	95	91
No of BCPs reviewed	70	82	117
No BIA reviewed	70	82	117
No of BCP Internal audits done	33	35	106
No of new BCPs written (Datix, waste, bleep, ICNET)	8	16	200
No of BCP exercise	8	7	88
No of BCP leads Trained on BC awareness and toolkit	15	32	213
No of Tactical and Strategic commanders Trained on BC Awareness	10	8	80
No of people at BCP exercise/workshop	24	58	242
Number of Business Continuity Summits	1	1	100

In line with the NHSE EPRR Core Standard 44, the Trust Business Continuity Policy (EPRR003) must be approved by the Trust Board in order to achieve full compliance. This Policy was signed off at the Public Trust Board in January 2025 and is extant until 2028.

The Major Incident Policy has also been amended to reflect the observational comments from NHSE in 2025 along with the requirements of the guidance documents. This requires sign off at Board in order to achieve full compliance in this standard and this was signed off at the Public Trust Board in January 2025 and is extant until 2028.

8.0 Conclusion

8.1 The Trust proposes to assess itself fully compliant with 57 of the 62 Core Standards applicable to Acute Trusts and partially compliant with 5 of these standards. Improvements to achieve increased compliancy for the following NHSE Core Standards for EPRR are in development and will be included in the 2025/26 EPRR Work programme.

The NHSE Core Standards for EPRR that the Trust proposes to Self-Assess as Partially Compliant are as follows:

CS21 Trained on Call Staff
CS24 Responder Training
CS37 LHRP Engagement
CS43 Information Sharing
CS49 Data Protection and Security Toolkit

Progress against all of the NSE Core Standards for EPRR will be tracked and monitored closely, and any areas of concern will be highlighted to the COO and DCOO through 1:1's.

APPENDIX A

Core Standard Reference	NHS Futures Document Naming Convention	Narrative for Futures	Uploaded to Futures YYYY MM DD
N/A	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 000 - 202507 nhs-core-standards-for-eprr-2025-template-v2.4 SaTH Self Assessment	SaTH Proposed Self Assessment Position 2025	2025 08 28
Core Standard 05 - EPRR Resource	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 001 SaTH-signed-Annual-Report-and-Accounts-2024-25-FINAL-2	See pages 121 and 122 of the Annual Report and Accounts	2025 08 28
Core Standard 05 - EPRR Resource	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 002 - EPRR policy statement	EPRR Policy includes the detail of the EPRR resource, this is scheduled to be signed off at Public Trust Board See email from Beverley Barnes on 09.01.2025.	2025 08 28
Core Standard 05 - EPRR Resource	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 003 - Annual Report	See section 5.0 of the report	2025 08 28
Core Standard 05 - EPRR Resource	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 004 - SaTH Annual Report Minutes of the Public Board Meeting	In line with Core Standard 1, the role of the AEO is noted in the Board Report. In line with Core Standard 5, Governance arrangements and EPRR resourcing are included in the Board Report. In line with Core Standard 22, EPRR Training is included in the Board Report In line with Core Standard 25, The number of staff trained are included in the Board Report In line with Core Standard 44, the BCMS has been signed off by the Trust Board in January 2025. In line with Core Standard 50, the BCMS is noted in the Board report. In line with Core Standard 51, the evidence of BC audits are included in the Board report. In line with Core Standard 64, details of staff trained to undertake and recognise decontamination are included in the Board report.	2025 08 28
Core Standard 05 - EPRR Resource	2025 - NHS -SaTH - EPRR - Core Standards - Evidence DOC005 - Tactical Commander Management of Change Document	The SOP clearly outlines the roles and responsibilities of the Strategic, Tactical and Operational Commanders	2025 08 28
Core Standard 05 - EPRR Resource	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 006 - SaTH Tactical Commander SOP	The SOP clearly outlines the roles and responsibilities of the Strategic, Tactical and Operational Commanders	2025 08 28
Core Standard 05 - EPRR Resource	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 007 - Resilience and Emergencies Practitioner Job Description and Person Specification	Resilience and Emergencies Practitioner JD and Person Specification has been uploaded to Futures . There is a requirement of the standard for the EPRR Policy to be approved by the Board - this was approved on 16.01.2025 as per	2025 08 28
Core Standard 19 - Excess Fatalities	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 008 - WMLRF Mass Fatalities Framework v1	The WMLRF Mass Fatalities Framework includes details of SaTH's partnership , roles and responsibilities as an LRF Partner. The Framework details of the locations and capacity for managing Mass Fatalities incidents (see page 33 and page 39). Triggers for activation can be found on page 8. Details for activating REMA and NEMA can be found on pages 26 and 37. Arrangements for managing BAU alongside DVI can be found 11. Security and the measures for movement of bodies can be found on page 20.	2025 08 28
Core Standard 19 - Excess Fatalities	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 009 - SaTH Excess Deaths Plan	This plan has been developed in line with the West Mercia LRF MassFatalities Framework and the Pathology BCP. See Evidence DOC008 and DOC010	2025 08 28
Core Standard 19 - Excess Fatalities	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 010 - SaTH Pathology BCP	Page 11 details the arrangements for transfer of patents in the event of a loss/ reduction of mortuary provision.	2025 08 28
Core Standard 22 - EPRR Training	2025 - NHS -SaTH - EPRR - Core Standards - Evidence DOC 005 - Tactical Commander Management of Change Document	Training needs processes set out in Policy Training Needs Assessment completed - See Page 1 Named roles match those in response - See Page 1 Courses for Tactical Commanders are included in the SOP Training materials Training Records Training is reported to Trust Board	2025 08 28
Core Standard 22 - EPRR Training	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 003 - Annual Report	Training is reported to Trust Board - See section 3.0 of Board Report.	2025 08 28
Core Standard 22 - EPRR Training	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 011 2024_2025 Training Records Amalgamated	See attached Excel Spreadsheet	2025 08 28
Core Standard 22 - EPRR Training	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 009 SOP On call roles and responsibilities 16.07.25-Final version	Courses for Tactical Commanders are included in the SOP	2025 08 28
Core Standard 33 - Warning and Informing	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 015 - Incident Communications Plan Approved V3 January 2025	Propose Full Compliance The Document has been ratified at Trust Board. Roles and responsibilities can be found on page 5. Stakeholder, staff and patient communications can be found on Page 7 and page 12/ throughout. Arrangements for training for on call participants can be found on page 10.	2025 08 28
Core Standard 33 - Warning and Informing	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 018 - WMLRF Warning & Informing Framework V1.2	Initial holding statements can be found on page 12	2025 08 28
Core Standard 34 - Incident Communication Plan	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 016 - EPRR Communications Toolkit for on call managersv2 (2)	Process for accessing Holding Statements can be found on Page 3 and examples can be found on Page 4.	2025 08 28
Core Standard 34 - Incident Communication Plan	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 017 - WMLRF Communication Cell Protocol V1.0	The document sets out Multi Agency Roles and Responsibilities.	2025 08 28
Core Standard 35- Communication with Partners and Stakeholders	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 015 - Incident Communications Plan Approved V3 January 2025	Propose Full Compliance Stakeholder communications can be found on Page 7	2025 08 28
Core Standard 36- Media Strategy	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 015 - Incident Communications Plan Approved V3 January 2025	Propose Full Compliance See reference to the STWICB Media Strategy on Page 3	2025 08 28
Core Standard 36- Media Strategy	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 017 - WMLRF Communication Cell Protocol V1.0	Sign off arrangements can be found on page6	2025 08 28
Core Standard 36- Media Strategy	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 019 - WMLRF Communications Lead Responder Protocol V1.0	This document outlines the lead responders responsible for Warning, Informing and educating the public about risks and civil protection matters.	2025 08 28
Core Standard 43- Information Sharing	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 020 - WMLRF Information Sharing Protocol	Propose Full Compliance Agreement and decision making process for sharing information can be found on page 6	2025 08 28
Core Standard 43- Information Sharing	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 021 - Exercise Tollard Presentation	Exercise Tollard tested the Vulnerable People and Premises Plan. This included how vulnerable person's data is shared across organisations in the event of an incident.	2025 08 28
Core Standard 43- Information Sharing	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 022 - Exercise Tollard Debrief Report	Exercise Tollard tested the Vulnerable People and Premises Plan. This included how vulnerable person's data is shared across organisations in the event of an incident.	2025 08 28
Core Standard 46 - Business Impact Assessment	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 012 - EPRR003 - Business Continuity Policy v11 2025	S46 Find supporting evidence in the BC policy page 11-15 covering the business continuity overview which establishes the annual review and format of BIAs, describes what assessment to use and how to administer a BIA at corporate, divisional and departmental levels. The document also describes the different types of BIA e.g. initial, incident, products, services, process, and activities that a BIA may focus on while ensuring that all key risk dependencies are linked within the BIA.	2025 08 28

Core Standard 46 - Business Impact Assessment	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 013 - EPRR004- SaTH Business Continuity Management System V2 2025	S46 Find supporting evidence on page 16, detailing a bottom-up approach for gathering information for BIA process. Page 21 details how people, building, products/suppliers, communication, utilities, IT, severe weather & process will be analysed. The document provides guidance for the BIA writing in a trust template for uniformity across the trust. The document explains how the BIA process links BCP management strategic Plan, Do, study Act.	2025 08 28
Core Standard 46 - Business Impact Assessment	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 014 - EPRR014 SaTH Corporate BCP V1 2025- Final	CS46 Find supporting evidence on page 13 template for reporting BC incidents, identification and scoring of trust critical services. description levels of disruptions explained on page 21.	2025 08 28
Core Standard 46 - Business Impact Assessment	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 023 - BCP Matrix	S46 Find supporting evidence showing key performance indicators. Number of BIA reviewed.	2025 08 28
Core Standard 46 - Business Impact Assessment	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 024 - Service Evaluation Report Careflow	S46 Find supporting evidence on how the trust use service evaluation study, debrief report and action logs to inform the review of BIA, BCPs and work programme.	2025 08 28
Core Standard 46 - Business Impact Assessment	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 025 - Critical Digital Systems BIA (Datix)	S46 Find supporting evidence on how the maximum period of disruption aligns with suppliers BCP and the internal contingences in place	2025 08 28
Core Standard 46 - Business Impact Assessment	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 026 - Digital Systems Summary	S46 Find supporting evidence on how the maximum period of disruption aligns with suppliers BCP and the internal contingences in place	2025 08 28
Core Standard 46 - Business Impact Assessment	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 027 - BCP Audiology	S46 Find supporting evidence on how itemed BIA process in Policy, BCMS have been used to develop a plan including BIA in the plan.	2025 08 28
Core Standard 46 - Business Impact Assessment	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 028 - BCP T&O	S46 Find supporting evidence on how itemed BIA process in Policy, BCMS have been used to develop a plan including BIA in the plan.	2025 08 28
Core Standard 46 - Business Impact Assessment	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 029 - BCP Waste	S46 Find supporting evidence on how itemed BIA process in Policy, BCMS have been used to develop a plan including BIA in the plan.	2025 08 28
Core Standard 46 - Business Impact Assessment	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 030 - BCPCardio Respiratory	S46 Find supporting evidence on how itemed BIA process in Policy, BCMS have been used to develop a plan including BIA in the plan.	2025 08 28
Core Standard 58 - Hazmat/ CBRN Planning Arrangements	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 031 - At the request of STWICB and NHSE CBRN Plan final version 2025	Additional evidence item that NHSE/STW ICB would like to see during this year's Core Standards process, in addition to those where you wish to improve the position of an individual standard. This contains any plans where a consultation has identified a potential challenge in terms of compliance with the standards. It also contains standards against which the organisation has failed in any aspect(s) over the past year (e.g., failed to follow the correct alerting process). To note, if an organisation moves a challenged item from full to partial in its assessment they would not be required to submit evidence against this.	2025 08 28
Core Standard 16 - Evacuation and Shelter	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 032 - At the request of STWICB and NHSE SaTH EPRR 006 - Evacuation And Shelter Plan V3.0 2025	Additional evidence item that NHSE/STW ICB would like to see during this year's Core Standards process, in addition to those where you wish to improve the position of an individual standard. This contains any plans where a consultation has identified a potential challenge in terms of compliance with the standards. It also contains standards against which the organisation has failed in any aspect(s) over the past year (e.g., failed to follow the correct alerting process). To note, if an organisation moves a challenged item from full to partial in its assessment they would not be required to submit evidence against this.	2025 08 28
Core Standard 18 - Protected Individuals	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 033 - At the request of STWICB and NHSE SaTH 2025 Protected Indviduals_VIP Plan Final	Additional evidence item that NHSE/STW ICB would like to see during this year's Core Standards process, in addition to those where you wish to improve the position of an individual standard. This contains any plans where a consultation has identified a potential challenge in terms of compliance with the standards. It also contains standards against which the organisation has failed in any aspect(s) over the past year (e.g., failed to follow the correct alerting process). To note, if an organisation moves a challenged item from full to partial in its assessment they would not be required to submit evidence against this.	2025 08 28
Core Standard 13 - New and Emerging Pandemics	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 034 - At the request of STWICB and NHSE EPRR011 SaTH New & Emerging Pandemics 2025	Additional evidence item that NHSE/STW ICB would like to see during this year's Core Standards process, in addition to those where you wish to improve the position of an individual standard. This contains any plans where a consultation has identified a potential challenge in terms of compliance with the standards. It also contains standards against which the organisation has failed in any aspect(s) over the past year (e.g., failed to follow the correct alerting process). To note, if an organisation moves a challenged item from full to partial in its assessment they would not be required to submit evidence against this.	2025 08 28
Already included	SaTH Corporate BCP V1 2025- Draft 2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 014 - EPRR014 SaTH Corporate BCP V1 2025- Final	Additional evidence item that NHSE/STW ICB would like to see during this year's Core Standards process, in addition to those where you wish to improve the position of an individual standard. This contains any plans where a consultation has identified a potential challenge in terms of compliance with the standards. It also contains standards against which the organisation has failed in any aspect(s) over the past year (e.g., failed to follow the correct alerting process). To note, if an organisation moves a challenged item from full to partial in its assessment they would not be required to submit evidence against this.	2025 08 28
Core Standard 10 - Incident Response Core Standard 15 - Mass Casualty	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 035 - SaTH Major Incident and Mass Casualty Plan 2025 V8.1 FINAL	Additional evidence item that NHSE/STW ICB would like to see during this year's Core Standards process, in addition to those where you wish to improve the position of an individual standard. This contains any plans where a consultation has identified a potential challenge in terms of compliance with the standards. It also contains standards against which the organisation has failed in any aspect(s) over the past year (e.g., failed to follow the correct alerting process). To note, if an organisation moves a challenged item from full to partial in its assessment they would not be required to submit evidence against this.	2025 08 28
Core Standard 12 - Infectious Diseases	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 036 - At the request of STWICB and NHSE EPRR010 SaTH Human Infectious Disease Plan 2025	Additional evidence item that NHSE/STW ICB would like to see during this year's Core Standards process, in addition to those where you wish to improve the position of an individual standard. This contains any plans where a consultation has identified a potential challenge in terms of compliance with the standards. It also contains standards against which the organisation has failed in any aspect(s) over the past year (e.g., failed to follow the correct alerting process). To note, if an organisation moves a challenged item from full to partial in its assessment they would not be required to submit evidence against this.	2025 08 28
N/A	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 037 - COO AEO Sign off of pre - EPRR Core Standards Confirm and Challenge Postition	Supplimentary Evidence - Approval from COO/ AEO regarding proposed EPRR Core Standards Self Assessment	2025 08 28
N/A	2025 - NHS - SaTH - EPRR - Core Standards - Evidence DOC 038 - 2025 08 25 Pre Core Standards Meeting with COO _ SaTH Proposed Self Assessment Position 2025	Supplimentary Evidence - Slides from meeting with COO/ AEO and DCOO outlining the proposed Trust SelfAssessment incliuding the raationale for pgrading/ dwngrading standards	2025 08 28
Additional Evidence			
Core Standard 05 - EPRR Resource	2025 - NHS - SaTH - EPRR - Core Standards - Evidence Doc 040 - Approved Board Report Minutes2025.01.16 PUBLIC Minutes - Final Approved	EJB Contacted the Trust Board Co-Ordinator and the Minutes with the DRAFT Watermark removed have been uploaded to NHS Futures	2025 10 14
Core Standard 10 - Incident Response	2025 - NHS - SaTH - EPRR - Core Standards - Evidence 041 - BB-OBS	Trust SOP for "Ordering Blood Components Online"	2025 10 14
Core Standard 10 - Incident Response	2025 - NHS - SaTH - EPRR - Core Standards - Evidence 042 - RECBC	Trust SOP for "Receiveing Blood Components"	2025 10 14
Core Standard 10 - Incident Response	2025 - NHS - SaTH - EPRR - Core Standards - Evidence 043 - 20241022-IGG05 Information Sharing Guidance v1.0-DRAFT	Trust Information Sharing Guidance	2025 10 14
Core Standard 13 - New and Emerging Pandemics	2025 - NHS - SaTH - EPRR - Core Standards - Evidence 044 - Exercise Pegasus - workbook development	See email attached from Kath Titley (Head of Health and Safety) in relation to the Trust response to Exercise Pegasus workbook and input on 23.09.25	2025 10 14
Core Standard 13 - New and Emerging Pandemics	2025 - NHS - SaTH - EPRR - Core Standards - Evidence 045 - EPRR011 SaTH New & Emerging Pandemics 2025 V2.1	Updated document uploaded	2025 10 14
Core Standard 15 - Mass Casualty	2025 - NHS - SaTH - EPRR - Core Standards - Evidence 046 -SaTH ACC Surge Plan 25_26 V1.4	Document uploaded	2025 10 14
Core Standard 22 - EPRR Training	2025- NHS - SaTH - EPRR - Core Standards - Evidence 047 - Command Post Exercise Welcome Brief	Additional Evidence - Tactical Commanders Command Post Training	2025 10 14
Core Standard 22 - EPRR Training	2025 - NHS - SaTH - EPRR - Core Standards - Evidence 048 - 2025 10 06 Tactical Commanders Training	Additional Evidence - Tactical Commanders Training	2025 10 14
Core Standard 22 - EPRR Training	2025 - NHS - SaTH - EPRR - Core Standards - Evidence 049 - Feedback Evaluation Forms	Additional Evidence - Feedback forms uploaded to NHS Futures	2025 10 14
Core Standard 16 - Evacuation and Shelter	2025 - NHS - SATH - EPRR - Core Standards - Evidence 050 - 024 10 10 Evacuation and Shelter Exercise EJB	Additional Evidence - Evodence of Evacuation and Shelter Exericse in the last 3 years uploaded to NHS Futures	2025 10 14

Core Standard 15 - Mass Casualty	2025 - NHS - SaTH - EPRR - Core Standards - Evidence 051 - 2025 08 30 SaTH Major Incident and Mass Casualty Plan 2025 V8.1	Additional Evidence - updated document uploaded to NHS Future	2025 10 14
Additional Evidence Post Confirm and Challenge Meeting			
Core Standard 36 - Warning and Informing - Media Strategy	2025 - NHS - SaTH - EPRR - Core Standards - Evidence 052 - 2025 02 06 EPRR Communications Toolkit for on call managers	6	2025 10 22
Core Standard 36 - Warning and Informing - Media Strategy	2025 - NHS - SaTH - EPRR - Core Standards - Evidence 015 - Incident Communications Plan Approved V3. January 2025 **n.b. this was submitted in August - see line 21 above.**	Additional Evidence - See page Page 5 of the attached states that "On Call participants will be provided with media and communications training every two years to support this element of their on-call role". Page 8 states that: The Chief Communications Officer will work with the Executive Lead/Executive On Call Lead to identify media spokespeople within the organisations involved in the incident. These will be Executive level professionals, unless delegated spokespeople are agreed by the Executive Lead and Chief Communications Officer. They should all receive media training to support their ability to respond. Key individuals include: •Medical Director, John Jones •Interim Chief Nurse, Paula Gardner •Chief Operating Officer, Ned Hobbs •Director of Strategy and Partnerships, Nigel Lee. Page 9 states that: Depending on the nature of the incident •Interim Chief Executive Officer, Jo Williams •Assistant Chief Executive Officer, Inese Robotham •Director of Finance, Helen Trosalen •Director of People, Rhia Boyode •Director of Governance, Anna Milanec	2025 10 22
Core Standard 36 - Warning and Informing - Media Strategy	2025 - NHS - SaTH - EPRR - Core Standards - Evidence 053 -Media Training Signed Form John Jones	Additional Evidence - Medical Director Self Certification of Media Training	2025 10 29
Core Standard 36 - Warning and Informing - Media Strategy	2025 - NHS - SaTH - EPRR - Core Standards - Evidence 054 - Re EPRR Assurance - Confirm and Challenge - SATH and Letter for Signature - Confirmation of Company Used	Email from the Chief Communications Officer confirming that the training company was Lodestone.	2025 10 29
Core Standard 36 - Warning and Informing - Media Strategy	2025 - NHS - SaTH -EPRR - Core Standards - Evidence 055 - Self-Declaration form (1) Communications Training Nigel Lee 29.10.2025	Additional Evidence - Director of Strategy and Partnerships Self Certification of Media Training	2025 10 29
Core Standard 36 - Warning and Informing - Media Strategy	2025 - NHS - SaTH - EPRR - Core Standards - Evidence 056 - Self Declaration - Communications Training Ned Hobbs COO_AEO_ Screenshot 2025-10-29 113725	Additional Evidence - COO and AEO Self Certification of Media Training	2025 10 29

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
13 November 2025

Agenda item		175/25		
Report Title		Safeguarding Children and Young People Policy		
Executive Lead		Paula Gardner, Interim Chief Nursing Officer		
Report Author		Teresa Tanner, Lead Nurse for Safeguarding Children & Young People		
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		Quality & Safety Assurance Committee, 30 September 2025 Quality Operational Committee Safeguarding Assurance Committee		
Executive summary:		The Safeguarding Children and Young People Policy has been subject to its annual review, and has been amended to ensure the format is consistent with the Safeguarding of Adults Policy. Following review by the Quality and Safety Assurance Committee (QSAC) at its meeting on 30 September 2025, the Committee is recommending approval to the Board.		
Recommendations for the Board:		The Board of Directors is asked to **approve** the Safeguarding Children and Young People Policy.		
Appendices:		Appendix 1: Safeguarding Children and Young People Policy		

Safeguarding Children and Young People Policy

Doc ID: 1119

Additionally refer to:

CG 26 Managing Allegations against Staff who work with Children and Young People
CG15a - Safeguarding Children Supervision Framework
Prevent Policy
W4 - Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy
ID 2478: Domestic Abuse
ID 45: Disclosure and Barring Service Checks Policy

Original Version	November 2008		
Version	14		
Date issued	September 2025		
Approved by	Safeguarding Assurance Committee	Quality and Safety Assurance Committee	Policy Approval Group
Date approved			
Ratified by	Trust Board		
Date ratified			
Document Lead	Lead Nurse for Safeguarding Children & Young People		
Lead Director	Interim Chief Nursing Officer		
Review date	September 2028		
Target Audience	All staff, employees and volunteers		

Document Control Sheet

Document Lead/Contact:	Named Nurse, Lead Nurse Safeguarding Children and Young People
Document ID	
Version	14
Status	Final
Date Equality Impact Assessment completed	14.01.2025
Issue Date	
Review Date	May 2028
Distribution	Please refer to the intranet version for the latest version of this policy. **Any printed copies may not necessarily be the most up to date**
Key Words	Child Abuse, Safeguarding, Child Protection
Dissemination Process	Operational Safeguarding Group, Training, Intranet.

Version history

Version	Item	Date	Author	Status	Comment
V1		Nov 08	T Tanner	Draft	
V2		June 2010	T Tanner / F Hinde		Additions of Discharge and failure to attend appointments
V3		Dec 2011	T Tanner / F Hinde		Policy reviewed
V4		March 2015	T Tanner / F Hinde		Policy reviewed, dates changed, additions made to Supervision and TNA updated
V5		Jan 2016	T Tanner		Addition of definitions of FGM, Human Trafficking. Prevent
V6		April 2018	T Tanner		Amendment to missed appts. Taking out PLHV
V7		October 2020	T Tanner / Alison Belfitt		Legislation up dated Policy reviewed

V8		November 2021	T Tanner / S Browne / A Belfitt		Updated in view of DA Act 2021, TNA and Looked After Ch
V9		October 2022	T Tanner / A Cowley / T Parsons. K Davies and children		Review CSE / CCA. Include Voice of the Child and the Not Brought to Appts considering Covid. Voice of the child
V10		September 2023	T Tanner		Annual Review. Addition of bruising in non mobile babies
V11		December 2024	T Tanner		Added information about condition 31 to policy Reviewed by NHS England Safeguarding West Midlands Lead and approved.
V12		May 2025	T Tanner		Comments from Non-Executive Directors noted
V13		July 2025	T Tanner		Reviewed and approved by Head of Information Governance & Data Protection. Service Managers for Telford & Wrekin and Shropshire Children's Social Care
V14		September 2025	T Tanner		Policy split into Policy and Procedures to be consistent with adult policy

Contents

The Voice of the Child

As a Trust we have spoken to Children and Young People who have been In Patients and asked them what they think the staff should be doing to keep them safe.

Adults working in our Trust will always try and keep our Children and Young People safe.

With special thanks to Lacey 12, Holly 13, Courtney 17, Will 14, Daisy 14, Eleanor 16 and Sam 11 and Kerry, Youth Worker for her help with this project

1 Policy on a Page

1.1 This document is designed for all staff working within The Shrewsbury and Telford Hospital NHS Trust, to help them to recognise and respond to cases of abuse and neglect of children and young people and are intended to reflect the Safeguarding Guidelines for Telford & Wrekin, Shropshire and Powys Safeguarding Community Partnerships. This document relates to young people aged from birth to the day before their 18th birthday.

1.2 Working Together to Safeguard Children: A Guide to Inter-agency Working to Safeguarding and Promote the Welfare of Children (2023) (Working Together 2023) sets out how professionals should work together in multi-agency team to promote children's welfare and protect them from abuse.

1.3 The Children Act 2004, as amended by the Children and Social Work Act 2017, strengthens this already important relationship by placing new duties on key agencies in a local area. Specifically, the Police, Integrated Care Board and the Local Authority are under a duty to plan to work together, and with other partners locally, to safeguard and promote the welfare of all children in their area.

1.4 Everyone who encounters children and families has a role to play in keeping children safe.

1.5 Safeguarding and promoting the welfare of children is defined for the purposes of this guidance as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care
- taking action to enable all children to have the best outcomes and hear their voice.

(Working Together To Safeguard Children HM Govt 2023)

1.6 All services must be provided in a manner that respects dignity, privacy and beliefs of all individuals concerned and does not discriminate based on race, gender, language, sexual orientation or disability.

1.7 When communication with a child is necessary for the purpose of safeguarding and the first language is not English, an interpreter must be used and not a family member.

1.8 The responsibility to refer children to Children's Social Care considered to be at risk, rests with the professional who has the concern and not the Named / Lead Professionals.

2 Scope

The contents of this policy will apply to all staff and volunteers working within the Trust. This includes agency staff and all contractors.

3 Purpose

3.1 The purpose of this policy is to ensure that all child protection and safeguarding issues identified within the Trust are reported and referred professionally and that effective and appropriate action is taken to always ensure the welfare of all children by all staff.

3.2 To help staff to take all reasonable measures to protect children and young people from abuse and neglect by:

- Early recognition of potential abuse situations so that preventive measures can be taken.
- Early identification of known or suspected abuse of children and young people (there may be firm evidence or merely suspicions and concerns)
- Taking appropriate actions at the right time.
- Co-operation with other relevant agencies to ensure the safety and wellbeing of children and young adults.
- To ensure discharge to a safe environment.

4 Framework

4.1 This section describes the broad framework for the safeguarding of children and young people throughout the Trust. Detailed instructions and definitions of types of abuse are provided in the associated procedural documents.

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

4.3 The Framework for this policy is based on the West Midlands Safeguarding Procedures https://westmids.trixonline.co.uk

5 Information

5.1 The Trust will ensure that awareness is raised within staff, patients and visitors through information via Trust intranet, internet and information leaflets about safeguarding children & young people, giving a clear message that it is everyone's responsibility and

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

6 Training

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

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

7 Governance

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

7.2 Lead Nurse for Safeguarding Children ensures supervision and monitoring of staff working with children & young people.

7.3 All staff to share information in line with the Shropshire and Telford & Wrekin Safeguarding Partnerships Information Sharing agreement through the Lead Nurse for Safeguarding Children & Young People.

7.4 All staff to participate in joint working with other agencies in investigations and actions to protect adults at risk of abuse through the Lead Nurse for Safeguarding Children & Young People.

7.5 Safeguarding Children Team to contribute to Safeguarding assessments/enquiries through attendance at multi agency strategy meetings

7.6 Lead Nurse for Safeguarding Children to attend meetings of the Shropshire and Telford & Wrekin Safeguarding Partnerships

7.7 Lead Nurse for Safeguarding Children to contribute to the annual safeguarding report to the Board of Directors.

7.8 Lead Nurse for Safeguarding Children to ensure staff know they are protected in law if they report abuse and are concerned about their name being used (please refer to the Trust Freedom to Speak Up: Raising Concerns (Whistleblowing) policy)

7.9 All suspicions and allegations of abuse or inappropriate behaviour will be taken seriously by the Trust and responded to in line with the Managing Safeguarding Allegations against Staff who work with children and young people policy. Disciplinary Policy and its associated procedures.

7.10 Safeguarding is everyone's business, and everyone matters, and all staff and volunteers have a responsibility for reporting any suspicions or concerns of abuse or inappropriate behaviour following the Procedures for Safeguarding Children & Young People

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

7.12 The Chief Nursing Officer has established the Trust Safeguarding Operational Group to oversee the management and implementation of this policy across the Trust. The membership and roles and responsibilities of the Trust Safeguarding Operational Group are detailed in the terms of reference.

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

8 Duties

Chief Nursing Officer

The Chief Nursing Officer will.

- Sponsor the local safeguarding and control procedural documents.
- Be responsible to the Board of Directors for safeguarding children and young people within the Trust
- Provide an annual safeguarding report to the Board of Directors
- Appoint a nominated Lead Nurse / Named Nurse for Safeguarding Children & Young People

Lead Nurse for Safeguarding Children & Young People

The Lead Nurse for Safeguarding Children & Young People will.

- Ensure all policy and procedural documents are current and reflect best practice.
- Provide specialist advice concerning the safeguarding of children & young people.
- Ensure all clinical staff within the Trust have access to appropriate training in Safeguarding children & young people
- Review all Trust Incident reports related to Safeguarding children & young people and ensure examples of good practice or required changes in practice are shared throughout the Trust via the Trust Safeguarding Operational Group which will report to the Trust Safeguarding Committee.
- Ensure an accurate record of child protection cases within the Trust is maintained.
- Ensure that managers to whom safeguarding concerns are raised take appropriate action as to which route to take.
- Lead on the Domestic Abuse, Child Sexual / criminal exploitation and Sexual Safety and Violence agenda within the Trust
- The Lead Nurse for Safeguarding Children & Young People will ensure the following of the Trust Safeguarding Operational Group.
- The membership of this group is detailed in terms of reference which are approved by the Chief Nursing Officer. The Trust safeguarding operational group will be chaired by the Deputy Chief Nursing Officer and will meet on a monthly basis

- Monitor, maintain and oversee the infrastructure in order to safeguard children & young people
- Support the development and delivery of training and the provision of best practice.
- Ensure the monitoring of incidents related to the safeguarding children & young people
- Ensure the lessons learned for adverse incidents and near misses both within and external to the Trust are considered and relevant actions and changes are implemented across the organisation.
- Ensure that working practices are in line with legal and national requirements in relation to safeguarding children & young people
- Provide a quarterly report to the Chief Nursing Officer through the Safeguarding Committee and an annual report to the Board of Directors.
- Provide expert safeguarding advice particularly in relation to child protection, to the Chief Nursing Officer and thereby to the Executive team.
- Oversee and monitor the attainment and required standards of training and development for the safeguarding of children and monitor and ensure the implementation of findings from Child Safeguarding Practice Reviews (CSPRs) and Rapid Reviews

Named Doctor:

The Named Doctor will

- Support other professionals in the Trust to recognise Safeguarding Children & Young People concerns.
- To promote good practice within the Trust.
- To safeguard children & young people within the Organisation.
- To provide advice and expertise to staff.
- To provide safeguarding supervision for medical staff.
- To participate in internal management, Child Safeguarding Practice Reviews.

Director of People and OD

The Director of people and OD will:

- Develop HR policies and procedures which support safeguarding children & young people.
- Ensure appropriate background checks on prospective staff are rigorous in line with current policy and procedure and NHS Employment Checking Standards.
- Ensure HR and recruitment staff are appropriately trained and briefed on safeguarding children & young people to be able to fulfil the responsibilities within their own role and to help others detect and report.
- Provide support and advice to staff involved in safeguarding children & young people procedures where staff members may be personally involved.
- Ensure the provision of Occupational Health services and staff support.
- Attend the Trust Safeguarding Committee and report on case management concerning staff who have an allegation made against them involving the care of a child or young person
- Jointly attend multi-agency meetings with the Lead Nurse for Safeguarding Children & Young People where staff are involved

Managers

Anyone who has responsibility for staff potentially involved in the safeguarding of children & young people must ensure.

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

All Staff and Volunteers

All staff and volunteers will:

- Be vigilant to the possibility that any child or young person could be the victim of abuse.
- Adhere to the policy and associated procedural documents. In particular please see procedure for Safeguarding Children and Young People.
- Attend or complete relevant training sessions and comply with Safeguarding Mandatory training.

9 Implementation and Monitoring

Implementation

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

Monitoring

Monitoring of Implementation	Monitoring Lead	Reported to:	Monitoring process	Monitoring Frequency
Attendance/Compliance with the Local and National Safeguarding Children Training Targets for Level 2 and 3	Lead Nurse for Safeguarding Children & Young People	Trust Safeguarding Committee	Training data Training Needs Analysis	Bi-monthly
Monitoring and ensuring the implementation of findings from Child Safeguarding Practice Reviews and Rapid Reviews within the Trust.	Lead Nurse for Safeguarding Children & Young People	Trust Safeguarding Committee	Presented to Trust Operational Group and Assurance Committee	Ad hoc

10 Training

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

11 EQIA Statement

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

12 References

- HM Government (2023) Working Together to Safeguard Children: A guide to inter-agency Working to Safeguard and Promote the Welfare of Children
- NMC (2015) Code of Professional Conduct – updated in 2018 to include Nursing Associates.
- Intercollegiate Document for Looked After Children: Roles and Competencies of Health care Staff 2020
- Care Quality Commission (Registration) Regulations 2009
- Children Act 1989
- Children Act 2004
- Health and Social Care Act (Regulated Activities) Regulations 2008
- Domestic Abuse Act 2021
- Safeguarding and Protecting Children and Young People: roles and competencies for health care staff; Intercollegiate document (2020)

Appendix A: Training Needs Analysis (December 2024)

Training	Frequency	Delivery Methods	Staff Groups	Trust Target
Level 1 All staff working in healthcare settings				
Level 1 Safeguarding Children	On induction and 3 yearly	e-learning initially with Newsletter (refresh)	**All staff on induction**	100%
			3 yearly refresh for non - front facing staff. All health care staff including receptionists, administrative staff, caterers, domestic and transport staff, porters, maintenance staff, board level executives and non-executives	90%
Level 2 All staff working in healthcare who have regular contact with patients, their families or carers				
Level 2 / 3 Safeguarding Children	3 yearly (min 3hrs per 3 years)	Training needs will be met through attendance at SSU training day	To include administrators for safeguarding teams and all front facing trust staff groups, including Chaplains Medical staff with no patient/front facing contact. Nursing staff on designated adult wards	90%
Level 3 All staff working in health care who are working with Children and their Families.				
Level 3 Safeguarding Children	Annually (12-16 hours over 3 years)	Through dedicated 4 hour training session each year	All clinical staff who work with children on a daily basis. Paediatrics and Emergency Department Specialist Nurse for Safeguarding Children	90%
Level 4: Specialist roles – named professionals, safeguarding leads (and equivalent roles directly advising staff on safeguarding).				
Level 4 Safeguarding Children	3 yearly (24hrs over 3 years)	Accumulative independent training	Lead Nurse Safeguarding Children and Young People Named Doctor for Safeguarding Children	100%