The Shrewsbury and Telford Hospital NHS Trust

BOARD OF DIRECTORS' MEETING IN PUBLIC
AGENDA

Date: 12 March 2026
Time: 0930hrs – 1230hrs
Venue: Shropshire Education & Conference Centre
Group Chair: Mr Andrew Morgan

Time	Item no.	Item	Paper / Verbal	Page	Lead	Action
Procedural Items						
0930hrs	036/26	Welcome and apologies	Verbal	-	Group Chair	For noting
	037/26	Patient Story	Enc	**3**	Interim Chief Nursing Officer	For noting
	038/26	Public Questions	Verbal	-	Group Chair	For noting
	039/26	Quorum	Verbal	-	Group Chair	For noting
	040/26	Declarations of conflicts of interest	Verbal	-	Group Chair	For noting
	041/26	Minutes of the previous meeting held on 15 January 2026	Enc	**4**	Group Chair	For approval
	042/26	Action log	Enc	**31**	Group Chair	For approval
	043/26	Matters arising from the previous minutes (not covered elsewhere on the agenda or action log)	Verbal	-	Group Chair	For discussion
Reports from the Group Chair and Group Chief Executive						
1010hrs	044/26	Exit from the Recovery Support Programme	Enc	**32**	*Director of Governance	For noting
	045/26	Report from the Group Chair	Verbal	-	Group Chair	For noting
	046/26	Report from the Group Chief Executive	Enc	**36**	Group Chief Executive	For noting
Reports from Assurance Committee Chairs						
1025hrs	047/26	Audit & Risk Assurance Committee Chair's Report (February 2026)	Enc	**41**	Committee Chair	For assurance
	048/26	Quality & Safety Assurance Committee Chair's Report (Jan & Feb 2026)	Enc	**43 46**	Committee Chair	For assurance
	049/26	Performance Assurance Committee Chair's Report (Jan & Feb 2026)	Enc	**49 52**	Committee Chair	For assurance
SHORT BREAK						
1050hrs	050/26	Finance Assurance Committee Chair's Report (Jan & Feb 2026))	Enc	**55 57**	Committee Chair	For assurance
	051/26	Group People Committee Chair's Report (January 2026)	Enc	**59**	Committee Chair	For assurance
	052/26	HTP Assurance Committee Chair's Report (January 2026)	Enc	**62**	Committee Chair	For assurance
Quality & Performance						
1110hrs	053/26	Integrated Performance Report	Enc	**65**	Group Chief Executive	For noting

Assurance Framework						
1120hrs	054/26	SaTH Integrated Improvement Plan (SIIP) Report	Enc	**146**	Group Chief Executive	For noting
	055/26	Integrated Maternity & Neonatal Report	Enc	**150**	Interim Chief Nursing Officer	For assurance
	056/26	Board Maternity & Neonatal Safety Champions Report	Encs	**155**	Executive Medical Director	For assurance
	057/26	Board Assurance Framework Q3 2025/26	Enc	**157**	*Director of Governance	For approval
	058/26	Risk Management Report Q3 2025/26	Enc	**180**	*Director of Governance	For assurance
Regulatory and Statutory Reporting						
1145hrs	059/26	Bi-annual Nurse Staffing Review	Enc	**192**	Interim Chief Nursing Officer	For noting
	060/26	Patient Safety Committee Report Q3 2025/26	Enc	**224**	Executive Medical Director	For noting
	061/26	Infection Prevention & Control (IPC) Report Q3 2025/26	Enc	**228**	Interim Chief Nursing Officer	For noting
	062/26	Antimicrobial Resistance (AMR) – national call to action - Presentation	Enc	**238**	Interim Chief Nursing Officer	For noting
	063/26	Gender Pay Gap Report 2025	Enc	**253**	*Chief People Officer	For approval
Items for Consent - approval recommended from Board Committees						
1220hrs	064/26	Business Continuity Management Policy	Enc	**268**	Chief Operating Officer	For consent
Procedural Items						
1225hrs	065/26	Any other business – agreed by the Chair	Verbal	-	Group Chair	Discussion
1230hrs	066/26	Date and time of next meeting: 0930hrs on **Thurs 14 May 2026: First Public Boards Meeting in Common – SaTH & SCHT**	Verbal	-	Group Chair	Information
Close of meeting						

*Non-voting

ITEMS WITHIN THE BOARD INFORMATION PACK		
Reports / Appendices	**Lead**	**Page No.**
01 052/26 HTP Director SRO Update *March 2026*	*Director of HTP	**1**
02 054/26 SIIP Report: *Appendices 1-8*	Group Chief Executive	**12**
03 055/26 Integrated Maternity & Neonatal Report Appendices:	Int Chief Nursing Officer	
Appendix 1: Ockenden Report Action Plan		**59**
Appendix 2: Neonatal External Mortality Review (NEMR) Action Plan		**122**
Appendix 3: Phase 2 Slides		**134**
Appendix 4: CNST MIS Year 7 Final Completion Report		**138**

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
12 March 2026

Agenda item		037/26		
Report Title		EDI Midwife Impact Story (Patient Story)		
Executive Lead		Paula Gardner, Chief Nursing Officer		
Report Author		Paula Gardner, Chief Nursing Officer		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people		
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners		
Consultation Communication				
Executive summary:		The EDI Midwife has been in post for just over one year; her impact on the Communities we serve and individual patients has been tremendous Today, in Board, she will explain her role, the different groups she has experienced in our Communities and future work		
Recommendations for the Board:		The Board is asked to note this patient story		
Appendices:		N/A		

The Shrewsbury and Telford Hospital NHS Trust

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

Thursday 15 January 2026
Held in Shrewsbury Education & Conference Centre

MINUTES

Name	Title
MEMBERS	
Mr A Morgan	Group Chair
Ms J Williams	Group Chief Executive
Mrs T Boughey	Non-Executive Director
Mr R Dhaliwal	Non-Executive Director
Ms S Dunnett	Non-Executive Director
Ms R Edwards	Non-Executive Director
Ms P Gardner	Interim Chief Nursing Officer
Mr N Hobbs	Chief Operating Officer
Dr J Jones	Executive Medical Director
Mr R Miner	Non-Executive Director
Ms W Nicholson MBE	Non-Executive Director
Prof T Purt	Non-Executive Director / Vice Chair
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
Prof H Fuller	Associate Non-Executive Director
Mr N Lee	Director of Strategy & Partnerships
Ms A Milanec	Director of Governance
Ms I Robotham	Assistant Chief Executive
Mr J Sargeant	Associate Non-Executive Director
Ms B Barnes	Board Coordinator (Minute Taker)
GUEST ATTENDANCE	
Ms J Bolton	Acting Head of Midwifery *(agenda item 019/26)*
Dr R Hollands & Dr A P Naing	Guardian of Safe Working & Resident Dr Peer Lead *(agenda item 024/26)*
APOLOGIES	
Mr S Crowther	Associate Non-Executive Director

No.	ITEM	ACTION
PROCEDURAL ITEMS		
001/26	**Welcome and Apologies** The Group Chair welcomed all those present, including observing colleagues and members of the public. Apologies were noted.	
002/26	**Patient Story** The Interim Chief Nursing Officer welcomed Nick and his wife, Maggie to the meeting, to share with the Board their experiences of Nick's time as a SaTH inpatient for almost 10 months, which included over 50 days spent in Critical Care. Nick thanked all staff for their commitment, care, kindness and professionalism during his time in hospital, and he felt that the rapport he had enjoyed with such a wide variety of staff had a positive impact on his recovery. Maggie added that she had also got to know everyone who had cared for Nick over the months, and she and their family felt reassured about the care he was receiving because of the warmth of the engagement they experienced. Referring also to patient diaries, Nick stated how helpful and informative it had been to read through his own when he was on the road to recovery, which had helped him to 'complete his story/fill in the blanks' from the time when he was most unwell. Nick also shared two less positive observations with the Board. The first related to his transition from critical care to a general ward. Whilst accepting that the two environments are very different, Nick had been totally unprepared for such a radical change and he had found the level of general ward activity and noise, and clear time pressures impacting on the amount of time staff were able to spend with each patient, quite overwhelming and unsettling initially. Nick explained that he was highlighting this because he did not like to think of other patients having the same unprepared experience. Ms Gardner thanked Nick for his honesty and compassion for others in bringing this to our attention, particularly as in a pressured hospital environment, the impact of unexpected environmental change on patient morale and wellbeing can sometimes be inadvertently overlooked. She gave her assurance that Nick's words will not be forgotten and will be used to consider how we can better prepare and support patients in their transition to new and unfamiliar hospital environments so they can continue to receive a positive and caring recovery experience. Secondly, Nick wished to highlight the less than desirable patient behaviour he had witnessed towards staff on several occasions, and his concern and respect for the staff who were having to deal with such difficult situations whilst continuing to demonstrate professional composure and kindness. Ms Williams thanked Nick for his comments and concern and reassured him that the Trust	

	will continue to provide and develop any support our staff need because of poor patient behaviours. Finally, Nick wished to express sincere thanks to his consultant, Mr Mark Cheetham, all staff in Critical Care, Gastroenterology, Physiology, Nutrition, Colorectal, the Outreach Team, university students, and many more besides, stating that he and his family are eternally grateful for everything that was done by SaTH to 'put him back together'. Whilst he still has some health issues, he feels very lucky that he is here to see his grandchildren grow, and that he and Maggie can now get on with ticking items off their ever-increasing bucket list! Mr Morgan sincerely thanked Nick and Maggie for taking the time to join today's meeting to share their fantastic patient story and wished them both health and happiness for 2026 and beyond.	
003/26	**Public Questions** The Group Chair thanked members of the public who had submitted written questions in advance of today's meeting. The questions, and the responses provided at the meeting, are included at the end of these minutes, together with a question which was asked on the day.	
004/26	**Quorum** The meeting was declared quorate.	
005/26	**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.	
006/26	**Minutes of previous meeting** The minutes of the previous meeting held on 13 November 2025 were accepted and approved by the Board of Directors as an accurate record, subject to a minor addition to the last sentence of the final bullet of agenda item 158/25, as follows: 'Mrs Boughey added that she sits on an All-***Party*** Parliamentary Group ….'	
007/26	**Action Log** The action log was reviewed, and the closure of action no. 12 was agreed following an update provided by Mr Hobbs and Mr Lee on the diabetic podiatry service all-system and SaTH approach. Action no. 11 was noted as not yet due.	
008/26	**Matters arising from the previous minutes**	

	No additional matters were raised.	
REPORTS FROM THE GROUP CHAIR AND GROUP CHIEF EXECUTIVE		
009/26	**Report from the Group Chair** The Group Chair thanked SaTH colleagues for all their efforts over the festive and new year period, recognising that circumstances were made all the more difficult by the adverse weather in January. He wished to particularly commended those colleagues who had slept on-site overnight to ensure we were able to maintain services for our patients. Mr Morgan also wished to express the Board's appreciation for the support which had been provided by colleagues across the system, noting that this was welcome tangible evidence of how system working has improved. The Board of Directors **noted** the verbal report.	
010/26	**Report from the Group Chief Executive** The Board of Directors received the report from the Group Chief Executive, who summarised some of the key points and provided further updates since her report had been produced: • Acknowledgement: Ms Williams added her thanks to those of the Group Chair to all colleagues who had worked over the Christmas and New Year period, recognising their commitment to caring for our patients at a time when they could have been with their own loved ones. Also referring in particular to Christmas Eve, it had been wonderful that we were able to get so many patients home to be with their families for Christmas, and she commended the support both of our colleagues and our partners in making this possible. • Performance: Whilst SaTH has made considerable advancements across several operational and financial performance metrics, we recognise that there is more work to be done to ease the front door pressures at our hospitals. We are conscious that behind every number, there is a patient, and our focus and priority continue to be on improving our waiting times and services. • Care Quality Commission (CQC): SaTH now has just one Section 31 condition remaining, out of the 60 previously placed on the Trust's licence. This concerns the initial assessment of all patients within 15 minutes of arrival at ED. We are currently making good progress with this, and it will be reviewed in the next few months. • Hospitals Transformation Programme (HTP): On 17 December 2025 SaTH was delighted to mark our significant construction	

	milestone, as leaders, colleagues, and project partners gathered to celebrate the topping-out of the new four-storey healthcare facilities at RSH. It was a fantastic celebration, and Ms Williams thanked the IHP team for their continued support and partnership. The building now moves into the next stage of construction, with an increase to 600 contractors on-site to provide the services and trades needed to move ahead with the next exciting phase. • Flu vaccinations: We have exceeded our staff flu vaccination target of 52.5%, reaching 52.9% for all staff and 52.6% for frontline healthcare workers. Ms Williams thanked the vaccination team for their support. The Board of Directors accepted and **noted** the report.	
REPORTS FROM ASSURANCE COMMITTEE CHAIRS		
011/26	**Audit & Risk Assurance Committee (ARAC) Report** The Board of Directors received the report from the Committee Chair, Prof Purt. Taking the report as read, colleagues' attention was drawn to the following points: • Internal audit – Waiting List Initiatives (WLIs) and e-Rostering/Roster Management: The Committee had noted with concern the respective limited and moderate assurance outcomes from these reviews, particularly as the issues had long been raised and challenged by ARAC without resolution. As we move into the last quarter of the year, Prof Purt emphasised the importance of maintaining a real focus on outstanding audit recommendations, to ensure there is no slippage in the overall annual Substantial Assurance rating the Trust has worked so hard to achieve over several years now. Mr Hobbs acknowledged the legitimate frustration expressed by the Committee, specifically on WLIs, confirming that he will be returning to ARAC in February to provide assurance on action completions. • Contract waivers: The Committee continued to express concern about the growth in waivers and waiver breaches, and is hoping to see some significant progress during the remainder of the year. Mr Winstanley provided assurance that information is now being shared with the Divisions at an early stage when equipment contracts are coming to an end. The greater flexibility this will provide to research market alternatives should reduce some of the breaches. Ms Williams also highlighted that an unvoidable element of the issue is late receipt of capital funding, leaving no option but to raise a waiver, to enable the funding to be expended in-year.	

	The Board of Directors accepted and **took assurance** from the report.	
012/26	**Quality & Safety Assurance Committee (QSAC) Report** The Board of Directors received the report from the Committee Chair, Ms Dunnett. Taking the report as read, colleagues' attention was drawn to the following: • Never Events: The Committee will monitor the responses and any learning from the two never events reported to QSAC, one from September 2025 (retained swab) and one in October 2025 (retained guidewire). Dr Jones also provided assurance to the Board that he has launched a programme of work around safety standards. The Board of Directors accepted and **took assurance** from the report.	
013/26	**Performance Assurance Committee (PAC) Report** The Board of Directors received the report from the Committee Chair, Ms Edwards. Taking the report as read, colleagues' attention was drawn to the following points: • Additional capacity: Referring to the RSH modular ward opening, and the introduction of additional beds at PRH, the Committee will be focusing on what impact this additional capacity has on long waits in the Emergency Department (ED), noting the expectation that this should sharply reduce and eliminate over 48-hour waits. • High intensity users of ED: The Committee received a report which identified 2500 high intensity users, of whom 32 attended ED more than 24 times in a 12-month period. SaTH has established a working group with ShropCom which will seek to formalise mental health involvement, the involvement of GPs and local authorities, and work with Neighbourhood Health teams, to develop care which avoids the need to attend ED. • Committee effectiveness: Discussion had taken place on whether it continued to be beneficial for PAC and FAC to remain as separate committees, noting that combined finance and performance committees were generally the norm. The Board acknowledged that the split of the committees in 2024 is still considered valid, as it allows for each to be given sufficient dedicated time and focus. Mr Morgan emphasised that this remains particularly relevant given the Trust's current context. The Board of Directors accepted and **took assurance** from the report.	

014/26	**Finance Assurance Committee (FAC) Report** The Board of Directors received the report from the Committee Chair, Mr Miner. Taking the report as read, colleagues' attention was drawn to the following points: • Financial deficit: Mr Miner emphasised that the projected £3.0m deficit for the year remains dependent upon mitigating risks of some £8.5m. The Committee recognised that the Executive continue to work tirelessly to identify any further mitigating actions to manage the residual financial risk. This was particularly important as our quarter 4 cash support and exit from the NHSE Recovery Support Programme (RSP) depend on our achievement at year end. Ms Cotterill provided assurance of the close monitoring taking place. She also confirmed that, whilst actions have been identified in areas of particularly high costs, the pace at which these can be delivered, due to workforce and technology constraints etc, creates a barrier to year-end achievement. • HFMA Awards: The Committee recorded its thanks and congratulations to the following colleagues for their recent HFMA Award successes - Carol McInnes who was the winner of the 'Finance Champion' award, Kara Blackwell who was highly commended in the 'Working with Finance – Clinician of the Year' category, and Adam Winstanley who was also shortlisted. • Closing comments: Mr Winstanley reiterated all the points made, providing assurance that we know where the pressures are and what needs to be done. Ms Williams added for context that at this point last year, SaTH was going off plan by £28m, illustrating the improved position in 2025/26. Whilst acknowledging this improvement, Mr Morgan expressed concern around the undoubted challenge in meeting the 2025/26 plan we signed up to. However, he wished to equally recognise that delivering a £41.4m cost improvement programme far exceeds anything this Trust has ever achieved previously. The Board of Directors accepted and **took assurance** from the report.	
015/26	**Group People Committee Report and SaTH People & OD Assurance Committee (PODAC) Report** The Board of Directors received the reports from Mrs Boughey, as Joint Chair of the People Committee in Common with ShropCom, and Chair of PODAC for SaTH. Taking both reports as read, colleagues' attention was drawn to the following points: • Committee meeting in common: The first meeting in common with ShropCom colleagues had been positive, and discussions were productive. Whilst recognising that the meeting flow requires further work, there was a clear benefit in the two	

	organisations coming together and sharing challenges. A forward plan will be created for both organisations, with joint workforce planning featuring heavily. • PODAC: Going forward, SaTH-specific PODAC meetings will take place only in exceptional circumstances, as all business will be considered by the Committee meeting in common with the ShropCom People Committee. • Clinical Support Workers (CSWs) national re-banding: The Chief People Officer was pleased to report that negotiations have progressed to ballot stage and, if accepted, the relevant individuals will receive appropriate backpay. The Board of Directors accepted and **took assurance** from the report.	
016/26	**HTP Assurance Committee (HPAC) Chair's Report** Ms Dunnett presented the report on behalf of Prof Purt, the HTP Assurance Committee Chair. The report was taken as read, with the following key points discussed: • Modelling and Planning (including consideration of the Group Model): The Committee had requested the provision of a high-level scenario plan at its next meeting to illustrate the programme and activities should the building be completed and delivered earlier than currently scheduled. Ms Williams stated that the significant amount of clinical, operational and workforce transformation required by the organisation is recognised, to ensure implementation of the new clinical model in alignment with the building completion schedule. However, she observed from the report and today's discussion that there appeared to be a lot of activity taking place which is not currently feeding through to HPAC. She provided assurance that the UEC Transformation Committee (which she chairs) and the System Transformation Committee (chaired by Mr Morgan) will be focusing on how all these strands come together, and they will ensure that HPAC receives regular and timely assurance updates. It was also confirmed that a great deal of activity is taking place between the team (SaTH/ShropCom) on joint working opportunities and improvements. A number of consultants are also actively involved in discussions with system partners around the potential move of services into the community. • Commissioning: The Committee was updated on commissioning intentions within the Integrated Care Board (ICB) and alignment with HTP, and was informed that the first meeting of the HTP Oversight Goup had taken place. One of the	

	Oversight Group's core responsibilities was to ensure that close links remain established between HTP and the Out of Hospital programmes of work to support the requirements under HTP, and the Committee requested a regular update on the Group's progress as the HTP moves forward. The Board of Directors accepted and **took assurance** from the report.	
STRATEGIC, QUALITY AND PERFORMANCE MATTERS		
017/26	**Integrated Performance Report (IPR)** The Board of Directors received the report from the Group Chief Executive, providing an update on progress against the Trust's Operating Plan and associated objectives and enablers to the end of October/November 2025. 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 Medical Director and Interim Chief Nursing Officer drew the Board's attention to the following points: • Medication – Omitted doses: The Trust is an outlier in relation to the implementation of Electronic Prescribing and Medication Administration (EPMA), which 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, and aligned to the Patient Safety Incident Response Framework (PSIRF) Trust Priority – 'Omitted doses of time critical medication', Ms Gardner reported on ongoing efforts to improve and increase incident reporting, including improvement and standardisation of data collection and analysis, until EPMA can be implemented within the Trust. • Patient harm – pressure ulcers: There was an increase in category 2 pressure ulcers in-month, whilst the number of category 3 pressure ulcers decreased. Concerns have been raised about preventable cases and the need for improved patient assessment, care plans including repositioning patients, mattress access, and heel offloading. Metrics meetings are in place for added assurance. • Infection Prevention and Control (IPC): National flu cases were tripling at the time of report production. In SaTH, four flu outbreaks and one COVID outbreak in the period were managed well, and there are no current outbreaks. The C.difficile target continues to be breached, although a decrease was seen in October 2025, with the reduction extending into November.	

Deep clearning of at-risk wards is under review, with fogging considered for certain areas.

- Mortality data: Dr Jones advised that in the current absence of reliable risk-adjusted mortality data (nationally published Trust Summary Hospital-Level Mortality Indicator – SHMI), internal crude mortality data continues to be reviewed. Until the ongoing data warehouse issues are rectified (anticipated early 2026) mortality continues to be scrutinised by the Learning from Deaths team, Medical Examiners and through standard incident review processes where concerns have been raised.

Operational Summary

The Chief Operating Officer drew the Board's attention to the following points:

- Urgent and Emergency Care: The Integrated Community Front Door (IFD) Team are now in place in both Emergency Departments and, whilst our performance remains challenged, early signs of improvement were seen in December 2025, with delivery of the Trust's best December performance against 4 and 12-hour measures.

- Patient Flow/Hospital discharges: The No Criteria to Reside (NCTR) position was challenging in December 2025, rose to 192 in early January 2026, and stands at 150 at the date of today's meeting. The stabilisation and reduction in numbers has been due to a collective system effort, with our colleague partners demonstrating their proactivity.

- Cancer performance: Significant progress is being made against cancer waiting time standards, with the Trust ahead of plan against all cancer metrics for November 2025. SaTH is now well into the top half of Trusts nationally and on the cusp of the upper quartile. The Trust has now been de-escalated to Tier 2 NHSE monitoring for cancer due to our improved performance.

- Elective activity: The elective recovery programme continues to deliver at a high level of performance, with the unvalidated Trust position for November 2025 standing at: English 0 x 104 weeks, 0 x 78 weeks, 0 x 65 weeks, 68 x 52 weeks (adult) and 0 x 52 weeks (CYP); and Welsh 1 x 104 weeks, 17 x 78 weeks and 73 x 65 weeks.

- Diagnostic waiting times: The submitted DM01 position for November 2025 was 86.39%, representing maintained performance. Continued recovery actions include additional insourcing to support Endoscopy DM01 at weekends, supported through the Elective Recovery Fund (ERF). The use of insourcing for USS and MRI is also proving successful, with DM01 continuing to improve towards the target of 99%. Ongoing

	recruitment is taking place for radiologists, radiographers and sonographers. • Referral to Treatment (RTT): The Trust is ahead of plan on all RTT metrics. This has been achieved by insourcing support for SaTH's Outpatient Transformation Programme. The methodology to enable a 'route to zero' has been developed and a commitment has been made to sustain a zero position for 65 weeks, in addition to reducing waiting times for children and young people (CYP). The Group Chair congratulated the RTT Team on their achievements, in full recognition that this is not just 'numbers on a spreadsheet' and the Trust remains acutely aware that each patient is someone's loved one. **Workforce Summary** The Chief People Officer drew the Board's attention to the following points: • Wellbeing of our staff: The November 2025 sickness rate of 5.1% (384 WTE) remained above target by 0.64% (48 WTE), which was higher than anticipated. However, the provision of mental health support for colleagues has been going well and a reduction has been seen in stress-related illness. Regarding long-term sickness, the Trust does have a number of staff who are unfortunately experiencing long-term health issues, such as cancer. • Agency and temporary staffing: The Trust's agency position is at the lowest levels seen this year and is now below the expected reduction at month 12. Bank usage remains above plan however, with a range of actions in place to achieve a reduction during the last quarter. **Finance Summary** Noting that a number of the key points relating to the Trust's financial performance had already been covered in earlier discussions, the Acting Director of Finance additionally highlighted the current significant gap in the Trust's Capital Programme performance. This was currently being worked through with capital leads, and it is anticipated that the programme will recover by year end. The Board of Directors accepted and **noted** the Integrated Performance Report.	
ASSURANCE FRAMEWORK		
018/26	**SaTH Integrated Improvement Plan (SIIP) Report** The Board of Directors received the report from the Group Chief Executive, and noted that the Trust is on track to deliver the majority of 2025/26 IIP actions, supporting its application to exit the NHSE	

	Recovery Support Programme in quarter 4. The Trust continues to address key challenges, particularly in financial sustainability and urgent and emergency care, with robust monitoring and escalation processes in place. The Board **took assurance** from the information provided, and • **noted** that, following a comprehensive review of the evidence, the IIP Oversight Meeting chaired by NHSE Midlands confirmed that all 2024/25 actions are delivered, with the exception of a small number of deliverables that now have revised end dates extending into 2025/26; • **noted** that delivery of IIP elements is monitored by the relevant Assurance Committees, with overall progress reported to the Board; • **noted** that the IIP plans for 2025/26 have been fully reviewed (appendices 1-4), and that a formal change form (appendix 5) has been produced to record revised end dates for outstanding 2024/25 deliverables, alongside any amendments or new actions incorporated into the updated IIP plans; • **approved** SaTH IIP plans for 2025/26 and the associated formal change form; and • **noted** that this position will be subject to formal confirmation through a series of Evidence Review Panel meetings scheduled in January, and that the Trust will present an update on its current position at the NHSE Provider Review Meeting on 16 January 2026.	
019/26	**Integrated Maternity & Neonatal Report** Ms Gardner welcomed 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. The Board was referred to the detail contained within the main report, together with the accompanying appendices in the 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 11 November 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 expected completion dates, pending evidence that they have been appropriately embedded. Seven actions continue to 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. As advised in previous reports, 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 11 November 2025, is included as **Appendix 2** in the Board Supplementary Information Pack.

All actions remain on track for their expected delivery dates, with the exception, as reported previously, of an action relating to the service's 'golden hour' provision, in collaboration with the LMNS, for compliance with the 'golden hour' audit. Following guidance from Network members on how compliance is achieved in other units, it has been noted that units only have a checklist for preterm infants, with none having a checklist for term infants. These findings have been shared with the reviewing team and, as a result, an admission checklist, in line with other Trusts, is being designed.

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 review.

NHS Resolution's Maternity (and Perinatal) Incentive Scheme (Clinical Negligence Scheme for Trusts – CNST): The service continues to make good progress to evidence all Year 7 scheme actions.

The Board of Directors formally acknowledged that it had received and read all the accompanying appendices listed in the table under section 5.2 of the paper, detailed as follows:

- **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 have continued in line with Year 7 technical guidance. Compliance for this action has been achieved and a closure report has been provided at **Appendices 5 and 5a** in the supplementary information pack.

  Full details are available in section 3.1 of the Year 7 CNST Progress Report December 2025, which is provided in the supplementary information pack at **Appendix 4**.

- **SA2** – '*Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?'* – Compliance for this

	action has been achieved, with evidence provided to Board in November 2025. Full details are available in section 3.2 of the Year 7 CNST Progress Report December 2025, which is provided in the supplementary information pack at **Appendix 4**. • **SA3** – '*Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of mothers and their babies?'* – Compliance with this action has been achieved, with quarterly reports provided to Board and Quality Improvement continuing within the Service. Additionally, an action plan co-developed with the Network to improve Transitional Care provision within the unit is provided at **Appendix 6** in the supplementary information pack for Board sign off. Full details are available in section 3.3 of the Year 7 CNST Progress Report December 2025, which is provided in the supplementary information pack at **Appendix 4.** • **SA4** – *'Can you demonstrate an effective system of clinical workforce planning to the required standard?'* – Compliance has been achieved against standards a, b and c of this action with closure reports provided at **Appendix 7a** for a) Obstetric workforce and at **Appendix 7b** for c) Neonatal medical workforce and d) Neonatal nursing workforce. Evidence of compliance against **standard b) Anaesthetic medical workforce** was provided to Board in November 2025. Full details are available in section 3.4 of the Year 7 CNST Progress Report December 2025, which is provided in the supplementary information pack at **Appendix 4.** • **SA5** – *'Can you demonstrate an effective system of midwifery workforce planning to the required standard?'* – Compliance has now been demonstrated for this action. Full details are available in section 3.5 of the Year 7 CNST Progress Report December 2025, which is provided in the supplementary information pack at **Appendix 4.** • **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. Progress has been benchmarked against version 3.2 of the bundle and compliance with the CNST standard has been achieved. Full details are available in section 3.6 of the Year 7 CNST Progress Report December 2025, which is provided in the supplementary information pack at **Appendix 4.**	

- **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.

  Compliance with this action has been achieved, with the last of the evidence being compiled within 'Monday.com' ahead of sign off.

  Full details are available in section 3.7 of the Year 7 CNST Progress Report December 2025, which is provided in the supplementary information pack at **Appendix 4.**

- **SA8** – *'Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training?'* – Compliance against this action has been achieved, with a closure report provided at **Appendix 8** demonstrating training compliance against all standards.

  Full details are available in section 3.8 of the Year 7 CNST Progress Report December 2025, which is provided in the supplementary information pack at **Appendix 4.**

- **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 revised model has now been received and is being assessed for changes. Reporting templates provided with the model are being considered for adoption.
  - The Safety Champions Locally Agreed Dashboard is presented to the Board each quarter during the reporting period, and is provided as **Appendix 9** in the supplementary information pack.
  - The Trust's Claims Scorecard has been reviewed alongside incident and complaint data and discussed by the Maternity, Neonatal and Trust Board level Safety Champions at Trust level (Board or Directorate) meetings throughout the reporting period.
  - The Perinatal Quadrumvirate Leadership team has met in May, June, July and November 2025, fulfilling the requirement for meeting at least three times within the reporting period.
  - Full details are available in section 3.9 of the Year 7 CNST Progress Report December 2025, which is provided in the supplementary information pack at **Appendix 4.**

- **SA10** – *'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.

  A closure report, demonstrating compliance against all requirements, is provided at **Appendix 10.**

  Full details are available in section 3.10 of the Year 7 CNST Progress Report December 2025, which is provided in the supplementary information pack at **Appendix 4.**

NHSE issued letter - urgent review of homebirth services following Coroner Prevention of Future Deaths report: The Board's attention was drawn to a request from NHSE to Trusts in the region, to consider issues highlighted in a recent homebirth case. Assurance was provided to the Board that a gap analysis had been completed and presented to Maternity Governance in December 2025.

It has been identified that, as an organisation, governance and risk assessment require additional Board oversight, and the Board agreed that this should most appropriately be linked in with the existing Maternity and Neonatal Safety Champions agenda. It was further noted that the gap analysis has been triangulated with a previous MNSI briefing 'Birthing outside of guidance' published in February 2025, with both included as **Appendix 11** in the supplementary information pack.

The Board of Directors, following comprehensive review of the Integrated Maternity & Neonatal Report and all associated appendices within the accompanying supplementary information pack (Appendices 1 to 11), accepted and **took assurance** from the report.

The following was also confirmed:

- The Trust Board **approves** the Transitional Care (TC) action plan (SA3).
- The Trust Board **has received** the CNST Obstetric Workforce Closure Paper (SA4) indicating compliance against the obstetric workforce standards within CNST Safety Action 4.
- The Trust Board **has received** the CNST Neonatal Workforce Closure Paper (SA4) showing the service meets the BAPM recommendations for neonatal medical workforce.
- The Trust Board **has received** the CNST Neonatal Workforce Closure Paper (SA4) showing the service does not meet the BAPM recommendations for neonatal nursing workforce and agrees the action plan included in that closure paper to meet the

	QIS standard (70%), noting that the associated risk is monitored through the risk register (Datix risk ID 684). • The Trust Board **has received** evidence that the Board Safety Champions have met with the Perinatal leadership team in May, June, September and November 2025, meeting the requirement of at least three times within the reporting period. Ms Williams thanked Jacqui for the leadership she has shown during her time as Acting Head of Midwifery, referring in particular to the incredible feedback which has been received on social media and to our excellent CQC Patient Survey results. On behalf of the Board, Mr Morgan added his own thanks, and commended Jacqui and her team for their excellent work.	
020/26	**Board Maternity & Neonatal Safety Champions Report** The Board of Directors received the report from the Medical Director, providing assurance on the effectiveness of the Safety Champion roles. Taking the report as read, Dr Jones was pleased to advise the Board that the obstetric workforce issues referenced in the 'Alert' section of the report have since been resolved. Obstetric consultant recruitment has been successful, arrangements have been formalised with University Hospitals of North Midlands NHS Trust (UHNM) to provide support on foetal medicine, and an obstetric safety champion will be in post soon. The Board of Directors **noted** and **took assurance** from the report.	
021/26	**Risk Management Strategy** The Director of Governance advised the Board that a major update had taken place to the Risk Management Strategy to reflect the strategic direction of risk management across the system. This had been carried out in conjunction with the Risk Management Policy, as covered later in the meeting. As the review had commenced before the Trust embarked upon the work undertaken to form a Group Model, Ms Milanec confirmed that the strategy will be further reviewed over coming months to recognise the relationship with Shropshire Community Health NHS Trust, and a revised version will be brought to Board for approval at that time. Ms Edwards referred to 'the role of the Non-Executive Director' in risk management processes, as detailed on page 160 of the Board pack. On the assumption that this definition currently includes the Chair, she queried whether the Chair's role should have a more significant definition. This point was acknowledged by the Board and noted by Ms Milanec for consideration in the forthcoming Group model review.	

	The Board of Directors **approved** the Risk Management Strategy.	
022/26	**Risk Appetite Statement 2025/26** The Director of Governance presented a report proposing that the Board's 2024/25 agreed risk appetite is carried forward and extended into 2027, ahead of any further detailed work in this area within the Group Model. The Board of Directors **approved** this proposal and the content of the risk appetite statement.	
023/26	**Risk Management Report Q2 2025/26** The Board of Directors received the report from the Director of Governance, highlighting progress in managing risks and enhancing the risk culture at SaTH. Taking the report as read, Ms Milanec drew the Board's attention to key highlights from the sections detailing the effectiveness of risk mitigation, risk management progress, and training and culture improvement. Of particular note was the closure, in conjunction with risk owners, of 58 risks in quarter 2. In response to a query from Mr Miner on the total number of active risks, Ms Milanec agreed to the inclusion of a further metric in future reporting to identify whether the number has increased or decreased. The Board of Directors accepted the report, subject to the point made by Mr Miner above, **noted** the current risk position, and **took assurance** from the mitigation in place to ensure that risk management is practiced consistently across the Trust.	
REGULATORY AND STATUTORY REPORTING		
024/26	**Guardian of Safe Working Hours (GoSW) Report Q2 2025/26** Dr Jones welcomed Dr Robin Hollands to provide his first report to the Board as SaTH's new GoSW, and Dr Aung Phyo Naing (Aung), the Trust's resident doctor peer lead, to provide feedback on the 10-Point Plan to improve resident doctors' working lives. The Board was referred to the detail in the report, with key points summarised as follows: • This Q2 report provides a comprehensive overview of safe working hours governance for resident and locally employed doctors across the Trust. Progress continues on digital rostering, with Emergency and Acute Medicine now fully live rostered and General Medicine templates in development. • The Trust is progressing towards full compliance with national reforms to the exception reporting process for resident doctors,	

	due for implementation on 4 February 2026. Rota improvements have been made in a number of specialties in response to feedback/exception reports and further changes anticipated, although from experience elsewhere, there is likely to be a rise in exception reporting. • The GoSW wished to draw the Board's attention to the timeliness of rota publication in the Emergency Department, which remains a concern despite the inclusion of the specialty on the digital platform 'Healthroster'. Trainees report that rotas are delivered late, and that they experience difficulties in obtaining leave in a timely manner, with no clear means of contacting rota managers. This is a requirement of the 10-Point Plan for improving resident doctors' working lives, and the GoSW is working with Medical People Services and managers within the Emergency Department to resolve the issue, which is causing a lot of distress to resident doctors who are unable to book leave. Dr Hollands requested the support of the Board in resolving this issue, and the Group Chair asked that the Executive give their early attention to this matter and provide assurance to the Board that the issue has been rectified. Prof Purt also highlighted that this issue is being focused on by ARAC following the Internal Audit Report referenced earlier in the meeting. **Action: CPO/MD** • 10-Point Plan to improvement resident doctors' working lives: Dr Aung thanked the Board for the opportunity to join today's meeting and was pleased to report that good progress is being made with the 10-Point Plan initiative. He reported that a key theme which had emerged from the first Resident Doctor Committee meeting was the importance of clear communication, particularly around where feedback sits within the process and ensuring transparency when issues cannot be resolved. To strengthen communication, monthly Resident Doctor Committee meetings and forums have been introduced, including the Guardian of Safe Working forum. It was, however, highlighted that resident doctors often face challenges leaving the ward to attend these meetings, and that attendance could be significantly improved if consultants were informed of the scheduled meetings and actively encourage resident doctors to participate. • Dr Aung advised in conclusion that whilst the Trust is initiating improvements at the highest level, some challenges remain within individual clinical areas, although it is anticipated that these issues will be addressed through strengthened communication channels and ongoing engagement. The ultimate goal is to ensure that every resident doctor benefits from this initiative and that high standards are maintained consistently across all areas.	**CPO / MD**

	• Ms Williams thanked Dr Aung for his very useful feedback, and expressed her confidence that the 10-Point Plan was not simply being undertaken as a tick box exercise. She invited any further support that herself and/or Dr Jones could provide. Mr Morgan also expressed his appreciation of being able to hear directly from the resident doctor peer lead, and provided assurance of the Board's continued support. • Finally, Dr Hollands touched on the softer areas of his work, and the key perception that people can put up with a lot if they are looked after by the organisation they work for. He has personally always felt this is 'his hospital', and this affinity is exactly what he would like colleagues to feel. The Board of Directors **noted** the report and supported the GoSW's continued efforts to ensure safe, sustainable working practices.	
025/26	**Patient Safety Committee Report Q2 2025/26** The Medical Director introduced the Board to this new, more concise, report which replaces previous individual reports. Dr Jones confirmed that the report describes themes that have been identified by the Learning from Deaths team and the Medical Examiner Service, in addition to taking information from the patient safety incident management report from the Quality Operational Committee for triangulation. The Board of Directors **noted** the content of the report and welcomed the new format.	
026/26	**Infection Prevention & Control Report Q2 2025/26** The Board of Directors received the report from the Interim Chief Nursing Officer. Taking the report as read, Ms Gardner clarified that she had nothing further to add to the key points which had already been covered in the earlier IPR. The Board accepted and **noted** the report.	
BOARD GOVERNANCE		
027/26	**a. Annual Review of Standing Orders (SOs), and Scheme of Reservation & Delegation (SoRD)** The Director of Governance advised that both of these important documents had been subject to their annual review, thanking finance colleagues and Ms Cotterill for their input and support. The report outlined the proposed updates to both documents, which were agreed by the Audit & Risk Assurance Committee on 24 November 2025.	

	The Board of Directors **approved** the updated Standing Orders and Scheme of Reservation & Delegation. **b. Annual Review of Standing Financial Instructions (SFIs)** The Acting Director of Finance advised that the Trust's SFIs have also been subject to their annual review. New procurement laws and regulations have been enacted and the major amendments to the SFIs are therefore around the required updates to ensure compliance with these changes. Colleagues' attention was also drawn to the revised authorisation limits detailed within the report. The Board of Directors **approved** the updated Standing Financial Instructions.	
028/26	**Board Member Conflicts of Interest Report** The Board of Directors received the report from the Director of Governance following the six-monthly review which had been considered by the Audit & Risk Assurance Committee (ARAC). It is intended that the Board member interests are published on the Trust's website alongside the other Trust registers of interest which had been reviewed by the Committee. Queries were raised by two Board members regarding interests which had been declared on the Electronic Staff Record (ESR) but did not appear on the register. **Action:** The Group Chair asked that all Board members review their declarations on ESR for accuracy as soon as possible and advise Ms Milanec of any identified issues. The Board of Directors considered and **noted** the Board member interests and agreed publication on the Trust's website, subject to resolution of the above queries.	**All Board members**
ITEMS FOR CONSENT – approval recommended from Board Committees		
029/26	**Annual Review of Board Code of Conduct** The Director of Governance advised that the Board Code of Conduct had been reviewed and agreed by ARAC at its latest meeting. Following Committee discussion it was proposed that this document move from its current annual review to a biennial review cycle. The Board of Directors **approved** the updated Board Code of Conduct, and the change to a biennial review cycle.	
030/26	**Risk Management Policy** Following review by ARAC at its meeting on 24 November 2025, the Director of Governance advised that the Committee is recommending approval of the updated Risk Management Policy to	

	the Board. The policy had been reviewed in conjunction with the Risk Management Strategy covered earlier in the meeting, to reflect the strategic direction of risk management across the system. As with the strategy, Ms Milanec confirmed that the Risk Management Policy will be further reviewed over coming months to recognise the relationship with Shropshire Community Health NHS Trust, and a revised version will be brought to Board for approval once finalised. Ms Edwards expressed a view that the policy would benefit from better definition/a more concise format, to make it more useful for staff. Ms Milanec clarified that both the policy and strategy documents are reviewed by regulators during inspections, which was the main rationale for their comprehensive format. She also confirmed that complementary training/videos are available to staff on the intranet. The benefit of all policies being as concise as possible was however recognised. The Board of Directors **approved** the Risk Management Policy.	
031/26	**Health & Safety Management Policy** The Chief Operating Officer advised that the Health & Safety Management Policy had been subject to its periodic review. The version presented for approval today reflects all feedback received during the consultation and review process, following which the Quality & Safety Assurance Committee (QSAC) had recommended approval to the Board at its November 2025 meeting. The Board of Directors **approved** the revised Health & Safety Management Policy	
032/26	**Finance Assurance Committee Terms of Reference** The Director of Governance advised that the terms of reference of the Finance Assurance Committee (FAC) have been subject to their annual review, and were considered and agreed by FAC at the Committee's November 2025 meeting. The Board of Directors **approved** the updated Finance Assurance Committee terms of reference.	
033/26	**Performance Assurance Committee Terms of Reference** The Director of Governance advised that the terms of reference of the Performance Assurance Committee (PAC) have been subject to their annual review, and were considered and agreed by PAC at the Committee's November 2025 meeting. The Board of Directors **approved** the updated Performance Assurance Committee terms of reference.	

PROCEDURAL ITEMS		
034/26	**Any Other Business** There were no further items of business, and the meeting was declared closed.	
035/26	**Date and Time of Next Meeting** The next meeting of the Board of Directors in public was scheduled for Thursday 12 March 2026 from 0930hrs–1230hrs. The Group Chair advised that there may be a need to change some Board meeting dates from April 2026 to accommodate meetings of the ShropCom/SaTH Boards in Common. Further details would be made available once confirmed.	

Public Q&As *(agenda item 003/26)*

Q1 – submitted by Vanessa Perry:

The Trust has recently stated in its public Board papers that SaTH's current national ranking of 113 out of 134 represents a "significant improvement" on its previous position. This necessarily means that for much of the past year the Trust has been performing even lower than 113th nationally, while remaining in Segment 5 of the NHS Recovery Support Programme. These published rankings reflect whole-system performance in areas directly linked to patient safety, including timeliness, escalation, and the Trust's ability to provide safe and effective care.

Given the seriousness of these indicators, and their direct impact on patient safety, can the Board explain how it assures itself that the current leadership team is the right team to turn the organisation around, and what clear, visible evidence the Board can point to that demonstrates leadership is improving the Trust quickly enough to keep patients safe and restore public confidence?

A - provided by Anna Milanec, Director of Governance

It is the Board's Assurance Framework and processes that are essential to the Board of Directors for them to gain assurance that the organisation's principal risks are managed effectively. It also provides transparency and promotes accountability for those responsible.

This is reflected within the Chief Executive Officer's assertion in the Annual Governance Statement appearing in the Trust's Annual Report (and Accounts) which confirms that …"… each member of the executive team has an area of responsibility for risk management in accordance with their portfolios and as reflected in their role descriptions…"…

https://pdf.browsealoud.com/PDFViewer/_Desktop/viewer.aspx?file=https://pdf.browsealoud.com/StreamingProxy.ashx?url=https://www.sath.nhs.uk/wp-content/uploads/2025/07/SaTH-signed-Annual-Report-and-Accounts-2024-25-FINAL-2.pdf&opts=www.sath.nhs.uk#langidsrc=en-gb&locale=en-gb&dom=www.sath.nhs.uk.aspx (pg109)

Applications for the appointment of executive director and/or very senior managers are robustly managed, often with the support of independent professional search and leadership recruitment consultants. Once a preferred suitable candidate is selected by the panel, rigorous checks are carried out, which may include psychological testing, but will definitely

include checking the veracity of qualifications, references, legal and financial standing, and further background checks.

Each of our Board members (executive directors, non-executive directors and very senior managers) must comply with the requirements of the *Fit and Proper Person Test (FPPT) Framework,* originally arising from *Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014,* and last updated in 2025 by NHSE.

The regulations' requirements include, inter alia, the need for individuals to be of good character, in good health as far as reasonable for their role, not responsible for, or having facilitated any serious misconduct or mismanagement, and they must have *"the qualifications, competence, skills and experience that are relevant for the relevant office or position for which they are employed."*

The Chairman is accountable for taking all reasonable steps to ensure that the FPPT process is effective. This specifically includes the requirement of ensuring that robust systems and processes are in place so that the FPPT assessments are accurate. A recent internal audit into the FPPT process was carried out earlier this financial year by independent auditors and gave a 'substantial assurance' rating as to the Trust's processes.

All board members are subject to annual documented appraisals carried out by the Chief Executive Officer, and / or the Chairman. Board members have a duty to keep their Declarations of Interests up to date and must comply with the Board's Code of Conduct, Standing Orders and Standing Financial Instructions, and various national codes.

The current leadership team includes some members who have been in post for less than one year, with the longest serving having been in place for up to seven years.

The Trust received a poor CQC outcome in 2018 and has struggled, through Covid, Maternity Reviews, CQC inspections, litigation, poor publicity and a high turn-over in executive leadership until recently. It also had over 60 CQC conditions on its licence – the CQC has recently now confirmed that there remains only one.

Several independent maternity reports indicate that there have been improvements with our maternity services, although, we fully appreciate that there is more to do. Similarly, the Trust has been successful in achieving the annual maternity CNST standards since 2023 and has completed +90% of Ockenden Recommendations.

Likewise, evidence shows that the number of patients on waiting lists has decreased over the last 12 months, with more patients receiving timely care. This is reflected in the December 2025 publication of the National Oversight Framework where the Trust improved by 17 places and is now positioned at 96 out of 134 Trusts for Q2.

The Chief Executive's report for the January Board Meeting in public provides more information of how the Trust has recently improved. You may access her report on the website, on the following link beginning at page 29:

https://pdf.browsealoud.com/PDFViewer/_Desktop/viewer.aspx?file=https://pdf.browsealoud.com/StreamingProxy.ashx?url=https://www.sath.nhs.uk/wp-content/uploads/2026/01/01-BoD-MEETING-IN-PUBLIC-15.01.2026-COMBINED-PAPERS.pdf&opts=www.sath.nhs.uk#langidsrc=en-gb&locale=en-gb&dom=www.sath.nhs.uk

Within the same document, you will also find the Integrated Performance Report, reporting at each Board Meeting the national and local healthcare, financial and other performance standards which indicate how far the Trust is improving on an ongoing basis.

Q2 – also submitted by Vanessa Perry:

1. **The Chair reminded the Board / public that there are occasions where we are unable to respond to questions, as stated on the Trust's website:**

   The Chair reserves the right to refuse to accept any question that is not within the powers and duties of the Trust; is defamatory, frivolous, offensive or vexatious; is deemed to be overtly political; is substantially the same as a question that has already been answered in the previous 6 months; or would require the wrongful disclosure of confidential or exempt information (as per the exemptions under the Freedom of Information Act 2000) – this includes matters relating to specific patients or members of staff.

2. ***Question read out by Anna Milanec, Director of Governance:***

   I am the daughter of a patient, who died earlier this year following treatment under The Shrewsbury & Telford Hospital NHS Trust (SaTH). I am participating as an Interested Person in their inquest.

   In early September 2025, I submitted a Subject Access Request (SAR) to obtain my own personal data relevant to the handling of my complaint and to my parent's care and death.

   No lawful extension was issued, and the statutory deadline of early October 2025 has expired. The Trust is therefore in continuing breach of Articles 12(3) and 15(1) UK GDPR, while withholding information directly relevant to an ongoing coronial investigation.

   On 25 November 2025, SaTH's Senior Information Risk Owner informed me that the Trust will not process my SAR unless and until the ICO contacts them. This is not a lawful position under the UK GDPR. ICO involvement does not suspend or remove the Trust's continuing duty to comply with statutory subject access obligations.

   Given the Trust's governance history and the need for transparency during a legal process, can the Board explain why SaTH is withholding legally required personal data from a bereaved family during an active inquest, and what steps the Board will take to ensure full, lawful, and timely compliance with Subject Access Request obligations?

A – provided by the Director of Governance:

Whilst I am conflicted (I am the SIRO mentioned in the question), I can advise, without disclosing any confidential information, that this is an ongoing, complex case, with elements of legal and regulatory matters involved.

The individual submitting the question has stated that the Trust is in "continuing breach of Articles 12(3) and 15(1) of UKGDPR". The DPA 2018 itself contains provisions (Section 15) for exemptions and adaptations to these GDPR rules, balancing data rights with other interests, including legal.

For these reasons, I am advising the Chairman that, whilst the Trust does not consider it has unlawfully withheld information, it is appropriate to go into no further detail in a public setting at this time.

In addition, the individual has confirmed her involvement in an ongoing inquest relating to a patient who died at the Trust.

Q3 – submitted by Jamie Perry:

Across the NHS there has been significant concern about staffing levels, rota gaps, and reliance on bank and agency staff, particularly during periods of high demand.

SaTH's own Integrated Performance Reports indicate continued pressure on substantive staffing in several areas, including medical, nursing, and allied health roles.

Given that safe staffing is fundamental to patient care, can the Board clarify:

a) what the current staffing shortfalls are across key clinical areas,
b) what immediate steps are being taken to ensure minimum safe staffing is maintained at all times – especially during winter pressures, and
c) how the Board assures itself that patient safety is not compromised when actual staffing falls below planned levels?

As staffing is a Trust-wide safety issue affecting every patient, I believe clear Board-level assurance is important.

a) Provided by Rhia Boyode, Chief People Officer:

Staffing shortfalls can vary due to sickness absence or vacancies; most workforce gaps are mitigated by using our own internal bank of clinical professionals or, where absolutely necessary, we may need to cover gaps with agency workers through our approved and compliant framework. Agency usage has become less frequent over the last 12 months as we have been able to successfully recruit to vacancies across our nursing and medical workforce.

The areas with the greatest shortfalls are as follows, however it should be noted that we have a healthy supply of bank workforce and use our workforce flexibility to ensure safe staffing is maintained.

Nursing	M8 - Vacancies	Temp Staffing
Accident & Emergency - Shrewsbury	8	10 Bank
Acute Floor RSH	22.83	14 Bank
Ward 10 Short Stay	2.61	4 Bank
Ward 17 Respiratory PRH (28B)	2.65	6 Bank
Theatres - Shrewsbury	7.87	10 Bank
Ward 32 Acute Orthopaedic Trauma Unit RSH	6.65	2 Bank
Ward 12/14 Women's Services	3.5	3 Bank

Medical Speciality	Vacancy (All grades)	Recruitment / Temp Staffing
Accident and Emergency	4	2 Specialty Doctors starting in Feb, gaps covered with temp
Acute Internal Medicine	8	2 Starting in Feb, gaps covered with temp
Elderly Care Medicine	3	Gaps covered with temp
General Medicine	8	2 Starting in Jan, gaps covered with temp
Urgent Treatment Centre	3	2 GP starting Jan, gaps covered with temp
Obstetrics and Gynaecology	8	3 Starting in Jan, gaps covered with temp
Anaesthetics	9	1 Starting in February, gaps covered with temp

Gastroenterology	4	LED starting in Jan, gaps covered with temp

b) Provided by Paula Gardner, Interim Chief Nursing Officer:

The clinical areas use a web-based NHS application called SafeCare-Live, which uses information about staffing levels and patient acuity data to indicate where there could be safety or efficiency problems. However, this does not replace professional judgement. When staffing on a unit is short, or patient acuity level increases, it is then essential to take a few minutes to input professional judgements data into the SafeCare system to make sure that change is reflected in real time.

In addition to this, the divisions have twice daily staffing meetings to enable them to move staff across areas within the divisions. They also work with other divisions to move staff across divisions where skills are adaptable.

There are also two corporate staffing meetings which meet in the morning and late afternoon, chaired by the CNO or Deputy, to review allocation of enhanced care nurses, to ensure our most vulnerable patients have extra Health Care Assistants to monitor the patients on a 1:1 basis due mainly to the patients having cognitive issues in hours. Out of hours, the wards or depts contact the flow matron, who is a senior nurse, to escalate any shortfalls. This is then discussed with the Executive On-Call for a decision and for the Exec to be aware of any escalated staffing issues emerging. These can then be discussed on the four times a day site calls.

Bank nurses will be booked where there are gaps that we cannot otherwise fill by moving staff around.

We also have nursing metrics meetings to review all quality metrics in relation to staffing levels. The wards and depts discuss their rosters, fill rates, vacancies, sickness and overall staffing numbers to ensure we have oversight of safe staffing and full rosters.

All wards and depts have dashboards whereby we can identify any red flags and address immediately.

c) Also provided by Paula Gardner:

We ensure a bi-annual staffing establishment review is undertaken across all clinical areas. The numbers of staff to beds are recorded along with acuity and dependency using a validated tool known as SNCT = SAFER NURSING CARE TOOL, which is used in conjunction with clinical judgement. This is reported to Board twice a year. The Board also has oversight of staffing levels across the month within the Integrated Performance Report which talks to vacancies, sickness levels and fill rates etc.

Q4 - received verbally at the meeting from David Sandbach:

West Midlands Ambulance Service (WMAS) recently received £23m to cover handover delays outside hospitals. What share of this figure was SaTH required to pay?

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

This £23m was provided directly by NHS commissioners and does not therefore feature in our Trust finances.

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								
11	13/11/2025	151/25	SaTH/ShropCom joint estates strategy	Request from Group Chief Executive for a map showing all locations across our communities to aid in discussions on joint estates strategy.	DS&P	30/01/2026 (to JW)	In progress, per DS&P. Recommend to close for purposes of Board action log.	Recommend to close
2026								
13	15/01/2026	024/26	GoSW Report	Board support requested by GoSW for assistance in resolution of an issue relating to timeliness of rota publication in the Emergency Dept. Trainees report that rotas are delivered late, and that they experience difficulties in obtaining leave in a timely manner, with no clear means of contacting rota managers. **This is a requirement of the 10-Point Plan for improving resident doctors' working lives, and is causing a lot of distress to resident doctors who are unable to book leave**. Request to Executive from the Group Chair to give their early attention to this matter and provide assurance to the Board that the issue has been rectified.	CPO / MD	31/03/2026	4/03/2026 update: The GoSW has accepted an invitation from the CPO to join the next People Committee on 23 March to provide an opportunity to explore previously discussed operational matters in greater depth, including discussion on rota management and annual leave approvals within ED. The aim is to agree actionable steps through the Committee, to offer both the GoSW and the Board the necessary assurance.	Open
14	15/01/2026	028/26	Board member conflicts of interest report	Following queries raised by two Board members regarding interests which had been declared on the Electronic Staff Record (ESR) but did not appear on the register, the Group Chair asked that all Board members review their declarations on ESR for accuracy as soon as possible and advise Ms Milanec of any identified issues.	All Board Members	15/03/2026	Verbal confirmation to be provided by Board members at 15/03 Board meeting that all declarations have been reviewed for accuracy/completeness.	Recommend to close

Board of Directors' Meeting
12 March 2026

Agenda item		044/26		
Report Title		Exit from the Recovery Support Programme		
Executive Lead		Anna Milanec, Director of Governance		
Report Author		Anna Milanec, as above		
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:		NHSE has confirmed that SATH has exited the RSP (Recovery Support Programme) (previously known as 'Special Measures') after demonstrable and sustainable improvements across a range of areas over the last 18 months, The Trust first entered Special Measures in 2018 and has been in receipt of significant support and intervention ever since. The exit from the Recovery Support Programme is therefore a significant milestone in the Trust's improvement journey and is a testament to the hard work, dedication, and perseverance of staff over many years, However, it is recognised that this is not the end of the Trust's improvement journey, as there is much more still to do. A copy of the letter from NHSE formally confirming the Trust's exit from the Recovery Support programme is attached.		
Recommendations for the Board:		The Board is asked to: • Note the Trust's exit from the Recovery Support Programme.		
Appendices:		Appendix 1: Letter dated 2 March 2026 from NHSE to the Trust.		

To:

Jo Williams, Chief Executive Officer

Andrew Morgan, Chair

The Shrewsbury and Telford Hospital NHS Trust

Mark Brassington
Director of Operation Improvement and Recovery Support
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

2nd March 2026

Dear Jo and Andrew

Formal notice of The Shrewsbury and Telford Hospital NHS Trust's transition to NHS Oversight Framework (NOF) segment 3 and exit from the Recovery Support Programme (RSP)

This letter providers formal notice that The Shrewsbury and Telford Hospital NHS Trust (SaTH) has achieved the important milestone of exiting the RSP and moving to NOF segment 3, following approval from NHS England's Operational Executive on 24 February 2026.

As you will be aware, SaTH first entered national intensive support in 2018 following an inadequate CQC rating. Since then, it has been in receipt of significant support and intervention by NHS England (and pre-cursor bodies). However, over the last 18 months, we have seen demonstrable and sustainable improvements across a range of areas, including meeting SaTH's RSP exit criteria. This is a testament to your leadership and the dedication, perseverance and hard work of staff over many years.

You have made significant strides, and whilst there is more to do to continue improving services for your patients, we hope you will feel able to take a moment to acknowledge the improvements you have achieved. These include:

- SaTH has been the most improved Trust nationally for elective recovery and ranks second for the cancer 28-day Faster Diagnosis Standard.

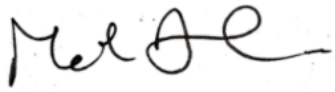
- Demonstrable strengthening of quality governance and oversight, particularly safety and patient experience in the Trust's Emergency Departments.
- Excellent progress in delivery of the 2025/26 financial and workforce plans, with the foundations laid for medium-term sustainable recovery.
- Significant improvement in stakeholder confidence and engagement with the organisation.
- The development of a group model with Shropshire Community NHS Trust – with good progress having been made in advance of the arrangement being formalised on 1 April 2026.

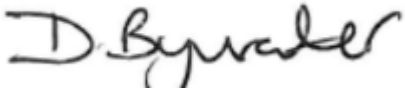
We are keen that you share learning from your success with other challenged organisations and will work with you to ensure there are opportunities to show-case the improvements and how these were achieved.

The Midlands region will continue to work with you to support improvements required in urgent and emergency care, as well as delivery of an ambitious and balanced operational plan for 2026/27 onwards and realising the benefits of the group model. As you are aware, Midlands region has also reassessed SaTH's progress against its undertakings and Rebecca Farmer (Director of System Coordination and Oversight – Midlands Region) will write to you separately about the conclusion of this process and refreshed oversight arrangements for the Trust.

If you wish to discuss the above or any related issues in more detail, please contact myself, or Dale Bywater, Regional Director - NHS England, in the first instance.

Kind regards





Mark Brassington
Director of Operational Improvement and Recovery Support Programme
NHS England

Dale Bywater
Midlands Regional Director
NHS England

Copy:

Glen Burley, Financial Reset and Accountability Director, NHS England

Sarah Jane Marsh, National Priority Programme Director – Urgent and Emergency Care, NHS England

Elizabeth O'Mahoney, Director General – Finance, NHS England

Simon Whitehouse, CEO, Shropshire, Telford & Wrekin ICB

Rebecca Farmer, Director of System Co-ordination & Oversight, NHS England - Midlands

Donna Hadley, Deputy Director of Improvement – Intensive Support, NHS England - Midlands

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
12 March 2026

Agenda item		046/26		
Report Title		Chief Executive's Report		
Executive Lead		Jo Williams, Group Chief Executive The Shrewsbury and Telford Hospital NHS Trust Shropshire Community Health NHS Trust		
Report Author		Jo Williams, Group Chief Executive As above		
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:		We are delighted to bring incredible news in that NHSE has taken the Trust out of its Recovery Support Programme, formally known as 'Special Measures'. Whilst it is refreshing to be able to provide some excellent news, it has taken almost eight years, and a tremendous amount of hard work by those who went before, and our current teams, to be at this juncture. Although we have made many improvents, we are not being complacent, and we understand that there is still much for us to do on our improvement expedition to achieve excellence, and the road will remain rocky in parts. With the submission of our three year plan, and the establishment of our Group Model with Shropshire Community Healthcare NHS Trust as from 1 April 2026, the future is immediate and we look forward to further working with our communities and partners to meet the healthcare needs of those who rely upon us.		
Recommendations for the Board:		The Board is asked to note the contents of the report and to take assurance where appropriate.		
Appendices		None		

1.0 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last public Board on 12 January 2026 from the Chief Executive's position, this includes an overall update, SaTH news and wider NHS updates.

2.0 OVERALL SaTH UPDATE

2.1 After nearly eight years, we have exited the Recovery Support Programme (RSP). This represents a significant achievement and is a testament to the comprehensive transformation efforts undertaken across the organisation. Exiting the RSP highlights the hard work, commitment, and perseverance demonstrated by all involved. Each contribution has played a vital role in enhancing confidence in our organisation.

Our progress reflects the skills and dedication of TeamSaTH, and this accomplishment would not have been possible without your collective efforts. I hope that you feel a great sense of pride in all that you have accomplished together, and you should all take a moment today to be proud of this achievement.

For our patients and our communities, it brings renewed confidence and demonstrates our commitment to delivering consistent, high-quality care. It means they will see visible, reliable improvements in their care, with services that are designed with their needs at the heart.

Thanks to the improvements that colleagues have made, the Trust has:

- Improved performance in the national league tables – moving from being traditionally at the bottom to 96 out of 134 in Q2 2025/26 – with further improvement expected in Q3. We are currently in Segment 5, the lowest, but moving out of RSP means we move up to Segment 3, a phenomenal achievement
- Moved to ninth nationally - and first regionally - for productivity growth (maximising the resources we have to improve access to care for patients)
- Been the most improved Trust nationally for elective recovery and ranks second for cancer 28-day Faster Diagnosis Standard. Diagnostics is at its strongest level in five years – and as a result the Trust has exited both Tier 1 and Tier 2 oversight arrangements
- Shown early but consistent improvement in the 12-hour and 4-hour performance and ambulance handover metric with December 2025 seeing the strongest performance in some areas since the pandemic.
- An improved CQC rating of Requires Improvement with Good ratings across all domains for Maternity, Children and Young People, and End of Life Care.Of all the original 60 CQC conditions imposed – only one remains for UEC, with a robust plan in place
- Continued to make sustainable progress in Maternity and Neonatal services, and on track to exit the Maternity Safety Support Programme (MSSP)
- Significantly strengthened financial controls with a substantial reduction in agency expenditure. Our Cost Improvement Programme (CIP) is on track to deliver £41m, our highest improvement plan to date. We are on track to achieve our 2025/26 financial plan - a milestone not reached in over 10 years which would see a remarkable 50% reduction in the Trust's deficit since 2023/24
- Secured University Trust status with Keele University – strengthening research, education and evidenced-based practice

This marks a significant milestone in our ongoing improvement efforts. Our journey continues, and we remain focused on further progress without complacency. We will persist in seeking feedback, reflecting on outcomes, and enhancing our practices.

Recognising that there is much more to accomplish, we are dedicated to improving urgent and emergency care for patients, ensuring they receive safe and timely access to necessary services. Although steady advancements have been made, we acknowledge that sustainable change requires time. Our commitment is reflected in the completion of phase one of our improvement plan, which has increased inpatient bed capacity and assessment spaces. Planning for phase two is underway.

We view the upcoming year with confidence. By continuing to collaborate across our Group, we are well positioned to build upon these achievements, advancing improvements that address the evolving needs of our communities.

I am extremely proud to lead this Trust during such an important time in its history, and I am truly grateful to work with colleagues who have achieved meaningful, lasting change together. I would like to thank all our partners for their support and for the messages of congratulations they have sent us as we mark this key milestone in our transformation.

2.2 On 1 April 2026, we will formally operate as a Group, aligning with our Case for Change, Better Together. I would like to extend my sincere gratitude to both Executive teams across SaTH and SCHT for their continued support. It is very encouraging to observe the collaborative efforts between our teams, placing patients and citizens at the centre of our work, and proactively identifying opportunities to improve and adapt our pathways.

I am pleased to announce that, following an external recruitment process, we have successfully appointed a Group Chief Nurse as part of our Group structure. The new Group Chief Nurse will begin their role with the Trust this summer. I would like to thank all colleagues across the Group who contributed to this process.

Congratulations to Ned Hobbs, Chief Operating Officer, who has been appointed Deputy CEO (SaTH) in addition to his current portfolio. I would also like to express my gratitude to Inese Robotham, Assistant Chief Executive, who will retire at the end of March 2026—thank you for all your support, and I wish you the very best for the future.

This month at the Board, we welcome Matthew Neal, Director of Hospital Transformation HTP. He will commence on 1 April 2026 in his expanded role as Group Director of Estates, Facilities, and Capital Programmes which is a new Board role reflecting this is a critical focus for the Trust moving forward.

2.3 We have formally submitted our 3-year operational plan to NHSE which we will share more widely in the organisation. It sets out how we will move forward over the next three years to build on our progress. This sets out a clear and credible trajectory for continued improvement across the organisation, including delivery of the Hospitals Transformation Programme by 2028, further digital transformation and more care delivered in the community. The plan has been developed collaboratively with colleagues at Shropshire Community Trust to ensure accurate identification and delivery of the opportunities offered by the Group, aligning with the objectives of the 10-year strategy.

2.4 On Tuesday, 3 and Wednesday, 4 March 2026, the CQC carried out an unannounced inspection of UEC and Medicine departments at both RSH and PRH sites. I want to express my gratitude to staff throughout the Trust for the warm reception they extended to the inspection team. Our initial feedback was positive, highlighting the progress made so far and identifying areas for further improvement. We are now awaiting the official report.

2.5 On 12 March 2026, the annual NHS staff survey will be published. We would like to thank all those who participated in the survey. Over the coming months, we will carefully review the feedback received and determine the appropriate next steps. During this period, we will relaunch our culture programme across the Group to purposefully re-energise staff engagement, strengthen staff voices, and actively consider how best to support our teams with their health and workload pressures. Our aim is for all employees to feel safe, valued, respected, motivated, and recognised. We are committed to providing the necessary support to help our workforce thrive in their roles. We remain committed to continuously improving the two key metrics, ensuring that our staff feel proud to work at SaTH and would confidently recommend it as a place for care.

2.6 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.

2.7 On Thursday, 26 February 2026, we welcomed the National Elective Care Programme team, together with representatives from No10 and the Secretary of State Delivery Unit.

My thanks to James Wright, Deputy COO, and all colleagues across the Trust for presenting a thorough overview of the improvement journey. The session was both inspiring and informative, clearly demonstrating the collaborative, clinically driven, operational leadership within the Trust.

2.8 As of 5 March, our flu vaccination rate reached 54.2% for all staff exceeding our target of 52.5% for this group. We appreciate the commitment of all colleagues who have received the vaccination, thereby contributing to the protection of fellow staff, their families, our patients, and those most at risk.

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

Division	Post Name	Start Date
Surgery and Anaesthetics	Locum Consultant ENT	01/04/2026
	Consultant Anaesthetist	01/06/2026

Division	Post Name	Start Date
Women and Childrens'	Locum Consultant Obstetrician and Gynaecologist	04/05/2026
	Locum Consultant Paediatrician	01/04/2026
	Consultant Obstetrician and Gynaecologist	05/05/2026

Division	Post Name	Start Date
Medicine and Emergency Care	Locum Consultants (x2) in general Medicine	01/06/2026 & 08/06/2026
	Consultant Cardiologist	01/094/2026

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

3.1 The next public board meeting is being held on Thursday 26 March 2026.

4.0 NHSE

4.1 On 4 March NHSE have NHS England has issued new national actions to accelerate the eradication of corridor care, reaffirming that it is unacceptable due to its impact on patient experience, staff morale and public confidence. A single national definition has been agreed, defining corridor care as a patient spending 45 minutes or more in a clinically inappropriate area of an emergency department or general and acute ward, aligned with the W45 ambulance protocol, with an ambition to reduce this to 30 minutes in 2027/28.

From 6 March 2026, new corridor care fields will be included in the UEC Daily Sitrep, replacing Temporary Escalation Spaces reporting, and monthly national publication of corridor care data will begin from May 2026. Trust boards are expected to treat corridor care as an organisational risk, ensure executive-level oversight and incident reporting, increase executive visibility, and strengthen discharge and operational leadership, alongside national support through GIRFT guidance, clearer escalation expectations, workforce considerations and wider urgent and emergency care reforms. The Trust is currently reviewing the guidance and the recommendations in the letter.

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
6 March 2026

Audit and Risk Assurance Committee, Key Issues Report		
Report Date: 2026.02.27		**Report on:** Audit and Risk Assurance Committee
Date of meeting: 24 November 2025		All NED and Associate NED members were present. Also present but not part of the quorum: Director of Governance, Acting Director of Finance, Director of Financial Recovery & Transformation, NHSE Improvement Director, together with representatives from the Trust's Internal Auditors MIAA, the Trust's external auditors KMPG, with several Trust officers from the Governance and Risk Teams, and Operational Teams. In addition, Mr David Moon from NHSE, observing the meeting relating to the Trust's RSP position.
1	**Agendas**	The Committee considered the following specific items: • External Auditors – Draft External Audit Plan and fees (2025/26 audit) • Internal Audit – Progress Report • Internal Audit Report – NHSE Grip & Control (*substantial assurance)* • Internal Audit Report – Key Financial Controls (*substantial assurance)* • Internal Audit Report – Waiting Lists & Performance *(moderate assurance)* • Follow Up Report – WLI/ Consultant Job Planning from COO • Internal Audit – Draft Internal Audit Annual Report HoIA Opinion 2025/26 • Internal Audit – Draft Internal Audit Plan 2026/27 • Anti-Fraud - Progress Report • Losses and Special Payments Report (quarterly) • Procurement Waivers Report (quarterly) • Non-pay controls report (quarterly) • Contract Award Report (quarterly) • SATH Recovery Support Funding • SATH End of financial year matters 2025/26 • Risk Management Report Q3 2025/26 • Board Assurance Report Q3 2025/25 • Freedom to Speak Up Report Q3 2025/26 • Business Continuity Management Policy renewal
2a	**Alert** *Matters of concern, gaps in assurance or key risks to escalate to the Board.*	• Regarding compliance with the Functional Counter Fraud Standard, the organisation had slipped from green compliance to amber in sector three (of 13). This was partly due to updated training for the senior team having been delayed. Actions are in place to ensure the training is undertaken before the end of March 2026 which will return the amber compliance to green. • Costs of pharmacy items, wastage and write-offs remained a concern. The Committee was advised of a pharmacy fridge door which was recently inadvertently left ajar and led to £25K of medication being rendered unusable. However, regarding pharmacy wastage, it was noted that several mitigations had been identified which could save a significant amount of money for the Trust; a business case was in the process of being developed, which if successful, would increase the

		capacity for medicines recycling, leading to less wastage.		
	Assurance *Positive assurances and highlights of note for the Board*	• The Committee members were pleased with the Trust's receipt of substantial assurance against the internal audit in relation to the self-assessment re compliance with NHSE's Grip and Control checklist and the HMFA's Financial Sustainability Checklist. Internal audit substantial assurance was also received for the Key Financial Controls audit. • Seventeen Waivers were received by the Procurement Team between November 2025 and January 2026, which was a reduction of 14 from the previous period. It was also reported that a new Waiver Control Process had been finalised, which would go live in April 2026. • The Trust implemented a 'No PO (purchase order) no payment' policy in October 2023, with monthly figures being reported monthly to the ICB. Compliance across the latest three-month period to December 2025 stood at 99% (97% previous period) (including balance sheet items) and 96% (90% previous period) (excluding balance sheet items).		
2c	**Advise** *Areas that continue to be reported on, and / or where some assurance has been noted / further assurance sought.*	• Following review by the Executive Team, several proposed changes to the draft internal audit plan were highlighted. This included the removal of Group Structure audits for 2026/27 as it had been agreed that this would be a transition year for the Group model, and too early for auditing. However, it was agreed that these audits would take place during the 2027/2028 financial year. • Recommendation received from the Committee for the Board to approve the revised Business Continuity Management Policy. • There were no proposed changes to the risk scores in the Q3 BAF, and the Committee recommended approval of the BAF to the Board. The recognition of the Group model and its implications for members of the Executive being pulled into Group matters at the risk of their time and attention on the Trust being reduced, had been highlighted.		
2d	**Actions** *Significant follow-up actions*	No *significant* actions at this time.		
	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: 06.02.2026		**Report of:** Quality & Safety Assurance Committee (QSAC)
Date of meeting: 27.01.2026		All NED and Executive Director members, and regular Trust Officer attendees, were present.
1	**Agenda**	The Committee considered the following: • Bi-annual Nursing & Midwifery Staffing Report • Board Assurance Framework Q3 • Max Fax service provision • Regulation 28 case update • UEC SIIP 4A Report • Moving to Excellence Quarterly Report • UECTAC Report • QOC 4A Report • Quality Indicators IPR and Exception Report • Medical Regulatory Group Report • PTAC Annual Report • PSIRF Quarterly Update • IPC Quarterly Report • Antimicrobial resistance – call to action • MNTAC 4A Report, inc Maternity Dashboard key issues • MNSC Report • National surveys: Adult Inpatient, Cancer Patient Experience, CYP Survey
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Significant increase in ambulance offload delays during December, with 52 patients delayed by over 8 hours, and low harm identified for 5 of these.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• QSAC received the Bi-Annual Nursing & Midwifery Staffing report which identified that staffing ratio is better than recommended ratio of 1:8 and Care hours per patient day are in line with peer and provider median. Where action was identified, these were in train: Renal Unit, SAU and Ward 14. • QSAC received updates on three patient surveys: Adult Inpatient, Cancer and Children and Young People. There were strengths and areas for improvement in all, and the divisions are to attend QSAC in May to present progress on action plans and the impact for patients. • Maternity acuity rates in delivery remained above target at 92% in December. There were no delays in Category 1 Caesarean Sections in December, although there was an increase in the number of delays in Category 2 which are being reviewed. CQC published Maternity Survey results for 2025 10th December. The Trust results were very positive, showing that women cared for by our teams felt that they were treated with kindness and compassion and were spoken to in a way they could understand. Once the qualitative results have been received, as in previous years, an action plan for further improvements will be co-produced with the MNVP.

		• Two members of staff on the Neonatal Unit have completed their Qualification in Speciality training bringing the ratio to 59% from January, and 3 have completed their foundation training. While still short of the 70% ratio target, the unit has achieved the highest compliance within the region. The Committee heard that the challenge was retaining staff once they had the qualification. • QSAC received the UEC System Integrated Improvement Plan (SIIP) Key Issues Summary Report. The Trust had presented the evidence to NHSE, and a number of elements signed off. Nine elements relating to UEC are at risk. An updated action plan will return to QSAC next month. • QSAC received the Moving to Excellence Quarterly Report. Four of the six transformational programmes are on track with two at risk- UEC and Financial Recovery Strategy. • Paediatric Transformation Programme Annual Report: QSAC received the report and was pleased to note the progress against the action plan with 91% actions now completed and evidenced. PTAC is to stand down from March and oversight of outstanding actions to be via usual governance routes. The positive impact of the programme on the workforce was recognised along with the focus on ensuring that the impact of actions on outcomes for children and young people was recognised.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• Third and fourth-degree tears in December reported 4.5.%; this is above the national average, our usual reporting is below 2%. This is being reviewed and an update to be brought back to QSAC. • Maternity and Neonate Safety Champions Report: In preparation for the move to the new build, the visit to Midland Metropolitan Hospital to look at how they transfer babies to the neonate unit was highlighted as constructive. The team are now looking at identifying equipment needs. • Staff have been impacted by the loss of programme support for quality improvement strategies and are concerned of the impact this will have. QSAC requested a report on QI in the Trust, to identify current capacity and plans. • QSAC received a verbal update on the Max Fax service and how the arrangements with support from RWT and UHNM are working. SaTH hold fortnightly meetings with RWT to monitor and there is a clear escalation route should issues arise. There have been no incidents and patients are receiving the care they need. Regionally, Max Fax services are challenged and the NHSE is supporting SaTH identified as the first area for a review. • CQC Update Report: The Trust continues to work towards the removal of the final conditions imposed by the CQC which relate to time to assessment in ED. The Trust has invited CQC in for a further visit. • The maternity service has been awarded 'Student Placement of the Year' by Keele University which reflects on the positive experience and contribution the Trust is making to midwifery training. • The maternity service has been selected to participate in the first cohort of the Perinatal Equity and Anti-Discrimination programme. The Committee noted the improvements in reporting on demographics and ethnicity in maternity reports and were pleased that this will provide an opportunity to further strengthen work to improve outcomes for all. • QSAC received an update on the Regulation 28 notice the Trust received in October 2025 and the Trust response to HM Coroner. A number of actions are in progress: • patient safety incident investigation is due at RALIG in February 2026

		• implementation of clear standard operating procedures (SOPs) for inpatient to outpatient referrals with a single email contact point for each team - due by March 2026. • consideration of the feasibility of a digital solution to reduce this risk. • While Summary Hospital-level Mortality indicator data is now available, there remains caution about the quality of the data. • The Trust is to be part of a regional pilot which will review the care of two patients who were delayed in ED. This is an opportunity to identify further learning of the impact of delays on patients and their family. • Infection Prevention & Control Quarterly Report (IPC) Q3: The Trust has exceeded the target for C-Diff this year. Action plans are being refreshed. Deep cleaning took place in four wards during December. Plans are being drawn up to identify priority areas for deep cleaning. • Antimicrobial resistance - Act now: protect our present, secure our future letter: The World Health Organisation has declared antimicrobial resistance (AMR) as one of the top global public health and development threats, and AMR is listed on the UK government's National Risk Register. In response to a letter sent to all organisations, which asks the Trust to agree and publish three priority areas for AMR improvement by April 2026. For each priority the Trust must: • Define specific, measurable objectives. • Assign executive-level accountability. • Establish timelines and reporting mechanisms. The Trust is on track to meet the deadline, and an action plan will be presented at QSAC in February. • Board Assurance Framework: The Committee noted the updates to the Board Assurance Framework. For the risks overseen by QSAC (1,2,8,9,10 and 12), the committee agreed that the current ratings for risks) were appropriate and no changes to 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, both for BAF risk 9, have been closed this quarter.		
2d	**Actions** ***Significant*** *follow up actions*	• As the Trust has now achieved University status, there was a discussion of what this means for the Trust. An action was agreed that there should be a meeting to discuss next steps between the Trust and the University. • A request for Moving to Excellence, and all reports to focus on what the impact is on patients.		
3	**Report compiled by**	*Ms Sarah Dunnett* *Chair of Quality and Safety Assurance Committee*	**Minutes available from**	*Mike Wright* *Committee Support*

The Shrewsbury and Telford Hospital NHS Trust

Quality and Safety Assurance Committee, Key Issues Report		
Report Date: 02.03.2026		**Report of:** Quality & Safety Assurance Committee (QSAC)
Date of meeting: 24.02.2026		All NED and Executive Director members, and regular Trust Officer attendees, were present.
1	**Agenda**	The Committee considered the following: • PSIRF Quarterly Update • UECTAC Report • QOC 4A Report • Quality Indicators IPR and Exception Report • Safeguarding Q3 Report • Legal Report • ME Q3 Report • PALS, Complaints, Patient Experience & PACE Report Q3 • UEC SIIP 4A Report • IPC – Deep Clean Action Plans • IPC – Antimicrobial Resistance • MNTAC 4A Report • Maternity Dashboard and key issues report • MNSC Report • Tuberculosis Call to Action Letter
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• The number of people with no criteria to reside (NCTR) remains high. QSAC requested further detail about the pathways NCTR patients are on to help understand the reasons for delays, and any actions needed. The discharge improvement group has invited a representative from the care home sector to support work to improve timely and appropriate discharge. • The Trust received an outlier notification alert for National Vascular Registry, for risk adjusted in-hospital mortality following lower limb angioplasty for 2022-24. Action plan is to be prepared for the CQC and be followed up by QOC. • There have been five occasions in last 12 months where the mortuary fridge alarm at PRH has not automatically triggered alert at switchboard. These have been reported as near misses as staff had intervened. This has been escalated and action identified to ensure that the alarms are received by the appropriate person.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	**Safeguarding Q3 Report:** The training rates for the Trust are 85% and over for all categories of safeguarding training, there are areas where rates are low, including some wards for Mental Capacity Act and Deprivation of Liberty Safeguards. QSAC requested that future reports capture any impacts and mitigating actions where there are identified gaps. The Trust is to liaise with Public Health regarding prevention/early help regarding their role in reducing the impact of childhood dog bites which have not reduced. **Clinical Claims and Litigation Update:** There were 8 inquests closed in the reporting period. Witnesses were called to give live evidence in 2 cases, which is lower than in previous quarters. Updated guidance for clinicians involved in

		inquests has been approved. Subject access request performance has improved, with more being responded to in time and a reduction in overdue requests. **Medical Examiner & Bereavement Service Report Q3:** Overall, quarter three reflects a period of robust performance, positive family engagement, strengthened governance arrangements, and progress towards securing a sustainable, system-supported service model. • A total of 1,284 deaths were reviewed, demonstrating sustained activity across both acute and community settings. • Community notification times showed a marginal deterioration, increasing from 2.2 to 2.5 days, and will remain an area of focus. • Performance against the national expectation for issuing MCCDs remained strong, with 86% issued within 3 days. Although 14% exceeded this timeframe, this was influenced by the increase in deaths and by reduced medical workforce availability during junior doctor industrial action, yet the overall standard of timeliness was maintained. Feedback from bereaved families continued to be highly positive, reinforcing the quality and compassion of the service. This quarter also saw progress in strengthening the complaints process for the ME Service, ensuring alignment with both the ME's required independence and the Trust's established NHS complaints procedure. Assurance has been confirmed that the Trust's process remains the appropriate mechanism for managing any concerns relating to the ME Service. A business case to address the funding gap seeking recurrent system-wide funding to support a sustainable ME service has been completed. **Trust PSIRF Safety Priorities Update:** QSAC received an update on the current priorities and plans going forward. The team have identified that for complex programmes such as adult deterioration, there is a need for structured support to maximise the impact and track actions. QSAC was pleased to hear of the progress being made in cross working and joint ownership. Following recent inspection by Specialist Pharmacy Service (SPS) of aseptic preparation services the overall risk rating now reduced from 'high' to 'medium' following substantial work in this area. **PALS, Complaints and Patient Experience Q3 Report:** QSAC heard that there was a reduction in the backlog of complaints, however the number of complaints remains high. Minority groups are under-represented in making complaints and QSAC asked for an update on work to encourage feedback from all our citizens. The 15 steps challenge is being refreshed and led to a discussion on the importance of NED walkarounds. A risk has been identified that the Trust inpatient FFT response rate for October and November would place the Trust 3rd lowest when benchmarked against other trusts nationally. The reliance upon QR codes and telephone feedback across inpatient and outpatient areas to capture FFT is likely to continue to achieve low response rates next quarter. There is a plan to expand the use of SMS for the FFT which should improve performance as it has in ED. The option of using paper will remain to reduce the risk of digital exclusion. **Maternity Dashboard and Key Issues Report:** Maternity acuity rates in delivery remained above target at 95% in January. There was an increase in the number of women smoking at time of delivery, which reported as above the national target at 6.6%, which was unexpected. There was also an increase of term admissions to neonatal which was attributed to respiratory issues. **UEC System Integrated Improvement Plan (SIIP):** QSAC received the UEC System Integrated Improvement Plan (SIIP) Key Issues Summary Report. Eleven elements relating to UEC are at risk and will be transferred on to the 2026/2027

		SIIP. An updated draft action plan was shared with QSAC.		
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	**Deep Clean Actions:** As of 5 February 2026, the Trust has reported 105 cases of CDiff against a target of 98. Twelve wards - six at PRH and six at RSH - have been identified as priorities for deep cleaning. QSAC heard there is a risk that we will continue to not meet infection targets if the deep clean programme is not delivered. **Tuberculosis Call to Action Letter:** NHSE Midlands wrote to the Trust in December 2025 regarding Tuberculosis (TB) – Call to Action in response to the West Midlands having the second highest TB notification outside of London with the highest rise of any region at 22.2%. A plan is being developed by the medical division which will be monitored via the Quality Operational Committee and escalated through to Quality & Safety Assurance Committee. An update will be brought to QSAC in April. **Maternity & Neonatal Safety Champions Report:** A joint Foetal Medicine service with Stoke is being implemented to allow the provision of foetal medicine locally instead of service users having to travel to UHNM. **Antimicrobial resistance – 'Act now: protect our present, secure our future' letter:** QSAC received an update on the current position and performance and the three priority areas for action. QSAC heard that the Trust has a strong performance in reducing total anti-microbial usage and access category usage. The antimicrobial steering committee has completed a risk and capability assessment and identified the three priority areas. The antimicrobial steering committee (AMSC) has good engagement from Medicine but requires more engagement from other specialities which the medical director will support. The AMSC will report on progress quarterly to QSAC.		
2d	**Actions** ***Significant*** *follow up actions*	• None from this meeting.		
3	**Report compiled by**	*Ms Sarah Dunnett* *Chair of Quality and Safety Assurance Committee*	**Minutes available from**	*Mike Wright* *Committee Support*

The Shrewsbury and Telford Hospital NHS Trust

Performance Assurance Committee, Key Issues Report		
Report Date: 20 January 2026		**Report of:** Performance Assurance Committee
Date of meeting: 20 January 2026		Present: R Edwards (Chair), S Dunnett, R Dhaliwal, N Hobbs, I Robotham, N Lee, T Cotterill, L Mitchell, A Winstanley (part), J Cunningham (part), S Buckland(part), R Boyode (part)
1	**Agenda**	The Committee considered the following: • Performance Highlights • UEC System Integrated Improvement Plan (SIIP) • NHSE Tiering de-escalation letter • Integrated Performance Report • Workforce Plan and Performance Impact • Strategy & Partnerships update • SaTH Provision of Alcohol Support Services • Digital Programme Update • Board Assurance Framework
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• <u>UEC performance</u>: while December's 4 hour performance for type 1 and type 3 attendances, at 52.3%, remained below the planned target of 54.9%, the over 12 hour performance at 78% was above the planned target of 77.4% and the best SaTH December performance since 2021. This is still well below the performance needed by our patients, is still in the bottom decile of trusts and still involves very long average waits in ED. PAC continues to monitor the length of these long waits. • <u>No Criteria to Reside (NCTR)</u>: despite the additional beds and assessment unit capacity coming on stream in December, the number of patients with NCTR reached an average over 160 in the first week in January (peaking at 192), reducing to an average of 150 the following week and to the high 120s so far in the third week. This was an unusually high level compared with previous Christmas and New Year periods. It had negated the majority of the benefit PAC was hoping to see from the additional 56 beds in modular wards at RSH and the additional beds at PRH. PAC wanted to know what had happened and what could be done, recognising this was a system-wide issue that only the system as a whole could deal with. There will be a review of how and why this spike occurred in the Winter review. PAC agreed to a joint review with QSAC of the impact in terms of harm and health outcomes of the delays in discharging these patients. • <u>Alcohol Care Team:</u> PAC received a paper explaining why this service had ceased to be commissioned at SaTH and what provision currently existed for the community treatment of patients presenting with drug and alcohol misuse and dependency. It was noted that there is good evidence that fully optimised Alcohol Care Teams are effective and cost-effective interventions. Agreed that a report should come to PAC looking at the best way to provide such a service and the costs and predicted benefits.

2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Elective Care: the improving trajectory continued in December. On the 28 day faster diagnostic standard (FDS) SaTH is now 2nd out of 134 trusts. PAC noted the letter of 15 December 2025 from NHSE Midlands which de-escalates SaTH from Tier 2 to Tier 3, ending the external monitoring regime of SaTH's elective performance. PAC considered when it would be appropriate to reconsider the BAF score for risk 9, elective care and agreed to do so as part of the 4th quarter BAF report.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• Data on protected characteristics: PAC received data on access to UEC care in terms of 4 hour and over 12 hour waits and access to elective care. Regarding elective care, graphs showed that average waiting times had reduced for all groups with very little differences between them. For UEC, older patients predominated in over 4 hour and over 12 hour waits, as they were more likely to require admission. PAC asked for more information about the profiles of those admitted compared with those not admitted, and about the underlying reasons why older people wait longer and what could be done about it. This work is a core part of our Trust's duty, mandated by law (Equality Act 2010 and Health and Social Care Act 2012) and strengthened by the Health and Care Act 2022, to analyse waiting times against health inequalities, identifying disparities by deprivation, ethnicity, and other factors, and then actively working to reduce these gaps through targeted service delivery and inclusive recovery plans. • Workforce: PAC received a report on the actions underway in the short term and longer term to manage staff costs, including careful balancing of annual leave and sick leave, while ensuring we have the right mix of staff for the work we need to do. PAC heard that staffing of the modular wards was almost complete. • Digital update: PAC received a detailed report on the Digital Programme for 2025/2026. PAC noted the extent and importance of this work and the need for careful prioritisation, which was built into the system. PAC wanted to understand how SaTH compared with other trusts in our digital maturity, noting that we were advanced in some aspects (FDP) but behind in others (Electronic Prescribing and Medicines Administration). A paper will be brought to PAC on this in April/May 2026. • Data Warehouse and Federated Data Platform Update: PAC heard that the legacy DWH is no longer used for statutory submissions. Work is ongoing to give assurance that the FDP is accurately carrying out Service Level Agreement Monitoring (SLAM). The intention is to have the FDP fully functional, for business and clinical (including SHMI) purposes by April 2026, but it may be that data quality checks show that further refinement is necessary in which case the date may be deferred to May 2026. • Switchboard alarms update: PAC heard that the immediate risk has been mitigated, and that a longer-term solution is actively being pursued, which will take into account prospects for robotic process automation and potential cost savings. • Strategy and Partnership Update: PAC received a comprehensive report covering developments in the ICB, the Shropshire Telford and Wrekin Health and Wellbeing Boards, the STW Integrated Place

		Partnership Boards and SaTH's partnership activities regarding shared pathways and Neighbourhood Health developments. PAC also saw a draft of the ICB's health strategy and considered what this meant for SaTH and ShropCom in terms of the shift towards prevention and providing care closer to home.		
2d	**Actions** ***Significant*** *follow up actions*	• BAF Q4 to consider whether to reduce the score for BAF Risk 9 Elective Care. • Paper to come to QSAC and PAC on the health outcomes and harm arising from the spike in NCTR over Christmas and New Year. • Further data on UEC long waits separating admitted and non-admitted to be included in the Performance Highlights report • Paper comparing SaTH's digital maturity with that of other trusts to come to PAC in April/May • Paper to come to PAC on ways to provide an effective Alcohol and Drug care team.		
3	**Report compiled by**	*Rosi Edwards, Non-Executive Director/Chair*	**Minutes availablefrom**	*Lisa Mitchell Senior Governance Support Officer*

The Shrewsbury and Telford Hospital NHS Trust

Performance Assurance Committee, Key Issues Report		
Report Date: 17.02.2026		**Report of:** Performance Assurance Committee
Date of meeting: 17.02.2026		**Attendees** R Edwards (Chair), S Dunnett, R Dhaliwal, N Hobbs, C Bickley, F Blakeman(NHSE), T Cotterill, L Mitchell(minute taker), S Buckland(part), A Winstanley(part), J Cunningham(part), L Wyatt(part) **Apologies** I Robotham, R Boyode, N Lee, T Long
1	**Agenda**	The Committee considered the following: • Performance Highlights • UEC System Integrated Improvement Plan • Integrated Performance Report • Workforce Plan and Performance Impact • Annual Fire Safety Audit 2025 • Fire Enforcement Notice update • Climate Change 4A Report • Datawarehouse Update • Digital Transformation Steering Group 4A Report • Strategy & Partnership update • Health & Inequalities update • Review PAC Cycle of Reporting
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Urgent and Emergency care: the additional capacity introduced in December and January has not had the intended impact on waiting times and flow through ED due to the very high levels of patients with no criteria to reside. The numbers have stayed high and worsened in the week preceding the meeting. SaTH has written formally to the Integrated Care Board summarising our concern about the rise in patients with NCTR. SaTH will also be meeting the Chief Executive of Shropshire County Council where the largest proportion of NCTR patients are from. • Long waits in ED: PAC received data for January 2026 on the age profile of those experiencing long waits in ED both for those admitted and those not admitted. In each case older people faced significantly longer waits. PAC wanted to know why this was and what could be done about it, given that these tend to be the frailest of our patients. A further report looking at the reasons why older people spend so much longer in ED, and what could be done to reduce the time, will come to PAC in March. • Shropshire Fire and Rescue Service Enforcement Notices: PAC received copies of the two notices issued by Shropshire Fire and Rescue Service in January 2026 following their 5 visits to PRH in November and December 2025 as part of a fire safety audit. These covered a range of issues including fire compartmentation, storage of oxygen cylinders and other materials on escape routes, training in fire safety, obstruction of fire exits and overcrowding. In particular SFRS stated that it can no longer support the Hospital Full Protocol "*as a reliable long-term means of escape. SaTH may continue to use the current arrangement only on a strictly temporary basis while an alternative, safe and consistently manageable solution is identified and implemented.*" PAC considered that the high level of NCTR was driving the need to apply the protocol, and that the consequential risks were something SaTH should explain to local authorities. SaTH has until 26 April 2026 to produce an alternative protocol.

		• PAC were told that while many of the risks had already been dealt with some - replacing damaged fire doors - had a longer lead time. PAC heard that while these fire doors were held open with magnetic catches, tugs and trolleys still bashed into them, causing damage even to new doors. In addition to comms activity to explain the impact on safety and finances, protective measures such as bollards will be fitted. A programme of replacement based on an independent assessor's report will be prepared and funding will be allocated
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Cancer: November performance was 85.7% for the 28-day faster Diagnostic Standard (FDS) and put SaTH second best performing Trust in the country after being the bottom placed Trust in Feb 2025. Confirmed December 28-day FDS cancer performance is 83.0% against the local plan of 76.5%. 62-day December performance was 70.1% against the local plan of 67.2%. 31-day December performance was 98.0% against a national target of 94.7%. • Elective: remains ahead of plan, despite plateauing in Q3 when activity was reined in to support the financial plan. It is notable that SaTH met its own stretch target of zero over 40 week waits for children and young persons in January 2026. • Outpatient Sprint Funding has become available to ensure the system delivers its elective care plans for 25/26 and encourages providers who are able to do so to over-perform against their plans and so improve on the original performance ambitions and catch up on some of the lost activity from the periods of industrial action. It will enable providers to be paid for all first outpatient activity (including procedures) above their Q4 plan. SaTH's initial plan submitted to NHSE would see us deliver an additional 6,712 Outpatient First Appointments (OPFAs) during Q4. Early internal figures suggest that we are likely to exceed what we initially committed to. This will lead to additional income and improvement in access times as OPFAs are seen earlier. • Climate Change Group reported that - operational EV chargers were installed at RSH, PRH and Sentinel works, supporting the Trusts operational vehicles, ie the new electric waste vehicle in Facilities. - SaTH are constructing a 340 kWh solar car canopy at PRH in the W&Cs car park, due to be completed by 31 March 2026. SaTH secured £100k for LED lighting upgrades at PRH, RSH and Queensway. - Facilities are launching the reuseable cup scheme (2 February 2026) to reduce costs and waste; the Trust purchase 220,300 disposable cups. - SaTH are working with SCHT and RJAH for shared waste services. • Digital: progress with the Federated Data Platform continues, with financial and clinical data handling being validated. As part of this process, NHSE has removed the red flag on SaTH's Summary Hospital-level Mortality Indicator (SHMI).
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• Financial risks and impacts within the UEC transformation programme: the financial recovery taskforce is developing an overarching efficiency and transformation plan that will align all current transformation, improvement and financial recovery projects under one governance structure. This will utilise existing governance arrangements where possible but ensure that each is comprehensive and covers all the elements of each discipline in a standardised approach. Work is underway to determine the format and content to be utilised as the methodology for all projects and is expected to be presented to FRG by end March for approval to proceed. The outline proposal will go to FAC and PAC for assurance. Developing the efficiency and transformation plan is likely to take 3-6 months, and it will be a living document. The plan will align with the Group integration and HTP and will include UEC and the other programmes of work. Specifically for UEC, metrics covering the overall cost and productivity of the UEC pathway are

		being developed, as well as sub-metrics of the primary drivers of pathway cost and productivity. • Authorised Engineer's Annual Fire Safety Audit Report 2025: this report built on previous years' reports and showed some improvement on previous years and identified some issues also raised by SFRS (eg training, need for protocols). It did not identify the issues with damaged fire doors and Hospital Full Protocol found by SFRS at PRH. This gives PAC some cause for concern that AE Audits may not give a full picture of the level of risk across the Trust's sites.		
2d	**Actions** ***Significant*** *follow up actions*	• Action plan in response to Shropshire Fire and Rescue Service Notices and Authorised Engineer Annual Report to come to PAC in April 2026 • Training in Fire Safety: chair to inform co-chair of Group People Committee of issues raised by SFRS and AE. • Chair to write to Chief people Officer and Co-chair of Group People Committee about "owed hours" asking how these have accrued and how they are being managed.		
3	**Report compiled by**	R Edwards (Chair) Non-Executive Director	**Minutes availablefrom**	Lisa Mitchell Senior Governance Support Officer

Finance Assurance Committee, Key Issues Report		
Report Date: 27 January 2026		**Report of:** Finance Assurance Committee
Date of meeting: 27 January 2026		R Miner(chair), S Crowther, J Sargeant, A Winstanley, P Gardner, T Cotterill, C McInnes, L Mitchell (minutes and support), D Wright (NHSE in F Blakeman absence), R Muskett, R Boyode(part), D Bryce(part) & S Edmonds(part) In attendance: M Mansfield (RSP review)
1	**Agenda**	The Committee considered the following: • Financial Report M9 • Financial System Integrated Improvement Plan (SIIP) • Efficiency & Financial Recovery Report • Draft Budget setting 2026-27 • Workforce Plan and Financial Impact progress • OPOG 4A Report • CPG 4A Report • FRG 4A Report • Employers National Insurance Increase – HTP contractors • BAF • Review FAC cycle of reporting
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• A deficit for M9 of £1.92m making a cumulative deficit of £5.8m against the agreed deficit support ("break-even") of £45.15m. The reasons include additional capacity costs and elective over-performance. • This leaves a current best forecast to the year-end of £3.6m albeit if the various risks cannot be managed, then this could increase significantly. • Cash balances at the end of December were £16.41m, a reduction but due to certain capital expenditure. This should therefore improve by the end of M10. However, non-achievement of the 25/26 financial plan, and the potential reclaim of cash support for Q4, could significantly impact the Trust's cash position by Q2 of 26/27 and require "an ask" for additional support. Various scenarios have been "stress tested". • Achievement of the workforce plan and its financial impact continues to pose the biggest challenge to the Trust's overall financial performance. • Capital expenditure is behind plan but is being managed.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Efficiency savings are currently £28.6m, which is £0.2m over plan to date and is forecast to achieve its £41.4m plan by 31 March. • The Committee notes the contents of the 4A Reports in respect of the Operational Performance Oversight Group (OPOG), the Capital Planning Group (CPG) and the Financial Recovery Group (FRG) all demonstrating consistency with other reporting. • The Committee approved the mechanism for the Employers national Insurance Increase on the HTP which is being underwritten by NHSE. • The Committee approved the draft budget setting paper for 26/27. • The Committee notes the continued completion of actions on the Financial Systems Integrated Improvement Plan (SIIP), achievement of which is dependent upon the Trust's financial outturn. • The committee noted the SIIP actions for 2026/27.

		• The Committee confirmed its agreement to the "20" score in the Board Assurance Framework, particularly on the basis that financial performance will have on the future cash position.		
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• Workforce costs have been reduced as the MARS scheme works through but challenges remain with levels of sickness and divisional spend.		
2d	**Actions *Significant*** *follow up actions*	• The Committee will keep under review the effectiveness and trajectories of cost mitigations in Q4 such that the outturn for 25/26 becomes as accurate as possible.		
3	**Report compiled by**	*Richard Miner, Chair/Non-Executive Director*	**Minutes availablefrom**	*Lisa Mitchell, Senior Governance Support Officer*

Finance Assurance Committee, Key Issues Report		
Report Date: 24.02.2026		**Report of:** Finance Assurance Committee
Date of meeting: 24.02.2026		R Miner (Chair), S Crowther, J Sargeant, A Winstanley, P Gardner, R Musket, S Edmonds, T Cotterill, C McInnes, L Mitchell(Minute taker) R Boyode(part), M Neal(part), N Hobbs(part)
1	**Agenda**	The Committee considered the following: • Financial Report M10, incl forecast to year-end • Finance System Integrated Improvement Plan 4A Report • Efficiency & Financial Recovery Report • Quarterly Contract Award Report • Energy, Security & Decarbonisation – contract variation • Draft Modular Theatre Business Case • Workforce Plan & Financial Impact • Operational Performance Oversight Group 4A Report • Capital Planning Group 4A Report • FRG 4A Report • Review FAC Cycle of Reporting
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• M10 results showed a cumulative deficit of £5.6m (to the breakeven plan, noting £45.1m of deficit support funding full year) to the end of January with an in-month surplus of £0.2m. The cumulative performance is predominantly due to additional capacity costs, elective over performance, premium rate staffing and unavailability. • The Trust may require some cash support in Q2 of 2026/27. • There is currently £2m of unmitigated risk to the year-end breakeven plan but with an expectation that with the various ongoing negotiations and continuing governance controls, this can be mitigated. • The capital programme is some £32m behind plan but senior leaders know what they need to do and there may be opportunities to incur costs early under “vesting” arrangements for HTP. • The £8.6m “gap” in the Operational Plan for 2026/27 is now the subject of NHSE scrutiny with pressure to close the gap.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Cash balances at the end of M10 were £89.05m but this is partly due to capital drawdown and is expected to be c£50m by year end. • The Committee noted the System Integrated Improvement Plan (SIIP) update and received a verbal update on those actions required for 2026/27. • The Trust is in a positive position over the efficiency savings, having achieved £32.7m out of a target of £41.4m by year end which puts it ahead of its trajectory. • Notwithstanding worked workforce numbers remain over plan, more rigorous governance (eg accountability for sickness absence and approval of bank spend) are being applied. • 4A reports were noted for the Operational Performance Oversight Group (OPOG), Capital Planning Group (CPG) and Financial Recovery Group (FRG). The CPG Terms of Reference were approved.

2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• The Committee approved the Energy, Security and De-carbonisation contract variations noting it had no implications for cost but that it was agreed that there was a cap to these costs with Vital Energi. • The Draft Modular Theatre Business Case was approved for submission to the Board but with further clarity around the net present value (NPV) of the purchase options to make clear which was the most advantageous to the Trust.		
2d	**Actions *Significant*** *follow up actions*	• The Committee noted that while no contracts had been awarded between the beginning of November 2025 and 31 January 2026, the reporting felt incomplete and the Committee considered that it would be helpful if a list of wavers came to the Committee together with a forward list of expected contracts. • A more transparent financial quantification of excess workforce costs (albeit acknowledged as difficult) would be helpful in identifying trends. • The cycle of reporting remains a work in progress with further items to be added including Data Warehouse updates, divisional deep dives and a “report back” on previous business case approvals.		
3	**Report compiled by**	R Miner, (Chair) Non-Executive Director	**Minutes availablefrom**	Lisa Mitchell Senior Governance Support Officer

** This report has been produced for assurance for Boards based on the SaTH People & OD Assurance Committee and Shropshire Community People Committee meeting together in common (under their existing terms of reference). It is hoped in due course that a joint committee will be established with one terms of reference.*

Group People Committee, Key Issues Report	
Report Date: 27 January 2026	**Report on: Group People Committee**
Date of meeting: 26 January 20265	**Those present:** Cathy Purt — Non-Executive Director – meeting Chair (Shropcom) Teresa Boughey — Non-Executive Director (SaTH) Rosi Edwards — Non-Executive Director (SaTH) Claire Horsfield — Director of Operations & Chief AHP (Shropcom) Rhia Boyode — Chief People Officer (SaTH and Shropcom) Nigel Lee — Director of Strategy and Partnerships, SaTH Shelley Ramtuhul — Director of Governance (Shropcom) Jill Barker — Non-Executive Director (SCHT) Wendy Nicholson MBE — Non-Executive Director (SaTH) **In Attendance** Jo Williams — Group Chief Executive Jonathan Gould — Deputy Director of Finance (Shropcom) Jennie Rowlands — Deputy Medical Director (SaTH) Simon Balderstone — Director of Workforce & People Services (SaTH) Heidi Fuller — Non-Executive Director (SaTH) Tracie Black — Associate Director for Workforce, Education & Professional Standards (Shropcom) Sabenna Khanna — HTP Workforce Transformation Lead (SaTH) Paula Gardner — Interim Chief Nurse (SaTH) Dawn Thompson — Associate Director of Culture (SaTH) Anna Milanec — Director of Governance Nick Dowd — Head of People Advisory Team & Governance (SaTH) – Item 3.7 Mary Aubrey — Programme Director (SaTH) – Item 3.3 Danielle Alexander — People & OD Business Partner – Medical & Dental – People Advisory Service (SaTH) – Item 5.3 Apologies: Emma Wilkins Interim People Director, Clair Hobbs Director of Nursing & Clinical Delivery, Dr J Jones Executive Medical Director, Deborah Bryce Head of Corporate Governance & Compliance

1	**Agendas**	The Committee considered the following: • *Workforce Integrated Performance Report* • *2025/26 SIIP Workforce and Leadership Plan* • *Board Assurance Framework* • *Shropcom Policy Tracker* • *Quarterly Employee Relations Report – SaTH and SCHT* • *Nursing & Midwifery Staffing Update – SaTH* • *EDS 2022 – SaTH* • *Chief People Officer Update* • *Culture* • *Staff Survey – SaTH and SCHT* • *Sexual Safety* • *Gender Pay – SaTH and SCHT* • *Integrated Strategic Workforce update 25/26 and 26/27* • *HTP update and Neighbourhood Workforce*
2a	**Alert** *Matters of concern, gaps in assurance or key risks to escalate to the Board.*	• Strategic Workforce Plan deliverables need completion by end of March 2026 with some work extending into next year. • Low compliance with fire safety training and resuscitation training was noted—these have been picked by the Patient Safety Committee (ShropCom). • Sickness Absence is a rising trend and is a key risk for both Organisations. • Bank usage remains over plan, although progress has been made and remain dependant on temporary staffing in areas such as ED, paediatrics, Prison and urgent care. • Large number of Policies are overdue and work progressing but need continued oversight and a priority list required. • Employee relations trends have increased with the use of AI grievances
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Shropcom reported 97% mandatory training compliance, the highest recorded to date. Although specific areas like Fire safety training and RESUS require focus. • Nursing vacancies at SaTH have reduced significantly and recruited newly qualified nurses. Recruitment days and proactive strategies are in place, providing continued assurance. • Appraisal compliance is an improving picture at both Organisations.
2c	**Advise** *Areas that continue to be reported on, and / or where some assurance has been noted / further assurance sought.*	• Staff survey result responses for both Organisations were lower than last year with a number of the People Promise themes deteriorated across both Trusts. Update will be provided to the Board. • Gender Pay Gap reports for both Organisations will be presented to the March Board for approval prior to publication. • The Cultural and Leadership Development programme is underway with some new initiatives.

2d	**Actions** *Significant follow-up actions*	• Update on the Armed Forces covenant to be provided at the March Group People Committee meeting. • The Policy alignment work will continue as part of the Group Transition programme. • An update on the sickness levels relating to stress and the round table discussion to be provided to the Group People Committee. • Focus on mandatory training compliance relating to Fire Safety and RESUS for Shropcom.		
	Report compiled by:	Diane Davenport (committee administrator) and Cathy Purt (meeting chair)	**Minutes available from:**	Diane Davenport, committee administrator, ShropCom.

HTP Assurance Committee, Key Issues Report		
Report Date:		**Report of:** Hospitals Transformation Programme Assurance Committee (HPAC)
Date of meeting: 22 January 2026		**Attended by**: Chaired by the HPAC Chair with NED members present. Acting Director of Finance, Deputy Medical Director Group Chief Executive Officer, Director of HTP, HTP Clinical Lead and additional colleagues in attendance.
1	**Agenda**	The HPAC considered the following: • Programme updates including the Emergency Department (ED) Phase 2 and New Building Critical Path Overviews • Latest construction update on the new build • Review of contract delivery scheduled date • Risk overview, governance and processes • The remaining phases of refurbishment for ED • The new build phases • Clinical and operational matters in respect of the new HTP model for Medicine and Emergency Care (MEC) • High Level clinical and operational timelines for MEC • Clinical and operational matters in respect of the new HTP model for surgery, anaesthetics, and critical care (SACC) • High Level clinical and operational timelines for SACC • Clinical and operational matters in respect of the new HTP model for Women and Children (W&C) • High Level clinical and operational timelines for W&C • Clinical and operational matters in respect of the new HTP model for Clinical Scientific Services (CSS) • High Level clinical and operational timelines for CSS • Site health and safety update • Workforce and training • Communications and engagement • Finance including year to date spending and expenditure and the delivery of the project capital programme for year end.
2a	**Alert** *Matters of concern, gaps in assurance or key risks to escalate to the Board*	• A plan was presented to the Committee to describe how services will be migrated into the new building. This included a schedule for how different services will transition into the new building. Committee members asked that clinical risks associated with the transfer are considered appropriately and that partners are engaged with prior to any shift in activity. • Committee members would like to escalate to the Board the need to be very clear, as part of the HTP, of which services should be provided within an Acute and Community setting. Furthermore, the Committee sought further assurance around the clinical pathway work and how the community health (neighbourhoods) work aligns with HTP. • The Committee was informed that the bed numbers required for the new HTP clinical model had been reviewed, but further validation is needed before confirmation. Once governance approvals are complete, results will be presented to the Committee for assurance.

2b	**Assurance** *Positive assurances and highlights of note for the Board*	**The HTP Assurance Committee wish to assure members of SaTH Board of Directors that:** • The Committee received assurance from the Senior Responsible Owner (SRO) around the construction build programme. The Committee is assured this is progressing to schedule. The Committee was informed that the next Section due for handover was scheduled to complete on time at the end of February 26. • Assurance was given around the health and safety aspects of the new build construction site on the operation of the existing hospital. No reportable incidents have occurred, and the Committee was assured that weekly site health and safety walks take place between the Trust health and safety team plus a representative from the Contractor (IHP) to check patient and staff areas. • Assurance was received that the HTP Communications and engagement work continues to reach out and engage with local neighbourhoods with efforts to reach diverse communities. The Committee emphasised the need to include everyone's perspectives and to make sure all opinions are considered. • The Committee received assurance that the masterclass training sessions and the pilot of the full-day management training have been successfully delivered, receiving positive feedback. Plans are in place to extend training to all managers responsible for leading change within HTP. Thus far, 84 out of 120 managers have participated in the sessions. The next phase involves continuing the training programme.
2c	**Advise** *Areas that continue to be reported on, and / or where some assurance has been noted / further assurance sought.*	• The Committee discussed the new Urgent Treatment Centre to be delivered at Princess Royal Hospital (PRH). Whilst the Committee was assured that the model was confirmed, further reports will be provided around its development. Furthermore, there will be an extensive communications plan to describe the UTC and the processing of accessing this nearer the time of "go live". • The Committee would like to highlight that whilst they received some assurance around clinical and operational delivery there are some areas that remain off track. Further assurance has been requested on these for the next Committee meeting. • Whilst construction is progressing well, the more challenging phase will involve integrating new and existing systems, operationalising the new building, and ensuring workforce readiness. The Committee will continue to regularly monitor the opening date and ensure alignment with operational and financial plans.
2d	**Actions**	• Director of HTP to distribute the Terms of Reference for the newly formed System Transformation Group to members of this committee. • Director of HTP to provide a high-level scenario plan at the next HPAC meeting to illustrate the programme and activities should the building be delivered earlier than currently planned. • HTP Delivery Director to provide a migration of services plan alongside timeframe and model. The plan would detail the services that would be in the acute and community settings. • HTP Delivery Director to review out of county activity.

		• HTP Delivery Director to provide plans to bring task related activities back to green status. • Chief Communications Officer to engage with the health literacy teams and patient information panel to ensure that messages meet the equality and accessibility standards.		
3	**Report compiled by**	*Professor Purt* *Chair of HTP Assurance Committee*	**Minutes available from**	*Sharon Stuart*

Board of Directors' Meeting: 12 March 2026

Agenda item		053/26		
Report Title		Integrated Performance Report		
Executive Lead		Jo Williams, Chief Executive Officer		
Report Author		Ned Hobbs, Deputy Chief Executive Officer		
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 2026.02.17 Performance Assurance Committee 2026.02.17 Finance Assurance Committee 2026.02.24		
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 December 2025/January 2026; and 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 12th March 2026

Presenting Month 10 performance data

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Executive Summary

The Shrewsbury and Telford Hospital NHS Trust

Urgent and Emergency Care (UEC) performance against the four-hour, 12-hour and ambulance handover standards are demonstrating common cause variation in January 2026 and remain below the improvement trajectory. The number of patients with No Criteria to Reside in an acute hospital has demonstrated special cause deterioration, rising to an average of

The Trust has a break-even plan for 2025/26 (this includes deficit support of £45.1m). At the end of month ten the Trust has delivered a deficit position of £5.6m against the breakeven plan. The trust has an efficiency target of £41.4m in 2025/26. At the end of month ten £32.70m has been delivered which is £0.20m more than plan. In terms of WTE reduction, at the end of January against the numbers reported in December (actual worked) there has been no material change, a reduction in worked agency of 12 WTE is offset by increases in bank (6 WTE) and substantive (5 WTE) staff. The Trust has set an operational capital programme of £22.53m (including IFRS 16 expenditure) and externally funded schemes of £125.38m in FY25/26, giving a total capital programme of £147.91m. The Trust held a cash balance at the end of January 2026 of £89.05m.

For Electives, the unvalidated Trust Position for January is English 0 x 104 weeks, 0 x 78 weeks, 0 x 65 weeks, 31 x 52 week (adult) and 0 x 52 weeks CYP. The unvalidated Trust Position for Welsh is 1 x 104 weeks, 18 x 78 weeks, 51 x 65 weeks 207 x 52 weeks. The Trust is ahead of plan and demonstrating special cause improvement against all RTT metrics. 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 during March as part of the March Elective sprint. Theatre utilisation in January 2026 remained steady at 80%.

Confirmed December cancer performance is 83.0% (28-day FDS) vs the local plan of 76.5%. 62-day performance was 70.1% against a (local target 67.2%) and 31 day was 98.0% (national target 94.7%), demonstrating special cause improvement against all three standards. The 62-day backlog is 153 patients over 62 days of which 29 are over 104 days (as at 08/02/2026).

The submitted DM01 position for January 2026 was 80.5%, a declined performance driven by a drop in non obstetric ultrasound (NOUS) and audiology, but still demonstrating special cause improvement. The number of 6-week breaches increased to 2610.

Quality Patient Safety, Clinical Effectiveness and Patient Experience

Executive Leads :

Interim Chief Nursing Officer
Paula Gardner

Medical Director
John Jones

Integrated Performance Report

The Shrewsbury and Telford Hospital NHS Trust

Domain	Description	Regulatory	National Standard 25/26	Current Month Trajectory (RAG)	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Trend
Patient Safety & Effectiveness	Pressure Ulcers - Category 2		20% < 2024-25	22	28	36	15	34	26	27	28	26	21	27	35	24	21	
	Pressure Ulcers - Category 2 per 1000 Bed Days		20% < 2024-25	0.90	1.12	1.36	0.62	1.28	1.08	1.00	1.17	1.15	0.93	1.18	1.53	1.00	0.89	
	Pressure Ulcers - Category 3		10% < 2024-25	6	7	7	8	11	8	1	4	4	9	6	2	9	3	
	Pressure Ulcers - Category 3 per 1000 Bed Days		10% < 2024-25	0.18	0.28	0.26	0.33	0.42	0.33	0.04	0.17	0.18	0.40	0.26	0.09	0.38	0.13	
	Pressure Ulcers - Category 4		0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	
	Falls - per 1000 Bed Days		5% < 2024-25	4.50	4.74	4.26	3.96	4.19	4.31	3.78	3.98	5.22	4.24	4.82	4.80	4.14	4.93	
	Falls - total		-	112	118	113	102	111	104	104	95	118	106	110	110	99	116	
	Falls - with Harm per 1000 Bed Days		5% < 2024-25	0.19	0.20	0.23	0.08	0.30	0.21	0.07	0.21	0.27	0.12	0.26	0.09	0.08	0.14	
	Falls - Resulting in Harm Moderate or Severe		0	0	5	6	2	8	5	2	5	6	3	6	2	2	4	
Patient Experience	Complaints		-	-	66	77	77	87	85	91	114	127	106	114	116	105	102	
	Complaints - responded within agreed timeframe - based on month response du		85%	85%	49.0%	49.0%	50.0%	48.0%	48.0%	42.0%	44.0%	49.0%	49.0%	43.0%	50.0%	50.0%	51.0%	
	Complaints by Theme - Access to Treatment or Drugs				1	3	1	7	2	0	4	5	6	4	4	8	13	
	Complaints by Theme - Admission / Discharge				18	14	18	20	25	16	18	25	27	16	19	23	24	
	Complaints by Theme - Appointment				5	9	9	15	11	16	24	19	21	19	17	16	27	
	Complaints by Theme - Clinical treatment				34	41	49	49	42	47	72	71	63	59	55	53	63	
	Complaints by Theme - Commissioning Decisions				0	0	0	0	0	0	0	0	0	1	0	1	0	
	Complaints by Theme - Communication				37	46	38	51	48	40	62	60	60	49	46	57	64	
	Complaints by Theme - Consent to treatment				3	3	1	2	2	2	2	2	1	2	2	3	7	
	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				1	4	3	4	2	2	5	0	6	2	2	5	1	
	Complaints by Theme - Facilities				7	7	3	9	7	4	5	7	13	2	2	2	5	
	Complaints by Theme - Mortuary				0	0	0	0	0	0	0	0	0	0	0	0	0	
	Complaints by Theme - Other				0	0	4	2	2	0	2	2	1	0	1	0	2	
	Complaints by Theme - Patient care				21	17	22	34	28	21	27	18	29	22	23	24	28	
	Complaints by Theme - Prescribing				2	4	1	2	4	6	7	9	6	3	5	5	7	
	Complaints by Theme - Privacy & Dignity				3	10	10	8	7	11	16	7	15	8	8	10	17	
	Complaints by Theme - Restraint				1	0	0	0	1	1	0	1	0	0	0	0	1	
	Complaints by Theme - Staff numbers				1	0	2	3	3	0	0	2	0	2	3	3	2	
	Complaints by Theme - Trust admin / procedure / records				2	2	6	4	3	7	10	11	15	12	7	2	9	
	Complaints by Theme - Values & Behaviours (staff)				19	18	18	17	24	27	37	41	31	34	35	46	40	
	Complaints by Theme - Waiting time				13	13	11	18	16	15	17	19	16	12	13	12	11	
	PALS - Count of concerns		-	-	285	352	366	362	330	365	351	375	318	397	407	321	278	
	Compliments		-	-	87	91	81	112	105	93	110	81	109	145	132	95	145	
	Friends and Family Test -SaTH		95%	95%	88.8%	91.7%	98.1%	97.6%	97.1%	93.2%	96.8%	88.3%	92.4%	79.8%	73.7%	77.1%	76.1%	
	Friends and Family Test - Inpatient		95%	95%	98.0%	98.5%	98.8%	97.5%	97.2%	91.4%	97.4%	96.9%	96.4%	92.0%	93.6%	95.1%	94.0%	
	Friends and Family Test - A&E		85%	85%	60.5%	71.0%	77.7%	77.0%	64.9%	51.7%	57.6%	63.0%	33.3%	62.1%	67.6%	70.5%	71.1%	
	Friends and Family Test - Maternity		95%	95%	93.8%	97.8%	100.0%	96.7%	95.5%	88.6%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	
	Friends and Family Test - Outpatients		95%	95%	98.9%	99.2%	99.5%	98.7%	99.0%	99.0%	97.6%	94.0%	92.9%	93.7%	92.2%	95.3%	92.8%	
	Friends and Family Test - SaTH Response rate %		-	-	8.9%	9.7%	5.5%	6.8%	5.2%	5.3%	4.8%	1.3%	1.2%	1.6%	3.6%	4.7%	4.5%	
	Friends and Family Test - Inpatient Response rate %		-	-	13.4%	12.9%	11.6%	16.8%	11.9%	12.8%	11.5%	2.2%	2.9%	2.0%	1.5%	2.6%	1.8%	
	Friends and Family Test - A&E Response rate %		-	-	5.9%	7.3%	1.0%	0.4%	0.6%	0.4%	0.3%	0.7%	0.1%	1.4%	5.0%	6.2%	6.2%	
	Friends and Family Test - Maternity (Birth) Response rate %		-	-	0.9%	1.0%	5.7%	6.9%	0.5%	6.6%	2.1%	0.7%	0.2%	0.4%	0.8%	0.7%	0.0%	

Integrated Performance Report

The Shrewsbury and Telford Hospital NHS Trust

Domain	Description	Regulatory	National Standard 25/26	Current Month Trajectory (RAG)	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Trend
Patient Safety & Effectiveness	Trust SHMI (HED)		100	100	85	105	96	104	94	115	91	-	-	-	-	-	-	
	Trust SHMI - Expected Deaths		-	-	283	285	243	252	237	215	221	-	-	-	-	-	-	
	Trust SHMI - Observed Deaths		-	-	241	299	233	262	224	248	201	-	-	-	-	-	-	
	SJRs Completed by Month				19	21	25	31	20	33	20	17	15	17	18	14	11	
	MRSA - HOHA				1	1	0	1	0	0	0	0	0	0	0	1	0	
	MRSA - COHA				0	0	0	0	0	0	0	0	0	0	0	0	0	
	MRSA - Total	R	0	0	1	1	0	1	0	0	0	0	0	0	0	1	0	
	MSSA - HOHA		-	-	2	2	3	2	2	3	1	2	2	1	0	2	3	
	C. difficile - HOHA				9	8	5	4	9	2	6	5	10	8	6	2	7	
	C. difficile - COHA				6	4	2	3	5	2	6	5	3	4	3	3	7	
	C. difficile - Total	R	98	8	15	12	7	7	14	4	12	10	13	12	9	5	14	
	E. coli - HOHA				8	6	6	2	3	2	3	2	8	6	5	5	5	
	E. coli - COHA				9	11	6	8	9	14	9	10	10	15	11	10	7	
	E. coli - Total	R	146	12	17	17	12	10	12	16	12	12	18	21	16	15	12	
	Klebsiella - HOHA				4	3	4	4	1	4	0	2	1	4	2	1	2	
	Klebsiella - COHA				2	4	2	1	5	2	1	1	5	4	3	3	2	
	Klebsiella - Total	R	36	3	6	7	6	5	6	6	1	3	6	8	5	4	4	
	Pseudomonas Aeruginosa - HOHA				1	1	0	1	0	0	1	0	0	0	1	0	0	
	Pseudomonas Aeruginosa - COHA				1	1	2	0	2	0	0	3	1	1	2	1	0	
	Pseudomonas Aeruginosa - Total	R	16	1	2	2	2	1	2	0	1	3	1	1	3	1	0	
	VTE Risk Assessment completion - SATH		95%	95%	74.8%	76.2%	75.6%	74.3%	75.6%	75.0%	75.5%	77.4%	77.2%	79.2%	79.6%	80.7%	78.3%	
	Never Events		0	0	0	0	0	0	1	0	0	1	0	1	1	0	0	
	Psii		-	-	0	1	2	2	4	1	0	1	0	3	2	3	0	
	Mixed Sex Accommodation - breaches		10% < 2024-25	105	117	108	60	86	101	87	65	52	38	46	63	56	46	
	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%	90%	99%	94%	95%	97%	96%	96%	99%	95%	97%	98%	95%	92%	
	Smoking Rate at Delivery		6%	6%	9.6%	5.8%	5.4%	5.6%	5.6%	4.0%	5.9%	5.0%	4.4%	5.9%	4.2%	4.3%	4.9%	

Patient Safety, Clinical Effectiveness, Patient Experience Executive Summary

The Shrewsbury and Telford Hospital NHS Trust

Deteriorating patients: High escalation compliance, but low timeliness of observations, particularly in ED. Issues linked to digital capture, continuous monitoring, and lack of de-escalation. Actions underway to improve accuracy and relevance.

Falls / 1,000 bed-day metrics: Falls per 1,000 bed days shown as red, but data is not reliable due to data-warehouse issues and expanded bed base. Narrative must state benchmarking is currently inaccurate. Updated figures to reflect expanded bed base will be included next month.

Restrictive interventions: Remains a high corporate risk due to Mental Capacity Act compliance and documentation gaps. Weekly Trust-wide review meeting reinstated as a control, with confidence this will restore compliance.

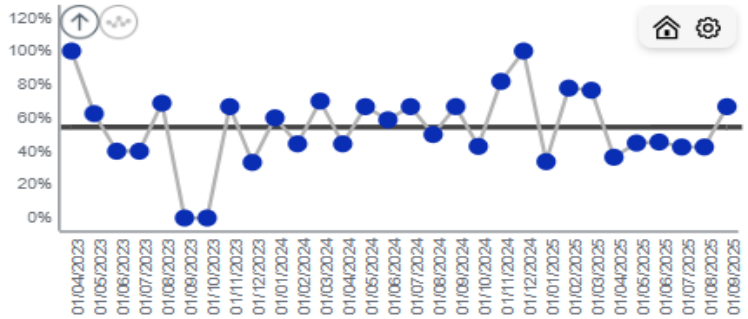
Ambulance handover delays: Ongoing long waits, including >8 hours, but harm levels reduced. All patients triaged within required timeframes. Mitigations include OTTER, maximum handover thresholds, and UEC transformation work.

Data quality: Repeated emphasis that IPR narrative must clearly explain data limitations to avoid misinterpretation at QSAC and Board level.

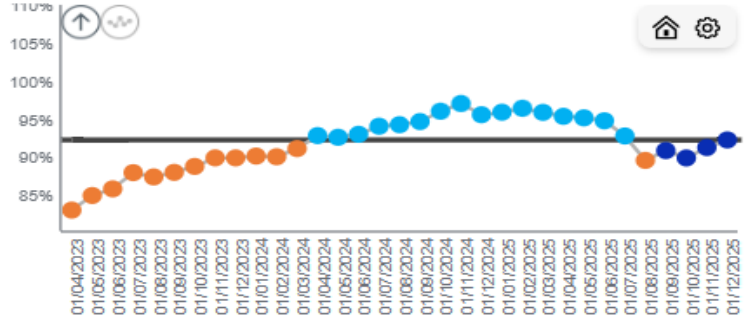
Quality - Safe - Deteriorating Patients - Fragility

	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025
Improve Dementia screening rates - Patient had an AMT - ED	66.7	42.9	81.8	100.0	33.8	77.8	76.5	36.4	44.9	45.5	42.5	42.5	66.7			
Improve Dementia screening rates - Patient had an AMT - Adult IP	37.3	73.0	67.0	55.7	58.2	44.6	53.7	47.1	44.7	43.2	48.1	53.1	52.7	58.4	64.1	70.3
Dementia Awareness Tier 1 3 Yearly	94.85	96.21	97.22	95.75	96.08	96.60	96.06	95.54	95.34	94.95	92.96	89.75	91.04	90.07	91.44	92.44
Dementia Awareness Tier 2 3 Yearly	91.35	91.95	92.59	93.25	93.51	93.02	92.99	93.53	93.19	91.93	92.86	93.00	92.26	92.01	91.19	86.13
Dementia Screening % Score	59	67	73	67	83	86	87	84	86	92	95	93	97	94	97	98
Dementia Screening Audited	273	251	246	189	207	202	200	245	248	234	250	245	242	238	210	214

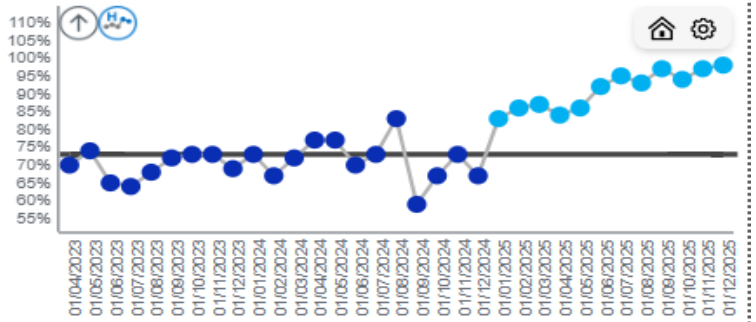
Improve Dementia screening rates - ED



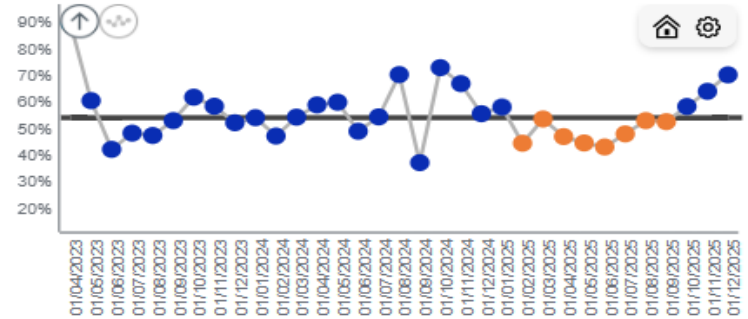
Dementia Awareness Tier 1 - 3 Yearly



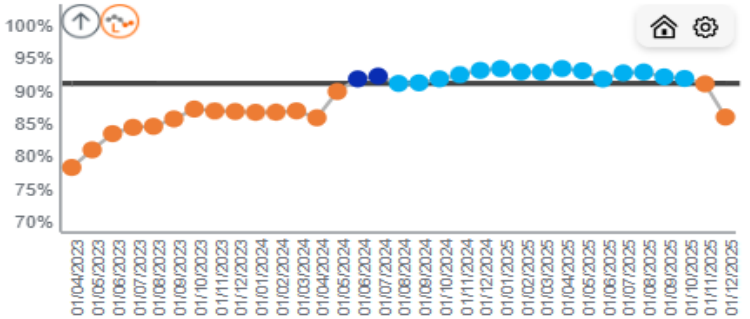
Dementia screening score %



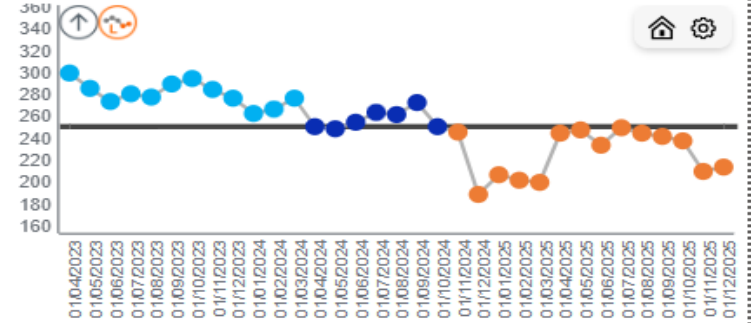
Improve Dementia screening rates - Adult IP



Dementia Awareness Tier 2 - 3 Yearly

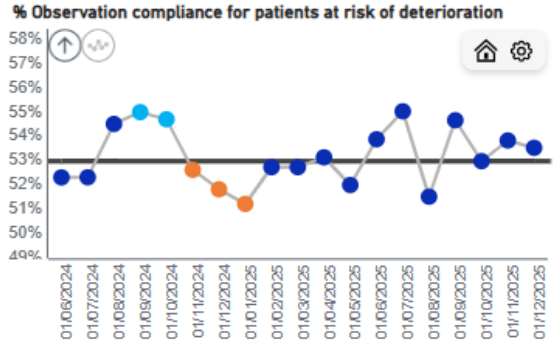


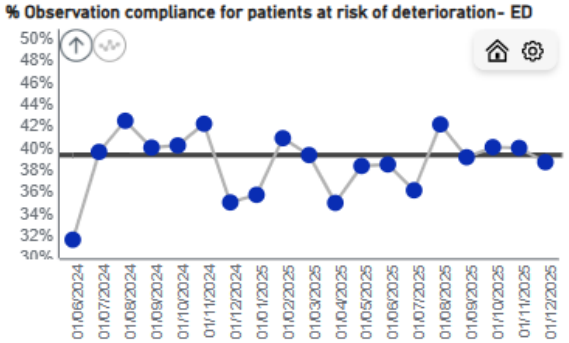
Dementia screening audited

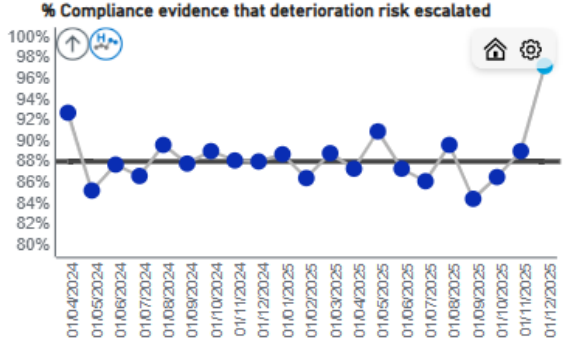


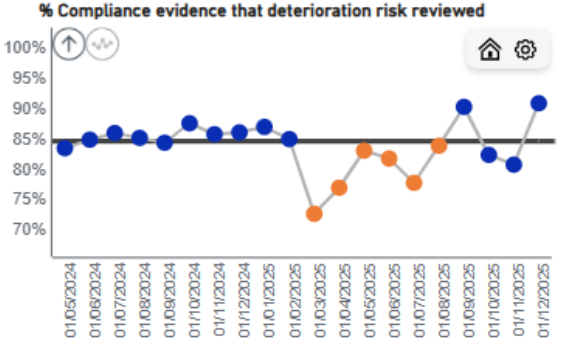
Quality - Safe - Deteriorating Patients - NEWS

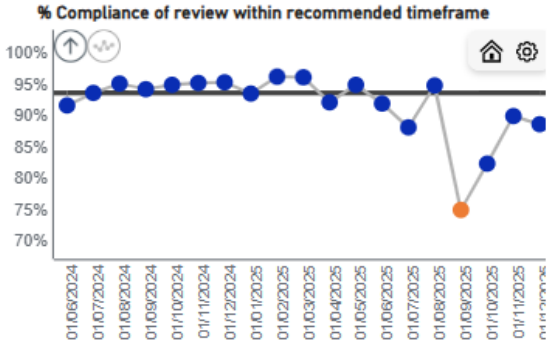
	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025
% Observation compliance for patients at risk of deterioration	52.28	52.29	54.48	54.96	54.67	52.59	51.79	51.19	52.70	52.70	53.11	51.97	53.85	55.00	51.49	54.63	52.95	53.80	53.50
% Observation compliance for patients at risk of deterioration - 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	39.18	40.10	40.03	38.73
% Compliance evidence that deterioration risk (NEWS2) escalated	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	84.40	86.50	89.00	97.20
% Compliance evidence that deterioration risk (NEWS2) reviewed	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	90.30	82.40	80.80	90.90
% 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	75.00	82.40	90.00	88.70
% 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	92.10	88.60	89.10	98.40
% Compliance those stratified high-risk of Sepsis, received antibiotics within 1hr	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	82.60	68.20	100.00	90.00

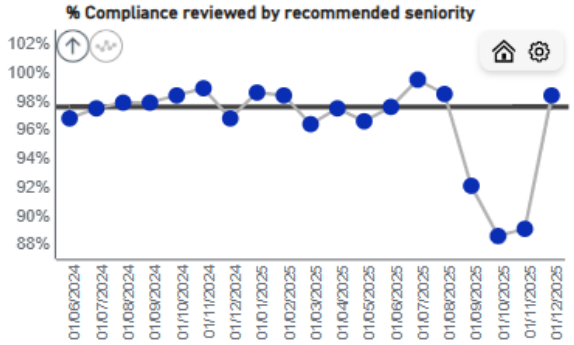


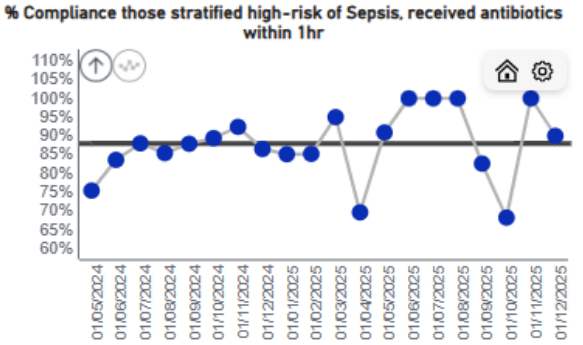












Deteriorating patients – NEWS2

The Shrewsbury and Telford Hospital NHS Trust

Summary:
Observation compliance remains well below the ≥90% standard, with inpatients at 53.50% and ED at 38.73%, reflecting ongoing challenges in early recognition. Escalation compliance has risen to 97.20%, with review compliance also improved (90.90%) and supported by strong senior oversight (98.40%). Review timeliness is 88.70%. Antibiotics within 1 hour for high-risk sepsis has decreased to 90% (2 patients out of 22 audited as not receiving antibiotics within one hour, no further details given). Overall, while escalation and senior review processes continue to strengthen, sustained improvement in timely observations is required to reduce avoidable deterioration.

Recovery Actions:

1.**Driving team-led observation safety** to embed consistent, safe practice
- Embed consistent observation safety through team-led practice
- Integrate observation reports for system feedback and oversight
- Improve visibility via digital tools and dashboards
- Work with clinical teams to address issues identified through system feedback
- Work with ED teams to support implementation of new observation protocols

2. Enhance personalised care to ensure the right escalation and response for each patient
- Tailored patient response tools (e.g. individualised management plans aligned to enhanced response standards such as the MECTP project) have been designed and are now awaiting medical governance approval to commence trial.

3. Continue monitoring review timeliness and flagging areas for improvement with clinical teams

4. Sepsis Recognition and Management:
- Maintain sepsis oversight on key metrics, share learning and success stories, ongoing assurance to governance teams

Anticipated impact and timescales.

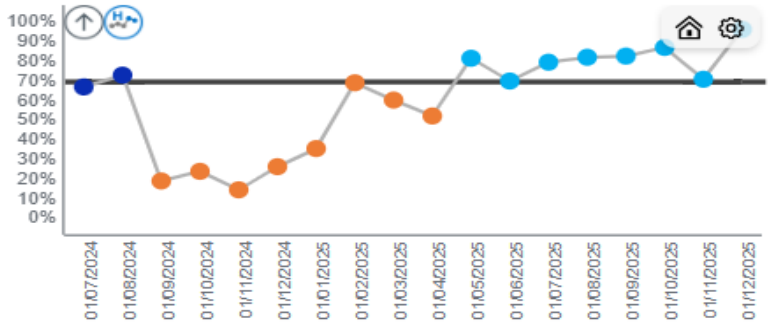
1. 3 months
2. 12 months
3. 1months
4. 6 months

Recovery dependencies:	• Deteriorating patient team to Support understanding of systems data to drive improvement • Continue governance and clinical engagement in deteriorating patient workstreams

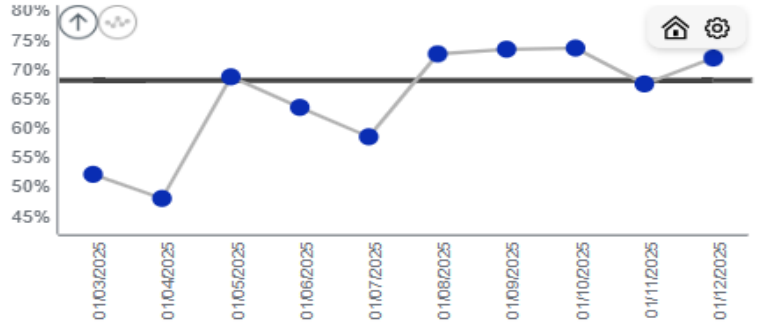
Quality - Safe - Deteriorating Patients - PEWS

	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025
% Compliance evidence that deterioration risk (PEWS) escalated	14.30	26.10	35.30	68.80	60.00	51.90	81.30	69.70	79.30	81.80	82.40	86.80	70.60	96.00
% Compliance evidence that deterioration risk (PEWS) reviewed					52.20	48.10	68.80	63.60	58.60	72.70	73.50	73.70	67.60	72.00
% Compliance of review within recommended timeframe - PEWS	65.50	54.80	50.00	50.00	92.90	92.30	81.80	85.70	82.40	81.30	88.00	89.30	82.60	94.40
% Compliance reviewed by recommended seniority - PEWS			33.30	57.90	71.40	69.20	69.60	57.10	52.90	86.70	66.70	67.90	73.90	58.80
% Compliance those stratified high-risk of Sepsis, received antibiotics within 1hr - PEWS	100.00	0.00	0.00	0.00	0.00	14.30	25.00	0.00	0.00	0.00	0.00	16.70	0.00	6.30

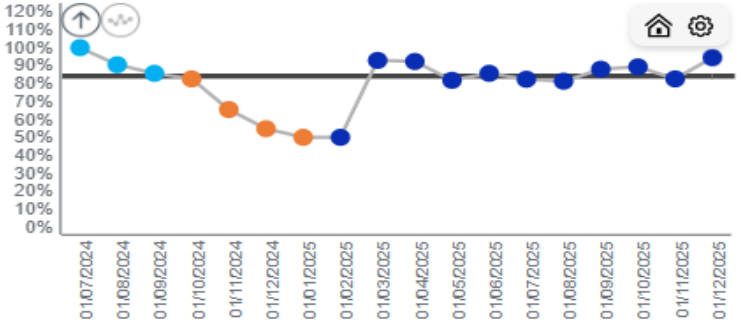
% Compliance evidence that deterioration risk (PEWS) escalated



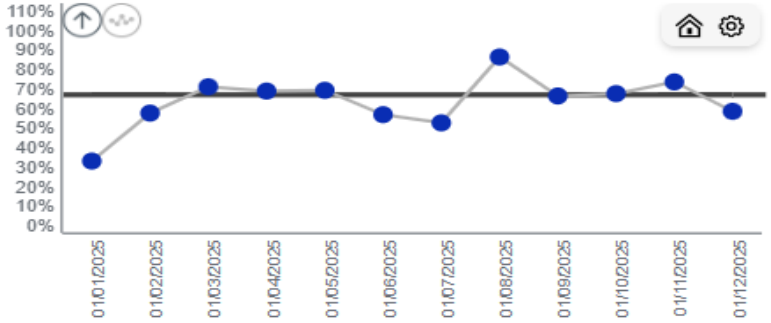
% Compliance evidence that deterioration risk (PEWS) reviewed



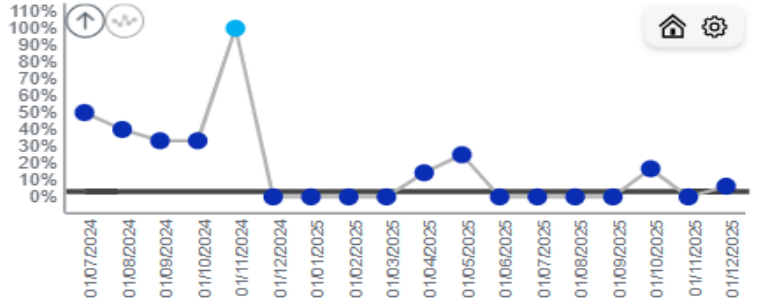
% Compliance of review within recommended timeframe - PEWS



% Compliance reviewed by recommended seniority - PEWS



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



Deteriorating patients – PEWS & NEWTT2

The Shrewsbury and Telford Hospital NHS Trust

Summary:
In December, 28 patients were audited. Of those requiring escalation, 85.7% (24 CYP) had documented evidence of escalation. However, 14.3% (4 CYP) were not escalated but 100% (4 CYP) had a valid reason with documentation and justification.

An increase was observed in review compliance, with 96 % (24 CYP) of patients reviewed in December, compared to November. Among the 4% (1 patient) was not reviewed but had been reviewed 30 minutes prior to trigger by the tier 2 medic and further investigation planned with a documented plan for criteria of antibiotics.

With regards to sepsis, 82% of CYP were screened for sepsis at initial assessment which is an increase in compliance from 80% in November. 67.9% (19 patients) showed high-risk indicators. 15.8% (3 patients) have been de-escalated, as they were deemed not septic but were being treated for alternative diagnoses. 84.2% (16 CYP) were eligible for IV antibiotics, 6.25 % (1 CYP) received IV antibiotics within 60 minutes and 1 CYP received antibiotics within 2 hours, this child had negative blood cultures and a positive swab for RSV, the other 14 CYP audit review showed that 2 CYP already receiving IV antibiotics, 2 CYP were receiving treatment for Asthma, 1 CYP being treated as a head injury, 1 CYP on an individualised care plan, 4 CYP treated for bronchiolitis and 4 CYP was receiving oral antibiotics.

Recovery actions:
On reviewing the audits further improvement is required in relation to documentation following reviews, and escalation of PEWS which remains a key message within Paediatrics.

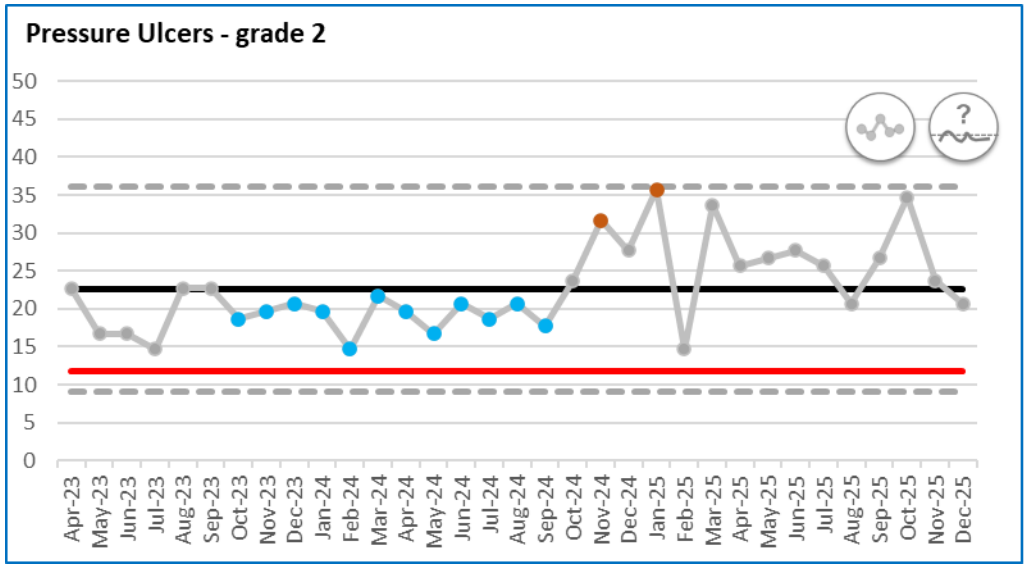
- Escalation Compliance: Work to improve documentation of escalation is being supported by the paediatric PEF team, simulation training, and audit feedback via newsletters and huddles
- Data is discussed at Governance and sent to the Tier 2 medics/ ACP
- IV Antibiotic Compliance: 100% compliance with only 1 CYP requiring IV Antibiotics
- Documentation: De-escalation of sepsis triggers via vitals and documenting reviews one of the key challenge within Paediatrics as the majority of children presenting to the department triggering sepsis is due to children's physiology and response to illness. Ongoing education continues for both medical and new nurses
- New board huddle introduced with Consultants, Ward managers, Matrons to highlight the children triggering for sepsis who haven't been de-escalated. Huddle introduced 10/11/25

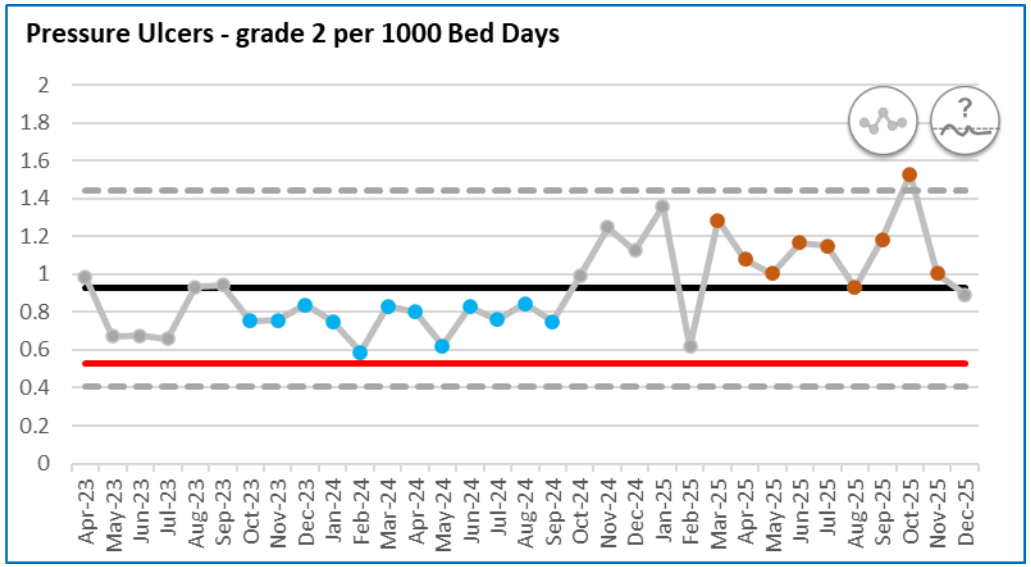
Anticipated impact and timescales for improvement:
6-12 months

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

Patient harm – pressure ulcers – Category 2

The Shrewsbury and Telford Hospital NHS Trust

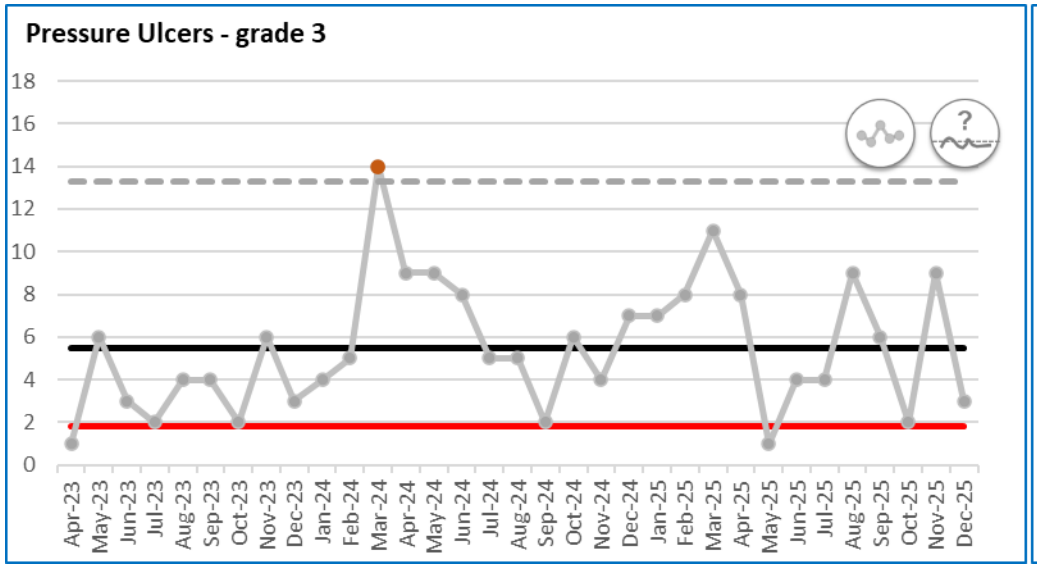


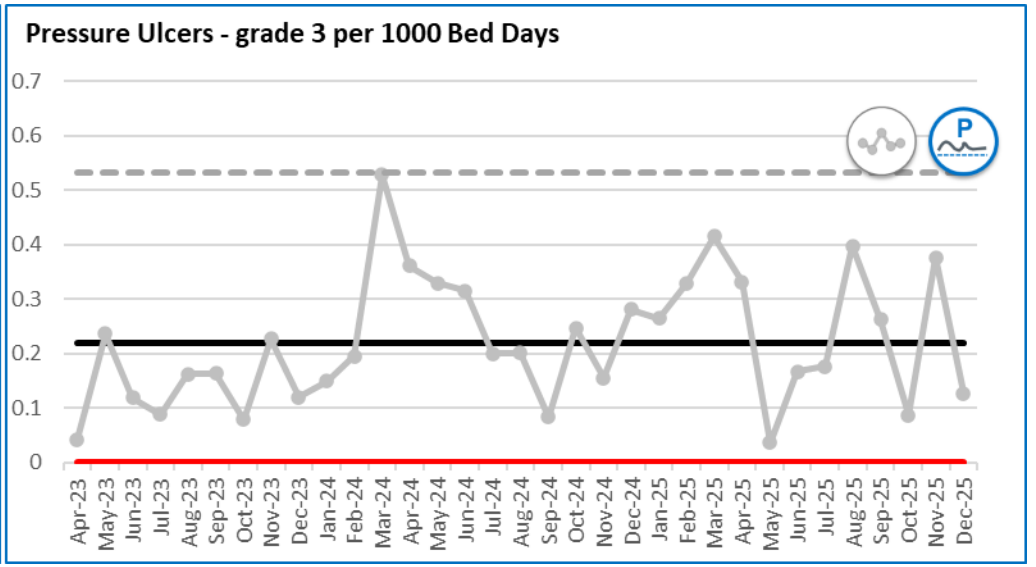


Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	15
Surgery, Anaesthetics and Cancer	6
Women's & Children's	0
Clinical Support Services	0

Patient harm – pressure ulcers – Category 3

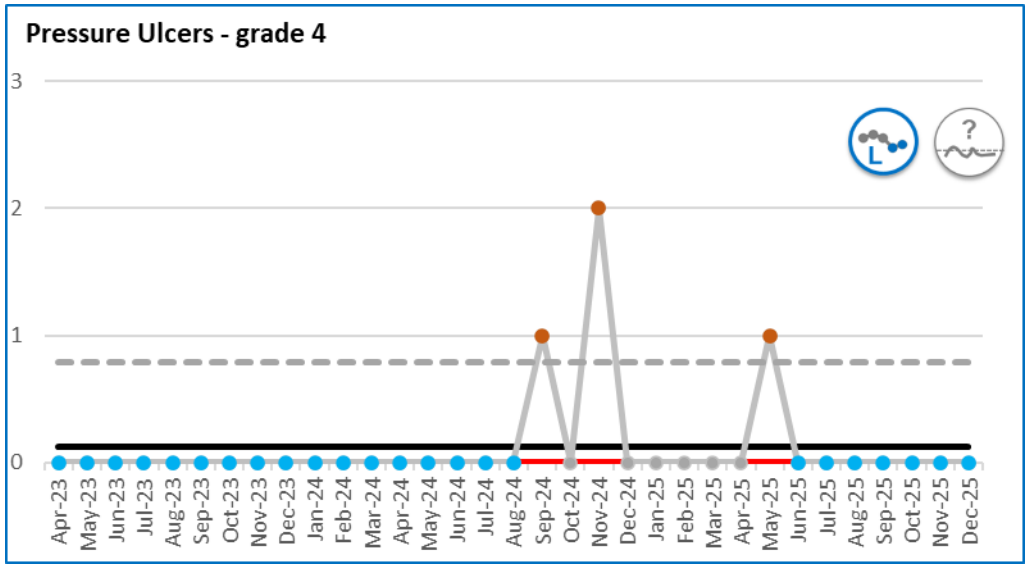
The Shrewsbury and Telford Hospital NHS Trust





Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	3
Surgery, Anaesthetics and Cancer	0
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 3 this month. The number of category 3 pressure ulcers has also decreased in month. The 3 category 3 pressure ulcers in month were attributed to ward 15/16 and 2 on ward 17. Of these 3 category 3 pressure ulcers all 3 were located on buttock/sacrum. Following the pressure ulcer review meeting the missing elements in documentation were skin assessments, patient repositioning schedule and position changed including device position change was not highlighted and core care plan was not completed for one patient. There were occasions where pressure relieving equipment was not available, and therefore mitigation would have been more frequent repositioning until equipment became available. There have been no category 4 pressure ulcers this month. There have been no category 3 devices related pressure ulcers this month. There were 35 reported Deep Tissue Injuries this month which is an increase of 11 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 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, this has now been supported and is following the tendering process. An increase of 20%, 40 more pressure relieving mattresses has been agreed to meet the shortfall due to increasing request for mattresses. There are still occasions where the demand for a pressure mattress cannot be met and more frequent repositioning should be considered

Current actions in place/ongoing are:

- Trial of NIV face mask to reduce device related pressure ulcers is ongoing on ward 17 and 24
- 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 in November to meet the demand of patients requiring one (as above)
- 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 more 1:1 face to face sessions on ward
- Ward manager focus on Tissue Viability Documentation completion, discussed in safety huddle and spot checks carried out and discussed at monthly Nursing Quality metrics

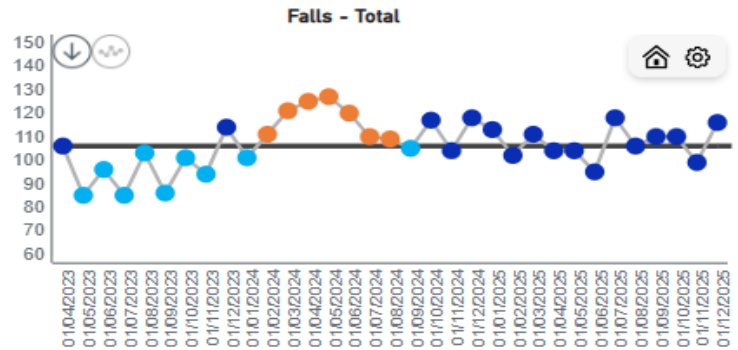
Anticipated impact and timescales for improvement:
Hybrid mattresses are hoped to be in place by July 26 which will mean all patients requiring a pressure relieving mattress will be in in place timely.

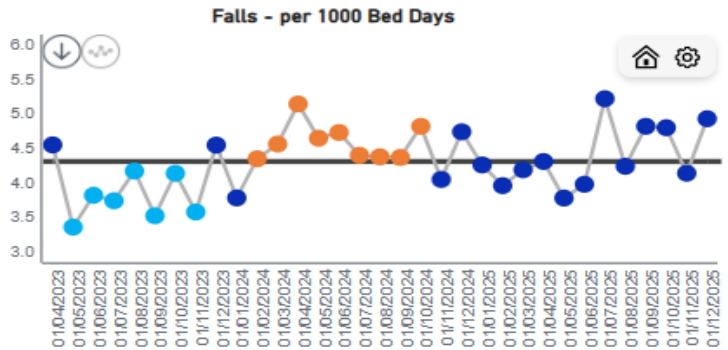
Recovery dependencies:	Ownership of action plans for pressure ulcer prevention at ward and matron level. Monthly review meetings for Category 2,3 and 4

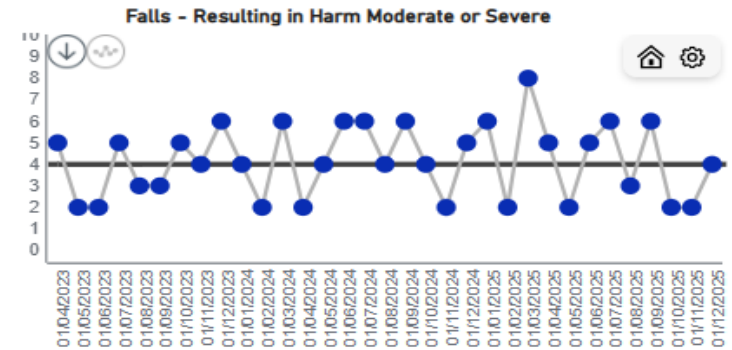
Quality - Safe - Falls

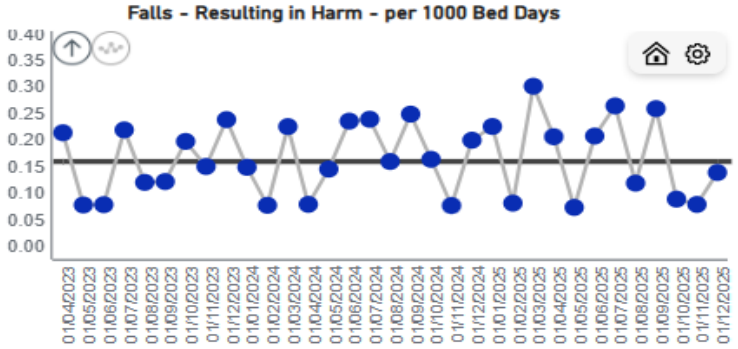
Deteriorating Patient - Fragility | Deteriorating Patients - NEWS | Deteriorating Patients - PEWS | Medication - Omitted Doses

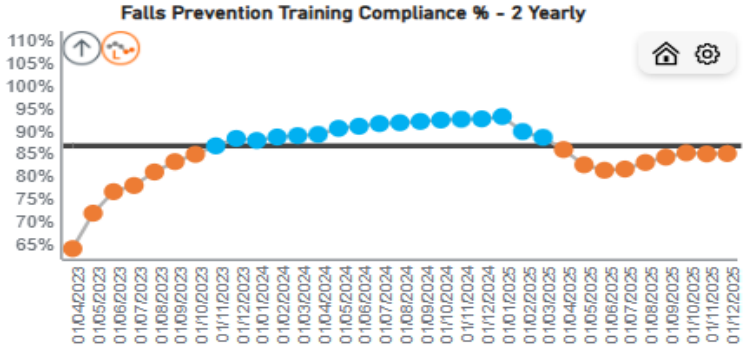
	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025
Falls - Total	109	105	117	104	118	113	102	111	104	104	95	118	106	110	110	99	116
Falls - per 1000 Bed Days	4.38	4.37	4.82	4.05	4.74	4.26	3.96	4.19	4.31	3.78	3.98	5.22	4.24	4.82	4.80	4.14	4.93
Falls - Resulting in Harm Moderate or Severe	4	6	4	2	5	6	2	8	5	2	5	6	3	6	2	2	4
Falls - Resulting in Harm - per 1000 Bed Days	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	0.26	0.09	0.08	0.14
Falls Prevention Training Compliance % - 2 Yearly	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	84.36	85.31	85.08	85.16
% Completion of Falls Risk Assessments	94	94	93	93	95	96	93	93	92	92	91	90	92	90	92	93	91

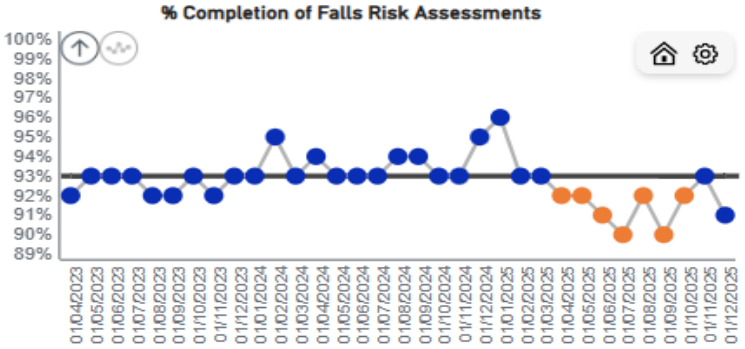












Our Vision: To provide excellent care for the communities we serve

Patient harm - falls

The Shrewsbury and Telford Hospital NHS Trust

Summary:
There were 116 falls in December which is an increase of 17 from the previous month. 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. From April 2025 until December 2025 there has been a decrease of 54 falls for the same time-period in 2024.
The falls resulting in moderate harm or above in December was the same as the previous month with a total of 4 falls. The injuries sustained were 3 head injury's resulting in a subdural bleed ward 26, subarachnoid haemorrhage ward 25 and one still under review on ward AAU PRH. The other moderate harm injury was a periprosthetic fracture of the greater trochanter on ward 37. On review of these falls the risk assessments, management plan, lying and standing blood pressure were correct and in place pre fall. Post falls the risk assessment and management plan for one patient had not been updated. Three lying and standing blood pressure were completed post fall and 1 that could not be completed due to the patient's condition. There was also an increase in the bed base in November/December which may reflect the increase in falls for December.
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 slightly this month to 85.16 and completion of risk assessments pre fall decreased to 91% from 93% from previous month.

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. Ward 26 and ward 11 will commence the trial on 16th February 2026.
The Quality team review each patient fall to check process pre/post fall. There were 4 falls with harm in December 2025.
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. Education takes place at the time of the falls review addressing any non-compliance
Completion of lying and standing BP is an issue, and the quality team are focusing on raising awareness and improving compliance. This is also discussed in Metrics.
Falls training and completion of risks assessments discussed in monthly Metrics meetings.

Anticipated impact and timescales for improvement:
Beside mobility assessment – BMAT to commence with a pilot on ward 11 and ward 26 in February and March 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 and discussed in Nursing Quality assurance meeting

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

Under reporting Summary	May 21	Nov 21	May 22	May 23	Aug 24	Sep 25
Responses	324	285	252	227	206	253
Total number of staff who recalled a recent fall	222 (67%)	183 (64%)	168 (67%)	143 (63%)	144 (69%)	191 (75%)
Total who were 99-100% certain that they or a colleague had reported the fall (confident reported)	205/218 94%	166/183 91%	154/165 93%	127/139 96%	140/144 97%	184/187 98%
Total who were 50-98% certain that they or a colleague had reported the fall (possibly reported)	13/218 6%	8/183 4%	11/165 7%	12/139 8%	4/144 3%	3/187 2%
Total who were 0-49% certain that they or a colleague had reported the fall (unlikely to have been reported)	0 0%	4/183 2%	0/183 0%	0/139 0%	0/144 0%	0/187 0%

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 98% 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 2026.

Anticipated impact and timescales for improvement:

Recovery dependencies:

Quality - Safe - Medication - Omitted Doses

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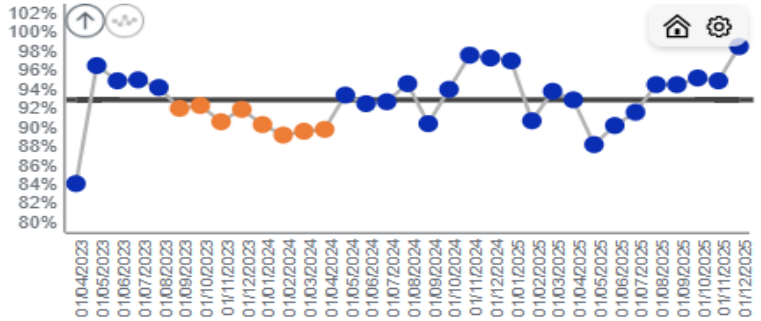
The Shrewsbury and Telford Hospital NHS Trust

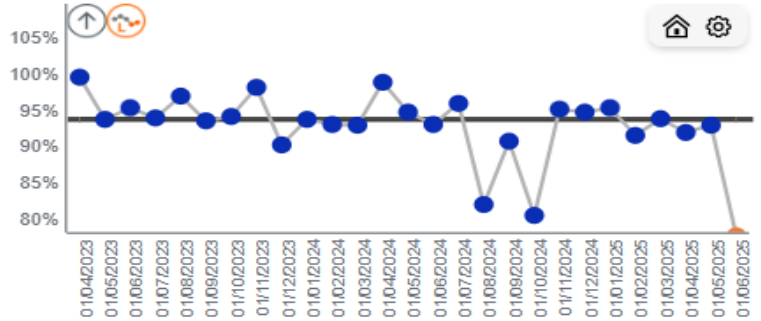
Falls | Deteriorating Patients - Fragility | Deteriorating Patient

	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025
Has all prescribed medication been administered?	90.4	94.0	97.6	97.3	97.0	90.7	93.8	92.9	88.2	90.2	91.6	94.5	94.5	95.2	94.9	98.5
Was the reason for the omission documented?	90.8	80.6	95.2	94.8	95.4	91.6	93.9	92.0	93.0	77.8						
Was appropriate action such as ordering medication, documented?	92.5	93.3	92.5	89.1	94.2	92.6	95.2	91.8	92.5	93.8						

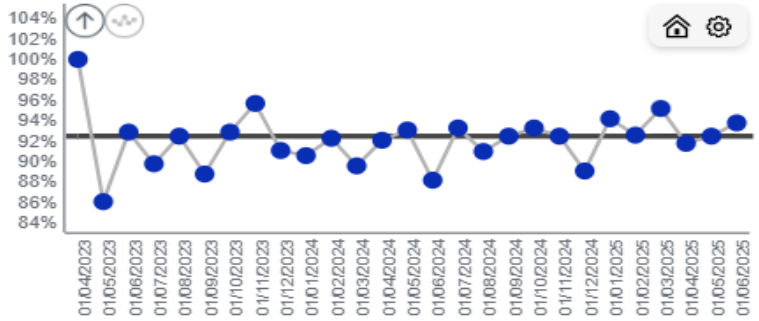
Has all prescribed medication been administered



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

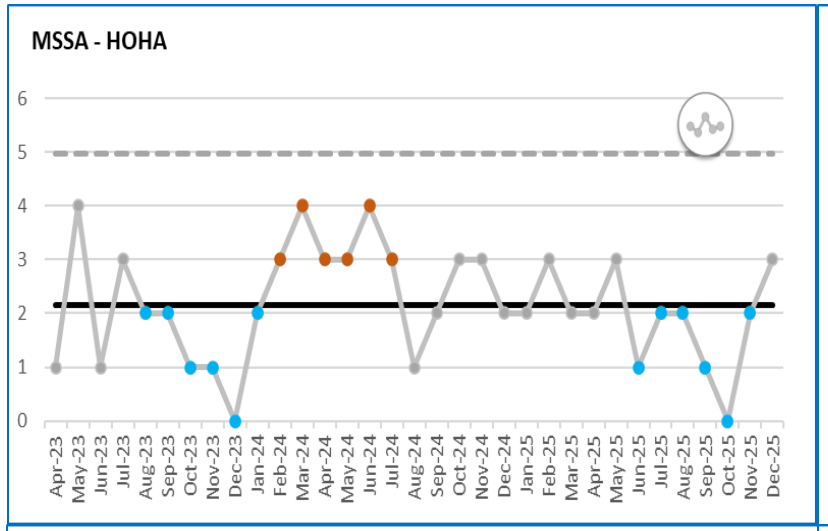
Anticipated impact and timescales for improvement:
In-line and aligned to the PSIRF Trust Priority – Omitted doses of time critical medication.

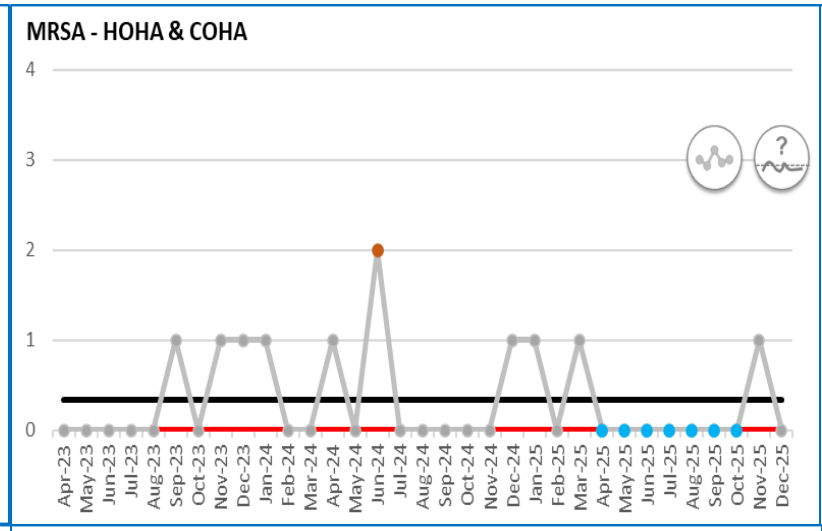
In line with full implementation of EPMA within the Trust.

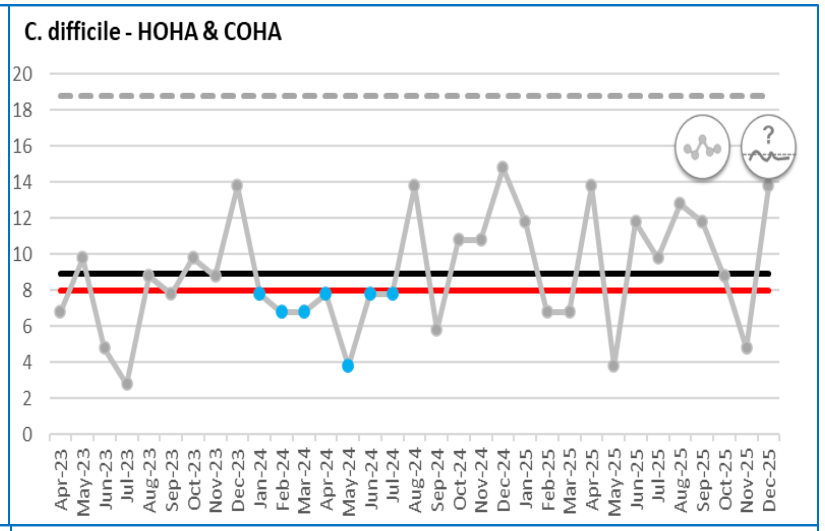
Recovery dependencies:

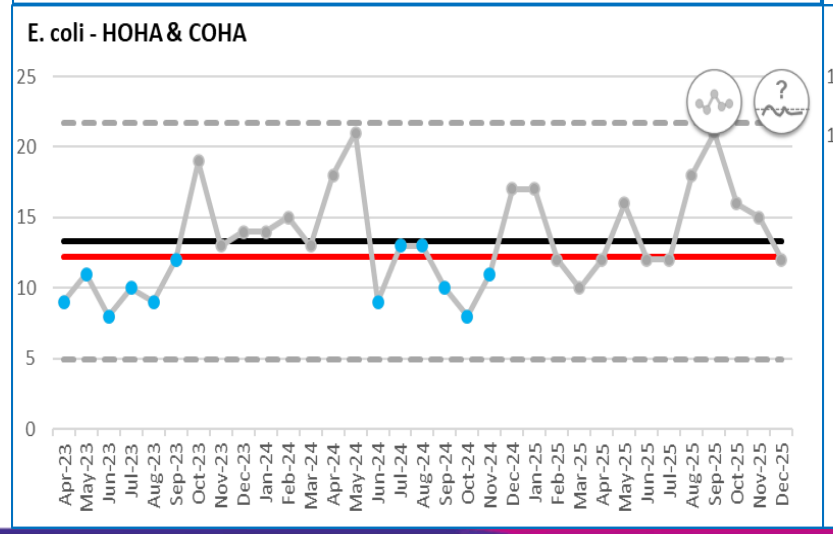
Infection prevention and control

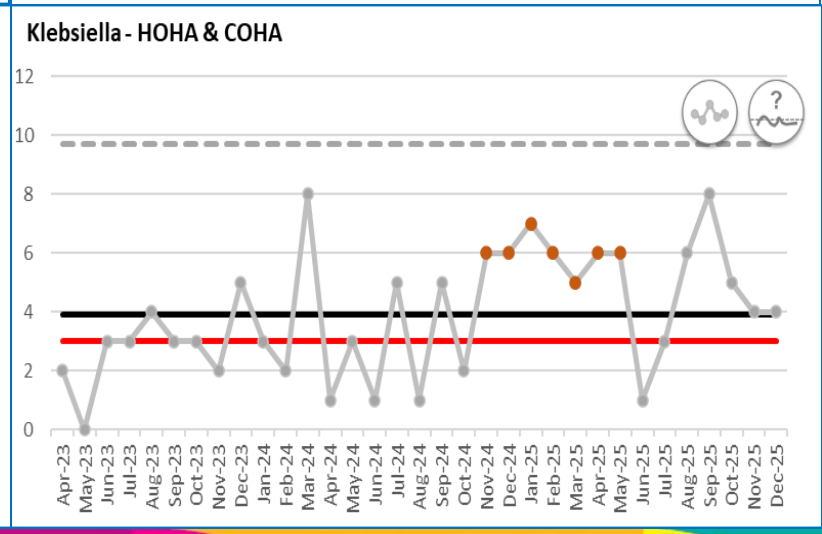
The Shrewsbury and Telford Hospital NHS Trust

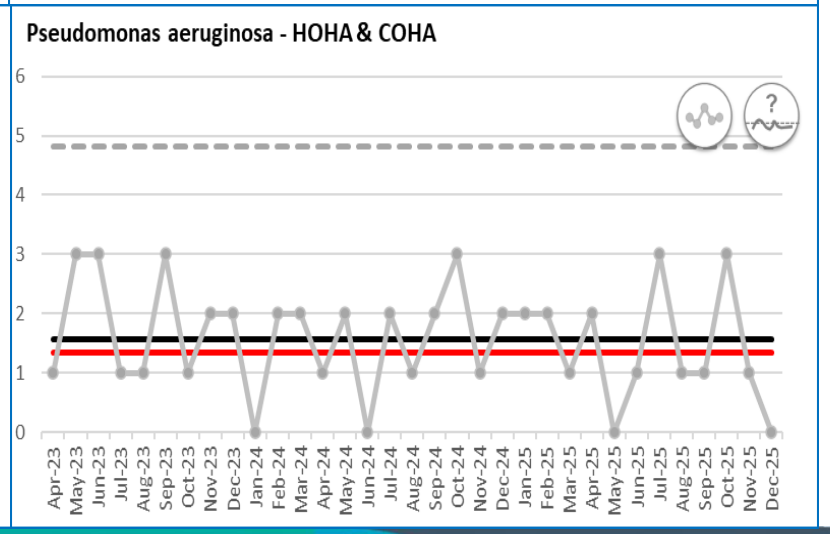












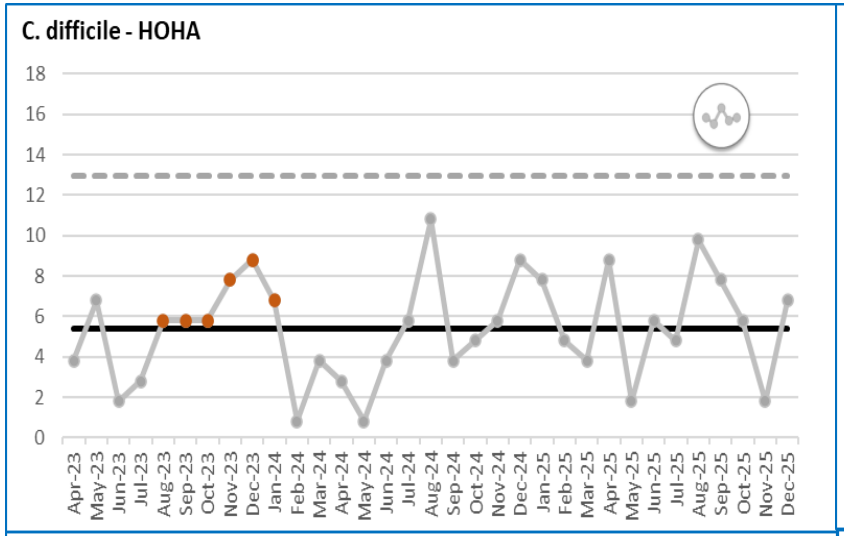
Partnering Ambitious Caring Trusted

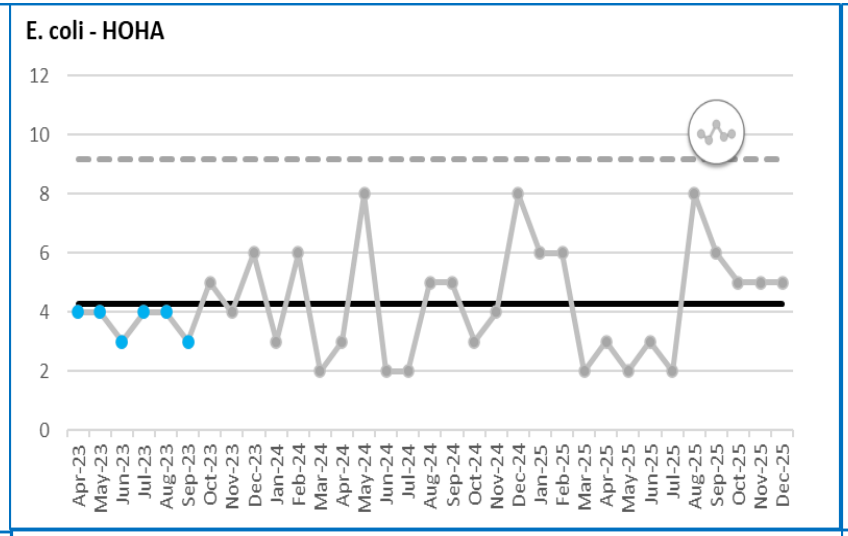
VETERAN AWARE

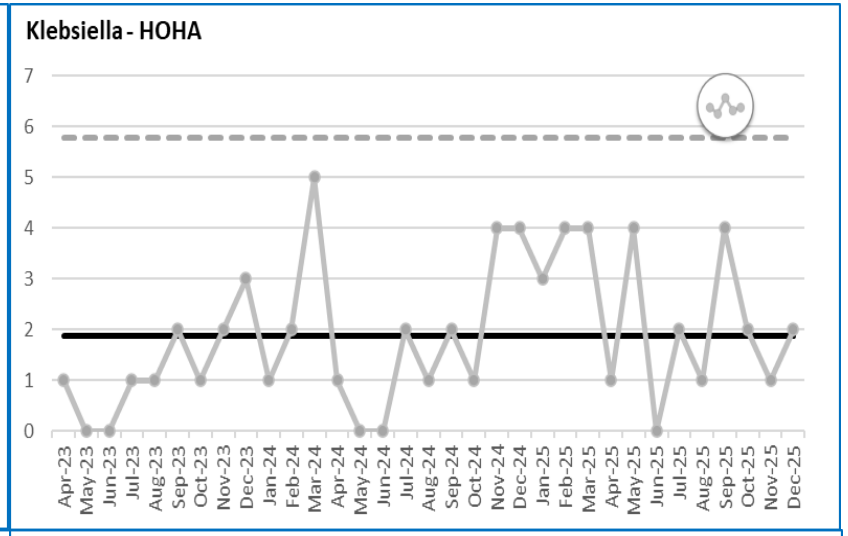
Our Vision: To provide excellent care for the communities we serve

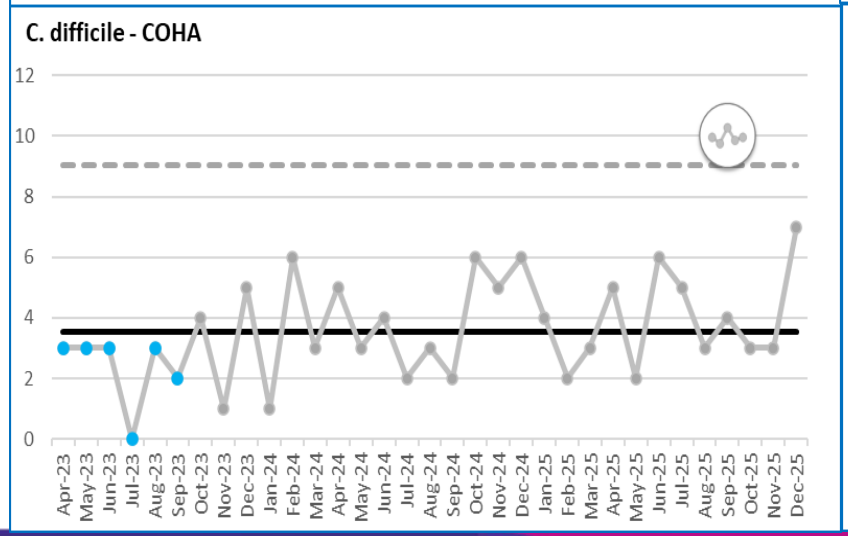
Infection prevention and control

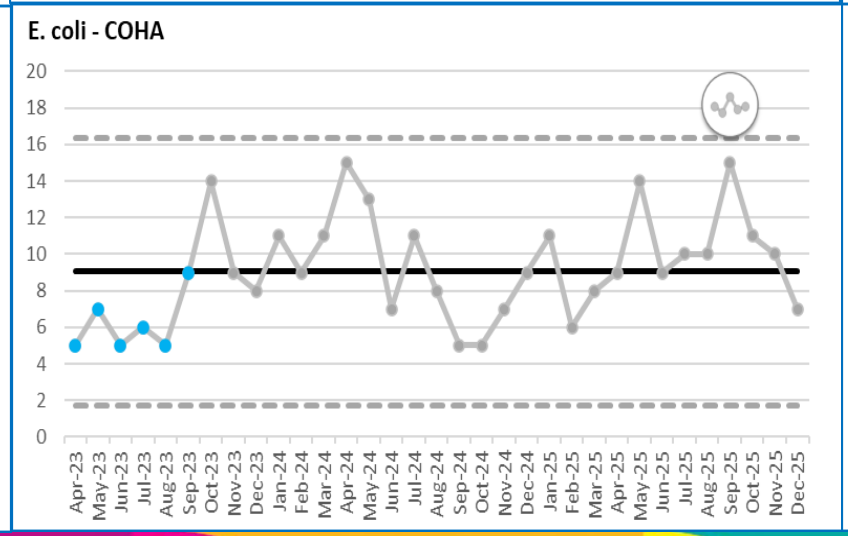
The Shrewsbury and Telford Hospital NHS Trust

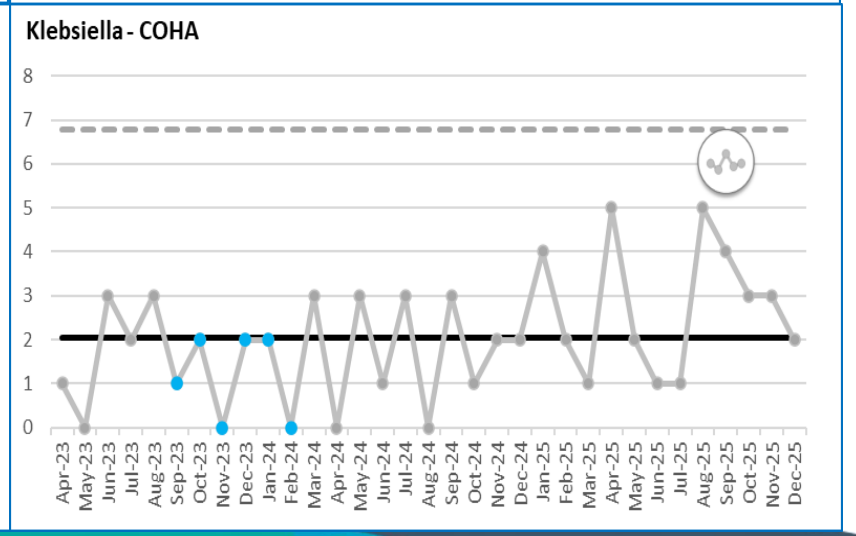












Partnering Ambitious Caring Trusted

VETERAN AWARE

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

Infection prevention and control

The Shrewsbury and Telford Hospital NHS Trust

Summary:
In December 2025 there were the following bacteraemia:

- 14 C. diff cases (7 HOHA, 7 COHA)
- 0 MRSA Bacteraemia
- 6 MSSA Bacteraemia (3 HOHA, 3 COHA)
- 12 E. coli Bacteraemia (5 HOHA, 7 COHA)
- 4 Klebsiella Bacteraemia (2 HOHA, 2 COHA)
- 0 Pseudomonas Bacteraemia

Measure	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD 25/26
C diff Infections	14	4	12	10	13	12	9	5	14	93
MRSA Bacteraemia	0	0	0	0	0	0	0	1	0	1
MSSA Bacteraemia	5	5	3	5	7	2	3	3	6	39
E. Coli Bacteraemia	12	16	12	12	18	21	16	15	12	134
Klebsiella Bacteraemia	6	6	1	3	6	8	5	4	4	43
Pseudomonas aeruginosa Bacteraemia	2	0	1	3	1	1	3	1	0	12

Recovery actions:

- C. diff action plan ongoing. Deep clean was completed in December on 2 of the highest incidence wards at RSH (25&26). Plan led by deputy COO/Deputy Chief Nurse, to revisit the rest of RSH and a plan for deep clean at both RSH and PRH in 2026/27 to be developed by end March 2026 ready for implementation in the new financial year
- YTD C. diff case rate 44.4 per 100,000 bed days (Q1 42.2, Q2 51.4 & Q3 39.8), this is based on estimated figures
- Business case to move forward with Fidaxomicin as first line treatment of C. diff is progressing. Fidaxomicin reduces the rate of recurrent C. diff infections and is associated with reduced environmental contamination with C. diff which would reduce the risk of onward transmission to others
- IPC and Quality team working on catheter improvement plan to help reduce the risk of Gram-Negative bacteraemias (E. Coli, Klebsiella & Pseudomonas)

Anticipated impact and timescales for improvement:

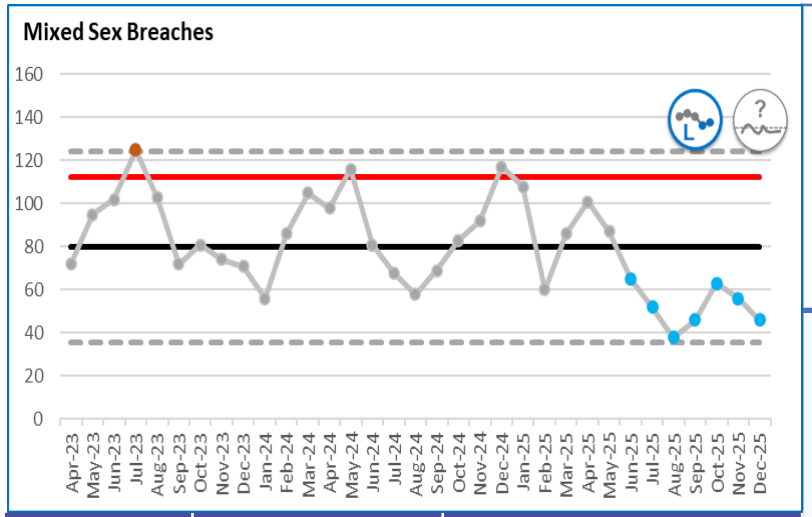
There is currently no further timescales for a deep clean programme on either site following the deep clean of ward 25 and 26. The plans for deep clean in 2026/27 are currently being developed

Recovery dependencies:

Input from education /clear escalation processes & criteria for catheter insertion, review & removal.
Staff engagement & compliance /support from ward managers & matrons.
Stable plans required to implement and manage a deep clean programme.

Mixed sex accommodation breaches

The Shrewsbury and Telford Hospital NHS Trust



Location	Number of breaches	Additional Information
ITU / HDU (PRH)	3 primary breaches	3 Medical
AAU (RSH)	8 breaches	
ITU / HDU (RSH)	35 breaches	10 Medical, 23 Surgical, 1 T&O, 1 Nephrology

Summary:
December saw a slight decrease in Mixed Sex breaches across the Trust, which is a positive shift given the increase we have seen in hospital admissions, and capacity pressures that we are seeing as we move through the Winter months. Mixed sex breaches in Critical Care are due to bed availability across the Trust and the delay in step down of patients from HDU/ITU particularly at RSH . The number of Mixed sex beaches across the acute floor at RSH has decreased in comparison to the previous month following the transfer to AAU, however, there were two occasions when mixed sex breaches occurred following the bed reconfiguration due to capacity pressures.

Recovery actions:

- Ensure Trust's application of the MSA Policy is consistently applied 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
- The opening of additional beds at RSH and additional assessment spaces at PRH will help in relation to not bedding in the assessment areas and the timelier step down of ITU patients
- 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 AAU is used
- Reconfiguration of the Acute Floor (RSH)
- Reconfiguration of Apley beds (PRH)

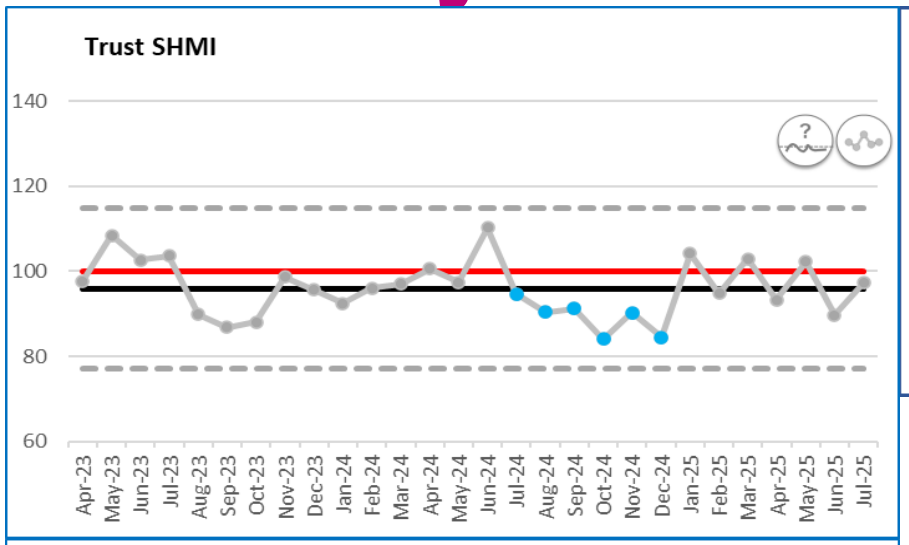
Anticipated impact and timescales for improvement:

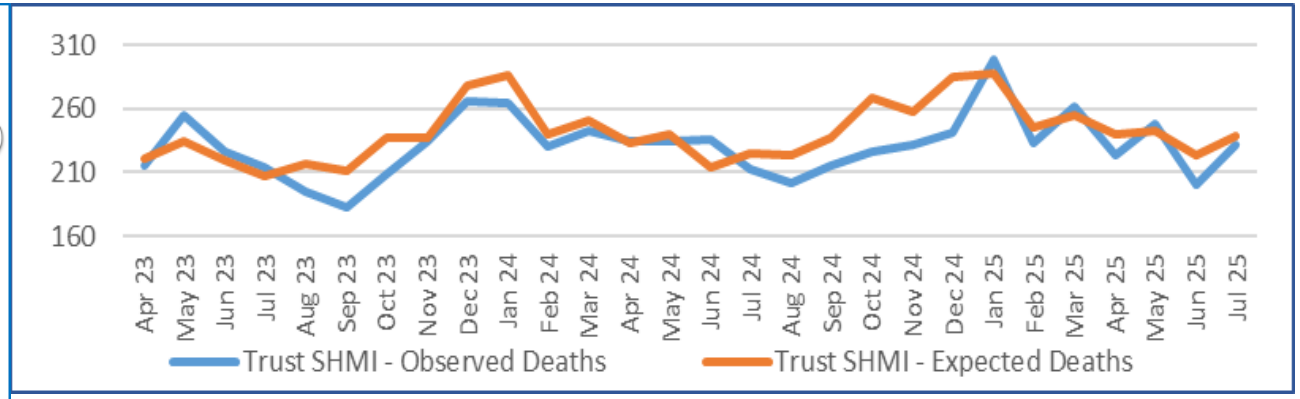
- Beds available earlier in day
- Reduction in no criteria to reside patients in hospital
- Patients cared for in the most appropriate environment to meet their needs
- Reconfiguration of the Acute Floor (RSH) in December 2025
- Reconfiguration of Apley beds (PRH) in February 2026

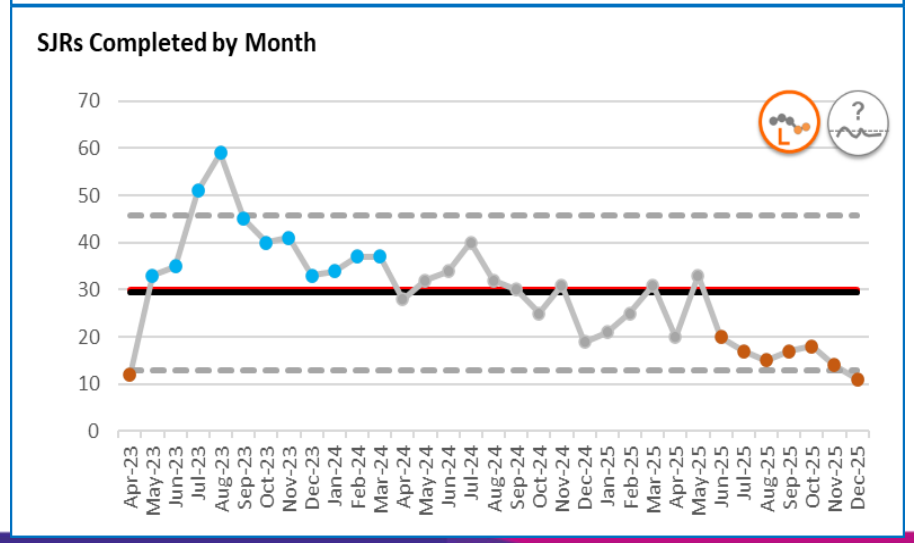
Recovery dependencies:

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

Mortality outcome data







Please note: data quality concerns remain due to uncoded episodes therefore nationally published figures regarding SHMI should not yet be considered fully reliable

Mortality outcome data

The Shrewsbury and Telford Hospital NHS Trust

Summary:

- Due to data quality issues, published SHMI data remains unreliable. Mortality benchmarking across CHKS peer groups is unavailable & wider mortality metrics are impacted.
- Inter-dependency of Trust data & SHMI output is a key concern and results in 'unreliability' of the Trust published SHMI score. This can be 'corrected' upon re-submission of data*
- By example NHS England noted an outlier SHMI publication for July 2025 data when the SaTH submission contained 64% uncoded data. The Trust made a resubmission of data in November 25 for the same period containing only 0.6% uncoded data. The re-submission 'corrected' the outlier SHMI publication
- It is anticipated that data re-submissions will be used to create a SHMI indicator for the period covering October 2024 - September 2025, likely publication due 12th February 2026. Further analysis of SHMI is inadvisable at this time as recommended by CHKS
- Inpatient crude mortality data remains the current, most assured method for reviewing mortality outcomes at Trust level. This shows common cause variation only as is reviewed as a standing agenda item within the Learning from Deaths Group. All deaths in the ED are currently being reviewed at departmental level and a wider Trust review of mortality in the ED is being overseen by the Deputy Medical Director
- SJR continues to offer case by case mortality assurance, but SJR numbers are currently impacted by long term sickness, hopefully with a return to full establishment early 2026

*SHMI indicator = Observed number of deaths ÷ Expected number of deaths. Expected number of deaths is derived from coded data; sex & diagnoses. If there are issues with coding, this will affect Expected number of deaths, which will affect SHMI. E.g. Missing diagnosis codes causes a decrease in Expected deaths which will 'artificially' increase the Trust SHMI indicator.

Recovery actions:

- In the absence of a reliable SHMI internal crude mortality data continues to be reviewed.
- Crude mortality is a standing agenda item at the monthly Trust LfD Group meeting
- Digital and Business Intelligence Teams are actively reviewing potential data quality issues.
- CDS re-submissions will hopefully resolve unreliability by early 2026
- CHKS representation continues as external assurance of data warehouse issues
- Return to SJR reviewer establishment expected early 2026. Senior nursing reviewers to be explored

Anticipated impact and timescales for improvement:

- Data Warehouse issues continue. Possible resolution by early 2026
- SMHI is unreliably impacted
- CHKS peer group benchmarking & primary diagnosis mortality is unavailable
- SJR output reduces the learning opportunities

Recovery dependencies:	Resolution of Data Warehouse challenges & subsequent availability of reliable SHMI data and wider Learning from Deaths metrics. Medical SJR Reviewers to be available for weekly planned PA sessions and existing senior nurse SJR reviewer to continue with 1 day per month availability for SJR completion.

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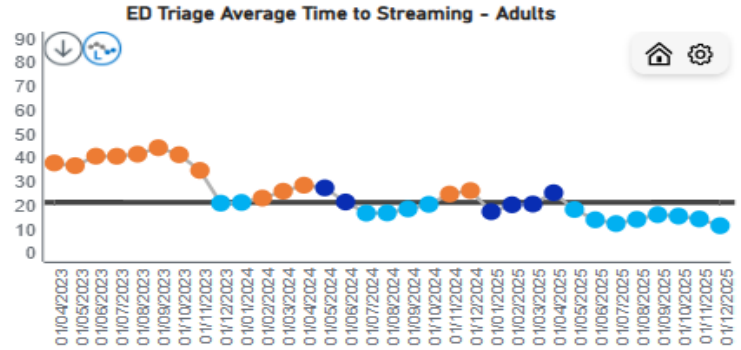
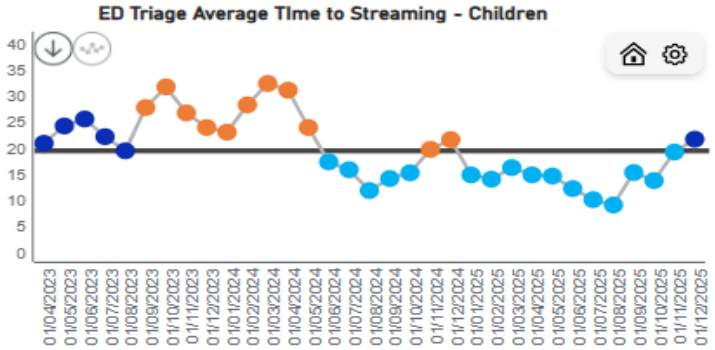
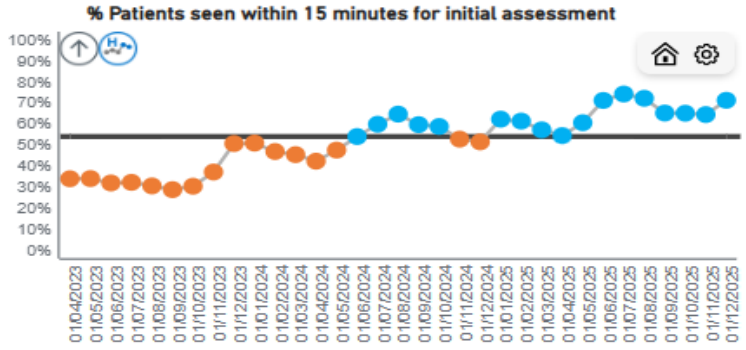
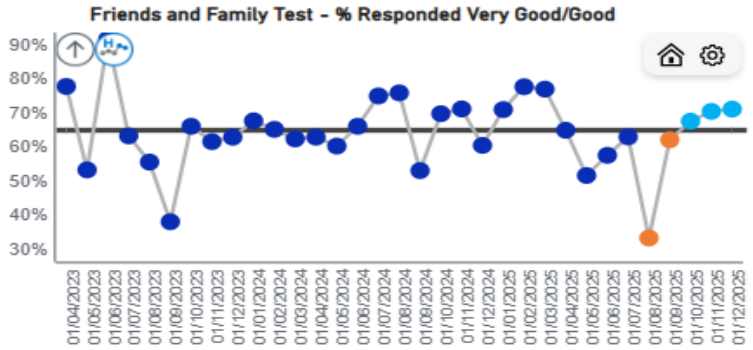
Best Clinical Outcomes

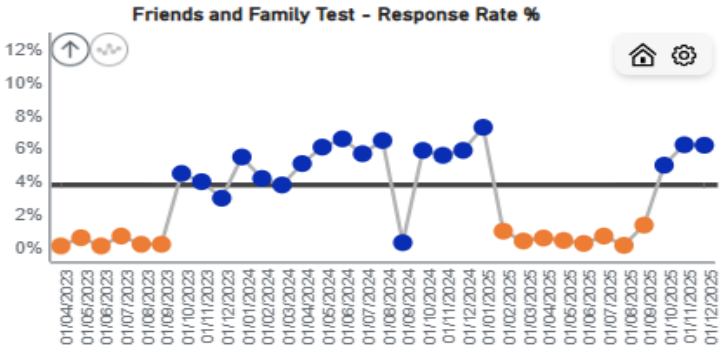
	Apr-2023	May-2023	Jun-2023	Jul-2023	Aug-2023	Sep-2023	Oct-2023	Nov-2023	Dec-2023	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024
ED Triage Average Time To Streaming - Adults	38.12	37.00	40.98	40.95	41.82	44.51	41.59	35.01	21.30	21.59	23.43	26.28	28.82	27.70	21.79	17.11
ED Triage Average Time To Streaming - Children	21.07	24.39	25.72	22.34	19.62	27.92	31.88	26.89	24.09	23.20	28.44	32.54	31.26	24.10	17.50	16.00
% Patients seen within 15 minutes for initial assessment	34.07	34.15	32.07	32.37	30.68	28.91	30.52	37.27	50.80	51.02	47.02	45.54	42.43	47.70	54.14	59.99
Friends and Family Test - A&E - % responded Very Good/Good	77.80	53.30	91.70	63.30	55.60	38.10	66.10	61.60	62.90	67.70	65.20	62.40	62.90	60.30	66.10	75.00
Friends and Family Test - A&E - Response Rate %	0.10	0.60	0.10	0.70	0.20	0.20	4.50	4.00	3.00	5.50	4.20	3.80	5.10	6.10	6.60	5.70
Complaints by Theme - Admission / Discharge	17	23	15	18	20	12	18	8	12	14	13	12	20	14	17	17

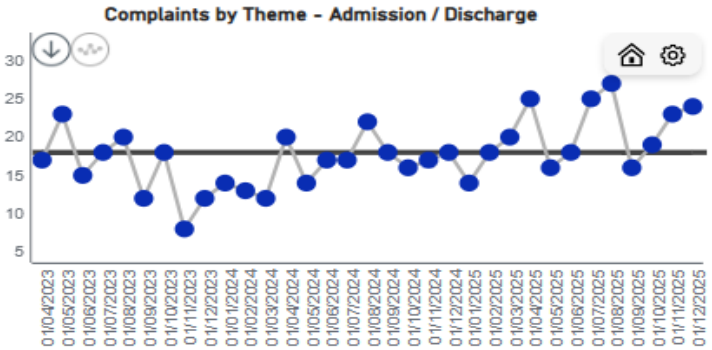












Quality - Effective - Right Care, Right Place, Right Time

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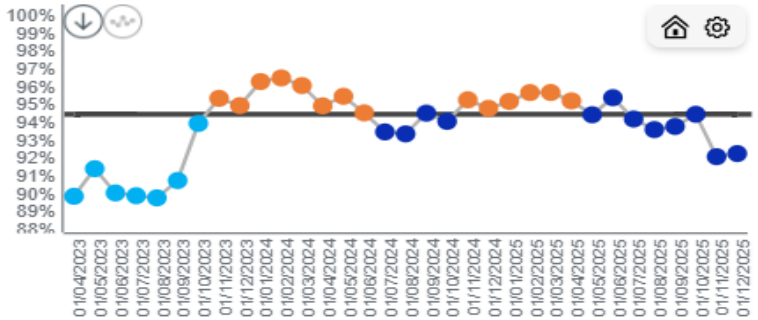
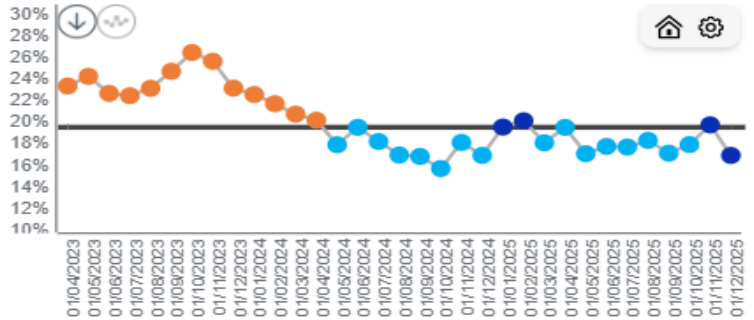
Best Clinical Outcomes

	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	Sep-2025	Oct-2025	Nov-2025	Dec-2025
Occupancy Rate %	93.37	94.54	94.08	95.29	94.81	95.20	95.69	95.70	95.23	94.45	95.41	94.21	93.61	93.79	94.48	92.09	92.27
% beds occupied by patients with LOS >14 days	16.92	16.78	15.66	18.09	16.88	19.53	20.11	18.06	19.50	17.04	17.72	17.67	18.28	17.09	17.89	19.73	16.88
% beds occupied by patients with LOS >21 days	9.75	9.36	8.40	10.45	9.37	10.90	12.16	10.34	11.10	9.36	9.93	10.26	10.47	10.00	10.03	10.98	8.82
% Discharged By 10am																	
% Discharged By 12pm																	
No criteria to reside	92	89	101	117	102	108	105	106	111	112	111	111	114	108	114	109	110

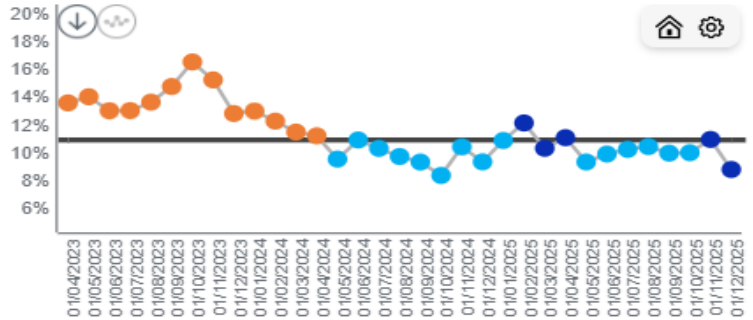
Occupancy Rate %



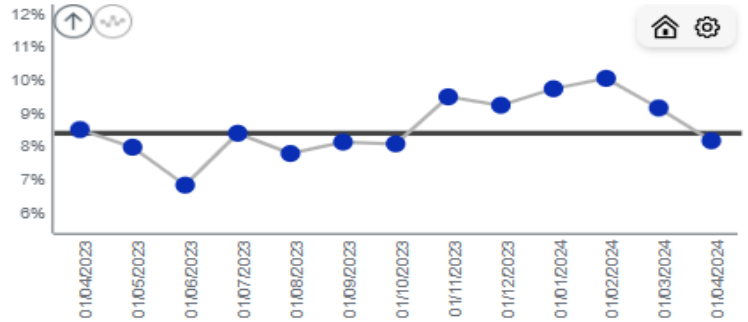
% beds occupied by patients with LOS >14 days



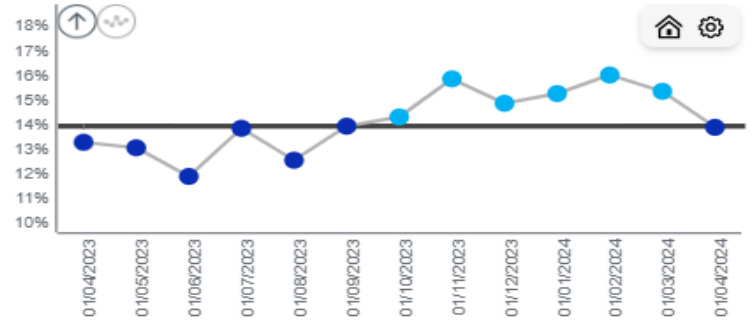
% beds occupied by patients with LOS >21 days



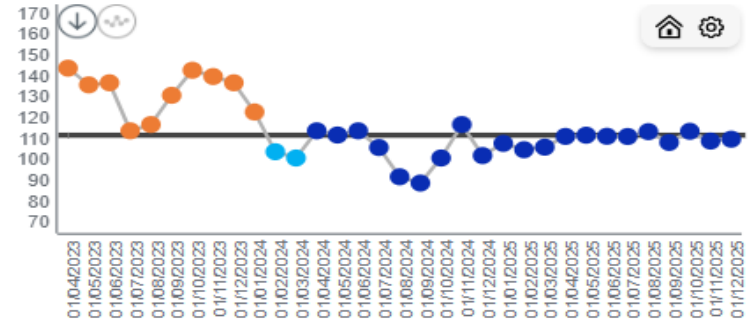
% Discharged By 10am



% Discharged By 12pm



No criteria to reside



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

Diabetic foot

The Shrewsbury and Telford Hospital NHS Trust

Summary:
Shropshire, Telford and Wrekin (STW) ICB are an outlier for minor and major diabetes foot ulcers. We have a higher than national average of hospital spells for foot disease for people with diabetes (PWD).
Audit 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 0.91 weeks. (18% within 72 hours and 77% within 13 days) More than 70% of new ulcers should receive first expert assessment within 0-13 days by 2026, which we have exceeded

Recovery actions:

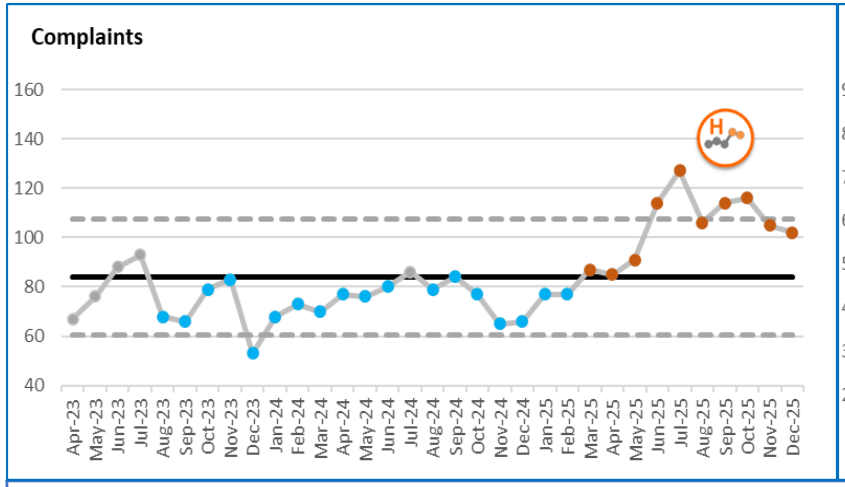
- Heel offloading available on ward – Heel boot available to order on wards – complete
- Hot clinics introduced for A&E and UCC for quick access to multidisciplinary team (MDT) clinic
- New online documentation for admissions - in process
- Quick access to outpatients with new diabetes foot complication's introduction of Hot phone complete
- Introduction of integrated orthopaedic prevention clinic for diabetes foot patients – complete
- Lift the sheet check the feet education campaign & annual wound conference introduced – complete
- Inhouse Diabetes Podiatry team - complete
- Safety team will compile monthly reports on diabetes foot. This will be cross linked with treatment list. Requested SQL report to be shared – delayed
- Monthly minor and major amputation statistics for people with diabetes awaiting data
- Introduction of mirrored cards for all necessary staff with Achilles tool – In process
- Better preventative care offered in primary and community sectors including foot screening which is the cornerstone of diabetes care. (On hold with ICB)

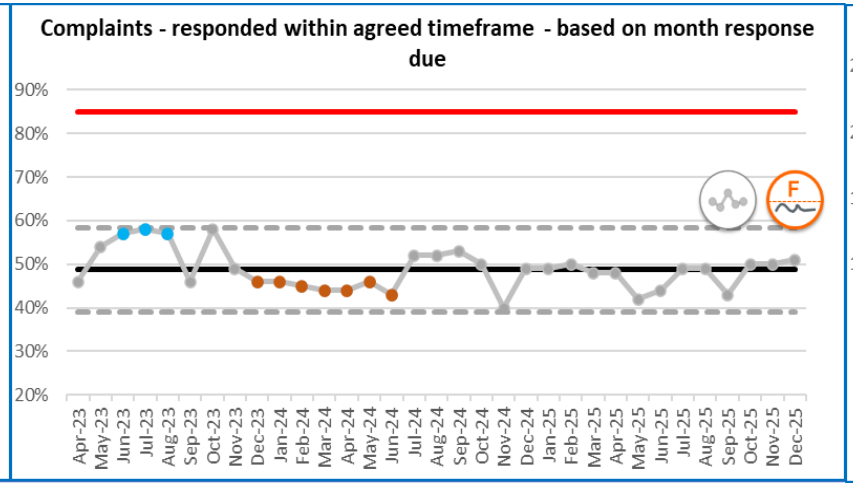
Anticipated impact and timescales for improvement:
Business Case agreed. Staff in post (Nov 2025)
Reaudit of inpatient data to show anticipated improvement in statistics nearing NICE guidance standards July 2025. Complete
Root Cause analysis of all diabetes foot amputations highlighting gaps in care and areas of improvement March 2026
Audit of diabetes foot wound categorisation and reporting – in progress linking with TVNs
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

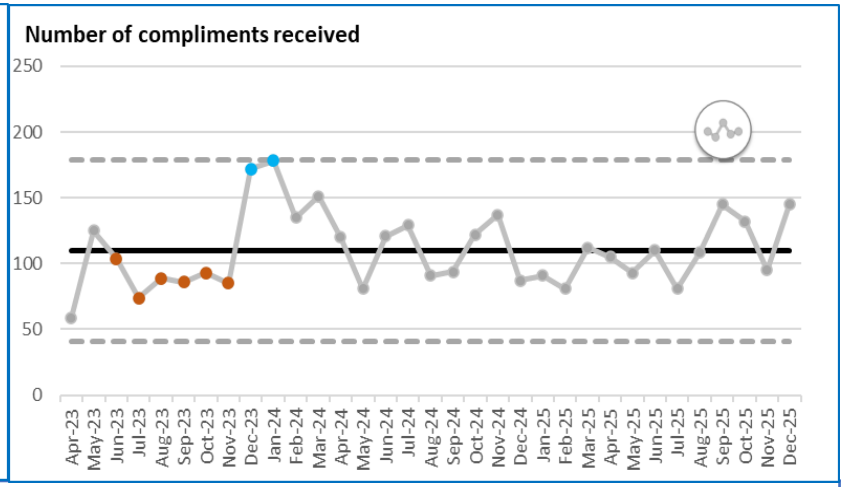
Recovery dependencies:	Ownership of new documentation and education for diabetes foot at ward and matron level Diabetes foot screening must be undertaken in primary care, foot protection in community reducing clinical need in Acute service

Complaints and compliments

The Shrewsbury and Telford Hospital NHS Trust







Summary:
Numbers of new complaints have continued to remain above expected levels, although there are no specific themes. Response rates are being maintained, and work is ongoing with the divisions to ensure that these improve further. There are plans to roll out the fast-track process to include more specialties.

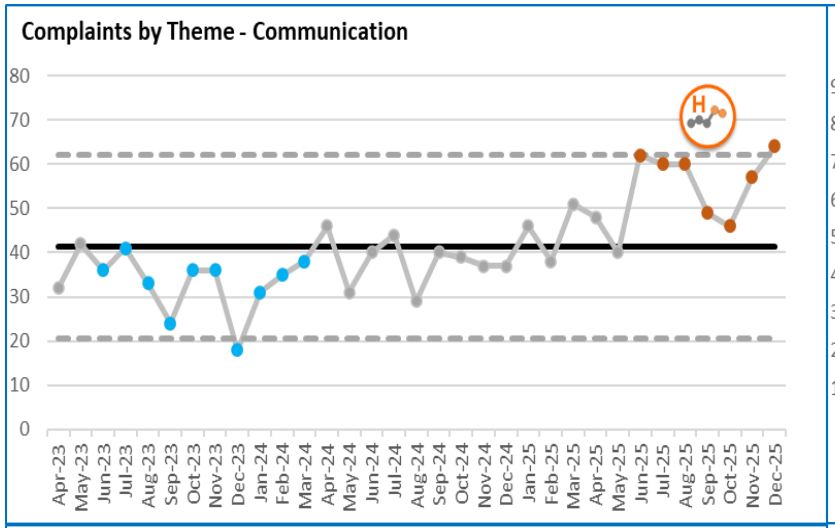
Recovery actions:
Dashboards on Datix give greater visibility of open cases for specialties.
Weekly complaints review meetings with Divisional and Specialty Teams.
Fast-track process being rolled out more widely

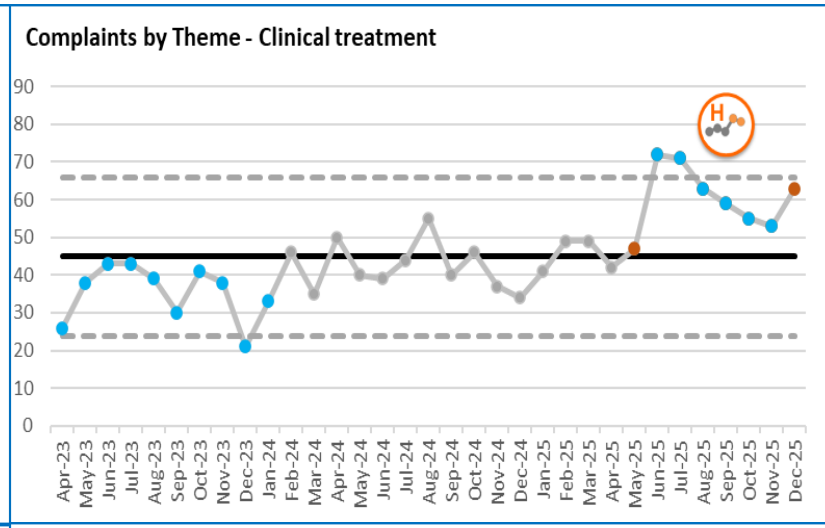
Anticipated impact and timescales for improvement:
Improvement in timeliness of responses.
Evidence of early involvement and support from Divisions/Specialities with complainants

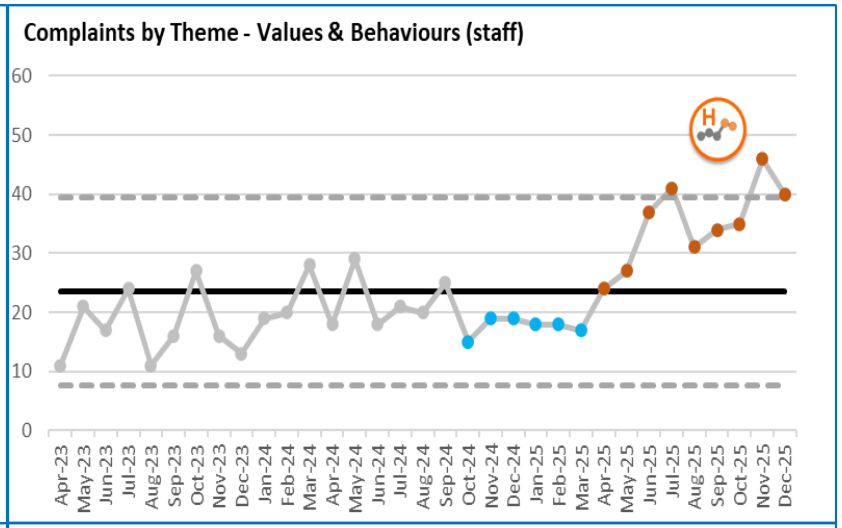
Recovery dependencies:	Capacity within Divisional teams due to high levels of clinical activity and increase in new cases. Delays in accessing records to respond fully to complaints

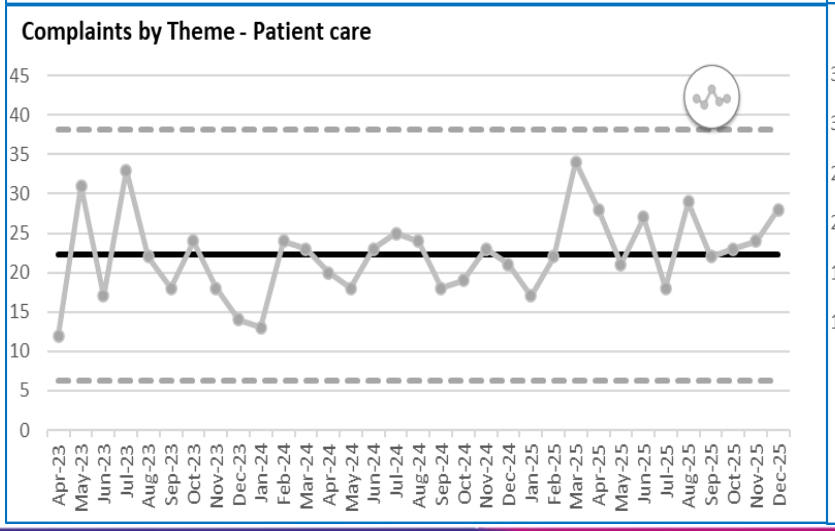
Complaints by theme – Top 6

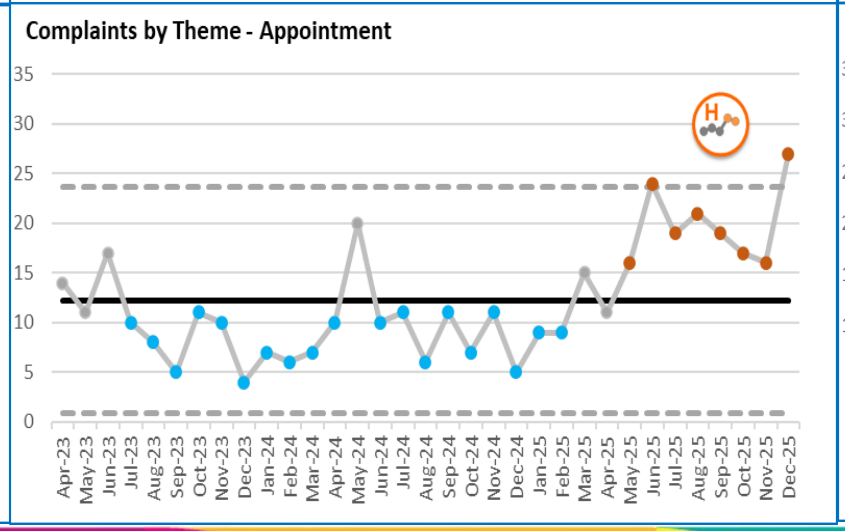
The Shrewsbury and Telford Hospital NHS Trust

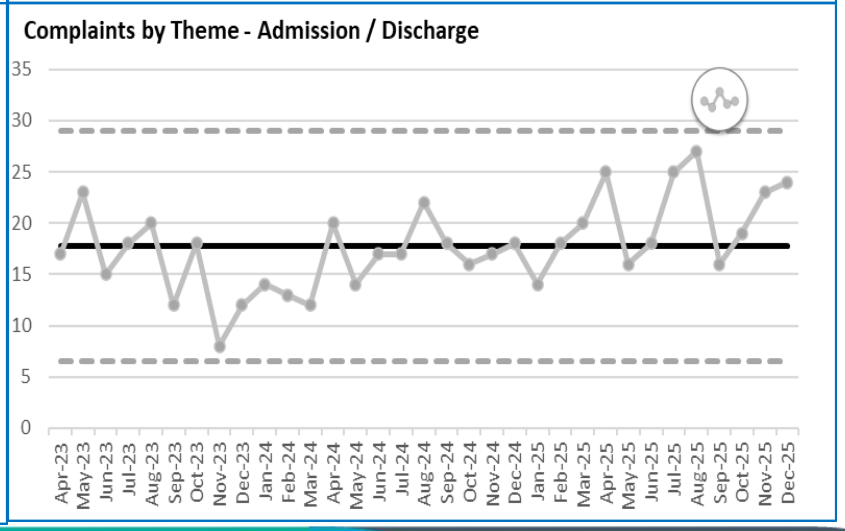












Partnering Ambitious Caring Trusted

VETERAN AWARE

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

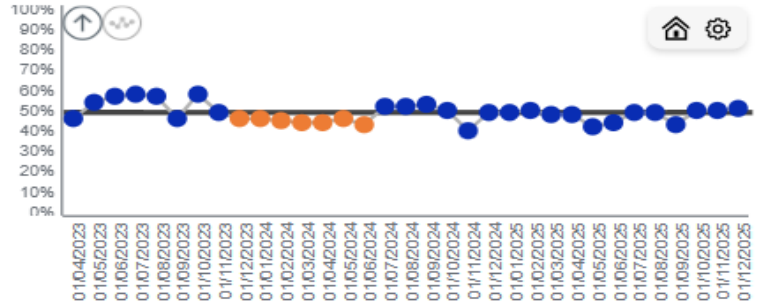
Quality - Patient Experience - Learning from Experience

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

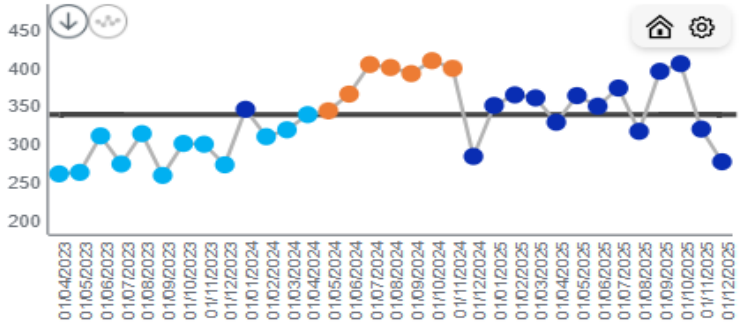
End of Life Care

	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025
Complaints - % Responded to within agreed timeframe based on month response due	40	49	49	50	48	48	42	44	49	49	43	50	50	51
PALS contacts	401	285	352	366	362	330	365	351	375	318	397	407	321	278
Complaints by Theme - Staff	67	59	74	66	76	79	78	115	108	106	91	89	113	121
Re-opened complaints upheld	1	0	0	1	0	0	0	0	1	0	1	0	0	0
Compliments Received	137	87	91	81	112	105	93	110	81	109	145	132	95	145
Friends and Family Test % recommenders	92.7	88.8	91.7	98.1	97.6	97.1	93.2	96.8	88.3	92.4	79.8	73.7	77.1	76.1

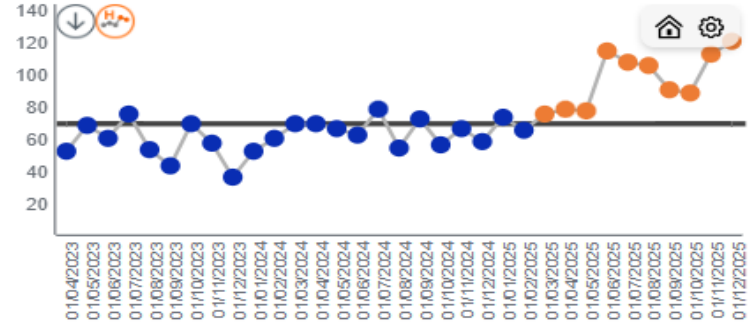
Complaints - % Responded to within agreed timeframe based on month response due



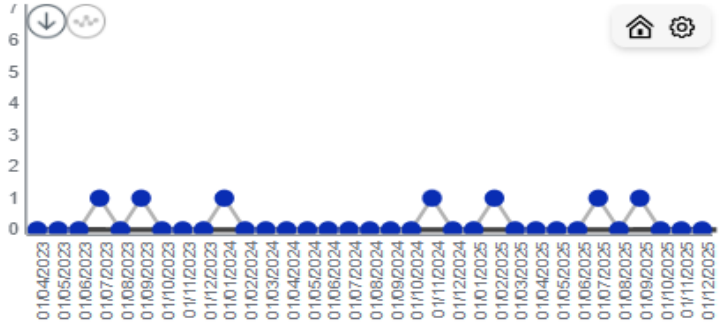
PALS contacts



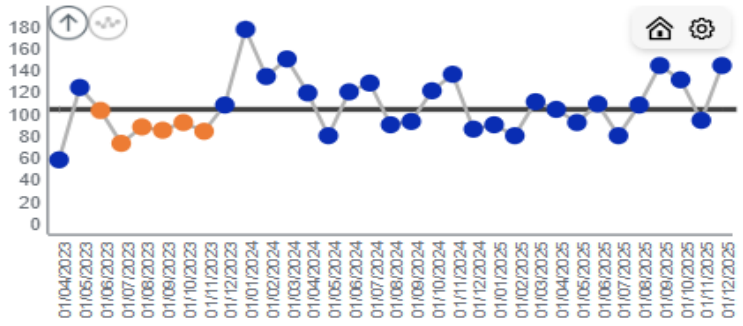
Complaints by Theme - Staff



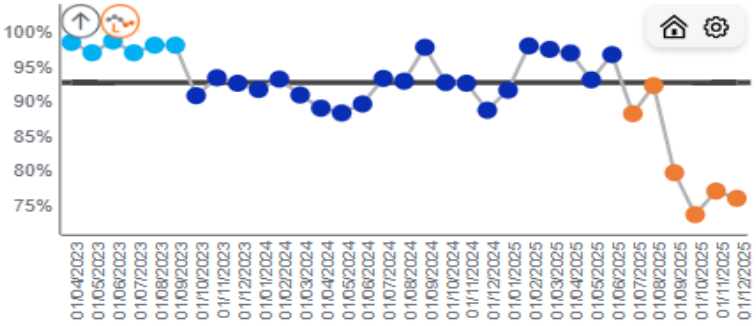
Re-opened complaints upheld



Compliments Received

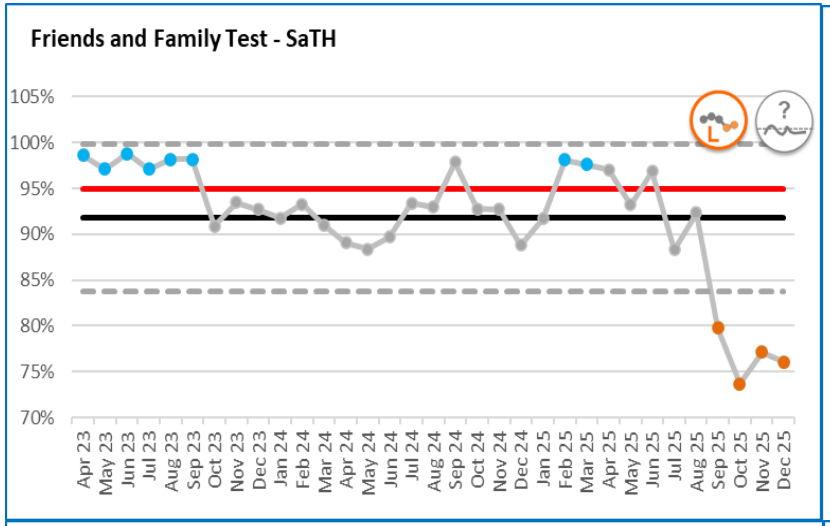


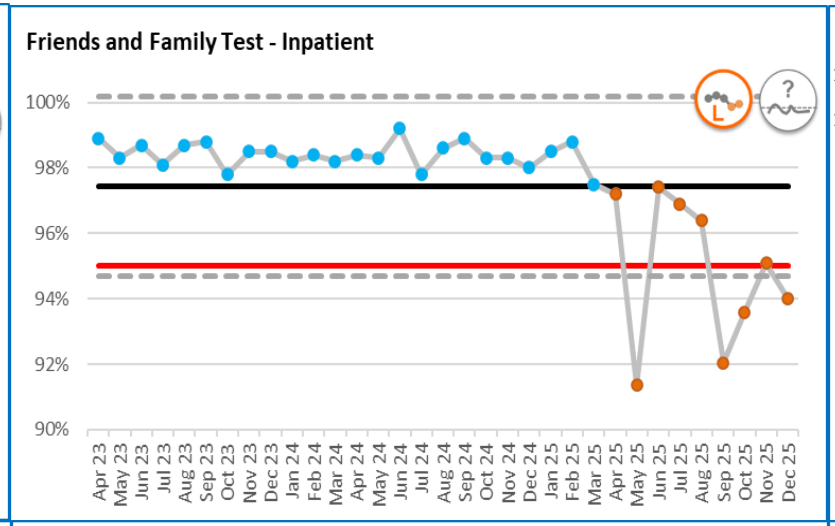
Freinds & Family Test % recommenders

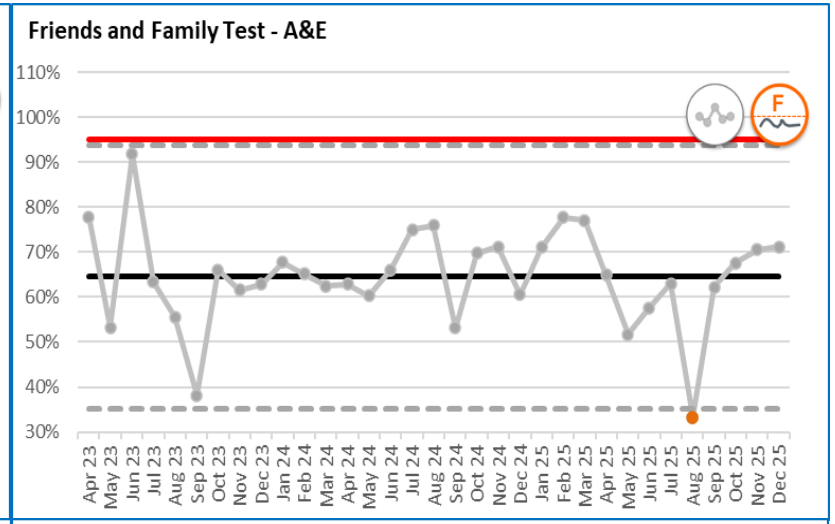


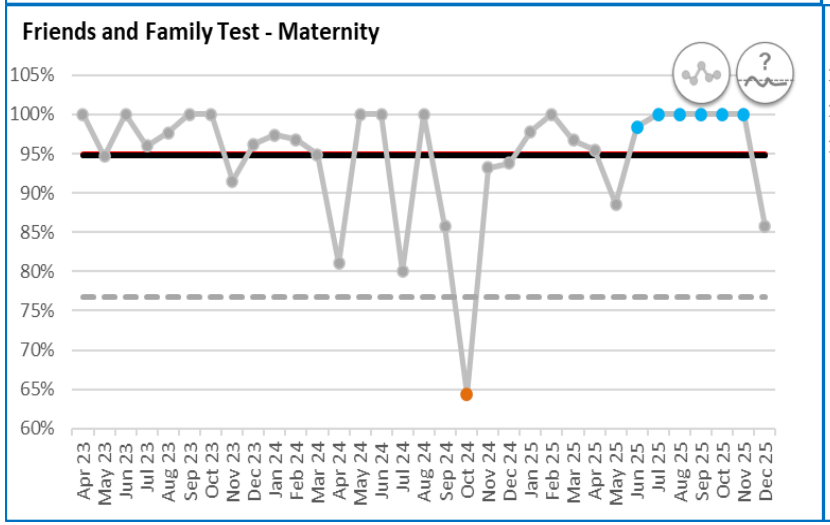
Friends and family test

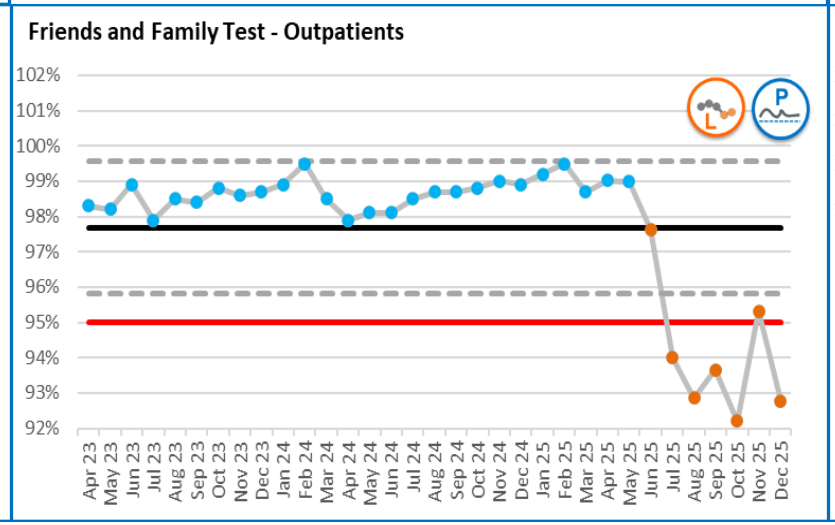
The Shrewsbury and Telford Hospital NHS Trust

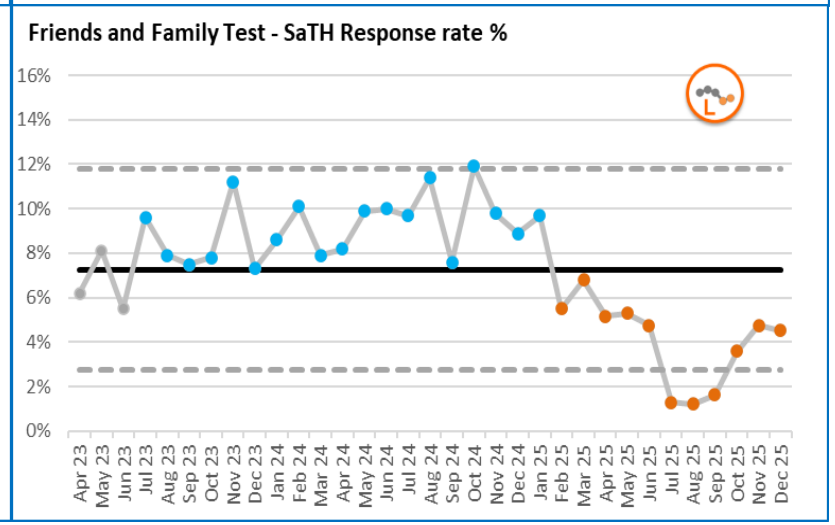




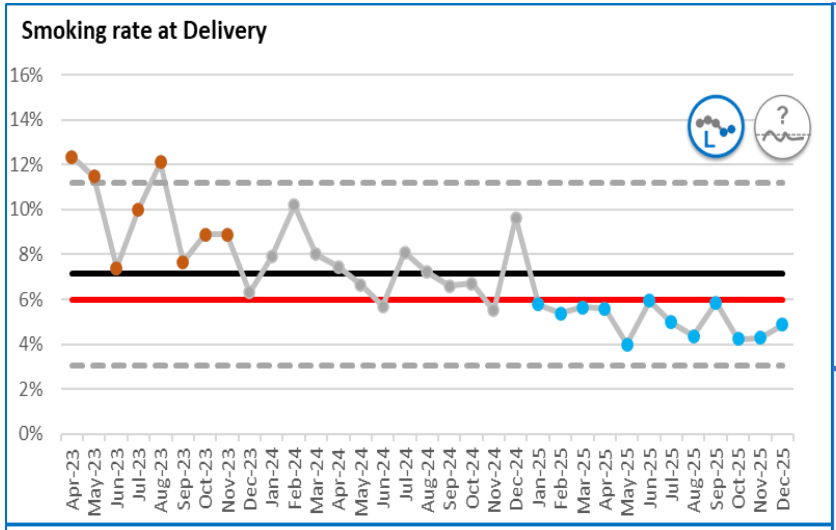


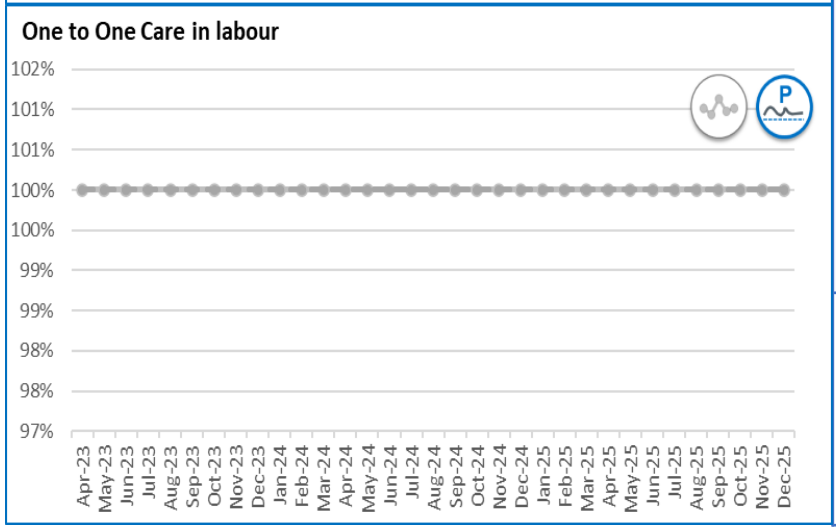






Maternity





Summary:
December data has shown a very slight increase from 4.3% to 4.9% Rates remain low and stable.

The overall SATOD rate for the financial year 2025/26 remains at 4.9%, which is well below Government target of 6%.

The overall SATOD rate for 2024/25 was 6.7% Accurate recording of SATOD status is being closely monitored by the Healthy Pregnancy Support Service (HPSS) team to ensure accurate data is being recorded at time of delivery.

Recovery actions:
Continue to further decrease SATOD throughout 2025/26.

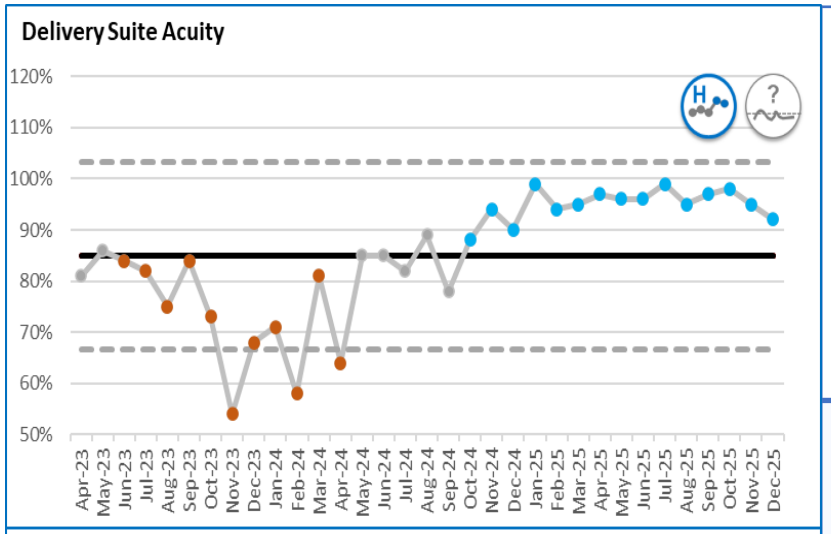
Continue to exceed Government target of 6%.

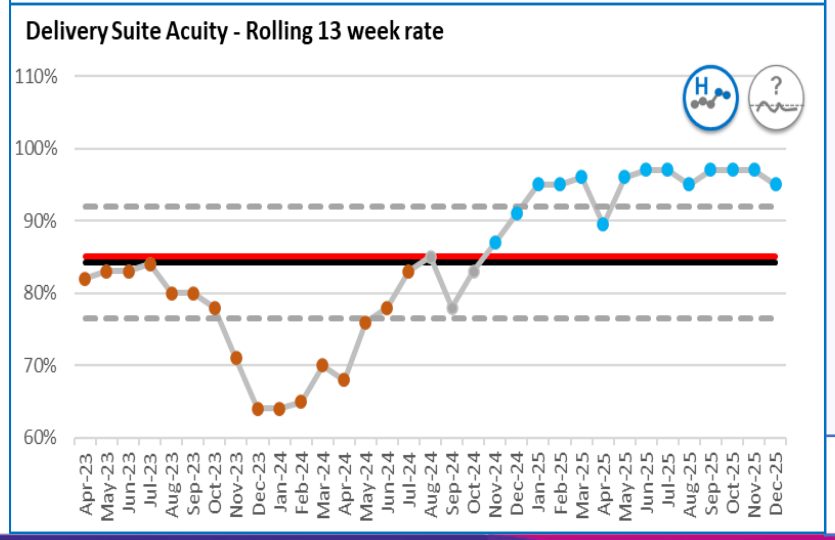
The HPSS team refer partners/family for support to quit smoking through Telford Council or Shropshire Social prescribing service dependant on where they live.

Anticipated impact and timescales for improvement:
Continue to target areas of deprivation and refer family members to local smoking cessation services. The biggest barrier to pregnant women quitting smoking is having a partner who smokes.
As per Saving Babies Lives, all Maternity staff are trained to offer very brief advice (VBA) and smoking cessation referral at every appointment.
Carbon Monoxide monitoring is completed at every routine antenatal appointment.

Recovery dependencies:
The local demographic has a higher-than-average deprivation index with increased unemployment and complex social needs, which is linked to higher rates of tobacco dependence. However, SaTH figures are now exceeding Government targets, which demonstrates the value of the HPSS model and the health improvements implemented to support local families.

Maternity – delivery suite acuity





Summary:
Delivery suite acuity continues to be maintained above the National target above 85% and has been consistently above 90% for the last eleven months with December acuity reported at 92%. We are seeing improvements in unavailability related to sickness; however, parenting leave remains high (>22 WTE combined sickness and parenting leave against template) . 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.

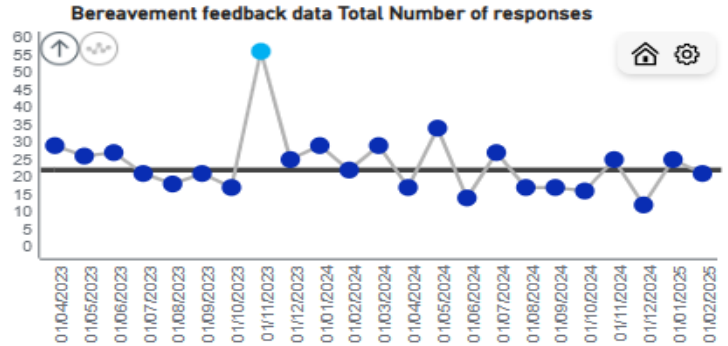
Recovery dependencies:	The introduction of vacancy panels have hindered recruitment, as proactive management of attrition rates has been affected significantly.

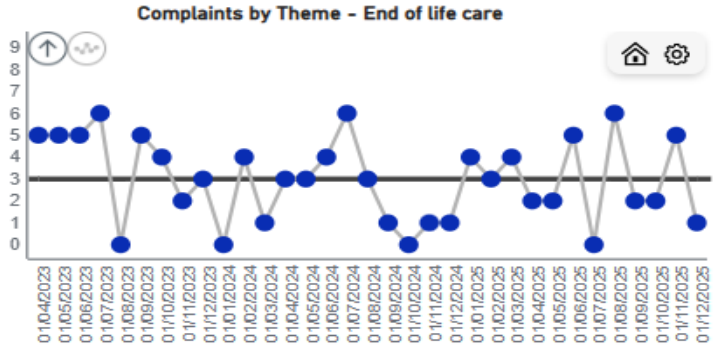
Quality - Patient Experience - End of Life Care

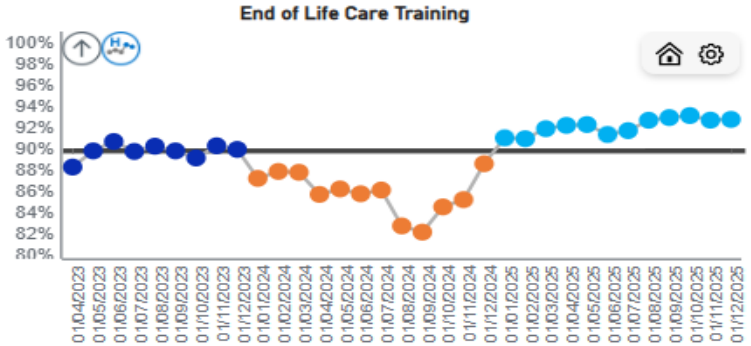
Page 1

Learning from Experience

	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	Sep-2025	Oct-2025	Nov-2025	Dec-2025
Bereavement feedback data - Total Number of responses	17	17	16	25	12	25	21										
Complaints by Theme - End of life care	3	1	0	1	1	4	3	4	2	2	5	0	6	2	2	5	1
End of Life Care Training	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	92.93	93.12	92.69	92.76







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

End of life

The Shrewsbury and Telford Hospital NHS Trust

Summary:
Performance in relation to Palliative and End of Life Care (PEOLC) metrics remain good. Training is above Trust 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 the Learning Management System (LMS). This training provides an overview of the Mental Health Act (1983), its application within an acute hospital setting, and key considerations following detention, including the giving of patients' rights
- Mental Health Act (1983): Scrutiny and Acceptance of Section Papers / Giving of Rights training is available on LMS for Clinical Site Managers. Clinical Site Managers are responsible for scrutinising and accepting Mental Health Act documentation in line with the Mental Health Act 1983 – Receipt of Section Papers: Acceptance of Detention Documentation standard operating procedure
- Restrictive Intervention Training (De-escalation, Management and Intervention – DMI) competency is valid for 12 months. An update is required before expiry, typically at half the duration of the original training (e.g. a two-day DMI course requires a one-day update). DMI training spaces are available on LMS until April 2026, with current funding provided through the CPD budget
- The Mental Health Liaison Team has developed a training package covering mental health conditions, presentations and symptoms, mental health triage, and brief risk assessment. This is available as e-learning modules on LMS, with classroom-based training currently being developed according to area, risk, and service need

Recovery actions:

- Monitor completion rates through LMS reporting
- Mental Health Liaison (Midlands Partnership Foundation Trust - MPFT) progressing with development of classroom based training package
- Confirm all Clinical Site Managers (CSM) have received training in scrutiny and acceptance of Section Papers
- Ongoing monitoring of compliance of Section Paper via monthly audits carried out by the Mental Health Administrator

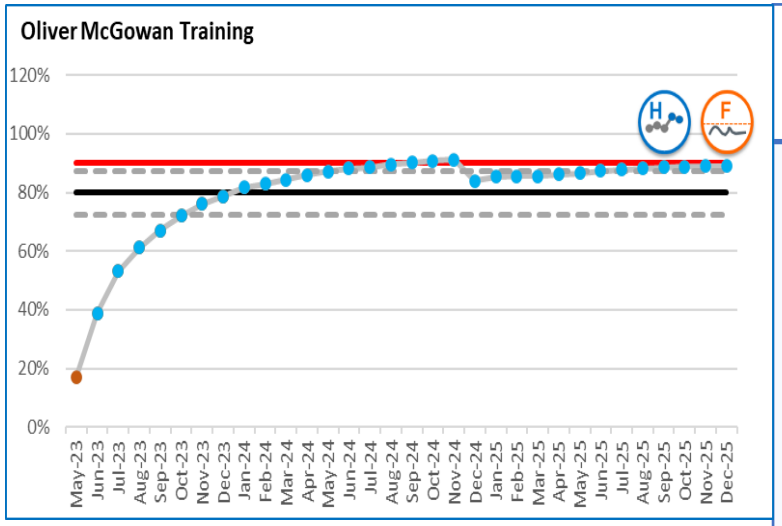
Anticipated impact and timescales for improvement:

- Improved legal compliance, increased understanding of the Mental Health Act (1983) will reduce the risk of unlawful detention, invalid paperwork and failures in giving patients their rights
- Up to date DMI competencies will lower the risk of harm to patients and staff
- Increased workforce confidence and capability, staff will demonstrate improved confidence in recognising mental health conditions, conducting basic risk assessment and referring for appropriate support

Recovery dependencies:

- Joint working with Mental Health Liaison Team (Midlands Partnership Foundation Trust) to ensure targets are met
- Staff uptake of training offered
- Funding allocation

Learning disability and/or Autism



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

Recovery actions:

- Oliver McGowan e-learning training is at 88.87%
- A Trust wide plan for delivery of the T1 and 2 training is now in place with roll out from Q4 and the plans to provide training for 3,000 staff in 2026/27
- 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)	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Trend
Responsiveness	ED - 4 Hour Performance (SaTH Type 1 & 3) %		78% Mar'26	57.0%	52.1%	52.7%	52.8%	46.9%	49.3%	53.1%	52.7%	52.1%	53.8%	54.2%	53.6%	52.0%	51.3%	
	ED - 4 Hour Performance (All Types inc MIU) %		-	-	61.4%	61.5%	61.6%	56.7%	59.0%	62.4%	62.8%	61.1%	63.4%	62.7%	61.7%	60.1%	60.1%	
	ED - 4 Hour Performance (SaTH Type 1) %		-	48.1%	42.2%	42.0%	43.1%	41.0%	42.1%	45.7%	45.4%	45.6%	45.6%	46.3%	45.5%	43.8%	43.2%	
	ED - 4 Hour Performance (SaTH Type 3) %		-	89.9%	91.2%	93.1%	89.9%	74.5%	79.1%	83.4%	85.5%	80.9%	87.6%	87.1%	85.9%	83.7%	85.9%	
	ED - 12 Hour Trolley Breaches	R	0	0	1316	1130	1390	1362	1379	1334	1407	1300	1492	1618	1453	1429	1601	
	Number of Ambulance Arrivals	R	-	-	3186	2937	3451	3301	3489	3335	3484	3392	3041	3210	3221	3373	3294	
	Average ambulance handover time (ED and non-ED)		-	-	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	01:21:39	01:23:23	01:35:52	01:35:15	
	Ambulance handovers > 15 minutes	R	-	-	2562	2390	2799	2748	2692	2544	2509	2557	2488	2647	2577	2691	2767	
	Ambulance handovers > 15 minutes %	R	0%		80.4%	81.4%	81.1%	83.2%	77.2%	76.3%	72.0%	75.4%	81.8%	82.5%	80.0%	79.8%	84.0%	
	Ambulance handovers > 45 minutes						New Metric April '25		1127	1227	884	932	1335	1433	1332	1451	1585	
	Ambulance handovers > 45 minutes %		0%				New Metric April '25		32.3%	36.8%	25.4%	26.7%	43.9%	44.6%	41.4%	43.0%	52.9%	
	Ambulance handovers > 60 minutes %	R	0%		38.8%	34.7%	33.2%	38.5%	25.8%	29.5%	19.9%	20.7%	37.9%	37.5%	35.3%	37.1%	41.3%	
	ED activity (total excluding planned returns)		-	12241	11856	11516	13917	13267	13908	13528	13638	13230	12951	13619	13361	13569	13020	
	ED activity (type 1 excluding planned returns)		-	9913	9479	9112	11050	10941	11190	10864	11143	10802	10445	10982	10683	10764	10549	
	Total Emergency Admissions from A&E		-	-	3248	2899	3363	3142	3345	3266	3323	3381	3301	3655	3614	3768	3659	
	% Patients seen within 15 minutes for initial assessment		-		62.4%	61.5%	57.3%	54.6%	60.7%	71.3%	74.4%	72.3%	65.3%	65.2%	64.6%	71.4%	68.5%	
	Average time to initial assessment (mins)		15 Mins	15	17.1	19.2	19.8	23.3	17.8	13.9	12.2	13.6	16.3	15.5	15.8	14.2	14.2	
	Average time to initial assessment (mins) Adults		15 Mins	15	17.7	20.6	20.9	25.7	18.6	14.3	12.7	14.5	16.5	15.9	14.7	11.8	14.8	
	Average time to initial assessment (mins) Children		15 Mins	15	15.0	14.2	16.4	15.0	14.8	12.4	10.2	9.2	15.5	13.9	19.4	21.9	12.1	
	Mean Time in ED Non Admitted (mins)		-	215	324	309	311	346	323	304	292	291	293	292	294	298	304	
	Mean Time in ED admitted (mins)		-	500	1339	1279	1159	1350	1165	1202	1127	1084	1227	1145	1121	1124	1213	
	Percentages of attendances in A&E over 12 hours - Type 1		-	21.43%	24.53%	23.23%	23.45%	23.44%	23.27%	22.04%	21.75%	21.94%	23.39%	23.27%	22.36%	22.01%	24.74%	
	No. Of Patients who spend more than 12 Hours in ED - Type 1		-	2177	2325	2117	2591	2565	2604	2394	2424	2370	2443	2555	2389	2369	2610	
	Bed Occupancy Rate - G&A (SitReps)		92%	-	95.2%	95.7%	95.7%	95.2%	94.4%	95.4%	94.2%	93.6%	93.8%	94.5%	92.1%	92.3%	95.6%	
	Diagnostic Activity Total - All commissioners			-	23202	22623	24212	24021	24580	23930	25161	23367	24860	24881	22628	24080	24199	
	Diagnostic Total Waiting List - All commissioners			-	17493	16509	15738	13866	12511	11453	12013	11471	11634	12437	12437	12256	13037	
	Diagnostic 6 Week Wait Performance %		99% Mar'26	-	56.6%	71.7%	78.2%	78.5%	79.4%	82.2%	83.2%	81.8%	85.5%	86.9%	86.4%	81.7%	80.5%	
	Diagnostic 6+ Week Breaches		0	-	7524	4676	3437	2982	2577	2039	2016	2086	1692	1632	1707	2249	2690	
	Number of episodes moved or discharged to PIFU		-	2945	2299	2090	2300	2196	2203	2633	2627	2288	2523	2488	2472	2283	2325	
	RTT Incomplete 18 Week Performance		65% Mar'26	57.57%	48.2%	48.9%	48.1%	49.6%	53.0%	54.9%	56.4%	58.8%	62.3%	64.0%	65.5%	64.1%	62.9%	
	RTT Waiting list - Total size	R	-	-	49827	48383	46775	46242	44005	42449	39438	37132	36022	36674	37997	36982	37932	
	RTT Waiting list - English only		-	40137	44411	43218	41669	41238	39042	37630	34742	32670	31652	32263	33621	32790	33637	
	RTT 52+ Week Breaches (All)	R	0	-	3036	2493	1933	1778	1592	1103	734	600	369	313	284	212	238	
	RTT 52+ Week Breaches - English only		-	522	2392	1987	1512	1312	1170	718	444	305	125	84	68	20	31	
	RTT 65+ Week Breaches (All)		-	-	374	173	115	166	139	114	98	98	87	75	59	37	51	
	RTT 65+ Week Breaches - English only		0	0	166	84	26	18	5	0	3	0	0	0	0	0	0	
	RTT 78+ Week Breaches (All)	R	0	0	50	25	29	34	30	33	27	23	15	14	15	17	18	
	RTT 78+ Week Breaches - English only		0	0	4	0	4	1	0	0	0	0	0	0	0	0	0	
	RTT 104+ Week Breaches (All)	R	0	0	0	0	1	4	3	1	1	1	1	1	1	2	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	67.2%	52.9%	54.7%	66.6%	56.6%	63.1%	62.6%	66.6%	68.8%	65.2%	71.4%	70.2%	70.1%	-	
	Cancer 31 Day First Treatment		96%	94.7%	88.5%	93.7%	96.6%	90.5%	88.2%	87.9%	94.7%	91.6%	94.2%	96.2%	95.5%	98.0%	-	
	Cancer 28 Day Faster Diagnosis - combined	R	80% Mar'26	76.5%	57.5%	65.1%	62.5%	68.6%	71.4%	72.5%	75.5%	75.9%	80.1%	80.3%	85.7%	83.0%	-	
	Theatre productivity			85%	80%	79%	78%	79%	79%	80%	81%	81%	81%	80%	81%	81%	80%	

Operational Executive Summary

The Shrewsbury and Telford Hospital NHS Trust

SaTH ED 4-hour performance (type 1 & type 3) moved to common cause variation in January 2026. Type 1 performance deceased to 43.5% and Type 3 performance increased to 85.9%.
Average ambulance handover time shows common cause variation in January with 57.2% within 60 mins. The number of Type 1 patients who spend more than 12 hours in ED shows common cause natural variation.

RTT for January is English 0 x 104 weeks, 0 x 78 weeks, 0 x 65 weeks, 31 x 52 week (adult) and 0 x 52 weeks CYP. The unvalidated Trust Position for Welsh is 1 x 104 weeks, 18 x 78 weeks, 51 x 65 weeks 207 x 52 weeks

The total waiting list size remains above plan. 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, respiratory, dermatology, cardiology for outpatients and endoscopy. Theatre Utilisation for January was 80%, with no insourced sessions undertaken during the month.

Cancer - Confirmed December cancer performance is 83.0% (28-day FDS) vs the local plan of 76.5%. 62-day performance was 70.1% against a (local target 67.2%) and 31 day was 98.0% (national target 94.7%). The 62-day backlog is 153 patients over 62 days of which 29 are over 104 days (as at 08/02/2026).

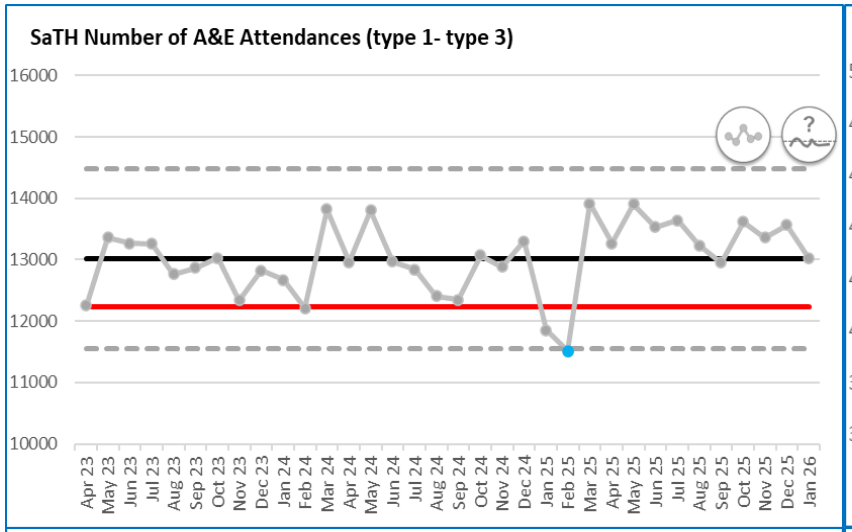
DM01 - The submitted DM01 position for January was 80.5%, a declined performance driven by a drop in NOUS and Audiology.
Radiology reporting turnaround times are being maintained. TATs from referral to report for USC are:- CT 2 weeks, MRI 2 weeks and NOUS 1-2 weeks.

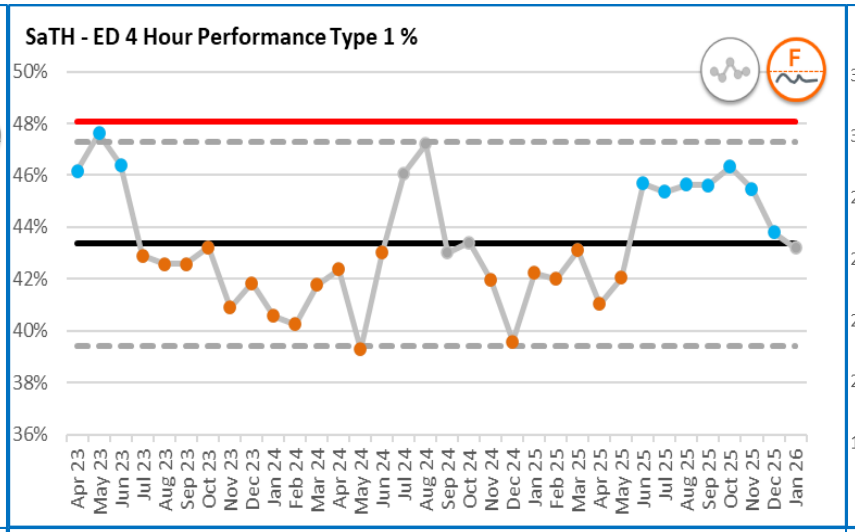
Key actions

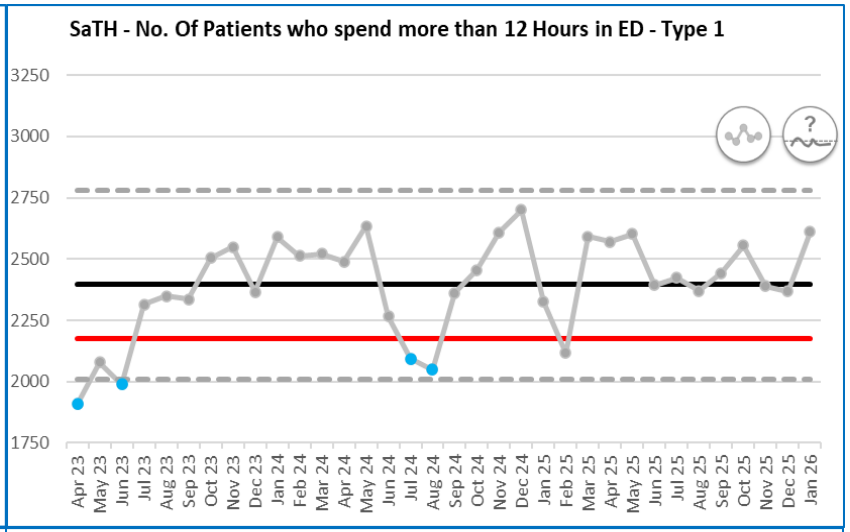
- Ambulance threshold Plan
- Safe and timely UEC campaign to launch for the month of March 2026
- New productivity workstream started with endoscopy, with insourcing being reduced in Q4
- Outpatient productivity now focussed on in session utilisation looking to increase the number of slots delivered per clinic
- Diagnostic improvement programme now focussed on NOUS & Urodynamics
- Cancer Improvement Plan Phase 2 being developed with a focus on the treatment end of the pathway
- Q4 Sprint delivery plan rolled out with good uptake seen in a number of specialties

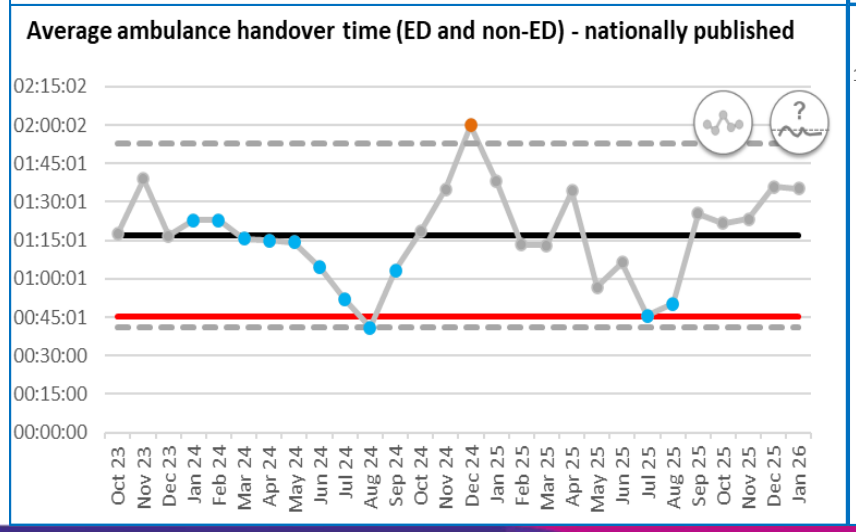
Operational – Emergency Care

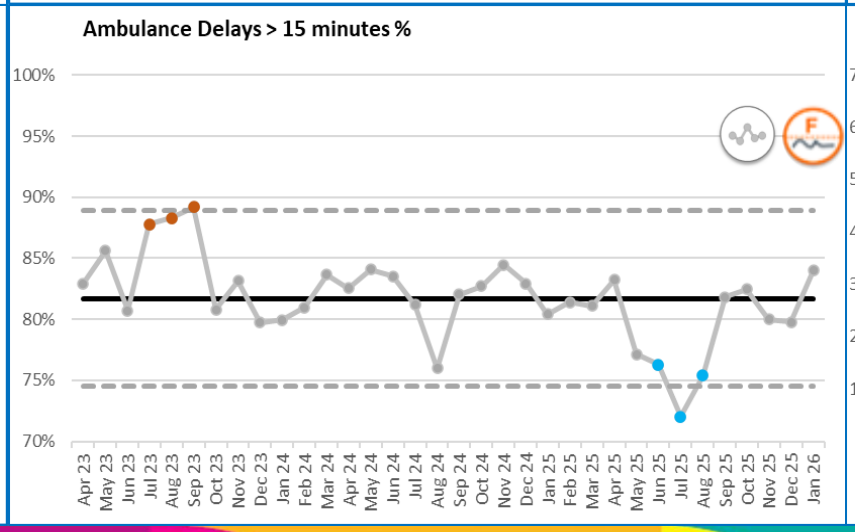
The Shrewsbury and Telford Hospital NHS Trust

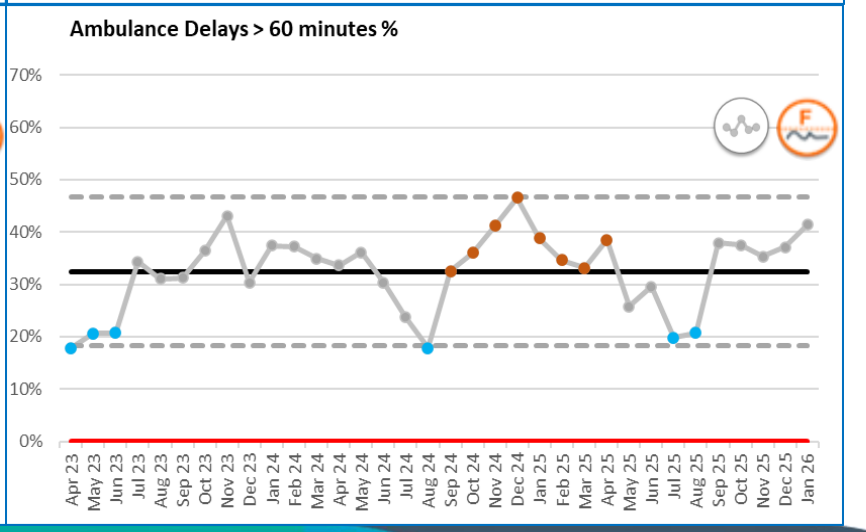












Operational – Emergency Care

The Shrewsbury and Telford Hospital NHS Trust

Summary:

- SaTH ED 4-hour performance was 51.6% (type 1 & type 3) and moved to common cause variation in January 2026
- SaTH number of patients who spend more than 12 hours in ED has remained in common cause natural variation at 75.3% in January 2026
- Average Ambulance handover of patients to SaTH premises shows common cause variation in January with 57.2% within 60 mins

Recovery actions:

- 25/26 plan agreed to reach 55 minutes mean ambulance handover performance by March 2026
- Continue to work with Health Hero to progress admission avoidance opportunities
- Continue to work with WMAS/WAS on maximum handover threshold and immediate handover process
- Integrated Community Front Door (IFD) Team in place in both ED Departments
- 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; Embed processes in line with UEC recovery plan in line with all additional bed and assessment capacity now opened; system wide 25/26 schemes including; expanded UCR to midnight; additional discharge planning capacity. Safe and timely UEC campaign to launch for the month of March 2026

Anticipated impact and timescales for improvement:

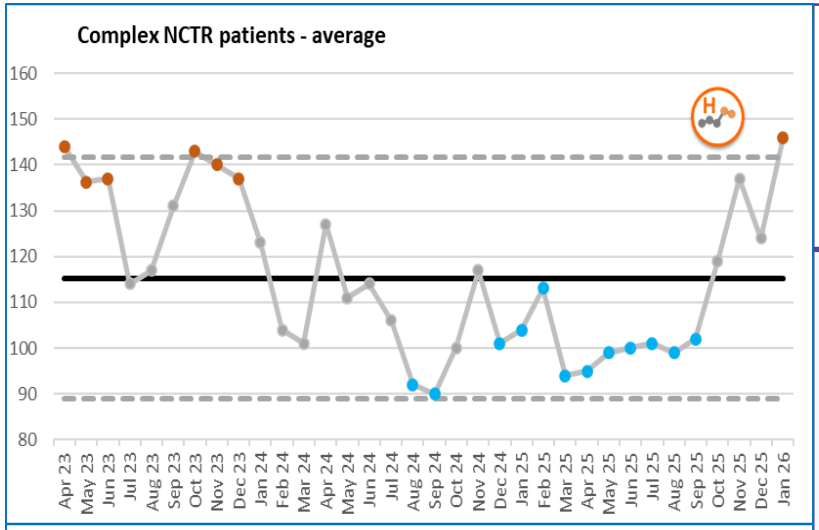
Progress reported monthly through UEC Flow improvement group to Performance Assurance Committee (PAC) and system UEC meeting.

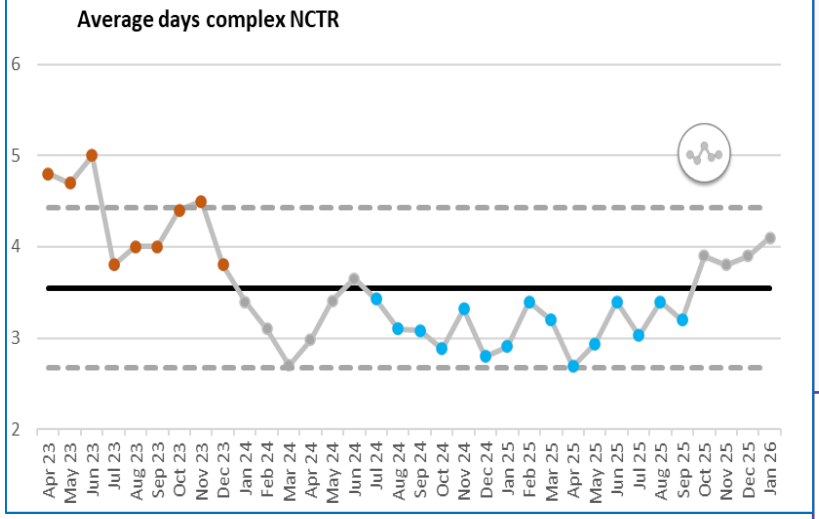
Progress reported monthly through Urgent and Emergency Care Transformation Committee (UECTAC) and weekly cross Divisional metrics meeting.

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

Operational – Patient Flow

The Shrewsbury and Telford Hospital NHS Trust





Summary:

- The average number of complex no criteria to reside (NCTR) patients this month has exceeded the upper process control limit, indicating special cause variation
- The average number of days that patients are identified as complex no criteria to reside and awaiting discharge remains above the mean, demonstrating common cause variation.

Recovery actions:

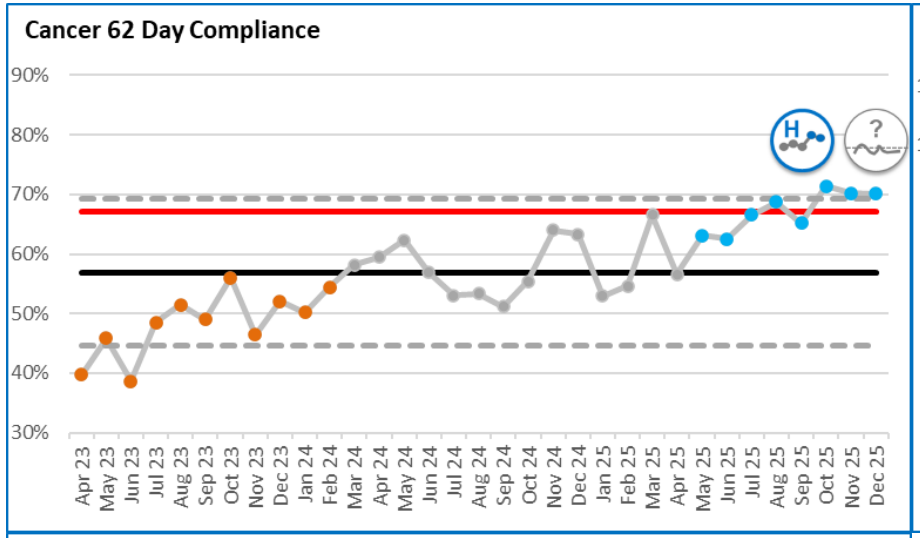
- Focus on accurate Estimated Discharge Date (EDD) to refer into Care Transfer Hub (CTH) 5 days prior to EDD to enable CTH to work up patient for discharge on EDD
- Tracking of community beds, complex discharges and transport to reduce incomplete (failed) discharges
- Trust long length of stay review meeting increased to twice weekly with local authorities and Divisional representatives, focusing on patients with CTR
- Continued focus on the CTH and therapy processes to reduce the length of time between NCTR and discharge
- Daily CTH meetings, reviewing patients with NCTR
- CTH extended hours 08.00 - 20.00
- Roll out of the deconditioning change model to all wards continues
- Rolling schedule of deep dives by MEC Matrons continues
- Daily monitoring of out of area patients by capacity team- Patient flow managers supporting transfers to local acute trusts
- Increased transfers to the Discharge Lounge by 08.45 - handover the previous night. DL hours extended. Now open 07.00 - 22.00 both sites

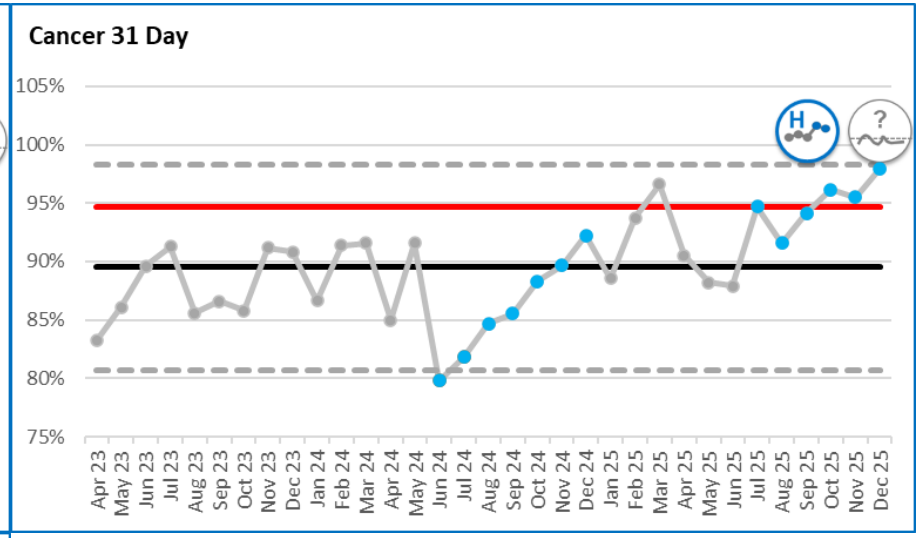
Anticipated impact and timescales for improvement:

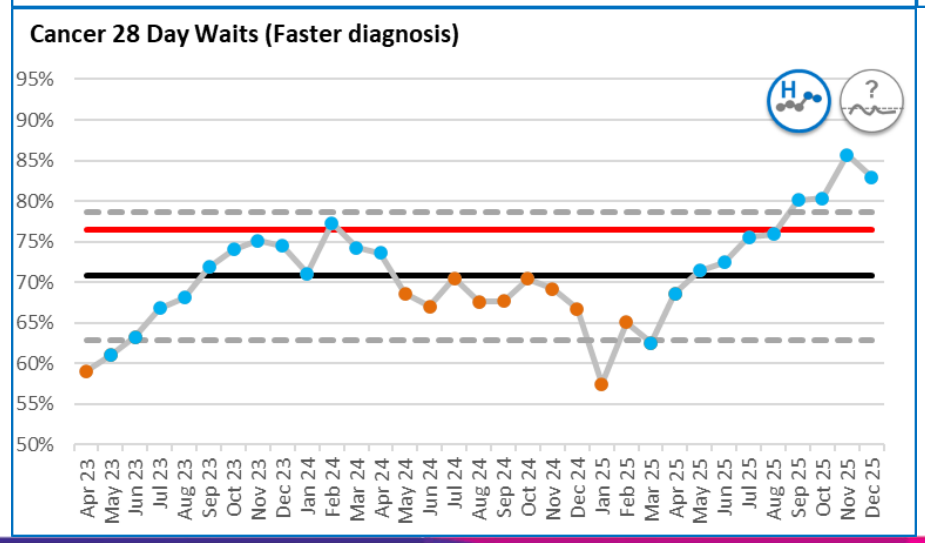
Progress reported monthly through UEC Flow improvement group to Performance Assurance Committee (PAC) and system UEC meeting.

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:
Confirmed December cancer performance is 83.0% (28-day FDS) vs the local plan of 76.5%. 62-day performance was 70.1% against a (local target 67.2%) and 31 day was 98.0% (national target 94.7%). The 62-day backlog is 153 patients over 62 days of which 29 are over 104 days (as at 08/02/2026).

Recovery actions:
The Trust is now in Tier 3 of 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. The phase one cancer improvement plan has delivered the required improvement in time to first appointment and diagnostic access, thereby improving the FDS performance significantly. Improvement is clear. In September, October and November 2025 and December SaTH 28-day FDS standard performance was over 80% - with November performance second highest in the country at 85.7%. In December 2025, SaTH 62-day RTT standard performance was 70.1%, lifting us out of the bottom quartile nationally. As phase two of our improvement programme progresses through Q3 and Q4 we are confident of seeing further improvement in the timeliness of our time to treatment.

Clinical and operational workforce constraints continue most notably in Oncology, Max Fax and Urology pathways. Mitigations are in place, including partnership working with a neighbouring Trust and insourcing additional capacity.

Anticipated impact and timescales for improvement:

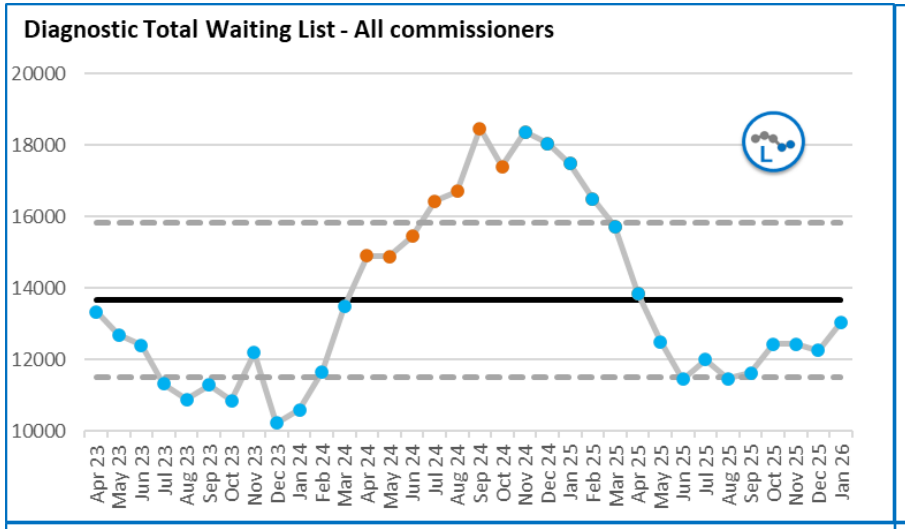
Phase one improvement plan has over delivered against operational plan as at end of Q2.

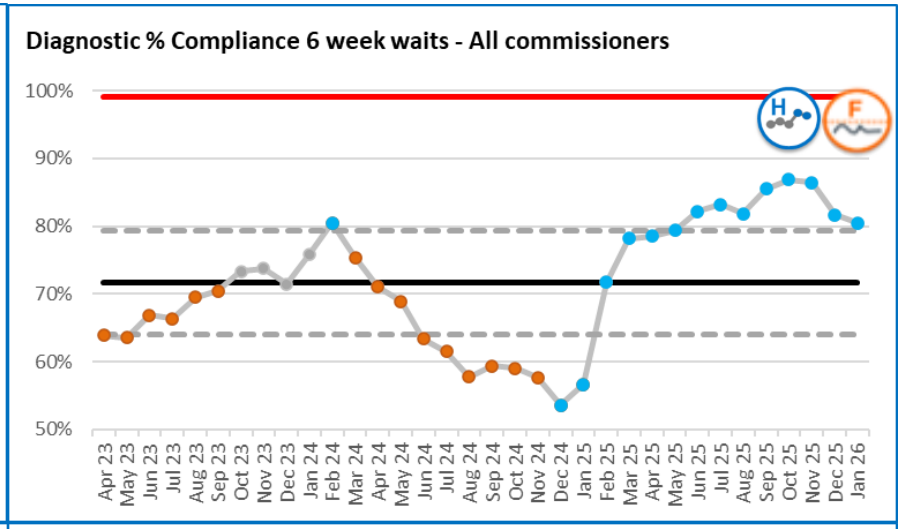
Phase two improvement plan is in place to deliver operational plan as at end of Q4.

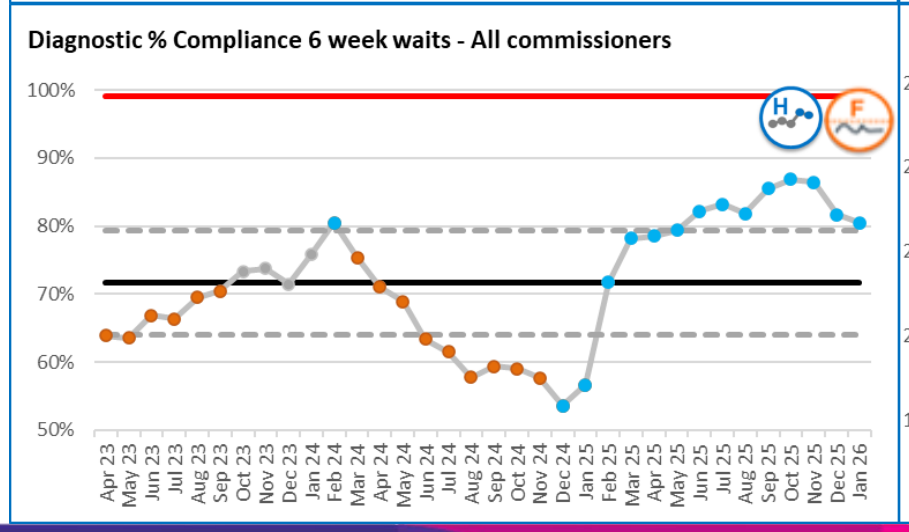
Recovery dependencies:	WMCA funding of approx. 1.7 million allocated to drive diagnostic cancer turnaround times for 25/26. Radiotherapy recovery plan.

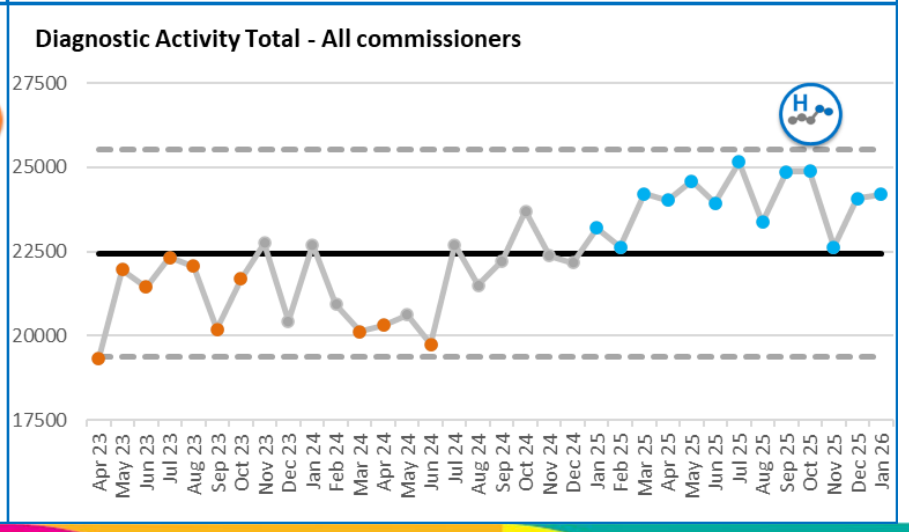
Operational – Diagnostic waiting times

The Shrewsbury and Telford Hospital NHS Trust









Operational – Diagnostic waiting times

The Shrewsbury and Telford Hospital NHS Trust

Summary:
The submitted DM01 position for January was 80.5%, a declined performance driven by a drop in NOUS and Audiology.
Radiology reporting turnaround times are being maintained. TATs from referral to report for USC are:- CT 2 weeks, MRI 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 and outsourcing 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 - additional WLI and insourcing support continue to support reduction of 13+ww and continued improvement of DM01 performance and Cancer TAT.
- DM01 performance for CT continues to meet national target of 99%, with MRI consistently performing above 90%

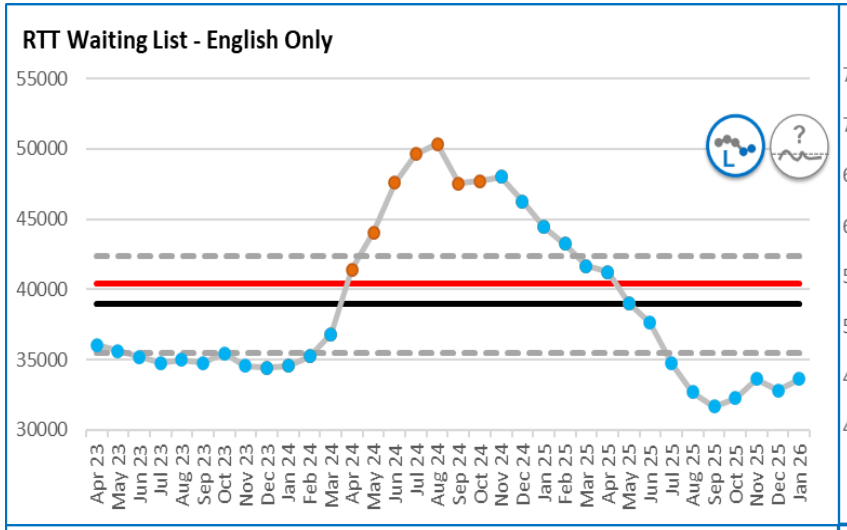
Recovery actions: Outsourced reporting continues to provide additional capacity supporting MRI and CT turnaround times. Enhanced payments and WLIs are encouraging additional in-house reporting sessions across all modalities.
MRI performance continues to fluctuate with a rise in the number of Cardiac scans remaining outstanding over 6 weeks. A mobile van is operational to increase scanning capacity and support with cancer performance, which has improved significantly since March 2025 for MRI.
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.
Additional U/S slots are being identified to support the urology cancer performance.
The sustainable endoscopy business case has been approved and is a 3-year programme of work requiring support from an IS provider pending recruitment to substantive posts and lead time for training until endoscopy practitioners become independent.

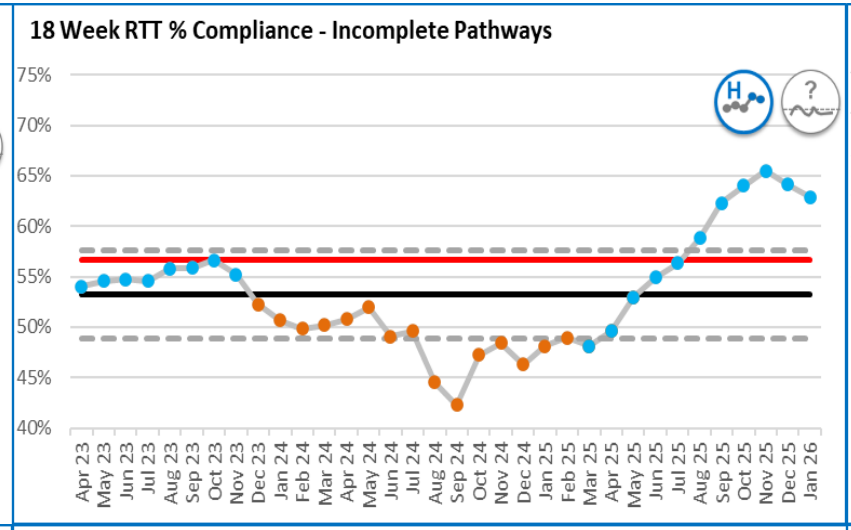
Anticipated impact and timescales for improvement:
Additional insourcing from '18 Weeks' to support Endoscopy DM01 at weekends has been supported through the ERF. It There is ongoing recruitment for radiologists, radiographers and sonographers.

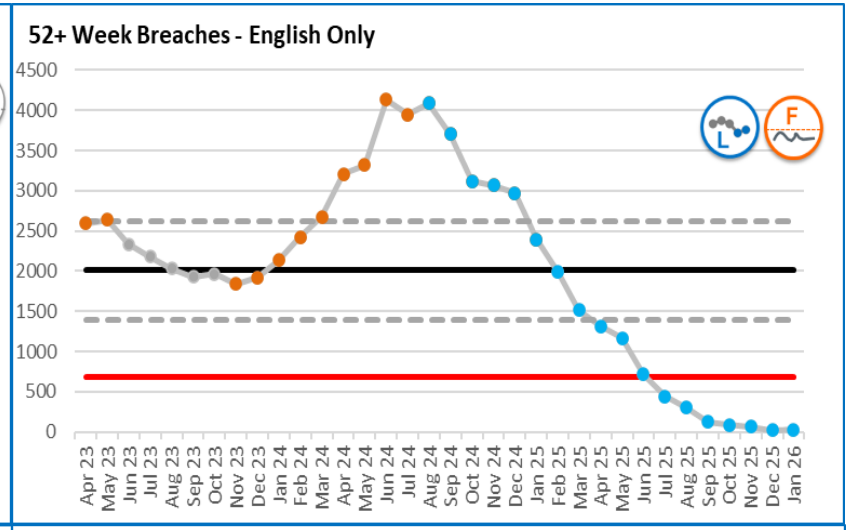
Use of insourcing for USS and MRI is proving successful with DM01, significant focus and targeted capacity it being generated to manage the US performance.

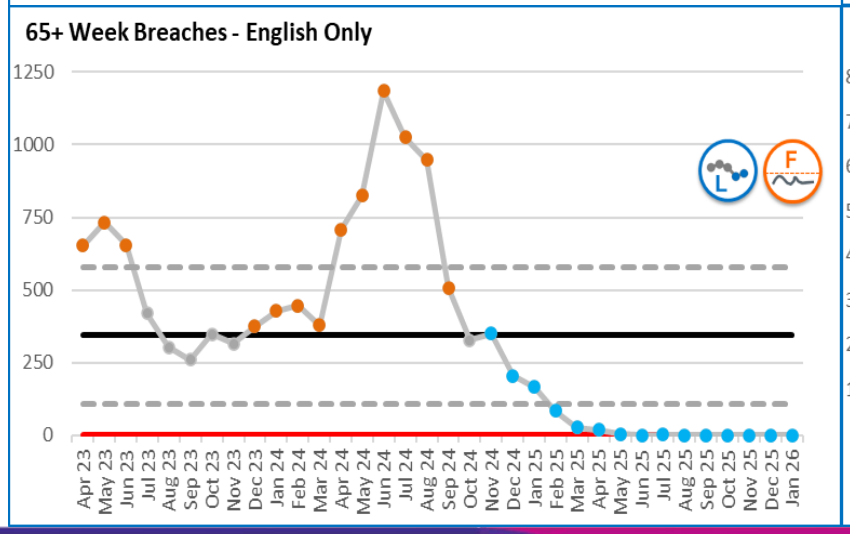
Operational – Referral to treatment (RTT)

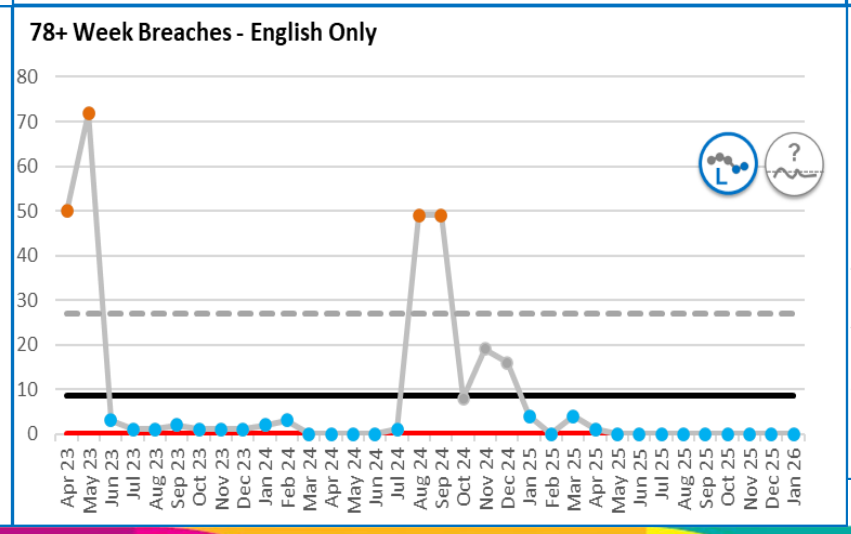
The Shrewsbury and Telford Hospital NHS Trust

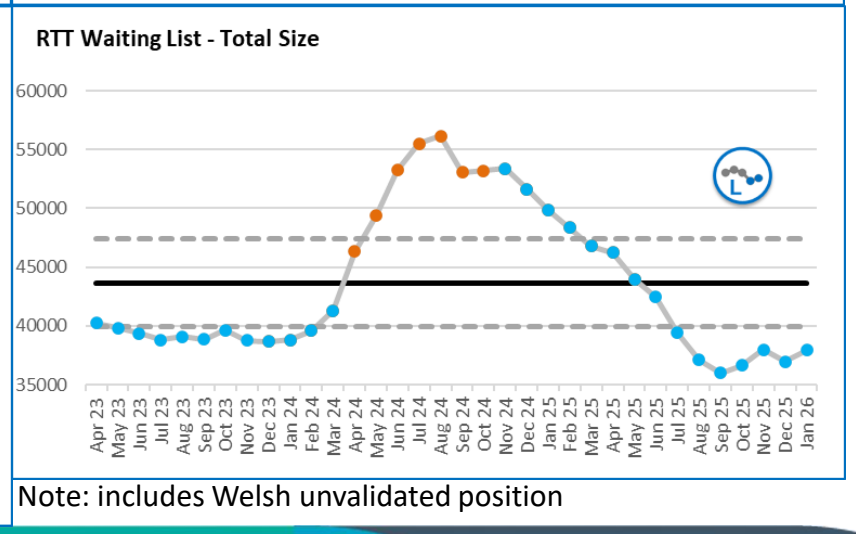












Note: includes Welsh unvalidated position

Operational – Referral to treatment (RTT)

The Shrewsbury and Telford Hospital NHS Trust

Summary:
The unvalidated Trust Position for January 2026: English is 0 x 104 weeks, 0 x 78 weeks, 0 x 65 weeks, 31 x 52 week (adult) and 0 x 52 weeks CYP. The unvalidated Trust Position for Welsh is 1 x 104 weeks, 18 x 78 weeks, 51 x 65 weeks 207 x 52 weeks.
The Trust remains on plan across all RTT metrics. This progress has been supported significantly by the work delivered through the outpatient transformation programme with Four Eyes Consultancy. As a result, we have achieved a 3–4% improvement in the outpatient booking rate, equating to approximately 300 additional appointments each week.
The theatre planner is currently being reviewed to ensure that each specialty has the appropriate allocation to meet projected demand for 2026/27. The expectation continues to be that 97% of weekly core lists will run, including the cataract suite. This approach has also contributed to a reduction in insourcing activity, with zero insourcing lists being used in the month of January 2026 compared with 96 sessions delivered by insourcing in March 2025.
MBI continues to support the Trust with validation activity.
Daily meetings continue to take place with the teams to ensure that there is a focus to ensure our long waits are treated. Each specialty has been given individual targets to achieve and this PTL is now being using to improve 18-week performance and reduce the number of patients waiting 52 weeks for treatment.
All teams are now focusing on the Q4 sprint.

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: The teams have now submitted plans for the Q4 sprint and are focusing on delivery.

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 focusing on clinic template optimisation and the implementation of key digital tools. This programme has recognised further success with an additional 5,000 appointments being created and the roll out of Dr Doctor across all specialties booked by the Patient Access team supporting patient communication.

Anticipated impact and timescales for improvement:

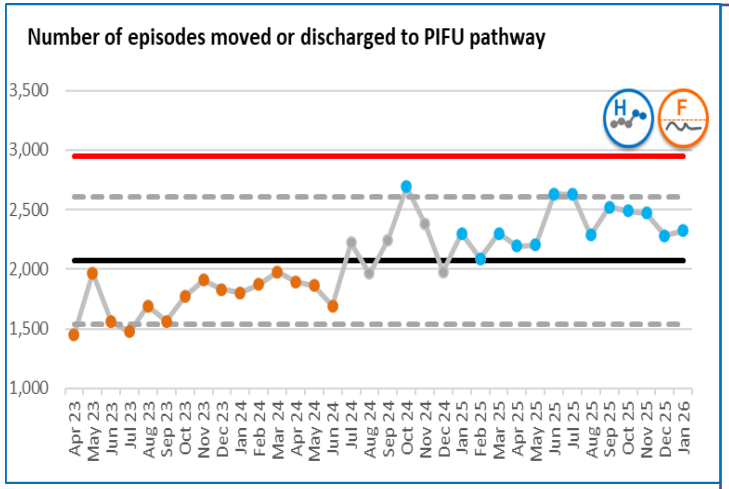
The methodology to enable a 'route to zero' has been developed and a commitment to sustain a zero position for 65 weeks has been made and in addition reduce waiting times for CYP.

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 13th February 2026 is 72.

Recovery dependencies:	Continued capacity to validate the PTL, administrative staffing capacity, workforce and theatre staffing.

Operational – PIFU



Summary:

The unvalidated Patient Initiated Follow-Up (PIFU) performance in January maintained performance at 5.9%, which remains below the 6% target.

- The Patient Engagement Portal, designed to support PIFU, is currently in its pilot phase with some ENT pathways
- A regular Data Quality Workgroup has been established, involving key stakeholders from the trust and ICB, this will address issues and enhance data quality for monitoring
- Clinician attendance at the GIRFT Action Plan Review meetings is allowing more direct clinical conversation and challenge
- The SaTH Outpatient Pathway Transformation Programme, comprises of three workstreams: outpatient productivity (initially supported by Four Eyes), outpatient pathway transformation, and outpatient advice and guidance
- Cardiology is participating in a pilot using Consultant Connect, rollout to other specialties has begun in urology as well as gastro, diabetes & endocrinology, dermatology and haematology, in small numbers

SaTH acknowledges the potential to enhance outpatient service productivity. The identified improvement opportunities include reducing waiting times for planned care by optimising processes and resource allocation through digital tools, improving the quality of planned care via evidence-based practices and better coordination through digital systems, and enhancing data and digitalisation efforts.

It is anticipated that these initiatives will positively impact 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.

The implementation of (PEP)Dr Doctor to support the PIFU pathway across all specialties is hoped to encourage engagement.

Anticipated timescales for improvement:

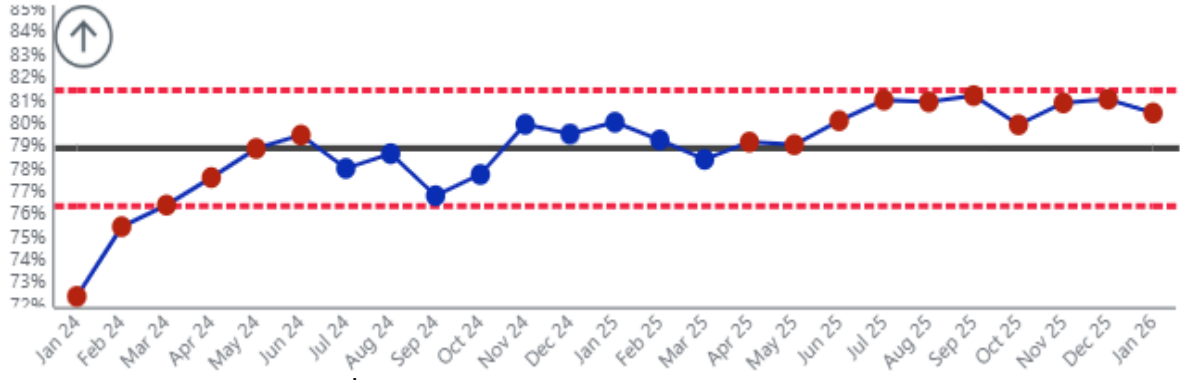
Performance will continue to be monitored at bi-weekly Outpatient Transformation meetings

Recovery dependencies:

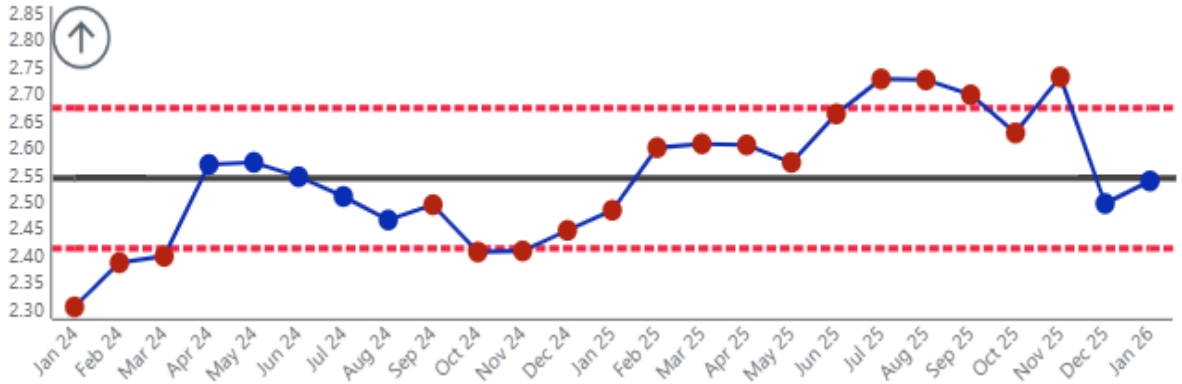
Operational – Theatre Productivity

The Shrewsbury and Telford Hospital NHS Trust

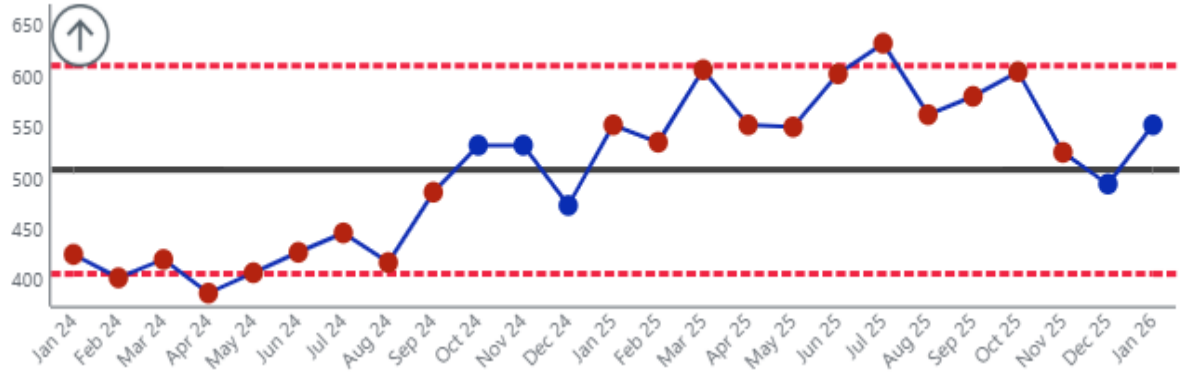
Theatre Capped Utilisation %



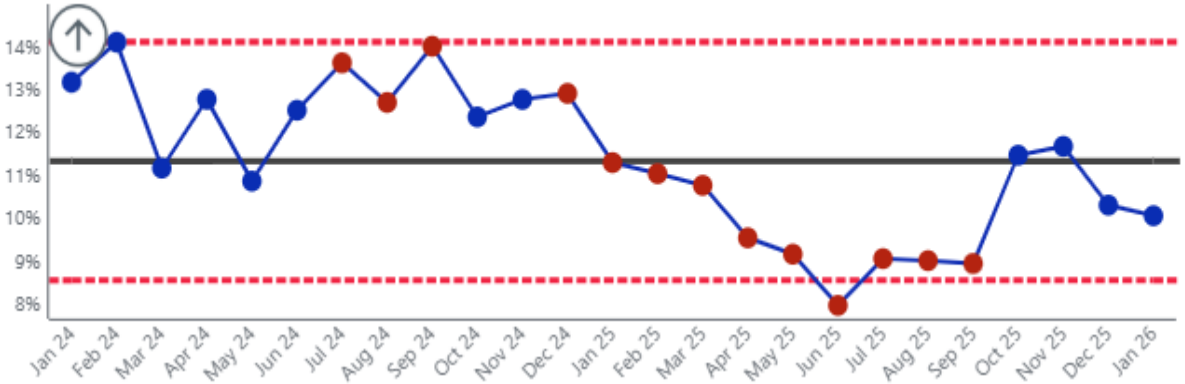
Average Cases Per List Rate



Total Number of Sessions



Cancelled Operation %



Operational – Theatre Productivity

The Shrewsbury and Telford Hospital NHS Trust

January 2026 Summary:

Elective Theatre Utilisation

- Overall utilisation held steady at 80%
- PRH Elective Hub achieved its highest monthly utilisation to date: 82%

Cancellations

- Cancellation rate dropped for the second consecutive month, now at 9%
- This improvement occurred despite 29 same-day cancellations caused by surgeon sickness

Elective Activity

- 1,391 elective procedures completed - an increase on December
- Activity was lower in the first week of January due to fewer sessions but returned to normal levels for the remaining three weeks
- Cataract suite sessions stood down due to reduced utilisation and cases per list; focus now on increasing outpatient activity to rebuild the waiting list
- No insourced lists took place in January

Theatre Task & Finish Group Priorities:

1. Identifying opportunities to shift suitable procedures out of theatre using GIRFT RPRP principles
2. Embedding learning from High Flow Theatre Lists across multiple specialties to make these lists routine
3.Improving Elective Hub productivity through root-cause analysis and enhanced data insights

Using new BI data on average and median procedure times per surgeon to support planning and optimisation.

Performance Recovery and Planning:	**Anticipated timescales for improvement:**
••Ongoing collaboration with the NHSE Regional Theatre Productivity Lead to ensure alignment with regional priorities and best-practice approach to improving theatre efficiency. ••Ongoing collaborative work across the Theatre Performance Team, Booking & Scheduling, and clinical specialties continues to refine theatre allocation to meet the theatre session allocation KPI target and ensure lists are assigned to surgeons with suitable waiting list demand to support well-utilised sessions.	New theatre plans to be introduced in phases in March to support the reopening of ward 5, enabling the arthroplasty service to resume and also to better reflect the anticipated demand across specialties.

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

Well Led

Executive Lead:

Chief People Officer
Rhia Boyode

Integrated Performance Report

The Shrewsbury and Telford Hospital NHS Trust

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Trend
Well Led	WTE employed		-	7915	7259	7252	7192	7229	7227	7225	7213	7222	7380	7403	7429	7423	7439	
	Temporary/agency staffing		-	-	752	786	780	705	722	738	783	749	679	683	652	617	612	
	Staff Turnover Rate (FTE) (excluding Junior		0.8%	0.75%	0.8%	0.5%	1.2%	0.6%	0.9%	0.7%	0.7%	0.9%	0.7%	0.8%	0.9%	1.0%	0.9%	
	Vacancies - month end %		10%	<10%	9.2%	9.2%	10.0%	4.5%	4.4%	5.7%	5.9%	5.8%	3.8%	4.0%	3.9%	4.5%	6.0%	
	Sickness Absence rate		-	4.5%	5.9%	5.5%	5.0%	4.8%	4.6%	4.8%	4.9%	4.7%	4.9%	5.2%	5.2%	5.66%	5.81%	
	Trust - Talent Conversation (Appraisal)		90%	90%	86.7%	85.3%	85.8%	85.5%	86.0%	86.1%	86.6%	86.1%	86.4%	86.9%	86.8%	86.1%	85.0%	
	Talent Conversations (Appraisal) – Medical Staff		90%	90%	96.4%	92.2%	90.7%	92.5%	93.8%	93.5%	93.3%	94.4%	95.3%	94.9%	93.5%	92.7%	92.9%	
	Trust Statutory and mandatory training compliance		90%	90%	94.1%	91.7%	91.3%	92.9%	93.1%	93.2%	93.4%	93.2%	93.1%	93.3%	92.9%	92.3%	92.5%	
	Trust MCA – DOLS and MHA		90%	90%	87.0%	85.4%	85.1%	85.0%	85.0%	85.2%	86.0%	85.8%	85.3%	85.2%	85.8%	84.7%	84.8%	
	Safeguarding Children - Level 2		90%	90%	96.0%	94.1%	94.5%	96.0%	96.4%	96.6%	96.4%	96.2%	95.8%	95.8%	95.4%	95.1%	95.2%	
	Safeguarding Adult - Level 2		90%	90%	96.7%	94.6%	94.4%	95.8%	95.9%	95.9%	96.0%	95.7%	95.5%	95.6%	95.5%	94.7%	95.0%	
	Safeguarding Children - Level 3		90%	90%	91.9%	89.6%	90.8%	89.2%	89.8%	90.5%	90.8%	90.3%	88.2%	88.6%	87.1%	86.0%	85.0%	
	Safeguarding Adult - Level 3		90%	90%	92.4%	90.4%	90.5%	90.0%	91.0%	91.7%	92.1%	91.5%	90.5%	90.9%	91.4%	90.3%	90.7%	
	Diabetic Foot - Nurse Training		90%	90%	78.3%	83.4%	85.0%	86.8%	87.5%	88.8%	90.2%	91.3%	90.7%	91.3%	92.2%	92.4%	92.3%	
	Oliver McGowan Training		90%	90%	85.3%	85.5%	85.6%	86.2%	86.6%	87.5%	87.8%	88.2%	88.5%	88.9%	89.0%	88.9%	88.8%	
	Oliver McGowan Mandatory Training - T1		90%	90%		0.3%	18.4%	21.2%	24.3%	28.5%	25.7%	25.4%	25.3%	0.0%	5.6%	6.7%	10.0%	
	Oliver McGowan Mandatory Training - T2		90%	90%		3.3%	17.0%	17.2%	21.1%	23.6%	24.6%	24.2%	23.9%	11.3%	11.3%	11.1%	12.0%	
	Monthly agency expenditure (£'000)		-	547	1203	985	955	1063	684	817	873	921	820	504	500	525	306	
Safe Staffing	Fill Rate % - All Staff - Day/Night			100%	94.4%	93.3%	93.3%	93.9%	93.5%	95.0%	95.2%	94.0%	95.4%	93.8%	95.1%	94.3%	93.2%	
	Fill Rate % - All Staff - Day			100%	93.1%	91.8%	92.5%	92.7%	91.8%	93.7%	93.7%	93.0%	94.3%	93.6%	94.4%	93.2%	92.1%	
	Fill Rate % - All Staff - Night			100%	95.9%	95.1%	94.3%	95.3%	95.7%	96.6%	97.0%	95.1%	96.7%	94.1%	95.9%	95.5%	94.5%	
	Fill Rate % - Registered Nurses/Midwives - Day/Night			100%	104.1%	101.3%	101.7%	101.4%	99.3%	101.5%	102.3%	101.1%	100.4%	98.6%	102.0%	102.2%	99.7%	
	Fill Rate % - Registered Nurses/Midwives - Day			100%	104.4%	101.0%	101.6%	100.8%	98.1%	100.0%	101.0%	99.8%	99.1%	99.2%	101.7%	102.7%	99.5%	
	Fill Rate % - Registered Nurses/Midwives - Night			100%	103.8%	101.6%	101.8%	102.1%	100.7%	103.1%	103.7%	102.5%	101.9%	98.0%	102.2%	101.7%	100.0%	
	Fill Rate % - Non-Registered Nurses/Midwives - Day/Night			100%	96.3%	98.5%	97.8%	98.5%	100.2%	99.8%	100.7%	100.4%	103.3%	101.7%	99.2%	96.7%	96.6%	
	Fill Rate % - Non-Registered Nurses/Midwives - Day			100%	93.1%	95.8%	95.8%	96.2%	97.3%	98.8%	98.6%	99.2%	102.2%	100.4%	97.4%	94.1%	94.4%	
	Fill Rate % - Non-Registered Nurses/Midwives - Night			100%	100.0%	101.7%	100.1%	101.1%	103.7%	101.1%	103.3%	101.9%	104.5%	103.3%	101.3%	99.7%	99.0%	
	Fill Rate % - Registered Nursing Associates - Day/Night			-	22.1%	18.6%	18.6%	24.9%	24.5%	27.8%	25.4%	22.4%	25.7%	29.3%	28.6%	30.2%	28.2%	
	Fill Rate % - Registered Nursing Associates - Day			-	25.4%	21.0%	24.7%	30.8%	30.5%	33.4%	30.5%	29.2%	32.3%	33.3%	35.0%	35.0%	33.6%	
	Fill Rate % - Registered Nursing Associates - Night			-	17.4%	15.3%	10.0%	16.6%	15.4%	19.6%	18.4%	13.1%	16.1%	24.0%	20.0%	23.4%	20.3%	
	CHPPD - Overall - National 11.99			11.99	8.7	8.6	8.5	8.6	8.7	9.1	8.8	8.8	8.7	8.4	8.5	8.3	8.0	
	CHPPD - Registered Nurses/Midwives - National 4.9			4.9	5.2	5.1	5.1	5.1	5.1	5.4	5.2	5.2	5.0	4.9	5.1	5.0	4.7	
	CHPPD - Non-Registered Nurses/Midwives - National 4.9			4.9	3.3	3.4	3.3	3.3	3.4	3.5	3.4	3.4	3.5	3.3	3.2	3.1	3.1	
	CHPPD - Registered Nursing Associates			-	0.2	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	

Workforce Executive Summary

The Shrewsbury and Telford Hospital NHS Trust

2025/26 Workforce Plan – Overall workforce at Month 10 is 83 WTE (contracted) over the planned levels based on our submitted workforce plan. The variance to plan has increased from the December position following an increase to substantive workforce and an increase in bank usage. There was a high number of new employees commencing in the Trust relative to leavers which contributed to the substantive levels. The substantive workforce decreased across divisional teams however the overall increase was driven from additional workforce in the Medicine division which saw a 15 WTE increase following recruitment into Urgent and Emergency Care as part of the approved business case.

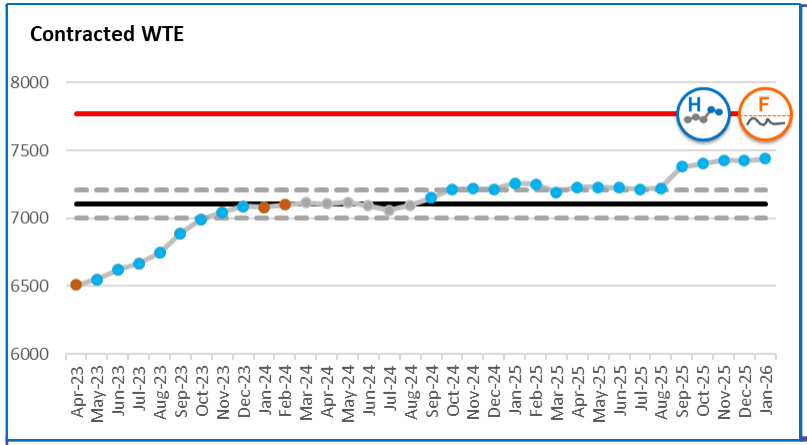
Turnover – the rolling 12-month turnover rate for January is 9.9% equating to 681 WTE leavers. An in-month turnover rate of 0.9% equates to 62 WTE leavers in January. NHS Leaver turnover rate (those moving outside of the NHS) over the last 12 months is 6.7% equating to 464 WTE NHS leavers.

Wellbeing of our staff – January sickness rate of 5.8% (435 WTE) remaining above target by 1.3% (98 WTE). Sickness attributed to mental health continues to be the top reason for sickness making up 28% of calendar days lost in January equating to 120 WTE. 14% (61 WTE) of sickness was attributed to cold, cough, flu; other known causes was at 11% (49 WTE).

Agency and temporary staffing - Agency usage levels have continued to decrease, now 24 WTE under planned levels our lowest levels of agency to date. There has been a total reduction in temporary workforce of 5 WTE. Our agency position is now below the expected reduction required at M12. Our combined temporary workforce usage has continued to reduce since the peak in October following key actions to strengthen controls of bank workforce including the introduction of a two-tier approval for nursing bank requests.

Workforce – Contracted WTE

The Shrewsbury and Telford Hospital NHS Trust



Summary:
Substantive figure of 7,439 WTE in January, which is an increase of 16 WTE in month.
Total workforce utilisation in January increased by 11 WTE to 8051 WTE attributable to an increase in substantive of 11 and bank use by 7 WTE offset by a decrease in agency of 12 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.

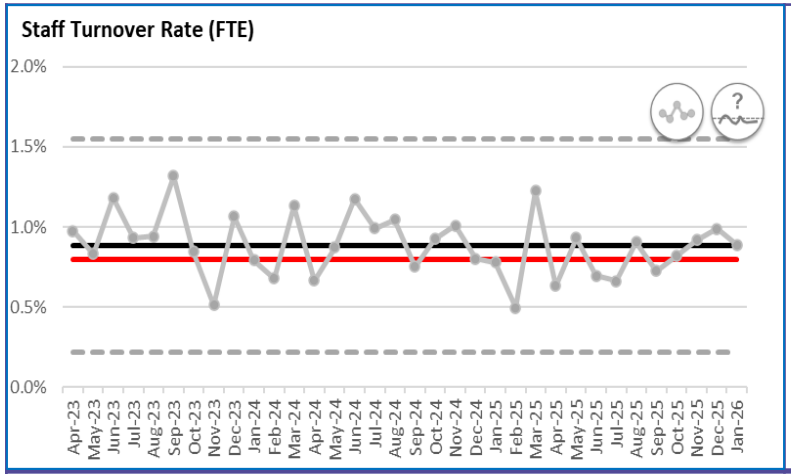
Recovery actions to achieve our target:

- Workforce planning – focus on medical and on identifying efficiency and savings, in areas such as Outpatients
- Delay start dates and/ or freeze recruitment for specific types roles – c. 60 WTE leavers per month
- Headcount reductions plans progressing with some risk in specific teams of delivery in this financial year, however mitigation via holding vacancy is expected to bridge the gap across divisions. Full review of vacancies across both SCHT and SaTH to support redeployment, review of employee relation and sickness cases to assess potential to reduce workforce or improve workforce availability
- 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
- 96% of departments are live or on track for Manager Self Service (MSS); all departments on-track to go-live by May.

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 and will be seen in the second half of the year. However, there is a risk that a proportion of workforce reductions will not be seen until 26/27

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 January is 9.9% equating to 681 WTE leavers. An in-month turnover rate of 0.9% equates to 62 WTE leavers in January. NHS Leaver turnover rate (those moving outside of the NHS) over the last 12 months is 6.7% equating to 464 WTE NHS leavers.
Staff groups with highest turnover rates are: Additional Clinical Services (13.4%); Admin and Clerical (11.6%) ; Healthcare Scientist (9.6%).
Nursing and Midwifery has the lowest turnover rate at 7.2%.
Work life balance is currently the highest reason for leaving with 109 WTE leavers with relocation as the second highest reason with 101 WTE leavers over the last 12 months.

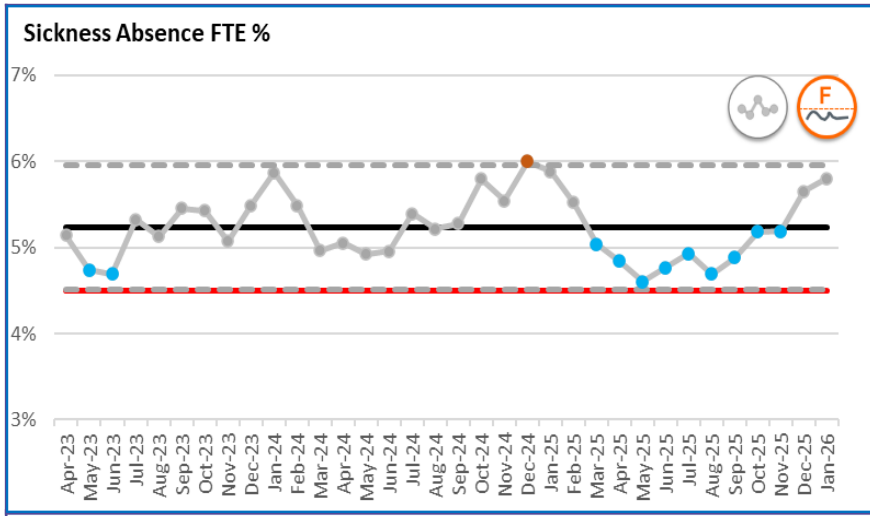
Recovery actions to achieve our target:

- MARS Scheme: individuals approved for MARS to leave between September – January 2026
- Staff Engagement: NSS 2025 results due end December/ January. Results will be reviewed and shared under embargo to commence action
- 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 continue to support cultural 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. Release of colleagues to access support available.

Workforce – Sickness absence



Summary:
Our sickness target for 2026 is 4.5%. January sickness rate of 5.8% (435 WTE) remaining above target by 1.3% (98 WTE). Sickness attributed to mental health continues to be the top reason for sickness making up 28% of calendar days lost in January equating to 120 WTE. 14% (61 WTE) of sickness was attributed to cold, cough, flu; other known causes was at 11% (49 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 7.7%, Additional Clinical Services staff group has the second highest rate at 7.5% with Nursing and Midwifery at 5.4%.

Recovery actions to achieve our target:

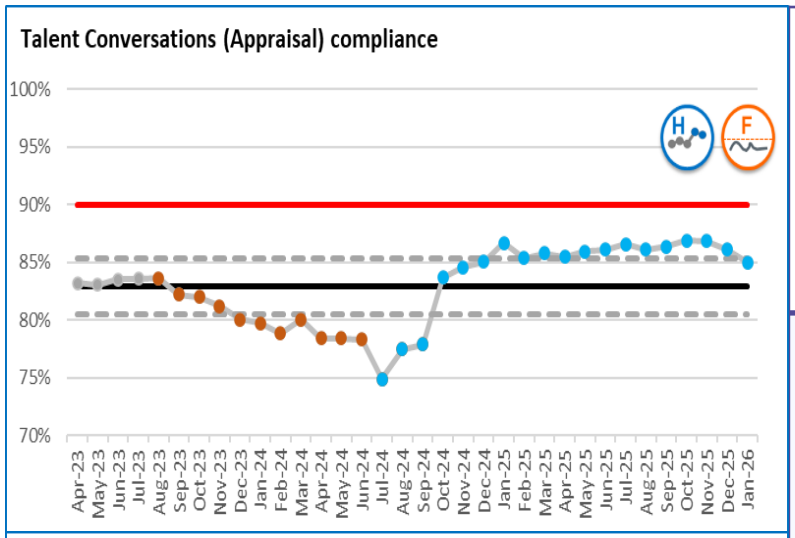
- Review of all long-term absence (currently 94 WTE) we are now undertaking a full review of long-term sickness cases to identify any cases that can be concluded
- Management of Change Masterclasses: Supporting staff through change to reduce stress-related absence continue
- Sickness Management Trial: 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 results expected
- 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

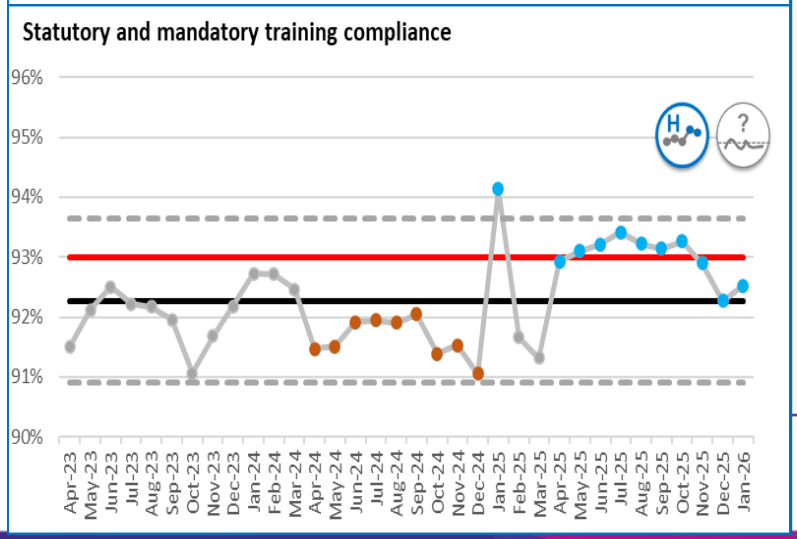
Anticipated impact and timescales for improvement:
Expected reductions in absence levels throughout the year in line with plan with a level of increase over winter months after which we expect a 1% reduction.

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%. Medical appraisals remain above target. For non-medical colleagues, talent conversations slightly decreased to 85.0% in January.

Our Mandatory and statutory training compliance target by 2026 is 93%, currently our target is 90%. The current rate in January is 92.5% which is above target.

The slight dip in compliance figures is usual for January and usually recovers during February – March.

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:

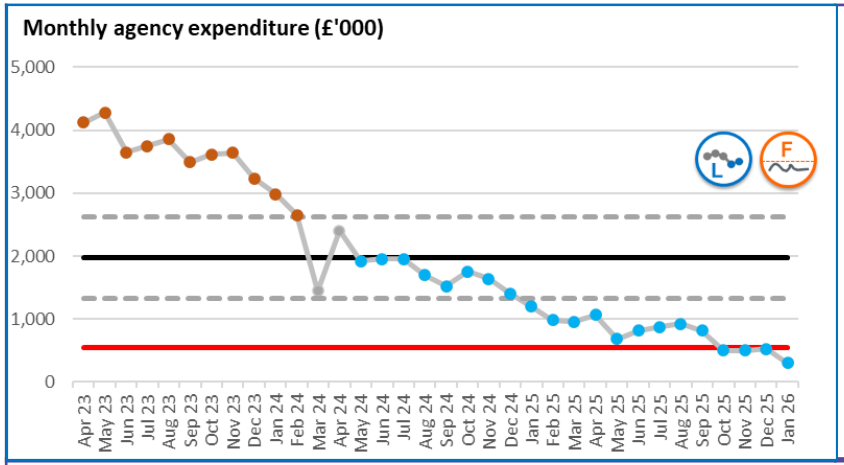
Expected steady increase in training compliance as next quarter and on track to meet target.

Recovery dependencies:

Investment in AI and technology enhanced learning. Capacity and capability to deliver new training delivery model.

Agency Expenditure – Monthly

The Shrewsbury and Telford Hospital NHS Trust



Summary:
Agency usage levels have continued to decrease, now 24 WTE under planned levels. There has been a total reduction in temporary workforce of 5 WTE. Our agency position is now below the expected reduction required at M12. Further action is being taken to reduce further and to go beyond planned levels to help mitigate the higher use in bank workforce. Plans are in place to reduce workforce in last quarter as part Trust wide programme aiming to reduce via strengthened vacancy control, mutual agreed resignation scheme, management of change process and reform of our workforce. We have delivered over 100 WTE reductions to date and significant reduction in agency with a 60% reduction from our March 25 position.

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
- Regional Price Cap Compliance: The Trust is actively supporting the region to meet PCC targets and is currently reporting zero above-cap agency usage
- 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:

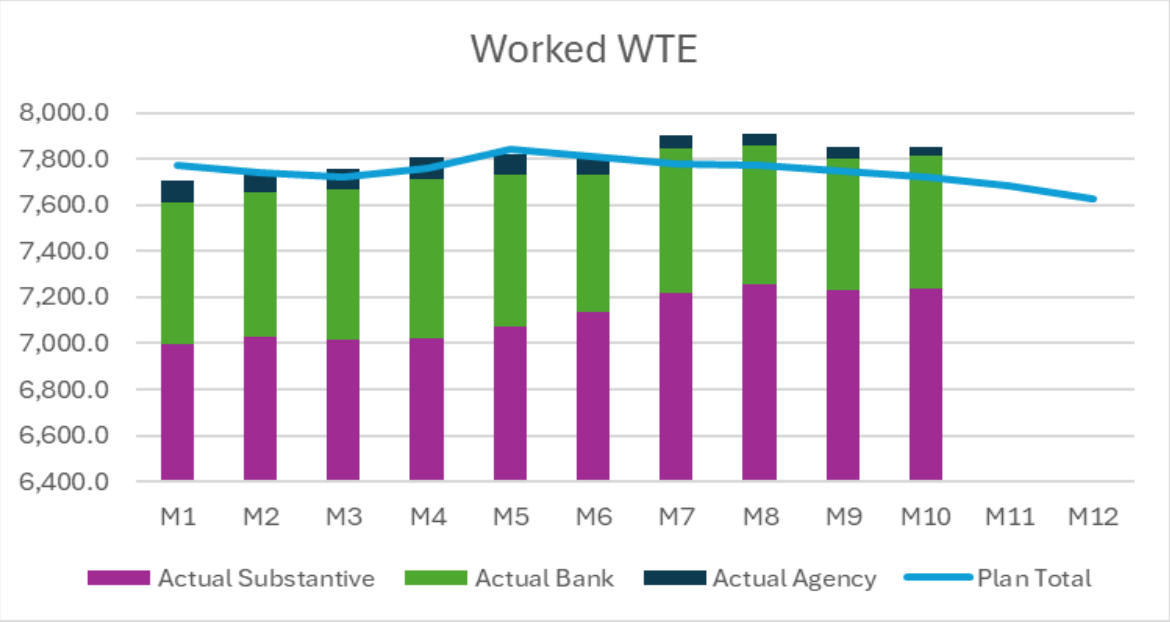
Continued reduction of agency nursing expected to end of year. At month 7 agency is under plan, with recruitment trajectories in place the end of year position is expected to reduce further in line with plan.

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

Staffing – worked actuals vs plan

The Shrewsbury and Telford Hospital NHS Trust

Worked WTE													
Plan / Actual	**Staff Group**	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**
Plan	Substantive	7,015.0	7,028.0	7,024.0	7,074.0	7,179.0	7,203.0	7,178.0	7,149.0	7,131.0	7,112.0	7,079.0	7,031.0
	Bank	641.0	603.0	598.0	593.0	588.0	533.0	529.0	557.0	553.0	549.0	545.0	542.0
	Agency	118.0	110.0	102.0	95.0	78.0	73.0	69.0	69.0	66.0	62.0	59.0	55.0
	Total	**7,774.0**	**7,741.0**	**7,724.0**	**7,762.0**	**7,845.0**	**7,809.0**	**7,776.0**	**7,775.0**	**7,750.0**	**7,723.0**	**7,683.0**	**7,628.0**
Actual	Substantive	6,998.0	7,027.0	7,018.0	7,022.0	7,072.4	7,133.4	7,220.0	7,256.7	7,232.0	7,237.2		
	Bank	610.0	628.0	652.0	692.0	658.8	599.5	624.9	602.1	568	574.51		
	Agency	95.0	94.0	86.0	91.0	90.7	79.4	58.4	50.1	50	37.9		
	Total	**7,703.0**	**7,749.0**	**7,756.0**	**7,805.0**	**7,821.9**	**7,812.4**	**7,903.2**	**7,908.9**	**7,849.3**	**7,849.5**	**0.0**	**0.0**
Variance	Substantive	-17.0	-1.0	-6.0	-52.0	-106.6	-69.6	42.0	107.7	101.0	125.2		
	Bank	-31.0	25.0	54.0	99.0	70.8	66.5	95.9	45.1	14.7	25.5		
	Agency	-23.0	-16.0	-16.0	-4.0	12.7	6.4	-10.6	-18.9	-16.4	-24.1		
	Total	**-71.0**	**8.0**	**32.0**	**43.0**	**-23.1**	**3.4**	**127.2**	**133.9**	**99.3**	**126.5**	**0.0**	**0.0**



Summary:
Whilst performance against the contracted WTE is submitted externally, internally we continue to monitor delivery against the worked WTE which correlates more to finances. However, the WTE plan is not aligned to the financial plan; in M2 a re-categorisation of insourcing took place between pay and non pay in the provider finance return (PFR) and this change has not been reflected in the WTE plan. It is important to note that the WTE plan reflects an increase of 75 WTE for insourcing between M4 and M5 and does not reflect the increase to UEC in January.

Total staff usage of 7,849 WTE in January is consistent with the figure reported in December with agency usage dropping by 12 WTE, and is 24 WTE below plan along, however, substantive (125 WTE) and Bank (26 WTE) remain above plan. There has been a 5 WTE substantive increase between M9 and M10 and an increase in worked bank of 6 WTE.

The continued reductions in agency staffing reflects the impact of FRG agreed actions.

Continued actions:
Continued focus to keep reducing the reliance on agency staffing and increased focus on bank usage as well as rates for locum doctors.

Delivery of WTE reduction plans at a divisional level are key to reducing substantive WTE's.

Anticipated impact and timescales for improvement:
N/A

Recovery 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)	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Trend
Finance	End of month cash balance £'000	53,249	54,932	48,821	61,762	45,006	35,131	41,161	44,343	51,400	40,294	49,296	39,293	16,298	89,066	
	CIP Delivery £'000	4,128	3,654	4,287	5,659	2,392	2,568	2,742	3,579	3,166	3,843	3,363	3,268	3,692	4,076	
	Balanced £ Position £'000 (Cumulative)	0	(22,661)	(27,570)	(18,563)	5	1	10	8	4	(1,274)	(2,290)	(3,927)	(5,848)	(5,604)	
	Year to date capital expenditure £'000	118,432	26,936	39,110	69,194	2,044	12,632	19,759	24,803	32,363	41,608	53,139	61,724	76,556	87,885	

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 January (month ten), the Trust has delivered a deficit position of £5.6m 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 (£2.14m) and income backed posts (£1.07m) offset by income. There had also been a cost pressure associated with the industrial action (£1.4m) in July, November and December. The costs in July were mitigated by bringing forward an expected CIP scheme in non-pay however, the Trust is now in receipt of £2.5m to support the impact of industrial action. The cost pressure associated with the pay award (£1.41m) had been partially mitigated in earlier months however, this can no longer be mitigated and is a cost pressure along with the premium payments associated with temporary staffing (£10.91m). An increase in pass through devices has also been seen in non-pay increasing expenditure 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:

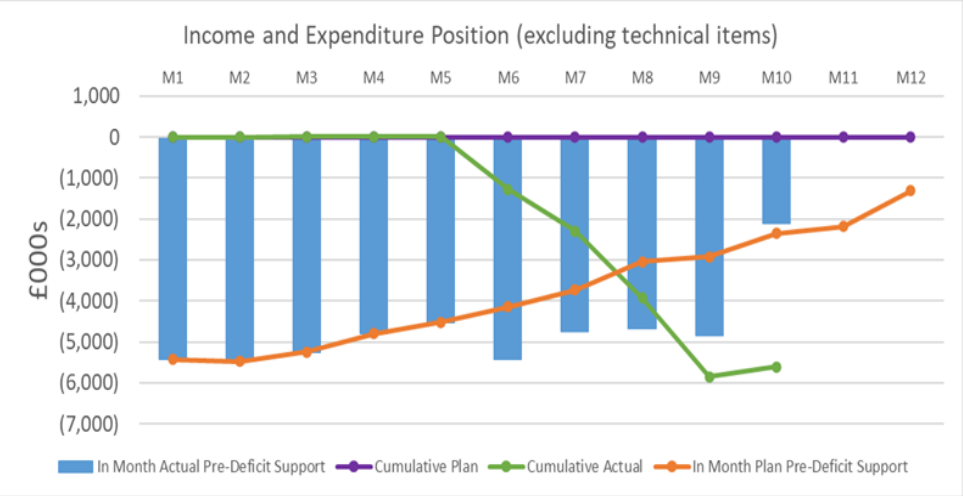
- Delivery of the activity plan to secure the ERF and potentially additional income – there is no change in the reporting of income due to the data warehouse issues at present, however the Trust is actively making CDS submissions through to SUS. The Trust have reduced waiting lists significantly in year which has increased costs above funded levels. The Trust is now in receipt of Q4 elective sprint funding for which the Trust was able to re-base the YTD plan to reflect the additional activity undertaken in Q1-3 and as such means an additional £3m of income to go against costs already incurred.
- Delivery of the efficiency plan – The Trust has an efficiency target of £41.40m in FY25/26. At the end of January, £32.70m has been delivered which is £0.20m more than plan.
- WTE reduction plan – At the end of January against the numbers reported in December (actual worked) there has been no material change, a reduction in worked agency of 12 WTE is offset by increases in bank (6 WTE) and substantive (5 WTE) staff.
- Delivery of the agency reduction plan – Expenditure has decreased in month compared to December 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 ten there has been an overspend of £2.14m against plan.

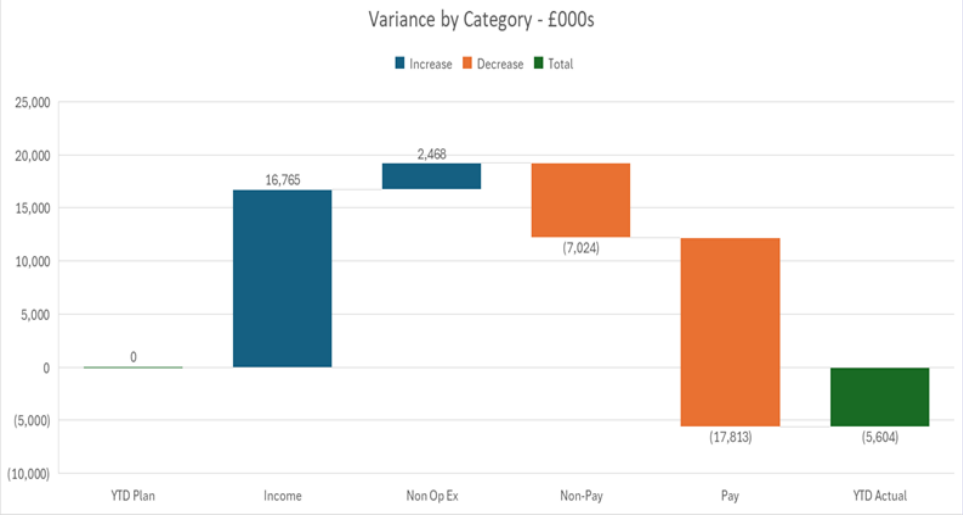
The Trust has set an operational capital programme of £22.53m (including IFRS 16 expenditure) and externally funded schemes of £125.38m in FY25/26, giving a total capital programme of £147.91m.

The Trust held a cash balance at end of January 2026 of £89.05m.

Additional grip and control actions have been phased in since August, including additional non pay controls (operational in November) with oversight from Executives and a Cash Committee.

Income and Expenditure – Year to Date





The Trust has a breakeven plan with deficit support of £45.1m for FY25/26. At the end of January (month ten), the Trust has delivered a deficit position of £5.6m against the breakeven plan.

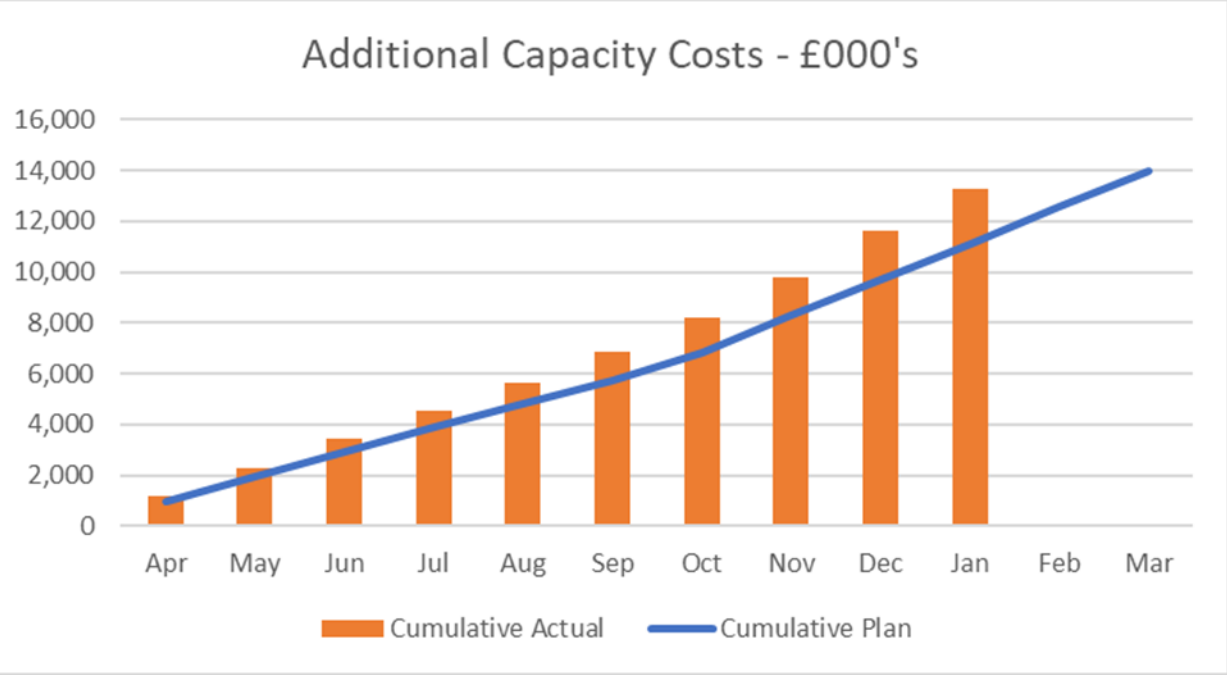
The drivers of the deficit to plan:

- additional capacity costs for patient safety
- additional cost of accelerated delivery of elective performance improvements
- cost pressure associated with the FY25/26 pay award
- premium staffing costs

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. The Trust however have reduced waiting lists significantly in year which has increased costs above funded levels,. The Trust are in discussions with commissioners and NHSE to potentially recognise this additional income.
- Delivery of the efficiency plan – The Trust has an efficiency target of £41.4m in FY25/26. At the end of January, £32.7m has been delivered which is £0.2m more than plan.
- WTE reduction plan – At the end of January against the numbers reported in December (actual worked) there has been no material change overall, however, there have been reductions in worked agency of 12 WTE, an increase in worked bank of 6 WTE and an increase of 5 WTE in substantive.
- Delivery of the agency reduction plan – expenditure has decreased in month compared to December 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 ten there has been an overspend of £2.1m against plan.

Additional capacity



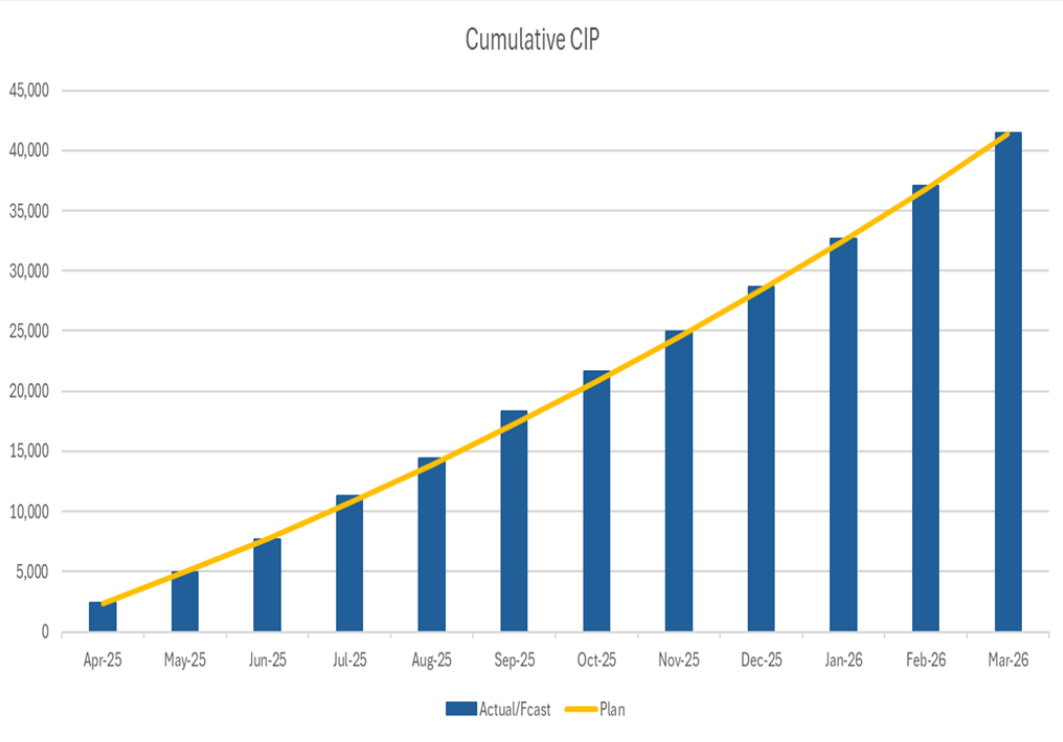
Summary:
Included within the operational plan bed model is a requirement for varying levels of additional capacity throughout the year including core beds as well as utilising unconventional capacity.

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 January additional capacity costs increased compared with December and remain above the planned levels both in month and year to date with year-to-date costs at £13.27m against a plan of £11.13m.

Recovery actions: 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.	**Anticipated impact and timescales for improvement:** 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.

Efficiency



Summary:
The Trust has a total efficiency target for FY25/26 of £41.4m.
As at the end of January (month ten), the Trust has delivered £32.7m of efficiency savings for FY25/26 which is £0.2m 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 M10 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.**

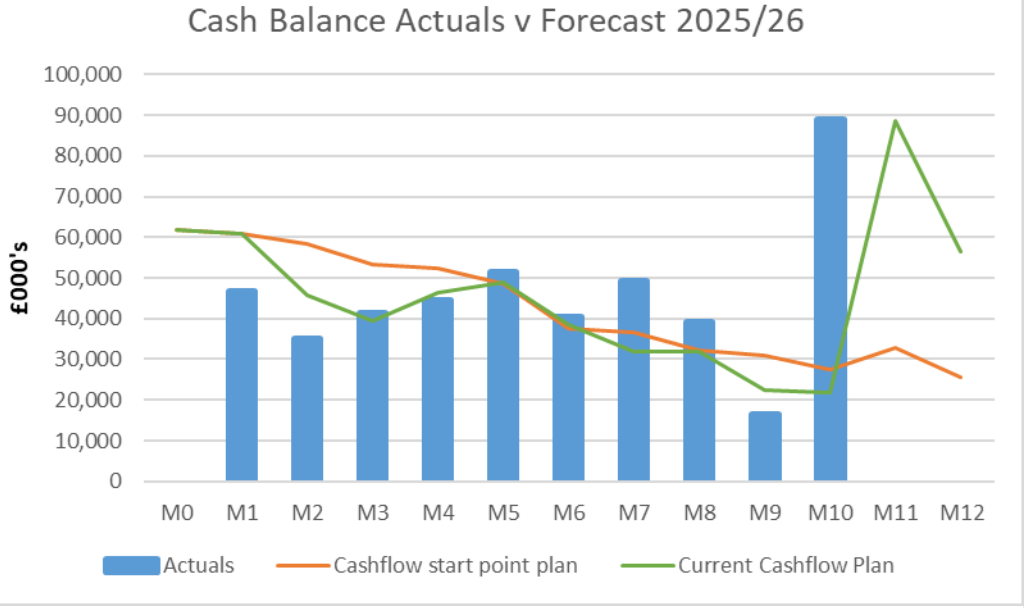
Recovery actions:

Continue to develop mitigation plans potential under-delivery in high-risk schemes.

Anticipated impact and timescales for improvement:
N/A

Dependencies:	Delivery of actions against PIDs.

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.

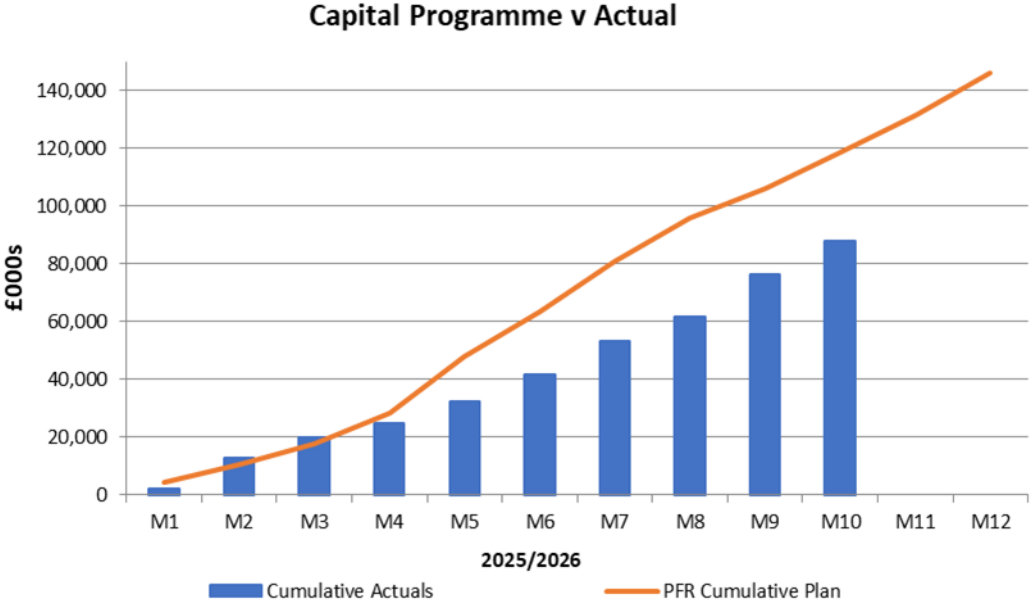
The cash balance brought forward into FY25/26 was £61.76m with a cash and ledger balance of £89.05m held at end of month ten.

The graph illustrates overall actual cash held against the plan. At month ten, actual cash balances were higher than forecast, due to the timing of a capital drawdown request.

To note the difference in the February and March 2026 cashflow forecast from the start point to the current is primarily driven by emerging pay pressures and the assumptions around cash releasing CIP, offset in part by additional income received and delays in the FY25/26 capital programme resulting in the Trust expecting to hold a capital cash balance of £35.0m.

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

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 reduced to £125.38m following a reduction of £9.14m for HTP, giving an overall Capital Programme of £147.91m (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 M10 FY25/26, £12.48m of expenditure (including IFRS 16) relating to System Allocation has been expended and £75.41m of external expenditure has been incurred, giving total expenditure of £87.88m.

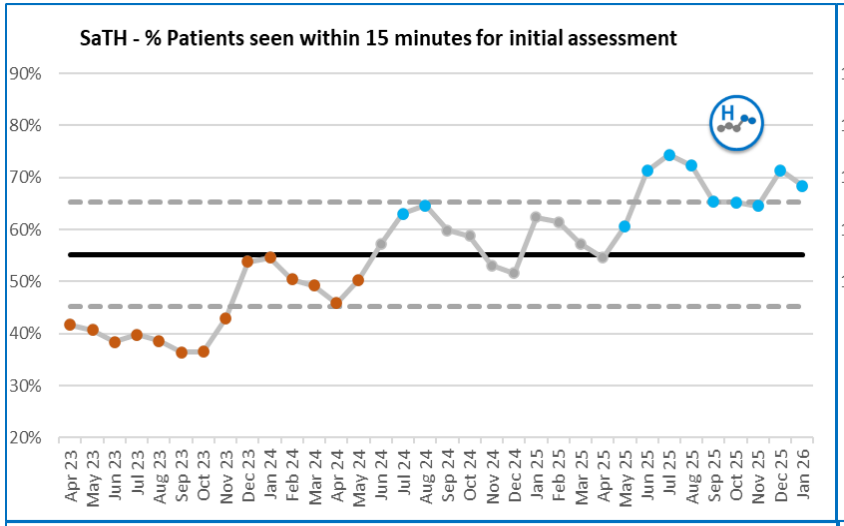
Recovery actions:	**Anticipated impact and timescales for improvement:**
Whilst the Capital Programme is behind at month ten assurances have been given by the Capital leads that all FY25/26 CDEL will be accounted for by year end.	N/A
Recovery dependencies:	N/A

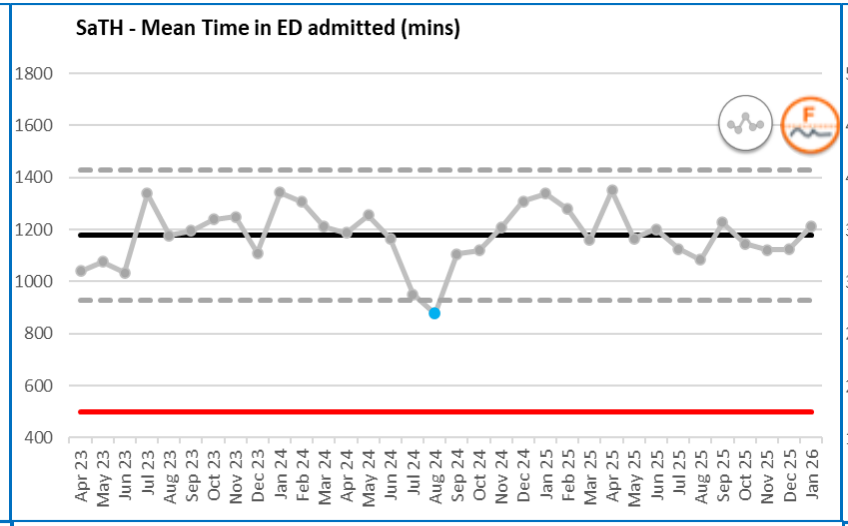
The Shrewsbury and Telford Hospital NHS Trust

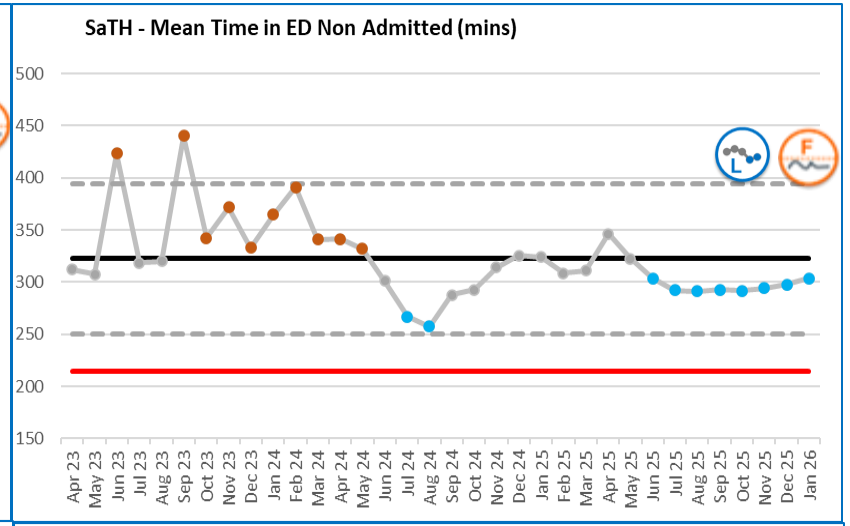
Appendices – Responsiveness And Well Led

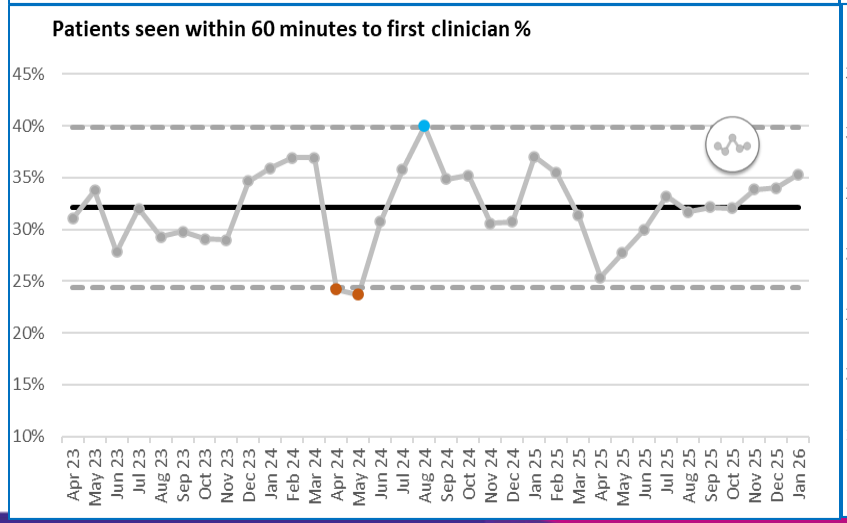
Appendix 1 – supporting detail on Responsiveness

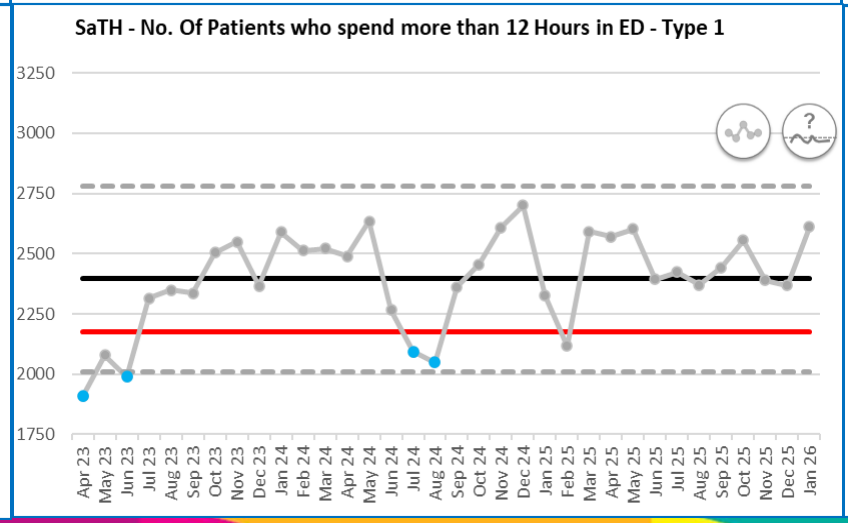
The Shrewsbury and Telford Hospital NHS Trust

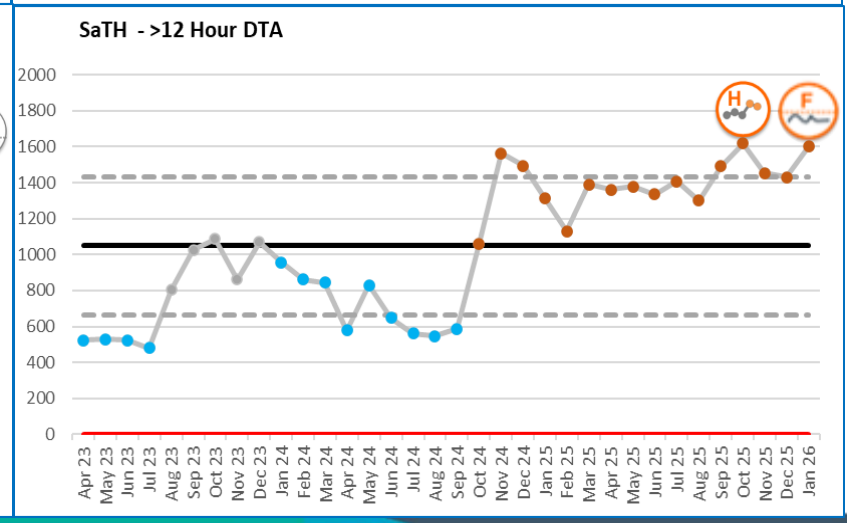






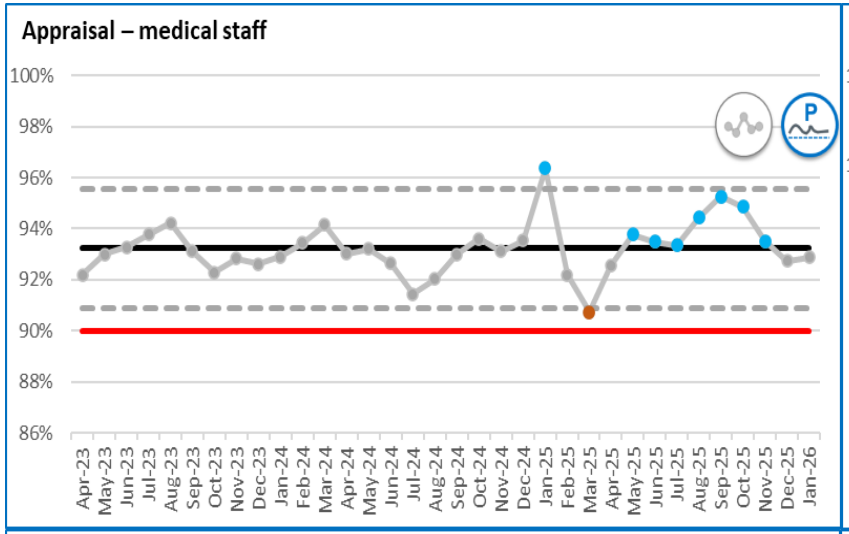


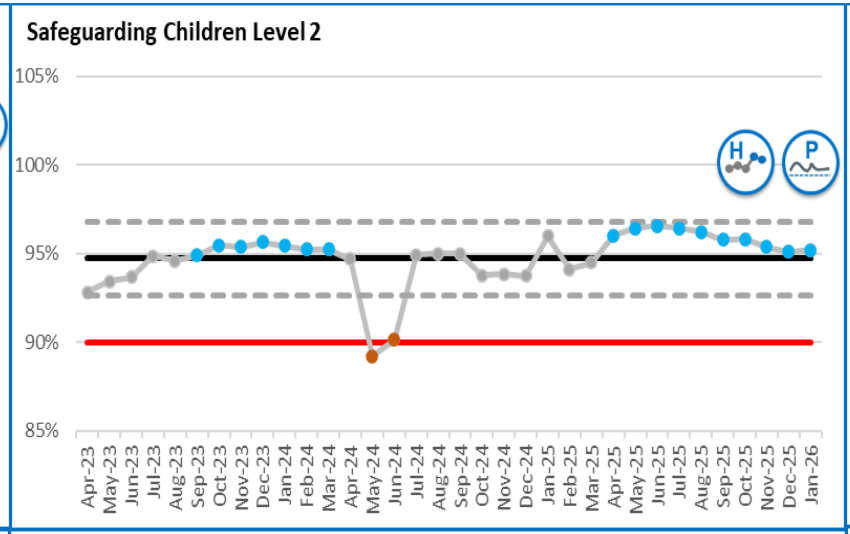


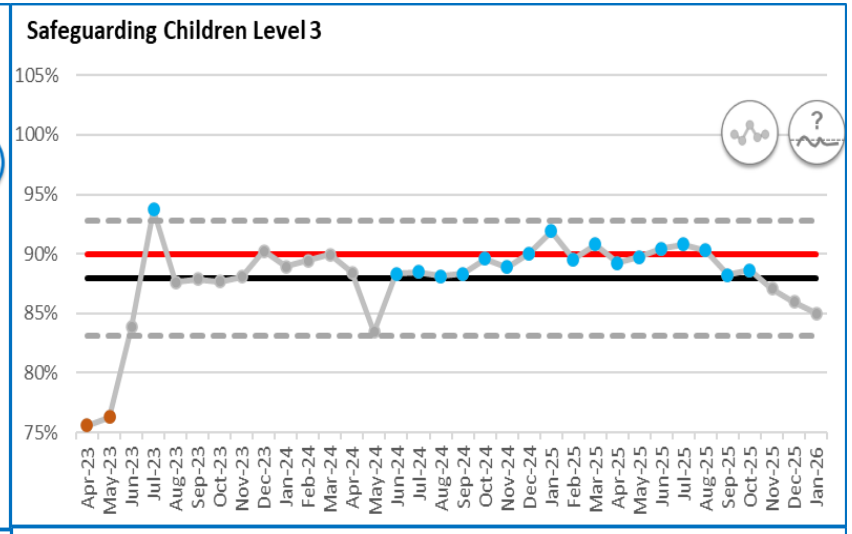


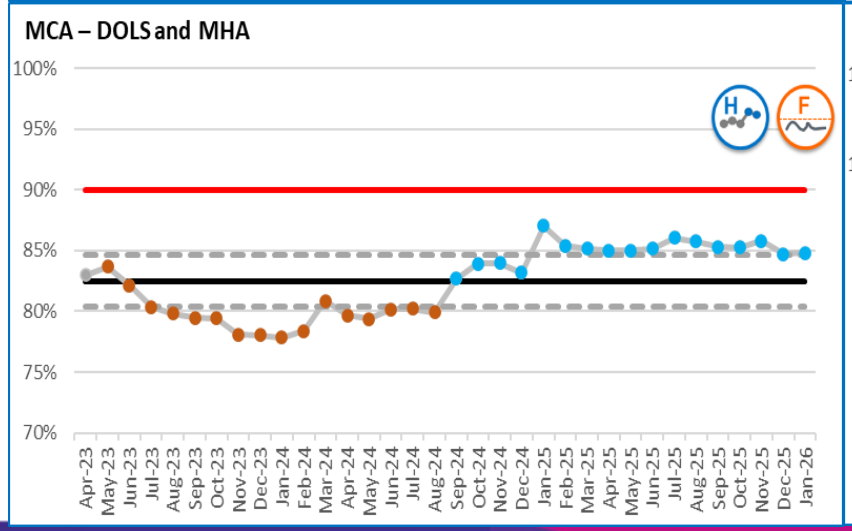
Appendix 2 – supporting detail on Well Led

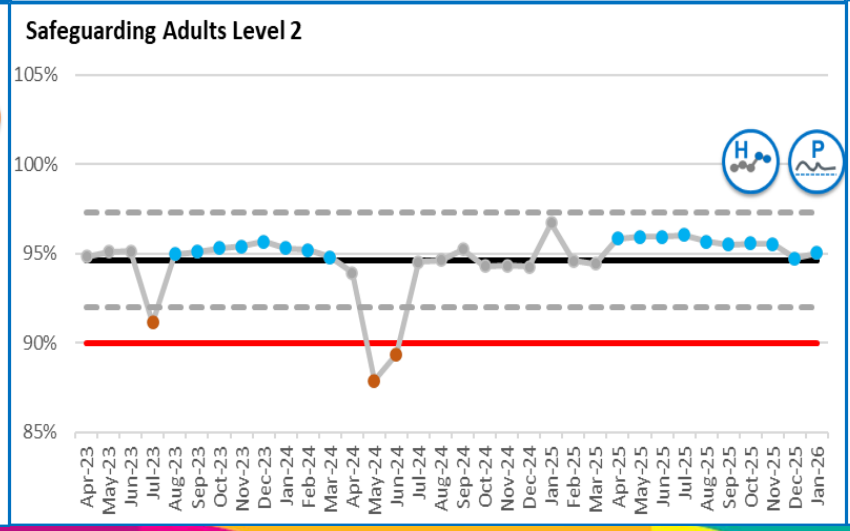
The Shrewsbury and Telford Hospital NHS Trust

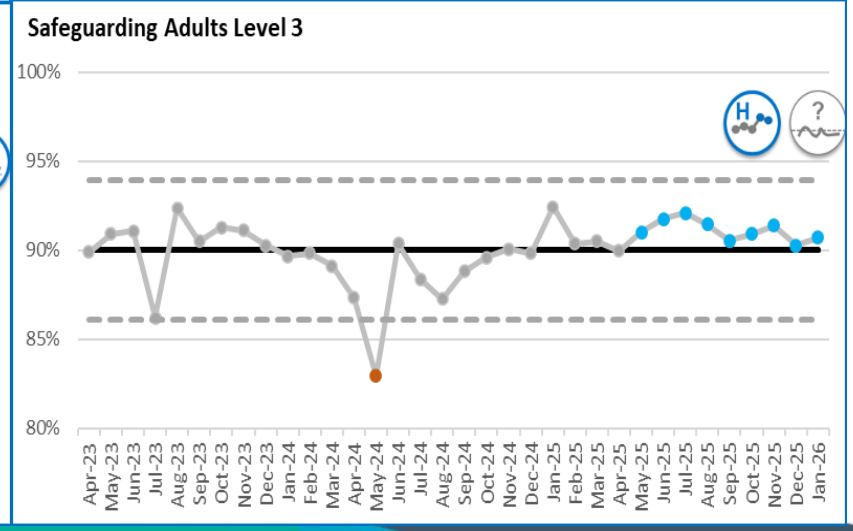










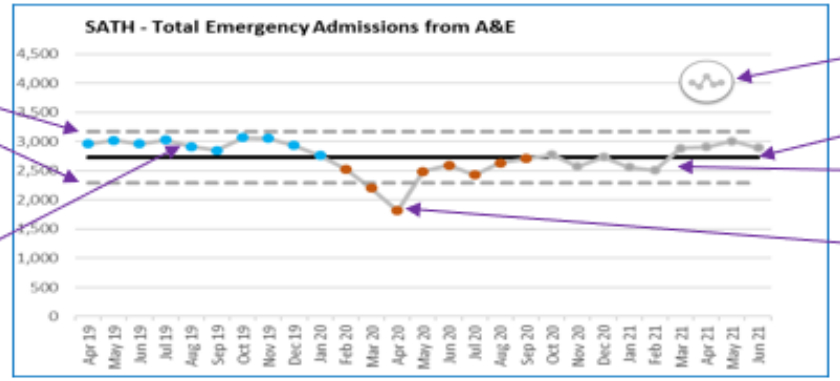


Appendix 3 – Understanding statistical control process charts in this report

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

Process limits – upper and lower

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



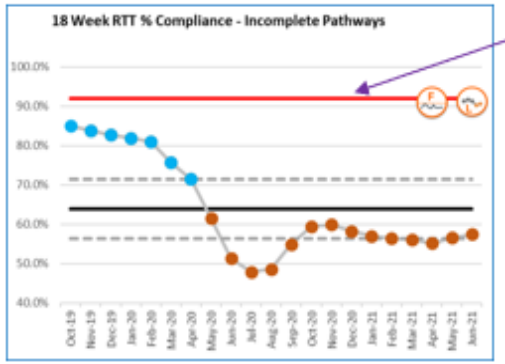
Icon showing most recent point type of variation

Mean or median line

Common cause variation

Special cause variation – data point outside of the process limit

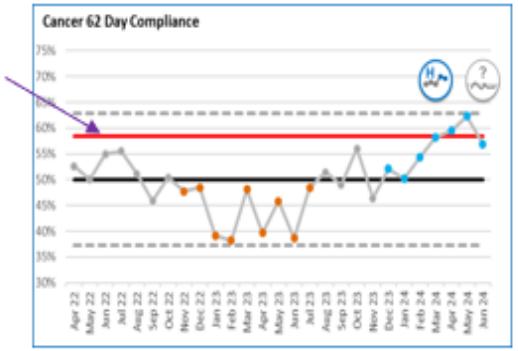
Where a target has been set the target line is superimposed on the SPC chart. It is not a function of the process.

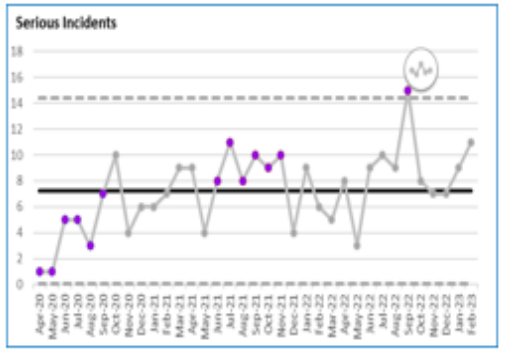


Target line – outside the process limits.

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

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





Appendix 4 – Abbreviations used in this report

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

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

Appendix 4 – Abbreviations used in this report

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

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

Appendix 4 – Abbreviations used in this report

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

Board of Directors' Meeting: 12 March 2026

Agenda item		054/26			
Contract Title		**SaTH's Integrated Improvement Plan (SIIP)**			
Executive Lead		Jo Williams, Chief Executive Officer			
Report Author		Mary Aubrey, Programme Director			
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**	
Safe		Our patients & community	√	BAF 1, BAF 2, BAF 4, BAF 5, BAF 10	
Effective		Our people	√		
Caring		Our service delivery	√	**Trust Risk Register id:**	
Responsive		Our governance	√	CRR1, CRR2, CRR3, CRR4, CRR5, CRR6, CRR9, CRR10, CRR11, CRR12, CRR13, CRR15, CRR17, CRR19, CRR21, CRR22, CRR23, CRR27	
Well Led		Our partners	√		
Consultation Communication		Performance Assurance Committee Chair 17 February 2026 Group People & OD Assurance Committee in Common 26 January 2026 Quality & Safety Assurance Committee 24 February 2026 Finance Assurance Committee 24 February 2026 Audit and Risk Committee Chair 16 February 2026			
Executive summary:		SaTH's Integrated Improvement Plan (SIIP) is on track, with the majority of 2025/26 actions progressing to agreed timescales. With continued support and oversight from NHSE and the ICB, the Trust is addressing key challenges, particularly in financial sustainability and urgent and emergency care, underpinned by robust monitoring and escalation processes. The Board's attention is drawn to Section 2, which details key highlights.			
Recommendations:		The Board of Directors is asked to: • **Note** that the Trust remains on track to deliver the majority of 2025/26 IIP actions (Appendices 1-4), providing assurance to NHSE as part of the Trust's RSP exit process in Q4. • **Note** that any 2025/26 actions at risk have been transferred into the 2026/27 plan. • **Review** and **formally Approve** the 2026/27 SaTH Integrated Improvement Plans for Governance, Workforce, Leadership, Finance, and UEC (Appendices 5–8), which have been developed to provide assurance to NHSE as part of the Trust's RSP exit process.			
Appendices		Appendix 1 - SaTH Governance and Leadership Plan 2025-26 Appendix 2 - SaTH Workforce and Leadership Plan 2025-26 Appendix 3 - SaTH Finance Plan 2025-26 Appendix 4 - SaTH UEC Plan 2025-26 Appendix 5-8 SaTH IIP plans for 2026/27 for Governance, Workforce, Leadership, Finance, and UEC.			

1. Introduction

The purpose of this paper is to provide the Board of Directors with a comprehensive overview of progress against the agreed exit criteria, enabling SaTH's transition from the National Oversight Framework (NOF) segment 4 to segment 3 by March 2026. The Integrated Improvement Plan (IIP), developed collaboratively with the ICB and NHSE colleagues, underpins this transition. Oversight is provided through the IIP Oversight Meeting, chaired by NHSE Midlands. The 2025/26 SaTH Integrated Improvement Plan has been reviewed and endorsed, with progress continuing through internal governance processes for assurance. The Trust remains on track to deliver the majority of 2025/26 actions, with a small number of at-risk actions transferred into the 2026/27 plan to ensure continued oversight and delivery. Progress across the governance, workforce and leadership, finance, and urgent and emergency care (UEC) domains is summarised within this report.

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

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

Governance / Leadership

- **SaTH Metric 4.1.0:** Governance Structure Review: The Trust has continued strengthening its internal governance arrangements as part of the Recovery Support Programme (RSP).
- **SaTH Metric 4.2.7:** Joint Committee & Group Model Development: A new Group Accelerator Meeting has been established (February 2026) and reports into the Group Transition Committee.
- **SaTH Metric 4.2.9:** Shared Governance Framework: A Group Partnering Agreement is being prepared for Board approval in March 2026, aiming to be in place for 1 April 2026.
- **SaTH Metric 4.2.10:** Appointment of Joint Leadership Team: Remuneration Committees have met and agreed next steps. Interviews for the Group Chief Nursing Officer are scheduled for 3 March 2026.
- **SaTH Metric 4.2.11:** Joint Board Development: The February 2026 joint Board development meeting was postponed, but replacement sessions have been added for March and April, with further sessions scheduled through 2026/27.
- **SaTH Metric 4.3.5:** Risk Management Strategy Review: The Risk Management Strategy has been reviewed and approved (Nov 2025 committee, Jan 2026 Board). A further review is planned in 2026/27 as part of the Group model development.

Workforce and Leadership Collaborative

- **SaTH Metric 2.1.10:** A comprehensive programme of People & OD and Divisional workshops has been completed, identifying the priority workforce actions required to support delivery of the HTP workforce plan. Evidence of completion has been collated, demonstrating strong engagement and shared ownership across the organisation.
- **SaTH Metric 2.1.12:** The Trust's full workforce plan for 2025/26 and 2026/27 has been completed, triangulated with Finance and Operations, reviewed with Divisions, and formally submitted to NHSE on 12 February 2026. This provides clear assurance that workforce planning is aligned to operational and strategic priorities and is supported by a strengthened narrative describing impact and benefit.
- **SaTH Metric 2.1.26:** Phase 1 of the medical e-rostering rollout continues to progress, with priority given to resident doctor rosters to support the newly introduced exception reporting requirements. This work strengthens governance, safer staffing, and visibility of working hours, with full implementation expected to take a minimum of 12 months.
- **SaTH Metric 5.1.8 & 5.1.9:** The MSK provider collaborative between RJAH, SCHT and SaTH has been established, and acute provider arrangements with UHNM and ROH are now in place. These developments demonstrate strengthened system integration, shared governance, and improved pathway alignment across organisational boundaries.
- **SaTH Metric 5.3.3:** Oversight of SIIP delivery has been strengthened, with monthly progress reporting to assurance committees and the Board. The refreshed ward-to-board governance structure was

approved at the December 2025 Board meeting, providing clear assurance on accountability and delivery.

- **SaTH Metric 5.4.5:** Pulse survey results have been analysed and reported through Strategic People Group and PODAC, informing strategy milestones and supporting ongoing cultural improvement. Staff Survey results will be shared once the national embargo is lifted in mid-March 2026.

Finance

- **SaTH Metric 1.1.2:** The financial position across the system and at SaTH remains a risk especially in relation to escalation, premium rate staffing and efficiency. SaTH has a deficit to plan of £5.6m at the end of month 10, with the system having a small deficit to plan.
- **SaTH Metric 1.2.23:** NHS Planning guidance for FY25/26 was delayed and was released on 30th January 2025.
- Financial Recovery Director appointed and Financial Recovery Group in place to support efficiency delivery and financial recovery.
- The increasing alignment between financial and workforce governance is vital.
- Reducing reliance on agency staffing is making good progress however more work to achieve the same with our use of bank staff.

UEC

Key Risks and Areas Requiring Continued Oversight

- **SaTH Metric 3.1.1.1:** UTC utilisation remains below the 25% target (January 2026: 19%) and is a risk with workforce gaps and skills-mix issues continuing to impact performance. This action will roll into 2026/27.
- **SaTH Metric 3.1.1.7:** Time to be seen by an ED clinician continues to exceed the 60-minute standard. Further interventions, including extended twilight doctor cover and a Rapid Assessment and Treatment model, are being scoped. The action remains at risk and will continue into 2026/27.
- **SaTH Metric 3.1.1.8:** Staff survey improvements show early positive indications but remain at risk, requiring a strengthened People & OD action plan for MEC to secure sustained cultural improvement.
- **SaTH Metric 3.1.1.10:** Embedding of the Initial Assessment model remains at risk (January 2026: 68.4%), though CYP performance has improved significantly. Continued focus is required to achieve the 75% target.
- **SaTH Metric 3.1.1.12:** UTC 4-hour performance has improved (January 2026: 86.1%) but remains below the >90% target. This action will roll into the 2026/27 plan to support continued recruitment and performance improvement.
- **SaTH Metric 3.1.2.1:** Cardio-respiratory response times cannot yet evidence improvement and remain at risk, with work underway to establish reliable tracking and reporting.
- **SaTH Metric 3.1.2.16:** Back pain pathway implementation is at risk, pending recruitment and full 24/7 MRI cover to support pathway delivery.
- **SaTH Metric 3.1.2.17:** Reductions in 14- and 21-day length of stay show no significant improvement, with actions rolling into 2026/27 alongside the launch of the new Flow Centre model.
- **SaTH Metric 3.1.4.3:** ECDS data quality improvements remain at risk, requiring continued focus to support identification of alternative pathways and improve coding reliability.
- **SaTH Metric 3.4.1:** Reduction in inappropriate therapy referrals remains at risk, with coded F10 activity increasing. A revised plan is being developed within Therapies to address this.

Off-Track Items Requiring Strengthened Assurance

- **SaTH Metric 3.1.2.3:** PRH bed base reconfiguration is off track due to estates delays, though completion is expected imminently (12 February 2026) after which the action will move to completed.
- **SaTH Metric 3.1.2.10:** ED Pharmacy business case implementation is off track due to unavailable supporting data despite recruitment being completed. Further assurance is required to evidence impact.

The information in Appendices 1–4 provides a summary of progress against delivery of the tasks and actions due up to and including 02 March 2026, as set out in SaTH's Integrated Improvement Plan. These have been approved by the relevant Executive Director and overseen by the Chair of the Committee.

3. Governance Arrangements

The delivery of individual elements of SaTH's Integrated Improvement Plan is reported and monitored via the relevant Assurance Committee with overall progress reported to the Board of Directors.
Delivery against the Quality Improvement Plan (QIP) continues to be reported and monitored via the Quality and Safety Assurance Committee with overall progress reported to the Board of Directors.

4. Recommendations

The Board of Directors is asked to:

- **Note** that the Trust remains on track to deliver the majority of 2025/26 IIP actions (Appendices 1-4), providing assurance to NHSE as part of the Trust's RSP exit process in Q4.
- **Note** that any 2025/26 actions at risk have been transferred into the 2026/27 plan.
- **Review** and **formally Approve** the 2026/27 SaTH Integrated Improvement Plans for Governance, Workforce, Leadership, Finance, and UEC (Appendices 5–8), which have been developed to provide assurance to NHSE as part of the Trust's RSP exit process.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 12 March 2026

Agenda item		055/26			
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 **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.

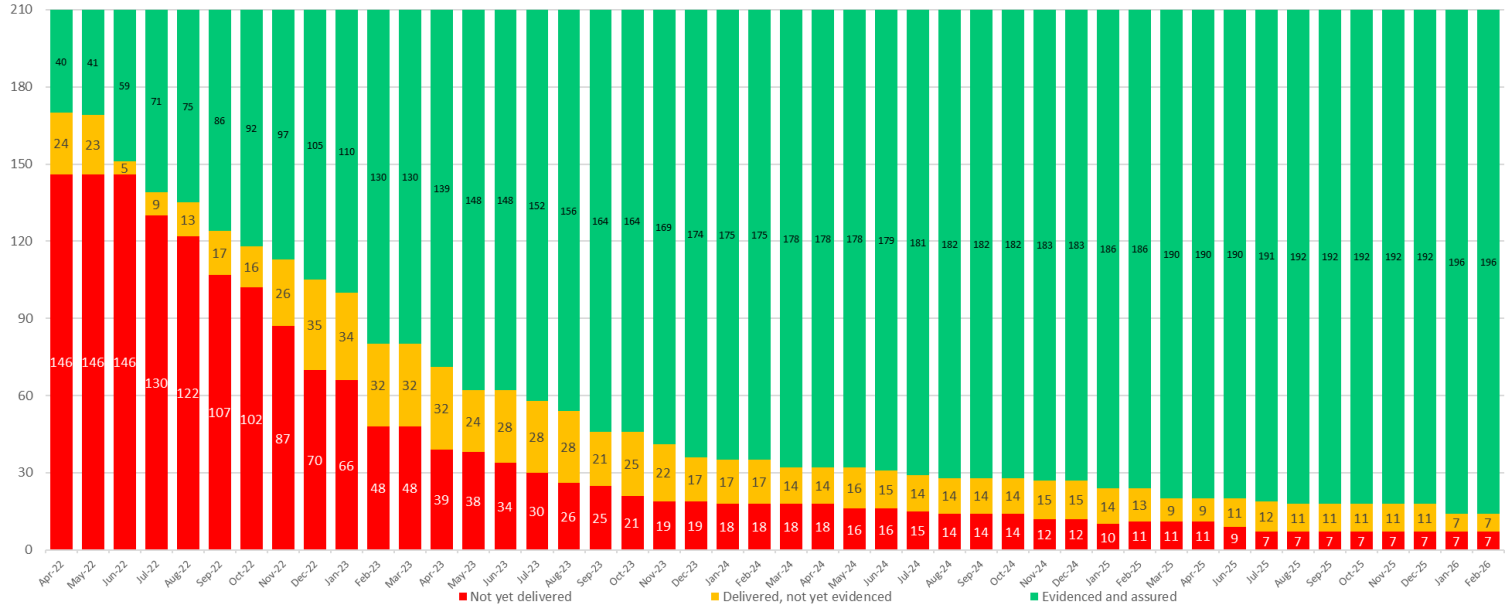
1.4 A summary of progress with the Maternity and Neonatal Transformation Programme (MNTP), which is an IMR action requirement, including an update on the Cultural Improvement Plan.

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 10 February 2026. The overall delivery over time, including current position, is as follows:



Delivery Status	Number (change since last report)	Percentage
Evidenced and Assured	196 (⇧4)	94%
Delivered, Not Yet Evidenced	7 (⇩4)	3%
Not Yet Delivered	7 (⇔)	3%
TOTAL	210	

**Rounded percentages

Progress Status	Number (change since last report)	Percentage
Completed fully (Evidenced and Assured)	196 (⇧4)	94%
On track	6 (⇩5)	2.5%
Off track	1 (⇧1)	0.5%
At Risk	0 (⇔)	0
De-scoped	7 (⇔)	3%
Total	210	100%

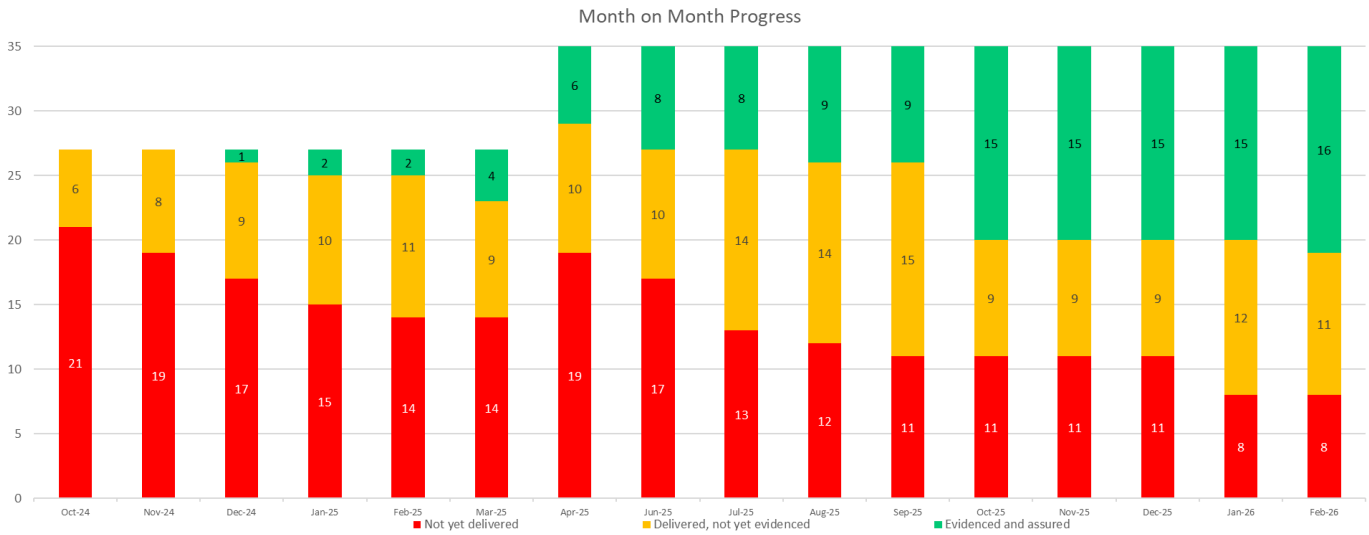
**Rounded percentages

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. Those actions have continued to be reviewed on a quarterly basis and will be escalated again to the national team in Q1. The Local Maternity and Neonatal System continues to oversee these actions. The next quarterly review is now due in April 2026.

2.4 Progress against all other actions within the Trust's gift to deliver continues. Six of the remaining seven are currently on track for their expected delivery dates, pending evidence that they have been appropriately embedded. One action has been flagged as Off Track, relating to the requirement for Labour Ward coordinators to attend a nationally accredited programme. Whilst the Service has been updating its competencies to align with the national framework, the national team issued a Labour Ward Co-ordinator Training Directory. We have asked for clarification from the Regional Team to advise if the directory is a suggestion of course for each of organisation to then agree a specific training package to attend so accurate costings can be reviewed.

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 10 February 2026. The overall trajectory and position are, as follows:



Delivery Status	Number	Percentage
Evidenced and Assured	16 (⇧1)	46%
Delivered, Not Yet Evidenced	11 (⇧2)	31%
Not Yet Delivered	8 (⇩4)	23%
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)	16 (⇧1)	46%
On track	16 (⇔)	46%
Off track	2 (⇧1)	5%
At Risk	0 (⇩1)	0%
Not Started	0 (⇩2)	0%
Descoped	1 (⇧1)	3%
Total	35	100%

**Rounded percentages

3.2 Of note, NEMR 2, linked to improvements of the golden hour provision remains Off track while the service seeks feedback from network partners and absences within the clinical leadership team have led to NEMR 18 to go Off Track, progress is expected to be presented in March.

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. All actions in the 3 Year Delivery Plan are expected to be implemented (Amber or Green) by the end of March 2026, with the exception of the Maternity services certification for BFI stage 3.

4.3 Progress continues to be made with the cultural improvement review. A high-level divisional plan has been developed, setting the direction for the financial year, with more detailed goals devised every quarter to achieve the overall vision, aligned with the current priorities of the services. Outputs in Q4 included the launch of a Divisional newsletter, coordinating for participation to the national Perinatal Equity and Anti-Discrimination programme and for the nominations of improvement initiatives to national awards (NHS Excellence/HSJ awards). Staff survey results will be utilised to set the priorities in Q1.

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 and the Trust has now signed off on the delivery of all 10 Safety Actions during a dedicated Board session in February. The required forms have been provided to NHS England and official validation is expected before the launch of the scheme for Year 8, in April (Appendix 4 CNST Year 7 Completion 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.

Jacqueline Bolton
Interim Head of Midwifery

Julie Plant
Divisional Director of Nursing

March 2026

All appendices are in the Board Supplementary Information Pack

Appendix 1:	BOD Ockenden Report
Appendix 2:	Neonatal review Board of Directors
Appendix 3:	Phase 2 slides
Appendix 4:	CNST Year 7 Completion Report

Maternity & Neonatal Safety Champions - Key Issues Report

Report Date: 5th February 2026		**Report of:** Maternity and Neonatal Safety Champions Meeting
Date of last meeting: 05/02/2026		**Membership Numbers:** Quoracy met
1	**Agenda**	• Chair's welcome and apologies, conflict of interest and minutes reviewed. • Action log and review of AAAA from January 2026 • Safety Champions walkabout feedback from Telford Outpatients • Maternity Quality Dashboard and Oversight Report (AAA) • Neonatal Quality Dashboard and Oversight Report (AAA) • MTP/Ockenden Report Action Plan and Assurance Report • Locally Agreed Safety Intelligence Dashboard (SA9) • PMRT Quarterly report (including learning points) and Board Report • Transitional Care Audit Report • Neonatal Staffing & BAPM Report (Safety Action 4) • Our Staff Said, We Listened Poster and Safety Champions Poster • Maternity Governance Report (including MNSIs and Action Plans) • Maternity & Neonatal Service User Feedback • Maternity & Neonatal Independent Senior Advocate Feedback - Themes and Actions • Home Birth Team Update • QI Project Support • Information Pack
2a	**Alert**	• No alerts
2b	**Assurance**	• Neonatal unit preparing for BFI stage 3 accreditation in March, preparations are ongoing. • CNST has been fully delivered. Final board presentation due in February to allow sign-off before March deadline. • Maternity service awarded 'Student Placement of the Year' by Keele University. • CQC Maternity Survey results for 2025 have been published on 10th December and were very positive, showing that women cared for by our teams felt that they were treated with kindness and compassion and were spoken to in a way they could understand. Once the qualitative results have been received, as in previous years, an action plan for further improvements will be co-produced with the MNVP.

		• A Joint Fetal Medicine service with Stoke is being implemented, they will come on site to allow the provision of Fetal medicine locally instead of having service users travel.		
2c	**Advise**	• A higher rate of ethnic minorities has been noted amongst PMRT cases when compared to the ethnicity data of women birthing at SaTH, with some groups disproportionately affected by perinatal bereavement. This is in line with the national picture and work is ongoing to reduce health inequalities both locally and nationally. • The following reports were shared with the group for information ahead of the meeting, with the opportunity to raise any comments or questions at the meeting: - Decision to Delivery Report - Monthly Staffing Report - Education and Training Report - ATAIN Quarterly Report - Maternity Services CQIM MSDS Dashboard and AAA - MNSC ToR due for review - MNSC Attendance Log Jan 26		
3	**Actions to be considered by the MTAC / QSAC / Trust Board**	• Note the report		
4	**Report compiled by**	Steve McKew (Deputy Medical Director)	**Minutes available from**	Charlotte Allmark (PA to Deputy Medical Directors)

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
12 March 2026

Agenda item		057/26		
Report Title		**Board Assurance Framework – Draft Quarter 3, 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		Performance Assurance Committee (20.01.26); Group People Committee (26.01.26); Finance Assurance Committee (27.01.26); Quality & Safety Assurance Committee (27.01.26); Audit & Risk Assurance Committee (16.02.26).		
Executive summary:		The Board Assurance Framework (BAF) content has been reviewed and refreshed for quarter 3 of 2025/26 by the executive risk owners and their relevant senior team members. There are no proposed changes to current total risk scores this quarter.		
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 3 BAF.		
Appendices:		**Appendix 1**: Board Assurance Framework (draft) - Quarter 3		

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 3 was undertaken during December 2025.

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

2.0 Significant changes to the BAF during quarter 3 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 There are no proposed changes to BAF current total risk scores this quarter.

2.3 During this quarter, one action has been closed within BAF risk 4, three actions closed within BAF risk 5, one action closed within BAF risk 7b, two actions closed within BAF risk 9, and one action closed within BAF risk 13.

2.4 Three target dates of actions have been extended this quarter within BAF risk 2 and also within BAF risk 5. One target date has also been extended within BAF risk 6.

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 3, 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 3:

Risk No.	Risk title	Overseeing Committee	Current proposed risk score at quarter 3, 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.

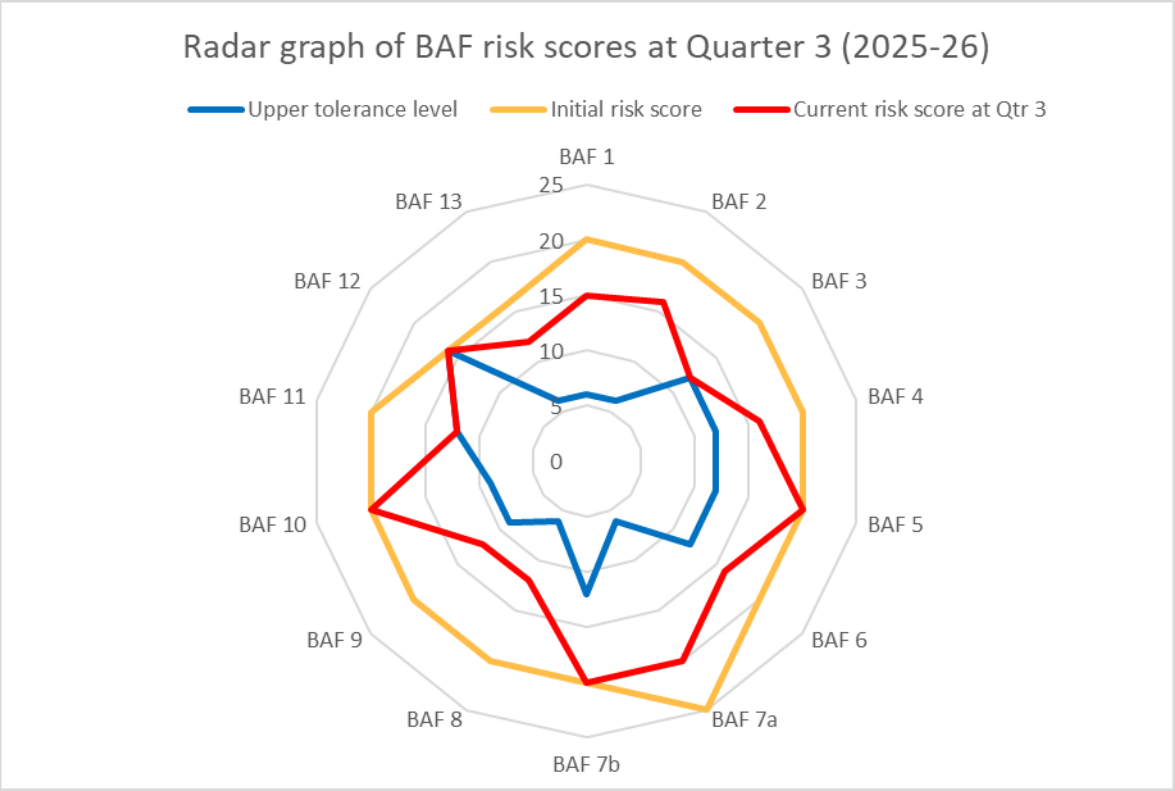
3.4 Being aware of the proposed top scoring risk(s) should assist the Board to consider:

- 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 Committee/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 3 BAF.

Appendix 1

The Shrewsbury and Telford Hospital NHS Trust

Board Assurance Framework (BAF) 2025/26 - draft quarter 3 (Oct-Dec 2025)

(Updated December 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

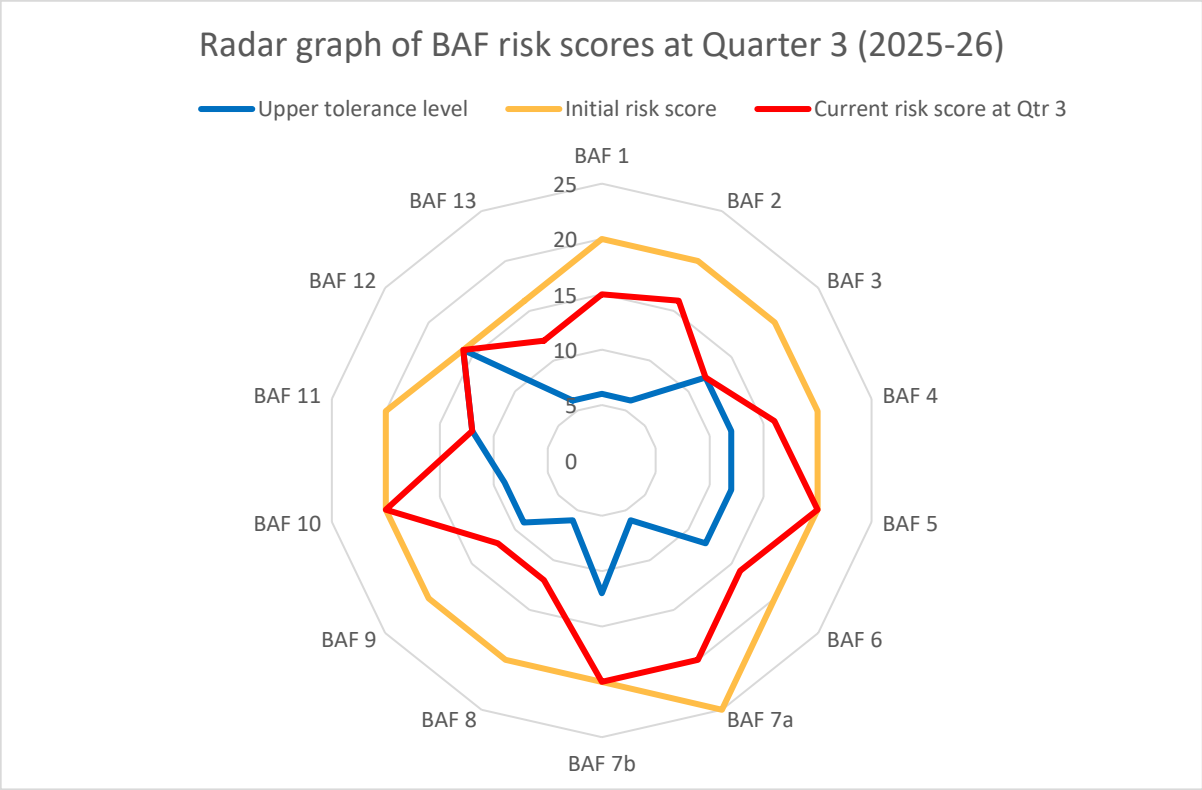
The Shrewsbury and Telford Hospital NHS Trust

							Current total risk score in previous quarters (IxL):				Current total risk score (IxL):	
Board Assurance Framework 2025/26 - Summary at Quarter 3 (October-December)		**Alignment to Trust Strategy - strategic themes/objectives**	**Initial (inherent) risk score**	**Upper tolerance level (and risk appetite)**	**Lead Executive**	**Lead Committee**	**Quarter 3 (2024-25)**	**Quarter 4 (2024-25)**	**Quarter 1 (2025-26)**	**Quarter 2 (2025-26)**	**Quarter 3 (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 (in common)	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x3 = 12**	**4x3 = 12**	↔ No change
BAF 4	A shortage of workforce capacity and capability leads to deterioration of staff experience, morale, and well-being.	Make SaTH a great place to work. Deliver a better patient journey and experience. Make our organisation more sustainable.	**5x4 = 20**	**12 (open)**	Chief People Officer	People & OD Assurance Committee (in common)	**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**	**5x4 = 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)**	Acting Director of Finance	Audit and Risk Assurance Committee	**5x3 = 15**	**5x4 = 20**	**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)**	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 3 (October-December)		**Alignment to Trust Strategy - strategic themes/objectives**	**Initial (inherent) risk score**	**Upper tolerance level (and risk appetite)**	**Lead Executive**	**Lead Committee**	**Quarter 3 (2024-25)**	**Quarter 4 (2024-25)**	**Quarter 1 (2025-26)**	**Quarter 2 (2025-26)**	**Quarter 3 (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**	**4x3 = 12**	**4x3 = 12**	↔ No change
BAF 10	The Trust is unable to meet the required national urgent and emergency standards.	Deliver a better patient journey and experience. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**4x5 = 20**	**9 (cautious)**	Chief Operating Officer	Performance Assurance Committee and Quality & Safety Assurance Committee	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	↔ No change
BAF 11	The current configuration and layout of acute services in Shrewsbury and Telford will not support future population needs and will present an increasing risk to the quality and continuity of services.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**5x4 = 20**	**12 (open)**	Director of Hospitals Transformation Programme	Hospitals Transformation Programme Assurance Committee	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	↔ No change
BAF 12	There is a risk of non-delivery of integrated pathways, led by the ICB and ICS.	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. NHSE Specialised Commisssioning review of head and neck services across the Midlands started 15 December 2025. • 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) • Maternity Survey Results (Q3) improvement in all questions and none in the worse than other trusts sections (3rd) . Results due at QSAC. • All national patient surveys reported to QSAC with associated action plans (2nd)	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. 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. Q3: Recruitment of Student Nurse Associates remains ongoing - had biggest cohort with 50 appointed to undertake the training in September 2025. Also about to potentially appoint fully to critical care consultants and almost fully recruited to emergency department for consultants. The main remaining challenges in recruitment are Cardiology, Max Fax, Neurology, General Anaesthetics, Haematology and Oncology. 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. Q3: Vitals system upgrade due 19/20 January 2026. The Trust is preparing to roll out CareFlow Connect (CFC) to support digital handover, referrals and task management across inpatient areas, from March 2026. 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. Q3: Meeting with stakeholders (Surgery, Medicine and W&C) held in November 2025. Follow up meeting due to finalise priorities and metrics - due by end of January 2026. Completion of draft strategy now expected end of Q4, followed by subsequent approvals. 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. Q3: The two cohorts of training for ward managers is complete, with the matron training ongoing. We are looking to review divisional Directors of Nursing development programme in 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. 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. Q3: Developing a job description for a joint consultant appointment with UHB. The locum support is due to end at the end of January 2026. 8. Single Group being created to consolidate the outputs from learning from deaths, medical examiner and incidents during quarter 3. Q3: The first example of a joint paper between Learning From Deaths, Medical Examiner and Patient Safety is due at Board in January 2026.			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 • Patient Safety Committee • As part of the Ten Point Plan for improving Resident Doctors working lives, the Trust has appointed Resident and/or representative for resident doctors and the first report of the Resident Doctor Representative will be included as part of the Guardian of Safe Working Report to Board in January 2026.	**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~~ Q4, 25-26 and into Q1/Q2 2026/27. Executive Lead: Chief People Officer/ Chief Nursing Officer 2. Develop a three year Quality and Safety Strategy by ~~Q3~~ Q4 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~~ March 2026. 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. Q3: Work ongoing. 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. Q3: Meeting with stakeholders (Surgery, Medicine and W&C) held in November 2025. Follow up meeting due to finalise priorities and metrics - due by end of January 2026. Completion of draft strategy now expected end of Q4, followed by subsequent approvals. 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. Q3: Divisions are engaged in responding to complaints. An independent complaints review panel is in place (chaired by a patient representative) and Divisional Directors of Nursing attend to take away the learning and share within Divisions. 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. Q3: A new Patient Safety Committee has been established, chaired by the Deputy Medical Director. It brings together Patient Safety, Learning from Deaths, Medical Examiner Service, and the Deteriorating Patient Group. The aim of the committee is to ensure a shared approach to improvement and learning and to combine specialities to ensure triangulation and focus. The first Patient Safety Committee report to the Board of Directors will be presented in January 2026 and will replace the previous individual reports for Learning from Deaths and Medical Examiner Service. 4. Q2: Rolling programme - currently there are 68 ambassadors at various stages of recruitment/training. Speak Up Week was held on 13th-17th October 2025. Q3: Since the previous quarter, three in person training sessions have taken place. A programme of ambassador engagement/meetings are also scheduled. 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.* 6c. Work remains ongoing. 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 (in common)**					
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) (2nd). PODAC meeting in common with Shropshire Community Trust since November 2025. • Reports to 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. • MIAA (internal audit) E-Rostering/Roster Management Report 2025/26 - 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. Q3: meetings are established and ongoing. 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, Q2 and Q3. 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. Q3: Patient experience story presented to November 2025 Board highlighting the link between culture, staff and patient experience. 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 (in common)**						
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 • Nursing Bank review process in place since November 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). PODAC meeting in common with Shropshire Community Trust since November 2025. • 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) • MIAA (internal audit) E-Rostering/Roster Management Report 2025/26 - Moderate assurance	4	4	16	**Gaps in control:** 1. Process for picking up and addressing wherever possible dissatisfaction in new starters before they decide to leave is in place 2. Developing workforce supply routes 3. New ways of working 4. Systematic process throughout the Trust to support succession planning. 5. EDI champions and local EDI objectives to create a diverse workforce, leadership and inclusive culture 6. High levels of mental health related sickness absence **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. Q3: **Action closed**. Cohorts underway. 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 weekly from December 2025 • 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 • Chief Nursing Officer and Medical Director approval of bank shifts from December 2025 • Daily panel for the approval of non-clinical bank shifts from October 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. 1d. Developing an overarching 3-year efficiency and improvement plan that incorporates all transformation (including HTP) across the group and aligns it to the strategic objectives including financial sustainability. Target date - September 2026. Lead Executive: Director of Finance. 1e. Divisional key variance reports to highlight risks and develop mitigations through the divisional meetings and PRMs's to provide greater granularity and visibility of issues. Target date - Feb 2026. 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 2c. Additional controls over bank usage have been tightened and continue to be in place to manage cost pressures. Target date - Ongoing. Lead Executive: Chief Nursing Office, Medical Director and Director of Finance. 2d. Updated self assessment against the grip and control toolkit has highlighted a number of actions to facilitate improved grip. Target date - Ongoing. Executive Lead - Director of Finance. 2e. Weekly dashboard to Financial Recovery Group (FRG) to be incorporated where possible to a dashboard for Divisions. Target date - March 2026. Executive Lead- Director of Finance. 3. Scoping exercise to link Electronic Staff Record (ESR) with finance budgets - ~~Q3~~ Q4 2025/26. 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~~ Q4 25/26. Executive lead: Director of Finance and Assistant CEO. 6b. Devolve Clinical Income to divisions - end of ~~Q3~~ Q4 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. Q3: Plans for 2026/27 in development. 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. Q3: Additional support programme in place for divisions who are off-track financially. 1d. Framework designed, meetings planned with SCHT and Improve & Transformation teams in SaTH to establish the key pillars. 1e. Draft in progress and to be finalised during Feb 2026. 2a. Full efficiency programme identified. De-risking continues to be monitored via Financial Recovery Group and Finance Assurance Committee. Q3: **Original action complete**. Continue to monitor to ensure any further risk is mitigated. 2b. Action complete Q1. 2c. Daily nurse, tri-weekly medical and tri-weekly non-medical panels to review requests in place and executive led. 2d. Self assessment completed and action plans being monitored and managed. Internal audit provides substantial assurance. 2e. Weekly metrics evolving as processes put in place to capture data. Meetings arranged to understand the potential for inclusion in a senior leaders dashboard. 3. Work ongoing during 2025/26. Q3: Discussions have taken place with NHSE as to whether any other trusts have gone through a similar process and could share their learning. 4a. Review of monthly meetings taking place and escalation process to be implemented by Q2 2025/26 following divisional forecasting at the end of Q1. Q3: Additional support programme in place for divisions who are off-track financially. **Action closed.** 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. **Q3: Action closed.** 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. Q3: Data is now being shared, however data quality issues remain and are being worked through.			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, however Critical Infrastructure Risks (CIR) applications are now welcome by NHSE • 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 • Critical Infrastructure capital funding applied for in 2025 and granted for backlog works; new applications now open for 2026.	**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~~ October 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. Q3: Project completion date is now expected as October 2026. Change request form submitted to NHSE, awaiting formal approval for date extension and increased budget of £2.9m. 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 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). Q3: Cyber update to be presented at February 2026 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. Q3: ICS Digital Lead no longer in post. Review alternative meeting chair. In addition, Digital Shared Services Task & Finish Group meetings are in place, with Staffordshire & Stoke-On-Trent and Shropshire Telford and Wrekin ICB cluster representatives attending. One of the Task & Finish Groups being Cyber Security and Compliance. 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. Q3: 2026/27 work to be undertaken to strategically align with the Group Model. 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. Q3: Initial medical device working group took place November 2025. **Action Closed.**			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. Q3: Digital update presented at October 2025 Board. **Action closed.** 2b. Q1 and Q2: In progress. Q3: As new projects are submitted, a review of key project stakeholders are identified. 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). Q3: Funding beyond 25/26 not yet secured. Submission for external funding through Diagnostics Digital Capabilities being submitted. 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 with controlled proof of concepts within 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) • NHSE IPC inspection for C'Diff undertaken April 2025 - action plan updated and reported 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) • SaTH Provider Review Meeting with NHSE, and ICB attendance - monthly (3rd)	4	3	12	**Gaps in control:** 1. Lack of whole system support for healthcare services (e.g. children and young peoples mental health and Urgent and Emergency Care - UEC). 2. 79 Must and should do actions from CQC Report from May 2024 . *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. Q3: Work remains ongoing on a case by case basis. 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. Q3: outcome of application of Section 31 removal not yet received. 3. Q3: Work remains ongoing. Updates received at Quality Operational Committee (QOC). 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 Q3, 25/26 • Planned Care Transformation Assurance Committee - meets monthly - commenced April 2025 (2nd) • Improvement in performance reported to Performance Assurance Committee - November 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 over 30% in the last year; Eradicated 65 week waits; Biggest improvement - reduced 52 week waits from 7% to 0.2% at Q3 : Best 18 week RTT performance in October 2025 for 5 years. Cancer: Improved performance in cancer 28 day Faster Diagnostic Standard (FDS), with October 2025 performance the best on record and well into the top half nationally; Improved performance in cancer 62-day Referral To Treatment with October 2025 performance the best since the combined standards has been reported, 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 5.5 years in October 2025; De-escalated out of NHSE Tier 1 oversight to Tier 2 (Q2). • The Trust has received £2m capital as most improved trust in the country for 18 weeks RTT.	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. **Q3: Action closed.** 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. **Q3: Action closed.** 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 was part of Cohort 1 for leadership training delivery with NHS Impact commenced Aug 2025. 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) • Trust Board approved UEC Improvement Plan at September 2025 meeting (2nd)	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 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/ January 2026. Q3: New modular wards opened 08 December 2025 at RSH. 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. Q3: continued recovery of Type 3 four-hour performance. 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 - implemented Q3. Q2: New GP Out of Hours care co-ordination centre provider (Health Hero) commenced 1 October 2025. Q3: Urgent Community Response service extended until midnight; commenced December 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) • Emergency Treatment and Transfer Group (2nd)	4	3	12	**Gaps in control:** 1. Insufficient capacity at present for divisions to deliver all of the key milestones within the master programme. **Gaps in assurance:** 2. Dependency on system-wide programmes to deliver the clinical model.	**Actions aligned to gaps:** 1. Meet with Divisions to further align some dedicated resource - by 31 December 2025. Executive Lead: COO 2. 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. Meeting on 09 December 2025. 2. HTP Director is a member of the Neighbourhood Health Implementation Group to ensure HTP aligns with local care transformation programmes. Work has been ongoing to create stronger links between the two programmes. 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. Q3: Metrics to be identified which demonstrate the move of services/patients into a community care setting.			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.			**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 • Capacity of ICB to support and lead local Neighbourhood health programme under pressure. STW ICB moving to cluster with SSOT ICB. Single exec team in place with effect from 01 Dec 2025. Voluntary resignation scheme for both ICBs commenced 01 Dec 2025. **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 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 • SATH/Shropcom Group model approved by Trust Boards on 23 Sep 2025. Ongoing development of transition plan, with focus on hospital to community shift.	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 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. Q3: STW Frailty strategy and delivery plan year 1 and year 2 approved (Sept 2025). STW Cardio Vascular, Renal and Metabolic/Diabetes strategy drafted. Risk stratification approach endorsed and embedded in General Practice. National Neighbourhood Health Implementation Programme (NNHIP) commenced in Shropshire Place area October 2025 - focus on patients with two or more long term conditions, with aim to reduce UEC demand. SaTH Deputy Medical Director supporting NNHIP. 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. Q3:2026/27 STW UEC plan under development and expected to include greater inter-relationship between UEC and Neighbourhood Health/Place programmes. 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. Q3: STW Chief Medical Officer & Chief Nursing Officer have updated the ICS clinical strategy, to represent the priority clinical pathways, three shifts and neighbourhood health as part of the medium term planning framework submission.			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. • There is a potential risk that Group Model development may not proceed at the required pace, which may result in ambiguity in roles and responsibilities, inconsistent decision-making and reduced oversight and assurance • Additional level of risk during the Group Model transition period.	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 2025 and due at January 2026 Board • 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 ARAC, FAC, QSAC and PODAC committees February 2025 and PAC November 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 (Q2/Q3 2025/26) • Financial Recovery Group now meeting weekly instead of fortnightly (Q3) • Shared corporate and clinical arrangements for Group Model under development and will be shared with NHSE to support transparency and enable effective oversight.	**Reported to Board, committees and elsewhere:** • SFI's, Standing Orders and Scheme of Reservation and Delegation to Audit & Risk Assurance Committee during November 2025 and due at Board January 2026 (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) - 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 in 2025/26 (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 - November 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 - updates 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) • NHS Provider Board Capability Assessment to Board - October 2025 Board (2nd) and onward to NHSE.	4	3	12	**Gaps in control:** 1. Trust Policy Framework (and document access). 2. Outstanding subject access requests (SAR's), and subsequent complaints. 3. Delivery of the Group Model with Shropshire Community Healthcare NHS Trust **Gaps in assurance:** 4. 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. Appoint a Project Manager for delivery of the Group Model by Q3. 4. 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 agreed by lead Executive. Policy Approval Group commenced during August 2024, and continues to meet monthly. **Action closed Q3** 1b. Q1: Support offered. Q2: Communications Team have developed a new intranet specification (under consultation in Sept 2025). Q3: More work required following November 2025 intranet working group meeting where it was confirmed that a policy archive will not form part of the new intranet. 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. Q3: action closed. 2d. Action plan in place and continues to be monitored by management. Q3: Action closed. 3. Project Manager to begin mid-December 2025 4. 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. Q3: Action plan has been accepted by NHSE and Trust is now 'approaching standards'. MIAA (digital side) are supporting cyber and IG work to further improve.			6

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 12 March 2026

Agenda item		058/26		
Report Title		Risk Management Report Q3 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:		The Risk Management Report for Q3 2025/26 is presented to the Board, 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 20 extreme risks (scored ≥15) have either resulted in a reduced risk score or overall risk closure throughout Q3. • **Risk Management Progress:** The report notes a reduction in overdue risks and actions, with 41 risks closed in Q3, bringing the number of active risks at the end of December 2025 to 362 (including risks opened in Q3) • **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 October, November and December 2025 (Q3 2025/26) with severity breakdown. Appendix 2: Summary of the Corporate Risk Position on 14 January 2026. Appendix 3: Corporate Risk Register on 14 January 2026.		

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 covering 2024/25 was presented at the May 2025 ARAC, Q1 2025/26 was presented at the September ARAC and Q2 2025/26 was presented at the 24 November ARAC.

The Trust's Risk Management Policy and Risk Management Strategy have been reviewed to broadly align with other providers in the system, whilst recognising the additional challenges that the Trust has faced. These papers were approved at the January 2026 Board meeting.

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 October, November and December 2025 (Q3 2025/26).

Trust Wide Risk Position by Approval Status	Oct 2025 Total	Nov 2025 Total	Dec 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)*	**364**	**359**	**362**
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)*	**5**	**12**	**10**
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)*	**6**	**6**	**2**
4. Total number of **Overdue Risk Reviews** for **Open risks**	**71**	**143**	**113**
5. Total number of **Overdue Actions Reviews**	**143**	**261**	**198**

See Appendix 1 for Divisional risk profile from October, November and December 2025 (Q3 2025/26) with severity breakdown. N.B. The total numbers in Appendix 1 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 into the five CQC domains, aligns them to the eight categories of risk (corporate goals) and highlights which aspects of the BAF the themes relate to. This is updated every month - see Appendix 2 for a breakdown of the thematic analysis of the risk position. See Appendix 3 for the detail of the Corporate Risk Register on 14 January 2026. N.B. This Corporate Risk Register is a completely separate display of any 'Corporate' risks that come under SaTH's 'Corporate Division' as listed in Datix (not W&C, SACC, CSS or M&E).

3.0 Effectiveness of Risk Mitigation

The table below demonstrates how the controls and actions of 20 extreme risks (scored ≥15) have either resulted in a reduced risk score or overall risk closure throughout October, November and December 2025 (Q3 2025/26).

Month	Risk	Risk Status	Actions Taken to Mitigate / Close Extreme Risk *(at 04/02/2026)*
October 2025	1186 'Recruitment Freeze – Risk to MEC Division (Division Wide Risk)'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 16 to 12 because blanket recruitment freeze no longer in place and embedded vacancy approval processes have been in place for >12 months.
	927 'Risk to provision of ophthalmology service due to shortage of consultant medical staff for key specialists'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 16 to 12 because locum is in post.
	1094 'Secretarial staffing shortages unable to meet typing demand in Trauma / haematology'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 20 to 9 because due to reduced typing backlog letters and typing within two weeks. Typing being monitored due to a 4.5 WTE reduction in secretarial support in December 2025.
	1250 'Call bells within CYPU do not alarm within the other paediatric clinical rooms'	Closed	Call bells fitted on 04/09/2025.
Month	**Risk**	**Risk Status**	**Actions Taken to Mitigate / Close Extreme Risk *(at 04/02/2026)***
November 2025	952 'Risk to the achievement of patient pathway targets due to delays in requests reaching Radiology'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 15 to 9 because. *This risk was closed on 15/01/2026 because SaTH has come off tiering for DM01. Improvements identified and mitigating actions in place.*

	1181 'The risk to patients in STW not being able to access specialist rehabilitation post lower limb amputation'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 20 to 9 because SLA meetings were continuing with BCH. *This risk was closed on 13/01/2026 because the service is now fully staffed and both SLA for Consultant and prosthetist with BCH and MPFT are back up and running.*
	881 'There is a risk due to initial adult patient assessments not happening within 15 minutes in times of extremis'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 16 to 8 due to sustained improvements as part of tier 1. This was reviewed at Divisional Committee 20/09/24.
	556 'Long waits for paediatric clinic appointments'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 16 to 12 because recent reopening of clinics led by Middle-grades has helped to significantly reduce waiting times.
	1143 'Potential for period of prolonged hypoxia to a baby due to delays in transport to a level 3 unit for Nitric Oxide (NO) therapy'	Closed	No anticipated risk - agreed at Triumvirate and Governance. Approved at W&C Risk Register Committee meeting.
	1264 'Crane oversailing of the Emergency Department on 16th and 17th October 2025'	Closed	Lifts completed successfully and crane has left site.
	1112 'Lack of Pharmacy Clinical service provided to the Emergency Department (ED)'	Closed	All posts recruited to. Team of 5 technicians and 2 pharmacists to be on ED 01/12/2025. Remaining 3 pharmacists recruited to and due to start December 2025 x 1 and January 2026 x 2.
	397 'Unsupported/End of Life Laboratory	Closed	We now have a new server in place which is up and running with a support contract in place. There is a plan (with funding) for a replacement LIMS with the project due to start imminently. Anticipated new LIMS will mitigate all potential consequences and new risk will be raised if required. The new

	Information System - multiple risks including clinical, financial and data security'		server that is in place has a 3-year support contract mitigating potential consequences. This will be place for the duration of replacement LIMS project. Once the new LIMS is in place data will continue to be available on the old LIMS.
Month	**Risk**	**Risk Status**	**Actions Taken to Mitigate / Close Extreme Risk *(at 04/02/2026)***
December 2025	537 'Risk to Category 2 Cancer patients due to low staffing'	Score reduced but still ≥15 (extreme) and kept on Corporate Risk Register	Score reduced from 20 to 9 because staffing levels improved but referral numbers high.
	963 'Risk of delayed diagnosis or incorrect clinical management of patients created by duplicate electronic patient records'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 16 to 12 because lower numbers are coming through.
	1010 'Critical Care Specialist Pharmacist Vacancy'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 12 to 9 because SaTH is meeting minimum staffing requirement. However, there is no provision if one member is off.
	1243 'Industrial Action by Resident Doctors (July 2025 to January 2026)'	Closed	Appropriate to close the risk, with the option to reopen or create a new risk should further industrial action be announced.
	626 'Lack of handwashing sinks on Ward 25'	Closed	New ward in place (ward 38).
	986 'Non-compliant tier 2 rota in urology'	Closed	Rota now compliant.
	1075 'Trust not supporting use of the electronic labelling and software safety	Closed	Software now in place.

	features available on infusion pumps’		
	1139 ‘Risk of discontinuation of Living Well Sessions provided by SaTH Cancer Personalised team effective from April 01, 2025’	Closed	Funding approved for service.

4.0 Next Steps (**forward projection detailing plans for closure of active risks):**

- Meet with all Executive Directors to determine whether/how they receive risk assurance from the centres within their portfolio. Link each extreme corporate risk with each portfolio (this was previously undertaken December 2024) **- December 2025 – January 2026**
- Regularly meet with Trust-wide senior and junior Risk / Governance staff face-to-face to track progress and determine support needed, including discussions on status reports and where risks are escalated to **- ongoing**
- Ensure all Trust-wide senior and junior Risk / Governance staff have received risk management training by **01/06/2026** providing divisions and the Patient Safety Hub with a monthly update
- Continue to work with Improvement Director from NHSE on Trust-wide risk cleansing exercise, highlighting where risks could be rescoped and determining whether the issue(s) exists **- 28/02/2026**
- Evaluate Corporate division's risks by meeting periodically with a lead for each 'centre' to review their risks, e.g. Estates, the Nursing Directorate and Digital, and the Deputy Chief Operating Officers for operational issues **- 31/03/2026**
- Ensure no *proposed* risks are over six months old as per the Risk Management Policy **- 31/03/2026**
- Ensure any risk older than three years is accepted (and closed if they have not been reviewed regularly as per RM Policy) **- 31/03/2026**

Appendices

Appendix 1 - Divisional risk profile from October, November and December 2025 (Q3 2025/26) with severity breakdown:

Open Risks by Division and Level of risk	Oct 2025 LOW (1-3)	Nov 2025 LOW (1-3)	Dec 2025 LOW (1-3)	Oct 2025 MOD (4-6)	Nov 2025 MOD (4-6)	Dec 2025 MOD (4-6)	Oct 2025 HIGH (8-12)	Nov 2025 HIGH (8-12)	Dec 2025 HIGH (8-12)	Oct 2025 EXT (15-25)	Nov 2025 EXT (15-25)	Dec 2025 EXT (15-25)	Oct 2025 Total	Nov 2025 Total	Dec 2025 Total	Difference Month on Month
SA&C	0	0	0	0	9	8	60	61	59	19	21	21	79	91	88	⇓
M&E	0	0	0	2	2	3	36	34	32	21	19	21	59	55	56	⇑
W&C	0	0	0	4	4	4	43	41	38	11	11	10	58	56	52	⇓
CSS	0	0	2	12	12	12	48	47	48	35	30	28	95	89	90	⇑
CORP	2	2	5	17	20	19	40	44	43	17	22	22	76	88	89	⇑
Total	2⇑	2⇔	7⇑	44⇓	47⇑	46⇓	227⇑	227⇔	220⇓	103⇓	103⇔	102⇓	376	379	375	⇓

Appendix 2 – Summary of Corporate Risk Register Position at 04/02/2026

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	16
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	15

Appendix 3 - CORPORATE RISK REGISTER 14 January 2026

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*	consequence	Score	Controls already in place	Current risk score (with current controls in place): Likelihood	consequence	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), 535 (15), 861 (15), 698 (20), 652 (15), 1222 (16), 1223 (16), 1224 (15), 1233 (15) **M&E:** 884 (20), 612 (15), 195 (16), 564 (16), 1167 (16), 793 (15), 1172 (15), 1174 (16) **SA&C:** 454 (16), 804 (20), 912 (16), 1074 (15), 1173 (16), 929 (20), 1030 (20), 1271 (15) **W&C:** 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:** 861 (15), 652 (15), 665 (20) **M&E:** 195 (16), 612 (15), 1167 (16), 793 (15) **SACC:** 912 (16), 1173 (16), 929 (20), 1030 (20), 1271 (15) **W&C:** 1092 (15) **Corp:** 347 (16), 904 (15), 1131 (15)	CSS M&E SA&C W&C Corp
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:** 612 (15), 195 (16), 177 (20), **878 (25)**, 793 (15) **SACC:** 804 (20)	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	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) **SACC:** 804 (20) **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), 665 (20), 1111 (15), 1160 (20), 1151 (16), 1223 (16), 808 (20), 1216 (20) **M&E:** 884 (20), 1017 (15), 882 (15), 1172 (15), 1174 (16), 1185 (20), 1238 (16) **SACC:** 906 (16), 804 (20), 1121 (16), 929 (20), 970 (20), 628 (20), 629 (20), 985 (20), 1269 (16) **WAC:** 1159 (16), 1195 (20) **Corp:** 774 (15), 1206 (15), 1254 (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	16	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:** 1174 (16), 878 (25) **SACC:** 1173 (16)	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:** 955 (16), 645 (15), 861 (15), 848 (15), 72 (15), 1222 (16), 1224 (15) **SACC:** 912 (16), 1074 (15), 1030 (20) **W&C:** 700 (15) **Corp:** 645 (15), 1102 (15), 1266 (16)	CSS M&E SA&C W&C Corp
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

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	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	15	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), 1234 (16), 1281 (15)** **M&E:** **793 (15), 1231 (15), 1251 (15)** **SACC:** **1232 (15)** **W&C:** **1034 (16)** **Corp:** **1039 (16), 1259 (16), 1276 (16)**	**CSS** **M&E** **SA&C** **W&C** **Corp**

The Shrewsbury and Telford Hospital NHS Trust

Board Of Directors' Meeting: 12 March 2026

Agenda item		059/26			
Report Title		Bi-annual Nurse Staffing Review			
Executive Lead		Paula Gardner, Interim Chief Nurse			
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	√	BAF1, BAF4, BAF 8	
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		Quality and Safety Assurance Committee, 27 January 2026			
Executive summary:		This paper provides a summary of the results and outcomes for nursing across the inpatient and emergency departments for the June/July 2025 establishment review. Key items to highlight include: • All areas have planned and actual daytime ratio which are better than the minimum recommended ratio of 1:8 Nurse/Patient. • CHPPD are in line with peer median and provider median • The review recommendations in relation to progressing the review of the renal templates and development of the business case based on the outcome of this review. • The review recommendations for SAU and Ward 14			
Recommendations for the Board.		The Board is asked to note and endorse the recommendations from the establishment review and the actions taken at individual ward and service level.			
Appendices:		Appendix 1: SNCT data collected June/July 2025			

Bi-annual Safer Staffing Report

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.

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

The Safer Nursing Care Tool (SNCT) census data was collected in June/July 2025 across a period of 30-days in the adult inpatient wards, acute assessment units, and paediatric ward. The SNCT for the Emergency Departments was collected over a 12-day period in line with SNCT guidance. Establishment review meetings were completed in September and October 2025 and followed a triangulated approach where quantitative, qualitative and operational contexts were considered. Professional judgement was applied alongside reviewing key metrics and outputs of the Safer Nursing Care Tool (SNCT) census, where applicable.

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.

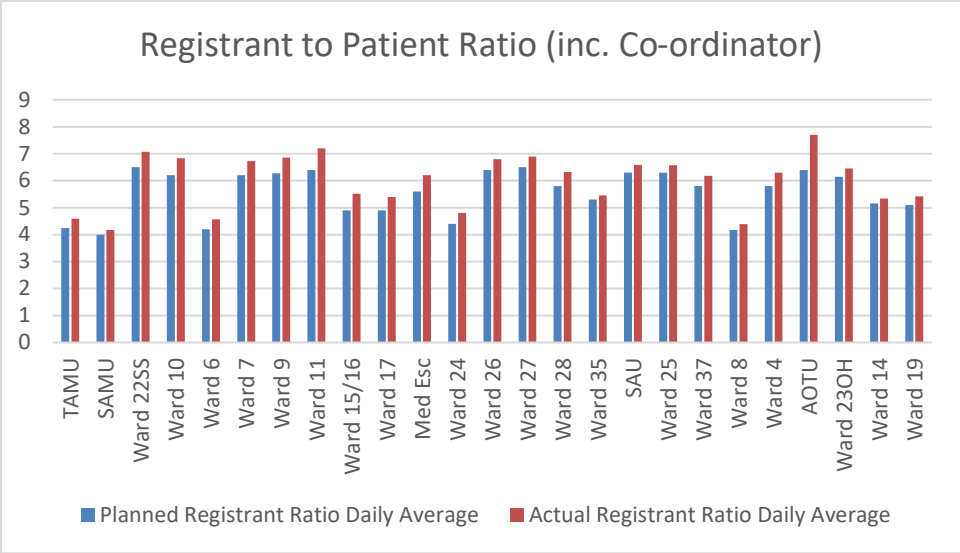


Chart 1. – Patient to registrant ratio

Chart 1 shows the average RN: Patient Ratio at Shrewsbury and Telford Hospital (SaTH) during the months of June/July 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. All areas have a planned and actual daytime ratio which is better than the minimum recommended ratio of 1:8 Nurse/Patient.

Comparison of data from June/July 2024 versus 2025, and January/February 2024 versus 2025, indicates a slight increase in the number of patients cared for by a nurse (nurse-to-patient ratio) on adult wards for daytime periods. However, overall average ratios remain consistent with previous census period. All three divisions reported nurse-to-patient ratios which are better than the threshold of 1 RN to 8 patients, supporting safe staffing standards.

Table 1: Average RN: Patient Ratio

Division	Jan/Feb 2024 Registrant: Patient Ratio (Daytime Average)	Jan/Feb 2025 Registrant: Patient Ratio (Overall Average)	Jun/Jul 2024 Registrant: Patient Ratio (Daytime Average)	Jun Jul 2025 Registrant: Patient Ratio (Overall Average)
Medicine & Emergency Care	1:5.3	1:5.9	1:5.7	1:5.9
Surgery, Anaesthetics & Critical Care	1:5.5	1:6.2	1:5.7	1:6.3
W&C (ward 14)	1:5	1:5.2	1:5	1:5.3
Clinical Support Services (ward 23OH)	NA	NA	1:5.4	1:6.5

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 census was completed twice, across a 30-day period in January/February 2025 and June/July 2025. Establishment changes that were agreed from last year's establishment reviews were enacted in March 2025.
- A multi-professional meeting is held with the Ward Manager/Unit Manager, Matron, Divisional Director of Nursing, Corporate Lead Nurse for Workforce and Deputy Chief Nurse/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.
- 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, all ward managers were in a supervisory at the time of the census being undertaken. The headroom uplift is 24%; 20.5% is allocated in ward/department budgets for annual leave, study leave and sickness, 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.

The SNCT does not apply to departments, but establishment reviews were also completed in Neonatal Unit, Theatres, ITU, Outpatients, Endoscopy, Renal Units, SDEC, Chemotherapy Day Unit, Haematology Day Unit, Elective surgical hubs and Pre-op using triangulation approach which includes relevant methodology and consideration of professional judgement.

2.3 Nursing Establishment Review June/July 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 tools:

- Provide organisational level metrics to monitor impact on the quality of patient care and outcomes.
- Give a defined measure of patient acuity and dependency.
- Supports benchmarking activity in organisations when used across Trusts.
- Embrace all the principles that should be considered when evaluating decision support tools set out in the relevant NHSE 'Safe, sustainable and productive staffing' resources.
- Include staffing multipliers to support professional judgement.
- Provide accurate data collection methodology.

The levels of acuity within the tool range from Level 0 to Level 3 (Table 2). Level 3 patient acuity is only delivered within ED and Critical Care for adult patients. A new version of the Emergency Department and Children and Young persons tool is due for release imminently as current versions of the tools don't reflect currently complexity and intensity of care in these departments.

Table 2. SNCT levels of acuity -Adult inpatient and Acute Assessment areas

Level	Definition
Level 0	Hospital Inpatient. Needs met by provision of normal ward cares.
Level 1a	Acutely ill patients requiring intervention or those who are **UNSTABLE** with a **GREATER POTENTIAL** to deteriorate.
Level 1b	Patients who are in a **STABLE** condition but are dependent on nursing care to meet most or all of their care needs.
Level 1c	Patients who are in a **STABLE** condition but are requiring additional intervention to mitigate risk and maintain safety
Level 1d	Patients who are in a **STABLE** condition but are requiring additional intervention by 2 or more people to mitigate risk and maintain safety
Level 2	May be managed within clearly identified, designated beds, resources with the required expertise and staffing level **OR** may require transfer to a dedicated Level 2 facility / unit.
Level 3	Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

The review was undertaken across the adult inpatient wards and acute assessment areas, Emergency Departments and Paediatric wards. The data from this census was not reviewed in isolation as data from previous years census is reviewed in the establishment review meetings. No new wards had 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 these escalation beds were in use for the majority or whole time during the census data collection period and so have been included for these areas when 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.

Table 3 - Summary of SNCT recommended WTE for June/July 2025 Census Period

	Recommended WTE inc 1c/1d			Recommended WTE exc 1c/1d			
Ward	Reg	Unreg	Total	Reg	Unreg	Total	1c/1d
TAMU	19.68	8.13	28.12	19.68	8.13	28.12	-
SAMU	25.27	13.61	38.83	24.26	14.37	38.99	0.16
SAMA	22.01	9.43	31.44	21.75	9.32	31.07	0.37
AOTU	24.10	18.94	43.04	24.05	18.89	42.94	0.1
Ward 4 Ortho	24.46	19.22	43.68	24.46	19.22	43.68	-
Ward 5 Elective Ortho	10.9	6.67	17.87	10.9	6.67	17.87	-
Ward 6/CCU	25.67	11.0	36.66	25.67	11.0	36.66	-
Ward 7 Med	25.23	20.65	45.88	25.08	20.52	45.59	0.29
Ward 8 H&N	14.42	6.79	21.21	14.29	6.73	21.02	0.19
Ward 9 Frailty	20.16	16.49	36.65	20.16	16.49	36.65	-
Ward 10SS	21.69	14.46	46.52	21.44	14.3	35.75	0.41
Ward 11 Med	25.58	20.93	46.52	24.93	20.4	45.33	1.19
Ward 14 Gynae	8.61	4.24	12.85	8.54	4.21	12.75	0.1
Ward 15 Stroke/Rehab	24.23	19.82	44.05	24.23	19.82	44.05	-
Ward 16 Acute Stroke	19.42	8.32	27.74	19.42	8.32	27.74	-
Ward 17 R	29.58	15.93	45.51	29.58	15.93	45.51	-
Ward 22SS	18.59	14.03	32.62	18.47	13.93	32.40	0.22
Ward 23OH	25.87	14.55	40.43	25.67	14.44	40.11	0.31
Ward 24 R	32.12	18.07	50.19	32.12	18.07	50.19	-
Ward 25 CR/G	28.27	23.13	51.39	27.92	22.84	50.76	0.63
Ward 26 Med	34.58	26.08	60.66	32.37	24.42	56.79	3.87
Ward 27 Med	25.07	26.45	61.52	33.65	25.38	59.03	2.49
Ward 28 Frailty	28.26	18.84	47.11	27.56	18.73	45.93	1.98
SAU	40.62	24.9	65.52	40.62	24.9	65.52	-
Ward 35 Renal	15.37	8.27	23.64	15.37	8.27	23.64	-
Ward 37 Surgery	30.8	20.54	51.34	30.8	20.54	51.34	-
Med Esc	15.51	10.34	25.86	15.51	10.34	25.86	-
Ward 19 Paeds	n/a	n/a	n/a	37.3	19	56.3	n/a
Ward 20 Paeds Onc.	n/a	n/a	n/a	3.1	1.6	4.6	n/a

SNCT guidance requires a review of data from a minimum of two census periods before making changes to establishments/budgets. Where data is significantly different, further census may be required. With multiple changes in ward function, and a number of ward moves the SNCT has limitations if subsequent census periods do not analyse the same ward functions/locations. When applying methodology for safer staffing reviews, the SNCT evidence-based tools should always be considered alongside outcomes and professional judgement.

For the purpose of the bi-annual staffing reviews, a benchmark of RN: HCA ratio of 65:35 was utilised within the SNCT for adult inpatient wards (it should be noted that the gold standard would be a mix of RN: HCA ratio of 70:30). Evidence suggests that increasing RNs within a ward skill mix reduces mortality and increases patient safety and quality of care. 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 June/Jul 2025 in line with censuses completed in 2024, and as such templates currently reflect a ratio with higher levels of HCA. Any recommended changes in establishments which results in a ratio of less than 65:35 ratio of RN:HCA require a Quality Impact Assessment (QIA), these are in place for wards with ratios below this level. QIA are also required with any proposed establishment change.

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 46.18% and 42.37% respectively in June/July 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
Jun/Jul 2025	3.44	46.18	5.34	42.37	0.76	0	1.91	0
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

2.3.3 Surgery, Anaesthetics and Cancer Wards SNCT Establishment Review Jun/Jul 2025

Recent data collected for surgical areas (see Chart 2) indicates that the highest proportion of patients were recorded in the '0' category, representing normal ward care and level '1b' (stable dependent patients). There have been notable divisional changes since the last census This suggests a predominance of lower-acuity patients during the census period. However:

- **Ward 5 (Elective Orthopaedics)** had reopened, contributing to a shift in patient mix.
- **Ward 23 (Oncology Haematology)** has transitioned to the Clinical Support Services division.

These changes have likely influenced the overall average acuity, potentially lowering it due to the nature of elective surgery that was being undertaken and the divisional change for Ward 23OH. Additionally, the number of patients requiring 1:1 care (Category 1c) has shown a slight increase since January/February 2025**,** although it remains lower than the same period in the previous year**,** which was identified as an outlier month due to elevated Enhanced Care Support (ECS) requirements.

Chart 2 -SAC Average acuity by census period.

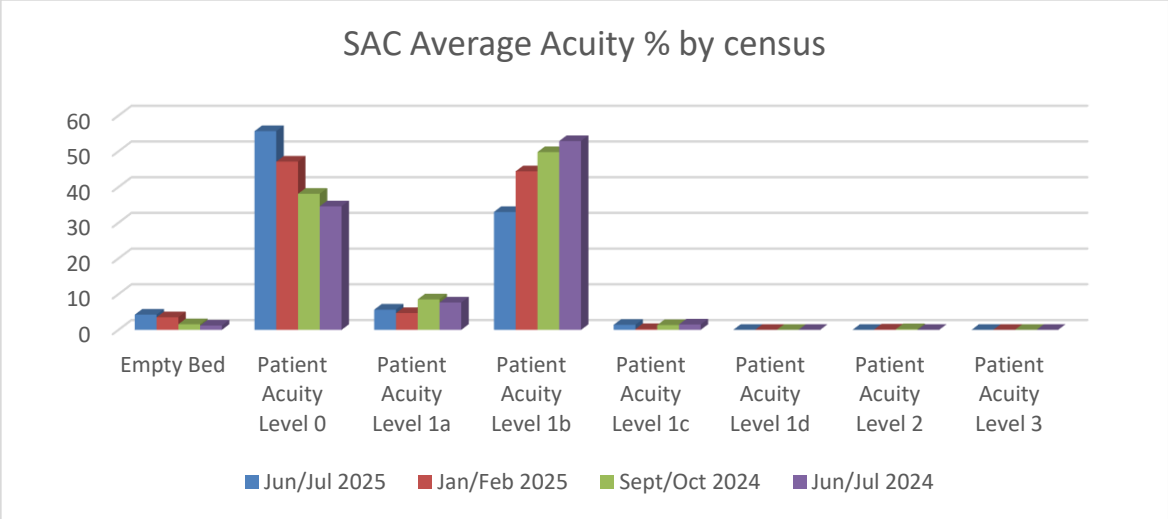


Table 5 - SAC Average acuity by census period.

SAC	Empty Bed	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
Jun/Jul 2025	4.25	55.66	5.66	33.02	1.42	0	0	0
Jan/Feb 2025	3.53	47.12	4.69	44.41	0.22	0	0.1	0
Sept/Oct 2024	1.56	38.1	8.55	49.78	1.33	0	0.19	0
Jun/Jul 2024	1.2	34.6	7.66	52.87	1.51	0.01	0.01	0

During the June/July 2025 SNCT census period, **Ward 5** recorded below-expected activity and reduced patient numbers, resulting in lower recommended staffing levels**.** This was due to temporary under-occupation while essential estates work for IPC compliance was undertaken. The SNCT outputs reflect current activity and not future operational requirements therefore workforce planning for ward 5 was based on anticipated reopening and normal activity, not temporary reduced occupancy applying professional judgement. No immediate changes to the template should be made on the census alone and planned closure an estate works were noted during the establishment review meetings.

The Acute Orthopaedic Trauma Unit (AOTU) includes both inpatient ward beds and an assessment area that was funded through the SDEC business case. The assessment area is planned to open on Ward 31 but is currently operating on Ward 32. This has resulted in:

- Reduced assessment capacity: Instead of the planned 8 trolley spaces, the current area accommodates 2 to 3 patients.
- Variance in funded vs. actual staffing deployment, as not all funded establishment is being utilised.

SNCT recommendations are based on inpatient beds only, so assessment area activity is excluded. The last two census periods showed a higher dependency of patients cared for on the ward when comparing to the previous year. It was noted it was usual for lower acuity patients to be outlied to other surgical wards. SNCT outputs therefore reflect the higher dependency and is reported slightly above budgeted staff. No changes to the establishment template are

recommended currently. The ward can flexibly use its assessment space and associated staffing during periods of higher demand. Professional judgement and operational context should guide workforce planning until the unit moves to its intended location.

Ward 4 regularly flexes the use of its assessment area to support inpatient care and planned admissions. Staffing for this area is supported by:

- Trauma Nurse during the day
- Additional senior nurse on nights, agreed during November 2024 establishment review.

This senior nurse often provides care across both the ward and assessment area, due to fluctuating activity. For workforce reporting purposes, this staff member is included in ward staff numbers, while acknowledging their dual function. Noted outputs of the establishment review show the recommended WTE for Ward 4 is slightly above the budgeted template, even when accounting for the additional senior nurse. Census data indicates a higher patient dependency from previous census periods with lower acuity speciality patients being outliers in other surgical areas. The situation will continue to be monitored**,** but no changes to the staffing template are recommended based on this census, whilst professional judgement and operational flexibility remain key to maintaining safe staffing.

Ward 8 has experienced a shift in patient acuity over the past year due to the following:

- Increase in outliers (orthopaedic and medical patients) placed on the ward.
- Reduction in complex head and neck cases, including fewer patients with tracheostomies.
- Ongoing discussions regarding future plans for head and neck surgery, with no final decisions yet made.

Current budgeted staffing remains above SNCT recommendations but does not capture additional workload from head and neck ward attenders that are redirected from the emergency department and seen and treated in the wards treatment room and waiting area. Activity within this area has not been robustly collated. Plans are now in place to capture activity data and patient follow-up requirements. This information will be systematically recorded and made available for review during future establishment review meetings as ward staff are flexibly deployed to support these additional patient flows, and activity would not be included in SNCT audits. Professional judgement is essential to ensure staffing decisions account for these unmeasured demands. No changes to the establishment template are recommended at this time and the situation will be monitored, particularly if any service changes for head and neck surgery are confirmed.

No recommendations for change were made on **Ward 25** this time. It is noted that the ward will be moving into a new modular build this year which will see an overall increase in beds for gastro and colorectal specialities. The new modular ward is split over two levels each with 28 beds which is an increase of 18 beds and increase in staffing requirements for the team. Templates for these areas have been reviewed and agreed outside the establishment review process.

Staffing template adjustments agreed for **Ward 37** during the November 2024 establishment review were enacted in March 2025. The template was reduced by 1 register nurse day and night and was in line with SNCT recommendations and the application of professional judgement. Over the winter period, escalation beds were opened on Ward 37, with the ward regularly caring for up to 4 additional patients above planned capacity**.** A temporary increase in the staffing template was implemented outside the formal establishment review process to reflect the additional staff required to support care and maintain safety. A decision has now been made to increase the number of beds from 32 to 38 from mid-September 2025. This

requires a permanent adjustment to the staffing template. SNCT outputs saw budget above SNCT recommended staffing but as 6 additional beds are opening and considering ward size, modular design and patient visibility challenges, an additional RN and HCA is recommended across days and nights. Funding will be realigned from escalation capacity in the Emergency department which is closing areas of escalation in line with need to reduce corridor care and improve flow from the department.

The current budget for the **Surgical Assessment Unit (SAU)** covers both the clinic/assessment area and the ward area. While SNCT outputs indicate that recommended WTE for inpatient beds exceeds the budget, there is concern from ward and divisional senior nurses that the greater risk lies in the assessment area, due to significant activity directed from both emergency departments, direct ambulance admissions and direct referrals from GPs via the care co-ordination centre.

The current day-time staffing model in the assessment area is as follows:

- Band 6 Assessment Nurse: Bleep holder for all surgical admissions; workload includes CCC, A&E, outpatient clinics; primarily focused on flow and capacity, with limited time for direct care.
- Two Band 5 RNs: Responsible for 12 assessment trolleys, caring for patients pre/post-theatre and those most unwell during initial admission.
- Waiting Area: Staffed by 1 RN and 1 HCA (07:10–19:40), managing triage and initial assessment for patients arriving from multiple sources (A&E, paramedics, CCC, clinics, radiology)

The department reported concerns at the establishment review meeting regarding out of hours cover due to the number of patients in the assessment area in the evening. At peak times it has been reported there are up to 20 patients waiting in the waiting room and as staffing levels reduce from day to night from 4 registrants in total to 2 of which one is a Band 5 RN and one a Band 6 RN. The Band 6 in addition to providing direct patient care also remains the bleep holder for surgery overnight and will field calls from A&E and the care co-ordination centre.

In view of concerns regards patient number and visibility across the assessment area out of hours, a recommendation is made for consideration of an additional RN in the assessment area on a twilight shift to support oversight of patients in the waiting room, facilitate late transfers and flow and support patient transfers to radiology, whilst also ensuring patients care and safety needs are met.

Further concerns were raised by the SAU team in relation to ward beds and the oversight of patients at night as there is no visibility into patient bays from the corridor. Window heights do not allow viewing and there are no options for estates work to rectify this. The outputs of the SNCT tool for the inpatient bedded area, sees the recommended WTE 11.58WTE above the ward budget. Planned staff on a night shift are split between ward 33 and ward 34 but it was felt more difficult to maintain visual observation of patients on nights as the bays are doubled up. Patient falls are reported to be more of an issue on night shifts therefore in view of overall variance in SNCT outputs and visibility concerns raised, consideration should be given to the allocation of an additional HCA on nights, this will be reviewed as part of the next establishment review prior to making a final recommendation.

Establishment reviews were completed in a number of departments where the SNCT doesn't apply in the surgical division and are listed as follows:

- PRH and RSH Endoscopy
- PRH and RSH Theatres

- Pre-op
- PRH and RSH ITU/HDU
- Telford Elective Surgical Hub (TESH)
- Shrewsbury Elective Surgical Hub
- ENT OPD
- General OPD PRH and RSH

Meetings followed the same principals where data is triangulated with outcomes and professional judgement, and methodology used would consider activity capacity/demand in line with department specific guidance or standards where they apply.

Specific consideration or actions required from establishment review meetings are as follows:

- **ENT OPD:** to review templates as specialist nurses need to be split out from department rosters.
- **OPD PRH:** no current changes required but operational changes will see areas of specialism relocated in the department. A review of staffing plans will be required as the department.
- **PRH Theatres:** with plans for robots in the elective surgical hub, templates will need to be reviewed to reflect the experience and skills required.
- **Theatres both sites:** an operational request to review templates in view of Theatre sustainability and capacity for a business case. This will include considering training requirements, sickness and maternity leave cover to ensure all Theatres are running to maximise activity. Recruitment to the department is usually staff without training and experience. It is important to note the significant supernumerary time for new starters is require as they need to gain skills and experience across multiple specialities. The Lead Nurse for Theatre advised that theatre work is more complex than it used to be, with increase in equipment that staff need to be familiar with and experienced in using, especially with an increase in laparoscopic procedures and robotics. There is also a need to have double scrub in place. There are concerns regarding the age profile of staff, especially at RSH. Further work is required on workforce planning to ensure there is staff with the right skills and experience is in place for when staff retire.
- **Endoscopy:** templates have been developed in line with planned activity following an extension of rooms and capacity. The department has a number of new staff that will need on the job training and development of competencies to have the appropriate skills and knowledge to work independently in a room.
- With digital changes planned, **Pre-op** template will require review. The department is vacating onsite accommodation and will be moving to an off-site location. There are expected benefits for patients and staffing with this change.
- **TESH:** currently operates Monday to Friday, however as part of Theatre sustainability plans it will be required to open on Saturdays. As plans are finalised the template will be considered to ensure workforce is planned to provide Saturday cover.
- **ITU/HDU:** financial templates require updating as Critical Care Outreach and ward clerk provisions is in a separate budget code, and template not reflecting what is included/excluded.

2.3.4 Medicine and Emergency Care Wards SNCT Establishment Review June/July 2025

Data collected for the medical ward areas show the highest proportion of patients fall into the level '0' (stable - normal ward care) and '1b' categories (stable dependent patients). It is noted the number of patients requiring a level '2' high dependency bed was at its greatest over the last two years.

Chart 3 -MEC Average acuity by census period.

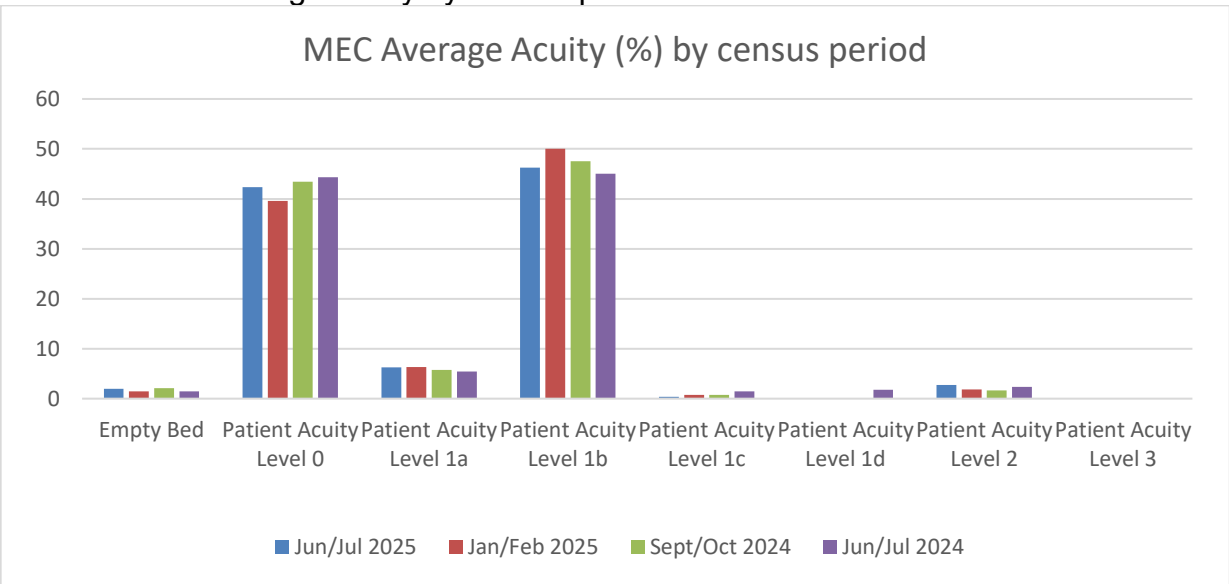


Table 9 – MEC acuity by census period

MEC 2024	Empty Bed	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
Jun/Jul 2025	1.96	42.35	6.27	46.27	0.39	0	2.75	0
Jan/Feb 2025	1.46	39.57	6.31	50.04	0.73	0.02	1.85	0
Sept/Oct 2024	2.13	43.41	5.76	47.56	0.76	0.03	1.64	0.01
Jun/Jul 2024	1.47	44.3	5.44	45.04	1.48	1.76	2.36	0

Recommendations to increase the staffing template on **Ward 7** were enacted in March 2025, following the November 2024 establishment review. The ward continues to have the highest SNCT recommended WTE among similar wards at PRH and the staffing template is now in line with these wards. Despite this, the ward team reports workload is hard and pressured, with morale impacted when staff are asked to move to cover gaps elsewhere. Ward acuity and dependency is lower than the previous census period but still above the budgeted WTE. The ward has seen some reductions in numbers of dependent patients, though the majority are still in this SNCT category. No changes are recommended at this time, but ongoing monitoring of quality and safety indicators is required.

The November 2024 establishment review recommended a decrease of 1 HCA for both day and night shifts for **Ward 17,** which was implemented in March 2025. The latest SNCT census shows recommended staffing levels have increased, reflecting:

- More patients requiring Level 2 care.
- A reduction in patients requiring standard ward care.

- An increase in patients with acute needs.

Previous census periods averaged 1–2 Level 2 patients per day whereas June/July 2025 saw an increase to an average of 4 Level 2 patients daily, which is the maximum capacity planned for the ward.

The ward manager reported morale has improved since the templates changed and nursing teams are more actively engaged in patient care, delegating less to HCAs which has support teamworking. High sickness levels have been reported but are being managed effectively. No staffing changes are recommend following this review however ongoing monitoring of level 2 activity is required to ensure safe care delivery and maintenance of staff to patient ratios for the NIV cohort of patients.

Ward 15 & 16 although operating as a unit are separated across a corridor with ward 16 being the Hyper Acute Stroke Unit whereas Ward 15 focuses on caring for patients with rehabilitation needs. The wards have different staffing requirements with ward 16 admitting level 2 patients with acute illness into the thrombolysis room. This area is in addition to ward beds and is not included in census. The staffing for this area reflects the need to be responsive with treatment and care of a patient with an acute ischemic stroke, admitting patients directly to the ward from the emergency department. The previous census saw ward 16 template reduced by 1 HCA and no change to ward 15 template with roster template changes enacted in March 2025. Current SNCT recommended staffing is in line with budgets apart from a small variance for Ward 16. As this area can take patient in hyper acute state and need to deliver Level 2 care, the current template will allow for some flexibility to support any peaks in acute admissions into the Thrombolysis room. To note, the ward reported lower registrant fill rates over the past 6 months, due to vacancies and sickness. Eight newly qualified nurses are due to start on the ward which will improve current staffing position and fill rates. No recommended changes are required for this area following the review.

Since the previous census, **Ward 10** has reverted back to a short-stay model, with an increase in patients requiring normal ward care. This change in acuity is reflected in the latest SNCT outputs, which recommend a reduced WTE compared to the February census. Staffing reductions agreed in the November 2024 establishment review were enacted in March 2025, reducing HCA by 1 on day shifts. Current budget now aligns more closely with the most recent SNCT recommendation. No immediate changes are recommended.

The recommended SNCT for **AMU** at the **Princess Royal Hospital** is similar to previous census periods and current staffing reflects a higher level of lower acuity patients. The template includes a B6 co-ordinator who is the bleep holder for all medical admissions and who's role is mostly focused on flow and capacity and limited time for direct care. AMU bed based is planned to expand with a new co-located bedded area of beds. While SNCT currently shows staffing below budget, this does not account for the additional patients regularly cared for on the corridor and or AMA space. Professional judgement is required to ensure staffing templates reflect operational realities, not just SNCT outputs. No immediate changes recommended, but in view of additional area and beds opening a new template is being implemented when this additional capacity is opened.

Ward 35 is situated in the Copthorne building at the Royal Shrewsbury Hospital, separate from the main hospital. Staff must travel through an underground tunnel to access the main hospital, which present logistical and safety challenges. Fire regulations necessitate higher staffing levels than SNCT would typically recommend, particularly at night. The current staffing template also considered the patient transport requirement (2 staff per transfer) the distance from the ward to the renal unit and transfer times, renal nurse support for peritoneal dialysis across the site, leading to staffing being off the ward for extended periods. The roster template was updated in March 2025 following establishment review in November 2024. The fire office

at this time agreed with proposals to reduce the planned staffing out of hours. Current SNCT recommendations continue to be below budgeted staffing, but minimum safe staffing levels must be maintained due to location specific risks. It is noted frequent staff deployment to other areas and increased sickness are impacting on staffing in this area and additional operational pressures for ward attenders or outpatient activity can impact staffing for the ward. A long-term plan is recommended with this activity being considered in relation to the medical day case unit, due to the volume of procedures and therapies happening on the ward.

The acuity of patients on **Ward 28** has changed across the last few months which reflects changes put in place with frailty patients, as there has been an increase of patients on the level '0' pathway resulting in a lower overall dependency profile. The frailty ward and unit focus on limiting deconditioning of patients, assessment and ensuring patients discharge and pathway of care minimise discharge delays. The ward operates with 33 beds and a staffed Frailty Unit. The Frailty unit works well on ward 28 as operationally it has been allowed to function as a assessment space and not utilised for in patients. This has seen the length of stay reduce on the ward as the right patients are on the right pathway. Staff skill set and knowledge of frailty patients has been enhanced, and this has been of benefit to patients as there is a focus on deconditioning and enablement of patients and closer working relationships with the frailty MDT. This has improved morale and retention of staff on the ward.

The recommended SNCT WTE for this review is below budget but this is the first data set where a change is noted. If further data sets reflect the same SNCT outputs then changes in the staffing template should be considered, however, no changes are recommended at this time.

Ward 9 has also opened a Frailty Assessment Unit in the summer of 2024 with conversion of a bedded bay into an assessment area with trollies and seats. Staffing for the assessment area was realigned from the ward with the closing of beds to accommodate the new configuration. The patient profile on ward 9 has increased in dependency this census period and SNCT recommended WTE is slightly above budget. The functionality of FAU on ward 9 has been challenged by operational priorities as the assessment area has regularly been closed due to IPC and frailty patients have been allocated across the ward. This has meant the targeted workforce has been unable to focus solely on same day assessment and discharge as they have been absorbed into caring for patients on ward 9. Due to limited successes and inability to protect the space, a rework of plans for PRH Frailty unit has been agreed, with a new location for Frailty SDEC set to open in December 2025. This planned move would see ward 9 return to functioning as a 28 bedded ward rather than 22 beds and FAU. No recommendations regard changes are required following this census.

The staffing template for **Ward 27** was increased following the November 2024 establishment review with changes enacted on the March 2025 roster. In recent months the ward has been impacted by elevated levels of maternity leave which saw a need to continue with agency staffing. Morale on the ward was impacted but is now reported to have improved as the staffing situation is resolving and agency staffing ceased in September 2025. The ward has a high number of patients where a deprivation of liberty safeguards (DOLS) is required which impacts the flexibility of staff and care delivery as cohorting is required for a number of patients. The Enhanced Care Team will respond to requests for additional staffing where 1:1 observation is required. Cohorting of patients is built into ward templates. The most recent census period sees the recommended SNCT WTE for the staffing is slightly above budget and reflects a higher number of dependant patients, and requirements for cohorting and enhanced care support. No recommendations are made at this time.

Ward 6/CCU is staffed for 23 beds which includes Level 2 beds in the coronary care unit. This census period has seen an increase in Level 2 care from the previous periods. The ward is regularly asked to move staff to support other areas. The ward staffing template also provides

cover for the cardiac day unit and staff are flexibly deployed between ward and unit as required. It was noted that planned day case activity is seeing an increased need for a senior nurse due to the type of activity being undertaken. This does impact the skill mix on the ward. The ward reported a positive position with no registrant vacancies. No recommendations have been made for changes in the staffing template at this time.

Ward 11 SNCT audit recommendation remains above the budget for this area, requiring ongoing monitoring in relation to the staffing requirements for this ward. The ward continues to care for a high number of dependent patients requiring cohorting to maintain safety. It was noted the ward annex is consistently in operation as well as an additional patients placed in two of the bays, meaning the ward is routinely caring for an additional 3 patients. The additional patients have been included in the census as they have consistently been on the ward and staffing should reflect the ward requirements. No recommendations were made for ward 11 but the impact of the additional patients on staffing will continue to be monitored.

The staffing template for **Ward 24** was reduced by one Healthcare Assistant on both days and nights after the November 2024 establishment review. These changes were implemented from March 2025. The ward is budgeted for six level 2 beds supporting patients with enhanced respiratory support. Four of these beds are in PODS that can be used for isolation. The requirement for donning and doffing of PPE alongside the need for isolation should be considered in the staffing model as the as the visibility of patients and responsiveness of staff to patient deterioration and equipment disconnection creates risk. It is expected that some seasonal variation will impact patient case mix and periods where flu or covid is prevalent will increase the likelihood isolation facilities are required. The current SNCT is below the budget, but the recommended WTE has increased from previous census. No recommended changes to the template have been made, due to fluctuation in level 2 care and isolation complexities in the RIU.

No changes were recommended for **Ward 26** at this establishment review. The current SNCT recommended WTE is above the planned budget. When reviewing patient dependency and acuity, it was noted in the previous census that the number of patients who were dependent on care has increased on this ward, and this has continued with this census. The ward team report that it is challenging at times, especially with the number of patients with a DOLS in place and cohorting needs. The staffing for cohorting is included in the template but with high numbers of patients requiring observation the ward strains resources, especially as the day-time template drops by 1 staff member on the late shift. This situation can be compounded when short term sickness occurs as the late part of the shift will be reduced by 2 staff. The ward manager has covered a higher percentage of clinical duties compared to peers. The ward team has also reported challenges with temporary vacancies created by high levels of maternity leave. Agreement to recruit fixed-term maternity cover has eased pressure and improved workforce planning responsiveness. No recommended changes to the ward template are advised based on the current SNCT census

No changes are planned for the **Medical Escalation Ward** following the June/July census as the department has since moved to a new location on ward 36 with an increase in bed numbers. SNCT data collected would not be applicable to the new ward environment and a template was developed outside the establishment review process with new ward area opening.

The staffing for the Acute Floor at the Royal Shrewsbury Hospital is stratified into **Acute Medical Unit** (AMU), **Acute Medical Assessment** (AMA) and **Medical Same Day Emergency Care** (SDEC). AMU and AMA remain on a combined roster, but are physically separate areas, so census data is collected for each bedded area.

A patient mapping exercise was completed in May 2025, focusing on the non-bedded areas in AMA and SDEC in both hospitals with support from ECIST Head of Improvement. The outputs of this work have provided key data which has been reviewed in relation to demand and flow and has highlighted inefficiencies with SDEC flow, and particularly the number of returners and length of stay. The tool can assist with identify demand and can support with providing information for future staffing reviews. With current assumptions that activity will increase, it is anticipated that current workforce will be able to absorb activity, and assumptions have been made that it is not likely to impact workforce at this time. To note, the vast majority of admissions through SDEC are emergency rather than GP initiated, which creates some risk in relation to acuity of patients being reviewed as they have an increased risk for deterioration. All admissions are managed through a single co-ordinator and streamed to the most appropriate area within the acute floor. The review also permitted a review of the task and skills set framework required for the area.

Recommended changes to staffing templates for AMU and AMA from the establishment review November 2024 were enacted in March 2025. This included a reduction of one HCA on day and night on AMU and a reciprocal increase on AMA. The AMU ward manager reports some challenges since the change, in part due to staffing gaps and vacancies, and patient case mix admitted to the ward. The manager advised it is usual for AMU to take the admissions from the emergency department of patients that required enhanced observation and care. The team were finding it difficult to support patients requiring 1:1 observation and care with the reduction in HCA. The process had been reviewed prior to this establishment review meeting, and the emergency department are now ensuring staffing considerations for patients who need additional support is assessed and requested. The ward manager did report some concerns in relation to falls but the review of falls shows the numbers of falls were similar and it was not clear that the workforce changes were the issue. The situation will be monitored.

AMA is split into inpatient beds and an ambulatory assessment area. The staffing is planned for inpatient beds, assessment trollies and a seated area, triage, telemetry monitoring, and admission/discharge co-ordination. The manager for this area reported the biggest concern was the seating area as patients could be waiting excessive amounts of time for admission and patient numbers would increase to a point where it was difficult to maintain safety. These issues have now been addressed and following the last establishment review it was noted the budget for the area wasn't aligned to the roster template and budget was in place to increase the number of nurses caring for patients in this area. Also, the department will be undergoing a reconfiguration shortly as the ambulatory area will move to ward 21, creating an increase in assessment space. SDEC will then relocate into the vacated space on AMA. The inpatient beds that are currently on AMA won't change. Staffing has been reviewed based on the change and it is advised that current planned staffing will move with the patient cohort without any adjustments required. Staffing for the bed base on AMA is planned at a higher ratio due to the enhanced care and acute needs of patients; this is in line with national guidance. No further changes have been made at the most recent establishment review meeting and the SNCT staffing recommendations are slightly below budget and is consistent with previous audits. It must be noted that the additional staff member for telemetry monitoring is included in staffing although they are limited in their ability to provide direct patient care.

At the establishment review in November 2024 the template for **Ward 22** short stay was reduced by 1 HCA during the day with changes to roster templates enacted in March 2025. The recommended SNCT remains slightly below budget, indicating no immediate concerns from a tool perspective. This area operates a discharge area for the acute floor, which supports flow in daytime hours. It is not included in the SNCT, as does not involve inpatient beds so any recommendations would need to consider staffing in addition for this area. Since the staffing changes enacted in March 2025, the ward has reported an increase in patient falls. The ward has 6 bays with limited visibility. Staffing levels have been impacted by lower fill rates due to high sickness, so situation will be monitored particularly in regards of falls and staffing

pressures if high levels of sickness continue. No further recommendation was made for the ward at this time.

Establishment reviews were completed in a number of departments in the medical division where the SNCT doesn't apply and are listed as follows:

- SDEC PRH and RSH
- Renal Unit RSH
- Renal Unit Ludlow
- Renal Unit SP (Hollinswood House)

Meetings followed the same principals where data is triangulated with outcomes and professional judgement, and methodology used would consider activity capacity/demand in line with department specific guidance or standards where they apply.

Specific considerations/actions required from establishment review meetings include:

- RSH SDEC reconfiguration plans at RSH (currently set up as 12 chairs and 8 trolley) as SDEC location will move to AMA. Trolley numbers will reduce to 6 and seated area will increase. The department is seeing 35-40 patients a day and activity is expected to increase by a further 5%. No change in template is required as increase in patient numbers will be managed in current template.
- PRH SDEC reconfiguration plans will see SDEC expand into the area that was previously AMA, as AMA will move to a new area and significantly increase trolley numbers. Activity at PRH is less than RSH with 20 patients per day seen. It is expected this activity will grow similar to that expected at RSH. There is no anticipated head count change for SDEC staffing template.
- Ludlow renal unit is an isolated unit, in Ludlow hospital. The number of patients seen are small, but a minimum staffing level is required of 2 nurses. There is a further requirement to review the activity and staffing at Ludlow renal unit alongside consideration of the renal staffing requirements as a whole.
- The acuity of patients has seen an increase in numbers needing to be treated at RSH renal unit rather than at the Telford off site unit. This has created challenges as there is limited capacity in the unit at RSH to accommodate the acute patients, and as such an expansion of capacity for additional dialysis spaces is now in operation in a bay located on ward 35. Monthly reviews of acuity are undertaken by the department using guidance from the British Renal Society.

2.3.5 Clinical Support Services (ward 23 Oncology/Haematology)

Chart 4 – Ward 23OH Establishment review June/July 2025

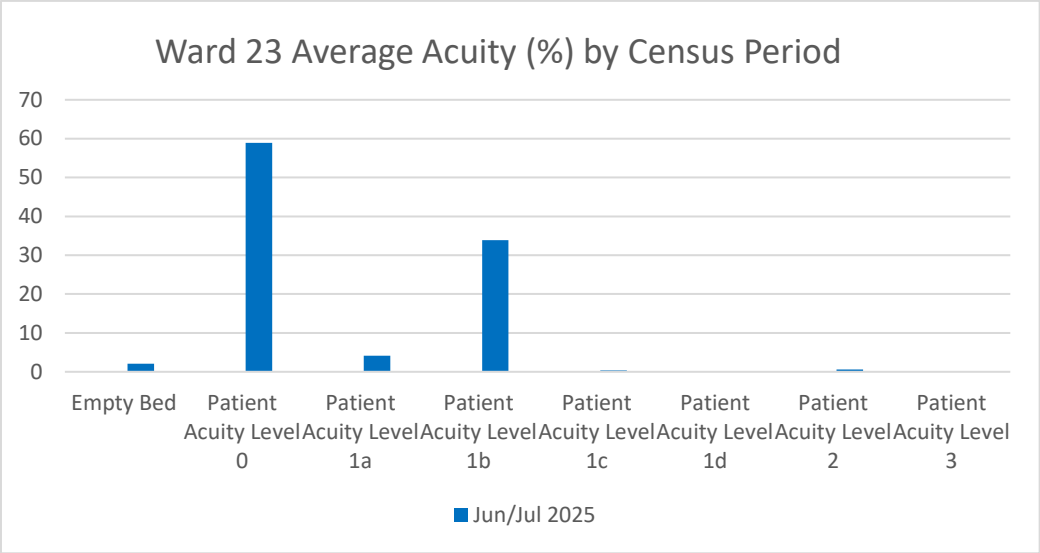


Table 10 – Ward 23OH Average acuity by census period

CSS 2025	Empty Bed	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
Jun/Jul 2025	2.1	58.9	4.1	33.9	0.33	0	0.57	0

Ward 23 Oncology/Haematology acuity is similar to the previous census. The ward cares for neutropenic patients due to high intensity chemotherapy where minimum ratio of one Registered Nurse (RN) to two patients. The wards ratio of RN to HCA is 65% registered: non-registered. It is also planned for 24-hour Band 6 RN cover and a further Band 6 RN in the day due to the complex needs of patients. An assessment area was opened in 2023 to take direct admissions from Emergency Department however the area is now used for additional capacity for Chemotherapy and Haematology Day Units. This area is in operation 5 days per week and staff that were originally planned for the assessment area now deliver treatment regimens.

Both the Chemotherapy Day Unit and Haematology Day Unit are experiencing evolving activity patterns due to changes in the types of treatments being delivered. The teams have remained responsive to planned activity changes, ensuring safe and effective care delivery. No changes are required at this time, as current staffing levels are meeting service need.

2.3.6 Women and Children (Ward 14 Gynae and Ward 19 Paediatrics Establishment Review)

Ward 14

Chart 5 – Ward 14 Average acuity by census period.

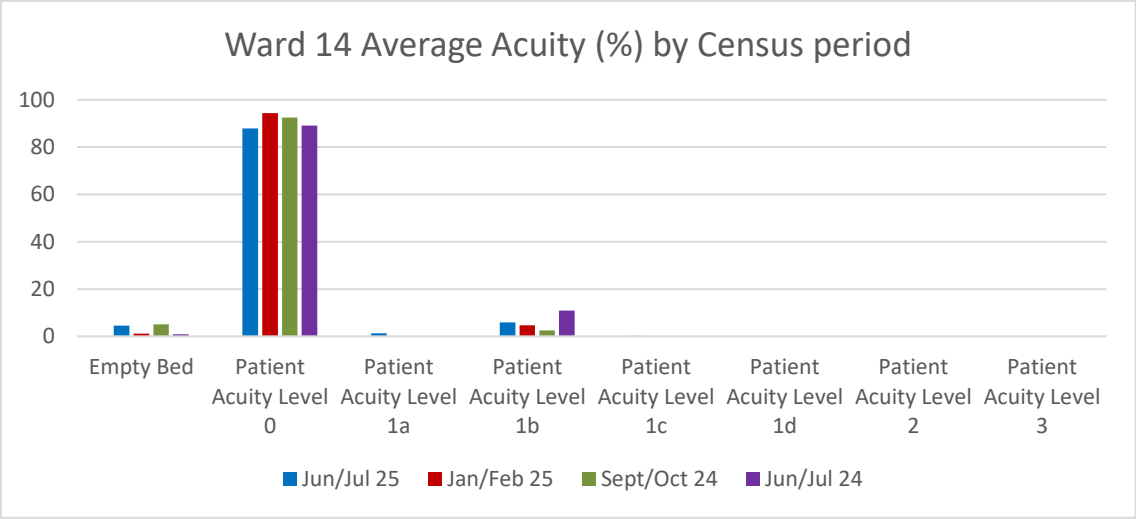


Table 11 – ward 14 acuity by census period

Ward 14	Empty Bed	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
Jun/Jul 2025	4.6	87.9	1.3	5.9	0.25	0	0	0
Jan/Feb 2025	1.1	94.4	0	4.6	0	0	0	0
Sept/Oct 2024	5	92.5	0	2.5	0	0	0	0
Jun/Jul 2024	0.83	89.17	0	10.83	0	0	0	0

Limitations for smaller wards is a known issue for SNCT with reduced reliability of the tool due to fewer data points during acuity assessment and less flexibility to adjust staffing in response to acuity changes. Minimum staffing requirements of two registered nurses on any shift can result in the budgeted WTE exceeding SNCT recommended budget, which is the case on ward 14. However, the current staffing template for ward 14 is justified and ensures patient safety and care standards are met.

Currently the weekend staffing plan for ward 14 requires 1 Band 6 RN and 1 Band 5 RN on nights. A proposal was made to replace the Band 6 with a Band 5 on weekend nights as skill mix needs could be met without the Band 6 on duty. As Band 6 cover is consistently availability across day shifts 7 days a week, senior support is available to support staffing decisions, and the oversight of patient care. Weekend skill mix is currently misaligned with weekday patterns, and the context for the Band 6 nighttime cover has now changed as there is less reliance on temporary staffing and agency, and minimal substantive vacancies.

Template considerations which are not reflected in the budget see the co-ordinator role on ward 14 functionally supporting both Ward 14 and the Acute Gynaecology Treatment Unit (GATU). No recommendations were made for GATU, however opening of GATU on Sundays is still under review, which may require adjustments to the template.

Paediatrics and Neonates

Chart 6 – Ward 19/20 - Average acuity by census period.

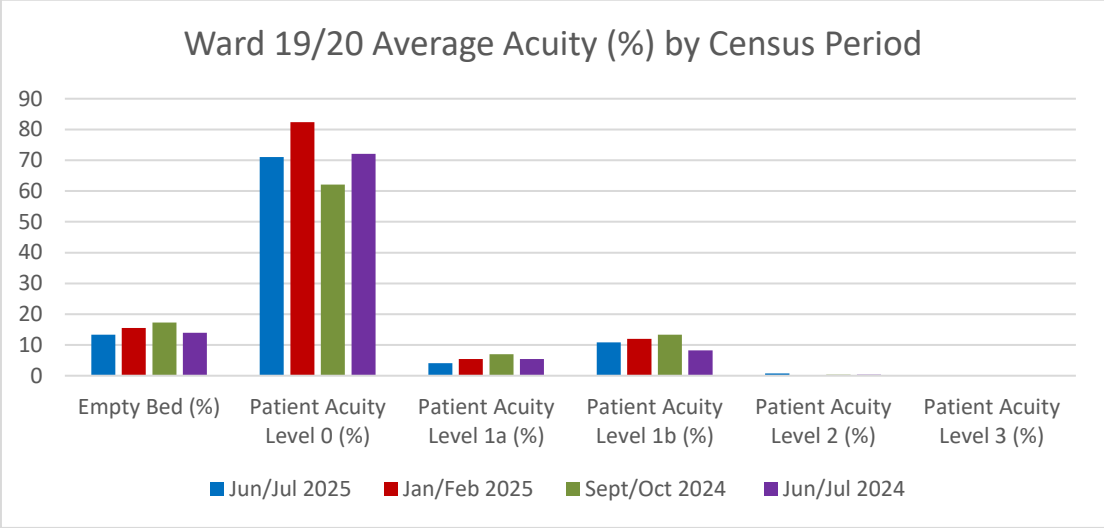


Table 12 – Ward 19 acuity by census period

Ward 19	Empty Bed (%)	Patient Acuity Level 0 (%)	Patient Acuity Level 1a (%)	Patient Acuity Level 1b (%)	Patient Acuity Level 2 (%)	Patient Acuity Level 3 (%)
Jun/Jul 2025	13.29	71	4.08	10.88	0.76	0
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

Recommendations made in 2024 saw the development of a Paediatric summer and winter template due to noted seasonal variation and roster stratification to clarify planned staffing needs across:

- Ward 19 Paediatrics
- Ward 20 Paediatric Oncology and Haematology Unit
- Children's Assessment Unit
- Paediatric day case
- Paediatric Day Surgery (which is undertaken in the Elective Hub)

The SNCT calculated from the census in June/July 2025 saw ward 19 open with 28 beds operational. Staffing for the winter template is based on 33 beds open.

During June and July 2025, Ward 19's Safe Nursing Care Tool (SNCT) recommended staffing levels exceeded the budgeted establishment, with 56.3 WTE recommended versus 50.4 WTE budgeted. The ward team reported that during peak periods, staff were flexibly deployed to support activity in other areas. However, this cross-deployment was not consistently reflected in the electronic rosters. Ward managers acknowledge the importance of accurately recording staff movement, particularly for safe staffing reporting and assurance.

The ward experienced higher-than-expected activity during the summer months, with no significant reduction until August 2025. In August, patient numbers averaged 12 per day, compared to 24 per day during the census period, with 3–4 beds typically unoccupied. This

deviation from previous seasonal trends suggests a need to ensure roster accuracy to reflect actual deployment. No changes to templates are required at this time as the variation is not consistent and the new summer template was not introduced until April 2025.

Ward 20 comprises 3 inpatient beds and 2 day-case beds, with activity levels varying significantly week to week. Some weeks see full bed occupancy with acutely unwell patients, while other weeks have no inpatients. This variability presents challenges for staffing models, particularly as the SNCT tool is less reliable for areas with a small bed base and fluctuating activity. Additionally, day-case activity is not captured in SNCT outputs, yet it requires staffing consideration alongside inpatient care.

Ward 20 is co-located with Ward 19 and operates with a planned staffing model of 2 Registered Nurses (RN) during both day and night shifts. When activity is low, staff are flexibly redeployed across the paediatric service. Despite this flexibility, the SNCT recommended staffing level is currently below the budgeted requirement, as 2 RNs are essential to safely support both inpatient and day-case activity.

The paediatric team has highlighted several off-ward responsibilities that significantly impact real-time staffing availability but are not captured within SNCT data. These include:

- Emergency Department Resuscitation Support: A ward-based paediatric nurse attends all paediatric resus calls at the Princess Royal Hospital, often resulting in extended periods away from the ward.
- Specialist Transfers: Nurses escort paediatric patients to tertiary children's hospitals when specialist care is required.
- MRI Sedation Support: Nurses accompany paediatric patients to MRI when sedation is needed, again requiring time away from the ward.

These duties, while essential to patient safety and care continuity, are not reflected in SNCT outputs. However, when reviewing SNCT recommendations against the combined budgets for Ward 19 and Ward 20, there is some buffer capacity that could support these operational demands. Accurate reflection of these responsibilities in staffing models and reporting will be important for future workforce planning.

Following the establishment review in November 2024, the Children's Assessment Unit (CAU) staffing template was updated to reflect anticipated seasonal variation between summer and winter. However, activity levels over the summer of 2025 did not decrease as expected. This sustained demand has raised concerns among the team that the current staffing model may not be sufficient if this trend continues.

Unlike adult assessment areas, activity data for the Paediatric Assessment Unit is not routinely reported. As a result, staffing decisions have relied heavily on professional judgement and clinical experience. The team has recognised the need to implement formal data collection and reporting processes. This will be essential to inform future staffing models, support safe and effective service delivery, and provide a more robust evidence base for workforce planning.

Staffing for paediatric wards must align with the defined standards for children and young people's services, as outlined in the **Royal College of Nursing (RCN) guidance (2013)**. This guidance provides indicative nurse-to-patient ratios based on acuity levels:

- Level 3 Critical Care: 1:1
- Level 2 Critical Care: 1:2
- Level 1 Critical Care: 1:3
- Ward Care (Children over 2 years): 1:4
- Ward Care (Children under 2 years): 1:3

In addition, RCN recommends a 25% uplift to account for non-patient-facing time, leave, and training. The National Quality Board (NQB) guidance (2018) further advises that uplift may need adjustment in paediatric settings due to:

- A younger workforce demographic
- Higher levels of parenting leave
- The need to support interhospital transfers.
- Outreach of registered children's nurses into areas such as Emergency Departments
- The impact of caring for children and adolescents with mental health needs in general paediatric wards

Currently, the uplift applied remains at 24%, consistent with other clinical ward areas. However, it has been agreed that fixed-term posts may be offered to cover maternity leave, helping to maintain safe staffing.

The recruitment position for the paediatric wards has significantly improved compared to the previous year. This progress is attributed to the development of staffing templates and the implementation of a robust workforce plan. As a result, there has been a notable increase in the substantive employment of Registered Children's Nurses.

Vacancy levels are now minimal, with very few expected by Autumn 2025. Furthermore, the reliance on agency staffing ended in March 2025, marking a key milestone in achieving a stable and sustainable workforce. This improvement supports safer staffing, continuity of care, and better alignment with professional standards and guidance.

Ward 23 Neonatal Unit staffing requirements are guided by the Neonatal Network planning for acuity and cot numbers. With a mix of ITU, HDU and special bay care provision planned across the region depending on anticipated demand. The BAPM (British Association of Perinatal Medicine) Service and Quality Standards set out clear expectations for neonatal staffing across different unit types and the unit is in line with these standards. All units should aim for 70% qualified in speciality staff. Currently Ward 23NNU has plans in place to improve compliance which is reported at 55%. More staff have started this training course in September 2025. The department also has a number of quality posts that are being recruited to in staggered approach to reduce the risk of losing experienced staff from the neonatal unit without ability to replace. No recommendations were made in relation to establishment changes following this review.

2.3.7 Emergency Department Establishment Review February 2025

Chart 7 - ED Average acuity by census period.

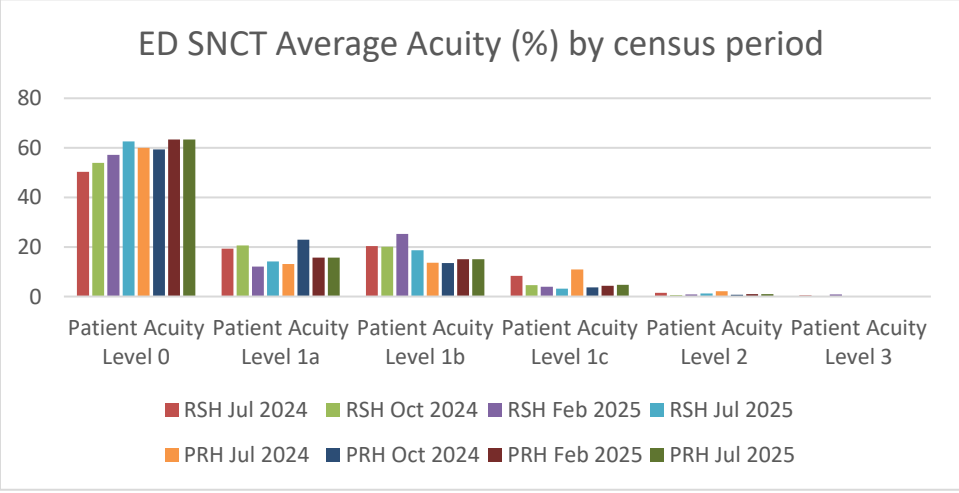


Table 13 – ED acuity by census period

	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 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
RSH Jul 2025	62.6	14.1	18.7	3.2	1.3	0.1
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
PRH Jul 2025	63.4	15.7	15.1	4.7	1.0	0.2

The current ED Safe Nursing Care Tool (SNCT) was developed under assumptions that no longer reflect the operational realities of modern emergency care. Notably, it presumes patients will be transferred out of EDs within 12 hours. This does not account for the increasing number of patients remaining in EDs beyond this timeframe due to high demand and limited capacity across hospital and social care systems.

As a result, the tool fails to capture the complexity and intensity of care required for patients who remain in the department for extended periods. EDs are increasingly functioning as holding areas for admitted patients, placing additional strain on nursing staff that is not reflected in current SNCT outputs.

The department has seen notable improvements in key performance metrics over the past 12 months, particularly in the percentage of assessments completed within 15 minutes. Ambulance handover delays were significantly reduced during the summer months.

Patient flow delays from the department remain a challenge, though some progress has been made. Both hospitals are impacted but the Royal Shrewsbury Hospital (RSH) faces particular pressure, with a number of patients waiting over 24 hours for admission to inpatient beds. This results in patients receiving inpatient-level care within the ED, placing additional demands on nursing staff.

The current ED SNCT tool does not adequately reflect this reality. The tool was originally designed under assumptions that patients would be transferred out within 12 hours and does not account for the complexity or intensity of care required for patients remaining beyond that timeframe. As a result, the care hours required for dependent patients exceed SNCT recommendations.

A new version of the ED SNCT tool is expected to be released in Q3 of 2025/26, which should better reflect the operational demands of modern emergency departments. Conversations with regional Safer Staffing Fellows confirm that this is a widespread issue, and there is currently no national guidance on how to quantify or capture the workload associated with patients staying longer than 12 hours.

At present, no changes to the staffing templates are recommended, but it is recognised that the department will need to continue adapting its working practices to meet demand safely and effectively.

2.3.8 Nurse Sensitive Indicators

Quality data and nurse-sensitive indicators are routinely reviewed and triangulated during establishment review meetings. For the latest review, six months of data were analysed to identify trends and assess any correlation between staffing levels and patient harm, particularly during SNCT census periods.

All patient safety incident investigations included a review of staffing levels to determine whether staffing may have been a contributing factor. No incidents reported during this period identified staffing concerns as a root cause, providing assurance around current staffing models.

However, from February 2025**,** a significant increase in delays in patient observations was noted across wards. This coincided with a system update that reduced the allowable time for recording late observations. Ward managers have acknowledged the need for improvement, but the reduction in compliance appears to be linked to process changes rather than lower staffing fill rates, as the trend was consistent across all areas. Managers are working on improving compliance, however data from July 2025 was still below target but work is still ongoing on improvements.

Table 14 - Quality Metrics dashboard July 2025

Location	Quality Indicators Complaints	Medication Errors	Nursing medication - administration errors	MRSA	MSSA	cDiff	Falls - Total (exc severe)	Falls with Harm	Pressure Ulcer Category 1 - Hospital Acquired	Pressure Ulcer Category 2 - Hospital Acquired and TVN validated	Pressure Ulcer Category 3U (unstageable) - Hospital acquired	Pressure Ulcer Category 4 - Hospital Acquired and TVN validated	Serious Incidents (SIs) - reported to STEIS	Patient Safety Incident Investigations (PSIIs)	Staffing issues - Datix raised	Missed Dose Audit
Accident & Emergency Department (PRH)	20	9	7	0	0	1	3	0	0	1	0	0	0	0	1	No data
Accident & Emergency Department (RSH)	18	9	6	0	2	0	4	0	0	1	0	0	0	0	1	No data
Acute Medical Unit (AMU) (PRH)	0	7	0	0	0	0	2	0	0	0	1	0	0	0	0	100
Acute Medical Unit (AMU) (RSH)	0	6	0	0	0	0	6	0	0	2	0	0	0	0	0	96.6
Acute Orthopaedic Trauma Unit (AOTU) (RSH)	0	2	2	0	0	0	0	0	0	0	0	0	0	0	0	93.3
Day Surgery - Short Stay (RSH)	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	79.2
General Outpatient Department (PRH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	No data
General Outpatient Department (RSH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	No data
ITU/HDU (PRH)	0	4	1	0	0	0	0	0	0	0	0	0	0	0	0	100
ITU/HDU (RSH)	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	40
Medical Escalation (PRH)	0	1	1	0	0	0	1	0	0	0	0	0	0	0	0	91.7
Same Day Emergency Care (SDEC RSH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	No data
Telford Elective Surgical Hub	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	No data
Ward 10 - Short Stay (PRH)	0	4	3	0	0	0	1	1	0	0	0	0	0	0	0	100
Ward 11 Nephrology (PRH)	0	1	0	0	0	1	4	0	0	1	0	0	0	0	2	81.8
Ward 14 - Gynaecology	0	8	1	0	0	0	0	0	0	0	0	0	0	0	2	100
Ward 15/16 Stroke Unit (PRH) Structure	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	No data
Ward 17 - Respiratory (PRH)	0	2	1	0	0	0	4	0	3	3	0	0	0	0	0	78.6
Ward 19	0	8	3	0	0	0	0	0	0	0	0	0	0	0	0	100
Ward 20 Cataract Suite (RSH)	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	No data
Ward 22 - Short Stay (RSH)	0	0	0	0	0	0	5	0	0	0	0	0	0	0	0	89.5
Ward 23 - Neonatal	0	10	3	0	0	0	0	0	0	0	0	0	0	0	1	No data
Ward 23 - Oncology & Haematology	0	2	0	0	1	0	5	0	0	0	0	0	0	0	1	71.4
Ward 24 - Delivery Suite (PRH)	0	4	1	0	0	0	0	0	0	1	0	0	0	0	0	No data
Ward 24 - Respiratory (RSH)	0	2	1	0	0	0	6	0	0	2	0	0	0	0	2	94.7
Ward 25 - Colorectal and Gastroenterology	0	0	0	0	0	1	12	1	0	0	1	0	0	0	4	100
Ward 26 - Endo/Medicine (RSH)	0	4	3	0	0	0	6	1	0	1	0	0	0	0	2	93.3
Ward 27 (RSH)	0	2	1	0	0	0	9	0	0	0	0	0	0	0	2	100
Ward 28 Medicine & Frailty (RSH)	0	2	0	0	0	1	16	0	0	0	0	0	0	0	2	68.4
Ward 34 Surgical Assessment Unit (SAU) & Short Stay Surgical	0	2	0	0	0	0	1	0	0	0	0	0	0	0	1	73.7
Ward 35 Nephrology (RSH)	0	2	1	0	0	0	6	0	0	0	0	0	0	0	4	73.9
Ward 37 - Surgical (RSH)	0	3	1	0	0	0	7	0	0	1	0	0	0	0	2	83.3
Ward 4 - Trauma & Orthopaedics (PRH)	0	0	0	0	0	0	1	0	0	3	1	0	0	0	2	87.5
Ward 5 - Elective Orthopaedic (PRH)	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	75
Ward 6 - Coronary Care Unit (PRH)	0	3	3	0	0	0	0	0	0	0	0	0	0	0	0	93.8
Ward 7 - Endo/Cardio (PRH)	0	3	1	0	0	2	0	1	0	3	0	0	0	0	4	78.9
Ward 8 - Head & Neck (PRH)	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	100
Ward 9 - Frail and Complex (PRH)	0	0	0	0	0	0	4	2	0	1	0	0	0	0	0	90
Wrekin Midwife Led Unit	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	No data

2.3.9 Datix reported for staffing issues/missed breaks/leaving late.

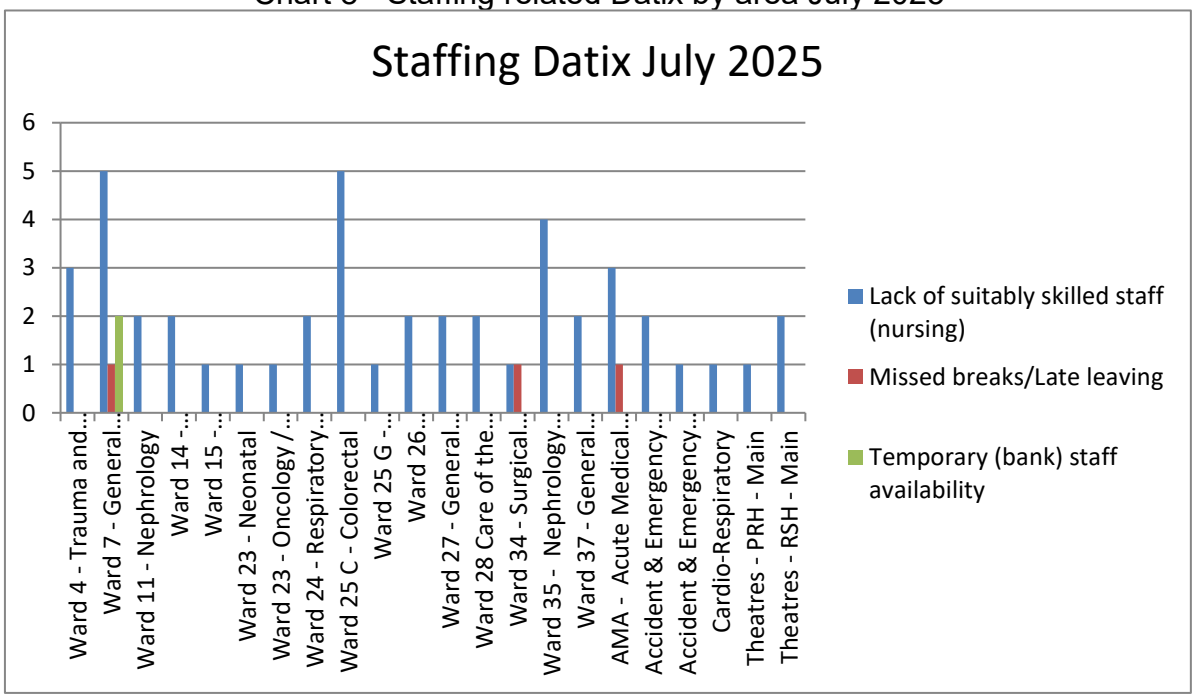
In July 2025, a total of 66 Datix reports were submitted relating to staffing concerns:

- 60 reports cited a lack of suitable staff (nursing & midwifery)
- 3 reports related to missed breaks or staff leaving late.
- 3 reports concerned temporary staffing availability.

All incidents were classified as no or low harm, with recurring themes including:

- Delays in care delivery
- Medication administration delays
- Missed or delayed observations and patient checks
- Disruption to ward routines and cleaning
- Cancellation of training to support departmental cover
- Impact on patient streaming
- One occasion in the Neonatal Unit where BAPM standards were not met, though no harm was recorded.

Chart 8 - Staffing related Datix by area July 2025



Triangulation of staffing and incident data is undertaken by Matrons, with monthly metrics feeding into regular review meetings to identify and address emerging issues.

2.3.10 Red Flag Reporting

The use of Safecare live was relaunched in the organisation in 2024. It is a tool that supports staffing decision making and red flag reporting in real time and contributes to safer more responsive workforce management.

A total of 71 red flags related to workforce issues were reported in July 2025, with the most common being shortfall in registered nurse hours (67 instances in total). Safecare live allows frontline staff to log red flags as indicators that staffing may be insufficient to deliver safe care. These flags are actively monitored, and Matrons are required to follow up all open flags to assess potential risks to quality and safety of care. If actual or potential harm is identified, a Datix incident report must be sumitted. No Datix raised for staffing were recorded as moderate or severe harm. All incidents were recorded as no or low harm events. Mitigation actions were documented including staff being deployed from other clinical areas or ward managers covering clinical cover.

Table 15 – Red Flag reporting

	February	March	April	May	June	July
Open	2	1	1	0	0	3
Reviewed	28	29	32	25	27	33
Resolved	28	34	30	37	26	35
Total	58	64	63	62	53	71

2.3.11 Ward Manager Clinical Cover

Since May 2025, Ward Managers have been asked to record time spent working clinically to fill staffing gaps. While managers are expected to operate in a supervisory capacity, focusing on patient experience, quality, and safety, taking on full clinical shifts can compromise their ability to fulfil non-clinical responsibilities. This includes strategic oversight, staff development, and service improvement work.

The situation is being actively monitored, with consideration being given to the frequency and duration of clinical cover by managers and the impact on their core responsibilities. Further actions may be required to protect management time and ensure sustainable leadership capacity, however July data showed there was an improvement from previous two months with only two managers recording more than 40% of their time spent in clinical duties.

2.4 Comparison with Peers

2.4.1 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).

Over the past 12 months, Registered Nurse (RN) fill rates have consistently remained above the 95% target**.** When combining Registered Nurses (RNs**)** and Nursing Associates (NAs), the overall registrant fill rate has dipped just below the 95% target over the last 6 months but has remained above 90% apart from one occasion in May 2025, where daytime registrant fill rate dropped to 89%. While this remains above the red flag threshold, it represents a notable deviation from usual trend, highlighting need for ongoing monitoring and potential intervention.

Although overall fill rates have been maintained, there have been instances where:

- Individual wards reported on-the-day fill rates below 80%
- Some wards recorded monthly average fill rates below 80%

In these cases, red flags were raised, and/or Datix reports were submitted where there was actual or potential harm. Importantly, all Datix incidents related to staffing over the past six months were classified as no harm or low harm events, providing assurance that mitigation strategies have been effective.

Recent workforce planning decisions have directly influenced fill rate patterns across the organisation. A strategic move to cease agency usage, with the exception of Emergency Departments and Theatres, has contributed to some variation in fill rates. Despite this, the Registered Nurse (RN) vacancy position is positive, supported by an agreed approach to recruit into both substantive and temporary RN vacancies.

However, Band 4 Nurse Associate (NA) vacancies remain high. In response, it has been agreed that Registered Nurses will be recruited to offset NA vacancies where appropriate. This explains the intentional elevation in RN fill rates, while NA fill rates remain lower. This is a planned and managed substitution, recognising that the NA role is still relatively new within the NHS and will take time to embed.

To address the NA shortfall, a pipeline of trainees has been established. Current projections indicate that, based on recruitment to training programmes, NA vacancies could reduce to

approximately 37 WTE by September 2027. A further cohort is anticipated in 2026, ensuring sufficient qualified staff are available to fill all substantive NA roles by 2028.

HCSW fill rates have been consistently maintained above 95%, demonstrating strong staffing resilience in this workforce group. On occasion, fill rates have exceeded 100%, typically in response to:

- Opening of escalation beds
- Temporary changes in ward function
- Deployment of Enhanced Care Support (ECS) staff to provide in-arms reach observation for patients requiring continual supervision.

Since May 2025, ECS hours have been reported separately in the monthly staffing report to ensure that core HCSW staffing levels remain visible and satisfactory. This distinction helps avoid masking potential shortfalls in baseline staffing.

While some individual wards have reported HCSW fill rates below 85% when ECS hours are excluded, no concerns have been raised by Matrons during metric reviews. This suggests that care quality and safety have been maintained.

Table 16 - Trust Safe Staffing fill rate (NStf_Fil)

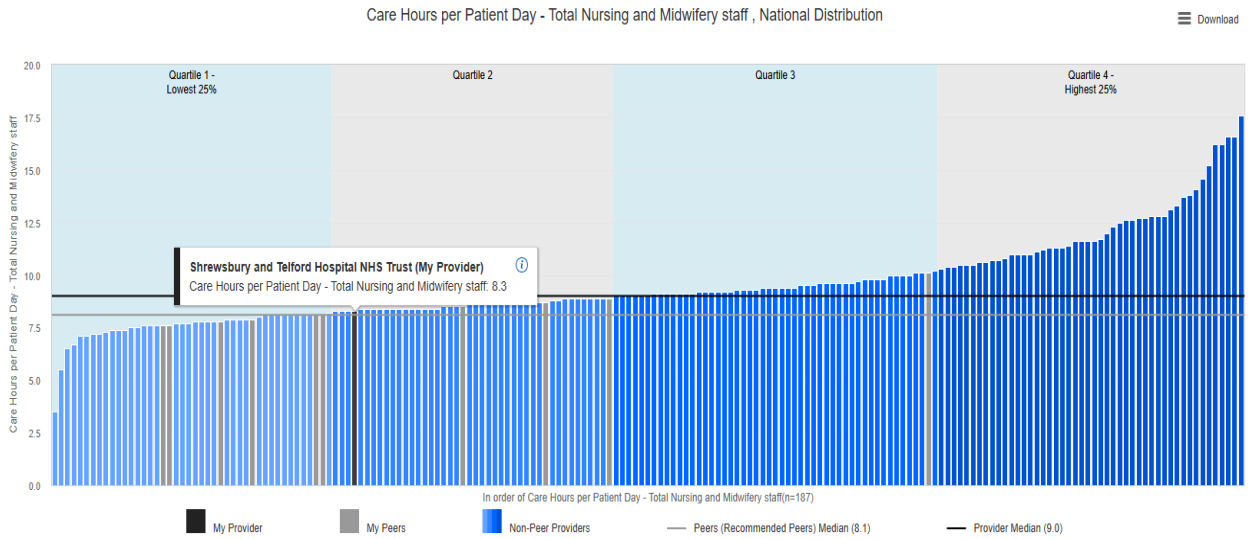
	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
RN Fill Rate Day	105%	104%	103%	104%	105%	104%	101%	101%	101%	98%	100%	101%
Registrant Fill Rate	93%	91%	93%	93%	93%	93%	89%	91%	91%	89%	91%	91%
NA Fill Rate Day	24%	21%	29%	26%	22%	25%	21%	25%	31%	31%	33%	31%
HCA Fill Rate Day	98%	98%	97%	95%	91%	93%	96%	95%	96%	97%	99%	99%
RN Fill Rate Night	104%	104%	106%	105%	105%	104%	102%	101%	102%	101%	103%	104%
Registrant Fill Rate	93%	93%	95%	95%	94%	93%	92%	91%	92%	91%	94%	93%
NA Fill Rate Night	14%	21%	19%	19%	15%	17%	15%	10%	17%	15%	19%	18%
HCA Fill Rate Night	99%	98%	102%	103%	97%	100%	102%	101%	101%	104%	101%	103%

2.4.2 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 July 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 peer median of 8.3 and provider median of 9.0. It has been noted over the last 6 months the CHPPD has reduced slightly which has reflected decisions to cease agency and higher levels of unavailability.

Chart 10 – CHPPD national distribution



[Source Model Hospital CHPPD (July 2025 data, accessed 1st October 2025)]

CHPPD is a key metric that offers ward managers, nurse leaders, and senior hospital leaders a quantitative view of staffing deployment and productivity. It reflects the total care hours provided per patient per day, including:

- Direct patient care
- Indirect care activities, such as:
    - Preparing and administering medications
    - Documenting care
    - Communicating with multidisciplinary teams

CHPPD includes both permanent and temporary care staff, but excludes:

- Student nurses and student midwives
- Staff working across multiple wards
- Non-inpatient areas (e.g., outpatient or day-case units)

5.0 Recommendations and Key Actions 2025/26

- Recommended template changes include:
    - Consideration of additional RN Twilight shift in assessment area on SAU and how this can be provided from existing staffing across surgical Division
    - Ward 14 - Reduction of Band 6 to Band 5 on weekend nights.
- Progress the review of the renal templates and the development of a business case based on the outcome of this review.
- Agree templates and sign off QIA in relation to operational ward and department changes planned, which includes:
    - FAU relocation and ward bed increase on ward 28 and 9.
    - AMA relocation PRH
    - Additional AMU capacity PRH
    - Opening of new ward 25
    - Opening of Ward 38/39
- Continue the recruitment and retention work to sustain reduced vacancies across the Trust.

- Eliminate agency nurse usage across all clinical areas in Trust.
- Deliver an e-roster improvement plan.
- Undertake exercise in CAU to map staffing against daily activity, acuity, and peaks in service demand.
- Implement new versions of SNCT in the Emergency Departments and Paediatrics wards as part of next census if released in time.

The Board is asked to note and endorse the recommendations from the establishment review and the actions taken at individual ward and service level.

6.0 Conclusion

The Chief Nurse continues to work with Medical Director and Divisional Operational Management Teams 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. Key actions have been identified.

Appendix 1 SNCT data collected Jun/Jul 2025

Specialty/ Ward	Beds as per SNCT audit	SitRep occupancy Rate %	Empty Bed %	Dependency Level Summary / SNCT element 0 %	1a %	1b %	1c %	1d %	2 %	3 %	Proposed SNCT FTE (excluding 1c/1d)	Budget (inc Band 7, RN, NA and HCA)	correct or over/under established based on stratified budgets	Ratio (percentage of RN to non RN day and night) - Budget	Recommendations or comments
Emergency Care															
AMU PRH	17	93.00%	0.0%	75.5%	4.5%	20.0%	0.0%	0.0%	0.0%	0.0%	28.12	37.42	8.30	57%	No change recommended
AMU RSH	20	95.80%	2.5%	37.5%	5.5%	54.0%	0.3%	0.0%	0.3%	0.0%	38.49	42.59	3.10	63%	No change recommended
SAU (W33/W34)	38	97.40%	1.2%	64.3%	13.5%	21.1%	0.0%	0.0%	0.0%	0.0%	65.52	55.94	-11.58	62%	Recommendation - 1RN on Twilight for assesment area
AMA (18 beds only)	18	81%	2.7%	57.7%	11.8%	27.4%	0.3%	0.2%	0.0%	0.0%	31.07	32.05	-0.02	71%	No change recommended
A&E RSH				62.6%	14.1%	18.7%	3.2%		1.3%	0.1%	62.8	149.32	85.52	68%	No change recommended
A&E PRH				63.4%	15.7%	15.1%	4.7%		1.0%	0.2%	75.9	135.96	59.06	79%	No change recommended
Medical															
Ward 6 CCU	24	97.80%	2.0%	20.0%	46.1%	16.2%	0.0%	0.0%	15.8%	0.0%	36.66	40.01	2.35	69%	No change recommended
Ward 7 - Endo/Gen Med (PRH)	29	97.80%	1.4%	36.4%	0.3%	61.5%	0.3%	0.0%	0.0%	0.0%	45.59	42.59	-4.00	56%	No change recommended
Ward 9 Frail and Complexe	22	98.40%	0.5%	27.7%	0.0%	71.8%	0.0%	0.0%	0.0%	0.0%	36.65	34.83	-2.82	54%	No change recommended
Ward 11 Nephrology (PRH)	30	96.10%	1.7%	47.1%	0.4%	49.6%	1.2%	0.0%	0.0%	0.0%	45.33	42.59	-3.74	56%	No change recommended
Ward 10 Short Stay	30	97.10%	0.9%	78.5%	0.0%	21.1%	0.4%	0.0%	0.1%	0.0%	35.74	40.01	3.27	60%	No change recommended
Ward 15	25	99.90%	0.3%	17.4%	0.0%	82.2%	0.0%	0.0%	0.0%	0.0%	44.05	46.56	1.51	50%	No change recommended
Ward 16	17	85.40%	14.8%	23.7%	0.9%	50.2%	0.0%	0.0%	10.4%	0.0%	27.74	32.25	3.51	67%	
Ward 17 Respiratory	27	94.40%	1.4%	26.5%	13.0%	42.6%	0.0%	0.0%	15.5%	0.0%	45.5	45.18	-1.32	65%	No change recommended
Medical Escaltion	17	66.10%	1.8%	41.8%	0.6%	55.9%	0.0%	0.0%	0.0%	0.0%	25.86	27.07	0.21	60%	No change recommended
Ward 22 Short Stay	26	97.10%	0.3%	16.8%	2.9%	5.9%	0.0%	0.0%	0.0%	0.0%	32.4	37.42	4.02	57%	No change recommended
Ward 24 Respiratory	30	96.30%	0.4%	26.0%	11.9%	51.4%	0.0%	0.0%	10.4%	0.0%	50.19	57.62	6.43	64%	No change recommended
Ward 27 Gen Med	39	99.00%	0.1%	41.6%	2.0%	54.7%	1.4%	0.3%	0.0%	0.0%	59.03	58.12	-1.91	57%	No change recommended
Ward 28 Medicine & Frailty (RSH)	33	95.70%	1.3%	56.2%	0.0%	42.0%	0.0%	0.5%	0.0%	0.0%	45.93	52.59	5.66	55%	No change recommended
Ward 26 Endo / Medicine	37	98.50%	0.1%	14.1%	0.5%	21.2%	1.2%	0.0%	0.0%	0.0%	56.79	54.62	-3.17	57%	No change recommended
Ward 35 Renal	17	91.10%	8.5%	43.5%	8.6%	39.4%	0.0%	0.0%	0.0%	0.0%	24.36	37.42	12.06	50%	No change recommended
Surgery															
Ward 25G Colorectal & Gastroenterology (RSH)	38	97.40%	0.3%	62.8%	0.7%	35.6%	0.3%	0.1%	0.1%	0.0%	50.67	58.11	6.44	55%	No change recommended
Ward 37 Surgery	34	97.70%	2.1%	40.3%	3.9%	53.7%	0.0%	0.0%	0.0%	0.0%	51.34	55.52	3.18	60%	No change recommended
Ward 8 H&N	14	86.40%	0.6%	40.2%	8.3%	49.1%	0.4%	0.0%	1.4%	0.0%	21.02	24.3	2.28	68%	No change recommended
Muscoloskeletal															
Ward 4 Trauma and Orthopaedic	26	85.70%	3.2%	23.9%	0.0%	72.4%	0.0%	0.0%	0.5%	0.0%	43.68	41.59	-3.09	56%	No change. Budget includes assement area
Ward 5 Elective Orthopaedic	16	41.90%	28.6%	41.9%	0.0%	29.5%	0.0%	0.0%	0.0%	0.0%	15.8	20	3.20	60%	Ward not operating fully as elective orthopaedics due to IPC works required - no changes recommened.
Ward 32 Acute Orthopaedic Trauma Unit	25	97.20%	0.8%	13.5%	0.5%	85.0%	0.1%	0.0%	0.0%	0.0%	42.94	42.59	-1.35	56%	No change
Oncology															
Ward 23OC Oncology & Haematology	30	97.70%	2.2%	58.9%	4.1%	33.9%	0.3%	0.0%	0.6%	0.0%	40.11	41.6	0.49	64%	No change recommended
Womens & Childrens															
Ward 14 Gynaecology	12	73.40%	4.5%	87.9%	1.3%	5.9%	0.3%	0.0%	0.0%	0.0%	12.56	19.52	5.96	68%	1 Band 6 weekend nights, change skill mix for Band 5
Ward 20 Paediatric Oncology	3	no data	0.0%	15.0%	70.0%	15.0%	NA	NA	0.0%	0.0%	4.6	10.35	5.75	100%	No change recommended
Ward 19	28	66.30%	0.0%	84.0%	3.0%	11.0%	NA	NA	1.0%	0.0%	56.3	52.40	-5.90	74%	No change recommended (budget is based on summer seasonal template for SNCT)
Total													183.4		

Supporting literature

National Institute for Health and Clinical Excellence (2014) *Clinical guideline 1: Safe staffing for nursing in adult in patient wards in hospitals*. London, Department of Health.

National Quality Board (2013) *How to ensure the right people, with the right skills, are in the right place at the right time.* NQB, London

National Quality Board (2016) *Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time.* NQB, London

NHSI. (2018) *Developing Workforce Safeguards. Supporting providers to deliver high quality care through safe and effective staffing.* London: NHSI. Publication Code: CG 84/18.

National Quality Board (2018) *Safe, sustainable and productive staffing: An improvement resource for children and young people's inpatient wards in acute hospitals.* NHSI: London.

Royal College of Nursing (2012). *Mandatory Nurse Staffing Levels.* London: RCN.

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Royal College of Nursing (2021). *Nursing Workforce Standards. Supporting a safe and effective nursing workforce*. London: RCN.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 12 March 2026

Agenda item		060/26		
Report Title		Patient Safety Committee quarterly report		
Executive Lead		John Jones Executive Medical Director		
Report Author		Kath Preece Head of Clinical Governance Lindsay Barker Head of Bereavement & Medical Examiner Services Pete Jeffries Patient Safety Specialist		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF 1, BAF 2, BAF 8
Effective	√	Our people		
Caring	√	Our service delivery		**Trust Risk Register id:**
Responsive	√	Our governance	√	CRR 1078, 904
Well Led	√	Our partners		
Consultation Communication		Quality Operational Committee – individual reports 18 November 2025 Quality and Safety Assurance Committee – individual reports 25 November 2025		
Executive summary:		The Board's attention is drawn to: Section 2.4 – Compliance with death certification Section 2.5 – Service user feedback Section 3.1 – Patienty Safety Investigations		
Recommendations for the Board:		The Board is asked to: **Note** the contents of the report		
Appendices:		N/A		

1.0 Introduction

1.1 The Patient Safety Committee report will be presented to the Board of Directors quarterly and will include updates from the Medical Examiner Service, Learning from Death and Patient Safety. Note, Q3 Learning from Deaths section will be covered in July Board report.

2.0 Summary of Hospital Deaths – Quarter 3 2025/26

There were 521 hospital deaths reported to the ME Service within the Trust during quarter three, which was an increase of 68 deaths from what was reported in Q2 and a recognised pattern for the time of year. There were no acute neonatal or paediatric deaths during this period

2.1 Medical Examiner (ME) review

During Q3 the ME service undertook the reviews of 1284 deaths, 504 of these being hospital deaths. Of the 504 hospital reviews, families in 11 cases did not interact with an ME, therefore 97% of cases received timely support from an ME or MEO during this reporting period.

2.2 Coronial cases

Across both hospital sites 54 deaths were referred to the coroner during Q3. The coroner did not accept 24 of the cases by deciding the death did not meet their duty to engage and therefore issued a CN1A, the ME therefore authorised these deaths. The coroner took 30 of the cases to investigation by authorising either an investigation, a post-mortem or proceeded to an inquest. The coroner issued 3 CN1B's for deaths where an attending practitioner could not complete death certification and so this is undertaken by the Medical Examiner at the request of the coroner.

2.3 Structured Judgement Review (SJR) & Potential Learning Cases

The Medical Examiner recommended SJRs in 40 of the hospital deaths reviewed in Q3. Concerns raised by bereaved families have shown a slight increase compared with quarter two and continue to constitute the largest proportion of all recommended SJRs. This pattern reflects the core intention of the Medical Examiner system: providing bereaved relatives with a meaningful and timely opportunity to discuss the care of their loved one, offer feedback, and receive reassurance that their views have been acknowledged and taken seriously. Medical Examiners raised potential learning in 78 deaths during Q3.

2.4 Compliance with death certification

485 MCCDs were requested following ME review for hospital deaths and completed by the hospital attending practitioner.

Of the total certificates issued, 398 (86%) were completed and released for registration within the standard timeframe of three calendar days. Although 14% exceeded this target, the Medical Examiner and Bereavement Service continues to demonstrate sustained improvement in the timeliness of issuing hospital MCCDs, achieving the three-day standard in seven of the nine months reported for 2025/26.

2.5 Service highlights

Service user feedback for the quarter shows a positive picture with the Bereavement Feedback Survey report showing that of 47 returned forms 95% felt that the ME service was helpful to them, which remains consistent with performance in previous quarters. 95% responded to say that the ME had given them the opportunity to raise concerns and 97% reported that the ME explained the cause of death in a clear and compassionate way.

During the reporting period, the ME Service and Complaints Department met to discuss its approach to managing complaints that relate specifically to the work or conduct of the ME Service. This review has confirmed that the Trust's arrangements remain compliant with the National Medical Examiner's Guidance, which requires that the ME Service operates with independence from the organisation in relation to the review of deaths but works within the boundaries of the procedures and policies of the organisation in which it is hosted, including in matters relating to concerns or complaints raised by bereaved families.

Where a bereaved individual raises a concern that constitutes a complaint about the ME or the ME review process, the Trust's NHS Complaints Procedure is followed in full accordance with the NHS Complaints Regulations.

3.0 Patient Safety Update

3.1 Patient Safety Incident Investigations (PSII) Q3

In Q3 there were 5 PSII commissioned, which included 1 Never Event and 1 MNSI Maternity Investigation. There were 2 closed in the quarter which included 1 MNSI Maternity investigation.

Newly commissioned PSII
2025/5711 Never Event – retained foreign object
2025/5748 Deteriorating patient – fluid overload
2025/6172 Lost to follow up
2025/6593 Deteriorating patient – escalation of care
2025/6592 MNSI – Therapeutic cooling Maternity

PSII closed
2025/1938 Deteriorating patient ED corridor
2025/2014 MNSI Therapeutic cooling - Maternity

4.0 Learning from incidents in Q3

Triangulation of learning from incidents has identified the same themes through Q3, as previous quarters, with ongoing improvement work underway.

Summarised theme/learning	Improvement activity
Use of bleeps	Significant work being undertaken via the bleep working group to replace bleep system and develop 'standard work' for bleep use
Responding to the deteriorating patient	These themes have all been identified under key workstreams of the adult deteriorating patient programme and PSIRF priority and work being undertaken to embed Martha's rule
Consent for procedure/marking up for procedures	Consent working group has updated consent and marking policy which is in the process of approval. Roll out of existing EIDO e-consent tool being explored via CIO. The use of insourcing companies is a wiser issue which concerns/incidents and learning responses highlighting issues from initial engagement of companies which creates risk.
Clinical Handover	Handover remains a consistent theme through incidents and learning responses. Medical handover has been identified as a key workstream in the deteriorating patient programme. The scope of this workstream is being outlined.
Embedding of NatSSIPPs 2 guidance	Work undertaken in theatres but wider issue around overarching embedding of NaTSIPPS2 principles and development of LoCSIPPS Trust wide planned, with working group Chaired by Associate Medical Director.
Advanced care planning/ReSPECT documentation	Learning shared with the End-of-Life Care Group to be incorporated in improvement work
Communication with relatives and carers	Learning shared with all Divisions
Discharges including fast track	Discharge improvement group in progress with key workstreams including discharge planning/discharge communication and medication
Documentation of nutrition and hydration assessment	Improvement programme in place support by Quality Matrons

Board of Directors' Meeting:
12 March 2026

Agenda item		061/26		
Report Title		Infection Prevention and Control (IPC) Report Q3 2025/26		
Executive Lead		Paula Gardner, Interim Chief Nursing Officer		
Report Author		Kelly Pardy, Deputy Lead Nurse IPC/IPC Team		
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		Infection Prevention Control Assurance Committee, 22 January 2026 Quality & Safety Assurance Committee, 27 January 2026		
Executive summary:		The Trust continues to face significant challenges in achieving its HCAI reduction targets for 2025/26. Quarter 3 data show continued exceedance of trajectories for Clostridioides difficile (28 cases YTD 97/98), E. coli (43 cases YTD 122/146), Klebsiella (13 cases YTD 39/36), and MRSA bacteraemia (1 case YTD 3/0). Multiple outbreaks and Periods of Increased Incidence (PIIs) occurred in Q3, predominantly COVID & Influenza. Recurring themes included delay in isolation, suboptimal cleanliness of the immediate patient environment and shared equipment, frequent patient moves between bays and wards. Infrastructure and resourcing constraints persist — notably limited isolation facilities, lack of decant space, and restricted deep-cleaning capacity. These continue to feature on the IPC risk register as extreme risks. Overall compliance with the Health and Social Care Act (2008) remains high at 97%, with a single, red-rated element linked to gaps in occupational health contact tracing.		
Recommendations for the Board:		The Board is asked to: 1. Note the continued exceedance of HCAI trajectories and actions in place to mitigate. 2. Support investment in IPC infrastructure and workforce to address systemic constraints. 3. Endorse strengthened clinical engagement and accountability in RCA and infection prevention processes. 4. Review the outstanding occupational health contact tracing gap as a contractual and governance risk		
Appendices:		Appendix 1 HCAI targets 2025/26 Appendix 2 HCAI graphs Appendix 3 – Health and Social Care Act 2008 self-assessment tool		

INTRODUCTION

This paper provides a report for Infection Prevention and Control for Quarter 3 (October – December 2025) against the 2025/26 objectives for Infection Prevention and Control. An update on hospital acquired infections: - Methicillin Resistant *Staphylococcus aureus* (MRSA), Clostridioides Difficile (CDI), Methicillin-Sensitive Staphylococcus (MSSA), Escherichia Coli (E. Coli), Klebsiella and Pseudomonas Aeruginosa bacteraemia for October – December 2025 is provided. An update in relation to Covid-19 is also provided. The report also outlines any recent IPC initiatives and relevant infection prevention incidents. The updated IPC BAF is also included.

2.0 KEY QUALITY MEASURES PERFORMANCE

The HCAI targets (See Appendix 1)

2.1 MRSA Bacteraemia

The target for MRSA bacteraemia remains at zero cases for 2025/26. In Quarter 3, there was one MRSA bacteraemia cases (table 1, appendix 2).

Patient had a known history of MRSA who was repatriated from Switzerland (Initial elective surgery followed by multiple remedial surgeries and critical care stay), tested MRSA positive in wound on admission and was nursed in a side room throughout.
Patient consistently declined decolonisation. Developed an MRSA bacteraemia over 1 month into admission.
A full post infection review has been undertaken in this case and it was decided that this infection was unavoidable to patient specific risk factors and inability to decolonise.
Ward was commended for conducting appropriate screening and isolating the patient on admission

2.2 Clostridioides Difficile

The Trust trajectory for C diff cases in 2025/26 is no more than 98 cases.

There was a total of 28 cases of C diff for Quarter 3 2025/26 (table 2 appendix 2). 15 of these cases were HOHA and the remaining 13 cases were COHA.
This is a rate of 39.8 per 100,000 bed days for Q3 2025/26, table 3 appendix 2 (this is based on an estimated bed day figure). This is a reduction on both Q1 and Q2 C. diff rate.

The Trust continues to review all cases through investigations to identify any potential lapses in care or any common themes that may have contributed to the infection. All cases have been reviewed, most common contributing factors identified and an action plan created.

So far, of the 68 case C. diff cases reviewed for this financial year 24 cases are likely to have been caused by inappropriately prescribed antibiotics.

The Trust C. diff reduction action plan remains in place and progress is reported monthly to IPCOG. Our main struggles have been ability to complete a deep clean and slow progression of the proposal to move to Fidaxomicin for fist line treatment of C. diff. The antimicrobial actions now also sit on the antimicrobial stewardship group's agenda report on progress against the actions.

2.3 E. coli Bacteraemia

The target for 2025/26 is no more than 146 cases.

In Quarter 3 there were 43 cases attributed to the Trust (table 4, appendix 2). 15 of these cases were HOHA, and the remaining 28 cases were COHA. 10 cases in Q3 were considered to be device or intervention related, and the source in all 10 cases was considered to be a UTI with a catheter in place.

2.4 MSSA Bacteraemia
There is no nationally set target for MSSA. In Quarter 3 2025/26, there was a total of 12 cases of MSSA Bacteraemia. 5 of these cases were HOHA and the remaining 7 were COHA (table 5, appendix 2). No HOHA cases were deemed to be linked to a device in Q3.

2.5 Klebsiella Bacteraemia
The target for 2025/26 is no more than 36 cases. In Quarter 3 2025/26 there were 13 cases of Klebsiella Bacteraemia attributed to the Trust (table 6, appendix 2). 5 of these cases were HOHA, and the remaining 8 cases were COHA. Of the 5 HOHA cases, 1 was considered to be device related and was urinary with a catheter in situ.

2.6 Pseudomonas Aeruginosa
The target for 2025/26 is no more than 16 cases. In Quarter 3 2025/26 there were 4 cases of Pseudomonas Aeruginosa attributed to the Trust (table 7, appendix 2). 1 of these cases was a HOHA, and the remaining 3 cases were COHA. The HOHA case was not considered to be device or intervention related.

2.7 Root Cause Analysis Infections for MSSA and E. Coli Bacteraemia
All MSSA and E. coli post 48-hour bacteraemia are reviewed by the microbiology team. Those deemed to be device related, or, where the source of infection cannot be determined are expected to have a Root Cause Analysis (RCA) completed.

In Quarter 3:
- 1 of the 12 MSSA bacteraemia's required an RCA as the source was unclear upon initial review- the source of infection was decided to be an aspiration pneumonia.
- 1 of the 43 E. coli bacteraemia's required an RCA, the source of the infection was a Urinary catheter.

Learning from completed RCAs include:
- Inappropriate antibiotics for UTI.
- Mismanagement of IV cannula- not recorded on vitals and not dated

Actions implemented in relation to improvements include:
- Lessons learned from all cases cascaded to staff in huddles, handovers, and clinical governance meetings.
- IPC statutory training includes discussion about the issues identified.
- VIP score posters were created and shared with divisions.
- Medical teams Face to Face statutory training includes issues identified during RCA meetings.
- Ward managers and nurses in charge monitor the VIP scores and compliance monitored at monthly nursing metrics meetings; these being reported by division through their IPCOG reports.
- Continuous monitoring and education on unnecessary use of gloves provided to various staff groups during ward visits.
- Education on hand hygiene provided to staff members.
- Hand Hygiene Assessors training extended to include discussion regarding understanding on 5 moments of Hand Hygiene.

Month	Ward	Organism	Outcome/ Typing	Comments
October	T8	COVID	OUTBREAK	2 PATIENTS
	T9	COVID	OUTBREAK	2 PATIENTS
	S24	FLU	OUTBREAK	12 PATIENTS
	S26	FLU	OUTBREAK	7 PATIENTS, 4 STAFF
	T10	CDI	PERIOD OF INCREASED INCIDENCE	2 PATIENTS
November	T11	COVID	OUTBREAK	4 PATIENTS
	S24	COVID	OUTBREAK	4 PATIENTS
	S25	COVID	OUTBREAK	7 PATIENTS
	S25	COVID	OUTBREAK	2 PATIENTS
	S35	FLU	OUTBREAK	2 PATIENTS
	S SURG WARDS	VRE	OUTBREAK	7 PATIENTS (AWAITING TYPING ON A FURTHER 13)
December	T6	COVID	OUTBREAK	3 PATIENTS
	T9	COVID	OUTBREAK	3 PATIENTS
	T11	COVID	OUTBREAK	3 PATIENTS
	S23	COVID	OUTBREAK	5 PATIENTS
	S24	COVID	OUTBREAK	2 PATIENTS
	S24	COVID	OUTBREAK	2 PATIENTS
	S26	COVID	OUTBREAK	2 PATIENTS
	S27	COVID	OUTBREAK	4 PATIENTS
	S22SS	FLU	OUTBREAK	2 PATIENTS
	S28	FLU	OUTBREAK	3 PATENTS
	T9	NORWEIGIAN SCABIES	OUTBREAK	1 PATIENT & 9 SYMPTOMATIC STAFF TREATED
	TNNU	ESBL KLEBSIELLA/ E. COLI	2 X KLEBSIELLA- OUTBREAK 4 X E. COLI AWAITING 1 TYPING RESULT TO CONFIRM	2 X ESBL KLEBSIELLA 4X ESBL E.COLI

The themes identified during the investigation of these incidents are

- Missed opportunities for hand hygiene for staff and patients (mealtimes)
- IPC care plan, screening tool and daily documentation of poor quality in nursing notes
- Substandard cleanliness of the immediate patient environment and equipment
- Non-compliance with Bare Below the Elbows
- Delay in diagnosis (Norwegian scabies) and subsequent treatment, causing confusion relating to IPC measures and isolation
- Frequent movement of patients between bays and wards that does not seem to relate to clinical need.
- Suboptimal cleaning/disinfection of the environment, particularly in NNU due to issues with use of Tristel Fuse (staff sensitivities).

4.0 INCIDENTS RELATED TO INFECTION PREVENTION & CONTROL

1 case of Candidozyma auris in a patient who was repatriated from Rhodes following a subarachnoid haemorrhage on holiday and resultant surgery and critical care stay.
This patient tested positive following transfer to UHNM for procedure.

His initial stay on ward 28 generated several contacts which were all managed appropriately, and no onward transmission was identified.

5.0 IPC INITIATIVES

- Quality ward walks continue monthly by matrons, quarterly by the IPC team and more frequently in response to outbreaks and periods of increased incidence.
- Daily ward visits with IPC advice and education
- IPC support to NNU and education discussions held with medics
- Statutory Face to Face training delivered on both sites to all grades of staff.
- Progressing with trial of hypochlorous acid on NNU as an alternative to Tristel Fuse, this may be rolled out more widely across the trust if well received.
- IPC input into national pandemic response scenario (Exercise Pegasus)
- Training given to all inpatient areas to introduce new MRSA swabs, this new swab should increase pick up rate and include groin swab to bring SaTH in line with National guidance.
- COVID/Flu/RSV lateral flow test kit introduced into ED on both sites to speed up the testing process.

6.0 RISKS AND ACTIONS

There are 4 risks on the IPC risk register, all of which are rated as extreme risks and are reviewed monthly

- Risk 923 Risk of HCAI due to the lack of isolation facilities
- Risk 1241 Hospital overcrowding and associated IPC risk (requested that this is owned by operations)
- Risk 444 Lack of deep clean programme
- Risk 722 Exceeding nationally set targets for reportable HCAIs

7.0 IPC BOARD ASSURANCE FRAMEWORK

This is reviewed and reported to the Trust Infection Prevention and Control Operational Group and Assurance Committee on a quarterly basis. The BAF has a total of 54 Key Lines of Enquiry. 41 of which are rated as Green, 13 are rated as Amber, and 0 rated as Red.

8.0 HEALTH AND SOCIAL CARE ACT COMPLIANCE UPDATE

The Health and Social Care Act (previously known as Hygiene Code) is reviewed quarterly by the IPC team and presented at the IPC Operational Group. Following the full review, the Trust is currently 97% compliant, being RAG rated ‘Green’ for 248 elements, ‘Amber’ for 19 and RAG rated ‘Red’ for 1. The “red” element is in relation to follow of up of staff by occupational health as contact tracing is not included in the contract with Optima. This has been escalated to workforce as a risk. The Trust self-assessment compliance against each of the 10 domains and the current gaps are shown the self-assessment Tool (see appendix 3)

9.0 CONCLUSION

This IPC report has provided a summary of the performance in relation to the key performance indicators for IPC in Quarter 3 of 2025/26.

Appendix 1 HCAI targets 2025/26

	2023/24 Target	2023/24 Actual	2024/25 Target	2025/26 Target
MRSA	0	0	0	0
C. diff	32	97	98	98
E. coli	90	147	146	146
Klebsiella	22	38	36	36
Pseudomonas	18	21	19	16

Appendix 2 HCAI graphs

Table 1

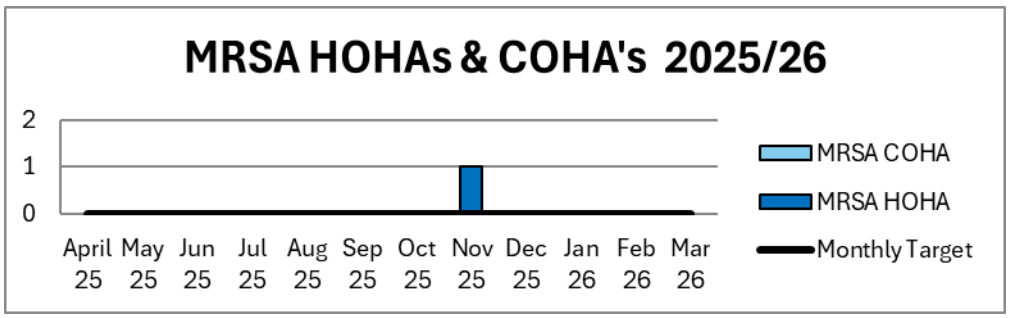


Table 2

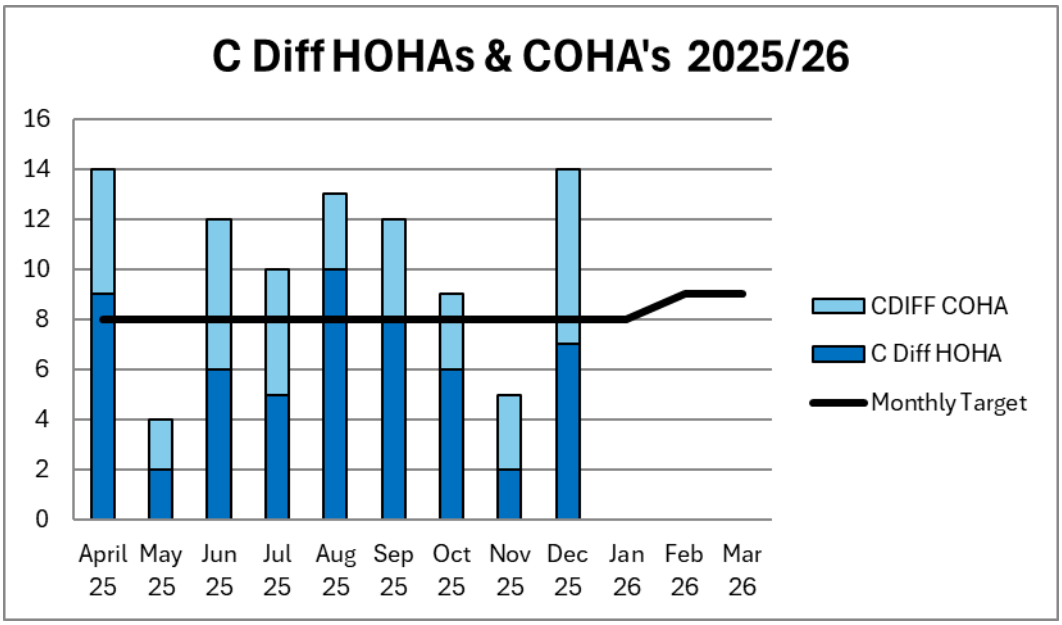


Table 3

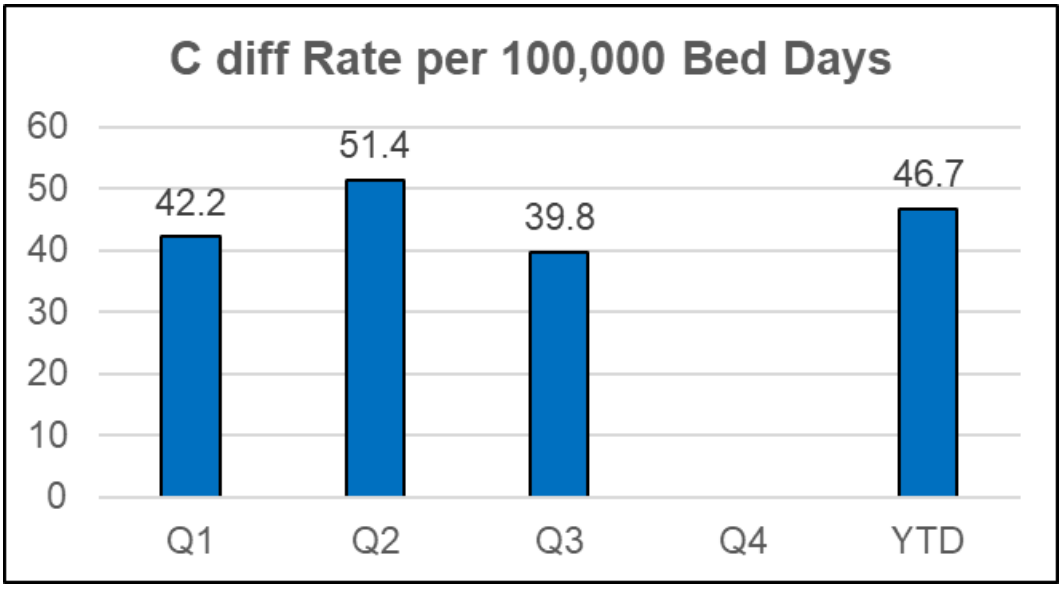


Table 4

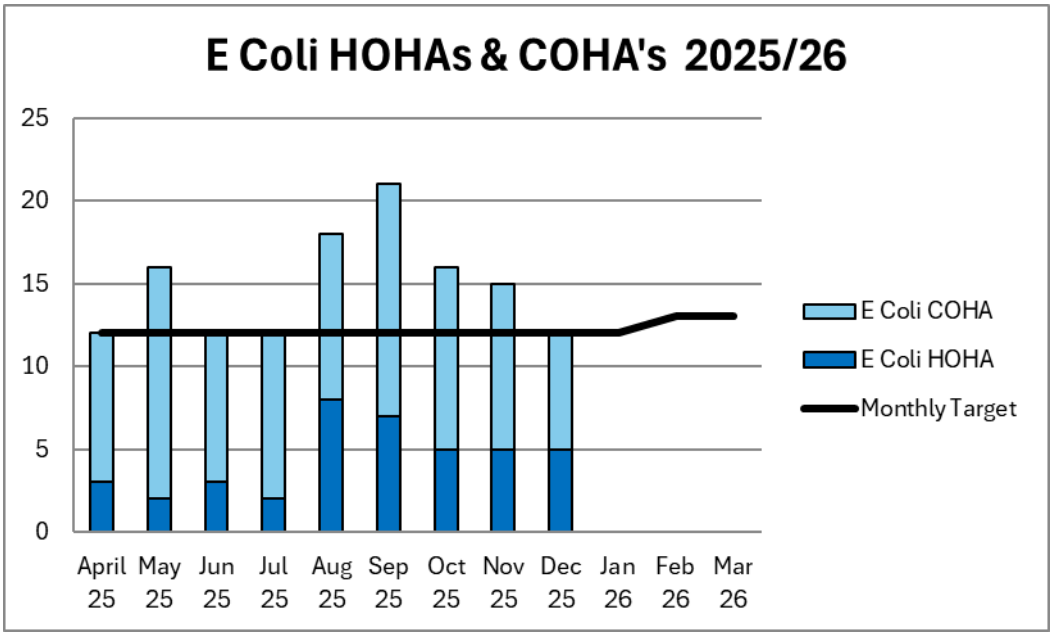


Table 5

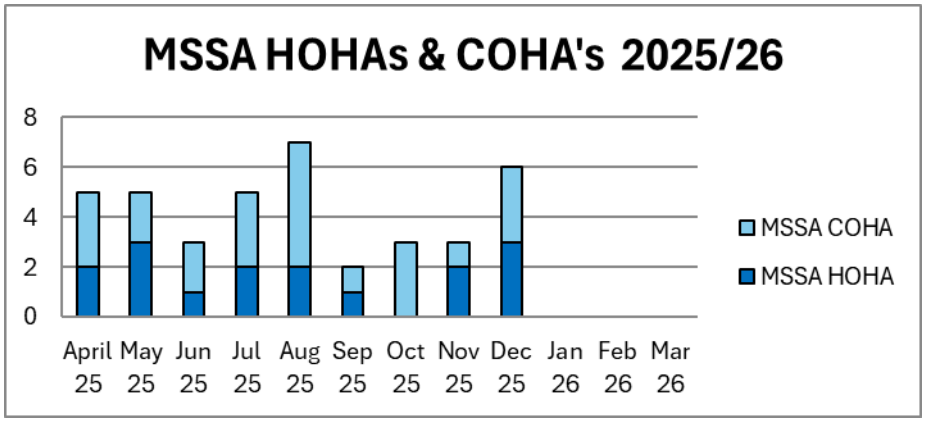


Table 6

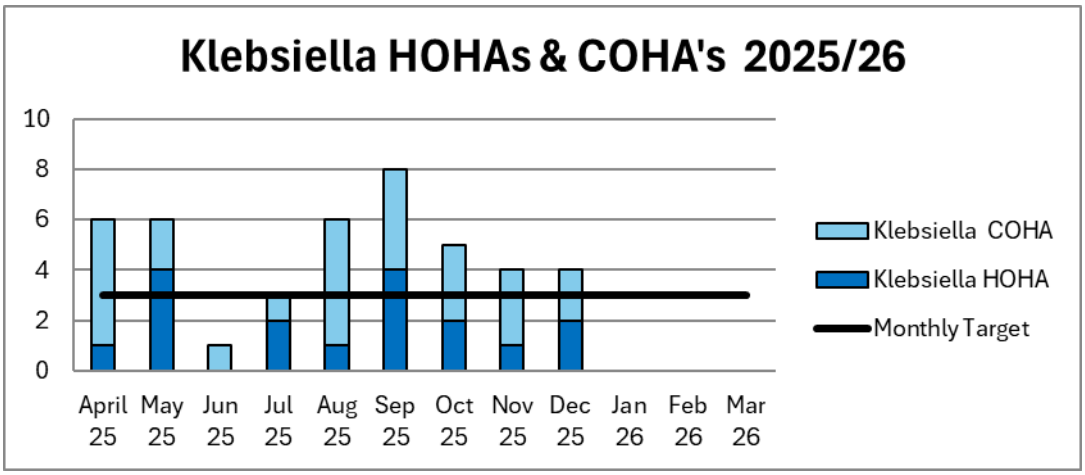
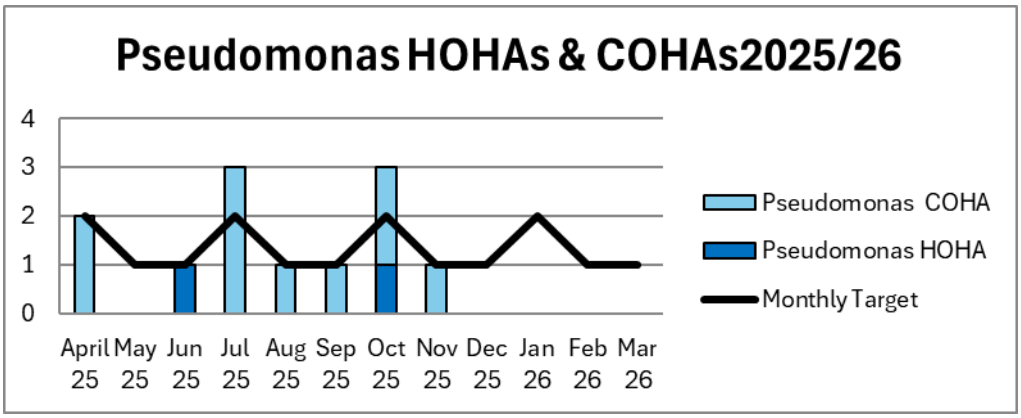


Table 7


Pseudomonas HOHAs & COHAs2025/26
4
3
2
1
0
April 25
May 25
Jun 25
Jul 25
Aug 25
Sep 25
Oct 25
Nov 25
Dec 25
Jan 26
Feb 26
Mar 26
Pseudomonas COHA
Pseudomonas HOHA
Monthly Target

Appendix 3 – Health and Social Care Act 2008 self-assessment tool (Dec 25)

Board Assurance Framework					
Key Lines of enquiry		Total		54	
		Non Compliant		0	
		Partially Compliant		13	
		Compliant		41	
Criterion	Statement of Compliance	Compliance Score	Score	Potential Score	Comments
Criterion 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them	100.00%	24	24	This criterion is completed
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	96.30%	26	27	1. Multidisciplinary efficacy audits not fully implemented (process agreed). 2. Offensive waste rollout not fully implemented currently on 85% with all areas moved over by end of the year, 2 years ahead of NHSE's target 3. Decontamination action plan now in place, Decontamination is going through process to be improved
Criterion 3	Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance	72.22%	13	18	1. Antimicrobial stewardship report to be realigned to the AMR national action plan. 2. Formalised education programme not in place/evidence of lack of adequate reviews or antimicrobial in line with start smart then focus. 3. Depleated pharmacy workforce.
Criterion 4	Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion	100.00%	15	15	This Criterion is completed
Criterion 5	Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.	100.00%	15	15	This Criterion is completed
Criterion 6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	94.44%	17	18	Not all staff fit tested, records kept on intranet. Buisness case with finance awaiting an agenda slot for the business case review group to re-introduce a stock of hoods/PAPR units
Criterion 7	Provide or secure adequate isolation precautions and facilities	91.67%	11	12	Isolation capacity low, especially in PRH ED. Request that more redirooms are purchased
Criterion 8	Provide secure and adequate access to laboratory/diagnostic support as appropriate	90.48%	19	21	Laboratory requires ongoing/additional investment to keep up to date with technological demands and evolving infectious diseases.
Criterion 9	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections	100.00%	3	3	This Criterion is completed
Criterion 10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	88.89%	8	9	Assurance not in place that all staff are vaccinated or that the required health checks have been undertaken. workforce . update 05/08/25 Immunisation policy approved July 25, further ratification process to follow. DNA rates reduced following new process implementation. Close monitoring in place via contract management roup who will monitor immunisation rates
Total Compliance		93.21%	151	162	

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 12 March 2026

Agenda item		062/26		
Report Title		Antimicrobial Resistance – Call to action		
Executive Lead		Paula Gardner, Chief Nursing Officer		
Report Author		Paula Gardner, Chief Nursing Officer		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people		
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners		
Consultation Communication		Quality & Safety Assurance Committee, 24 February 2026		
Executive summary:		The Trust received a letter from NHSE in November 2025 to advise that The World Health Organistation has declared antimicrobial resistance (AMR) as a top global health and development threat and that AMR has been listed on the UK Government's Risk Register The Trust is asked to take the following actions by the end of Q1 2026: • Board Level Review & Executive Oversight • Risk & Capability Assessment • Set Priorities & Deliver Improvement By April 2026 the organisation needs to agree and publish three priority areas for AMR improvement. For each priority: • Define specific, measurable objectives • Assign executive-level accountability • Establish timelines and reporting mechanisms		
Recommendations for the Board:		The Board is asked to **note** the letter at Appendix 1, and the three proposed priorities for SaTH at Appendix 2		
Appendices:		Appendix 1: Antimicrobial Resistance (AMR) letter Appendix 2: Presentation to Board *(to be delivered on the day but also circulating with the paper for advance consideration of any questions).*		

APPENDIX 1

To:
- Trusts and integrated care boards:
  - chairs
  - chief executive officers

cc.
- Chief nurses
- Medical directors
- Chief pharmacists

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

November 2025

Dear colleagues,

Act now: protect our present, secure our future

The World Health Organisation has declared antimicrobial resistance (AMR) as one of the top global public health and development threats, and AMR is listed on the UK government's National Risk Register.

As a senior NHS leader, your commitment is critical to tackling AMR and protecting patient safety.

We are writing to you with a **call to action** – to work with your prescribers and your clinical leads to make the changes required to meet the targets in the national action plan for AMR.

Why Action Is Urgent

Antimicrobial resistance is not a future challenge – it's happening now.

While overall antibiotic prescribing is decreasing, prescribing in secondary care is rising. Rates of Gram-negative bloodstream infections are increasing and already exceed the 2028/29 targets in most areas.

In the UK, AMR is associated with **twice as many deaths annually as breast cancer**. It makes infections harder or sometimes impossible to treat, prolonging illness and increasing the risk of harm or death. AMR also drives up healthcare costs and threatens the delivery of safe and effective care across the NHS.

Actions Required by Q1 2026

The national action plan for AMR sets ambitious targets. Meeting them will require coordinated, sustained action across all levels of the NHS.

To ensure your organisation is on track to meet AMR targets, we ask that you take the following actions **by the end of Q1 2026**:

Board-Level Review & Executive oversight

1. Schedule a joint presentation to your board from IPC and AMS teams covering:

    - Current performance against national AMR targets
    - Benchmarking using the latest English surveillance programme for antimicrobial utilisation and resistance (ESPAUR) report and AMR information found on Model Health System, together with the thresholds for each trust to reduce exposure to antibiotics, announced in the Medium Term Planning Framework[1], and shortly to be issued.
    - Key concerns and immediate actions required

Risk and Capability Assessment

2. Complete the following assessments to i) Evaluate current performance and compliance ii) Identify gaps in leadership, workforce capability, and resource allocation and iii) Inform risk registers and strategic planning.

    - The national infection prevention and control **board assurance framework**
    - The ICB Antimicrobial Stewardship **Self-Assessment Toolkit**

Set Priorities and Deliver Improvement

3. By April 2026, agree and publish three priority areas for AMR improvement within your organisation. For each priority:

    - Define specific, measurable objectives.
    - Assign executive-level accountability.
    - Establish timelines and reporting mechanisms.

Progress should be reviewed quarterly, with a formal update to the board at least annually.

Thank you for your continued leadership in confronting this growing threat to patient safety and public health.

Yours sincerely,

Dr Claire Fuller
National Medical Director and AMR Senior Responsible Officer
NHS England

Duncan Burton
Chief Nursing Officer for England

Dr Shona Arora
Interim Chief Medical Advisor
UK Health Security Agency

[1] Medium term planning framework - delivering change together 2026/27 to 2028/29 p17

Antimicrobial Resistance

Response to letter Nov 2025:

Act now: protect our present, secure our future.

Nature of Antimicrobial Resistance (AMR)

The Shrewsbury and Telford Hospital NHS Trust

- Antimicrobial resistance occurs when bacteria, viruses, fungi and parasites no longer respond to antimicrobial medicines.
- Phenotypic resistance of organisms is an expression of genetic elements coding for resistance.
  - Resistance can be transmitted via expansion of the organism, or
  - Transfer of the gene from one bacteria to another (species) of bacteria.
- The resultant effect of antimicrobial resistance is that antibiotics and other antimicrobial medicines become ineffective, and infections become difficult or impossible to treat.
- Infections that are difficult or impossible to treat increase the risk of disease spread, severe illness, disability and death.

*'AMR is associated with **twice as many deaths annually as breast cancer'***

Theme 1	**Reducing the need for, and unintentional exposure to, antimicrobials** IPC, public engagement, better surveillance
Theme 2	**Optimising the use of antimicrobials** AMR stewardship, workforce
Theme 3	**Investing in innovation, supply and access** Innovation, surveillance data, inequality
Theme 4	**Being a good global partner** AMR international diplamcy

National Action Plan Targets

Theme 2 – Optimising the use of antimicrobials

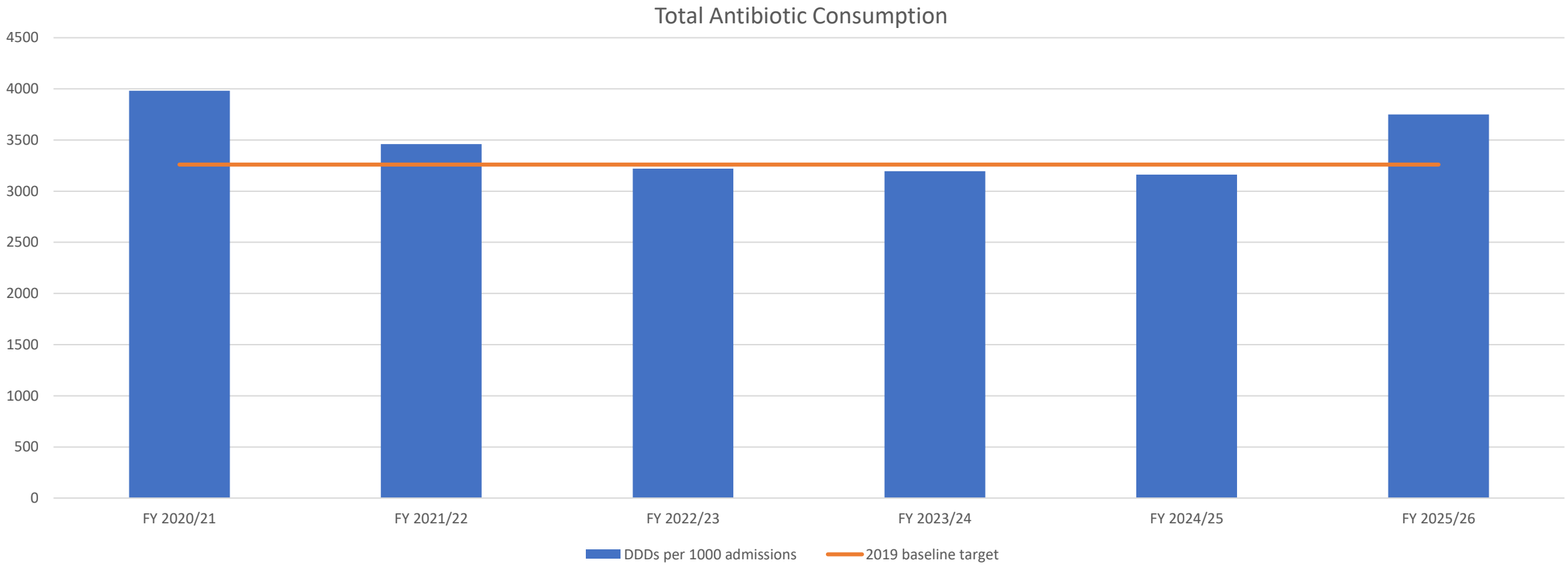
- **Target 4a: Total Antimicrobial Usage**
  - We aim to reduce total antibiotic use in human populations by 5% from the 2019 baseline by 2029.

- **Target 4b: Access Category Usage (Helps support reduction in resistance to antimicrobials)**
  - We aim to achieve 70% of total use of antibiotics (narrow spectrum) from the Access category (new UK category) across the human healthcare system by 2029

Current performance against national AMR targets

- Awaiting confirmation of specific secondary care targets for antibiotic usage.
- Potential for NHSE to remove admissions denominator from usage targets.
    - Will significantly impact all trusts due to overall increased activity since 2019.
        - SaTH admissions in 2019-20 = 140,442
        - SaTH admissions in Q2 2024/25 to Q1 2025/26 = 155,957
- Target 4a: Total Antimicrobial Usage
    - Achieved reduction in consumption from 2019 baseline in previous years when reviewed per 1000 admissions.
    - Q2 2024/25 to Q1 2025/26 rolling 4 quarter performance –7.6% difference in total DDDs per 1000 admissions from 2019/20 baseline.
- Target 4b: Access Category Usage
    - Previous years have looked at reducing watch and reserve category usage.
    - Q2 2024/25 to Q1 2025/26 rolling 4 quarter performance –3.7% difference in total DDDs per 1000 admissions from 2019/20 baseline.

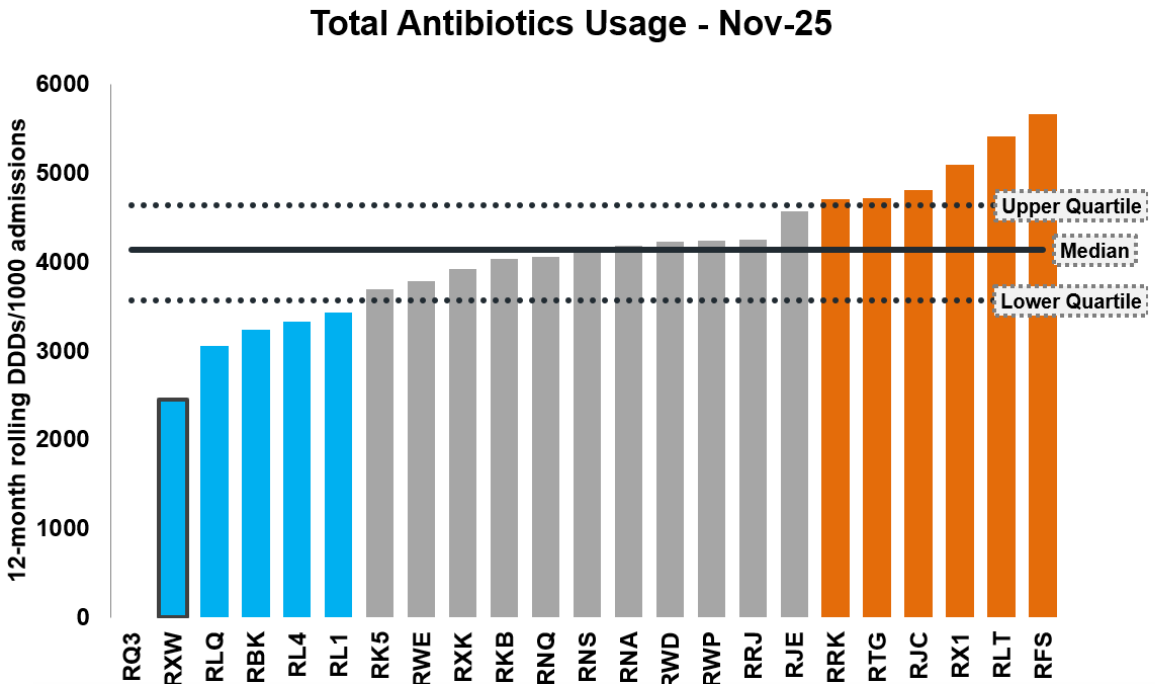
Target 4a: Aim to reduce total antibiotic use in human populations by 5% from 2019 baseline – DDDs per 1000 admissions

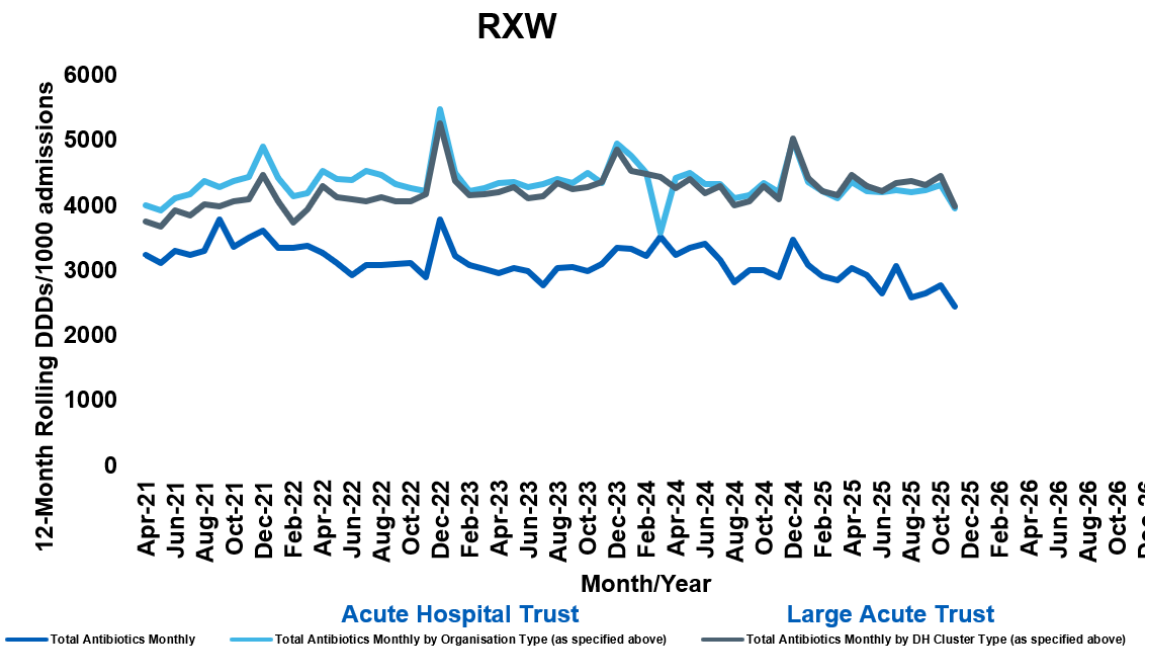


Benchmarking – Total Antibiotic Usage

The Shrewsbury and Telford Hospital NHS Trust

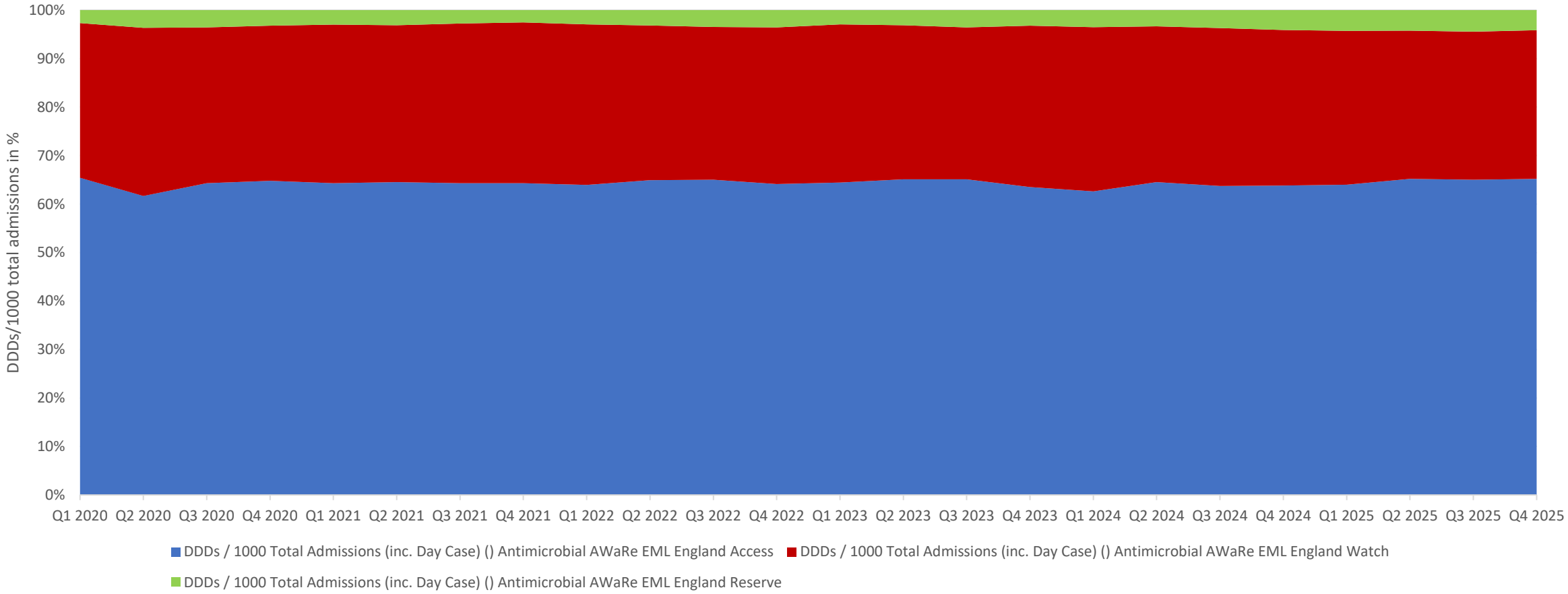
Latest Month Organisation Ranking <- Total Antibiotic Usage -> Organisation Monthly Trending vs Organisation Type vs DH Cluster Type



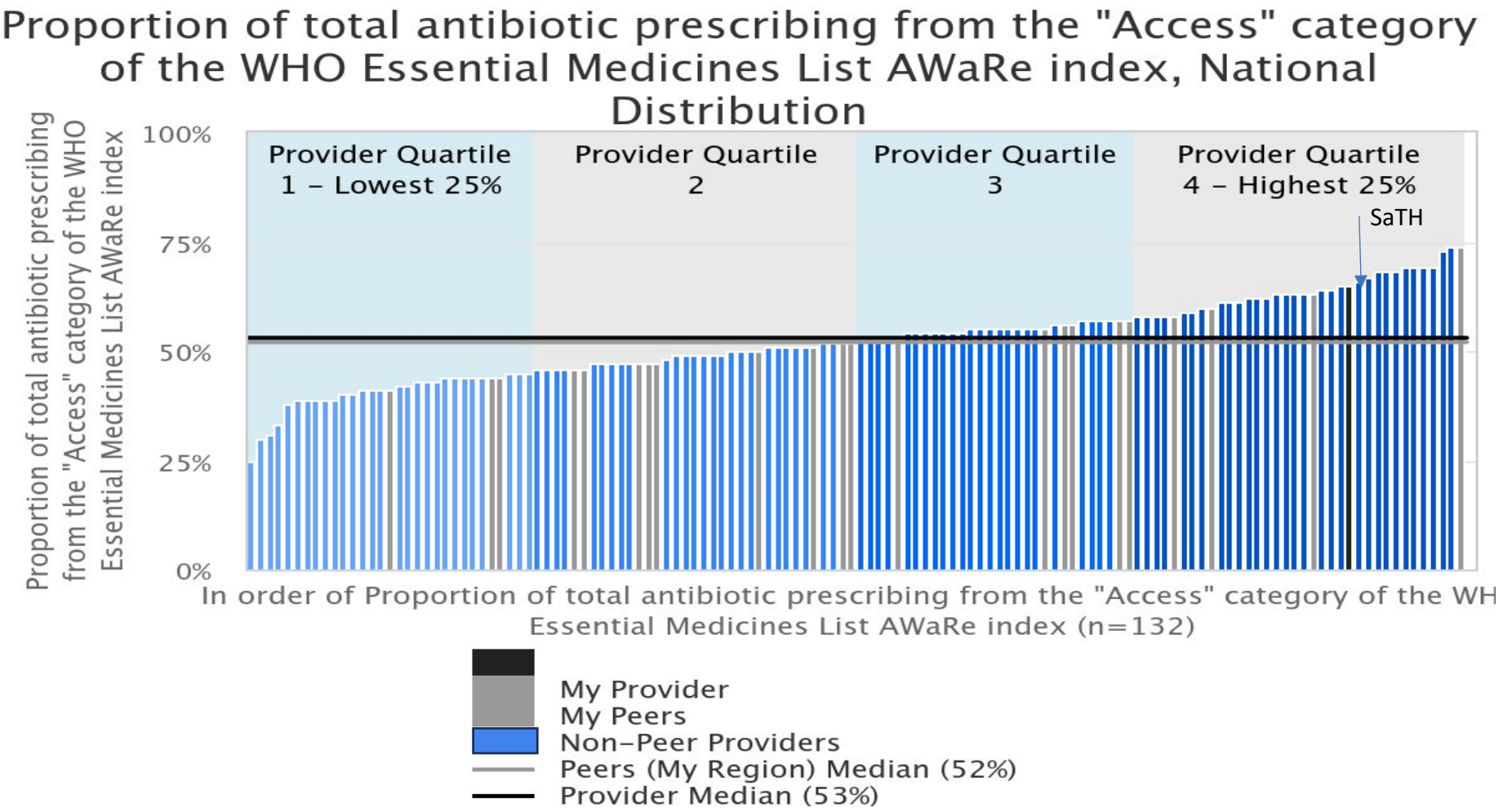


Data April 21-Nov 25 from NHSE Midlands Hospital Trust Antibiotic Usage Dashboard

Target 4b: Aim to achieve 70% access category usage



Benchmarking – Access category usage



Risk and Capability Assessment - Key Concerns

- Missing review of antibiotic prescribing at 48-72 hours.
- Abundance of piperacillin/tazobactam usage
    - Respiratory infections
    - Too rapid escalation of treatment
    - Often used for ‘infection query source’ or LRTI/UTI
- Mislabelling of penicillin allergy leading to increased usage of second or third-line agents such as meropenem.
- Concerns over prescribing and side-effects relating to gentamicin usage drives use of other more broad-spectrum antibiotics.
- Lack of decant facilities to enable deep cleaning of ward areas
- Lack of isolation capacity including negative pressure rooms
- Delayed identification of Healthcare associated Infections (HCAIs) e.g. Clostridioides difficile.

IPC Board Assurance Framework

The Shrewsbury and Telford Hospital NHS Trust

Board Assurance Framework		
Key Lines of enquiry	Total	54
	Non-Compliant	0
	Partially Compliant	13
	Compliant	41

- Partially compliant
  - Criterion 3 - Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance.
  - Criterion 6 - Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
  - Criterion 7 - Provide or secure adequate isolation precautions and facilities.
  - Criterion 8 - Provide secure and adequate access to laboratory/diagnostic support as appropriate.
  - Criterion 10 - Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Immediate Actions Required March 2026

The Shrewsbury and Telford Hospital NHS Trust

- Confirm executive-level accountability – Chief Nursing Officer / Executive Medical Director
- Identification of gaps
  - Leadership – clinical leadership across divisions
  - Workforce capability – e.g. AMR word rounds
  - Resource allocation – resource allocation / ringfencing
- Update risk registers
- Strategic planning – update and the share the AMR committee workplan
- Agree and publish three priority areas for AMR improvement - by April 2026
  - **Proposed Priorities for Sath**
    - 48-72 hour review of antimicrobial prescriptions
    - Intravenous to oral switch
    - Reduction in delayed identification of HCAIs

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 12 March 2026

Agenda item		063/26		
Report Title		The Shrewsbury and Telford Hospital NHS Trust Gender Pay Gap Report 2025		
Executive Lead		Rhia Boyode, Chief People Officer (CPO)		
Report Author		Dawn Thompson, Associate Director of Culture		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF 2 BAF 3, BAF 4
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Strategic People Committee- 20251104 Verbal update at EDI group- November 2025 Group People Committee in Common – 20260126		
Executive summary:		To provide the Board of Directors with the SaTH Gender Pay Gap report 2025 for final approval. The report was discussed and endorsed at the Group People Committee in Common on 26th January 2026. The approved data will be publicised on the SaTH website by the 30th March 2026 and on the online government services to ensure that the Trust is compliant with its statutory obligations.		
Recommendations for the Board:		The Board of Directors is asked to approve the report.		
Appendices:		Appendix 1: Gender Pay Gap Report 2025		

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Gender Pay Gap Report 2025

PACT
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Introduction

The Shrewsbury and Telford Hospital NHS Trust are one of the region's largest employers. We are proud to have a diverse workforce of 8247 substantive colleagues.

The Shrewsbury and Telford Hospital NHS Trust (SaTH) is the lifeblood for nearly 500,000 people in Shropshire, Telford & Wrekin, and mid Wales, delivering vital district general hospital services.

The majority of our care (99%) takes place across our two major sites: the Princess Royal Hospital (Telford) and the Royal Shrewsbury Hospital (Shrewsbury). From A&E and critical care to diagnostics and inpatient services, both hospitals offer the complete range of acute care our community relies on.

The Trust's People Strategy embeds inclusion and equity at it's core, ensuring our workforce reflects the people we treat and cultivate strong healthcare partnerships. We provide a broad array of career opportunities to attract and keep top professionals. Our goal is simple: to create a workplace where every colleague feels valued and supported. Through the consistent review of our gender pay gap, we are proactively addressing inequalities to offer a fair and equitable working environment for everyone.

Background.

Gender pay reporting is mandatory under UK law (Equality Act 2010). This report data illustrates the earnings gap between male and female employees at our organisation.

The gender pay gap shows the difference in the average hourly rate of pay between men and women. A gender pay gap can be driven by several factors including, crucially, underrepresentation of women in senior positions.

We use this information to assess:

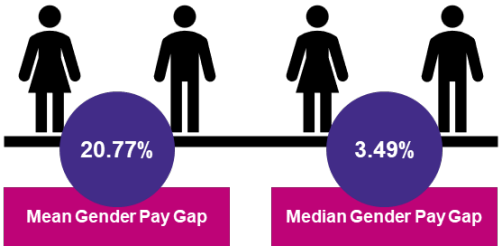
- Gender equality across our workforce
- Representation of men and women at different pay levels
- Our effectiveness in recognising and rewarding talent.

Important points of note:

- **Gender pay gap is not the same as unequal pay.** Equal pay for equal work is a separate legal requirement.
- **Our current records do not include non-binary gender identities**. We fully acknowledge and respect the diversity of gender identities, including non-binary and transgender individuals.
- **The public sector deadline for publication of the data** is 30th March each year, with calculations based on a 'snapshot date' of the previous 31st March.

Our headline Gender Pay Gap data

Our mean gender pay gap is 20.77%. The median gender pay gap is 3.49%. This is inclusive of our Medical and Dental colleagues. This gap is driven primarily by under-representation of women in senior medical roles. Our non-medical workforce gap remains in favour of women.

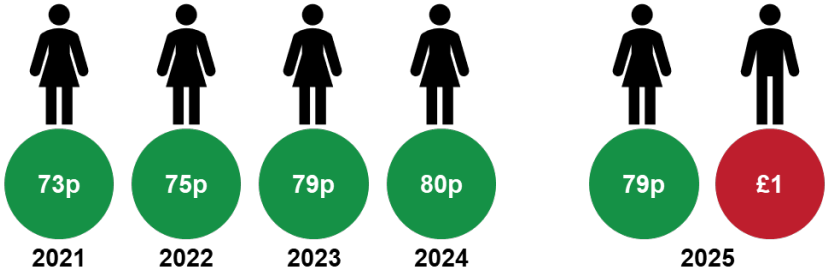


Mean average Rates of Pay by Gender in The Shrewsbury and Telford Hospital NHS Trust – All staff (inclusive of Medical and Dental)

To calculate the mean pay gap, we add together all the hourly pay rates that women received, divided by the number of women in our workforce. We then repeat this calculation for men. The difference between these figures is the mean gender pay gap.

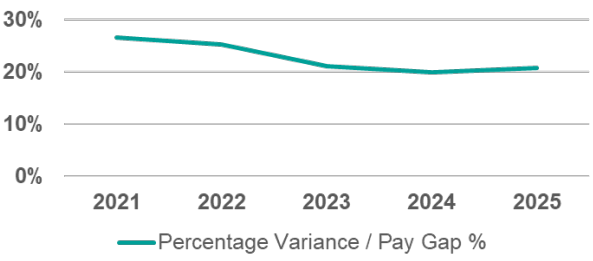
The hourly rate is calculated using "ordinary pay," which includes basic pay, allowances, and shift premium. Our pay rates exceed the national living wage.

This means women earn 79p for every £1 that men earn when comparing mean hourly pay.



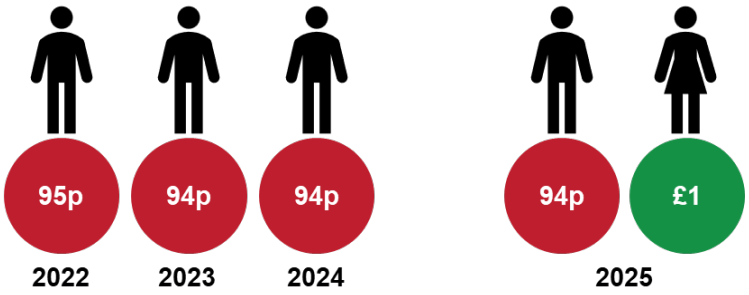
Our overall mean pay gap has grown in 2025 by 0.85% to 20.77% for all staff. This is equivalent to male colleagues receiving on average 62p per hour more than women.

	2021	2022	2023	2024	2025
Male	£21.73	£22.23↑	£22.13↓	£23.05↑	£25.10↑
Female	£15.97	£16.62↑	£17.46↑	£18.46↑	£19.89↑
£ Difference	£5.76	£5.61↓	£4.67↓	£4.59↓	£5.21↑
Percentage Variance / Pay Gap %	26.50%	25.24%↓	21.07%↓	19.92%↓	20.77%↑

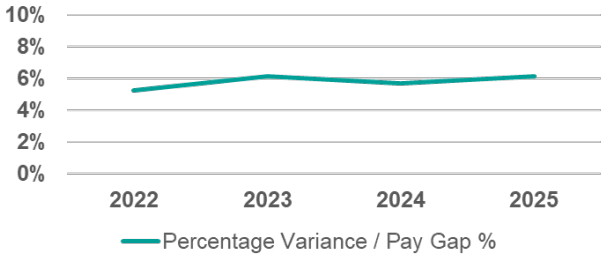


Mean average Rates of Pay by Gender in The Shrewsbury and Telford Hospital NHS Trust – Excluding Medical and Dental

- Female colleagues in positions that are non Medical and Dental are paid more than their male counterparts and have been for the last 4 years. The overall mean pay gap for non medical colleagues is 6.13% in favour of women and this has increased by 0.46 percentage points (pp) compared with 2024.
- **This means men earn 94p for every £1 that women earn when comparing mean hourly pay.**

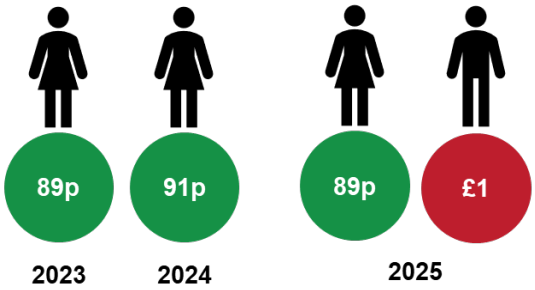


	2022	2023	2024	2025
Male	£14.83	£15.64	£16.57↑	£17.61↑
Female	£15.65	£16.59	£17.50↑	£18.69↑
£ Difference	£0.82	£0.96	£0.94↓	£1.08↑
Percentage Variance / Pay Gap %	5.24%	6.12%	5.67%↓	6.13%↑

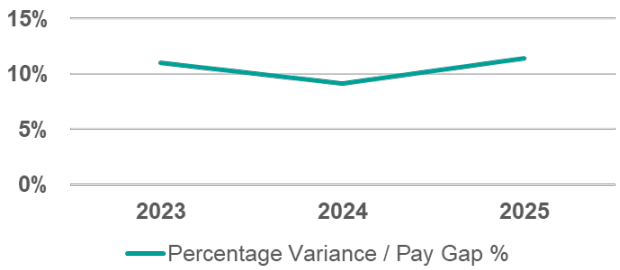


Mean average Rates of Pay by Gender in The Shrewsbury and Telford Hospital NHS Trust – Medical and Dental only

- The overall mean pay gap for medical and dental colleagues is 11.36% in favour of men and this has increased by 2.2 percentage points (pp) compared with 2024.
- **This means women earn 89p for every £1 that men earn when comparing mean hourly pay on average.**



	2023	2024	2025
Male	£39.63	£40.37↑	£44.72↑
Female	£35.29	£36.67↑	£39.64↑
£ Difference	£4.34	£3.70↓	£5.08↑
Percentage Variance / Pay Gap %	10.96%	9.16%↓	11.36%↑

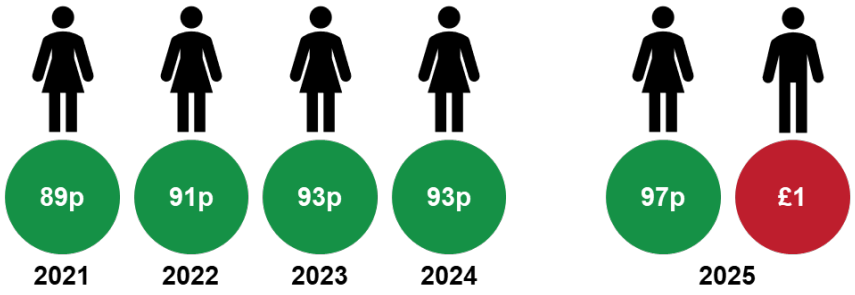


Median average Rates of Pay by Gender in The Shrewsbury and Telford Hospital NHS Trust – All staff (inclusive of Medical and Dental)

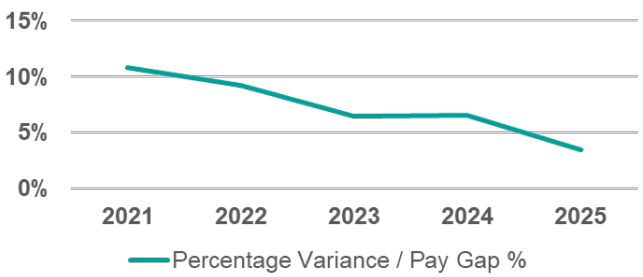
To calculate our median gender pay gap, we first rank all our people by their hourly pay. Then we compare what the woman in the middle of the female pay range received with what the man in the middle of the male pay range received. The difference between these figures is the median gender pay gap.

Our median pay gap has seen a **significant decrease** this year from 6.57% to 3.49%. This equates to **a reduction of 51p year on year.**

This means women earn 97p for every £1 men earn when comparing the median average



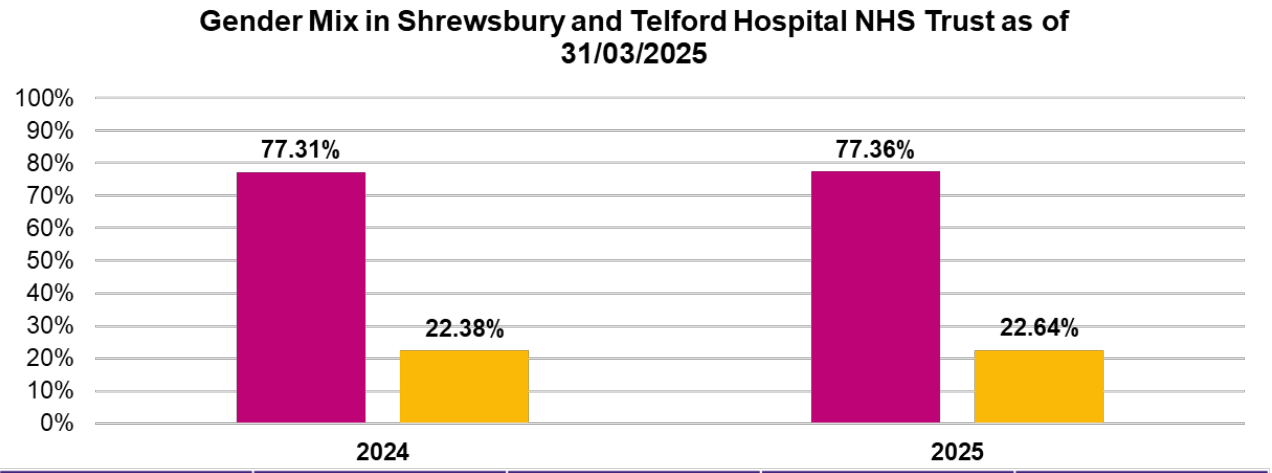
	2021	2022	2023	2024	2025
Male	£15.65	£16.13↑	£16.68↑	£17.68↑	£18.51↑
Female	£13.96	£14.64↑	£15.59↑	£16.52↑	£17.87↑
£ Difference	£1.69	£1.49↓	£1.09↓	£1.16↑	£0.65↓
Percentage Variance / Pay Gap %	10.82%	9.24%↓	6.51%↓	6.57%↑	3.49%↓



Understanding our Gap at Shrewsbury and Telford NHS Trust

Our Trust gender profile is 77% female (6350 colleagues) and 23% male (1897 colleagues) detailed in Table 1

Table 1



	Headcount 2024	Headcount 2025	Percentage 2024	Percentage 2025
Female	6429	6459	77.31%	77.36%
Male	1886	1890	22.68%	22.64%
Total	8315	8349		

Overall Workforce Gender Split

- The Trust's overall gender profile is 77% female (6,459 colleagues) and 23% male (1,890 colleagues).
- The data reflects a classic NHS pattern: a predominantly female workforce concentrated in the lower to mid-level clinical and support roles, with men disproportionately represented in the highest-paying bands and Non-Agenda for Change (AfC) roles.

Gender Representation by Pay Band and Quartile

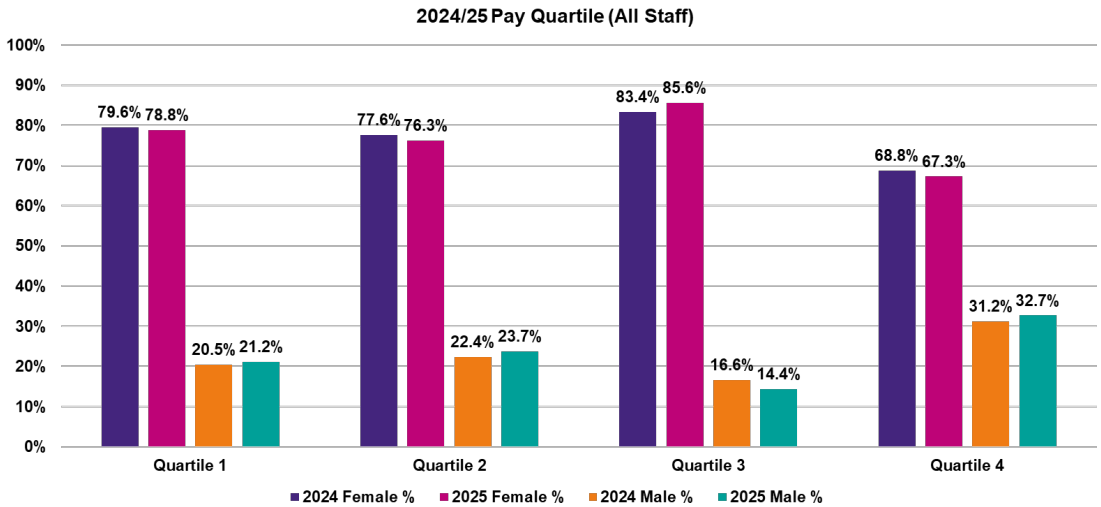
- **Lower and mid-bands (bands 1 through 7):** Women significantly outnumber men, consistently representing over 77% of the staff up to Band 8a. Peak female representation is in Bands 3 and 4, with over 88% female staff in 2025 (see table 2)
- **Highest salaried quartile (quartile 4**): This quartile sees the largest representation of males at 32.72%, an increase of 1.5% since 2024. Women are most highly represented in quartile 3 (see table 3)

Table 2

Gender Mix at Pay Band Level within The Shrewsbury and Telford NHS Trust as 31/03/2025

	2024 Female	2024 Female %	2024 Male	2024 Male %	2025 Female	2025 Female %	2025 Male	2025 Male %
Band 1	6	66.67%	3	33.33%	6	75%↔	2	25%↓
Band 2	1448	75.03%	482	24.97%	1460	74.53%↓	499	25.03%↑
Band 3	750	85.23%	130	14.77%	686	84.28%↓	128	15.72%↑
Band 4	505	89.38%	60	10.62%	516	88.81%↓	65	9.54%↑
Band 5	1266	85.60%	213	14.40%	1315	86.83%↓	241	15.49%↑
Band 6	1074	86.27%	171	13.73%	1117	86.19%↓	179	13.81%↑
Band 7	564	82.58%	119	17.42%	598	82.94%↑	121	16.78%
Band 8a	189	80.77%	45	19.23%	188	77.37%↓	55	22.63↑
Band 8b	86	75.44%	28	24.56%	94	78.33%↑	26	21.67%↓
Band 8c	30	71.43%	12	28.57%	28	66.67%↓	14	33.33↑
Band 8d	10	90.91%	1	9.09%	9	90%↓	1	10%↑
Band 9	9	69.23%	4	30.77%	9	56.25%↓	7	43.75%↑
Non AFC	358	40.18%	553	59.82%	433	43.96%↑	552	56.04%↓

Table 3



Quartile	2024 Female	2024 Female %	2025 Female	2025 Female %	2024 Male	2024 Male %	2025 Male	2025 Male %
1	1653.00	79.55%	1624.00	78.83%	425.00	20.45%	436.00	21.17%
2	1613.00	77.59%	1573.00	76.29%	466.00	22.41%	489.00	23.71%
3	1729.00	83.41%	1765.00	85.60%	344.00	16.59%	297.00	14.40%
4	1434.00	68.78%	1388.00	67.28%	651.00	31.22%	675.00	32.72%

Male dominance in senior/specialist Roles:

- **Band 9 (Highest AfC Band):** Male percentage is over 40% (43.75% in 2025), significantly higher than in the mid-bands.
- **Non-AfC Roles:** These roles (often including medical consultants and very senior managers) are heavily male dominated, with men representing **56.04%** in 2025. This structural imbalance in the highest-paying roles is the primary cause of the overall gender pay gap.

Trend Analysis (2024 to 2025)

Band	Female % Change (2024 → 2025)	Male % Change (2024 → 2025)	Interpretation of Trend
Bands 2, 5, 6, 7	Decrease	Increase	**Increasing Balance:** The shift is positive, with a slight increase in the male percentage and a corresponding decrease in the female percentage.
Bands 3, 4, 8a, 8b	Increase	Decrease	**Decreasing Balance:** The female percentage increased, and the male percentage decreased, further cementing the female dominance in these bands.
Band 9	Decrease	Increase	**Notable Shift:** The female percentage dropped from 69.23% to 56.25%, while the male percentage jumped from 30.77% to 43.75%. This is the largest shift towards male representation in the highest AfC band.
Non-AfC	Increase	Decrease	**Positive Shift:** While still majority male, the female percentage increased from 40.18% to 43.96%, and the male percentage decreased from 59.82% to 56.04%, indicating some progress toward gender balance in the most senior roles.

Bonus Payments

The bonus payments referred to in this section relate exclusively to doctors. The contractual entitlement to access an annual award round ceased on 1 April 2024 in England, although recipients of pre-2018 awards will continue to receive them and their value is frozen (Table 4).

Table 4 **Local clinical excellence awards pre-2018**

Award level for pre-2018 LCEA holders	Value (£)
1	3,016
2	6,032
3	9,048
4	12,064
5	15,080
6	18,096
7	24,128
8	30,160
9	36,192

The pot for the pre-2018 local clinical excellence awards scheme (LCEA), introduced in 2004, was worth more than £400 million, and awards granted were consolidated and pensionable.

Between 2018 and 2023, consultants were eligible for another scheme of local awards, although these were non-consolidated, non-pensionable and time limited. As part of the consultant contract terms and conditions, a minimum amount of money per consultant needed to be made available as a multiplier per eligible Consultant. These funds were shared out pro-rata with all eligible Consultants capped at 1.0 WTE. These awards ceased in 2024 as part of the Consultant pay reform which meant that Local Clinical Excellence Award funds were consolidated and redeployed into the remuneration for new consultant pay scales.

Table 5 displays the mean bonus pay gap as 42.64%. This disparity is primarily due to the underrepresentation of female consultants in receipt of the pre 2018 CEAs. Additionally, the mean bonus pay gap is skewed by the disproportionate number of male consultants receiving these higher-level pre 2018 CEAs detailed in table 6. The mean bonus pay gap is further skewed by the disproportionate number of male consultants receiving these higher-level pre-2018 CEAs (Levels 7, 8, and 9). As shown in Table 4, the highest award is over £36,000, which is 12 times the lowest award. If the highest awards are predominantly held by men, the mean pay gap will be dramatically amplified. Only 2% of the pre 2018 awards at level 5-9 were awarded to women in the Trust.

Table 5

Average Bonus Pay (all staff)

	2021	2022	2023	2024	2025
Male	£11,594.26	£11,871.78	£11,999.51	£11,614.19	£11,449.03
Female	£7,347.09	£7,650.42	£6,612.43	£6,567.90	£6,566.68
£ Difference	£4,246.91	£4,220.58	£5,387.08	£5,046.29	£4,882.35
Percentage Variance / Pay Gap %	36.6%	35.56%	44.89%	43.45%	42.64%↓

Table 6

2023/24 Bonus Data

	2023			2024			2025		
	Employees Paid Bonus	Total Relevant Employees	Percentage %	Employees Paid Bonus	Total Relevant Employees	Percentage %	Employees Paid Bonus	Total Relevant Employees	Percentage %
Female	32	6927	0.46%	26	7299	0.36%↓	25	7187	0.35%↓
Male	78	1894	4.12%	71	2177	3.26%↓	67	2204	3.04%↓

The Trust acknowledges that presenting the bonus pay gap across the whole staff group (as in Table 5) dilutes the real evidence of the gender pay gap by including a staff M:F ratio that is skewed. The true driver is the historical distribution of the consolidated, high-value CEAs among the consultant workforce, which heavily favours male doctors, particularly at the highest levels.

Since there is no longer an award round for bonus payments in England, there is no opportunity for the Trust to close this gap through new awards. The gap will only reduce over time as the long-serving consultants who hold these pre-2018 CEAs retire or leave the Trust.

Consultant doctors and dentists pay progression system guidance | NHS Employers.

Conclusion

The Trust's gender pay gap profile is improving for most staff groups, with median gap halving since 2024. The remaining mean gap reflects occupational segregation rather than pay inequity. The significant reduction in the median gender pay gap demonstrates active, measurable progress. Suggesting that the Trust is successfully addressing pay inequality for the "typical" or "middle-earning employee". Further inferring that women and men in equivalent or comparable work are being paid more equally. The median is less affected by a few very high or very low salaries (unlike the mean). Therefore, a strong reduction in the median gap is robust evidence that the pay structure for most employees has become fairer.

The organisation exhibits a significant gender pay gap of 20.77% based on average hourly rates. This gap is primarily driven not by unequal pay for the median worker, but by under-representation of females in the highest-paid roles and a corresponding over-representation of males in those same roles. When medical and dental staff are excluded from the calculations, a pay gap of 6.13% in favour of females is observed.

Our annual staff survey for the corresponding year, which asks "I am satisfied with my level of pay," has shown that 30.9% (3113 surveyed) of women are satisfied or very satisfied with their pay versus males (746 surveyed) at 34.8%. This has seen a decrease from 35.2% in 2023/4 staff survey Our comparator scores for other acute and acute community trusts were 30.4% for the 2024/5 year suggesting Shrewsbury and Telford NHS Hospital Trust colleagues are more satisfied than their peers in comparable organisations.

Reducing the Gender Pay Gap at The Shrewsbury and Telford NHS Trust

The gender pay gap, is a persistent issue in many workplaces and here at The Shrewsbury and Telford NHS Hospital Trust, we are committed to closing that gap. We are proud to advance our initiatives in leadership development, promoting and shaping training and development opportunities and apprenticeship programs. This has been achieved by collaborating with our staff networks, EDI steering groups, and ICS to ensure an equitable and inclusive workplace.

Our strategy for tackling our pay gap connects within pillar two of our People Strategy "Belonging in the NHS". Progress will be governed and monitored under High Impact Action 3 (Eliminate total pay gaps with respect to race, disability, and

gender) of the NHS six high impact actions improvement tool for Equality Diversity and Inclusion.

Actions for 2025-2026

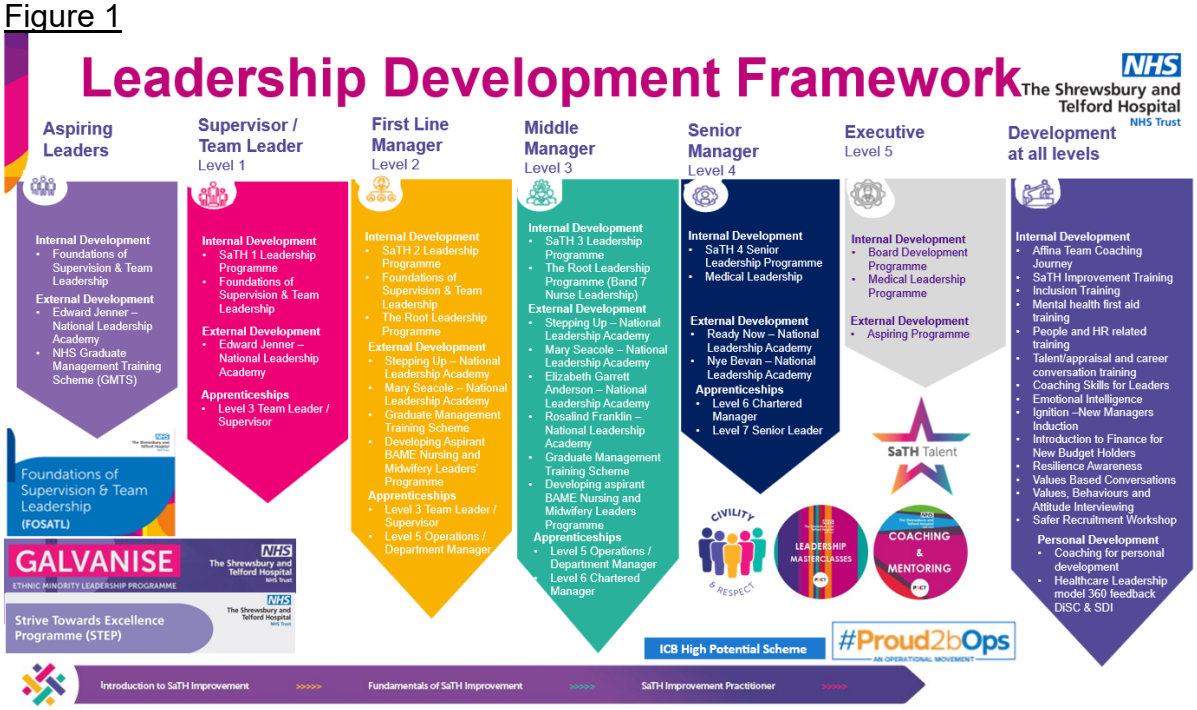
Many of the impacts to address the gender pay gap are longer term initiatives and these will include:

- **Retention and promotion of women** into Bands 8c, 8d, and 9
- **Increasing female representation** in the Medical and Dental higher pay quartiles. Currently a project is underway to seek to understand barriers to construct a robust long term action plan to rectify this.
- **Recruiting males** into the lower and mid-bands (Bands 2-7) to better balance the general workforce and reduce the overall gender concentration.

Developing our people

Providing a comprehensive suite of leadership development opportunities (Figure 1), accessible to all colleagues, is fundamental in addressing any pay gap. At SaTH, we believe we have achieved this through our various offerings. Our non-medical leadership development programs have seen 380 participants since January 2023, of whom 312 were female (89%). Additionally, our Medical Leadership Development Training, introduced in 2022, has been offered to all medical leaders in post, with 100 completing the training, including 40 females (40%). This proportion aligns with the number of female senior medical staff within the organisation. To further support our colleagues' development, we offer a dedicated career portal, coaching and mentoring services, and apprenticeship schemes. Since 2018, 154 females and 20 males have accessed formal coaching and mentoring. In 2024-5, of the 219 colleagues who joined or were on our apprenticeship schemes, 177 were female (80.8%).

Figure 1



Our Commitment to Fair Recruitment and Transparent Pay

We are committed to building an inclusive environment by promoting equitable opportunities for all staff and maintaining robust pay transparency. To foster an inclusive workplace, we continuously deliver "Safer Recruitment" training to address unconscious bias and embed inclusive practices in our hiring. This has recently been reviewed and updated in conjunction with network representatives. We have also achieved our Disability Confident Leader status in 2025 by making significant accessibility adjustments. We continue to provide assistive software (e.g., Dragon Naturally Speaking, Caption ED) and supporting staff and managers through the Staff Health Passport and the Sunflower Scheme. Furthermore, we have streamlined our workplace adjustment process with clear management guidance. Through partnerships like DFN Project SEARCH*, we ensure valuable opportunities by offering supported internships and training for young adults with learning disabilities or autism.

Regarding pay equity and competitiveness, we minimise the risk of pay bias by using the nationally agreed job evaluation scheme, which ensures equal pay for work of equal value. Our reliance on Agenda for Change pay scales keeps us competitive and allows managers to appropriately compensate new hires based on experience. This approach is reflected in our hiring data: out of 483 new hires (Bands 3–9), 111 (22.98%) were placed at the top of their band's pay scale. Importantly, 82% (91) of those highly compensated new hires were female, demonstrating a successful, experience-based approach to female remuneration. In the most senior groups (Bands 8b–9), four of 13 new hires received top-of-band pay, with an equal split between two men and two women. Furthermore our hiring data for medical and dental colleagues 2024-5 demonstrates that from shortlisting to appointment we hired more women than men.

**DFN Project SEARCH is a transition-to-work program for young adults with a learning disability or autism spectrum conditions, or both.*

Enabling a flexible working mindset

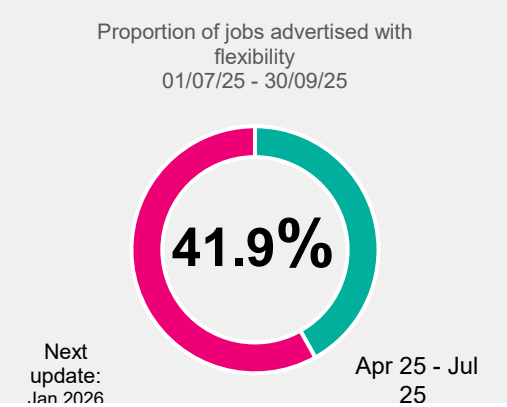
Encouraging and supporting colleagues to work more flexibly at all levels within our organisation can help reduce the Gender Pay Gap. By offering more options that empower staff members to have a greater say in where, when, and how they work, we can create more job and career opportunities, attract high-quality candidates, and retain a diverse workforce. Flexible working also contributes to enhanced work-life balance and overall well-being, reducing stress and absenteeism.

To support SaTH staff and managers in embracing flexible working, the Flexible Working Group continues to promote flexible working through the Flexible Working Masterclasses and Toolkit Briefings for both staff and line managers. These initiatives share the benefits of flexible working, provide success stories, and encourage creative thinking to identify practical options where possible. The Flexible Working Masterclass is now included as part of the Strive Towards Excellence Programme (STEP) for new managers to encourage more managers to see the benefits of working flexibly within their teams.

Our 2024 Staff Survey results saw improvements in the NHS People Promise element, We work Flexibly. The score (6.26) has continued to increase since 2021 (5.57) and is now above average for our sector of Acute and Acute & Community Trusts (6.24). As with 2023, the Staff Survey results demonstrated a strong correlation between increased flexibility and improved employee outcomes. Clinical areas that significantly increased their scores in the NHS People Promise element "We work flexibly" also experienced improvements in morale, engagement, and turnover.

SaTH developed a Flexible working dashboard to support the identification of areas that would benefit from focussed intervention. SaTH has seen an increase in the number of vacancies that are advertised with flexibility in the 2nd quarter. Between July – September 2025 41.9% of vacancies were advertised flexibly (Figure 2). Information on recruiting flexibly has been included in our flexible working masterclass, this is an improvement from the previous quarter (37.5%), however more work is needed to encourage more recruiting managers to recruit flexibly.

Figure 2



Empowering Staff Networks and External Learning

Staff networks play a vital and strategic role in enhancing our culture of inclusivity, promoting a positive working environment, and ensuring staff feel empowered to bring their authentic selves to work. Our Trust is fortunate to have a range of dynamic networks, including the Race Equality Network, PRIDE Network (LGBTQIA+), Disability and Long-Term Health Conditions Forum, DAWN, and our Multi-Faith and Belief Network. All networks have executive sponsorship and are chaired by a mix of both male and female colleagues, providing valuable platforms for community building, engagement, and direct influence on decision-making.

In addition to internal initiatives, we actively engage across our Integrated Care System (ICS) and outside our region. This external collaboration allows us to share learning and benchmark our success against peers, furthering our progress toward making the Trust an excellent place for both staff and patients.

Through the collective implementation of these strategies—focused on recruitment, pay equity, and culture—The Shrewsbury and Telford Hospital NHS Trust is positioned to significantly reduce the gender pay gap, foster a more equitable workplace, and successfully promote gender equality across the organisation

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 12 March 2026

Agenda item		064/26		
Report Title		Business Continuity Management Policy		
Executive Lead		Ned Hobbs, Chief Operating Officer		
Report Author		Emma-Jane Beattie & Musili Oshevire, Emergency Planning Team		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk, if appropriate:**
Safe	√	Our patients and community	√	BAF1, BAF2, BAF3, BAF 8
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id, if appropriate:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Health, Safety and Security Committee, 14 August 2025 Policy Approval Group, 24 September 2025 and 17 December 2025 Audit & Risk Assurance Committee, 16 February 2026		
Summary:		In line with the NHSE Core Standards 46 & 47 for EPRR-Business Continuity Plan (BCP), Business Impact Analysis (BIA), The Shrewsbury and Telford NHS Trust must have arrangements in place to respond effectively to: • Link BCP strategies for management • Establish an overview of trust wide critical services. • Show the interdependence of services and priority ranking. • Align the plan to the BC toolkit 2023 • Embed learnings from BC events, debriefs and exercises The updated policy addresses all of the above requirements.		
Recommendation(s):		The Board of Directors is asked to approve the policy (as a policy reserved to the Board under the Trust's Scheme of Reservation and Delegation).		
Appendices:		Appendix 1: SaTH Business Continuity Management Policy		

1.0 Introduction

1.1 In line with the NHSE Core Standards 46 & 47 for Emergency Preparedness, Resilience and Response, all plans must be reviewed at least annually or after any incident or exercise.

1.2 The UK Government Resilience Action Plan which was published by the Cabinet Office on 24 June 2025 indicates that the risks that the UK faces are volatile, varied and interconnected. The UK Government Action Plan sets out further detail on the Government's plan to strengthen domestic resilience and details how the UK government is investing to protect the nation. It is underpinned by the UK government's recognition that these era-defining challenges create risks that, ultimately, can impact our everyday lives. They can disrupt our public services, our infrastructure, our health, our communities, our national defence, the environment and the economy. Furthermore, these consequences do not fall evenly across our society, so assessing and planning for people who are vulnerable in different types of emergencies is also core to the Governments action plan. The Shrewsbury and Telford Hospitals Trust endeavours to align to the principles of the UK Resilience Action Plan with the Trust Business Continuity Management System and Business Continuity Policy.

1.3 NHSE Core Standard 46 requires the trust to have a corporate Business Impact Analysis and corporate Business Continuity Plan in place, which must be regularly reviewed, tested and exercised and that relevant staff with a role in business continuity should be trained to undertake their role within the plan.

1.4 The Business Continuity Plan is a policy which is 'reserved' to Board, as per the Scheme of Reservation & Delegation.

2.0 Updates to the policy

2.1 The policy has been circulated to internal and external stakeholders and comments/ amendments/ recommendations have been included in the revised policy.

2.2 The policy has been reviewed in line with the NHSE Core Standards 46 & 47 for EPRR.

2.3 The policy has been updated to include and reflect the Policy Approval Group Comments of 24 September 2025 and 17 December 2025 in relation to policy format.

Emma-Jane Beattie
Emergency Planning Manager
February 2026

The Shrewsbury and Telford Hospital NHS Trust

Business Continuity Policy

EPRR003

Version 12.0

If this policy has been activated and you have not reviewed this document recently- do not attempt now. Go to Business Continuity management system EPRR004 document and follow the action cards.

Additionally refer to:

- Business Continuity Management System (EPRR004)
- Major Incident Policy (EPRR001)
- Major Incident Operational Plan (EPRR002)
- SaTH Corporate Business Continuity Plan (EPRR014)

Version:	V12.0
V1 issued	August 2011
V12 Ratified by	Trust Board
V12.0 Date ratified	TBC
V12.0 approved by	Audit and Risk Assurance Committee (ARAC), Policy Approval Group (PAG), Health Safety, Security and Fire (HSSFC)
V12.0 Date approved	February 2026, 17th December 2025 & 14th August 2025
Document Written by	Emergency Planning & Business Continuity Officer
Document Lead Director	Chief Operating Officer
Current Issue Date:	December 2025
Next Review date:	December 2028
Target audience:	All staff members with a role during business continuity disruption & Major Incidents

Document Control sheet

Document Lead/Contact	Emergency Planning Team
Version	V12.0
Document ID	EPRR003
Status	Final
EQIA completed Date	15.06.2025
First Issue Date	August 2011
Next Review Date	January 2029
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	Business Continuity, Major Incident, Disruption. Business Impact Analysis, Plan, Emergency Preparedness Resilience and Response.
Dissemination plan	Email to Senior Managers EPBC Meetings, Staff Meetings Training / Exercising Online, Newsletters

Version history

Version	Date	Author	Status	Comment
V1	Sept 2011	Keith Lister	Final	
V2	Sept 2012	Keith Lister	Final	
V3	May 2013	Keith Lister	Final	
V4	Nov 2014	Keith Lister	Final	
V5	April 2015	Keith Lister	Final	
V6	Dec 2016	Fran Collins	Final	
V7	March 2019	Stewart Mason	Final	Shared for comment by EPBC Group and SLT
V8	March 2021	Emma-Jane Beattie	Draft	Shared for comment by EPBC Group
V9	July 2023	Emma-Jane Beattie	Final	Shared for comment by HSS&FC Committee

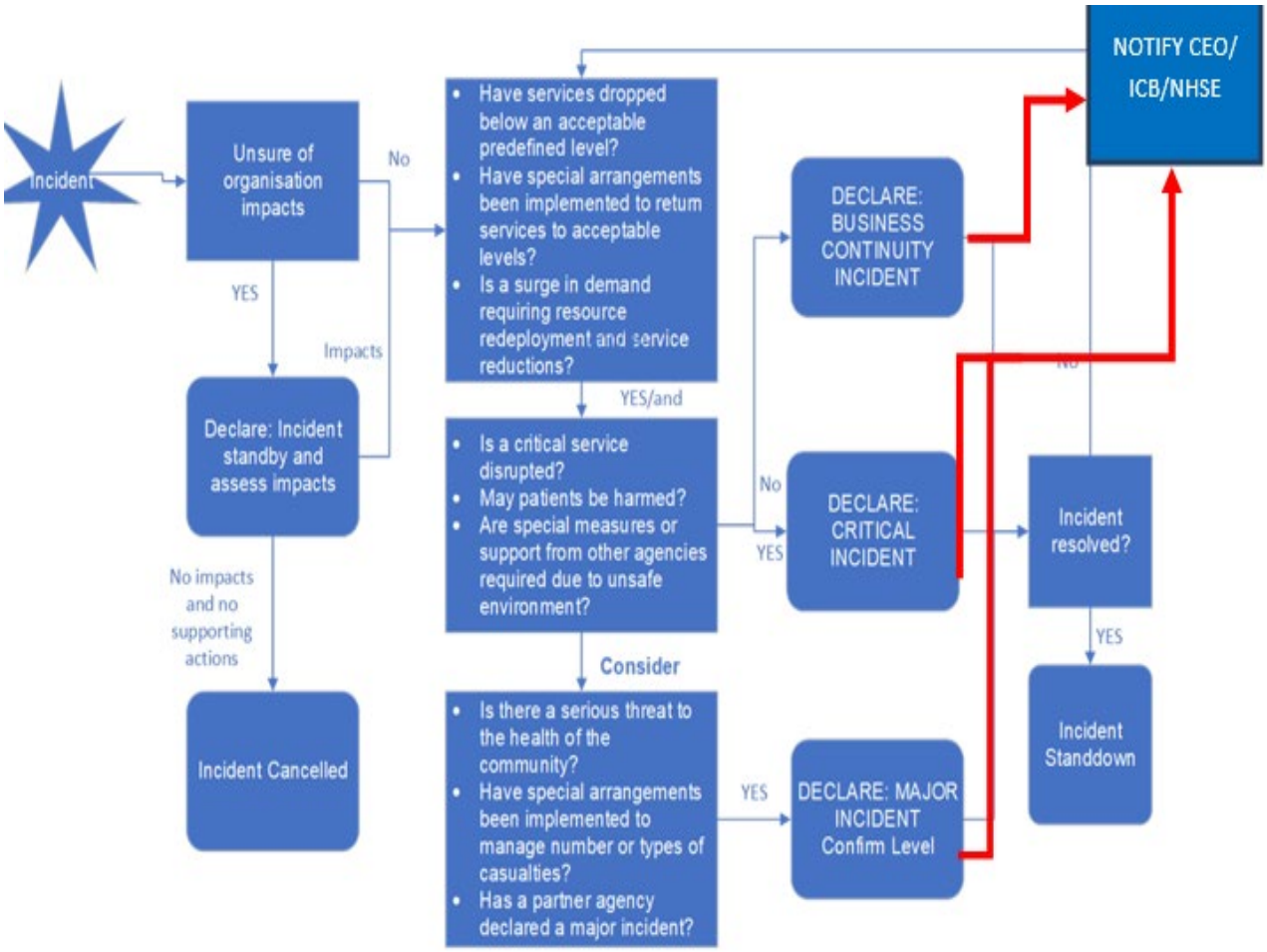
V10	May 2024	Musili Oshevire	Final	Updated to reflect NHSE feedback during core standards assurance 2023 Updated to reflect BCP toolkit 2023 best practices. Updated to reflect improvements and learnings from BCP exercises, testing and risk assessment. Updated to reflect BCP toolkit 2023 best practices. Updated to reflect improvements and learnings from BCP exercises, testing and risk assessment
V11	Jan 2025	Musili Oshevire	Final	Updated to reflect NHSE feedback during core standards assurance 2024 Updated with suggestions from trust Board
V11.1	09/07/2025	Musili Oshevire	Final	Feedback from consultation with stakeholders. Updated date for EQIA to 2025., add online and newsletters as policy dissemination routes. Rephrase governance route page 6. Updated roles and responsibility on page 7-9, Rephrase function of RMC in page 14, added the word template to Appendix B, clarified who uses appendix C, D, E, G, deleted duplicated F
V12.0	02/12/2025 and 20/01/26	Musili Oshevire	Final	Updated to reflect Policy Approval Group feedback. Embedded lessons and best practises from EPRR core standards assurance 2025.

Review and Amendment log for minor changes

Version	Type of Change	Date	Description of change
V2	Update	18/09/2012	Minor changes to standards and structures
V10	Updates	10/06/2024	Minor feedback from consultation and approval process at HSSFC (June 2024)
V10	Updates	06/12/2024	Minor feedback from core standard assurance. Include definitions for criterial functions and list critical services.
V11	Updates	31/01/2024	Feedback from NHSE EPRR core standard assurance Feedback on governance structure of the BC policy reviewed to reflect feedback from board meeting.

			Board approved Jan 2025
V11	Organisation name	21-08-2024	Change PHE to UKHSA
V11	Contact number	21-05-2025	Change NHSE First on call contact number
	Organisation name	21-05-2025	Change CCG to ICB
V11	Updates	21/05/2025	Change SBAR template to version 3
V11.1	Updates	11/07/2025	Update of table of content

1.0 Policy on a Page



2.0 Introduction

The International Standard Organisation (ISO) 22301 defines business continuity as an organisation's capability to continue delivering products and services within acceptable timeframes, at predefined capacity, during a disruption. This Business Continuity Policy sets out to guide the Shrewsbury and Telford Hospital (SaTH) delivering safe and quality service to patients during disruptions. This policy aligns with the overall objectives of the organisation's Operational Plan 2025/2026 (Issuu Reader). The policy is also developed in conjunction with the NHS Emergency Preparedness, Resilience and Response (EPRR) guidance.

The Business Continuity Policy sets out the strategic direction for which all business continuity plans in the trust are built, while the Business Continuity Management System is details activities and arrangements that must be maintained in order to achieve this policy statement. The business continuity policy, Business continuity management system, and all BCP documents can be found here on the intranet SaTH Intranet - Business Continuity Plans.

Whilst the Trust will make every effort to cover everything in relation to all Business Continuity and its systems, there will be limitations and unforeseen risk due to a Business Continuity Incident being an event or occurrence that disrupts an organisations normal service delivery below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level.

Under the Civil Contingencies Act 2004 and the Health and Social Care Act 2012 all NHS organisations have a duty of care. This duty must be reflected in Business Continuity plans because when an incident occurs, impacting upon their ability to maintain critical function; service provision may be affected, hence impacting lives. The incident can affect buildings, people, equipment, systems, supply chain or a change in demand during an infectious disease outbreak.

The strategic intent of this policy is to ensure that each division have tactical Business Continuity plans and departments/services have operational Business Continuity Plans that are developed in line with national guidance, the BC toolkit, consulted and exercised accordingly. Within the BCPs there should be a detailed business impact analysis (BIA) of critical functions and recovery measures that will be implemented in the event of a business continuity incident.

3.0 Purpose and Scope

This policy applies to all staff involved in business continuity and major incident response.

3.1 The strategic Intent of the policy are;

- To maintain safe, quality patient care during disruptions.
- Develop and exercise tactical and operational BCPs.
- Embed Business Impact Analysis (BIA) and risk assessment.

4.0 Key Objectives

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

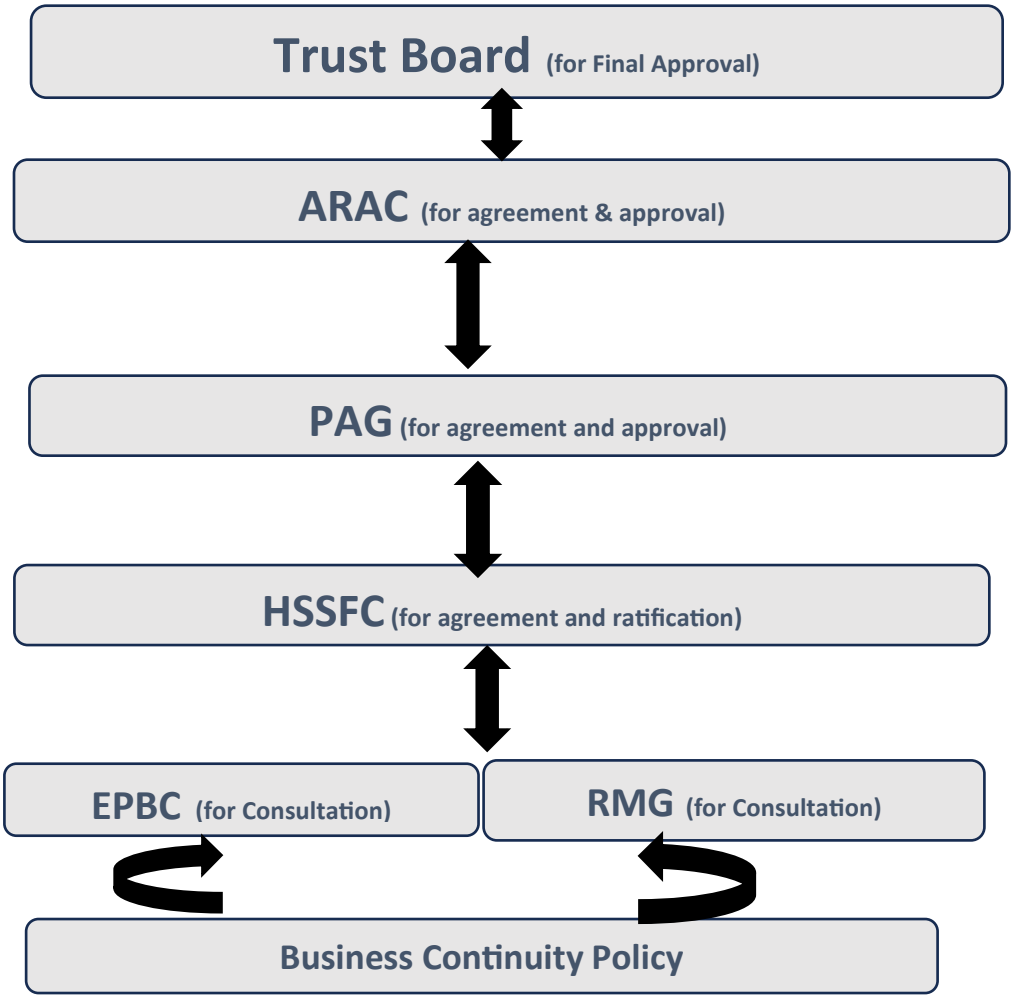
5.0 Business Continuity Policy Governance Structure

The Business Continuity Policy will go through two routes for consultation. The first route is the Emergency Planning and Business Continuity (EPBC) group; a working group of all BC plan holders in the trust. The group meet every quarter to deliberate on the operations of new guidelines, exercises, workshops, and training. All business continuity actions, and planning are followed up in EPBC group for assurance that they are completed and embedded into organisation business as usual.

The second route is the Risk Management Group (RMG). This committee monitors all risks reported on the Datix System. All risks scoring more than 15 are discussed and action plans agreed to address the risks identified. The committee also ensures that open extreme risks that need to be linked to a BCP are actioned and those that require a business case are identified. The Emergency Planning and Business Continuity lead work in collaboration with the Head of Risk to ensure that any reported risk requiring BCP is written and exercised.

The ratification and approval of this policy begin at the Health, Safety, Security and Fire Committee (HSSFC). This committee include departments and divisional lead who meet quarterly to consult on new and updated plans and policies, get updates on EPRR core standard compliance, and share information on best practices. The members will agree that the policy can move forward to the next phase of governance.

The next stage is the Policy Approval Group (PAG). This group ensures all Policies are up to trust standard and approves the policy before it goes to the Audit, Risk, and Assurance Committee (ARAC). ARAC is a non-executive committee responsible for ratifying and signing off the Business Continuity Policy and arrangements before it goes to the Trust Board. The Accountable Emergency Officer (AEO) who is the Chief Operating Officer (COO) will be responsible for seeking approval of the BC policy approved at the Trust Board. The Business Continuity section of the Annual Board Report should report on the business continuity events or incidents experienced in the trust and the tracked on the Key Performance Indictors.



6.0 Responsibilities, Accountabilities, and Duties.

There are key responsibilities for different staff in ensuring the Trust's business continuity policy is written, exercised and implemented. This is to ensure that the policy reflect the national guideline, learnings from incidents, and intelligence gathered towards achieving the objectives of the policy.

During any business continuity incident or event, participating staff member and managers should attend huddle meeting and eventually a hot and cold debrief after the incident is stepped down. The following responsibilities are not exhaustive and can be amended as suitable to the event. A sample of an agenda in appendix F can be used by chairs of business continuity incident meetings

6.1 The Chief Executive or nominated Deputy is responsible for:

- Ensuring that the organisation has effective Business Continuity Management System (BCMS) and processes in place to perform during an incident.
- Making the decision to invoke a Business Continuity Plan (BCP).
- Making the decision on when to convene and chair the Strategic Coordinating Group.
- Notifying and liaising with external agencies / ICB / /NHS England Regional and National teams as appropriate.
- Ensuring an effective communication framework is in place between the strategic, tactical and operational command.
- Monitoring business continuity activity and escalating to a Critical or Major Incident when necessary.
- Gathering and maintaining strategic overview of response to the incident.
- Managing potential harm to SaTH's reputation.
- Ensuring records are kept for governance, audit and future reviews.
- Planning for timely recovery process.

6.2 The Chief Operating Officer (COO) / Deputy Chief Operating Officer (DCOO) is responsible for:

- Being the Accountable Emergency Officer (AEO) for the trust; hence the default strategic commander during in hours while the on-call Senior Executive will be the strategic commander duties out of hours.
- Ensuring that expert lead is available for incident requiring it e.g. new and emerging pandemic.
- Having oversight of Emergency Planning Resilience and Response (EPRR) for the trust.
- Being the executive lead for the SaTH's Business Continuity Policy, and Business Impact Analysis (BIA) for the trust.

- Ensuring an effective communications framework is in place between the strategic, tactical and operational command.
- Ensuring that all divisions and service delivery areas have robust business continuity and recovery plans that are exercised and tested.
- Making the decision to invoke a Business Continuity Plan (BCP).
- Making the decision on when to convene and chair the Strategic Coordinating Group (SCG).
- Carrying out any delegated responsibilities from CEO, ICB, Local Health Resilience Forums (LHRP) and NHS England.
- Monitoring business continuity activity and escalating to a Critical or Major Incident when necessary.
- Chairing the Trust's Emergency Planning & Business Continuity group.
- Ensuring records are kept for governance, audit and future reviews.
- Updating other executives on situation as it evolves.
- Planning for timely recovery process.

6.3 Trust Executive Directors are responsible for:

- Ensuring that all managers in designated areas have robust business continuity and recovery plans, which are exercised and tested.
- Being a member of the Strategic Coordinating Group (SCG).
- Carrying out any delegated responsibilities from CEO, AEO, ICB, LHRP and NHS England.
- Ensuring records are kept for governance and audit.
- When acting in the capacity of Strategic Commander, activating plans and notifying the partners, ICB, Local Health Resilience Forums (LHRP) and NHS England.
- Ensuring an effective communication framework is in place between the strategic, tactical and operational command.
- Liaising with medical leads of neighbouring hospitals and the private sector to seek support as required.

6.4 The Divisional Directors and Deputy are responsible for:

- Ensuring that every division, centre and service area have a robust Business Continuity Plan.
- Ensuring that every Centre Manager, Tactical and Operational Commander understand their responsibility in implementing the Business Continuity Policy and their respective BC plans.
- Ensuring that all BC plans are tested, exercised and implemented appropriately.

- Carrying out any delegated responsibilities from CEO, AEO, ICB, LHRP and NHS England.
- Ensuring an effective communication framework is in place between the tactical and operational command.
- Taking responsibility as Tactical Commander when necessary.
- Making the decision on when to convene and chair the Tactical Coordinating Group.
- Being a member of the Tactical Coordinating Group (TCG).
- Providing SITREPs and briefings to Executives and wider groups affected by the incident.
- Ensuring records are kept for governance and audit.
- Liaising with operational commanders to ensure resources are available to meet BC requirements.

6.5 The Emergency Planning & Resilience Manager (EPRM) is responsible for:

- Providing specialist role and advice to the organisation, both in planning and response to incidents.
- Responsible for the development of Business Continuity Policy, Business Continuity Management System and supporting divisional leads in completing a Business Impact Analysis (BIA) for their service area towards informing a BC plan.
- Providing support and advice to managers on their Business Continuity Plans and incident management.
- Organise the Trust's Emergency Planning & Business Continuity (EPBC) group meeting.
- Deputises the DCOO in chairing the Trust's Emergency Planning & Business Continuity group.
- Organising trainings, exercises and scenarios to test business continuity and emergency planning arrangements.
- Developing and maintaining a Training Need Analysis for the Emergency Planning team, Strategic, Tactical and Operational commanders.
- Engaging and Liaising with the ICB, NHSE, Business continuity partners and local health resilience forums on behalf of SaTH.
- Planning and facilitating post incident debriefs for best practices.

6.6 Centre Manager/ Operational Managers are responsible for:

- Leading on the development of Business Impact Analysis (BIA) and Business continuity Plan (BCP)
- Attending at BIA and BCP review and training workshops.
- Testing and exercising of BC plans for improvement and embedding of best practises.
- Reviewing BC plans after incidents to ensure plans are effective, adequate and fit for purpose.

- Monitoring BC activity, escalating appropriately.
- Activating BC plans and alerting divisional leads.
- Keeping training record of staff.
- Maintaining communication channels during periods of disruption - mobiles, red phones, radio's, etc.
- Acting as a member of the Operational/ Tactical Coordinating Group as directed or required.
- Providing Situation reports (SITREPs) during a Business Continuity incident to Trust management, ICB, NHS and partners
- Leading annual assurance of EPRR core standard assessment and compliance for the trust.
- Maintaining close link with risk management of all service units towards building resilience.

6.7 Action Cards

Action Cards template (appendix B) can be used to develop an action card for the Strategic, Tactical and key Operational personnel. Examples of tailored action cards to services and divisions can be found at the following.

a) In departmental/services business continuity plan annex.
b) In the Major Incident boxes at RSH & PRH incident command Centre.
c) On the Intranet. SaTH Intranet - Business Continuity Plans

7.0 Incident Declaration Flow Diagram

The activation of this policy will require the decision to declare a business continuity incident in response to a notification of an incident that disrupt the business as usual or safe delivery of service within the trust. **Appendix A** details the escalation routes for when an incident is identified.

The Chief Operating Officer/Deputies, Emergency Planning Team and On-Call staff should consider the policy on a page flow chart for incident definition to assist with the correct incident declaration. The AEO or the Strategic Commander leading an incident response will be responsible for signing off a completed situation report referred to as SBAR **(Appendix D).** The SBAR is required to be submitted to the ICB and NHSE within 1 hour of incident declaration. The sitrep will be updated and submitted daily until the incident is stood down.

In declaration and responding to an incident, documentation of situational awareness, actions required, and rational for the decision made are very important. A logbook can be used to capture this information. **Appendix E** is a sample log sheet to use in documentation during BC incidents/ events. In **Appendix C**, the Emergency Response Checklist itemises vital activities be carried out while responding to an incident.

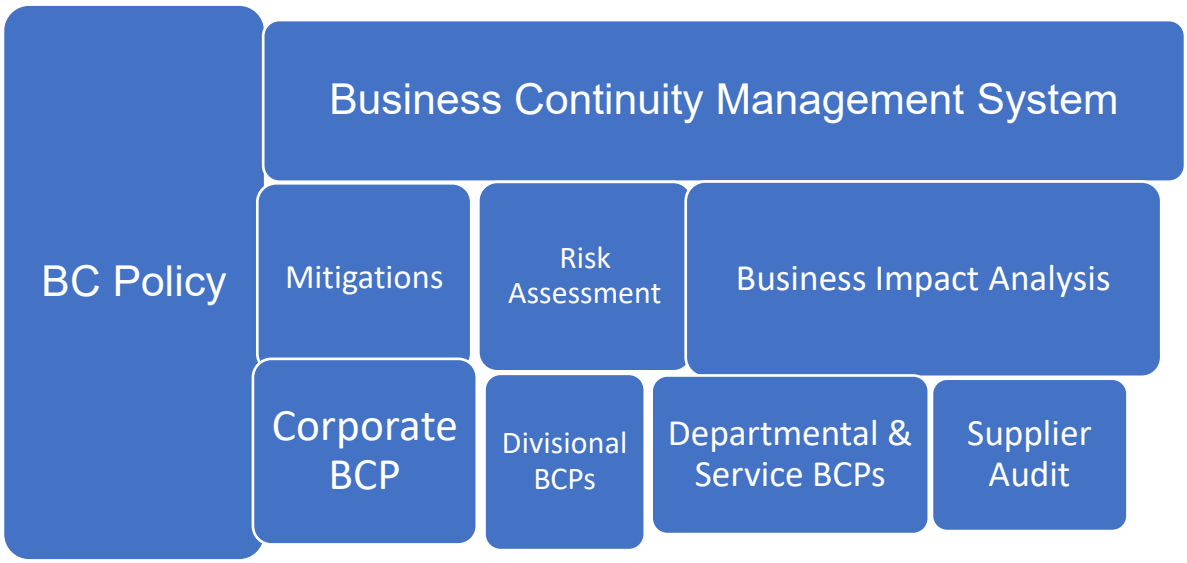
8.0 Business Continuity Overview

Business continuity encompasses the policy, plans (corporate, divisional, departmental, services) and BC management system. These documents explore the different components of the business continuity toolkit and the ISO 22301 recommendations for the management of business continuity in an acute trust.

In reference to Core Standard 44 of the EPRR self-assessment guideline for compliance, SaTH is required to assess climate change risks and how to plan to manage them. Considering that complex business continuity events can often be linked to climate change. The trust Adverse Weather and Disruption Policy (W20.4) will ensure monitoring of weather warning e.g. Heat and Cold alerts from the Met Office to ensure safety of staff during travel to work and maintaining safe service delivery to patients.

8.1 The Business Continuity Management system (BCMS)

This is a plan expanding on core standard 28,45-55 required for managing BC incidents at corporate, divisional and departmental and service level. The BCMS ensure that risk assessment, business impact assessment, mitigations and supplier audits are monitored appropriately. The BCMS document (EPRR004) should be used for operationalising and management of this BC policy.



SaTH operates a dynamic division covering Medicine and Emergency Care (MEC), Surgery Anaesthetics and Critical Care (SACC), Clinical Support and Scientific Services (CSSS), Women and Children (W&C) hence there will be different types of Business Impact Analysis (BIA) within the division. Generally, there are four types of BIAs that the division, departments, and services area can explore and adopt to write their BCPs, namely

8.1.1 Initial BIA- This provides a high-level analysis that can be used to develop a framework for more detailed BIAs. It is usually required the first time an organisation or unit is conducting a BIA.

8.1.2 Product and Services BIA: This identify and prioritises products and services based on the organisations business continuity requirements at a strategic level. It uses the severity of impact of a disruption before an organisational can implement any contingencies to allocate priority to products and services.

8.1.3 Process BIA: This determines the processes required for the delivery of the trust's important products and service. Building on the result of the Product and Services BIA, guidance and significant timeframes can be generated to summarise the impact for each process.

8.1.4 Activity BIA: This identify and prioritise activities that deliver the most important products and services to the trust. It also captures the resources required to deliver these activities. The activity BIA also explores dependencies on external partners, suppliers and service providers because it can largely determine emerging vulnerability and understanding the resource required to prepare.

The corporate BCP is at a strategic level **initial BIA** to understand the critical functions identified from the divisions.

The divisional BCPs are at tactical level ensuring that all key risk dependencies (people, premises, products, information and processes) are analysis and contingencies are identified for all crucial function/service in Medicine and Emergency Care (MEC), Surgery Anesthetics and Critical Care (SACC), Clinical Support and Scientific Services (CSSS), Women and Children (W&C), Estate, facilities, IT, telephony & communication.

The BIAs in **divisional BCPs** are **product and processes focused**. The divisional BCPs unpick the priority services/functions in the **corporate BCP** by ensuring that possible disruption originating from suppliers and partners are identified and mitigated.

The departmental/service BCPs are usually at the **activity BIA** level, covering the immediate service risk e.g loss of people, premises, products, processes nd information to function. As this risk emergency they are routinely reported on Datix.

The starting point for a BIA can either be bottom up or top bottom. The most important factor is ensuring priority functions/services are itemised and learning all reflected across the BIAs.

9.0 Business Impact Analysis

In developing the Business Impact Analysis (BIA), the business functions are itemised to enable the team to distinguish between critical and non-critical function. When a BIA is done in a bottom-up approach, the analysis starts at the department/ services levels and scored based on the below parameters.

9.1 Critical functions are those functions or activities:

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

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

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

9.2 Defining Essential or Critical services

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

Defining essential or critical service or function is determined by the allowable Maximum Time Period of Disruption (MTPD), the below represents the estimated or predefined maximum duration that an organisation's critical business services or operations can sustain a disruption before it reaches a point of critical impact or unacceptable consequences.

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

Activity category	**Essential: Class 0**	**High Priority: Class A**	**Medium Priority: Class B**	**Low Priority: Class C**
Maximum Time Period of Disruption (MTPD)	**Non permissible**	**24 Hours**	**48 Hours**	**72 Hours+**
Activity Example	Activities which cannot tolerate any disruption. If activities are not resumed immediately it may result in: • The loss of life • Significant patient outcome impact • Significantly impact on other NHS services	Activities which can tolerate very short periods of disruption. If activities are not resumed within 24 hours: • Patient care may be compromised • Infrastructure may be lost • There may be a significant loss of revenue	Activities which can tolerate disruption between 24 hours and 48 hours. If service or functions are not resumed in this timeframe it may result in the deterioration of: • Patient condition • Infrastructure • Revenue loss	Activities that could be delayed for 72 hours or more but are required to return to normal operation conditions and alleviate further disruption to normal conditions.

Using the define MTPD above the critical services and functions in all departmental/service BCPs can be summarised in the below format to support uniform information gathering across divisions, departments and services to inform decision making and action as to which function must be always continued, to be reinstated first or scaled down.

Activities which must be always continued:

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

Activities which could be scaled down if necessary:

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

Activities which could be suspended if necessary:

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

9.3 Business Continuity Classifications

NHS Incident Levels

NHS England may also declare and/or communicate a Major, Critical or Business Continuity Incident dependent upon the scale and complexity of the incident, which may require a combined NHS response. There are 4 level that incident declared can be managed. This includes:

Level 1	An incident that can be responded to and managed by an NHS-funded organisation within its respective business as usual capabilities and business continuity plans.
Level 2	An incident that requires the response of a few NHS-funded organisations within an Integrated Care system (ICS) and NHS coordination by the Integrate Care Board (ICB) in liaison with the relevant NHS England region.
Level 3	An incident that requires a few NHS-funded organisations within an NHS England region to respond. NHS England region to coordinate the NHS response in collaboration with the ICB from the affected region. Support may be provided by the NHS England Incident Management Team (National).
Level 4	An incident that requires NHS England national command and control to lead the NHS response. NHS England Incident Management Team (National) to coordinate the NHS response at the strategic level. NHS England (Region) to coordinate the NHS response, in collaboration with the ICB System.NHSE may advise or instruct activation of a local/ trust Major Incident Plan in the event of a Level 4 emergency.

Business Continuity Classifications according to ISO22301 aligns NHS incident levels as shown below.

Level	Category 1 - External Environment	Category 2 - Internal Environment
	Incidents outside the Trust e.g. utilities, terrorism	Incidents originating within the Trust e.g. systems failing, loss of high number of staff.
Local Disruption	The member of staff managing the incident should inform the relevant Directors (clinical & non-clinical) and/or Divisional Directors who will assess the severity of the incident and its possible consequences. If the incident is unlikely to escalate beyond Level 1 status, then control of the incident will be handled locally.	
Minor Disruption	Where the incident is deemed to be Level 2 by a Director (Clinical & Non- clinical) and/or Divisional Directors, this should be escalated to the Trust's Operational Management (COO/DCOO) who will escalate further to the ICB in liaison with the relevant NHS England region for decision to management.	
Major Disruption	Where the incident is deemed to be Level 3 by the Chief Executive/Duty Executive on Call. The decision to convene a West Mercia Local Resilience Forum SCG/TCG may be activated by SaTH Incident Command Centre. To manage the Level 3 incident, a quick Partner Awareness Meeting (PAM) may be called by the Chief Executive, AEO, On-call Executive to share immediate assessment of the threat to the wellbeing of staff, patients or visitors including damage to property or disruption to operations. Depending on the severity of the incident. The level may be upgraded to level 4 or reduced to level 2 after the golden hour, and threats is better understood.	

10.0 Risk Assessment

The Trust takes an integrated approach to risk management, regardless of whether risks are clinical, non-clinical, financial, operational, business, or strategic. The Risk Register outlines the organisation's risks. Risks are graded and ranked using the Trust's Risk Matrix to establish a priority level. Action plans are drawn up for each risk to reduce the likelihood of occurrence and best practice is embedded into the appropriate Business Continuity Plans.

A risk scored 15 and above (including Business continuity themes) are monitored and managed by the Risk Management Team & Emergency Planning Team. The Risk Management Group (RMG) reviews all extreme risk scored 15 and above monthly. Risks scoring 15 or over are referred to as extreme. They must be signed off by the appropriate director or senior executive before presenting at the Risk Management Group (RMG) for agreed actions.

The RMC will discuss the risk and agree the risk scoring, considering all known factors. All these extreme risks may require a Business Continuity Plan or embedded into an already existing department or service BCPs. The ownership and responsibility of a risk lie within the division/department affected or registered the risk. However, the Risk Management Team and Emergency Planning Team must ensure oversight and escalate to appropriate levels of executive for risk level reduction.

Continual review of hazards/threats is important to ensure that potential disruption to the Trust is mitigated. **Appendix G** provide list of hazards to score and monitor in BCPs. The list is not exhaustive, as it's representing a small proportion of the potential hazards/threats that may be present in the organisation.

Appendix H provide risk Scoring Matrix as per Governance guidelines. The trust risk assessments will ensure identified risk are at the minimum acceptable levels.

11.0 Training

The Trust will ensure that business continuity training is made available to all staff for awareness purpose and to equip them with the fundamentals of having business continuity. The training will cover how to write, implement and manage a business Continuity Plan.

In alignment with the Skills for Justice National Occupational Standards and the NHS Minimum Occupational Standards, the Business Continuity training will be part of the Training Need Assessment (TNA) for Emergency Planning Team, On call staff (operational, tactical, strategic) executive directors, divisional directors, centre managers, departmental managers and service leads.

12.0 Equality Impact Assessment Statement

An Equality Impact Assessment (EQIA) has been completed and submitted to Policy Approval Group (PAG) for this Business Continuity Policy and the Business Continuity Management System. This document is available via the intranet to consult in all business continuity incident. The business Continuity Policy applies to staff regardless of their protected characteristics.

The Trust is committed to ensure that, as far as reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on the grounds of any protected characteristic. Monitoring during business continuity events should ensure that BC interventions do not contribute to increased health inequalities amongst staff and the patients we serve.

13.0 Monitoring and Compliance

The monitoring of this policy for compliance will be detailed in the Business continuity management system (BCMS). There will be set targets for annual tracking and reporting for different levels of indicators. Key Performance Indicators includes.

- Number of BCPs reviewed.
- Number BIA reviewed.
- Number of BCP Internal audits done.
- Number of new BCPs written.
- Number of BCP exercise.
- Number of BCP leads Trained on BC awareness and toolkit.
- Number of Tactical and Strategic commanders Trained on BC Awareness.
- Number of people at BC exercise/workshop.
- Number of BCP Exercise Workshop.
- Number of BCP Incidents/Events across divisions.

13.1 Key Performance Indicators (KPI)

Aspect of compliance or effectiveness being monitored	**Monitoring Method**	**Responsibility for Monitoring**	**Frequency of Monitoring**	**Group or committee that will review the findings and monitor completion of any resulting action plan**
No. of departmental/services BCPs at SATH	Business Continuity Dashboard	Emergency planning Manager	Quarterly	Emergency planning and Business continuity Group
No. of BCPs reviewed for compliance	Business Continuity Dashboard	Emergency planning Manager	Quarterly	Emergency planning and Business continuity Group
No. Business Impact Assessment (BIA) reviewed	Business Continuity Dashboard	Emergency planning Manager	Quarterly	Emergency planning and Business continuity Group
No. of BCP Internal audits	Business Continuity Dashboard	Emergency planning Manager	Quarterly	Emergency planning and Business continuity Group
No. of new BCPs written	Business Continuity Dashboard	Emergency planning Manager	Quarterly	Emergency planning and Business continuity Group

No. of BCP exercise	Business Continuity Dashboard	Emergency planning Manager	Quarterly	Emergency planning and Business continuity Group
No. of BCP leads Trained on BC	Learning Made simple	Emergency planning Manager	Quarterly	Emergency planning and Business continuity Group
No. of Tactical and Strategic commanders Trained on BC	Learning Made simple	Emergency planning Manager	Quarterly	Emergency planning and Business continuity Group
No. of people attending BCP exercise/workshop	Business Continuity exercise/workshop register	Emergency planning Manager	Quarterly	Emergency planning and Business continuity Group
No. of BCP Exercise Workshop.	Business Continuity exercise/workshop register	Emergency planning Manager	Quarterly	Emergency planning and Business continuity Group
No. of BCP Incidents/Events across divisions	Business Continuity Dashboard	Emergency planning Manager	Quarterly	Emergency planning and Business continuity Group

14.0 Business Continuity policy Review Timeline

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

15.0 References

The Shrewsbury and Telford Operational Plan 2025/2026 (Issuu Reader).

National Occupational Standards (NOS) guidance

NHS England » NHS core standards for emergency preparedness, resilience and response guidance

NHS England » NHS England business continuity management toolkit

ISO 22301:2019 - Business continuity management systems

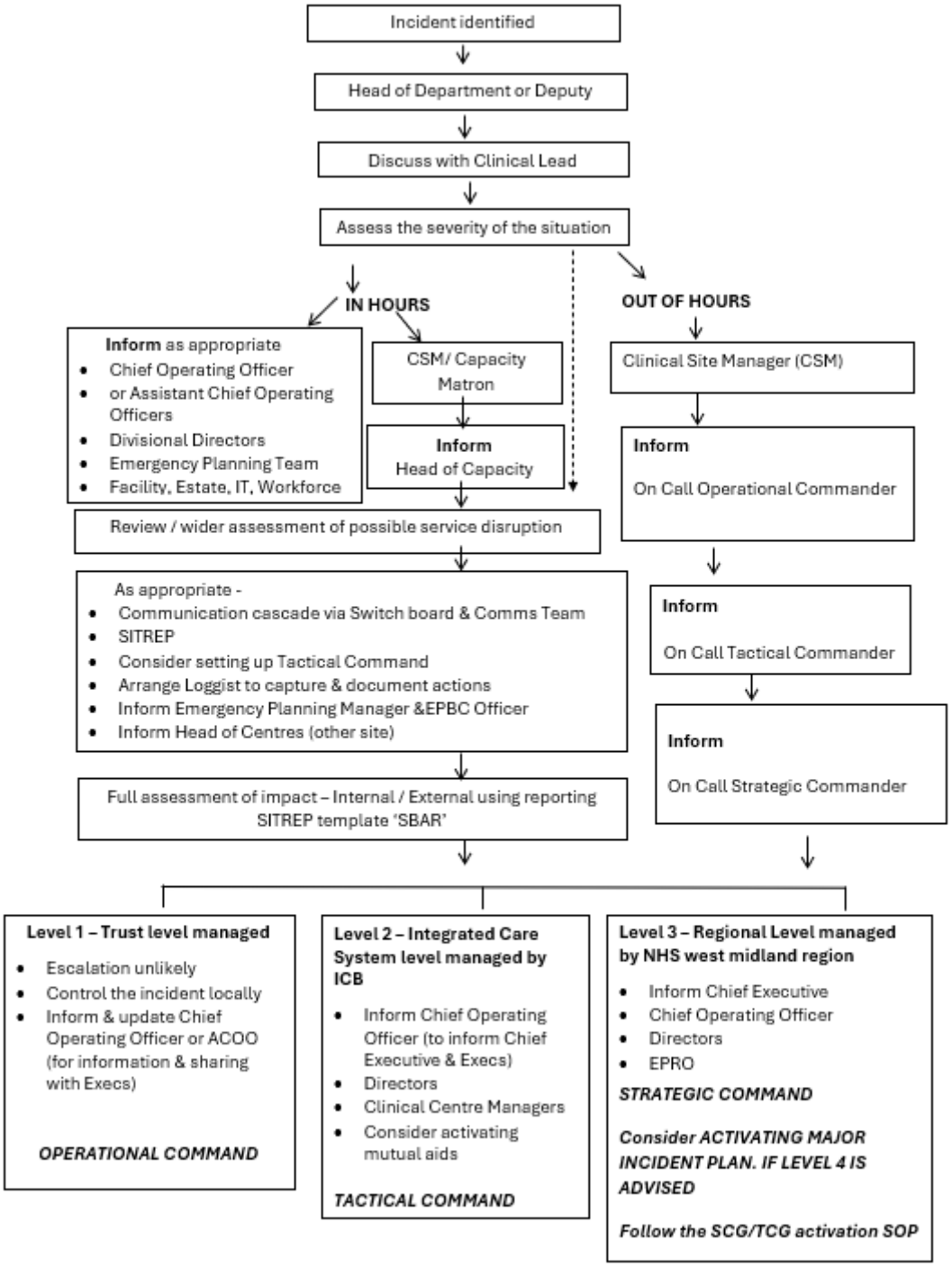
NHS England » Guidance and framework

NHS England » Emergency preparedness, resilience and response (EPRR)

Civil Contingencies Act 2004

Health and Social Care Act 2012

Appendix A: Incident Escalation flow chart



Appendix B: Action Card Template

Use to complete action cards for different roles within a BCP

Action Card **Ref: xx**	**ROLE TITLE**
Role function:	
Performed by:	
Alerted by:	
Located:	

Incident declared	**Information relating to your role and responsibilities:**
Immediate Actions	• xx
Ongoing	• xx
Recovery	• xx

Appendix C: Emergency Response Checklist

Use in relevant BCPs. The checklist is for management team. E.g AEO, Commanders and Emergency Planning Team and Single Point of Contact.

For use during an emergency

- Start a log of actions taken: ☐
- Liaise with Senior Management/Emergency Services: ☐
- Identify any damage: ☐
- Identify Functions disrupted: ☐
- Convene your Response / Recovery Team: ☐
- Provide information to staff: ☐
- Decide on course of action: ☐
- Communicate decisions to staff, other departments & management: ☐
- Provide public information to maintain reputation and continuing performance: ☐
- Arrange a Debrief: ☐
- Review Business Continuity Plan: ☐

Appendix D: Situation Report Template

Situation Report (SBAR) is a structured method for communicating critical information that requires immediate attention. This should be completed by the Emergency planning Team or Tactical commander, signed off by the AEO or strategic commander, sent to ICB within I hour of incident declaration or notification of standby via the Single Point of contact (SPOC) email/ mechanism for the trust, and saved in the SPOC & emergency planning drives and email folders.

For continuing incidents when a second, third or more SBAR is submitted, new additions should be included on the previous version highlighted in yellow. This current version of this template should be included in all BCPs to enable accessibility and uniformity in template for reporting.

SBAR reporting template (version 3) (report 1/1)

Organisation name		The Shrewsbury and Telford Hospitals NHS Trust	
Site name(s) affected			
Date of report		Time of report	
Type of incident declared			
Date declared		Time declared	
Completed by (name, role)			
Exec Sign off by (name, role)			
Signature			
Element	Prompts	Description	
S	**Situation** Clearly and briefly describe the current situation.		
B	**Background** Provide clear, relevant background information on the incident including: • Timings • Media • Exact situation		
A	**Assessment** State your assessment of the situation based on the situation and background. Include impacts to the hospital		

	and services	
R	**Recommendations** Explain the actions being taken by the organisation to standdown from the incident/situation alongside any support required of ICB or NHS England	
Integrated Care Board only		
Additional system actions/ commentary		
Sign off		
Signature		

Appendix E: Log Sheet Template

Use the below template to keep log of situational awareness, decisions, actions and rationale during and after an incident. The documents can be submitted to the emergency planning team by scan or hardcopy for storage.

Date	Time	Information / Decisions / Actions	Initials

Appendix F: Sample Agenda for business continuity Management Meeting

	Immediate Action Confirm chair – who will take primacy (normally Agreed SPOC / Facilities Manager if on Site) Chair Logs or confirms a Loggist- who logs situational awareness, decisions, actions and rational for the chair. The Loggist and chair should review log and have Chair sign off on logs. Logs to be kept with chair or emergency planning team. Nominate individual to meet Emergency Services
1	Confirm Loggist/minute taker. Confirm attendees / make introductions if needed
2	Overall situation report including nature and extent of disruption and summary of key events
3	Situation reports to be provided • Update from affected services • Building damage – estates, engineers and security • IT/telephone availability • Staffing • Suppliers/contractors • Partner agencies
4	Patients • Do inpatients need to be moved? • Numbers • Organise transport • Does outpatient activity need to be cancelled? • Are patient lists for the day/week available? • Does a helpline need to be set up?
5	Employees • Do staff need to be moved/relocated?

	• Agree Communications lead / messages / channels • Consider the need for a staff helpline • Inform staff not to speak to the media • Do not let staff leave without taking contact information • Hotel accommodation required. • Transport arrangements
6	Media and Communications • Internal communications – to staff • Stakeholder communications – to patients, families, commissioners etc. • Media communications: agree media message, agree methods of delivery
8	Suppliers / Subcontractors • Are suppliers and contractors affected? • contact and communicate incident
9	Any other business- Items to escalate to the incident room.
10	Decide date and time of the next meeting

Appendix G: Hazard Table

Hazard	Risk	Likelihood (1-5)	Impact (1-5)	Mitigation in Place	Residual Risk Matrix Score (L, M, H, E)
Loss/ Theft of Data	**Data Loss**				
Destruction of Paper Files/records					
Temporary loss of connection					
Damage to internal telephone network	**ICT Failure**				
Localised hardware failure					
Loss of major application					
Loss of mobile/telephone networks					
Loss of switchboard					
Server Failure					
Contamination	**Loss of Premises**				
Disruption to direct medical gas					
Disruption to water supplies					
Electric supply disruption					
Fire					
Flooding					
Introduction of a Cordon					
Loss of heating/cooling					
Structural defect/failure					
Clustered notice giving	**Staffing shortage**				

Epidemic					
Industrial Action					
Pandemic Illness					
School closures					
Transport disruption					
Severe weather					
Contamination/product quality	**Supplier Failure**				
Contract breach					
Failure to fund/supply					
Industrial action by drivers					
Industrial action in supplier					
Stock management failure					
Supplier goes into administration					
Supply chain collapse					
Under production by supplier					

Appendix H: Risk Scoring Matrix

	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

Appendix I: New Document Consultation Checklist

Use this form to record the consultation and to ensure your consultation has been adequate for purpose. This list is provided as a prompt. It may not be appropriate to involve all the below in a consultation – a decision on who should be consulted should form part of the policy development.

Version history

Version	Date	Author	Status	Comment
V12	20.01.26	Musili Oshevire	Approved	

Name – *examples (complete with details)*	Date Sent	Date reply received	Modification	Modification Made	2nd draft sent?
Executive Medical Director	05/06/25				
Chief Operating Officer	05/06/25				
Chief Nursing Officer	05/06/25				
Director of Corporate Governance	05/06/25				
Finance Director	05/06/25				
Communications	05/06/25				
Workforce Director	05/06/25				
Assistant Chief Operating Officers	05/06/25				
Divisional Medical Directors	05/06/25				
Divisional Directors of Nursing	05/06/25				
Divisional Directors of Operations	05/06/25				
Operational Managers	05/06/25				
Clinical Directors	05/06/25				
Chief Pharmacist	05/06/25				
Patient Safety Advisors	05/06/25				
Head of Legal	05/06/25				
Security Manager (Simpson Jon)	05/06/25				
Medical staff (Mohammad Ibrahim)	05/06/25				
Health and Safety Team Manager	05/06/25				
Finance team	05/06/25				
Corporate Nursing Team	05/06/25				
Any other affected staff (Tanner Theresa, Jannette Pritchard)	05/06/25				
Head of Risk (James Webb)	05/06/25 25/08/25 17/12/20				

	25				
Deputy Procurement director (James Richards)	05/06/25				
West Mercia Police	05/06/25				
Shropshire Fire and Rescue	05/06/25				
West Midlands Ambulance Service	05/06/25				
Shropshire Council	05/06/25				
Telford and Wrekin Council	05/06/25				
Shropshire Community Health Trust	05/06/25				
STWICB	05/06/25	26/06/2025	Y	Y	Yes
NHSE Midlands	05/06/25	03/07/2025	Y	Y	Yes
West Mercia Local Resilience Forum Secretariat and BC Working group	05/06/25				
Policy Approval Group (Debroah Bryce, James Webb, Laura, Nick Dowd)	15.09.2025 17/12/2025	02/12/2025 20/01/2026	Y	Y	Yes
Dissemination Method	Via Email, Teams, Face to Face				