Shropshire Community Health NHS Trust

The Shrewsbury and Telford Hospital NHS Trust

Boards in Common Meeting in Public Agenda

Date: 9 July 2026
Time: 0930-1230hrs
Venue: **AFC Telford Utd, SEAH Stadium, Bucks Way, Wellington, Telford, TF1 2TU (sat nav TF1 2NW)**
Chair: Mr Andrew Morgan, Group Chair

Time	Item no.	Item	Paper / Verbal	Page	Lead	Action
Procedural Items						
0930 hrs	027/26	Welcome, and apologies	Verbal	-	Group Chair	Noting
	028/26	Patient Story	Enc	**4**	Group CNO	Noting
	029/26	Public Questions	Verbal	-	Group Chair	Noting
	030/26	Noting of Quorum for each Board	Verbal	-	Group Chair	Noting
	031/26	Declarations of conflicts of interest	Verbal	-	Group Chair	Noting
	032/26	Minutes of previous meeting in public 14/5/26	Encs	**5**	Group Chair	Approval
	032/26	Action Log – no actions outstanding	Verbal	-	Group Chair	Noting
	033/26	Matters arising from previous minutes (not covered on today's agenda):	Verbal	-	Group Chair	Discussion
Reports from the Group Chair and Group Chief Executive						
0955 hrs	034/26	Report from the Group Chair	Verbal	-	Group Chair	Noting
	035/26	Report from the Group Chief Executive	Enc	**29**	Group Chief Executive	Noting
Board Committee Reports						
1010 hrs	036/26	**SCHT:** a. Activity Reports from NEDs b. Quality & Safety Committee Report c. Resource & Performance Committee Report	Verbal Enc Enc	- **36** **49**	All NEDs NED Chair NED Chair	Noting
	037/26	**SaTH:** a. Quality & Safety Assurance Committee Report b. Performance Assurance Committee Report c. Finance Assurance Committee Report	Verbal Enc Enc	- **53** **55**	NED Chair NED Chair NED Chair	Noting

	038/26	**Group:** a. People Committee Report b. Local Care Transformation Assurance Committee Report	Encs	**57** **59**	NED Chair NED Chair	Noting
		SHORT BREAK				
Strategic, Performance, Financial & Operational Reporting						
1100 hrs	039/26	**Performance Reports** **SCHT:** a. Integrated Performance Report b. Integrated Quality & Safety Performance Report c. Integrated People Performance Report **SaTH:** d. Integrated Performance Report	Encs	**62** **73** **80** **93**	CFO/D.CEO SCHT Group CNO *Group CPO Group Chief Executive	Noting
	040/26	**SaTH** Community Engagement Strategy 2026-2030	Enc	**174**	*Group Chief S&I Officer	Approval
	041/26	**SaTH** Volunteer Strategy 2026-2030	Enc	**189**	*Group Chief S&I Officer	Approval
Assurance Framework						
1130 hrs	042/26	**SaTH** Integrated Improvement Plan (SIIP) Monthly Update Report	Enc	**204**	Group Chief Executive	Noting
	043/26	**SaTH** Integrated Maternity & Neonatal Report	Enc	**207**	Group CNO	Assurance
	044/26	**SaTH** Board Maternity & Neonatal Safety Champions Reports	Enc	**216**	Group CMO	Assurance
Regulatory and Statutory Reporting						
1145 hrs	045/26	**SaTH** Patient Safety Committee Q4 / Annual Report 2025/26	Encs	**220**	Group CMO	Noting
	046/26	**SaTH** Freedom to Speak Up Q4 / Annual Report 2025/26	Encs	**224**	*Group CGO	Noting
Board Governance						
1210 hrs	047/26	**Annual Review of compliance with the Fit & Proper Persons Test (FPPT)** a. SaTH b. SCHT	Encs	**233** **234**	*Group CGO	Noting
Items for consent – approval recommended by Board Committees						
1215 hrs	048/26	**SaTH** Anti-Fraud, Bribery and Corruption Policy renewal	Enc	**235**	*Group CGO	Consent
Procedural Items						
1220 hrs	049/26	Any other Business – agreed by the Chair	Verbal	-	Group Chair	Discussion
	050/26	Date of next meeting of Boards in Common in public: 13 August 2026 **(AFC Telford Utd)**	Verbal	-	Group Chair	Noting
Close of meeting						

**Non-voting*

ITEMS WITHIN THE BOARD INFORMATION PACK		
Reports / Appendices	**Executive Lead**	**Page No.**
01 039/26a **SCHT** R&P Report - Action Plans	Chief Finance Officer	**1**
02 039/26b **SCHT** Q&S Perf Report – Action Plans	Group Chief Nursing Officer	**38**
03 039/26c **SCHT** People Performance Report – Action Plans	Group Chief People Officer	**50**
04 042/26 **SaTH** IIP Report – Appendices 1-4	Group Chief Executive	**62**
05 043/26 **SaTH** Int Maternity & Neonatal Report – Appendices 1-6	Group Chief Nursing Officer	**86-200**
06 SCHT Infection Prevention & Control Annual Report 2025/26	Group Chief Nursing Officer	**201**
07 SaTH ARAC Annual Chair's Report 2025/26	Committee Chair	**238**
08 SaTH QSAC Annual Chair's Report 2025/26	Committee Chair	**243**
09 SaTH PAC Annual Chair's Report 2025/26	Committee Chair	**248**
10 SaTH FAC Annual Chair's Report 2025/26	Committee Chair	**253**
11 Group People Committee Annual Chair's Report 2025/26	Committee Chair	**259**
12 046/26 **SaTH** Freedom to Speak Up Report – Appendix 1	Group Chief Gov Officer	**266**

Board of Directors' Meeting in Common – 9 July 2026

Agenda item	028/26		
Report Title	Patient Story: The life changing impact of Admiral Nurse support		
Executive Lead	Martina Morris, Group Chief Nursing Officer		
Report Author	Sara Ellis-Anderson, Director of Nursing – Community (Interim)		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
SCHT Patient Experience Committee 25 Feb 2026	Safe	√	N/A
	Effective	√	
	Caring	√	**(SaTH) Risk Register id(s):**
	Responsive	√	N/A
	Well Led	√	
Executive Summary	Through Jayne's story, the Board will hear how specialist Admiral Nurse support transformed the experience of caring for a loved one with dementia. The case study provides evidence of the positive impact of early intervention, expert clinical advice and ongoing emotional support, helping families to navigate complex dementia journeys.		
Recommendations for the Boards	The Boards are asked to **note** the patient story.		
Appendices:	Appendix 1: Patient Story Presentation		

Shropshire Community Health NHS Trust &
The Shrewsbury & Telford Hospital NHS Trust
Meeting of Boards in Common in PUBLIC
Thursday 14 May 2026 @ 0930hrs, held at SECC

MINUTES

Name	Title
MEMBERS	
Mr A Morgan	Group Chair
Ms J Williams	Group Chief Executive
Mrs T Boughey	Non-Executive Director (SaTH)
Mr H Darbhanga	Non-Executive Director (SCHT)
Mr R Dhaliwal	Non-Executive Director (SaTH)
Ms S Dunnett	Non-Executive Director (SaTH)
Ms R Edwards	Non-Executive Director (SaTH) *(joined meeting at 1130hrs)*
Ms P Gardner	Group Chief Nursing Officer *(Interim)*
Mr N Hobbs	Group Chief Operating Officer & Deputy Chief Executive (SaTH)
Dr J Jones	Group Chief Medical Officer
Ms S Lloyd	Chief Finance Officer & Deputy Chief Executive (SCHT)
Ms T Long	Non-Executive Director/Vice Chair (SCHT)
Mr R Miner	Non-Executive Director (SaTH)
Ms W Nicholson MBE	Non-Executive Director (SaTH)
Mrs C Purt	Non-Executive Director (SCHT)
Prof T Purt	Non-Executive Director/Vice Chair (SaTH)
Mr A Winstanley	Acting Chief Finance Officer (SaTH)
IN ATTENDANCE	
Mrs R Boyode	Group Chief People Officer
Ms T Cotterill	Group Chief Recovery and Transformation Director *(Interim)*
Mr S Crowther	Associate Non-Executive Director (SaTH)
Prof H Fuller	Associate Non-Executive Director (SaTH)
Mr N Lee	Group Chief Strategy & Integration Officer
Ms A Milanec	Group Chief Governance Officer *(joined meeting at 1030hrs)*
Mr M Neal	Group Chief Estates, Facilities & Capital Officer
Mr J Sargeant	Associate Non-Executive Director (SaTH)
Ms B Barnes	Board Coordinator (Minute Taker)
GUEST ATTENDANCE	
Ms J Fullard-Slawson	Group Chief Communications Officer
Mr J Mairs/Ms D Thompson	Group Deputy CPO/Ass. Director of Culture *(agenda item 023/26)*
Dr R Hollands Dr Aung	SaTH Guardian of Safe Working *(agenda item 024/26)* accompanied by Dr Aung, Resident Dr Peer Lead
APOLOGIES	
Ms J Barker	Non-Executive Director (SCHT)

No	ITEM	ACTION
Procedural Items		
001/26	**Welcome, and Apologies** The Group Chair welcomed all those present, including observing members of the public, to this first meeting of the SCHT and SaTH 'Boards in Common' being held in Public. This follows the launch of the Group arrangement between the two organisations on 1 April 2026, under the title of the Shropshire, Telford and Wrekin Community and Hospitals NHS Group. Apologies were noted.	
002/26	**Patient/Staff Story** Ms Gardner was pleased to introduce Sharon (Ward Manager, Wards 15 & 16) and Sam (Clinical Lead for the Enhanced Care Team), who joined the meeting to speak to the Boards about the benefits for patients from Acute and Community Services working together. They shared the story of a vulnerable patient who was cared for on Ward 15/16 following a prolonged stay in ITU. The care the patient received in SaTH, alongside the intensive support from the Enhanced Care Team, enabled him to continue his recovery journey and rehabilitation. Due to the dedicated focus on his physical and cognitive development it was very rewarding for staff that he was ultimately able to be discharged home to the community with wraparound support. There were subsequent questions from the Boards on the engagement and de-escalation techniques which were needed in this case, and the support available for staff when maintaining care in difficult circumstances. The Boards heard that rotation and teamworking provide an opportunity for colleagues to take some 'time out' in these situations. Ms Williams asked if there was anything further which could be done to support patients and staff when faced with challenging circumstances. Sam explained how valuable it would be, for the other patients on the ward as well as staff, if a specialised area could be made available, to where challenging patients could be accompanied, to take some 'time out' from the ward. Ms Williams assured Sam and Sharon that the request would be investigated to see if such an area could be created as it would clearly be of value. Mrs Boughey, as Chair of the Charitable Funds Committee, also invited Sam and Sharon to engage with the Committee for potential support from the SaTH Charity. The Boards were pleased to **note** this positive story as an example of joint team and partnership working, benefiting both our patients and staff, and the Group Chair commended Sharon and Sam for being such great advocates for the service.	
003/26	**Public Questions** The Group Chair thanked members of the public who had submitted questions in advance of today's meeting. The questions (including two accepted from the floor), and the responses provided at the meeting, are included at the end of these minutes.	

004/26	**Noting of Quorum for each Board** Quoracy was declared for both Boards.	
005/26	**Declarations of conflicts of Interest** No conflicts of interest were declared that were not already included on the Registers of Directors' Interests for each organisation. Members of both Boards were reminded of the need to highlight any interests which may arise during the meeting.	
006/26	**Minutes of previous meetings in public session** The minutes of the meetings held on 5 February 2026 (SCHT), and 12 March 2026 (SaTH), were accepted and approved by the respective Boards as an accurate record, subject to the following point of clarification from Mr Hobbs on the question which had been asked at the SaTH Board meeting on 12 March regarding the elective waiting list validation process: ***Q. What support was provided to patients to challenge or correct a wrong removal from the list?*** ***A. (Revised response) Many patients will have SaTH contact numbers on their outpatient clinic letter, or a discharge summary following treatment, to be used in the event of any concerns. This should be the first port of call for patients under SaTH's care. Alternatively, if a patient has been referred, but not yet seen by SaTH, or they feel their clinical condition has deteriorated, they should contact their GP.***	
007/26	**Private Action Logs** There were no SCHT or SaTH outstanding/open Board actions.	
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** Mr Morgan provided a verbal report covering the following points: • National Performance Position: Congratulations to SCHT colleagues in achieving Segment 1 in the National Oversight Framework (NOF), up from Segment 2 previously, and a league table position of 14 out of 61, up from 17 previously. Congratulations also to SaTH for their improvement to Segment 3, up from Segment 5 previously, and a league table position of 78 out of 134,up from 96 previously. It was very encouraging to see positive results for both Trusts, whilst acknowledging that there is still further work to do to improve the experience for our patients and communities. • Regional Chair appointment: Mr Russell Hardy has been appointed as the new Regional Chair for NHSE Midlands. • Reference Group invitation: Mr Morgan has been invited to	

	participate in an NHSE Reference Group which will focus on terms and conditions, development, workloads and other elements of Chair and Non-Executive Director roles. Further details are awaited. • Group Chief Executive: Mr Morgan was delighted to publicly recognise Ms Williams' inclusion in the Health Service Journal (HSJ) list of Top 50 NHS Trust CEOs, having achieved the position of No.10 on the list. The Boards joined Mr Morgan in their congratulations on this well-deserved accolade. The Boards **noted** the report.	
010/26	**Report from the Group Chief Executive** Ms Williams, taking her report as read, summarised the following key points: • She firstly thanked Mr Morgan and Board colleagues for their above kind acknowledgement and congratulations. Whilst not naturally comfortable with such personal accolades, she understands the importance of acknowledging the HSJ recognition on behalf of colleagues across the Group, as it reflects the growing national profile of our Group and its reputation for quality, improvement, and innovation. • SaTH and SCHT Financial Performance 2025/26: o SaTH: For the first time in 10 years, SaTH has delivered its financial plan. £41.5m in Cost Improvement Programme (CIP) efficiencies has also been delivered, against a plan of £41.4m. This is the highest level of efficiencies achieved by the Trust to date and more than double that of 2023/24. This is a significant milestone for SaTH, demonstrating both delivery against plan and a clear collective commitment to financial discipline from colleagues across the organisation. o SCHT: Congratulations also to SCHT, who have exceeded their financial plan, as well as delivering efficiencies above target for 2025/26. This continues to reflect the strong collective commitment, professionalism, and effective financial stewardship demonstrated across the organisation. Both SCHT and SaTH have submitted compliant finance plans to NHSE for 2026/27. • Elective Activity: SaTH and SCHT currently have zero English patients waiting over 52 weeks, placing the Group amongst the top performers nationally for Referral to Treatment (RTT) waiting times. This achievement marks a major milestone in improving timely access to care and demonstrates sustained system-wide improvement in flow, productivity, and patient experience. The Boards accepted and **noted** the report.	
Board Committee Reports		
011/26	**SCHT Reports:**	

a. Non-Executive Director Activity Report

Ms Long reported on her recent walkaround of Whitchurch Hospital and was pleased to share her observation that it was clearly a busy and thriving hospital.

b. Quality & Safety Committee Report

The Boards received the report from Ms Long in the absence of the Committee Chair, Ms Barker. Taking the report as read, the following key points were summarised:

- Quality and Safety Performance: The Committee noted areas of improvement alongside ongoing risks and agreed that assurance should be strengthened through clearer narrative where targets remain at zero-tolerance, but trajectories reflect system complexity.

- Prison Improvement Plan / Fire Safety actions: The Committee received assurance on progress against both, acknowledging positive external feedback, while agreeing further review and follow-up actions to address residual risks and capacity pressures.

- Medical Leadership in the Community: An ongoing risk was recognised relating to the lack of Community medical leadership, in addition to out-of-hours cover (a deep dive has identified there are more patients defaulting to A&E than need to). Dr Jones acknowledged the benefits created by the Group, both of increased Multi-Disciplinary Teamwork (MDT), and an opportunity for consultant support for the Virtual Ward, which a lot of clinicians have expressed interest in. Dr Jones advised the Board that this is regarded as a really interesting and valuable service which we want to expand further, and he will be leading on these developments over the coming months.

c. Resource & Performance Committee Report

The Boards received the report from the Committee Chair, Mr Darbhanga, which was taken as read. The following key points were summarised:

- 2025/26 Financial Performance: SCHT delivered a 2025/26 revenue surplus of £3.9m, subject to audit, which exceeded the planned target surplus of £2m and was largely due to receipt of £1.6m additional national funding during March 2026.

  The Committee agreed full assurance in relation to the full update provided.

- Integrated Performance Report: No KPIs within the Committee's remit were reported as an assurance concern or special cause variation concern.

  The Committee agreed full assurance in relation to the full update provided.

d. Audit Committee Report

The Boards received the report from the Committee Chair, Mr Darbhanga, which was taken as read. Full assurance was agreed in

	relation to the updates provided, apart from partial assurance on risk management KPIs due to continued improvement work. The Boards accepted and **noted** the above SCHT reports.	
012/26	**SaTH Reports:** **a. Quality & Safety Assurance Committee Report** The Boards received the report from the Committee Chair, Ms Dunnett. Taking the report as read, colleagues' attention was drawn to the following points: • Sentinel Stroke National Audit Programme (SSNAP): The Committee heard that the overall score for the Trust was E (lowest) for this quarter. QSAC has requested a deep dive into stroke care, to set out the improvement actions being taken. • TB Service: The Committee received an update on the newly expanded service, and work is ongoing to establish the service model, including patient facing work, education and outreach work. Performance outcome measures will be included in future Integrated Performance Reports **b. Performance Assurance Committee Report** The report was received from Mr Dhaliwal on behalf of the Committee Chair, Ms Edwards. Taking the report as read, the following points were highlighted: • Urgent and Emergency Care: Although behind plan regarding our commitments for UEC improvement, colleagues' attention was drawn to the statistically significant improvements now being seen in the weekly data sets for 12-hour, 4-hour and ambulance handover standards. • Digital Update: The Committee heard that in addition to process automation and the Electronic Prescribing and Medicines Administration (EPMA) project, SaTH is also planning transformational work using AI, such as Ambient Voice Technology in clinical areas. The Boards recognised that digital transformation has significant implications for cultural change as well as information governance. **c. Finance Assurance Committee Report** The report was received from the Committee Chair, Mr Miner. Taking the report as read, colleagues' attention was drawn to the following key points relating to 2026/27: • Acknowledging the positive significance of the Trust achieving its 2025/26 financial plan, the Committee recognised the scale of challenge now facing SaTH in 2026/27. National deficit support is dependent upon achieving our efficiency plans once again and the delivery of transformation this year will be crucial. Colleagues acknowledged that delivery of the 2026/27 workforce plan, which is itself predicated on substantial digital transformation, is critical to	

	achievement of the 2026/27 financial plan. **d. Audit & Risk Assurance Committee Report** The report was received from the Committee Chair, Prof Purt. Taking the report as read, colleagues' attention was drawn to the following key points: • Internal Audit: A high assurance opinion was provided for the Risk Management Core Controls audit findings, and the internal auditors provided positive findings on the Assurance Framework (AF), with all findings representing a positive reflection of the effectiveness of AF processes. The Head of Internal Audit (HoIA) Opinion for 2025/26 provided substantial assurance, for the fourth year in a row, that there was a good system of internal control designed to meet the organisation's objectives, and that controls were generally applied consistently. • External Audit: The draft external auditors' Value for Money (VFM) Risk Assessment 2025/26 identified no significant risks. This represents an improved position from previous years, when 'financial stability' had been highlighted as an amber risk. **e. HTP Assurance Committee Report** The report was received from Prof Purt, the Committee Chair. Taking the report as read, assurance was provided to the Committee that the Programme remains on schedule, ahead of budget, and with no major issues or concerns. Prof Purt highlighted the requirement to link the Committee Terms of Reference (ToRs) with those of the Local Care Transformation Assurance Committee, which is shortly to be established and which he will also be chairing. The Group Chair agreed with the proposal to establish the new Committee as soon as possible, with ToRs to be agreed at its first meeting, followed by their approval at Board. The Boards accepted and **noted** the above SaTH reports.	
013/26	**Group People Committee Report** The report was received from Mrs Boughey, the Committee Joint Chair. Taking the report as read, with no additional points to raise, Mrs Boughey advised the Board that the Committee continues to evolve as Group working develops and becomes more established. Ms Williams added that our people will be a massive focus for the Group, and the importance was recognised of ensuring that we deliver consistently across both organisations. The Boards accepted and **noted** the report.	
Strategic, Performance, Financial & Operational Reporting		
014/26	**Performance Reports - SCHT:** **a. SCHT Integrated Performance Report** Ms Lloyd presented the following information in relation to the key areas of performance relevant to the SCHT Performance Framework,	

directing colleagues to her report for further supporting information:

- KPIs: The report focuses on the 27 indicators which are reviewed by the Resource & Performance Committee (RPC). Of these, 11 KPIs are an assurance concern only, with 10 of the 11 relating to access to services and waiting times (apart from the local waits KPI for 65+ and 78+ weeks as these both remain at zero). Additionally, the variance year to date to the financial plan is no longer flagged as having a variation concern.

  The action plans submitted to the RPC, and presented in the Board Information Pack, describe further detail and the actions being taken with the trajectories for improvement.

- KPI proposed changes: Approval was requested from the Boards in line with existing SCHT governance arrangements, for the following two changes:
  - Deaths in custody per 1000 prisoners - a definition adjustment to use prison population reporting as at the end of month instead of the average.
  - Bank Usage (WTE) – a change in name to 'Bank Usage' – Variance from plan (WTE)'.

- National Oversight Framework (NOF): As referenced in the Group Chair's report, the Quarter 3 position published on 18 March 2026 has shown improvement for SCHT, and the Trust has been allocated an overall NOF score of 1 (best performing segment). Whilst this is positive news, it is recognised that there are areas which still require improvement. Details of the actions being taken to improve the performance are shown within actions plans presented to the relevant Committees, as contained in the Board Information Pack.

- Urgent & Emergency Care (UEC): Mr Hobbs wished to put on record his thanks to SCHT colleagues for their support in the reduction of SaTH's No Criteria to Reside (NCTR) numbers, and the positive impact this has had on patient flow and, in turn, UEC performance.

Finally, Ms Long referred to the importance of understanding areas of significant improvement, and she asked Ms Lloyd to include a few key bullet points in future reports to capture the key components to success. Ms Lloyd agreed that this would be reflected in future reports.

The Boards:

- **Considered** SCHT's performance to date and the assurance provided to the Resource and Performance Committee on the actions being taken to improve performance and minimise risks where required.
- **Noted** the information presented in relation to the National Oversight Framework and areas which may require particular focus.
- **Approved** the changes to the KPI definitions, as documented above.

b. SCHT Integrated Quality & Safety Performance Report

Ms Gardner presented the following summary of key areas of improvement, and those requiring improvement, directing colleagues to her report for further supporting information:

- Clostridium Difficile: There were two cases of C-Difficile reported in March, one at Whitchurch Community Hospital and one at Ludlow Community Hospital. There were 11 Hospital-onset healthcare associated (HOHA) C-difficile cases in 2025/26 against a threshold of four. Thematic reviews continue quarterly, and actions for improvement are ongoing, with a specific focus on cleanliness, decontamination of equipment and recruitment to Housekeeper roles.

- Pressure Ulcers: Four patients developed a Category 4 Pressure Ulcer in service. Recurring themes identified include patients with complex co-morbidities and those nearing the end of life. Additionally, delays in equipment delivery have been recognised, and the Trust is actively collaborating with MediEquip to resolve these issues.

- Unexpected Death: There was one unexpected death in March, related to a self-inflicted death of a Patient in Custody at HMP Stoke Heath. A full patient safety incident investigation has been commissioned by way of a learning response, and immediate actions taken are to ensure follow up of 'Did Not Attend' (DNAs) of primary mental health appointments. A thematic review has also been commissioned to review the three deaths in custody over the last 12 months.

- KPIs: The following KPIs are no longer flagged as having a variation concern –
    a. Deaths – unexpected
    b. Medication Incidents with Moderate Harm
    c. Rates of Healthcare Associated Infection (E-Coli)

The Boards **noted** and took assurance from the report that appropriate actions are being taken to address any areas of concern.

c. SCHT Integrated People Performance Report

Mrs Boyode presented a summary of key areas of workforce performance, including a review against the Month 12 Workforce Plan position, directing colleagues to her report and the appendices in the Board Information Pack for full supporting information.

- KPIs: There are several KPIs under the delivery of the Workforce Plan that are outside of agreed targets, including:
    - appraisals
    - temporary staffing,
    - absence management
    - price cap compliance.

  Additionally, Workforce colleagues are working with the Group Chief Medical Officer on a recruitment and retention plan for

medical roles which are hard to fill.

- Sickness absence management: Recognising that short-term absence is seeing an increasing trend, interventions include reporting to line managers with real time data on individuals who have reached short-term absence triggers. Work also continues to improve management of long-term absences, including timely referral to occupational health, prompt and accurate recording of absences, and improved communication between line managers and the People Team.

The Boards **noted** the performance across relevant indicators to date, the actions being taken to mitigate risks, and the level of assurance provided through revised reporting processes and SPC charts.

d. SaTH Integrated Performance Report (IPR)

The Boards received the report from the Group Chief Executive, providing an update on progress against SaTH's Operating Plan and associated objectives and enablers to the end of February/March 2026. Taking the report as read, Ms Williams invited executive colleagues to provide the headlines from their sections:

Patient Safety, Clinical Effectiveness & Patient Experience Summary

Ms Gardner drew the Boards' attention to the following points:

- Infection Prevention and Control (IPC): Colleagues were reminded that all 2025/26 targets for Healthcare Acquired Infections (HCAIs) were breached. The C-Difficile action plan is ongoing, but the stable plans required to implement and manage a deep clean programme remain outstanding due to hospital capacity challenges. An increase in the necessary ward moves to enable decants to take place is, however, now starting to be seen.

- Deteriorating patients - national paediatric early warning system (PEWS): The Boards' attention was drawn to the findings of a compliance audit conducted in February 2026. On reviewing the audit findings, further improvement is required in relation to documentation following reviews, de-escalating sepsis when indicated, and escalation of PEWS, which remains a key message within Paediatrics. Actions are underway to improve escalation compliance, including work to improve associated documentation, simulation training, and audit feedback via newsletters and huddles.

- Complaints: Mr Miner sought clarity on whether the ongoing work to reduce response times will address the delay issue, or whether there has been an overall increase in complaints, creating further delays. Ms Gardner clarified that work is underway on a revised process, to separate cases of a less complex nature (eg values and behaviours, which have seen an increase) for 'fast track' responses, from the more complex cases where the Complaints team are dependent upon the receipt of information from Divisions to inform responses.

	Referring to complaints relating to values and behaviours, Ms Williams highlighted the work which has been taking place between the Trust and a bereaved family to create a development programme (Poppy's Promise) focused on the delivery of compassionate care. This will be a structured programme, and will be delivered across the Group. **Operational Summary** Mr Hobbs summarised the following points: • Planned Care: The Trust is ahead of plan and demonstrating special cause improvement against all RTT metrics, and also delivering above plan for all cancer metrics. In Diagnostics, the submitted DM01 position for March saw improved performance in Echocardiology and Non-Obstetric Ultrasound (NOUS), with Radiology reporting turnaround times being maintained. Mr Hobbs emphasised that, to be able to report this positive performance across Planned Care, is testament to the commitment and actions of colleagues across all areas. • Urgent and Emergency Care: SaTH delivered its best 12-hour type 1 (month to date) performance in April, with 82.8% of patients being admitted, transferred or discharged within 12 hours. This represents the strongest performance seen since August 2022. The recently released national statistics show that SaTH is now out of the bottom quartile for ambulance handovers for the first time in many years, with April (month to date) performance at 26 minutes, representing the strongest performance since the Covid-19 pandemic. **Workforce Summary** Mrs Boyode had nothing to report in addition to the details within the Workforce Summary. She wished to reinforce the point made by Mr Miner earlier in the meeting, however, around the transformation space and how important digital solutions will be to achieve our transformation plans. She also highlighted that, as services are digitally transformed, colleagues will require a significant amount of education provision. **Finance Summary** Mr Winstanley advised that financial performance will be covered in the following agenda item, and he therefore had nothing additional to report under the IPR. The Boards accepted and **noted** the SaTH Integrated Performance Report.	
015/26	**Financial Performance Reports** **a. SCHT Financial Performance Report M12/Year End 2025/26** Noting that most financial performance elements had been covered earlier in the meeting, Ms Lloyd summarised to the Boards that SCHT has delivered all of its 2025/26 financial obligations, subject to external	

	audit review, with colleagues directed to the report for full details. The Boards, in accepting the report: • **Considered** the adjusted annual financial position of £3,910k surplus; the underlying surplus position of £1,137k, which is a favourable variance of £250k compared to the annual plan of £932k surplus; and the capital expenditure for the year of £4,958k which is in line with plan. • **Acknowledged** SCHT's CIP target for 2025/26 of £5,359k was exceeded by £271k, with actual delivery of £5,630k; and that the reported 2025/26 financial position remains subject to audit. Mr Morgan congratulated Ms Lloyd and her colleagues on a good year's financial performance as ever. **b. SCHT 2026/27 Opening Budget** Ms Lloyd advised that the opening 2026/27 budget proposes a breakeven revenue plan and planned capital expenditure of £6.38m, with colleagues directed to the report for supporting information. This is consistent with the Trust's financial plan, which was submitted to NHSE in March, and is compliant with all financial requirements. The Boards, in accepting the report: • **Considered** the review by the Resource and Performance Committee of the opening budgets in detail on 25 March 2026 and the Committee's recommendation for approval. • **Approved** the SCHT opening 2026/27 annual budgets. **c. SaTH Financial Performance Report M12/Year End 2025/26** Mr Winstanley summarised SaTH's month 12/year end position, confirming that the Trust recorded a £4.9m surplus (to the break-even plan), with colleagues directed to the report for full details. This in-year delivery is in line with forecast after £45.1m of deficit support funding, and prior to bonus funding of £4.9m. As referenced by Ms Williams earlier in the meeting, this is the first time in 10 years that SaTH has delivered its financial plan. Mr Morgan, whilst congratulating Mr Winstanley and colleagues on delivery of the 2025/26 financial plan, wished the Boards to be mindful that this was in the context of receiving the above deficit support funding. It was recognised that financial planning in future years would need to reflect a phased reduction in the Trust's deficit support figure. The Boards accepted the report and **noted** the financial, capital and cash position at the end of 2025/26.	
016/26	**SaTH Bi-annual Public Participation Report** Mr Lee presented the report for Quarters 3 and 4 2025/26. Taking the report as read, colleagues were also directed to the comprehensive details available in the full 6-month Public Participation Report included	

	within the Board Information Pack. Mr Lee wished to particularly recognise the significant contribution of the Trust's 214 volunteers, and how proud and grateful the Trust is of the work they do across the sites. He highlighted two particular areas, firstly the Volunteer Driver Service, which has continued to build and increase the number of patients they help and support; and the pioneering Volunteer to Career programme, which has seen a range of people, of all ages, who started off volunteering at the Trust now in a variety of permanent roles across the organisation. The team has plans to work with our SCHT colleagues to maximise opportunities for joint engagement working with a focus on neighbourhood care. Mr Darbhanga asked how well ethnic diversity is represented in the cohort of volunteers, and Mr Morgan supported the importance of this, based on the need to be representative of the communities we serve. Ms Williams added that this was also the case for people with disabilities and other protected characteristics. Mr Lee undertook to gather appropriate information and take this back through the People Committee. Finally, Ms Williams referred to the several significant local Charities that the SaTH Charity works very closely and positively with, and she expressed her thanks to all those who fundraise incredible amounts. The Boards **noted** the activity from October 2025-March 2026 across the Public Participation Team and **took assurance** from this work that statutory duties and CQC Well-Led requirements are being met.	
Assurance Framework		
017/26	**Board Assurance Framework (BAF) and Risk Management** The following reports were presented by Ms Milanec, with the content taken as read. **a. SCHT BAF Report Q4 2025/26** The BAF has been reviewed with the relevant Director Leads and Committees, with oversight from the Audit Committee, and the Boards were asked to note the changes to the BAF since its last presentation, as detailed in the report. Colleagues' attention was drawn in particular to the following three proposed reduced risks: • The reduced risk in workforce team capacity reflecting the benefits of the strengthened leadership across the Group. • The reduced risk for recruitment restrictions reflecting a more streamlined decision-making process. • The reduced risk in relation to patient harm linked to waiting times, reflecting the downward trajectory of waiting times from the strengthened clinical prioritisation measures in place.	

The Boards:

- **Considered** the assurances provided regarding the mitigation of risks to delivering the strategic objectives, and
- **Approved** the proposed amendments to the SCHT Quarter 4 BAF.

b. SaTH BAF Report Q4 2025/26

The BAF content has been reviewed and refreshed for Quarter 4 by the Executive risk owners and their relevant senior team members, and the Boards are asked to note the changes to the BAF since its last presentation, as detailed in the report.

Colleagues' attention was drawn in particular to the proposed reduction to the current total scores of the following three risks:

- BAF risk 4, due to consultant vacancies being their lowest in recent times/history, with some difficult to fill roles being recruited to. This risk score reduction was agreed at People Committee/PODAC on 23 March 2026.
- BAF risk 5, which is linked to the forecast out-turn to deliver the financial plan in 2025/26. However, risk remains in relation to the underlying position going into 2026/27. This risk score reduction was supported by the Finance Assurance Committee on 28 April 2026 due to the Trust exiting the Recovery Support Programme (RSP) and having delivered the 2025/26 financial plan. The risk score will be kept under review in early 2026/27.
- BAF risk 9, due to zero patients waiting over 52 weeks (NHSE, March 2026); and 18-week performance now in the upper quartile nationally. This risk score reduction was agreed at Performance Assurance Committee on 21 April 2026 and Quality and Safety Assurance Committee on 28 April 2026, as a jointly owned risk.

The Boards:

- **Considered** if the BAF content reflects the strategic risks within the organisation, if the risk scores are appropriate, 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, and
- **Approved** the SaTH Quarter 4 BAF.

Ms Milanec advised colleagues that two senior members of her team, from SaTH and SCHT, are working together to create a joint BAF. This will include reporting alignment, as the SaTH BAF is currently presented quarterly, and the SCHT BAF is presented monthly.

c. SaTH Annual Risk Management Report (inc Q4) 2025/26

The report details the progress made in managing risks and improving SaTH's risk culture during 2025/26.

Ms Edwards was pleased to observe how much the risk report has improved in strength and structure, and she thanked all those involved.

The Boards **noted** the current risk position, and the mitigation in place to ensure that risk management is practiced consistently across the

	Trust.	
018/26	**SaTH Integrated Improvement Plan (SIIP) Monthly Update Report** Ms Williams provided key points from the report, directing colleagues to the full report and accompanying appendices for further information. The Boards: • **Noted** the actions and **took assurance** from the updates provided. • **Noted** progress against delivery of the tasks/actions that were due up to and including 30 April 2026, as detailed in Appendices 1-4. • **Noted** that all RSP undertakings have now been removed, with the exception of the UEC undertakings, which have been incorporated into the 2026/27 UEC SIIP plan as Appendix 4, and • **Noted** that the 2026/27 SaTH Integrated Improvement Plans include any 2025/26 tasks that have not yet been completed alongside actions that are intentionally continuing as part of planned sustained improvement.	
019/26	**SaTH Integrated Maternity & Neonatal Report** Ms Gardner presented the report, detailing 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 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 provides further comprehensive information. Highlights from the report include the following: **The Ockenden Report (Independent Maternity Review) Progress Report:** Appendix 1 within the supplementary information pack provides the summary Ockenden Report Action Plan at 10 March 2026, as the April meeting of the Maternity and Neonatal Transformation Assurance Committee (MNTAC) was not quorate and therefore could not agree any status changes.197 out of the total of 210 actions have now been fully completed (evidenced and assured), with five actions currently on track for their expected delivery dates pending evidence that they have been appropriately embedded. Seven actions continue to remain 'de-scoped', relating to nationally-led external actions (led by NHSE 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. **Invited Neonatology Service Review (2023/24):** Continued progress is being made to deliver the recommendations from the external invited review of the Trust's neonatal services, led by the Royal College of Physicians. The summary action plan as at 10 February 2026 is included as	

	Appendix 2 in the supplementary information pack. All actions, with the exception of two, remain on track for their expected delivery dates, with actions underway to address the two which are off track. **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 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 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 Trust has now received the public official release to confirm achievement of all 10 Safety Actions forming Year 7 of the scheme. Year 8 was launched on 23 April 2026 with six core safety actions, with the focus being on outcomes. The Boards, following comprehensive review of the Integrated Maternity & Neonatal Report and all associated appendices within the accompanying supplementary information pack (Appendices 1-3), accepted and **took assurance** from the report.	
020/26	**SaTH Board Maternity & Neonatal Safety Champions Reports** Dr Jones presented the reports of the March and April meetings. The reports were taken as read, with the following points highlighted: • The Safety Champions had recently visited the Ludlow Maternity Led Unit (MLU), where they heard of the increasing prevalence of choice to give birth outside of guidance. • There has been a gradual increase in the number of caesarean sections which is creating challenges in terms of planning theatre capacity. • Ms Williams advised of ongoing engagement with families within the Ockenden Review, and their invited participation in the stakeholder panels for the upcoming Director of Midwifery recruitment. The Boards accepted and **took assurance** from the report.	
Regulatory and Statutory Reporting		
021/26	**SaTH Safer Staffing Bi-Annual Review** The report was received from Ms Gardner, presenting the results and outcomes for nursing across the inpatient and emergency departments for the January/February 2026 Safer Nursing Care Tool (SNCT) census and subsequent staffing establishment review. Colleagues were referred to the details in the report, which was taken as read.	

	The Boards: • **Noted** the recommendations arising from the establishment review and confirmation from Mr Winstanley that there are no financial consequences from the requested additions to establishment, with funding available through UEC Phase 1 or Phase 2, and • **approved** the additions to establishment detailed within Section 5 of the report to mitigate patient safety risk associated with sustained service change.	
022/26	**SaTH Infection Prevention & Control (IPC) Report Q4 2025/26** The report was received from Ms Gardner who, taking the report as read, drew the Boards' attention to the following key points: • The Trust has breached all set targets for reportable Healthcare Acquired Infections (HCAIs) for 2025/26. Whilst management of infections continues to be dealt with through action plans, infrastructure and resourcing constraints persist, notably limited isolation facilities, lack of decant space, and restricted deep-cleaning capacity. Ms Williams provided context that the decision had been taken as a team to delay ward moves during the challenging Winter period and as reported earlier in the meeting, an increase is now starting to be seen in the necessary ward moves to enable decants to take place. • The Trust continues to await a response from the ICB on the availability of Fidaxomicin for first line treatment of C.Difficile, and Ms Williams offered to escalate this with ICB colleagues. In response to a request from Prof Purt, Ms Gardner agreed to provide him with information on the cost of the drug offline. The Boards **noted** the report and the proposed and ongoing mitigating actions being taken.	
023/26	**Group Annual NHS Staff Survey Results 2025** Mrs Boyode introduced Mr Jake Mairs and Ms Dawn Thompson to present on the key points of the 2025 NHS Staff Survey across the Group. The Boards were directed to the report for full details, with a summary of the key survey findings provided as follows: • SaTH achieved a response rate of 46%, which is a 5% decrease compared to the previous year; and SCHT achieved a response rate of 50.25%, an 11% decrease since 2024. • The results show that both SaTH and SCHT are below the respective sector average in scores for all the People Promises, apart from SaTH's score for 'We work flexibly', where the Trust is ranked 8th out of 22 in the relevant sector in the region. • The common areas for focus across both Trusts in 2026/27 were confirmed as Advocacy, Involvement, and Health and Wellbeing. • The Boards were asked to acknowledge that several actions can take longer periods of time to embed before they are	

	felt/experienced by staff. NHSE suggests that the staff survey data provides rich and valuable data to support and inform continuous improvement and cultural change for longer term 3-5-year planning. • Even though many scores for both organisations remain below sector average, the Group focus is on continuing with an upward trend, as evidenced by the improvements seen in both Trusts since 2021. • Noting that there are clearly some Trusts who have done much better than us, Mr Morgan asked if there is anything we can learn from them. Mr Mairs responded that learning is much wider than the NHS, particularly in terms of health and wellbeing, which we need to bring together and make more accessible for our colleagues. Mrs Boyode added that top NHS Trusts are always asking the question "what does it take for colleagues to feel/see improvements embedded?" The following comments and queries were received from Non-Executive Directors: • Mr Miner referred to the free text comments and recurring themes around leadership, culture and fairness, and he questioned whether there is a bigger piece of work needed in terms of culture transformation. Mr Mairs supported this view and advised of plans being developed to help our leaders on that journey, which will be shared at Board when finalised. • Mr Crowther, noting the low survey response rate, particularly for SaTH, asked what the challenges are in getting people to respond. Mr Mairs advised that one of the key challenges is the perception of a lack of anonymity, which links to leadership culture. • Ms Dunnett highlighted the need to consider how low psychological safety of staff impacts on patients. Mrs Boyode responded that our ongoing focus has always been to manage and mitigate any negative impact on our patients. • Ms Long asked how we are going to ensure we receive feedback from staff, and Mrs Boyode confirmed that this will be through regular pulse surveys in addition to engaging with colleagues regularly to ask how they feel about interventions which are introduced. The Boards **noted** the report and acknowledged the level of improvement work required. Mrs Boyode clarified that progress against Staff Survey actions will be a standing item at every People Committee and reported to Board.	
024/26	**SaTH Guardian of Safe Working Hours (GoSW) Report Q4 2025/26** Dr Robin Hollands, the Trust's Guardian of Safe Working Hours, was welcomed to the meeting to present his report, along with Dr Aung, the Resident Doctor peer lead for the NHS 10-Point Plan to Improve Resident Doctors' Working Lives.	

	Dr Hollands drew the Boards' attention to the following key points from his report: • National reforms to exception reporting have been implemented within the Trust, with good initial feedback. • Healthroster implementation is almost complete, with 96% of Resident Drs' rotas now live. • During Q4, the GoSW Hours levied four fines in response to breaches of maximum permitted working hours, specifically where shift length was exceeded. Dr Aung updated the Board on progress against the 10-Point Plan, as detailed within Section 12 of the report, reiterating that he appreciated the opportunity of direct access to the Board, as well as regular meetings with Dr Jones. Referring to an increase in the number of exception reports, most of which relate to the need to stay late with patients, Dr Hollands reported that a universal message from the Resident Dr Forums is that no-one minds staying late sometimes, however what they do mind is the lifestyle impact caused by problems with booking annual leave. There is also a perception of unfairness, with less restrictions on non-training posts than those on training posts. He noted that one of the consequences of the hospital being so much bigger than it was is the challenge of Resident Drs having a voice to get through layers of management, and he strongly supported a review of how to better manage annual leave. Mr Morgan expressed his sympathy for Resident Dr colleagues at the difficulties being experienced in booking annual leave and he emphasised the importance of finding a prompt sustainable solution. Dr Jones commented that one of the challenges with exception reporting is that he is unable to access the reports and, whilst it is good to hear things through different routes, he would like to be able to do more. Mrs Boyode clarified that there is currently silo working on rostering and the Trust is working on bringing all rosters together for more effective roster management. Finally, Ms Williams provided assurance that the 10-Point Plan is not merely a tick box exercise for this organisation, and the Trust will continue to work with our Resident Drs to ensure they receive effective and timely support. Ms Fullard-Slawson added that she would like to work with them to review how we can support communication with this key group of colleagues. The Boards **noted** the report.	
Procedural Items		
025/26	**Any Other Business** **Farewell to Board colleagues** a. The Group Chair advised colleagues that Mr Harmesh Darbhanga has reached the end of his term as a Non-Executive Director and	

	this will be his last Public Board meeting. Mr Morgan thanked Harmesh for his valued contribution, and everything he has done for the people of Shropshire, Telford and Wrekin, and beyond, over the last seven years. The Boards joined Mr Morgan in wishing Harmesh a fond farewell and best wishes for the future. b. As this would be Ms Paula Gardner's last Public Board meeting as Interim Chief Nursing Officer before leaving the organisation, Mr Morgan expressed his huge thanks to Paula for her enthusiasm and the clear expectations of standards and behaviour which she has championed during her time in post. The Boards joined Mr Morgan in wishing Paula all the very best for the future. There were no further items of business.	
026/26	**Date of Next Meeting** The next meeting of the Boards in Common in Public session is scheduled for Thursday 9 July 2026, at **AFC Telford Utd, SEAH Stadium, Bucks Way, Wellington, Telford, TF1 2TU (sat nav TF1 2NW)**.	
The meeting was declared closed.		

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

Q1 ***Submitted by Gill George (Chair, STW Defend our NHS)***

Q Context

I recently went with a friend to 'Ambulatory Majors' (previously Fit to Sit) at the Royal Shrewsbury Hospital. The new area was opened in March this year. The SaTH report at the time stated:

"The redesigned area now houses Ambulatory Majors (previously known as Fit to Sit), providing timely assessment and treatment for patients who are stable, able to walk, and do not require an overnight stay…"

I left; I suppose after about seven hours. My friend was there overnight, spending around 20 hours in Ambulatory Majors before transfer to another part of the hospital. This included an uncomfortable overnight stay. She was increasingly concerned about the welfare of another patient who had been there for almost 30 hours by the time my friend was moved. That patient was felt by their partner (and by my friend) to be in distress and to be deteriorating.

There were, according to my friend, around eight people spending the night in that small area. There were three reclining chairs available in total, clearly insufficient for that number of people.

Patients (and relatives on their behalf) of course asked if beds were available for overnight stays and were told no beds were available.

The professionalism and courtesy of staff was evident throughout, which is of course a huge positive. Staff were exemplary. However, there seemed to be very long waits for assessment, for test results, and for management plans to be decided and communicated.

A short Facebook post about 'Fit to Sit' has attracted 65,897 views in less than two days. This is unprecedented. Shropshire Defend Our NHS will collate comments and share those

with you. They included reports of an elderly person with pneumonia being there for 33 hours; of patients spending up to 36 hours there; of patients there despite e.g. 'crippling pain' and 'agony'; of inappropriate management of suspected cauda equina. There are some scary stories there.

Questions

- Does SaTH agree this area – whether you call it 'Fit to Sit' or 'Ambulatory Majors' – is not an appropriate environment for long stays and overnight stays – particularly for frail elderly patients, for deteriorating patients, and for patients in severe pain or with life threatening conditions?
- How many patients stayed overnight in Ambulatory Majors in April 2026?
- Has the NHS England crackdown on corridor care led to greater pressure on Ambulatory Majors?
- What are SaTH's plans to end these longer stays in what should be a short-stay area, and what are the plans to end overnight stays?
- As an immediate short-term measure, will SaTH ensure pillows and blankets are offered to any patient having to remain overnight in Ambulatory Majors?
- This improved Ambulatory Majors area exists because of investment tied to moving from two A&Es to one. What is the current target date for closure of the A&E at Princess Royal Hospital? Is SaTH confident that emergency care at the Royal Shrewsbury is adequate to meet current and future demand?

A ***Provided by Ned Hobbs, Chief Operating Officer / Deputy CEO (SaTH)***

Mr Hobbs began his response with a personal apology to Ms George for the poor experience she has described. The Trust recognises that this is not good enough and we are committed to improve.

Urgent and Emergency Care (UEC) remains a top priority for Shropshire, Telford and Wrekin Community and Hospitals NHS Group. This is supported with a system wide UEC transformation programme.

We recognise that access to UEC services for our patients is not good enough for the people we serve. However, our April 12-hour (Type 1) performance was the best since August 2022, our April 4-hour (All Type) performance was the best since May 2022 and our April ambulance handover performance was the best since the pandemic (26mins) – so we can see statistically significant evidence of improvement.

Our system wide UEC transformation programme has three pillars to continue to help improve flow and reduce the risk in this pathway. This includes a SaTH-commissioned external delivery partner to expedite this work.

Ambulatory Majors is part of the Emergency Department (ED) footprint and operational 24/7. This is a nationally recognised model of care, and all patients are monitored in line with the 4- and 12-hour performance standards. The area is designed to support the rapid assessment and treatment of ED patients, and most will require a period of observation or investigation. Due to the nature of an ambulatory pathway, there are strict inclusion and exclusion criteria.

Patients can and do deteriorate and subsequently convert to needing an admission into hospital. The aim is to transfer these patients into another area of the ED for monitoring or a bed. The length of stay (LOS) in Ambulatory Majors is discussed in the 4 times a day site safety meeting and an organisational-wide response is initiated at times of increased pressure. A senior nurse is allocated to Ambulatory Majors who works with the ED nurse in charge to maintain quality and safety. We recognise at times of increased pressure the

LOS in Ambulatory Majors does increase. For April the average time spent in Ambulatory Majors was 289 minutes, and 127 patients remained in Ambulatory Majors overnight. We absolutely recognise that Ambulatory Majors is not an ideal environment for patients who need to remain in hospital overnight, and in particular is not appropriate for more vulnerable patients to spend prolonged time within, such as those living with Frailty.

We would like to thank Shropshire Defend our NHS for highlighting the episodes of care and as a direct result we have taken the following measures:

- An immediate review of all patients within the area was completed.
- Increased presence of ED Nurse In Charge and Matron.
- Review of the area and ensuring patients understand how to raise a concern.
- Patients are prioritised to move into a more suitable area if required.
- Pillows and blankets are stocked within this area.
- Staff are aware that more recliner chairs are available if required.

Ambulatory Majors' model of care is not influenced by the latest guidelines from NHS England and the use of temporary escalation space. NHS England latest guidance on 'corridor care' was published in March 2026. The average time patients spent in Ambulatory Majors in 2025/26 was 421 minutes and has reduced to 289 minutes in April 2026 – there is no evidence that the latest guidelines have added pressure to Ambulatory Majors.

Over the last two years we have made considerable progress with addressing significant deficiencies in the quality, dignity and experience of care in the UEC pathway, including:

- Eliminated use of the Main Corridor at PRH to care for ED patients (July 2023)
- Eliminated use of the X-Ray Corridor at RSH to care for ED patients (March 2025)
- Eliminated use of the AMA seated area at RSH to care for Acute Medical patients (November 2025)
- Eliminated the routine practice of corridor care for Acute Medical patients awaiting a space on SDEC/AMU at PRH (December 2025)
- Ceased use of the Portakabin at PRH (formerly known as Ambulance Receival Area and Decision to Admit Unit) for 24/7 overnight care (December 2025)
- Significant reduction in the use of the internal corridor at PRH in March/April 2026.

This improved Ambulatory Majors area exists because of investment tied to moving from two A&Es to one. What is the current target date for closure of the A&E at Princess Royal Hospital?

The current Hospitals Transformation Programme (HTP) is on track to deliver for 2028, which is the anticipated timeframe for the move from two A&Es to a single-site model, including the transition of services from Princess Royal Hospital.

Is SaTH confident that emergency care at the Royal Shrewsbury is adequate to meet current and future demand?

SaTH recognises that demand for emergency care at the Royal Shrewsbury Hospital is both high and continuing to grow, and we do not underestimate the challenges this creates. In the short term, the Trust has put in place a range of measures to ensure we can safely manage current demand. These include 56 additional beds at RSH and 40 new acute assessment spaces at PRH in the last 6 months.

Looking ahead, the Trust is not complacent about future demand. We know that without transformation, current arrangements would not be sufficient in the long term. This is why the Hospitals Transformation Programme is so important. The development of a modern, purpose-built emergency care centre at Royal Shrewsbury, alongside changes to how

urgent and emergency care is delivered across the system, is designed specifically to provide the capacity, resilience and clinical model needed for the future.

In summary, while current services are under pressure, we are maintaining safe care. At the same time, we are investing in longer-term solutions to ensure emergency care at Royal Shrewsbury is sustainable and able to meet future demand.

What are SaTH's plans to end these longer stays in what should be a short-stay area, and what are the plans to end overnight stays?

We are working with an external delivery partner to expedite access to assessment, diagnostics and treatment within the Emergency Department. Through the formation of Group, there is a specific workstream addressing the No Criteria to Reside position to support reducing the time spent in the Emergency Department waiting for admission. We are also establishing a Community Transformation Programme to support reducing acute hospital admissions where clinically appropriate.

Q2 Submitted by Diane Peacock

Q Context

I asked two questions at 12th March 2026 SaTH Board. The first concerned the lack of published **disaggregated** SaTH emergency department (ED) and urgent treatment centre (UTC) data for RSH and PRH. The second question related to the publication backlog of responses from SaTH Freedom of Information (FoI) requests. I was concerned by both the responses I received.

A*ggregated* hospital data at Trust level is nationally and locally available. However, **disaggregated data at RSH and PRH level** is not a visible part of SaTH's Hospitals Transformation Programme (HTP) quality oversight and improvement process. If this information was available to the public, it would not require an FoI request. During this period of considerable change for both our Shropshire and Telford area populations when all aspects of the HTP and associated ICS/ICB partners' plans are in train, the FoI process can play a vital role in demonstrating openness and accountability as well as engendering trust and confidence in institutions.

While acknowledging the internal pressures outlined by the Director of Governance, it is possible that many of the absent FoI responses are already completed and meet current local and national criteria for publication. It is difficult to see why current technology can't support fairly straightforward data uploading functions or why the relatively modest sum needed for a suitably qualified person to upload anonymised FoIs cannot be found within or from outside of this large organisation.

Questions

- **Question 1a: Do Board members agree it is vital that completed FoI responses for 2026 should be promptly uploaded onto the SaTH Disclosure Log and FoI Information Responses Page followed by FoI responses from 2025 and 2024?**
- **Question 1b: If 'no', could the Board please explain why not?**
  If 'yes', could the Board advise when this work will be progressed?

A ***Provided by the Group Chief Executive on behalf of Anna Milanec, Group Chief Governance Officer***

As explained in the previous response to Mrs Peacock, there are several reasons why there is not a public disclosure log on our website yet. We are aware that this should be in place, and this is something that we have been trying to rectify for some time.

However, the main issue is workforce availability since, as explained previously, FOIs have significantly increased in volume and complexity. We are currently looking at resource for this area as part of our Group work, with a view to sharing of resource, and Ms Williams will work with Ms Milanec to ensure there is adequate resourcing to support the increased volume and complexity of FOIs and Data Subject Access requests.

Q3 ***Question from the floor - Gill George***

Q Ludlow Hospital x-ray service has been closed for the last few months. Patients are being directed to the x-ray service at Bridgnorth instead, which involves significant travel time. Also, patients seem to have been left with the impression that they have a choice, ie Bridgnorth or wait three months for the Ludlow service to resume. This has led to clinical risk and in turn has led to additional work for GPs in trying to untangle the situation.

1. When is Ludlow going to be open?
2. Can there be better liaison?

A ***Provided by Ned Hobbs, Chief Operating Officer / Deputy CEO (SaTH)***

The x-ray facility at Ludlow Hospital resumed last week. Apologies for the inconvenience to our patients over the last few months.

More generally, community diagnostic services across this and other hospital locations are an area that can improve going forward following formation of the Group, through SaTH and ShropCom colleagues working in partnership.

Ms Williams added that we want to build trust back up with the community, and GPs have been invited to an event in September to emphasise their role as a critical partner.

Q4 ***Question from the floor – David Sandbach***

Q The number of patient deaths in A&E has increased. Compared to other providers SaTH has the worst statistics in this respect. What is the reason for the increase?

A ***Provided by Dr John Jones, Group Chief Medical Officer***

The Trust investigates every death in ED to ensure we fully understand why it happened (noting that the published data also includes deaths that have occurred outside of hospital).

The Quality & Safety Assurance Committee (QSAC) focuses regularly on reviewing the data and investigation outcomes to provide appropriate challenge and assurance in this respect. Dr Jones offered to respond in more detail offline if required.

Board of Directors' Meeting in Common – 9 July 2026

Agenda item	035/26		
Report Title	Group Chief Executive's Report		
Executive Lead	Joanne Williams, Group Chief Executive		
Report Author	As above		
Prior Consultation:	**CQC Domain:**		**Link to BAF risks (strategic)**
None	Safe	√	All SCHT BAF Risks All SATH BAF Risks
	Effective	√	
	Caring	√	**Risk Register id(s):**
	Responsive	√	-
	Well Led	√	
Executive Summary	The Group Chief Executive's report updates the Board on key recent events and ongoing local, regional, and national matters affecting Shropshire Community Health NHS Trust (SCHT) and The Shrewsbury and Telford Hospital NHS Trust (SaTH) since the last report to our Boards. The final week of June was marked by the publication of a further review of poor NHS maternity care. We recognise the considerable courage shown by the approximately 2,000 Nottingham families who came forward and whose voices were not heard at the time. We are deeply sorry for those families, and others, affected by the events at Nottingham, and whose lives have been forever impacted. As a Trust, which continues with its own maternity improvement journey, SaTH commits to continue to learn, and to listen. The Trust is honoured to be supporting the launch of Poppy's Promise this week; the devastating loss experienced by Poppy's parents, led to the development of this extraordinary cultural programme, and provides an enduring legacy for their daughter.		
Recommendations for the Boards	The Boards are asked to **note** the contents of this report		
Appendices:	N/A		

1.0 Introduction/General updates

1.1 This paper provides an update regarding some of the most noteworthy events and updates, since the last public Board on 14 May 2026, from the Chief Executive's position.

1.2 On Wednesday 24 June 2026, the Independent Maternity Review of Maternity Services at Nottingham University Hospitals NHS Trust, led by Donna Ockenden, was published. Our thoughts are with all the families at the heart of the review, including those whose experiences were reflected in the SaTH reports four years ago. We know these publications may bring back painful memories for them, and we are truly sorry.

These reports carry the voices of families who have shown extraordinary courage in sharing what happened to them. Their experiences have had a profound impact on people's lives, and they remind us why the work we all do across our hospitals and community services matters so deeply. These are not statistics; they are women, babies, and families whose lives have been changed forever, and they deserve to be acknowledged with compassion and respect.

We also recognise that these reports may feel personal for many of our colleagues. Some of you will have your own experiences of maternity care or may know families directly affected. We are part of the same communities, and the impact of these events reaches into our own homes and lives.

We are proud of the dedication shown by colleagues working in maternity services and the progress that has been made. The themes raised in the reviews - listening, learning, teamwork, safety, and respect - are relevant to every service, every team, and every role across SaTH and SCHT. Each of us contributes to the culture, compassion, and quality of care that our communities experience.

Across the NHS, there is a renewed and urgent focus on learning, improvement, and rebuilding trust. For us, this means continuing the work already underway: strengthening teamwork, supporting each other, embedding consistent safety practices, and ensuring that people feel heard and respected in every interaction - whether in our hospitals, clinics, or community settings.

The report sets out a series of immediate and essential actions and recommends significant structural reforms required both at individual trust level and across the wider National Health Service. The following 8 key headings for the Immediate and Essential Actions must be completed across all maternity services in England:

i. Listening to Women & Families
ii. Workforce Planning & Safe Staffing
iii. Training & Multi-Professional Learning
iv. Risk Assessment Throughout Pregnancy
v. Incident Investigation & Family Involvement
vi. Governance & Board Accountability
vii. Culture, Teamwork & Psychological Safety
viii. Mothers Who Have Died and Post Death Care

A communication was received from NHS England on the day of publication, outlining three immediate actions required by all Trusts with maternity services which include:

i. Roll out of Martha's Rule to all maternity and neonatal settings in England.
ii. Strengthening candour and cooperation in future reviews
iii. Human Tissue Authority (HTA) action requiring all Trusts to review mortuary records.

Considering the Nottingham report's findings on post-death processes, I want to offer assurance to the Board, and most importantly to families, that SaTH has arrangements in place to provide thoughtful, compassionate, and respectful support to families who are bereaved.

A standard operating procedure is in place to guide the safe, dignified, and respectful transfer of babies who have died from maternity and emergency settings to the Swan Room or mortuary. It also sets out how families and staff are kept informed, so that bereaved families are supported with kindness, compassion, and care throughout.

SaTH has a dedicated bereavement team, with trained staff available on the delivery suite 24 hours a day to provide sensitive care and support. Bereavement care training is also part of the mandatory annual training programme, helping staff provide kind, compassionate, and respectful care to families when they need it most.

The Maternity Bereavement Room has been created to give families a private, quiet space where they can spend precious time together and grieve in their own way. Families can enter and leave the room separately from the delivery suite, helping to protect their privacy at an extremely difficult time. The room also has a cool cot and a privacy pram, so families can spend time with their baby outside if they wish.

The report also requires all Trusts to review and provide assurance against the seven immediate and essential actions set out originally in Mrs Ockenden's SaTH report. Within SaTH, these actions are subject to regular audit and are embedded within the established audit cycle. The newly appointed Head of Midwifery, who is due to commence in mid-July, will review the approach undertaken to date and assess the progress achieved.

The Women and Children's Division (SaTH) have undertaken a significant programme of work in response to the 210 recommendations set out in our Ockenden report published in March 2022. However, working with families the Trust committed to an independent external review to validate our progress to date and to confirm that all recommendations have been fully delivered. This has been a substantial undertaking, involving more than 700 individual actions and over 1,200 pieces of supporting evidence. The report is due later this summer, and we will share the findings with families so they can see the progress made and understand how their voices and experiences have shaped meaningful change.

Baroness Amos is due to publish her report on maternity services on Tuesday 30 July 2026. At the time of writing, we had not yet received the report. The Trust will undertake a detailed review of both reports and actions required, and oversight will be maintained via the Trust's Maternity and Neonatal Transformation Assurance Committee, Quality and Safety Assurance Committee, and the Trust Board.

The Nottingham families, those affected by events at SaTH, and many others across the country have shown remarkable courage in sharing their experiences. Their loss and resilience remain central to our learning and continue to drive our commitment to meaningful, lasting improvement now and in the future.

2.0 Group Update

2.1 The Board papers for this meeting include a comprehensive Integrated Performance Report, outlining our performance against the plans agreed with NHS England for both SCHT and SaTH.

2.2 Performance continues to improve. In May 2026, 83.6% of patients spent less than 12 hours in ED, our strongest performance since August 2022, and the average ambulance handover time was 28 minutes, the best since the pandemic. The UCR two-hour response rate was 88.52%, above the national target, and virtual ward occupancy was 81.53%, also above target. While we recognise there is still more to do, it is encouraging to see this improvement, which reflects the significant effort of teams working together across our Group.

2.3 Although this report will be published a few days after the anniversary itself, I would like to take the opportunity to recognise the birthday of the National Health Service, founded on 5 July 1948. The NHS remains one of our nation's greatest achievements, built on the enduring principles of providing high-quality care that is free at the point of need. As we mark this important anniversary, I would like to thank every member of staff, volunteer, and partner organisation for their unwavering commitment to our patients and communities. Your compassion, professionalism, and dedication continue to uphold the values on which the NHS was founded. I hope colleagues had the opportunity to reflect on this significant milestone and to take pride in the remarkable contribution you make every day. Together, we continue to build on the NHS's proud legacy while shaping a sustainable and equitable future for those we serve.

2.4 This week, we are launching Poppy's Promise across the organisation. Poppy's Promise is a commitment to ensuring that every person who encounters our services feels seen, heard, respected, and cared for as a human being. It reminds us that healthcare is not only about treatments, procedures, and outcomes; it is also about compassion, communication and the experience people have while receiving care. It provides a simple but powerful framework for how we treat patients, families, and one another.

Poppy's story is at the heart of this programme. Her death was a tragedy, and the circumstances surrounding it highlighted the profound consequences when people feel unheard, unsupported, or disconnected from those caring for them. Rather than allowing that loss to be remembered only for what went wrong.

Poppy's Promise seeks to create lasting positive change. It honours her memory by helping ensure that compassion, listening, and human connection remain central to every interaction and decision we make.

Many people struggle to remember the details of a procedure or a clinical conversation years later, but they remember how they were made to feel. They remember whether someone listened, whether they felt reassured, whether they were treated with dignity and kindness. Human beings connect emotionally to experiences, and those feelings often remain long after the technical details have faded.

Compassion is present in the way we greet people, the way we listen, the patience we show, and how we respond when someone is distressed or uncertain. It is evident in clinical areas, reception desks, offices, support services, and community settings. Compassion is not confined to one role; it is expressed through thousands of everyday interactions that shape how people experience our organisation. Truly human healthcare is about recognising that every patient, family member, and colleague is a person first. It means combining professional expertise with compassion, empathy, and respect. It values clinical outcomes alongside the human experience, ensuring people feel heard, understood and cared for throughout their journey. We will share more in the coming weeks and months as the programme is rolled out across the Trust.

I am deeply grateful to Poppy's parents for their unwavering commitment, time, and compassion in working with the Trust, in such tragic circumstances, to develop this programme in their daughter's legacy. It is a privilege to be the first Trust to launch Poppy's Promise, and I know the Board, leaders and colleagues across the Group will take it to heart and help ensure it makes a meaningful difference for our patients and staff.

2.5 A warm welcome to Martina Morris, who officially assumed her role as Group Chief Nurse on 29 June 2026. I am delighted that Martina has joined us and want to thank her for choosing to be part of our Group. I know she will lead with care, compassion and a deep commitment to our patients, colleagues, and communities across SaTH and SCHT. Since joining us at the start of June, Martina has been incredibly busy meeting colleagues across the Group, and I would like to thank everyone who has taken the time to welcome and support her.

2.6 I would also like to express my sincere thanks to colleagues across the Group who have continued to provide exceptional care and support during the recent period of exceptionally hot weather. Working in such challenging conditions places additional demands on our staff, and I am grateful for your resilience, professionalism, and unwavering commitment to ensuring our patients and communities continued to receive safe, high-quality care. Your dedication during these demanding circumstances is greatly appreciated.

2.7 On 9 June, I had the privilege of representing the Trust at 10 Downing Street, where I was invited to meet with the Prime Minister and the Secretary of State for Health and Social Care. The invitation recognised the significant contribution our Trust has made in reducing elective waiting times and improving access to planned care for our patients.
This recognition reflects the outstanding commitment and hard work of colleagues across the Group. It is a testament to the dedication, innovation, and collaboration demonstrated by our clinical and operational teams, whose collective efforts continue to improve outcomes and deliver timely care for the communities we serve.

2.8 The publication of Lord Mann's Review on Racism in the NHS, finds that racism, including Antisemitism and Islamophobia, remains a systemic issue in the NHS, affecting both staff and patient experience. While some progress has been made, consistently safe and inclusive environments are not yet in place.

NHS England has accepted all recommendations, including adopting anti-racism principles, introducing staff standards, mandating training for leaders, strengthening oversight, and improving data collection and guidance.

Boards are expected to implement these measures, ensure compliance with training, use staff data to drive action, and engage with communities.

Oversight will sit with the People Committee, which will provide regular assurance to the Board on progress against the agreed actions. This will include compliance with mandated training, the effectiveness of anti-racism initiatives, and the use of workforce data to identify and address inequalities. The Committee will also monitor delivery against national expectations, ensure appropriate challenge and support are in place, and escalate any risks or gaps in implementation to the Board as required.

Eliminating racism requires sustained, system-wide leadership to create a culture of dignity, compassion, and inclusion.

2.9 A major milestone in reducing waiting times for planned care has been reached at The Princess Royal Hospital. More than 10,000 patients have now received operations at the elective surgery hub since it opened. The 10,000th procedure was completed on Sunday, June 7. Following a visit to the hub on 27 April 2026, the Accreditation Panel met on 20 May 2026 and confirmed that The Princess Royal Hospital Hub has been recognised as an accredited adult surgical hub. This is a significant achievement and reflects the clinical and operational excellence of the team, as well as their strong engagement in the accreditation process. The visiting team highlighted the professionalism and enthusiasm of colleagues and their commitment to making the most of the opportunities offered through the accreditation scheme.

2.10 Therapies colleagues from SaTH and SCHT have come together as one integrated team. This is a clinically led approach where teams will continue to shape how services develop. By working together, we have a real opportunity to create more joined-up care for our patients that is delivered at the right time, in the right place and build great opportunities for our staff, making the Group a great place to work.

2.11 Recent national media reports have highlighted incidents of staff accessing confidential patient records without a legitimate need, which has reinforced the importance of robust information governance arrangements across the NHS. National guidance and legislation is clear that access to patient, or staff, information must only occur where there is a lawful and legitimate purpose. Any inappropriate access is treated as a serious matter and may result in disciplinary action, including findings of misconduct. We continue to reinforce these expectations through mandatory training, staff awareness, and routine audit and monitoring of system access to safeguard patient and staff confidentiality and maintain public confidence.

3.0 Shropshire Telford and Wrekin Integrated Care System (ICS) / Staffs & Stoke-on-Trent ICS Combined Update

3.1 The next Board meeting is 24 September 2026, 1.30pm, the venue is still to be confirmed.

4.0 NHSE

4.1 On Tuesday 30 June 2026, all Provider and ICB Chief Executives will be attending the planned National NHS England Leadership Meeting in London, alongside National Directors and the Executive Team.

5.0 Recommendations

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
Shropshire Community Health NHS Trust
The Shrewsbury and Telford Hospital NHS Trust

26 June 2026

Shropshire Community Health NHS Trust

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Quality and Safety Committee Thursday 28th May 2026

0. Reference Information

Author:	Jessica Donegan, Executive Assistant	**Paper date:**	9th July 2026
Executive Sponsor:	Jill Barker, Non-Executive Director	**Paper written on:**	30th June 2026
Paper Reviewed by:	Sara Ellis-Anderson, Interim Director of Nursing Community	**Paper Category:**	Quality & Safety
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Quality & Safety Committee at Shropshire Community Trust meeting held on Monday 29th June 2026 for assurance purposes. The Board is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Quality and Safety Committee is a sub-committee of the Board of Shropshire Community Health NHS Trust (the Trust) and has delegated authority from the Board to oversee, co-ordinate, review and assess the quality and clinical safety arrangements within the Trust.

The Quality & Safety Committee will provide scrutiny and challenge regarding all aspects of quality and clinical safety, including strategy, delivery, clinical governance, research, and clinical audit, to obtain assurance and make appropriate reports or recommendations to the Board (Group Board from 1/4/26).

2.2 Summary

Assure

- HMIP/CQC prison inspection report provided positive assurance, with none of the priority concerns relating directly to SCHT healthcare and several examples of notable practice recognised within the healthcare service
- Winter planning update received with acknowledgement of an improved position compared with previous years.
- The Infection Prevention and Control Annual Report was received, and committee was assured that robust IPC governance arrangements remain in place
- The Committee received assurance regarding the safety and quality of Virtual Ward care delivery, with mitigating actions in place to address medical workforce and clinical leadership challenges, including strengthened oversight and development of a sustainable future medical model

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Alert

- The Integrated Quality report demonstrated annual staff survey sub-score results as being below national average with recommendation for full action plan triangulating with Freedom to Speak Up returns to support focussed organisational improvements.

- Patient Experience Committee provided partial assurance due to continued low Friends and Family Test response rates. A complaints deep-dive also received partial assurance pending evidence of sustained improvement in patient experience outcomes.

Advise

- The committee requested the completion of a Quality and Equality Impact Assessment (QEIA) to inform final consideration of the prison healthcare contract

2.3. Conclusion

The Board is asked to **note** the Chair's Report for assurance purposes and consider any additional assurances required.

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Shropshire Community Trust Quality and Safety Committee which met on 29th June 2026. The meeting was quorate with a full list of the attendance is outlined below:

Chair/ Attendance:
Jill Barker, Non-Executive Director (Chair)
Tina Long, Non-Executive Director
Sara Ellis-Anderson, Interim Director of Nursing Community
Martina Morris, Group Chief Nursing Officer
John Jones, Group Medical Director
Shelley Ramtuhul, Director of Governance Community
Anna Milanec, Group Director of Governance
Gemma McIver, Deputy Director of Operations Community
Steve Ellis, Deputy Director of Operational Service Development Community
Sharon Simkin, Quality Lead, ICB
Sarah Hoyes, Interim Deputy Director of Nursing, Community

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Martin Howard, Patient Experience Volunteer Jessica Donegan, Executive Assistant
Apologies:
Jo Williams, Group Chief Executive Claire Horsfield, Director of Operations Community & Group Chief AHP Dr Ganesh, Medical Director Community

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and received an update on the progress of each. All actions which were due to be completed before the meeting were confirmed as accomplished or substantial updates were provided.

3.3 Key Agenda

The Committee received all items required on the work plan with an outline provided below for each:

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Integrated Quality & Safety Performance report		
The Committee noted several areas requiring continued oversight. The *Clostridioides difficile (C. difficile)* indicator remains outside the expected threshold due to performance against the rolling 12-month measure, despite no cases being reported during May 2026. Two cases were subsequently identified in June (Bridgnorth and Ludlow), and work is underway to develop a year-to-date performance measure that better reflects current performance. Falls performance is improving, with the rate at 5.23 falls per 1,000 occupied bed days but remains above the organisational target. In addition, the NHS Staff Survey sub-score relating to staff confidence in raising concerns remains below the desired position. Committee members expressed significant concern regarding this organisational culture indicator and	Full	Assurance was provided that quality improvement activity continues across key patient safety priorities, including delivery of PSIRF-related improvement plans.

emphasised the importance of understanding the underlying causes. The Committee requested further work to strengthen understanding of quality and workforce-related risks. A formal improvement plan will be developed to address the Staff Survey sub-score relating to raising concerns, informed by staff engagement activity and Freedom to Speak Up themes. Members also requested triangulation of workforce indicators, including vacancies and sickness absence, with quality and safety metrics to identify potential relationships between workforce pressures and quality outcomes. Governance arrangements between the Quality & Safety Committee and People Committee will be reviewed to ensure clear oversight and avoid duplication of reporting.		
2. Winter Planning Update		
The Committee noted that, despite a significantly improved winter performance, challenges remain in relation to patient flow, particularly the ongoing impact of No Criteria to Reside (NCTR) patients and sustained demand for Pathway 1 discharge capacity. These pressures continue to contribute to longer lengths of stay and reliance on bed-based care, including escalation capacity. Workforce sickness absence also affected resilience in some operational areas, although mitigations were successfully implemented. Members further recognised the need to improve staff flu vaccination uptake ahead of winter 2026/27 to strengthen workforce resilience. Work is underway with local authority and system partners to increase Pathway 1 capacity and reduce reliance on bed-based care ahead of winter 2026/27. The Committee supported the continued delivery of Community Transformation Programme milestones that will enhance community-based alternatives and improve patient flow. A	Full	The Committee received substantial assurance that winter preparedness arrangements were fully implemented and delivered effectively, with services remaining safe and responsive throughout the period. Members noted that the Trust demonstrated improved resilience compared with previous winters, supported by stronger operational oversight, enhanced partnership working

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joint SCHT and SaTH winter plan is being developed to provide a more integrated system response to future winter pressures. In addition, targeted actions are being implemented to improve staff flu vaccination uptake, including increasing peer vaccinators, improving accessibility for shift workers and removing organisational barriers to participation. The introduction of initiatives such as the Integrated Front Door Team, extended Care Transfer Hub and Urgent Community Response services, and the Two-Hour Bridging Service were highlighted as key contributors to improved system flow and reduced reliance on reactive escalation measures. Positive feedback from staff and system partners, together with evidence of learning from previous winters being embedded into planning and delivery, provided assurance that the organisation is better positioned to respond to future winter pressures.		and investment in community services.
3. Policy Tracker		
The Committee noted that while significant progress has been made in reducing the backlog of overdue policies, a small number of policies remain outstanding and continue to require active monitoring. Members also highlighted that policy review compliance alone does not provide assurance that policies are being consistently implemented in practice. Continued oversight will be maintained through the policy tracker to ensure the remaining overdue policies are reviewed and ratified within agreed timescales. The Committee also supported further consideration of how policy compliance and implementation can be evidenced alongside policy review activity. Future governance arrangements for policy oversight will be considered as part of the development of the joint Quality & Safety Committee structure, with opportunities to streamline reporting whilst maintaining robust assurance. In addition, learning from SCHT's successful policy management process will be	Full	The Committee received strong assurance regarding the effectiveness of the Policy Tracker and the substantial improvement in organisational oversight of policy management.

shared with SaTH to support improvements in policy governance across the wider Group. The Committee recognised the tracker as a significant governance improvement, reducing what had previously been a backlog of approximately 62 overdue quality and safety policies to a small number of outstanding reviews, providing confidence that policy reviews are being managed proactively and that forward planning is in place to minimise future non-compliance.		
4. Chairs Reports		
Patient Experience Committee The Patient Experience Committee noted ongoing concerns regarding low Friends and Family Test (FFT) response rates, which continue to limit the breadth of patient feedback available to inform service improvement. In addition, the Committee did not receive an Estates Report and therefore requested further assurance regarding estates-related issues and any potential impact on patient experience. Actions are underway to improve FFT response rates across services and to strengthen the capture of patient feedback. Further assurance has been requested from the Associate Director of Estates regarding estates matters, and Locality Clinical Managers have been tasked with undertaking additional PLACE based improvement work and reporting progress back through the Patient Experience governance structure.	Partial	The Committee received partial assurance, reflecting ongoing improvement work in relation to FFT response rates.
Infection Prevention & Control The Committee noted that MRSA screening compliance remains below the expected standard across some community hospital sites and requires continued improvement to ensure consistency of practice. In addition, a cluster of Invasive Group A Streptococcus (iGAS) cases within the Shrewsbury South Community Nursing Team was	Full	Overall, the Committee received substantial assurance regarding the effectiveness of IPC governance, training compliance and infection prevention controls, whilst recognising the need

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reviewed, with the investigation and management actions being led by the UK Health Security Agency. Immediate actions have been taken to address MRSA screening compliance, including reinstatement of the label printer at Whitchurch Community Hospital, which had been identified as a contributory factor to non-compliance. Work is also underway to strengthen FFP3 fit-testing compliance to meet the national requirement for recording on ESR by November 2026. **Health & Safety Committee** The Committee noted two areas requiring continued oversight. Firstly, 15 staff assaults were reported during the period, and a deeper review has been commissioned to better understand whether incidents were clinically or non-clinically related, enabling targeted prevention and response measures. Secondly, findings from an Independent Ligature Audit identified environmental risks requiring further assessment and mitigation, although no ligature-related incidents have occurred. Mortuary security audits also identified two breaches relating to unauthorised access arrangements involving funeral directors, which were addressed immediately. Further analysis of staff assaults will be undertaken and reported back to Committee to identify themes and ensure appropriate controls are in place. Work is also underway to review ligature audit findings and develop a proportionate risk-based approach for patient placement and environmental risk management. The Committee will continue to oversee implementation of the revised Violence Prevention and Reduction Policy and monitor actions arising from mortuary security audits. Additionally, concerns regarding the recording of fire drills are being addressed through the Building Manager training	Full	for continued focus on MRSA screening compliance. The Committee received full assurance, with targeted improvement activity in place for staff safety and a risk-based response to the recent ligature audit.

programme and strengthened fire safety governance arrangements. There were no RIDDOR-reportable incidents during the reporting period and mandatory training compliance exceeded 97%, demonstrating continued improvement. Ongoing progress was also noted in policy review and governance arrangements, providing confidence that health and safety risks are being actively managed. **Palliative End Of Life Care (PEOLC)** No significant risks, incidents or complaints relating to palliative and end of life care were escalated to the Committee. The Committee did, however, note the forthcoming publication of the National Audit of Care at the End of Life (NACEL) findings, which may identify future improvement priorities and areas requiring further scrutiny. The Committee was advised that the national NACEL audit findings are expected shortly and will be reviewed through governance processes once published. A further report will be presented to the next Quality & Safety Committee detailing the development of the system-wide All-Age Palliative and End of Life Care Strategy and the Trust's associated programme of work to support implementation.	Full	
Corporate Risk Register		
No new corporate risks were escalated to the Committee, and there were no increases in risk scores reported during the period. The principal risk remaining within the Committee's remit continues to relate to the Building Manager arrangements, reflecting the need to embed fire safety and estates governance responsibilities consistently across Trust sites. Mitigating actions continue through the implementation of the Building Manager programme. Designated Building Managers	Full	The Committee received assurance that the Corporate Risk Register remains stable, with no increases or decreases in risk ratings, no new risks requiring escalation, and no significant changes to the Trust's

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have now been identified and training sessions are scheduled during July and August. Following completion of the training programme, the risk will be reviewed to determine whether the residual risk score can be reduced. Routine monitoring of corporate risks will continue through established governance arrangements.		risk profile. Existing risks are being actively managed and monitored, and the Committee was satisfied that appropriate controls and mitigations remain in place.
Fire Safety Update		
Whilst no significant fire safety concerns were escalated, the Committee noted that the Trust remains focused on addressing risks associated with the sustainability of fire safety management arrangements and ensuring consistent fire safety governance across all sites. In addition, Whitchurch Community Hospital remains due for a future Fire Service audit, although a date has not yet been confirmed. A programme of work is underway to strengthen and sustain fire safety arrangements across the organisation. Building Managers have been identified, and training is being delivered during July and August to improve local fire safety leadership and assurance. Work is also progressing jointly with SaTH colleagues to develop a unified Group-wide approach to fire safety management. Proactive action has been undertaken at Whitchurch Community Hospital to address previously identified fire safety and evacuation risks, and a comprehensive fire safety report will be presented to a future Committee meeting. The Fire Service recognised that identified recommendations were already being addressed through existing improvement plans and was sufficiently assured by Trust governance arrangements that a repeat audit of Bishop's Castle Community Hospital was not required. Members were assured that fire safety governance, oversight and risk management arrangements have significantly strengthened through the work of the Fire Safety Group and that the organisation has moved from a position of potential	Full	The Committee received strong assurance following a recent Fire Service audit of Ludlow Community Hospital, which was assessed as "broadly compliant", representing the highest level of compliance available through the audit process.

regulatory concern to one of compliance and improved assurance.		
IPC Annual Report		
The Committee noted two areas requiring continued focus. Clostridioides difficile (C. difficile) performance remained above the expected threshold, with 11 cases reported during 2025/26 against an expected threshold of four, reflecting ongoing system pressures and remaining a key priority for improvement. In addition, MRSA screening compliance remained slightly below target across the year, highlighting variation in compliance between community hospital sites and the need for greater consistency in screening practices. The Committee supported the forward priorities outlined within the IPC Annual Report for 2026/27, including targeted work to reduce C. difficile infections, improve MRSA screening compliance, strengthen antimicrobial stewardship and continue quality improvement initiatives across the organisation.	Full	The Annual Report provided assurance that appropriate IPC governance, reporting and improvement processes remain in place and that the organisation continues to demonstrate effective infection prevention and control practices across services. The Committee approved the report for onward submission to Board.
HMIP/CQC/Ofsted Inspection Stoke Briefing Paper & Prison Contract Update		
The unannounced HMIP/CQC inspection identified a number of areas requiring improvement across the wider prison environment, including support for vulnerable prisoners and reducing levels of self-harm. Whilst none of the six priority concerns or six key concerns identified by the joint HM Inspectorate of Prisons and CQC inspection related directly to SCHT healthcare services, the Committee recognised that there are opportunities for the Trust to support system-wide improvement, particularly in relation to self-harm prevention, prisoner wellbeing and engagement. The Committee also noted concerns raised regarding deaths in custody and the importance of ensuring these continue to be monitored through relevant governance and thematic review processes with learning from reviews embedded in practice.	Full	Overall, the Committee received substantial assurance regarding the quality, safety and effectiveness of prison healthcare services and approved the proposed improvement plan.

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An initial improvement plan has been developed in response to the inspection findings. Actions within the Trust's remit include strengthening prisoner engagement, improving awareness and accessibility of complaints processes, and incorporating learning from thematic reviews relating to self-harm and deaths in custody. The action plan will be further strengthened through the inclusion of clear milestones, outcome measures and evidence of impact. A six-month progress update will be presented to the Committee, and work continues with prison partners on actions relating to the wider prison environment that sit outside SCHT's direct control. The Committee received strong assurance from the inspection findings. None of the priority concerns identified by inspectors related to SCHT healthcare services, and five of the seven examples of notable positive practice highlighted during the inspection were attributed to healthcare provision delivered by SCHT. The inspection concluded that prison healthcare services were delivering care equivalent to community standards in many areas. Additional leadership capacity has already been established through interim Head of Healthcare arrangements and the appointment of an Operational Head of Nursing. **Prison Contract Update** The Committee discussed the proposed continuation of the prison healthcare contract and noted concerns regarding the increasing complexity of the prison population, the ongoing challenge of self-harm and deaths in custody, and the need to ensure that service improvements remain sustainable. Members also highlighted the importance of understanding the full quality and equality implications of the contract through completion of a Quality and Equality Impact Assessment (QEIA) before final Board consideration. The Committee recognised that whilst healthcare quality was positively reflected within the recent prison inspection, continued focus is required on integrated mental health provision and support for vulnerable prisoners.	Partial	Members acknowledged the quality improvements already achieved within prison healthcare. Further assurance was sought through completion of the QEIA.

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Work is underway to redesign and improve prison healthcare pathways, including enhanced use of SCHT Minor Injury Units, development of a prison Virtual Ward offer, reduction in avoidable emergency department transfers and implementation of a more integrated mental health service model. Following Committee discussion, it was agreed that a full QEIA should be completed, for consideration at Board. Committee received assurance that significant improvements have been made to the financial and operational sustainability of the service through workforce recruitment, reduced agency reliance, revised care pathways and additional commissioner investment. Assurance was also received that the recent independent prison inspection found healthcare provision to be equivalent to community standards and identified several examples of notable practice delivered by SCHT services.		
Virtual Ward Gap Analysis		
The Committee reviewed a gap analysis against the NHS England Virtual Ward core standards and noted that, whilst the service is compliant with the majority of requirements, two areas remain partially compliant: the establishment of a sustainable medical model and provision of out-of-hours medical cover. These gaps are recognised risks and remain recorded on the Corporate Risk Register. Discussion highlighted challenges relating to recruitment of permanent medical staff, clinical leadership capacity, and the development of a sustainable long-term workforce solution. Work is progressing at Group level with SaTH colleagues to develop a sustainable clinical leadership and medical workforce model for the Virtual Ward service. Further work is also underway to address out-of-hours arrangements and establish a compliant long-term service model. In the interim, robust escalation pathways remain in place through NHS 111	Full	Committee received assurance regarding the quality and effectiveness of the Virtual Ward service and acknowledged the mitigations in place and actions being taken for the two aspects that remain partially compliant.

and emergency services, and the Committee requested a further update on the medical model and workforce plans later in the year.		
Complaints Deep Dive		
The Committee reviewed a deep dive into complaints categorised under Quality of Care and noted recurring themes relating to communication with patients and families, timeliness of care and variation in documentation standards. Whilst complaint volumes remain relatively low, areas of concentrated concern were identified, particularly within Bridgnorth MIU and Bridgnorth Ward, where clusters of complaints prompted further scrutiny. Members also recognised a wider NHS trend of increasing complaints and the need to focus on patient experience as a means of reducing future complaints. A number of improvement actions have been implemented through the Patient Experience Committee, including strengthened learning and tracking arrangements to ensure actions arising from complaints are monitored through to completion. Targeted improvement work has been undertaken within Bridgnorth services, including enhanced leadership, quality improvement boards, and focused work on compassionate communication with patients and families. The Committee supported the development of a more outcome-focused improvement plan, aligned to patient experience priorities and initiatives such as Poppy's Promise,	Partial	Committee received partial assurance, recognising that improvement actions are in place but further evidence is required to demonstrate a measurable reduction in complaints and sustained improvements in patient experience outcomes.

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with a six-month update requested to assess the impact on complaint themes and trends.		
Any Other Business		
Supreme Court DoLS Committee received a verbal update on the recent Supreme Court judgment of 2 June 2026, which overturns the long-established Cheshire West ruling and removes the previous "acid test" used to determine whether a person is deprived of their liberty. The decision represents a significant change to the legal framework underpinning DoLS assessments and is expected to have far-reaching implications for health and social care organisations, including assessment processes, professional decision-making and safeguarding practice.	N/A	
ASEND The SEND thematic review recognised that whilst there is significant improvement activity taking place across Shropshire SEND system, there remains a gap between organisational improvements and the lived experience of children, young people and their families. The review highlighted that improvements reported by system partners are not yet being consistently experienced or felt by service users, indicating a need for greater focus on outcomes and impact.	N/A	

4. Conclusion

The Board of Directors is asked to note the meeting that took place, and the assurances obtained.

Shropshire Community Health NHS Trust

Chair's Assurance Report

Resource and Performance Committee Part 1 – 24 June 2026

0. Reference Information

Author:	Stacey Worthington Executive Assistant	**Paper date:**	9 July 2026
Executive Sponsor:	Tina Long, RPC Chair	**Paper written on:**	24 June 2026
Paper Reviewed by:	Sarah Lloyd Chief Finance Officer	**Paper Category:**	Governance
Forum submitted to:	Trust Boards in Common	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Resource and Performance Committee meeting held on 24 June 2026 for assurance purposes.

2. Executive Summary

2.1 Summary

- The meeting was well attended.
- The agenda items included:
    - National Oversight Framework Update
    - Month 2 Financial Performance
    - Integrated Performance Report

2.3. Conclusion

The Board is asked to note the Chair's Report for assurance purposes.

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Resource and Performance Committee which met on 24 June 2026. The meeting was quorate with three Non-Executive Director and six Directors present. A full list of the attendance is outlined below:

Chair/ Attendance:	
Tina Long	Non-Executive Director (RPC Chair)
Harmesh Darbhanga	Non-Executive Director
Jill Barker	Non-Executive Director
Sarah Lloyd	Chief Finance Officer
Ned Hobbs	Group Chief Operating Officer
Claire Horsfield	Director of Operations for Community and Chief AHP
Jonathan Gould	Deputy Chief Finance Officer
Rhia Boyode	Group Chief People Officer
Shelley Ramtuhul	Director of Governance

Chair's Assurance Report

Resource and Performance Committee Part 1 – 24 June 2026

Sara Ellis-Anderson	Interim Director of Nursing (Community)
Steve Price	Head of Information and Performance Assurance

Apologies:	
Jo Williams	Group Chief Executive
Cathy Purt	Non-Executive Director
Gemma McIver	Deputy Director of Operations
Richard Milner	Non-Executive Director (SaTH)

3.2 Actions from the Previous Meeting

The action log was reviewed; there were no actions due for this committee.

3.3 Key Agenda

The Committee received all items required on the work plan with an outline provided below for each.

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
8. National Oversight Framework Update		
The Committee received a presentation on the updated NOF following its recent publication. The metrics against which community trusts will be monitored will increase to 19. Each metric is scored and an average score is then calculated, and the organisation is assigned to a segment based on this score. Organisations will no longer be assigned a segment in relation to relative performance against peers but instead, will be allocated to specific segments based on the score. It was noted that there may be additional national measures, over and above the 19 allocated to community trusts, which are relevant to SCHT, and this is currently being assessed, As per the current arrangement, organisations operating within Group models will be assessed as separate statutory organisations and not based on overall Group performance.	N/A	
9. Month 2 Financial Performance		
The Committee received the Trust's financial performance report for month 2. The Trust delivered a surplus of £168k at the end of month 2 which is £209k favourable to plan. This is mainly due to substantive vacancies which are not being fully covered by temporary staff. Bank and Agency costs are not materially different from planned levels.	Full	

Chair's Assurance Report

Resource and Performance Committee Part 1 – 24 June 2026

CIP delivery was marginally ahead of planned levels and capital spend was slightly ahead of schedule. The detailed financial forecasts will be presented from month 3, together with an updated financial risk assessment. The Committee noted that the Trust continues to forecast delivery of the break-even position at year end, subject to mitigation of key financial risks.		
10. Integrated Performance Report		
The Committee considered the latest performance information, in line with the Trust's Performance Framework. There are no KPIs within this committees remit which are reported as both an assurance concern and special cause variation concern this month. Two KPIs are reported as a variance concern, both financial, in relation to the move from previously delivering a financial surplus to delivering a breakeven plan. Thirteen KPIs are flagged as an assurance concern, twelve of which relate to access and waiting times for our services. The Trust continued to report zero RTT 52 week waits. The Committee discussed that the Trust had received a NOF score of 2 in quarter 4, a deterioration from previous score of 1, and the reasons for this were discussed.	Full	
Meeting Evaluation		
The Committee agreed it was a positive meeting, with strong assurance provided.		

3.4 Approvals

None.

3.5 Risks to be Escalated

No new risks were identified within the course of the meeting; all are captured within the current BAF.

4. Conclusion

The Board of Directors is asked to note the meeting that took place and the assurances obtained.

Performance Assurance Committee, Key Issues Report		
Report Date: 23 June 2026		**Report of:** Performance Assurance Committee
Date of meeting: 23 June 2026		R Edwards (Chair), S Dunnett, R Dhaliwal, N Hobbs, N Lee, M Neal, A Winstanley, H Ainsbury, J Cunningham, L Mitchell
1	**Agenda**	The Committee considered the following: • Performance Highlights • UEC SIIP • Integrated Performance Report • Performance Assurance & Accountability Framework • Health Inequalities • Workforce Plan and Performance Impact • Estates Annual & Operational Plan • Digital Transformation Assurance Committee 4A Report • Data Quality Update • Digital Roadmap and Programme Milestones; Forward look • PAC Cycle of Reporting
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Urgent and Emergency Care: PAC heard that there had been statistically significant improvements in over 12 hour waits including further reductions in numbers of people experiencing very long waits (over 24 hours and over 48 hours) with SaTH showing improvements against its own performance and peers - now out of bottom decile, though there is still a long way to go. There were sustained improvements in ambulance handover timeliness in May, at an average of 28.1 minutes, with a second consecutive month lifted out of the bottom quartile nationally. However, 4-hour waits were still not showing sustained improvement. • Regarding the UEC System Integrated Improvement Plan, PAC heard that the Non-Admitted Working Group is now building in recent feedback from Nexus Consulting on measures that can be taken to reduce the time spent in ED, eg in waiting for blood test results and CT scans.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Estates, Facilities and MES Report 2026-2027: PAC received this report and noted that the main risks are capital programme delivery, backlog plant issues vs finance available and resources to keep facilities safe, operational and compliant. PAC heard that the estates, facilities and MES teams are working together with colleagues at Shropshire Community Health Trust to provide a Group approach to these activities. (Notice has been given to MPFT, Shropcom's incumbent provider, with a contract end date of 31 March 2027). PAC noted that Facilities will be standardising job descriptions with a view to having a more modern and flexible workforce and is recruiting into Facilities Assistant posts. An Estates Strategy is now being developed to adopt a more proactive/forward-thinking approach to service delivery. Consequently, more digital systems will be implemented into Business As Usual operations. PAC noted the considerable number of high-risk works completed during 2025-2026 and the plans for 2026-2027. PAC also noted the benchmarking of facilities services costs against national values, and that SaTH were below the median for in-patient food services and asked if that this might have a bearing on the decrease in PLACE scores for food. This is an area SaTH is working on, seeking advice from neighbouring trusts who benchmark well. • PAC received a paper on the Performance Assurance and Accountability Framework and liked the principle of proportionate oversight and autonomy. PAC sought assurance that the metrics focused on did not preclude consideration of other metrics including safety, quality and staff behaviours

		and were informed that the full suite of measures was still available for triangulation.		
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• Prevention and Health Inequalities Update: PAC received a paper outlining the work being done by SaTH along with system partners to continue the programme of work. This includes identifying the association between long waits and age in ED and taking actions to reduce long waits; improved data collection in maternity and significant outreach with seldom-heard groups to build trust, better understand local needs and identify barriers to early engagement. A particular success has been reducing the level of smoking at time of delivery, now consistently below the government target of 6%. PAC particularly noted the need for work to support the health of people with learning disabilities and autism, and those with mental health conditions. • Data Quality: the Final Contract Monitoring Return for 2025-2026 has been submitted to the ICB fulfilling SaTH's commitment, though this process is not yet fully automated and required Finance to make manual adjustments. Radiology and Cardiorespiratory datasets remain outstanding with further work required to ensure this data can be fed accurately into SLAM. This will form part of the 26/27 plan to move to business as usual. Phase 2 of the FDP has been completed, and phase 3 is underway. PAC noted that the complexity of some of the SLAM feeds from FDP is likely to result in a hybrid model being developed. • PAC approved the terms of reference of the Digital Transformation Assurance Committee. • PAC received a report on SaTH's digital maturity and noted the progress made so far, particularly the implementation of the first phase of CareFlow EPR, and the plans to go further. Benchmarking using the NHSE England Digital Maturity Assessment identifies strengths and gaps and is intended to support year on year improvement. SaTH has moved from 1.8 (out of 5) in 2023/2024 to 2 in 2024-2025 against a national average of 2.4 and 2.8 in those years. PAC noted the developments underway in 2026-2027, continuing the move from legacy, fragmented and paper-dependent processes towards safer, more standardised and more connected digital care. The DMA benchmark makes clear that higher maturity depends on optimisation rather than implementation alone. SaTH's next phase is therefore focused on completing clinical digitisation, strengthening interoperability, expanding patient-facing capability, embedding digital workflows and demonstrating measurable benefits. PAC wanted to know how AI was being used as part of this strategy of transformation.		
2d	**Actions** ***Significant*** *follow up actions*	• PAC to receive a paper at the July meeting on the GIRFT Accreditation of the Elective Surgical Hub and the resulting action plan. • PAC to receive a report at the July meeting on SaTH's programme for introducing and embedding AI, in accordance with the NHSE guidelines. • PAC to receive a report at the July meeting on the proposed expansion of short-term domiciliary bridging care and its likely impact on levels of patients at SaTH with no criteria to reside. • A further report to come to PAC on the impact of measures to reduce the number of high intensity users of ED; a slide or slides to be considered for inclusion in the Performance Highlights pack.		
3	**Report compiled by**	Rosi Edwards, Non-Executive Director (Chair)	**Minutes available from**	*Lisa Mitchell* *Senior Governance Support Officer*

The Shrewsbury and Telford Hospital NHS Trust

Finance Assurance Committee, Key Issues Report		
Report Date: 30.06.2026		**Report of:** Finance Assurance Committee
Date of meeting: 30.06.2026		**Attendees:** R Miner (Chair), A Winstanley, S Crowther , J Sargeant, T Cotterill , R Muskett, S Edmonds, R Boyode (Part), C McInnes, H Ainsbury, S Ellis-Anderson(part), L Mitchell (Minutes), E Oxenham (part)

1	**Agenda**	The Committee considered the following:
		• Financial Report M2 incl data quality/SLAM update & Workforce Plan and Financial Impact
		• Finance System Integrated Improvement Plan 4A Report
		• Efficiency & Financial Recovery Report and Workforce Transformation Programme update – Action 31
		• Contract Approvals over £1m
		  ○ Park & Ride
		  ○ Occupational Health & Counselling
		• Debtors Deep Dive
		• Operational Performance Oversight Group ("OPOG") 4A Report
		• Capital Planning Group ("CPG") 4A Report
		• Financial Recovery Group ("FRG") 4A Report
		• Chair's Annual Report
		• Review FAC Cycle of Reporting

2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Month 2 showed a cumulative deficit of £7.4m against a plan of £5.6m, a deficit plan of £1.8m mainly as a result of Industrial Action and slippage on efficiency of £1m. The deficit plan for the year is £30.49m. • Efficiency savings have £4.1m have so far been delivered, which is £1.8m below plan although the £40m is still expected to be delivered by year end albeit the risk rated calculation currently places this at £30m. • While noting that workforce cost savings hadn't been achieved in M2, pay expenditure and as part of the overall income and expenditure variances is a deficit to plan by nearly £6m and splits by division. A detailed high level workforce transformation programme update was presented at FAC. This will be developed at a more granular level with targets and dates for further consideration in July. • A number of scenarios have been developed for the Trust's cash flow for the remainder of the financial year indicating cash flow pressures in Qs 3 and 4, when support may well be required of up to £14.5m as a worst case. • Discussion around overperformance in activity levels highlighted the potential risk to its recovery where no contract had been agreed with commissioners including the danger of activity being performed at premium cost (excess activity and cost without the income). • Insourcing costs are likely to be a further focus for NHSE to go with agency and bank costs. • Such are the financial pressures noted above, and taking account of the update on the current financial recovery actions and expected revenue and cash outlook for the year, FAC was clear that a series

		of “early warnings or “triggers” were in place to drive quick decisions around confirmation of income, deferral of investments, the paring back of activity and the realisation of “group” benefits.		
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Cash balances as the end of M2 were £40.26m. • Q1 and Q2 deficit support has now been confirmed. • Capital expenditure (£15.3m) is on target at M2 • Noted the 4A reports for OPOG, CPG and FRG and the assurances from these committees. • Subject to setting out some positive changes in the approach of FAC during the course of 2024/25 the chair’s report was approved for ratification by the Board. • A debtors deep dive was considered by FAC noting the grip and control work being done to maximise recoverability as well as the recommendations from Red Circle. • Progress was noted in a further action in the Finance System Integrated Improvement Plan (SIIP)		
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• FAC approved the business case for the park and ride scheme while noting cost pressure of c£300k over the next 3 years but with the provision for some potential upside in the contract should (for example) if fuel costs reduce. • A Winstanley provided a verbal summary of a late business case paper on an occupational and health counselling service. Further work is required on this and FAC may have to schedule a further meeting to consider. • The cycle of business is reviewed and updated at each meeting.		
2d	**Actions *Significant*** *follow up actions*	• SLAM activity reporting is still being checked and is expected to be achieved by the end of Q1.		
3	**Report compiled by**	*Richard Miner, Non-Executive Director, Chair*	**Minutes available from**	*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: 2nd June 2026		**Report on: Group People Committee**
Date of meeting: 1st June 2026		**Those present:** Cathy Purt — Non-Executive Director – meeting Chair (SCHT) Teresa Boughey — Non-Executive Director (SaTH) Rosi Edwards — Non-Executive Director (SaTH) Claire Horsfield — Director of Operations Community & Group Chief AHP Rhia Boyode — Group Chief People Officer Nigel Lee — Group Chief Strategy & Integration Officer Shelley Ramtuhul — Director of Governance (SCHT) 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 (SCHT) John Jones — Group Chief Medical Officer Simon Balderstone — Director of Workforce & People Services (SaTH) Sabeena Khanna — HTP Workforce Transformation Lead (SaTH) Paula Gardner — Interim Group Chief Nursing Officer Dawn Thompson — Associate Director of Culture (SaTH) Nick Dowd — Head of People Advisory Service & Governance (SaTH) - Item 34/26 Apologies: Tracie Black Associate Director for Workforce, Education & professional Standards (SCHT), Heidi Fuller Non-Executive Director (SaTH), Deborah Bryce Head of Corporate Governance & Compliance (SaTH), Jake Mairs Deputy Group Chief People Officer
1	**Agenda**	The Committee considered the following: • *SCHT & SATH Workforce Performance* • *Quarterly Employee Relations* • *Culture and Leadership Update* • *HTP and Neighbourhood Project update* • *SATH Nursing & Midwifery Staffing report* • *SCHT Policy tracker* • *Risk report – People Risks* • *Group Workforce Reduction update*

2a	**Alert** *Matters of concern, gaps in assurance or key risks to escalate to the Board.*	• The Committee noted an increase in the DBS backlog and sought assurance that staff continue to be subject to the appropriate level of pre-employment checks. Additional resource has been deployed, with a risk-based approach to prioritising outstanding cases. • The People risk profile has improved, with high and extreme risks reducing from nine to seven since January 2026. Staff immunisation remains a high risk; however, the data visibility issue has now been resolved, enabling further mitigation. • An increase in workforce cases relating to sexual safety was noted. The Committee requested a dedicated report, including triangulation with Freedom to Speak Up data alongside workforce case data, to strengthen Board assurance regarding the organisational response and culture.		
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Committee Members noted the successful integration of Therapies Services on 1 June 2026 and requested that learning, staff experience and patient outcomes are evaluated and reported back to inform future service integration across the Group. • The Committee received assurance on the governance arrangements for the Group Culture Programme, approving the Terms of Reference for the Group Culture Accelerator, which will oversee delivery and provide regular assurance to the Group People Committee.		
2c	**Advise** *Areas that continue to be reported on, and / or where some assurance has been noted / further assurance sought.*	• High-risk fire training compliance remains below target. The Committee was advised that this may be partly due to a lag in reporting, with compliance improving through the Fire Safety Group. Assurance was provided that appropriately trained staff are available on every shift and that the Fire Service is satisfied with the mitigation in place.		
2d	**Actions** *Significant follow-up actions*	• The People Committee requested more detail on the stronger pipeline development and succession planning mentioned in the Workforce Performance report and how to encourage people to work for the Trust. • The roadmap to future state to include Education and Training to develop the skills for the future.		
	Report compiled by:	Diane Davenport (and approved by Cathy Purt)	**Minutes available from:**	Diane Davenport, Committee administrator, SCHT

Local Care Transformation Assurance Committee, Key Issues Report		
Report Date 26 June 2026		Report of: Local Care Transformation Assurance Committee
Date of Meeting 26 June 2026		**Attendees** Professor T Purt (Chair), S Dunnett, J Barker, S Biffen, N Hobbs, N Lee, S Lloyd, S Khanna, R Boyode, G Murphy-Walken, C Horsfield, L Mitchell **Apologies** C McInnes, J Jones, M Neal, P Bason
1	Agenda	The Committee considered the following:- • Acknowledge Board agreed Terms of Reference • Agree 5 initial Priority areas for focus of reporting • Agree reporting methodology, work programmes and indicators • Highlight Report Pack • Local Care Transformation Operational Group 4A Report • Review LCTAC cycle of reporting
2a	**Alert** ***Matters of concerns, gaps in assurance or key risks to escalate to the Board***	• Understandably A fully developed reporting and assurance framework is not yet in place. This to be addressed however over the next 2/3 months • There also remained a gap to be addressed as above in confirming outcome metrics, programmes of work and gateway management including: ○ Demonstrable impact on acute bed capacity and system flow ○ Patient experience and quality outcomes ○ Measurement of inequalities ○ Support to the HTP programme • It was Recognised a number of risks with: ○ the scale and complexity of the programme, with circa 50 projects identified across workstreams, requiring prioritisation. ○ whether there was sufficient leadership capacity, workforce, and resources to deliver the full programme at pace. ○ that transformation could result in “lift and shift” of services, rather than genuine pathway redesign, and sought assurance this would not occur. ○ fragmented communications was identified as an additional risk as was: ○ lack of Alignment across system partners (ICB, Local Authority) ○ Avoidance of duplication or mixed messaging to communities • That financial alignment and benefits realisation had not yet been fully articulated, particularly in comparison to established HTP reporting. • A fully developed reporting and assurance framework was not yet in place, limiting the ability to provide robust assurance on programme delivery and impact.

2b	**Assurance** ***Positive assurances and highlights of note for the Board***	• The Committee's focus would remain at a strategic level, with ongoing review of priorities and membership, ensuring the right expertise was engaged as the programme developed. 5 areas of initial focus were agreed:
		  • Acute bed alternatives as per the recent bed model
		  • Support to the UEC pathway and NCR discharge
		  • Estate and aligned capital plan to support Local Care, the 10-yr plan and HTP
		  • Integrated care pathway development to support HTP
		  • Focus on risk stratification, case management and PCN relationships
		
		• The programme was focused on genuine pathway redesign, and not a "lift and shift" of services, with priority cohorts identified for transformation (e.g. frailty, stroke, cardiovascular)
		• The Integrated Neighbourhood Team model would ensure services were tailored to local population needs, including variation across geographies.
		• Work was underway to develop data monitoring and reporting mechanisms, particularly to demonstrate impact on occupied bed days and care delivered in community settings.
		• Plans were in place to prioritise high-impact interventions and assess leadership capacity and resource requirements to support delivery.
		• Communications and engagement arrangements were established within the operational group, with a focus on both public messaging and involving service users in shaping services.
		• There was a clear commitment to develop and mature the assurance framework over the coming meetings, with recognition that it was not yet fully established.
		• There was strong progress in shifting care closer to home, including expansion of virtual wards, urgent community response, and integrated care coordination.
		• Early pilot work (e.g. Integrated Neighbourhood Team model) had demonstrated measurable improvements, including:
		  ○ Reduced admissions
		  ○ Reduced length of stay
		  ○ Increased use of community-based pathways
		• There was active engagement to ensure the programme remained aligned with wider system strategy and commissioning direction, including influencing system partners.
		• Clear governance and reporting routes existed, including:
		  ○ Use of established organisational governance for service changes
		  ○ Defined pathways for clinical oversight and assurance reporting into wider governance structures

-2c	**Advise** ***Areas that continue to be reported***	The Committee advised that the following areas should continue to be reported to enable robust assurance:

	on and/or where some assurance has been noted/further assurance sought.	• Development and implementation of a comprehensive reporting framework, including:
		  ○ Standardised metrics aligned to the five priority areas
		  ○ Progress against delivery plans
		  ○ Clear links to HTP outcomes and system performance
		• Demonstration of delivery against the bed gap, including validation of planned and realised capacity improvements
		• Ongoing reporting on:
		  ○ Patient outcomes, experience, and safety
		  ○ Health inequalities and population health impact
		• Clarity on:
		  ○ Workforce planning and capacity requirements
		  ○ Financial implications, investment requirements, and benefits realisation
		  ○ Assist the ICB in designing its community commissioning intensions
		• Evidence of effective pathway redesign, ensuring:
		  ○ Services are transformed rather than relocated
		  ○ Models are tailored to local population needs
		• Continued assurance on:
		  ○ System alignment, including commissioning intentions and partnership working
		  ○ Communications strategy, including internal staff awareness and external engagement		

2d	**Actions** ***Significant follow up actions***	• Develop a comprehensive reporting and assurance framework, including identifiable work streams or programmes supporting each of the 5 principle focus areas, clear outcome measures, KPIs, and metrics on bed capacity, system flow, and patient experience, alongside confirming programme prioritisation and reviewing leadership, workforce, and resource capacity. • Establish a robust measurement approach to track delivery against the bed gap and strengthen outcomes monitoring, including inequalities. • Support alignment with system-wide outcomes and commissioning plans, • circulate HTP reporting packs to aid understanding to committee members • Offer Jenny Fullard committee membership to support Communication • Seek clarity of relationship between CAG and this programme.		
3	**Report compiled by**	Prof Trevor Purt. Non-Executive Director (Chair)	**Minutes available from**	Lisa Mitchell Senior Governance Support Officer

Board of Directors' Meeting in Common – 9 July 2026

Agenda item	039/26a		
Report Title	SCHT - Integrated Performance Report		
Executive Lead	Sarah Lloyd, SCHT CFO		
Report Author	Steve Price, Head of Information and Performance Assurance Operational Leads		
Prior Consultation:	**CQC Domain:**		**Link to SCHT BAF id(s)**
Resource and Performance Committee (SCHT), 24th June 2026	Safe	√	BAF 3.5
	Effective	√	
	Caring	√	**Risk Register id(s):**
	Responsive	√	
	Well Led	√	
Executive Summary	This report provides oversight and assessment of the key areas of performance relevant to the SCHT's Performance Framework. The Resource and Performance Committee reviewed the content of this report in June, and full assurance was provided in relation to the actions being taken to improve performance and minimise risk. Access and waiting times for services remain the key areas of focus with details, actions and trajectories for improvement included in the Board Information Pack. This report includes the 2025/26 Quarter 4 NHS Oversight Framework segmentation update for information.		
Recommendations for the Boards	The Boards in Common are asked to: • **Consider** SCHT's performance to date and the assurance provided to the Resource and Performance Committee in relation to the actions being taken to improve performance and minimise risks where required. • **Note** the information presented in relation to the National Oversight Framework and areas which may require particular focus.		
Appendices:	**Appendix 1:** Board SCHT Performance KPI May 2026 **Appendix 2:** Board SCHT Performance Icons **Appendix 3:** Assurance Action Plans – Information Pack		

1. Introduction

The purpose of this report is to provide oversight of the performance indicators included within SCHT's Performance Framework, together with assurance regarding the actions being taken to minimise risk and improve performance where required.

As our Group matures, it is expected that all aspects of performance including frameworks, measures, monitoring, and reporting, will be aligned and presented across the Group as appropriate.

2. Executive Summary

2.1 Context

The purpose of this report is to provide oversight and an assessment of the key areas of performance relevant to the SCHT's Performance Framework.

This report focuses on the measures relevant to the Resource & Performance Committee only, with any areas of exception in relation to Quality and Safety or People Committee measures reported separately to the Boards.

The Resource and Performance Committee reviewed relevant information in detail at its meeting in June, and full assurance was provided in relation to the actions to reduce risk and improve performance, where required.

2.2 Summary

The key points for the Boards in Common to consider are:

- There are 56 performance indicators reported in this period, each assigned to a SCHT committee for oversight.
- The table below summarises the number of KPIs highlighted as a concern against each responsible Committee. 24 indicators are highlighted as a concern (42.9%), although there are interdependencies across many of these.

Committee	Variation concern	Assurance concern	Both Variation and Assurance	Total KPIs reviewed	Total Requiring Attention
People	1	2	2	**11**	**5 (45.5%)**
Quality & Safety	2	1	1	**18**	**4 (22.2%)**
Resource & Performance	2	13	0	**27**	**15 (55.6%)**

Table 1: SCHT KPI Summary May 2026

Each Committee is responsible for reviewing its KPIs, seeking assurance and agreeing actions to improve performance where required, and subsequent reporting to the Board.

There have been the following changes to SCHT's KPIs flagged as a concern during the month:

- **People Committee**
  -Proportion of temporary staff is no longer flagged as an assurance concern

- **Quality and Safety Committee**
  -No change

- **Resource and Performance Committee**
  -Average number of days from discharge ready date and actual discharge date is now flagged as an assurance concern.

Action Plans to improve performance and minimise risks are developed in a multi-disciplinary team workshop including Operational Leads and Support Services. The action plans were reviewed at the Resource and Performance Committee for all measures flagged as a concern within this report, with the exception of:-

1. The RTT KPIs for 52+ weeks as these both remain at 0 this month.
2. Variance year-to-date to financial plan and Planned surplus/ deficit, both of which have been affected by the change to the financial plan and assurance is provided through the Finance paper.

The Committee reviewed the action plans, and confirmed full assurance was provided by the report and action plans which are included within information pack presented to the Boards.

Please note that the RTT measures for May are subject to change as the validation for the national submission continued at the time of preparing the paper/dashboards.

The Boards should note that whilst other performance indicators are not flagged as an area of concern there are instances where the dashboards/SPC charts are showing that an indicator/process will not consistently hit or miss the target. Further details are included in the appendices should members wish to review this position.

3. Main Report

3.1 Introduction

An agreed set of KPIs is in place to monitor SCHT's performance. The full list of KPIs monitored across SCHT's Committees is shown in Appendix 1 of this document.

Our dashboards include icons that describe both variation and assurance against target and Appendix 2 includes more detail on the icon descriptions.

3.2 Summary of key points in report

This report focuses on the 27 indicators which are reviewed by SCHT's Resource and Performance Committee (RPC). Of these, 15 require focused attention with 12 of the 15 relating to access to services and waiting times.

SPC charts are presented within the action plans, including the actual trend lines; the red dotted line is the target and the two dotted grey lines the control limits one upper and one lower. The **blue data points indicate a positive theme** and the **orange a concerning one.**

Of the KPIs for which the Resource and Performance Committee is responsible, the following are currently highlighted as special cause variation of a concerning nature and/or the process is not capable and will fail the target without process redesign:

Two KPIs are reported this month as a variation concern only – special cause variation of a concerning nature.

1. Variance year-to-date to financial plan
2. Planned surplus/deficit

Thirteen KPIs are an assurance concern only - the process is not capable and will fail the target without process redesign. However, with the exception of the 'average number of days from discharge ready date to actual discharge date', all the below KPIs are reporting special cause variation of an improving nature.

1. Average number of days from discharge ready date and actual discharge date
2. Percentage of patients waiting less than 18 weeks - RTT
3. Percentage of patients waiting over 52-weeks RTT
4. Proportion of patients within 18 weeks
5. Proportion of patients within 18 weeks - Children's Services
6. Percentage of patients waiting over 52-weeks for community services
7. Data Quality Maturity Index
8. Total patients waiting more than 52 Weeks – All services
9. Total patients waiting more than 40 Weeks – All services
10. Total patients waiting more than 30 Weeks – All services
11. Total patients waiting more than 52 Weeks to start consultant-led treatment
12. Total patients waiting more than 40 Weeks to start consultant-led treatment
13. Total patients waiting more than 30 Weeks to start consultant-led treatment

There are no KPIs reported this month as both an assurance concern *and* special cause variation concern.

There is a change to note since the last report to Committee:-

1. Average number of days from discharge ready date and actual discharge date is now flagged as an assurance concern.

May 2026 position:

	Children's Services incl. Dental		**Adult Services**		**Total**	
Patients Waiting	Nationally Mandated Referral to Treatment (Consultant-Led Services)	Local Waiting List Management (All Services)	Nationally Mandated Referral to Treatment (Consultant-Led Services)	Local Waiting List Management (All Services)	Nationally Mandated Referral to Treatment (Consultant-Led Services)	Local Waiting List Management (All Services)
30+ weeks	39	368	45	206	84	574
40+ weeks	1	52	4	43	5	95
52+ weeks	0	1	0	2	0	3

This table is categorised based on services within organisational structure and not age of patient.

Since the last report to Boards in Common in June, there have been both improvements and deterioration across the groups noted above. Overall total of RTT 30+, local 40+ and 52+ week waits have improved. The local 30+ has deteriorated and the RTT 40+ has remained stable.

The action plans submitted to SCHT's Resource and Performance Committee, and presented in the Board Information Pack, describe further detail and the actions being taken to reduce risk and improve performance and include the forecast trajectories for improvement.

The 'Percentage of patients waiting less than 18 weeks – RTT' has shown a recent levelling although there has been a slight improvement with 81.86% in May compared with 80.56% in April; the May position was still being validated at the time of preparing the paper/dashboards. Whilst the target is not being achieved, the indicator is still flagged as special cause variation of an improving nature. Further detail is captured in the action plans.

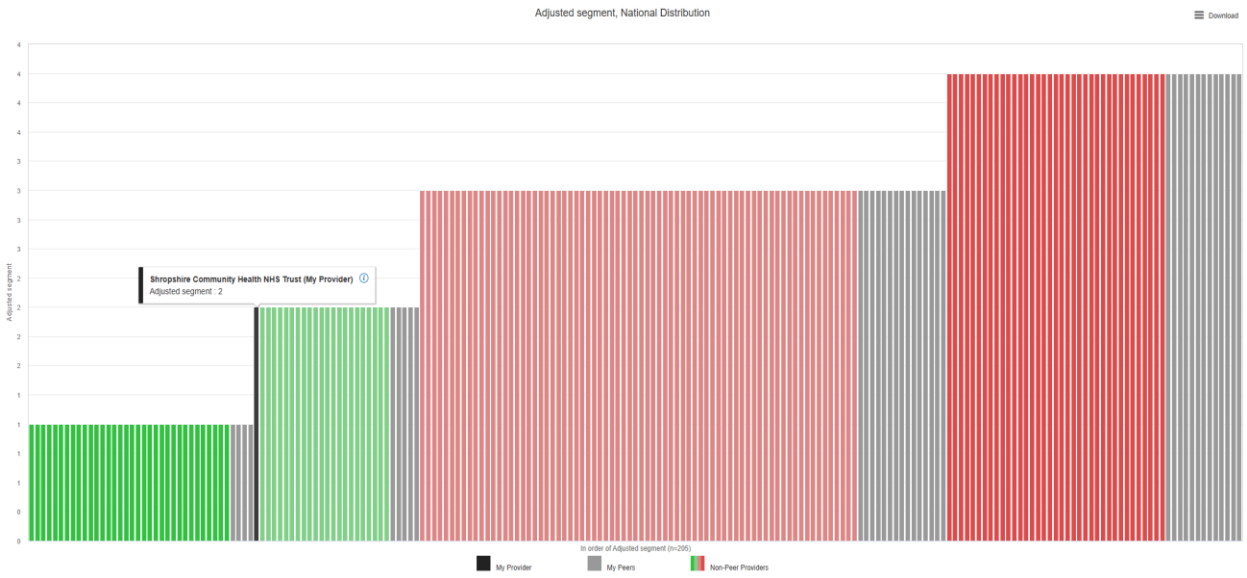
The indicator for 'Proportion of patients within 18 weeks' has also levelled recently, although there has been a slight improvement with 82.88% in May compared with 82.09% in April. While the target is not being achieved, the indicator is still flagged as special cause variation of an improving nature.

The data issue previously reported in relation to Continence products still exists, impacting the May 2026 position and the indicator 'total activity undertaken against current year plan' will be refreshed once resolved.

There is work being undertaken across our Group to reflect 'True North' KPIs within performance dashboards. This will ensure a standardised approach to performance reporting in line with NHSE Making Data Count, including Statistical Process Control.

3.3 National Oversight Framework

NHSE published the Quarter 4 National Oversight Framework segmentations on 11th June 2026 and SCHT was allocated an overall National Oversight Framework score of 2, which is a deterioration from the previous rating of 1 but still strong performance. Organisations rated as 1 are reported as the best performing and organisations rated as 4 requiring the most support.



SCHT performs well across 3 out of 5 domains scoring above average or higher within the Oversight Framework and is ranked 29th out of 61 Trusts.

Each Committee has responsibility to review the individual metric rankings and scores to ensure actions are being taken to improve performance, and gain assurance as to the scope and pace of these.

3.4 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

3.5 Conclusion

The Boards in Common are asked to:

- **Consider** SCHT's performance to date and the assurance provided to the Resource and Performance Committee in relation to the actions being taken to improve performance and minimise risks where required

- **Note** the information presented in relation to the National Oversight Framework Quarter 4 segmentation.

Resource and Performance Committee - SPC Summary

Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Effectiveness and experience of care	Average number of days from discharge ready date and actual discharge date	2026-05-31		7.1	4.0	3.1	7.1	4.0	3.1	F
Finance and Productivity	Data Quality Maturity Index	2026-02-28	H	96.1%	95.0%	1.1%	96.1%	95.0%	1.1%	F
Access	Difference between actual and planned 18 week elective performance	2026-05-31		-10.60	0.00	-10.60	-10.60	0.00	-10.60	
Finance and Productivity	Financial efficiency - variance from efficiency plan	2026-05-31	H	1.45%	0.00%	1.45%	1.45%	0.00%	1.45%	?
Finance and Productivity	Implied productivity level	2026-05-31		84.88%	100.00%	-15.12%	84.88%	100.00%	-15.12%	?
Access	New Birth Visits % within 14 days - Dudley	2026-04-30		91.36%	90.00%	1.36%	91.36%	90.00%	1.36%	?
Access	New Birth Visits % within 14 days - Shropshire	2026-04-30	H	89.25%	90.00%	-0.75%	89.25%	90.00%	-0.75%	?
Access	New Birth Visits % within 14 days - Telford	2026-04-30		86.62%	90.00%	-3.38%	86.62%	90.00%	-3.38%	?
Access	Number of patients not treated within 28 days of last minute cancellation	2026-05-31		0	0	0	0	0	0	?
Access	Percentage of patients waiting less than 18 weeks - RTT	2026-05-31	H	81.86%	92.00%	-10.14%	81.86%	92.00%	-10.14%	F
Access	Percentage of patients waiting over 52-weeks for community services	2026-05-31	L	0.02%	0.00%	0.02%	0.02%	0.00%	0.02%	F
Access	Percentage of patients waiting over 52-weeks RTT	2026-05-31	L	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	F
Improving health and reducing inequality	Percentage of people waiting less than 6 weeks for a diagnostic procedure ...	2026-04-30	H	100.00%	99.00%	1.00%	100.00%	99.00%	1.00%	?
Finance and Productivity	Planned surplus/deficit	2026-05-31	L	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	P
Access	Proportion of patients within 18 weeks	2026-05-31	H	82.88%	92.00%	-9.12%	82.88%	92.00%	-9.12%	F
Access	Proportion of patients within 18 weeks - Childrens Services	2026-05-31	H	74.93%	92.00%	-17.07%	74.93%	92.00%	-17.07%	F
Finance and Productivity	Relative difference in costs	2024-03-31		102.52%	100.00%	2.52%	102.52%	100.00%	2.52%	

Resource and Performance Committee - SPC Summary (continued)

Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Finance and Productivity	Total activity undertaken against current year plan	2026-05-31		87.55%	100.00%	-12.45%	96.83%	100.00%	-3.17%	
Access	Total patients waiting more than 30 weeks - all services	2026-05-31		574	0	574	574	0	574	
Access	Total patients waiting more than 30 weeks to start consultant-led treatment	2026-05-31		84	0	84	84	0	84	
Access	Total patients waiting more than 40 weeks - all services	2026-05-31		95	0	95	95	0	95	
Access	Total patients waiting more than 40 weeks to start consultant-led treatment	2026-05-31		5	0	5	5	0	5	
Access	Total patients waiting more than 52 weeks - all services	2026-05-31		3	0	3	3	0	3	
Access	Total patients waiting more than 52 weeks to start consultant-led treatment	2026-05-31		0	0	0	0	0	0	
Effectiveness and experience of care	Urgent Community Response 2-hour performance	2026-03-31		88.52%	70.00%	18.52%	88.52%	70.00%	18.52%	
Finance and Productivity	Variance year-to-date to financial plan	2026-05-31		-409.76%	100.00%	-509.76%	-409.76%	100.00%	-509.7...	
Finance and Productivity	Virtual ward bed occupancy	2026-05-31		81.53%	83.00%	-1.47%	81.53%	83.00%	-1.47%	

Quality and Safety Committee - SPC Summary

Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Patient Safety	Category 3 Pressure Ulcers	2026-05-31		3	0	3	3	0	3	
Patient Safety	Category 4 Pressure Ulcers	2026-05-31	H	1	0	1	1	0	1	
Effectiveness and experience of care	Complaints - (Open) % within response timescales	2026-05-31	H	100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	
Patient Safety	Compliance with Duty of Candour	2026-05-31		100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	
Effectiveness and experience of care	CQC Conditions or Warning Notices	2026-05-31		0	0	0	0	0	0	P
Patient Safety	Deaths - unexpected	2026-05-31		0	0	0	0	0	0	
Patient Safety	Deaths in Custody per 1000 prisoners	2026-05-31		0.00	0.00	0.00	0.00	0.00	0.00	
Patient Safety	Falls per 1000 Occupied Bed Days	2026-05-31		5.23	4.00	1.23	5.23	4.00	1.23	
Patient Safety	Medication Incidents with Moderate Harm	2026-05-31		0	0	0	0	0	0	
Patient Safety	NHS Staff Survey - raising concerns sub-score	2026-05-31	L	6.48	7.01	-0.53	6.48	7.01	-0.53	F
Patient Safety	Patient Safety Incident Investigations	2026-05-31		0	0	0	3	0	3	
Patient Safety	Rates of Healthcare Associated Infection (C-Difficile)	2026-05-31		175.00%	100.00%	75.00%	175.00%	100.00%	75.00%	F
Patient Safety	Rates of Healthcare Associated Infection (E-Coli)	2026-05-31		100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	
Patient Safety	Rates of Healthcare Associated Infection (MRSA)	2026-05-31		0	0	0	0	0	0	P
Patient Safety	Safer Staffing - Average Fill Rate Non-Registered Nurses - Day	2026-04-30		104%	95%	9%	104%	95%	9%	
Patient Safety	Safer Staffing - Average Fill Rate Non-Registered Nurses - Night	2026-04-30	L	103%	95%	8%	103%	95%	8%	
Patient Safety	Safer Staffing - Average Fill Rate Registered Nurses - Day	2026-04-30		104%	95%	9%	104%	95%	9%	
Patient Safety	Safer Staffing - Average Fill Rate Registered Nurses - Night	2026-04-30		104%	95%	9%	104%	95%	9%	

People Committee - SPC Summary

Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
People and Workforce	Appraisal Rates	2026-05-31	H	87.19%	90.00%	-2.81%	87.11%	90.00%	-2.90%	F
People and Workforce	Bank Usage - Variance from plan (WTE)	2026-05-31	L	-15.52	0.00	-15.52	-8.65	0.00	-8.65	?
People and Workforce	Mandatory Training Compliance	2026-05-31	H	96.61%	95.00%	1.61%	96.61%	95.00%	1.61%	?
People and Workforce	National Education and Training Survey overall satisfaction score	2025-12-31	L	74.08%	90.00%	-15.92%	74.08%	90.00%	-15.92%	F
People and Workforce	Net Staff in Post Change	2026-05-31	-	10.03	0.00	10.03	9.31	0.00	9.31	
People and Workforce	NHS staff survey engagement theme score	2026-05-31	L	6.91	7.09	-0.18	6.91	7.09	-0.18	?
People and Workforce	Proportion of temporary staff	2026-05-31	L	2.9%	3.4%	-0.5%	2.8%	3.4%	-0.6%	?
People and Workforce	Sickness Absence Rate	2026-05-31	H	5.68%	4.75%	0.93%	5.68%	4.75%	0.93%	F
People and Workforce	Total shifts exceeding NHSI capped rate	2026-05-31	L	129	0	129	138	0	138	F
People and Workforce	Total shifts on a non-framework agreement	2026-05-31	L	0	0	0	0	0	0	?
People and Workforce	Vacancies - all	2026-05-31	-	9.14%	8.00%	1.14%	9.37%	8.00%	1.37%	?

Icon Descriptions

Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: (none)
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
(none)	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is capable and will consistently **PASS** the target if nothing changes.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FAIL** the target without process redesign.	Common cause variation, **NO SIGNIFICANT CHANGE**. Assurance cannot be given as there is no target.
H	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
↗				Special cause variation of an increasing nature where **UP** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
↘				Special cause variation of an increasing nature where **DOWN** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
(none)				There is not enough data for an SPC chart, so variation and assurance cannot be given. Assurance cannot be given as there are no process limits.

Board of Directors' Meeting in Common – 9 July 2026

Agenda item	039/26b		
Report Title	SCHT Integrated Q&S Performance Report		
Executive Lead	Martina Morris, Group Chief Nursing Officer		
Report Author	Sara Ellis-Anderson, Director of Nursing – Community (Interim)		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
SCHT Quality and Safety Committee 29th June 2026	Safe	√	
	Effective	√	
	Caring	√	**(SaTH) Risk Register id(s):**
	Responsive	√	
	Well Led	√	
Executive Summary	The report provides an update on progress against the Shropshire Community Health NHS Trust's Quality and Safety metrics. The report provides an overview of the performance indicators to the end of May 2026 and supported by agreed improvement action plans outline in Appendix 2. **Assure** • No medication incidents resulting in moderate harm were reported in May 2026, representing the third consecutive month with zero moderate harm events. • No unexpected deaths were reported during May 2026, with governance processes continuing to review all deaths in line with Trust policy. • Staffing establishments remain safe across inpatient services, with registered and non-registered staffing fill rates consistently achieving or exceeding planned levels. The reported variation in non-registered nurse night staffing reflects a reduction in previous over-fill levels rather than any staffing shortfall and does not indicate a staffing risk. **Advise** • One Category 4 pressure ulcer and three Category 3 pressure ulcers were reported during May. Reviews identified significant patient complexity in the Community and evidence of appropriate escalation and clinical management. Ongoing thematic review work will support organisational learning and further improvement with a specific focus on the South East Community Nursing team. • Inpatient falls reduced from 16 in April to 13 in May, with the falls rate reducing from 6.48 to 5.23 per 1,000 occupied bed days. Whilst performance remains above target, a comprehensive improvement programme continues. • No cases of C. difficile were reported during May 2026 and the rolling 12-month position has reduced to seven cases. Improvement activity remains focused on antimicrobial stewardship, environmental cleanliness, equipment decontamination and learning from thematic reviews.		

	Alert • The NHS Staff Survey "Raising Concerns" sub-score is below the national benchmark. An improvement plan is being developed as part of the Trust's annual Quality Priority focused on strengthening organisational learning, staff voice and speaking up culture.
Recommendations for the Boards	The Boards are asked to consider and **note** this report.
Appendices	Appendix 1: SCHT Quality and Safety Report – May 2026 QSC summary Appendix 2: QSC Action Plans – in Information Pack

0. Quality and Safety Report – June 2026

Author:	Tracie Black – Associate Director for Workforce, Education and Professional Standards	**Paper date:**	29 June 2026
Executive Sponsor:	Martina Morris, Group Chief Nursing Officer	**Paper written on:**	17 June 2026
Paper Reviewed by:	Sara Ellis-Anderson Director of Nursing – Community (interim)	**Paper Category:**	Quality and Safety
Forum submitted to:	Quality and Safety Committee	**Paper FOIA Status:**	Full

1. Purpose of Paper

1.1.
This paper aims to provide assurance to the Quality and Safety Committee to support the organisation in the provision of evidence against key lines of enquiry and to contribute to the Trust strategic goals and priorities.

2. Executive Summary

2.1 Context

The report aims to:
- Provide the Board with an executive summary focusing on areas for and areas of improvement.
- Provide access to the suite of detailed quantifiable information from the Trust's single data performance repository for reliability and accuracy.
- Track progress of actions being taken to improve areas identified as requiring improvement

2.2 Summary

3 of the 18 Quality and Safety dashboard KPIs are showing **special cause variation of a concerning nature** in Month 2 (May); Category 4 Pressure Ulcers, NHS Staff Survey Raising Concerns sub score and Safer Staffing, Average fill rate for non-registered nurse night.

Category 4 Pressure Ulcer

There was 1 patient that developed a Category 4 Pressure Ulcer in service. This was an extremely complex patient with extensive medical needs, although had capacity and was aware of the risks chose to decline pressure relieving equipment and to repositioning regularly. This incident was discussed at PSIP on 20/05/2026. The panel felt that this was a good example of outstanding care that should be share as a case study. It was also noted that the regional TV nurse network are also seeing increases in pressure ulcer numbers and deterioration and wider thematic review to be planned as a region.

NHS Staff Survey Raising Concerns sub score

Staff survey report – Raising concerns metric, the annual staff survey metric on the dashboard showed 6.48 against 7.01 national result. The Trust will continue with quarterly pulse survey. An action plan is being developed to link to the organisation's annual Quality Priority 3: Enhancing Learning across the organisation and will be included in the Integrated Quality Report from July 2026.

Safer Staffing, Average fill rate for non-registered nurse night.

The dashboard indicate variation in Safer Staffing for non-registered nurses (night); however, this reflects a shift from previously elevated over-fill levels rather than deterioration in performance. Fill rates remain consistently at or above 100%, with no evidence of staffing risk or under-fill. This position provides assurance that safe staffing levels are being maintained.

The C. difficile indicator is flagged as an assurance concern, reflecting performance above the agreed threshold for the rolling 12 months.

There have been no cases of C-Difficile reported in May 2026, the rolling 12 months now stands at 7. Thematic reviews continue quarterly. Actions for continued improvement are ongoing with a specific focus on cleanliness, decontamination of equipment and review of Housekeeper roles as well as de-prescribing PPIs and Anti-microbial Stewardship. Threshold for 26/27 have not been set by ICB and are expect in June 2026.

The PSIRF priorities although not demonstrating special cause variation have been included to demonstrate the ongoing improvement actions being taken:

Pressure Ulcers

In May 2026, there were two Category 3 pressure ulcers reported in-service. The first incident relates to the North West team. The patient being extremely complex, with all appropriate pressure relieving equipment in place; however, the patient declined to use this equipment, and ADDER has therefore been completed and updated every 4 weeks. All appropriate referrals have been made to Tissue Viability and Podiatry, with good evidence of escalation when the wound deteriorated. The second incident relates to South East team. This was pressure damage to the bridge of the nose due to NIV mask. All appropriate action had been taken. As part of a wider piece of work, a thematic review will be completed focusing specifically on SEIDT incidents to identify themes and agree actions to address the issues identified.

Category 3 and 4 Pressure Ulcer totals across Community teams from January 2026:

- Community Nursing Team – South East: 9
- Community Nursing Team – North West: 7
- Telford Community Nursing Team – South: 7
- Shrewsbury Community Nursing Team – South: 2
- Shrewsbury Community Nursing Team – North: 1
- Telford Community Nursing Team – North: 1

Falls

In May 2026 there were 13 inpatient falls reported within our care (a decrease of 3 from April 2026 data of 16). The falls per 1000 occupied bed days has subsequently decreased to 5.23 but remains above the 4.0 target. Falls thematic reviews are presented quarterly to Patient Safety Committee with ongoing improvement work focussing on digital technology with Rambleguard rolled out in February 2026 and the pilot of a post fall therapy checklist aiming to improve MDT communication and reduce the risk of patient's falling more than once.

Medication

There were zero medication incidents resulting in moderate harm for the third consecutive month. This metric is under review with the expectation it will change to an incident rate per 1000 occupied bed days and per 1000 community contacts.

Unexpected Deaths

There has been 0 unexpected deaths in May 2026. The Governance Team continue to monitor all deaths recorded at point of triage so that appropriate consideration through PSIP where indicated and in accordance with Trust Policy. The Trust has introduced a new KPI for Duty of Candour compliance and this is currently 100%.

Several of our quality and safety metrics are set with a zero-harm target, reflecting the organisational ambition rather than an expected baseline; therefore, performance should not be interpreted on target compliance alone. Assurance is instead should be derived from a triangulated view and include Statistical Process Control (SPC) interpretation, whether variation is within the expected upper and lower control limits or shows signals of concern.

Safer staffing data

- Data reporting period covers April **2026**
- Average fill rates for RNs were at 104% for day and 104% for night shift.
- Average fill rates for non-registered workers were at 104% for day and 103% for night shift

2.3. Conclusion

The Committee is asked to:

- **Note** the information in the report.
- **Take assurance** from the report that appropriate actions are being taken to address any areas of concern and support continuous improvement.
- **Request** any future information that will increase assurance.
- **Support** the recommendations for reviewing the medication KPI

Quality and Safety Committee - SPC Summary

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Quality & Safety Committee	Effectiveness and experience of care	Complaints - (Open) % within response timescales	2026-05-31		100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	
Quality & Safety Committee	Effectiveness and experience of care	CQC Conditions or Warning Notices	2026-05-31		0	0	0	0	0	0	
Quality & Safety Committee	Patient Safety	Category 3 Pressure Ulcers	2026-05-31		3	0	3	3	0	3	
Quality & Safety Committee	Patient Safety	Category 4 Pressure Ulcers	2026-05-31		1	0	1	1	0	1	
Quality & Safety Committee	Patient Safety	Compliance with Duty of Candour	2026-05-31		100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	
Quality & Safety Committee	Patient Safety	Deaths - unexpected	2026-05-31		0	0	0	0	0	0	
Quality & Safety Committee	Patient Safety	Deaths in Custody per 1000 prisoners	2026-05-31		0.00	0.00	0.00	0.00	0.00	0.00	
Quality & Safety Committee	Patient Safety	Falls per 1000 Occupied Bed Days	2026-05-31		5.23	4.00	1.23	5.23	4.00	1.23	
Quality & Safety Committee	Patient Safety	Medication Incidents with Moderate Harm	2026-05-31		0	0	0	0	0	0	
Quality & Safety Committee	Patient Safety	NHS Staff Survey - raising concerns sub-score	2026-05-31		6.48	7.01	-0.53	6.48	7.01	-0.53	
Quality & Safety Committee	Patient Safety	Patient Safety Incident Investigations	2026-05-31		0	0	0	3	0	3	
Quality & Safety Committee	Patient Safety	Rates of Healthcare Associated Infection (C-Difficile)	2026-05-31		175.00%	100.00%	75.00%	175.00%	100.00%	75.00%	
Quality & Safety Committee	Patient Safety	Rates of Healthcare Associated Infection (E-Coli)	2026-05-31		100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	
Quality & Safety Committee	Patient Safety	Rates of Healthcare Associated Infection (MRSA)	2026-05-31		0	0	0	0	0	0	
Quality & Safety Committee	Patient Safety	Safer Staffing - Average Fill Rate Non-Registered Nurses - Day	2026-04-30		104%	95%	9%	104%	95%	9%	
Quality & Safety Committee	Patient Safety	Safer Staffing - Average Fill Rate Non-Registered Nurses - Night	2026-04-30		103%	95%	8%	103%	95%	8%	
Quality & Safety Committee	Patient Safety	Safer Staffing - Average Fill Rate Registered Nurses - Day	2026-04-30		104%	95%	9%	104%	95%	9%	
Quality & Safety Committee	Patient Safety	Safer Staffing - Average Fill Rate Registered Nurses - Night	2026-04-30		104%	95%	9%	104%	95%	9%	

0. Reference Information

Authors:	Gina Billington, Head of Resourcing, Fiona MacPherson, Head of People Services Sarah Allan, Deputy Workforce Operations Director (Interim)	**Paper date:**	9 July 2026
Executive Sponsor:	Rhia Boyode, Group Chief People Officer SCHT & SaTH	**Paper written on:**	29th June 2026
Paper Reviewed by:	Simon Balderstone, Director of Workforce and People Services Sarah Allan, Deputy Workforce Operations Director (Interim)	**Paper Category:**	Performance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

The purpose of this report is to provide an oversight of the key areas of performance which are most relevant to this Committee based on the Trust's Performance Framework.

The paper is intended to provide information and assurance on the key workforce performance metrics that support delivery of our operational plan.

2. Executive Summary

2.1 Context

This report focuses on the key areas of performance relevant to People Committee, including a review of performance against the Month 2 workforce plan position. The KPI's throughout the report are key drivers of performance, which underpin the delivery of the 2026/27 workforce plan.

There are several workforce KPI's under the delivery of our plan that are outside of agreed targets including:

- Sickness/Absence management
- Price cap compliance

Sickness absence is a significant driver of temporary workforce usage. Work across the Group is underway to identify interventions that will make tangible improvements to sickness absence. This includes, preventative measures and improved data analysis, changes to practices and policy and exploring digital systems. A business case is being prepared in support of implementing a sickness management digital system which has proven successful

in other NHS providers, early estimates suggest there could be absence reductions made of 20% by investing in this approach.

Actions to shape our culture will also support sickness absence. The Group Culture Programme is underway, working in partnership with Aqua and A Kind Life, with the current culture diagnostic and review underway. This will be further supported by the launch of Poppy's Promise in July.

The level of agency remains high with use of medical agency above price cap mainly used across UEC Virtual Ward and Integrated Front door). The expansion of these services has required new medical posts, and a full review is underway to determine the most cost-effective medical workforce model.

2.2 Summary

The table below summarises each KPIs variation status as at Month 2.

Committee	Variation concern	Variation concern of an improving nature	Both Variation and Assurance concern	Common Cause Variation – no significant concern	Total KPIs reviewed	Total Requiring Attention
People	2	6	2	2	**11**	**5 (45%)**

Action Plans have been developed included as Appendix 4.

2.3. Conclusion

The Trust Board is asked to:

- **Consider** the performance across relevant indicators to date.
- **Discuss** the actions being taken to mitigate any risks relating to either the resources available to the Trust or the Trust's performance.
- **Consider** the level of assurance provided through the revised reporting processes and SPC charts.

3. Main Report

3.1 Introduction

The full list of KPIs to be reviewed as per our Performance Framework, are shown in Appendix 1 of this document.

The dashboards include icons that describe both variation and assurance against target and Appendix 2 includes more detail on the icon descriptions.

3.2 Summary of key points in report

The workforce plan for 2026/27 set an overall 134.86 WTE increase from the start of the year, which incorporates a 150.41 WTE increase in substantive workforce and a reduction of 6.65 WTE in bank usage and 8.9 WTE agency usage.

At Month 2 the total workforce was under plan by 74.56 WTE.

Temporary staffing usage in Month 2 remains static (table below) with Bank usage showing a positive variance of 15.52 WTE and Agency usage showing a positive variance of 7.65 WTE against plan.

	Month 1			Month 2		
WTE	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Substantive	1655.30	1,602.65	(21.87)	1655.17	1,603.78	(51.39)
Bank	82.04	80.27	(1.77)	82.04	66.52	(15.52)
Agency	27.28	18.56	(8.72)	26.28	18.63	(7.65)
Totals	**1733.84**	**1701.48**	**(32.36)**	**1763.49**	**1,688.93**	**(74.56)**

Admissions avoidance were again the highest users of agency in Month 2: 8.06 WTE which is slightly below plan (8.10 WTE) a variance of (0.04) WTE. This is an increase on month 1 when the usage was 7.63 WTE.

Vacancy levels have increased due to additional investment into services in month 1 (UCR expansion, HCAs for Community Hospitals, Children in Care and Children Psychology services) resulting in an increase from month 12 vacancy rate of 7.9% to 9.5% in month 1(168 WTE). Month 2 vacancy rate stands at 9.14% (162 WTE).

Year to date workforce plan position

Plan	**Apr 26**	**May 26**	**Jun 26**	**Jul 26**	**Aug 26**	**Sept 26**	**Oct 26**	**Nov 26**	**Dec 26**	**Jan 27**	**Feb 27**	**Mar 27**
Substantive	1,655.30	1,655.17	1,655.17	1,658.81	1,657.41	1,656.61	1,655.15	1,655.15	1,655.15	1,654.05	1,653.55	1,650.06
Bank	82.04	82.04	82.04	82.04	82.04	82.04	82.04	82.04	82.04	82.04	82.04	82.04
Agency	27.28	26.28	26.28	23.30	23.30	22.30	20.76	20.76	20.76	20.76	20.76	20.76
	1,764.62	**1,763.49**	**1,763.49**	**1,764.15**	**1,762.75**	**1,760.95**	**1,757.95**	**1,757.95**	**1,757.95**	**1,756.85**	**1,756.35**	**1,752.86**
Actual												
Substantive	1,596.76	1,603.78	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Bank	80.27	66.52	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Agency	19.42	18.63	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	1,696.45	**1,688.93**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Variance												
Substantive	(58.54)	(51.39)	(1,655.17)	(1,658.81)	(1,657.41)	(1,656.61)	(1,655.15)	(1,655.15)	(1,655.15)	(1,654.05)	(1,653.55)	(1,650.06)

Bank	(1.77)	(15.52)	(82.04)	(82.04)	(82.04)	(82.04)	(82.04)	(82.04)	(82.04)	(82.04)	(82.04)	(82.04)
Agency	(7.86)	(7.65)	(26.28)	(23.30)	(23.30)	(22.30)	(20.76)	(20.76)	(20.76)	(20.76)	(20.76)	(20.76)
	(68.17)	**(74.56)**	**(1,763.49)**	**(1,764.15)**	**(1,762.75)**	**(1,760.95)**	**(1,757.95)**	**(1,757.95)**	**(1,757.95)**	**(1,756.85)**	**(1,756.35)**	**(1,752.86)**

There are several workforce KPI's under the delivery of our plan that are outside of agreed targets (see table below) including:

- Appraisals
- Sickness/Absence management
- Price cap compliance

Metric	Target	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
Appraisal	**90%**	91.05%	87.81%	87.28%	86.61%	88.56%	87.89%	87.66%	87.37%	87.02%	87.19%
Sickness	**4.75%**	5.41%	5.48%	5.52%	5.60%	5.68%	5.65%	5.68%	5.73%	5.69%	5.68%
Total Shifts exceeding NHSI capped rate	**No Target**	64	64	108	279	303	256	261	114	146	129

SPC charts are included in the Action Plans and Appendix 3 for further consideration from a people perspective.

As well as the actual trend line itself, the red dotted line is the target and the two dotted grey lines the control limits one upper and one lower. The **blue data points indicate a positive theme** and the **amber a concerning one**.

Of the KPIs that the People Committee is responsible for, 6 KPIs are a special cause variation of an improving nature and will pass or continue to pass the target if nothing changes, 3 are a special cause variation of a concerning nature where the process is not capable and will fail without process redesign and 2 are of a common cause variation with no significant change.

1. Appraisal Rates – remains below target but a variation of improving nature.
2. Bank Usage – variance from plan - a variation of improving nature with a positive variance below target.
3. Mandatory Training Compliance – a variation of improving nature, remains above target.
4. National Education and Training Survey overall satisfaction score - below target, concerning.
5. Net Staff in Post Change – common cause variation with no significant change
6. Proportion of temporary staff – below target but a variation of improving nature
7. Sickness Rate – above target, concerning (short term sickness increasing trend, long-term decreasing trend)
8. Staff survey engagement theme score - variation of concerning nature, below target.
9. Total shifts exceeding NHSI capped rate – above target due to medical staffing requirements but a variation of improving nature.
10. Total shifts on a non-framework agreement – a variation of improving nature. No shifts were booked off framework in Month 2.
11. Vacancy rate – common cause variation with no significant change.

Appraisal Rates

The May compliance rate has slightly increased from 87.02% in March to 87.19%. Work is continuing to **ensure** hot spot areas are being supported to ensure their outstanding appraisals are completed.

Top 3 Hotspots

1. **Medical Division** – 75/% this reflects 1 outstanding appraisal which has reduced from 3 outstanding in January.
2. **Urgent care Division –** 75.70% this reflects 52 outstanding appraisals.
3. **Planned care Division** – 80.38% this reflects 41 outstanding appraisals.

The relevant Exec lead will be contacted to discuss support that can be provided to ensure compliance.

Actions to Deliver Improvements - Current Focus

- Detailed appraisal reports are sent to Managers to ensure they have sight of those appraisals out of date on ESR, and regular appraisal training is in place. The focus is on setting plans for the services with the lowest completion rates and to set dates for completion.
- A process for monitoring progress is in place, with targeted support for managers and alerts and reminders to ensure completion.
- Appraisals being discussed at monthly meetings with senior leaders within the relevant areas.

Mandatory Training

In May, compliance rates experienced decrease of nearly 0.5%, dropping to 96.61%. Overall, we are still performing well and still above the 95% target. Over the course of the month, compliance dropped against most topics (21 topics), with reductions ranging from 0.17% (Fire Safety) to -4.62% for Moving and Handling - Level 2. Compliance only improved in 3 topics, increases range from 0.35% (Infection Prevention and Control - Level 2) up to 1.44% (Fire Safety - High Risk).

It is important to note that High Risk Fire Safety training saw an increase in compliance in May, following training in various locations throughout the county. We are still below the target 95%, this is still being raised with managers.

We have seen compliance drop in Resus Level 2 and Level 3 unfortunately. Individuals have been emailed where they are non-compliant or due to expire prior in the next 3 months.

We have several new topics being launched over the coming months. Hand Hygiene will be included in the mandatory compliance figures from the 1st June 2026. We have seen increases in compliance since it was launched in March 2026. April's compliance was at 84.52%.
ABDCE Approach Universal, which is the new Sepsis package, is being launched on the 1st June 2026. This will show as a requirement on ESR for the positions that require training to be completed.

Mental Capacity Act has also been reviewed, from the 1st June, positions will be updated where the training is a requirement. However, due to national changes these packages have been temporarily withdrawn (nationally) so they can be updated to reflect these changes. Timelines have been altered to reflect this.

Sickness rate

Since April 2025, sickness absence has remained above target, with small month-on-month increases until a slight fall in January 2026. Rates then rose modestly again in February and March until a slight drop in April to 5.69% and a further drop in May to 5.68%.

The main drivers are stress, anxiety and depression conditions. From the absence trigger reports we continue to see lower numbers than we have previously in terms of long term absence. Absence trigger reports continue to show fewer long-term cases. than previously (55 in March, down from 68 in December to 50 in May (41 in April)). All 50 individuals are being supported in line with the Managing Attendance Policy; 18 have an agreed outcome, such as planned return-to-work date or ill-health retirement etc.

Review of Short-Term sickness absence

It is recognised that we continue to see short term absence increasing; on this basis, we continue to send short term absence reports to Line Managers flagging individuals who have reached the short-term absences triggers. This is being overseen by the People Team.

Actions to Deliver Improvements - Current Focus

- Conduct an absence masterclass for Bridgnorth Hospital and the South-East Community Nursing team, incorporating an audit of absence management practices in accordance with Trust policy. Review the audit results and deliver tailored sessions based on the identified findings. If successful, evaluate rolling out to all areas of the Trust. The audit on personal files for Bridgnorth Hospital inpatients and Community team was completed on 20 May 2026. The data gathered is currently being analysed and actions will be developed.
- Explore digital solutions to support Line Managers in timely management of attendance in line with the Managing Attendance policy. This includes a review of eroster to establish absence management capabilities and other digital solutions.
- HWB Workshop took place on 12 June 2026 to understand the offers and what is in place across the Group, working together to develop a collective plan of what can be done as Group.
- Support around health and wellbeing, resilience and flexibility to support reduction in absence levels are being implemented by the People Team.

Vacancies

Vacancy levels have increased due to additional investments to services and at Month 2 is over target (9.14% vs 8.0%) which is a slight decrease on Month 1 (9.39%).

Month 2 top hotspots are: HV Dudley (On hold), Ludlow CH, BCCH, VW management (budget in review) UCR NW, Children in Care, DN NE. The recruitment team are focusing on these areas and prioritising recruitment activity accordingly with 23.43 of these vacancies in the recruitment process as at 16/06/26.

Actions to Deliver Improvements - Current Focus

- Focussing recruitment efforts by prioritising recruitment hotspot areas. The recruitment team are liaising with managers on shortlisting times/interview dates and follow up on successful applicants and prioritising pre-employment checks.
- Development of a trust recruitment video, which is in the final stages of completion and awaiting feedback from the comms team.
- Rolling bank recruitment adverts events are now live and the recruitment team will support ops in the processes.

Agency Spend

Month 2 agency use is 18.6 WTE with an expenditure of £225K against a plan of 26.2 WTE and £228k, a variance of (7.65) WTE and (£22k) respectively.

A number of medical agency/locums are in place – these are on the West Midlands agency rate as NHSE have not yet advised of a new price cap for this staff group - any use will continue to be recorded as above price cap. Currently there are medical agency in:

- UEC (Virtual Ward and Integrated Frontdoor, expansion of services so new medical posts),
- Paediatrics (LTS and wait list)

Actions to Deliver Improvements - Current Focus:

- New medical posts in UEC – a review of how medical staffing is provided by the service is taking place.
- Use of NHSP National Bank.
- Fast tracking any HCA's going through recruitment for bank and permanent roles
- Centralised Bank - a high-level implementation plan is in progress.
- Introduction of Stream – launched 1 May 2026.
- Price Cap Compliance - Medical and Dental staff groups are following the West Midlands Regional Rate card until NHSE advise of the new Price Cap.
- Actions to support reducing vacancies which includes a monthly focus on targeted hotspots and recruitment events.
- Maximise the availability of our workforce through monitoring and improving roster practices.

Total shifts exceeding capped rate

All Agenda for Change agency shifts are price cap compliant. We will continue to report shifts exceeding price cap due to the rates for medical and dental staff however we are compliant with the West Midlands Region Price Rate card (this is slightly higher than the current NHSE rate).

3. Key Issues & Recommendations

The key issues are summarised within this report and appendices.

4. Conclusion

The Committee is asked to:

- **Consider** the performance across relevant indicators to date.
- **Discuss** the actions being taken to mitigate any risks relating to either the resources available to the Trust or the Trust's performance.
- **Consider** the level of assurance provided through the revised reporting processes and SPC charts.

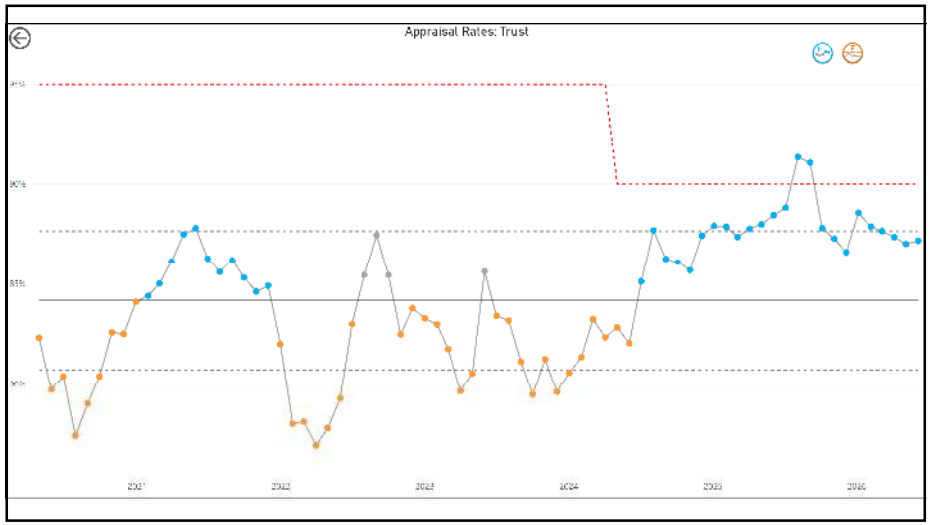
Appendix 1
People Committee – SPC Summary
Month 02 (May) 2026/2027 Performance

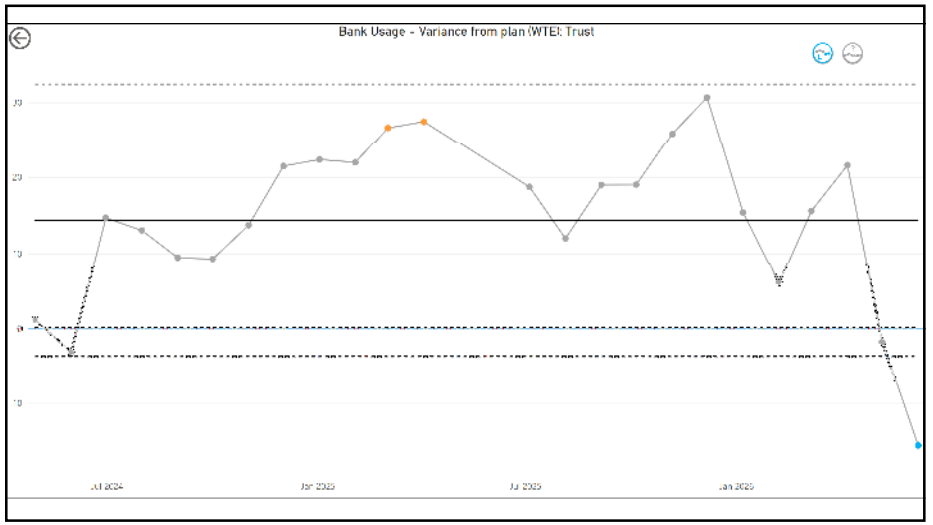
Shropshire Community Health NHS
NHS Trust

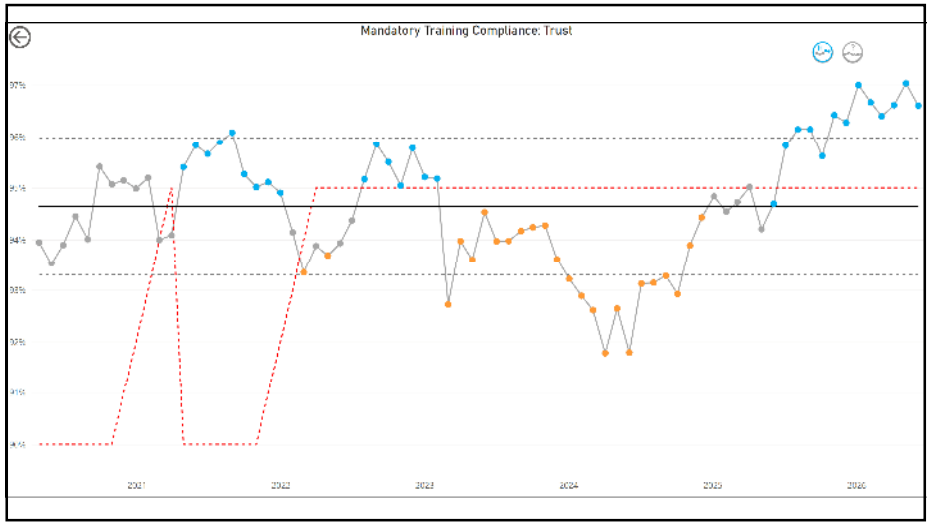
Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
People Committee	People and Workforce	Appraisal Rates	2026-05-31	H	87.19%	90.00%	-2.81%	87.11%	90.00%	-2.90%	F
People Committee	People and Workforce	Bank Usage - Variance from plan (WTE)	2026-05-31	L	-15.52	0.00	-15.52	-8.65	0.00	-8.65	?
People Committee	People and Workforce	Mandatory Training Compliance	2026-05-31	H	96.61%	95.00%	1.61%	96.61%	95.00%	1.61%	?
People Committee	People and Workforce	National Education and Training Survey overall satisfaction score	2025-12-31	L	74.08%	90.00%	-15.92%	74.08%	90.00%	-15.92%	F
People Committee	People and Workforce	Net Staff in Post Change	2026-05-31		10.03	0.00	10.03	9.31	0.00	9.31	
People Committee	People and Workforce	NHS staff survey engagement theme score	2026-05-31	L	6.91	7.09	-0.18	6.91	7.09	-0.18	?
People Committee	People and Workforce	Proportion of temporary staff	2026-05-31	L	2.9%	3.4%	-0.5%	2.8%	3.4%	-0.6%	?
People Committee	People and Workforce	Sickness Absence Rate	2026-05-31	H	5.68%	4.75%	0.93%	5.68%	4.75%	0.93%	F
People Committee	People and Workforce	Total shifts exceeding NHSI capped rate	2026-05-31	L	129	0	129	138	0	138	F
People Committee	People and Workforce	Total shifts on a non-framework agreement	2026-05-31	L	0	0	0	0	0	0	?
People Committee	People and Workforce	Vacancies - all	2026-05-31		9.14%	8.00%	1.14%	9.37%	8.00%	1.37%	?

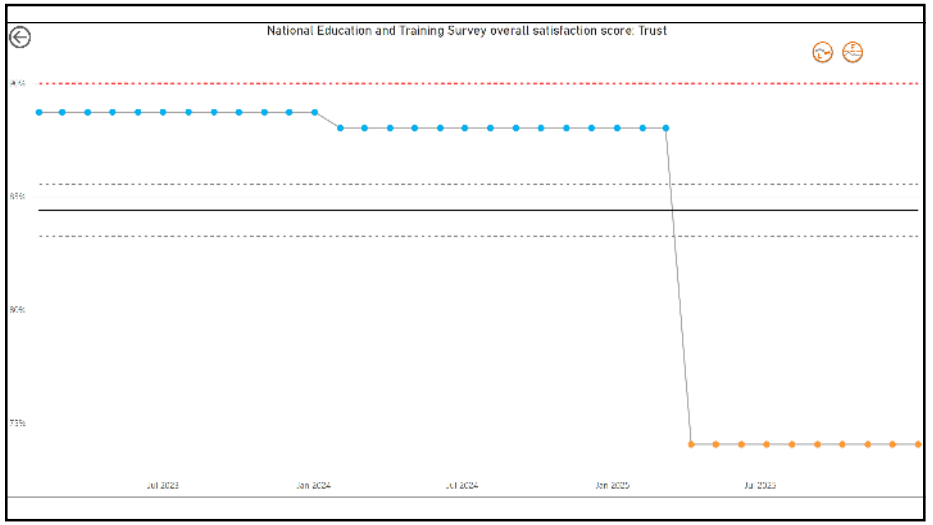
Appendix 2
People Committee
Month 02 (May) 2026/2027 Performance

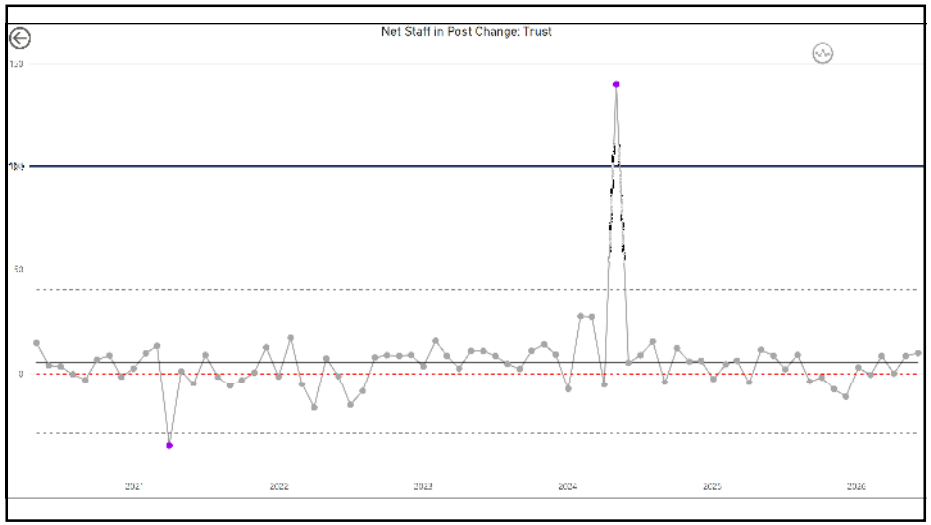
Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
~	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is capable and will consistently **PASS** the target if nothing changes.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FAIL** the target without process redesign.	Common cause variation, **NO SIGNIFICANT CHANGE**. Assurance cannot be given as there is no target.
H	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
↗				Special cause variation of an increasing nature where **UP** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
↘				Special cause variation of an increasing nature where **DOWN** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
○				There is not enough data for an SPC chart, so variation and assurance cannot be given. Assurance cannot be given as there are no process limits.

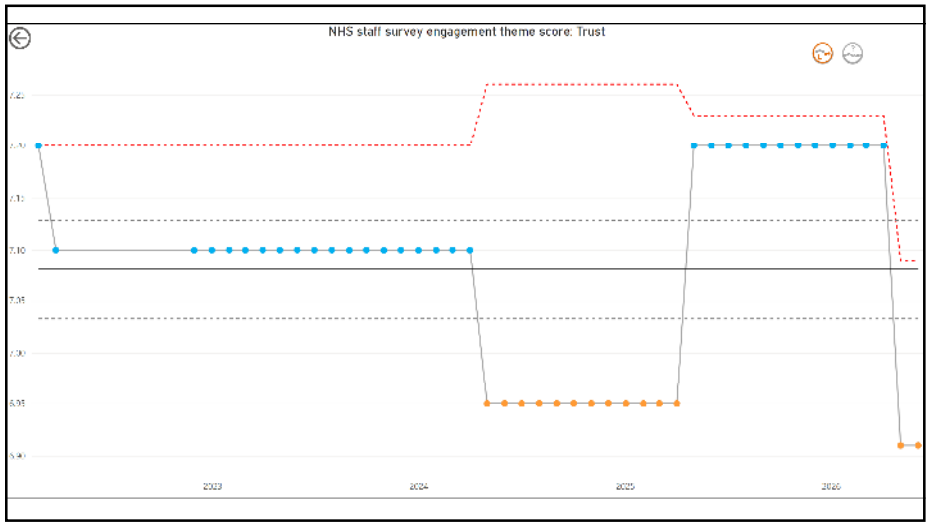

Appraisal Rates: Trust

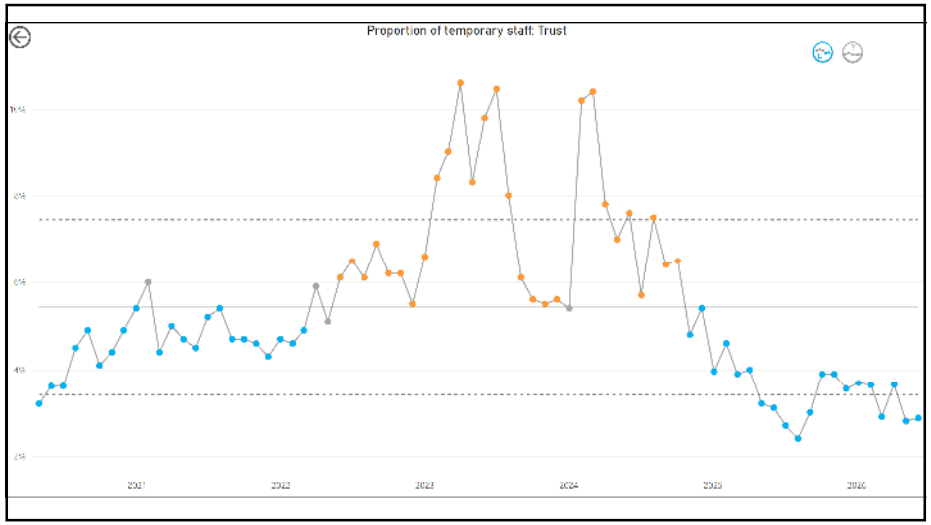

Bank Usage - Variance from plan (WTE): Trust

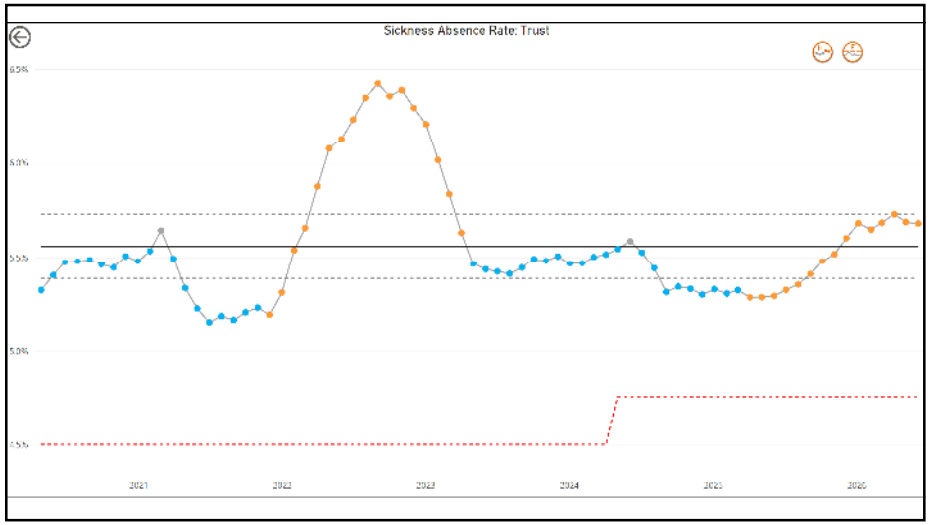

Mandatory Training Compliance: Trust

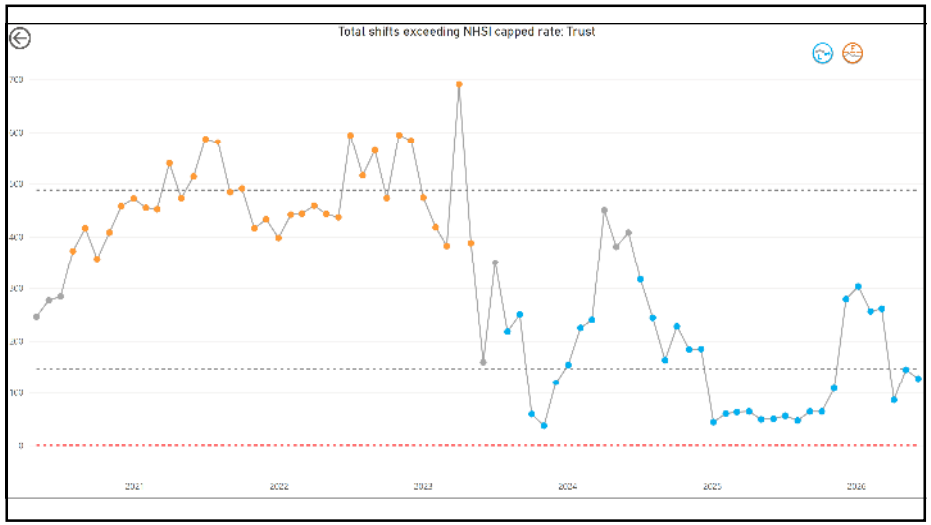

National Education and Training Survey overall satisfaction score: Trust

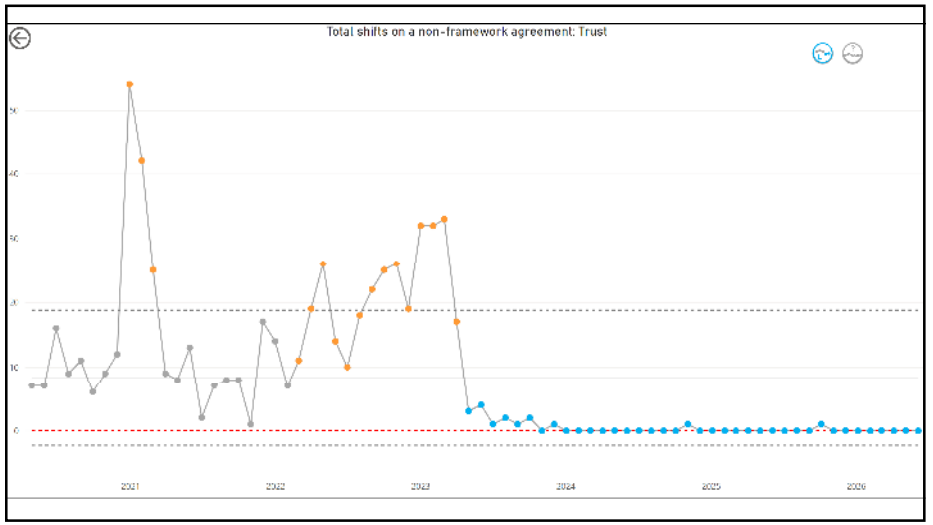

Net Staff in Post Change: Trust

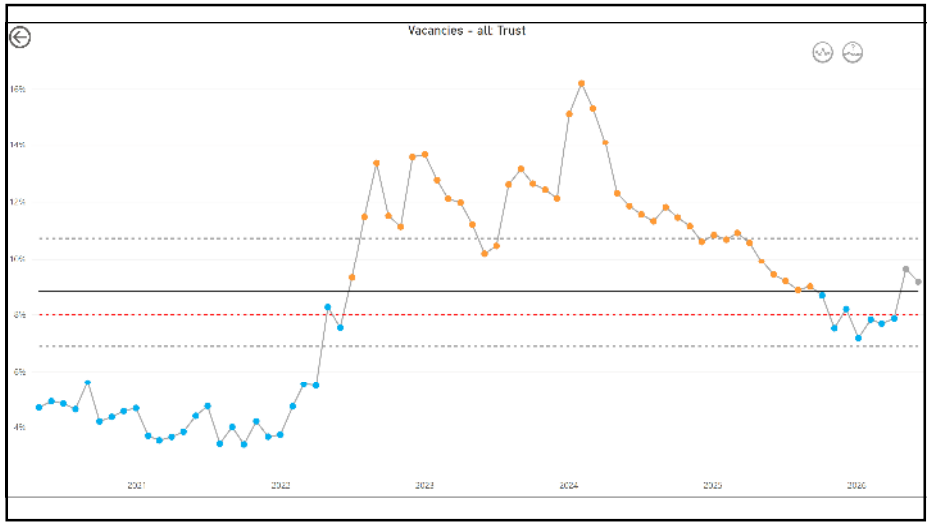

NHS staff survey engagement theme score: Trust


Proportion of temporary staff: Trust


Sickness Absence Rate: Trust


Total shifts exceeding NHSI capped rate: Trust


Total shifts on a non-framework agreement: Trust


Vacancies - all: Trust

Board of Directors' Meeting in Common – 9 July 2026

Agenda item	039/26d		
Report Title	SaTH Integrated Performance Report		
Executive Lead	Jo Williams, Group Chief Executive Officer		
Report Author	Ned Hobbs, Deputy Chief Executive Officer		
Prior Consultation:	**CQC Domain:**		**Link to SaTH BAF id(s)**
QOC - 2026.06.16 PAC - 2026.06.16 FAC - 2026.06.30	Safe	√	BAF 1, 2, 3, 4, 5, 8, 9, 10, 11, 12
	Effective	√	
	Caring	√	**SaTH Risk Register id(s):**
	Responsive	√	**All risks**
	Well Led	√	
Executive Summary:	The report provides an update on progress against the Trust's Operating plan and associated objectives and enablers. The Board's attention is drawn to the sections of Quality, Patient Safety and Clinical Effectiveness, Responsiveness, and Well Led which incorporates both Workforce and Finance. The report provides an overview of the performance indicators to the end of April 2026/May 2026, summarises planned recovery actions, correlated impact, and timescales for improvement.		
Recommendations for the Boards:	The Boards are asked to: • **Note** the content of the report.		
Appendices:	Appendix 1: Integrated Performance Report		

Moving to EXCELLENCE

NHS
Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

Integrated Performance Report

Board of Directors Meeting 9th July 2026

Presenting Month 2 performance data

Contents

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Moving to EXCELLENCE

Executive Summary

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Urgent and Emergency Care (UEC) 4-hour performance (type 1 & type 3) has moved to common cause natural variation in May 26. Type 1 performance decreased to 45% and Type 3 performance decreased to 90.7%. Average ambulance handover time shows special cause improving variation in May and was better than plan with 90.8% within 60 mins. The number of Type 1 patients who spend more than 12 hours in ED shows special cause improving variation.

The Trust submitted a finance plan to NHSE on 18th March which showed a deficit plan of £30.49m pre deficit support (DSF) which moves to breakeven with deficit support for the year. At the end of May (month two), the Trust has delivered a deficit position of £7.37m against a deficit plan of £5.61m pre deficit support funding, an unfavourable variance of £1.76m. This moves to a deficit of £2.29m against a planned deficit of £0.53m post deficit support.

There have been some variances in the cost categories with income and non-pay favourable to plan and pay adverse to plan. The predominant driver of the variance is industrial action (£0.75m) and slippage against various efficiency schemes (£1.76m), these have been partly offset with other non-recurrent mitigations. The Trust has set an operational capital programme of £25.54m (including IFRS 16 expenditure) and externally funded schemes of £135.36m in FY26/27, giving a total capital programme of £160.90m. The Trust held a cash balance at end of May 2026 of £40.26m.

The unvalidated Trust Position for May 2026: English is 0 x 104 weeks, 0 x 78 weeks, 0 x 65 weeks, 0 x 52 week (adult) and 0 x 40 weeks CYP.
The unvalidated Trust Position for Welsh is 0 x 104 weeks, 11 x 78 weeks, 52 x 65 weeks 171 x 52 weeks.
The Trust is ahead of plan and demonstrating special cause improvement against all RTT metrics.

Confirmed April cancer performance is 80.9% (28-day FDS) vs the local plan of 80%. 62-day performance was 71.2% against a local target of 72.1% and 31 day was 96.4% against a local target of 96%. The 62-day backlog is 158 patients over 62 days of which 23 are over 104 days (as at 08/06/2026).

The submitted DM01 position for May was 80.6 %, with improved performance in Echocardiology. NOUS has seen a deterioration in performance with a recovery plan being implemented. 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.

NHS
Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

Quality Patient Safety, Clinical Effectiveness and Patient Experience

Executive Leads :

Group Chief Nursing Officer
Martina Morris

Medical Director
John Jones

Moving to EXCELLENCE

Integrated Performance Report

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Domain	Description	Regulatory	National Standard 26/27	Current Month Trajectory (RAG)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Trend
Patient Safety & Effectiveness	Pressure Ulcers - Category 2		20% < 2025-26	29	26	27	28	26	21	27	35	24	21	35	26	19	22	
	Pressure Ulcers - Category 2 per 1000 Bed Days		20% < 2025-26	1.06	1.00	0.99	1.11	1.01	0.81	1.03	1.30	0.95	0.80	1.25	1.04	0.72	0.86	
	Pressure Ulcers - Category 3		10% < 2025-26	6	8	1	4	4	9	6	2	9	3	9	6	4	6	
	Pressure Ulcers - Category 3 per 1000 Bed Days		10% < 2025-26	0.16	0.31	0.04	0.16	0.16	0.35	0.23	0.07	0.36	0.11	0.32	0.24	0.15	0.24	
	Pressure Ulcers - Category 4		0	0	0	1	0	0	0	0	0	0	0	1	1	1	0	
	Falls - per 1000 Bed Days		5% < 2025-26	3.94	3.99	3.80	3.75	4.58	4.10	4.20	4.10	3.94	4.42	4.71	4.87	4.51	5.25	
	Falls - total		-	107	104	104	95	118	106	110	110	99	116	132	122	119	134	
	Falls - with Harm per 1000 Bed Days		5% < 2025-26	0.21	0.19	0.07	0.20	0.23	0.12	0.23	0.07	0.08	0.15	0.11	0.04	0.27	0.16	
	Falls - Resulting in Harm Moderate or Severe		0	0	5	2	5	6	3	6	2	2	4	3	1	7	4	
Patient Experience	Complaints		-	-	85	91	114	127	106	114	116	105	102	122	118	133	120	
	Complaints - responded within agreed timeframe - based on month response du		85%	85%	48.0%	42.0%	44.0%	49.0%	49.0%	43.0%	50.0%	50.0%	51.0%	60.0%	56.0%	54.0%	52.0%	
	Complaints by Theme - Access to Treatment or Drugs				2	0	4	5	6	4	4	8	13	11	7	10	3	
	Complaints by Theme - Admission / Discharge				25	16	18	25	27	16	19	23	24	34	27	26	25	
	Complaints by Theme - Appointment				11	16	24	19	21	19	17	16	27	24	27	23	21	
	Complaints by Theme - Clinical treatment				42	47	72	71	63	59	55	53	63	71	71	78	71	
	Complaints by Theme - Commissioning Decisions				0	0	0	0	0	1	0	1	0	0	0	1	0	
	Complaints by Theme - Communication				48	40	62	60	60	49	46	57	64	70	60	75	85	
	Complaints by Theme - Consent to treatment				2	2	2	2	1	2	2	3	7	4	3	3	5	
	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				2	2	5	0	6	2	2	5	1	6	2	4	5	
	Complaints by Theme - Facilities				7	4	5	7	13	2	2	2	5	12	5	14	9	
	Complaints by Theme - Mortuary				0	0	0	0	0	0	0	0	0	0	0	0	1	
	Complaints by Theme - Other				2	0	2	2	1	0	1	0	2	3	3	3	1	
	Complaints by Theme - Patient care				28	21	27	18	29	22	23	24	28	36	35	56	51	
	Complaints by Theme - Prescribing				4	6	7	9	6	3	5	5	7	5	4	6	5	
	Complaints by Theme - Privacy & Dignity				7	11	16	7	15	8	8	10	17	17	14	17	10	
	Complaints by Theme - Restraint				1	1	0	1	0	0	0	0	1	0	1	0	0	
	Complaints by Theme - Staff numbers				3	0	0	2	0	2	3	3	2	5	2	4	1	
	Complaints by Theme - Trust admin / procedure / records				3	7	10	11	15	12	7	2	9	21	26	20	22	
	Complaints by Theme - Values & Behaviours (staff)				24	27	37	41	31	34	35	46	40	37	40	41	42	
	Complaints by Theme - Waiting time				16	15	17	19	16	12	13	12	11	15	14	13	11	
	PALS - Count of concerns		-	-	330	365	351	375	318	397	407	321	278	448	408	396	417	
	Compliments		-	-	105	93	110	81	109	145	132	95	145	89	91	84	89	
	Friends and Family Test -SaTH		95%	95%	97.1%	93.2%	96.8%	88.3%	92.4%	79.8%	73.7%	77.1%	76.1%	76.0%	75.0%	75.4%	80.3%	
	Friends and Family Test - Inpatient		95%	95%	97.2%	91.4%	97.4%	96.9%	96.4%	92.0%	93.6%	95.1%	94.0%	92.7%	92.8%	94.3%	92.7%	
	Friends and Family Test - A&E		85%	85%	64.9%	51.7%	57.6%	63.0%	33.3%	62.1%	67.6%	70.5%	71.1%	72.2%	70.9%	71.5%	77.3%	
	Friends and Family Test - Maternity		95%	95%	95.5%	88.6%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	85.7%	87.5%	55.6%	100.0%	
	Friends and Family Test - Outpatients		95%	95%	99.0%	99.0%	97.6%	94.0%	92.9%	93.7%	92.2%	95.3%	92.8%	87.1%	91.5%	85.7%	88.0%	
	Friends and Family Test - SaTH Response rate %		-	-	5.2%	5.3%	4.8%	1.3%	1.2%	1.6%	3.6%	4.7%	4.5%	5.2%	4.9%	4.7%	5.5%	
	Friends and Family Test - Inpatient Response rate %		-	-	11.9%	12.8%	11.5%	2.2%	2.9%	2.0%	1.5%	2.6%	1.8%	1.9%	1.8%	1.9%	2.2%	
	Friends and Family Test - A&E Response rate %		-	-	0.6%	0.4%	0.3%	0.7%	0.1%	1.4%	5.0%	6.2%	6.2%	7.4%	7.1%	6.6%	7.7%	
	Friends and Family Test - Maternity (Birth) Response rate %		-	-	0.5%	6.6%	2.1%	0.7%	0.2%	0.4%	0.8%	0.7%	0.0%	0.3%	0.0%	0.0%	0.6%	

Integrated Performance Report

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

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Patient Safety & Effectiveness	Trust SHMI (HED)		100	100	93	102	90	97	92	97	89	94	-	-	-	-	-	
	Trust SHMI - Expected Deaths		-	-	242	244	225	239	226	228	250	240	-	-	-	-	-	
	Trust SHMI - Observed Deaths		-	-	224	248	203	233	208	221	223	226	-	-	-	-	-	
	SJRs Completed by Month				20	33	20	17	12	17	18	14	11	16	10	17	0	
	MRSA - HOHA				0	0	0	0	0	0	0	1	0	2	1	0	0	
	MRSA - COHA				0	0	0	0	0	0	0	0	0	0	1	0	0	
	MRSA - Total	R	0	0	0	0	0	0	0	0	0	1	0	2	2	0	0	
	MSSA - HOHA		-	-	2	3	1	2	2	1	0	2	3	1	1	4	3	
	C. difficile - HOHA				9	2	6	5	10	8	6	2	7	6	3	9	6	
	C. difficile - COHA				5	2	6	5	3	4	3	3	7	5	6	9	4	
	C. difficile - Total	R	98	8	14	4	12	10	13	12	9	5	14	11	9	18	10	
	E. coli - HOHA				3	2	3	2	8	6	5	5	5	4	5	7	8	
	E. coli - COHA				9	14	9	10	10	15	11	10	7	9	6	6	7	
	E. coli - Total	R	146	12	12	16	12	12	18	21	16	15	12	13	11	13	15	
	Klebsiella - HOHA				1	4	0	2	1	4	2	1	2	2	1	0	0	
	Klebsiella - COHA				5	2	1	1	5	4	3	3	2	3	2	3	0	
	Klebsiella - Total	R	36	3	6	6	1	3	6	8	5	4	4	5	3	3	0	
	Pseudomonas Aeruginosa - HOHA				0	0	1	0	0	0	1	0	0	0	1	1	1	
	Pseudomonas Aeruginosa - COHA				2	0	0	3	1	1	2	1	0	2	2	0	0	
	Pseudomonas Aeruginosa - Total	R	16	1	2	0	1	3	1	1	3	1	0	2	3	1	1	
	VTE Risk Assessment completion - SATH		95%	95%	75.6%	75.0%	75.5%	77.4%	77.2%	79.2%	79.6%	80.7%	78.3%	77.7%	82.6%	84.7%	-	
	Never Events		0	0	1	0	0	1	0	1	1	0	0	0	0	1	1	
	Psii		-	-	4	1	0	1	0	3	2	3	0	1	0	2	1	
	Mixed Sex Accommodation - breaches		10% < 2025-26	97	101	87	65	52	38	46	63	56	46	66	40	59	38	
	One to One Care in Labour		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Delivery Suite Acuity		85%	85%	97%	96%	96%	99%	95%	97%	98%	95%	92%	95%	95%	97%	95%	
	Smoking Rate at Delivery		6%	6%	5.6%	4.0%	5.9%	5.0%	4.4%	5.9%	4.2%	4.3%	4.9%	6.6%	3.3%	4.0%	5.7%	

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Patient Safety, Clinical Effectiveness, Patient Experience Executive Summary

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

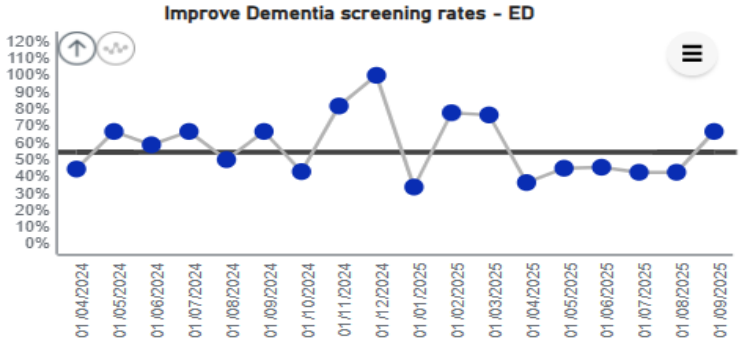
- Mortality rates (SHMI) remain below 100, but there is ongoing concern about the accuracy of data due to issues with the data warehouse
- Emergency Department deaths are not included in this metric
- Hospital-associated infections, particularly C difficile, continue to be a significant challenge
- Noted improvements in VTE assessment compliance
- Never Event reported in Ophthalmology May 2026. Ophthalmology Transformation Programme will include recommendations from the investigation. Plans are in place to incorporate recommendations from a combined PSI investigation into two never events
- A request made for further clarity in narrative for response to PEWS escalation
- There has been sustained improvement in overdue patient safety incidents
- Ambulance offload delays have improved, with only one over 8-hour delay in May and no harm identified

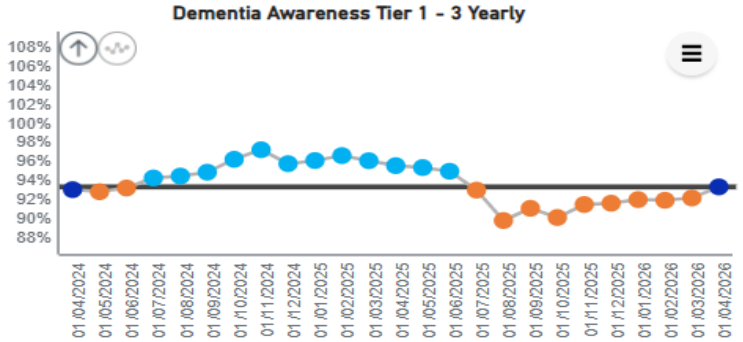
Quality - Safe - Deteriorating Patients - Fragility

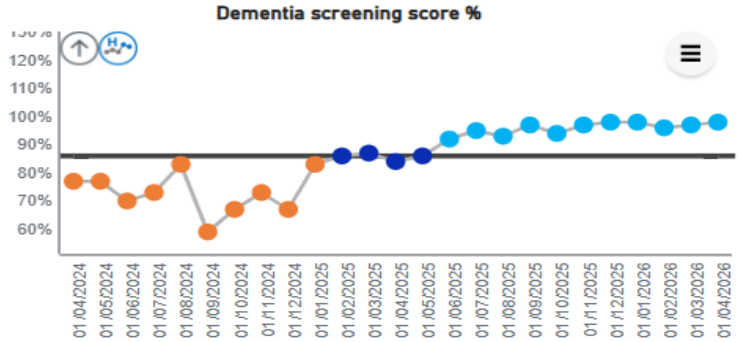
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

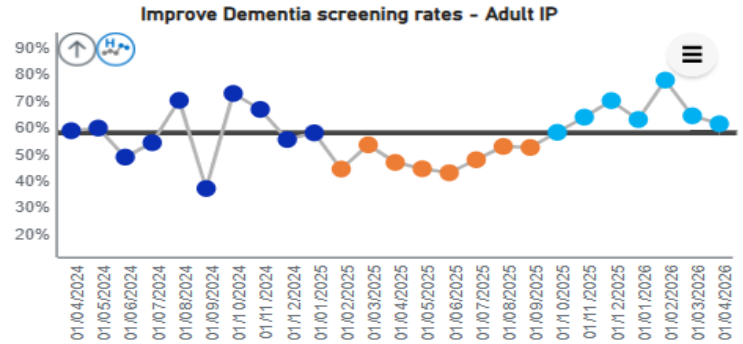
Falls | Deteriorating Patients - NEWS | Deteriorating Patients - PEWS | Medication - Omitted Doses

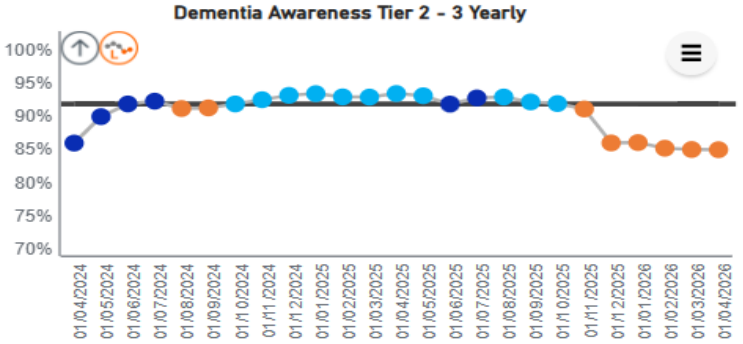
	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026
Improve Dementia screening rates - Patient had an AMT - ED	33.8	77.8	76.5	36.4	44.9	45.5	42.5	42.5	66.7							
Improve Dementia screening rates - Patient had an AMT - Adult IP	58.2	44.6	53.7	47.1	44.7	43.2	48.1	53.1	52.7	58.4	64.1	70.3	63.2	78.0	64.6	61.6
Dementia Awareness Tier 1 3 Yearly	96.08	96.60	96.06	95.54	95.34	94.95	92.96	89.75	91.04	90.07	91.44	91.58	91.96	91.89	92.13	93.30
Dementia Awareness Tier 2 3 Yearly	93.51	93.02	92.99	93.53	93.19	91.93	92.86	93.00	92.26	92.01	91.19	86.04	86.10	85.24	85.05	85.02
Dementia Screening % Score	83	86	87	84	86	92	95	93	97	94	97	98	98	96	97	98
Dementia Screening Audited	207	202	200	245	248	234	250	245	242	238	210	214	263	286	277	298

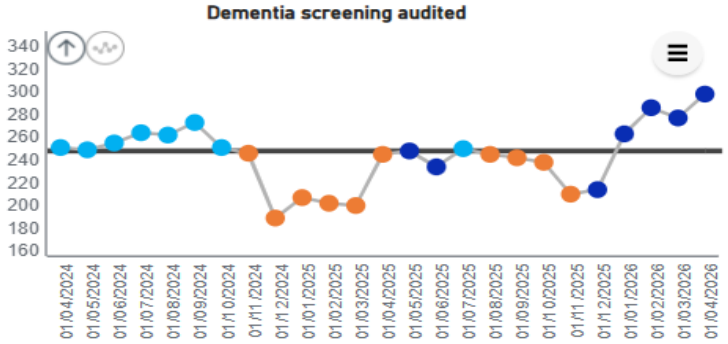










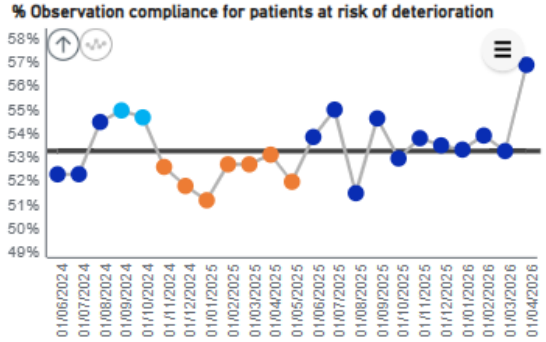


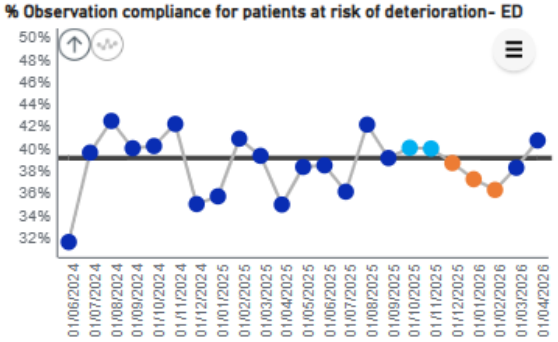
Moving to EXCELLENCE

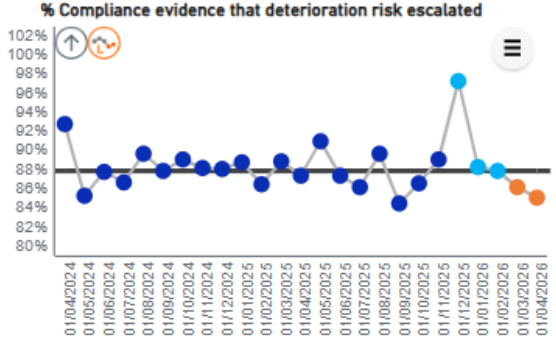
Quality - Safe - Deteriorating Patients - NEWS

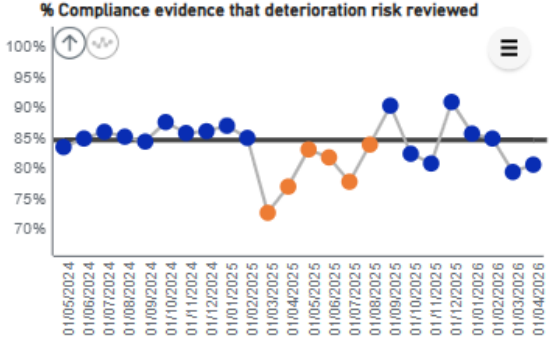
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

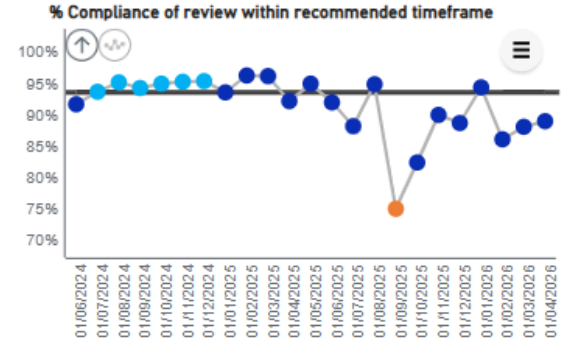
	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026
% Observation compliance for patients at risk of deterioration	54.67	52.59	51.79	51.19	52.70	52.70	53.11	51.97	53.85	55.00	51.49	54.63	52.95	53.80	53.50	53.32	53.91	53.26	56.88
% Observation compliance for patients at risk of deterioration - ED	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	37.28	36.32	38.31	40.76
% Compliance evidence that deterioration risk (NEWS2) escalated	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	88.20	87.80	86.10	85.00
% Compliance evidence that deterioration risk (NEWS2) reviewed	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	85.70	84.90	79.40	80.60
% Compliance of review within recommended timeframe	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	94.40	86.10	88.10	89.00
% Compliance reviewed by recommended seniority	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	94.40	93.60	85.40	89.30
% Compliance those stratified high-risk of Sepsis, received antibiotics within 1hr	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	90.00	84.00	96.00	82.10

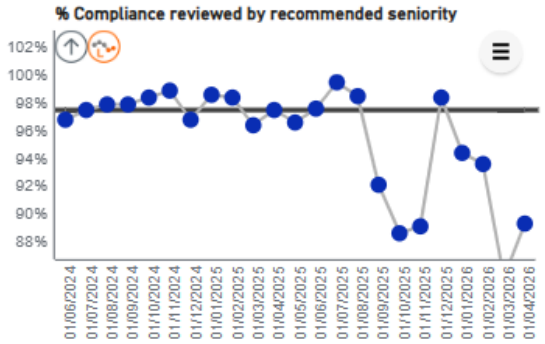


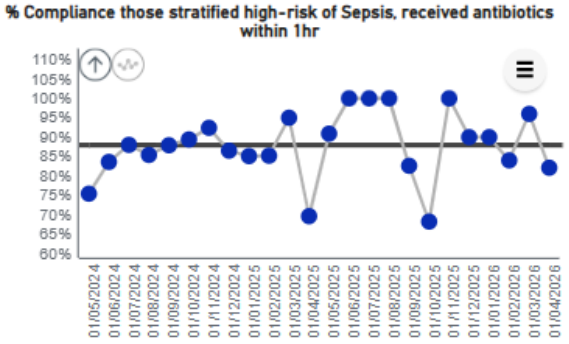












Moving to EXCELLENCE

Deteriorating patients – NEWS2

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:
Deteriorating patient observation compliance remains below the ≥90% standard; however, recently implemented standardised protocols are associated with a clear increase from the previous data point. Inpatient performance has risen to 56.8% (from 53.26% in March), and ED performance has also risen to 40.76% (from 38.31%). Escalation compliance has slightly reduced from 86.10% to 85% in April.
Review compliance has improved marginally to 80.6% but continues to fall short of the 90% target. Data continues to demonstrate variability in both the seniority of clinician review and timeliness of response in line with patient acuity (RCP guidance), with current compliance at 89% and 89.35% respectively, reinforcing the need for ongoing oversight and focus.
Antibiotic administration within 1 hour for high-risk sepsis has decreased to 82%. This represents 5 out of 28 patients not receiving treatment within 60 minutes; however, two cases should have been classified as exempt due to individualised care plans. Ongoing work to enhance digital visibility of deteriorating patients and associated workflows, alongside initiatives such as e-prescribing, is expected to support greater consistency and improved patient outcomes going forward.

Recovery Actions:	**Anticipated impact and timescales.**
1.Improve compliance with observations frequency for patients at risk of deterioration • Support teams in use of digital tools to ensure local oversight of most at risk patients • Reinforce expected standards for Escalation associated with clinical acuity (as per guidance) **2. Strengthen deterioration response reliability** • Embed expected response linking NEWS2 triggers and associated actions with the use of prompts. • Improve visibility of escalation and review status via digital projects • Work with clinical teams to address variation identified through local data • Reinforce senior clinical oversight and decision-making to increase focus on seniority of review, ensuring appropriate clinician involvement at trigger points • Promote clear documentation of reviewer seniority through prompts, projects such as response sticker trial (MECTP) and audit feedback. • Support clinical teams through targeted messaging and inclusion in induction programmes • Reinforce consistent escalation and review practice through focused safety huddles and case reviews **3. Improve timeliness and consistency of clinical review** • Continue monitoring response times against acuity standards, highlighting areas of delay • Align ward processes to ensure timely review is embedded within routine practice **4. Sepsis recognition and treatment reliability** • Reinforce delivery of antibiotics within 60 minutes, with clear identification of exemptions • Share learning from delayed cases, including documentation of individualised care plans	1. 3 months 2. 12 months 3. 3 months 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

Moving to EXCELLENCE

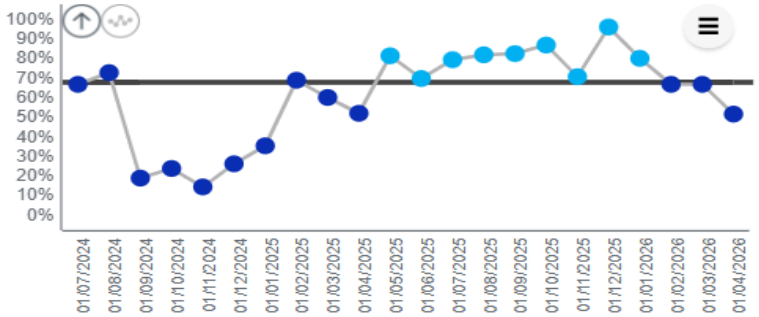
Quality - Safe - Deteriorating Patients - PEWS

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

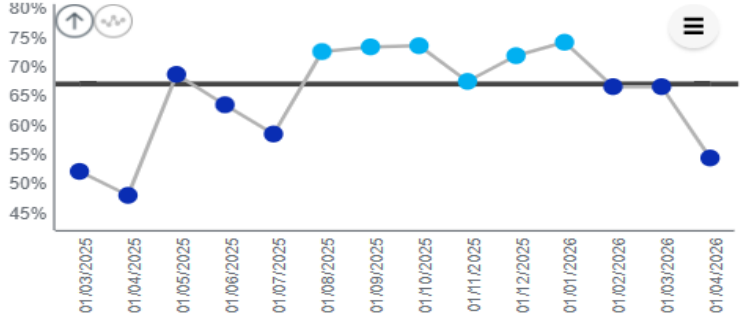
Falls | Deteriorating Patients - Fragility | Deteriorating Patients - NEWS | Medication - Omitted Doses

	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026
% Compliance evidence that deterioration risk (PEWS) escalated	60.00	51.90	81.30	69.70	79.30	81.80	82.40	86.80	70.60	96.00	80.00	66.70	66.70	51.50
% 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	74.30	66.70	66.70	54.50
% Compliance of review within recommended timeframe - PEWS	92.90	92.30	81.80	85.70	82.40	81.30	88.00	89.30	82.60	94.40	88.50	72.70	87.50	88.90
% Compliance reviewed by recommended seniority - PEWS	71.40	69.20	69.60	57.10	52.90	86.70	66.70	67.90	73.90	58.80	73.10	52.20	62.50	64.70
% Compliance those stratified high-risk of Sepsis, received antibiotics within 1hr - PEWS	0.00	14.30	25.00	0.00	0.00	0.00	0.00	16.70	0.00	6.30	12.50	0.00	0.00	0.00

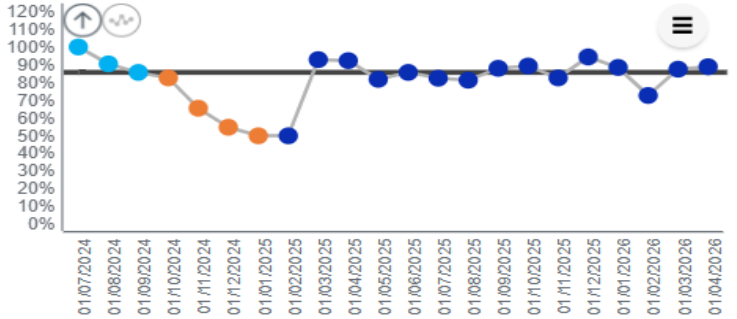
% Compliance evidence that deterioration risk (PEWS) escalated



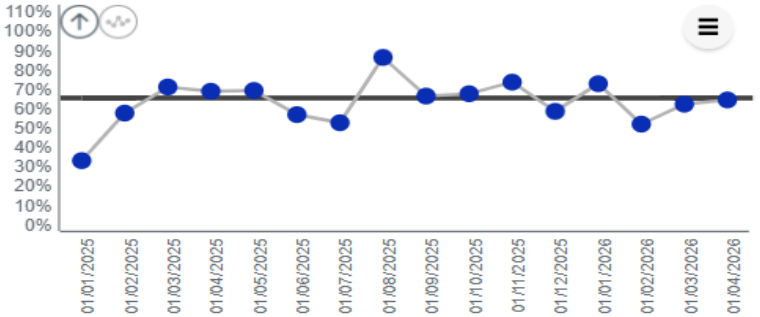
% Compliance evidence that deterioration risk (PEWS) reviewed



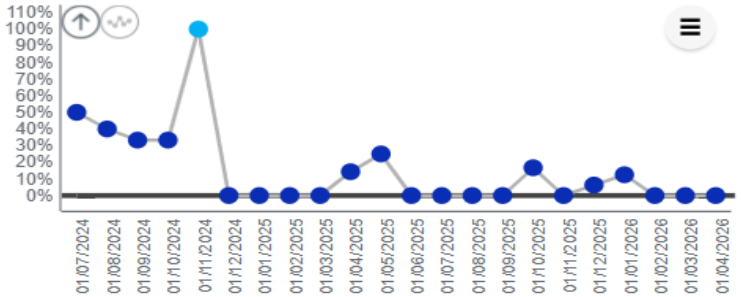
% Compliance of review within recommended timeframe - PEWS



% Compliance reviewed by recommended seniority - PEWS



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



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Deteriorating patients – PEWS & NEWTT2

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:
In April 2026, 40 patients were audited. Of those requiring escalation, 60% (24CYP) had documented evidence of escalation.
Of the 40% (16 CYP) who did not have documented evidence of escalation, 1 CYP was escalated and seen during the ward round which is documented by the consultant, 15 CYP had no documented evidence of escalation but came to no harm.

The CYP review, compliance has increased to 75% (18 CYP). The 25 % (6 CYP) who were not reviewed came to no harm.
With regards to sepsis, 82% (33 CYP) were screened for sepsis at their initial assessment which is a slight decrease in compliance from March. 18 CYP screened positively but on clinical assessment did not require IV antibiotics. All patients were treated appropriately.

Recovery actions:
On reviewing the audits further improvement is required in relation to documentation following reviews, De-escalating sepsis when indicated 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 meetings and sent to the Tier 2 medics/ ACP
- IV Antibiotic Compliance:0% due to no CYP requiring IV antibiotics within the audit, alternative diagnosis treated
- 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 staff and new nurses
- New board huddle introduced with Consultants, Ward Managers, Matrons to highlight the children triggering for sepsis who have not been de-escalated.

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

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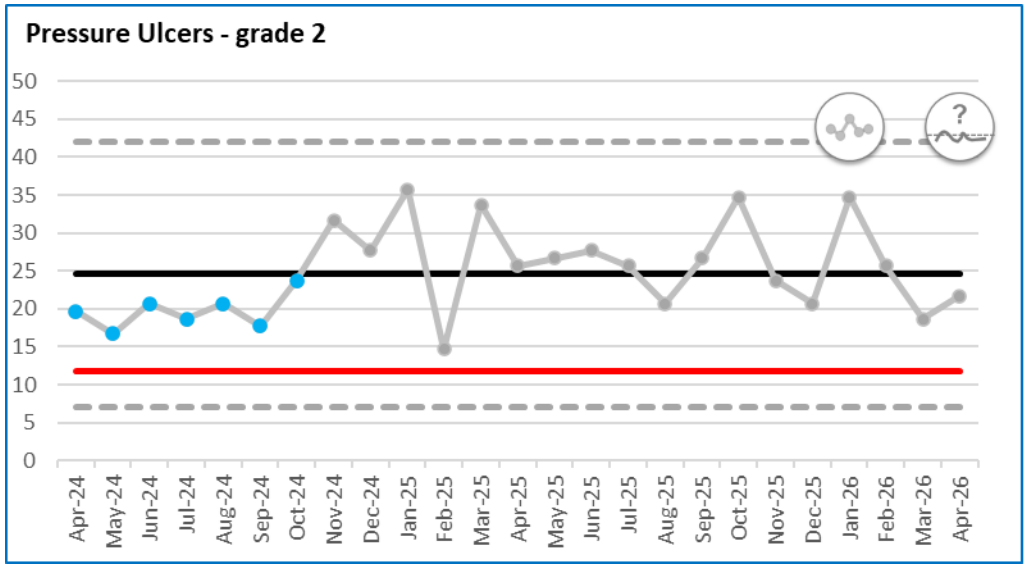
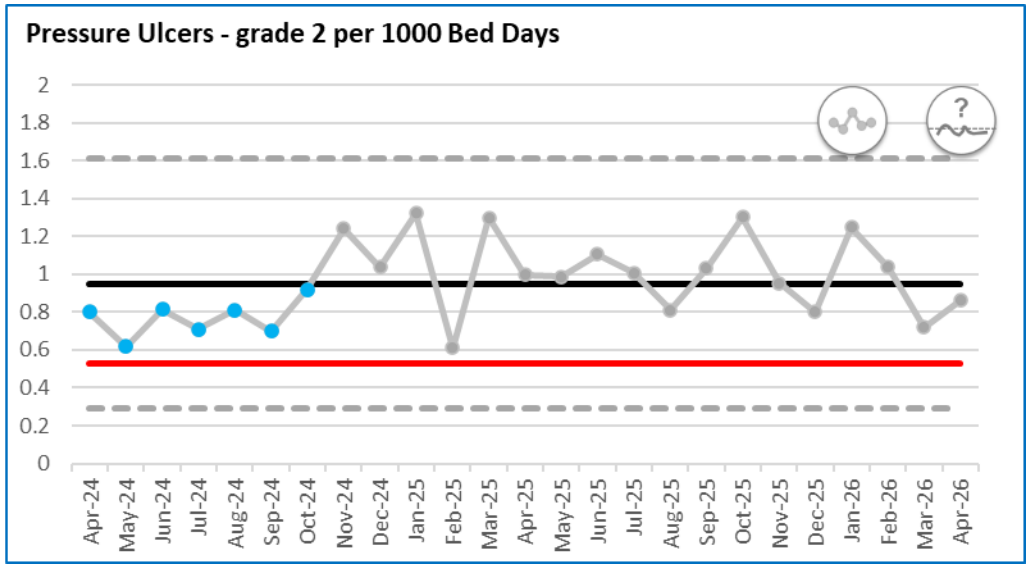
Patient harm – pressure ulcers – Category 2

Shropshire, Telford and Wrekin Community and Hospitals NHS Group





Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	13
Surgery, Anaesthetics and Cancer	9
Women's & Children's	0
Clinical Support Services	0

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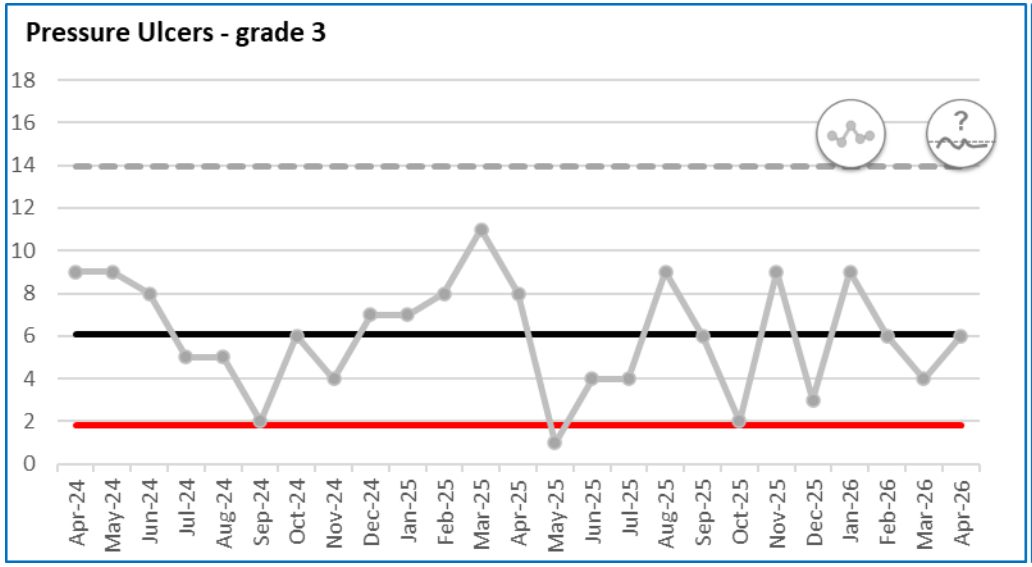
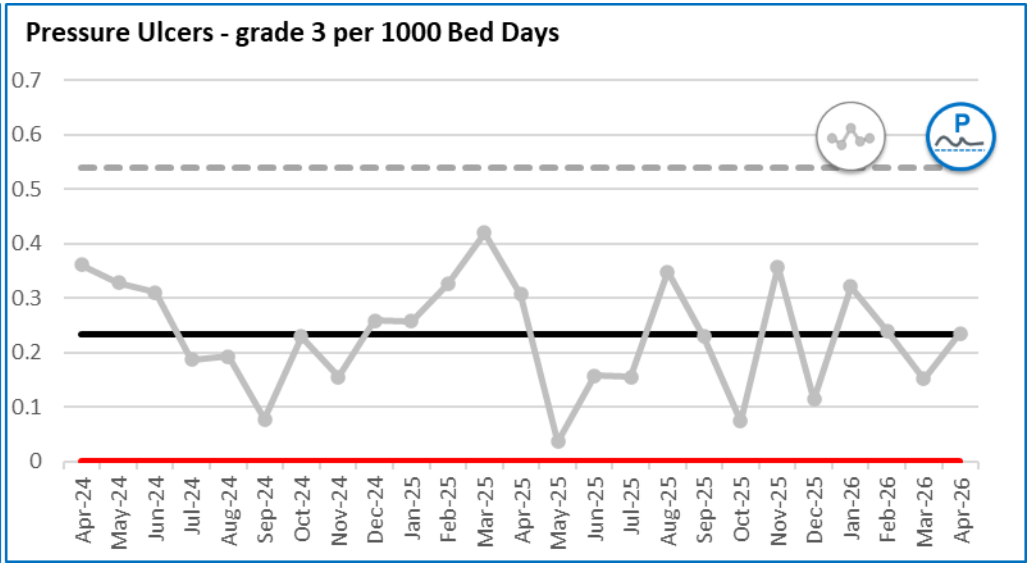
Patient harm – pressure ulcers – Category 3

Shropshire, Telford and Wrekin Community and Hospitals NHS Group





Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	2
Surgery, Anaesthetics and Cancer	3
Women's & Children's	0
Clinical Support Services	1

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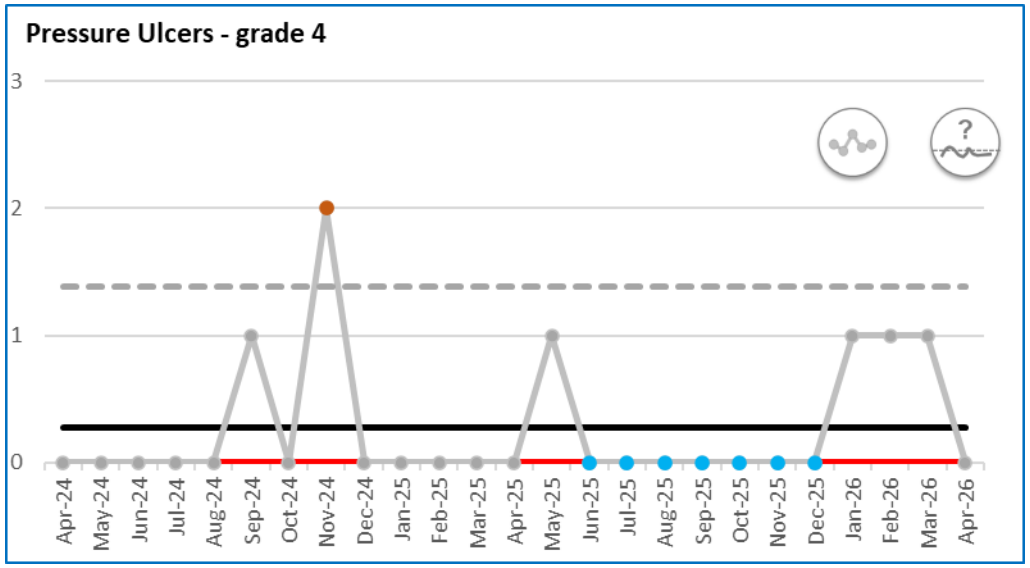
Patient harm – pressure ulcers – Category 4

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



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

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Patient Harm – pressure ulcers

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary: The number of Category 2 injuries has decreased this month. The number of category 3 pressure ulcers has also decreased in month. The 4 category 3 pressure ulcers in month were attributed to ward AMU RSH, 25,26 and ward 4. Of these 4 category 3 pressure ulcers 3 were to buttock/sacrum and 1 was to the heel. Following the pressure ulcer review meeting the missing elements in documentation were patient repositioning schedule, position change, the core care plan was not completed for 1 patient and skin assessment charts not being updated. There has been 1 category 4 pressure ulcer this month attributed to ward 36. On review of this there were gaps in skin inspection charts, body map documentation and there was no core care plan. There were 28 reported Deep Tissue Injuries this month which is an increase of 4 from last month. These figures are correct at the time of validation by the Tissue Viability Service.

Recovery actions:

- Hospital acquired pressure ulcer injuries are reviewed by the ward manager/matron within 2 week. 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 category 2 injuries sustained in Trust are presented at the monthly Pressure Ulcer Review Meeting where areas for learning and actions taken to embed are discussed. Category 3 and 4 pressure ulcer are discussed at a face-to-face meeting with the chief/deputy chief Nurse, ward manager, Matron and tissue viability. The tissue viability team will assist the ward team with any learning discussed at the initial meeting and a follow up meeting 6 weeks later will take place.
- Following a trial of hybrid pressure relieving mattresses and the tendering process has been completed a company has now been appointed to supply the trust with roll out in July 26

Current actions in place/ongoing are:

- Introduction of upgraded alternating air mattress with associated staff education to improve device use and availability
- 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 will be rolled out across the trust in 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

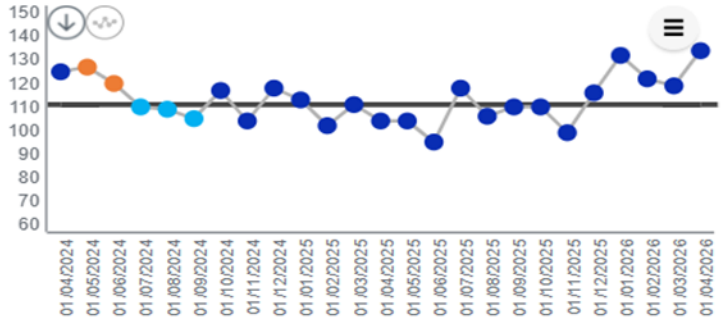
Moving to EXCELLENCE

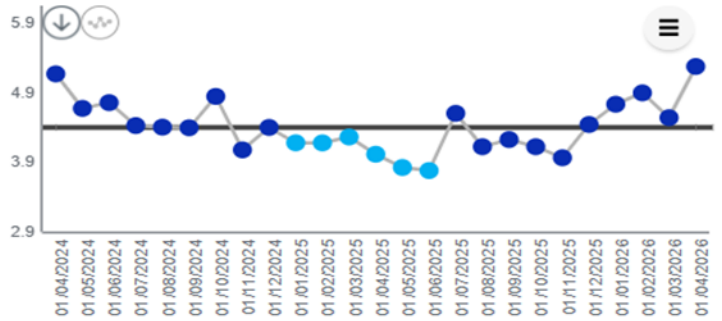
Quality - Safe - Falls

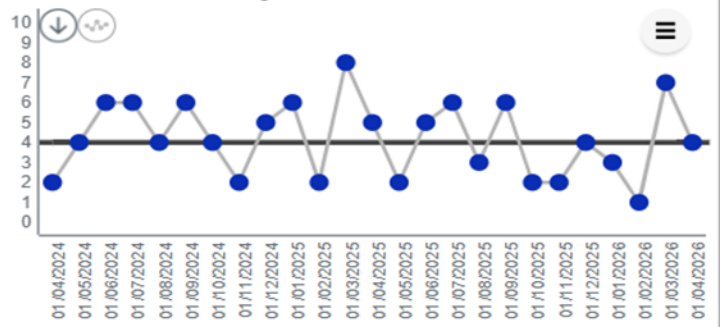
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

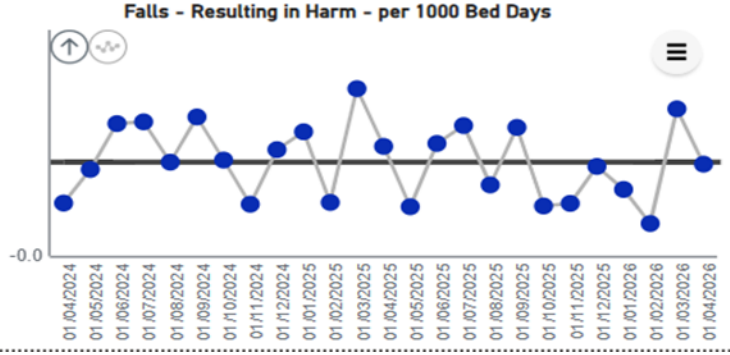
Deteriorating Patient - Fragility | Deteriorating Patients - NEWS | Deteriorating Patients - PEWS | Medication - Omitted Doses

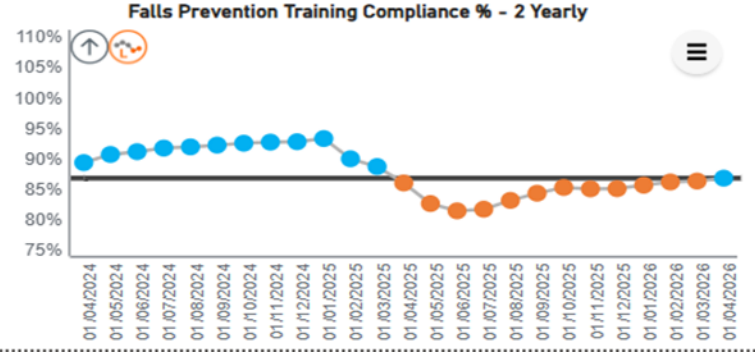
	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026
Falls - Total	118	113	102	111	104	104	95	118	106	110	110	99	116	132	122	119	134
Falls - per 1000 Bed Days	4.37	4.15	4.15	4.24	3.99	3.80	3.75	4.58	4.10	4.20	4.10	3.94	4.42	4.71	4.87	4.51	5.25
Falls - Resulting in Harm Moderate or Severe	5	6	2	8	5	2	5	6	3	6	2	2	4	3	1	7	4
Falls - Resulting in Harm - per 1000 Bed Days	0.19	0.22	0.08	0.31	0.19	0.07	0.20	0.23	0.12	0.23	0.07	0.08	0.15	0.11	0.04	0.27	0.16
Falls Prevention Training Compliance % - 2 Yearly	92.84	93.36	90.03	88.75	86.04	82.66	81.46	81.73	83.18	84.36	85.31	85.08	85.11	85.68	86.21	86.36	86.84
% Completion of Falls Risk Assessments	95	96	93	93	92	92	91	90	92	90	92	93	91	91	91	91	92

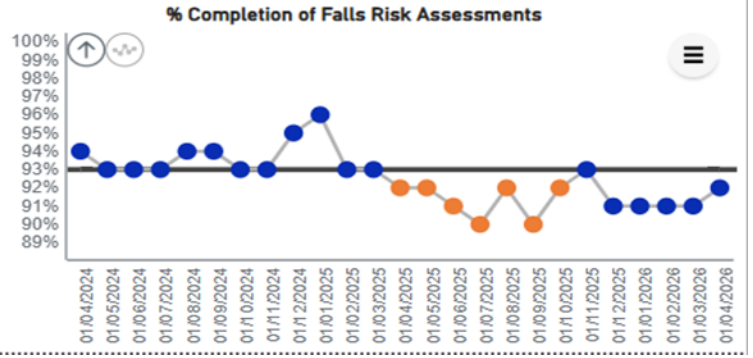












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Patient harm - falls

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:
There were 134 falls in April which is an increase from the previous month.
There were 3 falls resulting in moderate harm and 1 fall (fractured neck of Femur) resulting in severe harm in April which is a decrease from March.
On review of these falls the risk assessment, management plan, lying and standing blood pressure were all correct and in place pre fall. Post fall the risk assessments and management plan had all been updated. The lying and standing blood pressure could not be completed post fall due to the patient's condition for 1 patients. Common cause variation continues to be seen on the falls with harm and falls with harm per 1000 bed days charts.
Training compliance is 86.84% which is just below the target of 90%

Recovery actions:

A pilot of BMAT (Bedside Mobility Assessment Tool), a patient early mobilisation tool which will also help with hospital associated deconditioning took place in March on Ward 26 and ward 11. The project showed more patients were sitting out of bed and therefore less likely to fall due to deconditioning. BMAT will be implemented throughout the trust starting in June and will also include the digital risk assessment for BMAT.
The Quality team review each patient fall to check process pre and post fall. Ward Managers and Matrons review each fall on their wards with support from the Quality team. Education takes place at the time of the falls review addressing any non-compliance.
Completion of lying and standing BP compliance is still low pre fall, 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.
Training compliance and trajectories are discussed in Nursing Quality Metrics

Anticipated impact and timescales for improvement:
Beside mobility assessment – BMAT implementation this year.
Review of all falls continues with feedback presented to WM
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

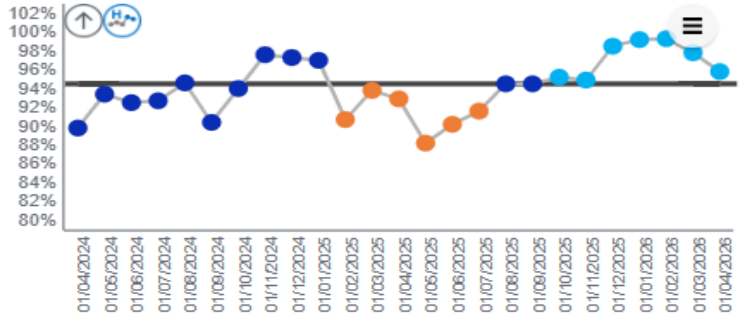
Moving to EXCELLENCE

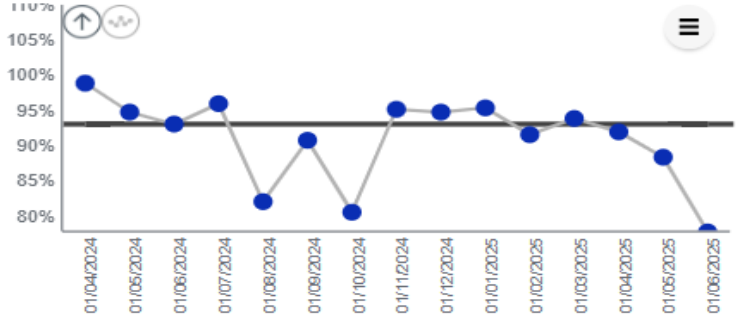
Quality - Safe - Medication - Omitted Doses

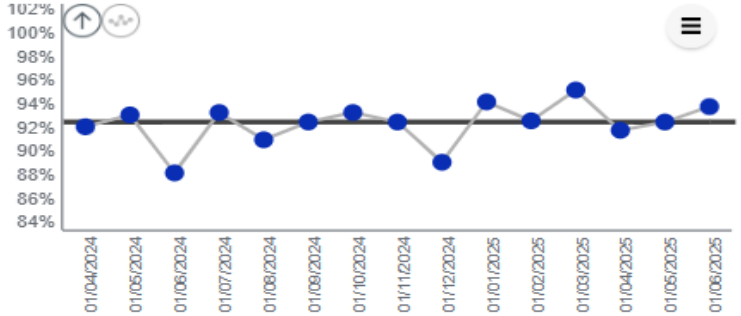
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Falls | Deteriorating Patients - Fragility | Deteriorating Patient

	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026
Has all prescribed medication been administered?	97.0	90.7	93.8	92.9	88.2	90.2	91.6	94.5	94.5	95.2	94.9	98.5	99.2	99.3	97.8	95.8
Was the reason for the omission documented?	95.4	91.6	93.9	92.0	88.4	77.8										
Was appropriate action such as ordering medication, documented?	94.2	92.6	95.2	91.8	92.5	93.8										







Medication – omitted doses

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

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:

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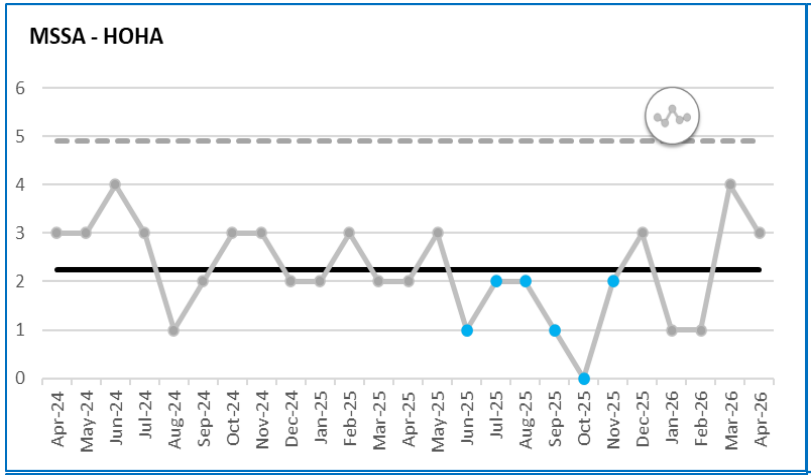
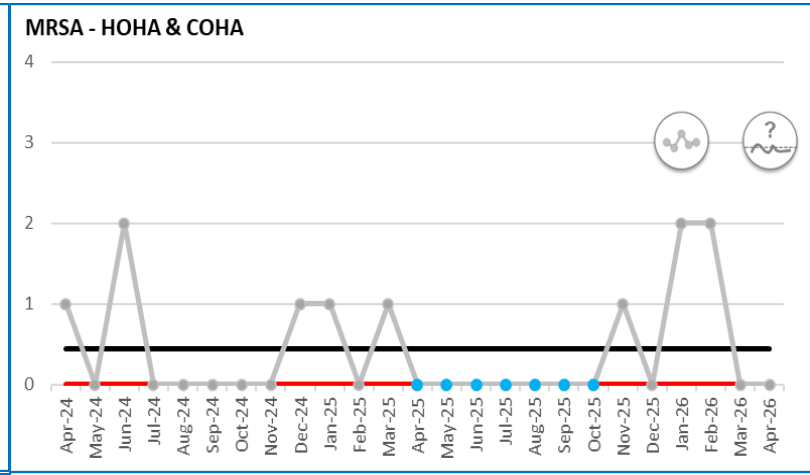
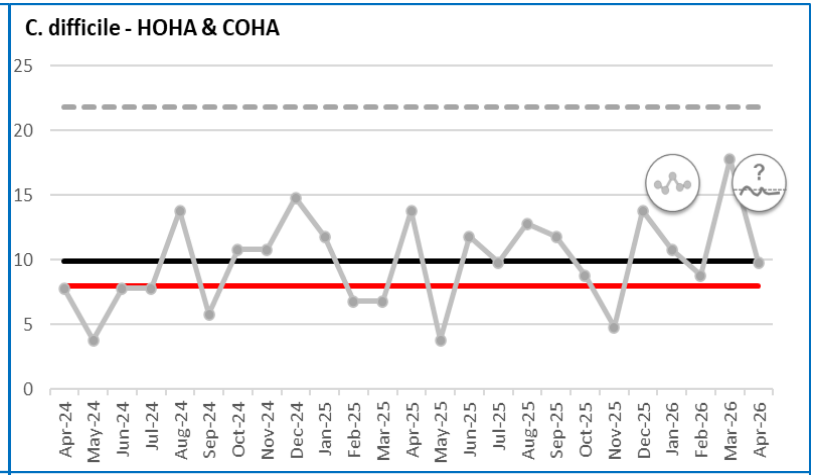
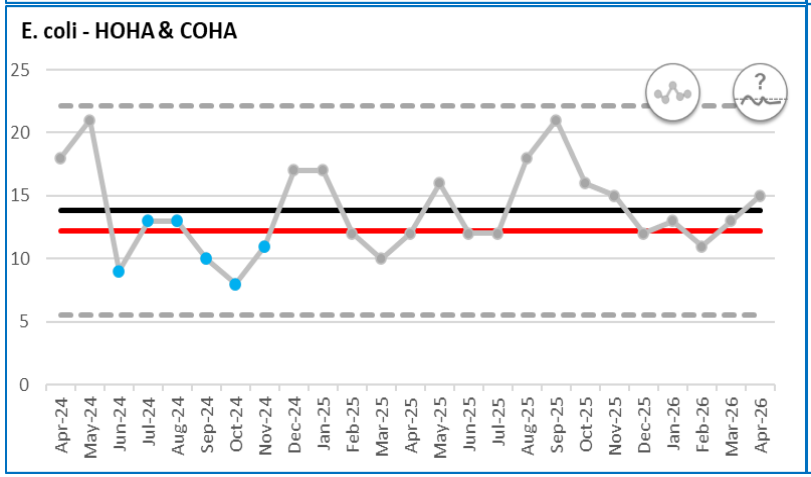
Infection prevention and control

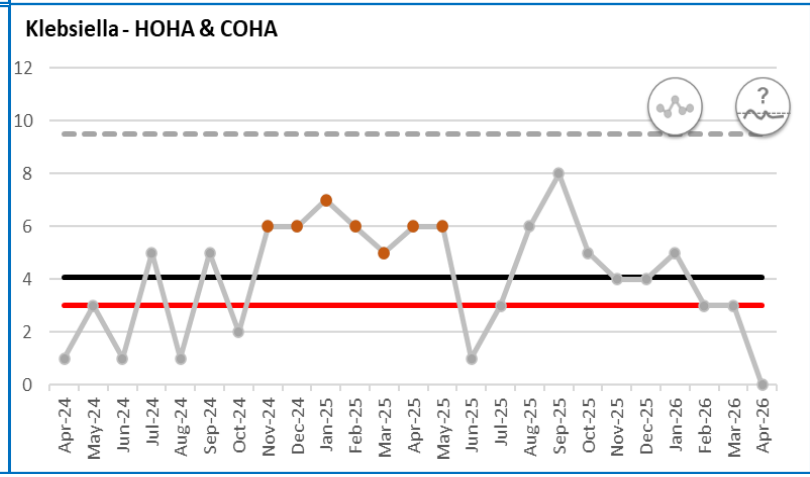
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

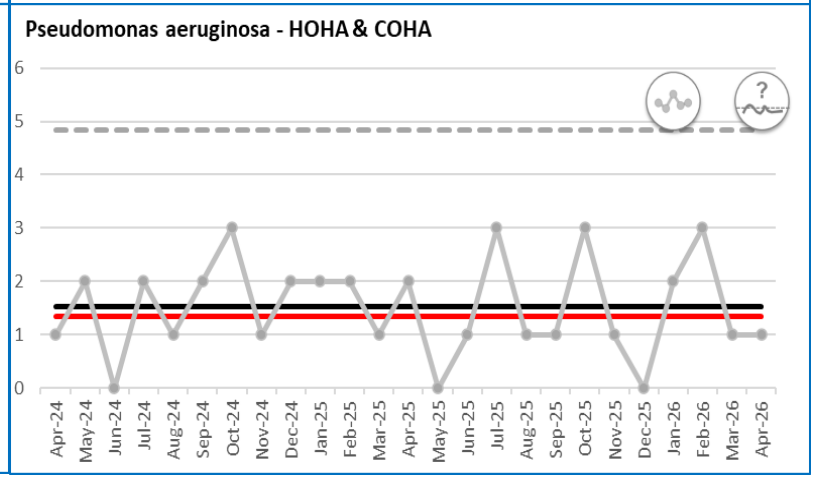












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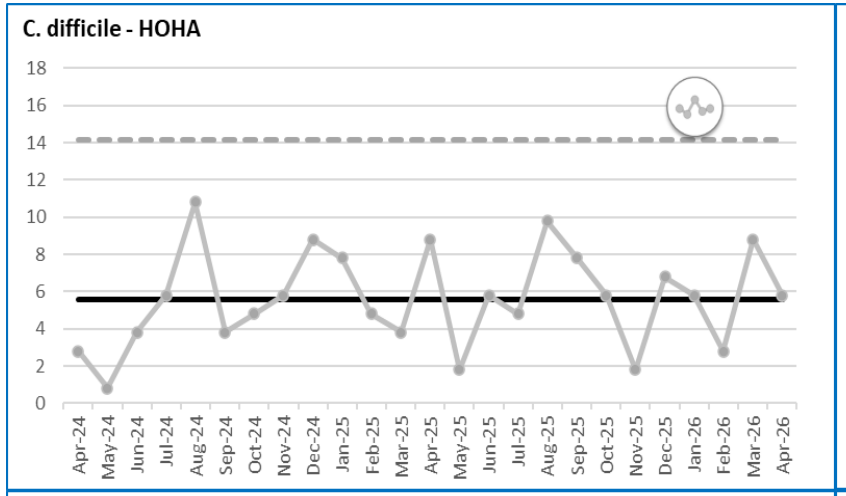
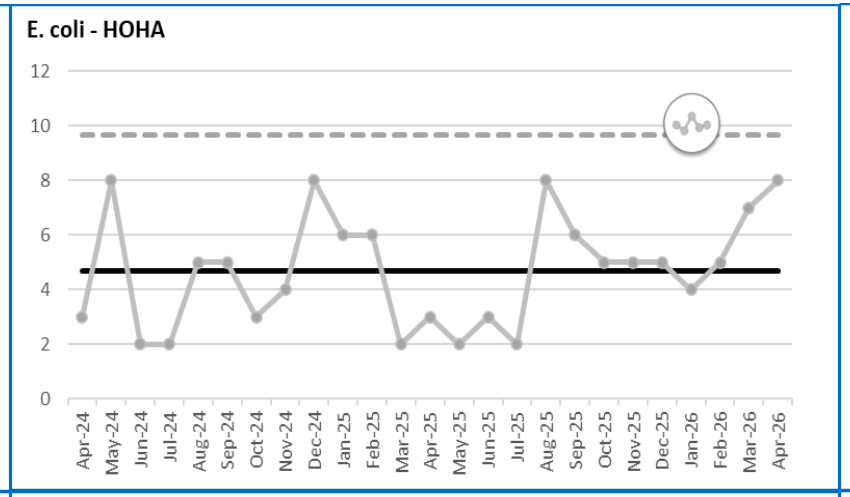
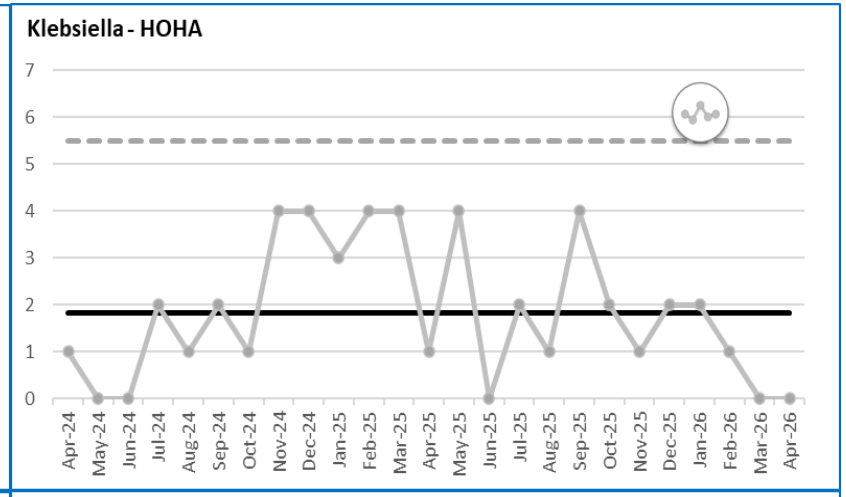
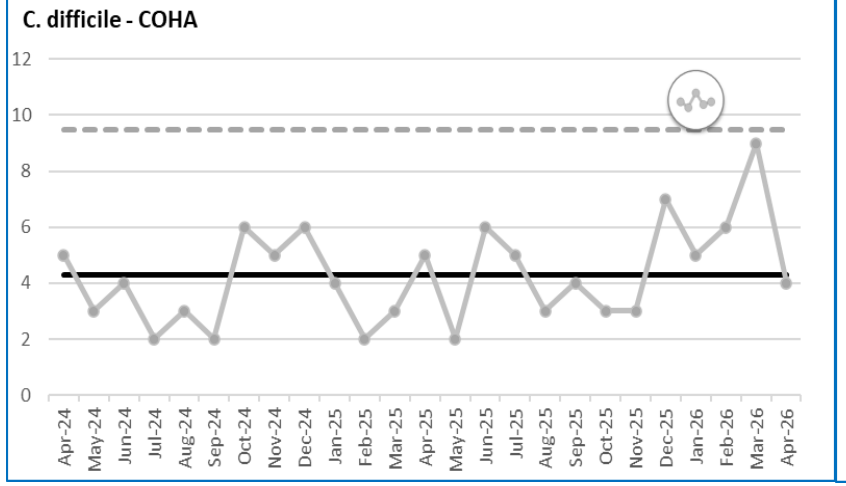
Infection prevention and control

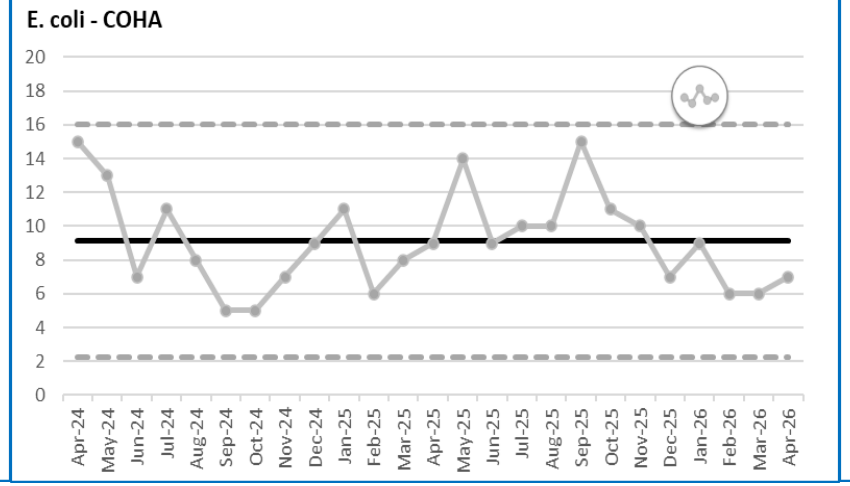
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

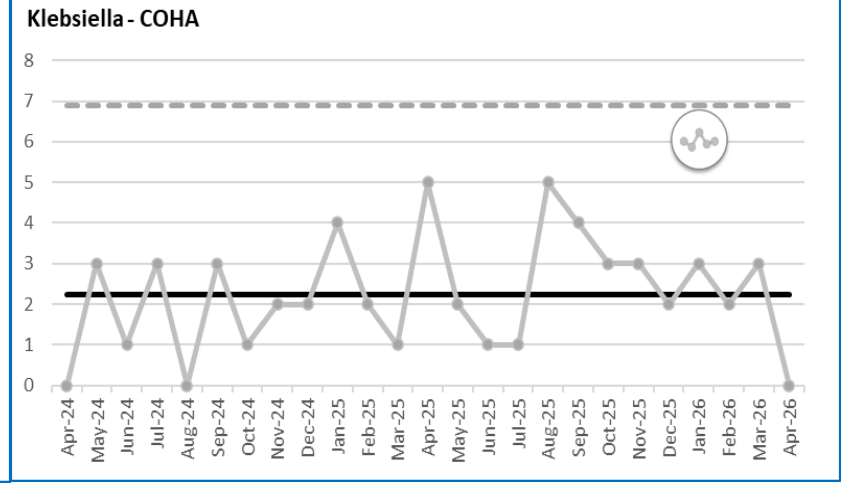












Moving to EXCELLENCE

Infection prevention and control

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:
In April 2026 there were the following bacteraemia:

- 10 C. diff cases (6 HOHA, 4 COHA)
- 0 MRSA Bacteraemia
- 5 MSSA Bacteraemia (3 HOHA, 2 COHA)
- 15 E. coli Bacteraemia (8 HOHA, 7 COHA)
- 0 Klebsiella Bacteraemia
- 1 Pseudomonas Bacteraemia (1 HOHA, 0 COHA)

Recovery actions:

- C. diff action plan ongoing. Deep clean programme commenced T9 5th May, S27 due to start w/c 11th May
- All targets for HCAIs 2025/26 breached
- Business case to move forward with Fidaxomicin as first line treatment of C. diff is being presented at ICB "Hard decisions group". 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
- Reportable bacteraemia reduction action lan to be written by IPC lead nurse which will cover actions intending to reduce MRSA, MSSA, E.coli, Pseudomonas and Klebsiella bacteraemia's, this will include work on management of IV access devices and Urinary catheters
- Working with Orthopaedics and SACC division to further reduce SSI rates in Fractured Neck of Femur surgery after being identified as high outliers in SSI annual report (UKHSA) for 2024/25. Rates already decreased (1.2% at RSH and 0.7% at PRH over last 4 completed quarters vs national average of 0.8%).

Anticipated impact and timescales for improvement:

Deep clean programme commenced, will be conducted on a rolling bay by bay basis encompassing estates jobs to ensure maximum effectiveness.

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.

Moving to EXCELLENCE

Infection prevention and control

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:
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- 0 Klebsiella Bacteraemia
- 1 Pseudomonas Bacteraemia (1 HOHA, 0 COHA)

Recovery actions:

- C. diff action plan ongoing. Deep clean programme commenced PRH completed T9 and T7, T11 due to complete WC 08/06/26, RSH programme slower due to being larger and needing more estates works, S27 due to complete WC 08/06/26, S23 to commence 09/06/26.
- Business case to move forward with Fidaxomicin as first line treatment of C. diff is being presented at ICB "Hard decisions group". 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
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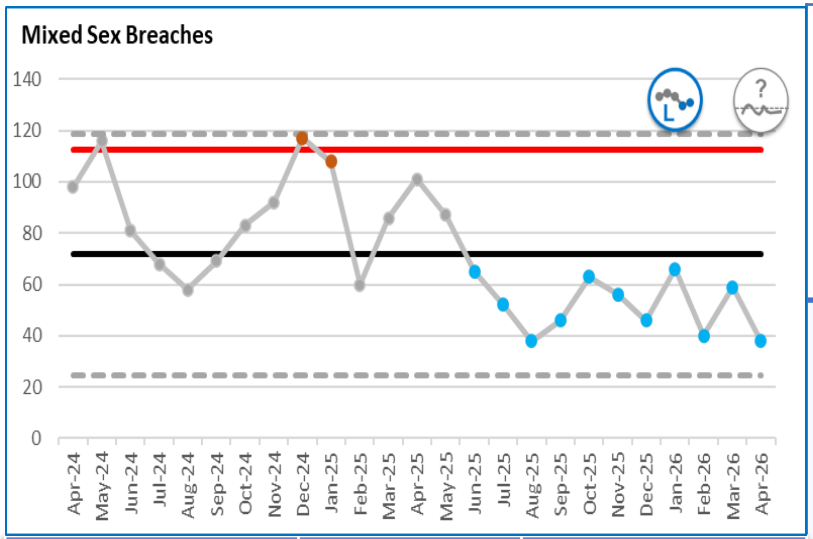
Mixed sex accommodation breaches

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



Location	Number of breaches	Additional Information
ITU / HDU (PRH)	7 primary	6 Medical, 1 Cardiology
AAU (RSH)	12	over 3 occasions
ITU / HDU (RSH)	19 primary	3 Medical, 10 Surgical, 1 Urology, 3 Gastro, 2 T&O

Summary:
The total breaches across the Trust reflect a low special cause improving variation, April 2026 reflected a decrease in mixed sex breaches compared to the previous month. The decrease reflected a reduction within both AAU (RSH), and across Critical Care areas at both hospitals.

The 12 breaches across the acute floor, and 26 breaches within Critical Care occurred due to capacity pressures across the site.

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, 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 Apley beds (PRH) in February 2026.
- Extended Discharge Lounge hours (07:00 to 22:00) from January 2026

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
- The March sprint in March 2026 to support ED transfers.
- Clinician at the front door trial (ED, PRH) March to May 2026.

Recovery dependencies:

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

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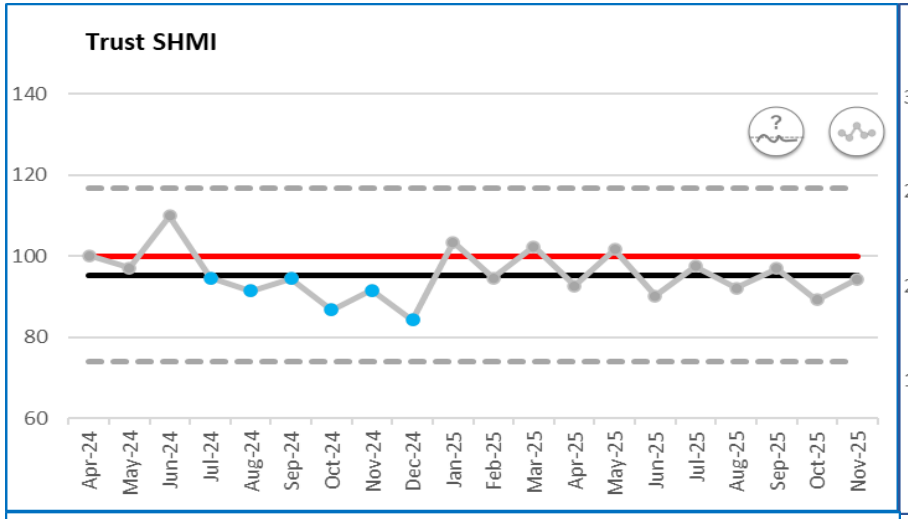
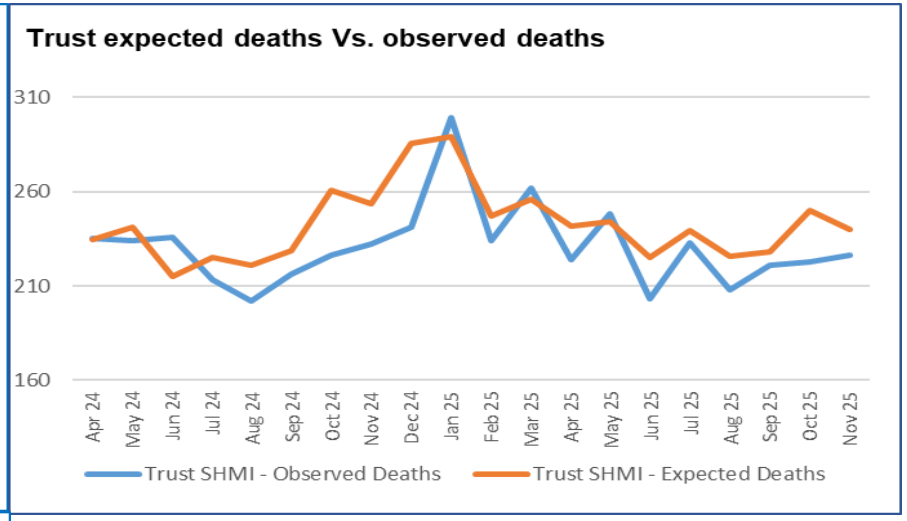
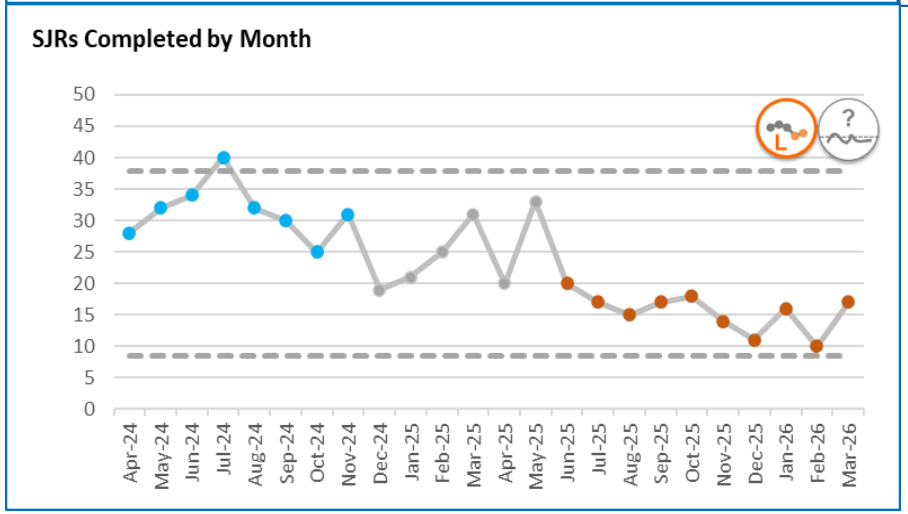
Mortality outcome data







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

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Mortality outcome data

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

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.

Moving to EXCELLENCE

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

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

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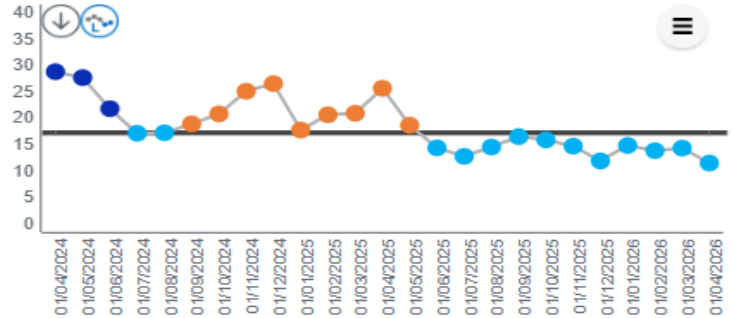
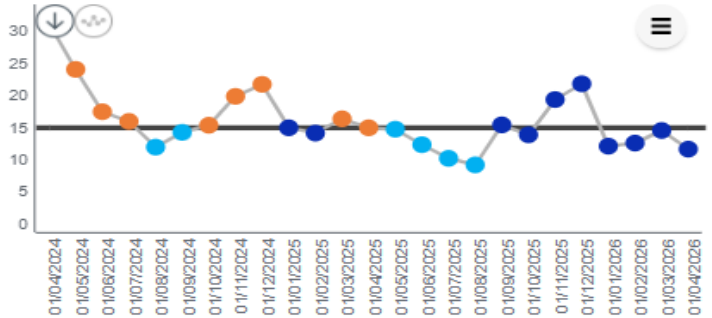
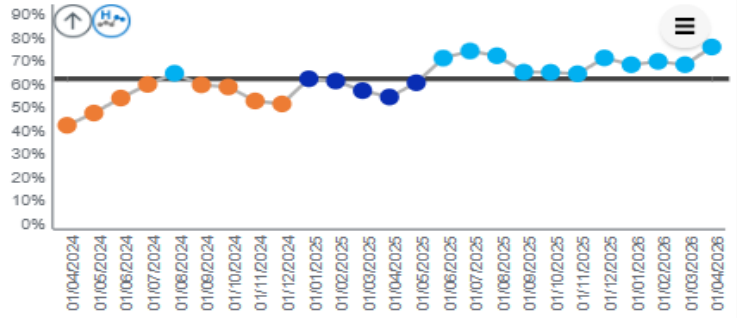
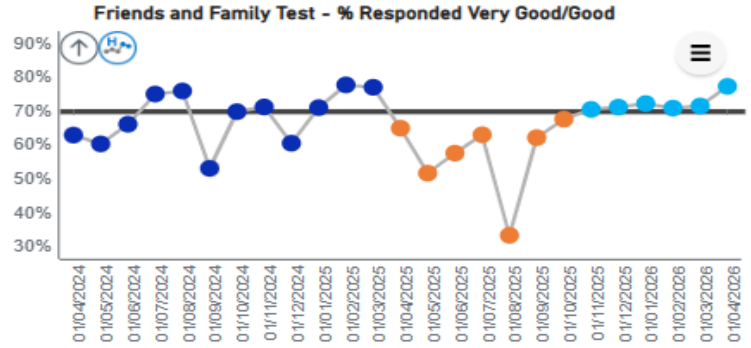
Best Clinical Outcomes

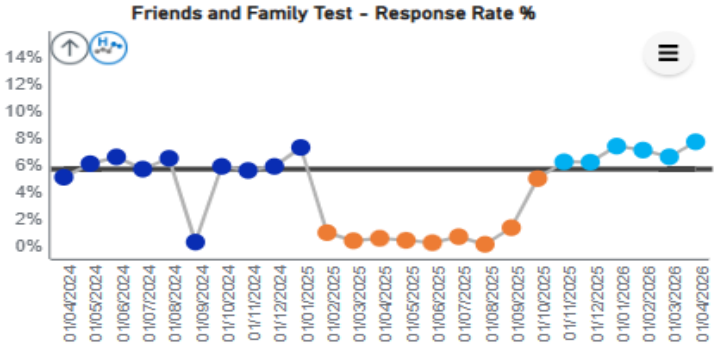
	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026
ED Triage Average Time To Streaming - Adults	17.72	20.63	20.91	25.67	18.65	14.33	12.73	14.51	16.48	15.86	14.67	11.85	14.79	13.81	14.29	11.44
ED Triage Average Time To Streaming - Children	15.00	14.17	16.40	15.00	14.79	12.37	10.25	9.23	15.46	13.91	19.40	21.85	12.14	12.62	14.58	11.68
% Patients seen within 15 minutes for initial assessment	62.40	61.49	57.31	54.58	60.71	71.30	74.36	72.31	65.30	65.21	64.58	71.37	68.46	69.89	68.48	76.07
Friends and Family Test - A&E - % responded Very Good/Good	71.00	77.70	77.00	64.94	51.67	57.58	63.00	33.33	62.15	67.60	70.47	71.14	72.20	70.86	71.47	77.28
Friends and Family Test - A&E - Response Rate %	7.30	1.00	0.40	0.58	0.43	0.25	0.70	0.14	1.37	5.00	6.24	6.21	7.40	7.11	6.61	7.72
Complaints by Theme - Admission / Discharge	14	18	20	25	16	18	25	27	16	19	23	24	34	27	26	25

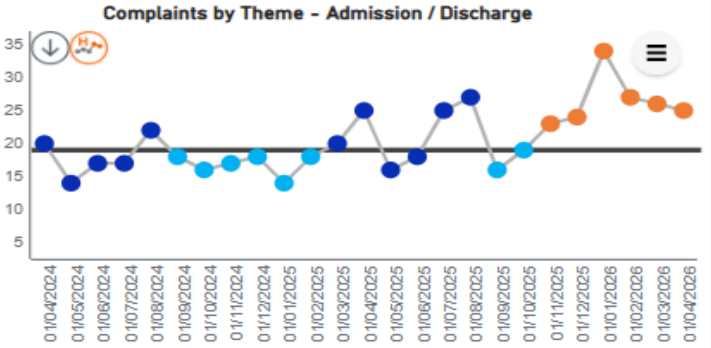












Moving to EXCELLENCE

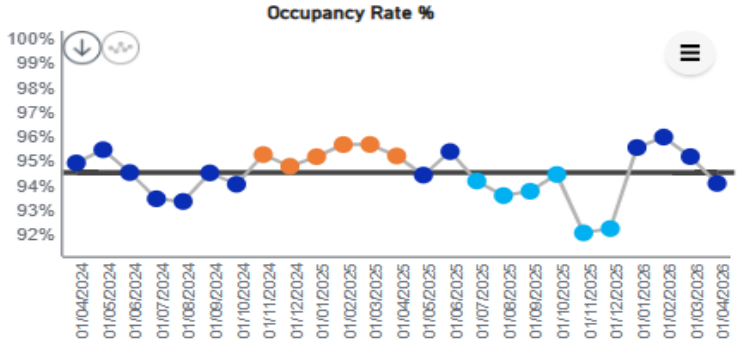
Quality - Effective - Right Care, Right Place, Right Time

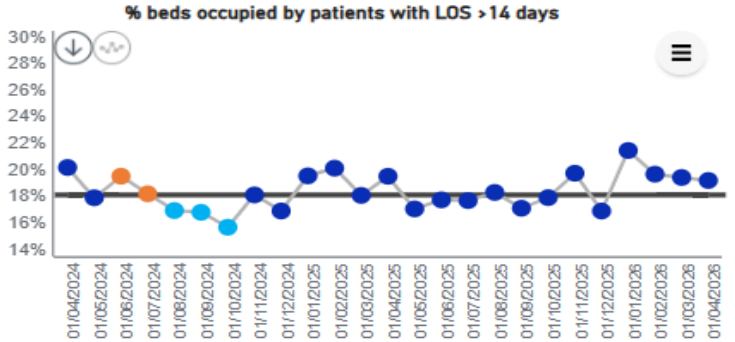
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

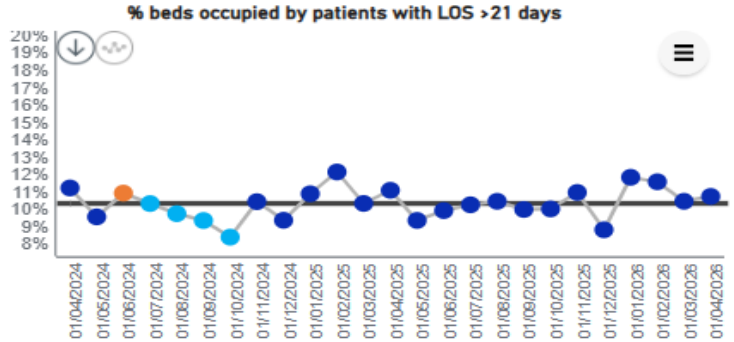
Page 1

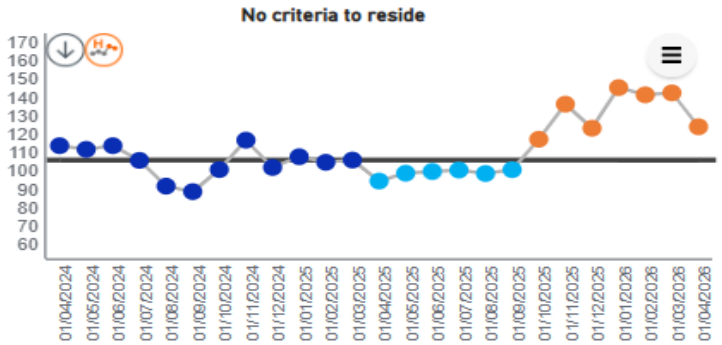
Best Clinical Outcomes

	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025
Occupancy Rate %	94.95	95.49	94.55	93.48	93.37	94.54	94.08	95.29	94.81	95.20	95.69	95.70	95.23	94.45	95.41	94.21	93.61
% beds occupied by patients with LOS >14 days	20.16	17.88	19.50	18.18	16.92	16.78	15.66	18.09	16.88	19.53	20.11	18.06	19.50	17.04	17.72	17.67	18.28
% beds occupied by patients with LOS >21 days	11.24	9.57	10.94	10.34	9.75	9.36	8.40	10.45	9.37	10.90	12.16	10.34	11.10	9.36	9.93	10.26	10.47
No criteria to reside	114	112	114	106	92	89	101	117	102	108	105	106	95	99	100	101	99









Diabetic foot

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

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 has increased in the foot clinic due to staffing issues. This is an increased duration (4.7% within 72 hours and 59.4% within 13 days down from 80.9% last month) More than 70% of new ulcers should receive first expert assessment within 0-13 days by 2026 – we have not achieved this, this month).
Increases patient numbers and staffing issues have meant reduction of Podiatry ward visits and inability to see urgent referrals – who have been signposted to A & E instead.

Recovery actions:

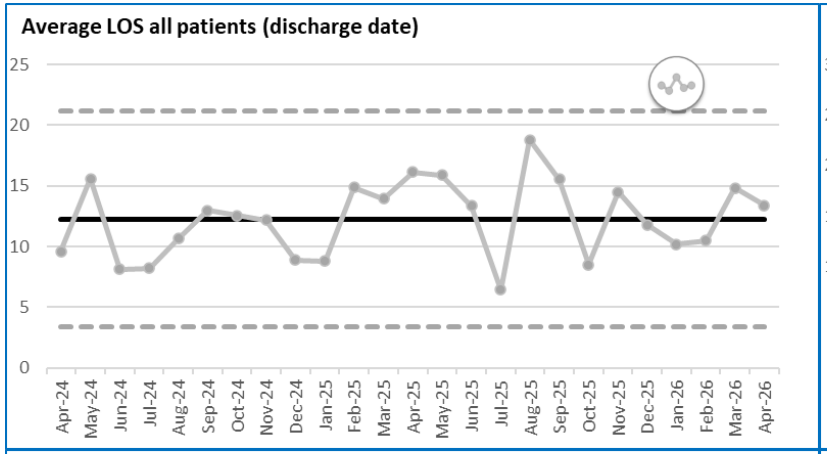
- Heel offloading available on ward – Heel boot available to order on wards – complete
- Hot clinics introduced for A&E and UCC for quick access to multidisciplinary team (MDT) clinic
- New online documentation for admissions - has been taken through the document group, this will lead to easier audit and targeted ward education
- 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
- Monthly minor and major amputation statistics for people with diabetes complete
- Introduction of mirrored cards for all necessary staff with Achiles tool – In process
- New NHS England QOF indicator (DM037) require all GP surgeries to complete all 8 care processes including foot screening. This will be incentive for GPs not currently undertaking this March 26
- Due to increased demand and staffing issues a Business case is needed for a further Podiatrist (In process)

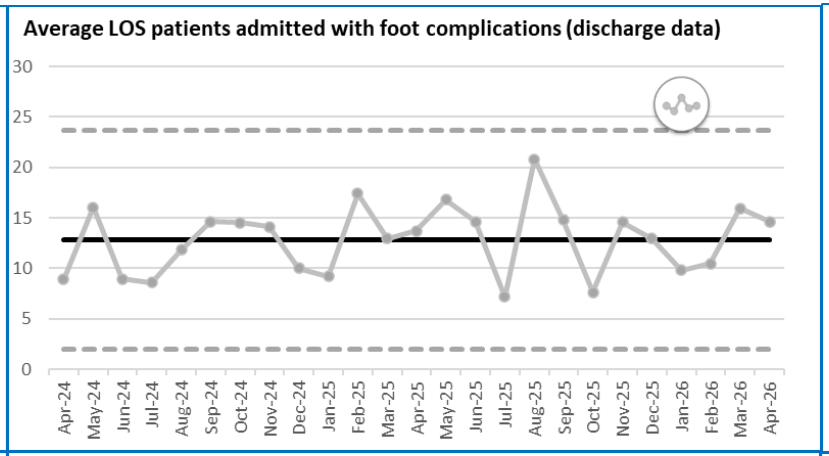
Anticipated impact and timescales for improvement:
Business Case agreed. Staff in post (Nov 2025) since then there has been increased demand that is now not being met. Requires further business case.
Reaudit of inpatient data to show anticipated improvement in statistics nearing NICE guidance standards July 2026
Root Cause analysis of all diabetes foot amputations highlighting gaps in care and areas of improvement July 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

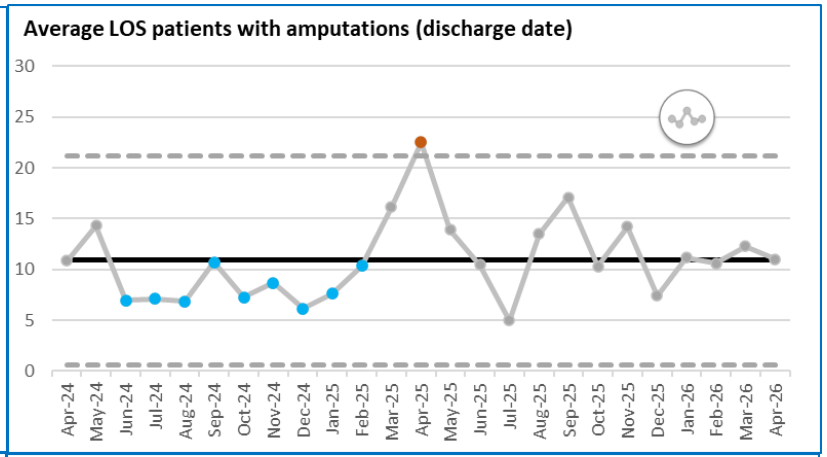
Recovery dependencies:	Ownership of new documentation and education for diabetes foot at ward and matron level Diabetes foot screening must be undertaken in primary care, foot protection in community reducing clinical need in Acute service

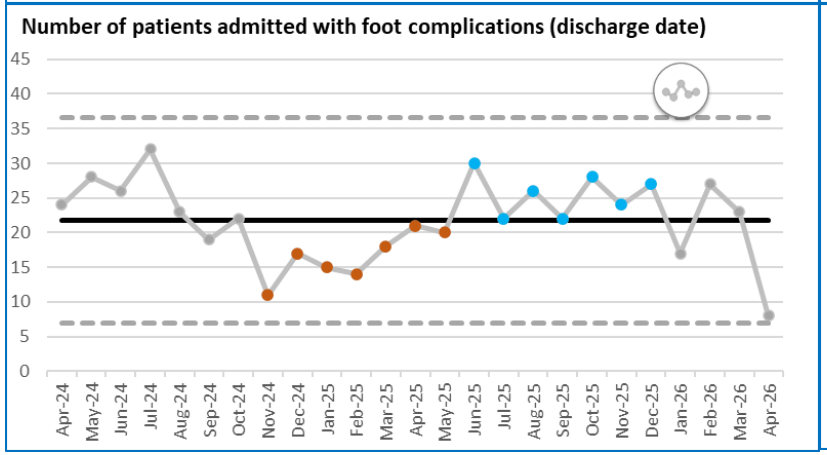
Diabetic foot

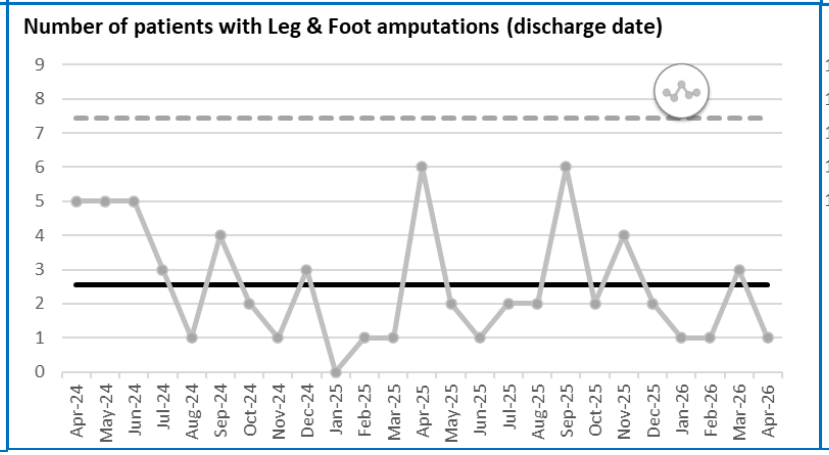
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

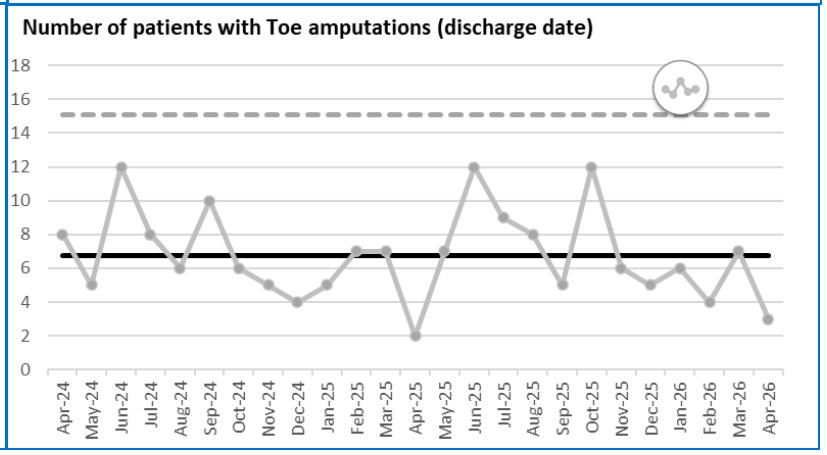












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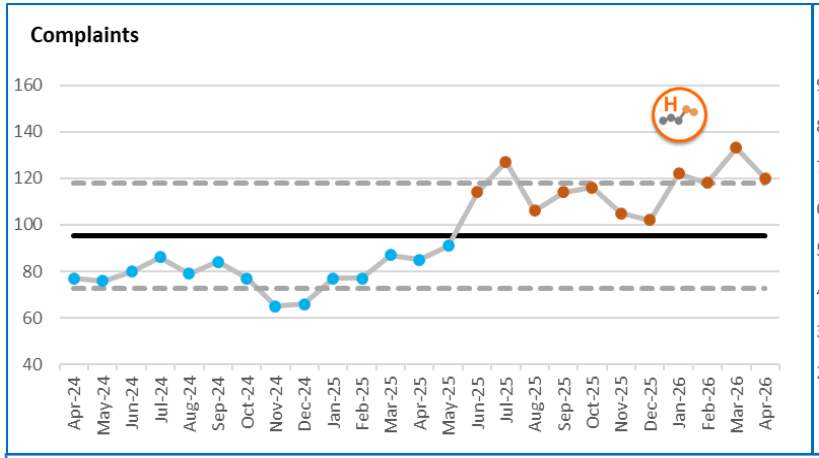
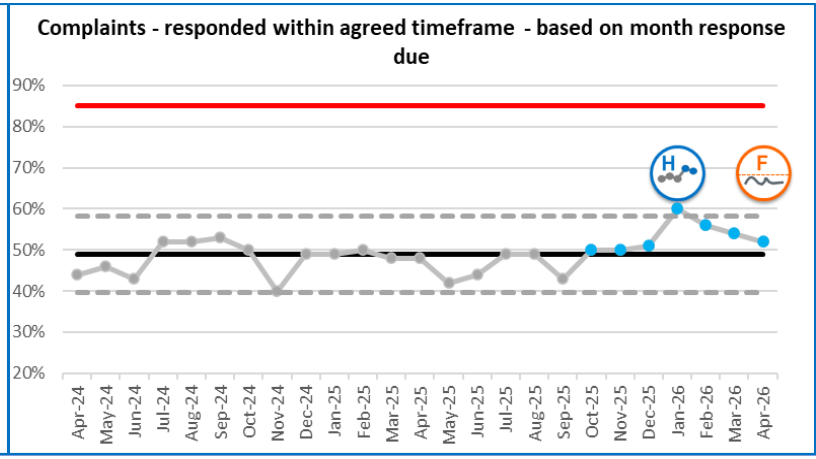
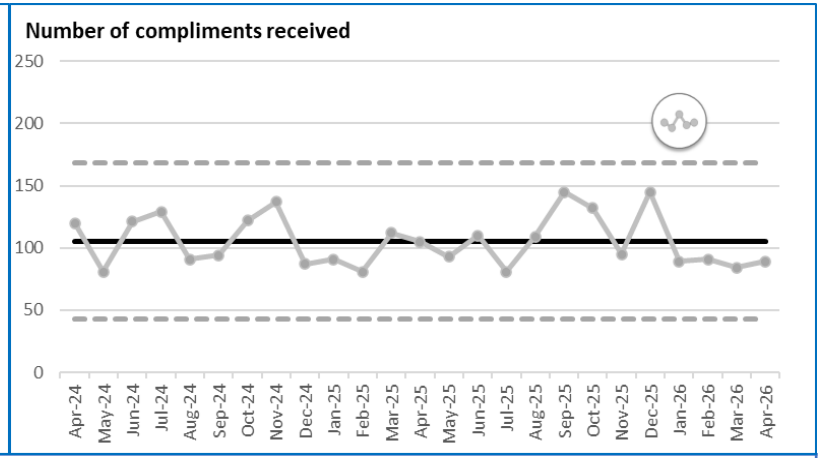
Complaints and compliments

Shropshire, Telford and Wrekin Community and Hospitals NHS Group







Summary:
The Trust continues to receive higher numbers of new complaints. The Complaints Team is working closely with the Divisions to manage this increase and to ensure responses are sent in as timely a way as possible, although this is challenging with the numbers of new cases. Work remains ongoing to improve response rates, and the improvement in reducing the amount of time that cases remain open for continues.

Recovery actions:	**Anticipated impact and timescales for improvement:**
Dashboards on Datix give greater visibility of open cases for specialties. Weekly complaints review meetings with Divisional and Specialty Teams. Fast-track process to be rolled out further.	Further improvement in timeliness of responses. Evidence of early involvement and support from divisions/ specialities with complainants.

Recovery dependencies:	Continued high levels of numbers are leading to delays in responses from specialties as they manage this increase. The PALS team continue to have significant staffing challenges which will impact on the ability to deal with issues before they become a formal complaint; the team are working on ways to manage this.

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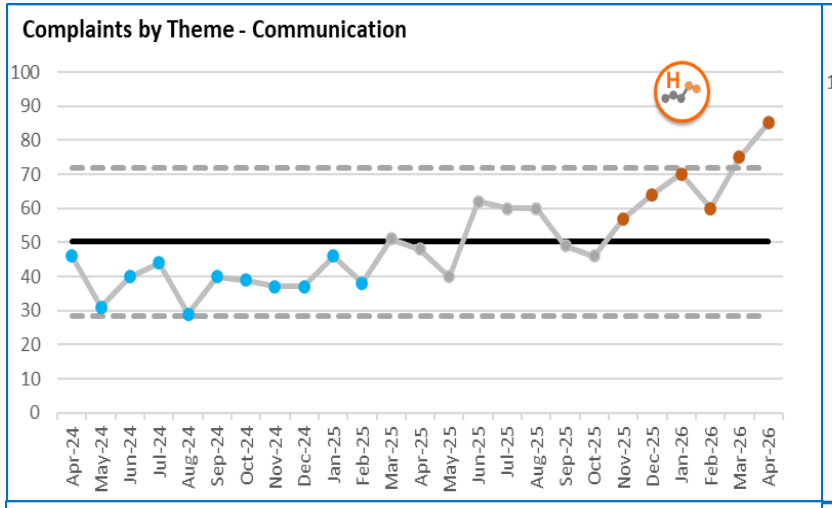
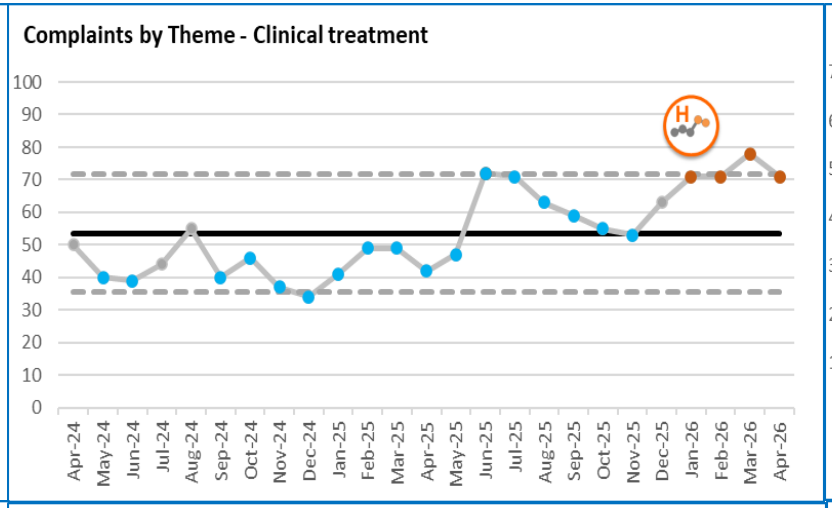
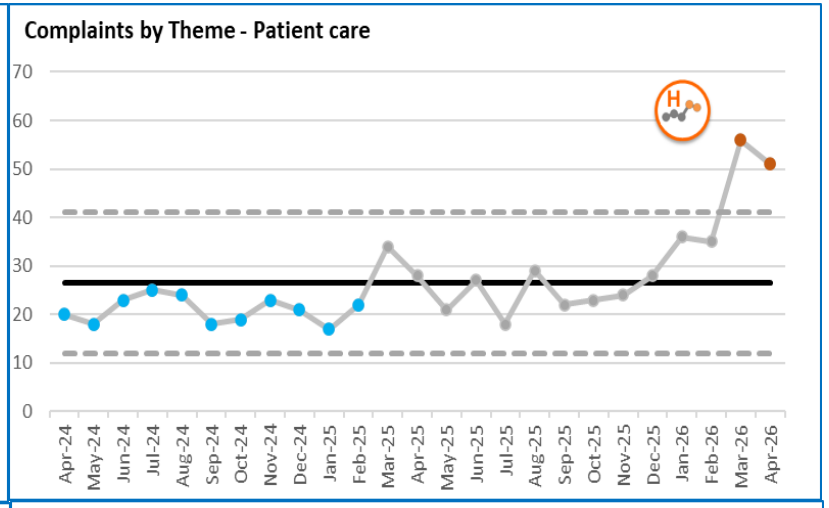
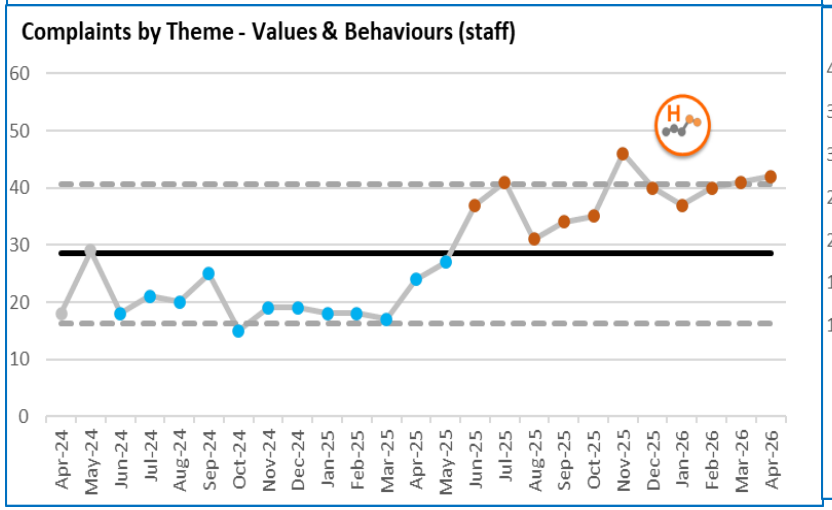
Complaints by theme – Top 6

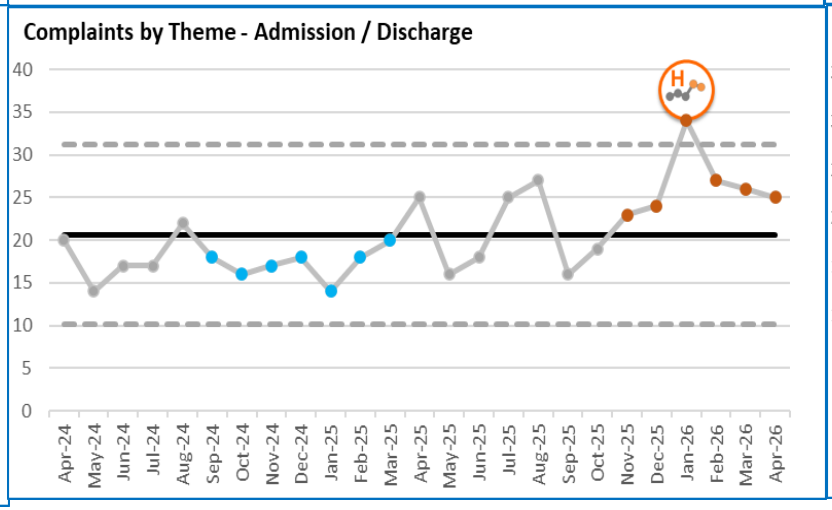
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

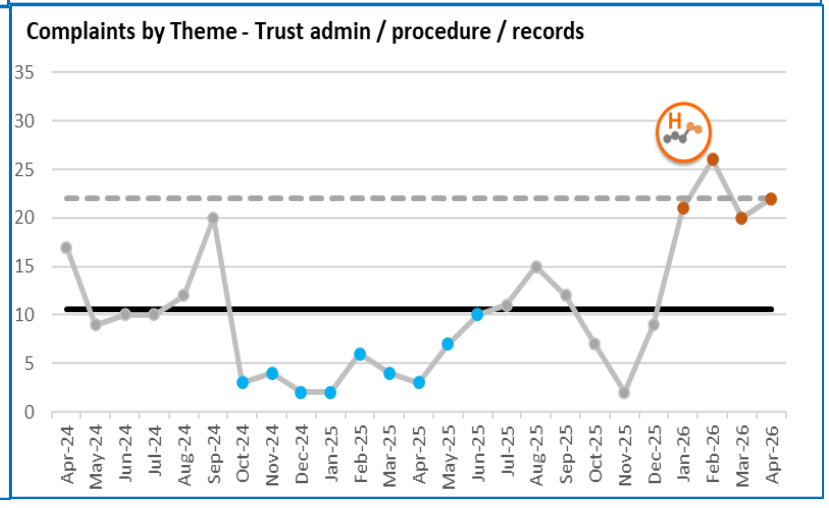












Moving to EXCELLENCE

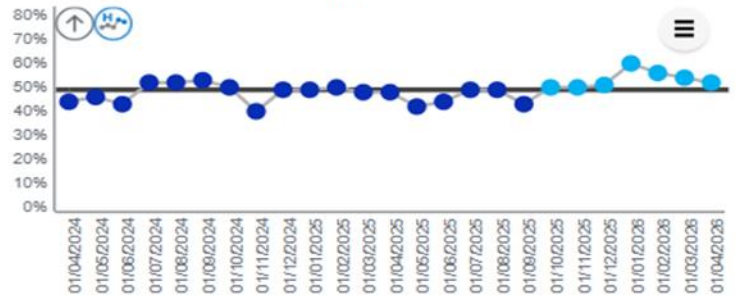
Quality - Patient Experience - Learning from Experience

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

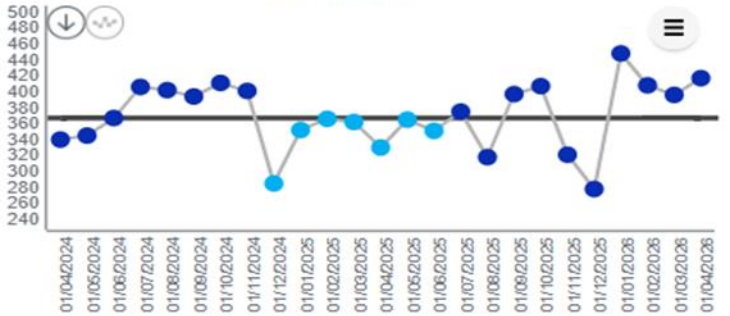
End of Life Care

	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026
Complaints - % Responded to within agreed timeframe based on month response due	48	48	42	44	49	49	43	50	50	51	60	56	54	52
PALS contacts	362	330	365	351	375	318	397	407	321	278	448	408	396	417
Complaints by Theme - Staff	76	79	78	115	108	106	91	89	113	121	124	114	133	137
Re-opened complaints upheld	0	0	0	0	1	0	1	0	0	0	0	0	0	0
Compliments Received	112	105	93	110	81	109	145	132	95	145	89	91	84	89
Friends and Family Test % recommenders	97.6	97.1	93.2	96.8	88.3	92.4	79.8	73.7	77.1	76.1	76.0	75.0	75.4	80.3

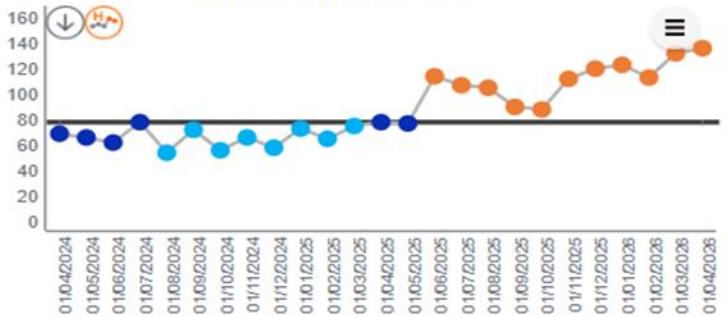
Complaints - % Responded to within agreed timeframe based on month response due



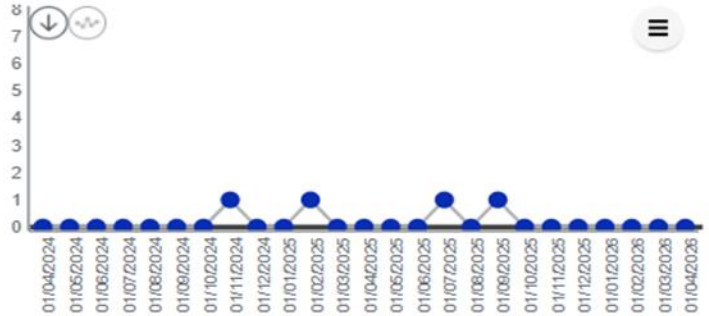
PALS contacts



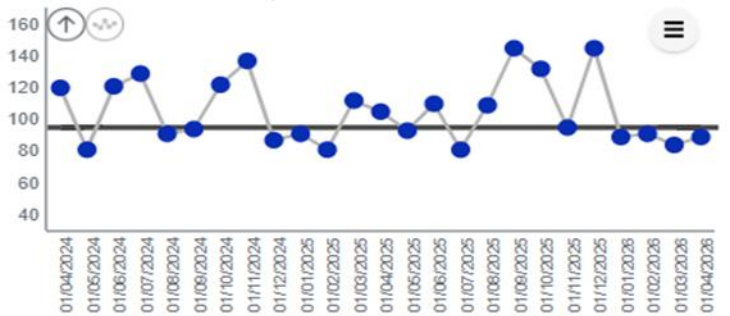
Complaints by Theme - Staff



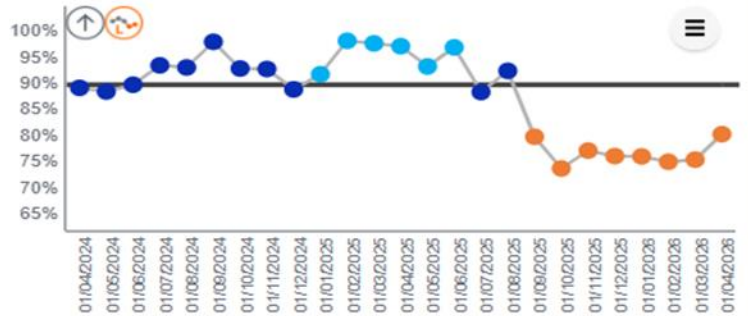
Re-opened complaints upheld



Compliments Received



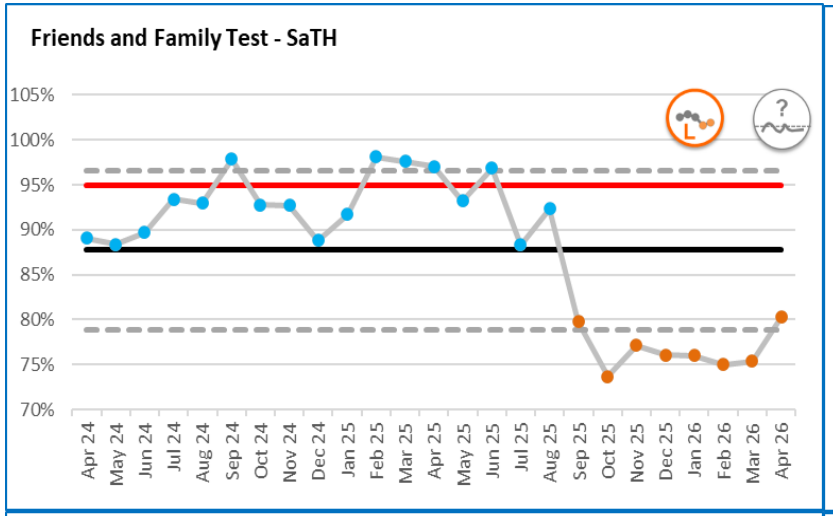
Freinds & Family Test % recommenders

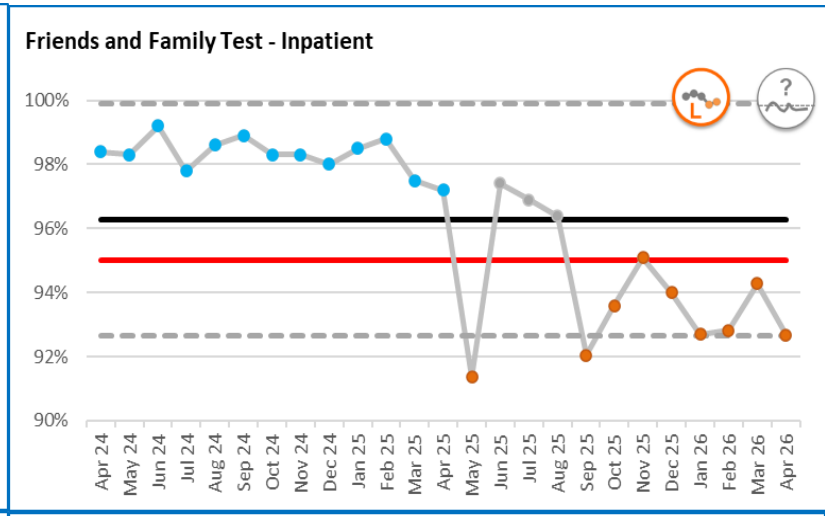


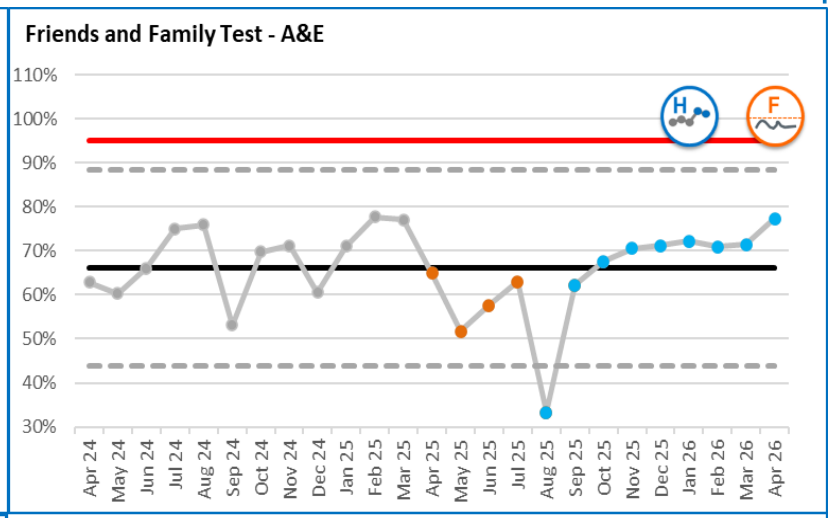
Moving to EXCELLENCE

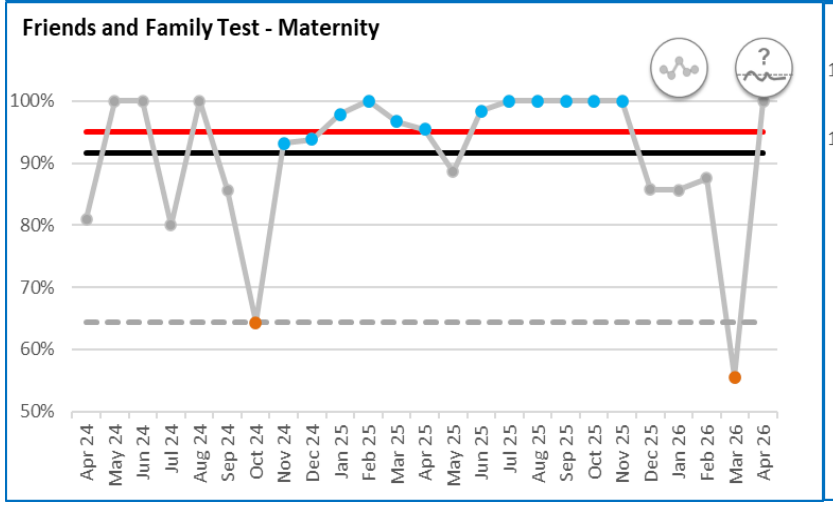
Friends and family test

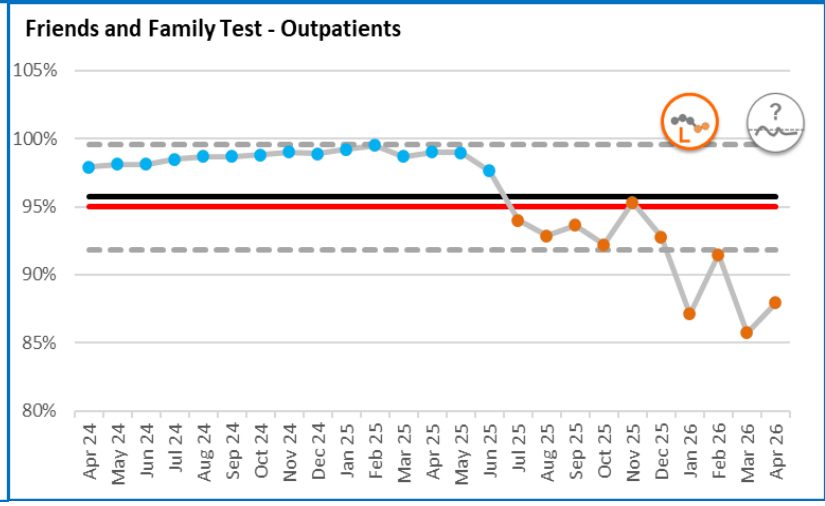
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

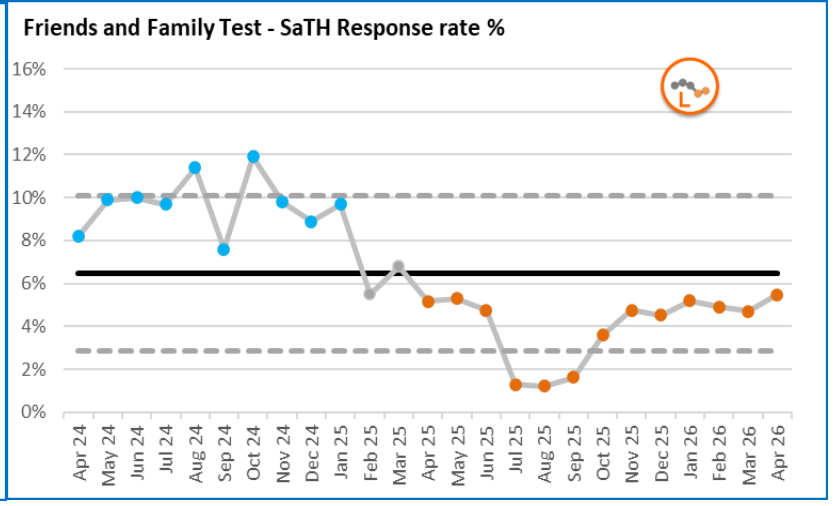








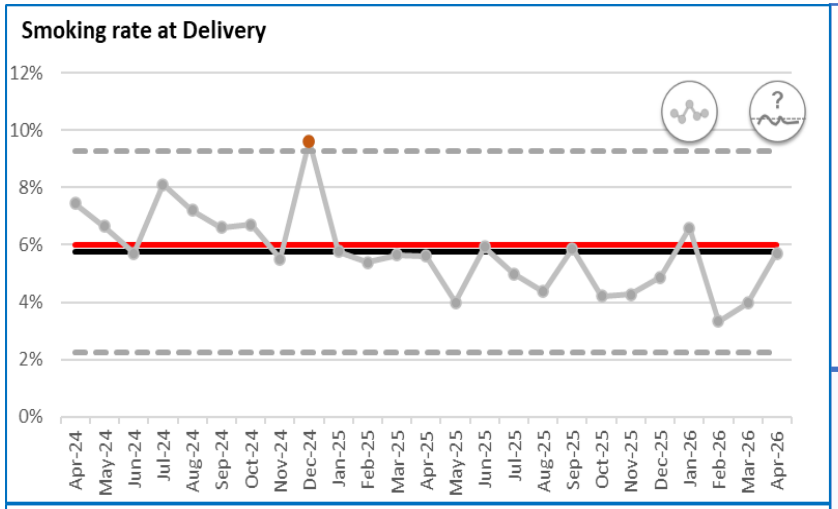


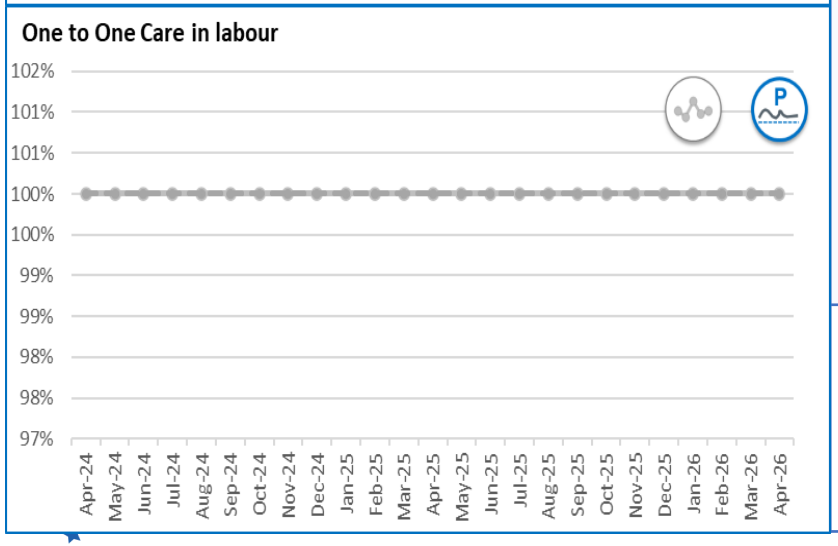


Moving to EXCELLENCE

Maternity

Shropshire, Telford and Wrekin Community and Hospitals NHS Group





Summary:
April data has risen slightly to 5.7% This is still below Government target of 6%
The overall SATOD rate for 2025/26 is 4.8%
This was a huge achievement for the Healthy pregnancy support service (HPSS) and the Trust as a whole.
This was the first time SATOD rates exceeded Government target of 6% and we saw a further decrease from last years SATOD of 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 into 2026/27.

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.

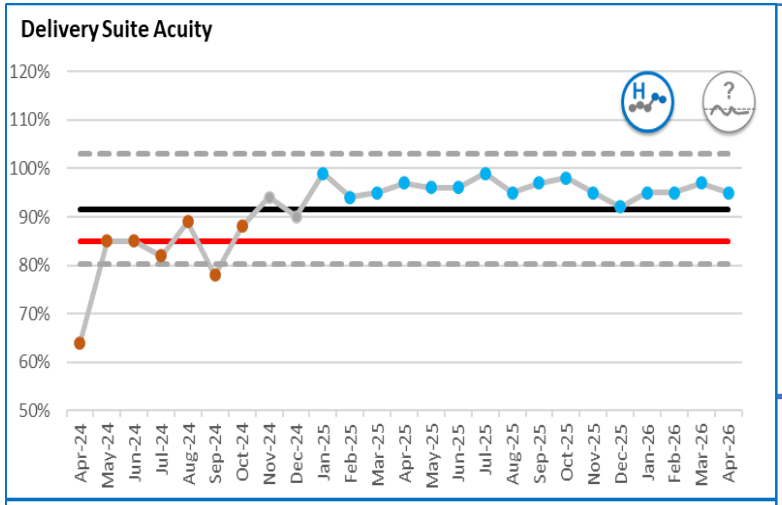
Anticipated impact and timescales for improvement:
Continue to target areas of deprivation and refer family members to local smoking cessation services. The biggest barrier to pregnant women quitting smoking is having a partner who smokes.
As per Saving Babies Lives, all Maternity staff are trained to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

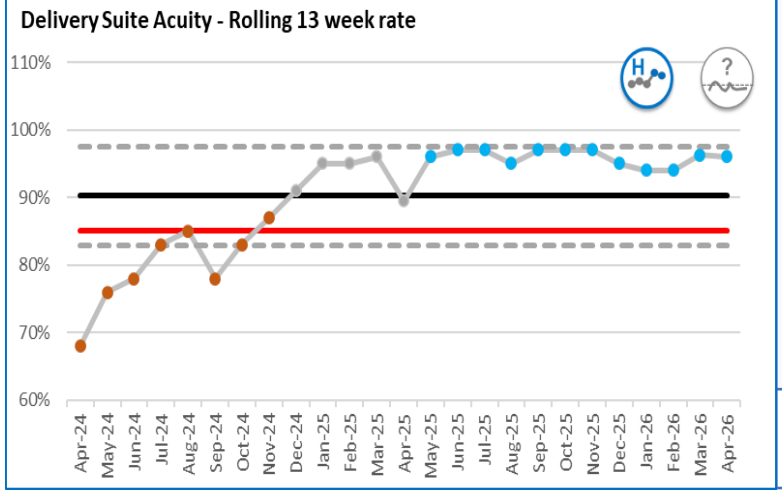
Recovery dependencies:	The local demographic has a higher-than-average deprivation index with increased unemployment and complex social needs, which is linked to higher rates of tobacco dependence. However, SaTH figures are now exceeding Government targets, which demonstrates the value of the HPSS model,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

Moving to EXCELLENCE

Maternity – delivery suite acuity

Shropshire, Telford and Wrekin Community and Hospitals NHS Group





Summary:
Delivery suite acuity continues to be maintained above the National target above 85% and has been consistently above 90% for the last 12 months with March acuity reported at 96%. We are seeing improvements in unavailability related to sickness; however, parenting leave remains high (>23 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.

Moving to EXCELLENCE

Quality - Patient Experience - End of Life Care

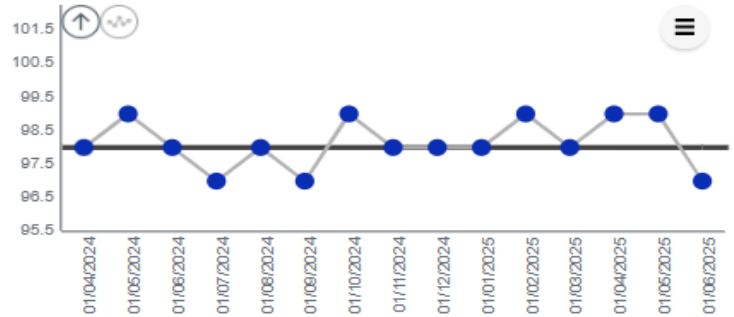
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Page 2

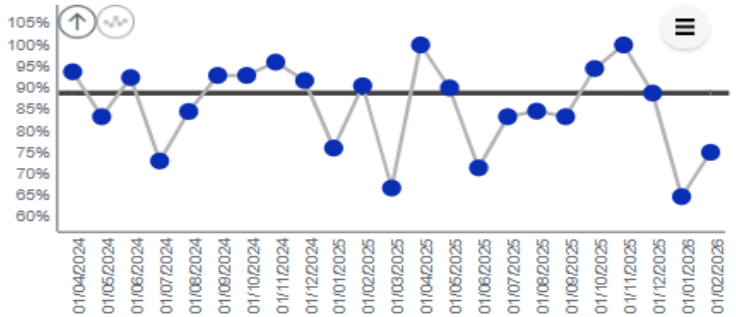
Learning from Experience

	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	Jan-2026	Feb-2026
Palliative and End of Life Care - Audit Score % Score	99	98	98	98	99	98	99	99	97								
% Overall rating of the PEoLC - Outstanding	92.9	96.0	91.7	76.0	90.5	66.7	100.0	90.0	71.4	83.3	84.6	83.3	94.5	100.0	88.8	64.7	75.0
PPOC Discussion - total number	96	109	92	131	79	98	102	98	88	124	88	88	97	95	95	95	122
PPOC Achieved - total number	87	101	89	124	75	95	94	86	80	119	79	83	89	84	89	95	108
% Felt their loved one was comfortable in last days	68.8	92.0	58.3	68.0	95.2	60.0	100.0	90.5	61.5	86.7	85.7	58.8	0.0		80.0	70.6	72.0
Palliative/End of Life Care - Nursing QA Audit	262	256	195	215	207	207	253	262	244								

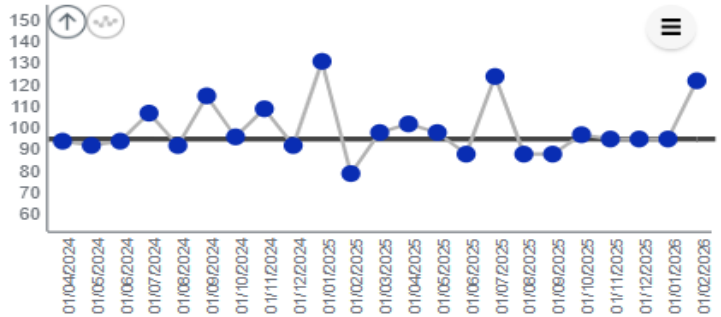
Palliative and End of Life Care - Audit Score % Score



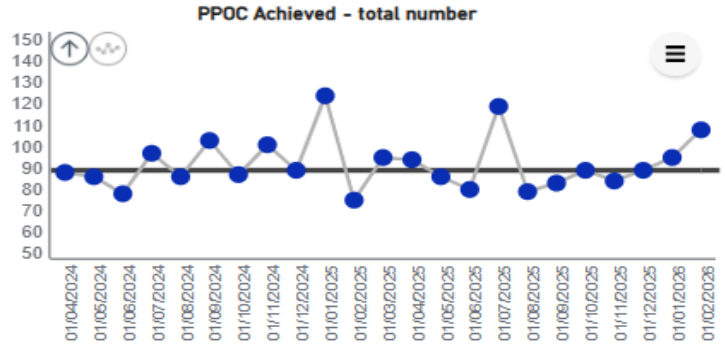
% Overall rating of the PEoLC - Outstanding



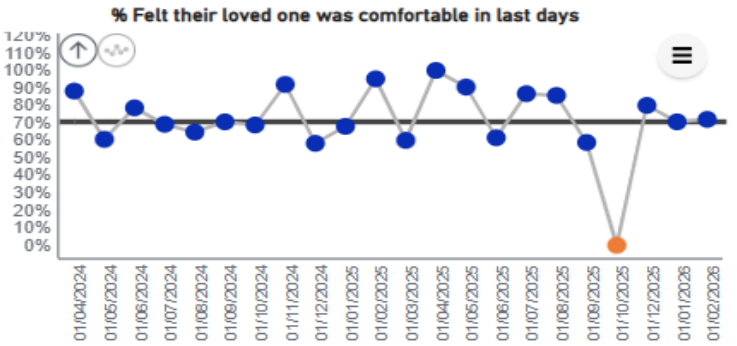
PPOC Discussion - total number



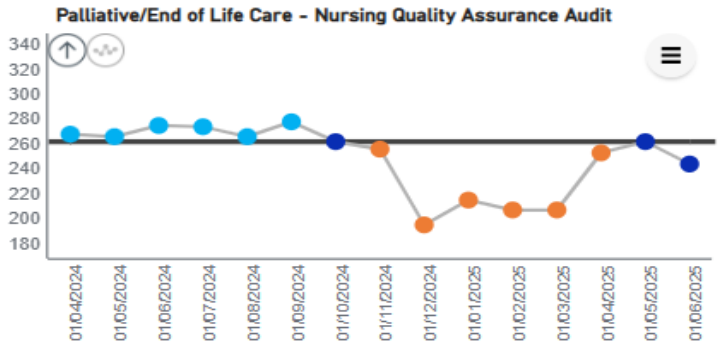
PPOC Achieved - total number



% Felt their loved one was comfortable in last days



Palliative/End of Life Care - Nursing Quality Assurance Audit



Moving to EXCELLENCE

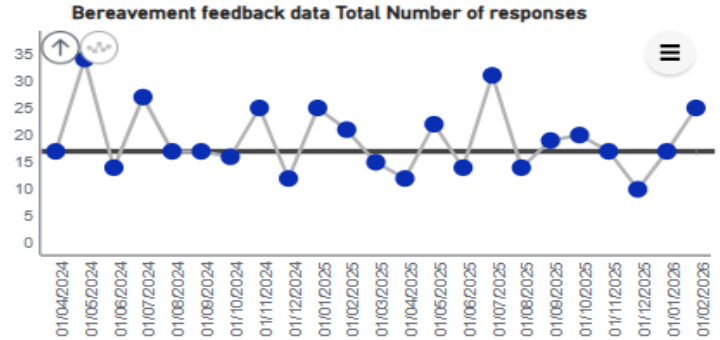
Quality - Patient Experience - End of Life Care

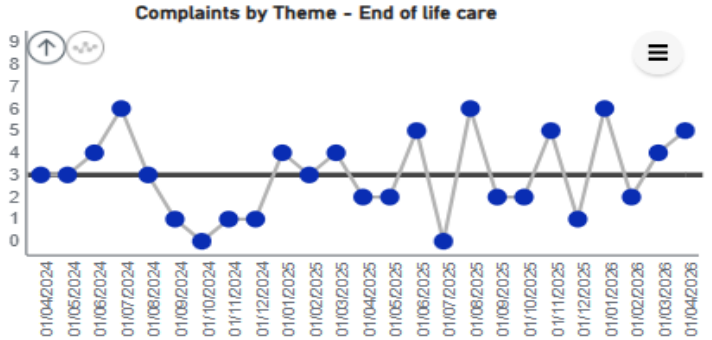
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

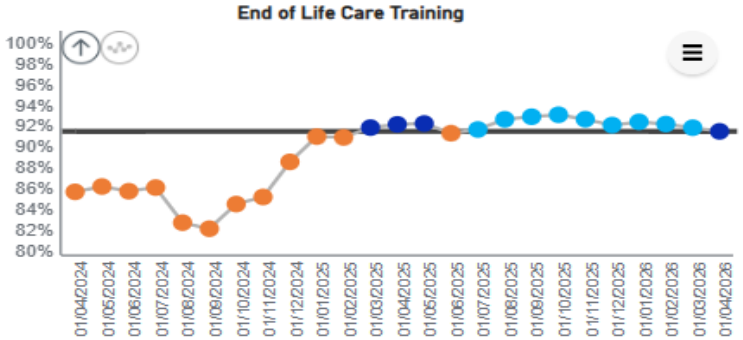
Page 1

Learning from Experience

	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	Jan-2026	Feb-2026	Mar-2026	Apr-2026
Bereavement feedback data - Total Number of responses	12	25	21	15	12	22	14	31	14	19	20	17	10	17	25		
Complaints by Theme - End of life care	1	4	3	4	2	2	5	0	6	2	2	5	1	6	2	4	5
End of Life Care Training	88.61	91.03	90.95	91.89	92.20	92.28	91.35	91.71	92.68	92.93	93.12	92.69	92.13	92.44	92.23	91.88	91.53







End of life

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

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: 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.	**Anticipated impact and timescales for improvement:** Ongoing monitoring via PEOLC Steering Group to ensure improvements are sustained
Recovery dependencies:	N/A

Moving to EXCELLENCE

Mental health training

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

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

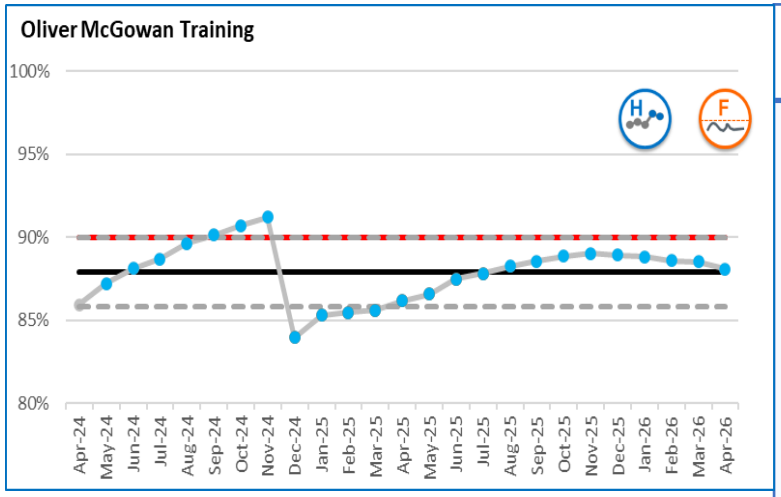
Recovery dependencies:

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

Moving to EXCELLENCE

Learning disability and/or Autism

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



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

Recovery actions:

- Oliver McGowan e-learning training is at 88.6%
- A Trust wide plan for delivery of the T1 and 2 training is now in place with plans to provide training for 3,000 staff in 2026/27
- LD and Autism Patient Experience Group now meeting regularly with good attendance and outputs including launch of patient packs for emergency attenders containing sensory items and easy read information
- 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
- Reasonable Adjustment Digital Flag implementation plan underway
- Full review and update of the LD policy has been completed
- LD Self Improvement Tool completed and associated improvement plan being actioned
- Targeted improvement work underway within ED
- LD and Autism Improvement Group planned to be joint with SCHT from Q1
- Group pledge poster co-produced at the patient experience group to be displayed in clinical areas

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.

Moving to EXCELLENCE

Responsiveness

Executive Lead:

Chief Operating Officer
Ned Hobbs

Integrated Performance Report

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Domain	Description	National Standard / Plan	Current Month Trajectory (RAG)	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Trend
Responsiveness	ED - 4 Hour Performance (SaTH Type 1 & 3) %	65.42% Mar'27	60.2%	49.3%	53.1%	52.7%	52.1%	53.8%	54.2%	53.6%	52.0%	51.3%	51.9%	52.8%	56.6%	52.9%	
	ED - 4 Hour Performance (All Types inc MIU) %	70.93% Mar'27	66.9%	59.0%	62.4%	62.8%	61.1%	63.4%	62.7%	61.7%	60.1%	60.1%	60.8%	61.5%	65.0%	62.4%	
	ED - 4 Hour Performance (SaTH Type 1) %	59.01% Mar'27	53.1%	42.1%	45.7%	45.4%	45.6%	45.6%	46.3%	45.5%	43.8%	43.2%	43.9%	45.1%	49.1%	44.8%	
	ED - 4 Hour Performance (SaTH Type 3) %	90%	90.0%	79.1%	83.4%	85.5%	80.9%	87.6%	87.1%	85.9%	83.7%	85.9%	85.4%	86.0%	91.7%	90.6%	
	ED - Paediatric 4 Hour Performance (SaTH Type 1 & 3) %	87% Mar'27	85.1%	74.6%	81.4%	85.1%	83.5%	86.6%	84.6%	78.9%	75.2%	82.2%	81.7%	81.0%	84.6%	80.6%	
	ED - 12 Hour Trolley Breaches	0	0	1379	1334	1407	1300	1492	1618	1453	1429	1601	1366	1173	1026	949	
	Number of Ambulance Arrivals	-	3580	3489	3335	3484	3392	3041	3210	3221	3373	3294	3103	3412	3371	3473	
	Average ambulance handover time (ED and non-ED)	00:45:00	00:50:00	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	01:13:47	00:46:02	00:25:42	00:28:20	
	Ambulance handovers > 15 minutes	-	2685	2692	2544	2509	2557	2488	2647	2577	2691	2767	2549	2614	2103	1984	
	Ambulance handovers > 15 minutes %	-	75.0%	77.2%	76.3%	72.0%	75.4%	81.8%	82.5%	80.0%	79.8%	84.0%	82.1%	76.6%	62.4%	57.1%	
	Ambulance handovers > 45 minutes	0	1038	1127	1227	884	932	1335	1433	1332	1451	1585	1252	875	389	451	
	Ambulance handovers > 45 minutes %	0%	29.0%	32.3%	36.8%	25.4%	26.7%	43.9%	44.6%	41.4%	43.0%	48.1%	40.3%	25.6%	11.5%	13.0%	
	Ambulance handovers > 60 minutes %	0%		25.8%	29.5%	19.9%	20.7%	37.9%	37.5%	35.3%	37.1%	40.3%	33.5%	19.7%	7.1%	8.8%	
	ED activity (SaTH Type 1 & 3 excluding planned returns)	-	14282	13908	13528	13638	13230	12951	13619	13361	13569	13020	12275	14083	13805	14077	
	ED Paediatric activity (SaTH Type 1 & 3 excluding planned returns)	-	2745	2662	2492	2329	1940	2332	2415	2731	2856	2326	2370	2870	2693	2759	
	ED activity (Type 1 excluding planned returns)	-	11549	11190	10864	11143	10802	10445	10982	10683	10764	10549	9920	11446	11354	11573	
	Total Emergency Admissions from A&E	-	-	3345	3266	3322	3381	3301	3655	3614	3769	3659	3460	3838	3726	3777	
	% Patients seen within 15 minutes for initial assessment	-		60.7%	71.3%	74.4%	72.3%	65.3%	65.2%	64.6%	71.4%	68.5%	69.9%	68.5%	76.1%	72.3%	
	Average time to initial assessment (mins)	15 Mins	15	17.8	13.9	12.2	13.6	16.3	15.5	15.8	14.2	14.2	13.5	14.4	11.5	12.3	
	Average time to initial assessment (mins) Adults	15 Mins	15	18.6	14.3	12.7	14.5	16.5	15.9	14.7	11.8	14.8	13.8	14.3	11.4	12.6	
	Average time to initial assessment (mins) Children	15 Mins	15	14.8	12.4	10.2	9.2	15.5	13.9	19.4	21.9	12.1	12.6	14.6	11.7	11.2	
	Mean Time in ED Non Admitted (mins)	-	215	323	304	292	291	293	292	294	298	304	281	269	244	257	
	Mean Time in ED admitted (mins)	-	500	1165	1202	1127	1084	1227	1145	1121	1124	1213	1091	917	759	810	
	Percentages of attendances in A&E over 12 hours - Type 1	-	17.27%	23.27%	22.04%	21.75%	21.94%	23.39%	23.27%	22.36%	22.01%	24.74%	22.35%	19.03%	16.77%	16.43%	
	No. Of Patients who spend more than 12 Hours in ED - Type 1	-	1995	2604	2394	2424	2370	2443	2555	2389	2369	2610	2217	2178	1904	1901	
	Bed Occupancy Rate - G&A (SitReps)	92%	94.96%	94.45%	95.41%	94.21%	93.61%	93.79%	94.48%	92.09%	92.27%	95.57%	96.00%	95.20%	94.11%	93.81%	
	Diagnostic Activity Total - All commissioners		24333	25333	24625	26211	24973	24860	24881	22628	24080	24199	24198	26130	24016	24612	
	Diagnostic Total Waiting List - All commissioners		11085	12511	11453	12013	11471	11634	12437	12437	12256	13037	14656	16010	15471	15188	
	Diagnostic 6 Week Wait Performance %	88% Mar'27	84.5%	79.4%	82.2%	83.2%	81.8%	85.5%	86.9%	86.4%	81.7%	80.5%	86.5%	86.4%	82.6%	82.3%	
	Diagnostic 6+ Week Breaches	0	1713	2577	2039	2016	2086	1692	1632	1707	2249	2690	1978	2184	2685	2688	
	Number of episodes moved or discharged to PIFU	-	2570	2203	2633	2627	2288	2523	2488	2472	2283	2325	2335	2575	2475	2199	
	RTT Incomplete 18 Week Performance	70% Mar'27	63.6%	53.0%	54.9%	56.4%	58.8%	62.3%	64.0%	65.5%	64.1%	62.9%	63.1%	68.9%	69.1%	69.9%	
	RTT Waiting list - Total size	-	-	44005	42449	39438	37132	36022	36674	37997	36982	37910	37266	38063	38918	40316	
	RTT Waiting list - English only	-	33011	39042	37630	34742	32670	31652	32263	33621	32790	33637	33359	34275	35084	36456	
	RTT 52+ Week Breaches (All)	0	-	1592	1103	734	600	369	313	284	226	235	241	196	189	171	
	RTT 52+ Week Breaches - English only	-	0	1170	718	444	305	125	84	68	20	31	47	0	0	0	
	RTT 40+ Week Breaches (All)	-	-	6053	4757	3661	3001	2154	1741	1731	1830	1833	1769	1569	1683	1706	
	RTT 40+ Week Breaches - English only	0	-	5052	3876	2939	2318	1590	1223	1232	1330	1301	1288	1127	1208	1286	
	RTT Total Waiting <18 Weeks - English Only	0	20990	20692	20670	19581	19210	19717	20652	22018	21026	21148	21060	23615	24233	25466	
	Cancer 62 Day Standard	77% Mar'27	70.0%	63.1%	62.6%	66.6%	68.8%	65.2%	71.4%	70.2%	70.1%	68.3%	75.0%	74.5%	71.2%	-	
	Cancer 31 Day First Treatment	96%	94.0%	88.2%	87.9%	94.7%	91.6%	94.2%	96.2%	95.5%	98.0%	96.2%	99.2%	97.6%	96.4%	-	
	Cancer 28 Day Faster Diagnosis - combined	80% Mar'27	80.0%	71.4%	72.5%	75.5%	75.9%	80.1%	80.3%	85.7%	83.0%	80.2%	85.5%	86.0%	80.9%	-	
	Theatre productivity		85%	79%	80%	81%	81%	81%	80%	81%	81%	80%	81%	81%	80%	81%	

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Operational Executive Summary

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

SaTH ED - 4-hour performance (type 1 & type 3) has moved to common cause natural variation in May 26. Type 1 performance decreased to 45%, and Type 3 performance decreased to 90.7%. Average ambulance handover time shows special cause improving variation in May and was better than plan with 90.8% within 60 mins. The number of Type 1 patients who spend more than 12 hours in ED shows special cause improving variation.

RTT - The unvalidated Trust Position for May 2026: English is 0 x 104 weeks, 0 x 78 weeks, 0 x 65 weeks, 0 x 52 week (adult) and 0 x 40 weeks CYP.
The unvalidated Trust Position for Welsh is 0 x 104 weeks, 11 x 78 weeks, 52 x 65 weeks 171 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 ERF capacity is being provided during April to a range of specialties. Theatre utilisation in May 2026 is 81%.

Cancer - Confirmed April cancer performance is 80.9% (28-day FDS) vs the local plan of 80%. 62-day performance was 71.2% against a local target of 72.1% and 31 day was 96.4% against a local target of 96%. The 62-day backlog is 158 patients over 62 days of which 23 are over 104 days (as at 08/06/2026).

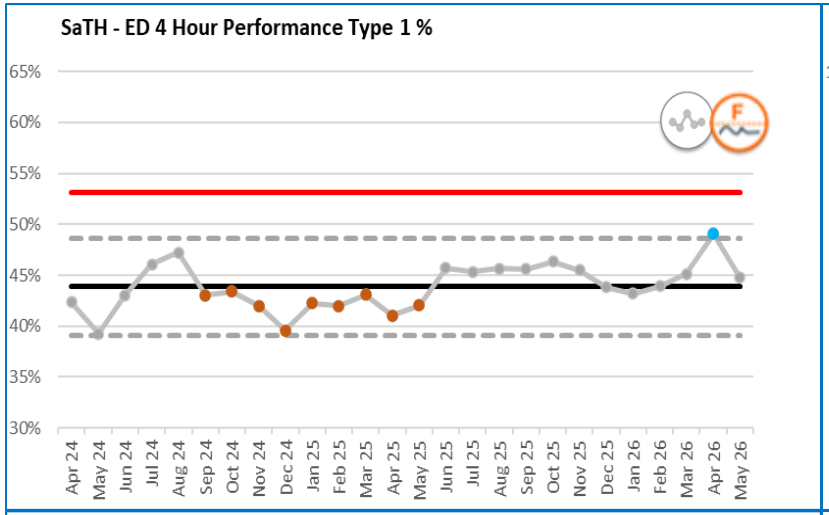
DM01 - The submitted DM01 position for May was 80.6%, improved performance in Echocardiology. NOUS has seen a deterioration in performance with a recovery plan being implemented. Radiology reporting turnaround times are being maintained. TATs from referral to report for USC are:- CT 2 weeks, MRI 2 weeks and NOUS 1-2 weeks.

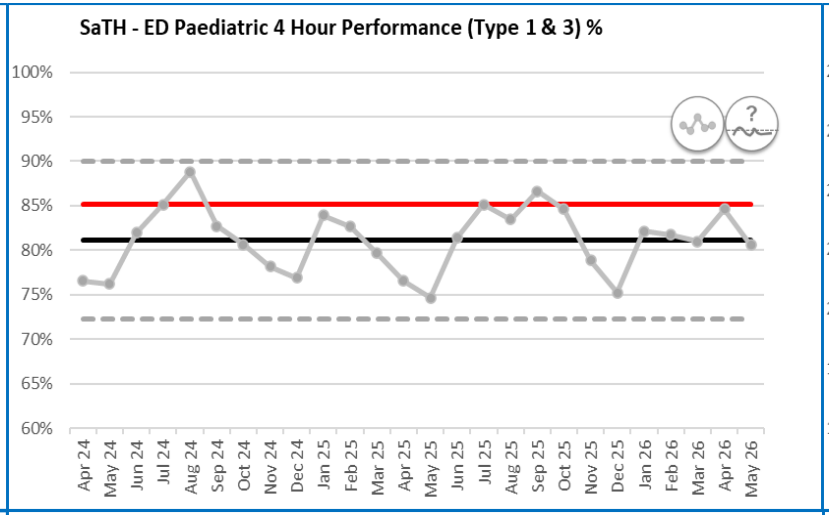
Key actions

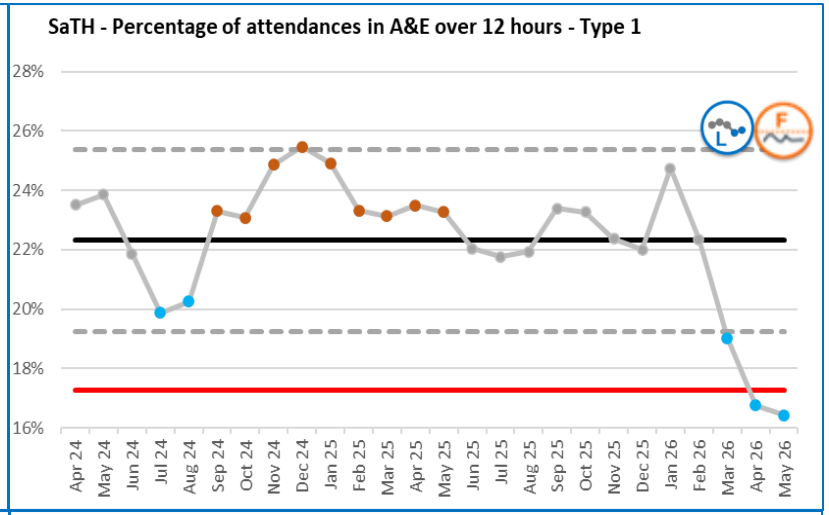
- Ambulance threshold Plan launched 45 minutes on 14th April
- March Safe and timely UEC campaign saw some schemes continue through April
- Endoscopy productivity workstream having material reduction on number of insourced sessions used
- Outpatient productivity now focussed Single Point of Access rollout along with ICB & Primary Care Colleagues
- Diagnostic improvement programme now focussed on NOUS & Urodynamics
- Cancer Improvement Plan for 26/27 in development
- Q1 planned care additional activity plan delivered with Elective Recovery Funding

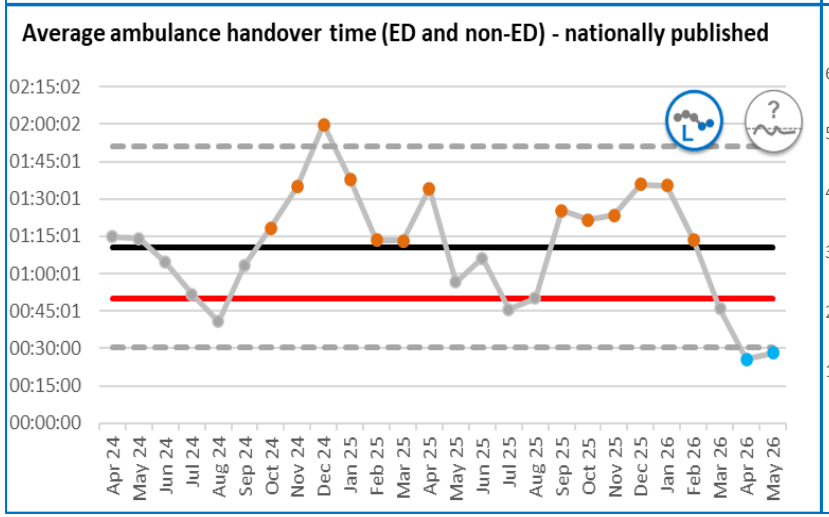
Operational – Emergency Care

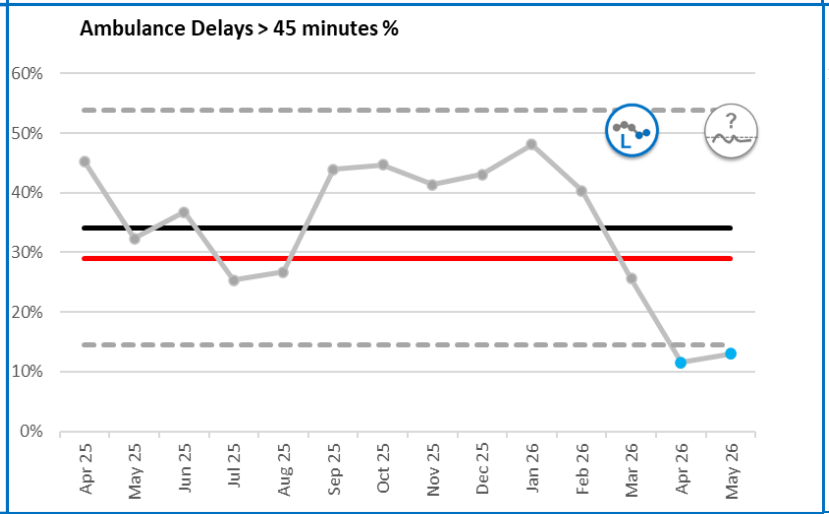
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

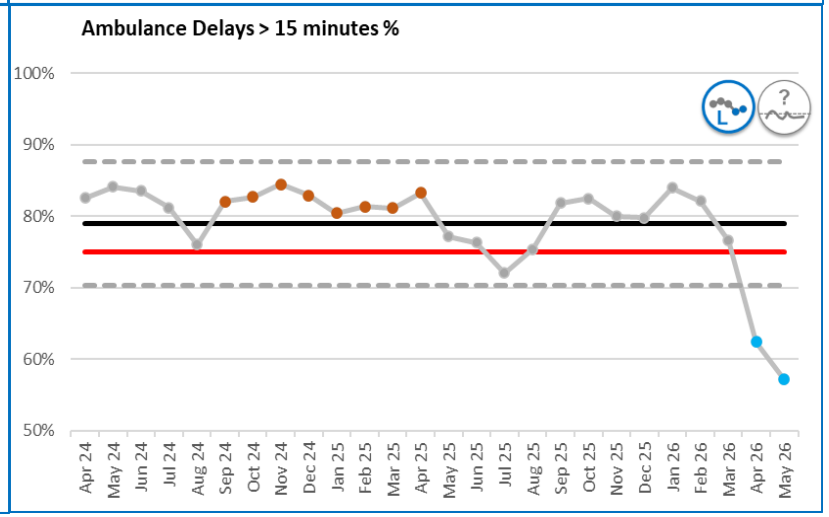












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Operational – Emergency Care

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:

- SaTH ED 4-hour performance was 53.1% (type 1 & type 3) and moved to common cause natural variation in May 2026
- SaTH number of patients who spend more than 12 hours in ED moved to special cause improving variation with 83.6% of patients were admitted and discharged within 12 hours during May 26
- Average Ambulance handover of patients to SaTH premises shows special cause improving variation in May and was better than plan with 90.8% of handovers within 60 mins

Recovery actions:

- Ambulance Threshold 45 release to respond launched in June 2026
- Continue to work with WMAS/WAS on maximum handover threshold and immediate handover process
- Continue to work with Health Hero to progress admission avoidance opportunities
- Integrated Community Front Door (IFD) Team in place in both ED Departments
- March Safe and Timely UEC Campaign improvement initiatives including, Flow Coordination, enhanced weekend ward rounds continuing into May 2026
- Delivery partner commenced discovery phase with a focus on 4 hour Non-Admitted ED pathways and No Criteria to Reside processes
- 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

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

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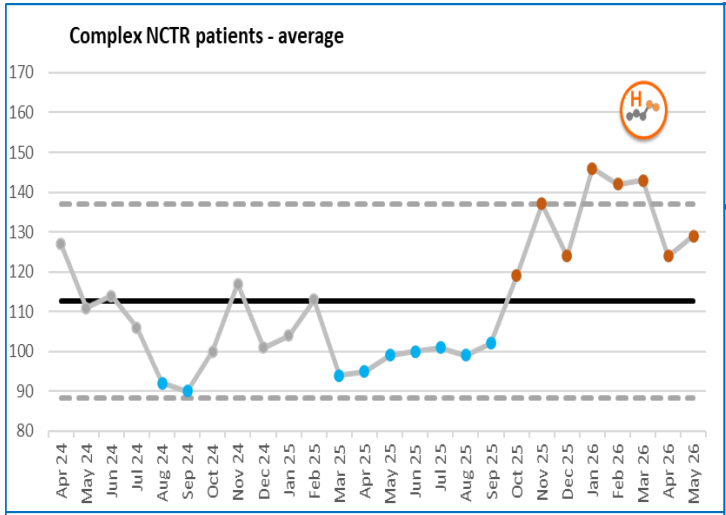
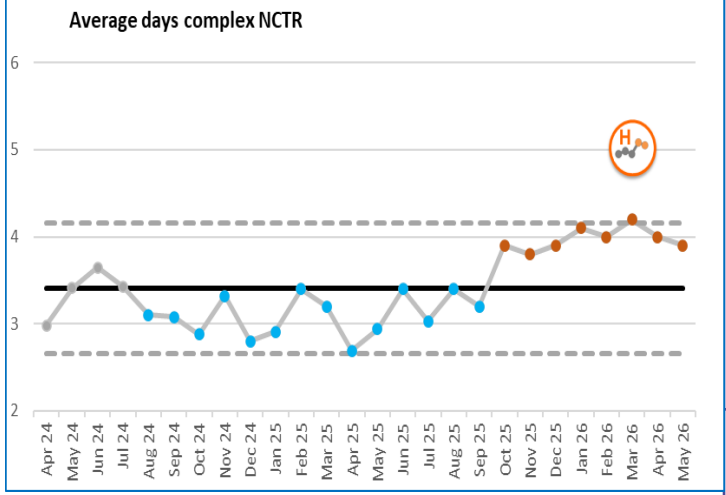
Operational – Patient Flow

Shropshire, Telford and Wrekin Community and Hospitals NHS Group





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
- Trial initiated for Transfer team across site for 1 month period to support flow.
- 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
- Capacity & Flow Matrons/ Head of patient flow completing daily line by line reviews on Medical wards (M-F)
- 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:

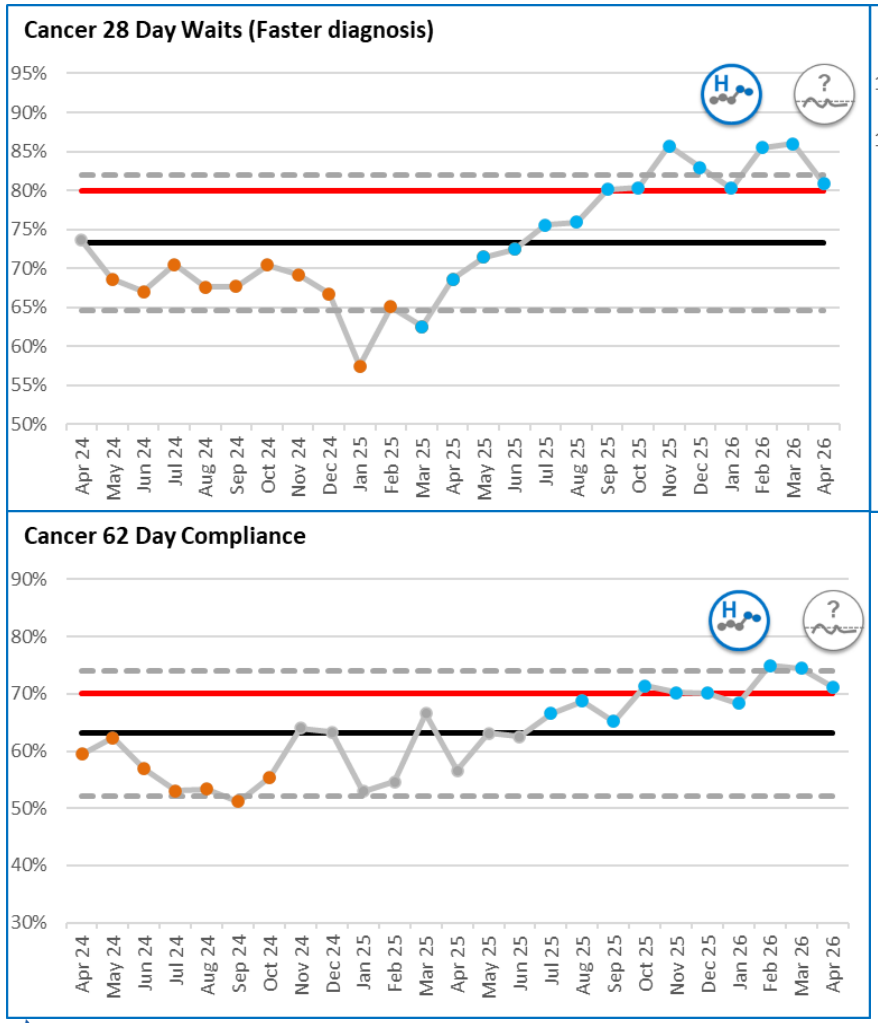
Progress reported monthly through UEC Flow improvement group to Performance Assurance Committee (PAC) and system UEC meeting.

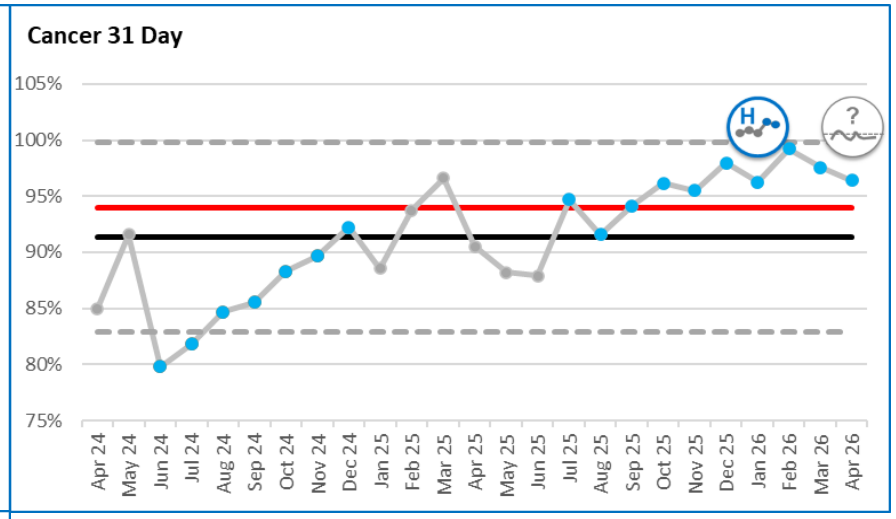
Recovery dependencies:	PW1, 2 and 3 capacity to support complex discharge pathways. Medical decision makers to support discharge decisions available on all wards throughout the day.

Moving to EXCELLENCE

Operational – Cancer performance

Shropshire, Telford and Wrekin Community and Hospitals NHS Group





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Operational – Cancer performance

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:
Confirmed April cancer performance is 80.9% (28-day FDS) vs the local plan of 80%. 62-day performance was 71.2% against a local target of 72.1% and 31 day was 96.4% against a local target of 96%. The 62-day backlog is 158 patients over 62 days of which 23 are over 104 days (as at 08/06/2026).

Recovery actions:
The Trust is now in Tier 3 of NHSE monitoring for cancer due to improved performance. April performance against the faster diagnosis standard (FDS) was 80.9%, making it our eight month of delivery of the national 80% standard. Performance against the 62-day standard in April was 71.2%. Significant focus is on how we optimise our pathways through 26/27 to achieve 80% on our 62-day performance.

Our two-year cancer improvement plan for 26/27 and 27/28 is in place which is designed to move us from recovery to excellence and will be crucial to the delivery of the 26/27 operational plan commitment. This will require significant investment and interventions aimed at high-priority areas of our pathways, in particular oncology services as well as key diagnostic constraints. The two-year plan improvement framework aligns clearly to the delivery of the National Cancer Plan.

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.

Our two-year cancer improvement plan has been launched with focus on 5 key pillars:

- Pathway optimisation
- Oncology improvement
- MDT optimisation
- Clinical outcomes
- Living with and beyond cancer

Recovery dependencies:	Workforce constraints

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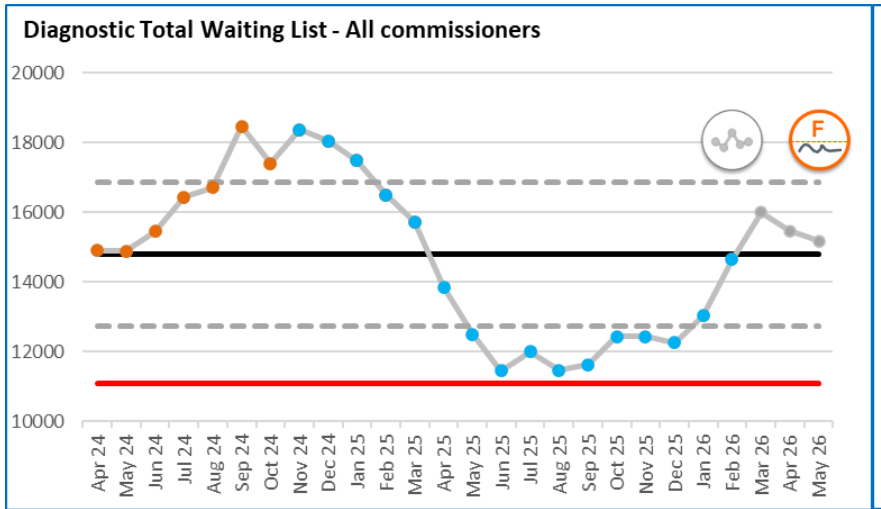
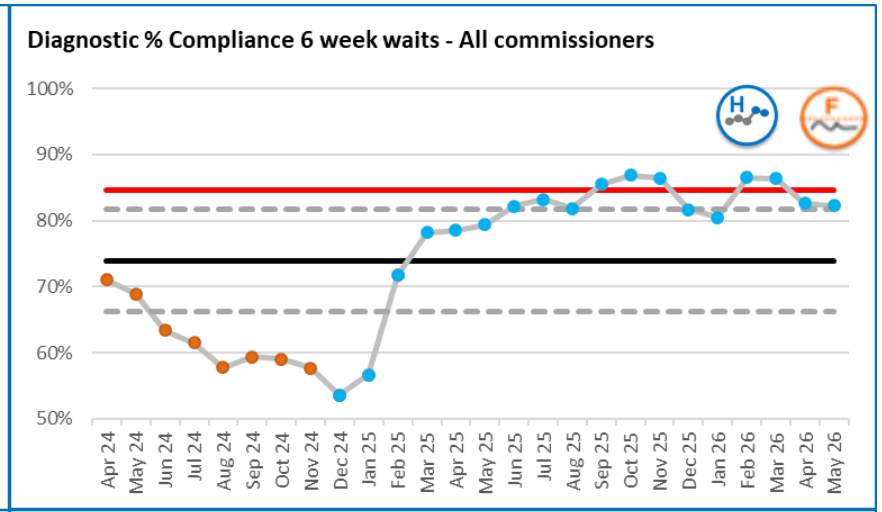
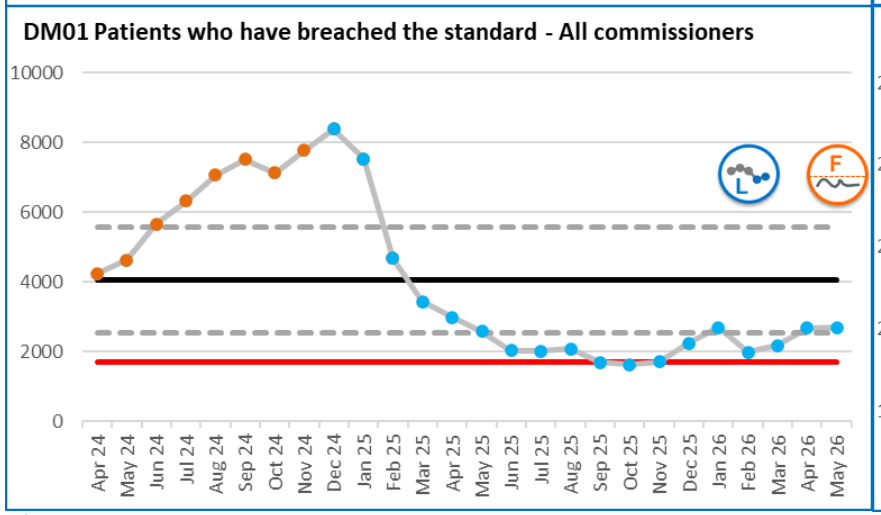
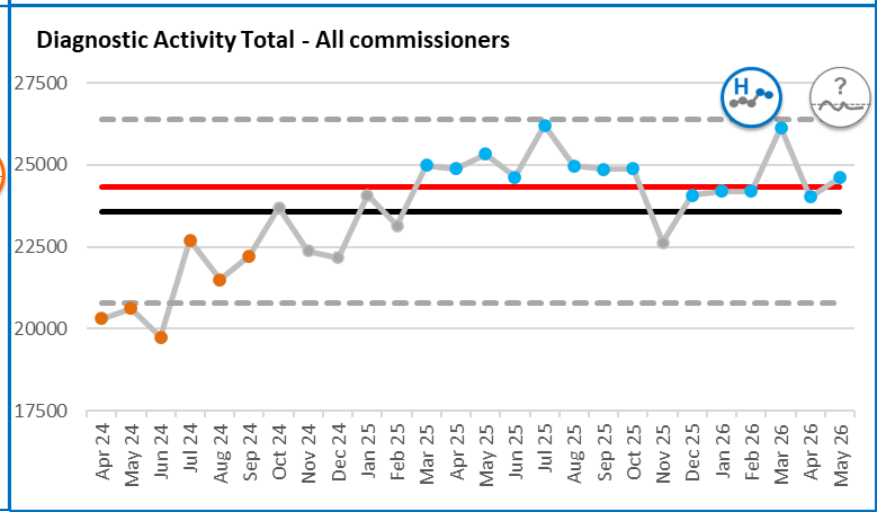
Operational – Diagnostics waiting times

Shropshire, Telford and Wrekin Community and Hospitals NHS Group









Moving to EXCELLENCE

Operational – Diagnostics waiting times

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:
The submitted DM01 position for May was 80.6 %, improved performance in Echocardiology. NOUS has seen a deterioration in performance with a recovery plan being implemented. 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
- 2 mobile MRI unit are 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%.

Recovery actions:
Outsourced reporting continues to provide additional capacity supporting MRI and CT turnaround times.
MRI performance continues to fluctuate with a rise in the number of Cardiac scans remaining outstanding over 6 weeks. 2 mobile vans are 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. A Radiology PTL for Cancer patients has been implemented. 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.

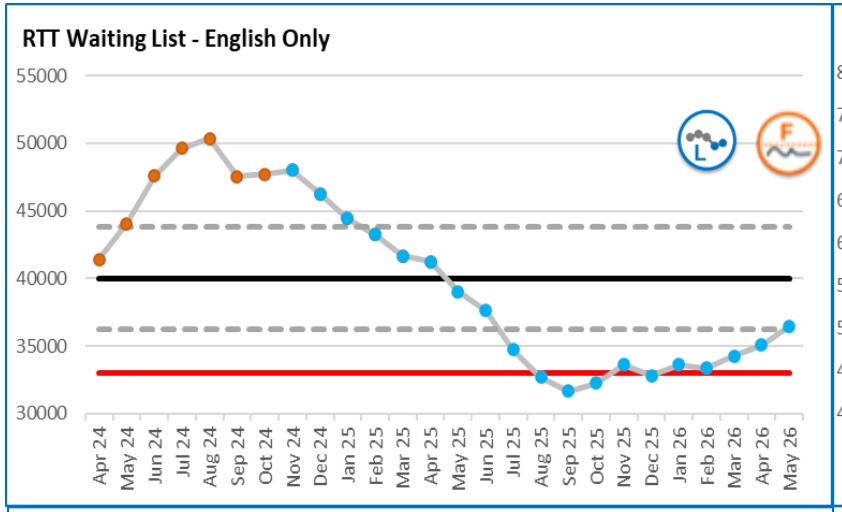
Anticipated impact and timescales for improvement:
Additional insourcing from '18 Weeks' to support Endoscopy DM01 at weekends has been supported through the ERF. It There is ongoing recruitment for radiologists, radiographers and sonographers.

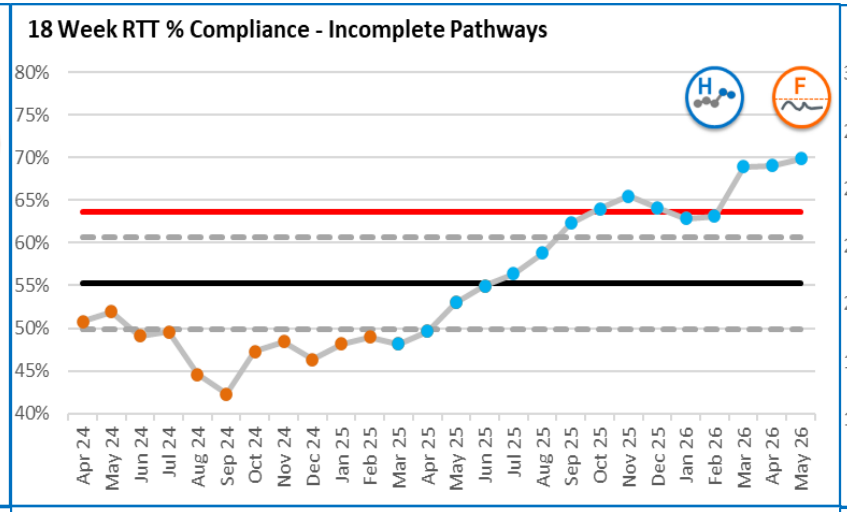
Use of insourcing for USS and MRI is proving successful with DM01, significant focus and targeted capacity it being generated to manage the US performance.

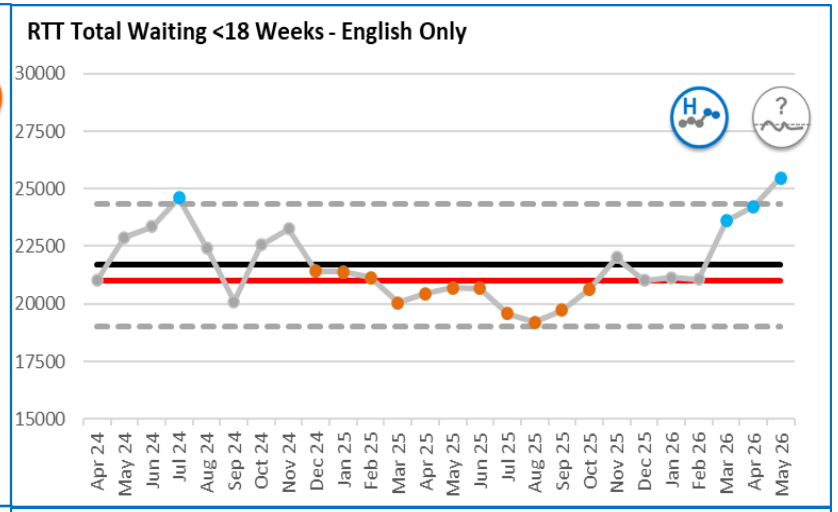
Recovery dependencies:

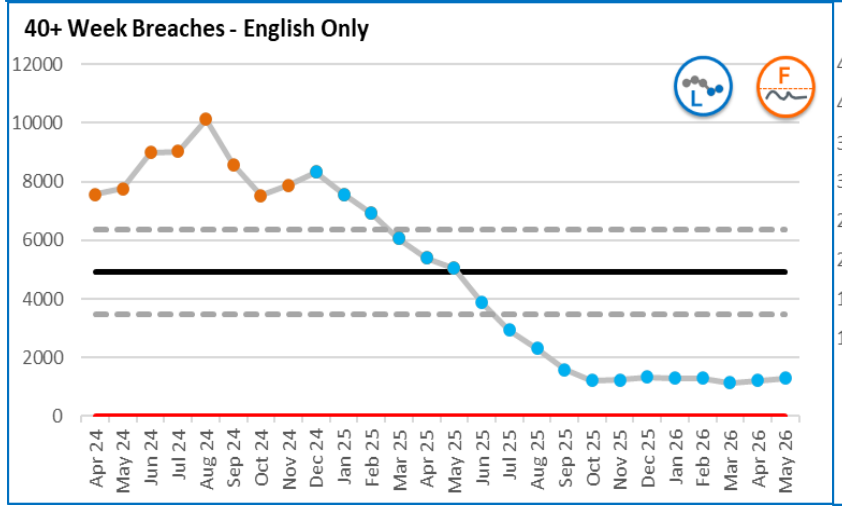
Operational – Referral to Treatment (RTT)

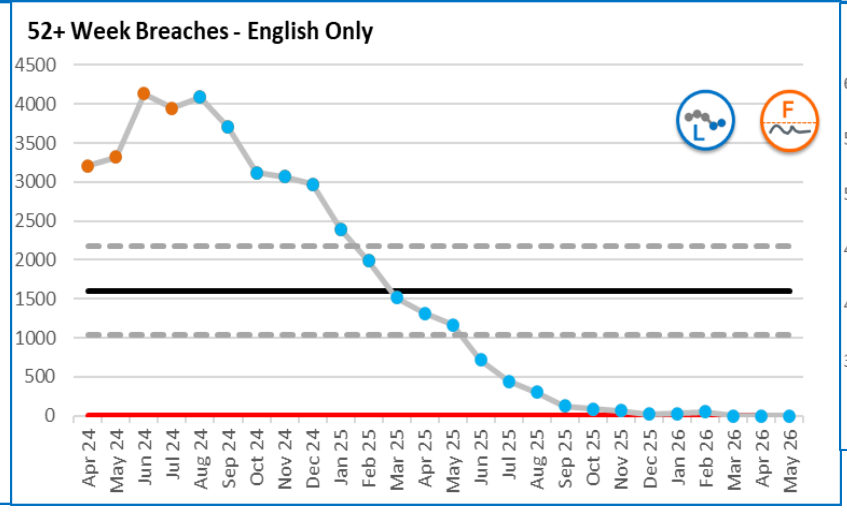
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

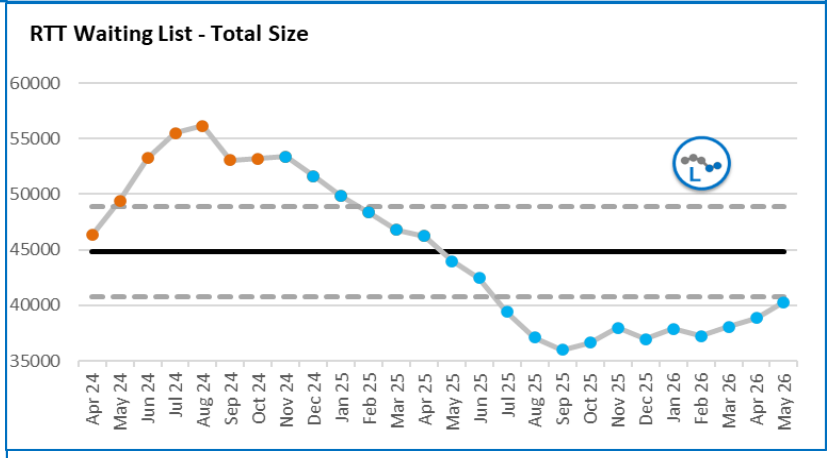












Note: includes Welsh unvalidated position

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Operational – Referral to Treatment (RTT)

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:
The submitted Trust Position for May 2026: English is 0 x 104 weeks, 0 x 78 weeks, 0 x 65 weeks, 0 x 52 week (adult) and 0 x 40 weeks CYP.
The unvalidated Trust Position for Welsh is 0 x 104 weeks, 11 x 78 weeks, 52 x 65 weeks 171 x 52 weeks.

The Trust is working to reduce the waiting times for Welsh patients in line with English.

The Trust has successfully delivered on its ambitious plan to deliver the nationally set Q4 sprint which aimed to increase the delivery of first outpatient attendances. 12,076 additional outpatient appointments were delivered during the sprint which attracted additional income from NHSE.

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. 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.
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 waiting times.

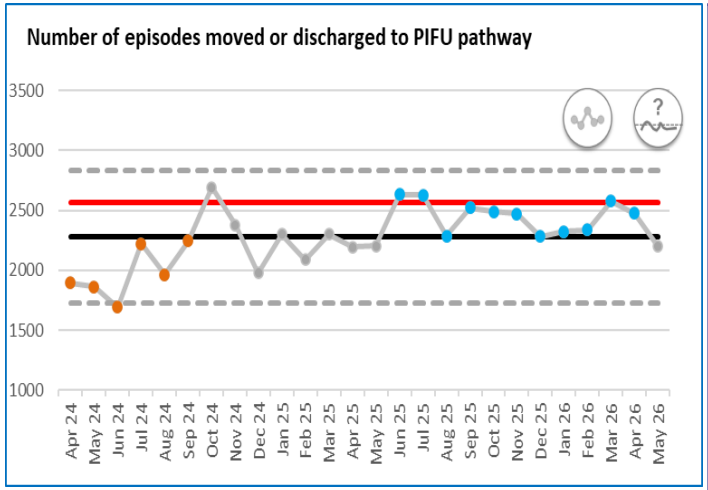
Recovery actions:	**Anticipated impact and timescales for improvement:**
Operational governance: The teams are actively using the breach forecasting tool to enable more accurate planning of the capacity needed by specialty to reduce waiting times for patients. Daily and weekly performance monitoring meetings are in place. A methodology to the maintenance of zero 52 weeks is in place. Plans have been developed to deliver the required RTT standards in line with Operating Plan targets for 2026/27. **Additional capacity**: The teams have now submitted plans for ERF funding with quarter 1 allocations in place to support delivery. **Productivity**: The planned care improvement programme (PCIP) continues for both outpatients and Inpatients. Four eyes have further been engaged to support our next phase with clinic optimisation focusing on clinic and nursing template optimisation and the implementation of centralising bookings.	The methodology to maintain zero 52 weeks and zero 40 weeks CYP is in place. The teams have now submitted plans for ERF funding with quarter 1 allocations in place to support delivery.

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

Moving to EXCELLENCE

Operational – PIFU

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



Summary:
The unvalidated Patient Initiated Follow-Up (PIFU) performance in May increased to 6.2%, which is just above the 6% target.
•The Patient Engagement Portal, designed to support PIFU, is remains in its pilot phase with some ENT pathways.
•A regular Data Quality Workgroup has been established, involving key stakeholders from the trust, 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.
•Outpatient Productivity continues to be a focus as well as Outpatient Pathway Transformation. Outpatient Advice and Guidance will be enhanced with the introduction of the SPOA process, due to be implemented by October 2026.
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 continue to positively impact PIFU performance with an above target percentage achieved in May.

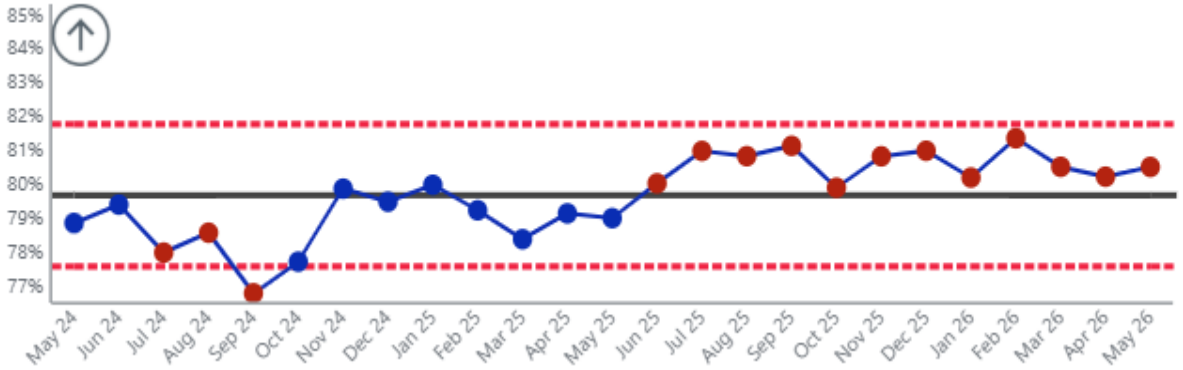
Recovery actions:	**Anticipated timescales for improvement:**
Conversations with Respiratory, Cardiology and Gynaecology clinical and operational leads have taken place, with their performance report has been completed, with plans to utilise the PIFU pathway. Further conversations required with Cardiology 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.	Performance will continue to be monitored at bi-weekly Outpatient Transformation meetings
Recovery dependencies:	

Moving to EXCELLENCE

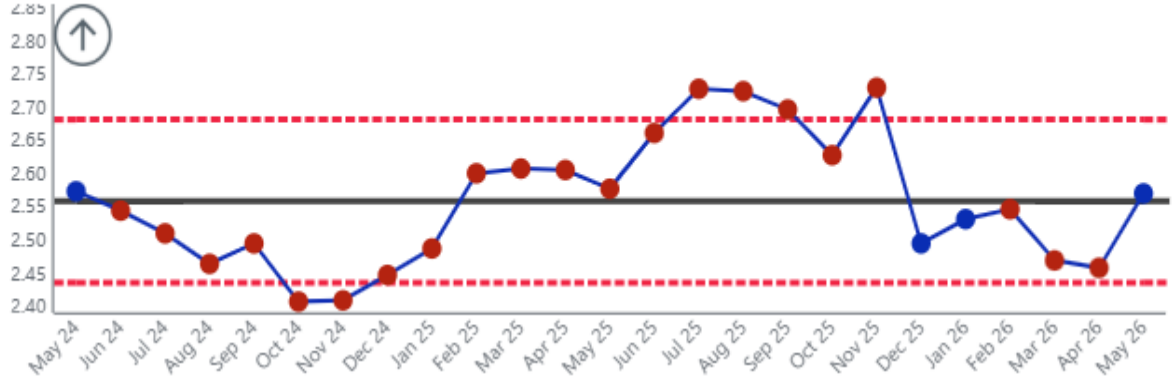
Operational – Theatre Productivity

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

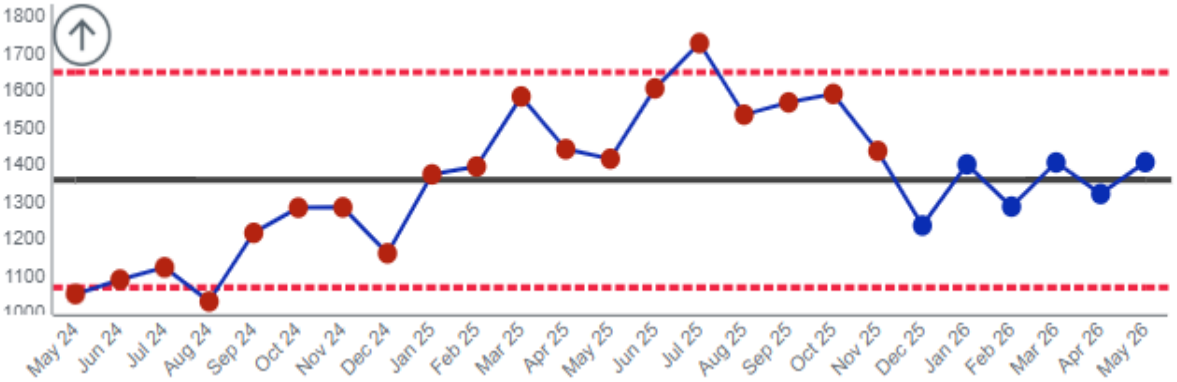
Theatre Capped Utilisation %



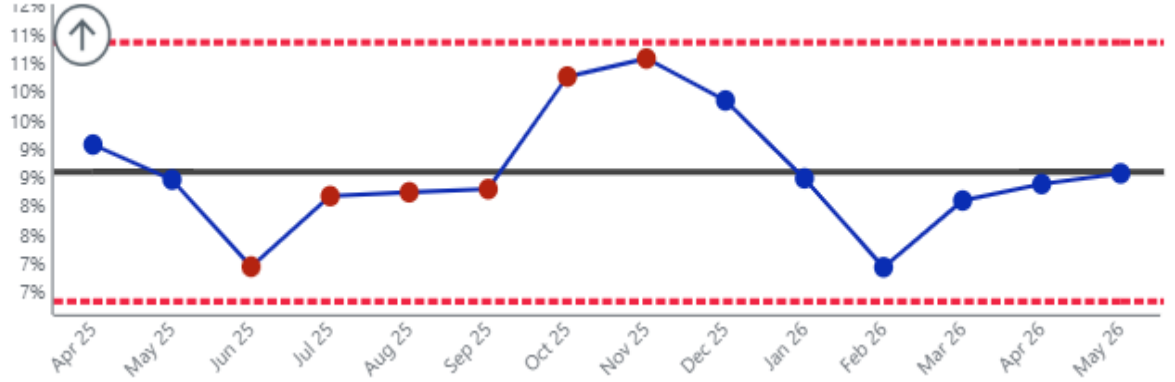
Average Cases Per List Rate



Total Number of Cases



Cancelled Operation %



Moving to EXCELLENCE

Operational – Theatre Productivity

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

May 2026 Summary:

Elective Theatre Utilisation

- Overall utilisation has remained stable at 81%
- Focus on Ophthalmology main theatre lists with support from the Improvement Team.

Cancellations

The cancellation also remained stable at 8.9%, driven by three main reasons.

1. List overruns due to complexity of previous procedure/s
2. Treatment deferred to a later date for multiple reasons
3. Staff shortage and sickness.

Elective Activity

- 1406 elective procedures were completed in May which is an increase from the 1320 in April with 10 extra sessions utilised, but core sessions reduced for the second consecutive month - PRH sessions in particular not being utilised well
- Cataract suite activity remains reduced, resulting in higher in-session utilisation but lower overall patient numbers
- Insourced sessions increased from 24 in April, to 68 in May

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. Introduce four joint arthroplasty lists to PRH

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:**
• Continued collaboration with the NHSE Regional Theatre Productivity Lead to align with regional priorities and best-practice approach to improving theatre efficiency • A double High Flow list day being planned in June in the elective hub with one of the two lists being robotic	New theatre plans have been introduced to support the reopening of the arthroplasty service and the introduction of a robotic theatre at PRH. Plans are underway to support training that will enable some ENT sessions to move to RSH, with a view to transitioning these lists and HTP.

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

Moving to EXCELLENCE

Well Led

Executive Lead:

Chief People Officer
Rhia Boyode

Integrated Performance Report

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Trend
Well Led	WTE employed		-	7874	7227	7225	7213	7222	7380	7403	7429	7423	7439	7430	7428	7476	0	
	Temporary/agency staffing		-	-	722	738	783	749	679	683	652	617	612	632	689	621	0	
	Staff Turnover Rate (FTE) (excluding Junior Doctors)		0.8%	0.75%	0.9%	0.7%	0.7%	0.9%	0.7%	0.8%	0.9%	1.0%	0.9%	0.7%	0.8%	0.7%	0.0%	
	Vacancies - month end %		10%	<10%	4.4%	5.7%	5.9%	5.8%	3.8%	4.0%	3.9%	4.5%	6.0%	5.6%	5.4%	5.1%	#DIV/0!	
	Sickness Absence rate		-	4.5%	4.6%	4.8%	4.9%	4.7%	4.9%	5.2%	5.2%	5.7%	5.8%	5.5%	5.0%	5.07%	0.00%	
	Trust - Talent Conversation (Appraisal)		90%	90%	86.0%	86.1%	86.6%	86.1%	86.4%	86.9%	86.8%	86.1%	85.0%	84.6%	84.7%	84.1%	82.7%	
	Talent Conversations (Appraisal) – Medical Staff		90%	90%	93.8%	93.5%	93.3%	94.4%	95.3%	94.9%	93.5%	92.7%	92.9%	93.6%	94.2%	93.3%	91.4%	
	Trust Statutory and mandatory training compliance		90%	90%	93.1%	93.2%	93.4%	93.2%	93.1%	93.3%	92.9%	92.3%	92.5%	91.9%	91.4%	91.5%	90.0%	
	Trust MCA – DOLS and MHA		90%	90%	85.0%	85.2%	86.0%	85.8%	85.3%	85.2%	85.8%	84.7%	84.8%	84.3%	84.2%	83.1%	82.0%	
	Safeguarding Children - Level 2		90%	90%	96.4%	96.6%	96.4%	96.2%	95.8%	95.8%	95.4%	95.1%	95.2%	94.8%	94.1%	94.1%	93.1%	
	Safeguarding Adult - Level 2		90%	90%	95.9%	95.9%	96.0%	95.7%	95.5%	95.6%	95.5%	94.7%	95.0%	94.6%	94.5%	94.5%	93.9%	
	Safeguarding Children - Level 3		90%	90%	89.8%	90.5%	90.8%	90.3%	88.2%	88.6%	87.1%	86.0%	85.0%	84.0%	81.3%	79.6%	81.1%	
	Safeguarding Adult - Level 3		90%	90%	91.0%	91.7%	92.1%	91.5%	90.5%	90.9%	91.4%	90.3%	90.7%	90.4%	90.7%	90.7%	90.6%	
	Diabetic Foot - Nurse Training		90%	90%	87.5%	88.8%	90.2%	91.3%	90.7%	91.3%	92.2%	92.4%	92.3%	92.1%	91.8%	92.5%	92.4%	
	Oliver McGowan Training		90%	90%	86.6%	87.5%	87.8%	88.2%	88.5%	88.9%	89.0%	88.9%	88.8%	88.6%	88.5%	88.1%	86.2%	
	Oliver McGowan Mandatory Training - T1		90%	90%		28.5%	25.7%	25.4%	25.3%	0.0%	5.6%	6.7%	10.0%	12.4%	13.0%	13.1%	14.5%	
	Oliver McGowan Mandatory Training - T2		90%	90%		23.6%	24.6%	24.2%	23.9%	11.3%	11.3%	11.1%	12.0%	13.3%	15.2%	16.0%	18.1%	
	Monthly agency expenditure (£'000)		-	514	684	817	873	921	820	504	500	525	306	369	520	418	523	

Moving to EXCELLENCE

Workforce Executive Summary

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

2026/27 Workforce Plan – There has been marginal decreases in substantive workforce across all divisions and corporate areas with an increase seen in our Women's and Children's Division (3 WTE from April). Our substantive workforce is over planned levels by 32 WTE, mainly attributed to our out turn position in March being higher than estimated in the workforce plan. There is a need to review all actions to support aligning our workforce back to planned levels within the next quarter. To support cost reductions a full review of all investments within our workforce plan is now being undertaken with a view to reduce expenditure in Q2.

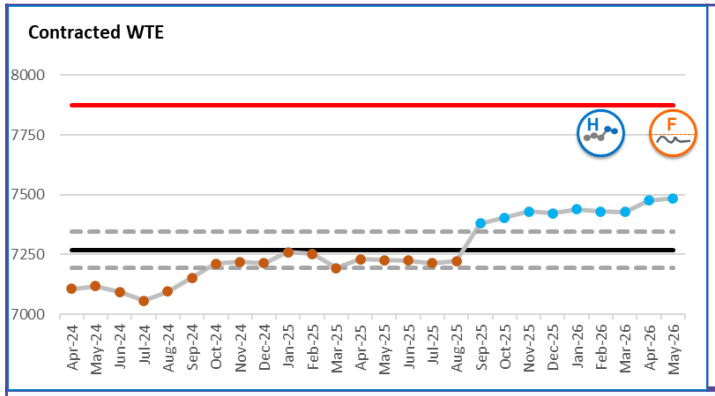
Turnover – The rolling 12-month turnover rate for May is 9.4% equating to 651 WTE leavers. An in-month turnover rate of 0.7% equates to 47 WTE leavers in May. NHS Leaver turnover rate (those moving outside of the NHS) over the last 12 months is 7.0% equating to 481 WTE NHS leavers. Staff groups with highest turnover rates are: Additional Clinical Services (12.5%); Admin and Clerical (11.7%); Estates and Ancillary (11.0%).

Wellbeing of our staff – The May sickness rate is 4.9% (369 WTE) remaining above target by 0.4% (31 WTE). Sickness attributed to mental health continues to be the top reason for sickness making up 29% of calendar days lost in May equating to 110 WTE. 12% (44 WTE) of sickness was attributed to other known causes; other musculoskeletal problems was at 12% (34 WTE).

Agency and temporary staffing - Agency has continued to decrease now 14 WTE under planned levels in month 2. From a cost improvement perspective one of the main areas of under delivery is the bank reductions particularly across our nursing workforce, which have not delivered projected savings in month 1 and 2 (£0.22m). One of the main drivers of the bank usage has been covering high levels of sickness absence. Several workshops have been set up to review our action plans to reduce sickness and to consider the impact of planned interventions and actions that would further support reductions. This includes exploring digital systems that will aid sickness management. There has been a positive reduction in Consultant bank usage seen on a weekly basis since early April.

Workforce – Contracted WTE

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



Summary:
Substantive figure of 7,484 WTE in May, which is an increase of 9 WTE in month.
Total workforce utilisation in May decreased by 2 WTE to 8094 WTE attributable to a decrease in bank of 8 WTE and a decrease in agency of 2 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:

- Introduce medical staffing templates and requirement tools; assess staffing gaps and skill mix
- Improve rostering, strengthen establishment controls, increase substantive staffing
- Workforce planning – focus on medical and on identifying efficiency and savings, in areas such as Outpatients
- 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 reviews on workforce plans taking place with a deadline of September
- Workforce planning is being driven by Demand & Capacity reviews, ensuring staffing aligns with service needs and future growth across divisions
- Manager Self Service has now been fully deployed which is a key digital enabler for the Future Workforce Solution

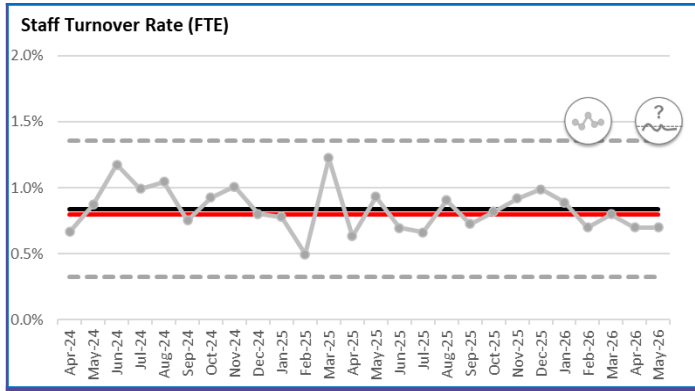
Anticipated impact and timescales for improvement:
Taking our learning from this year's shortfalls in delivery against the reduction plans we will take the following actions to ensure assurance team will deliver targets. Improved action planning, greater accountability and visibility of delivery through monitoring of plans, clear digital strategy to support reductions, utilising national guidance and support in relation to Bank. Improvements expected in 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.

Moving to EXCELLENCE

Workforce – Staff turnover rate

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



Summary:
Our Turnover target for 2026 is 10%. The rolling 12-month turnover rate for May is 9.4% equating to 651 WTE leavers.
An in-month turnover rate of 0.7% equates to 47 WTE leavers in May. NHS Leaver turnover rate (those moving outside of the NHS) over the last 12 months is 7.0% equating to 481 WTE NHS leavers.
Staff groups with highest turnover rates are: Additional Clinical Services (12.5%); Admin and Clerical (11.7%); Estates and Ancillary (11.0%).
Nursing and Midwifery has a turnover rate of 6.5%.
Relocation is currently the highest reason for leaving with 105 WTE leavers with work life balance as the second highest reason with 99 WTE leavers over the last 12 months.

Recovery actions to achieve our target:

- 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

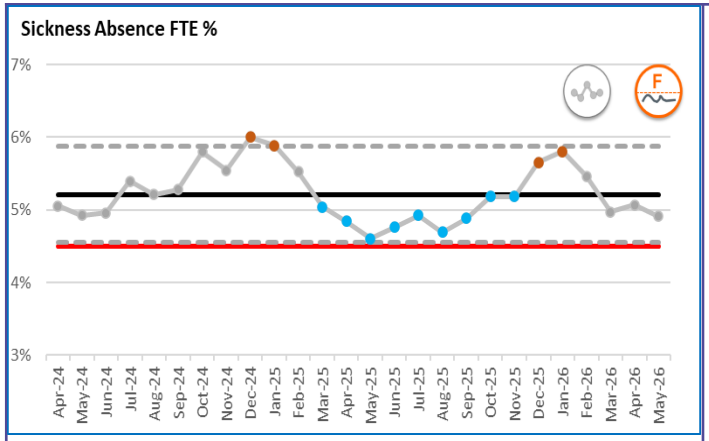
Anticipated impact and timescales for improvement:
Turnover is expected to increase towards end of this year in line with our workforce plans and reductions plans outlined for 26/27.

Recovery dependencies:	Estate and Digital are key enablers to improve environment and agility to work differently. Release of colleagues to access support available.

Moving to EXCELLENCE

Workforce – Sickness absence

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



Summary:
Our sickness target for 2026 is 4.5%. May sickness rate of 4.9% (369 WTE) remaining above target by 0.4% (31 WTE). Sickness attributed to mental health continues to be the top reason for sickness making up 29% of calendar days lost in May equating to 110 WTE. 12% (44 WTE) of sickness was attributed to other known causes; other musculoskeletal problems was at 12% (34 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 7.2% followed by Additional Clinical Services at 6.3% and Nursing and Midwifery at 5.4%.

Recovery actions to achieve our target:

- Review of all long-term absence (currently 65 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
- Strengthen sickness prevention and wellbeing interventions and policy.
- Targeted long-term absence management and occupational health support (Occupational Health procurement process underway).
- Prioritisation of retention and resilience strategies within Bands 5 and 6 and clinical workforce.
- Improving workforce planning for winter escalation periods.

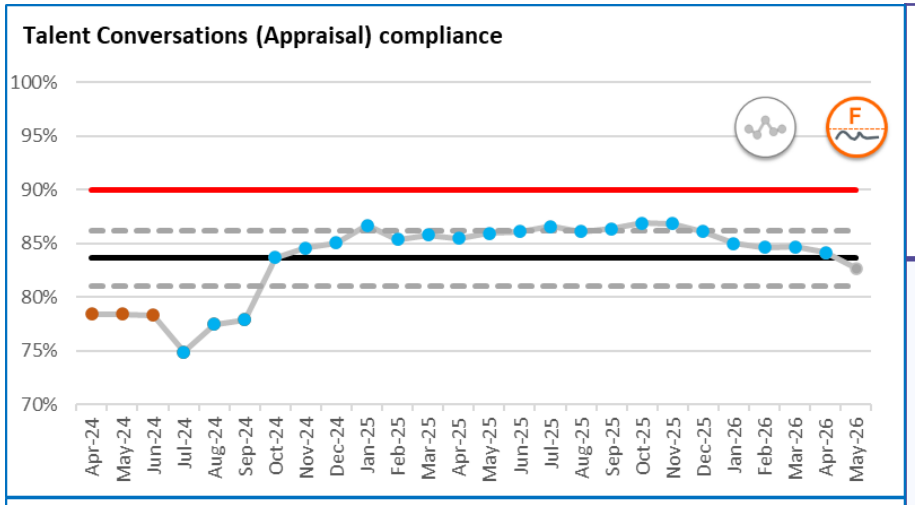
Anticipated impact and timescales for improvement:
Expected reductions in absence levels throughout the year in line with plan with a level of increase over winter months after which we expect a 0.6% reduction.

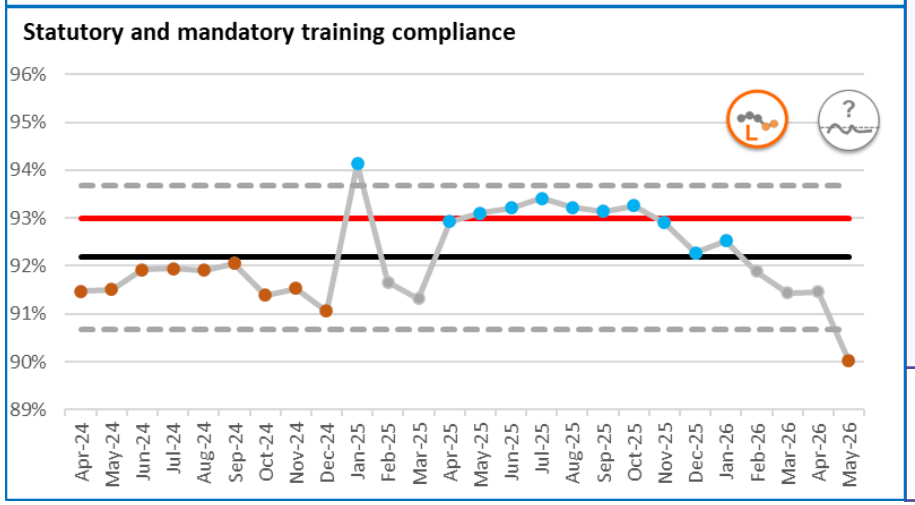
Recovery dependencies:	To ensure strong leadership behaviours, values to support desired culture during challenging times. Support from leaders to ensure proactive management of people and support provided.

Moving to EXCELLENCE

Workforce – Talent Conversations & Training

Shropshire, Telford and Wrekin Community and Hospitals NHS Group





Summary:
Talent Conversations (Appraisals) target is 90%. Medical appraisals remain above target. For non-medical colleagues, talent conversations compliance has reduced to 82.7% in May.
The compliance rate for Statutory and Mandatory Training in May has decreased to 90.20%. Both training compliance and appraisals have been decreasing month on month

Recovery actions:

- There is a risk that the Trust will not meet national targets for training and appraisal compliance. Appraisal rates are already below target, and training compliance is continuing to decline with a potential breach anticipated this month. Due to the ongoing Education management of change and reduced staffing capacity, improvement interventions cannot currently be implemented
- Review appraisal paperwork
- 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.
- 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:

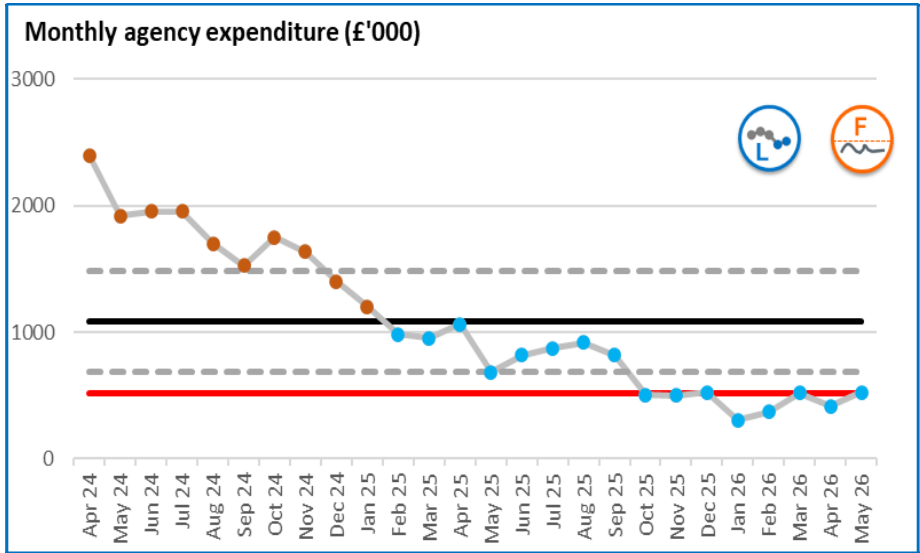
With current low staffing numbers in education timescales for improvement will not be possible until we have worked through the management of change and implemented a robust structure.

Recovery dependencies:	Completion of the management of change process

Moving to EXCELLENCE

Agency Expenditure - Monthly

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



Summary:
Agency spend increased from April into May. Key actions to support further reductions in our temporary workforce are being delivered through the workforce transformation programme. The Workforce Transformation Programme includes several initiatives to improve workforce productivity, governance, and alignment to service demand. These include:

- Standardisation of medical workforce templates to align staffing, skill mix, and deployment with clinical demand and financial sustainability
- Implementation of Activity Manager and expanded medical rostering to better match resources to service demand and capacity
- Standardised job planning for Specialist Nurses and other non-medical staff groups to improve governance and ensure specialist skills are used effectively
- Expansion of the rostering system to additional staff groups including Allied Health Professionals, Pharmacy, and Facilities services

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:
Agency expected to reduce in line with plan for 26/27.

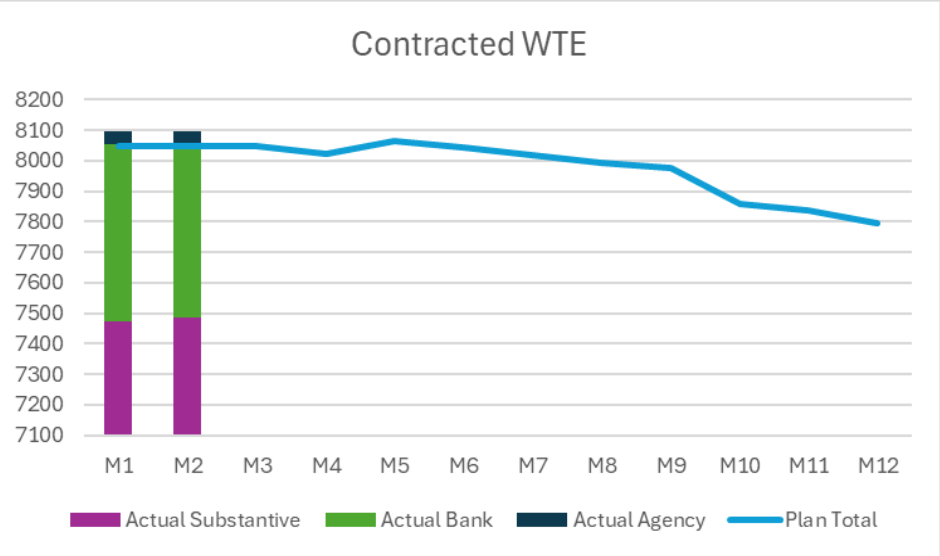
Recovery dependencies:	Escalation plan delivery and workforce unavailability going into winter.

Moving to EXCELLENCE

Staffing – contracted actuals vs plan

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Contracted WTE													
Plan / Actual	**Staff Group**	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**
Plan	Substantive	7,452	7,452	7,452	7,443	7,480	7,472	7,463	7,455	7,450	7,347	7,345	7,317
	Bank	542	542	542	528	535	522	508	495	482	468	455	442
	Agency	55	55	55	53	51	49	47	45	43	41	39	35
	Total	**8,048**	**8,048**	**8,048**	**8,025**	**8,066**	**8,042**	**8,019**	**7,995**	**7,975**	**7,856**	**7,838**	**7,793**
Actual	Substantive	7475	7,484										
	Bank	577	569										
	Agency	43	41										
	Total	**8,096**	**8,094**										
Variance	Substantive	23	32										
	Bank	36	28										
	Agency	-12	-14										
	Total	**47**	**46**										



Summary:
Total staff usage of 8094 WTE in May which is 46 WTE (Contracted) above plan. Substantive levels have decreased marginally this month. Bank reduced by 8 WTE. Agency usage levels have also reduced now under plan by 14 WTE.

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.

Moving to EXCELLENCE

Finance

Executive Lead:

Acting Director of Finance
Adam Winstanley

Integrated Performance Report

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Domain	Description	Current Month Trajectory (RAG)	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Trend
Finance	End of month cash balance £'000	32,153	35,131	41,161	44,343	51,400	40,294	49,296	39,293	16,298	89,066	83,003	72,968	40,867	35,115	
	CIP Delivery £'000	3,013	2,568	2,742	3,579	3,166	3,843	3,363	3,268	3,692	4,076	4,435	4,419	2,042	2,093	
	Balanced £ Position £'000 (Cumulative)	(5,610)	1	10	8	4	(1,274)	(2,290)	(3,927)	(5,848)	(5,604)	(4,098)	4,920	(3,628)	(7,368)	
	Year to date capital expenditure £'000	17,461	12,632	19,759	24,803	32,363	41,608	53,139	61,724	76,556	87,885	102,681	149,713	0	15,295	

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Financial Executive Summary

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

The Trust submitted a finance plan to NHSE on 18th March which showed a deficit plan of £30.49m pre deficit support (DSF) which moves to breakeven with deficit support for the year. At the end of May (month two), the Trust has delivered a deficit position of £7.37m against a deficit plan of £5.61m pre deficit support funding, an unfavourable variance of £1.76m. This moves to a deficit of £2.29m against a planned deficit of £0.53m post deficit support.

There have been some variances in the cost categories with income and non-pay favourable to plan and pay adverse to plan. The predominant driver of the variance is industrial action (£0.75m) and slippage against various efficiency schemes (£1.76m), these have been partly offset with other non-recurrent mitigations.

The Trust had four main deliverables within the operating plan for FY26/27:

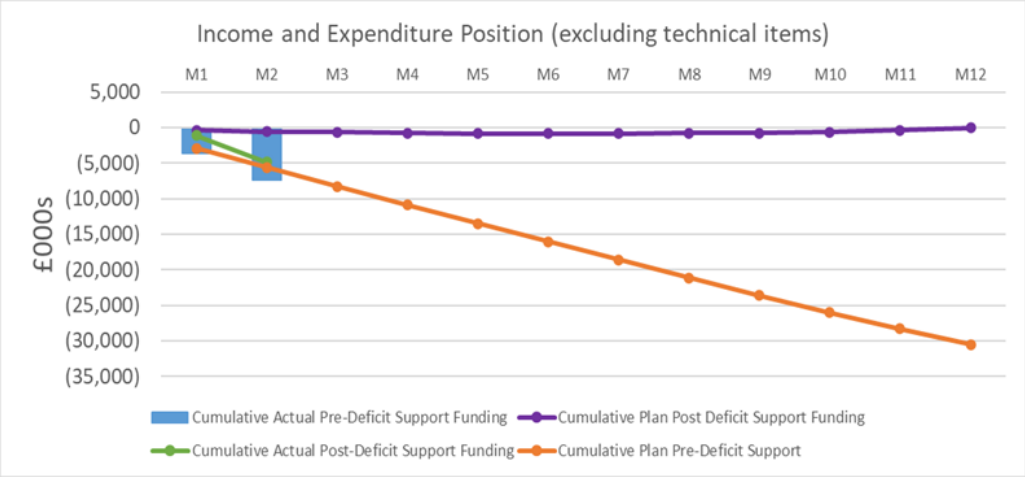
- Delivery of the activity plan – There is currently no change in the reporting of income due to the data warehouse issues at present which will be resolved during the first half of FY26/27. The Trust is actively making Commissioning Data Set (CDS) submissions through to the Secondary Uses Service (SUS) and completing Non-SUS aggregated contract monitoring
- Delivery of the efficiency plan – The Trust has an efficiency target of £39.98m in FY26/27. At the end of May, £4.13m has been delivered which is £1.76m less than plan
- Delivery of Whole Time Equivalent (WTE) reduction plan – At the end of May against the numbers planned (actual worked) there has been an adverse variance of 41 WTE
- Delivery of the agency reduction plan – Agency usage is below the planned levels by 14 WTE. There will continue to be a strong focus on medical agency in FY26/27.

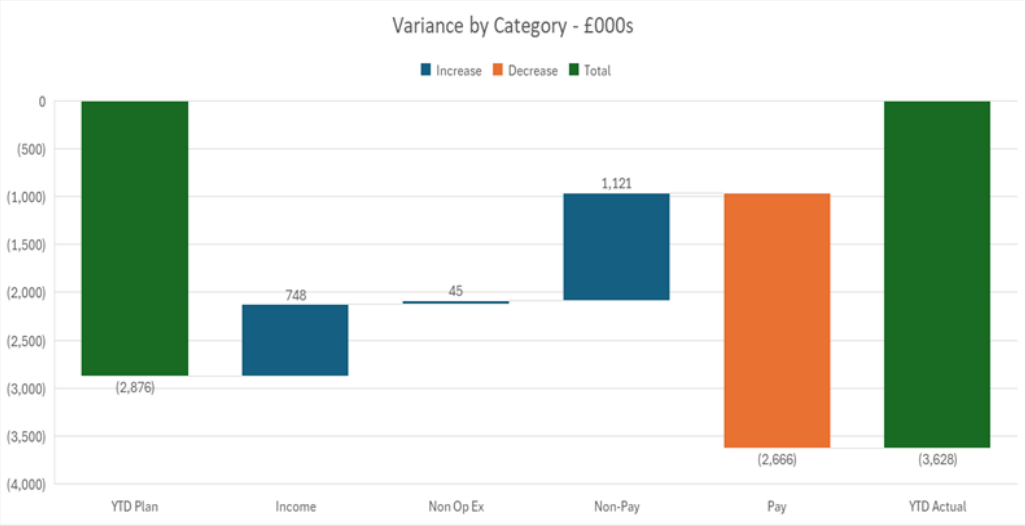
The Trust has set an operational capital programme of £25.54m (including IFRS 16 expenditure) and externally funded schemes of £135.36m in FY26/27, giving a total capital programme of £160.90m.

The Trust held a cash balance at end of May 2026 of £40.26m.

Income and Expenditure – Year to Date

Shropshire, Telford and Wrekin Community and Hospitals NHS Group





The Trust has a deficit plan of £30.49m pre DSF which moves to breakeven post DSF for FY26/27. At the end of May (month two), the Trust has delivered an adverse variance of £1.76m against a planned deficit of £5.61m.

The main drivers of this position are the cost pressure associated with the industrial action (£0.75m) and slippage against efficiency schemes (£1.76m). These pressures have been partially mitigated by bringing forward delivery of some of the central efficiency schemes associated with technical adjustments.

The Trust has four main deliverables within the operating plan for FY26/27:

- Delivery of the activity plan – There is currently no change in the reporting of income due to the data warehouse issues at present which will be resolved during the first half of FY26/27. The Trust is actively making Commissioning Data Set (CDS) submissions through to the Secondary Uses Service (SUS) and completing Non-SUS aggregated contract monitoring
- Delivery of the efficiency plan – The Trust has an efficiency target of £39.98m in FY26/27. At the end of May, £4.13m has been delivered which is £1.76m less than plan
- Delivery of WTE reduction plan – At the end of May against the numbers planned (actual worked) there has been adverse variance of 41 WTE
- Delivery of the agency reduction plan – Agency usage is below the planned levels by 14 WTE. There will continue to be a strong focus on medical agency in FY26/27

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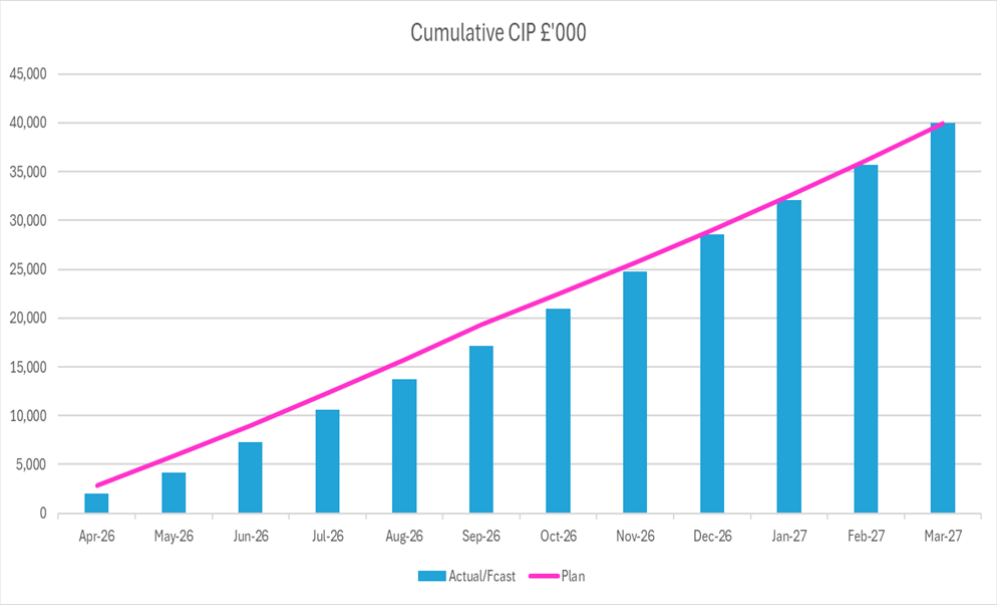
Efficiency

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



Summary:
The Trust has a total efficiency target of £39.98m for FY26/27, £35.36m recurrently.

As at the end of May (M02), the Trust has delivered £4.1m of efficiency savings for FY26/27 which is £1.8m below the planned delivery.

At M02 the Trust is forecasting to meet its target CIP by the end of the year. £23.7m of this is recurrent and £16.3m is non-recurrent, with a FYE of £30.2m.

The forecast is risk adjusted, however, there is still risk to this position as highlighted and additional schemes are being added to the programme to mitigate.

Recovery actions:	**Anticipated impact and timescales for improvement:**
• Identification of divisional CIP at pace • Identification of mitigations for high risk and undelivered CIP across the year	Mitigation plan in place and delivering by the end of Q2

Dependencies:	Delivery of actions against PIDs across 26/27

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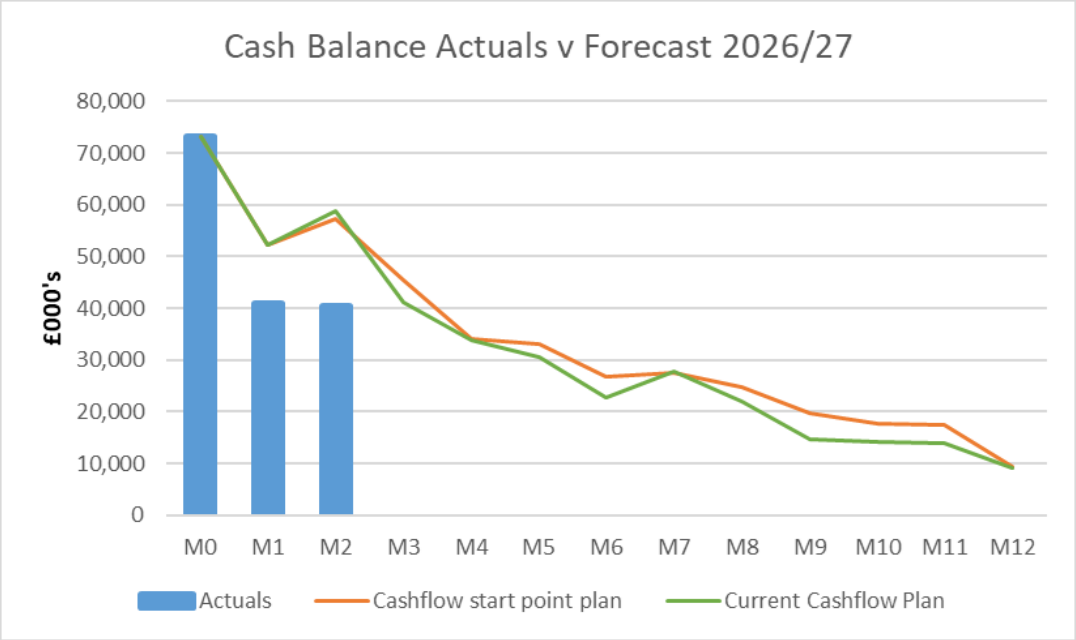
Cash and Cash Equivalents

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



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 FY26/27 was £73.21m with a cash and ledger balance of £40.26m held at end of month two.

The graph illustrates overall actual cash held against the plan. At month one, actual cash balances were less than forecast, due to the timing of prior year capital spend.

The current cashflow forecast for FY26/27 is predicated on receiving DSF through Q1-4 and assumes 45% cash releasing delivery of the efficiency programme. At present it is estimated that no Revenue Support will be required, due to bonus DSF received and additional STW allocations negotiated through the contracting route.

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

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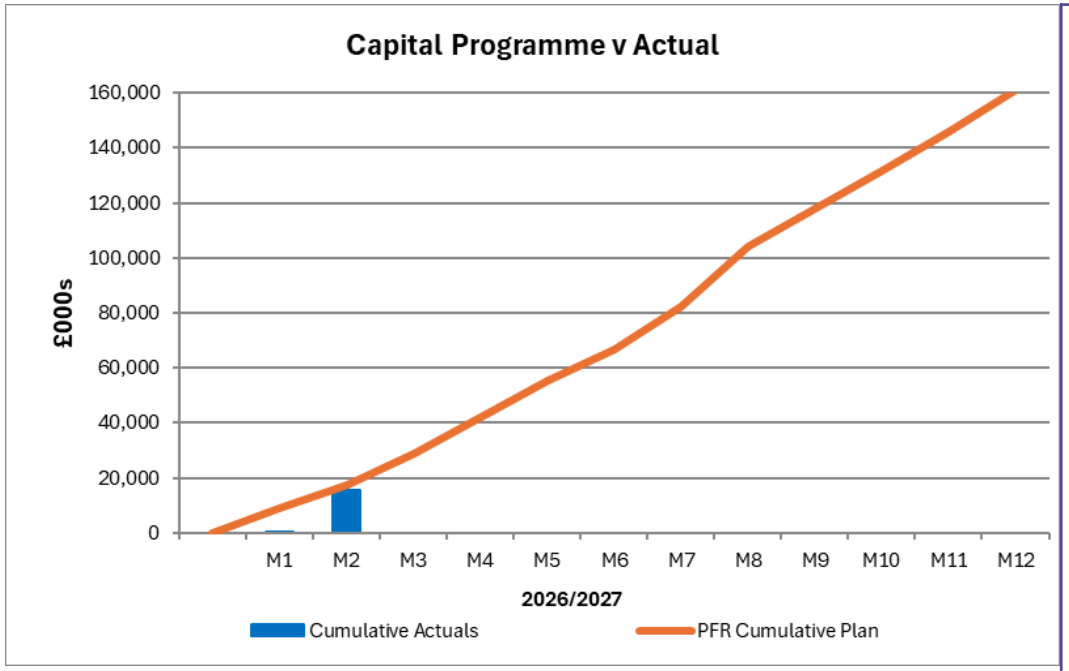
Capital

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



Summary:
The Trust received an operational capital allocation of £24.38m for FY26/27, this allocation is inclusive of IFRS 16 capital expenditure.

External allocations have been set at £135.36m; this includes £113.07m for HTP, £5.79m for Estates Safety, £13.10m for the CDC Cluster, £1.40m for Frailty SDEC and £2.00m Elective Incentive CDEL, giving an overall capital programme for FY26/27 of £160.90m.

At M2 FY26/27, £0.52m of expenditure (including IFRS 16) relating to the operational capital allocation has been expended and £14.82m of external expenditure incurred, giving total expenditure of £15.34m. This represents 9.5% of the overall spend required across FY26/27 against an expected 16.66% if the allocation was expended on a straight-line basis over the year.

Recovery actions:	**Anticipated impact and timescales for improvement:**
• Work with leads to develop robust spend profiles for agreed programmes	N/A
Recovery dependencies:	N/A

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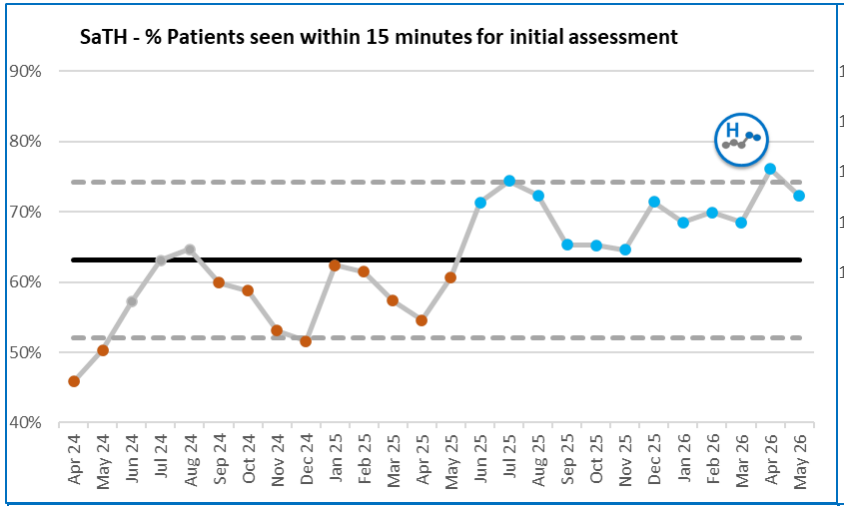
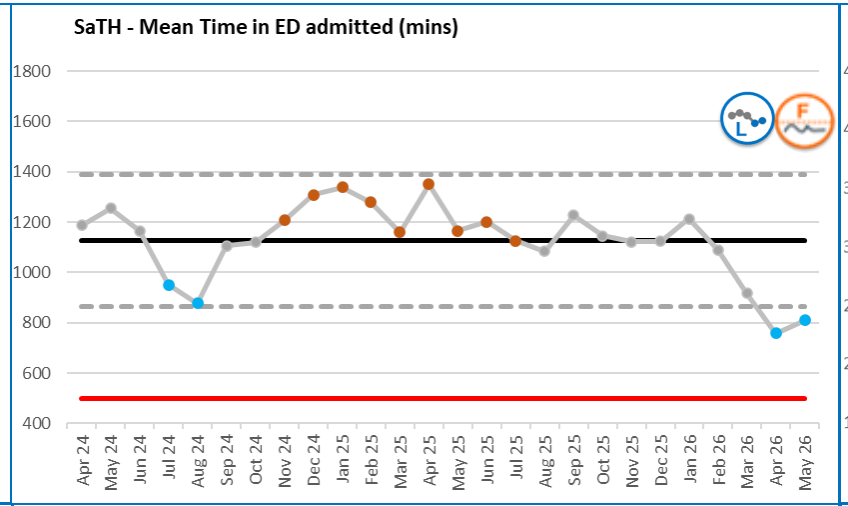
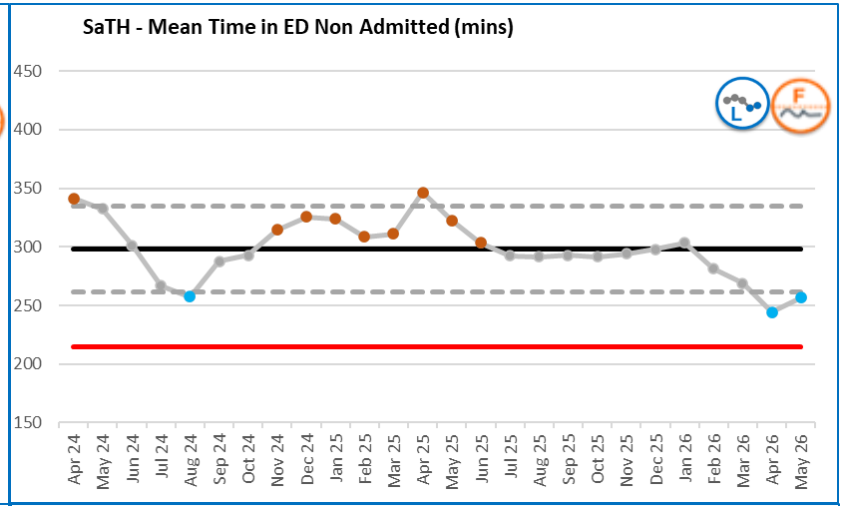
Appendices – Responsiveness And Well Led

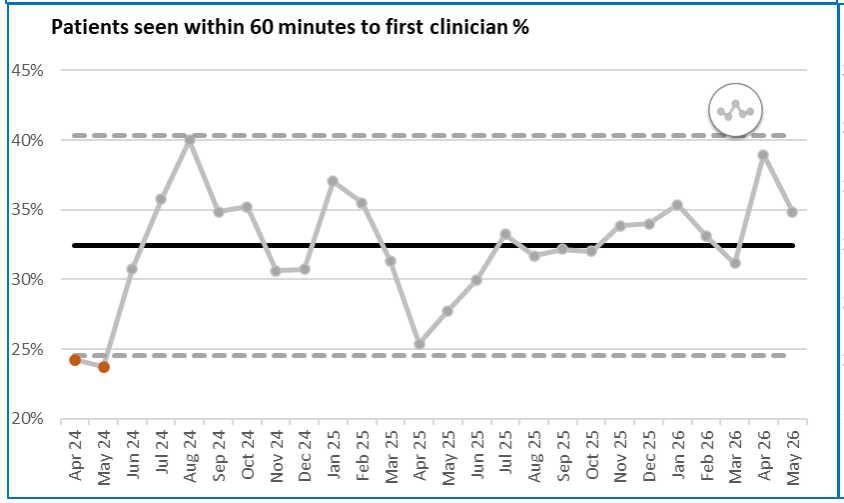
Appendix 1 – supporting detail on Responsiveness

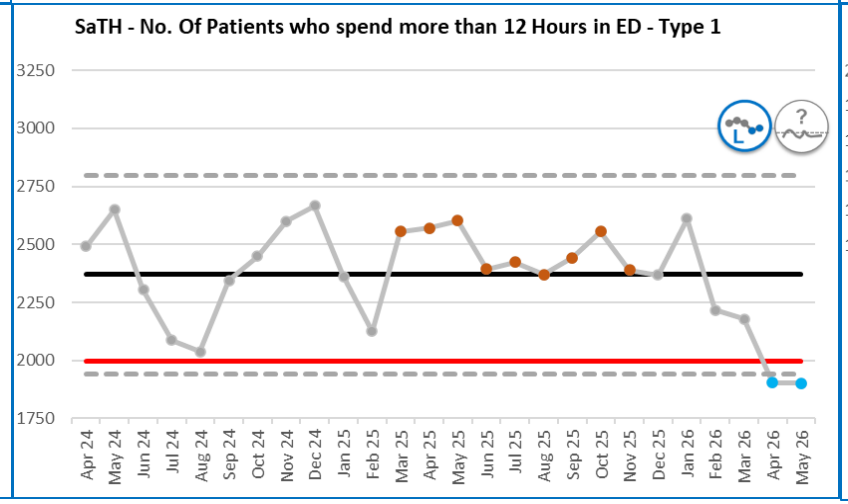
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

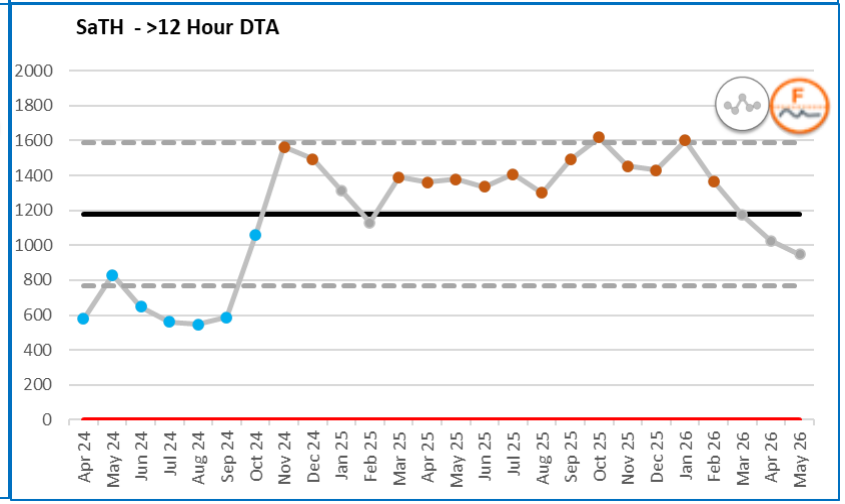












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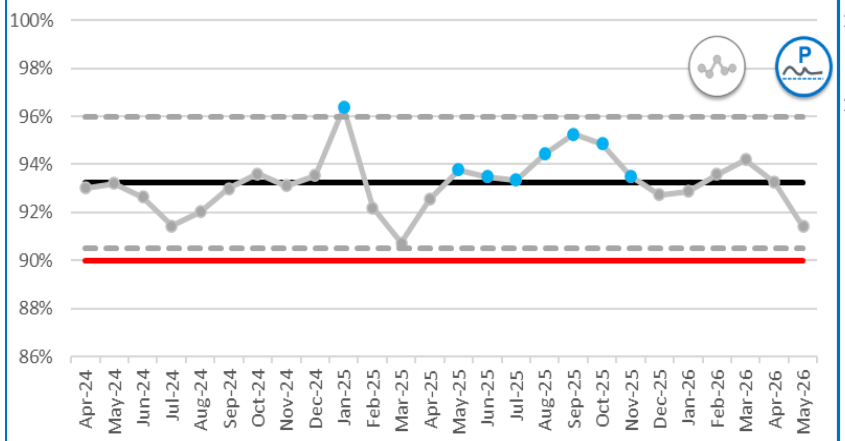
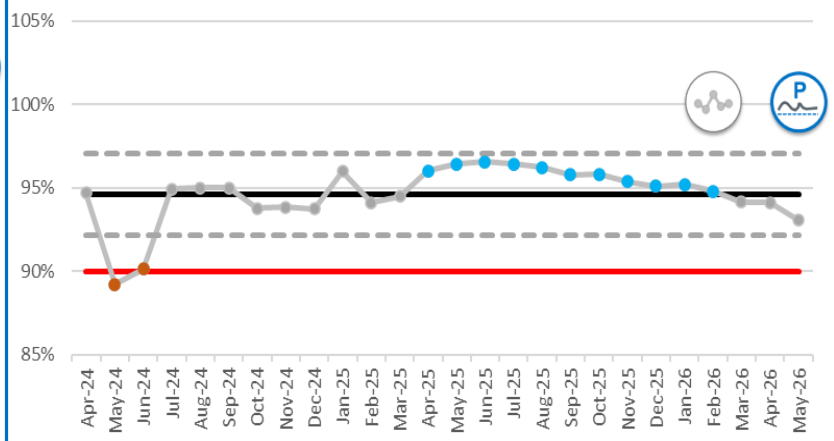
Appendix 2 – supporting Well Led

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

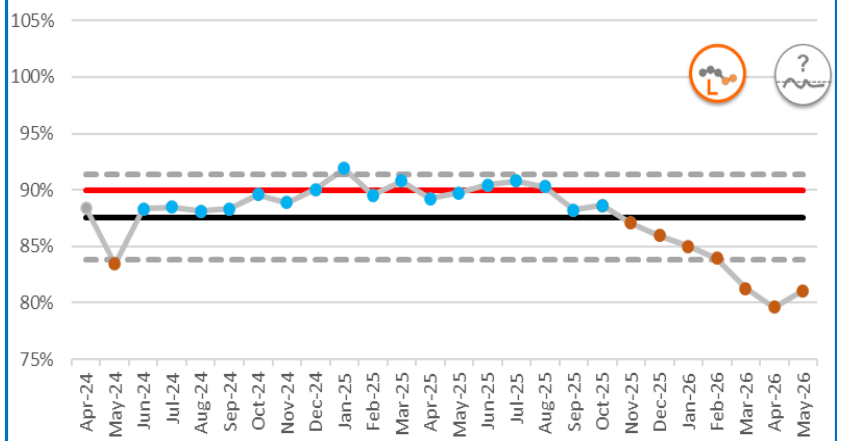
Appraisal – medical staff



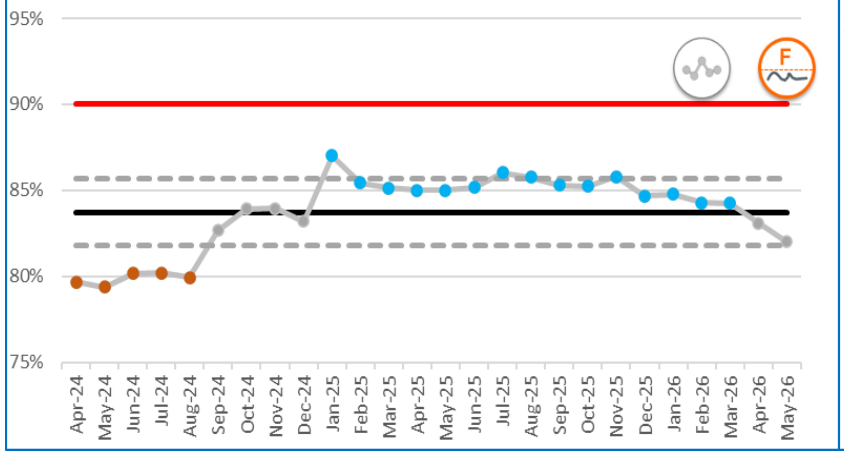
Safeguarding Children Level 2



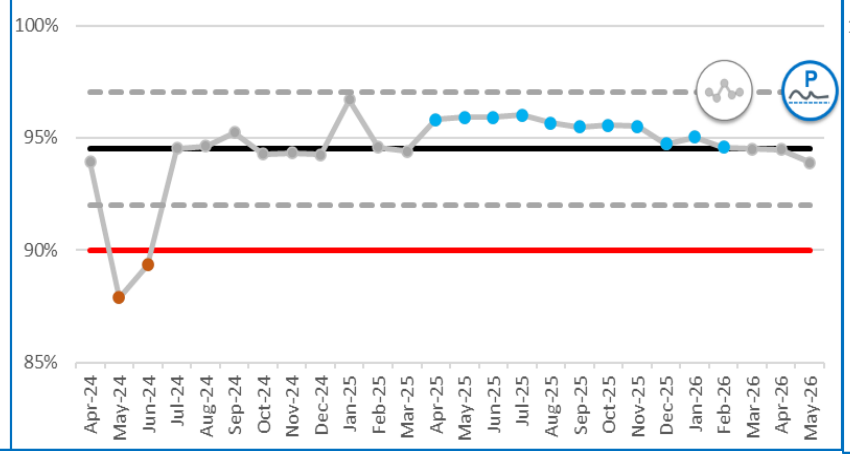
Safeguarding Children Level 3



MCA – DOLS and MHA



Safeguarding Adults Level 2



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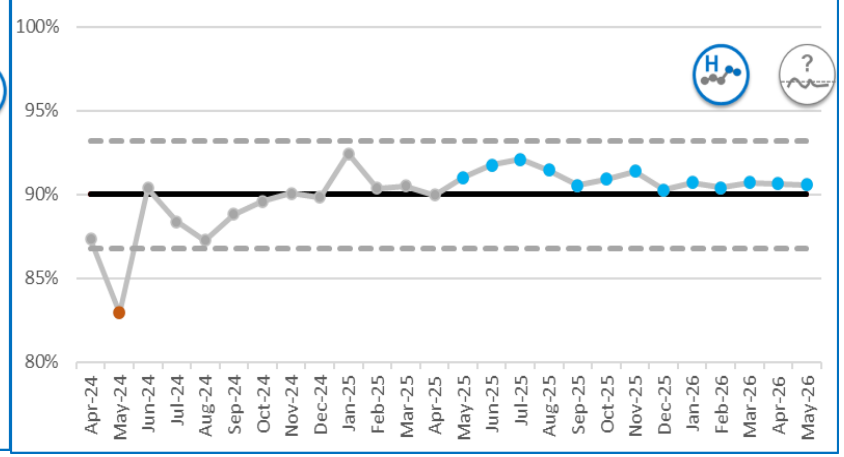

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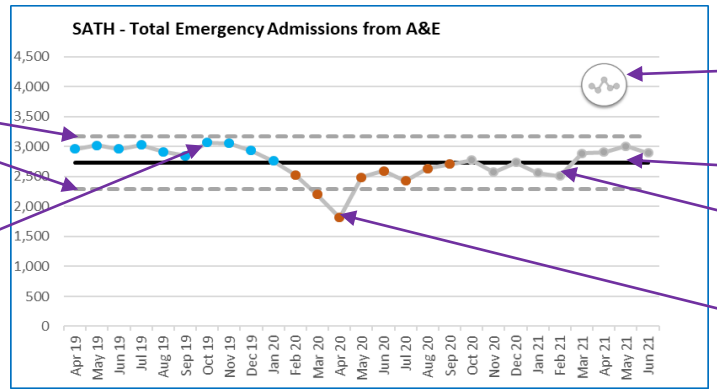
Appendix 3 – Understanding statistical control process charts in this report

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

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. SPC charts need more than 15 data points to accurately represent a process and distinguish between common cause variation and special cause variation. A minimum of 15 data points, and preferably 20 or more, is recommended to establish reliable control limits and detect meaningful shifts or trends.

Process limits – upper and lower

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



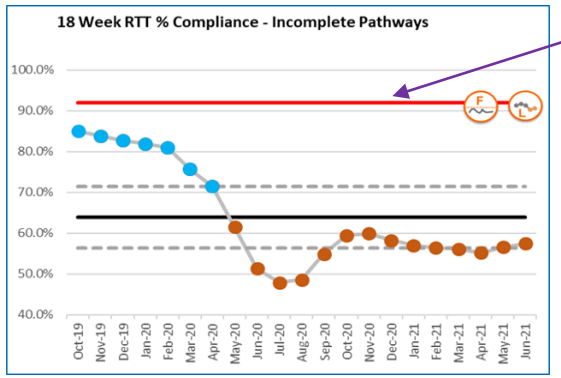
Icon showing most recent point type of variation

Mean or median line

Common cause variation

Special cause variation – data point outside of the process limit

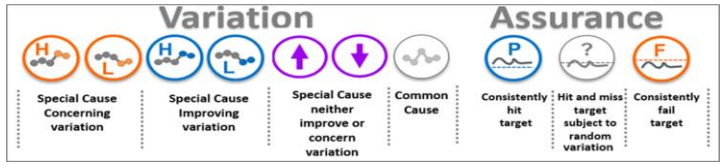
Where a target has been set the target line is superimposed on the SPC chart. It is not a function of the process.

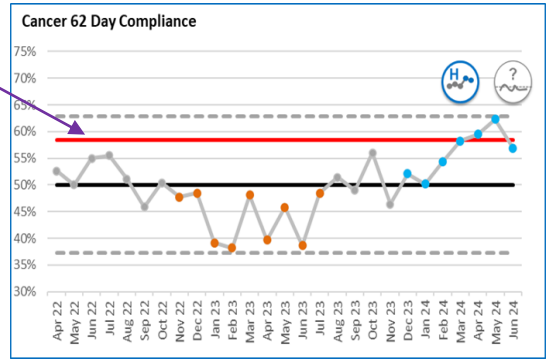


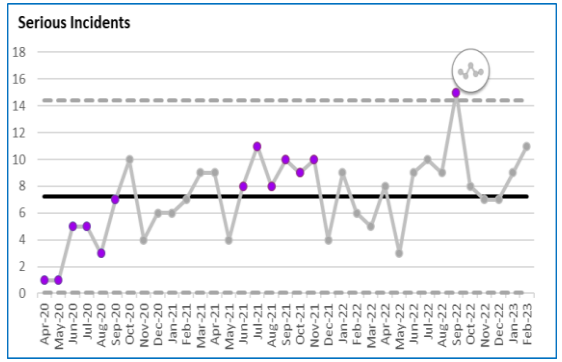
Target line – outside the process limits.

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







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Appendix 4 – Abbreviations used in this report

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

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

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

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

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

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 in Common: 9 July 2026

Agenda item		040/26		
Report Title		SaTH Community Engagement Strategy 2026-2030		
Executive Lead		Nigel Lee, Group Chief Strategy and Integration Officer		
Report Author		Julia Clarke, SaTH Director of Public Participation		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe		Our patients and community	√	BAF9
Effective		Our people		
Caring		Our service delivery		**Trust Risk Register id:**
Responsive		Our governance		
Well Led	√	Our partners		
Consultation Communication		Public Assurance Forum April/September 2025 and January/March 2026. Community Focus Groups Dec 2025 and Jan 2026, Community members and staff surveys - Sept 2025 and January2026 Senior Leadership Committee March 2026		
Executive summary:		The three elements of Public Participation are Community Engagement (including HTP), Volunteers and SaTH Charity (which is a separate legal entity but links closely with the other two NHS areas. The Shrewsbury and Telford Hospital NHS Trust published its five-year Strategy for SaTH Charity in 2025. Charity – SaTH This paper presents the SaTH Community Engagement Strategy (2026-2030) after extensive community and staff engagement in 2025/6. When approved it will be available separately and also combined with the other two Public Participation Strategies (Volunteers and Charity) into a single high-level Public Participation Strategy 2026-2030. Progress against the objectives will be monitored through the Trust Public Assurance Forum. We are also working with the Patient Reader Group to provide an accessible version of this combined document.		
Recommendations		The Boards in Common are asked to: **NOTE** the extensive engagement to date on the Community Engagement Strategy, and **APPROVE** the SaTH Community Engagement Strategy 2026-2030.		
Appendices:		Appendix 1: Community Engagement Strategy 2026-2030		

1.0 Public Participation Team

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

- Community Engagement including the Hospitals Transformation Programme
- Volunteering
- SaTH Charity

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

Updates on the Public Participation activity are reported to the Trust Public Assurance Forum, which was established in 2021 to oversee and scrutinise engagement activity across the Trust and is co-chaired by Professor Trevor Purt (SaTH NED) and Cllr Joy Jones (Montgomery Health Forum). It meets quarterly and reports to Trust Board. Other community members include representatives from patient organisations and the voluntary sector. SaTH representatives include directors and the four Divisions who also give a regular update to the meeting. At its next meeting the Public Assurance Forum will be asked to consider extending membership to include representatives from Shropshire Community Trust.

2.0 Community Engagement

2.1 Engagement to date:

- Workshop with engagement team and ICB and Strategy colleagues October 2025 (SCHT colleagues were invited).
- Away Day with wider Public Participation Team October 2025 to discuss
- Widespread conversations with communities at events around the county and mid-Wales with the community engagement team during 2025/6 to gather views
- Survey issued to 5000+ Community members November 2025– over 300 responses
- Survey issued to 300+ SaTH Managers November 2025– over 150 responses
- HTP Focus Group for members of the public held 2/12/25 and further focus group 22/1/26
- Draft Strategy issued to Public Assurance Forum, SaTH Managers, colleagues at ICB and Shropshire Community Trust and 5000 community members through newsletter 11/2/26 for feedback by 11/3/25 – all comments included in Strategy

2.2 The feedback from the public surveys and focus groups focused on five themes

Joined up working - Work together with system partners, VCSE and other stakeholders to identify the synergies in organisational priorities to streamline engagement and maximise capacity

Prevention - Work to support the reduction of health inequalities across the communities we serve. There are complex reasons why people and services don't always match up and understanding this and what people want can help reduce this gap

Communication - Increase opportunities to provide feedback to our communities on the difference their involvement has made, to establish

relationships based on trust and transparency and to empower local communities and build a culture of involvement

Transforming Care - Ensure early involvement in transformational programmes at SaTH and system-wide to build in engagement – better design involving local people can lead to improved access, experience and outcomes –those who rely on our services should have a say in the decisions we make

Foundation Trust status - Move towards the national objective of all Trusts achieving Foundation Trust status by 2035, with the first wave in 2026

2.3 The feedback from managers focused on:

Building stronger partnerships with community organisations
Improving health education in communities
Building trust with local communities

2.4 The updated Strategy was approved at SaTH Senior Leadership Committee and Public Assurance Forum in March 2026

3.0 Next steps

Work with SaTH Patient Reader Group to provide accessible copy of Public Participation high-level Strategy document (Including Community Engagement, Volunteers and SaTH Charity).

Progress against the Community Engagement element will be monitored quarterly through the Public Assurance Forum (with Volunteer Strategy updates reporting quarterly to the Group People Committee and SaTH Charity to the Charitable Funds Committee).

4. Recommendations

The Boards in Common are asked to:

NOTE the extensive engagement to date on the Community Engagement Strategy, and

APPROVE the SaTH Community Engagement Strategy

Julia Clarke
Director of Public Participation
June 2026

NHS
The Shrewsbury and Telford Hospital
NHS Trust

#GETINVOLVED

2026-2030

SHREWSBURY AND TELFORD HOSPITAL COMMUNITY ENGAGEMENT STRATEGY

WELCOME TO THE COMMUNITY ENGAGEMENT STRATEGY 2026 - 2030

by Jo Williams, Group Chief Executive and Andrew Morgan, Group Chair in Common

At The Shrewsbury and Telford Hospital NHS Trust, we believe that kindness and community involvement can make a real difference and transform lives. We have listened carefully to our patients, local communities, staff, and partners, and your feedback has helped shape our plans for the future.

This Community Engagement Strategy sets out our goals for the next five years. Together with our Volunteer Strategy and the Shrewsbury and Telford Hospital Charity Strategy, it will guide how we strengthen Public Participation across the Trust. Through #GetInvolved, we will offer a wide range of opportunities for people to take part, with a particular focus on supporting seldom-heard groups who may face barriers to accessing healthcare. This work will help reduce health inequalities and support our clinical teams to work closely with local communities when shaping future services.

As a hospital Trust working closely with Shropshire Community Health Trust through our newly formed Group Model, and with our partners at NHS Shropshire, Telford & Wrekin, we believe this Strategy supports the major changes happening across the NHS, including those set out in the NHS 10 Year Plan. We will work with all our partners to put this Strategy into practice as we redesign our services and how we work. Our aim is to improve the health and wellbeing of people across Shropshire, Telford & Wrekin and mid-Wales. This includes delivering the Hospitals Transformation Programme, which will bring significant improvements to how local health services are provided for the future.

We know we cannot achieve this alone. Patients, carers and our local communities must remain at the centre of everything we do. We now have more than 5,000 community members and 400 organisational members, and we will continue to build on this as we work towards becoming a Foundation Trust.

As you read this Strategy, we invite you to #GetInvolved and help us shape a healthier future for everyone in the communities we serve across Shrewsbury, Telford & Wrekin and Mid-Wales.

WHERE WE ARE NOW

Community Engagement Today

More than
5000
Community Members

Reducing Health Inequalities

Regular
About Health
events

More than
470
Networked Organisations

ATTEND 100s of
community events/meetings

ORGANISE dozens of
community events/meetings

Regular
Hospital Update
events

STRATEGY ON A PAGE

OUR VISION

To support the provision of excellent care for the communities we serve

OUR ENGAGEMENT VALUES

Partnering - Working effectively together with communities, colleagues, the local health & care system and other stakeholders

Ambitious - Engaging with our communities to deliver significant benefits to our patients and their families to have a positive input into the services we deliver

Caring - Showing compassion, inclusion and respect for our communities to enable their voices to be heard within our organisation

Trusted - Creating safe environments for our communities that enable them to receive and share information

STRATEGIC OBJECTIVE 1
MORE JOINED-UP WORKING

Work together with system partners, Voluntary, Community and Social Enterprise (VCSE) and other stakeholders to identify the synergies in organisational priorities to streamline engagement and maximise capacity

STRATEGIC OBJECTIVE 2
FOCUS ON PREVENTION NOT TREATMENT

Work to support the reduction of health inequalities across the communities we serve. There are complex reasons why people and services don't always match up and understanding this and what people want can help reduce this gap

STRATEGIC OBJECTIVE 3
SUPPORTING SERVICE TRANSFORMATION

Ensure early involvement in transformational programmes at SaTH and system-wide to build in engagement – better design involving local people can lead to improved access, experience and outcomes –those who rely on our services should have a say in the decisions we make

STRATEGIC OBJECTIVE 4
COMMUNICATION AND FEEDBACK

Increase opportunities to provide feedback to our communities on the difference their involvement has made, to establish relationships based on trust and transparency and to empower local communities and build a culture of involvement

STRATEGIC OBJECTIVE 5
FOUNDATION TRUST

Move towards the national objective of all Trusts achieving Foundation Trust (FT) status by 2035, with the first wave in 2026

OBJECTIVE 1

MORE JOINED-UP WORKING

Work together with system partners, Voluntary, VCSE and other stakeholders to identify the synergies in organisational priorities to streamline engagement and maximise capacity

WHAT WE WILL DO	ENABLERS	OUTCOMES	TIMESCALE
1. Develop system-wide approach to key health priorities eg obesity, smoking to ensure efficient, targeted engagement across all partners and agreed annual programme of engagement	Work with system colleagues to understand key programme priorities each year to ensure shared messages	Published schedule of targeted engagement for year ahead	2026-2030
2. Develop all opportunities for joint working with Shropshire Community Trust as part of the Group Model from April 2026.	Share work programmes and areas of joint interest with Engagement leads to avoid duplication and maximise resources	Jointly developed published programme of engagement	2026-2030
3. Work collaboratively with partners and support the Neighbourhoods and PLACE developments to share learning, good practice and impact	Use the health and wellbeing strategy that the Health and Wellbeing Board (HWBB) for Shropshire and Telford & Wrekin have developed to inform our annual workplan based on what matters most to local people	Develop mechanism to receive feedback from Shropshire Integrated Place Based Partnership (SHIPP) and Telford and Wrekin Integrated Place Partnerships (TWIPP) on engagement activity	2026-2030

OBJECTIVE 2

FOCUS ON PREVENTION NOT TREATMENT

Work to support the reduction of health inequalities across the communities we serve. There are complex reasons why people and services don't always match up and understanding this and what people want can help reduce this gap

WHAT WE WILL DO	ENABLERS	OUTCOMES	TIMESCALE
1. Utilise the Core20plus 5 Health Inequalities model (a national approach to reduce health inequalities in 5 clinical areas for the most deprived 20% of our population). This model is used to drive engagement activities and signpost patients and citizens to services available in primary and community care to support them and move towards prevention rather than treatment	Work with system partner colleagues to understand the range of support services available in the community and how to access them and obtain resources to share with relevant communities/individuals, focussing particularly on communities experiencing health inequalities	Published schedule of targeted engagement for year ahead in clinical areas such as cancer, diabetes, respiratory and cardiovascular as well as underlying conditions such as dementia and obesity	2027/8
2. Focus on reducing local health inequalities using data available through public health to drive engagement activities and proactively reach out to people who are often under-represented in our work. Meet with people where they live and go to their forums so we can focus on achieving maximum effectiveness	Work to publish annual workplan and shared with partners	Jointly developed published programme of engagement for groups more likely to experience health inequalities	2027/8
3. Develop an annual programme of visits to seldom heard groups that data shows experience inequity of health access to ensure they receive information face to face and their voice can be heard	Share work programmes and areas of joint interest with system Engagement leads to avoid duplication and maximise resources	Jointly developed published programme of engagement to seldom heard groups	2028/9

OBJECTIVE 3

SUPPORTING SERVICE TRANSFORMATION

Ensure early involvement in transformational programmes at SaTH and system-wide to build in engagement – better design involving local people can lead to improved access, experience and outcomes –those who rely on our services should have a say in the decisions we make

WHAT WE WILL DO	ENABLERS	OUTCOMES	TIMESCALE
1. Continue to deliver the programme of engagement supporting the Hospital Transformation Programme (HTP) and any associated projects	Continue to work closely with the HTP team and report to the HTP Programme Board	Public involvement in all areas and stages of the Programme	2026-28
2. Establish links with SaTH Service Improvement team and System Transformational teams to understand service changes/developments that are being planned and make sure engagement becomes part of the process for all service change programmes so early involvement of patients, carers and the public can take place and we can share messages and feedback with our communities	Develop involvement mechanism with Leads across the system to share/involve engagement team early in any proposed changes or developments	Greater structured involvement of the public/patient voice in service changes	2026/7
3. Help staff develop the skills and confidence to engage patients and the public. Provide training and tools to help more teams learn how to plan and deliver meaningful involvement activities and to ensure informed and high-quality engagement is undertaken	Attend Divisional Boards to provide update and make sure staff know where to find the engagement team, support and practical resources	Toolkits and training videos available on intranet and bespoke training sessions	2026-30

OBJECTIVE 4
COMMUNICATION AND FEEDBACK
Increase opportunities to provide feedback to our communities on the difference their involvement has made, to establish relationships based on trust and transparency and to empower local communities and build a culture of involvement

WHAT WE WILL DO	ENABLERS	OUTCOMES	TIMESCALE
1. Make sure our communities receive the right information, at the right time in a format that is accessible and inclusive and avoids NHS jargon	Work with patient reader panels and using AI	Timely, jargon-free information in different formats everyone can access and understand	2026/7
2. Share and measure the impact of involvement – show people how their input has made a difference and measure progress. Produce short summary reports following any engagement activities in a format that is easy to read and shared with the groups and also available more widely to share the learning and impact of our engagement. Be honest about what can't be changed and celebrate what we have done well together.	Measure and share engagement impact through easy-read reports that honestly show what changed, explain constraints, and celebrate collective achievements	Deliver timely, jargon-free information in different formats everyone can access and understand	2027/8
3. Share and measure the impact of involvement – show people how their input has made a difference and measure progress. Produce short summary reports following any engagement activities in a format that is easy to read and shared with the groups and also available more widely to share the learning and impact of our engagement. Be honest about what can't be changed and celebrate what we have done well together.	Measure and share engagement impact through easy-read reports that honestly show what changed, explain constraints, and celebrate collective achievements	Support aims of NHS Plan and supporting patients to move towards digital healthcare	2026/7

OBJECTIVE 5
FOUNDATION TRUST
Move towards the national objective of all Trusts achieving Foundation Trust (FT) status by 2035, with the first wave in 2026

WHAT WE WILL DO	ENABLERS	OUTCOMES	TIMESCALE
1. Increase Community members – In 2025 SaTH has 5300 community members and over 400 organisations but will need to review geographic spread, numbers etc when FT guidance issued. Community members are members of the public who have signed up to learn about their local hospitals, share their views on hospital services, and receive a monthly newsletter on ways to get involved.	Work closely with SaTH Foundation Trust Programme Board when established	Timely, jargon-free information in different formats everyone can access and understand	2026-30
2. Review function and membership of Public Assurance Forum – set up Forum with representative organisations and, as far as is practicable, similar constitution to a Council of Governors, co-chaired by a Non Executive Director and public member.	Review membership when guidance issued about FT membership /governors. Work closely with SaTH Director of Governance and FT Programme Board when established	Deliver timely, jargon-free information in different formats everyone can access and understand	2026/7
3. Continue to work with and develop our relationships with organisations that help and care for people in their Community (voluntary sector, Community Groups, GPs, HealthWatch and Llais) to help us listen to and learn from what our communities are saying about our services. We will be open to community feedback and honest about what we can do to make our services better.	Partner with community/voluntary organisations to actively listen to feedback and respond honestly about how we'll improve services	Support aims of Fit for the Future: NHS 10 Year Health Plan published in July 2025 and supporting patients to move towards digital healthcare	2026-30

COMMUNITY ENGAGEMENT ROADMAP

2026/7

Continue to deliver the programme of engagement supporting the Hospital Transformation Programme; Make sure our communities receive the right information, at the right time; Maximising digital opportunities for involvement and health; Review function and membership of Public Assurance Forum

2027/8

Utilise the Core20plus 5 Health Inequalities model to drive engagement activities; Focus on reducing local health inequalities; Establish links with SaTH Service Improvement team and System Transformational teams; Share and measure the impact of involvement

2028/30

Develop an annual programme of visits to seldom heard groups

2026 2027 2028 2029 2030

2026-2030

Develop a system-wide approach to key health priorities; Develop all opportunities for joint working with Shropshire Community Trust; Work collaboratively with partners and support the Neighbourhoods and PLACE developments; Help staff develop the skills and confidence to engage patients and the public; Increase Community members; Continue to work with and develop our relationships with organisations that help and care for people in their Community

GOVERNANCE AND REPORTING

WE WILL:

- Report quarterly to the Public Assurance Forum with community and voluntary public members who review processes, decision making and wider work at The Shrewsbury and Telford Hospital NHS Trust. It is an advisory group who ensure that decisions about services and the delivery of care are developed in partnership with our local communities. The joint Chairs are a Non-executive Director and lay member and all papers are published on our website.
- Six-monthly reports to SaTH Senior Leadership Committee and Public Trust Board
- Contribute to the Trust Annual Report and Quality Accounts

#GETINVOLVED

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Board of Directors' Meeting in Common: 9 July 2026

Agenda item		041/26		
Report Title		SaTH Volunteer Strategy 2026-2030		
Executive Lead		Nigel Lee, Group Chief Strategy and Integration Officer		
Report Author		Julia Clarke, SaTH Director of Public Participation		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe		Our patients and community	√	BAF9
Effective		Our people		
Caring		Our service delivery		**Trust Risk Register id:**
Responsive		Our governance		
Well Led	√	Our partners		
Consultation Communication		Public Assurance Forum April/September 2025 and January/March 2026. Volunteer Focus Group Dec 2025 and Volunteer and staff surveys - Sept 2025 and January2026 Senior Leadership Committee March 2026		
Executive summary:		The three elements of Public Participation are Community Engagement (including HTP), Volunteers and SaTH Charity (which is a separate legal entity but links closely with the other two NHS areas. The Shrewsbury and Telford Hospital NHS Trust published its five-year Strategy for SaTH Charity in 2025. Charity – SaTH This paper presents the SaTH Volunteer Strategy (2026-2030) after extensive volunteer and staff engagement in 2025/6. When approved it will be available separately and also combined with the other two Public Participation Strategies (Volunteers, Community Engagement and Charity) into a single high-level Public Participation Strategy 2026-2030. Progress against the objectives will be monitored through the Group People Committee. We are also working with the Patient Reader Group to provide an accessible version of this combined document.		
Recommendations		The Boards in Common are asked to: **NOTE** the extensive engagement to date on the Volunteer Strategy **APPROVE** the SaTH Volunteer Strategy		
Appendices:		Appendix 1: SaTH Volunteer Strategy 2026-2030		

1.0 Public Participation Team

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

- Volunteering
- Community Engagement including the Hospitals Transformation Programme
- SaTH Charity

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

Updates on the Public Participation activity are reported to the Trust Public Assurance Forum, which was established in 2021 to oversee and scrutinise engagement activity across the Trust and is co-chaired by Professor Trevor Purt (SaTH NED) and Cllr Joy Jones (Montgomery Health Forum). It meets quarterly and reports to Trust Board. Other community members include representatives from patient organisations and the voluntary sector. SaTH representatives include directors and the four Divisions who also give a regular update to the meeting. At its next meeting the Public Assurance Forum will be asked to consider extending membership to include representatives from Shropshire Community Trust.

From July 2026 the Volunteer Activity will also be reported to the Group People Committee quarterly, plus staff support provided by SaTH Charity. The report will also contain updates from Shropshire Community Trust.

2.0 Volunteers

2.2 Volunteer Strategy

Engagement to date:

- Workshop with engagement team and ICB and Strategy colleagues October 2025
- Away Day with wider Public Participation Team October 2025
- Conversations with communities at events around the county and mid-Wales
- Survey issued to 200 Volunteers November 2025
- Survey issued to SaTH Managers November 2025– over 150 responses
- Volunteers Focus Group held 5/12/25
- Draft Strategy issued to Public Assurance Forum, SaTH Managers, colleagues at ICB and Shropshire Community Trust and 230 volunteers 11/2/26 for feedback by 12/3/26 – all comments included in draft strategy

2.3 The feedback from our volunteers (58 responses) focuses on five themes

Recruitment - Offer a thriving and inclusive volunteer programme providing meaningful and rewarding opportunities for volunteers and an individualised and supportive experience which align with patient and clinical priorities

Experience - Develop models of volunteering that maximises the quality of the volunteering experience and lead to improved retention

Two-way communication and feedback - Provide more opportunities for our volunteers to share their ideas and feedback to them on outcomes

Transformational Volunteering partnerships - Develop strong strategic partnership links at national and local level to bring the greatest benefit to the patients and become a national beacon for innovative volunteer schemes

Information systems - Expand our volunteer management systems to manage and share our data to better capture the impact of volunteering in order to increase the recognition of its value and visibility

2.4 The feedback from managers (97% reported positive experience of working with volunteers) focuses on:

Majority want more volunteers
Need structured support/training for staff managing volunteers
Need flexible volunteer roles to keep volunteers engaged in long-term

2.5 The updated Strategy was approved at SaTH Senior Leadership Committee and Public Assurance Forum in March 2026

3.0 Next steps

Work with SaTH Patient Reader Group to provide accessible copy of Public Participation high-level Strategy document (Including Community Engagement, Volunteers and SaTH Charity).

Progress against the Community Engagement element will be monitored quarterly through the Public Assurance Forum (with Volunteer Strategy updates reporting quarterly to the Group People Committee and SaTH Charity to the Charitable Funds Committee).

4. Recommendations

The Boards in Common are asked to:

NOTE the extensive engagement to date on the Community Engagement Strategy, and

APPROVE the SaTH Community Engagement Strategy

Julia Clarke
Director of Public Participation
June 2026

NHS
The Shrewsbury and Telford Hospital
NHS Trust

VOLUNTEER
The Shrewsbury and Telford Hospital NHS Trust

SHREWSBURY AND TELFORD HOSPITAL

VOLUNTEER STRATEGY

2026-2030

WELCOME TO THE VOLUNTEER STRATEGY 2026 - 2030
by Jo Williams, Group Chief Executive and Andrew Morgan, Group Chair in Common

This strategy supports the important work of our volunteers who help in our local hospitals. We are very grateful for our amazing volunteers.

They make a real difference in so many ways, including:

- Improving patient experience
- Supporting staff wellbeing
- Gaining new skills, confidence and experience themselves

Our 200+ volunteers are an important part of the Shrewsbury and Telford Hospital NHS Trust family. Volunteers work in many different roles, but they all share the same goal — bringing comfort, kindness and reassurance to patients and their families. Volunteers also help shape hospital services by sharing their own experiences and listening to patients and what they would like to see.

The NHS 10 Year Plan highlights the importance of volunteering across the whole of the NHS. We will continue working with national organisations such as Helpforce to make volunteering even more beneficial for our volunteers, patients and our workforce. We want to offer opportunities for people of all ages and backgrounds to gain skills and experience in healthcare, which may lead to jobs or further education.
In April 2026, we will be part of a Group with Shropshire Community Trust. This creates new opportunities for closer working and better support for patients across Shropshire, Telford & Wrekin and Mid-Wales.

This Volunteer Strategy, along with our Charity and Community Engagement Strategies, sets the future direction for Public Participation at Shrewsbury and Telford Hospital NHS Trust. Through #GetInvolved, we will continue to offer many different ways for individuals and communities to take part.

Finally, we would like to thank all our volunteers for their time, dedication and care. We are truly grateful and look forward to building an even stronger and more rewarding volunteering programme for everyone involved

WHERE WE ARE NOW

26,637 hours of volunteer in 2025

National Volunteering Partnerships eg Helpforce, Duke of Edinburgh Scheme

220 Volunteers

57 volunteer roles available

STRATEGY ON A PAGE

OUR VISION

To provide excellent support for our volunteers and patients, along with offering opportunities to our communities.

OUR VOLUNTEER VALUES

Partnering - Working effectively with our volunteers, our communities, patients, families, staff and other stakeholders

PACT
Partnering Ambitious Caring Trusted

Ambitious - Supporting our volunteers to deliver significant benefits to our patients, their families and friends which will have a positive impact the services we deliver

Caring - Showing compassion, encouragement, respect and empathy to our volunteers and caring about the difference we make for our communities

Trusted - Being open, transparent and reliable, continuously learning, doing our best to consistently deliver excellent care for our volunteers and local communities

STRATEGIC OBJECTIVE 1

ENHANCE RECRUITMENT OFFER

Offer a thriving and inclusive volunteer programme providing meaningful and rewarding opportunities for volunteers and an individualised and supportive experience which align with patient and clinical priorities

STRATEGIC OBJECTIVE 2

IMPROVE OUR VOLUNTEER EXPERIENCE

Develop models of volunteering that maximise the quality of the volunteering experience and lead to improved retention

STRATEGIC OBJECTIVE 3

MORE TWO-WAY COMMUNICATION AND FEEDBACK

Feedback is a gift! Provide more opportunities for our volunteers to share their ideas and feedback to them on outcomes

STRATEGIC OBJECTIVE 4

BUILD TRANSFORMATIONAL VOLUNTEERING PARTNERSHIPS

Develop strong strategic partnership links at national and local level to bring the greatest benefit to the patients and become a national beacon for innovative volunteer schemes

STRATEGIC OBJECTIVE 5

USE INFORMATION SYSTEMS TO MEASURE PERFOMANCE AND ENSURE INCLUSIVITY

Expand our volunteer management systems to manage and share our data to better capture the impact of volunteering in order to increase the recognition of its value and visibility

OBJECTIVE 1
ENHANCE RECRUITMENT OFFER

Offer a thriving and inclusive volunteer programme providing meaningful and rewarding opportunities for volunteers and an individualised and supportive experience which align with patient and clinical priorities

WHAT WE WILL DO	ENABLERS	OUTCOMES	TIMESCALE
1. We will create and design volunteering roles with robust recruitment checks in partnership with clinicians/managers /volunteers for roles that make a difference, are best suited to the volunteers skills and wishes, help deliver the Trust's vision, support HTP, enhance the patient journey and are rewarding for volunteers	Review all current roles to ensure all roles are still relevant and effective, especially those roles with higher turnover rates and produce video clips showing the range of different roles for volunteers to view before interview	5% increase in annual hours delivered by volunteers through higher role satisfaction	2026-2030
2. We will enhance our wellbeing and peer support for volunteers, particularly to new volunteers through a system of regular follow-up meetings/calls during first 6 months to ensure new volunteer is well-supported.	Review all current roles to ensure all roles are still relevant and effective, especially those roles with higher turnover rates and produce video clips showing the range of different roles for volunteers to view before interview	5% Reduction in number of volunteers who leave within first six months	2026/7
3. We will develop a sustainable pipeline and route for volunteers looking for a future career in the NHS building on our existing links with local organisations	Offer the current Volunteer to Career (VtC) programme to all new volunteers interested in the NHS. Develop a formal programme as an 'Accredited Provider' for the full range of Duke of Edinburgh Awards	Double number of cohorts per year and increase number of VtC volunteers going onward with health-related careers/studies	2026/7

OBJECTIVE 2
IMPROVE OUR VOLUNTEER EXPERIENCE

Develop programme of recognition and celebration building on national Volunteers Week/Long Service Awards and Trust Awards and increase the visibility, value and recognition of volunteering

WHAT WE WILL DO	ENABLERS	OUTCOMES	TIMESCALE
1. Develop programme of recognition and celebration building on national Volunteers Week/Long Service Awards and Trust Awards and increase the visibility, value and recognition of volunteering	Develop the identity/brand with volunteers and staff and develop a clear celebration plan for Volunteering Week	Deliver a programme of recognition and celebration	2027/8
2. Implement a series of Volunteer group wellbeing sessions with the Trust Staff Support service. Sessions to focus on resilience, relaxations, mindfulness etc. Provide clear and readily available information on who to contact in difficult situation	Agree annual programme with SaTH staff support service and advertise to volunteers	Maintaining high volunteer satisfaction levels in annual survey	2026/7
3. Develop ward/department accreditation/recognition for excellent support provided to volunteers by local team leaders	Discuss accreditation/recognition model with Executive Nurse	Understanding of role of volunteers by local teams and better integration into area for volunteers	2027/8
4. Monitor and assess activity and feedback to ensure volunteer experience and team resources are used effectively	Develop short annual staff survey for local volunteer managers to complement annual Volunteer survey and to identify any new volunteering opportunities that may be available	To address any mismatch between volunteer experience and manager's perceptions	2028/9

OBJECTIVE 3

MORE TWO-WAY COMMUNICATION AND FEEDBACK

Feedback is a gift! Provide more opportunities for our volunteers to share their ideas and feedback to them on outcomes

WHAT WE WILL DO	ENABLERS	OUTCOMES	TIMESCALE
1. Introduce a formal six-monthly review meeting open to all volunteers to give feedback/suggestions and give volunteers the opportunity to contribute via survey/email/in writing to encourage maximum engagement and feedback	Arrange hybrid (Teams and face to face) meetings and vary times to make widely available	Open discussion on possible future developments and opportunities for volunteers to engage as Trust-wide team	2027/8
2. Enhance current monthly communication to volunteers – include feedback received and action taken and latest data on key performance measures in newsletters	Review content with volunteers	More tailored and meaningful communication	2026/7
3. Introduce quarterly focus groups for volunteers on different relevant topics eg HTP, Group Model etc	Agree annual programme with volunteers and options to change in light of local developments	Opportunities for volunteers to engage as Trust-wide team	2027/8

OBJECTIVE 4
BUILD VOLUNTEERING PARTNERSHIPS

Develop strong strategic partnership links at national and local level to bring the greatest benefit to the patients and become a national beacon for innovative volunteer schemes

WHAT WE WILL DO	ENABLERS	OUTCOMES	TIMESCALE
1. Build on our existing strong links with national organisations such as NHS Charities Together and Helpforce to develop and trial new volunteer roles identified at national level.	Continue to work closely and provide volunteer stories for national campaigns and to deliver established roles in most efficient way e.g. Volunteer to Career, Volunteer Discharge Driver scheme, Outpatient appointment "reminder" calls, and to continue to provide media interviews for national publicity launches	Maximum visibility for SaTH Volunteering offer and opportunities	2026-2030
2. Work across boundaries where opportunities present through the new Group model and look for opportunities to develop volunteer roles to support patients as they transition from hospital to community care.	Create links with Volunteer Leads at Shropshire Community Trust to maximise resources for the benefit of our patients	More joined up volunteer offer for patients and both organisations	2027/8
3. Work with new recognised partners to enhance volunteering offer eg Duke of Edinburgh scheme	Develop links at regional and national level	Volunteering offer extended to include accredited schemes	2026 - 2030

OBJECTIVE 5

USE INFORMATION SYSTEMS TO MEASURE PERFORMANCE AND ENSURE INCLUSIVITY

Expand our volunteer management systems to manage and share our data to better capture the impact of volunteering in order to increase the recognition of its value and visibility

WHAT WE WILL DO	ENABLERS	OUTCOMES	TIMESCALE
1. Develop wider and more meaningful performance measures with clear targets and reporting framework eg recruitment process at each stage (Application, training, DBS checks, Occupational Health checks, references, shadow shifts); leavers within six weeks, demographics to ensure representative of our communities	Clear performance targets and ensure regular measurement and reporting, including National Workforce Data Collection	Accessible and meaningful data on performance	2028/9
2. Enhance our systems to capture case studies from the perspective of volunteers, patients and staff for wide publication to demonstrate success of service at SaTH and potentially recruit more volunteers	Work with volunteers to ensure success stories are captured in different media forms eg "a day in the life of"	More meaningful information for prospective volunteers	2028/9

VOLUNTEER ROADMAP

2026/7

Annual reviews and regular wellbeing calls; extend volunteer to career opportunities; Introduce wellbeing session supported by SaTH staff service; revise current newsletter offer

2027/8

Develop clear volunteering brand and celebration events; introduce ward/department manager Volunteer accreditation scheme; introduce 6-monthly open sessions; introduce quarterly focus groups on requested topics; develop links and joint volunteering opportunities with Shropcom

2026 2027 2028 2029 2030

2026-2030

Review current roles and develop new ones; strengthen links with national organisations eg Helpforce and Duke of Edinburgh scheme

2028-30

Introduce annual survey for local team leaders; develop and share clear performance measures with volunteers; create a meaningful videos with volunteers of different roles

GOVERNANCE AND REPORTING

WE WILL:

- Report quarterly to the Public Assurance Forum with community and voluntary public members who review processes, decision making and wider work at The Shrewsbury and Telford Hospital NHS Trust. It is an advisory group who ensure that decisions about services and the delivery of care are developed in partnership with our local communities. The joint Chairs are a Non-executive Director and lay member and all papers are published on our website.
- Six-monthly reports to SaTH Senior Leadership Committee and Public Trust Board
- Contribute to the Trust Annual Report and Quality Accounts
- Provide our Volunteer statistics to the NHS Data Collection framework on the number of volunteers, hours provided and demographic information
- Ensure that feedback from our annual Volunteer survey is included in our future plans
- Capture and act upon any feedback from the formal Volunteer Group meetings

Director of Public Participation

Head of Public Participation

Volunteer Manager

Volunteer Facilitator(s)

Volunteer Administrator(s)

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Board of Directors' Meeting in Common – 9 July 2026

Agenda item	042/26		
Report Title	**SaTH's Integrated Improvement Plan (SIIP)**		
Executive Lead	Jo Williams, Group Chief Executive Officer		
Report Author	Mary Aubrey, Programme Director		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
Finance Assurance Committee 30/06/26. Perf Ass Committee 30/06/26 Group People Committee 25/05/26. Q&S Assurance Committee 03/07/26	Safe	√	BAF1, BAF2, BAF4, BAF5, BAF10
	Effective	√	
	Caring	√	**(SaTH) Risk Register id(s):**
	Responsive	√	CRR1, CRR2, CRR3, CRR4, CRR5, CRR6, CRR9, CRR10, CRR11, CRR12, CRR13, CRR15, CRR17, CRR19, CRR21, CRR22, CRR23, CRR27
	Well Led	√	
Executive Summary	• This report provides a summary of progress against the Integrated Improvement Plan (IIP) actions due for completion up to and including 30 June 2026, supported by evidence of delivery and assurance through established governance routes. • The remaining urgent and emergency care (UEC) undertakings have been incorporated into the 2026/27 UEC SIIP plan as Appendix 4 • The majority of actions due within the reporting period remain on track. A small number of actions have been identified as at risk, specifically Finance Action 1.5.1 and UEC Actions 3.1.1.7, 3.1.1.8 and 3.1.2.1, all of which are subject to ongoing monitoring and oversight through established governance arrangements. • The Boards' attention is drawn to Section 2, which details the most significant areas of progress, impact and ongoing focus.		
Recommendations	The Boards are asked to: • **Note** the actions and take assurance from the updates provided, including the evidence of delivery and governance oversight. • **Note** progress against delivery of the tasks/actions that were due up to and including 30 June 2026 as detailed in Appendices 1-4. • **Note** progress on the UEC undertakings, which have been incorporated into the 2026/27 UEC SIIP plan as Appendix 4, reflecting continued system focus and delivery trajectory		
Appendices (in Board Information Pack)	Appendix 1 - SaTH Governance and Leadership Plan 2026-27 Appendix 2 - SaTH Workforce and Leadership Plan 2026-27 Appendix 3 - SaTH Finance Plan 2026-27 Appendix 4 - SaTH UEC Plan 2026-27 and 2026/27 UEC Undertakings		

1. Introduction

SaTH exited the Recovery Support Programme (RSP) in FY2025/26. However, to demonstrate sustained improvement and oversight, the Trust has agreed with NHS England to continue with SaTH's Integrated Improvement Plan (SIIP) which has been refreshed for FY2026/27. This will support the continued embedding of improvement, strengthened governance, and sustained assurance of delivery.

This report summarises progress against all Integrated Improvement Plan (IIP) actions scheduled for completion up to and including 30 June 2026 and outlines the associated evidence and assurance demonstrating delivery.

The remaining urgent and emergency care (UEC) undertakings have been incorporated into the 2026/27 UEC SIIP plan as Appendix 4

Progress across the governance, workforce and leadership, finance, and urgent and emergency care (UEC) domains is detailed within this report providing the Board with a clear line of sight to delivery, impact and remaining focus.

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:

The information contained in Appendices 1–4 provides a summary of progress against delivery of the tasks and actions due up to and including 30 June 2026, as defined within SaTH's Integrated Improvement Plan. The UEC plan also includes an update on the UEC 2026/27 Undertakings. These have been approved by the relevant Executive Director and overseen through the appropriate Assurance Committee providing confidence in delivery, oversight and governance assurance.

Governance / Leadership

- **SaTH 4.1.0** – SaTH's governance arrangements continue to be reviewed and strengthened during 2026/27 to support effective oversight and assurance. The HTP Assurance Committee Terms of Reference have been reviewed and were considered at the May HTP Assurance Committee. These have been circulated for further comment ahead of the July 2026 meeting prior to onward approval by the Board of Directors. In addition, the Local Care Transformation Assurance Committee was established in June 2026, with Terms of Reference agreed at the June 2026 private Board and the first meeting was held on 26 June 2026.
- **SaTH 4.1.15** – The Hospitals Transformation Programme continues to be overseen through established governance and assurance arrangements. Recent progress includes ongoing workforce engagement activity, development of HTP workforce timescales for inclusion within the Master Programme, and continued alignment of HTP activity with wider Shropshire, Telford and Wrekin system transformation priorities.
- **SaTH 4.2.8** – The Group People and OD Committee in Common continues to develop as part of the emerging Group governance model. Following meetings held on 24 November 2025 and 26 January 2026, the People Committee forward workplan received further review in June 2026 with the Chief People Officer and team and is due to be considered at the September 2026 meeting. This supports continued development of joint workforce, culture and people governance across the Group.

Workforce and Leadership Collaborative

- **SaTH 2.1.26 / 2.2.9** – Workforce digital transformation continues, with 95% of resident doctors now on e-rostering, preparations underway for consultant rotas, and Manager Self-Service ESR fully deployed across the Trust.
- **SaTH 2.1.28 / 2.1.29** – The five-year workforce plan has been completed and is being socialised across the Trust, supported by launch of the 2026/27 job planning programme.
- **SaTH 2.1.30 / 2.1.31 / 2.1.32** – Workforce preparation for HTP is progressing through staff engagement, workforce timescale planning with the PMO, and continued alignment with STW system transformation priorities.
- **SaTH 2.1.33 / 2.1.34** – Workforce sustainability actions continue, including development of the sickness absence programme and Group temporary staffing strategy, supported by a task and finish group reviewing bank strategy and rates.
- **SaTH 2.2.8 / 5.4.2 / 5.4.5** – Leadership and cultural transformation activity continues through Executive development, Board development, People Pulse, NHS Staff Survey action planning, leadership programmes and Poppy's Promise cultural change work.

Finance

- There are no significant changes to report this month. Delivery of the Finance SIIP remains aligned to planned milestones.
- **SaTH 1.5.1** – This action has been identified as at risk of delivery due to revised implementation timescales associated with the business-as-usual target operating model. As a result, the completion date has been revised from 30 June 2026 to 31 August 2026 and will continue to be monitored through existing governance arrangements.

UEC

- **SaTH 3.1.1.7:** The Non-Admitted working group is awaiting feedback from Nexus Consulting on key drivers impacting ED performance which will help inform the group's work. ·
- **SaTH 3.1.1.8:** The Culture workstream is forming a sub-group to address the staff survey feedback relating to race discrimination. This is being worked on in collaboration with the Group Chief People Officer ·
- **SaTH 3.1.2.1** –The action relating to cardiology and respiratory referral response times remains at risk and continues to be monitored through established UEC governance arrangements.
- **SaTH 3.3.2:** Initial assessment performance has shown special cause improvement for 12 months with an average waiting time of 12 minutes in May 2026.
- **UEC Undertakings 2026/27** – The revised UEC undertakings remain on track. The 2026/27 UEC plan has now launched, reporting through UECTAC, with governance, programme management and assurance arrangements in place to support delivery. Sustained improvement continues to be demonstrated across 4-hour performance, 12-hour waits and ambulance handovers.

3. Recommendations

The Boards are asked to:

- **Note** the actions and take assurance from the updates provided, including the evidence of delivery and governance oversight.
- **Note** progress against delivery of the tasks/actions that were due up to and including 30 June 2026 as detailed in Appendices 1-4.
- **Note** progress on the UEC undertakings, which have been incorporated into the 2026/27 UEC SIIP plan as Appendix 4, reflecting continued system focus and delivery trajectory.

Board of Directors' Meeting in Common – 9 July 2026

Agenda item	043/26		
Report Title	SaTH Integrated Maternity & Neonatal Report		
Executive Lead	Martina Morris, Group Chief Nursing Officer John Jones, Group Chief Medical Officer		
Report Author	Lauren Taylor, Interim Head of Midwifery Julie Plant, Divisional Director of Nursing, Women & Children's		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
N/A	Safe	√	BAF1, BAF4, BAF3
	Effective	√	
	Caring	√	**(SaTH) Risk Register id(s):**
	Responsive	√	CRR, 16, 18, 19, 23, 27, 7,31
	Well Led	√	
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. **Assure** • In addition to the established internal audit process, through which the Trust's perinatal services test out how well the actions and recommendations from the Independent Maternity Review have been embedded, an independent external review has been commissioned to validate our progress and confirm that all actions recommendations have been fully delivered. The report is anticipated later this summer. • Monthly reporting of Maternity (Perinatal) Incentive Scheme (MIS) compliance has commenced for year 8. The service anticipates being fully compliant by the end of the reporting period. • The Trust has appropriate processes and documented guidance in place to ensure that compassionate care for bereaved babies and their families is provided. Following publication of the Independent Maternity Review at Nottingham University Hospitals NHS Trust (NUH), the Trust is awaiting confirmation of the requirements for review of mortuary records and incidents requested by NHS England and Human Tissue Authority.		

	Advise • The Independent Review of NUH Maternity services by Donna Ockenden was published on 24 June 2026. It contains 8 Immediate and Essential Action (IEA) headings, which contain a total of 18 EIAs. With the expected publication of Maternity services review by Baroness Amos on 30 June 2026, the Trust is planning to review and assess all recommendations against the current actions during July and ensure any additional learning is captured, including all immediate and essential actions for all maternity services in England arising from NUH review. The national Maternity Taskforce will be developing a national improvement plan for maternity services anticipated in December 2026. • One action, linked to the auditing of the Preterm Golden Hour remains at risk. Quarterly audits are in place and will be repeated until satisfactory compliance is reached. Progress is monitored and discussed monthly at the Quality and Safety LMNS workstream allowing for learning from practices within the region. **Alert** • A compliance risk has been raised for the Maternal Care Bundle/ Safety Action E, linked to the full implementation of the Maternity Care Bundle which require system support and partnership. However, the requirement for compliance with safety action E of the MIS Year 8 is to have a plan of implementation approved by Board which is anticipated to be completed by the end of the reporting period.
Recommendations for the Boards	The Boards are asked to receive this report for information and **assurance.**
Appendices: (All appendices are available in the Board Supplementary Information Pack)	Appendix 1: BOD Ockenden Report Appendix 2: Neonatal Review Board of Directors Appendix 3: MNTP Phase 2 – June 2026 Appendix 4: Year 8 CNST MIS Progress Report – June 2026 Appendix 5: Maternal Care Bundle Gap Analysis Appendix 6: BirthRate Plus Midwifery Workforce Report

1.0 Introduction

This report provides information and assurance on the following:

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

1.2 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.

1.3 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.

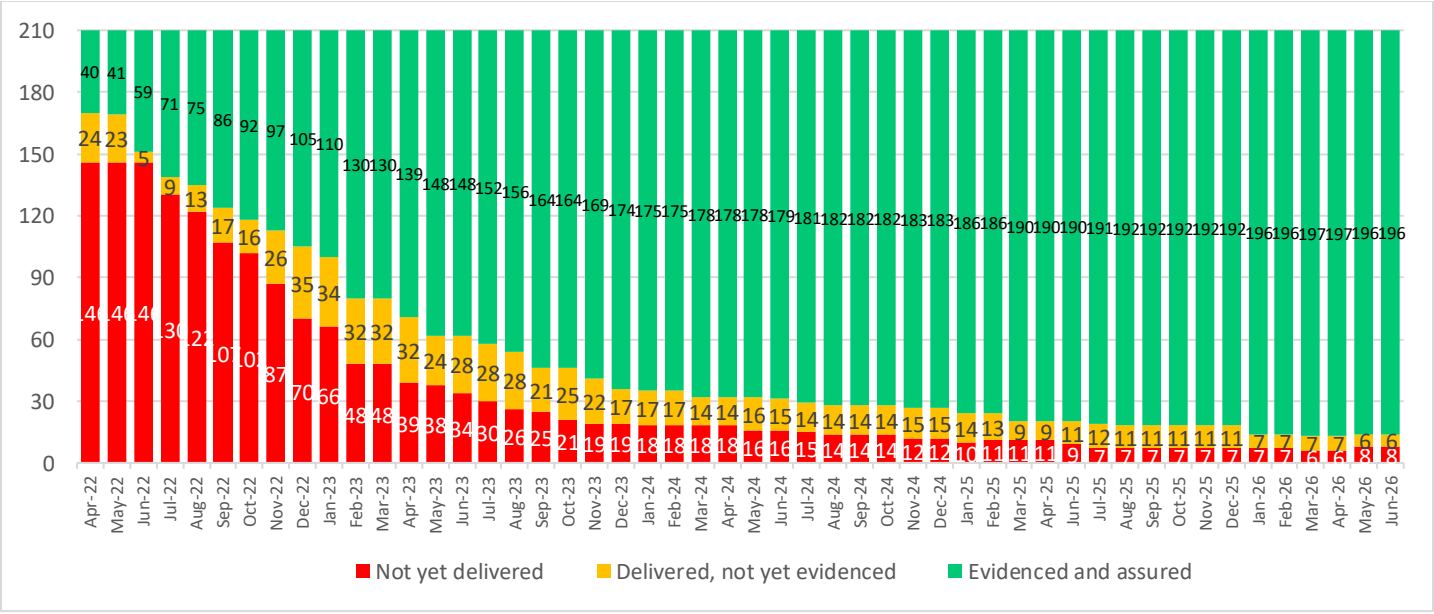
1.4 NHS Resolution's Maternity (and Perinatal) Incentive Scheme (Clinical Negligence Scheme for Trusts - CNST) Year Eight along with suggested wording for recording in the minutes of today's meeting.

1.5 Bereavement care of deceased babies and support for their families.

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 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 of Ockenden Report Action Plan as at 9th June 2026. The overall delivery over time, including current position, is as follows:



Delivery Status	Number (change since last report)	Percentage
Evidenced and Assured	196 (⇩1)	93%
Delivered, Not Yet Evidenced	6 (⇩1)	3%
Not Yet Delivered	8 (⇧2)	4%
TOTAL	210	

**Rounded percentages

Progress Status	Number (change since last report)	Percentage
Completed fully (Evidenced and Assured)	196 (⇩1)	93%
On track	5 (⇔)	2.5%
Off track	0 (⇩1)	0%
At Risk	0 (⇔)	0%
De-scoped	9 (⇧2)	3.5%
Total	210	100%

**Rounded percentages

2.2 Of note: two actions, linked to the National Maternity & Neonatal Independent Senior Advisor (MNISA) ending, have reverted to Not Yet Delivered and been descoped until National guidance is received on how to progress those actions again. In the meantime, Family Liaison Officers within the Trust will support families involved in Patient Safety Incident Investigations and some Learning Responses, Bereavement midwives will provide support to families experiencing a bereavement and the Governance team will coordinate with any family requiring additional support on an individual basis.

2.3 In total, nine 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 continue to oversee these actions. The next quarterly review is now due in August 2026.

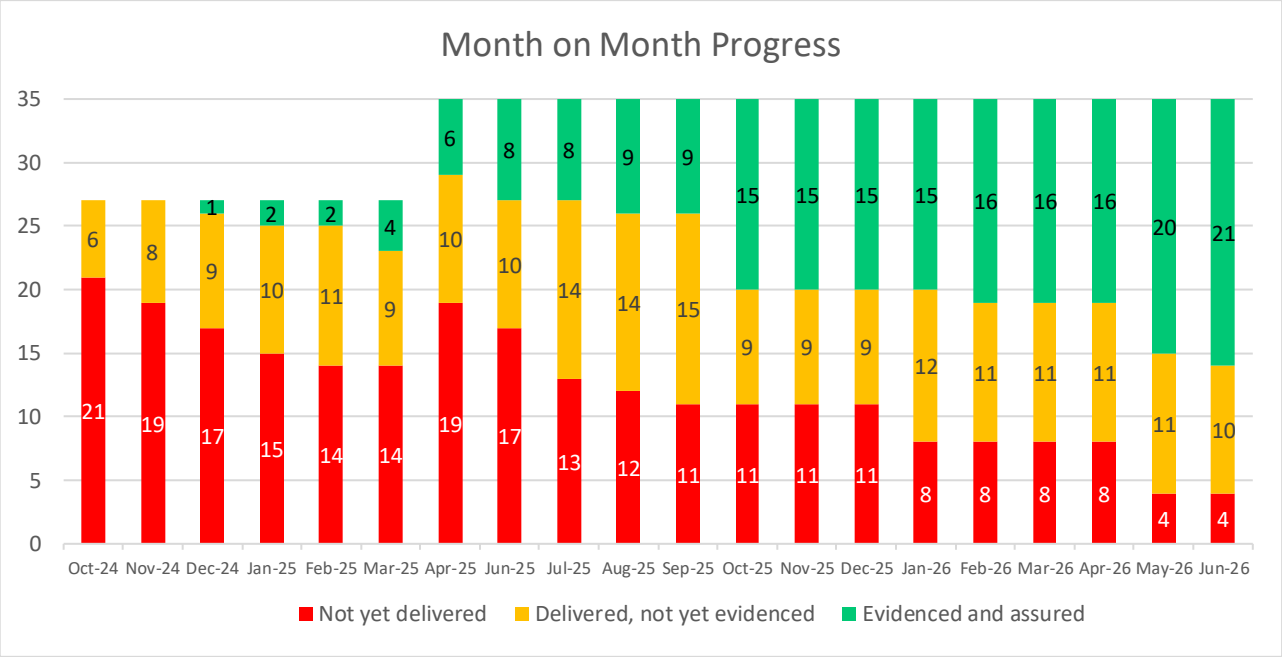
2.4 Progress against the five actions that remain within the control of the Trust to assure continues.

IEA 1.7, relating to the training required for Labour Ward Coordinators is no longer At Risk. Guidance from the national team has provided clarity on what courses are required for the team to complete. The internal competency framework aligns with the national requirement, and evidence is being reviewed by the team, with the expectation that it will be proposed for a status change by August 2026.

2.5 In terms of stress testing and assuring our position with all IEAs, dedicated audits have been created by the audit midwife to provide assurance of the actions previously assured within the programme. They have been integrated into the audit cycle. Next step to provide continued assurance is to map those audits against all actions in the Assurance Tool. In addition, with the new Head of Midwifery commencing in post mid-July 2026, we will take the opportunity to review our approach, including frequency of these audits. In addition, an independent external review has been commissioned to validate our progress and confirm that all recommendations have been fully delivered. This has been a substantial undertaking, involving more than 700 individual actions and over 1,200 pieces of supporting evidence. The report is due later this summer, and we will share the findings with families to ensure they can see the progress made and understand how their voices and experiences have shaped meaningful change.

3.0 Invited Review: The Shrewsbury and Telford Hospital NHS Trust Neonatology Service Review (2023/24)

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 9th June 2026. The overall trajectory and position are as follows:



Delivery Status	Number	Percentage
Evidenced and Assured	21 (⇧5)	60%
Delivered, Not Yet Evidenced	10 (⇩1)	29%
Not Yet Delivered	4 (⇩4)	11%
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)	21 (⇧5)	60%
On track	12 (⇩4)	34%
Off track	1 (⇩1)	3%
At Risk	0 (⇔)	0%
Not Started	0 (⇔)	0%
Descoped	1 (⇔)	3%
Total	35	100%

**Rounded percentages

3.2 One action, linked to the auditing of the Preterm Golden Hour remains At Risk. Quarterly audits are in place and will be repeated until satisfactory compliance is reached. Progress is monitored and discussed monthly at the Quality and Safety LMNS workstream allowing for learning from practices within the region.

3.3 Progress continues to assure the ten actions already implemented, while work is ongoing to implement the last four actions currently Not Yet Delivered. One is expected to be presented for a status change in July 2026, the other three require the recruitment of Neonatal Safeguarding and Family Integrated Care Lead Nurses which are currently at various stages of the recruitment process.

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 as **Appendix Three**.

4.2 Progress continues against the remaining actions within Phase 2 of the Programme. A review of all Not Started actions is underway to ensure that the correct status has been assigned to them and that no action should be descoped linked to changes within the Services or National priorities since the inception of the programme. This work is being completed by the Project Manager and the Senior Leadership, this work is expected to be completed by September 2026. There are no actions that are a particular concern, the main aim of the review is to ensure continuous alignment with service and trust priorities. All actions that might be proposed to be descoped was a result of that review will be brough to MNTAC for validation through an exception report.

4.3 Progress continues to be made on the cultural improvement programme within the Division and perinatal services. A monthly newsletter has been launched to provide a space for colleagues to find information about what is happening across the division, and for improvements and initiatives to be celebrated. A Divisional 'Who's Who' and regular Gemba Walks have been implemented to provide more leadership visibility and accessibility, offering opportunities for frontline staff to highlight ideas or concerns directly with the divisional senior leadership team. Initial feedback regarding the Women and Children's newsletter has been positive and anecdotal feedback suggests that there is increased awareness of senior leaders across the whole division.

Priorities for the next quarter will be to further embed Gemba Walks and implement a process to track progress on what has been raised, and ensure a feedback mechanism is implemented, such as "You told us, we listened". Further priorities include implementing listening events, and planning the development of a divisional charter, to ensure actions are addressing what matters most to colleagues, and that colleagues are empowered to hold one another to account for collectively agreed values and behaviours. By October 2026, the Division aims to have a fully functioning feedback tracker and 1st edition of the poster displayed in all areas and a plan of the creation of the charter. Organisational Development team has been contacted to provide support for this work.

The Division and perinatal services continue to fully engage in the implementation of Poppy's Promise, and in participating in cohort 1 of the national Perinatal Equity and Anti-Discrimination Programme.

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

5.1 Year 8 was launched on 23rd April 2026 with six core safety actions with the focus being on outcomes, this approach keeps the emphasis on improvements that have a real impact for women, babies and families, recognising the significance of local variation in priorities, pressures and workforce, and the central role of Board accountability.

5.2 The below table summarises progress against each Safety Action and their sub-items.

Safety Action	Not started	Compliance risk	In progress & on track	Meets compliance	Fully Evidenced	Total subitems
A	2	0	5	0	0	7
B	0	0	5	0	0	5
C	0	0	6	0	0	6
D	0	0	2	0	0	2
E	0	1	2	0	0	3
F	1	0	3	0	0	4
Total	**3**	**1**	**23**	**0**	**0**	

5.4 Details of progress against all Safety Actions and their sub-items are included in **Appendix Four**. Of note, a compliance risk has been flagged against the Maternal Care Bundle Element of Safety Action E. Implementation will require for system partners such as primary care, ICB and national digital services to update digital tools for the assessment of VTE as first point of contact during pregnancy which can occur before the booking assessment within our maternity services.

5.3 As per CNST Safety Action E Board Oversight is required for a plan to implement the Maternal Care Bundle Gap by March 2027, a gap analysis undertaken has been undertaken to assess the implementation of the Maternity Care Bundle within The Shrewsbury and Telford Hospital NHS Trust (SaTH). The Maternity Care Bundle sets out a series of evidence-based interventions designed to improve safety, reduce variation in care, and enhance outcomes for women and babies. Its effective implementation is essential to delivering high-quality, consistent maternity services aligned with national standards, please see **Appendix 5**.

6.0 Publication of the Independent Review of Maternity Services at Nottingham University Hospitals NHST and Baroness Amos Maternity Services Review Report

6.1 The Independent Review of Maternity Services at Nottingham University Hospitals NHST report was published on 24 June 2026 and highlighted several critical findings, including the scale of avoidable harm, the dismissal of families' concerns, instances of cover-ups and the downgrading of incidents, chronic understaffing, evidence of systemic racism and bias, and a lack of respect for the deceased.

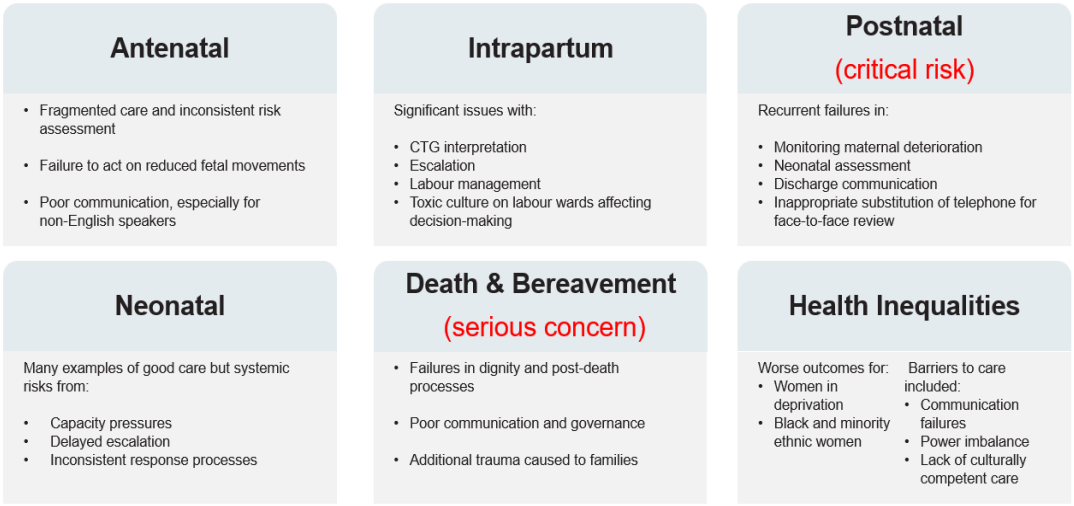
The report sets out a series of immediate and essential actions and recommends significant structural reforms required both at individual trust level and across the wider National Health Service. The following 8 key headings for the Immediate and Essential Actions must be completed across all maternity services in England include:

- Listening to Women & Families
- Workforce Planning & Safe Staffing
- Training & Multi-Professional Learning
- Risk Assessment Throughout Pregnancy
- Incident Investigation & Family Involvement

- Governance & Board Accountability
- Culture, Teamwork & Psychological Safety
- Mothers Who Have Died and Post Death Care

There are 18 EIAs within these headings.

Clinical themes include:



A communication was received from NHS England on the day of publication, outlying 3 immediate actions required by all Trusts with maternity services which include:

- Roll out of Martha's Rule to all maternity and neonatal settings in England
- Strengthening candour and cooperation in future reviews
- Human Tissue Authority (HTA) action requiring all Trusts to review mortuary records

More information is anticipated from NHS England and HTA on the approach required for the review of mortuary records and incidents.

The Baroness Amos Maternity Services review report is due to be published on 30 June 2026, with a further set of actions required to be implemented across maternity services in England.

During July 2026, the Trust will undertake a detailed review of both reports to determine our position in relation to all immediate and essential actions required as outlined in these reports, which will be in addition to the independent assurance audit taking place currently to provide assurance from the Trust's IMR conducted by Donna Ockenden (published in 2020 and 2022). Oversight will be maintained via the Trust's Maternity and Neonatal Transformation Assurance Committee, Quality and Safety Committee and ultimately Trust Board.

7.0 Other key updates

7.1 The Trust has appropriate processes and documented guidance in place to ensure that compassionate care for bereaved babies and their families is provided. Following publication of the Independent Maternity Review at Nottingham University Hospitals NHS Trust (NUH), the Trust is awaiting confirmation of the requirements for review of mortuary records and incidents requested by NHS England and Human Tissue Authority.

7.2 A Standard Operating Procedure (SOP) is in place that includes the transport of deceased babies from both maternity settings and emergency settings to the 'Swan Room' and the mortuary. Processes are in place to inform all family members and staff ensuring compassionate care for bereaved families.

7.3 The bereavement room in maternity has been specifically designed to provide privacy for the families and allow them time to grieve. A dedicated entrance and exit are available, so that families do not have to go through delivery suite to access the suite. Whilst the current set up is not soundproof, the new build has been designed to be soundproof following feedback from service users. A cool cot is present in the room along with a privacy pram if families wish to use to take baby outdoors.

7.4 The service has a dedicated bereavement team and delivery suite staff are also trained to ensure there are staff 24/7 to provide bereavement care. Bereavement training is part of the mandatory annual training programme.

7.5 Birthrate Plus (BR+) is a framework for workforce planning consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings endorsed by the RCM and RCOG.

The Independent Review of the Birthrate Plus® Methodology published in February 2026 concluded that the tool remains an appropriate and credible foundation for midwifery workforce planning.

The Maternity Incentive Scheme (MIS) Year 8 Safety Action A requires that Trusts must have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline. In addition, further adjustments based on professional judgement of the Director / Head of Midwifery should be added where appropriate.

The total clinical establishment as produced from Birthrate Plus® is **206.83wte** and this excludes the management and the non-clinical element of the specialist midwifery roles needed to provide maternity services.

As shown in **Appendix 6** our budgets and actual wte match the BR+ report, the only difference is bank, which we are actively managing through CIP schemes.

8.0 Summary

8.1 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.

9.0 Recommendations

The Board of Directors is requested to:

9.1 Receive this report for information and assurance.

9.2 Record formally in the minutes of this meeting that the Board has received updates and Appendices listed in the table.

Lauren Taylor
Interim Head of Midwifery

Julie Plant
Divisional Director of Nursing

July 2026

Maternity & Neonatal Safety Champions - Key Issues Report

Report Date: 7th May 2026		**Report of:** Maternity and Neonatal Safety Champions Meeting
Date of last meeting: 07/05/2026		**Membership Numbers:** Quoracy met
1	**Agenda**	• Chair's welcome and apologies, conflict of interest and minutes reviewed. • Action log and review of AAAA from April 2026 • Maternity Quality Dashboard and Oversight Report (AAA) • Neonatal Quality Dashboard and Oversight Report (AAA) • MTP/Ockenden Report Action Plan and Assurance Report • CNST Update • Locally Agreed Safety Intelligence Dashboard (SA9) • 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 • Sands and Tommy's New Guide for Trust Boards: Oversight of Maternity and Neonatal Services • Terms of Reference • Information Pack
2a	**Alert**	• A number of apologies were received for the meeting in April 2026 due to timetabling for Consultant Midwife interviews meaning deferral of some discussions for next month. Request to be made to avoid similar clashes in future.
2b	**Assurance**	• All midwives who support home births are up to date with Newborn Life Support training with the benefit of inhouse courses being clear.
2c	**Advise**	• The group heard from midwifery and obstetric colleagues that the number of caesarean sections continues to rise. This is creating additional demand on elective capacity. Additional planned lists have recently been introduced to support capacity, and updates will be provided to describe the impact of these additional lists.

3	**Actions to be considered by the MTAC / QSAC / Trust Board**	• Note that actions have been taken to respond to increased elective caesarean activity and that safety champions will be receiving information on impact of this new capacity.		
4	**Report compiled by**	Dr John Jones (Executive Medical Director, Board Level Safety Champion)	**Minutes available from**	Charlotte Allmark (PA to Deputy Medical Director & Associate Medical Director)

Maternity & Neonatal Safety Champions - Key Issues Report

Report Date: 4th June 2026		**Report of:** Maternity and Neonatal Safety Champions Meeting
Date of last meeting: 04/06/2026		**Membership Numbers:** Quoracy met

1	**Agenda**	• Chair's welcome and apologies, conflict of interest and minutes reviewed.
		• Action log and review of AAAA from May 2026
		• Safety Champions Update Document from April 2026
		• Walkabout feedback – Antenatal and Postnatal
		• 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)
		• 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 - Themes and Actions
		• MNVP Neonatal Families/Bereavement/BAME/High Deprivation - Prioritisation Action Plan
		• Maternity & Neonatal Independent Senior Advocate Feedback - Themes and Actions
		• Any other business:
		  ○ SANDs and Tommy's New Guide for Trust Boards: Oversight of Maternity and Neonatal Services
		  ○ Maternity Labour Ward Lead
		• Information Pack

2a	**Alert**	**Walkabout**: Due to operational pressures in antenatal and postnatal services, it was not possible to complete a full antenatal visit. However, the postnatal visit did take place, and the senior leadership team is progressing actions in response to feedback, including safety risks linked to the tagging system and prescription charts guidance compliance A further antenatal visit needs to be scheduled, however there were some issues which can be addressed in advance, including updating service user feedback boards, general decluttering, and ensuring staff are aware of the MNSC role.
2b	**Assurance**	Initial meetings to address delays in CS and access to theatre have taken place. An action plan is being developed and the additional theatre time on Wednesdays is in place

		Positive progress against the Baby Friendly Initiative (BFI) and preparation for accreditation with the commitment to initially revisit L2 as this was achieved 10 years ago The revised dashboard was shared – this provides opportunity to integrate data and use this for deep-dives or evidence or service development MNVP provided updates on service user engagement and the how the feedback is being actioned		
2c	**Advise**	The changes to senior leadership team were shared with the committee National shortage of paediatric ophthalmologists and the sustainability of ophthalmologist availability for ROP screening on the neonatal unit, a business case has been developed to purchase a retinal imaging device and ongoing training of neonatal unit staff and ophthalmology to address the gap and ensure timely ROP screening		
3	**Actions to be considered by the MTAC / QSAC / Trust Board**	Clear communication and media strategy for staff and public ahead of the publication of the 2 national maternity reports		
4	**Report compiled by**	Wendy Nicholson MBE (Non Executive Director, Board Level Safety Champion)	**Minutes available from**	Sabrina Kitcher (EA to Group Chief Medical Officer)

Board of Directors' Meeting in Common: 9 July 2026

Agenda item	045/26		
Report Title	SaTH Patient Safety Committee Report Q4/Annual 2025/26		
Executive Lead	John Jones Executive Group Medical Director		
Report Author	Kath Preece Head of Clinical Governance Lindsay Barker Head of Bereavement & Medical Examiner Services Pete Jeffries Patient Safety Specialist		
Prior Consultation:	**CQC Domain:**		**Link to SCHT BAF id(s)**
Quality Operational Committee – individual reports 19th May 2026 Quality and Safety Assurance Committee – individual reports 26th May 2026	Safe	√	BAF 1, BAF 2, BAF 8
	Effective	√	
	Caring	√	**Risk Register id(s):**
	Responsive	√	
	Well Led	√	CRR 1078, 904
Executive Summary	The Boards' attention is drawn to: Section 2.3 – Compliance with death certification Section 2.8 – Service user feedback Section 4.1 – Patienty Safety Investigations		
Recommendations for the Boards	The Boards are asked to **note** the contents of the report.		
Appendices:	**N/A**		

1.0 Introduction

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 Deaths and Patient Safety.

2.0 Medical Examiner (ME) Service Update

2.1 Hospital and Community Deaths

1,980 hospital deaths were reported in 2025/26. Anticipated seasonal spike in Q4 has not happened for hospital deaths – with 25 less deaths in Q4 compared to Q3 and overall, 134 less deaths across the year compared to 2024/25.

496 hospital deaths occurred in Q4, including 6 neonatal/paediatric cases.

834 community referrals were received in Q4, with GP services being the largest source.

The ME service reviewed 4,997 deaths across the Shropshire, Telford, and Wrekin (STW) health system in 2025/26.

2.2 Medical Examiner Reviews for SaTH deaths.

1,976 hospital deaths were reviewed by the ME service in 2025/26 (504 in Q4).

99% of hospital cases received timely ME support; only 7 cases in Q4 lacked next of kin contact.

No significant themes requiring escalation were identified in SaTH deaths.

2.3 Medical Certificates of Cause of Death (MCCD)

1,840 MCCDs were issued for hospital deaths in 2025/26; 478 in Q4.

Timeliness improved: certificates issued beyond 3 days dropped by nearly 70% from Q1 to Q4.

This positive trajectory reflects the continued embedding of the Medical Examiner Service, strengthened clinical engagement, strong operational cohesion between ME and Bereavement teams providing improved oversight of internal processes. The data provides clear assurance that delays are being effectively minimised, supporting timely registration of deaths and improved experience for bereaved families.

2.4 Structured Judgement Reviews (SJR) and Learning

153 SaTH deaths were recommended for SJR in 2025/26; 38 in Q4.

327 cases were identified for potential learning in 2025/26; 82 in Q4.

Most SJR recommendations stemmed from concerns raised by bereaved relatives (46% annually).

38 cases in Q4 were signposted to the PALS & Complaints Department, up from the previous quarter.

2.5 Coroner Referrals

258 hospital deaths were referred to the coroner in 2025/26 (12% of deaths); 57 in Q4.

Only 7% of deaths were accepted by the coroner for investigation.

2.6 Urgent Body Release and Faith Requests

3 urgent body release requests for faith reasons were managed successfully in Q4.

18 such requests were handled across the year, demonstrating responsiveness to religious needs.

2.7 Hospital-funded Cremations and Genealogy

5 hospital funded cremations were arranged for patients with no next of kin, costing £6,600

Enhanced genealogy efforts led to 12 families taking over funeral arrangements, with a saving of £15,500.

This is due to: improved communication and rapport with genealogy organisations with a point of contact for them to liaise with and follow up cases on. A regular point of contact in the bereavement service for NoK who have been found, who can be given time, options and support.

2.8 Feedback and Complaints

91% of bereavement survey respondents in Q4 found the ME service helpful; 100% felt able to raise concerns.

10 formal complaints involved the ME & Bereavement Service in 2025/26 (6 in Q4), mostly for clarification rather than dissatisfaction for the service.

3.0 Learning from Deaths Q4

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

There have been 4 deaths identified of patients who died within the Trust during Q4 with a learning disability or autism. A LeDeR referral has been completed for these cases. An SJR has been undertaken for 2 of these cases with the other 2 cases awaiting SJR completion.

There have been 5 deaths with confirmed SMI in Q4, all 5 have had SJR completed with a second review by the mental health lead. 1 SJR resulted in a patient safety datix which is currently under review.

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

There have been 2 cases in Q4 identified as potentially death more likely than not as a result in problems in health care and Patient Safety Incident Investigations (PSII) are underway.

4.0 Patient Safety Update Q4

4.1 Patient Safety Incident Investigations (PSII) Q4

In Q4 there were 3 PSII commissioned, which included 1 Never Event. There was 1 closed in the quarter.

Newly commissioned PSII
2026/593 Datix 320417 Pre-term HIE baby
2026/979 Deteriorating patient – failure to carry out observations ED
2026/1417 Never Event – Misplaced NG tube

PSII closed
2025/2063 Ophthalmology Never Event wrong site surgery

4.2 Learning from incidents in Q4

Triangulation of learning from incidents has identified the same themes through Q4, 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
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
Discharges including fast track	Discharge improvement group in progress with key workstreams including discharge planning/discharge communication and medication

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting in Common: 09 July 2026

Agenda item		046/26		
Report Title		**SaTH Freedom to Speak Up (FTSU) 2025/26 Report inc Q4 figures**		
Executive Lead		Anna Milanec, Director of Governance		
Report Author		Chan Kaur, FTSU Guardian		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe		Our patients and community		
Effective		Our people	√	
Caring		Our service delivery	√	**Trust Risk Register id:**
Responsive		Our governance	√	
Well Led	√	Our partners		
Consultation Communication		N/A		
Executive summary:		At SaTH, our FTSU vision is: "ALL staff, from frontline workers to Board level, feel psychologically safe to raise concerns—creating a Trust that is safe, transparent, kind and open, where staff at all levels feel empowered to 'Speak Up' and leaders 'Listen Up' and 'Follow Up'." This report presents FTSU Q4 data alongside the full year for 2025/26. The data demonstrates continued engagement with the FTSU service.		
Recommendations to the Boards:		The Boards are asked to **note** and take assurance from FTSU's continued contribution to supporting our colleagues and improving our culture.		
Appendices (in supplementary Information Pack):		Appendix 1: FTSU Feedback		

National Context

The National Guardian's Office (NGO) Annual Report 2025/26 highlights that speaking up remains a critical part of safe, high-quality care, with continued demand for FTSU services across the NHS. Whilst staff continue to raise concerns, national data shows a decline in confidence that organisations will act, with a widening gap between staff feeling able to speak up and believing action will follow. Culture and behaviour concerns remain the most common themes, alongside worker wellbeing and patient safety issues, reinforcing the link between staff experience and quality of care. As the NGO closes in June 2026 and responsibilities transition to NHS England, there is a clear expectation that organisations maintain visible, effective speaking up arrangements, with strong leadership, psychological safety and consistent follow-up central to improvement.

Annual Report April 2025 – March 2026

NHS England » The future of Freedom to Speak Up

Assessment of Themes

In 2025/26, SaTH received 238 contacts through the FTSU mechanism, an increase of twenty on the previous year, of these 207 are individual concerns.

	Number of Contacts	Number of Concerns
April 2025 – March 2026	238	207
April 2024 – March 2025	218	193
April 2023 – March 2024	217	188
April 2022 – March 2023	282	237
April 2021 – March 2022	369	295

Contacts & Concerns Overview

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

	Q1	Q2	Q3	Q4	Total	Local Increase/ Decrease	National Increase
2025/26	79	51	57	51	**238**	↑9%	N/A
2024/25	67	48	56	47	**218**	0.5	↑18.6%
2023/24	47	52	68	50	**217**	↓23%	↑27.6%
2022/23	71	73	79	59	**282**	↓23%	↑25%
2021/22	100	113	90	66	**369**	↑21%	0%

Contacts made with FTSU in the last 5 years.

The NGO requires all Trusts to submit their data to the national portal following the close of a quarter and to be submitted in the following categories.

Please note: In line with NGO guidance, we record our data using the 'element of' approach. This means that a single concern may include multiple elements from the categories listed below. As such, the total number of elements may exceed the total number of concerns raised.

Category	Q1	Q2	Q3	Q4
	25/26	25/26	25/26	25/26
Bullying and Harassment	15	5	4	3
Patient Safety	29	12	13	10
Worker Safety or Wellbeing	66	39	45	31
Inappropriate attitudes and behaviours	52	24	36	27
Policies, Processes and Procedures	38	33	28	22
Unknown	1	0	3	1
Other	0	5	0	3
Anonymously	1	0	3	0
Detriment	1	0	1	0

NGO reporting category themes

Across 2025/26, the pattern of concerns raised locally reflects national trends. Most concerns relate to staff wellbeing, behaviours and processes, with patient safety raised consistently; bullying concerns reduced, and only a small number were raised anonymously or about detriment.

Concerns Raised by Profession

Professional Group	Q1	Q2	Q3	Q4	Total
	(25/26)	(25/26)	(25/26)	(25/26)	
Nursing and midwifery registered	23	5	20	18	66
Administrative and clerical	18	20	12	8	58
Medical and dental	9	4	8	7	28
Additional Clinical Services	11	7	4	4	26
Estates and ancillary	3	4	9	8	24
Allied Health Professionals	8	8	1	4	21
Not known/Other	2	2	3	1	8
Additional professional scientific and technical	2	1	0	0	3
Students	2	0	0	0	2
Healthcare scientists	1	0	0	1	2
Total	**79**	**51**	**57**	**51**	**238**

Professional groups of people raising concerns 2025/26

Professional Group	21/22	22/23	23/24	24/25	25/26
Nursing and midwifery registered	30%	28%	28%	23%	28%
Administrative and clerical	20%	19%	28%	22%	24%
Additional clinical Services	8%	8%	13%	21%	11%
Allied health professionals	19%	12%	10%	11%	9%
Medical and dental	7%	12%	7%	10%	12%
Estates and ancillary	8%	13%	7%	6%	10%
Not known/Other	2%	5%	5%	6%	3%
Healthcare scientists	0%	0.70%	2%	2%	0.8%
Additional professional scientific and technical	0%	0.70%	0.90%	0%	1%

Professional groups speaking up proportionally over the last 5 years

In 2025/26, most concerns came from Nursing and Midwifery staff (28%), which is similar to previous years. Administrative and Clerical staff were the next biggest group at 24%, lower than their peak in 2023/24 but still higher than in the early years. Additional Clinical Services dropped to 11% after a big rise in 2024/25. Allied Health Professionals continued to fall, reaching 9% compared with much higher levels in 2021/22. Medical and Dental staff increased to 12%, one of their highest levels across the five years, and Estates and Ancillary staff rose to 10% after a dip the year before. All smaller groups stayed below 2%, which is in line with previous years

Breakdown of themes in Q4:
Across Q4, the main themes raised were worker wellbeing, attitudes and behaviours, and organisational processes. These themes were often interlinked and reflect ongoing pressures within teams. They remain consistent with national trends and highlight the importance of applying policies consistently and maintaining supportive team cultures.

Worker wellbeing was the most common concern across all staff groups, affecting both clinical and non-clinical roles. Issues included workload pressures, team capacity, reasonable adjustments, and the wider impact of work on staff wellbeing. A number of these cases remain open, indicating that some staff continue to need support and resolution.

Concerns relating to attitudes and behaviours were the second most frequent and were raised across multiple staff groups. These focused on communication, team relationships, and, in some cases, bullying or harassment. These issues were often closely linked to wellbeing concerns.

Organisational processes also featured consistently, with concerns about bank shifts, workload systems, organisational change, and the application of policies such as flexible working, annual leave, and time off for medical appointments. These concerns often contributed to or compounded wellbeing and behaviour-related issues.

Patient safety and quality concerns were fewer in number and mainly raised by clinical staff. However, these cases were more likely to be escalated. Actions have been taken in response, with ongoing follow-up to assess impact and support improvement.

Actions taken to address concerns raised in Q4.
A range of actions have been taken in response to the concerns raised. Cases involving higher risk, such as patient safety, bullying, or workload pressures, were escalated to senior leaders or relevant departments for immediate review. Many staff were signposted to appropriate support services, including HR, Occupational Health, or local management teams, to help resolve issues linked to wellbeing, behaviours, or processes.

Several concerns led to practical changes, such as reviewing procedures, clarifying policies, addressing communication issues, and improving local working arrangements.

Follow-up is ongoing for escalated cases to ensure actions are completed and to understand whether the interventions have improved staff experience and safety.

Report on Discrimination

Number of concerns with an element of discrimination				
	Q1	**Q2**	**Q3**	**Q4**
Disability	4	2	2	0
Sexual Orientation	2	0	0	0
Race	4	0	1	0
Religion	1	0	0	0
Total	**11**	**2**	**3**	**0**

In Q4, no concerns were raised through FTSU that included an element of discrimination.

Detriment
No cases of detriment were reported this quarter. A detriment guidance is also underway as part of the improvement action plan.

Escalation and signposting

In 2024/25, we began recording the outcomes of concerns raised through the FTSU process to better understand how issues are managed and resolved.

	Q1	**Q2**	**Q3**	**Q4**
Escalated	35	24	25	15
Signposted	29	23	26	32
No action	15	4	6	4

Many concerns in Q4 were appropriately resolved through signposting, reflecting that issues were often addressed at an early stage. A smaller number required escalation, particularly where concerns related to behaviours, patient safety, or complex workforce issues.

NB: FTSU encourages all individuals to seek support through line managers and other lines of escalation first before escalating through FTSU. It is noted here that there can be frustration from managers/supervisors that colleagues use FTSU to circumnavigate the line management process.

Divisional Contacts

Divisions	**23/24**	**24/25**	**25/26**
Medicine & Emergency Care	27%	41%	34%
Surgery, Anaesthetics, Critical Care and Cancer	22%	19%	16%
Corporate	25%	15%	24%
Clinical Support Services	11%	15%	12%
Women & Children's	12%	6%	9%
Unknown/Other	3%	4%	5%

Most concerns continue to come from Medicine & Emergency Care, increasing to 34% in 2025/26. Corporate also showed an increase compared to the previous year.

In contrast, concerns from Surgery, Anaesthetics, Critical Care and Cancer have steadily decreased over the three years.

Clinical Support Services and Women & Children contribute smaller and relatively stable proportions, while a small number of cases are recorded as Unknown/Other.

Open/Closed Contacts 2025/2026

	Q1	Q2	Q3	Q4
Contacts	**25/26**	**25/26**	**25/26**	**25/26**
Open	5	13	20	13
Closed	74	38	37	38

Please note: *We will only close a concern once the colleague has confirmed they are satisfied that their issue has been addressed or that they no longer require further follow-up support.*

Of the 51 open contacts in 2025/26 these equate to 41 open concerns.

The open cases are related to process problems and behaviors in the workplace, which continue to be the main themes raised by staff. A common issue within the process-related cases is the length of time HR processes take to complete, with staff reporting delays, slow decision-making, and unclear timelines.

Delays in processes and unclear timelines can impact on staff confidence and reinforce perceptions that concerns are not actioned promptly.

Improvement Story: Improving Communication and Staff Support

A staff member raised concerns about lack of training, support, and feeling targeted following a ward restructure. They described unclear meetings, limited communication from HR/management, and increased anxiety due to delays and lack of clarity around next steps.

The individual was encouraged by the FTSU Guardian to engage with HR and divisional processes, seek clarity on meetings, and access support. Escalation was offered where communication delays persisted. The FTSU Guardian provided ongoing support, practical advice, and regular follow-up.

Senior leadership became involved and a plan was implemented. The staff member reported a positive outcome following the interventions.

Learning

- Need for timely, proactive communication
- Clear meeting purpose and process
- Consistent training and supervision post-restructure
- Transparent decision-making affecting staff.

FTSU support helped the individual remain engaged and achieve a safe and positive resolution, reinforcing the importance of listening and follow up**.**

Feedback from colleague

"I wanted to let you know that I have now joined the XX team, and I would like to sincerely thank you all for your help and support throughout my hard time."

Raising the Profile of FTSU

The FTSU Guardian continues to increase awareness of speaking up across the Trust through a range of activities. Presentations at student midwife and resident doctor inductions help raise early awareness of the service.

Regular attendance at weekly discrimination meetings, monthly meetings with Divisional HR Business Partners, joint working with the Shropcom FTSU Guardian, and visibility visits across sites help strengthen relationships, improve access, and increase visibility of the service.

A network of 43 FTSU Ambassadors supports local signposting and awareness. Work is ongoing with Shropcom to further develop the programme through shared training and support.

In addition, involvement in STEP and Galvanise programmes, as well as attendance at national conferences and local FTSU networks, supports learning and sharing of best practice.

These activities aim to improve awareness and build staff confidence to speak up.

FTSU mandatory training compliance

FTSU training has been mandatory since June 2022 across three levels: Core, Listen Up and Follow Up. The table shows Q4 2025/26 compliance by division.

FTSU Training Completion by Division (Q4 2025/26)		
	FTSU – Core – Training for all Workers	FTSU – Listen Up – Training for all Managers
Medicine	90%	80%
Surgery, Anaesthetics & Cancer	95%	86%
Corporate	94%	86%
Clinical Support Services	95%	95%
Women & Children's	95%	80%

FTSU – Follow Up – Training for Senior Leaders is XX

Core training meets the 90% target across all divisions. However, compliance with the *Listen Up* manager training remains below the 90% target in most areas, with the exception of Clinical Support Services, which has achieved 95%.

Further improvement is needed to ensure managers are equipped to respond effectively when staff speak up.

Key Performance Indicators

1. Culture Dashboard

	2022	2023	2024	2025
Compassion	64%	66%	66%	67%
Learning and Innovation	52%	58%	58%	54%
Health and Wellbeing	51%	57%	57%	57%
Vision and Values	51%	57%	56%	55%
Goals and Performance	57%	62%	62%	61%
Teamwork	73%	75%	75%	74%

Culture dashboard scores

2. **Sickness Absence rate is below 4%**
   The sickness absence rate at the end of Q4 was 5.09%.
3. **Staff Turnover is below threshold of 14.1%**
   Turnover remains within target at 9.8%, below the 14.1% threshold.
4. **Staff Survey Response Rate Surpasses 45%**
   The 2025 response rate was 46%, meeting the target of 45% but representing a 5% decrease from 2024 (51%).
5. **Staff Survey key questions for speaking up.**
   Performance is monitored through key questions 20a, 20b, 25e and 25f.

The latest results show a decline across all four speaking-up measures compared with 2024.

20a) Fewer staff feel secure, raising concerns about unsafe clinical practice, falling from 68% to **66.5%**. This is consistent with the national picture, which dropped from 71.53% to **70.1%**.

20b) Confidence that the organisation would address concerns has decreased from 51% to **48.6%**. Again, this is consistent with the national picture with the national score declining from 56.83% to **54.7%**.

25e) Feelings of safety to speak up about anything have reduced from 54% to **52.6%.** Again, this is consistent with the national picture which has also fallen from 61.82% to **59.1%**.

25f) Confidence that the organisation would act on concerns has dropped from 41% to **39%**, And again, this is consistent with the national picture with the national figure decreasing from 49.52% to **46.6%**.

Overall, both local and national results show a downward trend, with data highlighting a widening gap between staff feeling able to speak up and their confidence that concerns will be addressed; this reinforces the importance of not only encouraging speaking up but also demonstrating visible, timely, and effective follow-up.

		2024 Organisation	2025 Organisation	2025 Movement	2025 National Score (2024)
20a	I would feel secure, raising concerns about unsafe clinical practice.	68%	66.5	↓1.5%	70.1% (71.53%)

20b	I am confident that my organisation will address my concern.	51%	48.6	↓2.4%	54.7% (56.83%)
25e	I feel safe to speak up about anything that concerns me in this organisation.	54%	52.6	↓1.4%	59.1% (61.82%)
25f	If I spoke up about something that concerned me, I am confident my organisation would address my concern.	41%	39.0	↓2%	46.6% (49.52%)

Staff survey raising concern questions

Conclusion and Next Steps.

Building on from last year, the priority is to deliver the actions from the NHSE action plan and get the basics right. This includes handling concerns well, ensuring staff receive clear and timely feedback, and improving confidence in the speaking up process. Work will continue on a new FTSU strategy for 2026 onwards and an updated improvement plan. It is anticipated that continued working across the Group and further development of the Ambassador programme will improve consistency, visibility and access. We will also strengthen how themes are linked with other data and support managers to promote a positive speaking up culture.

Board of Directors' Meeting in Common – 9 July 2026

Agenda item	047/26a		
Report Title	**Annual Review of compliance with the Fit & Proper Person Test (FPPT) Framework for Board Members (SaTH)**		
Executive Lead	Anna Milanec, Group Chief Governance Officer & Director of Governance, SaTH - on behalf of the Group Chair		
Report Author	Beverley Barnes, Board Coordinator		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
Direct to Board	Safe		
	Effective		
	Caring		**(SaTH) Risk Register id(s):**
	Responsive		
	Well Led	√	
Executive Summary	The national Fit and Proper Person Test (FPPT) Framework (launched by NHS England in September 2023) sits in the wider context of good governance, leadership and Board development, and is intended to strengthen individual accountability for Board members, thus enhancing the quality of leadership within the NHS. The Group Chair has overall accountability for adherence to the Framework, which applies to all voting and non-voting executive and non-executive members of the Board. In addition to the Framework requirement for all new Board members to demonstrate that they have met all the required criteria prior to appointment, there is also an ongoing requirement for individual assessments to be completed on currently serving Board members each year. This report provides confirmation that all necessary individual annual checks have been completed, where SaTH is the designated lead/host organisation, and the evidence reviewed confirms that all serving members of the Board are fit and proper. The requirements of the annual 2026 FPPT assessment have therefore been fully satisfied, and an overall SaTH summary has been submitted to the regional NHSE team in line with the Framework guidance.		
Recommendations	The Board is asked to **note** the report.		
Appendices:	N/A		

Board of Directors' Meeting in Common – 9 July 2026

Agenda item	047/26b		
Report Title	**Annual Review of compliance with the Fit & Proper Person Test (FPPT) Framework for Board Members (SCHT)**		
Executive Lead	Anna Milanec, Group Chief Governance Officer		
Report Author	Shelley Ramtuhul, Director of Governance		
Prior Consultation:	**CQC Domain:**		**Link to (SCHT) BAF id(s)**
Direct to Board	Safe		
	Effective		
	Caring		**(SCHT) Risk Register id(s):**
	Responsive		
	Well Led	√	
Executive Summary	The national Fit and Proper Person Test (FPPT) Framework (launched by NHS England in September 2023) sits in the wider context of good governance, leadership and Board development, and is intended to strengthen individual accountability for Board members, thus enhancing the quality of leadership within the NHS. The Group Chair has overall accountability for adherence to the Framework, which applies to all voting and non-voting executive and non-executive members and attendees of the Board. All Board members have to demonstrate that they meet the FPPT prior to appointment as well as continuing to demonstrate their fitness via an annual assessment. This report provides confirmation that all necessary individual annual checks have been completed for SCHT employed Board members. Where there are joint appointments and SaTH is the designated lead/host organisation, confirmation has been received that the annual assessment has been appropriately completed. On this basis the Board is advised that all serving members of the Board are fit and proper. The requirements of the annual 2026 FPPT assessment have therefore been fully satisfied, and an overall SCHT summary has been submitted to the regional NHSE team Framework guidance.		
Recommendations	The Board is asked to **note** the report.		
Appendices:	N/A		

Board of Directors' Meeting in Common – 09 July 2026

Agenda item	048/26		
Report Title	SaTH Anti-Fraud, Bribery and Corruption Policy		
Executive Lead	Anna Milanec, Group CGO & Director of Governance (SaTH)		
Report Author	Paul Kay, Anti-Fraud Specialist		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
Audit and Risk Assurance Committee – 18 May 2026. Policy Approval Group – 06 May 2026.	Safe		BAF risk 13
	Effective		
	Caring		**(SaTH) Risk Register id(s):**
	Responsive		-
	Well Led	✓	
Executive Summary	1. The Anti-Fraud, Bribery and Corruption Policy has been updated to reflect a new corporate fraud offence of 'failure to prevent fraud' which came into force on 1st September 2025. A Policy on a Page has also been added to the document. 2. This is a policy reserved to the Board and as such requires agreement from the Board of Directors.		
Recommendations to the Board	The Board is asked to **approve** the policy.		
Appendices:	Appendix 1: Anti-Fraud, Bribery and Corruption Policy		

1.0 Introduction

1.1 The purpose of the Anti-Fraud, Bribery and Corruption Policy is to provide a clear and robust framework for preventing, detecting, and responding to fraud, bribery, and corruption across the Trust. As a steward of public funds, the Trust has a duty to ensure that all resources are used appropriately, transparently, and in the best interests of patient care.

1.2 The policy has been reviewed and updated by the Trust's Anti-Fraud Specialist, MIAA. The policy was previously approved by the Board of Directors in March 2024.

1.3 Audit and Risk Assurance Committee reviewed and agreed the latest policy on 18 May 2026.

2.0 Main updates to the policy

2.1 A Policy on a Page has been added to the document.

2.2 Updates made to section 2.3 reflect a new corporate fraud offence of 'failure to prevent fraud' which came into force on 1st September 2025. This fraud is where someone connected with the organisation (what the Economic Crime and Corporate Transparency Act 2023 calls an 'associated person') commits a fraud offence that intentionally benefits the Trust, or a related body, rather than just the individual, and where the Trust should have had procedures in place to prevent it happening. If this offence occurs, the health body can be prosecuted.

Paul Kay
Anti-Fraud Specialist, MIAA

Anti-Fraud, Bribery and Corruption Policy

May 2026

Anti-Fraud, Bribery and Corruption Policy & Response Plan for The Shrewsbury and Telford Hospital NHS Trust

Policy reference: GOV07

Additionally refer to:

Disciplinary Policy (W7)
Managing Conflict of Interest Policy and Guidance (GOV06)
NHS Code of Conduct
Standing Financial Instructions
NHS Anti-Fraud Manual & Investigation Toolkit
Government Functional Standard 013 Counter Fraud Freedom to Speak Up: Raising Concerns (Whistleblowing)

Version:	V1
V1 issued	Date first issued – 28/10/2020
V4 approved by	Audit and Risk Assurance Committee
V4 date approved	Date approved
V4 Ratified by:	Board of Directors
V4 Date ratified:	*TBC*
Document Lead	Anti-Fraud Specialist
Lead Director	Adam Winstanley – Interim Chief Finance Officer
Date issued:	Date this version issued – TBC
Review date:	3 years
Target audience:	All staff

Document Lead/Contact:	Paul Kay / Darrell Davies – Anti-Fraud Specialist
Version	V4
Status	Draft
Date Equality Impact Assessment completed	January 2025
Issue Date	TBC
Review Date	3 years
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	Fraud, Bribery, Corruption
Dissemination plan	Trust-wide dissemination, through staff bulletin and uploaded to anti-fraud intranet page.

Version History

Version	Date	Author	Status	Comment
V1	28/10/20	MIAA		
V2	06/09/21	MIAA		
V3	08/01/24	MIAA		
V4	May 2026	MIAA	Final	Updated to reflect changes in legislation

Table of contents

4. The Response Plan

4.1 Bribery and Corruption

4.2 Reporting Fraud, Bribery or Corruption

4.3 Disciplinary Action

4.4 Sanctions and Redress

5. Review

5.1 Monitoring and auditing of policy effectiveness

5.2 Dissemination of the policy and training

5.3 Review of the policy

Policy on a Page

The purpose of this Anti-Fraud, Bribery and Corruption Policy is to provide a clear and robust framework for preventing, detecting, and responding to fraud, bribery, and corruption across the Trust. As a steward of public funds, the Trust has a duty to ensure that all resources are used appropriately, transparently, and in the best interests of patient care.

This policy sets out the Trust's commitment to maintaining the highest standards of honesty and integrity, outlines (in section 3) the responsibilities of staff, managers, contractors, and partners, and establishes the mechanisms through which concerns can be raised and investigated.

By promoting a culture of vigilance, accountability, and zero tolerance toward fraudulent activity, the policy supports the Trust in protecting its finances, safeguarding its reputation, and complying with national legislation and NHS Counter Fraud Authority standards.

Ultimately, it reinforces the Trust's dedication to delivering safe, effective, and sustainable healthcare services free from the impact of fraud.

Details of who to contact for all genuine suspicions of fraud, bribery and corruption can be found within section 4.2 of this policy.

The Trust will seek the appropriate disciplinary, regulatory, civil and criminal sanctions [as well as referral to professional bodies, where appropriate] against fraudsters and where possible will attempt to recover losses. Disciplinary action, sanctions and redress are covered within sections 4.3 and 4.4 of this policy.

1 Introduction

1.1 General

One of the basic principles of public sector organisations is the proper use of public funds. The majority of people who work in the NHS conduct themselves in an honest and professional manner and they believe that fraud, bribery and corruption, committed by a minority, is wholly unacceptable as it ultimately leads to a reduction in the resources available for patient care.

The Shrewsbury and Telford Hospital NHS Trust (the 'Trust') is committed to reducing the level of fraud, bribery and corruption within the NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care. The Trust does not tolerate fraud, bribery or corruption and aims to eliminate all such activity as far as possible.

The Trust, at its most senior levels, wishes to encourage anyone having reasonable suspicions of fraud, bribery or corruption to report them. For the purposes of this policy "reasonably held suspicions" shall mean any suspicions other than those which are totally groundless (and/or raised maliciously).

It is the Trust's policy that no employee will suffer in any way as a result of reporting these suspicions. This protection is given under the provisions of the Public Interest Disclosure Act, and other related legislation / regulations, which the Trust is obliged to comply with.

The Trust will take all necessary steps to counter fraud, bribery and corruption in accordance with this policy, with the Government Functional Standard GovS 013: Counter Fraud (NHS Requirements), NHS contractual requirements and with regard to the policies, directions, instructions and guidance as issued by the NHS Counter Fraud Authority (NHSCFA), as well as in accordance with relevant UK legislation.

The Trust will seek the appropriate disciplinary, regulatory, civil and criminal sanctions [as well as referral to professional bodies, where appropriate] against fraudsters and where possible will attempt to recover losses.

Each Trust is required to appoint its own dedicated Anti-Fraud Specialist (AFS), also known as Local Counter Fraud Specialist (LCFS), who is accredited by the NHSCFA and accountable to them professionally for the completion of a range of preventative anti-fraud and corruption work, as well as for undertaking any necessary investigations. Locally, the AFS is accountable on a day-to-day basis to the Trust's Chief Finance Officer and also reports, periodically, to the Trust Audit and Risk Assurance Committee.

All instances where fraud, bribery and/or corruption is suspected are thoroughly investigated by suitable accredited personnel. Any investigations will be undertake in accordance with the NHSCFA investigatory toolkit requirements.

[NB. For staff awareness, **theft issues** are usually dealt with by local security management (LSMS), not the AFS. However, the AFS will be mindful of any potential criminality identified in the course of any investigation and will, with the agreement of the Chief Finance Officer, notify the appropriate investigating authority].

1.2 Aims and Objectives/ Purpose

The Trust is committed to taking all necessary steps to counter fraud, bribery and corruption.

The aim of this policy is to provide a guide for employees as to what fraud is in the NHS, to emphasise that it's everyone's responsibility is to prevent fraud, bribery and corruption and to provide guidance on how to report it.

Tackling fraud in the NHS is guided by four strategic pillars (as detailed in the NHSCFA Strategy 2023-26):

Understand- how fraud, bribery and corruption affects the NHS;

Prevent- ensure the NHS is equipped to take proactive action to prevent future losses from occurring;

Respond- ensure the NHS is equipped to respond to fraud and;

Assure- key partners, stakeholders and the public that the overall response to fraud across the NHS is robust

Organisations must be held to account for their inaction.

The overall requirement underpinning these principles is effective strategic governance, strong leadership and a demonstrable level of commitment to tackling fraud from senior management within organisations.

1.3 Scope

This policy has been produced by the Trust's AFS, and is intended to provide a guide for all employees [regardless of position or employment status], contractors, consultants, vendors and other internal and external stakeholders who have a professional or business relationship with the Trust, on what fraud and corruption are in the NHS; what everyone's responsibility are to prevent fraud, bribery and corruption; and also how to report concerns and/or suspicions with the intention of reducing fraud to a minimum within the Trust.

This policy relates to all forms of fraud, bribery and corruption and is intended to provide direction and help to employees who may identify suspected fraud, corruption or bribery. It provides a framework for responding to suspicions of fraud, bribery and corruption, advice and information on various aspects of fraud, bribery and corruption and implications of an investigation. It is not intended to provide a comprehensive approach to preventing and detecting fraud, bribery and corruption.

2 Definitions

2.1 NHS Counter Fraud Authority (NHSCFA) / NHS Counter Fraud Strategy[1]

The NHS Counter Fraud Authority (NHSCFA) is a special health authority which has the responsibility for the detection, investigation and prevention of fraud and economic crime within the NHS. Its aim is to lead the fight against fraud affecting the NHS and wider health service, by using intelligence to understand the nature of fraud risks, investigate serious and complex fraud, reduce its impact and drive forward improvements.

NHSCFA also maintains a national NHS Counter Fraud Strategy which sets out the strategic approach and direction, key challenges and opportunities, and the priority areas identified for tackling fraud and corruption in the NHS. The Trust's local approach to tackling fraud and corruption, through the work of the Anti-Fraud Specialist, organisational resources and the annual risk-assessed counter fraud work-plan, fully acknowledges and aligns itself to the priorities set out in the national strategy.

2.2 Government Functional Standard GovS 013: Counter Fraud[2] (NHS Requirements)

A requirement in the NHS standard contract is that providers and commissioners of NHS services must take the necessary action to comply with the NHSCFA's counter fraud standards. Other's should have due regard to the standards. The contract places a requirement on providers / commissioners to have policies, procedures and processes in place to combat fraud, corruption and bribery to ensure compliance with the standards. The NHSCFA carries out regular assessments of health organisations in line with the counter fraud standards.

2.3 Fraud[3]

The Fraud Act 2006 introduced an entirely new way of investigating and prosecuting fraud, which can relate to money, property or other benefits of value. Previously, the

word ‘fraud’ was an umbrella term used to cover a variety of criminal offences falling under various legislative acts. It is no longer necessary to prove that a person has been deceived, or for a fraud to be successful. The focus is now on the dishonest behaviour of the suspect and their intent to make a gain either for themselves or another; to cause a loss to another; or, expose another to a risk of a loss.

There are several specific offences under the Fraud Act 2006; however, there are three primary ways in which it can be committed that are likely to be investigated by the AFS;

The offence of fraud can be committed in three ways:

- **Fraud by false representation (s.2)** – lying about something using any means, e.g. falsifying a CV or NHS job application form

- **Fraud by failing to disclose (s.3)** – not saying something when you have a legal duty to do so, e.g. failing to declare a conviction, disqualification or commercial interest when such information may have an impact on your NHS role, duties or obligation and where you are required to declare such information as part of a legal commitment to do so.

- **Fraud by abuse of a position of trust (s.4)** – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation, e.g. a carer abusing their access to patients monies, or an employee using commercially confidential NHS information to make a personal gain.

It should be noted that all offences under the Fraud Act 2006 occur where the act or omission is committed dishonestly and with intent to cause gain or loss. The gain or loss does not have to succeed, so long as the intent is there. Successful prosecutions under the Fraud Act 2006 may result in an unlimited fine and/or a potential custodial sentence of up to 10 years.

The Economic Crime and Corporate Transparency Act 2023 (ECCTA 2023) includes a new corporate fraud offence of ‘failure to prevent fraud’[1] which came into force on 1st September 2025.

This fraud is where someone connected with the organisation (what the Act calls an ‘associated person’) commits a fraud offence that intentionally benefits the Trust, or a related body, rather than just the individual, and where the Trust should have had procedures in place to prevent it happening. If this offence occurs, the health body can be prosecuted.

The offence applies to large organisations (which includes NHS organisations), and all those ‘associated persons’ conducting work on their behalf. ‘Associated persons’

includes employees of all levels and volunteers, but can also include contractors, subsidiaries, agents and other service providers or partner organisations.

Successful prosecutions under the 'failure to prevent fraud' section of the ECCTA 2023 may result in an unlimited fine to the organisation. In addition to this there may be associated reputational damage to the Trust as well as operational disruption and other sanctions against those who committed the fraud or allowed it to happen through their actions or inactions.

The 'benefit' to the Trust has not been defined, but is not limited to a purely financial benefit, and the benefit does not have to materialise; the intention is sufficient.

An example of this kind of fraud may be where a Trust manager liaises with an established recruitment agency to ensure that additional staff are available to meet demands; standard recruitment controls are intentionally ignored to ensure sufficient resources can be provided.

All organisations can prevent prosecution if they have 'reasonable procedures' in place, which are intended to make people aware of their responsibilities and mitigate the risk of someone committing the offence on behalf of the organisation. These procedures are supported by the work of the Anti-Fraud Specialist, who can provide further information.

The failure to prevent fraud offence | Failure to prevent | NHSCFA

2.4 Bribery and Corruption[4]

The Trust adopts a 'zero tolerance' attitude towards bribery and does not, and will not, pay or accept bribes or offers of inducement to or from anyone, for any purpose.

The Trust is fully committed to the objective of preventing bribery and will ensure that adequate procedures, which are proportionate to our risks, are in place to prevent bribery.

The Bribery Act 2010 reformed the criminal law of bribery, making it a criminal offence to:

- Give, promise or offer a bribe (s.1), and/or
- Request, agree to receive or accept a bribe (s.2).

Corruption is generally considered to be an "umbrella" term covering such various activities as bribery, corrupt preferential treatment, kickbacks, cronyism, theft or

embezzlement. Under the 2010 Act, however, bribery is now a series of specific offences.

Generally, bribery is defined as: ***an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage.***

Examples of bribery in an NHS context could be a contractor attempting to influence a procurement decision-maker by giving them an extra benefit or gift as part of a tender exercise; or, a medical or pharmaceutical company providing holidays or other excessive hospitality to a clinician in order to influence them to persuade their Trust to purchase that company's particular clinical supplies.

A bribe does not have to be in cash; it may be the awarding of a contract, the provision of gifts, hospitality, sponsorship, the promise of work or some other benefit. The persons making and receiving the bribe may be acting on behalf of others – under the Bribery Act 2010, all parties involved may be prosecuted for a bribery offence.

All staff are reminded to ensure that they are transparent in respect of recording any gifts, hospitality or sponsorship and they should refer to the separate Trust's policy, the 'Conflict of Interest Policy' covering:

- Acceptance of Gifts and Hospitality
- Declaration of Interests
- Sponsorship

The Bribery Act 2010 applies to (and can be triggered by) everyone "associated" with this Trust who performs services for us, or on our behalf, or who provides us with goods. This includes those who work for and with us, such as employees, agents, subsidiaries, contractors and suppliers (regardless of whether they are incorporated or not). The term 'associated persons' has an intentionally wide interpretation under the Bribery Act 2010.

Sanctions, following a successful prosecution, are similar to those of the Fraud Act 2006.

3 Roles and Responsibilities

Through our day-to-day work, we, i.e. all staff, are in the best position to recognise any specific risks within our own areas of responsibility. We also have a duty to ensure that those risks – however large or small – are identified and eliminated. Where you believe the opportunity for fraud, corruption or bribery exists, whether

because of poor procedures or oversight, you should report it to the AFS or the NHS Fraud and Corruption Reporting Line and/or online Fraud Reporting Form.

This section states the roles and responsibilities of employees and other relevant parties in reporting fraud or corruption.

3.1 Chief Executive Officer

The Trust's Chief Executive Officer, as the organisations accountable officer, has overall responsibility for securing funds, assets and resources entrusted to it, including instances of fraud, bribery and corruption.

The Chief Executive Officer must ensure adequate policies and procedures are in place to protect the organisation and the public funds it receives. However, responsibility for the operation and maintenance of controls falls directly to line managers and requires the involvement of all of Trust employees. The Trust therefore has a duty to ensure employees who are involved in or who are managing internal control systems receive adequate training and support in order to carry out their responsibilities. Therefore, the Chief Executive and Chief Finance Officer/Chief Finance Officer will monitor and ensure compliance with this policy.

3.2 Board of Directors

The Trust's Board has a duty to provide adequate governance and oversight of the Trust to ensure that it's funds, people and assets are adequately protected against criminal activity, including fraud, bribery and corruption.

The Board provides clear and demonstrable support and strategic direction for counter fraud, bribery and corruption work. They review the proactive management, control and the evaluation of counter fraud, bribery and corruption work. The Board and non-executive directors scrutinise NHSCFA assessment reports, where applicable, and ensure that the recommendations are fully actioned.

3.3 Chief Finance Officer

The Chief Finance Officer (DoF) has the power to approve financial transactions initiated by directorates across the organisation.

They prepare, document and maintain detailed financial procedures and systems and apply the principles of separation of duties and internal checks to supplement those procedures and systems.

The DoF will report annually to the Board on the adequacy of internal financial controls and risk management as part of the Board's overall responsibility to prepare a statement of internal control for inclusion in the annual report.

They also act as the Executive Lead for the organisation's counter fraud arrangements, liaising closely with the Anti-Fraud Specialist.

The DoF will, depending on the outcome of initial investigations, inform appropriate senior management of suspected cases of fraud, bribery and corruption, especially in cases where the loss may be above an agreed limit or where the incident may lead to adverse publicity.

3.4 Audit and Risk Assurance Committee

The role of the Audit and Risk Assurance Committee is in reviewing, approving and monitoring counter fraud workplans, receiving regular updates on counter fraud activity, monitoring the implementation of action plans, providing direct access and liaison with those responsible for counter fraud, reviewing annual reports on counter fraud, and discuss NHSCFA quality assessment reports[5].

3.5 Internal and External Audit

The role of internal and external audit includes reviewing controls and systems and ensuring compliance with financial instructions. They have a duty to pass on any suspicions of fraud, bribery or corruption to the Anti-Fraud Specialist (AFS).

3.6 Human Resources

Human Resources (HR) plays a role in relation to employees in suspected cases of fraud, bribery and corruption, including liaison with the AFS and the conduct of any investigation, and instigating the necessary disciplinary action against those who fail to comply with the policies, procedures and processes. HR work with the AFS to ensure that appropriate parallel sanctions are applied (in accordance with the NHSCFA Anti-Fraud Manual) where fraud, bribery or corruption is proven against employees'. Appropriate joint working protocols exist to detail this relationship.

3.7 Anti-Fraud Specialist (AFS)

The AFS is responsible for taking forward all anti-fraud work locally in accordance with the national functional counter fraud standards (NHS requirements), as well as the NHS Counter Fraud Strategy, and reports directly to the Chief Finance Officer.

Adhering to NHSCFA functional counter fraud standards (NHS requirements) is important in ensuring that the organisation has appropriate counter fraud, bribery and corruption arrangements in place and that the AFS will look to achieve the highest standards possible in their work.

The AFS will work with key colleagues and stakeholders to promote counter fraud work, apply effective preventative measures and investigate allegations of fraud and corruption.

The AFS will conduct risk assessments in relation to their work to prevent fraud, bribery and corruption.

The AFS has responsibility for investigating any allegations of fraud and corruption within the organisation.

3.8 Fraud Champion

Where a Fraud Champion has been appointed, their role and duties include:

- Promoting awareness of fraud, bribery and corruption within the organisation,
- Understanding the threat posed by fraud, bribery and corruption and,
- Understanding best practice on counter fraud.

They do not have any remit to investigate allegations of fraud or corruption.

3.9 Freedom to Speak-Up Guardians ('Whistleblowing')

Speak-Up Guardian has a responsibility to report allegations they receive relating to fraud or corruption against the organisation to the AFS (whilst protecting the identity of the referrer, if necessary).

3.10 Managers

All managers are responsible for ensuring that policies, procedures and processes within their local area are adhered to and kept under constant review.

Managers have a responsibility to ensure that staff are aware of fraud, bribery and corruption and understand the importance of protecting the organisation from it. Managers will also be responsible for the enforcement of disciplinary action for staff who do not comply with policies, procedures and processes.

Managers should report any instances of actual or suspected fraud, bribery or corruption brought to their attention to the AFS immediately. It is important that managers do not investigate any suspected financial crimes themselves.

Other responsibilities managers have included conducting risk assessments and mitigating identified risks.

3.11 All Employees

Employees are required to comply with the organisation's policies, procedures and processes and apply best practice in order to prevent fraud, bribery and corruption (for example in the areas of procurement, personal expenses and ethical business behaviour). Staff should be aware of their own responsibilities in accordance with the organisation's standards of behaviour and in protecting the organisation from these crimes.

Employees who are involved in or manage internal control systems should be adequately trained and supported in order to carry out their responsibilities.

If an employee suspects that fraud, bribery or corruption has taken place, they should ensure it is reported to the AFS and/or to NHSCFA as explained below.

3.12 Information Management and Technology

The Head of Information Security (or equivalent) will contact the AFS immediately in all cases where there is suspicion that Trust ICT (Information and Communications Technology) is being used for fraudulent purposes in accordance with the Computer Misuse Act 1990. Similarly, the Head of Information Security or equivalent will liaise closely with the AFS to ensure that a subject's access (both physical and electronic) to Trust ICT resources is suspended or removed where an investigation identifies that it is appropriate to do so.

4 The Response Plan

4.1 Bribery and Corruption

The AFS undertakes an annual fraud and bribery risk assessment, in conjunction with the organisation conducting periodic assessments (in line with Ministry of Justice guidance[6]) to assess how bribery and corruption may affect it. Proportionate procedures and measures have been put in place to mitigate identified risks.

The organisation also has a policy and procedure in place in relation to the completion of declarations of interest, declarations of secondary employment and the hospitality/gifts register. The relevant policy and procedures are accessible via the Trust's intranet policies page, and staff are required to comply with these arrangements. Instances of non-compliance may be referred to the AFS for further investigation.

The AFS has primary organisational responsibility for investigating allegations of fraud and corruption against or with the organisation.

4.2. Reporting Fraud, Bribery or Corruption

This section outlines the action to be taken if fraud, corruption or bribery is discovered or suspected.

All genuine suspicions of fraud, bribery and corruption must be reported directly to the Trust's AFS' – darrell.davies@miaa.nhs.uk (07785 286381) or paul.kay@miaa.nhs.uk (07990 082328)

If the referrer believes that the Chief Finance Officer or AFS is implicated, they should notify whichever party is not believed to be involved who will then inform the Chief Executive and Audit and Risk Assurance Committee Chairperson.

An employee can contact any executive or non-executive director of the Trust to discuss their concerns if they feel unable, for any reason, to report the matter to the AFS or Chief Finance Officer.

Details of a suspected fraud, bribery and corruption may also be reported through the **NHS Fraud and Corruption Reporting Line** on **Freephone 0800 028 40 60**, (powered by 'Crimestoppers 24/7') or online at **https://cfa.nhs.uk/reportfraud**, in addition to the AFS or the organisation's Chief Finance Officer.

The AFS and/or NHSCFA will undertake an investigation and seek to apply criminal and civil sanctions, where appropriate. Any investigation would follow set investigative procedures.

Investigations may also include police involvement, where appropriate.

All NHS bodies including private providers, commissioners and trusts refer to the Home Office's bribery and corruption assessment template[7] in order to assess their response to bribery and corruption.

Whistleblowing

Concerns regarding fraud, bribery or corruption may also be reported to the Trust via the Freedom to Speak Up Guardian ("Whistleblowing"), in accordance with the Trust's Freedom to Speak Up: Raising Concerns policy.

4.3 Disciplinary Action

Disciplinary procedures, in the context of fraud allegations, will be initiated where an employee is suspected of being directly involved in a fraudulent or illegal act, or where their negligent action has led to a fraud being perpetrated. The Disciplinary Policy (W7) can be located on the Trust's intranet policies page.

4.4 Sanctions and Redress

This section outlines the sanctions that can be applied and the redress that can be sought against individuals who commit fraud, bribery and corruption against the organisation.

The Trust's approach to pursuing sanctions in cases of fraud, bribery and corruption is that the full range of possible sanctions – including criminal, civil, disciplinary and regulatory – should be considered at the earliest opportunity and any or all of these may be pursued where and when appropriate. The consistent use of an appropriate combination of investigative processes in each case demonstrates this organisation's commitment to take fraud, bribery and corruption seriously and ultimately contributes to the deterrence and prevention of such actions.

Briefly, the types of sanction which the organisation may apply when a financial offence has occurred include:

Civil – civil sanctions can be taken against those who commit fraud, bribery and corruption to recover money and/or assets which have been fraudulently obtained, including interest and costs.

Criminal – The AFS will work in partnership with NHSCFA, the police and/or the Crown Prosecution Service to bring a case to court against an alleged offender. Outcomes can range from a criminal conviction to fines and imprisonment.

Disciplinary – Disciplinary procedures will be initiated where an employee is suspected of being involved in a fraudulent or illegal act, as per Section 4.3 of this policy.

Professional Body Disciplinary – If warranted, staff may be reported to their professional body as a result of a successful investigation/prosecution.

The organisation will seek financial redress whenever possible to recover losses to fraud, bribery and corruption. Redress can take the form of confiscation and compensation orders, a civil order for repayment, or a local agreement between the organisation and the offender to repay monies lost.

5 Review

5.1 Monitoring and auditing of policy effectiveness

Monitoring is essential to ensuring that controls are appropriate and robust enough to prevent or reduce fraud. Monitoring arrangements include reviewing system controls on an ongoing basis and identifying weaknesses in processes.

Where deficiencies are identified as a result of monitoring, appropriate recommendations and action plans are developed and implemented.

See **Appendix A**.

5.2 Dissemination of the policy and Training

This policy will be brought to the attention of all employees and will form part of the induction process for new staff.

This policy will be disseminated Trust-wide for all employees to understand and be made aware of via awareness presentations, the Trust's Staff Bulletin and on the Trust's Anti-Fraud intranet and internet pages.

It is important that staff understand and are aware of this policy.

5.3 Review of the policy

The AFS will periodically review the policy, and at least every three years, to ensure that it reflects the latest guidance from NHS CFA.

The AFS will also ensure that any organisational changes are reflected in updated versions of this policy.

Useful Links

1 NHS fraud: Organisational strategy 2020-2023 https://cfa.nhs.uk/about-nhscfa/corporate-publications

2 Government Functional Standard 013: Counter Fraud https://cfa.nhs.uk/counter-fraud-standards

3 Fraud Act 2006 1-4 https://www.legislation.gov.uk/ukpga/2006/35/contents

4 Bribery Act 2010 https://www.legislation.gov.uk/ukpga/2010/23/contents

5 The NHS Audit Committee Handbook 2018 https://www.hfma.org.uk/publications?Type=Guide

6 Ministry of Justice Guidance to the Bribery Act 2010 https://www.justice.gov.uk/downloads/legislation/bribery-act-2010-guidance.pdf

7 Home Office Bribery and corruption assessment template https://www.gov.uk/government/publications/bribery-and-corruption-assessment-template

Appendix A – monitoring matrix

Monitoring	Lead	Reported to/Committee	Process	Frequency
Number of instances of suspected fraud, bribery or corruption	Local Counter Fraud Specialist (LCFS)	Chief Finance Officer / Audit and Risk Assurance Committee.	LCFS referrals included in regular LCFS updates. Year on year trends included in LCFS annual report.	Quarterly Annually
Number of proven cases of fraud, bribery or corruption	Local Counter Fraud Specialist	Chief Finance Officer / Audit and Risk Assurance Committee.	Actual fraud, bribery or corruption cases included in the regular LCFS updates.	Quarterly
Attendance at counter fraud, bribery or corruption training sessions	Local Counter Fraud Specialist	Chief Finance Officer / Audit and Risk Assurance Committee.	Number of training sessions run, and numbers of staff and board members attending are in included in the LCFS annual report.	Annually
Meet criteria set by NHS Counter Fraud Authority	Local Counter Fraud Specialist	Chief Finance Officer / Audit and Risk Assurance Committee	Agree annual work plan for counter fraud to meet the criteria set out by NHS Counter Fraud Authority. This will include a progress report on implementation of the plan.	Annually